

How can medical schools encourage students to choose general practice as a career? *Br J Gen Pract* 2016; DOI: 10.3399/bjgp16X685297. <http://bjgp.org/content/66/647/292>.

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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

get to help us identify who's more at risk than the next person.

QOF encouraged us to identify chronic kidney disease (CKD), and now overburdened by its commonness, we are at risk of throwing away all we have achieved. Few diagnoses are predictably associated with such a dramatic increase in cardiovascular risk and none are so easily identified by a cheap and easily available blood test.^{2,3} The clustering of vascular pathologies with diabetes and hypertension makes this burden of disease the greatest challenge for the next generation of patients and doctors.

We investigated the reassurance given by NICE, that the previous decade's CKD QOF initiative had improved the identification and management of CKD. In a practice population of 10 264, 9% of adults aged ≥18 years had a diagnosis of CKD on repeated testing. Despite this remarkable prevalence (usual estimates 3–6%), a total of 75% of these patients with CKD were unaware of the diagnosis, and in more than 25% both GP and patients were unaware of the condition. The results demonstrated that this lack of awareness was not limited to those with mild renal compromise but applied to one-third of patients with CKD stage 4. Our short intervention, either by phone or letter, significantly improved attainment of NICE (health indicator and education) criteria but also identified the continued confusion between CKD and lower urinary tract symptoms.

It's time to remember why we estimated renal function in the first place. In a world of uncertainty, this is information for free. When associated with hypertension, diabetes, proteinuria, and vascular disease — pause — look again and feel confident that CKD means something. The lower the number the higher the risk.^{2,3}

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Interpretation of electrocardiograms in primary care

The recently published article by Begg and colleagues, 'Electrocardiogram interpretation and arrhythmia management: a primary and secondary care survey',¹ found that within primary care there was substantial error in the interpretation of electrocardiograms (ECGs) by healthcare professionals (HCPs), predominately comprising GPs, than secondary care cardiologists. Moreover, one-third of HCPs felt uncomfortable with interpreting ECGs. Begg and colleagues discuss the implications of unsafe ECG analysis and the wider impact on clinical practice. One proposed solution to this may be analysis of ECGs remotely by secondary care specialists.¹

Another recent survey determined the views of HCPs in primary care about screening for atrial fibrillation (AF).² There were similar findings between both surveys such as access to and interpretation of ECGs within practices. Taggar and colleagues also reported enthusiasm by GPs and nurses to up-skill in ECG interpretation.² These findings suggest that alternative models to improve accuracy of ECG interpretation warrant consideration, such as the development of validated, evidence-based ECG training programmes for primary care HCPs. The model suggested by Begg and colleagues could still be delivered within primary care using the hub and spoke/confederated working, with hub practices having the role of up-skilled ECG interpretation.

To minimise the increased burden on existing resources within primary or secondary care there is the potential to triage ECGs, referring only ECGs that are identified as abnormal. A systematic review compared the accuracy of different methods for interpreting 12-lead ECGs for AF diagnosis.³ Compared with ECGs interpreted

by trained cardiac specialists, automated software analysis had greater specificity for AF diagnosis than other HCPs.³ Automated software therefore has the potential to be used as a triage tool to correctly identify normal ECGs that do not require further analysis; ECGs identified as abnormal would warrant further interpretation by a trained professional.

There is growing evidence suggesting that skills of primary care HCPs for interpreting 12-lead ECGs needs improving; there are a number of approaches to achieve this that warrant further investigation and evaluation.

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Correction

In June 2016 Research by Prins A, Hemke F, Pols J, Moll van Charante EP. Diagnosing dementia in Dutch general practice: a qualitative study of GPs' practices and views. *Br J Gen Pract* 2016; DOI: 10.3399/bjgp16X685237, the authors' affiliations were shown incorrectly, and should have been: A Prins, MD, GP, Department of General Practice, Academic Medical Center, University of Amsterdam; F Hemke, MD, GP trainee, Department of General Practice, Academic Medical Center, University of Amsterdam; EP Moll van Charante, MD, PhD, senior researcher, Department of General Practice, Academic Medical Center, University of Amsterdam, Amsterdam, the Netherlands. J Pols, PhD, Socrates professor, Department of Anthropology, University of Amsterdam and associate professor, Section of Medical Ethics, Department of General Practice, Academic Medical Centre, University of Amsterdam, Amsterdam, The Netherlands. The online version has been corrected. We apologise for this error. DOI: 10.3399/bjgp16X686305