Radical Muslim doctors and what they mean for the NHS

PERSONAL VIEW **Irfan Al-Alawi, Stephen Schwartz**

ALISTAIR ROBERTSON/PAWIRE/PA PHOTOS

Shockwave: bomb attempt in Glasgow last year

The disclosure that the leading alleged conspirators in last year's bombing attempts in London and Glasgow were Muslim doctors sent a shockwave through the worldwide non-Muslim public. The same question was asked everywhere: how can those who are trained to heal turn to terrorism?

Our organisation, the Centre for Islamic Pluralism, has compiled a report, *Scientific Training and Radical Islam*, which we were preparing when the London and Glasgow events occurred. The report is now complete and available as a free download at www.islamicpluralism.eu. It is a distillation of field research, interpretation of major source materials in Arabic, Farsi, Urdu, and English, and collation of individual perspectives from a team of Muslim researchers. All members of the team are experienced in the observation of Islamist movements throughout the world. The report offers answers to the questions asked by personnel in the NHS, which employed three of the suspects in the London and Glasgow incidents. Firstly, did the doctors who were alleged to have been involved in such a conspiracy represent a freak phenomenon, marginal and uncharacteristic of Muslim medical staff? And secondly, were they radicalised before or after coming to Britain?

Our replies to both questions, based on our observations, are discomfiting. Many Muslim doctors, in Muslim and non-Muslim countries, have embraced the extremist doctrines of the Muslim Brotherhood, the Saudi Wahhabis, and the Pakistani jihadists. Such trends are also filtered through such groups as al-Muhajiroun, now banned in the United Kingdom but which recruited medical students, and Tabligh-i Jama'at, an Islamist movement that is particularly prominent in the UK. Also, radicalisation of elite professionals is more a product of conflict within Islam itself than of social conditions in Britain. But the problem is not one of religion; rather, it is ideological.

Most of the world's Muslims, including doctors, are neither fundamentalists nor followers of radical sharia and do not become tainted with Islamist prejudices. But our report suggests that many Muslim doctors and other professionals are attracted to an ideology that projects a solution to all human problems in a fundamentalist interpretation of Islam, along with a demand for exclusive governance that is based on the radical Wahhabi and related forms of religious law or sharia.

Medical and other professionals represent an elite in Muslim societies and have become an important component in the intra-Islamic "jihad" to impose an ultra-militant outlook on more than a billion Sunni Muslims across the globe. Such professionals have a moral and social standing that can influence others to stray from mainstream Islam, which sees itself as one faith among many. Furthermore, some Muslim doctors working in non-Muslim countries may bring from their native environments a propensity for radical ideology. In Muslim societies the physician is often seen as something very like a religious scholar—just as clerics are often consulted for physical ailments. Medical education, even if conducted in Western institutions, may not break down belief in this paradigm.

Indeed, the ordinary Muslim may consider the successful Muslim doctor to be superior to the mainstream cleric, and the radical Islamist doctor may easily usurp religious authority from a traditional imam. This disturbing phenomenon is visibly growing. A member of our centre, Khaleel Mohammed, has noted that in the Muslim diaspora in the English speaking countries "Muslim leaders have not traditionally been chosen for their Islamic knowledge but for their stature in society—a medical doctor, a computer scientist."

The role of Muslim doctors in taking extremist ideology to the Islamic masses has been well expressed by Mahmoud Abu Saud, an Islamist author active in several countries. He wrote, "The doctor has a big say and great weight in influencing his patients and in righteously guiding their orientation. Besides, he should be actively involved in propagating true Islam among Muslims and non-Muslims . . . the best missionary service to be rendered by a medical doctor is to behave at the time in accordance with his Islamic teachings."

Abu Saud offered these comments in his contribution to one of the most revealing sources on this topic, a volume titled *Islamic Medicine*, edited by Shahid Athar and published in Pakistan in 1989. Dr Athar is an endocrinologist. His work reflects an attitude also seen in the Islamic Code of Medical Ethics, published by the International Organization of Islamic Medicine in 1981, which states: "The Physician should be in possession of a threshold knowledge of jurisprudence, worship and essentials of Fiqh [Islamic religious law], enabling him to give counsel to patients seeking his guidance about health and body conditions, with a bearing on the rites of worship."

In an aspect of the problem that is little known or understood by Westerners, the version of Islam presented by radicals as "modern" and in keeping with the social status of the medical professional is one that is stripped of tradition and spirituality.

How, then, may medical professionals and the government in the UK, and the West in general, respond to this challenge? The Islamic Medical Association estimates that about 10 000 Muslim doctors and nurses practise in the UK. Vetting of Muslim doctors for radicalism may prove ineffective and will doubtless create a civil liberties problem. It is more important for the UK authorities to monitor closely the activities of radical Islamist groups and to act decisively against those that legitimise or incite violence. Most important of all is to strengthen the authentic and proved anti-extremist trends in the Muslim communities themselves. To that end, we call for the organisation of new professional associations of traditional and moderate Muslim medical personnel, engineers, and lawyers, to repudiate extremist ideology.

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Competing interests: The Centre for Islamic Pluralism is a transnational think tank supporting Islamic intellectual and spiritual alternatives to extremism. It is a public charity financed by private donations.

A longer version of this article is on bmj.com

"We doctors are now so fearful of criticism and complaints that we are no longer able to be honest in consultations, assessments, reports, or referrals"
Des Spence p 836

REVIEW OF THE WEEK

Are doctors heartless about death?

Do doctors neglect death and the dying, choosing instead to focus on flogging the last bit of life back into patients? **Jerome P Kassirer** looks at a new book on the subject

The litany of charges against American doctors is familiar. In our zeal to defeat disease we go too far. We don't know when to give up, and consequently we lose sight of our fundamental responsibility, namely the best interest of our patients. We put people through too many tests. We treat their diseases long after the chance of cure has dissipated. And when the end nears, we avoid or abandon them. We don't talk to them about options at the end of life. We don't even use the word death.

Are doctors truly that heartless? Have the rigours of medical school, training, and practice inured us to suffering and sealed us off from our patients' real needs? Grievances such as these, however, often ignore the uncertainties of clinical medicine, the uniqueness of each patient, and the enormous differences in the personalities and nature of practitioners. Doctors don't want to overtest or overtreat. They don't want to end up flogging the last bit of life back into their dying patients. Yet to deny that we view our mission as one to fight disease is to abnegate centuries of scientific advances that gave us the tools to win some of the toughest battles.

Critics of excessive testing and treating to the very end often lose sight of the sequence in which clinical decisions are made. Doctors who make decisions for a sick patient regarding the need for an expensive scan, for example, weigh the benefits and risks of the test, including the downstream therapeutic implications of a positive or negative result. When the test turns out to be unhelpful it is easy for a critic to complain that the test shouldn't have been ordered in the first place. When chemotherapy only makes a patient sicker and fails to affect a cancer, we regret having subjected the patient to the toxicity, but that doesn't make the decision wrong. When a sick patient appears to be slipping out of our hands we aggressively try to restore them to their functional status before their "crash." And when this sequence occurs repeatedly and ultimately fails, both we and the family may conceive of the sequence of tests and heroic treatments as "torture"—but if we had the opportunity to think through each decision again, would they be different? Not if each judgment was well considered and rational.

Our training, our professional oaths, and our mentors urge us to maintain hope, and sometimes we do try too hard. And when we do, it is not surprising that discussions of death never happen. Still, in the heat of the melange of intravenous fluids, catheters, pacemakers, and parenteral nutrition, we do need to pause more, switch gears, and reflect seriously on possible outcomes, discuss options with patients and families, and help ease those who are at the end of life.

It is true—perhaps out of neglect, lack of training, or lack of sympathy—that in years past doctors fell short, but many of today's older practitioners gained their experience with patients at a time when "cancer" was a term seldom uttered and "death" was a recondite noun. For the most part, we've gotten past these proscriptions, and many physicians face the inevitable squarely with their patients. Yet the pace of the modern hospital—with specialists coming and going, and house staff on short shifts—often makes it impossible to know the patient and the family well and hard to know who has responsibility for such decisions and discussions.

However, says Chen, our neglect of death and dying has other origins. Chen, a young transplant surgeon who has given up practice to write, attributes doctors' reticence in dealing with their patients' deaths to uneasy feelings of their own mortality; and throughout the story of her professional life her patients' deaths seem to have profoundly affected her view of her professional role and her perception of the profession. She attributes her progressive ennui, for example, to her inadequacy to deal with the illness of one of her close relatives, and in a revealing introspection she confesses that she was constantly terrified that she might make an error that would kill a patient. A close reading makes me wonder whether death and dying were the real reasons for her disenchantment. Throughout the descriptions of her professional experiences, even during medical school, she says she found the work arduous, provoking anxiety and anguish. She was irked and shaken by minor events, such as the revelation that some long venerated rituals were not evidence based. Maybe death, and the way the profession dealt with it, was the central reason for her anguish, or maybe not. Her message is ambiguous, her anguish at the work of becoming and being a doctor is evident, and her questionable assertion that physicians' view of their own mortality guides their approach to their patients' terminal illnesses made the story of her transitions less appealing.

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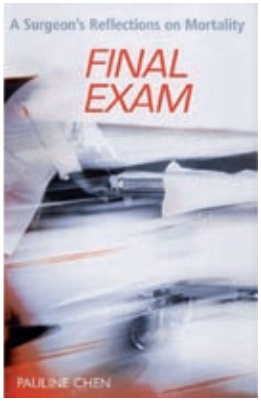

Final Exam: A Surgeon's Reflections on Mortality
Pauline Chen
Souvenir Press, pp 268, £15
ISBN 978 0285638112
Rating: ★★☆☆

Our training, our professional oaths, and our mentors urge us to maintain hope, and sometimes we do try too hard

Doublespeak

FROM THE FRONTLINE
Des Spence

"Lively" (disruptive), "independent" (selfish), "spirited" (appallingly spoilt), "enjoys maths" (no friends), "energetic at sport" (hopelessly uncoordinated), "special aptitude at art" (innumerate), "enjoys listening to music" (tone deaf), "a delight" (will never amount to anything), "making headway with reading" (stupid and slow)—welcome to the doublespeak of school report cards and the noxious "all positive" feedback.

Gone are the comments that spurred a generation. Our coffee stained report cards were at least honest. "Desmond would do much better if he occasionally listened." "Desmond's English would improve if he learnt to spell and occasionally used something we call punctuation." "Please provide Desmond with a gag next term." "Desmond is a clumsy boy." But now there is nothing worth hanging in your downstairs toilet to entertain your guests. Why has our society become so fake and lost the ability to be honest?

Many professional groups have suffered a succession of high profile inquiries, berated for perceived failings and accused of a catalogue of institutional "isms." The reaction of service directors has been to make their organisations ever more risk averse. But by introducing increasingly restrictive protocols, institutions are eroding the core values of professionalism: discretion and judgment. In turn power has shifted away from the professional to the client, the patient, the pupil, and even the pet. Some changes were of course overdue, much of the criticism justified—but we have gone too far. We have created a complaint economy with a hyperinflation in skewed and stupid feedback questionnaires and wads of bankrupt unrepresentative users groups.

We doctors are now so fearful of criticism and complaints that we are no longer able to be honest in consultations, assessments, reports, or referrals. This makes our job increasingly difficult. Being patient centred is important, but we struggle to challenge (even sensitively) people's lifestyles, parenting skills, behaviour—resulting in ever increasing medicalisation. In removing a sense of personal responsibility our society is in danger of decapitating our moral selves, leaving just a flailing corpse of entitlement, bleeding out the last of our self esteem.

Medicine isn't just another service industry, and the customer isn't always right. We don't need to return to the paternalism of the past, but for the sake of our patients we need to be able to be open and honest without the threat of unfounded complaints. We have the ability, but it may be too late; we should have done our homework, worked harder, and applied ourselves.

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Benchmarking the turf

OUTSIDE THE BOX
Trisha Greenhalgh

Many years ago, a small child was dropped to play at our house by a very snobby grandmother. As she left, she asked, "You're not going to take him across to that park, are you? I'd be happier if you kept him indoors. You see, this isn't what *I* would call a 'good area'."

It was true. The entire street was (at the time) occupied by teachers, nurses, academics, and even—perish the thought—a police officer and his wife. We sent our kids to the local state schools, and got our health care on the NHS. The only church within walking distance was Methodist; the synagogue was "reformed"; and both were overshadowed by the splendid local mosque. I could well see why my visitor wanted the infant prince protected from all this.

The area has moved on considerably, as London's house prices have outstripped even private sector salaries. Our neighbours now include merchant bankers, commercial lawyers, and someone with a (secondhand) Porsche. But is it actually a "better area"? And how would you benchmark yours?

If ego surfing is looking for references to oneself on Google, then we need a term for the practice of seeking objective indicators of the worth of one's locality. In the old days "deprivation" (and whatever you choose to call its opposite) were measured crudely, by assessing (for example) average number of occupants per room, access to a car, or the proportion of children receiving free school meals.

These days, neighbourhood snobbery has become a sophisticated science, with a wealth of comparative indicators downloadable from the internet. Take a look at www.communityhealthprofiles.info, for example. The next time your daughter says she's got a new boyfriend who lives in OtherBorough, you'll be able to check out whether to allow her to visit him on public transport, under armed guard, or not at all.

My own patch scores a smidgeon better than the UK average for most indicators (proportion of children living in poverty, obesity levels) but does much better on some (teenage pregnancy, binge drinking, sick days due to a mental health problem) and worse on others (ecological footprint, tooth decay). If I stay here, I can expect to live 19 months longer than the average female citizen, and I'm only half as likely to get run over or mugged as someone in Birmingham. All of which adds up to an evidence based ditty: "Girls and boys come out to play, whatever Oliver's Gran may say."

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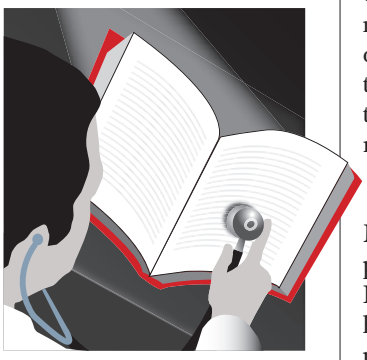
A touch of class

BETWEEN THE LINES

Theodore Dalrymple



The fundamental implausibility of *Cranford* is that anyone could be so misguided as to think a surgeon either vulgar or a social inferior

Genteel poverty, the subject of a great deal of English literature, is a thing of the past, not only because of the decline of gentility in general, but because the inflation of the 1960s and 1970s put paid to the very possibility of it once and for all. Now there are only lack of money and inability to buy what you want.

Cranford, still Mrs Gaskell's most popular book, is peopled by the genteel poor, almost all of them female. Of course, they are not really poor in the absolute sense, such as the industrial working classes of the time were. For example, all of Cranford's impoverished gentlefolk have at least one servant; and, as an American economist once said with more truth than delicacy, a single servant is worth a household full of appliances. As we have most of us learnt by experience, a rising income does not confer that greatest of all luxuries, time to call one's own. The women of Cranford were richly endowed with that luxurious luxury.

The surgeon at Cranford, who plays a large part in the story but never makes a personal appearance, is called Mr Hoggins. This name is in itself sufficient to disqualify him from moving in the best Cranford circles, for it is incompatible with refinement (indeed, it is rather difficult to imagine a romantic poet, say, or an orchestral conductor with such a name, though perhaps not a rugby forward).

As it happens, Mr Hoggins is described as a man of rather vulgar manner who has the temerity to marry Lady Glenmire, a misalliance that leads to a break in relations between the latter and her sister-in-law, the Honourable Mrs Jamieson.

Despite his vulgarity, however, Mr Hoggins is universally regarded as a competent medical man. But this (from our standpoint at the beginning of the 21st century) raises the interesting question: of what, exactly, did Mr Hoggins' competence consist? Refraining from harming as many people as his colleagues harmed? A country practitioner of the time would hardly have been able to cure anything.

The mystery deepens when we consider one of the medical incidents in the book. A travelling magician, who calls himself Signor Brunoni, but who is really named Brown, is injured in his horse-drawn vehicle, but does not break any bones. Signor Brunoni fails to improve until he is taken in hand by Mr Hoggins; and such was the reputation of the surgeon in the town that "when he said, that with care and attention [the Signor] might rally, we had no more fear for him."

And, indeed, the Signor really did rally, and rally fast, thanks to the surgeon's care. But what could the injury have been, and what the cure, that Mr Hoggins' intervention made all the difference? Try as I might, I can't think of anything that would answer this question.

Is it misguided to be so literal minded in reading fiction? Should one just suspend disbelief and accept the characters' estimate of Mr Hoggins' skill? Of course, the fundamental implausibility of *Cranford* is that anyone could be so misguided as to think a surgeon either vulgar or a social inferior.

Theodore Dalrymple is a writer and retired doctor

MEDICAL CLASSICS

A Treatise of the Rickets: Being a Disease Common to Children

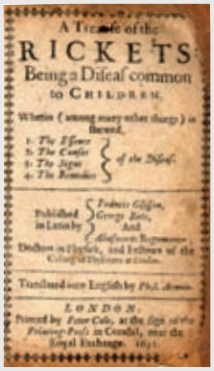
By Francis Glisson, George Bate, and Ahasuerus Regemorter

Translated into English by Philip Armin, 1651

When Glisson, Bate, and Regemorter studied rickets it was thought to be a new disease. Their joint work—a very early example of collaborative research—was published in 1650 under the title *De Rachitide, sive Morbo Puerili qui vulgo The Rickets dicitur* (*Concerning Rickets, or a disease of children which is commonly called the Rickets*) and was translated into English by Philip Armin the year after.

It described the clinical features of rickets: "The head bigger than ordinary, and the face fat and in good constitution in respect of other parts. About the joints, especially the Wrests and Ankles certain swellings are conspicuous. The articles and joynts, and the habits of all the external parts are less firm and rigid, and more flexible than at another time they are observed in dead bodies . . . the Brest, outwardly lean, and very narrow especially under the arms, and seemth on the side to be as it were, compressed, the [sternum] is somewhat pointed, like the keel of a ship or the breast of a hen. The top of the ribs to which the stern is conjoined with gristles [costal cartilages] are knotty."

The book has a lengthy discussion on why rickets is commoner in the south and west of England than in the north and in Scotland and suggests that the condition is rarely recognised there. Although this is rightly credited with being the first classic account of rickets, Daniel Whistler's inaugural dissertation about rickets for his degree was published in 1645. Whistler's work is much more concise but gives a similar clinical description of the disease. Whether Whistler plagiarised Glisson's work or whether Glisson drew on Whistler's thesis is much discussed. Neither author mentions the other's work.


A Treatise of the
RICKETS
Being a Disease common to CHILDREN.
LONDON,

Glisson—a well known medical eponym—was an important figure in medicine in the 17th century. A fellow at Cambridge and a lecturer in Greek, he turned to medicine in 1627. He was regius professor of medicine for more than 40 years, a president of the Royal College of Physicians, and one of the first fellows of the Royal Society.

Glisson also published *Anatomia Hepatis* (*The Anatomy of the Liver*) in 1654, a philosophical work on the nature of life in 1672, and *De Ventriculo et Intestinis* (*Concerning the Stomach and Intestines*) in 1677, the year of his death. He is buried in St Bride's church in London.

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