ethnic media, and places of worship. Survivors of myocardial infarction and those who have undergone successful coronary revascularisation should relay their experiences to members of their community. Failure to seek prompt medical advice and delays in diagnosis and treatment among ethnic groups often result from language difficulties,²⁶ and this issue also needs to be addressed.

General practitioners with a large proportion of patients from affected ethnic groups could set up "well Asian clinics" to identify subjects at high risk. Awareness of the risks could be increased by informing second generation Asians coming through the British educational system, who could convey the advice to their family and friends, as well as modify their own risk factors while young.

An effective campaign of primary prevention requires adequate central funding and planning. The Department of Health should consider issuing guidelines and highlighting targets for action. Dietary advice, particularly on restricting carbohydrates, needs to be sensitive. The food industry has a part to play by altering the fat content of food (for example, more monosaturates and n-3 fatty acids) and generally by promoting healthier, lower energy, and yet palatable products. Encouraging Asians to increase regular

physical activity may be worth while and should be evaluated.

Unless something is done to reduce the risk of heart disease in the Asian population in Britain all indicators suggest that the problem will increase.⁵ Data from Leicester indicate that, by 2008, half its Asian population will be over 50 and, if their risk of coronary death remains 1.4 times that of the rest of the population the number of deaths from coronary heart disease will double.²⁷ In other places with large Asian communities this will have a considerable impact on acute medical services. Spending now would make more medical and economic sense than paying later.

SANDEEP GUPTA

British Heart Foundation junior research fellow in cardiology
Department of Cardiological Sciences,
St George's Hospital Medical School,
London SW17 0RE

ADAM de BELDER

Senior registrar in cardiology

LIAM O HUGHES

Consultant cardiologist

King's Healthcare Trust,
London SE5 9RS

Norfolk and Norwich Healthcare Trust,
Norwich NR1 3SR

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European general practice

A new academic body should advance its interests

See p 1043

Europe has a new academic body for general practice. Meeting in the Hemicycle of the European parliament in Strasbourg earlier this month, representatives of colleges and academic societies from 27 countries agreed to establish the World Organisation of Family Doctors (WONCA) Region Europe—European Society of General Practice/Family Medicine. For historical reasons loyalties in Europe had become divided between two international organisations—the Societas Internationalis Medicinæ Generalis and the World Organisation of Family Doctors. The Societas Internationalis Medicinæ Generalis was founded by an Austrian general practitioner in 1959 and extended its membership from the German speaking parts of central Europe to include 23 countries. The World Organisation of Family Doctors was founded in 1972. Initially dominated by Anglophone

countries, it became more international than the societies and included countries in the Americas and Asia-Pacific region.

Recently, most European countries have joined the World Organisation of Family Doctors and its European regional activities have increasingly conflicted with those of the societies. Responding to a general desire for rationalisation among the colleges, many of which were contributing to both organisations, the societies convened a meeting of all interested parties in Lenzburg, Switzerland, in 1993. A working group was established which soon included three other informal academic networks whose activities were also supported by National colleges and associations: the European Academy of Teachers in General Practice, the European General Practice Research Workshop, and the European Quality Assurance Working Party.

It was decided that the core activities of a new academic body—education, research, and quality assurance—should be delegated to the network groups. The *European Journal of General Practice* was launched last January to act both as a journal of record and as a means of informing general practitioners throughout Europe of the growing number of workshops, courses, projects, and other developments of academic interest. Members of the *societas* were satisfied that these arrangements would continue their objectives and traditions and voted to dissolve it before the inauguration of the new body.

The new society aims to maintain and encourage high standards of general practice (which in some countries is called family medicine). It will promote general practice as a special discipline in Europe education, research, quality assurance, and publication. Annual European conferences are planned for Stockholm next July and Prague a year later. Dublin will host the next world conference, in 1998.

Europe has widely varying health care systems, medical school curriculums, and training programmes. Universal coverage, access to specialists, list systems and list sizes, the composition and distribution of the medical workforce, and level of spending differ throughout the region (which includes 11 former communist countries). The new society will encourage its strongest member colleges and associations to continue their efforts in support of colleagues struggling to establish the discipline in their countries, always respecting the right of each country to find solutions that accord with traditions and culture. It will use examples of “best practice”

in one country to press for change in another. In particular it will stimulate the development of effective colleges and academic associations embracing a majority of practising family doctors in all European countries. It will also encourage direct membership of the society by individual doctors.

The new society will represent academic general practice in Europe on all issues relating to standards of practice. Although lacking a statutory position within the European Union, its role in Europe will mirror that of its member colleges and associations at national level. It will concern itself with all decisions and policies affecting the standards of clinical practice and will represent the views of members to policymakers. It will seek to change the balance between primary care generalists and specialists in systems of health care and medical education. It will complement the European Union of Practitioners, the political voice of general practice. The union has successfully advanced academic general practice, notably in the continuing development of European Union directives on specific training, and an alliance between the two organisations would strengthen and widen their effectiveness. But the interests of the academic discipline and those of doctors will not always coincide, which is why separate representation is essential.

MICHAEL BOLAND

National director of continuing education

Irish College of General Practitioners,
Corrigan House,
Dublin 2,
Republic of Ireland

Creating new criminals

Locking up juvenile offenders is more likely to result in them reoffending

At its conference last week, the Conservative party announced plans for a new “get tough” policy of longer and harsher prison sentences for persistent and violent offenders. The British government is also planning to impose strict new regimes on juvenile offenders, looking to the “glasshouses” of British military prisons for inspiration.¹ The issue of locking up children and young people is nothing new. Parkhurst Prison for Boys was established in 1838 mainly as a consequence of the “moral panic” about juvenile gangs destroying property.^{2,3} Whether there was in fact an upsurge in juvenile crime is not known, but a perception that there was led to a drive to protect juveniles both from themselves and from contamination by professional criminals. The same pressures are at work today.

The interpretation of juvenile law breaking as posing a serious threat to social order has not really changed over the past 150 years. The British press has championed the right of victims to be protected from what is portrayed as a new breed of juvenile criminal,⁴ and public outcry against foreign trips designed to act as character building exercises for young offenders has increased the pressure to detain young offenders. Yet in the 1980s considerable expertise was developed in the United Kingdom in providing community based programmes for young offenders. These produced a fall of over 75% in the number of juveniles receiving custodial sentences. A U turn in government policy in the 1980s led to renewed enthusiasm to lock up juveniles. This oscillation in public opinion is not new and is well reflected in the development of legislation governing the treatment of young offenders.

The first secure institution designed specifically for young

offenders was set up at Borstal in Kent as a result of the Prevention of Crime Act 1908. In 1933 the Children and Young Persons Act saw the introduction of a new philosophy into the courts to conflict with the traditional one of criminal justice. The act directed magistrates to take primary account of the welfare of the child and set a concern for the needs of the individual child against the concept of full criminal responsibility. Nevertheless, young offenders were still seen foremost as criminals, and despite a wide range of sentencing options, from fines and discharge to imprisonment, the courts still tended to impose sentences similar to those meted out to adults.

In 1964 the Longford report emphasised that delinquents were a product of their society and of the deficiencies in its provision for them.⁵ Out of this arose the 1969 Children and Young Person's Act, which was heralded as the most decisive piece of decriminalising policy this century and allowed care proceedings to be an automatic alternative to criminal proceedings for all children aged 10–14. Despite the act, the numbers of juveniles sent to detention centres between 1971 and 1977 rose by 225%.

In 1991 the Criminal Justice Act introduced new powers for the courts to impose a “secure training order,” which allows juveniles aged 12 to 14 to be detained in secure settings. The new institutions to house this group of detainees were planned to be built with private funds and would complement facilities to be built with state funds. The new institutions have not, however, been created at a rate which has matched the enthusiasm of the courts to detain juveniles. As a result, the number of 15 and 16 year old boys detained in adult prisons in