goods vehicles was more successful. It was followed by a marked decrease in deaths and injuries among occupants of goods vehicles—37% fewer were killed in 1977 than in 1970.²

In 1977 in magistrates courts in England and Wales 1.2 million persons were found guilty of motoring offences; of these 97% were fined.³ Penalties for serious transgressions were too mild. In 82 480 driving licence offences, including driving while disqualified, a fine of £20 or less was imposed in 83%, and £50 or less in 97%. In 7899 cases of dangerous driving the penalty was £50 or less in 51%, and £100 or less in 96%. Fines must be increased if they are to remain a credible deterrent. Disqualification and penalties are ineffective in a small minority of habitual offenders, who often also have a past history of other criminal offences. These cases present a social as well as a legal problem.

Adequate enforcement with suitable penalties can improve road behaviour, but the real answer is to persuade the public that traffic regulations are an essential ingredient of road safety.

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¹ Department of Health and Social Security, *On the State of Public Health for the Year 1977*. London, HMSO, 1978.

² Department of Transport, *Roads to Safety*. London, Department of Transport, 1978.

³ Home Office, *Offences Relating to Motor Vehicles 1977*. London, HMSO, 1978.

Motorcycle and bicycle accidents

SIR,—As a general practitioner and life-long cyclist (in both competitive and touring fields), I have read your recent correspondence on motorcycle and bicycle accidents.

In my view, one of the prime causes of cycle accidents is the large percentage of drivers who just do not "think two-wheels." We read with monotonous regularity of cyclists suffering fatal injuries while riding innocently on their way. Personally, I have long since lost count of the number of times I have been within an inch or two of disaster.

I am in favour of separate cycle or cycle and bus lanes in cities, but until legislation is introduced to protect cyclists—for example, a minimum distance between cyclist and overtaking vehicle, as in France—I fear that the unnecessary slaughter will continue. We all know from the seat-belt fiasco, and the lack of results from supplying the general public with facts on smoking and health, what abysmal "progress" mere persuasion achieves.

Mr H Milnes Walker (10 February, p 413) maintains that cyclists should check usually whether there is a second overtaking vehicle. Surely, it is the responsibility of the overtaking vehicle or vehicles to avoid an accident. Also, the abominable state of many road surfaces, particularly on the near side, makes it mandatory to keep one's eyes ahead to avoid serious accidents caused by hitting pot-holes of various shapes and sizes.

The time is long overdue when cyclists should cease to be regarded as second-class road users—and be given just credit for their efficient, silent, non-polluting, health-giving, and economic mode of transport.

KEVIN J WATSON

Variations in number of births and perinatal mortality by day of week

SIR,—While in no way intending to influence the main conclusions of Alison MacFarlane's interesting article (16 December, p 1670) on the number of births and perinatal mortality by day of week in England and Wales, I think that there is one statistic quoted that could be misleading. She states, *inter alia*, that deliveries in general practitioner units accounted for 12% of total births in 1970 and that this figure had fallen to 8% in 1976. While it is acknowledged that the work load of the general practitioner obstetrician is diminishing,^{1,2} I believe that these figures are a considerable underestimate and may take into account only deliveries in isolated general practitioner units, ignoring those occurring in GPs' beds in consultant units.

The difficulty in determining the figure for all GP deliveries in England and Wales is considerable but, on the basis of claims for maternity services made by GPs for care during the confinement (DHSS form SBE 504), GPs had responsibility for 32.6% and 21.2% of deliveries respectively for the two years in question. Had these proportions been fully taken into account, it is possible that the concentration of births in NHS consultant beds from Tuesdays to Fridays would have been even more accentuated.

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¹ Lloyd, G, *British Medical Journal*, 1975, **1**, 79.

² Bull, M J V, *British Medical Journal*, 1975, **2**, 39.

Return to work after coronary artery surgery for angina

SIR,—Mr J Wallwork and others (16 December, p 1680) report encouraging return to work results in patients after surgical treatment for angina. It is implicit in their report that the improved postoperative return to work experience could be attributed to the benefits of the surgical procedure.

Logue¹ reported that, despite improvement in angina in 90% of patients, only 50% returned to work. Rimm² found that, of men gainfully employed before surgical treatment, 11% of those under 55 years and 26% of those aged 55 years or more retired after surgery. For the older age group this was a retirement rate 11 times that of the normal population. Barnes *et al*³ concluded that, contrary to expectation, rehabilitation benefits of surgical treatment appear to be few. This subject has been reviewed by McIntosh and Garcia.⁴

Why are there such differences in rehabilitation results after surgery? Are they caused by different patient groups, different standards of surgical or drug treatment, different economic motivating factors, different approaches to the analysis of data, or different attitudes to rehabilitation on the part of the doctor?

Of these factors, we believe the attitude of the patient's medical attendant to be by far the most important. Many patients do not work before operation because their physician may exaggerate their disability. The same physician's attitude may be very much more optimistic after dramatic treatment such as heart surgery or he may be instrumental in perpetuating cardiac invalidism. Logue¹ emphasised that the physician may advise the patient not to return to stressful working conditions, despite successful surgery and

despite the difficulties in defining and identifying stress and in evaluating its importance. Barnes³ also noted that doctors may provide insufficient encouragement to return to work. What is the basis of the common diagnosis of intractable angina, a diagnosis which is widely employed to justify disability and to encourage heart surgery? Who decides that the angina is intractable? Why do some physicians and surgeons see more of this than others?

More than 90% of 471 patients under 60 years seen by us returned to work after a first myocardial infarction.⁵ There was no significant difference in the return to work rate of the 173 patients with and the 298 patients without postinfarction angina. Only four of 15 anginal patients who failed to return to work were disabled by chest pain.

This high rate of return to work reflects an active and optimistic approach to rehabilitation with a strong emphasis on risk factor intervention. None of these patients had coronary artery bypass surgery and beta-blockers were used only in a small number of cases, and generally for the treatment of hypertension. With a positive and encouraging approach we have found little difficulty in getting the great majority of coronary patients under 60 years back to work and we have found disabling angina to be a rare problem among them.

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¹ Logue, N, King, S B, I I, Douglas, J S, jun, *Current Problems in Cardiology*, 1976, **1**, 5.

² Rimm, A A, *et al*, *Journal of the American Medical Association*, 1976, **236**, 361.

³ Barnes, G K, *et al*, *Circulation*, 1975, **51** and **52**, (Suppl II), 118.

⁴ McIntosh, N D, and Garcia, J A, *Circulation*, 1978, **57**, 405.

⁵ Mulcahy, R, Hickey, N, Graham, I, *British Heart Journal*, 1976, **38**, 873.

Malnutrition in infants receiving cult diets

SIR,—The malnourished infants whose parents adhered to extreme "health food" cults, as reported by Dr I F Roberts and others (3 February, p 296), supply fresh ammunition on one of the favourite battlefields of nutrition. Ever since kwashiorkor was described by Cicely Williams, it has been associated in lectures and textbooks with "dietary protein deficiency" or "shortage of good animal protein." Yet studies of protein-energy relationships, and of the capacity of plant proteins to supplement one another in food mixtures, demonstrate that pure dietary protein deficiency, without accompanying energy shortage, is comparatively rare.^{1,2} Gopalan,³ studying the diets of children who subsequently developed marasmus and kwashiorkor, was unable to detect a simple dietary protein deficiency in any instance.

Roberts *et al* report on four children. The foods consumed by cases 2, 3, and 4 prior to diagnosis are identical in kind though not in quantity. This implies that the proportion of protein to energy in each diet was the same. Each child was fed small amounts of breast milk, cereals, and legumes: an unexceptionally balanced diet, in protein terms, but clearly short on energy. Case 2 developed marasmic kwashiorkor, cases 3 and 4 marasmus. (Case 1, who also developed kwashiorkor, was fed