

active, Be healthy' and 'Change4life'.² For a medical student research project we examined self-reported exercise in cardiovascular and orthopaedic patients at Bedford Hospital. Following ethical review, Manning conducted a questionnaire survey in July 2009.

The response rate was 84% (63/75). Mean age of responders was 71 years (range 27 to 97) and 90% were white. Although 86% reported exercising regularly, only 29% complied with DOH recommendations (30 minutes of moderate exercise five times a week).³ White patients were significantly more likely than those from ethnic minorities to participate in regular exercise (91% 51/56 versus 43% 4/7, $P<0.05$). Similarly more men than women reported doing the DOH recommended amount of exercise (50% 12/24 men versus 15% 6/39 women $P<0.05$). Comparable results have been seen in previous studies.^{4,5}

Lack of awareness is a major problem in both exercise promotion and familial hypercholesterolaemia. Only one patient in our study knew how much exercise the DOH recommends. Similarly, it is estimated that 85% of people with familial hypercholesterolaemia remain undiagnosed.¹ GPs are often the first point of contact for patients with chronic diseases such as familial hypercholesterolaemia. They may have a vital role both in diagnosis of this important condition and in exercise promotion.

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Respiratory infections

I read the themed October *BJGP* on respiratory infections with both interest and nostalgia. I would like to make two general points.

First, although Verheij's admirable leading article uses and quotes the phrase 'antibiotic revolution',¹ what struck me most in the linked papers was not how much has changed over the last 30 years, but how little things have changed. Wang *et al*'s findings of large inter-practice prescribing variations² closely mirror the pattern of the 1970s. And extrapolating from the data Meropol *et al*³ present, it seems that in 2004 just over 50% of all consultations for respiratory infections (combining his figures for adults and children) resulted in an antibiotic being prescribed, a figure not very different from the 58% we reported three decades ago. If there has been a drop in the volume of antibiotic prescribing, it is as likely to be due to changing demography or consultation availability, as it is to any sustained influence of educational interventions aimed at doctors.

Second, I was struck by the fact that none of the 121 references in the four relevant articles was to papers published earlier than 1990. This is part of a now regular pattern resulting from the increased use of review articles to introduce literature reviews and meta-analyses to summarise clinical trials. Although labour-saving for the author, this trend results in the airbrushing out of apposite historical work which might illuminate the work being undertaken.

In this case, I was obviously disappointed that none of the work I and others had been associated with in earlier years to try to describe and influence the determinants of antibiotic prescribing had earned a reference, not least because it contributes to understanding why unnecessary prescribing continues.

However, a solution is at hand. The *J Health Serv Res Policy* runs a series 'Worth a Second Look', and I was recently invited to re-visit one of my apparently out-dated articles (from *J R Coll Gen Pract* 1972 entitled 'Diagnosis — the Achilles Heel'), and comment on its relevance to medicine today. The resulting paper is now available online⁴ and will be available in hard copy early in 2010. For those thinking of researching in this rich field, the essay includes relevant starter references, and also a model suggesting how difficult it is likely to be to make changes to the antibiotic prescribing *status quo*.

Come to think of it, given the proven effectiveness of the QOF financial incentives in changing patterns of care,⁵ why not simply debit practice incomes with the cost of all antibiotics prescribed, less whatever is deemed the necessary annual mean antibiotic requirement per patient? It could work!

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Antidepressant prescribing

In light of the debate concerning political targets to reduce antidepressant prescribing in Scotland,¹ we were interested to see Cameron *et al*'s paper addressing the appropriateness of antidepressant prescribing by GPs.² After consulting our Aberdeen colleagues, we