Pattern of stair use among men and women during study. Values are weekly sample percentages with 95% confidence intervals

week after the posters were removed. Subjects faced a binomial choice—that is, whether or not to use the stairs. A stepwise logistic regression was fitted with this choice as a response variable and the sex of the subject, the week of the study, and their interactions as potential explanatory factors.³ Simultaneous 95% confidence intervals were calculated to compare the percentage stair use at baseline with that during each of the seven subsequent observation weeks. This was achieved using a Bonferroni multiple comparisons procedure for men and women separately.³

A total of 22 275 observations were made. Overall stair use at baseline was around 8%. This increased to the order of 15%–17% during the three weeks when the sign was present. The figure shows that pattern of stair use for men and women during the campaign. Stair use by both men and women remained significantly higher than baseline values during the three intervention weeks. The motivational sign significantly increased

the percentage of men using the stairs from 12% at baseline to 21% throughout the duration of the intervention. The corresponding figures for women were 5% to 12%. Stair use decreased during the two weeks after the sign was removed. Twelve weeks after removal of the posters stair use remained significantly ($P=0.01$) higher than at baseline. There was, however, a downward trend suggesting a possible eventual return to baseline values.

The stepwise logistic regression showed a main effect for sex ($F=224$ v $F(1, \infty)$; $P<0.0001$), as well as week of study ($F=22$ v $F(7, \infty)$; $P<0.0001$). Women were more likely to use escalators than men at all times. The interaction between sex and week of study ($F=2.5$ v $F(7, \infty)$; $P=0.015$) and the day of the week ($F=3.2$ v $F(2, \infty)$; $P=0.04$) were also significant.

Comment

The motivational sign positively influenced stair use in a safe and well lit venue. The improvement in stair use was slightly greater than that found in a similar American study.⁴ Use of stairs can make an important contribution to an accumulated daily activity programme and is specifically mentioned in the guidelines of the American College of Sports Medicine.² Further study is required to establish whether sedentary people or those who are already active respond to these cues.

The Health Education Board for Scotland has distributed motivational stair walking posters throughout Scottish workplaces.

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Conflict of interest: None.

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Combined clinical and virological surveillance of influenza in winters of 1992 and 1993-4

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Influenza is a major public health problem. Some cases occur every winter; there have been six substantial epidemics in the United Kingdom during the past 25 years; pandemics following major shifts in the influenza virus occur less frequently but are particularly severe.¹

Most European countries support programmes of influenza surveillance.² In some countries—for example, France,³ the Netherlands, and Portugal—clinical and virological surveillance is undertaken in sentinel practices that monitor the incidence of influenza and obtain specimens for virological examination in the major virological laboratories. In the

United Kingdom the largest clinical surveillance network is the Royal College of General Practitioners' weekly returns service.⁴ Virological surveillance is based on the results of virological tests in patients admitted to hospital, with centralised reporting to the Public Health Laboratory Service.

Early identification of the organism responsible for epidemics of respiratory infection is important to facilitate the distribution of specific drugs when appropriate (for example, amantadine to elderly people in influenza A epidemics); vaccinate workers in essential services; to plan for the allocation of hospital beds; to grow new virus strains for the next manufacture of vaccine; and to provide the public with reliable, comprehensible information. We present the results of a project designed primarily to hasten recognition of an influenza epidemic.

Materials, methods, and results

During the winters of 1992-3 and of 1993-4, six practices in the weekly returns service sent nose and

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throat swabs from patients with new cases of influenza-like illness for virological examination at the Central Public Health Laboratory. The practices were in Northumberland, Merseyside, west midlands, Bedford, Kent, and Somerset and had a combined population of 51 000. Samples were sent by first class post and examined by direct immunofluorescence⁵ and by tissue culture according to standard methods. Specimens with positive results on immunofluorescence (and a sample of negative specimens) were also examined by the polymerase chain reaction.

Incidence of influenza and flu-like illness in six study practices (●—●) and all practices in weekly returns service (○—○). Numbers of throat and nose swabs with positive results are given

In the winter of 1992-3, 182 specimens were submitted and 11 viruses cultured. Three were influenza A H₁N₁, three influenza A H₃N₂, and five influenza B. Specimens containing influenza B viruses were also positive on immunofluorescence and were all found during the outbreak occurring late in March 1993. In the winter of 1993-4, 279 specimens were submitted; 66 (24%) were positive for influenza A (immunofluorescence or culture, or both). The proportion of positive results was highest in children (35% occurred in children aged 0-4 years, 33% in those aged 5-14, 17% in those aged 15-64, and 22% in those aged ≥65). The figure shows their distribution compared with the reported incidence of influenza-like illnesses in the six practices and in the weekly returns service network of 93 practices. Clinical and virological reports peaked simultaneously in week 45.

The polymerase chain reaction yielded 18 positive results in 20 specimens with positive results on

immunofluorescence. The reaction yielded eight positive results in a sample of 41 specimens with negative results on immunofluorescence.

Comments

These results show the value of virological surveillance in primary care. The combined nose and throat swabs were easy to take and their quality remained satisfactory after having been posted. The results of immunofluorescence were reported to practices within 24 hours of samples arriving at the Central Public Health Laboratory, providing early diagnostic confirmation for the general practitioners and alerting them to local influenza. The pattern of virological results was contemporaneous with the reported clinical incidence nationally, so they effectively monitored the onset and progress of the influenza A/Beijing/32/92(H₃N₂) epidemic late in 1993. The results also validate the clinical data reported in both epidemic and non-epidemic periods. Virology reports to the Public Health Laboratory Service from other sources peaked in week 50, five weeks later than those reported from the study practices, and did not indicate substantial influenza activity until week 46. Deaths peaked in week 48.

Effective management of influenza epidemics, whether caused by an existing or new virus strain, depends on effective surveillance. This study shows an improvement in influenza monitoring when virological specimens are obtained in general practice.

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Conflict of interest: None.

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ONE HUNDRED YEARS AGO

THE GENERAL MEDICAL COUNCIL AND DIRECT REPRESENTATION.

The approaching session of the General Medical Council will probably not be a heavy one, inasmuch as the number of penal cases is not large. There are, however, some other questions of great interest to be considered. The November session is that at which the resolutions passed at the annual meeting of the British Medical Association are received by the Council, and this year the registration of midwives and direct representation were the subjects of important resolutions. It is the latter question to which, we think, special attention should be drawn, for the resolution passed in London in August last, instructs the executive "to take immediate steps to have a Bill introduced into Parliament providing that the registered medical practitioners in England and Wales be empowered to elect five additional direct representatives, the practitioners in Scotland one additional direct representative, and the practitioners resident in Ireland one direct representative

to the General Medical Council." The Council of the Association in October directed that this resolution should be forwarded to the General Medical Council, with an intimation that the means for giving effect to the recommendation were under consideration. This is a grave position. It points to a possible conflict between the Association and the General Medical Council. The Act of 1886 provides that the General Medical Council may at any time represent to the Privy Council "that it is expedient to confer on the registered medical practitioners resident in any part of the United Kingdom the power of returning an additional member to the General Medical Council."

We wish that we could entertain the hope that this course will be adopted. On three separate occasions within the last five years the Council has deliberately rejected it. Twice they declined even to discuss the matter, and on the only occasion on which they allowed a debate they voted against any increase of the representatives of the profession by a majority of 21 to 5. (*BMJ* 1895;ii:1295.)