Several scoring systems have been developed to try to predict premature delivery—for instance, one by Fedrick[9]—but none is sensitive enough to identify most patients who will go into labour preterm while avoiding falsely labelling as high risk many patients who will not. Thus only a quarter of patients with a Fedrick score of five or more will go into labour preterm, but even this high risk group contains only a quarter of the multigravidas and 9% of the primigravidas who go into spontaneous preterm labour. Measurements of effacement and dilatation of the cervix in the latter half of pregnancy and uterine activity are also poor predictors.

Preventing preterm labour depends on understanding better the aetiology in cases where there are no clear contributory obstetric factors, and it may be that the aetiology is different in those whose labour starts with the membranes rupturing and in those who start with uterine contractions. Arias and Tomich found significantly higher morbidity rates in infants when labour had been heralded by premature rupture of the membranes.[10] Recently White *et al* studied 254 primigravidas delivered between 28 and 36 weeks' gestation and excluded those whose fetus had already died and those who had had antepartum haemorrhage, multiple pregnancy, an elective caesarean section, or an induced labour.[11] They compared those in whom labour was preceded by membranes rupturing (57%) with those in whom labour had started with uterine contractions (43%). When mothers of unclassified social class were excluded, there was no difference between the two groups in socioeconomic class, maternal height, weight, and smoking habit. Premature rupture of the membranes was associated with babies of lower birth weight, and in the group in which labour started with contractions there was an excess of unmarried mothers and teenagers (these factors being independent) but no association with babies that were light for dates. This suggests that there may, indeed, be two different pathological processes, and further studies relating risk factors to these two modes of onset may be very productive.

Meanwhile, the clinical dilemma is when to try to defer labour. Rest in bed is the most important factor, and if the membranes are intact uterine activity will diminish and labour will be deferred in 30-40% of cases. Although cervical encirclage performed at 14-16 weeks' gestation is effective in cervical incompetence, its value later in pregnancy—for example, when multiple pregnancy has been diagnosed—has not been proved. A trial by the Royal College of Obstetricians and Gynaecologists is investigating the question. Pharmacological options include reducing oestradiol concentrations by giving betamethasone[12]; inhibiting prostaglandin activity,[13] although indomethacin may lead to premature closure of the ductus arteriosus[14]; and giving β sympathomimetic agents such as ritodrine.[15,16] Combining sedation and inhibition of myometrial activity with ritodrine is a logical treatment, but there is little convincing evidence of benefit.

Deferring labour may be counterproductive if there is unrecognised placental insufficiency, and looking for failing placental function, particularly by cardiotocography, is important. Anderson has suggested that β sympathomimetic agents to try to stop labour should be considered only if the fetus is healthy, gestational age is less than 34 weeks, the estimated fetal weight is less than 1500-2000 g, the membranes are intact, and cervical dilatation is less than 3 cm.[17]

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An uncompromising report on health visiting for the elderly

The case for preventive care of the elderly is based on four propositions: (*a*) the elderly are often admitted to hospital; (*b*) they are often admitted because of a crisis; (*c*) the events leading up to the crisis usually have a long history; (*d*) therefore it would be profitable to prevent the crisis occurring. Williamson's group quantified the third proposition in their study of 200 people aged 65 or over selected randomly from three Edinburgh general practices.[1] Each old person had an average of three medical problems, many of them serious, of which only half were known to the doctor. Since that study was published in 1964 the case for surveillance has been made virtually irrefutable—notably by Barber in Glasgow using an annual postal questionnaire sent to all patients over 75 years old,[2] by three randomised trials of screening,[3-5] and by several other studies.[6-11]

Nevertheless, since the pioneering Edinburgh work case finding—the systematic search for symptomatic disease (screening looks for asymptomatic disease in addition)—has not become widespread. Does it generate too much work for doctors? Barber says that in the long run it does not.[2] Do old people like it? Burns showed that they do.[6] Are there enough professionals to do it? Barber claims that a health visitor can do the case finding in an average practice in 11-18 hours per week.[2] This would mean that unless health visitors stopped doing something else between 3000 and 6000 more would be required nationally.

In the latest report on the subject the British Geriatrics Society and the Health Visitors' Association, although quietly recognising that general practitioners would not welcome a national case finding endeavour, draw some startlingly bold conclusions.[12] Following the example of the Cumberlege report's dry disregard of doctors' likely objections,[13] they argue that health visiting should promote the

health of the elderly no less than that of children and other groups; health visitors should make contact with all people over 75 for health promotion and prevention and to assess their health, plan actions to satisfy unmet needs, and start surveillance programmes. Many more health visitors are called for, not only for routine work but also for specialist and liaison duties with geriatricians; these would include direct admission to hospital and the monitoring of drug taking at home. This new work would also require practice and health district population registers and clearly formulated policies by all health authorities for health visiting to the elderly. Suggestions are given for bringing the work of health visitors closer to that of primary care teams, other health and social workers, district nurses, community psychiatric nurses, informal carers, community groups, voluntary organisations, and health education officers.

In fact a national surveillance service of this kind would need another 19 000 health visitors in addition to the 9000 already in post if the report's suggestion of one health visitor to every 2000 people were adopted; no numbers are calculated for the additional liaison health visitors and those termed nurse consultants. Neither is any mention made of Williamson's well argued case for using not health visitors but nurses or even "persons of good intelligence who could readily be taught the techniques. . . ."[14 15] But if the cost and sheer impossibility of finding the staff were not a barrier the idea is likely to founder on the indifference and hostility of general practitioners. Many do not believe in the concept, do not have a working relationship with their present health visitor (let alone the consultants and managers envisaged, who would have a much higher profile), do not believe that they would not be overwhelmed and exhausted by the extra work, or do not particularly like elderly patients anyway. These negative feelings of general practitioners—what Simone de Beauvoir called a "biological repugnance" of old age[16]—are not very different from those of many other professionals.[17]

Faced by the proof of need, for which intellectual and moral justification exists, how are health service managers to respond? Three answers are possible—yes, no, and perhaps: to press for the services that would solve the problem; to say with weary realism that resources are simply not available; or to suggest a pilot project, preferably financed from research funds. The report will have none of this procrastination, and further research is not necessary: the bodies concerned do not accept that because a case finding service will make a lot of work for other people it should not be started. An "increased and uncomfortable burden will be placed on all the other services, but in their turn these other services will be able to argue the case for the necessary level of resourcing to meet the unmet need which health visitors seem best placed to uncover."

It is easy to be cynical about such an uncompromising view, but opposition should be based on more than disillusionment. One counter argument can be put by stating four more propositions not in health service but in patients' terms: "We old people spend nearly all our lives at home; we go into hospital in a crisis but most of us are dead within the year after our admission; we were managing pretty well at home for a long time before our admission; and we are almost always capable of knowing when we ought to see our doctor." This view needs amplification: ". . . but please give us a doctor who is available, interested,[18] educated in our special needs,[19] and in close touch with a vigorous and enthusiastic primary care team—including a health visitor; let them make contact with us about once a year, but give us the chance to say no to their ministrations if we want to."[20]

British people at home probably prefer this low key philosophical approach to their health care; Shanas showed that the severely incapacitated elderly in Britain were twice as likely to rate their health as "good" as were the same sort of disabled elderly in Denmark and the United States.[21] But the "spiral of expectation" is bound to change attitudes,[22] and the report of the British Geriatric Society and Health Visitors' Association, unrealistically overstated in some of its demands as it seems, is doing no more than articulate a predicted and growing need. General practitioners can no longer stand in the way of a more positive approach to the early detection of ill health in old people.[23]

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Correction

Time for action on hepatitis B immunisation

The second sentence of the leading article by Dr Roger Finch (24 January, p 197) should have read: "In England and Wales reported cases reached almost 2000 in 1984 and caused 30 deaths during 1980-4."