has been aggravated by an unanticipated rise in acute admissions, which is a cause for concern itself.

Secondly, hundreds of medical beds have been closed throughout Britain. Major difficulties are being experienced by general practitioners in getting people into hospital.

Thirdly, doctors perceive barriers to voices of complaint. Managers are on fixed term contracts; consultants fear for their future income; trust boards are unable and unwilling to speak out as standards fall; and eight new regional health boards, with no medical representation, are to be set up.

Fourthly, there are the iniquities of the two tier system produced by fundholding. More sinister, though, fundholders are spending health service money to buy cheap care in private hospitals. Meanwhile the NHS continues to pay for the costly chronic diseases and complex surgery.

Finally, the private sector is unable to cope with anything other than cold, predictable surgery.

All these matters are of great concern. In meeting many doctors locally and nationally we hear wide agreement about the unhappy way in which the NHS is moving and the lower standards of care that are developing, and our letters to the press seem to be supported. The fact that the national press is not filled with letters of complaint worries us: perhaps we are wrong in our observations.

We ask doctors to write in support, quoting their opinions and personal experiences; correspondence should be directed to JDW at the address below. In this way we might accumulate evidence to persuade the public and politicians that much is seriously wrong with the new arrangements in the health service. Only medical and other professionals' views in the health service can expose the true nature of the deterioration.

We would like to draw attention to a similar campaign by Dr Sandy Macara, the chairman of the BMA's council.

JOHN D WARD
Professor of diabetic medicine

Royal Hallamshire Hospital,
Sheffield S10 2JF

C PEAT
General practitioner

Sheffield S10 5PN

J REVILL
General practitioner

Sheffield S8 8OW

1 Ward JD. Sick sent home while wards stay empty. *Guardian* 1994 Jan 14:19.

2 Revill J, Peat C. Government gives patients the run around. *Guardian* 1994 Jan 25:19.

3 Ward JD. Failing factors in NHS. *Daily Telegraph* 1994 Jan 21:18.

4 Ward JD. Plundering the health service. *Guardian* 1994 Feb 7:19.

Social deprivation and diabetic patients

EDITOR,—William F Kelly and colleagues link social deprivation and illness in diabetic patients.¹ It would have been informative to know whether the patients living in the deprived wards were not using insulin simply because they had non-insulin dependent diabetes, which would be in agreement with their older age. Was the prevalence of insulin dependent diabetes comparable in the wards? In an earlier Danish study that linked diabetic ketoacidosis to social deprivation, patients from the lowest social classes had more severe ketoacidosis than patients from higher social classes.²

We evaluated patients who were admitted to our hospital with diabetic ketoacidosis between January 1987 and March 1990. Only patients over 15 years old were included, and diabetic ketoacidosis was defined as plasma bicarbonate

Data on the admissions according to the patients' educational level. Values are medians (interquartile range) unless indicated otherwise

	No advanced education	Advanced education	P value
Plasma bicarbonate (mmol/l)	8.8 (6.3-13.7)	12.3 (9.8-14.3)	<0.05*
Blood glucose (mmol/l)	24.8 (19.0-33.4)	20.4 (16.0-26.8)	<0.05*
Duration of diabetes (years)	13.0 (5.3-16.0)	10.0 (7.0-15.0)	>0.05
No unemployed	14	1	<0.01†

*Two sample rank sum test (Mann-Whitney test).

†Fisher's test.

<18 mmol/l, severe ketonuria, and raised blood glucose. These criteria had been used in the previous Danish study.²

Our hospital serves a district of 185 000 people, but patients from outside this district are admitted to the hospital. Admissions were identified from the central register of the hospital, and data were extracted from case records. There were 114 admissions represented by 68 patients (36 women and 32 men). Admissions were divided according to educational level. Patients were characterised as having no advanced education if they had not started any kind of school training after primary or public school.

Eighty five of the admissions were of residents of the district which our hospital serves. Reliable information about educational level was obtained in 75 cases; proportionally more (49; 26.5/100 000 inhabitants) were from the less educated group than from the group with advanced education (26; 14.1/100 000 inhabitants). The overall median values (interquartile range) at admission were plasma bicarbonate 10.2 (7.5-14.0) mmol/l and blood glucose 23.7 (18.0-31.9) mmol/l. The table compares the less educated groups with those with advanced education (median age 24 years in both groups).

The incidence of diabetic ketoacidosis in our district was 85 in 185 000 inhabitants in 39 months or 14.1/100 000 inhabitants/year, which was higher than the incidence found with data from 100 or more years previously.^{2,4} Our results show that patients with more education and thereby a presumably better socioeconomic status had less severe diabetic ketoacidosis than those without advanced education. Furthermore, the results support the view that the incidence of diabetic ketoacidosis is increasing.

JEPPE HAGSTRUP CHRISTENSEN
Senior registrar
JØRN MUNKHOF MØLLER
Registrar

Department of Clinical Physiology,
Aalborg Sygehus,
Postboks 561,
9100 Aalborg,
Denmark

1 Kelly WF, Mahmood R, Kelly MJ, Turner S, Elliott K. Influence of social deprivation on illness in diabetic patients. *BMJ* 1993;307:1115-6. (30 October.)

2 Ellemann K, Soerensen JN, Pedersen L, Edsberg B, Andersen OO. Epidemiology and treatment of diabetic ketoacidosis in a community population. *Diabetes Care* 1984;7:528-32.

3 Faich GA, Fishbein HA, Ellis SE. The epidemiology of diabetic acidosis: a population-based study. *Am J Epidemiol* 1983;117:551-8.

4 Snorgaard O, Eskildsen PC, Vadstrup S, Nerup J. Diabetic ketoacidosis in Denmark: epidemiology, incidence rates, precipitating factors and mortality rates. *J Intern Med* 1989;226:223-8.

Elderly people who get stuck in the bath

EDITOR,—Considering the alarmingly high incidence of elderly patients becoming stuck in the bath (1 in 7 patients interviewed) it would appear

very fortunate that only one of C Gooptu and G P Mulley's patients required skin grafting.¹ Since 1984 14 patients over the age of 70 have been admitted to the Wessex Regional Burns Centre after such an injury. Eight died as a direct result, of whom seven were over 80 years of age. The high mortality seen is a reflection of the size of the burn (mean 22% (range 5-65%), plus the advanced age of the patients (82 (71-97) years). Of those who survived, all but one required split skin grafting. The average length of stay for these patients was 28 (1-81) days, illustrating the considerable impact of such injuries on resources. Many of these elderly patients have pre-existing medical conditions, rendering them even more vulnerable. Additionally, most lived alone. Some of the accounts of the incidents were horrific, with the victim being stuck in their bath, the hot water tap running, no means of getting out, and no means for seeking help.

We strongly agree with the authors that additional safeguards are required to prevent these potentially fatal injuries, which even when not requiring hospital treatment have a profound psychological effect. Simple and relatively low cost measures such as side taps, larger and more accessible plugs, and hot water thermostats could have a dramatic impact on reducing the incidence of bath immersion injuries in elderly patients.²

M A CADIER
Registrar in plastic surgery
P J SHAKESPEARE
Clinical scientist

Wessex Regional Burns Centre,
Salisbury District Hospital,
Salisbury SP2 8BJ

1 Gooptu C, Mulley GP. Survey of elderly people who get stuck in the bath. *BMJ* 1994;308:762. (19 March.)

2 Stephen FR, Murray JP. Prevention of hot water tap burns—a comparative study of three types of automatic mixing valve. *Burns* 1993;19:56-62.

Obstetric care for disabled women

EDITOR,—We agree with Alleyna Claxton that, to combat doctors' widespread ignorance, teaching on the special needs of disabled people should be part of the new core curriculum in medical schools.¹ This is certainly a logical starting point, but current practice also needs improving. The process should have begun already in the maternity services in the light of *Changing Childbirth*, which has been adopted as government policy.² It states: "It is important that services reflect the needs of women who have disabilities and ensure that action is taken to overcome the obstacles which confront them. While physical problems are of course a frustrating problem, there are other equally daunting barriers resulting from the prejudice and ignorance of able-bodied professionals."

Maternity Alliance's charter for disabled parents and parents to be, aptly titled *Listen to Us for a Change*, was written as a result of direct surveys of parents' experiences and of discussions with disabled people and health and social work professionals.³ It suggests workable improvements. One aspect of care that could be addressed straight away is greater cooperation between obstetric and non-obstetric staff. This would facilitate coordinated care and treatment of pregnant women. Models of good practice exist, such as in joint antenatal clinics with diabetic teams, but our survey found many instances of problems arising in labour wards when staff were ill equipped to understand the needs of women with paraplegia or rheumatoid arthritis, for example. Continuity of carer, as recommended in *Changing Childbirth*, should ensure that special requirements are not only noted but acted on—for example, deaf women who lip read should not be cut off from com-