objective of a reduction in weight. This is the only measure of dietary compliance presented, except that 74% and 69% of non-obese and obese subjects respectively remained on the diet alone (but with no weight loss; in fact they gained weight).

I appreciate the difficulties of doing such a large study over so many years with so many centres participating, but this does not excuse the authors from drawing conclusions that may be misleading. A more prudent conclusion might have been that dietary advice given as part of normal care did not work but that there is no evidence to say whether a predetermined diet, given under controlled conditions with compliance properly monitored, is not effective. At a pragmatic level "usual care" is what people get, and this study is therefore helpful in that sense, but if readers draw the conclusion that diet does not work under any circumstances then this paper will have been unhelpful.

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1 United Kingdom Prospective Diabetes Study Group. United Kingdom prospective diabetes study (UKPDS) 13: relative efficacy of randomly allocated diet, sulphonylurea, insulin, or metformin in patients with newly diagnosed non-insulin dependent diabetes followed for three years. *BMJ* 1995;310: 83-8. (14 January.)

Authors' reply

EDITOR,—The dietary advice given to subjects in the United Kingdom prospective diabetes study is probably considerably more than that given as part of usual care. We have described in detail the response to diet over the initial three to four month run in period, when patients were seen monthly by a dietitian.¹ The reduction in fasting plasma glucose concentration was shown to depend on the degree of weight loss and the initial glucose concentration. In each clinic in the study a dietitian gave individual dietary advice to all subjects, irrespective of the treatment to which they had been allocated, and reviewed admitted compliance and gave further advice as necessary throughout the study. Over three years the group taking diet alone did not completely regain the mean 3.7 kg lost during the initial three to four month dietary period. Although we do not have formal dietary measures in all subjects in the study, the admitted dietary intake in a randomised subset, derived from three day food diary assessments, showed no significant differences between the treatment groups with respect to dietary composition.² We think it unlikely that dietary differences between the randomly allocated groups accounted for the differences in blood glucose control we described.

Long term dietary compliance is a well recognised problem in diabetic subjects, and many patients become refractory to dietary advice.³ We appreciate the concern that even more intensive dietary advice might have been more effective, but the degree of weight loss required to attain near normal glucose concentrations during the three month run in period was usually more than could be achieved realistically.¹ The conclusion that the pharmaceutical agents studied were each more effective than attentive dietary advice alone is justified.

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1 UK Prospective Diabetes Study Group. UK prospective diabetes study VII. Response of fasting plasma glucose to diet therapy in newly presenting type II diabetic patients. *Metabolism* 1990;39:905-12.

2 Eeley E, Stratton IM, James R, Holman RR. Dietary evaluation in type II diabetic subjects randomly allocated to therapy with insulin, sulphonylurea or diet alone. *Diabetologia* 1992;35: A165,635.
3 West KM. Diet therapy of diabetes: an analysis of failure. *Ann Intern Med* 1973;79:425-34.

Services for cleft lip and palate

All patients should have access to plastic surgery

EDITOR,—While much is written on cleft lip and palate in specialist plastic surgery journals, not enough information reaches the wider audience of general practitioners, paediatricians, and, importantly, purchasers. I was surprised to read that only 65% of patients with cleft lip and palate are treated by plastic surgeons.¹ Parents wishing the best for their children require treatment to be carried out by well trained, experienced teams of plastic surgeons and therapists. These teams manage the early problems of counselling and feeding through the surgical treatment of infancy and childhood and also deal with the cosmetic problems of scars, deviated noses, displaced teeth, and defective speech.

Every region in Britain has a plastic surgery department where such skill is available. The departments' activities and standards of training are monitored by the Royal College of Surgeons through specialist advisory committees. There is no reason why all patients with cleft lip and palate should not have access to, and benefit from, such departments. This runs contrary to the current philosophy of purchasers who wish to purchase treatment locally. Not all hospitals need a cleft lip and palate team, and if each trust decides to provide one, or part of one, the numbers treated by each will fall; skill and training will be diluted; and any study of outcome and quality of care will be meaningless. If purchasers are truly to act in the best interests of these patients, and if they care about quality, they will ensure that their contracts for surgery for cleft lip and palate are placed with multidisciplinary teams within the plastic surgery units that exist nationwide. This means that the advice of the local plastic surgeons regarding the placement of contracts is paramount.

Individual general surgeons; plastic surgeons; ear, nose, and throat surgeons; and oral surgeons are quite capable of repairing a cleft lip. For the best results, however, skill needs to be centralised, and in a free country without specialist registration or direction of patient care this is difficult to achieve.

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1 Williams A, Shaw WC, Devlin HB. Provision of services for cleft lip and palate in England and Wales. *BMJ* 1994;309:1552. (10 December.)

Plastic surgeons support centralisation of services

EDITOR,—I challenge the last sentence of Alison Williams and colleagues' paper on services for cleft lip and palate: "As yet clear leadership from the specialty groups concerned has not been forthcoming." The British Association of Plastic Surgeons has been encouraging centralisation and discouraging low volume operators for some time. A document prepared after a questionnaire had been sent to all members and after widespread consultation within the specialty recommended that surgeons should perform a minimum of 20 primary operations a year,² and there may well

be a case for increasing this. Plastic surgery has a strong regional base, and multidisciplinary units are being established, with the essential participation of other key specialties. This demands that infrequent operators relinquish their involvement.

The British Association of Plastic Surgeons Cleft Group is working in multicentre randomised trials, and this, too, demands large volume operating. Without centralisation the answers to many of the unsolved questions of management will not be obtained.

A great cause for concern is the trend for new district cleft lip and palate teams to be established, usually at the instigation of surgeons other than plastic surgeons and with the encouragement of managers and purchasers who wish to retain control of their patients. Such moves are contrary to the message of the paper and must be discouraged.

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1 Williams A, Shaw WC, Devlin HB. Provision of services for cleft lip and palate in England and Wales. *BMJ* 1994;309:1552. (10 December.)
2 British Association of Plastic Surgeons. *Plastic surgery in the British Isles—a plan for the rest of the 1990's*. London: BAPS, 1992.

Needs are never demands

EDITOR,—In the first paragraph of their article in the series on management for doctors John Stuart and colleagues refer to "the multiple demands of an increasingly aging population." From this single line one may guess the nature of the article. The phrase is pejorative and redolent of those ideas taken for granted in a selfish political age. The word "demands" is used when the less loaded word "needs" is more truthful; "aging" is used in a condemnatory sense when "old" is appropriate. Let me rewrite the phrase: "the needs of a people with many old among them." This rewritten phrase has an unusual sound to modern ears, but this would not have been so to those of former ages, when language was clear, fine, and active. With one phrase rewritten, the rest of the article will also have to be rewritten, for as it stands it will no longer make sense: the political import is no longer conveyed without the article seeming unreasonable.

To use words to persuade and so make a temporal truth rather than to convey a natural truth is to follow the course of the Sophists in the Greece of antiquity. It was Socrates, his words preserved in the clarity of Plato's early writing, who showed that persuasion by the distortion of language is finally harmful to speaker and hearer: unless speech is informed by that which is good, it cannot impart sense. And this is true. Once dogma has been deserted by the age that made it, the speech and writing that fed and maintained it also die. For an example of this we may look to the recent past. On reading the writings of the eugenicists earlier this century we are not persuaded by them but are, rather, appalled by their error, though these authors considered themselves to be reasonable people. We do not live in the climate of their thought, and their errors, hidden by motive from themselves, are by distance clear to us.

The needs of a people are never demands. Neither are they limitless. They should be met, not by unfairness but by clear address.

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1 Stuart J, Spurgeon PC, Cook A. Making finance work for you—strategic issues in clinical directorates. *BMJ* 1995;310:224-6. (28 January.)