study comparing a small number of children must not be taken as a standard by which to judge a project.

We looked with interest to find their viewpoints on "what lies ahead," as it is part of the title, but we thought that they missed the main lessons of this experience, which could help plan the future. The most significant lesson of the Smile Train project is that it could serve as a good model for health care delivery if the focus is on the care of a specific problem; for example, it could be used for the care of the club foot or for the care of postburn hand deformities. Second, a massive number of children (>282,000) with clefts have been treated over a span of 10 years, and this has been possible only because this project accepted the help of the local surgeons and the hospitals. Charities that depend on visiting surgeons to a developing country, regardless of the number of times they come, cannot address more than the tip of the iceberg of the problem. They cannot provide the continuity of care that this system has achieved. Third, the patients have shown that, regardless of how long an institution has treated a specific problem, when the quality of care is the same, they would migrate to facilities that do not have a waiting list and access to care is easy. No parents are willing to have their children on the waiting list for long.

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Reply: Changing Patterns in Demography of Cleft Lip–Cleft Palate Deformities in a Developing Country: The Smile Train Effect—What Lies Ahead?

Sir:

We thank the authors for their interest in the article and their subsequent reply. We would like to establish the fact that Smile Train and other such organizations have an immensely important role to play in cleft care in countries such as India. Smile Train has vastly expanded the horizon of cleft care in India. It has been instrumental in bringing such a population under care that would have otherwise not received as much attention. The article was intended not to pass judgment on Smile Train institutions in general but to highlight some lacunae that we have observed and that need to be verified and addressed urgently.

It is indeed true that the Smile Train public outreach camps are not meant to be operative camps. It is equally true that operative camps are conducted regularly in the partner hospitals and in hospitals attached to them.[1–4] The partner hospitals are not of uniform standing. It is our observation that the problem is pronounced in smaller centers. As rightly pointed out by the authors, Lifeline Express is another such place where follow-up care is logically difficult to deliver. As the camps involve a number of operations in a stipulated time, the amount of personal attention delivered is bound to suffer.

Years of work on cleft disorders has led us to believe that counseling is indeed the cornerstone of good cleft care. If the cleft deformities have to be viewed and treated holistically, without being focused on cleft lip–cleft palate alone, the patient has to cooperate with the treatment. It is impossible to expect institutions such as Smile Train to run to the patient on every occasion. All that can be done is to communicate thoroughly with the "cleft family" and not just the patient at the time of first contact. We found this to be lacking in our study. It is plausible that the problem is not general and is rather local in nature, but it definitely needs further investigation. The sole purpose of our article was to bring this issue to the forefront.

Answering their second question, the data reported from our institute are what have been observed by us. We do not intend to criticize the Smile Train institutions generally. We also agree with their observations that they are limited data and are definitely not applicable to the general population. However, it also needs to be understood that the data reported by the authors are from their institute only. These are data that stem from a single institute and should be applauded. We compliment them for the outstanding work being performed by them in cleft care. The authors belong to a very prestigious institute in India, which has set the standards of care for plastic surgery in general. We also agree that any small study, from any institute, should not be used to judge the project in general.

We agree with the authors' view that the Smile Train project is an excellent model of health care delivery. Their suggestion that a similar model could be of use in the treatment of other deformities is appreciated. The Smile Train model, the involvement of local surgeons, the tremendous outreach and awareness programs, and its singular focus on cleft care are definitely worth emulating. We join the authors in