and kept completely separate from the main clinical and scientific programme, although their content is still validated and approved by the scientific committee. In contrast, no commercial sponsors directly support any of the presentations within the official scientific programme.

The proposed guidelines tend to assume that presentations take a common format where a question is posed and then subjected to an oral systematic review. Whilst it is recognised that this is one approach for an oral presentation of a topic, we believe that a narrative review approach with expression of personal opinions is also legitimate. A format where these opinions are discussed and tested by an active session chair and distinct speakers may be particularly appropriate for many topics and is a format we intend to adopt widely at Europerio 8. The 'narrative' oral presentation with expression of opinions is particularly relevant where the body of high quality evidence is low, as is often the case in most areas of clinical dentistry.

The guidelines as set out make an important point about considering the quality of evidence in an oral presentation and we concur that speakers should be encouraged to consider these issues within their presentations, notwithstanding the caveats above.

As the author notes, a large conference such as Europerio is not sustainable without the generous support of industry sponsors, but we, like other conference organisers, are very aware of the need to avoid commercial bias. However, we are all affected by conflicts of interest (which may not only be related to links to industry) and whilst we strongly agree with the idea of full disclosure, it must also be recognised that a disclosed conflict of interest is not in some way considered a 'bad thing' rather than simply seen as an open declaration.[2] A wider debate on this issue deserves to be encouraged, as has occurred to some extent already by our medical colleagues.

F. Hughes, London
M. Sanz, Madrid

1. Faggion Jr C M. Are there guidelines for reporting clinical research findings in oral lectures and seminars at dental meetings ? *Br Dent J* 2013; **214:** 281-283.
2. Smith R. Conflicts of interest: how money clouds objectivity. *J R Soc Med* 2006; **99:** 292-297.

DOI: 10.1038/sj.bdj.2013.540

ARGUMENT BY ANECDOTE

Sir, this morning I have a little time before the first patient arrives so there is an opportunity to catch up on the latest journals. First the current newsletter from HealthWatch, the organisation devoted to promoting evidence based clinical practice; most interesting.

Then to the current *BDJ*, to find yet another letter from J. Mew (*Jaw surgery alternatives*; *BDJ* 2013; **214:** 376). What is it this time? It is argument by flimsy anecdote. Surely the *BDJ*, a peer-reviewed journal, can do better than this.

R. Reed
By email

DOI: 10.1038/sj.bdj.2013.541

LEADERSHIP ROLES

Sir, the paper *What is clinical leadership and why might it be important in dentistry?* (*BDJ* 2013; **214:** 243) is a timely contribution to an area that, I believe, requires further discussion within the profession. 'Clinical leadership' is a phrase we hear increasingly often, especially in the context of the recent reorganisation of the NHS and the emergence of Local Professional Networks. It is perhaps easy for dentists, DCPs and the wider practice team to consider leadership as relevant to only a few but when leadership, as the article points out, is described as 'a process of influence of one individual over a group of individuals'[1] then leadership is relevant to all members of the profession as we seek to influence the behaviour of our patients.

The trend within dentistry is towards larger teams working together and, and whilst the implications of direct access are still being explored, the expectation is that dental teams should work together in the interests of the patient with leadership a key feature of such a team.[2]

Many members of the profession are ill-prepared for such a role and many of us have had to learn 'on the job', with mistakes along the way. This has been highlighted for me by participating in a pilot leadership development scheme by the North Western Deanery. The LEAD programme (Leadership Exploration and Discovery) is facilitated by experienced leadership development coaches who allowed the participants to explore their own leadership roles and styles and, most importantly, learn how to work as part of a diverse team.

I would urge those responsible for undergraduate and foundation dental training to consider how we can prepare new colleagues for this role and it is my experience that it is never too late to explore this issue in whatever role you find yourself.

I. Redfearn
Nelson

1. Northouse P G. *Leadership theory and practice*, 3rd ed. London: Sage Publications, 2007.
2. General Dental Council. *Principles of dental team working*. London: GDC, 2006. Reprinted 2009.

DOI: 10.1038/sj.bdj.2013.542

OVERWHELMING GENEROSITY

Sir, I write with gratitude to the BDA following a Charity Auction during this year's Conference. I was recently informed of the outstanding contribution to Bridge2Aid and am simply overwhelmed by the generosity of the UK dental family.

Whilst visiting Tanzania in 2002, my wife and I observed suffering, pain and chronic disease caused by dental decay and knew from that moment that we couldn't walk away. We followed our dream to provide access to dental pain relief in developing countries where otherwise there is none.

As we stand today, our dream - Bridge2Aid – has created said access to over 2.4 million people in Tanzania. We have trained over 240 local healthcare workers in emergency dentistry and have directly treated nearly 20,000 during our Dental Volunteer Programmes.

As we move forward, increase access and expand our work into other East African countries, I thank you and your readers for their continued support. May I conclude with one thought: it costs Bridge2Aid approximately 50p to provide access to safe dental pain relief for one person in Tanzania. The BDA's contribution of over £4,000 will enable us to provide sustainable access for an entire community of over 8,000 people. Incredible. Thank you.

I. Wilson
Bridge2Aid Founder

DOI: 10.1038/sj.bdj.2013.543