Although dental hygienist-therapists have a shorter professional education, they are trained to the same high standards as dentists. Dental hygienist-therapists are more than capable of working within their remit and knowing when to refer. Most dental hygienist-therapists typically see patients every three months for a routine scale and polish so they see patients just as often, if not more often than a dentist. There is therefore no need for the current 'draconian' referral system.

Dental hygienist-therapists are an invaluable asset to the dental team. Removing the need for a referral from a dentist will not only allow dental hygienist-therapists to carry out their role more effectively, it will also allow better access to dental health care for patients.

C. H. Griffiths RDT RDH

By email

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A CONSTRUCTIVE DIALOGUE

Sir, A. C. L. Holden's letter (BDJ 2012; 212: 355-356) saying no to direct access raises the issue of what can be achieved within the length of training courses that hygienists and therapists currently have and whether diagnosis should be included in their courses.

If we look further afield than the UK we see that most courses for dental hygienists and therapists are of similar length to those in the UK and that they already include diagnosis and direct access to patients. Some courses such as those in New Zealand and Australia have allowed therapists to see patients directly for decades.

I would suggest there is still an attitude prevalent in this country that hygienists and therapists are not capable of understanding diagnosis of dental conditions, when in fact the outcomes in current UK courses could not be achieved without a substantial element of diagnostic skill.

Formal training in diagnosis can only enhance the work of dental hygienists and therapists by involving them fully in the decision-making processes used in the assessment of the oral tissues. This surely must be to the greater benefit of patients than the present referral system?

Those who oppose direct access *per se* should consider both the present and future training needs of hygienists and therapists, their usefulness to patients, and become involved in a constructive dialogue with all concerned with the safety and welfare of patients, seeking to offer ways in which the work of all DCPs can be moved forward in the twenty-first century.

C. D. Exley

Arnside

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LIMITED APPLICABILITY

Sir, we have thoroughly enjoyed reading the series of articles on *Current concepts on the management of tooth wear* by Mehta *et al.* (BDJ 2012; 212: [1-4]). However, we were surprised to read in part 3 that the final occlusal scheme should provide six listed criteria,¹ which referenced a paper by Stuart *et al.* in 1963.²

In 1963 it was widely believed that it was possible to make an instrument which would accurately reproduce the movements of the mandible; Stuart himself designed a fully adjustable articulator. Further, that it was possible to accurately transfer these movements to a mechanical device, such as an articulator.

Unfortunately, the practical applicability of these beliefs has been limited. Clark *et al.*³ described possible errors that can occur during the different stages of transferring occlusal information to an articulator, while Hangai *et al.*⁴ suggested that significant differences were observed in measurements of sagittal condylar inclination in seven types of semi-adjustable articulators using the check bite method. O'Malley and Milosevic⁵ measured the steepness of the occlusal plane produced by three different semi-adjustable articulators. Significant differences were observed between the results obtained by the Denar and Dentatus articulators (which introduced flattening of the occlusal plane by 5° and 6.5° respectively) and those of the cephalogram. Errors associated with programming a fully adjustable articulator relying on a pantographic tracing have also been widely reported.⁶⁻⁸

The authors claim that occlusal stability should be based on the principles of a mutually protective occlusal

scheme. However, studies involving unrestored dentition demonstrated that relatively few occlusions can be classified in this way.⁹ The validity of this concept has been recently scrutinised against the evidence base from which it was concluded that other functional occlusion types and patterns might be just as acceptable.¹⁰

Even if accurate transfer of occlusal data and reconstruction to the mutually protective scheme were possible, the suggested criteria ignore the most vital factors in creating a reorganised occlusion: the adaptive capability of the patient, the patient's comfort, and the aesthetic outcome. If Dahl principles were taken into account and full arch reconstructions were undertaken in stages, restoring initially in a reversible manner, the need for complex inaccurate instrumentation would be greatly reduced.

M. Ryan, M. Kaupus

By email

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Professor Brian Millar, Dr Subir Banerji and Dr Shamir Mehta respond: We agree with the points in the letter regarding the inability of articulators to completely reproduce jaw movements and that the conditions of the 'ideal occlusion' are