unlikely to be achieved in practice while recognising that the patient's adaptive mechanisms are important.

However, a semi-adjustable articulator can be used to plan the prescription of an occlusal scheme and its use is strongly advocated for complex cases. Once the prescription is decided upon, then it should be transferred onto the teeth in an additive, reversible, adjustable and non-invasive manner with the use of composites, provisional restorations and/or a stabilisation splint. The patient's ability to adapt to this occlusal scheme should then be ascertained and confirmed over a period of time.

We do feel that the listed features of the ideal occlusion are worth aiming for rather than allowing some random outcome to occur. The mutually protective scheme would prove a good starting point in complex cases, but this will need to be confirmed and hence the reversible and non-invasive approach is endorsed in our papers. Thereafter the semi-adjustable articulator is very useful to transfer the confirmed occlusal prescription onto the definitive restorations which in the majority of cases can be placed without any removal of healthy tooth tissue.

When placing such restorations, usually in composite resin, the occlusal adjustment would be best carried out aiming to include these desirable features of an occlusion where possible while accepting it may not be achievable or ultimately of importance.

Many other occlusal relationships can also work. Our firm belief in intruding and extruding teeth with supra-occlusal restorations and the use of carefully planned intentionally high restorations will convince the readers that we are not wedded to the 'occlusal ideal' and we depend on our patient's adaptive capacity.

We thank Drs Ryan and Kaupas for reinforcing our views and for helping move our profession on from a fixed view of occlusion.

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KEILKRAFT DEXTERITY

Sir, I read with interest the article in the issue of the *BDJ* relating to the multi-mini interviews introduced at the University of Cardiff Dental School (*BDJ* 2012; 212: 331–335). I was even

more impressed with a photograph of, I presume, a potential undergraduate, attempting to tighten up some screws in a block, using a screwdriver, but observing with a mouth mirror (*News; BDJ* 2012; 212: 309).

I think back to my time in the mid-1960s when I was being interviewed for a place at University College Hospital Dental School. I was questioned about any manual dexterity skills that I had acquired, and proudly explained that I had constructed and carefully painted virtually all the Airfix range of plastic model aircraft kits, not to mention Revell, KeilKraft and other brands from the distant past.

My ideal dinner party guests would probably have included The Shadows and John Lee Hooker.

This seemed to satisfy requirements, and I gladly accepted a place to study my chosen profession.

I am not sure if I would have been so successful had I been subjected to today's inquisition.

B. Crocker
Cheam

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MICRO ENGINEERING TECHNIQUES

Sir, further to Martin Kelleher's 'Opinion' article on the problem of unnecessary tooth tissue destruction during cosmetic restorations (*BDJ* 2012; 212: 365–367), I would suggest that the principles he expounds should be extended. I entirely agree with his sentiments and criticisms but I feel the problem extends beyond cosmetic restoration. All too often it seems dentists decide that the only criterion for providing a full coverage crown is that the tooth is already heavily restored, implying that all heavily restored teeth need a full coverage crown and a metaloceramic crown at that. However, it is patently obvious that many heavily restored teeth survive quite happily without being reduced to the shape of a beach sandcastle and having a new outer shell cemented to them. Furthermore, it would seem that the only cast restoration in some dentists' armamentarium is a full coverage metaloceramic crown, irrespective of the mix and distribution of the restorative materials already placed in the tooth.

In a heavily filled tooth, the only structure reliably connecting the crown to the root is the remaining wall of tooth around the filling and any further destruction of this in order to accommodate a crown will seriously weaken the preparation. All too often a patient will present with a crown in their hand and with the prep in the crown because this fundamental engineering principle has been ignored. Yet this may well have been avoided if a partial coverage gold restoration had been employed or composite used to bond the remaining walls of tooth together thus avoiding the need for a crown altogether. In addition few seem to be aware of the advantages of well-designed adhesive posterior bridges or the Dahl technique that allows us to create occlusal clearance without resorting to an over shortened prep that compromises retention and further threatens the pulp.

The alternative techniques I have mentioned do not of course constitute an exhaustive list but as a profession it is incumbent upon us to apply all the micro engineering techniques at our disposal and not rely on a 'one golf club' approach to the advanced restoration/replacement of a tooth.

G. R. Newman
West Moors

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GATHERING GROUNDSWELL

Sir, I was sadly delighted to read Martin Kelleher's letter in the latest *BDJ* (212: 365–367). At last there would appear to be a gathering groundswell of opinion regarding this terrible 'modern' trend for healthy tooth destruction to create so called cosmetic improvement. I speak with two hats. The first, as a practising dentist for 42 years, watching this greedy dental profiteering at the expense of our often gullible and innocent patients. Secondly, as a full time specialist endodontist, experiencing at first hand the catastrophic pulpal results of all this devastating dentine removal. Hopefully Martin's letter and 'campaign' will enable this iniquitous practice to gain some professional proportion.

C. Emery
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