IN BRIEF

- The selection of courses is based on an array of reasons, many of which are convenience-driven rather than 'educational'.
- The impact of courses on practice is enhanced when activities are chosen in relation to learning needs.
- Laddered courses offer the opportunity for dentists to develop their skills over the longer term.
- We suggest that GDPs are supported in the development of personal learning plans.

The impact of course attendance on the practice of dentists

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Introduction: This paper reports the impact of course attendance on the practice of dentists. **Method:** *Phase One:* A survey sent to all general dental practitioners (GDPs) in three deaneries in England. The survey included self-ratings of the impact of course attendance on practice. *Phase Two:* Interviews with 20 dentists before and two to three months after they had participated in a self-selected course. The response rate to the survey was 54% ($n = 2082$). Comparisons with national data showed no notable bias in the sample for gender, owners/partners and age/experience. An ordered logit model was used to explore the net effect of factors (including years' experience in general dental practice and gender) on dentists' ratings of course impact. **Results:** Course attendance was judged to impact on practice. Impact rating was affected by participation rate and years' experience. Barriers to implementation included cost, time, NHS constraints and personal or staff issues. Impact was enhanced when selection of courses was based on learning needs although courses may also serve usefully to confirm current practice. **Conclusion:** There is much that dentists themselves can do to enhance the impact of courses, principally by reflecting on learning needs. They should be supported in the development of personal learning plans.

The introduction of the General Dental Council's (GDC) *Lifelong Learning*¹ Scheme means all dentists are required to undertake continuing professional development (CPD). This is viewed as a key mechanism for ensuring that dentists regularly update their skills and knowledge. Short courses are a common form of verifiable CPD and

constitute a preferred learning format² for most general dental practitioners (GDPs) but course attendance alone is no guarantee of up-to-date practice. Questions must be asked about the impact of CPD on practice.

In an earlier paper³ we reported on the participation of GDPs in CPD and factors affecting participation and found that course attendance is the most frequently undertaken type of verifiable CPD: in the study period, 97% attended at least one 2½ hour session. We also investigated whether characteristics of dentists affect participation rates and calculated that those less likely to be doing 50 hours per year are those who have been in dental practice longer and single-handed practitioners. One of the conclusions of the paper was the suggestion that certain groups of dentists might be targeted and supported in their CPD. Yet, simply encouraging dentists to engage in CPD will not in itself necessarily result in improved practice.

This paper reports the impact of course attendance on the practice of GDPs and

factors affecting impact. Only a selection of findings is reported here and a full report⁴ is available from the authors.

METHODS

This paper draws on data from a large-scale study (funded by the Department of Health, England) whose purpose was to explore and evaluate whether education brings about change in professional practice, resulting in improved patient care. The research had two distinct phases. In the first, all GDPs in three deaneries – West Midlands, Anglia and the South West were surveyed. Respondents reported their participation in CPD in the year ending March 2000, as well as their assessments of its impact. Data on participation (and detail on the content of the survey) has been reported earlier.³ This paper focuses on respondents' assessments of the impact of courses on their practice from the survey data. This is complemented with findings from Phase Two of the study.

In Phase Two, 30 case studies of GDPs were developed to explore the impact of

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Refereed Paper

DOI: 10.1038/sj.bdj.4811391

Received 01.04.03; Accepted 20.06.03

© British Dental Journal 2004; 196: 773–777

CPD on practice and patient care. The participants were interviewed before and two to three months after they had undertaken a self-selected CPD activity; 20 of these chose courses. Others chose, for example, journal reading or clinical audit. This paper reports case study data only from the 20 who chose courses. In addition, small-scale surveys of 60 patients in each of the 30 case study practices were undertaken. These data are not reported here.

The sampling strategy for the case studies took account of the proportion of GDPs from each of the three deaneries, single/ multi-handed practices, socio-economic status of the catchment of patients served and CPD participation rate. The sample of 20 doing courses comprised seven from single-handed practices; eight serving patients with high (as assessed by the dentist) socio-economic deprivation; and nine who in the 12-month period had undertaken 'low' amounts of CPD (less than 50 hours, as calculated by our scoring system). This approach to sampling, which seeks to include a diverse range of cases, is a key criterion in the assessment of the quality of qualitative research.⁵

Survey data were analysed using SPSS and STATA. Case study interviews were transcribed and a thematic analysis of the content was undertaken.⁶ These themes, or categories were derived inductively, informed by the theoretical ideas developed during the research.⁷ The authenticity (validity and reliability) of the qualitative research was enhanced by: (a) having data from a range of methods of collection; (b) the sampling strategy for the selection of case studies; (c) a clear account of data collection and analysis in the extensive, peer-reviewed report⁴ (which also enables others to judge the application of the findings to similar settings); and, (d) a research team from diverse backgrounds.

RESULTS

Survey response rate

The response rate was 54%. A higher proportion of the West Midlands dentists responded (68%) compared with the South West (45%) and Anglia (44%). The overall response rate was disappointing and it might be that those who chose not to respond had a different attitude to CPD. What we can say is that for amount of participation in CPD, no statistical difference was found between those who responded on the first mailing with those who responded later. Just as many relatively low participators in CPD were found amongst the group who responded promptly. Neither was a significant difference found between those from the West Midlands where the response rate was higher and those from elsewhere.

We also compared our sample with national data specially calculated from the Dental Rate Study Group (DRSG) population by the Statistics Division 1B of the Department of Health (England). From these comparisons our statistician advised that, since for gender, owners/partners and age/experience there was no notable bias in our sample, rather than weight the data, we should analyse separately for multi- and single-handed practices or include as specific covariates in modelling. The logit model we used looked at net effects and controlled for all other covariates in the model.

Course participation

The most frequently undertaken forms of CPD in this sample were journal reading and courses. Almost all engaged in at least one of these activities in the year to 31 March 2000. Specifically, 97% attended at least one 2½ hour session in the study period; 43% attended more than 15 hours.

Course impact ratings

Does continuing professional development lead to improved practice? Respondents were asked which forms of CPD have had greatest impact on their practice. They rated impact on a five-point scale where 1 = no discernible impact and 5 = very great impact. The results for courses are presented in Table 1.

The table shows that 73% rated impact of course attendance on practice at least 4 (out of 5). The impact of courses was rated more highly than any of the other 14 CPD activities included on the survey.

Given the importance of course attendance in the respondents' profile of CPD (and indeed, other studies report greater course attendance)^{2,8} we decided to investigate, through statistical analysis, factors affecting the impact ratings.

Factors affecting impact rating

An ordered logit model was used to explore the impact of covariates on the impact rating response. This facilitates an examination of the effect of explanatory variables (for example, male rather than female) on the log odds of being above a certain point on the impact scale. These are marginal effects controlling for all other covariates in

the model. The covariates in the model were: rates of participation in courses, years' experience in general practice, gender, single/multi-handed practice, deanery, whether a practice owner or not, full/part-time work, holding a postgraduate qualification, specialisation in a single type of treatment, other related part-time work (eg university lecturer, course provider) and, views on the GDC's *Lifelong Learning*¹ scheme.

In terms of broad patterns, there were two main findings. Firstly, the net effect of course participation rate on assessment of the impact of courses on practice was clearly evident and statistically significant, even after controlling for characteristics that may be associated with both views on impact and CPD participation. Put simply, the odds of giving a higher impact rating were increased for those doing lots of courses. For those attending 10 or more courses in the year, the odds of giving a high impact rating were about 3½ times (reciprocal = 3.45) those attending three or fewer courses.

The second broad pattern related to years of experience in general dental practice. This had a sizeable and statistically significant net effect on impact rating. Those with least experience gave lowest ratings. Ratings generally increased with years experience but the pattern was U-shaped rather than monotonic since those with most experience were nearer to those with the least. Those with a middling number of years' experience (6-15 years) were about twice (reciprocal = 1.8) as likely to rate impact highly.

The net deanery effects were not statistically significant nor was the gender effect. Net of other effects (including number of courses attended) the effects of the single/ multi-handed dummy variable seem fairly small and statistically insignificant. Similarly, whether a practice owner or not seemed to have no real net effect on impact. Whether the dentist worked full or part-time, had a postgraduate qualification or specialised in a single type of treatment all had just small and statistically insignificant net effects. The effect of those undertaking part-time related work was also small but statistically significant.

The views on the GDC's *Lifelong Learning*¹ scheme had fairly large effects in expected directions even after controlling

Table 1 Impact of course attendance on practice

Impact rating					
Low			High		
1	2	3	4	5	Valid number
1.4%	4.7%	20.9%	36.0%	36.9%	1757

Note on valid number: The results have been calculated only for those who indicated that they had attended courses in the year to 31 March 2000

for course participation rate with which they were strongly related.

Thus far then, how dentists rate the impact of course attendance on their practice seems to be affected by the number of courses attended and years' experience. Other factors affecting impact were explored in Phase Two of the study, and in open questions in the Phase One survey, notably, the selection of courses and barriers to implementing change.

Selection of courses

The case study dentists were asked: 'How do you decide what CPD to do? What are your selection criteria?' From analysis of interview transcripts, a range of factors was identified including: convenience, interest, professional commitment, recommendation, cost, and others. We distilled two key features:

- Selection based on convenience; and,
- Selection based on learning needs.

The range of other factors played an important part and we distinguished five groups ranging from Group 1 that was very strong on convenience to Group 5 that was clearly driven by learning needs. The other factors were in play in Groups 2, 3 and 4. Where these groups differed was in the extent to which convenience factors featured; for Group 2 convenience remained strong, for Group 3 convenience received scant attention and Group 4 selected partly on the basis of identified weaknesses or learning needs. Further description of these groups and illustrative quotes are shown in Figure 1.

Table 2 shows how the 20 case study dentists who chose courses were distributed between these groups. For three it was not possible to identify where a Group 1 or a Group 2 classification was most appropriate.

Personal learning needs were rarely used as a selection criterion. Just four out of the 20 reported to review, even informally, their learning needs (see Group 4). Routinely, these dentists based their selection of courses on other factors and convenience featured strongly in nine out of the 20 cases. The key message is that these cases show limited reflection on learning needs.

Understanding impact

The flowchart in Figure 2 shows our understanding of how courses impact on

Fig. 1 A framework for categorising CPD selection

Group 1:

Convenience and availability drove the selection of CPD. There was no mention of individual learning needs. There was some, but only very little, mention of other significant factors.

'I get the sheets from the local Postgraduate Centres, flick through, see what days I am available, then look at what is interesting and can I get there?'

Group 2:

Although individual learning needs were not considered, a combination of factors was considered (eg new developments, colleagues' suggestions, the quality of the proposed CPD). However, responding to convenient opportunities also featured.

'I try to keep a record of what I've already done ... also update courses or a course that says it's a different slant on whatever it is, that might be interesting. And to be honest, what is fairly local. I don't want to be travelling up to Birmingham to go to things, unless it looks really good.'

Group 3:

A range of factors was featured, except learning needs (as Group 2) and convenience, which was briefly featured, if at all.

'Courses – we get the list sent through, so I will look through those ... I am always aware there is a feeling that things are changing or that I need to upgrade and these are the areas I am more likely to give attention to.'

Group 4:

At least some CPD was chosen in relation to learning needs, which drove the selection of CPD, and only then was convenience considered (if at all).

'I try, at the beginning of every year, identify where I'm lacking... so I'll quite often aim at something where I feel I'm deficient... The second way is that I look for courses... and think 'yeah, I fancy doing that'. Or finally, there are things local that I tend to go to anyway.'

Group 5:

Almost all CPD was planned according to learning needs. Convenience was not a driver.

practice. Put simply, courses must first be selected; barriers to attendance must then be overcome before a dentist can participate. As a result of the course, two things can happen – either little or no new learning occurs or, some new learning can be acquired. Where there is little or no new learning, the course can still usefully serve to reassure or confirm current practice. Where there is new learning, this can lead to change, an impact on practice, but this is subject to overcoming barriers to implementation.

Barriers to implementation

Survey results from Phase One shed some light on the perceived barriers to implementation experienced by GDPs following a CPD activity. An open question in the survey asked: 'Following a continuing educational activity, what barriers or constraints to change have you experienced?' A total of 973 respondents identified a total of 1,302 constraints. The four main constraints were:

- **Cost** (37% of respondents) – costs of new materials, the cost of time off work, cost to patient
- **Personal or staff issues** (26%) – resistance from other staff, personal lack of motivation, inertia
- **Time** (24%) – time to implement
- **Constraints related to the fee structure within the National Health Service (NHS)** (24%).

Clearly, cost, time and NHS constraints are interrelated making this composite factor very prominent. A few respondents identified a range of other barriers to implementation including domestic, poor quality CPD and insufficient evidence of benefits from the change. The main themes were matched in the qualitative data provided in the interviews.

The case studies – impact on practice

The numbers show how the 20 case studies fell out. Two failed to participate (through illness). Five learnt nothing new, although the course served to reassure. For those

Table 2 Distribution of case studies between selection groups

Group 1 (convenience)	Between Groups 1 and 2	Group 2	Group 3	Group 4	Group 5 (learning needs)
1	3	5	7	4	0

Fig. 2
A flowchart
from CPD
selection to
impact on
practice

who did learn something new, one did not implement change (for financial reasons related to the NHS fee structure). For four, impact on practice was low (amounting to, for example, improved advice for patients rather than changes in treatment). For three, impact was also low but there was evidence that barriers preventing implementation could be overcome (for example, through further training). Five made moderate changes in practice (for example, use of a new material or technique). None of the 20 showed high impact on practice.

Selection and impact

We reasoned that impact on practice would be enhanced if courses were chosen in line with learning needs. All those five whose course attendance served to reassure current practice selected the course largely on the basis of convenience (ie they were in our Groups 1 or 2. See Fig. 1). In contrast, of the 12 who showed some impact on practice as a result of the course, eight were in Groups 3 and above where convenience was a weak factor in the selection process. Thus, we have some evidence to suggest that selecting courses more on the basis of learning needs enhances the likelihood of impact.

Also of interest is that five of the courses were part of longer-term programmes. Some impact on practice resulted from four of these. For these longer-term programmes, convenience was a weak selection factor. There may

be interplay of factors here. Perhaps since longer-term programmes require greater commitment, they are chosen more carefully and in the light of some reflection of learning needs.

DISCUSSION

The findings need to be understood within the limitations and confines of this study. Despite our best efforts, it would have been better to have had a higher response rate outside the West Midlands. In terms of the qualitative aspect of the study, it would have been valuable to return to the case studies at a later point to explore whether impact on practice was sustained.

Despite such limitations, analysis of the quantitative data from the survey has shown how assessment of the impact of courses on practice is influenced by a number of factors. It is perhaps unsurprising that the more courses a dentist attends, the greater the likelihood that s/he rates course impact highly. This is to be welcomed. However, the inverse might suggest that more limited experience of courses results in a lower assessment of their impact. Perhaps 'low' attenders have been put off more frequent attendance by attending a small number of courses that have resulted in little or no impact. Alternatively, the explanation may lie in the way in which 'low' attenders select courses.

The other factor worthy of comment is years of experience: those with 6-15 years' experience seemed to rate course

impact more highly. The explanation for this may be that those with fewer years experience have completed training more recently; perhaps the courses they attend have limited impact-on-practice because they are at the outset 'up-to-date'. Those with more than 15 years' experience may attend courses that have limited impact simply because they are at a stage in their careers (possibly approaching retirement) when, although they might learn something new, decide not to implement change because, for example, it is not cost-effective to invest in new equipment.

Impact rating was not significantly affected by deanery, gender, single/multi-handed, practice owner/associate, full/part-time working, possession of a post-graduate qualification or specialisation in a single type of treatment.

Analysis of the qualitative data from the case studies has shown that many of these dentists select CPD in an *ad hoc* manner, with convenience being a strong factor. However, the evidence also suggests that impact on practice was greater where courses were selected less on the basis of convenience and more in relation to perceived learning needs. There is much that dentists themselves may be able to do to enhance the impact of courses. They might be encouraged to reflect on their learning needs and the preparation of a personal development plan (PDP) provides an appropriate mechanism for this. Few dentists currently have PDPs: the figure from the GDC survey⁹ was only 16%. The value and impact of PDPs for dentists needs to be studied and the evidence base developed.

The qualitative data also showed that courses usefully serve to confirm current practice rather than lead to change. This should not be overlooked: a balance needs to be struck between reassurance or reinforcement of existing skills or knowledge and impact on practice.

CONCLUSION

In the light of the findings, we suggest the following:

- Dentists should be supported in the preparation of PDPs. These should foster reflection on personal learning needs and encourage selection of courses that will meet learning needs and increase the likelihood of impact on practice.
- The value of confirmation or reassurance of current practice, as an outcome of course attendance, should not be overlooked. However, the balance may need shifting more towards new learning.
- Dentists in the later stages of their

career may require special guidance to enhance the impact of courses on practice.

- It may be appropriate to increase the availability of ladder levels of CPD (properly labelled) for different stages of learning, to facilitate better matches with learning needs.

Finally it is worth noting that the relationship between educational activity, learning and changed behaviour is complex. And, understanding how changed behaviour impacts on patient care is even more challenging.

The project team is grateful for the financial support of the Department of Health (England) for funding this project (RDO/90/48). The views and opinions expressed are the authors' and do not necessarily reflect those of the Department of Health. Special thanks go to Clive Belfield and David Thomas who contributed significantly to this project.

1. GDC. *Lifelong Learning*. London: General Dental Council, 2000.
2. Leggate M, Russell E. Attitudes and trends of primary care dentists to continuing professional development: a report from the Scottish dental practitioners survey 2000. *Br Dent J* 2002; **193**: 465-469.
3. Bullock A D, Firmstone V R, Fielding A, Frame J W, Thomas D, Belfield C. Participation of UK dentists in continuing professional development. *Br Dent J* 2003; **194**: 47-51.
4. Firmstone V R, Bullock A D, Frame J W. *The type, volume*

and impact of continuing professional development for general dental practitioners final report. Birmingham: The University of Birmingham, 2002.

5. Mays N, Pope C. Qualitative research in health care: assessing quality in qualitative research. *Br Med J* 2000; **320**: 50-52.
6. Coffey A, Atkinson P. *Making sense of qualitative data*. London: Sage Publications, 1996.
7. Pope C, Ziebland S, Mays N. Qualitative research in health care: analyzing qualitative data. *Br Med J* 2000; **320**: 114-116.
8. Buck D, Newton T. Continuing professional development amongst dental practitioners in the United Kingdom: how far are we from lifelong learning targets? *Eur J Dent Educ* 2002; **6**: 36-39.
9. GDC. *Report on continuing professional development survey: full report*. London: General Dental Council, 2001.

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ARTICLE 1: Smokeless tobacco

ARTICLE 2: Long-term cost-effectiveness

Q1.	B	C
Q2.	C	D
Q3.	D	B
Q4.	D	D

CPD Article 1 – Pages 749-754

An investigation of dentists' knowledge, attitudes and practices towards HIV positive and patients with other blood borne viruses in South Cheshire, UK

1. What could be considered the main methodological problem with this paper?
 - A. topic not relevant to dentists
 - B. postal questionnaire not appropriate
 - C. non response bias
 - D. sample too geographically limited
2. How many dentists in this study claimed to have treated a HIV+ patient?
 - A. 92%
 - B. 11%
 - C. 46%
 - D. 54%
3. What is the main mode of transmission of HIV?
 - A. blood
 - B. saliva
 - C. mucus
 - D. tears
4. What proportion of the dentists in this survey believed they were at risk to HIV because of their occupation?
 - A. 84%
 - B. 55%
 - C. 27%
 - D. 5%

CPD Article 2 – Pages 766-770

Marginal adaptation of three-unit fixed partial dentures constructed from pressed ceramic systems

1. Which one of the following is incorrect?
 - A. the extent of misfit of dental restorations is closely associated with the development of secondary caries and periodontitis
 - B. marginal degradation of cement films is an often diagnosed clinical drawback
 - C. resin cements are more resistant to wear both in neutral and acidic conditions in relation to other dental cement materials and always decrease the marginal gap width
 - D. misfit in all-ceramic crowns can also affect their fracture strength and thus reduce longevity
2. Molin *et al* (1996) examined four point bending strength of ceramic-cement-ceramic sandwiches with differing cement layer thickness. Taking into account the physical and clinical properties of resin based luting agents which of the following ranges is an ideal marginal gap for composite cement
 - A. 10-20 μm
 - B. 20-50 μm
 - C. 50-100 μm
 - D. 100-150 μm
3. Which one of the following is incorrect?
 - A. in the present study the impression replica technique was chosen for the evaluation of marginal accuracy, because this technique also provides information regarding the disintegration and micro leakage of the cement film
 - B. to simulate a long-term service time of five years, about 1,200,000 'masticatory' cycles had to be performed in the chewing simulator
 - C. the epoxy replicas were analysed with the help of a stereomicroscope and 250-300 single measurements were performed on a single crown margin circumference
 - D. all abutment teeth were prepared manually to a 6 degree convergence and a 1.2 mm circular 90 degree butt shoulder with a rounded inner angle
4. Which answer is wrong concerning the results of the present investigation?
 - A. the marginal accuracy of the control group was not significantly higher compared with both tests groups in the initial stage
 - B. the marginal gap of the metal ceramic FPD values increased significantly after artificial aging
 - C. the marginal accuracy of Empress®2 and experimental pressed ceramic (EPC) FPD were not significantly different in all stages of the investigation
 - D. the marginal gap values of the metal ceramic FPD were significantly lower only in the stage after cementation

Answer sheet – June 26 2004

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3. TICK (✓) the answer to each question for each article you select. You may complete one or both articles.

☐ CPD Article 1

☐ CPD Article 2

	A	B	C	D
Q1	☐	☐	☐	☐
Q2	☐	☐	☐	☐
Q3	☐	☐	☐	☐
Q4	☐	☐	☐	☐

	A	B	C	D
Q1	☐	☐	☐	☐
Q2	☐	☐	☐	☐
Q3	☐	☐	☐	☐
Q4	☐	☐	☐	☐

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