RACGP

RACGP Education

Exam report 2022.1 CCE

RACGP Education: Exam report 2022.1 CCE

Disclaimer

The information set out in this report is current at the date of first publication and is intended for use as a guide of a general nature only and may or may not be relevant to particular circumstances. Nor is this publication exhaustive of the subject matter. Persons implementing any recommendations contained in this publication must exercise their own independent skill or judgement or seek appropriate professional advice relevant to their own particular circumstances when so doing. Compliance with any recommendations cannot of itself guarantee discharge of the duty of care owed to patients and others coming into contact with the health professional and the premises from which the health professional operates.

Accordingly, The Royal Australian College of General Practitioners Ltd (RACGP) and its employees and agents shall have no liability (including without limitation liability by reason of negligence) to any users of the information contained in this publication for any loss or damage (consequential or otherwise), cost or expense incurred or arising by reason of any person using or relying on the information contained in this publication and whether caused by reason of any error, negligent act, omission or misrepresentation in the information.

Recommended citation

The Royal Australian College of General Practitioners. RACGP Education: Exam report 2022.1 CCE. East Melbourne, Vic: RACGP, 2022

The Royal Australian College of General Practitioners Ltd 100 Wellington Parade
East Melbourne, Victoria 3002
Wurundjeri Country

Tel 03 8699 0414
Fax 03 8699 0400
www.racgp.org.au
ABN: 34 000 223 807

Published August 2022

© The Royal Australian College of General Practitioners 2022

This resource is provided under licence by the RACGP. Full terms are available at www.racgp. org. au/usage/licence. In summary, you must not edit or adapt it or use it for any commercial purposes. You must acknowledge the RACGP as the owner.

We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.

ID-3335

Introduction to the Clinical Competency Exam

The Clinical Competency Exam (CCE) is the final general practice Fellowship examination for the Royal Australian College of General Practitioners (RACGP). The examination is blueprinted to both the RACGP Curriculum and to the clinical competency rubric. It is designed to assess clinical competence and readiness for independent practice as a specialist general practitioner (GP) at the point of Fellowship.

The CCE was introduced in 2021 to replace the Remote Clinical Exam (RCE) and the Objective Structured Clinical Examination (OSCE). In 2022.1, the CCE was delivered remotely to all candidates via videoconferencing technology. The CCE reflects contemporary assessment principles and standards. A significant amount of academic research, combined with local and international external consultation, informed the development of the CCE.

The CCE consists of nine clinical cases.

The 2022.1 CCE was delivered in two streams on non-consecutive days as follows:

- **Day 1A:** Saturday 18 June 2022, cases 1A–4A.
- **Day 1B:** Sunday 19 June 2022, cases 1B–4B.
- **Day 2A:** Saturday 25 June 2022, cases 5A–9A.
- **Day 2B:** Sunday 26 June 2022, cases 5B–9B.

This public exam report is provided under licence by the RACGP. Full terms are available at www.racgp.org.au/usage/licence. In summary, you must not edit or adapt it, and must only use it for educational and non-commercial purposes. You must also acknowledge the RACGP as the owner.

Exam psychometrics

The 2022.1 CCE proved to be reliable and valid. Table 1 shows the psychometrics for the entire cohort that sat the exam. These values can vary between exams. The reliability calculated using Cronbach's alpha is a measurement of the consistency of the exam, with values between 0 and 1. Each case had high internal reliability. There were two streams in the 2022.1 CCE, each independently reliable and valid.

The 'pass rate' is the percentage of candidates who achieved a pass mark. A candidate must achieve a score equal to or higher than the pass mark (or cut score) in order to pass the exam. The CCE pass mark is determined by the borderline regression method.

The RACGP has no quotas on pass rates; there is not a set number or percentage of people who pass the exam. Candidates are not required to achieve a pass in a minimum number of cases in order to achieve an overall pass. There is no negative scoring in the CCE. Table 2 shows the pass rate by number of attempts.

Table 1. 2022.1 CCE psychometrics

Average reliability	0.72
Pass rate (%)	85%
Number passed	663
Number sat	780

Table 2. 2022.1 CCE pass rate by number of attempts

Attempts	Pass rate
First attempt	90.09%
Second attempt	64.37%
Third attempt*	57.89%
Fourth and subsequent attempts*	27.78%

*Data from RCE/OSCE clinical exams.

This public exam report is provided under licence by the RACGP. Full terms are available at www.racgp.org.au/usage/licence. In summary, you must not edit or adapt it, and must only use it for educational and non-commercial purposes. You must also acknowledge the RACGP as the owner.

Exam banding

Table 3 provides a percentage breakdown of candidates into bandings.

Table 3. 2022.1 CCE candidates in each banding

Banding	Candidates (%)
P4	30.77%
P3	20.38%
P2	19.23%
P1	14.62%
F1	9.87%
F2	3.59%
F3	1.15%
F4	0.38%

P1 is the first band above the pass mark, and P4 is the highest band.
F1 is the first band below the pass mark, and F4 is the lowest band.

Figure 1 provides an overview of the number of candidates in each band.

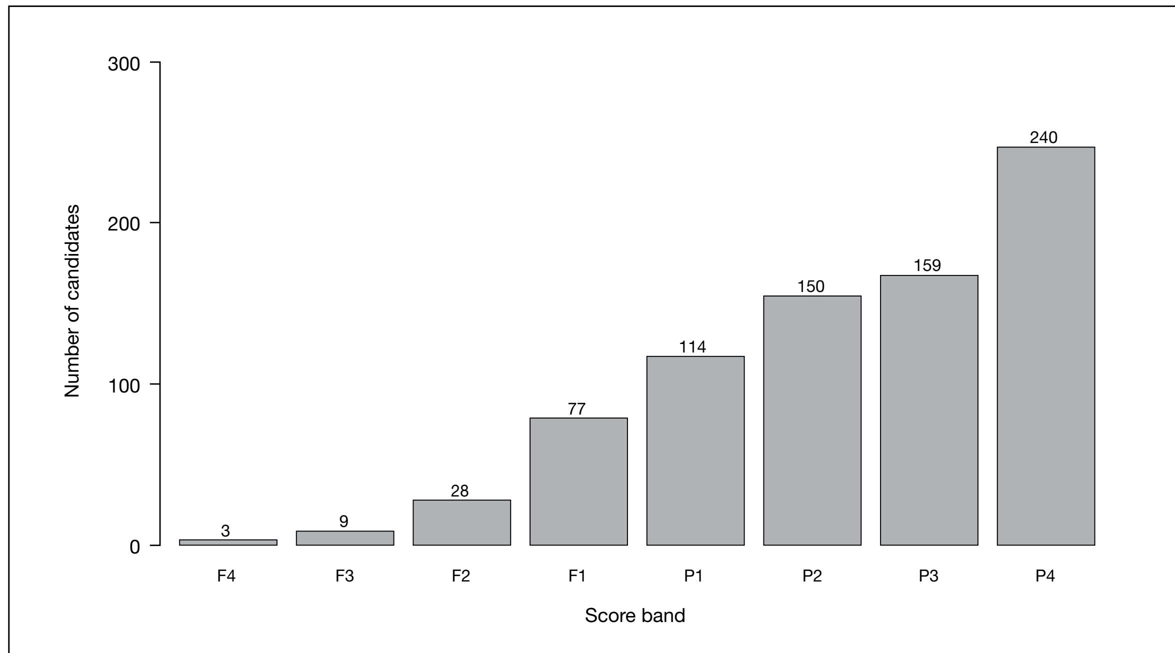

Figure 1. 2022.1 CCE banding distribution.

This public exam report is provided under licence by the RACGP. Full terms are available at www.racgp.org.au/usage/licence. In summary, you must not edit or adapt it, and must only use it for educational and non-commercial purposes. You must also acknowledge the RACGP as the owner.

Preparation for the CCE

Preparation for the CCE primarily involves working in and reflecting on comprehensive general practice. It is essential to practice case-based discussions with supervisors and colleagues, and it is important to understand and apply the clinical competencies, as outlined in the clinical competency rubric.

A two-part CCE preparation course is available on *gplearning*. The first module, 'Introduction to the RACGP Clinical Competency Exam for candidates', includes information on the competencies being assessed and how they can be demonstrated by candidates. The second module, 'Preparing for the CCE case discussions and clinical encounters', is a guided exam preparation activity that includes cases, marking grids and video examples.

Frequently asked questions, tips, technical resources and multiple additional practice cases are available on the CCE resources website, available to all RACGP members. This includes the clinical competency rubric with the criteria and performance lists against which candidates are being assessed.

The online delivery via Zoom requires candidates to have the ability to use Zoom's basic functions. The RACGP encourages all CCE candidates to practice in the online environment as much as possible to best prepare themselves for the exam-day experience.

This public exam report is provided under licence by the RACGP. Full terms are available at www.racgp.org.au/usage/licence. In summary, you must not edit or adapt it, and must only use it for educational and non-commercial purposes. You must also acknowledge the RACGP as the owner.

2022.1 CCE cases

All candidates are under strict confidentiality obligations, and must not disclose, distribute or reproduce any part of the exam without the RACGP's prior written consent.

This feedback report is published following each CCE in conjunction with candidate results. All cases within the CCE are written and quality assured by experienced GPs who currently work in clinical practice, and are based on clinical presentations typically seen in an Australian general practice setting.

The CCE assesses how a candidate applies their knowledge and clinical reasoning skills when presented with a range of common clinical scenarios. It allows a candidate to demonstrate their competence over a range of clinical situations and contexts.

Each case assesses multiple competencies, each of which comprises multiple criteria describing the performance expected at the point of Fellowship.

Examiners rate each candidate's performance in relation to the competencies being assessed in the context of each case. Ratings are recorded on a four-point Likert scale, ranging from 'competency not demonstrated' to 'competency fully demonstrated'.

The feedback report is provided so that all candidates can reflect upon their own performance in each case. It is also being provided so prospective candidates, as well as those assisting them in their preparation, can see the breadth of content in the exam.

Specific case details are outlined below (Saturday: Stream A, Sunday: Stream B). Equivalent competencies are assessed over both streams, and each clinical case provides a framework in which those competencies are assessed.

Each case assessed an average of 13 criteria. Competencies are assessed multiple times over the exam. Examiners were surveyed on exam day to identify candidate performance characteristics that demonstrated competency and common pitfalls observed.

Cases 1A and 1B

An Aboriginal man, aged 71 years, presents with leg pain (A), and an Aboriginal woman, aged 68 years, presents with a non-healing leg wound (B). The key to competency in this question was to demonstrate an inclusive attitude by optimising care in a patient-centred way and not making assumptions. Patient preferences and beliefs needed to be taken into account. Candidates demonstrating a flexible approach to medication timing (A), or using the whole range of non-pharmacological options, as well as pharmacological options, to improve diabetic care (B) were positively assessed. A paternalistic or dogmatic approach to medication compliance or medication options did not meet the criteria being assessed.

Cultural barriers and health beliefs needed to be identified by the candidates for the appropriate criteria to be met. A competent candidate required self-reflection and self-awareness to avoid harmful biases, assumptions, stereotyping and rote learned responses that did not consider the individual patient context.

This public exam report is provided under licence by the RACGP. Full terms are available at www.racgp.org.au/usage/licence. In summary, you must not edit or adapt it, and must only use it for educational and non-commercial purposes. You must also acknowledge the RACGP as the owner.

Examiners commented that candidates demonstrated competency by:

- demonstrating a non-judgemental patient-centred approach
- developing a comprehensive problem list, considering relevant investigations and holistically approaching management of complexity in the community setting
- exploring cultural barriers and health beliefs, and addressing these, catering to individual patient needs
- recognising barriers to care, especially those specific to an Aboriginal patient, their healthcare and their experience of the healthcare system
- working collaboratively, with a multidisciplinary team approach
- considering comprehensive and holistic management, following a biopsychosocial framework
- describing a range of both general and culturally specific communication strategies
- authentic, culturally safe and respectful practice described at each stage of the consultation.

Examiners commented that common pitfalls in these cases included:

- judgemental or paternalistic consulting styles
- emphasising medical priorities over patient concerns (even when prompted)
- making negative assumptions about the patient based on identification as an Aboriginal or Torres Strait Islander person
- insufficient exploration of social or cultural barriers, and not able to articulate beyond a tokenistic mention if probed
- failing to gain consent from the patient to involve an Aboriginal health worker, and relying heavily on this to achieve cultural safety
- lack of awareness of the range of resources available to cater to the needs of the patient.

Cases 2A and 2B

Both cases presented girls, aged 3 years, with undifferentiated symptoms in a rural setting. The social context was important in these cases, with the patients' parents having relationship disharmony. The cases explored the candidates' thinking around the differential diagnosis of the undifferentiated symptoms, and then moved through emergency management to long term follow up.

Examiners commented that candidates demonstrated competency by:

- having a systematic approach to taking a relevant and focused history
- having an organised approach considering a broad range of plausible differentials, and signposting the most and least likely differentials
- demonstrating an appreciation of the rural setting and adapting accordingly, considering the local facilities, available staff and services
- acknowledging and addressing the social issues
- identifying and prioritising management tasks
- detailing a safe and appropriate emergency management plan.

This public exam report is provided under licence by the RACGP. Full terms are available at www.racgp.org.au/usage/licence. In summary, you must not edit or adapt it, and must only use it for educational and non-commercial purposes. You must also acknowledge the RACGP as the owner.

Examiners commented that common pitfalls in these cases included:

- not taking into consideration the rural setting and not acknowledging the challenges associated with rural practice accessing tertiary care
- scattergun approach with a lack of a systematic approach to assessment
- narrowing focus too early, and therefore overlooking serious diagnoses or differentials
- not being able to identify priorities in the given situation
- focusing on only one aspect of the presentation
- failing to recognise markers of severity in the presentation.

Cases 3A and 3B

In these clinical encounters, a baby presented with perceived excessive vomiting after feeding. The cases remained undifferentiated; however, it was important that candidates considered most likely possibilities, and that they did not miss plausible diagnostic possibilities. The management of these cases should have included enquiring about the parents' wellbeing and how they are coping, and should also have included appropriate education and advice on infant feeding.

Examiners commented that candidates demonstrated competency by:

- using appropriate communication skills, such as active listening, and demonstrating empathy
- following an organised approach to history-taking using a hypothesis-driven manner with clinical features helping to explain why a diagnosis was more or less likely
- demonstrating breadth of history-taking, including biological history, psychosocial context and maternal mental wellbeing
- formulating a rational list of differential diagnoses without the pressure to provide a definitive diagnosis
- appreciating the diagnostic uncertainty and managing this appropriately
- provided safe advice to a breastfeeding mother in a non-judgemental and easily understood manner
- provided clear plans to follow up and re-evaluation as necessary.

Examiners commented that common pitfalls in these cases included:

- not reading the case instructions properly, and therefore not undertaking the prescribed tasks
- not managing time effectively within the case (commonly spending too much time on history at the expense of management)
- inability to manage the uncertainty and lack of knowledge of a normal experience of infant feeding
- failing to assess maternal mental health, experience and support network
- providing incorrect or damaging advice regarding breastfeeding
- failing to provide appropriate safety-netting and specific follow-up advice.

This public exam report is provided under licence by the RACGP. Full terms are available at www.racgp.org.au/usage/licence. In summary, you must not edit or adapt it, and must only use it for educational and non-commercial purposes. You must also acknowledge the RACGP as the owner.

Cases 4A and 4B

These clinical encounters offered candidates the opportunity to demonstrate competency in assessing and managing complex and undifferentiated cases. Both cases involved a patient with multiple symptoms seeking multiple medical opinions, creating the need for candidates to consider continuity of care and to arrange compilation of records.

Examiners commented that candidates demonstrated competency by:

- approaching the case in a systematic, methodical way, responding to patient cues to take a targeted, relevant history, and asking questions to demonstrate clinical reasoning
- avoiding premature closure, and instead establishing a list of differentials
- managing and highlighting uncertainty
- using investigations in a rational/modest and cost-effective way
- prioritising and balancing the patient and doctor's agenda
- using shared decision-making to establish a collaborative management plan.

Examiners commented that common pitfalls by candidates in these cases included:

- disorganised or scattergun approach to information gathering and regathering information already provided in the reading material
- not listening to, or addressing, the patients' concerns
- lacking a holistic approach to the problem and becoming bogged down in clinical minutia or following their own narrowed agenda
- not explaining their clinical reasoning, over-investigating, and dismissing or ignoring symptoms that did not fit with their narrow differential
- missing practical issues, such as recommending continuity of care or gathering information from other medical sources
- not following case instructions
- not planning specific follow up or safety-netting
- poor time management, with too much time spent on history, and limited time left to manage other access of the consultation holistically.

Cases 5A and 5B

In these case discussions, the patients presented with undifferentiated polyarthralgia, on a background of either intermittent migratory polyarthralgia (A) or osteoarthritis (B) and a new non-migratory polyarthralgia. Candidates were asked to articulate their thinking to define the problem and differential diagnosis, outline the investigations they would consider, and outline management and follow-up monitoring. Results of investigations were revealed as the case progressed, and candidates were asked how this altered their provisional diagnosis and management.

This public exam report is provided under licence by the RACGP. Full terms are available at www.racgp.org.au/usage/licence. In summary, you must not edit or adapt it, and must only use it for educational and non-commercial purposes. You must also acknowledge the RACGP as the owner.

Examiners commented that candidates demonstrated competency by:

- recognising that there was diagnostic uncertainty through the case, considering a wide range of differentials, and approaching initial symptomatic management safely without needing a clear-cut diagnosis
- demonstrating the ability to formulate a problem definition or problem representation and then to prioritise the diagnostic options
- demonstrating the reasoning behind their differential diagnosis list and provisional diagnosis, clearly explaining why this was more likely than others
- outlining appropriate, rational investigations and explaining the reason why each investigation was needed based on the differential list provided
- suggesting individualised non-pharmacological management, rather than generic rote responses, demonstrating adaptation to the individual patient
- recognising that the rheumatological presentations demonstrated are multisystem chronic diseases requiring holistic management, and understanding the role of the GP in that ongoing management
- considering education on the long-term risks of medication, and outlining appropriate monitoring.

Examiners commented that common pitfalls by candidates in these cases included:

- erratically repeating items from the stem, rather than synthesising the information to form a cohesive problem representation/definition using semantic qualifiers
- not taking into account the provided information in the history
- premature closure toward a diagnostic possibility and inflexible thinking, lacking demonstrated ability to reconsider when presented with further information
- ordering investigations that had no relationship to the differential list given, or that were out of context (eg pregnancy test in a patient who had had a hysterectomy)
- suggesting non-pharmacological management that was not relevant to the individual patient (eg smoking cessation in a non-smoker; exercise that was inappropriate, given the presenting complaint)
- management decisions without a clinically appropriate justification (eg temporal artery biopsy with no headache or tenderness)
- over-reliance on specialist advice for ongoing management.

Cases 6A and 6B

In these case discussions, a practice systems error led to a delay in a patient being notified of a significant abnormal result. Candidates were asked to consider the communication, clinical, medicolegal and organisational domains of the error, explain contributing factors and consider what processes might improve outcomes moving forward. There was also a component of procedure explanation in these cases; the procedure should have been explained to the level that the candidate might have been gaining consent. It is not assumed that the patients in the cases needed the procedure, or that the candidate themselves would undertake the procedure; however, the candidate still needed to be able to explain the procedure and what was involved for the patient. While these cases explored the organisational and medicolegal domains, the clinical scenario still relied on the applied knowledge domain by having to demonstrate appropriate management.

This public exam report is provided under licence by the RACGP. Full terms are available at www.racgp.org.au/usage/licence. In summary, you must not edit or adapt it, and must only use it for educational and non-commercial purposes. You must also acknowledge the RACGP as the owner.

Examiners commented that candidates demonstrated competency by:

- having an organised and structured approach
- recognising that an adverse event had occurred, sensitively communicating with the patient, and identifying and addressing the factors that might have contributed to the event while displaying care for colleagues
- demonstrating clinical competence with a symptomatic patient
- appropriately differentiating between a screening test and an investigation
- appropriately safety-netting and organising clear follow up.

Examiners commented that common pitfalls by candidates in these cases included:

- not reading the stem correctly
- not demonstrating that an incident or 'near miss' had occurred
- not apologising to the patient or acknowledging that an error had occurred
- focusing on errors perpetrated by individuals, rather than considering systems errors
- narrowed approach managing only the clinical/patient factors and not recognising contributing systems factors
- unprofessional approach, including blaming the colleague in the scenario or disclosing personal circumstances of the previous doctor
- wasted time explaining what was already known from the scenario
- failing to provide clear follow up and specific safety-netting.

Cases 7A and 7B

These clinical encounters gave candidates the opportunity to take a detailed history, and diagnose and outline emergency and ongoing management of an eating disorder. The patient met the criteria for hospital admission (medically) with recent significant weight loss and disturbance of their vital signs, despite a body mass index within, or close to, the normal range. Candidates needed to recognise the urgency of the clinical situation, despite the patient's hesitancy to acknowledge the serious nature of the condition.

Examiners commented that candidates demonstrated competency by:

- following the instructions for the case
- generating rapport with an adolescent patient
- undertaking a Home, Education/Employment, Eating/Exercise, Activities, Drugs, Sexuality, Suicide/Depression, Safety (HEEADSSS) assessment
- identifying an eating disorder presenting with a secondary complaint
- identifying the significance of the physical findings and the urgency to manage appropriately (seeking urgent specialist advice and likely inpatient assessment and management)
- overtly explaining the limits of confidentiality to a mature minor
- discussing collaborative care as part of a longer-term, holistic management plan.

This public exam report is provided under licence by the RACGP. Full terms are available at www.racgp.org.au/usage/licence. In summary, you must not edit or adapt it, and must only use it for educational and non-commercial purposes. You must also acknowledge the RACGP as the owner.

Examiners commented that common pitfalls by candidates in these cases included:

- communication styles that were unsafe for a young and vulnerable patient (paternalistic, dismissive, condescending, trivialising and judgemental)
- haphazard history-taking, cutting in and speaking over the patient, not listening, not taking a history of the presenting complaint, and making assumptions about sexual activity and alcohol intake
- not taking an appropriate dietary history and not probing when cues given in respect to dietary intake or body image
- use of jargon, lack of empathy and overly focused on physical symptoms
- not realising the severity or need for rapid management, despite recognising an eating disorder
- incorrect or no advice for investigation and management.

Cases 8A and 8B

In these clinical encounters, candidates were asked to manage a patient presenting with haematospermia (A) and premature ejaculation (B). The history also provided candidates the opportunity to demonstrate competencies in preventative health and discuss the role of sexually transmissible infection (STI) screening and the use of pre-exposure prophylaxis (PrEP) for human immunodeficiency virus (HIV) prevention.

Examiners commented that candidates demonstrated competency by:

- using appropriate, inclusive language and taking a sensitive sexual history
- articulating a clear problem definition and addressing the presenting complaint
- addressing confidentiality and contact tracing queries appropriately
- using an opportunistic approach to provide preventative care and health promotion, specifically discussing screening for STIs and considering the use of PrEP for HIV prevention.

Examiners commented that common pitfalls by candidates in these cases included:

- insensitive or judgemental communication style
- an approach that was doctor, rather than patient, centred
- failing to cover the case instructions, especially not giving a problem list
- failing to address the presenting complaint (focusing on STI screening only)
- conducting an incomplete STI screening for men who have sex with men
- not having adequate knowledge of PrEP use for HIV prevention.

This public exam report is provided under licence by the RACGP. Full terms are available at www.racgp.org.au/usage/licence. In summary, you must not edit or adapt it, and must only use it for educational and non-commercial purposes. You must also acknowledge the RACGP as the owner.

Cases 9A and 9B

In these clinical encounters, candidates were asked to gather a collateral history from a family member for a patient they will see next week. The focus was on clinical information gathering and education of the family member. Candidates were expected to demonstrate their understanding of what might be happening for the patient to inform and guide the family member with appropriate general advice to assist with caring for an aging person living alone. The intent was to set up the groundwork for a therapeutic alliance with the patient and their main carer.

Examiners commented that candidates demonstrated competency by:

- demonstrating active listening; sensitively exploring ideas, concerns and expectations of the patient's family member, and then synthesising these data into a problem list to be addressed
- including on the problem list the lack of medical review over the past 12 months following the death of their spouse
- demonstrating regard to maintaining patient confidentiality, while being able to address the concerns of the family member
- formulating a comprehensive problem list
- demonstrating knowledge of the types and range of services available for the older patient to maintain independent living
- following a structured approach to the case, which generally followed the instructions given in the stem.

Examiners commented that common pitfalls by candidates in these cases included:

- disorganised approach to the consultation
- premature closure/early anchoring of one diagnostic possibility, and therefore not exploring other options
- not listening to the role-players' concerns (eg the driving task) or not responding to cues
- cutting corners in history-taking, and therefore missing key issues
- lack of structure, with no clear list of problems or differentials
- not considering polypharmacy as a potential issue
- not expressing empathy at the loss of the patient's mother
- using jargon and abbreviations inappropriately
- not considering preventative health.

This public exam report is provided under licence by the RACGP. Full terms are available at www.racgp.org.au/usage/licence. In summary, you must not edit or adapt it, and must only use it for educational and non-commercial purposes. You must also acknowledge the RACGP as the owner.

Feedback on candidate performance

Candidate clinical performance: General comments

Successful candidates were able to demonstrate an empathic and non-biased approach to patient management, taking into consideration the patient's context.

An example of where candidates did not do this well was with culturally and linguistically diverse patients. General stereotyping is not appropriate and demonstrates a lack of understanding of patient context. Competent candidates should demonstrate a non-judgemental approach to all patients.

Other common pitfalls included formulaic responses that used a scattergun approach in answering the question. This does not demonstrate clinical reasoning ability or understanding of individual patient context and needs. Assumptions and formulaic responses to specific cultural groups, for example, without considering individual circumstance might lead to incorrect conclusions.

Reflecting on areas of practice with which a candidate might be less familiar, and addressing these gaps, is helpful in exam preparation. In some stations, it was obvious to examiners that candidates had not previously managed a certain type of presentation in practice. This leads to a formulaic, rather than patient-centred, approach.

A structured and systematic approach will assist candidates to encompass important potential diagnoses that guide their history, examination, investigations and management.

Process: General comments

Most candidates engaged well with the process and had a smooth examination experience. However, a small number of candidates had not tested their technology and arrived at the exam without adequate audio and camera functionality. The RACGP information technology team, administrators and examiners supported those candidates to progress through the examination, but pre-exam preparation would have ensured a better experience for them.

A reminder that, if needed, candidates should use the 'ask for help' button in Zoom to alert the administrator of a problem, and not leave the exam until speaking with an administrator if you have encountered a technology-related problem.

A small number of candidates appeared to be unfamiliar with the functionality of the Zoom platform, and were therefore less prepared to manage on-screen documents.

Additionally, some candidates experienced slow internet connections that affected their connectivity to the exam. The likelihood of this occurring can be reduced by testing internet speed prior to the exam. Refer to the CCE technical guide for more information.

Preparation is key to a smooth experience. We encourage all candidates to optimise their examination environment and tools when preparing to sit the CCE.

This public exam report is provided under licence by the RACGP. Full terms are available at www.racgp.org.au/usage/licence. In summary, you must not edit or adapt it, and must only use it for educational and non-commercial purposes. You must also acknowledge the RACGP as the owner.

Healthy Profession.
Healthy Australia.

racgp.org.au