RACGP

RACGP Education

Exam report 2023.2 CCE

RACGP Education: Exam report 2023.2 CCE

Disclaimer

Recommended citation

The Royal Australian College of General Practitioners (RACGP). RACGP Education: Exam report 2023.2 CCE. East Melbourne, Vic: RACGP, 2023.

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 December 2023

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-5527

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 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 2023.2, 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 2023.2 CCE was delivered in two streams on non-consecutive days as follows:

- **Day 1A:** Saturday 11 November 2023, cases 1A–4A
- **Day 1B:** Sunday 12 November 2023, cases 1B–4B
- **Day 2A:** Saturday 18 November 2023, cases 5A–9A
- **Day 2B:** Sunday 19 November 2023, cases 5B–9B.

Exam psychometrics

The 2023.2 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 2023.2 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) 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 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. 2023.2 CCE psychometrics

Average reliability	0.70
Pass rate (%)	85.48
Number passed	730
Number sat	854

Table 2. 2023.2 CCE pass rate by number of attempts

Attempts	Pass rate (%)
First attempt	88.34
Second attempt	70.37
Third attempt	69.57
Fourth and subsequent attempts	40.91

Exam banding

Table 3 provides a percentage breakdown of candidates into bandings.

Table 3. 2023.2 CCE candidates in each banding

Banding	% Candidates
P4	26
P3	22
P2	21
P1	16
F1	10
F2	2
F3	1
F4	<1

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.

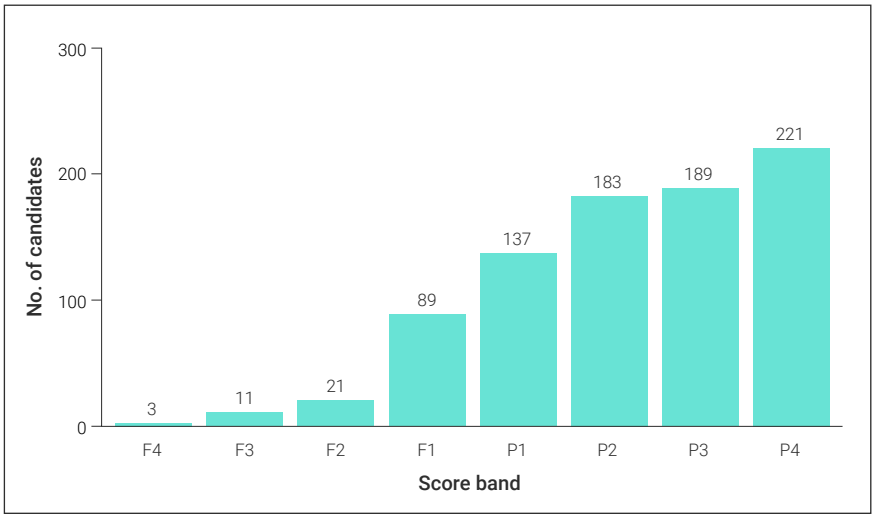

Figure 1. 2023.2 CCE banding distribution

Figure 2 shows the average performance of the cohort of passing candidates across clinical competency areas in the 2023.2 CCE.

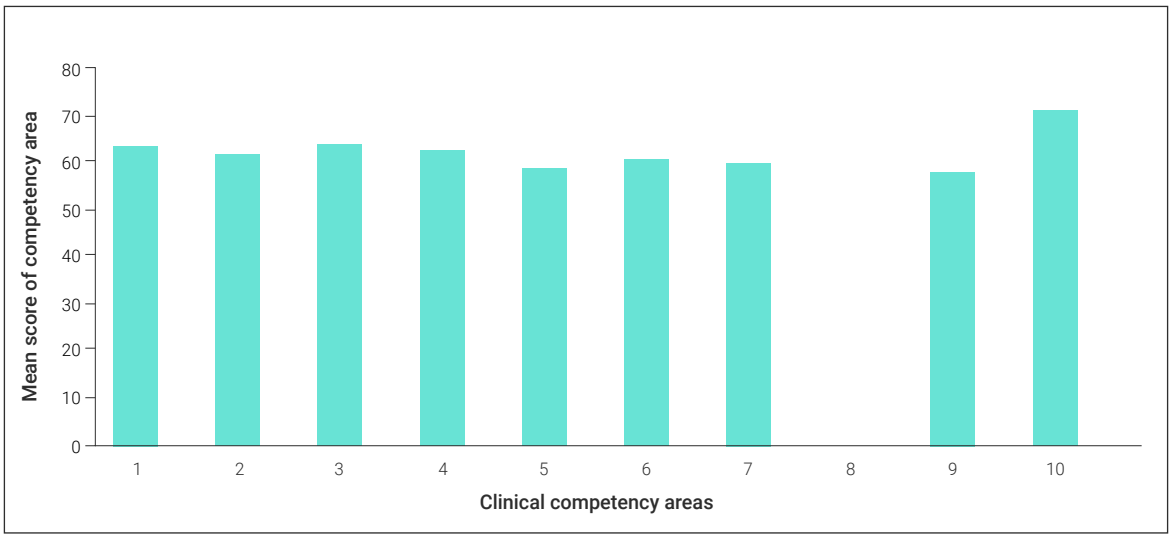

Figure 2. Average performance of passing candidates by competency area in the 2023.2 CCE.

Clinical competency areas are as follows: 1. Communication and consultation skills; 2. Clinical information gathering and interpretation; 3. Diagnosis, decision making and reasoning; 4. Clinical management and therapeutic reasoning; 5. Preventive and population health; 6. Professionalism; 7. General practice systems and regulatory requirements; 8. Procedural skills; 9. Managing uncertainty; 10. Identifying and managing the patient with significant illness.

For candidates who sat the 2023.2 CCE, refer to your candidate portal to see how your personal performance in each competency compares to that of the passing cohort. Some competency areas are examined more extensively than others in the CCE.

The list below provides a breakdown of the assessed criteria within each competency area. In the 2023.2 CCE, 114 individual competency criteria were assessed.

Breakdown of assessed criteria within competency area for the 2023.2 CCE

1. **Communication and consultation skills:** 26% (30/114)
2. **Clinical information gathering and interpretation:** 16% (18/114)
3. **Diagnosis, decision-making and reasoning:** 17% (19/114)
4. **Clinical management and therapeutic reasoning:** 18% (21/114)
5. **Preventive and population health:** 9% (10/114)
6. **Professionalism:** 6% (7/114)
7. **General practice systems and regulatory requirements:** 3% (3/114)
8. **Procedural skills:** 0% (0/114)
9. **Managing uncertainty:** 4% (4/114)
10. **Identifying and managing the patient with significant illness:** 2% (2/114)

Preparation for the CCE

Preparation for the CCE primarily involves working in and reflecting on comprehensive general practice. It is useful to practise 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. A technical guide is available on the CCE resources website. The RACGP encourages all CCE candidates to practise in the online environment as much as possible to best prepare themselves for the exam-day experience.

2023.2 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. It is helpful to consider your personal graph of performance in each of the competency areas when reflecting on the item feedback. 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'.

This assessment is designed as a summative measure of competency. It is not designed to give feedback to candidates and, as such, we do not ask examiners to comment on individual candidate performance; we ask examiners to rate performance based on the demonstration of competencies.

The public exam report is provided so that all candidates can reflect on their own performance. 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.

Selected case details are outlined below (Saturday: Stream A, Sunday: Stream B). Cases are not paired between streams; however, an equivalent number of competencies are assessed over both streams, and each unique 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. Some competencies are assessed more frequently over the exam. Examiners were surveyed on exam day to identify candidate performance characteristics that demonstrated competency and common pitfalls observed.

Case 1A

This case discussion presented an Aboriginal patient returning for follow up after a health assessment. The scenario advised the patient had had six months of productive cough, haemoptysis and weight loss on the background of diabetes, hypertension, hyperlipidaemia, smoking and recent bereavement. Candidates were asked to outline a problem list and consider barriers to care and cultural safety based on the scenario and further information provided through the case.

Competent candidates considered exploring the reasons why the patient may have been reluctant to present earlier with symptoms or his avoidance of mainstream health services, and considered solutions that may help meet the patient's needs while maintaining cultural safety.

A collection of resources and learning modules on Aboriginal and Torres Strait Islander health can be found in the 2022 RACGP curriculum and syllabus for Australian general practice and on the RACGP Aboriginal and Torres Strait Islander health website. Information on cultural awareness training is also available on *gplearning*.

Examiners commented that candidates demonstrated competency by:

- demonstrating a self-reflective and individualised approach in the management of an Aboriginal patient with complex care needs
- addressing why a patient may have experienced discomfort with previous health providers or health experiences
- both demonstrating an understanding of and expressing strategies they would use to explore potential barriers to the patient engaging in effective healthcare, and reaching a shared understanding and plan
- openly addressing the patient's recent bereavement
- demonstrating respect of the patient in his context and psychosocial background. This was demonstrated as a patient-centred problem list, navigating the barriers to care and exploring treatment goals that were important to the patient, rather than rote-learned responses
- recognising and appropriately prioritising the complex medical conditions and care needs, resulting in a shared agenda to address both the doctor's and the patient's concerns
- acknowledging the complexities of healthcare in an Aboriginal man who has cultural influences that impact on his health beliefs and priorities
- embracing the opportunity to reflect on their own cultural safety and training options, as well as those within the practice and community
- considering how they could seek out resources, educate themselves and ask for advice
- discussing existing inequities in healthcare for many Aboriginal and Torres Strait Islander patients
- genuine curiosity and a desire to seek the patient's perspective on what cultural safety means for them
- considering cultural perspectives on death and dying within a culturally appropriate plan
- considering comprehensive and holistic management, following a biopsychosocial framework being open about their knowledge limitations and experience, and being willing to seek help.

Examiners commented that common pitfalls in these cases included:

- listing engagement of an Aboriginal health worker or Aboriginal liaison officer as the solution to any and all cultural aspects of the case, and demonstrating no real understanding of the actual role or scope of the Aboriginal health worker
- overlooking the fact that this patient had just lost his life partner eight months earlier, and lack of empathy for a grieving man
- inability to demonstrate a personalised approach in addressing cultural challenges, thus hindering the promotion of a culturally safe practice environment
- taking a judgemental, offensive and racist approach in assuming why an Aboriginal man may not want to engage with the hospital system (eg 'he might have drug and alcohol issues and would be withdrawing if he went to hospital', even though the case notes state that the patient does not drink alcohol)

- making assumptions such as alcohol use, overcrowding of the home, 'non-compliance' of medication, 'running away' from hospital and assuming limited health literacy
- failing to address what they can do personally to be more culturally safe, and failing to reflect on their own behaviours and understanding their own cultural bias
- having rote-learned lists for cultural safety, such as 'displaying the flag' or 'cultural training' without further elaboration, and failing to mention the much more integral components of cultural safety, such as exploring the patient's understanding and cultural perspectives on their health, exploring barriers to healthcare from a patient perspective or being aware of one's own unconscious bias
- being doctor centred and not patient centred
- stereotyping or judgemental approaches, using generalisations and not approaching a lack of knowledge and understanding with humility and curiosity.

Case 3B

In this clinical encounter, a man aged 56 years presents with lower urinary tract symptoms and anxiety about possible prostate cancer on the background of treated hypertension, androgenic alopecia treated with finasteride and hazardous use of alcohol. It was commonly not recognised by candidates that finasteride artificially decreases prostate-specific antigen by up to 50%. Many candidates took a screening approach to the measurement of prostate-specific antigen and did not consider or check that the patient had symptoms, therefore missing the opportunity to appropriately follow up.

Examiners commented that candidates demonstrated competency by:

- taking an adequate history, including assessment of risks for prostate cancer, urinary tract symptoms, alcohol use and readiness to change, assessment of anxiety and assessment of lifestyle factors
- demonstrating communication skills, such as building rapport, active listening, using skills in motivational interviewing, demonstrating empathy and addressing health anxiety
- correctly interpreting investigation results, taking into account the patient's history, current presentation and medications
- arranging appropriate follow-up and safety netting
- assessing alcohol intake and impact by using a framework such as AUDIT-C or a FRAMES (Feedback, Responsibility, Advice, Menu of change options, Empathy, Self-efficacy) approach
- providing a plan of how to confirm and manage possible diagnostic possibilities and explaining this effectively to the patient
- communicating the uncertainty of the diagnostic possibilities to the patient
- taking the opportunity to discuss prevention tailored to this patient's needs.

Examiners commented that common pitfalls in these cases included:

- not reading the case instructions properly, and therefore not undertaking the prescribed tasks (eg not taking a history and therefore not exploring the lower urinary tract symptoms)
- being satisfied with a single diagnostic possibility and therefore limiting thinking
- disorganisation in the approach to the consultation
- not attending to the patients concerns, and focusing on their own agenda of health promotion and prevention

- missing the relationship between prostate-specific antigen and finasteride (artificially decreasing prostate-specific antigen by 50%)
- not recognising the patient's precontemplative state of change regarding alcohol use, so not limiting to brief advice for this state of behaviour change
- failing to listen to the patient and their concerns
- taking a judgemental approach to alcohol use
- providing generic lifestyle advice rather than tailoring advice to the patient
- failing to address the patient's less than optimal blood pressure management
- taking a paternalistic/doctor-centred approach to management rather than shared decision making.

Case 4A

In this clinical encounter the mother of a boy aged 11 months presented with concerns regarding her son's recent diagnosis of egg allergy in a rural setting. Candidates were asked to take a history and manage the condition after a recent assessment in the local emergency department.

Examiners commented that candidates demonstrated competency by:

- reading the instructions for the case and undertaking the prescribed tasks using active listening, as well as taking a full social history
- concurrently managing the anaphylactic child and the maternal stress – considering the possibility of postnatal depression
- providing clear explanations of anaphylaxis, education on how to use an EpiPen and an action plan for home and for day care if needed
- taking an assessment of the home situation
- considering the rurality of the patient and discussing organising accommodation and travel subsidy, or considering telehealth for specialist review
- recognising a mother in distress and providing immediate and medium-term support by ensuring the safety of the mother and children in her care, and then rebooking the mother for follow-up care.

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

- not taking a psychosocial history
- missing the opportunity to safety net for the patient, particularly about how to manage symptoms if they recurred
- referring for specialist review without taking into account the rurality of the patient or barriers that might be present for a mother of five with a partner who works away
- advising incorrectly to avoid any new foods until having an assessment from an allergist
- making assumptions about what had occurred rather than asking for history
- stating they would provide an anaphylaxis action plan without describing what it would contain
- speaking in an alarming way (eg advising that eating egg would kill her child)
- failing to provide appropriate follow-up.

Case 6B

In this case discussion, a man, aged 90 years, living in an aged care facility presented with worsening hip pain. Candidates were asked to outline a summary of the defining features of the case by generating a problem representation.

Candidates were then asked to list their differential diagnosis, investigate and manage his pain. This case also covered the professionalism competency of appropriately managing an ethical dilemma, assessing the approach to the conversation of death and dying with a patient and their family who wanted to discuss the option of voluntary assisted dying. The systems requirements of completing certification after dying were also assessed in this case.

Examiners commented that candidates demonstrated competency by:

- listening to the question and then answering the question posed
- focusing on this case, rather than a generic case
- generating an appropriate problem list and differential diagnosis, and considering conditions not to be missed
- discussing when they were at the limitations of their understanding, and when and who they would ask for help
- approaching the case in a systematic way, considering investigations in a rational way and having a patient-centred approach to management
- discussing and exploring patient wishes, beliefs and expectations.

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

- demonstrating a poor understanding of death certification and cremation paperwork
- failing to expand on non-pharmacological management of pain
- failing to answer the question asked (eg when asked about investigations, they described the further history they would ask)
- not considering a malignancy as a differential in an elderly person with a significant smoking history
- not considering a unifying diagnosis for the symptoms, rather considering a differential for each symptom
- generalising responses rather than making them specific to this patient and their wishes
- making assumptions that an elderly person in an aged care facility must have delirium or dementia
- failing to engage in a conversation about death and dying and what the patient's beliefs and preferences were.

Case 7A

This clinical encounter gave candidates the opportunity to demonstrate competencies in communication, gathering history, providing appropriate diagnostic impressions and providing patient education and advice. The case presented a single woman, aged 35 years, enquiring about fertility options and preservation.

Examiners commented that candidates demonstrated competency by:

- following the instructions for the case
- actively listening and taking a history, and identifying the patient's agenda, concerns, ideas, fears and expectations
- identifying the likelihood of polycystic ovary syndrome while considering other differentials and managing the uncertainty at this stage in the process
- using clear, succinct non-judgemental communication, checking in with the patient regarding her understanding and demonstrating empathy with and a genuine interest in the patient's situation
- considering a rational list of investigations
- providing clear explanations that attended to the patient's agenda
- considering medications, blood pressure and other lifestyle factors that could be optimised prior to a potential pregnancy.

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

- giving incorrect advice (eg not considering fertility to be an issue in her age range and thus inappropriately using time as a diagnostic tool)
- overfocusing on polycystic ovary syndrome and not addressing the patient's agenda or considering other diagnostic possibilities
- failing to organise follow-up
- not taking the patient seriously because she did not have a partner
- not having a structure to the history or failing to take an adequate history to recognise the likely diagnosis
- failing to recognise that her hypertensive treatment should be altered for a pregnancy
- failing to make a referral to a fertility specialist
- not considering the appropriate prenatal testing (eg failing to consider vaccinations or the immune status of relevant illness, such as varicella and rubella)
- ordering hormone levels while on the contraceptive pill
- providing false reassurance about falling pregnant with a future partner.

Case 8B

In this clinical encounter, a woman aged 72 years presented with concerns regarding the delayed diagnosis of a subdural haematoma. Candidates were required to take a history, appropriately manage the patient and address her distress at the events that had occurred.

Examiners commented that candidates demonstrated competency by:

- showing empathy and good communications skills, including active listening (eg open questions, summarising, reflecting back, checking their understanding and sign posting)
- taking an appropriate biopsychosocial history, particularly the psychosocial and functional issues rather than overfocusing on the medical issues that had already been managed, and asking about her function and roles before injury
- thinking of the patient as a person with a life beyond her illness, allowing her to express her fear and anger and then providing options without judgement
- de-escalating the patient's distress by exploring how her life had been impacted by her illness and tailoring their proposed management to her needs rather than their agenda
- demonstrating an understanding of how to access additional supports through My Aged Care
- considering both the patient's and the colleagues' perspectives
- demonstrating an understanding of the complaints process for a health complaint and guiding the patient in the process without speaking negatively about their colleague.

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

- failing to take a comprehensive biopsychosocial history
- demonstrating poor listening skills (eg asking for information that was already given or not picking up on patient cues of distress)
- moving to closed questions too quickly, thus failing to let the patient tell her story
- overfocusing on the original injury that had already been managed
- overfocusing on the biological aspects of the case without considering the patient's psychological recovery needs
- using phrases such as 'I'm sorry to hear that' or 'apologies for the inconvenience' without actually exploring or addressing the concern
- dismissing the patient's desire to complain
- being avoidant about the possible misdiagnosis by a colleague
- spending too much time on the doctor's agenda of preventative health and not addressing the patient's concerns
- dismissing or minimising the patient's distress and not listening to her story
- escalating the patient's fear by inappropriately discussing advanced health directives
- defending the colleague being complained about and advising the patient not to complain
- not considering or addressing falls prevention
- not demonstrating knowledge and understanding of the complaints process or options for escalation.

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.

General stereotyping and making assumptions are not appropriate and demonstrate 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. For example, assumptions and formulaic responses to specific cultural groups 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 situations, 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.

Making up resources that do not exist is not appropriate. Multiple candidates were observed to refer to the non-existent 'Gout Australia' for patient education; this is not acceptable in practice, so not acceptable in the clinical exam.

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. Bluetooth connections often reset when moved to a new Zoom room, so a Bluetooth headset that is paired to other devices is not recommended.

A reminder that, if needed, candidates should use the 'Ask for help' (NOT the 'Raise hand' function) button in Zoom to alert the administrator to a problem and they should not leave the exam until they have spoken with an administrator if they 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. Candidates should practise resizing documents and obtaining a gallery view in Zoom, allowing for resizing of the shared document and face tiles. Markings are not to be made on the PDF documents by candidates.

In addition, 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 candidate technical guidelines 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.

RACGP

Healthy Profession.
Healthy Australia.

racgp.org.au