

RACGP Education

Exam report 2023.1 AKT



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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.

1. Exam psychometrics

Table 1 shows the mean and standard deviation of the entire cohort who sat the exam. These values can vary between exams. The reliability is a measurement of the consistency of the exam.

A candidate must achieve a score equal to or higher than the pass mark in order to pass the exam. The pass mark for the Applied Knowledge Test (AKT) and Key Feature Problem (KFP) exam is determined by the internationally recognised Modified Angoff method, and outcomes may vary between each exam cycle. The Clinical Competency Exam (CCE) pass mark is determined by the borderline regression method (refer to The Royal Australian College of General Practitioners [RACGP] Education [Examination guide](#) for further details).

The 'pass rate' is the percentage of candidates who achieved the pass mark.

The RACGP has no quotas on pass rates; there is not a set number of candidates who may pass the exam. Pass rates may vary depending on a wide variety of variables.

Table 1. Psychometrics

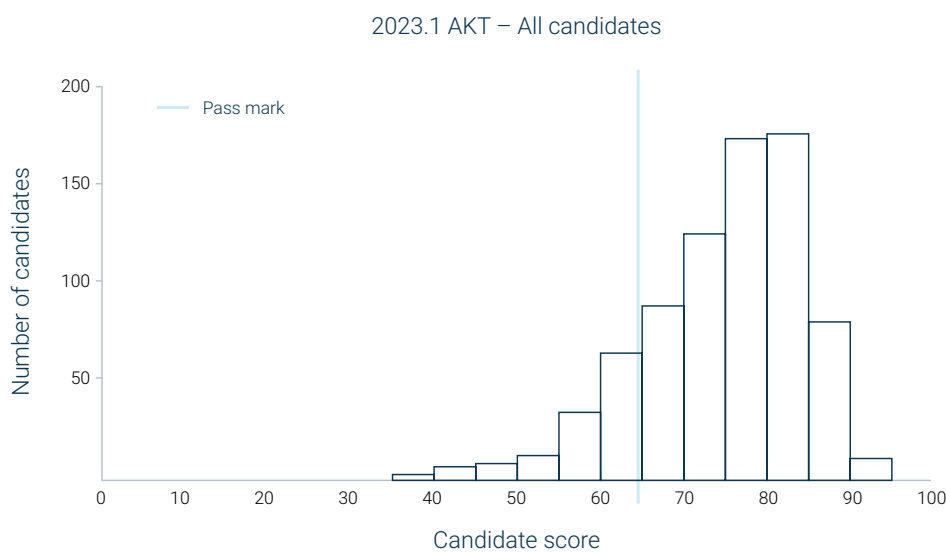
Mean score (%)	74.68
Standard deviation (%)	9.58
Reliability*	0.89
Pass mark (cut score %)	64.63
Pass rate (%)	85.09
Number sat	778

*The exam reliability is expressed as a value between 0 and 1, in line with international best practice in assessment reporting.

2. Candidate score distribution

The histogram shows the range and frequency of final scores for this exam (Figure 1). The vertical blue line represents the pass mark.

Figure 1. 2023.1 AKT score distribution.



3. Candidate outcomes by exam attempt

Table 2 provides pass rates (%) displayed by number of attempts. A general trend suggests the rate of passing diminishes with each subsequent attempt. Preparation and readiness to sit are important for candidate success.

Table 2. Pass rates by number of attempts

Attempts	Pass rate (%)
First attempt	92.3
Second attempt	60.9
Third attempt	70.0
Fourth and subsequent attempts	20.5

4. Feedback report on 2023.1 AKT

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.

All of the questions in the AKT are written by experienced general practitioners (GPs) who currently work in clinical practice, and are based on clinical presentations typically seen in an Australian general practice setting. The questions should be answered based on the context of Australian general practice.

It is important to carefully read the clinical scenario and question. Although more than one option may be plausible, only the most appropriate option for the clinical scenario provided should be selected.

It is useful for candidates to identify any areas of weakness in their clinical practice through self-reflection and feedback. A supervisor, mentor or peer may assist them in developing an appropriate learning plan to assist with future exams and ongoing professional development.

All questions in the AKT undergo extensive quality assurance processes. Questions are rigorously reviewed during the creation, pre-exam and post-exam review processes, and also during the standard-setting process following the AKT. Reviews are performed by GPs who are currently in clinical practice across Australia.

This report provides a sample of clinical scenarios from the 2023.1 AKT that some candidates found challenging. It describes alternative options selected by candidates and provides feedback regarding the correct answer to the question.

5. Example cases

Example 1

The clinical scenario described a woman, aged 59 years, with a history of insulin-dependent type 2 diabetes, presenting for her private driver's licence medical examination. She had recently experienced an episode of severe hypoglycaemia, requiring a bystander to administer glucagon.

The question asked, 'What is the MOST appropriate next step?'. Of the options provided, the most appropriate response was to advise a non-driving period of at least six weeks. Alternative options included providing a conditional driver's licence, allowing her to drive with blood sugar levels >5.0 mmol/L and referring her to an endocrinologist for review.

This question required candidates to safely prioritise the next steps in managing an episode of severe hypoglycaemia. The Australian Fitness to Drive guidelines advise a non-driving period of at least six weeks following an episode of severe hypoglycaemia. The guidelines take into consideration the safety of the patient and the community as it can take several weeks for impaired hypoglycaemic awareness to resolve. While referring to an endocrinologist might be appropriate, it is likely that the patient will not be seen immediately. Therefore, in this situation, it is the responsibility of the GP to advise the patient not to drive.

Example 2

The clinical scenario described a man, aged 44 years, presenting with a cough and shortness of breath on exertion for several months. A significant smoking history was provided. He had been using over-the-counter salbutamol with some benefit. Spirometry results consistent with an obstructive pattern with minimal change post-bronchodilator were provided.

The question asked, 'What is the MOST appropriate management?'. Of the options provided, the most appropriate response was prescription of aclidinium via inhalation twice daily. Alternative options included prescription of fluticasone via inhalation twice daily and tiotropium–olodaterol via inhalation daily.

This is an example of a two-step question. It required candidates to make a diagnosis of moderate chronic obstructive pulmonary disease (COPD) and then to select the most appropriate management. Candidates needed to apply their knowledge of the COPD guidelines to the clinical scenario. As this patient was already using a short-acting beta-agonist, the guidelines recommend a 'step-up' with the addition of a long-acting muscarinic antagonist. COPD is a common presentation in Australian general practice, and it is important for GPs to be able to prescribe appropriately based on symptom frequency and severity.

Example 3

The clinical scenario described a man, aged 55 years, presenting with urinary frequency, hesitancy and nocturia for four months. His urine microscopy, culture and sensitivity and prostate ultrasound were normal. Results from two recent prostate-specific antigen (PSA) tests performed one month apart were also provided. These were 4.3 µg/L and 4.4 µg/L, with a free-to-total PSA of 10% on both occasions.

The question asked, 'What is the MOST appropriate next step?'. Of the options provided, the most appropriate response was to refer to a urologist for MRI of the prostate. Alternative options included prescribing dutasteride and calculating the PSA velocity in six months.

This question required candidates to correctly interpret the PSA test result in the context of the patient's age and symptomatology. The Australian PSA testing guidelines recommend that, for men aged 50–69 years with an initial PSA of >3.0 µg/L, a repeat PSA test should be done in 1–3 months. If the repeat PSA testing level is also >3.0 µg/L, further investigation is indicated. Patients with lower urinary tract symptoms commonly present in Australian general practice. It is important that GPs can investigate appropriately and interpret the results of these investigations in order to exclude prostate cancer.

Example 4

The clinical scenario described a woman, aged 28 years, who was 38 weeks pregnant, presenting due to concerns about a change in fetal movements for four hours. She noted that movements varied between fast movements and no movement. A normal physical examination was provided, including a normal fetal heart rate.

The question asked, 'What is the MOST appropriate next step?'. Of the options provided, the most appropriate response was urgent referral to the obstetric unit for cardiotocography. Alternative options included recommending the use of a kick chart and reassuring the patient.

This question required candidates to have a knowledge of the current guidelines for managing reduced fetal movements and to apply this knowledge to the clinical scenario given. It is important that GPs are aware that sustained maternal perception of a change in fetal movements requires investigation with cardiotocography to reduce the risk of stillbirth. Changed or reduced fetal movements are a sensitive indicator of fetal compromise and are associated with impaired placental function. The use of kick charts is no longer recommended, and falsely reassuring the patient could result in fetal death.

Example 5

The clinical scenario described an infant, aged 6 months, who was brought in by his mother for routine immunisations. A physical examination identified a unilateral undescended testicle located in the inguinal canal.

The question asked, 'What is the MOST appropriate next step?'. Of the options provided, the most appropriate response was immediate referral to a surgeon for orchidopexy. Alternative options included reassurance that most testes would descend by 12 months and referral to a surgeon if still not descended by 18 months.

This question required candidates to correctly make the diagnosis of an undescended testicle and then to select the correct management. Current guidelines recommend referral to a surgeon by 3–6 months of age and orchidopexy between six and 12 months of age. Undescended testis is one of the most common paediatric surgical presentations in general practice. It is important that GPs are able to refer for timely surgical correction in order to reduce the risk of malignancy and infertility.

6. Further information

Refer to the RACGP Education Examination guide for exam-related information.

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