RACGP

# RACGP Education

## Exam report 2022.2 CCE

**RACGP Education: Exam report 2022.2 CCE**

## Disclaimer



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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.*

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# 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 2022.2, 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 2022.2 CCE was delivered in two streams on non-consecutive days as follows:

- **Day 1A:** Saturday 5 November 2022, cases 1A–4A.
- **Day 1B:** Sunday 6 November 2022, cases 1B–4B.
- **Day 2A:** Saturday 12 November 2022, cases 5A–9A.
- **Day 2B:** Sunday 13 November 2022, cases 5B–9B.

# Exam psychometrics

The 2022.2 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 2022.2 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) 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. 2022.2 CCE psychometrics**

| | |
|---|---|
| Average reliability | 0.73 |
| Pass rate (%) | 84.26% |
| Number passed | 578 |
| Number sat | 686 |

**Table 2. 2022.2 CCE pass rate by number of attempts**

| Attempts | Pass rate |
|---|---|
| First attempt | 88.72% |
| Second attempt | 55.36% |
| Third attempt | 54.55% |
| Fourth and subsequent attempts | <1% |

# Exam banding

Table 3 provides a percentage breakdown of candidates into bandings.

**Table 3. 2022.2 CCE candidates in each banding**

| Banding | Candidates (%) |
|---|---|
| P4 | 31.49% |
| P3 | 21.28% |
| P2 | 18.95% |
| P1 | 12.54% |
| F1 | 9.77% |
| F2 | 4.37% |
| F3 | 1.31% |
| F4 | 0.29% |

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.

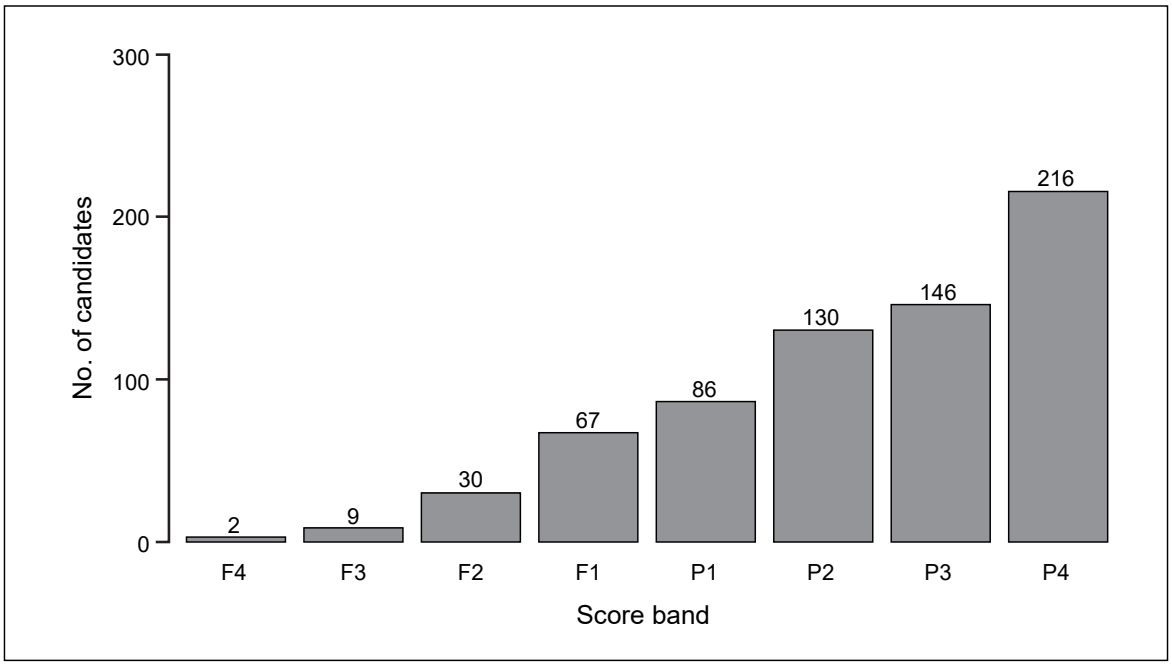


**Figure 1.** 2022.2 CCE banding distribution.

Figure 2 shows the average performance of the cohort of passing candidates across clinical competency areas in the 2022.2 CCE.

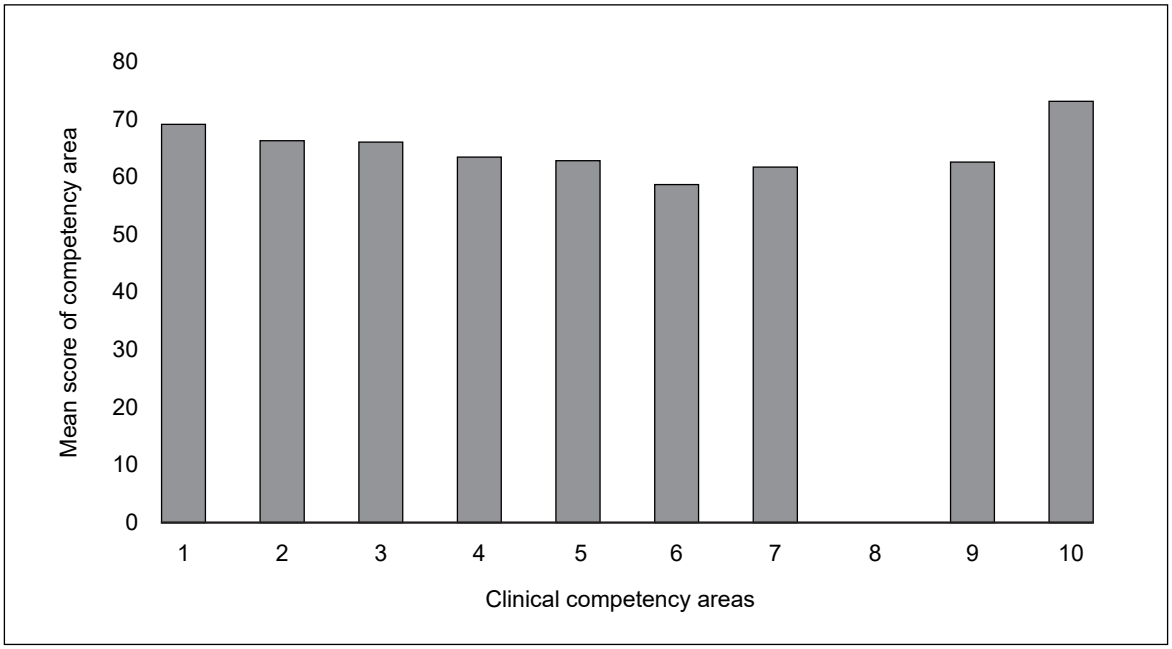


**Figure 2.** Average performance of CCE – by competency area.

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 2022.2 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.

# Preparation for the CCE

Preparation for the CCE primarily involves working in and reflecting on comprehensive general practice. It is useful 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. A technical guide has been provided on the CCE resources website. 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.

# 2022.2 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 feedback report is provided so that all candidates can reflect on 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 12 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.

## Cases 1A and 1B

This case discussion presented an Aboriginal doctor in training (1A) or medical student (1B) with situational stress and symptoms of anxiety on the background of personal and intergenerational trauma. The case examined the approach to trauma-informed care of Aboriginal and Torres Strait Islander peoples. It was important for the candidate to recognise intergenerational and personal trauma in this case, and to approach with sensitivity, avoiding gathering specific details of trauma(s) in a single consultation. The query regarding the approach to those who have experienced trauma was poorly answered by many candidates. The RACGP has developed many resources in this area including the White Book – Trauma-informed care in general practice. Building relationship and rapport was vital, as was offering support and follow up, and enquiring

about, and respecting, cultural values and needs when it comes to medical consultations and interventions. 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, family situation and career path. 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 Island Health website. Information on cultural awareness training is also available on *gplearning*.

Many examiners commented that, in this case, the mental health aspects were well managed; however, many candidates did not address cultural aspects, intergenerational trauma or the social situation for the patient.

Examiners commented that candidates demonstrated competency by:

- demonstrating a non-judgemental, patient-centred approach, with patient autonomy
- recognising the complexity of intergenerational trauma and how this contributed to the presentation
- understanding culturally informed care beyond offering an Aboriginal health worker
- having a grasp of the principles of trauma-informed care
- respecting the patient as a medical colleague and as an Aboriginal woman
- considering comprehensive and holistic management, following a biopsychosocial framework
- demonstrating authentic, culturally safe and respectful practice at each stage of the consultation, including being open about their knowledge limitations and experience, and being willing to seek help.

Examiners commented that common pitfalls in these cases included:

- using rote/generic rehearsed responses because the patient was Aboriginal when the response was not appropriate to the case
- not recognising or articulating the personal, family and intergenerational trauma experienced by the patient in the scenario
- making negative assumptions and preconceived judgements about the patient based on identification as an Aboriginal person, often missing she was a medical colleague
- using inappropriate language, an overreliance of 'buzzwords' relating to Aboriginal and Torres strait Islander healthcare; for example, mentioning an Aboriginal health worker, but not explaining what they would do, or stating they would be 'culturally appropriate', but not being able to articulate how, or using inappropriate acronyms, such as 'ATSI'
- overlooking the primacy of patient agency and self-determination. Candidates described a diagnostic and management plan, but did not consider checking to see if this is what the patient wanted
- not exploring patients' needs concerns and expectations
- being overly focused on the biological aspects of the case, and not addressing the psychological, social, spiritual or cultural aspects
- having a poor understanding of caring for a colleague and inappropriately referring to the Australian Health Practitioner Regulation Agency (AHPRA)
- poor understanding of the social determinants of health.

## Cases 2A and 2B

In this case discussion, candidates were asked to outline a problem representation/problem definition and a diagnostic approach to syncope/presyncope (2A) and shortness of breath (2B). A problem representation is a medicalised summary of the case so far. It is a step in clinical reasoning and relates to the assessment of criterion 3.5 'Articulates an appropriate problem definition' in the RACGP Clinical competency rubric 2022. The cases then moved through identifying appropriate investigations and creating a management plan for the patient. As for all case discussions, familiarity with the principles of random case analysis is useful. The case moved on to identifying an urgent care aspect, and both immediate and longer-term management approaches were needed.

Examiners commented that candidates demonstrated competency by:

- having a systematic approach. A good problem representation allowed a list of relevant differentials to be generated and management appropriate to the individual patient to be planned
- having an organised approach, considering a broad range of plausible differentials, and signposting the most and least likely differentials
- identifying and prioritising management tasks, considering acute conditions and long-term/preventative care
- detailing safe and appropriate urgent care management
- approaching the case in a holistic way.

Examiners commented that common pitfalls in these cases included:

- taking a scattergun approach, which impaired the generation of an appropriate differential diagnosis and a management plan that lacked specificity
- poor attention to the detail given in the stem; failure to correctly interpret electrocardiography/spirometry
- inability to clearly articulate a problem list or differential diagnosis
- failing to synthesise concerning features in the examination, and therefore not providing appropriate management
- not being able to identify priorities in the given situation
- making assumptions and adding clinical detail to the cases that were not present (eg assuming a prior diagnosis of atrial fibrillation)
- investigating without a rational approach
- focusing on only one aspect of the presentation at the cost of other important clinical aspects
- failing to recognise markers of severity or urgency in the presentation
- chaotic management with no organisation or prioritisation
- not curating the preventative activities appropriately to the patient.

## Cases 3A and 3B

In these clinical encounters, a patient presented with fatigue. This case examined communication skills, history-taking, diagnostic reasoning, problem definition, shared decision-making and management of uncertainty in a case of undifferentiated fatigue with the hallmarks of chronic fatigue syndrome (3A) or long COVID (3B). Management was required to be holistic in nature and be approached using a biopsychosocial model.

Examiners commented that candidates demonstrated competency by:

- using appropriate communication skills, such as active listening, and demonstrating empathy, including understanding how the condition was impacting the patient's life
- 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, and having confidence that a sinister underlying cause had been excluded
- formulating a rational list of differential diagnoses without the pressure to provide a definitive diagnosis
- appreciating the diagnostic uncertainty and managing this appropriately
- being able to elicit the patient's concerns, and adjust education and management based on this, rather than being driven by own agenda
- providing 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)
- not answering patient queries and ignoring the patient's agenda
- not rationalising further investigations
- becoming stuck on one aspect of the case; for example, sleep hygiene, and focusing on sleep, rather than fatigue, or perseverating on finding a clear organic cause, such as anaemia, when this had been excluded
- inability to manage diagnostic uncertainty
- failing to offer any non-pharmacological management
- failure to acknowledge the psychosocial impacts of the patient's symptomatology
- failing to tailor non-pharmacological advice to the patient; for example, advising 150 minutes of physical activity weekly when the patient could not undertake usual activity, such as grocery shopping
- poor patient education
- failing to provide specific follow-up advice.

## Cases 4A and 4B

In these clinical encounters, a parent presented concerned with their child's behaviour and development. Candidates were given the opportunity to demonstrate competencies in communication skills, history-taking, formulating a differential and probable diagnosis, and considering the first steps in management for the family. A sensitive approach to the possibility of attention deficit hyperactivity disorder (4A) or autistic spectrum disorder(4B) needed to be demonstrated. Management needed to be holistic using a biopsychosocial model.

Examiners commented that candidates demonstrated competency by:

- reading the instructions for the case and undertaking the prescribed tasks
- using active listening and taking a full social history
- approaching the parent in a non-judgemental way
- using shared decision-making to establish a collaborative management plan
- considering the range of potential assistance available to the family, including referrals to specialists for diagnosis and allied health support.

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

- disorganised or scattergun approach to information gathering, with closed questions and failure to listen to the patient (parent)
- not listening to, or addressing, the patient's (parent's) concerns
- poor time management, with too much time spent on history, and limited time left to manage other aspects of the consultation holistically
- not being familiar with a family structure that is non-traditional (ie two mothers or a single mother), and resulting in offensive assumptions or inappropriate management steps (eg reporting to Child Protection for not gaining father's permission for parental decision)
- patriarchal positioning – telling the mother that the child's behaviour was her fault because of parenting style/lack of father, and declining patient requests, such as a paediatric referral
- lacking a holistic approach to the problem and becoming bogged down in clinical minutia or following their own narrowed agenda; for example, a weight on the 25th percentile that has not changed percentiles over time is not pathological, rather a part of the normal range
- ordering multiple unnecessary investigations and a scattergun approach to differential diagnoses
- failing to ask about safety or family violence
- not providing practical assistance or management strategies to try at home while awaiting a definitive diagnosis
- not planning specific follow up or safety-netting.

## Cases 5A and 5B

In these case discussions, candidates were asked to provide a problem definition based on the information given in the stem; that is, to interpret and synthesise the clinical features into a brief summary and formulate a list of differential diagnoses. The case then provided the candidates with the presenting neurological condition (Parkinson's disease – 5A or multiple sclerosis – 5B), and assessed the candidate's competency in communicating the diagnosis and educating the patient about possible treatment options. A multidisciplinary approach to management was expected, including consideration of carer wellbeing and stressors, and managing the obstacles to care in a rural setting was assessed.

Examiners commented that candidates demonstrated competency by:

- synthesising the clinical information given in the stem to a succinct problem definition, not simply reiterating the information in the stem
- proposing a reasonable differential diagnosis based on the history and given clinical examination details
- providing patient-centred explanations of the diagnosis
- taking rurality into consideration when considering management and services that might be available
- discussing both pharmacological and non-pharmacological management
- providing clear safety-netting and considering impact of illness on carer.

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 (semantic qualifiers are paired opposing descriptive words, such as acute/chronic or proximal/distal)
- not being able to describe illness in patient-centred language or consider what the implications of the diagnosis might be for the patient
- identifying some barries to accessing care in a rural setting, and not providing any strategies to overcome this
- lack of knowledge on medicines used to treat Parkinson's disease or multiple sclerosis. Detailed knowledge was not expected; however, broad treatment principles were expected; for example, monitoring of common side effects of drugs that might be used in these conditions
- overreliance on specialist advice for ongoing management
- failing to consider preventative activities as part of the management plan.

## Cases 6A and 6B

In these case discussions, candidates were asked to interpret a summary table of a Cochrane Review and relate the findings to a clinical scenario. The summary table compared nicotine-containing e-cigarettes to nicotine replacement therapy for smoking cessation (6A) or compared probiotics to placebo, and looked at several perinatal outcomes (6B). The question also asked about how to effectively use practice systems to assist in health-promotion activities.

Examiners commented that candidates demonstrated competency by:

- understanding the data presented, and interpreting the statistics correctly, including recognising the relevance of the confidence interval not crossing one as a marker of statistical significance
- relating the summary data to the patient described, and being able to translate the data into meaningful, patient-specific advice
- discussing health-promotion principles, including motivational interviewing for behaviour change
- considering a diverse range of health-promotion activities and using practice systems to help identify appropriate population groups.

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

- not correctly interpreting data given in the Cochrane Review summary table. In particular, not understanding relative risk and confidence intervals
- not adjusting management advice to the patient's clinical context
- using statistical jargon while explaining impact to the patient or answering their question (provided in the stem)
- failing to recognise harms that were outlined in the data provided
- only considering individual patients for preventative activities and health promotion, rather than a practice population approach.

## Cases 7A and 7B

These clinical encounters gave candidates the opportunity to demonstrate competencies in communication, clinical information gathering, and interpretation and management of women's health, with cases covering dysmenorrhoea and menorrhagia in a perimenopausal woman (7A) and contraception and sexually transmitted infection screening in a young woman (7B).

Examiners commented that candidates demonstrated competency by:

- following the instructions for the case
- actively listening and taking a comprehensive structured history
- undertaking a Home, Education/Employment, Eating/Exercise, Activities, Drugs, Sexuality, Suicide/Depression and Safety (HEEADSSS) assessment (7B)
- identifying the patient's symptoms, agenda, concerns, ideas, fears and expectations
- clearly eliciting red flags, recognising important contraindications and tailoring management appropriately
- having a patient-centred approach to management, discussing all the available options and considering side effects of medications.

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

- spending too much time taking history at the expense of providing an appropriate management plan
- having a scattered approach to history-taking
- insensitive approach to taking a gynaecological or sexual history
- failing to listen to (or respond to) the role-player's prompts
- not being able to describe the procedure of contraceptive implants (eg Implanon or Mirena)
- not considering pregnancy
- not approaching management in a collaborative way.

## Cases 8A and 8B

In these clinical encounters, candidates were given the opportunity to demonstrate competencies in communication and consultation skills, information gathering, interpretation of clinical information from multiple sources, decision-making and reasoning, clinical management and managing uncertainty. In each case, an older patient presented with potential memory impairment, either wanting assessment for their private driver's licence (8A) or requesting recent results showing hyponatremia (8B). Each of these cases involved an approach to managing not only the patient's, but also their family member's, concerns.

Examiners commented that candidates demonstrated competency by:

- demonstrating communication skills, such as active listening, reflection, exploring patient concerns, demonstrating curiosity in the patient's life, validating concerns appropriately, showing empathy, deescalating stronger emotions and sensitively breaking bad news
- taking a thorough and organised history, and considering multiple sources of evidence (eg family reports or investigation results)
- curating a clear and comprehensive plan for further investigation, management and preventative care
- taking a rational approach to investigation
- clearly managing patient expectations and appropriately setting boundaries
- demonstrating an approach that allowed for safe patient-centred management
- appropriately safety-netting and organising specific follow up.

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

- an approach that was doctor, rather than patient, centred. Not responding to patient cues, and a failure to de-escalate or explore patient emotions
- spending too long on history and not leaving time for management, and not spending time taking a comprehensive history before diving into management
- failing to consider psychosocial aspects – either not taking history or not considering this in the management of the patient
- not providing adequate explanations to patients about their condition, with the assumption they would not understand or that it would take too long
- not creating a clear plan to manage (eg discussing generic aspects of care, such as a shingles vaccination, rather than specific aspects of the case) or creating a clear plan to follow up with the patient
- not deciding on driving capacity for the patient
- deferring responsibility of management by referring to a specialist (8A) or the emergency department (8B).

## Cases 9A and 9B

In these clinical encounters, candidates were assessed on communication and consultation skills, history-taking, interpretation of investigation results, clinical management and preventative health. The clinical context these skills were examined in were a fly-in fly-out worker with poorly controlled diabetes, elevated cholesterol and likely sleep apnoea (9A), and a postmenopausal woman with results of her bone mineral density, vitamin D deficiency, hyperthyroidism and low ferritin in the context of a low-impact fracture (9B).

Examiners commented that candidates demonstrated competency by:

- demonstrating clear communication, including a good explanation of results to patients
- balancing the patient and doctor's agenda
- interpreting investigations appropriately for the patient context
- showing clinical curiosity and following up on comments made by the patient
- taking focused additional history demonstrating a hypothetical-deductive approach
- demonstrating appropriate guideline-based care in management, while involving the patient in decisions about their care and giving them choices
- discussing both pharmacological and non-pharmacological elements to management
- considering appropriate safety-netting and follow up.

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

- a disorganised approach to the consultation
- using closed questions in history and jargon in explanations
- not listening to the patient, speaking to the results only, and not taking patient preferences or context into account
- missing the preventative elements of the case.

# 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. 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. Candidates should practise resizing documents and obtaining a gallery view in Zoom, allowing for resizing of the shared document and face tiles.

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 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.

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