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RACGP Education

Exam report 2024.1 CCE

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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 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). The 2024.1 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 2024.1 CCE was delivered in two streams on non-consecutive days as follows:

- **Day 1A:** Saturday 15 June 2024, cases 1A–4A
- **Day 1B:** Sunday 16 June 2024, cases 1B–4B
- **Day 2A:** Saturday 22 June 2024, cases 5A–9A
- **Day 2B:** Sunday 23 June 2024, cases 5B–9B.

Exam psychometrics

The 2024.1 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. Each case had high internal reliability. There were two streams in the 2024.1 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) 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. 2024.1 CCE psychometrics

Average reliability	0.73
Pass rate (%)	89.10
Number passed	711
Number sat	798

Table 2. 2024.1 CCE pass rate by number of attempts

Attempts	Pass rate (%)
First attempt	92.56
Second attempt	82.95
Third attempt	38.89
Fourth and subsequent attempts	45.00

Exam banding

Table 3 provides a percentage breakdown of candidates into bandings.

Table 3. 2024.1 CCE candidates in each banding

Banding	% Candidates
P4	33
P3	25
P2	19
P1	13
F1	7
F2	3
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.

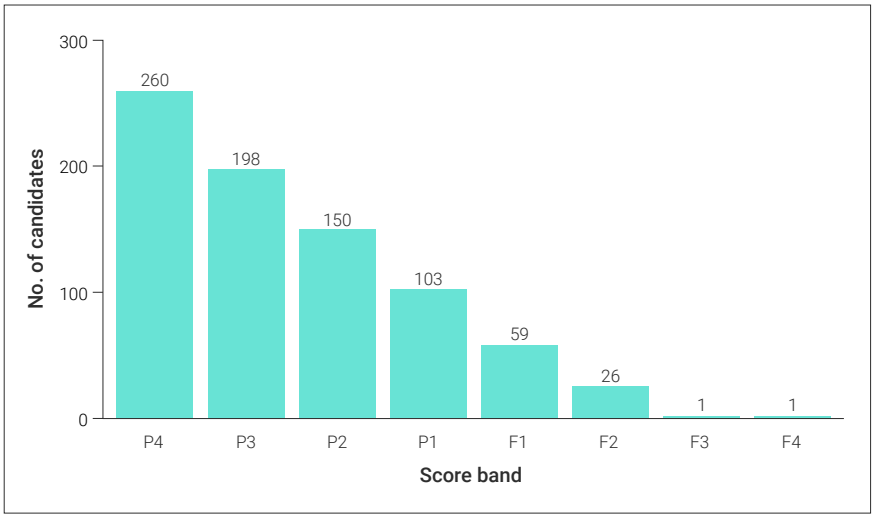

Figure 1. 2024.1 CCE banding distribution

Figure 2 shows the average performance of the cohort of passing candidates across clinical competency areas in the 2024.1 CCE.

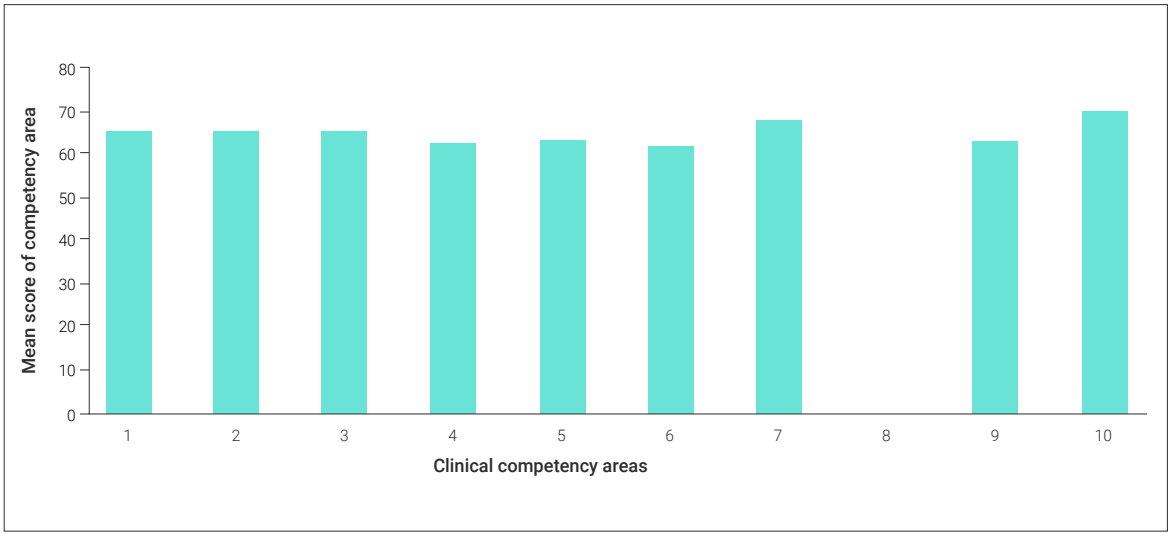

Figure 2. Average performance of passing candidates by competency area in the 2024.1 CCE.

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 2024.1 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 2024.1 CCE, 108 individual competency criteria were assessed.

Breakdown of assessed criteria within competency area for the 2024.1 CCE

1. Communication and consultation skills: 28%
2. Clinical information gathering and interpretation: 14%
3. Diagnosis, decision-making and reasoning: 14%
4. Clinical management and therapeutic reasoning: 25%
5. Preventive and population health: 9%
6. Professionalism: 4%
7. General practice systems and regulatory requirements: 1%
8. Procedural skills: 0%
9. Managing uncertainty: 3%
10. Identifying and managing the patient with significant illness: 2%

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. The ability to navigate a shared PDF document, including resizing to optimise viewing, is vital preparation.

2024.1 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. 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 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.

Case 1B

This case discussion presented an Aboriginal woman, four weeks postpartum with symptoms suggestive of a postpartum psychosis, who wants to return to her remote home community with limited health services. Candidates were asked to outline their concerns and provide a differential diagnosis. After appropriate management, candidates were asked how they could support the patient returning to her remote community. Candidates demonstrated competency by integrating cultural perspectives on and beliefs about health and wellbeing into their assessment and management of the case. They were also able to consider the obstacles to care from a medical, cultural and rural perspective.

Competent candidates considered exploring the reasons why the patient may have been reluctant to present earlier with symptoms or her 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*. Specific communication resources can be found online: Demonstrating inclusive and respectful language and 'I can sit and talk to her': Aboriginal people, chronic low back pain and heathcare practitioner communication.

Examiners commented that candidates demonstrated competency by:

- demonstrating an individualised approach in the management of an Aboriginal patient with complex care needs
- demonstrating an understanding of the difficulties in managing patients residing in remote communities and having a good understanding of the cultural impact of being away from their home community and Country
- managing a patient in a rural context appropriately with telehealth and outreach services
- identifying a serious postpartum mental health condition was the likely diagnosis
- being non-judgmental, empathetic and culturally safe
- being aware of the seriousness of the mental health condition and taking into consideration the cultural complexity of the case, and addressing both
- recognising the safety concern for both mother and baby
- acknowledgement of how Country and Community play a role in an Aboriginal experience of health and wellbeing
- demonstrating respect for the patient in her context. This was demonstrated by navigating the barriers to care and exploring goals that were important to the patient, rather than rote-learned responses such as Aboriginal health assessments and Closing the Gap payments (that were not relevant to this case)
- 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
- failure to consider the cultural and social context, not recognising the importance of the patient's relationship with her Aunty and the insights she could provide into the cultural setting
- taking a judgemental, offensive and racist approach by making assumptions such as 'abuse is common in Indigenous families' or discussing drug, alcohol, overcrowded housing and domestic violence as contributing factors to the scenario despite the stem and examiner clarifying they were not
- 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 paternalistic rather than patient-centred; for example, demanding that admission to a tertiary centre would be required, and removal of her newborn child into social services care
- lack of organisation of differential diagnoses into categories of most likely and most important to consider.

Case 3A

In this clinical encounter, a man presents for repeat antihypertensive medication and asks about erectile dysfunction.

Examiners commented that candidates demonstrated competency by:

- taking an adequate history, and considering multiple possible contributing factors to erectile dysfunction
- demonstrating communication skills, such as building rapport, active listening, using skills in motivational interviewing and demonstrating empathy
- being comfortable asking personal questions and avoiding euphemisms
- offering lifestyle advice, but not at the expense of the patient's agenda for the consultation
- arranging appropriate follow-up and safety netting
- taking the opportunity to discuss prevention tailored to this patient's needs
- providing appropriate management of the patient's erectile dysfunction in the setting of cardiovascular risk factors and mood disturbance.

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

- disorganisation in the approach to the consultation; some candidates started managing the patient before undertaking a history
- not attending to the patient's concerns, and focusing on their own agenda of health promotion and prevention
- not identifying the side effects of medication and the relationship this may have to the patient's symptoms
- not addressing the psychological aspects of the case.

Case 3B

In this clinical encounter, a woman, aged 37 years, with recent-onset back pain and radiculopathy requests advice on whether surgery would give her increased pain relief compared with non-surgical treatment. A forest plot summarising a meta-analysis of studies addressing this clinical question was provided.

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 history and exploring the impact of the patient's pain on her life
- recognising the forest plot indicated a small, statistically significant reduction in pain with surgical intervention – strongest in the short term and diminishing in the long term – and that these changes are unlikely to be clinically significant
- creating a comprehensive management plan for the patient by exploring this particular patient's experience of illness, social circumstances and feelings toward surgery
- discussing the alternative management options to surgery for acute low back pain and radicular leg pain.

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

- not taking a psychosocial history and therefore failing to acknowledge the stress of raising young kids, studying medicine full time and a fly-in, fly-out partner
- an unstructured approach to the consultation – usually being distracted by the article and forgetting to cover the other requirements for the case
- making assumptions about what had occurred rather than asking for history
- failing to provide appropriate follow up
- not being able to interpret the data and advising they would 'check with a supervisor' or making up information that was incorrect
- offering solutions to the patient that had already been attempted unsuccessfully (eg regular paracetamol)
- not drawing a conclusion from the forest plot data presented, or drawing an incorrect conclusion
- slipping into statistical or medical jargon and failing to explain in patient-centred terminology
- some spoke about weight loss even though they did not know the patient's body mass index.

Case 5A

In this case discussion, a woman, aged 63 years, presented with elevated blood glucose and elevated anti-glutamic acid decarboxylase (GAD) antibodies with a background history of recently diagnosed diabetes that had responded suboptimally to lifestyle modification and oral hypoglycaemics. Candidates were asked to interpret the results and propose a management plan. The case evolved to cover the management of an acute presentation, and education about how to manage a 'sick day' in the future.

Examiners commented that candidates demonstrated competency by:

- listening to the question and then answering the question posed
- correctly interpreting results and diagnosing latent autoimmune diabetes of adults (LADA) and then providing compassionate, patient-centred, appropriate care and management, including emergency care, long-term management and sick day planning
- covering issues such as driving status, National Diabetes Services Scheme (NDSS) access, optimising thyroid replacement and managing cardiovascular risk
- recognising the patient is very likely to be overwhelmed and anxious on being told of their new diagnosis, so considering how to deliver this information in a thoughtful manner
- having the confidence to commence insulin
- correctly recognising a critically ill patient with ketoacidosis and commencing appropriate management with fluid resuscitation and urgent hospital transfer.

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

- assuming this patient has poorly controlled type 2 diabetes and escalating oral hypoglycaemics rather than initiating insulin
- making assumptions about the patient (eg non-compliance as the reason for elevated blood glucose readings), wanting then to corroborate behaviour by breaking confidentiality and asking her partner about her compliance with medicine, diet and exercise
- focusing on smoking (despite the patient ceasing smoking decades ago) and immunisations rather than managing daily blood glucose levels
- a reluctance to treat with insulin, preferring to continue treatment with an oral hypoglycaemic agent while awaiting endocrinologist opinion
- failure to recognise ketoacidosis with hypoglycaemia, and that correction with oral glucose ('a few jellybeans') would be an inadequate and unsafe management plan in a seriously ill patient
- a disorganised approach to managing advice for a sick day.

Case 6B

In this case discussion, a rural patient presents for a care plan review with chest pain on exertion, increased alcohol consumption, suboptimal diabetes control and deranged liver function tests. Candidates were asked to summarise their care priorities for the patient. Further investigation revealed a pancreatic mass, and candidates are asked to manage this appropriately.

Examiners commented that candidates demonstrated competency by:

- describing a holistic list of care priorities, with priority given to her chest pain, and linking the differential diagnosis for deranged liver function tests (LFTs) to the context given
- describing clear follow-up plans after referral
- considering service availability in a rural setting and identifying potential barriers to care
- considering how to troubleshoot service delays and how to best advocate for the patient in a rural setting
- considering safety netting and follow up as a routine part of care.

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

- prioritising diabetes, weight loss or gout over chest pain in the problem/priority list of concerns
- assuming derangement of LFTs was due to alcohol alone and not considering other options
- not identifying that delayed secondary care review was a critical incident
- not taking rurality into context and making multiple referrals to multiple services
- focusing on a single, narrow issue for the patient and missing other vital issues
- providing a generic problem list that did not specifically relate to the scenario
- not making a plan to follow up after referral
- not considering management for comorbidities.

Case 7A

In this clinical encounter, a teenage male presented with acne. Candidates were asked to take a history and outline their diagnosis and management plan to the patient. This patient had significant social stressors, including being bullied, had a low mood and multiple risk behaviours to be identified on history.

Examiners commented that candidates demonstrated competency by:

- showing empathy and good communications skills, including active listening (eg open questions, summarising, reflecting, checking their understanding and sign posting)
- taking an appropriate biopsychosocial history, particularly the psychosocial aspects with a HEADSSS (Home, Education, Activities, Drugs/alcohol, Sexual, Suicide risk, Safety) screen
- managing the medical aspects of acne well and providing the patient with a range of management options
- being specific in identifying contributing factors regarding mental health concerns
- being specific with the pharmacological and over-the-counter options for managing acne
- demonstrating age-appropriate communication skills to engage and be understood by the patient in the scenario
- prioritising both the patient's and doctor's agendas, rather than just the doctor's.

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)
- failing to check the understanding of the management plan with the patient
- failing to offer treatment choices to the patient, instead following their own agenda
- failing to use the opportunity to provide screening and preventative care approaches that were tailored to the patient, in terms of both age and context
- failing to provide clear explanations and education to the patient regarding their condition and treatment choices.

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 demonstrate a non-judgemental approach to all patients.

Other common pitfalls included formulaic responses, or a response 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 circumstances often 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 a patient-centred, approach.

Making up resources that do not exist is not appropriate. Making up a false support or online information group was observed by examiners in some instances; 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' button (NOT the 'Raise hand' function) 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 practice 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.

Some candidates experienced slow internet connections that impacted 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. In addition, a video of what to expect as a candidate can be accessed on the CCE resource page.

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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