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RACGP Education

Exam report 2024.2 CCE

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Disclaimer

Recommended citation

The Royal Australian College of General Practitioners (RACGP). RACGP Education: Exam report 2024.2 CCE. East Melbourne, Vic: RACGP, 2024.

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Published December 2024

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-6979

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 2024.2 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, four case discussions and five clinical encounters mixed over both exam sessions.

The 2024.2 CCE was delivered in two streams on non-consecutive days as follows:

- **Day 1A:** Saturday 9 November 2024, cases 1A–4A
- **Day 1B:** Sunday 10 November 2024, cases 1B–4B
- **Day 2A:** Saturday 16 November 2024, cases 5A–9A
- **Day 2B:** Sunday 17 November 2024, cases 5B–9B.

Exam psychometrics

The 2024.2 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. Each case had high internal reliability. There were two streams in the 2024.2 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. 2024.2 CCE psychometrics

Average reliability	0.68
Pass rate (%)	89.12
Number passed	672
Number sat	754

Table 2. 2024.2 CCE pass rate by number of attempts

Attempts	Pass rate (%)
First attempt	91.48
Second attempt	76.92
Third attempt	58.34
Fourth and subsequent attempts	61.90

Exam banding

Table 3 provides a percentage breakdown of candidates into bandings.

Table 3. 2024.2 CCE candidates in each banding

Banding	% Candidates
P4	27
P3	22
P2	24
P1	16
F1	6
F2	4
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.

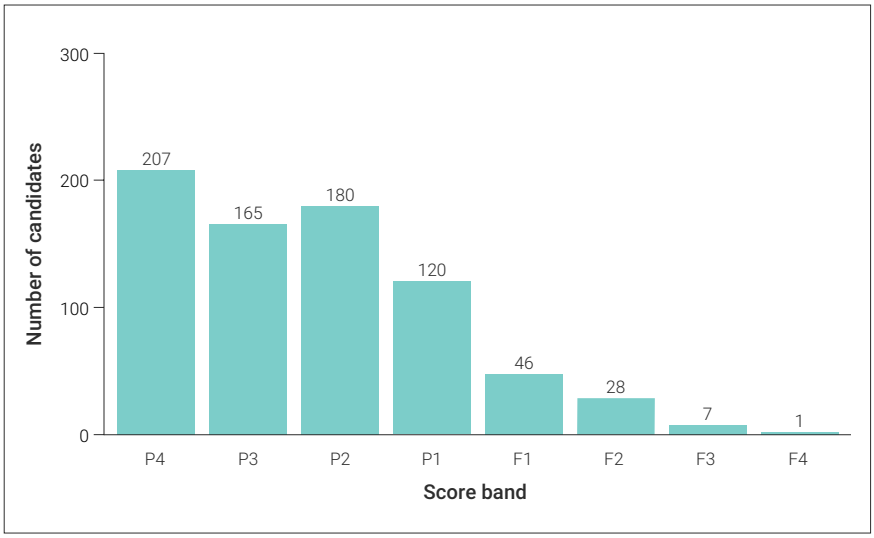

Figure 1. 2024.2 CCE banding distribution

Figure 2 shows the average performance of the cohort of passing candidates across clinical competency areas in the 2024.2 CCE.

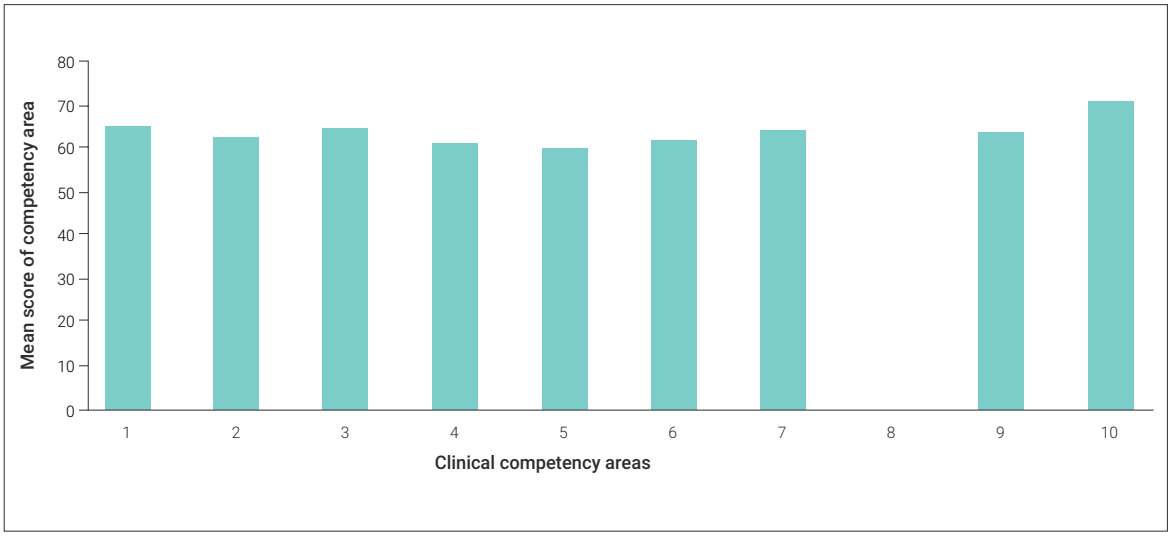

Figure 2. Average performance of passing candidates by competency area in the 2024.2 CCE.

The 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 2024.2 CCE, refer to your candidate portal to see how your personal performance in each competency compares to the average of the passing cohort. Some competency areas are examined more extensively than others in the CCE, and this should be considered when interpreting your results graph.

The list on the following page provides a breakdown of the assessed criteria within each competency area. In the 2024.2 CCE, 104 individual competency criteria were assessed.

Breakdown of assessed criteria within competency area for the 2024.2 CCE

1. Communication and consultation skills: 26%
2. Clinical information gathering and interpretation: 13%
3. Diagnosis, decision-making and reasoning: 15%
4. Clinical management and therapeutic reasoning: 23%
5. Preventive and population health: 8%
6. Professionalism: 7%
7. General practice systems and regulatory requirements: 3%
8. Procedural skills: 0%
9. Managing uncertainty: 2%
10. Identifying and managing the patient with significant illness: 3%

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, multiple additional practice cases and additional video examples 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.

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.

Candidates are not required to provide drug doses within the CCE. Candidates may still be required to provide route of administration or frequency of administration.

Candidates are encouraged to consider the range and scope of clinical exposure they have within their own practice and compare this to the range and scope of practice that might be expected for a point of Fellowship GP practising independently anywhere in Australia.

Managing performance anxiety is key to any exam preparation, and vital in a clinical examination where candidates are asked to articulate their thinking and decision making. The RACGP GP support program provides a library of resources to assist in managing performance anxiety, in addition to face-to-face or telephone counselling to support the wellbeing of all members.

2024.2 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 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 child with bronchiolitis requiring urgent care in a rural setting. The case provided complexity in assessing the principles of consent for a child who presents with a family member who is not their parent. 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 medical, cultural and rural perspectives.

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 healthcare practitioner communication.

Examiners commented that candidates demonstrated competency by:

- demonstrating an individualised approach in the management of an Aboriginal patient with urgent care needs
- recognising the acutely unwell child and the limitations in a rural or regional setting
- noticing the importance of the psychosocial elements of the case and incorporating this into the history, diagnostic and management aspects
- managing a patient in a rural context appropriately with telehealth and outreach services
- being non-judgemental, empathic and culturally safe
- considering the use of an Aboriginal and Torres Strait Islander Health Professional or liaison officer appropriately, and not offloading all the communication issues onto them to manage
- demonstrating an understanding of some of the barriers Aboriginal and Torres Strait Islander patients and their families may encounter while accessing health services (eg past trauma with healthcare professionals, racism or the death of community members)
- understanding or being curious about the role and importance of rituals in the setting of healthcare (eg smoking ceremonies)
- 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 included:

- not recognising the medical severity of the condition and the need for hospitalisation
- listing engagement of an Aboriginal and Torres Strait Islander Health Professional or Aboriginal and Torres Strait Islander 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 and Torres Strait Islander Health Professional
- not considering that Aboriginal and Torres Strait Islander patients may have a different perspective on healthcare, with fear and mistrust potentially being passed on through intergenerational trauma or past personal experience
- having a poor understanding of resources that may be available to assist
- failing to clarify consent
- not demonstrating how they would best engage/explore/learn with the patient and their carer
- taking a judgemental, offensive and racist approach by making assumptions about the lifestyle of First Nations peoples; having rote-learned lists for cultural safety, such as 'displaying the flag' or 'cultural training' without further elaboration; and failing to mention the 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's perspective and being aware of one's own unconscious bias
- being doctor-centred and paternalistic rather than patient-centred (eg insisting that admission to a tertiary centre would be required)

- failing to organise differential diagnoses into categories of most likely and most important to consider
- either not considering bronchiolitis, or not knowing how to manage bronchiolitis; some candidates instead considered rare diagnoses such as cancer
- not taking ownership or leadership in follow-up, or even in treating an Aboriginal child in a rural setting (eg believing such leadership was beyond their scope of practice).

Case 4A

In this clinical encounter, a woman presented with symptoms consistent with perimenopause.

Examiners commented that candidates demonstrated competency by:

- taking an adequate biopsychosocial history and considered other differential diagnoses
- providing a thought-out management plan and communicating this well
- demonstrating communication skills, such as building rapport, active listening, demonstrating empathy and providing a rationale for asking questions about mental health
- recognising perimenopause was the most likely diagnosis; safety-netting by using appropriate investigations to exclude other conditions, such as anaemia or thyroid dysfunction; and offering lifestyle advice, but not at the expense of the patient's agenda for the consultation
- recognising that not all concerns could be managed in a single consultation and establishing issues to address in a subsequent consultation, such as increased body mass index or elevated blood pressure; and demonstrating safe practice and a balance between meeting the patient's needs and clinical concerns
- taking the opportunity to discuss prevention tailored to this patient's needs.

Examiners commented that common pitfalls included:

- not addressing the tasks outlined in the instructions and therefore not meeting the assessment criteria (eg discussing the differential diagnosis with the patient)
- being disorganised in the approach to the consultation – spending too much time on history and running out of time to manage the patient
- not asking about the patient's menstrual cycle
- not demonstrating shared decision making, instead demonstrating an authoritarian approach to management
- not attending to the patient's concerns and instead focusing on their own agenda of health promotion and prevention (eg telling the patient to increase her exercise where she was already struggling to balance work and home life; focusing on hot flushes, which were infrequent and not the key concern; and making a detailed plan for vaginal dryness when the patient said she had none)
- fixating on the symptom of irritability and not considering diagnoses other than mental health, even when the patient redirected them
- repeatedly asking the patient what they thought was wrong with them diagnostically, rather than focusing on their concerns or worries
- offering management focusing solely on hormone replacement and not incorporating non-pharmacological or non-hormonal management options
- using language a patient might not understand (eg 'anhedonia' or drug names).

Case 6B

In this case discussion, candidates were asked to provide a provisional and differential diagnosis for an undifferentiated presentation of vomiting in a recently returned traveller who had sustained a recent fall. The case evolved to assess how urgent results might be followed up in a rural setting and managing multidisciplinary discharge care needs in a community setting.

Examiners commented that candidates demonstrated competency by:

- considering 'not to be missed' diagnoses in assessing nausea and vomiting
- being aware of the patient's remote location when considering investigation and management
- considering the importance of practice systems such as up-to-date contact details and next-of-kin information to enable patient contact and recalls
- demonstrating confidence in first aid and basic urgent management of a seizure, following a DRABC approach
- considering post-discharge needs of a patient with complex needs in a rural setting.

Examiners commented that common pitfalls included:

- not reading the stem carefully (eg mistakenly thinking the patient had diarrhoea)
- not considering the rural context
- overlooking 'not to be missed' diagnoses for vomiting
- not appreciating the challenges of accessing healthcare and allied health or specialised services in the rural setting
- not considering appropriate means of communications in rural areas (eg landlines or satellite phones), the limitations of mobile phone networks, and distance – some candidates thought they might drive to the patient's house, which was unrealistic considering the distances given in the case
- not considering the patient's context (eg his occupation, driving status and the impact of injury on his financial situation).

Case 7B

In this clinical encounter, candidates were asked to interpret a forest plot looking at the cardiovascular clinical outcomes associated with using a salt substitute, and relate those outcomes to their patient, who had poorly controlled hypertension and new-onset leg oedema.

Examiners commented that candidates demonstrated competency by:

- demonstrating good communication skills, listening to the patient and acknowledging the patient did not want to take more medication – balancing the clinical needs with the patient's agenda
- taking a comprehensive history and considering appropriate investigations
- soundly interpreting the statistical data and integrating this information with key features of history to give appropriate advice to the patient
- outlining a management plan that considered the patient's preferences and communicating the reasoning well to the patient.

Examiners commented that common pitfalls included:

- not having a clear structure for the consultation and jumping back and forth between history and management
- misinterpretation of the study information provided, not being able to interpret a forest plot, and not being able to explain the significance of the research and how it related to the patient and their concerns
- poor history taking: not asking about key cardiac symptoms such as chest pain, shortness of breath or orthopnoea; using closed questions; not asking about psychosocial elements of history; and not asking about red flag symptoms
- not recognising the patient had angioedema to ACE inhibitors and commencing the patient on this drug group
- talking over the patient, bombarding them with information
- lack of safety-netting or follow-up plans
- giving generic lifestyle advice about exercise and a low-salt diet without adapting to the patient – many candidates deferred all dietary and exercise advice to allied health.

Case 8A

In this clinical encounter, candidates were asked to discuss an unexpected investigation finding of a possible lung mass in a patient who had been screened for osteopenia.

Examiners commented that candidates demonstrated competency by:

- establishing good patient rapport using good communication skills and taking a biopsychosocial history, including home situation and support network, before discussing the results and management plan
- sensitively exploring risk factors associated with the two key diagnoses of osteopenia and new incidental lung pathology
- demonstrating active listening and sensitivity in breaking bad news
- indicating a clear follow-up plan to the patient
- explaining uncertainty of the diagnosis without minimising the possibility of a cancer
- demonstrating knowledge of appropriate management without overwhelming the patient
- checking in with the patient and exploring the patient's concerns as the consultation evolved.

Examiners commented that common pitfalls included:

- using jargon
- not allowing the patient to contribute to the management plan
- minimising bad news and setting up unrealistic expectations for the next consultation (eg implying benign reasons for a new lung mass and pleural effusion)
- attempting to do significant advance care planning without the context of a diagnosis, or going into extensive detail about how lung cancers may be managed by an oncologist
- confusing the patient with multiple unlikely differential diagnoses without clearly identifying which were more or less likely
- jumping to discuss the result before taking a history or contextualising the discussion

- having a paternalistic approach, such as telling the patient not to worry
- failing to check the patient's understanding of the information that had just been given
- completely omitting the osteopenia diagnosis
- demonstrating knowledge but not empathy in breaking bad news to the patient.

Case 9A

In this clinical encounter, a young woman presented with a headache. Attentive candidates responded to patient cues revealing relationship problems at home with domestic violence and psychosocial stressors.

An excellent resource on managing domestic violence in general practice can be found at https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/about-this-guideline

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 signposting), having a non-judgemental approach and not interrupting the patient
- taking a sensitive history and following up on patient cues
- prioritising the domestic violence over the headache after excluding the red flags in the headache history
- recognising that this was a case of domestic violence and being able to assess risk to both the patient and her children, developing an appropriate management plan, demonstrating empathy and clearly advising it was not okay to be subjected to abuse
- collaborating with the patient to develop a safety plan, referring to appropriate services and arranging follow-up
- assessing the patient's state of change in terms of their relationship
- appreciating the complexity of the issue and considering the barriers to leaving or accessing safety (eg finances, children, accommodation and supports)
- assessing risks, including the risk of violence escalation, by considering access to lethal weapons, prior injuries and strangulation, and assessing suicidality and risk to the children
- prioritising both the patient's and doctor's agendas, rather than just the doctor's.

Examiners commented that common pitfalls 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)
- being distracted by the domestic violence and not taking enough of a history to exclude red flags for the headache
- not considering legal obligations (eg not checking to see if the children were safe)
- not considering advice on pursuing a domestic violence order (DVO)
- not considering the background information and prior injuries
- not addressing some of the barriers to future care, such as the cost of follow-up or confidentiality

- not exploring the breadth of domestic violence – physical, sexual and financial control – as some of the considerations
- recognising intimate partner violence but having no approach to managing the presentation
- not considering safety planning
- not addressing confidentiality
- being paternalistic or directive in management suggestions (eg dangerous suggestions such as joint consultations for couples counselling or to discuss the partner's alcohol use, or calling an ambulance to take her to hospital) – some candidates suggested she should attempt to reconcile with her partner
- directing the patient to leave straight away and making plans on her behalf without checking what the patient wanted to do
- discovering the domestic violence and then going on to give preventive care advice on lifestyle as if the domestic violence had not been revealed.

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**. Scrolling on a shared screen is suboptimal when using a trackpad and a better experience is had by candidates who use a mouse with a scrolling wheel.

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 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.

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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