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RACGP Education

Exam report 2025.2 CCE

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The Royal Australian College of General Practitioners Ltd
100 Wellington Parade
East Melbourne, Victoria 3002
Wurundjeri Country

Tel 03 8699 0414
Fax 03 8699 0400
www.racgp.org.au
ABN: 34 000 223 807

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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.

ID-8548

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 2025.2 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), which are mixed over two exam sessions. Candidates are assigned to one of the two exam streams.

The 2025.2 CCE was delivered in two streams on non-consecutive days as follows:

- **Day 1A:** Saturday 18 October 2025, cases 1A–4A
- **Day 1B:** Sunday 19 October 2025, cases 1B–4B
- **Day 2A:** Saturday 25 October 2025, cases 5A–9A
- **Day 2B:** Sunday 26 October 2025, cases 5B–9B.

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Exam psychometrics

The 2025.2 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 2025.2 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. 2025.2 CCE psychometrics

Average reliability	0.69
Pass rate (%)	80.82
Number passed	813
Number sat	1006

Table 2. 2025.2 CCE pass rate by number of attempts

Attempts	Pass rate (%)
First attempt	83.58
Second attempt	67.92
Third attempt	59.09
Fourth and subsequent attempts	38.46

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Exam banding

Table 3 provides a percentage breakdown of candidates into bandings.

Table 3. 2025.2 CCE candidates in each banding

Banding	% Candidates
P4	18
P3	21
P2	22
P1	20
F1	12
F2	5
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.

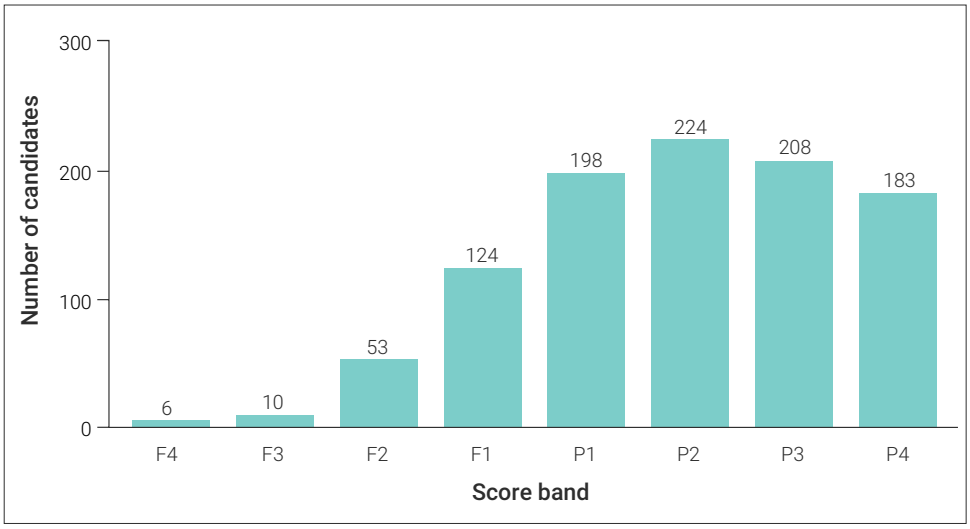

Figure 1. 2025.2 CCE banding distribution

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Figure 2 shows the average performance of the cohort of passing candidates across clinical competency areas in the 2025.2 CCE.

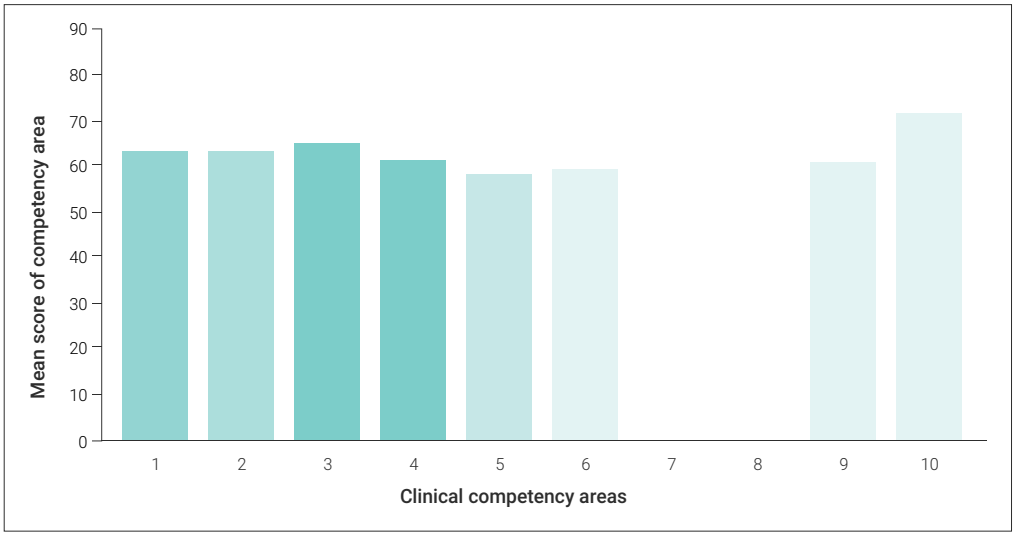

Figure 2. Average performance of passing candidates by competency area in the 2025.2 CCE

The clinical competency areas are as outlined in Box 1 (next page).

For candidates who sat the 2025.2 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.

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Breakdown of assessed criteria within competency area for the 2025.2 CCE

Box 1 provides a breakdown of the assessed criteria within each competency area. In the 2025.2 CCE, 108 individual competency criteria were assessed.

1. Communication and consultation skills: 21%
2. Clinical information gathering and interpretation: 15%
3. Diagnosis, decision-making and reasoning: 23%
4. Clinical management and therapeutic reasoning: 23%
5. Preventive and population health: 10%
6. Professionalism: 3%
7. General practice systems and regulatory requirements: 0%
8. Procedural skills: 0%
9. Managing uncertainty: 3%
10. Identifying and managing the patient with significant illness: 2%

Box 1. Assessed criteria

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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 Applied Knowledge Test (AKT), Key Feature Problem (KFP) and 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 is 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.

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2025.2 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. It is worth noting that some competency areas are examined at higher frequency in this exam when reviewing this data. 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 assesses an average of 12 criteria. Competencies are assessed multiple times over the exam. Some competencies are assessed more frequently than others over the exam. Examiners were surveyed on exam day to identify candidate performance characteristics that demonstrated competency and characteristics of common pitfalls.

Case 1B

This case discussion presented a scenario where the candidate was advised they were working in a regional Aboriginal Community Controlled Health Service and asked to assess an Aboriginal woman, aged 25 years, who has been referred by an Aboriginal and Torres Strait Islander Health Practitioner for preventive health assessment, review of her past medical history and to consider the need for ongoing prophylactic prevention of her rheumatic heart disease during her current pregnancy. Candidates were asked to articulate the list of issues they wanted to address and consider her cultural, preventive, and biopsychosocial needs. An understanding of the guidelines

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to preventive healthcare for Aboriginal and Torres Strait Islander people was required.

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, including '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:

- showing clinical competence at the level of Fellowship by
  - considering the information in the stem, and synthesising a clear problem list
  - identifying and managing key clinical issues such as anaemia, proteinuria, tachycardia, and dental caries
  - demonstrating understanding of rheumatic fever and rheumatic heart disease
  - providing appropriate antenatal care, noting what had already been undertaken in the clinic, and considering the patient's personal risks and tailoring advice
  - presenting a well-formulated problem list, problem representation and management plan
- demonstrating cultural awareness and safety by
  - demonstrating deep understanding of Aboriginal culture, including the importance of country, family and sorry business
  - respecting gender-specific care practices (eg women's business)
  - communicating respectfully, avoiding paternalism, and recognising intergenerational trauma
  - integrating cultural safety into clinical practice, including awareness of community services and Aboriginal Community Controlled Health Organisations (ACCHOs)
  - using inclusive language and avoiding 'othering' terminology
  - being non-judgemental, empathic and culturally safe
- undertaking holistic and patient-centered care by
  - showing compassion and curiosity about the patient's lived experience
  - taking an individualised and compassionate approach
  - respecting patient autonomy and self-determination by offering choices and agency in health decision making
  - considering social, emotional and community wellbeing in care planning
  - collaborating with the patient and avoiding assumptions or stereotypes
  - 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) and considering strategies that may assist in addressing some of the barriers

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- demonstrating communication and teamwork skills by
  - using culturally sensitive communication strategies beyond ideas, concerns and expectations (eg yarning or narrative-based approaches)
  - using inclusive, respectful language
  - engaging Aboriginal and Torres Strait Islander Health Professionals meaningfully and explaining their role
  - demonstrating teamwork and multidisciplinary collaboration
- demonstrating regional/remote and contextual understanding by
  - recognising barriers to care in remote settings and proposing realistic strategies
  - understanding the role and structure of ACCHOs
  - balancing clinical priorities with cultural obligations (eg attending funerals).

Examiners commented that common pitfalls included:

- demonstrating a lack of cultural awareness and sensitivity with
  - minimal understanding of Aboriginal cultural values and preferred communication styles
  - failure to acknowledge cultural practices such as sorry business or women's business
  - use of paternalistic or directive language ('educate her', 'tell her')
  - tokenistic references to cultural safety without meaningful integration
  - stereotyping or making assumptions about health literacy or living conditions
  - failure 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 the patient's perspective and being aware of one's own unconscious bias
- poorly integrating cultural aspects into clinical care by
  - focusing solely on medical aspects and neglecting cultural context
  - ignoring patient autonomy and failing to co-create care plans
  - not tailoring care to the patient's own setting or considering available community resources
  - lack of culturally safe discharge planning or birth support considerations
- inadequate demonstration of clinical knowledge and its application in this setting, such as
  - missing key findings such as anaemia, proteinuria or tachycardia
  - poor understanding of rheumatic fever and rheumatic heart disease
  - repeating irrelevant information (eg routine antenatal tests already completed)
  - failing to identify high-risk pregnancy or provide appropriate advice
  - lack of structured problem list and cohesive management plan
- inadequate demonstration of communication skills, including
  - limited communication techniques and poor engagement with the patient's perspective
  - overly directive approach rather than collaborative

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  - failing to adapt communication style to suit an Aboriginal or Torres Strait Islander patient
  - failing to ask the patient about their preferences for involvement of other people in their care and instead taking a paternalistic, directive approach
- providing superficial or incomplete responses, such as
  - vague plans lacking in specific actionable details
  - speaking in generalities rather than addressing the specific needs of the presenting patient
  - mentioning Aboriginal and Torres Strait Islander Health Professionals without explaining their role
  - failing to synthesise case information or respond to prompts effectively
  - poor listening and engagement with patient perspective
  - missing the opportunity to demonstrate cultural safety for this specific scenario.

Case 3A

In this clinical encounter, candidates were asked to review a female, aged 16 years, who presented following a recent hospital presentation with a headache, for results and follow-up of an unexpected, elevated blood sugar reading, meeting the diagnostic criteria for diabetes. The patient was not acutely unwell, and the diagnosis of the type of diabetes remained uncertain with the information provided. Candidates were asked to manage the next diagnostic and management steps for the patient and consider her rural context. Examiners commented that candidates demonstrated competency by:

- demonstrating diagnostic reasoning and clinical safety by
  - recognising the diagnostic uncertainty between type one and type two diabetes
  - considering the diagnostic possibilities, and taking a history that assists in evaluating the likelihood of each possibility
  - ordering appropriate diagnostic tests to clarify the type of diabetes
  - acknowledging the risk of diabetic ketoacidosis and providing safety netting
  - referring appropriately to an endocrinologist and arranging follow-up
  - considering the impact of this diagnosis on the patient's ability to drive and road safety
- demonstrating patient-centered communication by
  - recognising the consultation was breaking bad news to this patient
  - acknowledging the psychological impact of a new diagnosis of diabetes in a teenager
  - building rapport with empathy and respect, using age-appropriate language
  - clarifying understanding before giving information to the patient and avoiding jargon
  - engaging the patient in the management plan and offering her choices
- taking a structured and holistic history, including
  - conducting a thorough biopsychosocial history with appropriate exploration of a HEADSS assessment

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  - exploring sensitive topics such as sexual health and mental wellbeing with care
  - adjusting the approach to the patient's needs and preexisting understanding and concerns
- providing an appropriate management plan and appropriate safety netting, including
  - developing a comprehensive management plan tailored to the patient
  - explaining the options of oral hypoglycaemics or insulin depending on test results
  - providing clear safety netting advice and follow up instructions
  - considering rural barriers and obstacles to care and offering local care or telehealth options
- using a consultation structure that demonstrated a logical, methodical approach and managed time effectively
- maintaining confidentiality and demonstrating respect for patient autonomy.

Examiners commented that common pitfalls included:

- prematurely deciding on a diagnosis, either type one or two diabetes, without acknowledging the uncertainty or ordering the appropriate investigations to delineate
- missing providing a safety net for the possibility of diabetic ketoacidosis, not providing what symptoms to be alert for or when to follow up
- taking a paternalistic approach to management, giving directive instructions rather than involving the patient in decision making
- poor listening, demonstrated by missing patient cues, talking over the patient or not checking the patient's understanding
- overwhelming the patient with too much information, or discussing long term complications prematurely
- poorly organised consultation structure, jumping between topics, or spending too much time on less relevant areas (eg sexual history)
- poorly managing the time in the consultation, spending too long on history and not reaching management or safety netting
- missing rural considerations, not acknowledging potential obstacles to care, not offering local- or rural-appropriate solutions
- providing inappropriate referrals, either sending the patient to hospital unnecessarily or not safely managing in the community
- lack of clarity in medication options and management steps
- poor multidisciplinary planning, not considering diabetic educators, dietitian and endocrinologists appropriately
- vague or absent plans for ongoing care and monitoring.

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Case 3B

In this clinical encounter, candidates were asked to take a history, interpret investigations and advise the patient on the next steps in management. A young female presented for review with results from her recent hospital admission suggestive of a new diagnosis of Crohn's disease, and no discharge summary yet available.

Examiners commented that candidates demonstrated competency by:

- taking a well-structured, comprehensive and logical history, including social and psychological factors such as the impact of the diagnosis on the patient's university studies and her mental health
- demonstrating active listening skills, understanding the patient's agenda and addressing her concerns such as fear of bowel cancer, and responding to patient cues
- providing a clear plain language explanation of her diagnosis and management
- correctly diagnosing inflammatory bowel disease and considered the impact of immunosuppressive treatment
- linking the symptoms to clinical findings – for example, malabsorption leading to iron deficiency, B12 deficiency and break-through bleeding
- matching communication to the patient's health literacy level
- engaging the patient in shared decision making and actively addressing her concerns
- considering the broader implications of disease on her quality of life
- developing a multidisciplinary management plan and overtly discussing follow-up plans and safety netting
- considering immunisation, contraception, nutrition and the implication of a long-term chronic disease in management planning
- recognising potential risks such as pregnancy secondary to contraceptive failure, side effects of steroids and immunosuppression, and planning accordingly.

Examiners commented that common pitfalls included:

- demonstrating inadequate curiosity and exploration of the history contextualised to the patient and her presentation
- using a rehearsed formula for taking a history in an exam situation, asking a barrage of questions often irrelevant to the patient and their presentation
- spending too much time on history, with a focus on irrelevant aspects unrelated to the presentation
- taking a cursory history and making assumptions based on the investigations provided
- failing to explore both the history of the presenting complaint and the background history of the patient
- overusing jargon, overwhelming and scaring the patient with complex descriptions of the disease and complications
- talking over the patient, interrupting the patient and not listening attentively, missing important cues
- taking a paternalistic approach in management, advising a list of what the patient 'must do' rather than providing hope for effective management of inflammatory bowel disease and reassurance regarding her fear of bowel cancer

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- prescribing inappropriate management in the context of malabsorption – for example, oral iron supplementation, or continuing the oral contraceptive pill despite risk of failure due to malabsorption
- providing unclear or vague explanations for the patient, especially related to medication side effects
- poorly articulated follow-up plans.

Case 4A

In this clinical encounter, candidates were presented with a male, aged 64 years, following a myocardial infarction and stent insertion.

Examiners commented that candidates demonstrated competency by:

- building rapport through empathy, respect and non-judgemental dialogue
- using active listening and adapting communication to the patient's context
- avoiding jargon and explaining medical concepts clearly
- prioritising the patient's agenda and concerns
- taking a comprehensive history, including psychosocial factors, exploring the impact of the cardiac event on daily life, mental health and sexual health
- reviewing medications to ensure patient understanding and discussing side effects and contraindications
- considering cardiovascular risk factors and addressing them appropriately
- identifying driving restrictions and actively considering return-to-work planning
- addressing prevention, prioritising secondary prevention of cardiovascular disease and using this opportunity to promote smoking cessation
- using a structured, methodical approach to cover the key areas in the case within the time frame
- clearly organised follow-up planning, noting there were further prevention and management issues to discuss later.

Examiners commented that common pitfalls included:

- failing to prioritise the patient's agenda (eg concerns about erectile dysfunction, return to work)
- using closed-ended questions, limiting patient engagement and being dismissive of the patient's concerns
- missing opportunities to explore psychosocial and lifestyle impacts of the cardiac event, hence not addressing lifestyle modification or cardiac rehabilitation adequately
- jumping between topics, lacking a clear structure or prioritisation, and spending too long on one issue and thus missing key elements
- poor listening skills; missing cues or interrupting the patient
- using rote-learned lists instead of individualised reasoning
- not appreciating that post–myocardial infarction, it is common to feel lethargic and hence the importance of cardiac rehabilitation to improve stamina

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- providing handouts without explaining their relevance or expectations
- not recognising or explaining medication side effects, especially those contributing to erectile dysfunction
- unsafe prescribing practices (eg recommending phosphodiesterase [PDE] inhibitors without considering glyceryl trinitrate [GTN] use)
- not having an awareness of driving restrictions post–myocardial infarction
- missed safety netting and follow-up planning due to poor pacing
- disorganised consultations; jumping between topics or spending too long on one issue, running out of time before addressing key management aspects.

Case 5A

In this case discussion, candidates were presented with a middle-aged man presenting with a work-related injury. Candidates were asked to provide a problem representation, explain their provisional diagnoses, outline further examinations and investigations, and outline a patient-centered and comprehensive management plan.

Examiners commented that candidates demonstrated competency by:

- demonstrating clinical knowledge and reasoning skills by
  - accurately identifying the provisional diagnosis of a distal biceps tendon rupture
  - offering the appropriate investigations and referral pathway
  - recognising the urgency of referral due to the delayed presentation and the functional impact
  - justifying clinical decisions and demonstrating metacognition (articulating what factors influenced their reasoning)
  - synthethising the stem information into a concise problem representation
- considering the work-related context of the case by
  - correctly identifying the injury as work related
  - conveying an understanding of, and clear explanation to the patient about, management of work-related injuries under workers' compensation insurance
  - considering return-to-work planning and appropriate duties
- taking a whole-of-person and patient-centered approach to care by
  - considering psychosocial factors and impact of functional deficits
  - demonstrating respect for patient autonomy
  - recognising yellow flags such as the delayed presentation
- demonstrating application of prevention and opportunistic care by addressing
  - blood pressure
  - smoking cessation
  - bowel cancer screening
  - metabolic risk.

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Examiners commented that common pitfalls included:

- having had a narrow or incomplete problem list, focusing only on the presenting issue, missing broader concerns such as preventive health, functional impact and patient priorities
- stating diagnoses or management plans without explaining reasoning
- being unclear about why certain referrals or investigations were chosen
- missing the opportunity to educate the patient or justify urgency (eg semi-urgent orthopaedic referral)
- missing the significance of delayed diagnosis and its impact on outcomes
- failing to recognise the case as a WorkCover issue, leading to inappropriate referrals (eg Centrelink)
- poor understanding of complaint management processes and how to support the patient through them
- premature closure on diagnosis without considering implications or alternatives
- lacking a structured approach to assessment and management.

Case 9B

In this clinical encounter, candidates were presented with a social work student from Zimbabwe, aged 25 years, for blood test results and to discuss weight-loss options.

Examiners commented that candidates demonstrated competency by:

- providing a respectful, empathic and non-judgemental approach throughout the case
- using motivational interviewing techniques and appreciative enquiry appropriately
- using open questions to explore the patient's goals and concerns, not assuming her goals are the same as the doctor's priorities
- avoiding paternalism, instead demonstrating shared decision making
- checking the patient's understanding and tailoring explanations to the patient
- taking a comprehensive biopsychosocial history, exploring the patient's motivations, mental health and current lifestyle
- recognising potential barriers such as financial stress, language, cultural background and being time poor, but not assuming these barriers exist
- clearly explaining therapeutic options and understanding the use, contraindications, safety in pregnancy and interactions of pharmacological approaches, and considering a broad range of non-pharmacological options, including surgical and lifestyle treatments
- demonstrating a non-judgemental approach to weight and body image
- having a clear follow-up plan and providing appropriate safety netting.

Examiners commented that common pitfalls included:

- spending too much time on history-taking, leaving insufficient time for management discussion
- making assumptions about the patient without asking, for example, about her financial status, food choices and exercise
- failing to explore the patient's motivations, preferences or ability to implement lifestyle changes

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- inadequate demonstration of communication skills, including
  - missing cues, interrupting the patient, or failing to act on responses
  - using vague or superficial language, lacking clarity in follow-up planning and safety netting
  - failing to check the patient's understanding or to summarise and check their own understanding was correct
- gaps in clinical knowledge, such as
  - limited understanding of injectable weight-loss options, their use, risks and benefits
  - missing polycystic ovary syndrome (PCOS) as a metabolic condition
  - impacts of treatments on fertility and pregnancy
  - considering malabsorption and contraceptive efficacy
  - medical eligibility criteria (MEC) for the oral contraceptive pill in obesity
- failing to take a holistic assessment by taking an incomplete history, especially not taking a dietary and exercise assessment
- failing to explore mental health, body image, past or current eating disorders
- managing in a paternalistic way rather than negotiating options with the patient
- failing to detail lifestyle recommendations – not providing clear actionable advice and follow-up
- missing opportunities for preventive care and counselling regarding contraception.

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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, and so is not acceptable in the clinical exam.

A structured and systematic approach will assist candidates to encompass important potential diagnoses that guide their history-taking, examination, investigations and management.

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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 using a mouse with a scrolling wheel. Using the scroll bar allows smoother scrolling via a shared screen.

If needed, candidates should use the 'Ask for help' button (not the 'Raise hand' function) in Zoom to alert the administrator to a problem. 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. The layout and appearance of the screen is determined by the candidate's Zoom settings, and so is the choice and responsibility of the candidate. 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 resources 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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