RACGP

RACGP Education

Exam report 2026.1 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 2026.1 CCE was delivered remotely to all candidates via videoconferencing technology. The CCE reflects contemporary assessment principles and standards. The CCE consists of nine clinical cases (four case discussions and five clinical encounters), which are mixed over two exam sessions. Clinical encounters are a simulated consultation with trained standardised patients, with the examiner observing the candidate interaction. Case discussions are a conversation between the candidate and examiner where clinical reasoning and decision making are discussed.

Candidates are assigned to one of the two exam streams.

The 2026.1 CCE was delivered in two streams on non-consecutive days as follows:

- **Day 1A:** Saturday 13 June 2026, cases 1A–4A
- **Day 1B:** Sunday 14 June 2026, cases 1B–4B
- **Day 2A:** Saturday 20 June 2026, cases 5A–9A
- **Day 2B:** Sunday 21 June 2026, cases 5B–9B

Exam psychometrics

The 2026.1 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 2026.1 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. 2026.1 CCE psychometrics

Average reliability	0.72
Pass rate (%)	79
Number passed	850
Number sat	1076

Table 2. 2026.1 CCE pass rate by number of attempts

Attempts	Pass rate (%)
First attempt	81.90
Second attempt	66.93
Third attempt	64.52
Fourth attempt	28.57
Fifth and subsequent attempts	20.00

Exam banding

Table 3 provides a percentage breakdown of candidates into bandings.

Table 3. 2026.1 CCE candidates in each banding

Banding	% Candidates
P4	15
P3	20
P2	24
P1	20
F1	14
F2	5
F3	2
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.

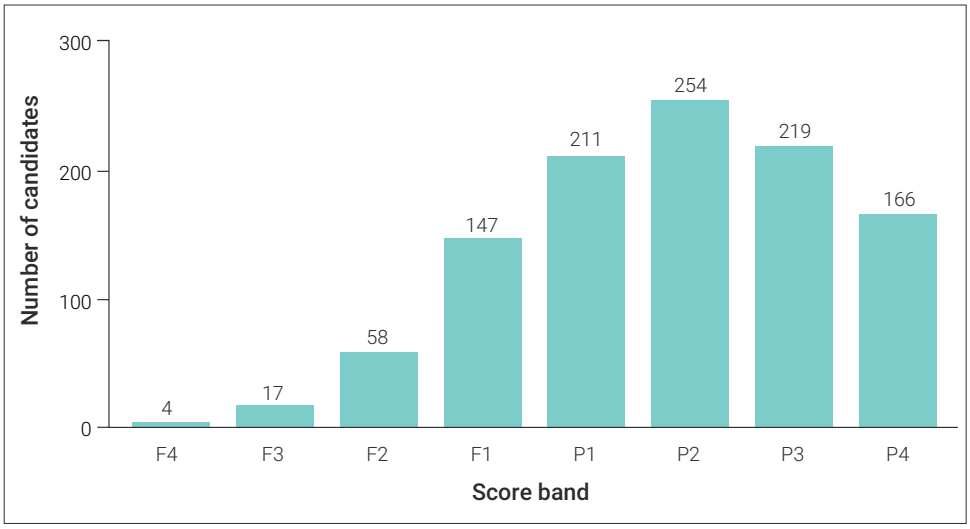

Figure 1. 2026.1 CCE banding distribution

Figure 2 shows the average performance of the cohort of passing candidates across clinical competency areas in the 2026.1 CCE.

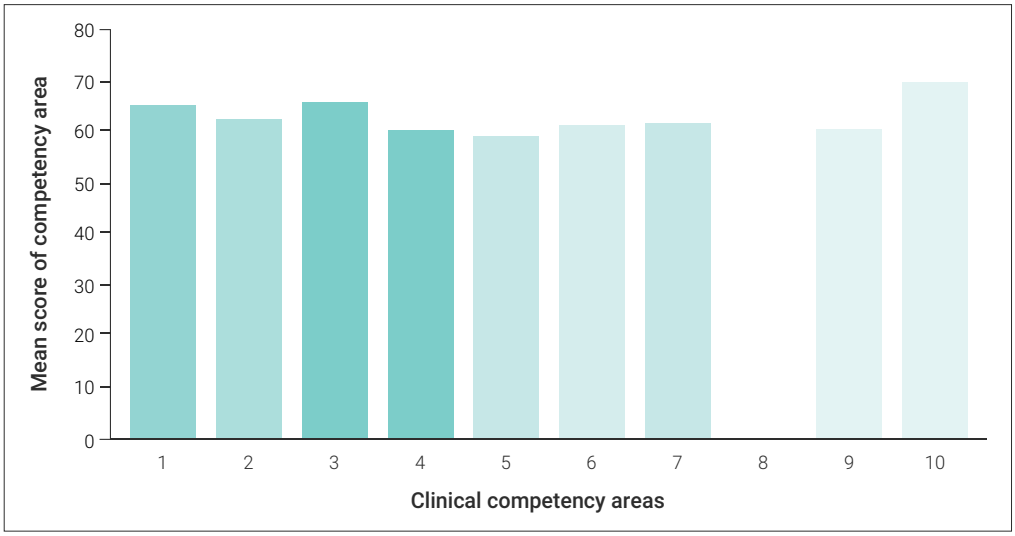

Figure 2. Average performance of passing candidates by competency area in the 2026.1 CCE

The clinical competency areas are as outlined in Box 1.

For candidates who sat the 2026.1 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.

Breakdown of assessed criteria within competency area for the 2026.1 CCE

Box 1 provides a breakdown of the assessed criteria within each competency area.
In the 2026.1 CCE, 105 individual competency criteria were assessed.

1. Communication and consultation skills: 22%
2. Clinical information gathering and interpretation: 14%
3. Diagnosis, decision-making and reasoning: 21%
4. Clinical management and therapeutic reasoning: 25%
5. Preventive and population health: 9%
6. Professionalism: 5%
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: <1%

Box 1. Assessed criteria

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 in the exam preparation toolkit *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. These resources are also available in the exam preparation toolkit on *gplearning*.

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. Candidates can also access the RACGP Wellbeing Hub with a full range of resources, including exam support.

2026.1 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. 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 over the exam. Examiners were surveyed on exam day to identify candidate performance characteristics that demonstrated competency and characteristics of common pitfalls.

Case 1A

This case discussion presented a scenario where the candidate was advised they were working in an urban Aboriginal Community Controlled Health Service and asked to assess an Aboriginal woman, aged 20 years, presenting with postpartum shortness of breath and chest pain. Candidates were asked to articulate the problem representation, provisional and differential diagnoses, outline a management plan that addressed her biopsychosocial and cultural needs, and identify and mitigate obstacles to her care.

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 Reconciliation Australia's 'Demonstrating inclusive and respectful language', Narragunnawali's 'Terminology guide' and the Australian Family Physician (now AJGP) article '"I can sit and talk to her": Aboriginal people, chronic low back pain and healthcare practitioner communication'.

Examiners commented that candidates demonstrated competency by:

- recognising the serious potential diagnosis of pulmonary embolism, and acted in a clinically appropriate way
- demonstrating a structured approach to differential diagnoses, including most likely and not to miss considerations
- advocating for the patient to remain with her baby and actively addressing this to overcome the patient's concerns
- integrating biopsychosocial and cultural factors into assessment and management in a meaningful way, acknowledging the need to explore with the patient what cultural needs she has, rather than assuming what her needs will be based on her Aboriginality
- using a team approach with purpose – for example, offering to organise an Aboriginal and Torres Strait Islander health professional to meet the patient in the emergency department, or asking the staff at the health service they were working at to recommend a mums and bubs group or culturally appropriate lactation support
- clearly respecting the patient's autonomy and describing a shared decision-making approach, prioritising patient preferences, without judgement
- approaching the case with a trauma-informed mindset, considering the patient's reluctance to accessing care might be linked to previous experiences (without making this assumption)
- considering using culturally safe communication, with appropriate pacing, adequate time and allowing silence; providing clear and structured explanations.

Examiners commented that common pitfalls included:

- demonstrating a lack of cultural awareness and sensitivity by making generalisations and assumptions rather than addressing specific barriers presented in the case, particularly in regard to social supports, health literacy and living conditions
- using paternalistic, infantilising or directive language ('educate her', 'tell her')
- tokenistic references to cultural safety without meaningful integration
- spending too much time on the medical aspects of the case with no acknowledgement of culture, or conversely only focusing on cultural, mental health and social aspects and not addressing the medical concerns

- insisting on involuntary treatment for the patient because she had declined care
- not identifying the patient had been in foster care and may not feel connected to her culture, that she may feel disconnected from her language, culture and country
- providing superficial or incomplete responses, vague plans lacking in specific actionable details – for example, 'I will explore barriers' without identifying any of the barriers that may exist
- speaking in generalities and using key phrases without being able to expand on how these suggestions would be managed in this situation
- failing to synthesise case information, respond to prompts effectively or not listening and responding to the questions asked – for example, not realising the case was set in an urban Community Controlled Aboriginal Health Service, and referring the patient's care onto 'the local AMS'.

Case 2B

In this case discussion, candidates reviewed a woman, aged 63 years, for planned follow-up of recently medicated hypercholesterolaemia and blood pressure monitoring, presenting with a new breast symptom, suspicious of breast cancer. Candidates were required to outline a problem representation, manage suspected breast cancer and discuss treatment options. Candidates were also expected to consider menopausal symptom management in the context of breast cancer and to discuss complaint management.

Examiners commented that candidates demonstrated competency by:

- approaching the discussion in a structured and patient-centred manner
- demonstrating sound clinical reasoning
- demonstrating safe clinical judgement
- appropriately identifying red flags that influence the management plan
- supporting the patient through the distress of concerns regarding missed or delayed diagnosis
- considering the patient as a person, including the psychological impact of diagnosis
- handling the patient's complaint about a colleague professionally.

Examiners commented that common pitfalls included:

- incomplete problem representation, focusing on the urgent presenting complaint but neglecting other chronic health issues
- not prioritising the breast lump and instead focusing on cardiovascular disease management
- not being aware of common investigations – for example, not ordering a mammogram or biopsy
- trying to be too specific with management concepts – for example, trying to explain a treatment option for a specific tissue diagnosis rather than broader concepts of lumpectomy versus mastectomy
- providing vague and unclear pharmacological and non-pharmacological options for vasomotor symptoms/insomnia in post-menopausal women off hormone replacement therapy
- not having a multidisciplinary team approach to the patient's care.

Case 3B

In this clinical encounter, candidates were presented with a female patient, aged 58 years, reporting an episode of expressive dysphasia with visual changes and headache. Candidates were asked to take a comprehensive history from the patient, outline diagnostic impressions and recommend investigations to the patient, then explain their management plan. There was an element of health anxiety to be identified and considered for this patient.

Examiners commented that candidates demonstrated competency by:

- taking a focused, hypothesis-driven history, prioritising gathering further information about the episode of dysphasia and associated symptoms
- communicating clearly with the patient, both when taking the history and explaining the proposed management plan
- demonstrating an empathetic and respectful approach, particularly when addressing health anxiety and patient concerns
- attending to both the patient's and the doctor's agendas, including identifying and acknowledging the patient's health anxiety while still focusing immediate attention on the assessment of the recent neurological symptoms
- identifying and prioritising the potential serious diagnosis of transient ischaemic attack (TIA)/stroke
- appropriate and timely investigation of TIA/stroke, including urgent brain imaging with CT scan or MRI
- addressing and appropriately managing patient requests for unnecessary screening tests
- developing a comprehensive management plan, including management of TIA/stroke, review of cardiovascular risk factor management, advice about driving, managing anxiety, and appropriate referrals
- managing time well to allow patient concerns to be addressed or sensitively deferred to a follow-up consultation.

Examiners commented that common pitfalls included:

- not recognising a possible TIA/stroke, or identifying this as the likely diagnosis but failing to investigate it appropriately with urgent brain imaging
- dismissing symptoms as being related to patient's health anxiety, suggesting somatisation disorder or hypochondriasis
- not recognising significant health anxiety and/or not taking this into consideration when discussing investigations and management
- starting aspirin and/or clopidogrel prior to brain imaging and a definitive diagnosis
- poorly managing case time – this varied from spending too long taking history, limited management of potentially serious diagnosis, not allowing sufficient time for comprehensive management planning, to spending too long addressing the less important issues such as the inappropriate referrals requested by the patient
- not identifying that symptoms had resolved some time before the appointment and referring to an emergency department, rather than investigating as an outpatient with appropriate safety netting
- not arranging follow-up and/or providing safety-netting advice to patient
- not addressing the patient's agenda and concerns.

Case 7A

In this clinical encounter, candidates were asked to review a patient, aged 72 years, with concurrent acute medical conditions, chronic medical conditions, and social issues. The patient had been brought in by a neighbour concerned about how the patient was not coping at home. Candidates were asked to take a comprehensive history from the patient, outline diagnostic impressions and recommended investigations to the patient, then explain their management of the complex health issues.

Examiners commented that candidates demonstrated competency by:

- engaging the patient to identify and clarify medical, social and psychological problems
- demonstrating active listening skills and an empathetic approach to assessing the patient's concerns and needs
- taking a well-structured, comprehensive biopsychosocial history
- identifying the patient's wish for independence, preference for staying at home and fear of potential need for residential care
- helping the patient prioritise the more immediate or important issues, and scheduling future appointments for less urgent issues without being dismissive of the patient's concerns
- following case instructions in a methodical fashion to summarise important information, listing key issues and diagnoses while allowing sufficient time to discuss management and relevant preventive health
- confidently managing medical needs of the patient, including atrial fibrillation, urinary tract infection, depression, recurrent falls, polypharmacy, medication adherence and medication risks
- identifying and addressing other key elements of this case, including functional deterioration at home, social isolation and preventive care
- formulating a patient-centred comprehensive team care management approach that takes into account the patient's concerns and expectations, recommending appropriate investigations, allied health referrals, home supports, opportunistic preventive care, safety netting and a clear follow-up plan.

Examiners commented that common pitfalls included:

- focusing on one or two issues rather than the broad range of acute and chronic conditions presented
- a disorganised approach to assessment and management of complex presenting issues
- recommending a limited number of investigations, in some cases not discussing investigations at all
- not addressing all tasks during case time, either due to not following the case instructions or poor time management
- being unable to incorporate the patient's agenda, providing a doctor-focused management plan
- limited consideration of non-pharmacological management for this patient – falls prevention, allied health care, support services and aged care packages not covered well
- poor communication skills, including talking over the patient, interrupting patient, not listening to what the patient was saying, overly directive management
- failing to offer the patient a clear follow-up plan and clear safety-netting advice

Case 8A

In this clinical encounter, candidates were asked to assess a man, aged 64 years, from a rural town presenting for review after a recent admission to hospital with diarrhoea and vomiting. His latest bloods showed poorly controlled diabetes and raised cholesterol. Candidates were required to take a history, interpret and explain investigations, discuss management and preventive activities and address the patient's concerns. Key aspects included education regarding optimisation of diabetes and cholesterol management using a patient-centred discussion around options, a sensitive discussion about the patient's erectile dysfunction and involvement of a multidisciplinary team in his care.

Examiners commented that candidates demonstrated competency by:

- eliciting the complex biopsychosocial picture in a systematic way and addressing the key issues specifically for the patient's context
- demonstrating active listening and motivating the patient to engage in healthier behaviours
- prioritising problems and establishing a plan that addresses patient concerns
- making appropriate decisions about medications and management of complex clinical situations
- adopting a more patient-centred approach, which included using the patient's concerns to drive motivation for change
- obtaining patient input into prioritising and selecting changes and the strategies to achieve them
- covering medication management of suboptimal diabetic control, lipid and erectile dysfunction.

Examiners commented that common pitfalls included:

- poor time management – spending too long on history taking and running out of time to discuss safety netting and follow-up
- not addressing rural context – generic allied health or specialist referral without acknowledging the requirement for telehealth, travelling two hours to the nearest tertiary hospital and financial considerations
- early closure preventing exploration of patient's agenda
- not taking enough history and focusing more on discussing blood test results and management
- not knowing management of diabetes or commencing patient on a sodium-glucose co-transporter 2 (SGLT2) inhibitor, which was a noted allergy for the patient.

Case 9B

In this clinical encounter, candidates were presented with a patient, aged 53 years, with a moderate to severe acute asthma exacerbation. Candidates were asked to take a history, interpret examination findings, including spirometry, explain management, and provide advice on preventive health activities. Management components included managing acute symptoms, developing a new asthma plan and discussing important health screening.

Examiners commented that candidates demonstrated competency by:

- asking open-ended questions early in the history and proceeding with hypothesis-driven history questions that have a clear clinical rationale
- assessing current asthma control, symptom burden, current management, adherence, triggers, risk factors and inhaler technique

- considering the possibility of other differential diagnoses, and excluding them by gathering appropriate history (eg lack of fever is less consistent with infection)
- accurately interpreting spirometry findings that showed significant obstruction with reversibility
- demonstrating shared decision-making and an educative approach to explaining symptoms and treatment, checking the patient's understanding and tailoring explanations to the patient
- managing acute asthma appropriately by commencing oral corticosteroid as soon as practical (within the hour)
- advising maintenance/preventer therapy to be commenced in alignment with an asthma management plan
- having a clear follow-up plan and providing appropriate safety netting (a written asthma action plan) in an appropriate time frame for the symptom severity (24–72 hours)
- providing preventive advice, including lung cancer screening, bowel screening, cardiovascular risk assessment, skin cancer risk assessment and vaccination advice.

Examiners commented that common pitfalls included:

- spending too much time on history-taking, leaving insufficient time for management discussion
- using closed questions, and not involving the patient in their own care or exploring the patient's ideas, concerns and expectations
- using an unfocused or checklist approach to history without having a purpose for each question asked of the patient
- misinterpreting the spirometry as chronic obstructive airways disease because of the smoking history and not noting the significant reversibility
- using overly technical patient explanations, and not clearly addressing the patient's concerns; advising they would institute an 'asthma management plan' without being able to elaborate on what that meant
- failing to recognise the acute escalation of asthma symptoms and therefore not providing appropriate management of oral corticosteroids, sometimes instead commencing an inhaled preventer alone; providing excessive reliever therapy without prevention
- failing to advise on follow-up or providing advice to follow up in an inappropriate timeframe – for example, in two weeks
- failing to provide clear safety netting – when to present to hospital, call an ambulance, how to manage escalating symptoms
- failing to provide any preventive care or advice.

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. Higher-performing candidates think broadly and clearly prioritise, balancing acute, chronic and preventive care aspects for a patient.

Stereotyping and making assumptions demonstrate a lack of understanding of patient context; poorer performing candidates missed the patient's agenda, contextual cues and did not integrate clinical, psychological and cultural elements. Being disorganised led to delivering incomplete or unsafe management. Competent candidates demonstrate a non-judgemental approach to all patients, deliver patient-centred care that integrates the patient's context and show structured reasoning to develop holistic care.

Common pitfalls included formulaic responses, or responses that used a scattergun approach in answering the question. This does not demonstrate clinical reasoning ability or understanding of individual patient context and needs.

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. The *gplearning* exam preparation toolkit has a study skills toolkit that includes a self-assessment grid to allow you to self-assess confidence in presentations and topics relevant to Australian general practice.

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 help candidates 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 using a mouse with a scrolling wheel. Using the scroll bar allows smoother scrolling via a shared screen. Candidates should slow down scrolling on a shared screen as the responsiveness is slower than on your own device.

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, so this 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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