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RACGP Education

Exam report 2025.1 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 2025.1 CCE was delivered remotely to all candidates via videoconferencing technology. The CCE reflects contemporary assessment principles and standards. A significant amount of academic research, combined with local and international external consultation, informed the development of the CCE.

The CCE consists of nine clinical cases (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 2025.1 CCE was delivered in two streams on non-consecutive days as follows:

- **Day 1A:** Saturday 14 June 2025, cases 1A–4A
- **Day 1B:** Sunday 15 June 2025, cases 1B–4B
- **Day 2A:** Saturday 21 June 2025, cases 5A–9A
- **Day 2B:** Sunday 22 June 2025, cases 5B–9B.

Exam psychometrics

The 2025.1 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 2025.1 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. 2025.1 CCE psychometrics

Average reliability	0.71
Pass rate (%)	79.66
Number passed	611
Number sat	767

Table 2. 2025.1 CCE pass rate by number of attempts

Attempts	Pass rate (%)
First attempt	83.86
Second attempt	58.46
Third attempt	46.15
Fourth and subsequent attempts	30.00

Exam banding

Table 3 provides a percentage breakdown of candidates into bandings.

Table 3. 2025.1 CCE candidates in each banding

Banding	% Candidates
P4	19
P3	21
P2	22
P1	17
F1	12
F2	6
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.

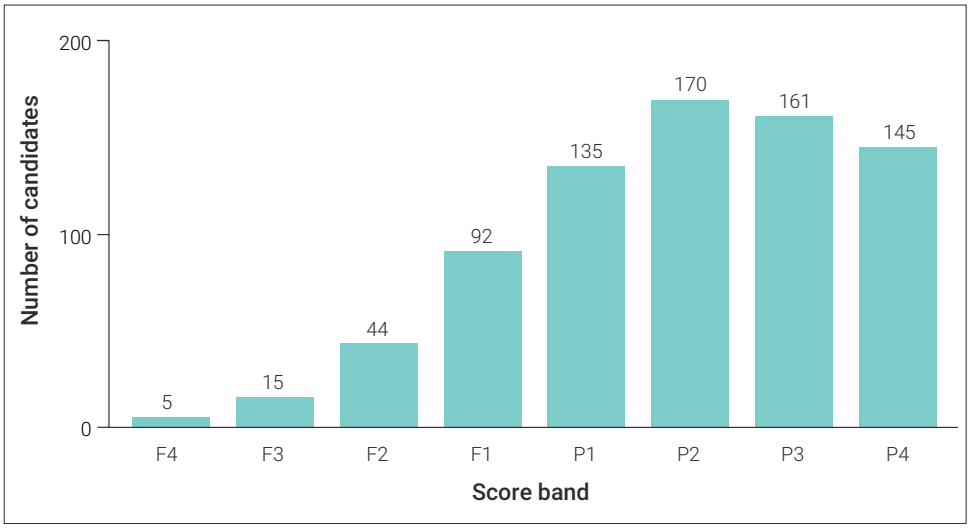

Figure 1. 2025.1 CCE banding distribution

Figure 2 shows the average performance of the cohort of passing candidates across clinical competency areas in the 2025.1 CCE.

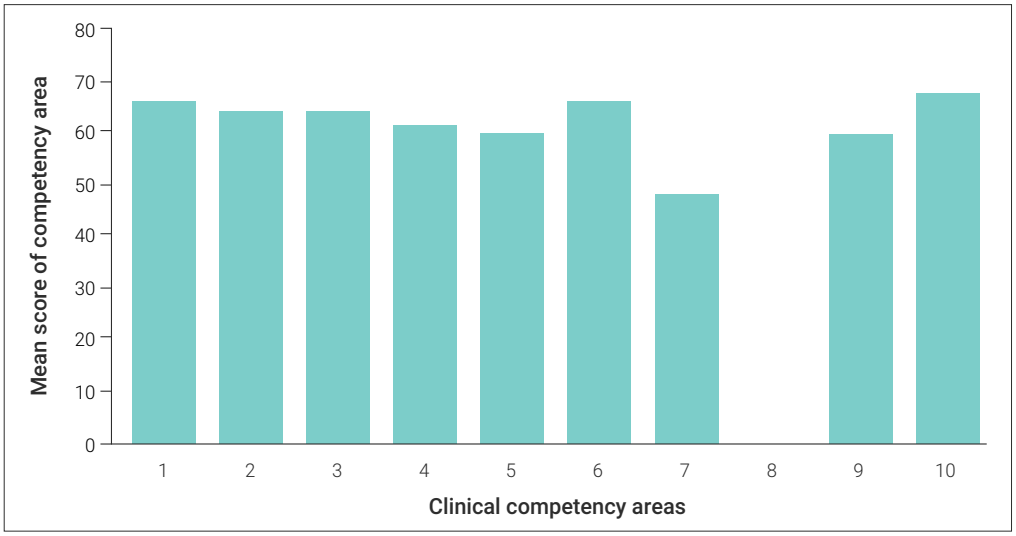

Figure 2. Average performance of passing candidates by competency area in the 2025.1 CCE

The clinical competency areas are as outlined in Box 1.

For candidates who sat the 2025.1 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.

Box 1 provides a breakdown of the assessed criteria within each competency area. In the 2025.1 CCE, 111 individual competency criteria were assessed.

Breakdown of assessed criteria within competency area for the 2025.1 CCE

1. Communication and consultation skills: 21%
2. Clinical information gathering and interpretation: 14%
3. Diagnosis, decision-making and reasoning: 20%
4. Clinical management and therapeutic reasoning: 27%
5. Preventive and population health: 8%
6. Professionalism: 3%
7. General practice systems and regulatory requirements: 1%
8. Procedural skills: 0%
9. Managing uncertainty: 4%
10. Identifying and managing the patient with significant illness: 2%

Preparation for the CCE

Preparation for the CCE primarily involves working in and reflecting on comprehensive general practice. It is useful to practise case-based discussions with supervisors and colleagues, and it is important to understand and apply the clinical competencies, as outlined in the clinical competency rubric.

A two-part CCE preparation course is available on *gplearning*. The first module, 'Introduction to the RACGP Clinical Competency Exam for candidates', includes information on the competencies being assessed and how they can be demonstrated by candidates. The second module, 'Preparing for the CCE case discussions and clinical encounters', is a guided exam preparation activity that includes cases, marking grids and video examples.

Frequently asked questions, tips, technical resources, 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.

2025.1 CCE cases

All candidates are under strict confidentiality obligations, and must not disclose, distribute or reproduce any part of the exam without the RACGP's prior written consent.

This feedback report is published following each CCE in conjunction with candidate results. It is helpful to consider your personal graph of performance in each of the competency areas when reflecting on the item feedback. All cases within the CCE are written and quality assured by experienced GPs who currently work in clinical practice, and are based on clinical presentations typically seen in an Australian general practice setting.

The CCE assesses how a candidate applies their knowledge and clinical reasoning skills when presented with a range of common clinical scenarios. It allows a candidate to demonstrate their competence over a range of clinical situations and contexts.

Each case assesses multiple competencies, each of which comprises multiple criteria describing the performance expected at the point of Fellowship.

Examiners rate each candidate's performance in relation to the competencies being assessed in the context of each case. Ratings are recorded on a four-point Likert scale, ranging from 'competency not demonstrated' to 'competency fully demonstrated'.

This assessment is designed as a summative measure of competency. It is not designed to give feedback to candidates and, as such, we do not ask examiners to comment on individual candidate performance; we ask examiners to rate performance based on the demonstration of competencies.

The public exam report is provided so that all candidates can reflect on their own performance. It is also 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 and 1B

These case discussions presented a scenario where the candidate was advised they were working in an urban Aboriginal Community Controlled Health Service. The clinic was undertaking a health initiative with a focus on completing preventive health assessments. Candidates were asked to articulate how they could assess the community's health needs and what strategies might help to enhance engagement and uptake of preventive healthcare to enhance the health outcomes of the community. An understanding of the guidelines to preventive healthcare for Aboriginal and Torres Strait Islander people was required to answer patient-specific concerns.

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:

- noticing the importance of the psychosocial elements of the case and incorporating this into the history, diagnostic and management aspects
- being non-judgemental, empathic and culturally safe
- addressing the specific needs of the presenting patient rather than speaking in generalities
- being willing to seek guidance and advice from relevant stakeholders, including Aboriginal Elders, transgenerational women or men in the community, local community groups, Aboriginal and Torres Strait Islander Health Practitioners and other staff in the Aboriginal Community Controlled Health Service
- being consultative and recognising that the initiative needed to be led by the local community
- considering the appropriate use of an Aboriginal and Torres Strait Islander Health Practitioner or liaison officer
- giving the patient choices and agency in health decision making
- considering an Aboriginal Health Assessment (MBS item 715) as an ideal way to facilitate screening and preventive assessment and interventions
- 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.

Examiners commented that common pitfalls included:

- discussing the case in broad generic terms and not being specific about how they would approach this consultation with this patient
- mentioning 'Aboriginal health worker' without providing context or consideration of the role of an Aboriginal and Torres Strait Islander Health Practitioner in providing holistic care with cultural sensitivity, thus demonstrating no real understanding of the role
- making stereotypical judgements about alcohol, smoking, domestic violence or illicit drug use, and providing paternalistic advice to a young Aboriginal person
- assuming rurality when the scenario specified an urban setting
- reeling off a long list of preventive investigations or having a scattergun approach that included tests or actions that were not indicated
- not being specific (eg suggesting diabetes screening without being specific about how this could be done – ie AUSDRISK versus blood sugar level versus HbA1c)
- missing psychosocial factors, specifically mental health issues, traumatic family history, potential poverty and crowded housing or isolation (ie social determinants of health), which all potentially impacted the patient
- not asking about nutrition and physical activity, vision, hearing and dentition
- missing immunisations as an important preventive activity

- having a paternalistic rather than consultative approach
- having rote-learned lists for cultural safety, such as displaying the flag or cultural training, without further elaboration
- 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 the patient's perspective and being aware of one's own unconscious bias.

Case 4A

In this clinical encounter, candidates were presented with a middle-aged man asking for his regular antihypertensive prescription to take with him while he travelled overseas for the next three months.

Examiners commented that candidates demonstrated competency by:

- establishing rapport through open questions and focusing on the patient's agenda
- taking a detailed travel history to provide tailored advice to the patient
- giving empathic responses to details about the patient's relationship breakdown
- summarising after a few minutes to ensure they understood the patient's ideas and expectations
- forming a problem list to manage their time in dealing with each issue
- providing a management plan that covered the patient's biopsychosocial needs – considering risks of travel and their mitigation, acute stressors of recent relationship breakdown and addressing preventive care for a middle-aged hypertensive man
- taking a history in an organised and focused way, including sexual history and potential risk-taking behaviour, and providing therapeutic options that considered the patient's needs
- prioritising imminent travel as the focus of the consultation, covering mental health briefly to ensure no safety concerns, and noting that preventive health needs such as elevated cholesterol, recent increase in alcohol intake and resumption of smoking could be followed up in a subsequent consultation
- demonstrating communication skills, such as building rapport, active listening, demonstrating empathy and providing a rationale for asking questions about mental health
- recognising that not all concerns could be managed in a single consultation and establishing issues to address in a subsequent consultation
- demonstrating safe practice and a balance between meeting the patient's needs and clinical concerns.

Examiners commented that common pitfalls included:

- failing to listen to the patient's concerns and agenda
- spending too much time on routine care and not enough on the immediate problem of imminent travel
- being disorganised in the approach to the consultation – spending too much time on history and running out of time to manage the patient, or covering only one aspect of the consultation
- prioritising cardiovascular risk and other health concerns and giving less attention to travel history and recommendations

- not demonstrating shared decision making but demonstrating an authoritarian approach to management
- providing advice on sexual risks without taking a sexual history
- concentrating on travel in the consultation but overlooking potential risk-taking behaviours, failing to contextualise the consultation, and providing generic, non-individualised advice
- not attending to the patient's concerns and instead focusing on their own agenda of health promotion and prevention
- failing to use a motivational interviewing approach to assess and provide behaviour change advice.

Case 4B

In this clinical encounter, candidates were asked to take a history, interpret investigations, and advise the patient on next steps in investigation and management. A middle-aged female with an intramural fibroid, recurrent mid-cycle pelvic pain, menorrhagia and dysmenorrhea was seeking family planning advice with her same-sex partner and analgesic options for her pain.

Examiners commented that candidates demonstrated competency by:

- taking a well-structured, logical history
- demonstrating active listening skills, understanding the patient's agenda and addressing the patient's concerns
- providing a clear explanation of an ultrasound showing a fibroid and a haemorrhagic ovarian cyst
- providing respectful and non-judgmental care of a woman seeking IVF treatment with her female fiancé; showing respect for and understanding of a non-heteronormative situation, and using language appropriate to the situation
- identifying reasonable differential diagnoses for the presentation, including endometriosis
- asking about timing of pain and associated symptoms such as bowel or bladder symptoms and dyspareunia, and assessing the impact on quality of life
- addressing pain management appropriately and provided safety-netting and a clear follow-up plan.

Examiners commented that common pitfalls included:

- demonstrating inadequate curiosity and exploration of the history
- assuming the patient had a male partner and using potentially offensive language or inappropriate questions (eg asking about condom/contraceptive use)
- not considering endometriosis as a cause of the patient's symptoms
- anchoring to the fibroid as a reason for pain and heavy bleeding and suggesting myomectomy as an appropriate treatment
- considering mid-cycle cyst rupture causing hours to days of severe pain restricting all function to be 'normal'
- anchoring to polycystic ovarian syndrome as a reason for recurrent cyst rupture, despite the scenario and history being inconsistent with this diagnosis
- declining the requested codeine script; offering only the options the patient was already using and had described as inadequate, with no offer of any alternatives or follow-up.

Case 5A

In this case discussion, candidates were presented with the scenario of a girl aged 10 years with bilateral heel pain, which worsened with activity such as running and improved with rest; there was tenderness over her posterior calcanei with no other abnormal examination findings.

Examiners commented that candidates demonstrated competency by:

- demonstrating an understanding of calcaneal apophysitis (Sever's disease)
- providing a concise problem representation and reasonable differential
- explaining that this condition is self-limiting and not over-investigating or referring unnecessarily
- considering the social and emotional impact that activity modification might have for the patient
- considering that there might be challenges in the family dynamics with parental separation and distance
- articulating what features of the history and examination would help to rule in or rule out their diagnostic possibilities.

Examiners commented that common pitfalls included:

- misinterpreting BMI in a child, leading to candidates considering the patient as being underweight (which she was not)
- offering generic or nonspecific management that did not take the patient or their context into consideration
- over-investigating and referring unnecessarily
- not understanding the natural history of Sever's disease – some mentioned full symptom resolution would be in four to six weeks, which might set unrealistic expectations for the family
- not knowing their obligations in cases of parental disagreement on medical care.

Case 5B

In this case discussion, candidates were presented with a mother and her baby initially presenting for a six-week check after a spontaneous vaginal delivery at 39 weeks' gestation. The patient was emotional, describing her baby as 'crying all the time'.

Examiners commented that candidates demonstrated competency by:

- having a structured approach to problem definition and listing the issues for both mother and child – recognising both as patients
- being patient-centred, considering both mother and baby, and recognising that there was maternal concern about a physiologically normal phenomenon
- considering differentials that encompassed both maternal and baby possibilities, and being able to prioritise 'most likely' and 'cannot miss' diagnostic possibilities
- considering the safety of both mother and baby by asking about domestic violence, recognising the clavicle fracture in a baby aged 4 months as a non-accidental injury and acting on it appropriately, to ensure safety for the infant

- considering routine and preventive care that is recommended at six weeks for both mother and baby, including screening and immunisations – and acknowledging that if these could not be addressed today, a plan to follow up needed to be made
- having knowledge about what supports, services and resources are available within the community and online (eg PANDA and Purple Crying).

Examiners commented that common pitfalls included:

- only addressing a single patient – focusing solely on mother or on baby
- not addressing the mother's agenda or concerns
- not clearly prioritising possible diagnostic reasons for the presentation
- considering orthopaedic advice or a sling for a delayed presentation of a clavicular fracture in a baby aged 4 months
- wanting to take further history and assessment of the clavicular fracture and only seeking further advice or reporting to child safety depending on their findings or opinion, which is outside the scope of any medical practitioner on their own.

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, 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

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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