Clinical challenge

Using *AJGP* for your CPD

Each issue of the *Australian Journal of General Practice* (*AJGP*) focuses on a specific clinical or health topic. Many GPs find the entire issue of interest and relevance to their practice and others explore the issue more selectively.

Below you'll find various ways you can use *AJGP* as part of your CPD. If you want to use the entire issue for CPD, carefully and critically work your way through each Focus article, considering how you might adjust your practice in response to what you have learnt, then complete the Clinical challenge.

Your CPD will be automatically recorded for you

When you complete the *AJGP* Clinical challenge and/or Measuring Outcomes (MO) companion activity through *gplearning*, your CPD hours will be automatically recorded on myCPD Home within 12 hours.

Self-recorded reading

If you prefer to read and reflect on specific articles without completing the Clinical challenge, record this via quick log on myCPD Home. As guidance, each article in AJGP can be recorded for up to two CPD hours, split evenly between EA and RP CPD time.

Clinical challenge

The Clinical challenge consists of multiple-choice and short answer questions based on the Focus articles in this issue of *AJGP*. Complete the Clinical challenge to earn 10 CPD hours, split evenly between Educational Activities (EA) and Reviewing Performance (RP). This CPD allocation includes reading time for the Focus articles.

MO companion activity

The MO companion activity assists you to implement and evaluate changes in your practice in line with the guidance provided in a specific article in this issue of *AJGP*. Complete the companion activity to earn five MO hours.

Visit https://bit.ly/March26CCMO and select the 'Register' button to find both the Clinical challenge and Measuring Outcomes companion activity.

Self-directed MO options

You can also do self-directed MO CPD related to this issue of *AJGP*.

Choose any topic area from within the issue and undertake a quality improvement activity. This can be done on your own, with a colleague, in a group, or perhaps with the assistance of our practice manager or PHN quality improvement team.

Consider evaluating your practice setting's approach to supporting Aboriginal and Torres Strait Islander patients' participation in the National Lung Cancer Screening Program and associated smoking cessation activity. Examine the language and strategies you use, including behavioural support and medications, as outlined in David Thomas's article.

A simple evaluation might be recorded for several MO hours, while a more comprehensive PDSA approach would provide at least 10 hours of MO CPD. Log in to myCPD Home (https://bit.ly/myCPDhome) for guides and templates to complete your self directed quality improvement activities and record your MO hours.

AI declaration: The Editors advise that artificial intelligence (AI)-assisted technology was used in the writing and/or editing of the March 2026 *AJGP* Clinical challenge and accept full responsibility for all content.

March 2026 Multiple-choice questions

These questions are based on the Focus articles in this issue. Please choose the single best answer for each question.

CASE 1

You are a general practitioner (GP) in a rural Victorian town serving a diverse community, including many Aboriginal and Torres Strait Islander peoples. An Aboriginal woman aged 32 years presents for preconception advice. She smokes daily, has experienced racial discrimination in healthcare and has Crohn's disease. You have read the March 2026 issue of *Australian Journal of General Practice* and wonder how it could apply to her.

QUESTION 1

According to the article on embedding cultural safety, what is central to cultural safety when providing healthcare for Aboriginal and Torres Strait Islander peoples?

A. Studying Aboriginal and Torres Strait Islander cultures within health contexts extensively

B. Ongoing self-reflection and addressing power differentials

C. Providing services regardless of the presence of cultural differences

D. Focusing solely on individual interpersonal interactions

QUESTION 2

According to the article on cultural safety, what is required to eradicate racism against Aboriginal and Torres Strait Islander peoples?

A. Dismantling settler-colonial systems

B. Optimising patient–doctor relationships

C. Focusing on healthcare worker attitudes

D. Reinforcing appropriate social norms

QUESTION 3

The article on reducing smoking recommends using the 'Ask Advise Help' model. What is the key action under 'Advise' for all people who smoke?

A. Assess the patient's stage of change before advising to quit

B. Provide brief, clear, non-confrontational advice to quit at every visit

C. Offer concise and relevant pamphlets as the primary intervention

D. Recommend participation in appropriately chosen support groups

QUESTION 4

The article on smoking cessation recommends assessing nicotine dependence with which questions?

A. Time to first cigarette, number of cigarettes per day, and severity of cravings.

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B. Time to first cigarette, frequency of cravings, and age of first cigarette use.

C. Number of cigarettes per day, number of previous attempts to quit, and impact of smoking upon function.

D. Number of cigarettes per day, total financial cost of tobacco, and stage of change within transtheoretical model.

QUESTION 5

For smoking cessation pharmacotherapy in pregnant Aboriginal and Torres Strait Islander women, which of the following is appropriate to use if counselling alone has not been effective?

A. Combination nicotine replacement therapy (NRT)

B. A noradrenaline–dopamine reuptake inhibitor such as bupropion

C. Oral NRT

D. A nicotinic acetylcholine receptor partial agonist such as varenicline

QUESTION 6

As a result of increasing rates of syphilis, what is the recommended screening schedule in pregnancy (including Aboriginal and Torres Strait Islander women)?

A. Once at the first visit

B. Twice: first visit and at 36 weeks or delivery

C. Three times: first visit, 26–28 weeks and 36 weeks or delivery

D. Only if symptoms are present

QUESTION 7

For smoking cessation in pregnancy, the article notes that Aboriginal and Torres Strait Islander women prefer what type of support?

A. Pharmaceutical options primarily

B. Group-based support by Aboriginal and Torres Strait Islander health workers

C. Self-help pamphlets

D. Online apps alone

QUESTION 8

For vaccinations in pregnancy, what is the new addition to the Australian Immunisation Handbook besides influenza and whooping cough?

A. COVID-19

B. Respiratory syncytial virus

C. Hepatitis B

D. Measles

March 2026 Short answer questions

These questions are based on the Focus articles in this issue. Please write a concise and focused response to each question.

CASE 1

You are a general practitioner (GP) in a rural Victorian town serving a diverse community, including many Aboriginal and Torres Strait Islander peoples. An Aboriginal woman aged 32 years presents for preconception advice. She smokes daily, has experienced racial discrimination in healthcare and has Crohn's disease. You have read the March 2026 issue of *Australian Journal of General Practice* and wonder how it could apply to her

QUESTION 1

Describe the definition of cultural safety as provided by the National Indigenous Health Leadership Alliance.

QUESTION 2

Outline the multiple pathways through which racism affects health and wellbeing.

QUESTION 3

Describe some behavioural support elements that could lead to successful cessation of smoking in Aboriginal and Torres Strait Islander peoples.

QUESTION 4

Explain the times and circumstances where advising people to quit smoking is appropriate.

QUESTION 5

Outline why general practitioners should ask parents/carers of children where they smoke.

QUESTION 6

Why is preconception and pregnancy a key time for health promotion in Aboriginal and Torres Strait Islander women, and how should this advice be given?

QUESTION 7

Discuss how Aboriginal and Torres Strait Islander men/fathers can be included more in antenatal care.

QUESTION 8

Write a reflection of your own practice, and what you can do differently to combat racism and provide culturally safe care.

January–February 2026 Multiple-choice question answers

ANSWER 1: B

Current guidelines recommend commencing light physical activity within 24–48 hours of concussion. This helps manage fatigue, sleep, mood and physical symptoms. Mild symptom exacerbation is accepted during the first three stages of return to sport. Previous recommendations for prolonged rest have been shown to delay recovery. Daily exercise of 20–30 minutes post-concussion is recommended and can include playing with friends or structured cardiovascular programs.

ANSWER 2: D

Symptom severity is the most consistent predictor of delayed recovery in paediatric concussion. Approximately 30% of children experience prolonged symptoms beyond 4 weeks (persistent post-concussion symptoms). Additional risk factors include pre-injury history of migraine, neurodevelopmental or mental health concerns, and parental concern. Loss of consciousness is not a reliable predictor of prolonged recovery.

ANSWER 3: A

Return to learn involves a stepwise process, gradually increasing cognitive load and allowing for mild, brief symptom provocation. Best practice emphasises initially returning a child to the school environment for social purposes rather than focusing immediately on academic performance and establishing a routine. In most instances, school return should be prioritised prior to extracurricular activities. Accommodations may be needed for those with persistent post-concussion symptoms, but complete rest is not recommended.

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ANSWER 4: D

Current evidence does not support routine use of neuroimaging in concussion. The ANZ Concussion Guidelines reference clinical decision rules (PREDICT and PECARN) to guide imaging decisions. Imaging is only indicated when structural injury is suspected or if symptoms significantly increase in days following concussion. Sarah's presentation does not have red flags requiring imaging. Her general practitioner should reassure her that imaging is not necessary.

ANSWER 5: B

According to the ANZ Concussion Guidelines, if symptoms continue for longer than 4 weeks, they are considered 'persisting symptoms' (persistent post-concussion symptoms [PPCS]). This occurs in 20–50% of adults and 30–40% of children. The number of concussion symptoms as well as pre-existing conditions often contribute to the prevalence and severity of persisting symptoms, making management more complex. Approximately 25–30% of cases are challenging because of the presence of intractable mood, anxiety or headache disorders and/or the complexity of pre-existing comorbid and environmental factors that complicate recovery. Sarah's symptoms at 5 weeks therefore qualify as PPCS and warrant consideration of multidisciplinary management.

ANSWER 6: D

There is little relationship between objective cognitive measures and self-reported cognitive symptoms in the post-acute period after a mild traumatic brain injury (mTBI). However, approximately 20% (not 5%) will demonstrate objective cognitive impairment. Computer-based 'brain training tasks' do not result in transferable functional improvements, but cognitive rehabilitation intervention has been shown effective if appropriately targeted to affected cognitive systems. Recent research shows post-acute neuropathological changes continue in some individuals with mTBI, associated with cognitive dysfunction. Referral to clinical neuropsychology is warranted for ongoing cognitive symptoms.

ANSWER 7: C

Readiness for return to work can be considered when patients can sustain approximately 2 hours of concentration or approximately 45 minutes of screen time. The approach should involve short, non-consecutive shifts initially, progressing gradually, with general practitioner reviews every 1–2 weeks. Nia meets these thresholds, suggesting she could commence a very graded return to work, though academic demands should be prioritised and coordinated with work schedule.

January–February 2026 Short answer question answers

ANSWER 1

Four symptom clusters to assess:

1. Somatic/physical symptoms (headache, dizziness, neck pain)
2. Cognitive symptoms (concentration difficulties, memory problems)
3. Emotional symptoms (anxiety, mood changes)
4. Sleep-related symptoms

ANSWER 2

Two allied health referrals to consider:

1. Physiotherapist with concussion/vestibular expertise: For systematic assessment and management of his dizziness (vestibular dysfunction) and neck stiffness (cervical dysfunction), and to guide graduated return to activity. Can provide oculomotor exercises, habituation exercises and cervical treatment.
2. Psychologist: To provide cognitive behavioural strategies for symptom management, to address any anxiety about recovery and performance (particularly given academic pressures) and to address any maladaptive thinking patterns or avoidance behaviours that may be developing.

ANSWER 3

Parental concern has been identified as a contributing factor for development of persistent post-concussion symptoms (PPCS). Lack of knowledge and understanding about concussion increases parental concern, which directly affects the child's recovery. Parents must be involved early and throughout concussion recovery as key parts of the multidisciplinary team, with appropriate education and reassurance about typical recovery trajectories.

ANSWER 4

Sarah should **not** return to martial arts, including her tournament this weekend. She must meet all of the following conditions prior to returning to contact sport:

- Symptoms must be completely resolved (return to baseline function)
- Must be symptom-free at rest and post-exertion
- Must be exercising at previous levels of intensity for 1–2 days
- Minimum of 21 days must have passed since concussion
- Must have medical clearance from a general practitioner before returning to contact practice/unrestricted play
- Should progress through non-contact martial arts drills (stage 4) before returning to full contact

ANSWER 5

Analgesic advice:

- Short-term use: Paracetamol and ibuprofen may be used for milder headaches; her usual medication for severe headaches/migraine
- Important precaution: Limit analgesic use to 2–3 times per week after the first 2 weeks because of risk of medication-overuse headache
- Avoid: Opioid medications and benzodiazepines
- Consider: If headaches persist beyond 10 days, consider other management strategies including physiotherapy

ANSWER 6

Sleep disturbance treatment options:

Non-pharmacological approaches (preferred):

- Cognitive behavioural therapy (CBT): Recent systematic review

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recommends CBT as treatment of choice over pharmacological and alternative interventions for sleep difficulties after mild traumatic brain injury
- Psychoeducation and counselling: Support to improve sleep hygiene has been shown to lead to improvement in sleep difficulties (though quality of evidence is variable)
- Light therapy: Has had some success demonstrated

Pharmacological approaches (short term only while behavioural strategies are implemented):

- Melatonin: Preferred to amitriptyline because of safety and low-risk profile despite equivalent efficacy
- Tricyclic antidepressants (eg amitriptyline): Can be used short term
- Benzodiazepines: Not recommended
- Dosage should be guided by safety considerations and patient preference

ANSWER 7

Relationship between sleep and other post-concussion symptoms (PCS):

- Contribution to maintenance of other PCS: Because of its contribution to maintenance of other symptoms, persistent sleep disturbance should be considered a high-priority focus for intervention
- Delays recovery: Sleep difficulties have been shown to delay recovery (demonstrated in elite athlete populations)
- High-priority target: Addressing sleep can have flow-on benefits for multiple symptom domains

ANSWER 8

Neuropsychological assessment indications:

When testing may be helpful:

- Cognitive symptoms are among the most common and most disabling post-concussion symptom difficulties
- Approximately 20% of individuals demonstrate objective cognitive impairment in the post-acute period
- For a small proportion with persistent cognitive symptoms, testing may be helpful but not recommended while significant symptoms persist (as these limit participation and tolerance)

Why referral to clinical neuropsychology is warranted:

- Little relationship between objective cognitive measures and self-reported cognitive symptoms in post-acute period – so subjective reports of cognitive symptoms do not necessarily predict objective impairment
- Treatment effectiveness: Cognitive rehabilitation has been shown to be effective in the short and long term if appropriately targeted to affected cognitive systems (not computer 'brain training')
- Comprehensive approach: Successful rehabilitation typically involves both psychological and cognitive intervention
- Specialist expertise: Clinical neuropsychologists have expertise with the multifactorial nature of mild traumatic brain injury (mTBI) recovery
- Multiple symptom management: Can address cognitive symptoms alongside psychological distress, pain, fatigue, sleep disturbance, frustration tolerance

For Kamal specifically: At 8 weeks with persistent functionally impairing cognitive symptoms alongside psychological distress, referral to clinical neuropsychology is certainly warranted.

ANSWER 9

Three specific return-to-work recommendations:

1. Spread working hours over multiple days: Work smaller blocks of time (eg 4 hours) spread over several days rather than 1 full day, as recovery from fatigue is non-linear. Build in regular rest breaks during the workday to prevent cumulative fatigue.
2. Monitor end-of-day fatigue levels: Use simple analogue scale (out of 100) at strategic times; if finishing days in moderate–severe exhaustion, pace is too rapid. Track pattern over days/weeks to guide progression of activities.
3. Incorporate all demands: Consider work, carer/family responsibilities and social demands in the overall activity budget – not just paid employment.

ANSWER 10

Advice about mild symptom increases:

- Psychoeducation and reassurance: Mild elevations in symptoms, when returning to life demands, are acceptable and importantly do **not** represent worsening of injury
- Acceptable parameters: Mild increases during or after activities are expected as part of recovery; only moderate–severe increases indicate need for more graded approach
- This reassurance is essential as patients often fear symptoms indicate ongoing damage

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