

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 an *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 Educational Activities (EA) and Reviewing Performance (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 8 CPD hours, split evenly between EA and RP. This CPD allocation includes reading time for the Focus articles.

Self-directed CPD options linked to this issue

Doctors are able to include the planning and evaluation of strategies that support their health and wellbeing as part of their annual CPD. In addition to contributing to your CPD hours, these activities address the MBA's program-level requirements around professionalism and ethical practice.

The RACGP is pleased to share resources to support both individual doctors and practice teams to plan and evaluate their doctor wellbeing strategies. Access these resources at www.racgp.org.au/wellbeingforgps.

To support member privacy, responses to questions posed in these activities and resources are not collected. Self-record RP and MO CPD (as appropriate) for time spent using the resources that best meet your needs.

AI declaration: The Editors advise that artificial intelligence (AI)-assisted technology was used in the writing and/or editing of the November 2025 *AJGP* Clinical challenge and accept full responsibility for all content.

November 2025 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

During a clinical review meeting a registrar supervisor discusses a medication error made by her registrar. She states: 'This is completely unacceptable. Good doctors simply do not make mistakes like this. We need to ensure this never happens again.' Several colleagues nod in agreement, while the registrar appears visibly distressed and withdraws from the discussion.

QUESTION 1

This response primarily reflects which problematic cultural shift?

- A. Evidence-based approach to quality improvement and risk management

- B. Maintenance of clinical standards and patient safety expectations
- C. Normal supervisory feedback designed to prevent future errors
- D. The transformation of excellence into unrelenting perfectionism

CASE 2

You are designing a professional development session for general practice registrars who have expressed feeling inadequate compared to their peers and have described feelings of isolation when facing clinical challenges.

QUESTION 2

Which intervention would most effectively address the cultural factors contributing to these feelings?

- A. Additional clinical-skills training to improve competency and reduce anxiety
- B. Implementing stricter supervision to ensure registrars meet expected standards
- C. Individual counselling sessions to build personal resilience and confidence
- D. Modelling appropriate self-compassion and normalising professional struggles

CASE 3

Dr Miguel, an experienced general practitioner (GP), regularly works through lunch, often stays late to complete notes and has been treating his own hypertension with samples from the practice rather than seeing a colleague. When asked about work-life balance at a practice retreat, he responds: 'Patients depend on us. Taking time for myself feels selfish when people are suffering.'

QUESTION 3

Dr Miguel's attitude most likely reflects:

- A. Appropriate prioritisation of patient needs over personal convenience
- B. Effective time management strategies developed through clinical experience
- C. Normal medical professionalism consistent with community expectations
- D. The distortion of altruism into excessive self-sacrifice

CASE 4

During a practice meeting, Dr Jagnu, a senior partner, states: 'I have been working 60-hour weeks for the past month, skipping lunch most days and I have had a persistent cough

for three weeks but have not had time to see anyone about it. That is just what we do as doctors — our patients come first.’

QUESTION 4

With regards to the relationship between doctor wellbeing and patient care, which statement is most accurate?

- A. Dr Jagnu is demonstrating appropriate medical professionalism by prioritising patient needs
- B. Dr Jagnu’s compromised wellbeing may increase his risk of making medical errors and impact patient care
- C. Self-neglect is a personal choice that doesn’t affect professional responsibilities or patient outcomes
- D. This represents normal medical culture and is unlikely to influence his clinical decision-making capacity

QUESTION 5

Following this practice meeting, Dr Ling, a GP supervisor, is reviewing the Medical Board of Australia’s Good medical practice: A code of conduct for doctors in Australia (The Code) with her registrar. The registrar asks: ‘Do we actually have a professional obligation to look after our own health, or is self care just a nice-to-have?’

Which response most accurately reflects the professional standards regarding doctor wellbeing?

- A. Professional obligations only extend to patient care, not personal wellbeing
- B. Self-care requirements only apply during training, not independent practice
- C. The Code specifically acknowledges doctors’ obligations to support their own health
- D. The Royal Australian College of General Practitioners (RACGP) recommends self-care, but the Medical Board has no position on this

QUESTION 6

Dr Jagnu and Dr Ling’s practice is considering implementing the new RACGP self-care package for all GPs. The practice manager asks about the practical benefits and requirements of this initiative.

Which statement most accurately describes the RACGP self-care package?

- A. It consists of a confidential self-assessment and 12-month self-care plan
- B. It focuses primarily on time management and work efficiency strategies
- C. It is only available to registrars and early career GPs who need it most
- D. It requires completion within a supervised group setting with peer review

CASE 5

You are supervising Sarah, a general practice registrar in her first term. She approaches you after a difficult consultation with a patient aged 45 years who presented with chest pain. Despite normal vital signs and electrocardiogram (ECG), she is visibly distressed and states: ‘I just cannot be certain it is not cardiac. What if I miss something serious? I feel like I should refer everyone to emergency.’

QUESTION 7

According to Beresford’s framework, which type of uncertainty is Sarah primarily experiencing?

- A. A combination of technical and conceptual uncertainty
- B. Conceptual uncertainty regarding application of guidelines
- C. Technical uncertainty due to limited diagnostic skills
- D. Personal uncertainty related to patient-specific factors

QUESTION 8

Which statement best describes the most effective approach to support Sarah’s development of uncertainty tolerance?

- A. Acknowledge that uncertainty tolerance develops with supervised experience
- B. Arrange immediate counselling as this indicates early career burnout
- C. Provide her with more clinical protocols and decision-making algorithms
- D. Refer her to the medical educator for remedial clinical skills training

CASE 6

A female general practice registrar aged 29 years in her second training term, presents with emotional exhaustion and feelings of professional inadequacy. She works in a rural practice and mentions

struggling with patient expectations and feeling isolated from colleagues.

QUESTION 9

You discuss the registrar’s concerns with other supervisors, who identify behaviours they’ve observed in registrars that may indicate burnout risk. According to recent Australian research, which observation should prompt the most immediate intervention?

- A. A registrar expressing uncertainty about patient management
- B. A registrar requesting feedback on clinical decision-making
- C. A registrar showing poor insight into their own wellbeing status
- D. A registrar working additional hours to meet financial goals

November 2025 Short answer questions

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

QUESTION 1

Dr Talya, a practice principal, notices that her younger colleagues seem reluctant to discuss clinical uncertainties or admit when they are struggling. She observes them working excessive hours and appearing increasingly stressed. During a partners’ meeting, she states: ‘We need to address this, but I am not sure how to change what seems to be deeply ingrained professional culture’.

Explain the concept of the ‘hidden curriculum’ and how it perpetuates problematic aspects of medical culture. In your answer, describe:

- a. What the hidden curriculum is and how it functions.
- b. **Two** specific ways the hidden curriculum reinforces cultural problems.
- c. **One** practical strategy Dr Talya could implement to counteract its negative effects.

QUESTION 2

During a registrar education session, Dr Kevin presents a case where he made

a clinical decision that, while ultimately correct, involved significant diagnostic uncertainty. He states: 'I felt like a fraud the entire time. A real doctor would have known exactly what to do. I kept thinking my supervisor would realise I am not cut out for this'.

- Identify and explain the **three** components of self-compassion that could help Dr Kevin.
- Explain how practising self-compassion could contribute to broader cultural change in medicine.

QUESTION 3

You are the medical educator for a regional training network where several registrar supervisors have expressed concern about registrar wellbeing.

How might a general practitioner (GP) in a supervisory or teaching role model healthier professional behaviours to influence positive cultural change? Provide specific examples of behaviours that could counteract the problematic aspects of medical culture.

QUESTION 4

You are conducting a mentoring session with Dr Ji-Su, a newly independent GP who expresses guilt about prioritising her own wellbeing. She states: 'I became a doctor to help others. When I take time for exercise or social activities, I feel like I am being selfish. Patient needs should always come first, right? How can I justify focusing on myself when there are people suffering?'

Address Dr Ji-Su's concerns by explaining:

- The 'kindergarten question' concept and its relevance to her situation.
- How the argument for 'inherent importance' of wellbeing applies to doctors themselves.
- One** practical way she could reframe self-care to align with her professional values.

QUESTION 5

As the medical director of a large general practice, you are developing a comprehensive wellbeing strategy following concerning results from a staff survey

showing high burnout levels and job dissatisfaction. Some partners argue that wellbeing initiatives are costly and question whether there is a genuine business case for investment in doctor wellbeing programs.

Develop a business case for wellbeing investment by explaining:

- Three** specific negative outcomes of poor doctor wellbeing that impact practice performance.
- How the 'shared responsibility' model justifies organisational investment in wellbeing initiatives.

QUESTION 6

A GP supervisor in an urban practice has noticed concerning changes in her current registrar, Tom, who is in his second term of training. Tom has been arriving early and staying late, appears increasingly anxious about patient consultations, and recently mentioned financial stress from his reduced income compared to his previous hospital role. He seems reluctant to seek help with complex cases and has cancelled his last two educational meetings.

Based on the research findings on burnout risk factors in general practice registrars:

- Identify **three** specific risk factors for burnout that Tom is displaying.
- Explain how these risk factors may interact to increase Tom's burnout risk.
- As Tom's supervisor, outline **three** evidence-based strategies you could implement to address his burnout risk, ensuring your interventions target different aspects of the identified risk factors.

October 2025 Multiple-choice question answers

ANSWER 1: D

Schedule an urgent long appointment to conduct a travel risk assessment.

ANSWER 2: C

Performing diving medical assessments.

ANSWER 3: A

Australian recommendations now support a 2-visit schedule (days 0 and 7) for

short-term protection of immunocompetent travellers to rabies-enzootic areas.

ANSWER 4: B

Give the measles-mumps-rubella (MMR) vaccine to Priya and early MMR vaccine to Rohan (noting that Rohan will still need routine doses).

ANSWER 5: D

The traveller's country of birth. While country of birth may be relevant for some diseases, it is the least important factor when compared with disease likelihood, severity, treatment availability and vaccine characteristics in the risk-benefit assessment.

ANSWER 6: A

Order malaria testing and consider an urgent referral.

ANSWER 7: B

Comprehensive stool testing including microscopy, culture and sensitivity (MC&S), ova, cysts and parasites (OC&P) and PCR.

ANSWER 8: B

Short (less than 2 weeks).

October 2025 Short answer question answers

ANSWER 1

Approach and key considerations should include:

- Medication management and supply planning: Emma requires comprehensive medication planning for her six-month placement, including a health summary and a sufficient supply of her routine medications for the duration of her trip. For insulin-dependent diabetes, this includes calculating total insulin requirements with 25–30% additional supply for contingencies. Consider insulin storage requirements in rural Kenyan climate, particularly temperature stability and refrigeration access.
- Self-management education and action planning: Patient education must

address acute diabetes management in resource-limited settings. It is recommended to educate patients to manage acute exacerbations of their diseases and provide written action plans to support them. Develop specific protocols for hypoglycaemic episodes, hyperglycaemia management and sick-day rules adapted for tropical conditions and limited healthcare access.

- Technology and equipment: Insulin pump and continuous glucose monitoring require comprehensive backup planning. Address power supply challenges in rural settings, equipment failure protocols and customs documentation for medical devices. Provide backup insulin delivery methods and blood glucose monitoring supplies, as well as equipment for safe disposal of sharps.
- Healthcare access and support networks: Research available healthcare facilities in rural Kenya and establish local medical contacts through the International Society of Travel Medicine global directory. Where local medical services are limited, patients might need to initiate their own medical care. Discuss medical evacuation insurance coverage for serious diabetic complications.

ANSWER 2

‘Primary care for the roaming patient’ recognises that travel medicine extends beyond exotic disease prevention to comprehensive health management for mobile populations. This perspective acknowledges that travellers mostly encounter issues related to primary care or public health, positioning travel medicine within the broader primary care framework rather than as a specialist discipline.

Three advantages would be:

1. Longitudinal therapeutic relationship: GPs’ knowledge of a patient’s history, vaccinations, and allergies allows holistic, patient-centred pre-travel advice and tailored risk assessment not possible in single-consultation specialist care.
2. Continuity of care: GPs provide seamless pre- and post-travel care.

Their involvement can improve decision making, as accurate diagnosis often depends on understanding how travel has affected a patient’s health.

3. Integrated health management: GPs coordinate travel advice with chronic disease care, routine health needs, and prevention, ensuring preparation does not fragment existing care or relationships.

ANSWER 3

- Indemnity and jurisdiction: Advice to patients overseas may fall outside professional indemnity cover, with differing legal and clinical standards.
- Funding: Such consultations are ineligible for Medicare benefits; travel insurance should provide coverage with local healthcare services being the appropriate first contact for acute problems.
- Clinical limitations: Telephone advice cannot replace examination or investigations, particularly with red-flag symptoms such as bloody diarrhoea and fever.

Recommended approach:

Dr Torres should strongly recommend urgent local medical review, directing James to emergency services or another appropriate facility (eg via the International Society of Travel Medicine directory). The consultation should be documented, noting limitations of remote advice, and only general guidance given until local assessment occurs.

ANSWER 4

Risk-benefit framework for travel vaccines

- Disease risk factors: destination epidemiology, outbreak status, rural versus urban exposure, itinerary, duration, accommodation, activities and traveller characteristics (age, comorbidities, immune status, visiting friends and relatives (VFR) travel, risk tolerance).
- Vaccine factors: efficacy, safety profile, timing, cost and long-term protection.

Application to Rebecca:

- Required: yellow fever.

- Recommended: hepatitis A, typhoid, meningococcal ACWY (given location in the meningitis belt).
- Routine: ensure up to date with measles, influenza, COVID-19.

Example – meningococcal ACWY: high incidence in West Africa during dry season, severe outcomes, single effective dose with excellent safety makes this a strong risk-benefit case.

Counselling approach: emphasise tailored recommendations over ‘every vaccine’, using risk-benefit reasoning and written advice to support decision-making.

ANSWER 5

Management of yellow fever vaccination in an immunocompromised patient:

- Contraindication: Yellow fever vaccine is a live vaccine. Significant immunosuppression with methotrexate and prednisolone makes it unsafe and less effective.
- Specialist referral: Indicated for immunosuppressed patients where live vaccines are considered, or when complex risk-benefit assessment is required.

Management options:

1. Specialist-supervised vaccination
 - Referral to a travel medicine clinic for detailed risk-benefit analysis.
 - Possible coordination with rheumatologist for temporary adjustment of immunosuppression.
 - Careful monitoring and informed consent regarding reduced efficacy and higher adverse event risk.
2. Medical exemption letter
 - Documentation of vaccine contraindication.
 - Note that acceptance varies by country; some may deny entry without proof of vaccination.
 - Patient must understand and accept infection risk.
3. Alternatives
 - Modify or defer travel if possible.
 - Maximise mosquito avoidance (repellent, treated nets, clothing).

- Ensure comprehensive travel insurance.

Summary: In this case, vaccination is contraindicated. Referral to a specialist is warranted to guide exemption documentation, assess options and reinforce mosquito avoidance strategies.

ANSWER 6

Dengue vaccine status in Australia: Qdenga (Takeda) is a new live attenuated vaccine that is not registered in Australia but can be accessed via the Therapeutic Goods Administration's Special Access Scheme.

Dengue vaccination might be considered for Sarah in the case of:

- Previous confirmed dengue infection – laboratory evidence required
- Extended exposure – travelling to dengue risk areas for >four weeks
- Sarah being a frequent traveller – multiple trips to endemic areas
- Higher-risk situations – long-term residence or occupational exposure.

Australian context differences:

- More conservative approach when compared with some international guidelines
- Emphasis on proven benefit–risk ratio before recommendation
- Focus on vector avoidance as primary prevention strategy
- Special Access Scheme requirement adds complexity and cost.

ANSWER 7

The key components of your assessment should include:

1. Trip details – Step-by-step account from day one until return, specific regions visited within countries.
2. Purpose of travel – VFR, business, tourism.
3. Accommodation type – Urban versus rural, five-star versus backpacking, availability of protective measures against insects (eg nets, screening).
4. Exposures – Recreational (hiking, freshwater), specific risks (animal bites, sexual activity), food/water.
5. Preventive measures – Malaria prophylaxis, mosquito nets, repellents.

6. Vaccinations – Routine and travel vaccines received.
7. Travel companions – Were others unwell with similar illness?
8. Medical history – Current medications, immunosuppression status, allergies.

ANSWER 8

Clinical features and management considerations for dengue:

- Importance – Third most common vaccine-preventable disease in travellers, becoming more common
- Warning signs for severe dengue – Often missed in Australian settings, include abdominal pain, persistent vomiting, fluid accumulation, mucosal bleeding, lethargy/restlessness, liver enlargement, increasing haematocrit with decreasing platelets
- Management issues – 40% present with warning signs of dengue, 20% of these were inappropriately prescribed nonsteroidal anti-inflammatory drugs (NSAIDs), which are contraindicated
- Public health implications – *Aedes aegypti* mosquitoes present in far North Queensland
- Diagnosis – non-structural protein 1 (NS1) antigen is best tested for early in disease, PCR or serology later.

ANSWER 9

Consider hospital referral when:

1. Deterioration risk – Is the patient likely to deteriorate rapidly or become unstable?
2. Investigation timing – How long will results take to return? If serious disease is suspected and results delayed, consider emergency department referral.
3. Support systems – Is the patient home alone? This may change management decisions.
4. Diagnostic confidence – If not confident with differential diagnosis, help should be sought.
5. Serious disease suspected – Conditions such as severe malaria, dengue with warning signs or other potentially life-threatening conditions.

6. Public health concerns – Diseases requiring isolation or notification.

(Any three key criteria from the above would be acceptable).

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