Clinical challenge

Using *AJGP* for your CPD

Each issue of *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 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 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 your practice manager or PHN quality improvement team.

Consider evaluating your practice setting's approach to supporting those who are embarking on travel, using Michael L Tong's article as a guide. Discuss how you approach and structure these consults to optimise outcomes. Consider provision of vaccinations, advice on mosquito-borne disease prevention and support for those with chronic conditions or medications that require additional paperwork, such as for attention deficit hyperactivity disorder (ADHD).

A simple evaluation might be recorded for several MO hours, whereas a more comprehensive PDSA approach would provide at least 10 hours of MO CPD.

Log in to **myCPD Home** for guides and templates to complete your selfdirected 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 October 2025 *AJGP* Clinical challenge and accept full responsibility for all content.

October 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

Dr Chen runs a busy suburban practice in Melbourne. She has noticed an increase in travel-related consultations since the COVID-19 pandemic and wants to improve her practice's approach to travel medicine.

QUESTION 1

During a routine consultation for hypertension management, David, aged 45 years, mentions that he is going to Bali next week for a wedding. He seems surprised when you suggest this needs proper discussion. Which of the following represents the most comprehensive initial approach?

- **A.** Advise basic mosquito precautions and recommend travel insurance
- **B.** Discuss the risks of sexual contact and highlight the spread of antibiotic resistance
- **C.** Provide a traveller's diarrhoea self-management kit with education
- **D.** Schedule an urgent long appointment to conduct a travel risk assessment

QUESTION 2

Dr Chen is reviewing The Royal Australian College of General Practitioners (RACGP) curriculum requirements for travel medicine to ensure her practice meets professional standards. According to the RACGP curriculum, which of the following is not considered a core component of travel medicine in general practice?

- **A.** Assessment of fitness for air travel
- **B.** Management of pre-existing conditions while travelling
- **C.** Performing diving medical assessments
- **D.** Education about insect bite prevention strategies

CASE 2

Dr Patel runs a travel medicine clinic within her general practice. She has been seeing an increase in last-minute travellers and complex vaccination scenarios.

Continued on page 2.

QUESTION 3

Dr Patel is particularly interested in rabies pre-exposure prophylaxis for a patient planning extended travel to rural India. Recent changes to rabies pre-exposure prophylaxis recommendations include:

- **A.** A 2-visit schedule (days 0, 7) for short-term protection of immunocompetent travellers to rabies-enzootic areas
- **B.** A 3-visit schedule (days 0, 7, 28) for short-term protection of immunocompetent travellers to rabies-enzootic areas
- **C.** Pre-exposure prophylaxis is no longer recommended
- **D.** Single-dose protection is sufficient for low-risk destinations

QUESTION 4

Priya, a woman aged 35 years born in Pakistan, presents to Dr Patel planning a four-week trip to Karachi, Pakistan, with her infant son, Rohan, aged eight months, to visit friends and family. Her serology shows measles IgG negative, while her son is up to date with routine vaccines. Which vaccination approach is most appropriate?

- **A.** Advise postponing travel until Rohan is older
- **B.** Give the measles-mumps-rubella (MMR) vaccine to Priya and early MMR vaccine to Rohan
- **C.** Give the MMR vaccine to Priya and wait until Rohan is 12 months for vaccination
- **D.** The MMR vaccine is contraindicated because of breastfeeding – defer until breastfeeding ceased

QUESTION 5

Dr Patel is discussing travel vaccination with her general practice registrar. When conducting a risk–benefit assessment for travel vaccinations, which factor is least important to consider?

- **A.** The availability of treatment for the disease
- **B.** The cost and duration of vaccine protection
- **C.** The likelihood of disease acquisition
- **D.** The traveller's country of birth

CASE 3

Dr Singh works in a busy medical centre near an international airport and frequently sees returned travellers.

QUESTION 6

Raj, a businessman aged 35 years, presents to Dr Singh's emergency evening clinic. He returned three days ago from a two-week business trip to Mumbai, where he stayed in luxury hotels but ate at local restaurants. He took no malaria prophylaxis. He now has a fever (38.5°C), severe headache and myalgia. What is your immediate priority?

- **A.** Order malaria testing and consider an urgent infectious diseases referral
- **B.** Order tests for dengue and other arboviral infections
- **C.** Prescribe symptomatic treatment and arrange follow-up
- **D.** Start empirical antibiotic therapy for bacterial infection

QUESTION 7

A backpacker aged 28 years returns from Southeast Asia with a five-day history of severe watery diarrhoea, abdominal pain and dehydration. She appears unwell but is haemodynamically stable. Which investigation strategy is most appropriate?

- **A.** Blood cultures and inflammatory markers only
- **B.** Comprehensive stool testing including microscopy, culture and sensitivity (MC&S), ova, cysts and parasites (OC&P) and PCR
- **C.** Stool microscopy, culture and sensitivity (MC&S) only
- **D.** Stool ova, cysts and parasites (OC&P) only

QUESTION 8

When assessing fever in a returned traveller, which incubation period category would most likely include typhoid fever?

- **A.** Immediate (less than 1 week)
- **B.** Short (less than 2 weeks)
- **C.** Intermediate (2–6 weeks)
- **D.** Long (more than 6 weeks)

October 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.

CASE 4

Dr Torres practises in a multicultural area with many patients who travel internationally for work or to visit family.

QUESTION 1

Emma, a primary school teacher aged 32 years, presents to Dr Torres four weeks before departing for a six-month volunteer teaching placement in rural Kenya. She has well-controlled type 1 diabetes managed with an insulin pump and continuous glucose monitoring. Outline your approach to her pre-travel health maintenance, including key considerations for her type 1 diabetes management.

QUESTION 2

Dr Torres has been discussing the integration of travel medicine into routine general practice with colleagues. One colleague argues that specialised travel clinics are better equipped to handle travel health. Explain the concept of 'primary care for the roaming patient' as it applies to travel medicine, and describe three specific advantages that general practitioners (GPs) have over standalone travel clinics in delivering travel health advice.

QUESTION 3

Dr Torres receives an urgent call from James, 38, in Thailand on business. James has bloody diarrhoea, fever and concerns about dehydration. He requests advice and a prescription be sent to a local pharmacy. Discuss the medico-legal and practical considerations Dr Torres should address before providing telephone advice.

CASE 5

Dr Kim is an experienced GP who has developed expertise in travel medicine.

QUESTION 4

Rebecca, 42, is planning a three-week business trip to Nigeria and Ghana.

She is healthy but anxious and requests Dr Kim administer 'every possible vaccine'. Describe the risk-benefit assessment framework for travel vaccinations, and provide a specific example relevant to Rebecca's trip.

QUESTION 5

Robert, a man aged 65 years with rheumatoid arthritis taking methotrexate and prednisolone, presents to Dr Kim requiring yellow fever vaccination for an essential business trip to endemic areas in Brazil. Outline your management approach, including when specialist referral would be indicated and what alternatives might be considered.

QUESTION 6

Sarah, a teacher aged 29 years, is planning a six-week volunteer program in rural Cambodia. She asks whether she should get dengue vaccination before travel. Explain the current situation regarding dengue vaccination for Australian travellers, including when it might be considered and how the Australian context differs from international recommendations.

CASE 6

Dr Lim sees James, an accountant aged 35 years who returned from a three-week business trip to Southeast Asia five days ago. He presents with fever, headache and myalgia.

QUESTION 7

Outline the key components of taking a travel history from an unwell returned traveller.

QUESTION 8

Describe the clinical features and management considerations that make dengue fever an important differential diagnosis in returned travellers.

QUESTION 9

When should a GP consider that an unwell returned traveller is too unwell to manage as an outpatient? Provide three key decision-making criteria.

September 2025 Multiple-choice question answers

ANSWER 1: D

The review identified that rural background combined with place-based training was a key influential factor for graduates choosing general practice/rural generalist training. McGrail et al observed that 61–70% of general practice graduates who had trained in their location of origin remained in that community five years after Fellowship. The combination of personal connection to place and training in that location was more influential than financial incentives or other factors.

ANSWER 2: C

The review found that a career in general practice is frequently preferred by women, older trainees and those with families because of its flexibility in terms of part-time working hours and shorter training period than other specialties. Multiple papers observed significantly more women (between 56% and 77%) in training pathways, and graduates who were married/partnered and those with children generally chose specialties with shorter training periods such as general practice.

ANSWER 3: D

The study described these inequities as 'particularly striking in that they are almost mirror images – with increasing socioeconomic disadvantage, we observe steadily falling antiviral uptake, yet steadily rising severe outcomes'. This suggests that those most in need of treatment were least likely to receive it.

ANSWER 4: B

Acceptance into the Lifeblood therapeutic program requires evidence of C282Y homozygosity or C282Y/H63D compound heterozygosity combined with elevated ferritin levels. Individual assessment without these genetic variants is possible with evidence from Ferriscan or liver biopsy.

ANSWER 5: B

A key theme from the research was 'patients are the experts'. Participants emphasised that while general practitioners (GPs) hold medical knowledge, each person's experience of pain is unique, and patients develop innate knowledge about their bodies that cannot be found in textbooks. Patients valued individualised rather than 'one-size-fits-all' approaches.

ANSWER 6: B

The research revealed that while 70% of GP visits for pain resulted in medication prescription, patients wanted much more comprehensive care including: access to multidisciplinary services, a menu of evidence-based treatment options, long-term management plans and regular follow-up. This systematic approach addresses multiple identified patient needs simultaneously.

ANSWER 7: B

The introduction of MBS urgent care item numbers is identified as a key solution that could address capacity (allowing more doctors per shift) and funding concerns and enable GPs to provide urgent care services in their own practices with appropriate remuneration.

ANSWER 8: D

The study by Shepherd et al found that participants were aware of challenges in recruiting and retaining supervisors, with 'not receiving suitable payment' seen as both being a disincentive to becoming a supervisor and leading to poorer quality of supervision. The research specifically identified that providing more financial incentives and support for supervision was seen as crucial to improving training supervision capacity.

ANSWER 9: B

The research identified that professional influences were 'dominated by perceptions of the archetypal GP career, including poorer prestige and remuneration compared with other medical specialists and stigma – particularly from other professionals within the hospital system'.

Multiple participants reported negative bias surrounding general practice careers experienced at medical school, with these pre-vocational experiences creating negative sentiment toward general practice careers long before formal engagement with training. This stigma perpetuated the sense that general practice careers are a 'fall back' position.

ANSWER 10: A

Training in a lower SES area was associated with 35% greater odds of having postgraduate qualifications (OR 1.35), possibly reflecting the need to enhance skill sets to meet clinical challenges in these areas.

September 2025 Short answer question answers

ANSWER 1

Three key components of integrated general practice training pathways with examples of barriers and enablers include the following:

1. Place-based training

- Component: Training conducted in the geographic location where GPs are needed, particularly rural/regional areas
- Enabler: Provides unique clinical experiences not available in metropolitan settings; influences career choices towards regional practice; graduates who train in their location of origin have 61–70% retention at five years
- Barrier: Can be costly for trainees (in terms of finances and time); there is a lack of available training positions; there is competition for popular locations; some trainees (particularly international) feel 'forced' into rural training

2. Strong support structures

- Component: Flexible course structure, part-time options, mentorship programs and professional development support
- Enabler: Allows favourable work–life balance; structured pathways provide required support for rural training; encourages further postgraduate qualifications
- Barrier: Rural trainees may be 'thrown to the wolves' without adequate support for complex cases; trainees need high clinical case exposure for ongoing rural practice

3. Professional identity development

- Component: Strong GP supervisor/mentor relationships and positive clinical experiences during training
- Enabler: Mentor relationships are as important as medical school experiences in influencing commitment; positive clinical experiences strengthen interest in general practice careers; provides greater autonomy and continuity of care
- Barrier: Negative stigma about general practice in hospital environments; poor practice culture can have a negative impact on registrar satisfaction; perception of GPs as susceptible to burnout

ANSWER 2

The Prevocational General Practice Placement Program (PGPPP) provided crucial exposure to general practice during junior doctors' hospital years. It created opportunities for developing relationships with GP mentors and preceptors, offered positive clinical experiences in general practice settings during early postgraduate training and served as a pivotal time for promoting general practice as a career option. Reduced exposure to GP role models after the cessation of the PGPPP led to decreased interest in GP training nationally.

Three evidence-based strategies that could be implemented to address the gap left by the discontinuation of the PGPPP include the following:

1. Reinstate structured GP placement programs

- Implement programs similar to the current John Flynn Prevocational Doctor Program (JFPDP)
- Ensure placements occur during critical decision-making periods in junior doctor training
- Provide sufficient funding and infrastructure to support widespread implementation

2. Strengthen mentor–trainee relationships

- Develop formal mentorship programs pairing junior doctors with experienced GPs
- Train GP supervisors in effective mentoring techniques
- Create continuity in mentor relationships throughout training pathway stages
- Recognise that strong mentor relationships are as influential as medical school experiences

3. Combat negative perceptions and stigma

- Address negative attitudes toward general practice in hospital environments
- Promote positive aspects of general practice: autonomy, diverse presentations, continuity of care, community impact
- Improve remuneration and employment models to compete with other specialties
- Develop campaigns highlighting career satisfaction and professional development opportunities in general practice.

ANSWER 3

The Victorian study by Robinson et al provides compelling evidence that antiviral dispensation disparities represent genuine access inequities by demonstrating that severe COVID-19 outcomes show the exact opposite pattern to antiviral dispensation. While antiviral dispensation rates decreased with increasing socioeconomic disadvantage, severe COVID-19 outcomes (hospitalisation or death) increased with socioeconomic disadvantage. Individuals with culturally and linguistically diverse (CALD) backgrounds had higher rates of severe outcomes within each socioeconomic stratum. Those in the most disadvantaged areas were 1.88-fold (CALD) and 1.68-fold (non-CALD) more likely to experience severe outcomes than those in the least disadvantaged areas.

This inverse relationship strongly suggests that the communities with greatest need for antivirals are paradoxically those with lowest access.

ANSWER 4

With regard to Lifeblood:

a. Weekly therapeutic venesections are permitted at Australian Red Cross Lifeblood (Lifeblood) during the de-ironing phase for patients with hereditary haemochromatosis whose ferritin levels are greater than 1000 μg/L. This frequency is gradually reduced as ferritin levels decrease, with the goal of reaching acceptable ferritin levels of 50–100 μg/L. Once target levels are achieved, patients revert to three-monthly maintenance donations. This intensive initial schedule allows for more rapid iron removal when compared with standard allogeneic donation intervals, optimising treatment outcomes during the critical de-ironing period.
b. Lifeblood provides therapeutic venesection services from which donated blood can be used to manufacture blood products for the Australian community. While in other settings the blood is discarded, at Lifeblood over 80% of therapeutic donations are suitable for clinical use. Lifeblood is the single largest provider of therapeutic venesection in Australia, performing approximately one-third of all therapeutic phlebotomies. Patients can be referred electronically using the High Ferritin Application, with most GPs reporting no difficulty with the referral process.

ANSWER 5

The two main genetic variants providing standard eligibility are C282Y homozygosity and C282Y/H63D compound heterozygosity, both requiring elevated ferritin levels. For patients without these specific genetic variants, individual assessment is possible using alternative evidence of iron overload. This includes FerriScan imaging or liver biopsy demonstrating hepatic iron accumulation. This flexible approach ensures that patients with clinically significant iron overload can access therapeutic services regardless of their specific genetic profile while maintaining evidence-based eligibility criteria for program entry. On the basis of these eligibility criteria, both Karin and Jens qualify for the Lifeblood therapeutic program.

ANSWER 6

Drawing on the findings from the 2021 National Pain Survey:

a. The theme of 'patients are the experts' recognises that while GPs have medical knowledge, patients have unique, lived experience of their pain conditions. Each person's pain experience is individual, and patients develop intimate knowledge of their body's responses, triggers and patterns that cannot be found in textbooks. Two practical examples include:
- asking detailed questions about the patient's pain patterns and triggers as well as what works or does not work for them
- involving patients in treatment decision-making by exploring their preferences and previous experiences with treatments.

b. Three specific therapeutic attributes that patients valued in their GPs were:
- empathy – patients need GPs to understand and share their feelings about living with chronic pain. This builds trust and improves health outcomes, with research showing significantly better pain outcomes when physicians display strong empathy.
- compassion – demonstrating genuine care and concern helps patients feel supported rather than judged, which is essential given many feel stigmatised as 'drug seekers'.
- non-judgmental approach – patients need to feel safe to express their pain experiences without fear of being labelled as drug-seeking or having their pain dismissed as psychological.

ANSWER 7

Drawing on the research findings about patient needs and GP–patient relationships in chronic pain management:

a. Three assumptions Shilong believes his GP may have about him, and the reason for the assumptions being problematic, include the following:
- 'Drug-seeking' assumption: Shilong believes his GP thinks he is seeking drugs for non-medical reasons. This is problematic because it damages trust, prevents open communication about pain management needs and can lead to inadequate pain relief.
- Disbelief about pain severity: The assumption that Shilong's GP believes his pain is not as severe as claimed undermines the therapeutic relationship and can lead to under-treatment and patient frustration. Patients value GPs who recognise and respect that patients are the experts in their own pain and know their bodies.
- Dismissal of impact on quality of life: Not recognising how pain affects work, relationships and mental health fails to address the holistic nature of chronic pain and its biopsychosocial impacts.

b. In terms of prescription of medicinal cannabis for chronic pain:
- The study indicates that two reasons for GP reluctance to prescribe medicinal cannabis can include limited education and training in medicinal cannabis use, as well as a lack of clear clinical guidelines on appropriate dosage, efficacy and safety for chronic pain conditions.
- The appropriate approach is engaging in an open discussion about Shilong's interest in medicinal cannabis, exploring current evidence and considering referral to a specialist with expertise in medicinal cannabis prescribing if appropriate.

c. In terms of the importance of multidisciplinary care in chronic pain management:
- Chronic pain requires comprehensive, biopsychosocial management addressing physical, psychological and social aspects that single-provider care cannot adequately address.
- Two types of healthcare professionals (other than medical specialists) that might benefit Shilong are

physiotherapists (for movement rehabilitation, strengthening and pain management strategies) and psychologists (for providing pain coping strategies, managing the emotional impact of chronic pain and addressing sleep and mood issues).

ANSWER 8

On the basis of evidence from Australian UCC research:

a. Three specific capacity-related safety concerns that Dr Chen should consider include:
- risk of 'collapse in the car park' when capacity is exceeded and patients are turned away
- adverse events during patient surges with only one doctor available
- extended waiting times (hours) with patients waiting in cars, which is particularly concerning for children with fever.

b. Professional isolation issues associated with the 'one doctor' model that have been identified in the literature include:
- limited collegiality and no colleagues for second opinions
- safety concerns when managing complex cases alone without immediate peer support
- difficulty managing workflow and patient surges without adequate medical staffing
- challenges in maintaining clinical standards when overwhelmed.

c. Practical solutions that could mitigate the safety risks associated with limited diagnostic facilities in this setting include:
- establishing formal protocols for urgent off-site imaging and pathology access
- developing telemedicine links to non-GP specialists for consultation on complex cases
- creating clear referral pathways to emergency departments for cases requiring immediate diagnostic imaging.

ANSWER 9

a. In New Zealand, the Primary Options for Acute Care (POAC) system provides specific item numbers for urgent care procedures, including intravenous (IV) antibiotics administration, IV rehydration therapy and urinary catheterisation. The POAC also provides up to a four-fold increase in remuneration for fracture management when compared with standard consultation fees. This enables financial viability for general practices to provide urgent care services.

b. Three ways that introducing Medicare urgent care item numbers could benefit both general practices and UCCs include:
- allowing more medical staff per UCC shift by improving financial viability
- enabling general practices to compete fairly by providing similar remuneration for urgent care
- encouraging GPs to develop urgent care skills and provide extended services to patients.

c. In terms of the potential impact of UCCs on the broader primary care system, benefits include improved access to urgent care, reduced emergency department burden and extended hours availability.

Drawbacks include potential fragmentation of care, loss of continuity with a regular GP and resource diversion from traditional general practice. There is a need for integration with existing primary care to maintain comprehensive patient care.

ANSWER 10

Mandatory practice rotations create significant barriers for both registrars and practices. Registrar impacts include disrupted continuity of learning, increased stress from relocating and reduced sense of belonging. Practice impacts include decreased willingness to participate in training because of lack of recruitment benefit and investment in temporary trainees. Evidence suggests this requirement is counterproductive to both registrar experience and practice engagement.

A beneficial modification may be to a change in policy to allow optional rotations while ensuring adequate breadth of experience through alternative mechanisms. This is similar to the Australian College of Rural and Remote Medicine's successful single-practice model, which demonstrates comparable training outcomes.

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