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 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 10 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 using Bindiscova et al's article and evaluating your practice setting's approach to the management of chronic non-cancer pain and steps that can enhance doctor–patient relationship and cooperation in treatment planning.

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. Evaluating and implementing your strategy with five patients could provide at least 10 hours of MO CPD.

Log in to **myCPD Home** 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 September 2025 *AJGP* Clinical challenge and accept full responsibility for all content.

September 2025 Multiple-choice questions

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

QUESTION 1

According to the scoping review by Penney et al, which of the following was identified as the most significant factor influencing general practice trainees to choose rural practice locations?

- **A.** Higher remuneration packages in rural areas
- **B.** Shorter training periods for rural general practice
- **C.** Availability of advanced technology in rural practices
- **D.** Place-based training combined with rural background

QUESTION 2

Which demographic factors were identified in the review by Penney et al as being associated with preference for general practice careers?

- **A.** Male gender, younger age and single status
- **B.** International medical graduate status and urban background
- **C.** Female gender, older age and having families
- **D.** Rural background only, regardless of other demographics

QUESTION 3

The study by Robinson et al found an association between COVID-19 antiviral dispensation rates and severe outcomes (hospitalisation or death). Which statement best describes this relationship?

- **A.** Both antiviral dispensation and severe outcomes increased with socioeconomic disadvantage
- **B.** Both antiviral dispensation and severe outcomes decreased with socioeconomic disadvantage
- **C.** Antiviral dispensation rates were higher in disadvantaged areas, and severe outcomes were lower
- **D.** Antiviral dispensation rates were lower in disadvantaged areas, and severe outcomes were higher

CASE 1

Dietmar, a male teacher aged 54 years, presents with fatigue and joint pain. His serum ferritin is 850 μg/L (normal range: 30–400 μg/L). His family history reveals Dietmar's brother was recently diagnosed with hereditary haemochromatosis (HHC). Genetic testing confirms C282Y homozygosity. You are considering referring Dietmar for therapeutic venesection at Australian Red Cross Lifeblood (Lifeblood).

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QUESTION 4

Which one of the following statements about Lifeblood's therapeutic program is most accurate?

- **A.** All therapeutic donors must have ferritin levels above 1000 µg/L to be accepted into the program
- **B.** Acceptance requires genetic evidence of haemochromatosis combined with elevated ferritin levels
- **C.** The blood collected from therapeutic donors is usually discarded and cannot be used for transfusion
- **D.** Therapeutic venesection can only be performed every three months regardless of ferritin levels

CASE 2

Rod, a construction worker aged 45 years, has been living with chronic lower back pain for two years following a workplace injury. He tells you, 'Doc, I know my body better than anyone. This isn't just muscle strain – something else is going on, but every doctor just gives me the same painkillers and tells me to rest.'

QUESTION 5

In terms of the qualitative research findings regarding patient experiences with chronic non-cancer pain management in Australian general practice, what does Rod's statement most likely reflect?

- **A.** Unrealistic patient expectations about diagnostic certainty in chronic pain
- **B.** The importance of patients being recognised as experts in their own pain
- **C.** Poor health literacy requiring more detailed medical explanations
- **D.** Drug-seeking behaviour disguised as legitimate medical concern

CASE 3

You are reviewing your practice's approach to chronic non-cancer pain management following recent Australian research highlighting patient needs and expectations. Your practice currently focuses primarily on pharmacological management, with 75% of chronic non-cancer pain consultations resulting in medication prescriptions.

QUESTION 6

According to the research findings, which practice change would best address the identified gap between current general practitioner (GP) care and patient expectations for chronic non-cancer pain management?

- **A.** Increase consultation times to 20 minutes for all patients with chronic pain
- **B.** Develop a systematic approach incorporating multidisciplinary referrals, patient education about treatment options and regular follow-up to assess treatment effectiveness
- **C.** Establish a practice policy limiting opioid prescriptions to a maximum of three months duration
- **D.** Refer all patients with chronic non-cancer pain to a pain clinic within six months of initial presentation

CASE 4

Dr Lisa Wong works in a busy urban urgent care clinic (UCC) and is concerned about the sustainability of the current funding model. She has observed that many presentations could be managed in general practice if appropriate funding was available.

QUESTION 7

According to the research findings, which of the following solutions would address the themes of capacity, funding and enabling GPs to perform UCC work in their own practices?

- **A.** Mandatory Fellowship training in urgent care medicine for all UCC doctors
- **B.** Medicare Benefits Schedule (MBS) urgent care item numbers for both UCCs and general practices
- **C.** Establishment of nurse practitioner–led triage in all UCCs
- **D.** Implementation of bulk-billing requirements for all urgent care services

CASE 5

You are a GP supervisor considering taking on registrars, but you are concerned about the sustainability of your supervision role.

QUESTION 8

According to the research findings, which intervention would be most effective in addressing the challenges faced by GP supervisors?

- **A.** Mandatory completion of formal teaching qualifications for all supervisors
- **B.** Standardised supervision protocols across all training organisations
- **C.** Reduced clinical workload requirements for supervising GPs
- **D.** Increased financial incentives and support for supervision activities

CASE 6

A final-year medical student approaches you during their general practice rotation, expressing interest in general practice training but concern about negative comments they've heard from hospital colleagues.

QUESTION 9

Based on the Shepherd et al research on the Tasmanian general practice training pathway, which factor is most likely to be a significant barrier to their engagement with general practice training?

- **A.** Limited availability of training positions in rural areas
- **B.** Stigma and negative perceptions of general practice careers from other medical professionals
- **C.** Requirement to complete rotations in multiple different practices
- **D.** Inadequate online learning platforms for educational delivery

CASE 7

Dr Michael Thompson is an early-career GP working in a practice located in a lower socioeconomic status (SES) area. He completed his general practice training in a similarly socioeconomically disadvantaged region.

QUESTION 10

Regarding his likelihood of having obtained postgraduate qualifications, recent research suggests:

- **A.** Training in a lower SES area is associated with 35% greater odds of having postgraduate qualifications
- **B.** Training in a lower SES area is associated with 35% lower odds of having postgraduate qualifications
- **C.** Socioeconomic status of practice location has no bearing on qualification pursuit
- **D.** Only post-Fellowship qualifications are influenced by practice location SES

September 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 1

Dr Sarah Chen is a senior GP trainer working with the local regional training organisation. She is reviewing the effectiveness of their integrated general practice training pathway and has noticed varying retention rates among different cohort groups.

QUESTION 1

On the basis of the current evidence, identify and explain three key components of integrated general practice training pathways that have been shown to enhance GP recruitment and retention. For each component, discuss one potential barrier and one enabler to its successful implementation.

CASE 2

Dr Mei Walsh is chairing a committee tasked with developing recommendations for improving general practice training pathways following the discontinuation of several government-funded placement programs. The cessation of the Prevocational General Practice Placement Program (PGPPP) has been identified as having negative impacts on GP recruitment.

QUESTION 2

Explain the mechanism by which the PGPPP supported GP career development, and propose three evidence-based strategies that could be implemented to address the gap left by its discontinuation.

CASE 3

Dr Ahmed Torres works in a busy community health centre and wants to improve COVID-19 antiviral access for his vulnerable patients. He is particularly concerned about whether the observed disparities in antiviral dispensation might simply reflect lower COVID-19 infection rates in disadvantaged communities.

QUESTION 3

What evidence from the study by Robinson et al best supports that disparities in antiviral dispensation represent genuine access inequities rather than differences in infection rates?

CASE 4

David, a man aged 52 years, was recently diagnosed with hereditary haemochromatosis after family screening revealed he is homozygous for C282Y. His initial ferritin was 1200 µg/L. You are planning to refer him to Australian Red Cross Lifeblood (Lifeblood) for therapeutic donation during his de-ironing phase.

QUESTION 4

With regard to Lifeblood:

a. What is the maximum frequency of therapeutic venesection permitted at Lifeblood for patients with ferritin levels greater than 1000 µg/L during the de-ironing phase?
b. How would you explain to David why you are suggesting he attend Lifeblood for therapeutic venesection?

CASE 5

You are considering referring patients to the Lifeblood therapeutic program. Karin is a C282Y/H63D compound heterozygote with elevated ferritin. Jens has elevated ferritin but is only heterozygous for C282Y, although his FerriScan demonstrates hepatic iron overload.

QUESTION 5

List the two main genetic variants that provide standard eligibility for the Lifeblood therapeutic program, and name one alternative form of evidence that can be used for individual assessment of patients without these variants.

CASE 6

Dr Adam Wisniak is seeking to learn more about the lived experiences of patients with chronic pain by familiarising himself with the responses to the 2021 National Pain Survey. He notes that two of the themes that emerged were 'patients are the experts' and 'common therapeutic factors'.

QUESTION 6

Drawing on the findings from the 2021 National Pain Survey:

a. Explain what 'patients are the experts' means in the context of chronic pain management, and provide **two** practical examples of how a GP can demonstrate recognition of this expertise during a consultation.
b. Regarding the theme of 'common therapeutic factors', identify **three** specific attributes that patients valued in their GPs, and explain why each is important in building a therapeutic alliance with patients with chronic pain.

CASE 7

Shilong, a tradesman aged 45 years, has been living with chronic neck and shoulder pain for two years following a motor vehicle accident. He has been seeing you regularly and is currently prescribed tramadol 100 mg twice daily. During today's consultation, he states, 'I know you think I'm just after drugs, but this pain is ruining my life. I can't work properly, I'm not sleeping, and my wife says I'm always grumpy. I've read about medicinal cannabis online – can you prescribe it? And why won't you refer me to that pain specialist I asked about?'

QUESTION 7

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

a. Identify **three** assumptions Shilong believes his GP may have about him, and explain why these perceptions are problematic for the therapeutic relationship.
b. On the basis of the study's findings about medication access, outline **two** reasons why GPs may be reluctant to prescribe medicinal cannabis for chronic pain, and suggest one approach to address Shilong's request appropriately.
c. Regarding Shilong's request for specialist referral, explain the importance of multidisciplinary care in chronic pain management, and identify **two** types of healthcare professionals (other than medical specialists) that might benefit Shilong on the basis of his presentation and the research findings.

CASE 8

Dr Yoon Min-jeung is considering taking up a position as the sole medical officer at a newly established Medicare-funded urgent care clinic (UCC) in regional Queensland. The clinic operates with a 'one doctor, one nurse' model and is expected to see 40–50 patients per 10-hour shift. During her orientation, Dr Yoon learns that the clinic has no on-site imaging facilities and limited after-hours pathology support.

QUESTION 8

On the basis of evidence from Australian UCC research:

a. List **three** specific capacity-related safety concerns that Dr Chen should consider before accepting this position.
b. Explain why the 'one doctor' model poses particular risks in urgent care settings, citing **two** specific professional isolation issues identified in the literature.
c. Describe **three** practical solutions that could mitigate the safety risks associated with limited diagnostic facilities in this setting.

CASE 9

Dr Lisa Wong operates a busy general practice and is frustrated that many of her patients are now attending the local UCC for conditions she could easily manage. The UCC is bulk billed while her practice charges gap fees. She argues that 'UCCs are taking work GPs could do if appropriately funded' and is considering how to compete with or complement UCC services.

QUESTION 9

In terms of funding for UCC and general practice:

a. Describe the funding model used by New Zealand for urgent care services that provides higher remuneration for specific procedures, giving **two** examples of procedures that attract increased funding.
b. Explain **three** ways that introducing Medicare urgent care item numbers could benefit both general practices and UCCs, addressing the concerns raised by Dr Wong.
c. Analyse the potential impact of UCCs on the broader primary care system, discussing both the benefits and drawbacks for patient care continuity and GP sustainability.

CASE 10

A rural practice is considering taking on general practice registrars, but the practice principal is concerned about the mandatory requirement for trainees to rotate between practices during their training program.

QUESTION 10

Evaluate the potential impacts of mandatory practice rotations on both registrar experience and practice engagement with training programs. Justify whether this requirement should be modified on the basis of available evidence.

August 2025 Multiple-choice question answers

ANSWER 1: C

Venlafaxine, along with mirtazapine, citalopram and escitalopram, is recommended for patients on tamoxifen because it results in minimal CYP2D6 inhibition, which reduces the risk of decreasing tamoxifen efficacy. Conversely, fluoxetine and paroxetine should be avoided where possible. Sertraline is a moderate inhibitor and could also reduce tamoxifen effectiveness.

ANSWER 2: A

Escitalopram is the only antidepressant available in an oral solution. However, citalopram, escitalopram and mirtazapine can be crushed before administration, and mirtazapine is available in a disintegrating tablet form. Consultation with a pharmacist may be necessary because of potential changes in bioavailability.

ANSWER 3: B

Lactulose is recommended as the first-line laxative for patients with cancer and cirrhosis, as it helps prevent and treat hepatic encephalopathy.

ANSWER 4: B

Methylnaltrexone is contraindicated in patients with bowel obstruction because of the risk of perforation.

ANSWER 5: B

5-Fluorouracil, along with platinum-based drugs, is noted for contributing to hyperglycaemia and worsening diabetic neuropathy in patients with T2DM. Monoclonal antibodies are not prominently associated with this complication.

ANSWER 6: C

SGLT2 inhibitors should be ceased in cases of acute illness, reduced oral intake or dehydration because of the risk of euglycaemic ketoacidosis.

ANSWER 7: B

Wheeled walkers and rollators have been shown to increase exercise tolerance and decrease breathlessness during a six-minute walk test. Walking sticks have not been shown to have this effect. Oxygen via a nasal cannula has not been shown to be more beneficial than room air via nasal cannula (medicalised air) for the symptomatic relief of breathlessness in individuals without hypoxia.

ANSWER 8: B

Benzodiazepines might assist in the management of breathlessness-associated anxiety, but there is no evidence to support their use in the management of breathlessness.

ANSWER 9: B

Massive hepatic metastatic disease; portal flow reversal because of neoplastic compression, thrombus or cirrhosis; and other conditions can all lead to variable naloxone bioavailability. When this happens, naloxone will reduce the efficacy of oxycodone.

ANSWER 10: B

Lacking renally cleared active metabolites, fentanyl can be prescribed to treat patients with renal impairment including those who have dialysis dependence. All others listed are renally excreted and should be avoided in patients with renal failure.

August 2025 Short answer question answers

ANSWER 1

A referral to a psychiatrist might be warranted if there is concern about medication interactions; if there is ambiguity regarding the diagnosis (eg depression vs bipolar affective disorder); if the clinician feels a request for voluntary assisted dying is being driven by an untreated mental health disorder rather than an expression of autonomy; or if the prognosis is very short, in which case a psychostimulant might be indicated. Furthermore, psychiatric referral might be valuable in more straightforward cases that nevertheless do not respond to first-line treatment.

ANSWER 2

Studies have shown that common reasons for patients who wish to hasten death are:

- fear of being a burden
- loss of independence
- loss of control
- fear of the dying process
- a desire to live well.

A desire to hasten death does not always mean a request for voluntary assisted dying. When a patient makes a statement such as 'I just want to die', a clinician should empathetically explore this. Communication skills such as 'tell me more' allow us to understand where the patient is coming from. Empathic statements that acknowledge the patient's emotions can connect us with the patient.

ANSWER 3

Bulking agents are not recommended for people receiving palliative care. These are common laxatives used to prevent constipation in the general population; examples include psyllium and sterculia. However, for bulking agents to be effective, a person must consume large volumes of fluids. This is often not possible for patients receiving palliative care. Bulking agents have no role in the prevention of constipation or opioid-induced constipation.

ANSWER 4

For patients with refractory opioid-induced constipation, methylnaltrexone can be useful if there are no contraindications. Methylnaltrexone is an opioid antagonist that reverses the effect of opioids in the peripheral nervous system and does not cross the blood–brain barrier. Therefore, it can alleviate opioid-induced constipation without reversing the analgesic effect of opioids in the central nervous system. Methylnaltrexone is subsidised by the Pharmaceutical Benefits Scheme (PBS), and dosage is based on weight and creatinine (refer to product information).

Laxation can occur within 30 minutes, so the patient should be kept near a toilet if mobile, and patients commonly experience crampy abdominal pain prior to defecation.

Methylnaltrexone should not be prescribed to patients with bowel obstructions, gastric ulcers or gastric malignancy because there might be an increased risk of bowel and gastric perforation. Additionally, it is not recommended in patients with known peritoneal carcinomatosis, particularly those with previous malignant obstruction or cancers commonly associated with malignant obstruction (eg ovarian cancer).

ANSWER 5

Glycated haemoglobin is unreliable in patients with advanced cancer receiving palliative care because of factors such as recent blood transfusions, blood loss, liver disease, hyperbilirubinemia, uraemia or chronic renal failure, which can falsely lower or elevate results. Additionally, the shift in goals of care towards symptom management rather than long-term complication prevention makes HbA1c less relevant.

ANSWER 6

Patients with type 2 diabetes mellitus might still produce endogenous insulin, which may make it safe to stop insulin use. This can be determined by measuring paired C-peptide and fasting blood glucose levels. C-peptide is a byproduct of endogenous insulin production and is useful to assess the residual pancreatic function in patients with diabetes being treated with insulin. In the presence of a normal–high fasting blood glucose level, C-peptide levels would be expected to be high in the presence of endogenous insulin. If the C-peptide levels are low, it can be inferred that there is minimal-to-no endogenous insulin production. Low C-peptide levels with high blood glucose levels suggest minimal endogenous insulin, requiring ongoing insulin to prevent complications.

ANSWER 7

Benzodiazepines lack evidence for directly relieving breathlessness in patients receiving palliative care. They are primarily effective for managing breathlessness-associated anxiety. Their use may cause side effects such as drowsiness, and there is no evidence supporting their role in alleviating the sensation of breathlessness itself.

ANSWER 8

A breathlessness management plan includes: adopting a comfortable position (eg sitting upright, leaning forward), using a fan or opening a window for air movement, practising slow breathing (3–5 seconds in through the nose, 5 seconds out through pursed lips), applying home oxygen if prescribed, taking morphine immediate release liquid 1–2.5 mg orally, and using lorazepam 0.5 mg sublingually for anxiety if needed. Safety netting includes instructions to contact a healthcare provider if breathlessness persists after three hourly doses of morphine.

Continued on page 5.

ANSWER 9

The tables are generated from data obtained from mostly single-dose studies in different patient populations. They do not account for each patient's unique physiology and interacting medications. Bidirectionality is assumed.

Because there is uncertainty as to what the target dose should be, practice errs on the side of underdosing when rotating to a different opioid. Reducing the calculated background dose by 25–50% means that the uncertainty is less likely to cause potentially fatal opioid toxicity.

ANSWER 10

Fentanyl disintegrating tablets are contraindicated in patients who are not opioid tolerant. The effect of orally disintegrating fentanyl is highly variable between patients of similar backgrounds. There is no relationship between an effective fentanyl disintegrating oral tablet dose and background opioid use. Therefore, there is a mandatory dose titration protocol detailed in the product information as well as in commonly used resources such as the Therapeutic Guidelines and Australian Medicines Handbook.

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