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 will 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.

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/June26CCMO and select the 'Register' button to find both the Clinical challenge and MO 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 your practice manager or PHN quality improvement team.

Consider evaluating your practice setting's approach to reducing overdiagnosis and overtesting and the ways in which your team are combatting social media–driven direct-to-consumer marketing. Compare your challenges and approach to what is outlined by Guppy et al and research conducted by Nickel et al and consider how, as a collective, you can help patients navigate misinformation in your role as a trusted, evidence-based gatekeeper within the healthcare system. 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 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 June 2026 *AJGP* Clinical challenge and accept full responsibility for all content.

June 2026 Multiple-choice questions

These questions are based on the Focus articles provided. Please choose the single best answer for each multiple-choice question.

QUESTION 1

According to the article by Guppy et al, which of the following factors contributes to overdiagnosis?

A. Increased sensitivity of newer diagnostic tests
B. Labelling of risk factors as diseases
C. Participation in population screening programs
D. Widening of disease definitions
E. All of the above

QUESTION 2

According to the article by Guppy et al, which of the following factors does **not** contribute to overtesting?

A. Clinicians ordering tests out of concern for medicolegal risk or fear of missing a serious diagnosis
B. Patients requesting specific investigations on the basis of online information or advice from alternative practitioners
C. Repeating tests because previous results are unavailable as a result of fragmented care or difficulty accessing prior investigations
D. Routine adherence to evidence-based guidelines that advise when tests are indicated and when they are not

QUESTION 3

According to the article by Guppy et al, which of the following is **not** identified as a potential consequence of overdiagnosis or overtesting?

A. Additional investigations, which may include the risk of further exposure to ionising radiation
B. False reassurance from certain test results, potentially reducing engagement with healthy lifestyle behaviours
C. Financial and practical burdens for patients, such as out-of-pocket costs, time away from work and insurance implications
D. Improved longer-term health outcomes and longevity due to earlier identification of clinically important abnormalities

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QUESTION 4

On the basis of the article by Quek et al, which of the following is **not** identified as a reason to consider deprescribing?

A. A medicine has no clear indication or may be part of an inappropriate prescribing cascade

B. A medicine is associated with adverse effects, new contraindications or interactions that outweigh potential benefits

C. A medicine is being used for prevention, but the likelihood of benefit is uncertain or unlikely to be realised

D. A medicine is prescribed at a stable dose for a long-term condition and continues to align with the patient's current goals of care

CASE 1

Mrs L, aged 82 years, attends for a routine review accompanied by her daughter. She takes eight regular medicines, including a proton pump inhibitor started several years ago for dyspepsia that has since resolved. When the general practitioner (GP) raises the possibility of deprescribing, Mrs L says she 'hasn't really thought about' her medicines, and she looks to her daughter to answer most questions. Her daughter reports that Mrs L 'just takes whatever the doctor gives her' and has never questioned her medicines. Mrs L appears comfortable with the GP making decisions on her behalf.

QUESTION 5

On the basis of the Patient Deprescribing Typology described in the article by Quek et al, which typology best fits Mrs L?

A. Attached to medicines and thus may be reluctant to deprescribe

B. Defers decision making to healthcare professionals or family members

C. Open to the possibility of deprescribing

D. Resistant to deprescribing because of previous adverse experiences

QUESTION 6

Which approach would be most appropriate for initiating a deprescribing discussion with a patient such as Mrs L?

A. Provide detailed summaries comparing long-term risks and benefits of each medicine to encourage her proactive involvement

B. Emphasise shared decision making by asking her to independently review her medicines at home before the next appointment

C. Initiate the conversation yourself, provide simple explanations and involve her daughter as appropriate while confirming Mrs L's preferences for involvement

D. Avoid discussing deprescribing unless the patient raises concerns, as she is unlikely to be interested in medication changes

CASE 2

Mr R, aged 79 years, attends for a review of his chronic conditions. He takes 10 regular medicines, including a statin, a proton pump inhibitor and two antihypertensives. When the general practitioner (GP) raises the idea of reviewing whether all medicines are still necessary, Mr R becomes visibly uneasy. He explains that he has 'always done well on these tablets' and believes they have kept him healthy, and he says he trusts his GP to 'keep things as they are'. He expresses concern that stopping any medicine might 'undo all the good work'. He has no current symptoms related to several of his long-term medicines.

QUESTION 7

On the basis of the Patient Deprescribing Typology described in the article by Quek et al, which typology best fits Mr R?

A. Attached to medicines and may thus be reluctant to deprescribe

B. Defers decision making to healthcare professionals and family members

C. Open to the possibility of deprescribing

D. Unsure about changing medications because of limited health literacy

QUESTION 8

Which approach would be most appropriate when discussing deprescribing with a patient such as Mr R?

A. Reassure him that deprescribing is routine and proceed to cease medicines without further discussion to avoid increasing his anxiety

B. Acknowledge his concerns, provide clear explanations about why a review is being considered and explore his values and goals while emphasising the safety of deprescribing

C. Encourage him to make an independent decision by providing written materials and asking him to choose which medicines to stop before the next visit

D. Focus solely on the evidence for deprescribing and avoid discussing his personal beliefs to prevent biasing the conversation

QUESTION 9

According to the article by Tracy et al about shared decision making, which of the following best describes the focus of 'option talk' in Elwyn et al's three-talk model?

A. Exploring who should be involved in the decision and establishing that a decision needs to be made

B. Outlining the available choices and discussing the benefits, risks and supporting evidence for each option

C. Supporting the patient to reach a decision that reflects their preferences, values and desired level of involvement

D. Understanding the patient's goals of care before initiating any discussion about treatment options

June 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.

QUESTION 1

According to the article by Guppy et al, what are the five questions that patients are encouraged to ask as part of the Choosing Wisely campaign to help reduce unnecessary testing?

QUESTION 2

According to the article by Guppy et al, name three tests that may have potential for overtesting and overdiagnosis.

QUESTION 3

According to the article by Quek et al, list four opportunities for reviewing medicines, which may then lead to deprescribing.

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QUESTION 4

According to the article by Quek et al, identify at least two barriers to deprescribing and briefly outline how each barrier might be addressed in routine clinical practice.

QUESTION 5

According to the article about shared decision making by Tracy et al, outline the three components of Elwyn et al's three-talk model and briefly describe the focus of each type of talk.

QUESTION 6

According to the article by Quek et al, describe two of the patient typologies within the Patient Deprescribing Typology and explain how each might influence a general practitioner's approach to deprescribing discussions.

QUESTION 7

A patient aged 42 years presents with a 3-year history of fluctuating fatigue, pain and cognitive fog. Multiple investigations have been normal, and the patient says, 'No one can tell me what's wrong – maybe it is all in my head.'

Using the narrative approaches outlined in the article by Stone et al, describe one narrative metaphor you could use to validate the patient's experience and explain medically unexplained symptoms in a way that maintains trust and supports ongoing care.

In your answer, outline:

- **which narrative fragment** you would choose
- **why** it is appropriate for this patient
- **how** it could help reframe the patient's concerns in a therapeutic way.

May 2026 Multiple-choice question answers

ANSWER 1: B

Practice A pursued a deliberate 'integration first' strategy, choosing technologies known to integrate seamlessly with their practice management software.

ANSWER 2: B

The portal deflected approximately 10% of inbound phone and email volume.

ANSWER 3: C

Dependency on vendor uptime is listed as a challenge for Practice B's product-led, cloud-based approach.

ANSWER 4: C

Epistemic opacity refers to the lack of transparency in how large language models generate outputs, making it difficult for learners to critically evaluate the basis of the artificial intelligence's responses.

ANSWER 5: D

The article by Tran et al ('Augmenting apprenticeship') discusses the social constructivist theory, in which generative artificial intelligence can scaffold learning through dialogic engagement and co-construction of knowledge.

ANSWER 6: C

Digital competencies include ethical, legal and critical engagement with digital tools, and communicating digitally with patients and artificial intelligence tools. It is not a key digital competency for general practitioners to extend or improve existing systems.

ANSWER 7: B

Victora's inverse equity hypothesis states that new interventions are initially adopted by wealthier segments who have less need.

ANSWER 8: D

The article identifies access to internet/devices, digital literacy and trust as key patient challenges.

ANSWER 9: B

MedicalDirector was co-founded by general practitioners and became widely used as a free, advertising-supported product.

ANSWER 10: B

Digital twins combine genomic, physiologic and lifestyle data to simulate scenarios.

May 2026 Short answer question answers

ANSWER 1

In Practice A, the cumulative effect was significant, with the practice estimating a saving equivalent to half a full-time reception position each day, which was reallocated to patient-facing tasks. Clinicians reported spending less time on retrospective note-taking and the additional paperwork required for higher-rebate item numbers. Financial performance also improved, with wages stabilised at less than 15% of billings, outperforming the industry average of 20%.

In Practice B, patients responded positively, particularly to the portal and voice agents, which provided after-hours access and reduced wait times on the phone. Some older patients described the system as improving equity by making routine access easier, rather than more difficult. For clinicians, the artificial intelligence scribe extended the reach of documentation support and reduced reliance on memory or retrospective data entry. The practice rapidly expanded its digital offering to include portals, scribes and voice agents. This approach showcased the potential for cloud platforms to transform patient access and streamline follow-up care.

ANSWER 2

Together, these two cases underscore that successful adoption is less about the specific technology chosen and more about alignment with practice context, values and systems, while also highlighting that the current evidence base in these practices relies predominantly on procedural and operational indicators rather than formal clinical outcome measures or structured patient and staff experience surveys. Integration brings stability and safety, while product-led adoption offers agility and differentiation. Both strategies require strong governance, transparent communication with patients and active involvement of the practice team.

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Table 1. Generative artificial intelligence (GenAI) use learning cases

Use case	Description
1. GenAI as a 'more knowledgeable other'	Drawing on social constructivist theory, GenAI can simulate the role of a 'more knowledgeable other' by scaffolding learning through dialogic engagement, personalised feedback and iterative refinement of understanding.[1] This is particularly valuable in general practice training, where supervision and peer-to-peer learning may be intermittent, and learners must often make decisions independently. GenAI can help bridge gaps in supervision by offering context-sensitive support and promoting reflective practice. This scaffolding should not be confused with that based around what we understand to be 'verified knowledge', which is not GenAI's promise, because co-creation of knowledge is based on its output of a reorganisation of linguistic tokens generated when a query is entered. More than ever, the learner must be prepared to question the 'more knowledgeable other'.
2. Conversational agents for reflective practice and empathy	An inherent strength of large language models is in simulating empathetic dialogue,[33] encouraging learners to reflect on clinical decisions, patient interactions and ethical dilemmas. This supports the development of relational competencies central to general practice. GenAI-facilitated reflection may also help learners navigate threshold concepts such as uncertainty and complexity.[3,5]
3. Simulation and case-based learning	GenAI can generate interactive clinical scenarios that mirror real-world complexity, allowing learners to test hypotheses, compare reasoning and receive feedback. By providing a simulacrum of simulation-based learning, GenAI can support experiential learning and can be tailored to individual learning needs.[17,34] GenAI can also provide opportunities to explore ethical dimensions and interdisciplinary collaboration. GenAI has demonstrated utility in creating simulations with diverse cultural and socioeconomic backgrounds[35] including rural and underserved populations,[36] overcoming geographic isolation and systemic bias in supporting Aboriginal and Torres Strait Islander students in medical education,[37] and providing culturally nuanced[38] and emotionally complex conversations and interactions with virtual patients.[39]
4. Personalised learning and feedback	GenAI tools can adapt to the learner's level of expertise, prior knowledge and preferred learning approaches, offering individualised pathways through clinical content. This supports just-in-time learning and helps registrars manage the breadth of general practice presentations.[10,11] Personalised feedback can also enhance metacognitive awareness and promote deeper learning. In addition, AI can learn from the learner's interactions and act as a coach or a teacher who really 'knows' their student.
5. Support for self-directed and competency-based learning	GenAI can assist in identifying knowledge gaps, curating relevant resources and tracking progress toward competency milestones. This aligns with the self-directed nature of general practice training and supports learners in managing their own development.[9]
6. Augmentation of clinical reasoning	Although GenAI cannot replace human judgement, it can augment clinical reasoning by offering alternative perspectives, prompting critical evaluation, recommending literature and guidelines, and supporting decision making under uncertainty. This is particularly useful in early training stages, where learners benefit from structured cognitive support.[4,40]
7. Narrative evaluation and progress mapping	GenAI can support rich, narrative-based evaluation by synthesising learner interactions, reflections and performance data into meaningful progress reports. Unlike traditional grading systems that reduce complex learning to binary outcomes (eg pass/fail), artificial intelligence can provide nuanced insights into a learner's development over time. This includes identifying patterns in clinical reasoning, communication style and ethical decision making. Such narrative feedback aligns with competency-based education and supports formative assessment, helping educators and learners engage in deeper conversations about growth, readiness and future learning goals.

ANSWER 3

Refer to Table 1 in Tran et al ('Augmenting apprenticeship: A discussion paper on integrating generative artificial intelligence into postgraduate general practice training' [left]) for seven use-cases.

ANSWER 4

Generative artificial intelligence (AI) cannot replicate the embodied, empathetic and interpersonal dimensions of medical education. There is a risk that learners may prioritise efficiency over relational depth, potentially diminishing the humanistic aspects of general practice. Effective learning requires effort and engagement; it cannot be outsourced to AI. Attempting to automate the learning process risks depriving learners of the opportunity to make mistakes, develop heuristics and cultivate a personal, context-sensitive understanding of their practice.

ANSWER 5

Artificial intelligence can offer practical solutions for managing the administrative demands of continuing professional development (CPD) by automating the processes of tracking CPD activities, maintaining portfolios and ensuring compliance with regulatory requirements and competency frameworks.

ANSWER 6

Surveys across healthcare systems reveal limited access to high-quality digital training, insufficient integration of digital skills into medical education and a lack of financial and institutional support for ongoing learning, potentially highlighting inequitable access to digital capability-building. Artificial intelligence (AI)-enhanced continuing professional development must be designed with equity in mind, which does not only pertain to general practitioners in rural and remote areas with less reliable internet access, but also already existing gaps in experience with AI, both of which risk exacerbating the digital divide. Infrastructure investment and offline-compatible tools are essential to ensure inclusive access.

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ANSWER 7

Patients

- Advocate for equitable implementation of digital healthcare (eg by co-design of user-friendly digital health interventions +/− non-digital alternatives)

Practitioners

- Ask all patients about and support digital health access as part of standard care
- Support implementation of digital healthcare that meets the needs of their patients, particularly vulnerable groups, noting one size does not fit all

Primary care

- Ensure transparency on use of healthcare data, use of artificial intelligence, and potential benefits/effectiveness and risks/unintended consequences of new technologies
- Measure and address social determinants of health in development and implementation of digital healthcare, and in decision making around adoption and endorsement

ANSWER 8

Healthcare Identifier service (including IHI and HPI-I) and NASH (National Authentication Service for Health).

ANSWER 9

The uptake was slow because of lack of interconnectivity, and it was poorly received by clinicians and patients. Following its lukewarm reception, Personally Controlled Electronic Health Record (PCEHR) was repurposed as My Health Record (MHR) in 2017. The MHR was controversially changed to be an opt out solution to ensure large-scale adoption. While adoption has improved significantly, there are still lingering concerns regarding usability, clinical value and privacy, and there is significant new government funding to modernise the MHR and new legislation to mandate 'sharing by default'.

ANSWER 10

Examples could include artificial intelligence, genomics and precision medicine, wellness technology, simulation and digital twins, or others.

ANSWER 11

Examples could include workforce task redistribution, health equity, bias in systems, or others.

correspondence **ajgp@racgp.org.au**

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