

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/CCMOMay26> and select the 'Register' button to find both the Clinical challenge and Measuring Outcomes companion activity.

Self-directed MO options

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

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

Consider evaluating your practice setting's strategy to expanding your digital health capabilities. Compare your practice requirements to the two real-world case studies outlined in the article by Stevens et al and explore the implications for how you might approach digital transformation to reduce administrative workload and improve efficiency.

A simple evaluation might be recorded for several MO hours, while a more PDSA comprehensive 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 May 2026 *AJGP* Clinical challenge and accept full responsibility for all content.

May 2026 Multiple-choice questions

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

CASE 1

You are a general practice principal in a medium-sized metropolitan practice. Your practice manager has proposed adopting new technology to improve efficiency in the practice. Two of your colleagues are enthusiastic, but others are concerned about cost, training, cybersecurity and potential workflow disruption. You read the article by Stevens et al (Digital transformation in general practice) to learn more.

QUESTION 1

Which of the following best describes Practice A's adoption strategy?

- A. Product-led, relying solely on vendor innovations within their practice management software
- B. Integration-first, selecting tools known to work seamlessly with their existing software
- C. Pilot-only, limiting deployment to one site

- D. Patient-led, driven by direct patient demand for specific apps and features

QUESTION 2

In Practice B, what proportion of inbound phone and email volume was deflected by the integrated patient portal?

- A. 5%
- B. 10%
- C. 15%
- D. 20%

QUESTION 3

Which of the following is NOT listed as a challenge specific to Practice A's integration-first approach?

- A. Ongoing software subscription costs
- B. Workflow redesign and staged rollouts
- C. Dependence on vendor uptime
- D. Cybersecurity risk from multiple third-party vendors

CASE 2

You are a general practice supervisor for a registrar who has started using a generative artificial intelligence (AI) (GenAI) conversational agent to simulate reflective practice discussions after complex consultations. The registrar finds it helpful for exploring uncertainty and ethical dilemmas but is unsure about risks to learning.

QUESTION 4

According to the article by Tran et al (Augmenting apprenticeship), which risk of GenAI in general practice training is best described as 'epistemic opacity'?

- A. Trainee over-reliance in AI leading to skill decay
- B. Perpetuation of bias in AI-generated training scenarios
- C. Lack of transparency in how the model generates responses
- D. Erosion of humanistic and relational learning due to unrealistic responses

QUESTION 5

Which theoretical framework is used to position GenAI as a potential 'more knowledgeable other' in general practice training?

- A. Experiential learning theory
- B. Competency-based assessment
- C. Transformative learning theory
- D. Social constructivist theory

CASE 3

You are designing a continuing professional development (CPD) activity for your practice on digital competencies. Several general practitioners (GPs) express concern that AI-enhanced CPD might undermine professional autonomy or raise privacy issues.

QUESTION 6

Which of the following is NOT identified as a key digital competency for general practitioners in the article by Tran et al (Artificial intelligence-enhanced continuing professional development)?

- A. Technical skills in digital communication
- B. Ethical and legal engagement with digital tools

- C. Improvement to existing systems to suit the workplace
- D. Critical appraisal of AI outputs

CASE 4

A patient from a low socioeconomic background attends your practice. They have limited internet access and low digital literacy. They express frustration that recent telehealth and patient portal initiatives seem inaccessible to them.

QUESTION 7

Which concept best explains why new digital health interventions might initially benefit those with the least need?

- A. Inverse care law
- B. Inverse equity hypothesis
- C. Digital divide
- D. Health literacy gradient

QUESTION 8

Which of the following is NOT listed as a prominent challenge for patients in accessing digital health?

- A. Access to internet and electronic devices
- B. Poor digital literacy
- C. Trust in digital systems and practitioners
- D. Availability of digitally competent general practitioners

CASE 5

You are mentoring a new general practitioner who is curious about the historical development of digital health in Australia and how it influences current practice.

QUESTION 9

Which practice management software, initially launched as an advertising-supported prescription tool in the early 1990s, achieved broad uptake in Australian general practice?

- A. Best Practice
- B. MedicalDirector
- C. MediRecords
- D. Zedmed

CASE 6

Your practice is planning its digital strategy for the next decade. You are considering

investments in AI, genomics and data governance to prepare for 2035.

QUESTION 10

Which emerging technology is described as allowing simulation of disease progression or treatment responses using patient-specific data?

- A. Ambient AI scribes
- B. Digital twins
- C. Polygenic risk scoring
- D. Agentic AI

May 2026 Short answer questions

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

CASE 1

You are a general practice principal in a medium-sized metropolitan practice. Your practice manager has proposed adopting new technology to improve efficiency in the practice. Two of your colleagues are enthusiastic, but others are concerned about cost, training, cybersecurity and potential workflow disruption. You read the article by Stevens et al (Digital transformation in general practice) to learn more.

QUESTION 1

Name two measurable efficiency gains reported by Practice A and Practice B after implementing their digital tools.

QUESTION 2

Outline the important principles to consider when selecting a digital implementation strategy.

CASE 2

You are a general practice supervisor for a registrar who has started using a generative artificial intelligence (AI) (GenAI) conversational agent to simulate reflective practice discussions after complex consultations. The registrar finds it helpful for exploring uncertainty and ethical dilemmas but is unsure about risks to learning.

QUESTION 3

Name two use-cases of GenAI in general practice training that align with the apprenticeship model.

QUESTION 4

Briefly explain why GenAI cannot fully replicate the relational dimensions of general practice training.

CASE 3

You are designing a continuing professional development (CPD) activity for your practice on digital competencies. Several general practitioners (GPs) express concern that AI-enhanced CPD might undermine professional autonomy or raise privacy issues.

QUESTION 5

Name two ways AI can enhance CPD efficiency and engagement for GPs.

QUESTION 6

Name some of the gaps that exist in AI use in CPD?

CASE 4

A patient from a low socioeconomic background attends your practice. They have limited internet access and low digital literacy. They express frustration that recent telehealth and patient portal initiatives seem inaccessible to them.

QUESTION 7

Name three practical ways that can help promote digital health equity.

CASE 5

You are mentoring a new general practitioner who is curious about the historical development of digital health in Australia and how it influences current practice.

QUESTION 8

Name two foundational services delivered by National Electronic Health Transition Authority (NEHTA) that remain critical today.

QUESTION 9

Describe some challenges in the initial rollout and development of the Personally

Controlled Electronic Health Record (PCEHR).

CASE 6

Your practice is planning its digital strategy for the next decade. You are considering investments in AI, genomics and data governance to prepare for 2035.

QUESTION 10

Name two system-level shifts that you are excited about and describe how you might imagine it influencing your practice by 2035.

QUESTION 11

Explain one major risk associated with emerging digital health technologies that makes you feel concerned. Why is it concerning to you?

April 2026 Multiple-choice question answers

ANSWER 1: C

The average length that a woman will experience bothersome menopausal symptoms is 7–8 years. Ten per cent of women will experience symptoms for >10 years.

ANSWER 2: C**ANSWER 3: B****ANSWER 4: D****ANSWER 5: C**

Fluoxetine should not be prescribed with tamoxifen because it inhibits CYP2D6, reducing tamoxifen's effectiveness. Citalopram, escitalopram and sertraline are safer selective serotonin reuptake inhibitors for use with tamoxifen, as they have minimal impact on CYP2D6 metabolism.

ANSWER 6: B

NK3 receptor antagonists reduce hot flashes and sweats rapidly, often within the first week, and are specifically developed for menopause vasomotor symptoms. NK3 receptor antagonists should **not** be combined with menopause

hormone therapy because concomitant use is contraindicated. These agents are **not licensed** for mood disorders; they target thermoregulatory pathways. While baseline and periodic liver function monitoring is recommended, it is not required indefinitely after 9 months of use.

ANSWER 7: A

Current venous thromboembolic disease is an **absolute contraindication** to initiating menopause hormone therapy.

ANSWER 8: D

Advice to limit menopause hormone therapy to 5 years or cease before 60 years of age is no longer recommended.

ANSWER 9: A

Progesterone and allopregnanolone are calming, modulating GABA to produce anxiolytic and sedative effects. During perimenopause, levels of these hormones fluctuate unpredictably, leading to reduced stability of GABAergic signalling. This loss of the calming influence can manifest as heightened anxiety, irritability and poor sleep, which Georgie is experiencing. B is incorrect because oestradiol fluctuations do affect emotional regulation and cognition. C is incorrect because serotonin regulation is strongly influenced by oestradiol, progesterone and testosterone. D is incorrect because testosterone levels decline with age and menopause, and changes can contribute to mood and cognitive symptoms.

ANSWER 10: B

A score of 30 on the Meno-D scale indicates moderate perimenopausal depression.

April 2026 Short answer question answers

ANSWER 1

Genetic causes of premature ovarian insufficiency (POI) include: Turner syndrome, Fragile X premutation (*FMR1* gene).

Autoimmune causes of POI include: autoimmune thyroid disease, Addison's disease. Other associated autoimmune

conditions include polyglandular autoimmune syndromes, systemic lupus erythematosus, rheumatoid arthritis, immune thrombocytopenic purpura, autoimmune haemolytic anaemia, pernicious anaemia, vitiligo, alopecia areata, inflammatory bowel disease, primary biliary cirrhosis, glomerulonephritis, multiple sclerosis, and myasthenia gravis.

ANSWER 2

As per the European Society of Human Reproduction and Embryology 2024 premature ovarian insufficiency (POI) guidelines, the initial investigations for a woman aged <40 years presenting with secondary amenorrhoea for 5 months include:

- pregnancy test – to exclude pregnancy
- follicle stimulating hormone (FSH) – >25 IU/L suggests POI; low levels suggest pituitary/hypothalamic causes; normal levels suggest polycystic ovary syndrome
- oestradiol – low levels support POI, though not required for diagnosis
- prolactin – to rule out prolactinoma
- thyroid function tests – to exclude thyroid dysfunction
- pelvic ultrasonography – ideally transvaginal; assesses ovarian size and follicle presence.

If diagnosis remains uncertain, measurement of FSH levels can be repeated after 4–6 weeks. Anti Müllerian hormone (AMH) may also be requested; undetectable AMH levels are consistent with POI.

ANSWER 3

Two genetic tests that may help ascertain the underlying cause of premature ovarian insufficiency (POI) are:

- chromosomal analysis (to detect Turner syndrome)
- FMR1 premutation testing (to detect CGG repeat expansion in Fragile X).

Two autoimmune tests that may help ascertain the underlying cause of POI are:

- thyroid function tests (to assess for autoimmune thyroid disease)

- 21-hydroxylase antibodies (to assess for autoimmune Addison’s disease).

Other autoimmune testing may be guided by history and examination findings.

ANSWER 4

Risk factors for perimenopausal depression include:

- history of mood disorders
- prior hormonal mood disorders (eg premenstrual dysphoric disorder, postnatal depression)
- early/surgical menopause or premature ovarian insufficiency
- neurodivergence (attention deficit hyperactivity disorder and/or autism, often undiagnosed or late diagnosis in females)
- childhood trauma
- living with family violence.

ANSWER 5

Differential diagnoses for perimenopausal depression include:

- bipolar affective disorder type 2
- unipolar depression
- undiagnosed attention deficit hyperactivity disorder
- complex post traumatic stress disorder.

Perimenopausal depression may coexist with these conditions. Organic causes and substance use (including alcohol) can mimic or exacerbate symptoms.

ANSWER 6

An initial management plan for Nicole’s perimenopausal depression includes:

- lifestyle education –
 - sleep hygiene
 - cardiovascular and resistance exercise per physical activity guidelines
 - healthy diet
 - brief intervention to reduce alcohol use
 - meditation/mindfulness for stress management
 - importance of social connections
- pharmacological –
 - recommend menopausal hormone therapy (MHT) as first line treatment,

after assessing contraindications/cautions, using either:

- continuous combined MHT (eg 50 mcg transdermal oestrogen patch changed twice per week + 100 mg micronised progesterone nightly) OR
- continuous combined oral contraceptive pill (eg Zoely), particularly if contraception is required
- consider transdermal testosterone if hypoactive sexual desire disorder is codiagnosed
- psychological therapy –
 - such as cognitive behavioural therapy or acceptance and commitment therapy
 - psychosexual therapy for Nicole and her partner may be indicated
- risk assessment –
 - assess risk of self harm, suicide or harm to others
 - screen for intimate partner violence
- preventive care –
 - assess cardiovascular and diabetes risk
 - discuss and/or implement cervical screening, bowel cancer screening, breast screening, bone densitometry on a case-by-case basis.

The Medicare Benefits Schedule (MBS)

item 695: Menopause and Perimenopause Health Assessment may be used for Nicole.

More information on MBS item 695 can be found at MBS Online (www9.health.gov.au/mbs/fullDisplay.cfm?type=item&q=695&qt=item).

correspondence ajgp@racgp.org.au