

# 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 EA and 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 Educational Activities (EA) and Reviewing Performance (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 our practice manager or PHN quality improvement team.

Consider evaluating your practice's approach to identification of paediatric concussion and your initial management strategies that include parent education, sleep management, and graded return to learning and physical activity, as outlined in the article by Charles et al.

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. 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 January–February 2026 AJGP Clinical challenge and accept full responsibility for all content.

## January–February 2026 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

Jordan, a student aged 14 years, presents to your practice 1 day after a minor head injury sustained during school football. His mother reports he initially seemed fine but has since developed a persistent headache, is having difficulty concentrating at school and is sleeping more than usual.

#### QUESTION 1

According to current evidence-based guidelines, what is the most appropriate initial advice regarding physical activity for Jordan?

- A. Immediate return to full sporting activities to prevent deconditioning
  - B. Light physical activity can commence within 24–48 hours
  - C. No physical activity until completely symptom-free at rest
  - D. Physical activity should be avoided for at least 2 weeks post injury
- B. Immediate full return to all classes and assessments
  - C. Home tutoring only until symptom-free for 2 weeks
  - D. Complete academic rest until all symptoms fully resolve

#### QUESTION 2

Which of the following factors is **most** consistently associated with an increased risk of persistent post-concussion symptoms (PPCS) in paediatric patients?

- A. Aged under 8 years
- B. Male
- C. Loss of consciousness at time of injury
- D. Symptom severity at initial presentation

#### QUESTION 3

Jordan's mother asks about returning to school. What is the **most** appropriate initial approach to return to learn?

- A. Return for social purposes, gradually increasing cognitive load

### CASE 2

Sarah, a lawyer aged 28 years, presents 4 days after tripping at the gym and striking her head on equipment. She did not lose consciousness but has experienced persistent headache with migrainous features, nausea, dizziness and difficulty concentrating at work. She has a history of infrequent migraines and mild anxiety. She is asking if she needs a computed tomography (CT) scan and whether complete rest at home will speed up her recovery. She practices martial arts and has an important tournament this weekend.

#### QUESTION 4

Which of the following are **true** regarding neuroimaging following concussion?

- A. All patients with concussion should undergo a CT scan

- B. Any loss of consciousness mandates immediate CT scanning
- C. Persistent headache beyond 72 hours requires magnetic resonance imaging (MRI)
- D. Neuroimaging is not routinely indicated in the absence of red-flag features

**QUESTION 5**

Sarah is 5 weeks post injury with a persisting headache and 'brain fog'. Her Rivermead Post Concussion Symptoms Questionnaire score is 19. According to the Australian and Aotearoa New Zealand Concussion Guidelines, at what point are her symptoms classified as 'persisting', and what proportion of adults experience this?

- A. After 2 weeks; affects 10–15% of adults
- B. After 4 weeks; affects 20–50% of adults
- C. After 6 weeks; affects 30–40% of adults
- D. After 8 weeks; affects 5–10% of adults

**CASE 3**

Kamal, an office manager aged 35 years, presents to your practice 6 weeks after falling from a ladder at home and striking his head. He had brief confusion but no loss of consciousness. He has returned to work but reports persistent headaches, difficulty concentrating, feeling exhausted by end of day and feeling 'not quite right'. He scored 32 on the Rivermead Post Concussion Symptoms Questionnaire. He has a history of mild anxiety but no other significant medical history.

**QUESTION 6**

Kamal asks about cognitive rehabilitation for his concentration difficulties. According to current evidence, which statement about cognitive rehabilitation after a mild traumatic brain injury (mTBI) is **most** accurate?

- A. Cognitive rehabilitation is not effective for mTBI-related cognitive symptoms
- B. Computer-based 'brain training tasks' result in transferable functional improvements
- C. Only 5% of individuals demonstrate objective cognitive impairment in the post-acute period
- D. Self-reported cognitive symptoms do

not reflect objective cognitive measures in the post-acute period

**CASE 4**

Nia, a university student aged 22 years, presents 5 weeks after sustaining a concussion in a car accident. She has returned to university but is struggling significantly – she can only tolerate 30–45 minutes of screen time, has difficulty with lectures and reports severe headaches by the end of each day. She has important exams approaching in 3 weeks and is anxious about falling behind. Her employer at the part-time cafe where she works is also requesting clarification about when she can return. She asks what accommodations she can request and whether she should push through her symptoms.

**QUESTION 7**

Nia can currently sustain approximately 45 minutes of screen time and 2 hours of concentration. According to evidence-based return-to-work guidelines, what does this indicate about her readiness for work?

- A. She should return for 2 × 2-hour shifts per day
- B. She will never be able to resume full-time work-related activities
- C. She meets reference thresholds for graded return to work
- D. She should return immediately to full pre-injury work duties

## January–February 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 5**

Jordan, a student aged 14 years, initially presented to your practice 1 day after a head injury sustained during school football, at which point he had developed persistent headaches, difficulty concentrating at school and excessive sleepiness. Jordan has a history of attention deficit hyperactivity disorder and had two previous concussions from sport 18 months ago. Jordan's symptoms persist at 3 weeks post injury. He reports ongoing headaches (worse with reading), dizziness

when turning his head quickly and neck stiffness. His mother is becoming increasingly concerned about his recovery.

**QUESTION 1**

List **four** specific symptom clusters that should be systematically assessed in Jordan's presentation.

**QUESTION 2**

Identify **two** allied health referrals you would consider and justify each with the specific symptoms they would address.

**QUESTION 3**

Explain why addressing parental concern is important in paediatric concussion management.

**CASE 6**

Sarah, a lawyer aged 28 years, presents to your clinic 4 days after tripping at the gym and striking her head on equipment. She did not lose consciousness but has experienced persistent headache with migrainous features, nausea, dizziness and difficulty concentrating at work. She has a history of infrequent migraines and mild anxiety. She practices martial arts and has an important tournament this weekend. Her examination shows non-focal cervical paraspinal muscle tenderness, and her Rivermead score is 26 (moderate-to-severe symptoms).

**QUESTION 4**

Provide specific advice regarding her return to martial arts, including time frames and conditions that must be met.

**QUESTION 5**

What analgesic advice should you provide, including important precautions?

**CASE 7**

Kamal, an office manager aged 35 years, presents to your practice 6 weeks after falling from a ladder at home and striking his head. He had brief confusion but no loss of consciousness. He has returned to work but reports persistent headaches, difficulty concentrating, feeling exhausted by end of day and feeling 'not quite right'. His sleep is disrupted, with difficulty falling asleep and multiple awakenings. He scored 32 on

the Rivermead Post Concussion Symptoms Questionnaire. He has a history of mild anxiety but no other significant medical history. His wife is concerned and asks whether he needs specialist referral.

You are considering treatment options for Kamal's sleep disturbance and ongoing cognitive symptoms at 8 weeks post injury. Kamal's fatigue is significantly affecting his work capacity. His employer is requesting guidance on workplace accommodations.

#### QUESTION 6

Compare the evidence for different treatment approaches for persistent sleep disturbance after a mild traumatic brain injury (mTBI), including both pharmacological and non-pharmacological options.

#### QUESTION 7

Explain the relationship between sleep disturbance and other post-concussion symptoms, and why sleep should be considered a high-priority treatment target.

#### QUESTION 8

Kamal asks whether his subjective cognitive complaints require neuropsychological testing. Outline when and why neuropsychological assessment and referral might be appropriate for his cognitive symptoms.

#### QUESTION 9

Provide **three** specific practical recommendations for Kamal's return to work schedule on the basis of principles of graded activity and fatigue management.

#### QUESTION 10

What advice would you give Kamal about the meaning of mild symptom increases during return to work?

### December 2025 Multiple-choice question answers

#### ANSWER 1: D

One in four women and girls in Australia have ever experienced physical or sexual intimate partner violence.

#### ANSWER 2: D

Hypertension with no other symptoms is not commonly associated with an increased likelihood of the person having experienced intimate partner violence.

#### ANSWER 3: B

Ensure privacy by seeing the patient alone before inquiring about intimate partner violence.

#### ANSWER 4: D

Use a non-judgemental motivational interviewing approach when consulting with a patient who may be a perpetrator of intimate partner violence.

#### ANSWER 5: B

A trauma-informed approach in general practice is best reflected by applying a universal precautions approach; recognising relational, cultural and systemic threats to safety; and prioritising dignity in all clinical interactions.

#### ANSWER 6: B

Explaining procedures step by step and obtaining consent throughout is a recommended strategy to support trauma-informed care in general practice settings.

#### ANSWER 7: C

A general practitioner's role in recognising coercive control involves identifying subtle relational and physiological patterns over time.

#### ANSWER 8: C

Encouraging the patient to immediately confront the perpetrator would not typically be part of a general practitioner's immediate safety planning with a survivor of intimate partner violence.

#### ANSWER 9: D

The survivor's own perception and assessment of their safety and risk is considered the most critical factor in determining the survivor's current level of risk.

#### ANSWER 10: A

The CARE model encourages general practitioners to provide choice and control, action and advocacy, recognition and understanding, and emotional connection.

### December 2025 Short answer question answers

#### ANSWER 1

General practitioners should consider asking about intimate partner violence (IPV) when patients present with the following evidence-based indicators:

- Mental health issues – conditions such as depression, anxiety or other psychological distress are strongly associated with IPV.
- Unexplained or chronic physical symptoms – chronic pain syndromes (eg headaches, pelvic or abdominal pain), chest pain and other medically unexplained symptoms that do not respond to treatment.
- Injuries – especially head, neck and facial injuries and non-fatal strangulation, which are strongly associated with IPV.
- Social or behavioural indicators – for example, if a patient is always accompanied by their partner who speaks on their behalf, or if there are signs of controlling behaviours.
- Pregnancy – antenatal care is an exception where universal screening is supported because of the high risk for both mother and baby during pregnancy.
- Children – presentations involving children showing behavioural, psychological or developmental issues may indicate exposure to IPV.

Universal screening for IPV in general practice is not recommended because current evidence does not support its effectiveness outside of antenatal care. Instead, a case-finding approach based on risk indicators is advocated. Additionally, screening may be ineffective or even harmful if not conducted in a safe, private and trauma-informed environment with systems for referral and support.

#### ANSWER 2

Systemic barriers include:

- lack of time during consultations
- inadequate privacy, such as partners or children being present
- insufficient training or protocols for dealing with intimate partner violence (IPV)

- health system limitations, such as lack of referral pathways or culturally appropriate services
- societal norms that enable victim-blaming or minimise the severity of IPV.

Personal barriers for general practitioners may include:

- belief that IPV is a social, not medical, issue
- frustration when patients do not follow advice or leave abusive relationships
- fear of damaging the doctor–patient relationship or eliciting negative responses
- lack of confidence or experience in handling disclosures of violence
- their own lived experience of family violence.

Strategies to increase readiness include:

- ensuring organisational support and protocols are in place
- receiving training in trauma- and violence-informed care
- building trust in the doctor–patient relationship
- collaborating with multidisciplinary teams and referral services
- displaying information (eg posters) about IPV and healthy relationships to encourage disclosure
- practising non-judgemental, empathetic communication and maintaining patient confidentiality while understanding the limits of confidentiality where safety is at risk.

Together, these strategies create a safer and more supportive environment for identifying and responding to IPV.

### ANSWER 3

Three key behavioural patterns that may indicate coercive control include the following:

- Unpredictable or incongruent kindness – the person using violence may alternate between intense affection and cruelty, creating confusion and dependency in the victim. In general practice, this may be misinterpreted as a healthy relationship with ‘ups and downs’.

- Excessive compliance or minimisation by the victim – victims might be overly apologetic or deferential, or they might minimise distressing experiences. This might be misunderstood by clinicians as anxiety, low self-esteem or a personality trait rather than signs of entrapment or fear.
- Controlling behaviours masked as care – the perpetrator may attend all appointments and speak for the patient, giving the appearance of concern. General practitioners may misread this as supportive behaviour when it is actually surveillance and control.

These patterns can be difficult to detect, particularly when the person using control presents as reasonable or charming, or when the victim appears disoriented or passive, potentially leading to misdiagnosis or inappropriate interventions (eg couple’s counselling).

### ANSWER 4

The Sense of Safety Framework outlines three core domains affected by coercive control:

1. Freedom (Integrity) – coercive control invades autonomy through threats, surveillance, punishment or enforced dependency, creating fear and a loss of self-agency.
2. Clarity (Coherence) – victims often experience gaslighting, deception and manipulation, leading to confusion and a loss of trust in their own perceptions and memory.
3. Belonging (Connection) – victims are isolated from social supports, experience shame and are made to feel that their suffering is their own fault, diminishing their sense of connection to others.

These disruptions can manifest as:

- physical symptoms – chronic pain, fatigue, gastrointestinal complaints or poorly explained multimorbidity due to prolonged activation of stress physiology
- psychological symptoms – anxiety, depression, dissociation or symptoms mistaken for personality disorders.

Understanding these impacts allows general practitioners to respond more appropriately by recognising coercive control as a root cause of complex health presentations rather than treating symptoms in isolation.

### ANSWER 5

A comprehensive risk assessment following a disclosure of intimate partner violence includes four key components:

- Survivor’s self-assessment of safety – this is the most critical element, as survivors have the deepest understanding of their own situation and the behaviours of the person using violence. General practitioners (GPs) should ask survivors how safe they feel and whether they have concerns for their children’s safety.
- Evidence-based risk factors – these include non-fatal strangulation, threats with weapons, sexual assault, escalation in severity or frequency of abuse, recent separation or plans to leave, and abuse during pregnancy. These are linked to increased risk of serious harm or homicide.
- Information sharing – with the survivor’s consent, GPs may incorporate relevant information from other services (eg family violence services or police) into their assessments. In some jurisdictions, specific information-sharing legislation supports this (eg in Victoria).
- Intersectional factors – these include systemic barriers and vulnerabilities affecting certain populations such as Aboriginal and Torres Strait Islander women; migrants and refugees; lesbian, gay, bisexual, transgender, gender diverse, intersex, queer, asexual and other (LGBTQIA+) people; and those in rural or remote areas.

The survivor’s self-assessment is central because they are often most familiar with the dynamics of their relationship and the patterns of violence. However, survivors may also minimise risks because of psychological manipulation or fear, so it is important to consider all four areas when forming a professional judgment about safety.

**ANSWER 6**

A trauma- and violence-informed response includes:

- listening without pressure – allowing survivors to share as much or as little as they feel comfortable with, without pushing for details
- believing survivors – validating their experience and making it clear that the violence is not their fault
- avoiding assumptions – asking about the survivor’s needs and concerns rather than assuming what support they need
- creating psychological safety – building trust, ensuring privacy and providing a supportive, non-judgemental environment.

The CARE model supports empowerment through:

- Choice and Control – offering survivors the autonomy to make their own decisions, which is crucial given that intimate partner violence (IPV) involves a loss of control
- Action and Advocacy – taking practical steps, such as referrals or safety planning, and advocating for the survivor’s needs
- Recognition and understanding – demonstrating awareness of the impacts of IPV and validating the survivor’s experiences
- Emotional connection – providing compassionate, empathetic care to foster trust and healing.

By integrating the CARE model, general practitioners help restore agency and dignity to survivors, which is a foundational step in their recovery and safety planning.