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.

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/DecemberCCMO 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 our practice manager or PHN quality improvement team.

Consider evaluating your practice setting's capability to integrate an understanding of trauma, and care for trauma, into your everyday work. Use Lynch et al's article to explore how this framework helps you as a practice team provide safe, trustworthy, collaborative, empowering and culturally respectful care.

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 December 2025 *AJGP* Clinical challenge and accept full responsibility for all content.

December 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

Approximately what proportion of women and girls in Australia have ever experienced physical or sexual intimate partner violence (IPV)?

- **A.** One in fourteen
- **B.** One in ten
- **C.** One in seven
- **D.** One in four

QUESTION 2

Which of the following presentations is not commonly associated with an increased likelihood of the person having experienced IPV?

- **A.** Accompanying partners attending all of a person's appointments
- **B.** Chronic diarrhoea in the absence of red flag symptoms
- **C.** Frequent presentations to the general practice clinic
- **D.** Hypertension with no other symptoms

QUESTION 3

According to the article by Neil et al, which of the following is a recommended practice when asking about IPV in general practice?

- **A.** Ask about IPV only if the patient raises the issue first
- **B.** Ensure privacy by seeing the patient alone before inquiring about IPV
- **C.** Speak directly to both partners together to assess relationship dynamics
- **D.** Withhold questions about IPV during antenatal care to avoid causing distress

QUESTION 4

When consulting with a patient who may be a perpetrator of IPV, what approach is recommended for general practitioners (GPs)?

- **A.** Address the patient's behaviour using clear, firm language that emphasises accountability
- **B.** Avoid discussing the alleged IPV to preserve the therapeutic relationship
- **C.** Inform the patient that their partner has disclosed intimate partner abuse
- **D.** Use a non-judgemental motivational interviewing approach with the perpetrator

QUESTION 5

Which of the following best reflects a trauma-informed approach in general practice, as described in the article by Lynch et al?

A. Acknowledging trauma only when patients disclose past experiences explicitly, and using psychiatric diagnoses to guide decisions about care

B. Applying a universal precautions approach; recognising relational, cultural and systemic threats to safety; and prioritising dignity in all clinical interactions

C. Managing trauma primarily through non-GP specialist referral, focusing on diagnosis within established psychiatric or biomedical frameworks

D. Providing trauma-informed care by increasing appointment lengths for all patients and encouraging detailed discussions about early childhood experiences

QUESTION 6

According to the article by Lynch et al, which of the following is a recommended strategy to support trauma-informed care in general practice settings?

A. Ensuring patients disclose any history of past traumatic experiences

B. Explaining procedures step by step and obtaining consent throughout

C. Referring all patients with medically unexplained symptoms for psychiatric evaluation

D. Setting clear boundaries for appointment scheduling and attendance

QUESTION 7

Which of the following most accurately reflects a GP's role in recognising coercive control, as described in the article by Lynch et al?

A. Assessing for coercive control only when physical injury is present or when the patient openly discloses fear in a relationship

B. Assuming that relational power imbalance can be assessed by observing which partner is more emotionally expressive or distressed during consultations

C. Identifying subtle relational and physiological patterns over time that suggest fear, control and entrapment, even in the absence of physical violence

D. Referring all couples presenting with relationship conflict to joint counselling to help facilitate mutual understanding and open communication

QUESTION 8

Which of the following would not typically be part of a GP's immediate safety planning with a survivor of IPV?

A. Asking the victim-survivor to create a code word for emergencies

B. Calling 000 or family violence services if there is imminent risk

C. Encouraging the victim-survivor to immediately confront the perpetrator

D. Discussing safe places the victim-survivor could go to in a crisis

QUESTION 9

When conducting a risk assessment after a disclosure of IPV, which of the following is considered the **most** critical factor in determining the survivor's current level of risk?

A. Clinical indicators such as visible distress and physical symptoms related to emotional trauma

B. Details from information shared by external agencies such as the police or family support services

C. The GP's own professional judgement based on prior clinical experience with victim-survivors of IPV

D. The victim-survivor's own perception and assessment of their safety and risk

QUESTION 10

What does the CARE model encourage GPs to provide when responding to disclosures of IPV?

A. Choice and control, Action and advocacy, Recognition and understanding, and Emotional connection

B. Choice and control, Assessment and action, Relationship counselling, Expectation setting

C. Clinical Assessment and Rapid referral to Emergency services

D. Consistency, Autonomy and action, Responsiveness, Empathy and engagement

December 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.

QUESTION 1

Identify the key clinical and social indicators that should prompt a GP to ask a patient about IPV, and explain why universal screening in general practice is not currently recommended.

QUESTION 2

Describe the barriers – both systemic and personal – that can prevent GPs from identifying and responding to IPV in clinical practice, and outline strategies that support increased readiness to address IPV.

QUESTION 3

Identify three key behavioural patterns that may indicate the presence of coercive control in a patient's relationship, and explain how these patterns may be misinterpreted in general practice.

QUESTION 4

Describe how coercive control can affect a person's sense of safety using the Sense of Safety Framework, and outline how this can manifest in physical or psychological symptoms.

QUESTION 5

Describe the components of a comprehensive risk assessment following a disclosure of intimate partner violence (IPV), and explain why a survivor's self-assessment of their own safety is central to this process.

QUESTION 6

Identify the key elements of a trauma- and violence-informed response that GPs should adopt when a patient discloses IPV, and explain how the CARE model supports survivor empowerment.

November 2025 Multiple-choice question answers

ANSWER 1: D

The transformation of excellence into unrelenting perfectionism (and intolerance of mistakes)

ANSWER 2: D

Modelling appropriate self-compassion and normalising professional struggles

ANSWER 3: D

The distortion of altruism into excessive self-sacrifice (with significantly lower self-valuation than the general population)

ANSWER 4: B

Dr Jagnu's compromised wellbeing may increase his risk of making medical errors and impact patient care

ANSWER 5: C

The Code specifically acknowledges doctors' obligations to support their own health (Section 11)

ANSWER 6: A

It consists of a confidential self-assessment and 12-month self-care plan worth 25 CPD hours

ANSWER 7: A

A combination of technical and conceptual uncertainty

ANSWER 8: A

Acknowledge that uncertainty tolerance develops with supervised experience

ANSWER 9: C

A registrar showing poor insight into their own wellbeing status

November 2025 Short answer question answers

ANSWER 1

a. The hidden curriculum refers to the implicit ways medical values are embedded within how doctors act and the structural/policy establishment of medicine. It functions through unspoken modelling of behaviours and attitudes, teaching trainees what it means to 'be' a doctor through observation rather than explicit instruction. It creates pressure to conform to professional expectations and shapes professional identity formation.

b. Perfectionism reinforcement: When senior doctors never openly discuss mistakes, uncertainties or struggles, trainees learn that 'good doctors' do not experience these challenges, perpetuating unrealistic expectations of invulnerability

   Self-sacrifice normalisation: When trainees observe supervisors working while ill, skipping meals or neglecting their own health, these behaviours become normalised as essential aspects of medical professionalism rather than problematic patterns

c. Dr Talya could engage in appropriate self-disclosure about her own professional challenges and how she manages them, explicitly discussing the realities of medical practice including uncertainties and difficulties, thereby bringing the hidden curriculum into conscious awareness and modelling healthier approaches.

ANSWER 2

a. Three components of self-compassion:
   - Self-kindness: Dr Kevin could treat himself with the same compassion he would show a colleague facing similar challenges
   - Common humanity: Recognising that uncertainty and self-doubt are normal experiences shared by all doctors, not personal failings
   - Mindfulness: Acknowledging his feelings of inadequacy without becoming overwhelmed by them or defining himself by them

b. Practising self-compassion contributes to cultural change because culture is learned through observation and 'fitting in' with others. When individuals such as Dr Kevin begin modelling self-compassionate behaviours – such as acknowledging uncertainty without harsh self-criticism or discussing challenges openly – this gradually shifts what is considered normal and acceptable within the profession. This is particularly powerful for trainees, whose professional identity formation is heavily influenced by observing how colleagues respond to challenges.

ANSWER 3

A GP in a supervisory or teaching role could model healthier professional behaviours by:

1. Openly discussing their own professional challenges and how they have addressed them, demonstrating appropriate vulnerability and normalising the difficulties of medical practice.
2. Visibly practising self-care, such as taking regular breaks, staying hydrated, leaving work at reasonable hours and discussing the importance of these practices with trainees.
3. Responding to mistakes (their own or others') with a growth mindset rather than harsh criticism, creating psychological safety for trainees to acknowledge and learn from errors.
4. Explicitly discussing the culture of medicine, including its strengths and weaknesses, bringing the 'hidden curriculum' into conscious awareness.
5. Supporting trainees and colleagues who express concerns about wellbeing or work–life balance rather than dismissing these as signs of weakness or lack of commitment.
6. Setting boundaries on working hours and availability, demonstrating that being a good doctor does not require constant self-sacrifice.
7. Seeking appropriate healthcare when needed rather than self-treating or working while unwell.
8. Acknowledging the systemic and structural factors that contribute to poor wellbeing rather than framing wellbeing as solely an individual responsibility.

ANSWER 4

a. The 'kindergarten question' refers to a hypothetical child asking a doctor 'Why do you look after people's health?' The simple answer is 'because people's

health is important'. This represents a fundamental, self-evident truth that society accepts. We value health and wellbeing as inherently important, not because of what they enable us to do, but simply because they matter in themselves.

b. Since Dr Ji-Su is also a person, the same principle that drives her dedication to patient care (that wellbeing is inherently important) applies equally to her own wellbeing. She deserves to experience good health and wellbeing for the same fundamental reason that her patients do. This challenges the false dichotomy between caring for others and caring for oneself, recognising that both have inherent value.

c. Dr Ji-Su could reframe self-care as essential professional maintenance that enables her to provide optimal patient care – just as maintaining medical equipment ensures better patient outcomes, maintaining her own wellbeing ensures she can deliver the quality of care her patients deserve and that motivated her to enter medicine.

ANSWER 5

a. Three negative outcomes affecting practice performance:
   - Increased medical errors: Multiple systematic reviews involving over 200,000 healthcare providers demonstrate that burnout significantly increases both self-reported and observed medical errors, potentially exposing the practice to litigation risk and reputation damage
   - Reduced patient retention: Research shows that patients are more likely to change GPs when their doctor experiences burnout, directly affecting practice revenue and continuity of care metrics
   - Staff turnover and recruitment costs: Evidence shows that burnout is associated with higher intention to leave practice, leading to expensive recruitment processes, training costs and temporary staffing arrangements

b. The shared responsibility model recognises that doctor wellbeing is influenced by individual, organisational and systemic factors, meaning organisations have both an obligation, and a vested interest in creating supportive environments. Since many wellbeing challenges stem from workplace factors (workload, practice culture, resources), organisational intervention is not just beneficial but necessary for effective wellbeing outcomes. The practice benefits from this investment through improved staff performance, retention and patient satisfaction, making it a sound business investment rather than merely an altruistic expense.

ANSWER 6

a. Three risk factors Tom is displaying:
   - Resource gaps (financial stress): Reduced income when compared with hospital role, creating personal resource deficit
   - High load (excessive working hours): Arriving early and staying late, potentially compounding exhaustion
   - Psychosocial context (help-seeking avoidance): Reluctance to seek help with complex cases and cancelled educational meetings, suggesting isolation and possible perfectionist attitudes

b. Tom's financial stress may drive him to work longer hours to see more patients, creating a cycle where increased workload leads to greater exhaustion. His reluctance to seek help suggests the influence of medical culture's perfectionist expectations, where admitting difficulty is perceived as professional weakness. This creates psychological isolation at a time when he needs support, exacerbating the resource–demand imbalance. The cancelled educational meetings further reduce his access to professional development resources and peer connection, while his anxiety about consultations may reflect concerns about competence.

c. Evidence-based strategies:
   1. Address resource gaps: Provide structured feedback and mentoring to build Tom's confidence and professional competence, ensuring regular supervision meetings are protected time
   2. Manage workload: Negotiate appropriate patient loads and consultation times, discussing realistic expectations for his stage of training
   3. Optimise psychosocial context: Foster a supportive practice culture by normalising help-seeking, sharing clinical challenges openly and connecting Tom with peer networks or registrar support groups

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