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 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. If you read the whole issue, use the custom Quick log below to record your CPD.

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 Measuring Outcomes options

You can also do self-directed Measuring Outcomes (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's disaster preparedness using Brooke Ah Shay's article as a guide. Assess how well your practice identifies and supports patients most vulnerable during a disaster (eg those with chronic disease, mobility limitations, or reliance on regular medication and equipment supply) and whether your continuity-of-care arrangements (patient records access, medication supply, telehealth capacity) would hold up if your practice were disrupted. Discuss with colleagues how your practice would maintain clinical coverage and access locum relief if a GP were directly affected as a disaster victim themselves, and what psychosocial support pathways exist for staff during and after a disaster event.

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. Assessing the effectiveness of your practice's disaster preparedness strategy through a review of at least five vulnerable patient records, then identifying and documenting improvements, could be logged for 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 November 2026 *AJGP* Clinical challenge and accept full responsibility for all content.

Scan the QR code to claim reading and reflection CPD once you've completed the Clinical Challenge or visit https://bit.ly/AJGPNov2026.

November 2026

These questions are based on the Focus articles in this issue. Please choose the single best answer for each multiple-choice question. For the short answer questions, please write a concise and focused response to each question.

CASE 1

You are a rural general practitioner (GP) in a community that has experienced repeated climate-related disasters. A severe bushfire has just passed through the region.

QUESTION 1

According to the literature summarised in the disaster article, rural Australians are approximately how many times more likely than city residents to have experienced a climate-related disaster since 2018?

- **A.** 3 times
- **B.** 6 times
- **C.** 12 times
- **D.** 18 times

QUESTION 2

Which of the following best describes the dual role of rural GPs during disasters?

- **A.** Both acute hospital responders and primary care providers
- **B.** Both essential responders and potential victims themselves
- **C.** Both physical health and mental health care providers
- **D.** Both providers of healthcare and consultants for government

QUESTION 3

Name two practical measures recommended to support rural GPs who are also affected by a disaster.

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CASE 2

A patient from a rural Victorian town reflects on her experience after a major intracranial event and retrieval to Melbourne.

QUESTION 4

Explain why you think the author states that 'the retrieval is only the beginning' in a rural context.

CASE 3

You are discussing workforce sustainability with a female rural general practice registrar who is considering long-term rural practice.

QUESTION 5

Describe the major challenges that female rural GPs face, as described in the article by Rodda et al.

QUESTION 6

Name two key strategies used by the Doctors for Women in Rural Medicine (DWRM) group to address the major challenges faced by female rural GPs.

CASE 4

A long-serving rural GP presents with symptoms of chronic stress after decades of practice.

QUESTION 7

In the reflective piece 'A fortunate doc', the author ultimately recognised that his presentation was more consistent with which diagnosis other than simple burnout?

A. Major depression
B. Post-traumatic stress disorder
C. Adjustment disorder
D. Somatic symptom disorder

QUESTION 8

In the reflective piece 'A fortunate doc', the author identifies which factor as potentially increasing vulnerability to the negative health impacts of rural general practice?

A. Lack of any non-clinical interests
B. Family-of-origin experiences
C. Refusal to take any leave
D. Working exclusively in procedural practice

QUESTION 9

List two lifestyle or practice habits the author of 'A fortunate doc' found protective or helpful in recovery.

QUESTION 10

Reflect on your own work–life balance and what you could apply from Dr Hilton Koppe's experience, the author of 'A fortunate doc'.

CASE 5

You are a rural workforce planner reviewing supports available for local doctors' own health.

QUESTION 11

According to the article by Benson et al on 'Supporting rural and remote doctors' health', approximately what percentage of rural and remote doctors in one survey reported needing to travel more than 300 kilometres for each appointment of their own healthcare (Modified Monash [MM]6–7)?

A. 30%
B. 50%
C. 70%
D. 90%

QUESTION 12

Approximately what proportion of consultations in the Doctors' Health South Australia rural outreach clinics were for physical health issues?

A. 25%
B. 50%
C. 75%
D. 90%

QUESTION 13

According to the rural doctors' health article, what is the most common category of health impairment notification for rural and remote doctors (in descending order of frequency)?

A. Physical illness, cognitive decline, mental illness, substance use
B. Substance use, mental illness, cognitive decline, physical illness
C. Mental illness, substance use, physical illness, cognitive decline
D. Cognitive decline, physical illness, substance use, mental illness

QUESTION 14

Name two major barriers that specifically impede rural and remote GPs from accessing their own healthcare.

CASE 6

A remote Aboriginal and Torres Strait Islander Community Controlled Primary Health Service is exploring sustainable medical workforce models after COVID-19 disruptions.

QUESTION 15

In the hybrid fly-in fly-out (FIFO) model proposed for sustainable rural workforce, what is the recommended minimum frequency of face-to-face visits by the regular visiting GP?

A. Determined by local needs
B. At least three times per year
C. Monthly
D. Fortnightly

QUESTION 16

Outline two core off-site responsibilities of the GP in the proposed hybrid model.

QUESTION 17

Why are highly skilled local health workers critical to the success of this hybrid model?

QUESTION 18

Name two systemic factors contributing to the current rural GP workforce crisis highlighted across the Focus articles in this issue.

QUESTION 19

In the context of disaster response, why must rural general practice be formally recognised as critical infrastructure?

October 2026 Multiple-choice question answers

ANSWER 1: B

ANSWER 2: C

Approximately 60 times the general population rate.

ANSWER 3: A

Annual screening for anal cancer is recommended for all people living with HIV from age 18 years. This includes

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an assessment of symptoms, a digital anorectal examination (DARE) and peri-anal examination.

ANSWER 4: B

ANSWER 5: C

ANSWER 6: B

ANSWER 7: A

October 2026 Short answer question answers

ANSWER 1

Transgender and gender diverse (TGD) patients with a cervix may experience multiple barriers to cervical screening. These may include:

1. Low rates of clinician recommendation, with nearly half never having had a cervical screening test suggested
2. Gender dysphoria triggered by the examination, particularly speculum insertion
3. Previous negative healthcare experiences which may include discrimination and misgendering
4. Physical discomfort related to vaginal atrophy in patients taking masculinising gender affirming hormone therapy

Adopting affirmative, patient-centred approaches may assist in improving screening rates. These may include:

- Asking patients about their chosen name, pronouns and terminology for their body parts and using these terms consistently. A trauma-informed model of care recognises and acknowledges trauma and its prevalence in the LGBTQIA+ (lesbian, gay, bisexual, transgender, queer/questioning, intersex, aromantic/asexual, with the + representing other gender identities/sexualities that are part of the community) population and demonstrates awareness and sensitivity of its impact on the different stages of the cervical screening pathway.
- Depending on a person's trauma background, symptoms and previous cervical screening test (CST) results, it may be appropriate to offer self-collection. If a clinician-collected sample is required or preferred then comfort-enhancing techniques such as self-insertion of the speculum, using the smallest suitable speculum, and patient-directed choices about positioning, environment and the level of discussion during the procedure may help to reduce any potential distress associated with the procedure. Providing routine reminders and normalising CST as part of preventive care may also help.
- For patients experiencing atrophy-related discomfort, a short course of intravaginal oestrogen (eg estradiol 10 µg pessary or estriol 0.1% cream daily for 2 weeks, ceasing 1–2 days before CST) may reduce pain and improve sample adequacy. This is not required for all patients, particularly those choosing self-collection, but can be offered when clinically appropriate.

ANSWER 2

1. Transgender and gender diverse (TGD) people have lower overall levels of physical activity than the broader population, with transgender women particularly affected.
2. Several factors may contribute to this reduced participation, including experiences of transphobia, stigma and discrimination, as well as body image concerns and the impact of binary male–female divisions in sport.
3. Exploring these barriers requires a trauma-informed, individualised approach. This involves sensitively asking about the patient's experiences, acknowledging the potential impact of stigma and discrimination, and collaboratively identifying what supports or adaptations might make physical activity feel safer and more accessible. Tailoring discussions to the patient's specific concerns and lived experience helps avoid replicating previous harms and supports engagement in movement and exercise.

ANSWER 3

1. Emerging evidence suggests that older transgender and gender diverse (TGD) people may be at higher risk of cognitive impairment and Alzheimer's disease, with chronic stress proposed as a contributing factor through its potential role in accelerating brain ageing.
2. The article identifies several unique challenges for TGD people living with dementia. These include:

- The risk of being pressured to 'detransition' – that is, to present according to their sex presumed at birth – by families of origin or aged-care providers. Such pressures can undermine identity and create distress.
- Fears of discrimination, including concerns about being forced to abandon affirmed gender expression, may discourage help-seeking, increase reliance on partners or friends rather than formal services and contribute to social withdrawal. These factors can reduce engagement with support systems and complicate care for older TGD people experiencing cognitive decline.

ANSWER 4

Having a diverse gender or sexual identity does not cause poor mental health. The minority stress model highlights how interacting stressors may explain the disparities in mental health experienced by people who have a diverse sexual identity. Broadly, distal (or external) stressors (which may include workplace discrimination), interact with proximal (or internal) stressors (which might include concealment of identity).

The modified gender minority stress model includes the impact of additional stressors – social norms and ideologies – uniquely experienced by TGD people.

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