

# Preface

Embarking on the journey towards Fellowship of the Royal Australian College of General Practitioners (FRACGP) is a significant undertaking for every General Practice trainee. The Fellowship examinations, particularly the Clinical Competency Examination (CCE), represent crucial milestones demanding not only broad clinical knowledge but also sophisticated clinical reasoning and application skills. Recognising the challenges and importance of these assessments, we at the GP Institute of Australia is proud to present this guide as part of our dedicated series to support GP trainees on their path to Fellowship.

**Purpose and Scope:** This book is specifically designed to be a comprehensive, high-yield resource focused squarely on preparing candidates not just for the FRACGP CCE, but also for everyday practice. Our primary purpose is to equip GP trainees with the knowledge, skills, and confidence needed to navigate these exams successfully. The scope encompasses the core domains of general practice as outlined in the RACGP curriculum, focusing on common and critical presentations, diagnostic strategies, and management principles frequently tested in the CCE format. We aim to bridge the gap between clinical experience and specific exam requirements.

**Who is this Guide for?** This resource is tailored for General Practice registrars who begin their GP training for Year 1 and after they have passed their FRACGP Fellowship exams, particularly the CCE component. While clinical experience is irreplaceable, this guide serves as an essential adjunct to consolidate learning and hone exam-specific techniques.

**Key Features:** Understanding the unique demands of each exam component, this guide offers:

- **Targeted Content Review:** Concise summaries of high-yield topics relevant to the CCE blueprint.
- **Structured Approach:** Guidance to focus on identifying key features, and formulating concise, relevant answers.
- **Exam Strategies:** Practical tips, techniques, and common pitfalls(mistakes) to guide you through the CCE successfully, including time management and question interpretation.
- **Clinical Encounter & Case Discussion examples:** Explained and demonstrated in detail along with the competency scoring sheets to improve practice and pass the CCE easily.

**Organization:** The book is structured logically to facilitate focused study. Initial sections concentrate on the breadth of knowledge required for the written exam, often organized by clinical domains. Subsequent sections delve into the CCE format, providing important differentials and red flags. Throughout the text, key learning points and exam tips are highlighted for easy reference.

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# How to Use This Resource: Your Guide to GP Fellowship Success

This textbook is your companion through the Australian and New Zealand (RACGP) General Practice fellowship journey. This book reveals all the secrets which no one will teach you in the real world. Designed as a concise, GP-focused version of *UpToDate*, it delivers high-yield, real-world information tailored to the ANZ clinical setting.

Organised by clinical topic, each chapter offers key summaries of core knowledge, diagnosis, and management strategies aligned with current ANZ guidelines. In addition to core content, you will find:

- System wise CCE-style clinical case examples: These reflect the oral RACGP assessment format and simulate real-life patient scenarios.
- CE/CD case examples: Tailored case-based discussions that target common clinical encounters and decision-making points, essential for workplace-based assessments.
- Competency-based scenarios: Highlighting communication, professionalism, clinical reasoning, population health, and evidence-based medicine — the core domains required for fellowship.

We update this resource every few months. Feel free to email us with suggestions, case ideas, or corrections — your input helps us stay current and relevant.

## **Navigating This Resource:**

- Start with chapters that match your current clinical learning needs. You can follow the sequence or jump to targeted topics.
- Read each section thoroughly, focusing on key concepts, management frameworks, designed to highlight exam-relevant insights.
- Use the included CCE, CE/CD, and competency-based cases to test your understanding, simulate exam scenarios, and build confidence in patient-centred, safe care.
- Link the content with your clinical practice. Reflect on similar cases you encounter and think through how the content applies to your decision-making.
- Use this as a revision aid before exams — the case examples and summaries are ideal for consolidating knowledge and preparing for real-life assessment formats.

## **Important Note:**

This textbook is designed to supplement — not replace — formal GP training, supervision, and official guidelines. Always consult local protocols, practice standards, and your supervisor for individual patient care decisions.

By using this resource effectively, you will build not only a solid clinical knowledge base but also sharpen the clinical reasoning and communication skills essential for success in the RACGP fellowship exams and your career in Australian general practice.

# The Role of the General Practitioner in Australia

## Introduction

Australian GPs are central to the nation's primary healthcare. They provide comprehensive, person-centred, continuous care across all life stages. Operating within Medicare, GPs are the first patient contact, managing diverse conditions, coordinating care, advocating, and promoting health/preventing disease. The GP-patient relationship is key to effective primary care. Understanding this role's breadth is vital for effective practice and fellowship pathways.

## 1. Clinical Care and Diagnosis

GP's core function is direct clinical care, including:

**Managing Undifferentiated Illness:** Skilled in history, examination, and differential diagnoses for non-specific symptoms.

**Diagnosing and Managing Acute Conditions:** Common infections, minor injuries, chronic condition exacerbations, and identifying urgent cases.

**Managing Chronic and Complex Conditions:** Central to long-term management of diseases like diabetes, cardiovascular disease, asthma, COPD, arthritis, chronic kidney disease, and mental health. Includes monitoring, medication, lifestyle advice, and multidisciplinary care using Medicare's Chronic Disease Management (CDM) items. Managing multimorbidity is key.

**Investigations and Prescribing:** Ordering/interpreting tests (blood, pathology, imaging) for diagnosis and management. Prescribing safe, rational, cost-effective medications adhering to the Pharmaceutical Benefits Scheme (PBS).

**Minor Procedures:** Performing appropriate minor surgical and therapeutic procedures like skin lesion assessment/excision, biopsies, suturing, wound care, abscess drainage, joint injections, cryotherapy, and long-acting reversible contraception insertion/removal.

## 2. Continuity of Care

Continuity of care is ongoing, relationship-based care by a GP over time, a defining feature of Australian general practice.

**Longitudinal Relationship:** Building trust through repeated consultations allows deep understanding of patient history, circumstances, values, and beliefs.

**Benefits:** Linked to improved patient satisfaction, adherence, health outcomes (especially chronic disease), reduced hospitalisation, and lower costs.

**Monitoring Health Trajectories:** GPs monitor physical, mental, and social changes, enabling early detection and proactive interventions.

**Care Transitions:** GPs ensure smooth transitions, following up hospital discharge summaries/specialist letters, reconciling medications, and integrating specialist advice.

## 3. Whole-of-Life Care and Prevention

GPs provide care across the lifespan, from prenatal to end-of-life, with a strong focus on preventive health.

**Preventive Activities:**

**Immunisations:** Delivering vaccines under the National Immunisation Program, seasonal influenza, COVID-19, and travel vaccines. Maintaining accurate records (Australian Immunisation Register).

Screening: Facilitating national cancer screening (cervical, breast, bowel). Performing cardiovascular risk assessments, diabetes risk screening (AUSDRISK), osteoporosis risk assessment, and STI screening.

Lifestyle Modification: Providing evidence-based advice and support for smoking cessation, nutrition, alcohol reduction, and physical activity (SNAP framework). Using behaviour change techniques.

#### Life Stages:

Antenatal/Postnatal: Offering GP-shared antenatal care, managing pregnancy ailments, providing postnatal checks.

Child and Adolescent Health: Monitoring growth/development, managing common illnesses, providing adolescent health checks (HEADSSS), addressing mental and sexual health.

Women's Health: Contraception advice/procedures, managing menstrual disorders, menopause, sexual health.

Men's Health: Addressing prostate health, erectile dysfunction, cardiovascular risk.

Aged Care: Conducting comprehensive health assessments, managing polypharmacy, frailty, cognitive decline/dementia, falls prevention, and providing care in Residential Aged Care Facilities.

Mental Health: Assessing, diagnosing, and managing common conditions. Developing Mental Health Treatment Plans under Medicare. Some GPs provide Focused Psychological Strategies. Managing crises and coordinating with mental health services.

Palliative Care: Providing symptom management and support for life-limiting illnesses, often with specialists. Facilitating Advance Care Planning.

## 4. Care Coordination and System Navigation

GPs are central coordinators within the Australian healthcare system.

Referral Management: Assessing need for specialist input and making timely referrals with effective letters. Understanding tiered referral systems.

Coordination with Allied Health: Referring to and collaborating with physiotherapists, dietitians, podiatrists, psychologists, exercise physiologists, occupational therapists, social workers, etc., often via CDM items (TCAs).

Multidisciplinary Care: Organising or participating in case conferences (MBS items available) for complex needs.

Communication Hub: Primary communicator between healthcare providers, ensuring appropriate information sharing (with consent).

Patient Advocacy: Assisting patients to navigate the system, understand options, access services (NDIS, My Aged Care, Centrelink), and advocate for their needs.

## 5. Emergency and After-Hours Care

While mostly during standard hours, GPs contribute to acute and after-hours care, especially in some settings.

Initial Emergency Management: Providing initial assessment and stabilisation for emergencies (cardiac events, trauma, acute asthma, anaphylaxis) prior to transfer, particularly in rural/remote areas. Basic and advanced life support skills needed.

After-Hours Services: Participating in rosters, working in dedicated clinics, or providing services via deputising services or telehealth.

Urgent Care Settings: Involvement in Urgent Care Clinics/Centres for less critical conditions.

Collaboration: Working with ambulance services, retrieval teams (RFDS), and local hospitals during emergencies.

## 6. Special Roles in Rural and Remote Areas

Rural and remote GPs often have a broader scope than urban counterparts.

Expanded Clinical Scope: Frequently possess extra skills in emergency medicine, obstetrics (including deliveries), anaesthetics, minor surgery, and inpatient care.

Hospital Role: Often hold Visiting Medical Officer (VMO) or Senior Medical Officer (SMO) roles in local rural hospitals, providing inpatient care, emergency coverage, and procedures.

Aboriginal and Torres Strait Islander Health: Providing primary care to Indigenous communities, requiring cultural safety, understanding specific health priorities (chronic disease, rheumatic heart disease), Closing the Gap initiatives, and collaboration with Aboriginal Community Controlled Health Organisations (ACCHOs) and Aboriginal Health Workers/Practitioners. Utilising relevant MBS items like the 715 Health Assessment.

Challenges & Rewards: Navigating isolation and resource limits while enjoying community integration and diverse practice.

## 7. Administrative and Professional Duties

Beyond patient care, GPs have significant professional responsibilities.

Medical Records: Maintaining accurate, legible, contemporaneous, and comprehensive records is legal and ethical. Proficiency with practice software and understanding health informatics (including My Health Record) are essential.

Ethical and Legal Practice: Adhering to the Medical Board of Australia's code of conduct. Understanding informed consent, confidentiality, privacy, mandatory reporting, and professional boundaries.

Medicare Compliance: Understanding the Medicare Benefits Schedule (MBS), billing accurately, meeting item descriptors, and maintaining records. Understanding Practice Incentives Program (PIP) requirements.

Continuing Professional Development (CPD): Engaging in ongoing learning to maintain skills, fulfilling Medical Board and RACGP requirements.

Teaching and Supervision: Many GPs teach medical students and supervise GP registrars.

Practice Management and Quality Improvement: Participating in meetings, audits, developing policies, and engaging in quality improvement activities (PIP QI data submission).

## 8. Alignment with RACGP Core Domains

GP roles align with RACGP core competency domains for training and assessment:

Communication and the Patient-Doctor Relationship: Empathy, listening, shared decision-making, clear information, cultural competence.

Applied Professional Knowledge and Skills: Integrating knowledge, procedural skills, and evidence-based practice.

Population Health and the Context of General Practice: Understanding epidemiology, prevention, screening, health promotion, social determinants, and the healthcare system.

Professional and Ethical Role: Demonstrating integrity, ethics, self-reflection, managing uncertainty, lifelong learning, fitness to practice.

Organisational and Legal Dimensions: Understanding practice management, Medicare, record-keeping, teamwork, quality improvement, and medico-legal responsibilities.

Demonstrating competence across these domains is fundamental to fellowship.



## The Core Competencies Tested in the CCE

Criteria and performance lists

1. Communication and consultation skills
2. Clinical information gathering and interpretation.
3. Diagnosis, decision-making and reasoning
4. Clinical management and therapeutic reasoning
5. Preventive and population health
6. Professionalism
7. General practice systems and regulatory requirements
8. Procedural skills
9. Managing uncertainty
10. Identifying and managing the patient with significant illness
11. Aboriginal and Torres Strait Islander health context
12. Rural health context

The RACGP curriculum outlines essential qualities for Australian GPs through a competency framework. This framework includes five domains of general practice, which are broken down into thirteen high-level core skills and numerous specific competency outcomes. These core skills define "what" a GP does.

For assessment, competencies are defined as tasks a candidate must handle using relevant knowledge, skills, attitudes, and meta-cognitions. They are behavioural descriptors linked to clinical practice. To facilitate clinical assessment, ten clinical competencies have been mapped to the curriculum's core skills, synthesizing outcomes across the five domains and emphasizing key consultation and practice areas. These cover clinical consultation, professionalism, general practice systems, and clinical reasoning. Two additional contextual units, Aboriginal and Torres Strait Islander health and Rural health, complement these core competencies.

Each clinical competency includes criteria describing expected performance at the early Fellowship level (ready for unsupervised practice). These criteria are measurable actions, each with a performance description. These "performance lists" guide assessors with narrative anchors for rating and frame competencies in a clinical context. They are not tied to training stages, acknowledging varied individual development rates.

Criteria and performance lists form the basis for clinical assessment rubrics. Assessments are binary (at standard or not), with the standard set at the point of Fellowship, indicating readiness for unsupervised general practice in Australia.

# 1. Communication and consultation skills

**Core Idea:** General practitioners must communicate effectively and appropriately to deliver quality care, promote health and wellbeing, and provide holistic, patient-centred primary contact.

This competency centres on effective communication with patients and the use of appropriate general practice consultation methods. Key aspects include:

- Patient-centred Approach: Engaging patients to understand their ideas, concerns, and expectations.
- Therapeutic Relationship: Building respectful relationships through empathy and sensitivity, trying to see things from the patient's perspective.
- Clear Explanations: Providing information about diagnosis and management that is appropriate to the patient's health literacy and beliefs.
- Shared Understanding: Checking for patient understanding and agreement throughout the consultation.

## Criteria:

### Communication:

- Communication is appropriate to the individual and sociocultural context.
- Engages patients to gather information about symptoms, ideas, concerns, expectations, and the illness's impact.
- Matches communication modality to patient needs, health literacy, and context.
- Communicates effectively in both routine and difficult situations.
- Demonstrates active listening.
- Uses varied communication techniques and materials (written, electronic) to adapt explanations.
- Uses appropriate strategies to motivate and assist patients in maintaining health behaviours.

### Consultation Skills:

- Adapts the consultation to optimize patient care.
- Consults effectively and focused within a normal time limit.
- Prioritizes problems, addressing both patient and doctor agendas.
- Implements safety-netting and specific follow-up arrangements.

### Aboriginal and Torres Strait Islander Health Context:

- Uses various methods for culturally safe communication with Aboriginal and Torres Strait Islander peoples.
- Integrates their cultural perspectives on health and wellbeing into holistic practice.
- Identifies and addresses barriers to effective therapeutic relationships with Aboriginal and Torres Strait Islander peoples.

### Rural Health Context:

- Develops, maintains, and reviews effective communication strategies for remote patients and health professionals.
- Adapts communication for rural/remote situations and maintains relevant communication infrastructure.
- Identifies appropriate communication modes in the practice and community.

## For the Trainee:

This area assesses your communication with patients, families, and other care providers. You need to show:

- Patient-centred communication skills, especially in difficult situations (breaking bad news).
- Active listening, use of open questions, avoiding unnecessary interruptions, and effective non-verbal skills.
- Responsiveness to cues from the patient to deepen understanding.

- Offers and discusses non-pharmacological therapies.
- Develops a patient-centred and comprehensive management plan.
- Provides effective explanations, education, and choices to the patient.

Aboriginal and Torres Strait Islander Health Context:

- Collaborates effectively with multidisciplinary teams to develop meaningful and holistic management plans.
- Identifies and uses professional resources to assist with delivering best-practice care to Aboriginal and Torres Strait Islander patients.
- Identifies and incorporates social and cultural determinants of health into management plans.

Rural Health Context:

- Links into existing networks of health professionals in rural and remote settings.

#### **For the Trainee:**

This focuses on how you develop appropriate and patient-centred management plans. Assessment includes:

- Using an evidence base for prescribing pharmacological treatments.
- Considering non-pharmacological options.
- Ensuring your management plan is appropriate for the working diagnosis and problem list, reflecting a good understanding of accepted general practice.
- Discussing and agreeing with the patient on the conditions, their implications, and intervals for follow-up or review.

## 5. Preventive and Population Health

**Core Idea:** General practitioners make rational decisions based on community and healthcare system needs, lead efforts to address unique community health needs, and use effective health education to empower patients.

This competency concerns providing general practice care that supports economically rational and effective use of the healthcare system. It involves identifying and managing public health issues, understanding the determinants of health at individual and community levels, and undertaking disease prevention and health promotion activities.

#### **Criteria:**

- Implements screening and prevention strategies to improve outcomes for individuals at risk of common causes of morbidity and mortality.
- Uses planned and opportunistic approaches for screening, preventative care, and health promotion.
- Coordinates a team-based approach to preventive and population health.
- Demonstrates understanding of available services in the local community.
- Manages current and emerging public health risks appropriately.
- Educates patients and families in disease management and health-promotion skills.
- Identifies opportunities to effect positive change through health education and promotion.
- Uses appropriate strategies to motivate and assist patients in maintaining health behaviours.

Aboriginal and Torres Strait Islander Health Context:

- Uses evidence-based preventive and population health approaches to reduce health inequalities in Aboriginal and Torres Strait Islander communities.
- Identifies health-delivery strategies to reduce inequities and enhance self-determination.

Rural Health Context:

- Develops and delivers health-promotion activities in the community to address identified risks.
- Establishes and sustains health-education and health-promotion networks.
- Implements strategies to minimize obstacles to accessing care.

- Effectively manages any conflicts between personal and professional roles.
- Effectively communicates limits of role boundaries to patients, staff, and community members.
- Regularly reviews and implements plans to meet professional learning and support needs.
- Supports and mentors' colleagues in managing professional isolation.

**For the Trainee:**

Developing reflective practice skills is emphasized throughout training and the GP lifecycle. This domain assesses your approach to receiving and accepting feedback, your commitment to professional development, and your awareness of the need for self-care, as well as ethical principles and legislation relevant to general practice.

## 7. General Practice Systems and Regulatory Requirements

**Core Idea:** General practitioners use quality and effective practice management processes and systems to optimize safety, effectively lead to address unique community health needs, and work within statutory and regulatory requirements and guidelines.

This competency is about understanding general practice systems. This includes the appropriate use of administration and IT systems, the importance of effective record-keeping, clinical handover, and recall systems. It also requires an understanding of how primary care is organized in Australia, along with the statutory and regulatory requirements and guidelines that are in place. Written communication skills (referral letters, clinical notes), patient consent, and maintaining confidentiality are also incorporated.

**Criteria:**

- Appropriately uses computer/IT systems to improve patient care in the consultation.
- Maintains comprehensive and accurate clinical notes.
- Written communication is clear, unambiguous, and appropriate to the task.
- Demonstrates efficient use of recall systems to optimize health outcomes.
- Accurately completes legal documentation appropriate to the situation.
- Implements best-practice guidelines for infection control measures.
- Manages patient confidentiality appropriately.
- Explains and obtains informed consent.

**Aboriginal and Torres Strait Islander Health Context:**

- Uses specific Medicare and Pharmaceutical Benefits Scheme (PBS) programs to improve health outcomes.
- Appraises the capacity of the primary healthcare model to comprehensively meet the needs of the community.
- Develops strategies to promote a culturally safe practice environment.
- Appropriately uses Medicare programs in the delivery of healthcare for Aboriginal and Torres Strait Islander patients.

**Rural Health Context:**

- Sets up systems to optimize time management for the practice in a rural community with limited resources.

**For the Trainee:**

This domain concerns your understanding of general practice organization and systems. This includes administration and IT systems, and the importance of effective record keeping, clinical handover, and recall systems. It also requires an understanding of how primary care is organized in Australia, and the applicable statutory requirements and guidelines.

## 8. Procedural Skills

**Core Idea:** Appropriate procedures are undertaken after receiving informed consent, considering benefits, evidence, risks, costs, and the individual's sociocultural context.

This competency focuses on performing procedures that are most likely to benefit an individual's health and wellbeing, from both diagnostic and management perspectives. The appropriateness of a procedure is linked to the practice setting, sociocultural context, and availability of specialized services. Recommendations for procedures must weigh potential benefits, the evidence base, risks, and costs, considering relevant sociocultural beliefs. Trainees should demonstrate a range of procedures suitable for general practice, tailored to local community or practice population needs.

**Criteria:**

- Demonstrates a wide range of procedural skills to a high standard and as appropriate to community requirements.
- Refers appropriately when a procedure is outside their level of competence.

Rural Health Context:

- Identifies, cultivates, and maintains skills relevant to the practice and specific to community needs.

**For the Trainee:**

You should be able to demonstrate knowledge and skills in the range of procedures appropriate for general practice. Additionally, you should identify skills that you need to develop, specifically considering the needs of the local community or the practice's population.

## 9. Managing Uncertainty

**Core Idea:** The uncertainty of ongoing undifferentiated conditions is managed effectively.

Ongoing undifferentiated conditions can cause significant anxiety for patients, their families, and the GP. This competency emphasizes a structured, evidence-based approach to minimize health and economic risks. These conditions often involve ambiguity and present management challenges. Clinical decision-making regarding investigations must be rational, balancing the potential risks of over- and under-investigation and management against the benefits for the individual.

**Criteria:**

- Manages the uncertainty of ongoing undifferentiated conditions.
- Addresses problems that present early and/or in an undifferentiated way by integrating all available information to help generate differential diagnoses.
- Recognizes when to act and when to defer doing so, using time as a diagnostic tool.

**For the Trainee:**

Your approach to ongoing undifferentiated conditions needs to be structured and evidence-based to minimize risk from health and economic perspectives. Clinical decision-making around choices of investigations needs to be rational and must balance the risks of over-investigating and under-investigating against the potential benefits for the individual.

## 10. Identifying and managing the patient with significant illness

**Core Idea:** A significantly ill patient is identified and managed appropriately.

A significantly ill patient is an individual at any life stage who is at risk of actual or acute, potentially life-threatening health problems. General practitioners are required to identify significant illness early and manage it in line with accepted guidelines.

**Criteria:**

- Uses specific Medicare and Pharmaceutical Benefits Scheme (PBS) programs to improve health outcomes.
- Appraises the capacity of the primary healthcare model to comprehensively meet the needs of the community.
- Develops strategies to promote a culturally safe practice environment.
- Appropriately uses Medicare programs in the delivery of healthcare for Aboriginal and Torres Strait Islander patients.
- Integrates knowledge of the history of government policies and consequent health impacts into the delivery of care.
- Advocates for and uses policies and initiatives that promote equity in healthcare.

#### **For the Trainee:**

You should develop knowledge and understanding of Aboriginal and Torres Strait Islander health and culture and how this applies to managing health outcomes for these patients and communities. Key areas include:

- Understanding screening tools, preventative health programs, referral methods, and Aboriginal and Torres Strait Islander health information sources.
- Awareness of primary healthcare models used by Aboriginal Community Controlled Health Services to support patients, families, and communities.
- Understanding the role of multidisciplinary teams and appropriate collaboration with Aboriginal and Torres Strait Islander Health Practitioners.
- Familiarity with resources like Closing the Gap, PBS, MBS, Access to Allied Psychological Services program, medical outreach programs, Care Coordination and Supplementary Services (CCSS) program, and community-based programs.
- Focus on the role of social and cultural determinants of health, evidence-based preventive activities, and management of prevalent conditions.

#### **Skills**

- Diagnostic acumen
- Management of complex and chronic conditions
- Effective use of health planning tools (Health Assessments, GPMPs, Closing the Gap)
- Sound clinical decision-making
- Promoting patient self-care strategies
- Cultural competence using frameworks (ASK model, FLASK-Tei)

#### **Attitudes**

- Awareness of personal cultural beliefs, biases, and behaviours
- Openness to cultural learning and immersion
- Valuing holistic health, including family and community wellbeing
- Respect for social, emotional, and cultural dimensions of health, including connection to land and sea.

#### **Behaviours**

- Driving organisational change to support better health outcomes
- Working in partnership with Aboriginal and Torres Strait Islander health professionals and cultural brokers
- Engaging family, community, and cultural supports in care planning
- Patient advocacy
- Building trust and long-term relationships with Aboriginal and Torres Strait Islander patients

# Structured Consultation Framework

# CCE Clinical Encounter Structured Consultation Framework

## 1. Introduction

- \* Introduce yourself and your role.
- \* Confirm the patient's name and date of birth.
- \* Explain the purpose of the consultation.
- \* Obtain consent for the consultation.

## 2. Presenting Complaint

- \* Ask an open-ended question about the reason for the visit.
- \* Allow the patient to describe their main complaint in their own words.
- \* Clarify the main symptom(s) and duration.
- \* Focus on the patient's main reason for seeking care.
- \* Recap key points using the patient's own words; keep it concise.
- \* Adapt the template based on patient presentation and clinical context.
- \* Ask, "Is there anything else I can help you with?" to uncover additional issues.
- \* Identify red flags and risk factors.

## 3. History of Presenting Complaint

- \* Onset and progression of symptoms.
- \* Character/quality of symptoms.
- \* Location and radiation.
- \* Severity (use scale if appropriate).
- \* Timing (constant/intermittent, any pattern).
- \* Exacerbating and relieving factors.
- \* Associated symptoms.
- \* Impact on daily life.
- \* Use frameworks like SOCRATES for pain (Site, Onset, Character, Radiation, Associated symptoms, Timing, Exacerbating/relieving factors, Severity).
- \* Note initial impressions and differential diagnoses. Avoid unnecessary repetition.

## 4. Systemic Enquiry

- \* Ask about other body systems as relevant.
- \* Cover key symptoms for major systems (cardiovascular, respiratory, gastrointestinal, genitourinary, neurological, musculoskeletal).

## 5. Past Medical History

- \* Document significant past illnesses, surgeries, hospitalizations, and chronic conditions.
- \* Highlight conditions relevant to the current complaint. Pay special attention to risk factors for suspected diagnosis.

## 6. Drug History

- \* Focus on medications that could be related to symptoms.
- \* Include current medications (with dose and frequency), over-the-counter medications, allergies, adverse reactions, and recent changes to medication.

## 7. Family History

- \* Explore familial diseases and hereditary conditions relevant to the current issue.
- \* Document age and health status of immediate family members.



In the following sections, each component of the CCE structured history taking framework is described in detail. This framework provides a comprehensive and systematic approach to assessing clinical skills and professional behaviour in a real-world general practice context. By breaking down the key areas—history taking, physical examination, problem definition, investigation planning, management planning, and communication and professionalism. The aim is to provide a clear understanding of what each component entails, why it is important, and how it contributes to overall clinical competence. This detailed exploration will help highlight how these elements work together to ensure high-quality, patient-centred care and safe clinical practice.

# Mastering History Taking in the CCE Clinical Encounter

(From 1. Introduction to 11. Clinical Reasoning)

Effective history taking is the cornerstone of diagnosis and patient management, serving as a critical diagnostic and relationship-building tool. In the time-constrained environment of the RACGP CCE Clinical Encounter, a systematic yet empathetic, patient-centred approach is essential. This chapter meticulously details the elements of a perfect history-taking process, guiding you through the introduction, exploration of the presenting complaint, and a thorough delve into the history of the presenting complaint.

## 1. Setting the Stage: Introduction and Purpose

The opening moments of the consultation are crucial for establishing rapport and trust, ensuring patient safety, and setting a clear agenda. Creating a comfortable and private environment is paramount.

### **Introduce yourself and your role:**

Begin with a clear, warm, and professional greeting, stating your name and your role. Use a reassuring tone and a smile to help put the patient at ease. Maintain appropriate eye contact and open body language (uncrossed arms, facing the patient). Consider sitting down to appear less rushed. *Example: "Good morning, I'm Dr. [Your Name], one of the doctors here today."*

### **Confirm the patient's name and date of birth:**

This is a vital step for patient identification and safety. Always confirm their full name and date of birth to ensure you are speaking with the correct individual. *Example: "Could you please confirm your full name and date of birth for me?"*

### **Explain the purpose of the consultation:**

Briefly outline what the consultation aims to achieve and the importance of the history-taking process. This helps manage patient expectations and focuses the interaction. *Example: "I'm here to understand what's brought you in today so we can work out how best to help you. To do that, I'll need to ask you some questions about your health. Is that okay?"*

### **Obtain consent for the consultation:**

Explicitly ask for the patient's permission to proceed with the consultation. This respects their autonomy and signals a patient-centred approach. Ensure the patient understands that their information will be kept confidential, explaining why certain information might be needed. *Example: "Is it alright if we have a chat about your health concerns now? Everything we discuss will be kept confidential."*

## 2. Uncovering the Core: Presenting Complaint

The presenting complaint is the patient's primary reason for seeking medical attention. It's crucial to allow the patient to articulate this in their own words before guiding the conversation, using clear, simple language, and avoiding medical jargon.

### **Ask an open-ended question about the reason for the visit:**

This encourages the patient to express themselves freely and reveals what they perceive as their most pressing issue. *Example: "What's brought you in to see us today?" or "How can I help you today?"*

### **Allow the patient to describe their main complaint in their own words:**

Resist the urge to interrupt and give the patient your full attention. Listen actively and attentively, using verbal ("I see," "Go on") and non-verbal cues (nodding, leaning in) to encourage them and show you are listening. Allow for silences, as these can give the patient space to gather their thoughts.

### **Clarify the main symptom(s) and duration:**

Once they have finished, gently probe to clarify the core symptom(s) and how long they have been experiencing them. Acknowledge their feelings and concerns ("It sounds like this has been quite worrying for you.") and validate their experience, showing that you believe it is real and important. Avoid dismissing or minimizing what they share. *Example: "So, just to be clear, your main concern is the [symptom], and this has been going on for [duration]? That sounds like it's been tough."*

**Focus on the patient's main reason for seeking care:**

While patients may present with multiple issues, identify and prioritize the primary concern for the purpose of this station.

**Recap key points using the patient's own words; keep it concise:**

Briefly summarise what you've heard to confirm understanding and show you've been listening. Use their exact phrasing where possible. This is also an opportunity to use reflective listening. *Example: "Okay, so you've been experiencing [symptom] for [duration], and it's been bothering you quite a bit. It sounds like you're feeling quite [emotion word patient used or implied]."*

**Adapt the template based on patient presentation and clinical context:**

Be flexible. Not every patient will fit a neat box. Adjust your questions and communication style based on their initial narrative, their needs, cultural background, and health literacy levels. Speak at an appropriate pace and volume.

**Ask, "Is there anything else I can help you with?" to uncover additional issues:**

This provides an opportunity for the patient to raise any other concerns that might not have been immediately apparent. It can also help manage time by revealing if there are multiple, unrelated issues. Empower them to ask questions if they don't understand something.

**Identify red flags and risk factors:**

Even at this early stage, be alert for any immediate "red flags" (sudden severe chest pain, profound shortness of breath) that would necessitate immediate action. Also, note any obvious risk factors mentioned by the patient.

### **3. Delving Deeper: History of Presenting Complaint**

This is where you systematically explore the nuances of the primary symptom, building a detailed clinical picture. Use clear, simple language, avoiding medical jargon, and check for understanding frequently. Strive to build trust gradually, especially if sensitive topics arise, by explaining why certain information is necessary. Pay attention to the patient's non-verbal cues (body language, facial expressions) and match your own facial expressions to the emotional tone of the conversation to demonstrate empathy. Avoid leading or judgmental questions.

**Onset and progression of symptoms:**

- **Onset:** "When did this [symptom] first start?" "Was it sudden or gradual?"
- **Progression:** "Has it been getting better, worse, or staying the same since it started?" "Have there been any changes in how it feels?"

**Character/quality of symptoms:**

Ask the patient to describe the nature of the symptom. Use open-ended questions to allow them to articulate their experience.

- **For pain:** "How would you describe the pain? Is it a sharp pain, a dull ache, a pressure, or something else?"
- **For breathlessness:** "How does the breathlessness feel? Is it like you can't get enough air in, or like you can't breathe out properly?"

**Location and radiation:**

Pinpoint the exact area of the symptom and if it spreads elsewhere.

- **For pain:** "Where exactly is the pain?" "Does it spread anywhere else, for example, to your arm, neck, or jaw?"

**Example:** In a patient with chronic cough:

- “Do you live with anyone who smokes?”
- “What kind of work do you do? Are you exposed to dust or fumes?”
- “How much alcohol do you drink in a week?”

## 9. Patient’s Ideas, Concerns, and Expectations

Understanding the patient's Ideas, Concerns, and Expectations promotes empathy, patient engagement, and shared decision-making.

**Key Practice Tip:** Ask open-ended questions and listen actively. Address fears and manage expectations honestly but sensitively.

**Example:** In a patient worried about a breast lump:

- **Idea:** “What do you think might be causing this?”
- **Concern:** “Is there anything in particular you're worried about?”
- **Expectation:** “What were you hoping we’d do today?”

## 10. Summarize and Check

Summarising shows the patient that you’ve been listening and ensures that nothing important is missed. It also serves as a transition to the next phase of the encounter.

**Key Practice Tip:** Summarize concisely and check for agreement or additions. Keep the patient informed of what’s coming next.

**Example:**

- “So, just to recap—you’ve had a burning chest pain for the past week, after meals, with no shortness of breath or palpitations, and your medical history includes well-controlled hypertension. Is that correct?”
- “Is there anything else I haven’t asked about that you think I should know?”
- “Next, I’d like to examine you to better understand what might be going on. Thank you for sharing all that information.”

## 11. Clinical Reasoning

Good clinical reasoning involves synthesizing all gathered information to form a focused list of differential diagnoses and a working diagnosis.

**Key Practice Tip:** Prioritise based on likelihood, severity, and red flags. Consider common conditions first, but don’t ignore atypical presentations.

**Example:** In a middle-aged smoker with chest discomfort:

- **Differential diagnosis:** GERD (most likely), angina (needs exclusion due to risk factors), musculoskeletal chest pain.
- **Reasoning:** “Given the burning nature of the pain after meals and absence of exertional component, reflux is likely, but your history of smoking and hypertension means we also need to rule out cardiac causes.”

Differential Diagnosis	Supporting Features (from History & Examination)	Refuting Features (from History & Examination)	Likelihood / Priority
Acute Coronary Syndrome	- Central chest discomfort (pressure/tightness) Radiation to left arm/jaw Associated nausea, diaphoresis, dyspnoea Worse with exertion Risk factors: age, male, smoker, hypertension,	- Atypical pain features (purely pleuritic, highly localised, fully relieved by antacids) No significant cardiac risk factors (less	High / Must Not Miss

	diabetes, family history IHD Abnormal ECG findings (if available)	common) Normal ECG (cannot fully rule out ACS)	
Gastroesophageal Reflux Disease (GERD) / Oesophageal Spasm	- Burning retrosternal pain Worse after meals or lying down Relieved by antacids Associated acid taste, dysphagia History of indigestion	- Pain primarily exertional No relationship to food/posture Radiation to arm/jaw less typical (though can occur with spasm) No relief with antacids	Moderate / Consider
Musculoskeletal Chest Pain (Costochondritis)	- Pain localised, sharp, or aching Reproducible with palpation of chest wall/specific movements Recent unusual physical activity or minor trauma	- Systemic symptoms (nausea, diaphoresis) Diffuse pressure not typical Exertional worsening not typical (unless movement-induced)	Moderate / Consider, especially if ACS less likely
Pulmonary Embolism	- Acute onset dyspnoea (may be predominant symptom) Pleuritic chest pain (pain with deep inspiration) Tachycardia, hypoxia (if present) Risk factors: recent surgery, immobility, DVT history, malignancy	- Non-pleuritic pain Gradual onset No specific PE risk factors Normal respiratory exam and oxygen saturation	Low to Moderate / Must Not Miss (if risk factors/suspicious signs)
Pericarditis	- Sharp, retrosternal, or left-sided chest pain. Pain worse lying flat, improved by sitting up and leaning forward Pleuritic component Recent viral illness Pericardial friction rub on auscultation	- Pain primarily dull/pressure-like No postural variation No preceding viral illness No friction rub	Low / Consider
Aortic Dissection	- Sudden onset, severe, tearing/ripping chest pain (often radiates to back) Pulse or blood pressure differentials Neurological deficits History of uncontrolled hypertension, connective tissue disease	- Gradual onset, pressure-like pain Symmetrical pulses and BP No neurological signs No specific risk factors for dissection	Low / Must Not Miss (very severe presentations)
Anxiety / Panic Attack	- Chest tightness/discomfort Associated palpitations, dyspnoea, dizziness, paraesthesia History of anxiety or panic disorder Symptoms occur in context of stress	- Pain consistently related to exertion Significant cardiac risk factors pointing elsewhere Absence of other typical anxiety symptoms	Consider (often a diagnosis of exclusion in acute setting)

# Common Pitfalls and Challenges in History Taking: Combined Framework

Category	Details
<b>Biases in History Taking</b>	<p>Be aware of common biases like anchoring, availability, and premature closure.</p> <p>Focus on understanding the patient's health state holistically.</p> <p>Seek colleague feedback to reduce diagnostic errors.</p>
<b>Ignoring Health Literacy</b>	<p>Ensure patients understand questions.</p> <p>Use colloquial terms when needed.</p> <p>Utilize language services to address language barriers.</p>
<b>Lack of Patient Privacy/Confidentiality</b>	<p>Reassure patients about information privacy.</p> <p>Follow HIPAA and other relevant regulations.</p>
<b>Time Constraints</b>	<p>Use focused history taking techniques for urgent care settings.</p> <p>Prioritize the most relevant information.</p> <p>Develop efficient questioning methods.</p>
<b>Overly Rigid Template</b>	<p>Adapt questioning style to the patient's needs.</p> <p>Allow flexibility to explore emerging concerns.</p>
<b>Incomplete Information Gathering</b>	<p>Use structured templates as guides.</p> <p>Cover all essential components (chief complaint, HPI, PMH, medications, family/social history).</p> <p>Follow up on concerning symptoms or risk factors.</p>
<b>Missing Key Components</b>	<p>Include essential sections like chief complaint, HPI, PMH, medications, and family/social history.</p> <p>Tailor the depth based on clinical presentation.</p>
<b>Failing to Prioritize</b>	<p>Focus on issues most relevant to the chief complaint.</p> <p>Adapt the template for urgent vs. routine care.</p>
<b>Poor Communication/Health Literacy</b>	<p>Ensure patients understand questions and explanations.</p> <p>Use clear, jargon free language.</p> <p>Adapt communication style to patient needs.</p>
<b>Poor Organization</b>	<p>Use a logical structure in documentation.</p> <p>Prepare summary sections for opening and closing discussions.</p>
<b>Overlooking Psychosocial Factors</b>	<p>Include social history, lifestyle factors, and psychiatric history.</p>
<b>Neglecting Patient Perspective</b>	<p>Ask about the patient's ideas, concerns, and expectations.</p> <p>Explore the impact of illness on the patient's life.</p>
<b>Lack of Patient Trust/Rapport</b>	<p>Approach with empathy and authenticity.</p> <p>Explain the purpose of questions.</p> <p>Reassure patients about confidentiality.</p>
<b>Overreliance on Tests vs. History</b>	<p>Recognize the value of history in diagnosis.</p> <p>Use history to guide focused testing.</p>

<b>Category</b>	<b>Details</b>
<b>Insufficient Context</b>	<p>Integrate history with physical exam findings.</p> <p>Consider the full context of the patient's medical history.</p> <p>Understand symptom timelines and progression.</p>
<b>Poor Documentation</b>	<p>Use clear organization and headings.</p> <p>Document pertinent positives and negatives.</p> <p>Avoid transcription errors with paper or electronic forms.</p>
<b>Insufficient Clinical Reasoning</b>	<p>Practice clinical reasoning exercises.</p> <p>Discuss cases in small groups.</p> <p>Relate history elements to differential diagnosis.</p>
<b>Key Principles</b>	<p>Maintain structure but allow flexibility.</p> <p>Focus on patient centred, empathetic communication.</p> <p>Continuously refine skills through practice and feedback.</p> <p>Use technology judiciously to support (not replace) thorough history taking.</p> <p>Recognize history taking as a critical diagnostic and relationship building tool.</p>

# Unravelling the Focused Physical Examination through to Time Management.

(From 12. Focused Physical Examination to 21. Time Management)

Now, we focus on the next set of essential components of the CCE structured clinical framework, beginning with the **Focused Physical Examination** and extending through to **Time Management**. These elements play a critical role in translating clinical reasoning into action, demonstrating diagnostic precision, therapeutic planning, and professional efficiency. A well-executed physical examination not only confirms or refines differential diagnoses but also builds rapport and patient trust. Equally, clear documentation, clinical judgment, safety netting, and structured follow-up are vital to delivering holistic and safe care. Effective time management underpins all aspects of the consultation, ensuring that each step—while thorough—is handled within the constraints of a typical general practice encounter. In the following sections, we will explore each of these components in depth, illustrating how they contribute to the delivery of a complete, competent, and patient-centred clinical consultation.



## 12. Focused Physical Examination

A targeted physical examination is a critical step to gather objective data, helping to confirm or refute differential diagnoses formulated during the history taking. It must be relevant to the patient's presenting complaint and performed efficiently and respectfully.

- Perform an examination relevant to the presenting complaint.
- Explain the examination process and obtain consent.
- Perform systematic and focused examinations as appropriate.
- Demonstrate proper technique and respect for patient dignity.
- Interpret findings accurately.
- Focus on areas most pertinent to the issue, including relevant screening exams.

**Key Practice Tip:** Always explain what you are going to do before you do it, and why it's relevant. Use clear, simple language. Ensure drapes are used appropriately to maintain patient dignity. Verbalise your findings as you go if appropriate or summarise them immediately after.

**Example:** For a patient presenting with right lower quadrant abdominal pain: "Mrs. Jones, based on what you've told me, I'd like to examine your abdomen to get a better idea of what might be causing the pain. This will involve me having a look, listening with my stethoscope, and gently feeling your tummy. I'll also check for any tenderness specifically where it hurts. Is that alright with you? I'll keep you covered as much as possible." (*During the exam*) "I'm just pressing gently here... any tenderness? ...Okay, there's some tenderness in this right lower area, and I notice some guarding. No obvious masses."

## 13. Systems Review (as part of examination)

Integrating a brief systems review during the physical examination ensures that related symptoms or signs in other body systems, which might have been missed or not fully explored in the history, are considered. This should be targeted and efficient.

- Conduct a brief review of other body systems.
- Target questions and assessment to systems related to the presenting complaint.

**Key Practice Tip:** While performing the focused examination, incorporate brief checks of related systems. For example, when examining a patient for a cough, you might also quickly check for peripheral oedema or listen to the heart sounds if the history suggests potential overlap.

**Example:** Patient presents with fatigue. During the cardiovascular examination (checking pulse, BP, listening to heart): "While I'm listening to your heart, have you had any chest pain or breathlessness recently?. And just checking your thyroid gland now as that can sometimes be related to tiredness... any changes in your weight or bowel habits?."

## 14. Assessment & Plan

This is where you synthesize the information from the history and physical examination to refine your differential diagnosis and formulate a coherent and justifiable diagnostic and management plan with the patient.

- Tailor differential diagnosis to the specific presentation.
- Propose diagnostic and treatment plans appropriate for the suspected conditions.

**Key Practice Tip:** Clearly state your leading diagnosis and key differentials. For each, outline your reasoning and the initial steps for investigation or management. Involve the patient in this process.

**Example:** Following history and examination

of a patient with knee pain after a fall: "Mr. Smith, based on our discussion and the examination, my main thought is that you may have sprained the ligaments in your knee, specifically the medial collateral ligament, given the tenderness on the inner side and how the injury occurred. It's also possible there could be a meniscal tear. An X-ray would be helpful to rule out any fracture, though I think that's less likely. So, the plan would be:

1. An X-ray of your knee today.
2. In the meantime, RICE – Rest, Ice, Compression with this bandage, and Elevation.
3. Simple pain relief like paracetamol or ibuprofen.
4. We'll review once we have the X-ray result, tomorrow, and discuss further steps, including whether a referral to a physiotherapist or specialist is needed. How does that sound?"

## 15. Investigations

Choosing appropriate investigations is key to confirming diagnoses, excluding others, and guiding management. Your choices should be evidence-based, cost-effective, and tailored to the individual patient.

- Select appropriate investigations based on clinical presentation.
- Explain the rationale for chosen tests to the patient.
- Interpret results accurately.
- Consider cost-effectiveness and patient factors.

**Key Practice Tip:** Explain clearly to the patient why a test is needed, what it involves, any potential risks or benefits, and when and how they will get the results. Avoid ordering a barrage of tests; be selective and justify each choice.

**Example:** For a patient with persistent fatigue and pallor, suspecting iron deficiency anaemia: "Mrs. Davis, to help understand why you're feeling so tired and looking a bit pale, I think it would be useful to do some blood tests. I'd like to check your full blood count, which tells us about your red blood cells and haemoglobin, and your iron levels, specifically a test called ferritin. This will help us see if you're anaemic and if it might be due to low iron. The blood test involves a simple needle stick in your arm. We should have the results back in a couple of days, and the clinic will contact you. Are you happy to proceed with that?"

## 16. Management

Developing a management plan involves collaborating with the patient to address their health issue, considering pharmacological and non-pharmacological options, lifestyle advice, and necessary follow-up.

- Develop a comprehensive management plan.
- Discuss treatment options, including risks and benefits.
- Provide lifestyle and preventive advice.
- Arrange appropriate follow-up and referrals.

**Key Practice Tip:** Use shared decision-making. Present options clearly, discuss pros and cons, and consider the patient's preferences and circumstances. Always include safety netting advice – what to do if things worsen or don't improve as expected.

**Example:** For a patient newly diagnosed with uncomplicated hypertension: "Mr. Brown, your blood pressure readings are consistently a bit high, which we call hypertension. The good news is there's a lot we can do. We have a few options. We can start with lifestyle changes – like reducing salt in your diet, regular exercise, and monitoring your weight – and see how your blood pressure responds over the next few months. Alternatively, given your readings, we could also consider starting a medication alongside these lifestyle changes, which can be very effective. Medications do have potential side effects, which we can discuss. What are your initial thoughts on these approaches? Regardless, I'd like to see you again in 4 weeks to recheck your blood pressure and discuss how you're going. If you experience any dizziness or other concerns before then, please contact us."

## 17. Communication

Effective communication is the bedrock of the entire clinical encounter, ensuring understanding, trust, and patient engagement. It involves clarity, empathy, and adapting to individual patient needs.

- Use clear, jargon-free language.
- Demonstrate active listening and empathy.

- Adapt communication style to patient needs.
- Provide clear explanations and check patient understanding.

**Key Practice Tip:** Regularly check for patient understanding using techniques like "teach-back" ("Just to make sure I've explained clearly, can you tell me in your own words what the plan is?"). Acknowledge and validate the patient's emotions.

**Example:** Explaining a new diagnosis of asthma to a patient: "So, the tests suggest you have asthma. This means the airways in your lungs can sometimes get a bit narrow and inflamed, which is what causes the wheezing and difficulty breathing you've experienced. We have some very good treatments to manage this. This blue inhaler, Salbutamol, is a 'reliever' – you use it when you feel symptoms. This other one, the brown one, is a 'preventer' that you'll use regularly to reduce the inflammation. It's important to use it even when you feel well. Does that make sense so far? What questions do you have about that?"

## 18. Professionalism

Professionalism encompasses ethical conduct, respect for patients, maintaining confidentiality, recognizing limitations, and upholding the standards of the medical profession.

- Maintain patient confidentiality and privacy.
- Demonstrate ethical decision-making.
- Show respect for patient autonomy and cultural beliefs.
- Recognize own limitations and seek help when needed.

**Key Practice Tip:** Always ensure you are in a private setting for consultations. If faced with a request or situation that challenges your ethical boundaries or knowledge, it's okay to state that you need to consider it further or consult a colleague.

**Example:** A patient asks for a medical certificate for an extended period that you don't feel is clinically justified: "Mr. Jones, I understand you're feeling unwell and need time off work. Based on my assessment today, I can provide a certificate for [clinically appropriate duration]. For a longer period, I would need to reassess you, or if your condition is more complex than initially apparent, it might be something that requires further investigation or input from a specialist before I could certify that. Let's focus on getting you better first. How about we review this in [agreed timeframe]?"

## 19. Health Promotion

Every consultation offers an opportunity for health promotion and preventive care, addressing lifestyle factors and screening relevant to the patient's age, gender, and risk profile.

- Identify opportunities for preventive care.
- Provide evidence-based screening recommendations.
- Offer lifestyle modification advice.
- Discuss vaccination and other preventive measures.

**Key Practice Tip:** Integrate health promotion messages concisely and relevantly. For example, while managing an acute issue, you might briefly touch upon smoking cessation if the patient is a smoker or remind them about due cancer screening.

**Example:** During a consultation with a 52-year-old male for a skin check: "While we're doing your skin check today, which is excellent for early detection, can I also quickly check when you last had your blood pressure and cholesterol checked? Given your age, it's also a good time to ensure you're up to date with bowel cancer screening. We can provide you with a kit today if you're due. Have you had any thoughts about quitting smoking? We have some great resources and support if that's something you're considering."

## 20. Procedural Skills

While the CCE may not involve performing complex procedures, it assesses your knowledge of common GP procedures, your ability to explain them, obtain informed consent, and demonstrate awareness of indications, contraindications, risks, benefits, and safety measures.

- Demonstrate knowledge of common GP procedures.
- Explain procedures clearly, including risks and benefits.
- Obtain informed consent.
- Show awareness of infection control and safety measures.

**Key Practice Tip:** Be prepared to talk through a common procedure as if you were explaining it to a patient or a junior colleague. This includes pre-procedure preparation, the steps involved, aftercare, and potential complications.

**Example:** Explaining a simple wound suturing to a patient: "Mrs. Green, this cut on your arm is a bit deep and would heal better and with less scarring if we put in a few stitches. Before we start, I'd clean the area thoroughly and then numb it with a small injection of local anaesthetic, so you shouldn't feel any pain during the procedure itself, just some initial sting from the injection. Then I'd use a sterile needle and thread to carefully bring the edges of the skin together. The main risks are a small chance of infection, some minor bleeding or bruising, and a scar, which we aim to keep as neat as possible. The stitches would need to stay in for about 7-10 days. Do you have any questions, and are you happy for us to go ahead with that?"

## 21. Time Management

Effectively managing time is crucial in the CCE and in real-life general practice. This involves prioritising issues, being efficient in history taking and examination, and ensuring the consultation flows logically within the allocated timeframe.

- Prioritize issues within the consultation.
- Complete tasks efficiently within the allocated time.
- Demonstrate ability to handle multiple problems in one consultation.

**Key Practice Tip:** If a patient presents with multiple issues, it's important to acknowledge them all and then negotiate an agenda for the current consultation. Verbalise your time management strategy if appropriate.

**Example:** Patient presents with a list of three unrelated problems: "Mr. Davis, thank you for sharing those concerns. We have about 15 minutes for our consultation today. To make sure we address your most pressing issue properly, which of these – the sore throat, the rash on your arm, or the repeat prescription for your blood pressure – is bothering you the most right now, or which one were you most hoping to get sorted today? We can focus on that one thoroughly, and then if we have time, we can touch on the others, or we might need to schedule another appointment to give the other issues the attention they deserve."

## Some Strategies for Time Management and Competency in CCE

Category	Details
	For Case Discussions
Use the 5Minute Reading Time	Quickly review case information. Make brief notes to organize thoughts. Start planning your approach.
Let Examiner Guide Timing	Examiner manages time and directs discussion. Be prepared for interruptions to stay on track.
Communicate Doctor to Doctor	Use medical terminology appropriately. Be concise and focused on responses.
Prioritize Key Issues	Identify the most important clinical reasoning points.

Category	Details
	Address ethical or legal considerations promptly.
	<b>For Clinical Encounters</b>
Set an Agenda Early	Quickly establish patient's main concerns. Ask "Is there something else?" to uncover all issues.
Demonstrate Active Listening	Allow patient to speak uninterrupted initially (about 2 minutes). Use verbal and nonverbal cues to show you are listening.
Prioritize Tasks	Focus on the 25 specific tasks assigned. Manage your time to cover all tasks.
Use Efficient Communication	Ask open-ended questions. Use reflective statements to confirm understanding. Provide clear, concise explanations.
Maintain a Patient Centred Approach	Explain medical terms in plain language. Check patient understanding throughout.
Create a Problem List	Include differential diagnoses. Address each issue systematically.
	<b>For Both Case Types</b>
Practice Time Management	Use mock exams to get comfortable with the 15minute time limit. Develop a mental "clock" to pace yourself.
Be Efficient but Thorough	Focus on communication quality over quantity. Use decision aids or standardized questions as guides.
Summarize Key Points	Recap essential information at the end. Ensure all significant issues are addressed.
Cover Key Competency Areas	Communication and consultation skills. Clinical information gathering and interpretation. Diagnosis, reasoning, and management skills. Preventive and population health considerations. Professional attitudes and behaviours.
Utilize Reading Time Effectively	Review case details and make brief notes. Begin forming a structured plan for the encounter or discussion.
Demonstrate Active Listening	Allow time for patient or examiner input without interruption. Use verbal and nonverbal cues to maintain engagement.
Summarize and Provide Clarity	Briefly summarize key information at the end. Provide written instructions if appropriate.
Manage Time Effectively	Allocate roughly 3 minutes per question or task for 5 key points. Allow extra time for history taking as it forms the basis for management.
	<b>Case Discussions vs. Clinical Encounters</b>
Interaction Style	Case Discussions: Direct interaction with the examiner.

<b>Category</b>	<b>Details</b>
	Clinical Encounters: Interaction with a role-player (observed by an examiner).
Information Delivery	Case Discussions: Most information given during reading time. Clinical Encounters: Some information from reading time, rest obtained via interaction.
Task Format	Case Discussions: Verbal responses to 5 questions over ~3 minutes each. Clinical Encounters: 25 specific tasks to address patient care.
Communication Level	Case Discussions: Doctor to doctor, with medical terminology. Clinical Encounters: Doctor to patient, avoiding jargon.
Time Management	Case Discussions: Examiner manages timing. Clinical Encounters: You manage time and task completion.
Key Similarities	5 minutes reading time and 15 minutes for the case. Both require clinical, communication, and professionalism skills. Mixed format over two exam days, conducted remotely via Zoom.