

****An Essential Companion for FRACGP Exam Success****

Preparing for the challenging CCE RACGP Fellowship examination demands more than solid clinical acumen—it requires strategic preparation and a thorough grasp of the clinical reasoning and communication skills being assessed. The GP Institute: CCE Fellowship Exam Guide stands out as an essential companion for GP registrars navigating this high-stakes clinical exam.

Published by the respected GP Institute of Australia, this guide is purpose-built for Australian General Practice trainees. It breaks down the CCE structure into manageable components, providing practical insights into station formats, examiner expectations, and core competencies. With a strong emphasis on patient-centred care and real-world scenarios, it ensures targeted preparation for success. Updated every 6 months.

"A great read, the FRACGP CCE Exam Guide is your essential study companion for RACGP Fellowship preparation. Focused on clinical reasoning, communication skills, and exam strategies, this guide helps you approach each case scenario with confidence. Ideal for GP registrars and IMGs, it offers practical tips that are easy to apply and structured support to enhance patient-centred care, diagnostic clarity, and performance under pressure."



Prof. Smith

About The Publisher

GP Institute of Australia



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The GP Institute of Australia (GPI) is a premier educational organisation dedicated to supporting general practice trainees and international medical graduates (IMGs) in their pursuit of Fellowship with the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM).

GP INSTITUTE OF AUSTRALIA

FELLOWSHIP EXAM PREPARATION GUIDE

FRACGP

CCE PREVIOUSLY KNOW AS OSCE

First Edition

DR. A G MATT

SYDNEY, AUSTRALIA

FRACGP CCE Exam Preparation Guide Dr A G Matt

GP Institute of Australia

FRACGP Fellowship Exam Guide Clinical Competency Exam Preparation First Edition Dr A G Matt

‘The eyes cannot see what the mind does not know’ – Unknown.

Acknowledgement of Country

We acknowledge the Traditional Custodians of the land on which we work and live, and recognise their continuing connection to land, waters, and culture. We pay our respects to Elders past and present and extend that respect to all Aboriginal and Torres Strait Islander peoples today.

FRACGP Fellowship Exam Guide: CCE Preparation

First Edition

Dr A G Matt, GP Institute of Australia Press
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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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Medicine is an ever-changing science. As new research and clinical experience broaden our knowledge, changes in treatment and drug therapy are required. The authors, editors, contributors, and the publisher of this work have checked with sources believed to be reliable in their efforts to provide information that is complete and in accord with the standards accepted at the time of publication. However, in view of the possibility of human error or changes in medical sciences, neither the authors, editors, contributors, nor the publisher, nor any other party who has been involved in the preparation or publication of this work warrants that the information contained herein is in every respect accurate or complete, and they disclaim all responsibility for any errors or omissions or for the results obtained from use of the information contained in this work.

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This book, *GP Institute of Australia: FRACGP Fellowship Exam Guide: CCE Preparation* is intended as an educational resource to assist General Practice trainees in preparing for the FRACGP CCE. It is not intended to replace individual clinical judgment, substitute for formal medical training or supervision, or guide specific patient care in any circumstances. The content reflects the knowledge and practices current at the time of writing, but standards and practices in medicine change. The views expressed are those of the authors/contributors and do not necessarily reflect the official policy or position of the GP Institute of Australia or any affiliated organisations. Reliance on information provided in this book is solely at the user's own risk.

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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.

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The CCE Core Competencies

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.

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?"

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:

Situation based questioning to aid effective consultation:

Simple open-ended questions to gather information, take a patient's history, based on the clinical case provided: Examples-

- "What brings you in to see me today?"
- "Tell me more about how you have been feeling lately."
- "How long have you been experiencing these symptoms?"
- "Can you describe your pain/discomfort for me?"
- "What concerns you most about these symptoms?"
- "How have these issues been affecting your daily life?"
- "Have you noticed anything that makes your symptoms better or worse?"
- "What have you tried so far to manage this problem?"
- "Are there any other symptoms you have been experiencing?"
- "How has your sleep been lately?"
- "Tell me about your typical day and any changes you've noticed."
- "Is there anything else you think I should know about your health?"

Follow on sentences from above to elicit more specific systemic symptoms from a patient: Examples-

- "Have you noticed any changes in your appetite or weight recently?"
- "How has your energy level been lately?"
- "Are you experiencing any muscle aches or joint pain?"
- "Have you had any headaches? If so, can you describe them?"
- "Have you noticed any changes in your vision or hearing?"
- "Are you having any trouble breathing or shortness of breath?"
- "Have you experienced any nausea, vomiting, or changes in your bowel movements?"
- "Are you having any difficulty urinating or noticing changes in your urine?"
- "Have you noticed any skin changes, rashes, or unusual marks?"
- "Are you experiencing any numbness or tingling sensations anywhere in your body?"
- "Have you been feeling more thirsty than usual?"
- "Have you noticed any changes in your sleep patterns?"

Sentences to elicit family and social history from patients: Examples-

- "Tell me about your living situation. Who do you live with?"
- "What's your occupation? How long have you been working there?"
- "Are you in a relationship? How would you describe it?"
- "Do you have any children? How old are they?"
- "How would you describe your relationship with your family?"
- "Are there any health conditions that run in your family?"
- "Do you smoke or drink alcohol? If so, how much and how often?"
- "Do you use any recreational drugs?"
- "How would you describe your diet and exercise habits?"

- "What do you do to relax or manage stress?"
- "Have you experienced any major life changes or stressors recently?"
- "Do you have a support system you can rely on when needed?"

Sentences to elicit past medical and medication history from patients: Examples-

- "Can you tell me about any medical conditions you've been diagnosed with in the past?"
- "Have you ever been hospitalized? If so, for what?"
- "Have you had any surgeries? When were they and what were they for?"
- "Do you have any chronic health conditions that you're currently managing?"
- "Are you taking any medications regularly? What are they and what are the doses?"
- "Do you take any over-the-counter medications or supplements?"
- "Have you had any allergic reactions to medications in the past?"
- "Are there any medications you've taken in the past that caused side effects?"
- "Have you ever been diagnosed with high blood pressure, diabetes, or high cholesterol?"
- "Do you see any specialists for ongoing health issues?"
- "Have you had any significant illnesses or injuries in the past few years?"
- "Are you up to date on your vaccinations?"

Sentences to elicit more details about presenting complaints from patients: Examples-

- "Can you describe your symptoms in more detail?"
- "When did you first notice these symptoms?"
- "How often do you experience this problem?"
- "On a scale of 1 to 10, how severe would you rate your discomfort?"
- "Does anything make your symptoms better or worse?"
- "Have you noticed any patterns in when the symptoms occur?"
- "Are there any other symptoms that accompany this main issue?"
- "How has this problem affected your daily activities?"
- "Have you experienced anything like this before?"
- "Have you tried any remedies or treatments on your own?"
- "Has there been any change in the symptoms since they first started?"
- "Can you show me exactly where you feel the discomfort?"

Sentences to demonstrate empathy and reassurance to patients: Examples-

- Empathy Statements:
 - "I can see this is really difficult for you."
 - "It must be challenging to deal with these symptoms."
 - "I understand how worried you must be feeling right now."
 - "Your feelings are completely valid."
 - "This sounds like it's been really tough on you."
- Reassurance Statements:
 - "We're going to work together to figure this out."
 - "You've done the right thing by coming to seek help."
 - "I'm here to support you through this."
 - "We'll take this step by step."
 - "Many people experience similar symptoms, and there are effective treatments available."

- Validating Statements:
- "Your concerns are important to me."
- "It's normal to feel anxious about your health."
- "I'm listening carefully to everything you're sharing."
- Compassionate Statements:
- "I can see how much this is affecting your quality of life."
- "Thank you for trusting me with your health concerns."
- "Your health and well-being are my priority."
- Supportive Statements:
- "We'll explore all options to help you feel better."
- "You're not alone in this journey."
- "I'm committed to helping you find the best solution."
- These statements help build rapport, reduce patient anxiety, and create a supportive healthcare environment.

Sentences to explain further investigation and treatment options to patients:

Examples-

- "Based on your symptoms, I'd like to run some additional tests to get a clearer picture."
- "There are a few treatment options we can consider. Let me explain each one and their potential benefits and risks."
- "We might need to do an imaging study, like an X-ray or MRI, to better understand what's going on."
- "One option is to start with medication. Another is to try physical therapy. We can discuss which might be best for your situation."
- "I'd like to refer you to a specialist who can provide more detailed insights about your condition."
- "We could take a 'watch and wait' approach, or we could pursue more active treatment. Let's talk about the pros and cons of each."
- "There's a new treatment available that might be suitable for you. Would you like me to explain how it works?"
- "Before we decide on a treatment plan, we should do some blood tests to rule out certain conditions."
- "I recommend we start with conservative treatment options first and then consider more aggressive approaches if needed."
- "Let's discuss the potential side effects of each treatment option, so you can make an informed decision."
- These sentences help explain the need for further investigation and outline treatment options in a clear, patient-friendly manner.

Sentences to reassure patients and advise on further management and follow-up:

Examples-

- "We have a clear plan to address your concerns, and I'm confident we can work together to improve your health."
- "I'll be here to support you throughout your treatment journey."
- "Let's schedule a follow-up appointment in two weeks to see how you're progressing."
- "If you have any questions or concerns between now and your next visit, please don't hesitate to contact my office."
- "We'll monitor your progress closely and adjust the treatment plan if needed."

- "Remember, healing takes time. Be patient with yourself as we work through this together."
- "I'd like you to keep a symptom diary. This will help us track your progress and make informed decisions."
- "Here's some information about your condition and treatment. Please review it and we can discuss any questions at your next appointment."
- "If you experience any new symptoms or side effects, please call the office right away."
- "We have support services available if you need additional help managing your condition."
- These sentences aim to provide reassurance, establish a follow-up plan, and encourage patient engagement in their care.

Some open-ended questions to ask patients to elicit mental health issues: Examples-

- "How have you been feeling lately?"
- "What brings you here today?"
- "Tell me about what's been on your mind recently."
- "How would you describe your mood over the past few weeks?"
- "What changes have you noticed in your thoughts or behaviours?"
- "How are your relationships with family and friends going?"
- "What's been causing you stress or worry lately?"
- "How has your sleep been? Can you describe your sleep patterns?"
- "What do you find yourself thinking about most often?"
- "How would you describe your energy levels and motivation?"
- "What coping strategies have you been using to manage difficult emotions?"
- These questions encourage patients to open up about their mental health experiences in their own words, allowing for a more comprehensive understanding of their concerns.

Cardiovascular Disorders

Mastering the Cardiovascular Clinical Encounter for the CCE

Introduction

The RACGP CCE is a pivotal assessment for aspiring general practitioners in Australia. Among the various clinical encounter stations, the cardiovascular case presents a unique challenge, demanding not only a robust understanding of cardiology but also exceptional communication and clinical reasoning skills within a time-constrained environment. This chapter serves as a comprehensive guide, designed to equip candidates with a detailed, structured approach to excel in the 10-minute cardiovascular clinical encounter station, focusing on the core assessment domains of clinical reasoning, communication, and patient safety.

1. The Art of First Impressions: Introduction and Agenda Setting

The initial minute of any consultation sets the tone for the entire encounter. In the high-stakes environment of the CCE, a professional and empathetic introduction is paramount, immediately establishing rapport and aligning expectations with the simulated patient.

Patient Greeting and Confirmation:

Begin with a warm and clear greeting, immediately identifying yourself as "Dr [Your Name]". Follow this with a polite request to confirm the patient's full name and date of birth. This not only ensures you are speaking to the correct person but also demonstrates attention to detail and patient safety. *Example:* "Good morning, I'm Dr [Your Name]. Could you please confirm your full name and date of birth for me?"

Rapport Building and Open-Ended Inquiry:

After confirming identity, transition smoothly into understanding the patient's primary concern. An open-ended question is crucial here, allowing the patient to articulate their reason for the visit in their own words. This fosters a patient-centred approach and can provide immediate clues to their main anxieties. *Example:* "Thank you for coming in today. What's brought you to see me?"

Consent and Agenda Alignment:

Once the patient has voiced their concern, clearly and concisely propose the focus of the consultation. It's essential to seek their consent to proceed with a focused assessment, demonstrating respect for patient autonomy and ensuring a shared understanding of the consultation's objectives. This is particularly important when the patient presents with multiple issues, but the station is designed to assess a specific cardiovascular scenario. *Example:* "I understand you're here today because you've been experiencing some chest discomfort. Would it be alright if we focus on that first to understand it better?"

2. Unravelling the Narrative: Focused History Taking

The history is the cornerstone of diagnosis. Within the limited timeframe, a systematic yet efficient approach to history taking is critical. The SOCRATES mnemonic (Site, Onset, Character, Radiation, Associated symptoms, Time course, Exacerbating/relieving factors, Severity) or PQRST (Provoking factors, Quality, Radiation, Severity, Timing) are invaluable frameworks for symptom analysis, particularly for chest pain. A well-taken history not only guides diagnosis but also builds patient confidence.

Symptom Exploration (Chest Pain):

- **Location and Radiation:** Precisely pinpointing the site of pain and any areas it spreads to can offer significant diagnostic clues. Is it central, left-sided, or radiating to the arm, jaw, or back?
 - *Clinical pearl:* Pain radiating to the jaw or left arm significantly increases the likelihood of a cardiac origin.
- **Onset and Duration:** Was the onset sudden or gradual? How long does the discomfort typically last? Is it intermittent or continuous?

- **Character:** How would the patient describe the pain? Is it an aching, crushing, sharp, burning sensation, or a feeling of pressure? The patient's own words are vital here.
- **Associated Symptoms:** Explore a range of associated symptoms that can differentiate cardiovascular conditions from other aetiologies. These include:
 - Dyspnoea Is it present at rest or only on exertion? Does it wake them from sleep (paroxysmal nocturnal dyspnoea) or occur when lying flat (orthopnoea)?
 - Diaphoresis: Often a significant red flag in acute coronary syndromes, particularly if it's a cold sweat.
 - Palpitations: A sensation of a racing, pounding, or irregular heartbeat. Ask about triggers and duration.
 - Nausea/Vomiting: Can accompany myocardial ischemia, especially in inferior myocardial infarctions or in female patients.
 - Syncope/Presyncope: Fainting or near-fainting spells can indicate arrhythmias or severe outflow obstruction.
- **Impact on Daily Activities:** Understanding how the symptom affects the patient's life provides insight into its severity and functional limitations. For instance, does it limit their ability to walk a certain distance, climb stairs, or perform household chores?
 - *Example Question:* "How has this chest discomfort affected what you can do day-to-day?"

Risk Factor Assessment:

A targeted inquiry into cardiovascular risk factors is essential for risk stratification and forms the basis for future management planning.

- **Modifiable Risk Factors:**
 - Smoking History: Current, ex-smoker, pack-years. "Do you smoke, or have you smoked in the past?"
 - Hypertension: Diagnosed, on treatment, last known blood pressure reading. "Have you ever been told you have high blood pressure?"
 - Diabetes Mellitus: Type, duration, control (last HbA1c), complications. "Are you diabetic?"
 - Dyslipidaemia: Diagnosed, on treatment, last cholesterol levels. "Do you have high cholesterol?"
 - Obesity/Physical Inactivity: BMI, exercise habits. "What's your typical exercise routine like?"
- **Non-Modifiable Risk Factors:**
 - Family History: Premature cardiovascular disease in first-degree relatives (males 55 years, females 65 years). "Is there any history of heart problems in your close family, like parents or siblings, especially at a young age?"
 - Age and Gender.
- **Psychosocial Factors:** Explore factors that can influence cardiovascular health and adherence to treatment. These are often overlooked but crucial for holistic care.
 - Occupational Stress: High-pressure jobs, long working hours.
 - Dietary Habits: Inquire about typical intake of high-fat, high-salt, or high-sugar foods.
 - Alcohol Consumption: Quantify in standard drinks per week.
 - Social Support: Living situation, support networks.

Medication Review:

A thorough review of current and recent medications is crucial to identify potential causes, exacerbating factors, or interactions.

- **Cardiovascular Medications:** Anticoagulants (warfarin, DOACs), antihypertensives, antiplatelets, statins, diuretics. Inquire about adherence ("How often do you miss a dose?") and any experienced side effects.

CVS Case Clinical Encounter Example

CANDIDATE INFORMATION

INSTRUCTIONS

You have 15 minutes to complete the tasks for this case. *Note: 5 minutes reading time provided.*

You are working in your GP Clinic. You are seeing Sarah, a 48-year-old woman, for a follow-up appointment to discuss recent routine blood test results.

Perform the following tasks:

1. Take a focused history exploring Sarah's understanding of her blood test results.
2. Interpret the clinical information and discuss evidence-based management options.
3. Collaboratively develop a patient-centred management plan

SCENARIO

Sarah, a 48-year-old woman who feels well, attends your clinic for a follow-up to discuss routine blood tests taken last week. The results show newly diagnosed hyperlipidaemia with a total cholesterol of 6.5 mmol/L and LDL of 4.3 mmol/L. She leads a moderately active lifestyle and believes her diet is balanced. She has no current symptoms and is unfamiliar with taking daily medications. She expresses surprise at the results and is sceptical about needing medication, especially statins, due to concerns about potential side effects she has heard about. She is keen to understand her risk and explore lifestyle options first.

PATIENT SUMMARY

Presenting Complaint: Follow-up of routine blood tests revealing hyperlipidaemia (Total Cholesterol 6.5 mmol/L, LDL 4.3 mmol/L). Asymptomatic. Sceptical about medication, concerned about statin side effects, prefers lifestyle management. **Background:**

- Medical History: No history of cardiovascular disease or Hypertension.
- Lifestyle: Moderately active, considers diet "balanced". Non-smoker. Occasional alcohol.
- Family History: Father had a myocardial infarction at age 60.

PATIENT RECORD SUMMARY

Allergies and adverse reactions None Known

Medications None regular. Does not take supplements regularly.

Past Medical History

Healthy. No diagnosed hypertension, diabetes, or previous cardiovascular disease. Menopausal status: Pre-menopausal, regular cycles. Last health check >2 years ago. This was a routine screening blood test.

Social history

Occupation: Office Administrator – mostly sedentary desk work. Reports moderate work stress.

Family/Living: Married, 2 teenage children. Supportive family. Smoking: Lifelong non-smoker. Alcohol:

Drinks 1-2 glasses of wine 2-3 nights per week (approx. 4-6 standard drinks/week). Diet: Considers her diet

"pretty balanced." Reports eating fruit and vegetables daily, lean protein. However, on further questioning,

admits to frequent convenience meals during busy work weeks, enjoys cheese, and has a "sweet tooth" for

biscuits/chocolates in the evening. Portion sizes may be large. Unsure about specific types of fats or fibre

content. Exercise: "Moderately active" – describes this as walking the dog for 20-30 minutes 3-4 times a week,

and occasional weekend gardening. Does not do structured vigorous exercise. Stress: Manages moderate work

and family stress, no specific coping strategies other than "a glass of wine to unwind."

Family History

Father: Myocardial Infarction at age 60. Was a smoker, had high cholesterol.

Mother: Has well-controlled hypertension.

Red Flags

1. Symptoms or Signs of Existing Cardiovascular Disease:
 - Chest pain/angina (exertional or at rest).
 - Shortness of breath on exertion, orthopnoea, PND (suggestive of heart failure).
 - Palpitations suggestive of arrhythmia.
 - Symptoms of peripheral vascular disease (claudication).
 - Symptoms of previous stroke/TIA.
2. Physical Signs of Severe Hyperlipidaemia / Familial Hypercholesterolaemia (FH):
 - Tendon Xanthomas (especially Achilles, extensor tendons of hands).
 - Xanthelasma (cholesterol deposits around eyelids).
 - Corneal Arcus (especially if present <45 years old).
 - (These are often absent even with high cholesterol).
3. Symptoms Suggestive of Secondary Causes of Dyslipidaemia:
 - Symptoms of Hypothyroidism (fatigue, weight gain, constipation, cold intolerance) – *TFTs normal here.*
 - Symptoms of Nephrotic Syndrome (significant oedema, frothy urine) – *UEC/urinalysis normal here.*
 - Symptoms of Cholestatic Liver Disease (jaundice, pruritus) – *LFTs normal here.*
 - Symptoms of Poorly Controlled Diabetes (polyuria, polydipsia, weight loss) – *Glucose/HbA1c normal here.*
4. Extremely High Lipid Levels: Total Cholesterol >7.5-8 mmol/L or LDL >5-6 mmol/L (increases suspicion of FH). Triglycerides >10 mmol/L (risk of pancreatitis). *(Sarah's levels are high but not typically in the extreme FH range without other features).*
5. Strong Family History of Very Premature Cardiovascular Disease or Very High Cholesterol: MI in first-degree relative <50 (male) or <60 (female) or known FH in family. *(Father MI at 60 is significant).*

Differential Diagnoses (For the Cause of Hyperlipidaemia):

1. Polygenic Hypercholesterolaemia: *Most common cause.* Multiple genes interacting with lifestyle factors (diet, lack of exercise) leading to elevated cholesterol. Often a family history of hyperlipidaemia or CVD.
2. Familial Hypercholesterolaemia (FH): Autosomal dominant genetic disorder causing very high LDL cholesterol from birth and significantly increased risk of premature CVD. Suspect if LDL is very high (>5 mmol/L in adult, or >4 mmol/L in child) +/- tendon xanthomas +/- strong FHx of premature CAD or FH. (Sarah's LDL 4.3 makes FH a consideration, especially with FHx of premature MI in father, but needs further assessment/criteria like Dutch Lipid Clinic Network Score).
3. Lifestyle-Related Dyslipidaemia: Primarily due to diet high in saturated/trans fats, low fibre, lack of physical activity, overweight/obesity. *Significant contributor here.*
4. Secondary Dyslipidaemia (Rule out with history/bloods - excluded here by normal results):
 - Hypothyroidism.
 - Poorly controlled Diabetes Mellitus.
 - Nephrotic Syndrome.
 - Cholestatic Liver Disease.
 - Medications: some diuretics (thiazides can slightly raise lipids), corticosteroids, beta-blockers, immunosuppressants, protease inhibitors.
 - Excessive Alcohol Consumption (raises triglycerides, can affect other lipids). *(Sarah's use moderate).*
 - Obesity.

CVS Case Discussion Example

CANDIDATE INFORMATION

PATIENT RECORD SUMMARY

Name: David CHEN

Age: 51 years

Gender: Male

Gender assigned at birth: Male.

Indigenous status: Not stated.

Allergies and adverse reactions: Nil known.

Medications: Nil regular prescription or over-the-counter medications.

Past Medical History:

- Well until recently.
- Reports occasional episodes of feeling lightheaded/faint during strenuous exercise over the past 6 months, previously attributed by him to "overdoing it".
- No diagnosed hypertension but admits BP readings have been "a bit high" occasionally when checked opportunistically.
- No known history of heart disease, diabetes, or other significant medical conditions.

Social history:

- **Occupation:** Office Manager
- **Lives:** With his wife and two teenage children.
- **Exercise:** Describes a sedentary lifestyle but started attending the gym 2-3 times per week about 8 months ago. Typically uses treadmill, cross-trainer, and some resistance machines.
- **Diet:** Describes a diet high in processed foods and fats, eats takeaway several times a week.
- **Smoking:** Non-smoker.
- **Alcohol:** Moderate consumption - drinks 2-3 standard drinks (beer or wine) 3-4 nights per week.
- **Other Substances:** Occasional caffeine use (1-2 coffees per day). Denies illicit drug use.

Family history:

- No known family history of sudden unexplained death (especially at young age), cardiomyopathy, or significant valvular heart disease.
- Father had hypertension, died of stroke age 75. Mother alive with osteoarthritis.

Vaccination and preventive activities:

- Up to date with routine vaccinations, including influenza and COVID-19.
- Has not had recent health checks or cardiovascular risk assessment.

SCENARIO You are working in your general practice clinic. David CHEN, a 51-year-old office manager whom you haven't seen for several years, presents today after an episode yesterday where he fainted while exercising at the gym. He reports he was on the cross-trainer, about 15 minutes into his workout yesterday afternoon, when he started feeling lightheaded and dizzy, like previous episodes during intense exercise over the last few months. This time, the feeling progressed rapidly, and he lost consciousness, collapsing. Gym staff reported he was unconscious for 15-20 seconds. He had no warning beyond the brief preceding lightheadedness. He did not injure himself significantly. There was no tongue biting or incontinence reported by witnesses. He felt confused for a few minutes upon waking but recovered fully within about 10-15 minutes and went home. He admits to 3-4 similar episodes of marked lightheadedness ("feeling like I might pass out") in the past 6 months, always during strenuous activity. He denies chest pain, palpitations, or significant shortness of breath during these pre-syncopal episodes or the syncope itself. He has no episodes at rest or with postural change. He is now very concerned.

- Anomalous Coronary Artery Origin: Rare cause of exertional syncope/sudden death.
- Pulmonary Hypertension (severe): Can cause exertional syncope but usually presents with right ventricular hypertrophy and different clinical signs.
- Non-cardiac causes are highly unlikely given the clear exertional trigger in a 51-year-old and the distinct cardiac examination and ECG findings. Vasovagal syncope is typically post-exertional or related to specific triggers, not during peak exertion. Orthostatic hypotension is related to postural change.

RACGP Competency Marking Sheet: Exertional Syncope with Cardiac Signs

Questions for You to Consider	Assessment Area and Competency Domains
How do you elicit a detailed history of David's syncopal and pre-syncopal episodes, specifically focusing on the relationship to exertion, associated symptoms (or lack thereof like chest pain), witness accounts, and recovery, to identify this as high-risk syncope?	1. Communication and consultation skills 1, 2, 5
What specific findings on cardiovascular examination (character of apex beat, quality/radiation of murmur) and ECG (LVH voltage criteria, 'strain' pattern) are critical to identify, and how do these guide your differential diagnosis towards serious structural heart disease like Aortic Stenosis or HOCM?	2. Clinical information gathering and interpretation 2
How do you interpret the absence of a significant family history of sudden death or known cardiomyopathy in David's case – does this lower your suspicion for conditions like HOCM, or are acquired conditions like Aortic Stenosis still high on the list?	2. Clinical information gathering and interpretation 2
Based on the high suspicion of Aortic Stenosis or HOCM causing exertional syncope, why is an urgent Echocardiogram the single most important next investigation, and what specific information will it provide to confirm/differentiate these diagnoses?	3. Making a diagnosis, decision making, and reasoning 2
What is your immediate and most critical management step regarding David's physical activity? How do you communicate the absolute necessity of ceasing all strenuous exercise due to the risk of sudden cardiac death, and how do you ensure he understands this?	4. Clinical management and therapeutic reasoning 2
What other lifestyle advice (avoiding dehydration, excessive caffeine, heavy lifting) and safety netting (symptoms requiring immediate ED visit, driving restrictions as per Austroads for high-risk cardiac syncope) must be given to David today?	5. Preventive and population health 1, 2, 3
How do you explain your serious concerns and the need for urgent cardiology referral and Echocardiogram to David in clear, simple terms, conveying the potential gravity without causing excessive alarm, and ensuring he feels supported?	6. Professionalism 4
How would you document this high-risk presentation, your examination findings, ECG interpretation, differential diagnoses, management plan (including urgent referrals and strict activity/driving advice), and safety netting in David's medical record?	7. General practice systems and regulatory requirements 5
N/A (Procedural skills are limited to ECG performance/interpretation and examination in this GP scenario)	8. Procedural skills 2