

Annual Trainee Meeting 2026

Exhibit-Based Assessment (EBA)

Practice Stations

4 Stations • 20 minutes each • Multiple exhibits per station

CANDIDATE INSTRUCTIONS

Each station presents a clinical scenario with exhibits including photographs, investigation results, occupational hygiene data, and workplace images. You will be asked a series of questions by the examiner. Answers should demonstrate integration of clinical medicine, occupational hygiene, legislation, and rehabilitation principles relevant to Australian practice.

Marks are allocated for accuracy, structure, and the ability to synthesise clinical and workplace information. Curriculum domains assessed include: Clinical Practice (10), Occupational Hygiene and Toxicology (20), Hazard and Risk Management (50), Health Surveillance (60), Legislation and Ethical Practice (80), and Rehabilitation and Disability Management (90).

EBA STATION 1

Heat Stress Management — Open-Cut Mine

Time allowed: 20 minutes

SCENARIO

You are the occupational physician for a large open-cut mining operation in Northern Queensland, Australia. It is mid-summer. Over the past month, there have been three incidents of heat-related illness requiring medical evacuation, including one case of exertional heat stroke. The site has recently purchased a new occupational hygiene monitoring device. Supervisors have been instructed to “monitor heat,” but there is inconsistency in how readings are used operationally.

You have been asked to review the site’s heat stress management program and provide recommendations to senior management. You are in a meeting with the Health and Safety Manager.

EXHIBIT 1 — Occupational Hygiene Instrument



Device available at the mine site

Question 1

- Identify this device and explain the physiological rationale for using Wet Bulb Globe Temperature (WBGT) rather than ambient temperature alone in occupational heat stress assessment.
- Describe the components of WBGT measurement and explain what each parameter represents in relation to human thermoregulation.

EXHIBIT 2 — Environmental Monitoring Data

WBGT reading at 1400 hrs in the pit: 31.5°C

Workers performing heavy manual tasks (estimated metabolic rate 400–500 W). (High heat risk)

Most workers are heat-acclimatised. Several new workers commenced within the last 7 days and have not completed an acclimatisation program.

Question 2

a) Referring to the WBGT value and metabolic rate data, outline the immediate risk controls you would recommend.

b) How would your recommendations differ for acclimatised versus unacclimatised workers? Reference the relevant WBGT action limit values.

Question 3

A supervisor states: “We’ve worked in this heat for 20 years. The men just need to toughen up.” How would you respond to this statement, addressing both the organisational risk management and medico-legal implications?

Question 4

The current heat policy relies solely on WBGT thresholds with no consideration given to PPE correction factors, individual risk factors, or task variability. Critically appraise this approach and outline how you would design a comprehensive heat stress management program for this site.

Question 5

Despite existing policies, workers frequently underreport heat symptoms and resist rest breaks due to production pressure and peer culture. You have been asked to lead organisational change to improve heat safety culture. Outline your change management strategy

EBA STATION 2

Occupational Lung Disease — Metal Fabrication and Welding

Time allowed: 20 minutes

SCENARIO

You are the occupational physician reviewing a 52-year-old male worker employed for 25 years as a boilermaker in a local small boiler making business. He presents with progressive exertional dyspnoea and chronic productive cough over three years. He is still working full-time. He reports symptoms are “worse at the end of the week.” He has a 15 pack-year smoking history but quit five years ago.

EXHIBIT 1 — Spirometry Report

Demographics: Male, 52 years, Height 188.3 cm, Weight 101 kg, BMI 28.5, Ex-smoker (15 pack-years, quit 5 years), Caucasian

Pre-Bronchodilator

Parameter	Best	LLN	Z-Score	%Pred	Pred	Trial 3	Trial 1
FVC (L)	5.79	5.04	-0.63	93	6.26	5.79	5.65
FEV1 (L)	3.39	4.07	-2.73	67	5.04	3.38	3.22
FEV1/FVC (%)	58.6	71.1	-3.54	71	72	58.6	57
FEF25-75 (L/s)	1.63	3.13	-2.94	32	3.13	1.63	1.52

Post-Bronchodilator

Parameter	Best	Z-Score	%Pred	Change	%Change	Trial 4	Trial 2
FVC (L)	5.80	-0.62	93	0.01	0%	5.80	5.64
FEV1 (L)	3.77	-2.12	74	0.38	7%	3.77	3.66
FEV1/FVC (%)	65	-2.57	79	6.4	6%	65	63
FEF25-75 (L/s)	2.22	-2.43	44	0.59	36%	2.22	2.05

Question 1

- a) Describe and interpret the spirometry findings.
- b) What is the most likely diagnosis, and what criteria support it?

Question 2

How would you identify occupational and non-occupational contributors to his condition? Outline the approach to assessing whether work has materially contributed to his COPD.

EXHIBIT 2 — Workplace Visit

You attend the metal fabrication and welding workshop for a site inspection.





Question 3

What hazards relevant to his respiratory disease might you identify during a workplace inspection of a welding and metal fabrication workshop?

Question 4

The worker wishes to continue working in the same role. Outline your approach to assessing fitness for duty, including the key clinical, functional, and workplace factors you would consider.

Question 5

What control measures, structured according to the hierarchy of controls, would you recommend to reduce the risk of further lung injury in this workplace?

Question 6

You have formed the view that this worker's condition has likely occupational contribution from long-term welding fume exposure. What advice would you provide to senior management regarding organisational responsibilities, risk management, and prevention of further cases?