ATM 2026 - Melbourne

CLINICAL STATION

Station	Upper Limb Clinical Examination
Reading Time	2 minutes
Station Time	Up to 10 minutes for examination; then describe/demonstrate findings and answer examiner questions

CANDIDATE INSTRUCTIONS

Read the clinical scenario below. You will have 2 minutes reading time before entering the station.

During the station, you are required to:

- Physically examine the patient (up to 10 minutes)
- Describe and demonstrate the clinical findings (positive and negative)
- Interpret and answer questions about your findings
- Comment on appropriate diagnostic tests
- Nominate appropriate further investigations where necessary

Where appropriate, you may re-position the patient to examine them. The patient may have varying acuteness of clinical signs. Where signs are not present, you should verbalise the absence of expected findings based on the information in the clinical scenario.

CLINICAL SCENARIO

You are an occupational physician conducting an assessment of a doctor employed by a Medical Practice because of concern by the employer that their computer work might be the cause of their wrist pain. The referral information is as follows:

Worker	Dr Paul Simpson
Date of Birth	01 March 1956 (Age 70)
Occupation	Medical Practitioner (40 years)
Employer	XYZ Medical
Mechanism	Gradual onset of left radial wrist pain
Symptoms	Gradual onset of pain over 6-9 months along radial border of hand and distal forearm; aching with sharp pain on thumb movement; aggravated by weekend activities (repetitive twisting of heavy gauge fencing wire to ‘tie off’ wires at ‘end assemblies’; gripping tools with left hand), Relieved by avoidance of above activities. Some aggravation of symptoms whilst using a computer in the course of work.
Relevant History	History of surgery for Dupuytren’s contracture to correct flexion deformity of left little finger about 12 months ago; Neuropathic right arm pain & sensory disturbance in C6 distribution in 2011

Please examine this patient’s cervical spine and upper limbs.

EXAMINER GUIDE

(Not to be shown to the candidate)

PHYSICAL EXAMINATION (up to 10 minutes)

A. Approach

Expected Candidate Behaviour	Achieved?
Introduces self, confirms patient identity, explains purpose of examination	□ Yes □ No
Obtains verbal consent; explains IME context (no treating relationship)	□ Yes □ No
Checks pain level and asks whether the patient can safely proceed	□ Yes □ No
Hand hygiene; adequate exposure of upper limbs and torso while maintaining dignity	□ Yes □ No
Professional, empathetic, and systematic approach throughout	□ Yes □ No

B. General observation

Expected Candidate Behaviour	Achieved?
Observes neck and spinal posture	□ Yes □ No
Notes hand scarring from previous Dupuytrens surgery and early Dupuytrens affecting right hand	□ Yes □ No
Expected finding: • *Mild head forward posture.* • *Cervical range consistent with age* • *No significant restriction of upper limb movement to casual observation*	Verbalised? □ Yes □ No

C. Upper limb inspection & palpation

Expected Candidate Behaviour	Achieved?
Inspection of painful area ? localised swelling; asymmetry; muscle wasting	□ Yes □ No
Palpation of painful area for tenderness, tendon crepitus	□ Yes □ No
Excludes pain on palpation in proximal areas e.g. lateral epicondyle / brachioradialis; supraclavicular tenderness (pectoral or scalene)	□ Yes □ No
Expected finding: • *Mild swelling over left CMC region; asymmetry compared to right; localised tenderness over radial styloid and tendon sheath*	Verbalised? □ Yes □ No

D. Cervical & Upper Limb range of movement

Expected Candidate Behaviour	Achieved?
Assesses passive & active ROM of cervical spine, bilateral shoulders, elbows, wrists and digits	□ Yes □ No
Specifically tests ulnar wrist deviation; resisted thumb extension & abduction communicates with patient about movements that are painful	□ Yes □ No
Performs Finkelstein's Test	□ Yes □ No
Compares active range with functional observation; asks about symptoms from area of Dupuytren's surgery	□ Yes □ No
Expected finding: • *Normal for age ROM of all joints.* • *Mildly positive Finkelstein's test and pain on active thumb opposition and resisted extension abduction* • *No inconsistency between formal and informal movement.*	Verbalised? □ Yes □ No

E. Upper limb neurological examination

Expected Candidate Behaviour	Achieved?
Tests grip strength and power in key upper limb myotomes bilaterally	□ Yes □ No
Assesses upper limb tone	□ Yes □ No
Assesses for sensory loss in hand	□ Yes □ No
Expected finding: • *Normal tone* • *Mild weakness of left hand grip strength reproducing lateral wrist pain* • *Possible reduction in muscle bulk of left thenar eminence* • *Minor partial sensory loss in area of previous surgery*	Verbalised? □ Yes □ No

F. Reflexes

Expected Candidate Behaviour	Achieved?
Tests biceps, supinator / brachioradialis & triceps reflexes	□ Yes □ No
Expected finding: intact reflexes	□ Yes □ No

DESCRIBE AND DEMONSTRATE CLINICAL FINDINGS

After the physical examination, ask the candidate:

Q1: "Please describe and demonstrate your clinical findings."

Expected Response	Achieved?
Presents a coherent, structured summary of positive AND negative findings	□ Yes □ No
States clinical diagnoses: probable mild DQT – Healed Dupuytrens surgery on left; early Dupuytrens on right	□ Yes □ No
Demonstrates key positive findings such as findings observed in relation to left thumb movements	□ Yes □ No
States absence of evidence to suggest Dupuytrens is relevant and normal proximal findings	□ Yes □ No

Q2: "What investigations would you recommend?"

Expected Response	Achieved?
• Imaging: Xray to assess CMC joints, US to assess tendon pathology • Workplace & Recreational activity assessment	□ Yes □ No

Q3: "Please comment on the Xray & US results provided." (see below)

Expected Response	Achieved?
• Identifies that investigations are most consistent with symptomatic left DQT • Xrays show early CMC arthritis, but not consistent with symptoms • US suggests mild DQT	□ Yes □ No

Q4: "What is your opinion on occupational causation in this case?"

Expected Response	Achieved?
• Identifies occupational risk factors for DQT: forceful, repetitive thumb movements • Demonstrates awareness of non-occupational risk factors including age, gender, anatomical variants, inflammatory disease etc • Awareness of controversy about the role of low demand occupational exposures to causation e.g gripping computer mouse • Distinguishes causation, aggravation, acceleration or exacerbation • Concludes that recreational activities are the likely "substantial contributing factor" and not computer employment in this case	□ Yes □ No

Q5: "What are your recommendations regarding work capacity and management"

Expected Response	Achieved?
Work capacity:	□ Yes □ No

Currently fit for substantive office-based role without restriction, but needs to restrict or avoid the relevant recreational activity	
Treatment recommendations: • Avoid or modify causative activity • NSAIDs if tolerated • Consider topical compounded anti-inflammatory cream e.g ketoprofen • Sports Physician/ Hand surgeon Referral if fails to settle	□ Yes □ No
Prognosis: • Generally good prognosis with conservative treatment	□ Yes □ No

Q6: "What other advice might you provide to the employer?"

Expected Response	Achieved?
• General advice about the importance of workstation ergonomics, pause breaks and other measures to reduce any risk of aggravation from sedentary based office work • Reinforce the importance of early intervention where employees report work-related or work-aggravated symptoms	□ Yes □ No

GLOBAL RATING SCALE

Rating	Descriptor

Clear Pass	Systematic, confident examination covering inspection, palpation, ROM, provocative tests, and neurological assessment. Correctly performs and interprets all key tests. Demonstrates appropriate screening for differential diagnoses. Presents findings clearly with sound interpretation of NCS results, discussion of occupational causation, and appropriate recommendations for management and work capacity.
Borderline	Adequate examination technique but may miss one key component (e.g., omits Durkan's test, fails to screen cervical spine, or does not test palmar cutaneous branch). Partially addresses occupational causation or NCS interpretation. Presentation lacks structure or confidence. Recommendations are incomplete.
Clear Fail	Disorganised or incomplete examination. Misses multiple key provocative tests. Fails to assess motor or sensory function of the median nerve. Unable to interpret NCS results or discuss occupational causation meaningfully. Unsafe technique or poor patient rapport.

EXAMINER NOTES

- Key discriminator: candidates who pass will perform a systematic lumbar spine and lower limb neurological examination and identify a clinically coherent right L5 radiculopathy.
- Strong candidates will correlate the L4/L5 disc protrusion with L5 clinical findings and avoid relying on imaging alone.
- Where signs are not present on the simulated patient, the candidate should verbalise what they would expect to find based on the clinical scenario.
- Strong candidates will discuss occupational causation in a balanced way, recognising both occupational aggravation and non-occupational contributors.
- Strong candidates will provide realistic suitable duties, not simply declare the worker unfit.
- Work capacity should focus on function: sitting tolerance, pedal control, safe cab access, walking, bending, twisting, lifting, manual pallet handling and ability to respond safely in the warehouse.
- Candidates should avoid excessive straight leg raise provocation or repeated painful testing.
- A safe answer must include escalation if there is progressive weakness, bowel or bladder dysfunction, saddle anaesthesia, fever, malignancy red flags or severe unremitting pain.