Obstetrician and Gynaecologist interview questions

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What to expect

Interviews for Obstetrician and Gynaecologist roles in Australia typically assess clinical competence, communication skills, and ability to work under pressure. Expect a mix of clinical scenario questions, behavioural questions, and discussions about your approach to patient care and teamwork.

- **Clinical scenario:** Questions that present a patient case and ask you to describe your assessment, diagnosis, and management plan.
- **Behavioural:** Questions about past experiences, using the STAR method to explore how you handled specific situations.
- **Technical and surgical:** Questions about your surgical skills, instrumentation, and management of intraoperative complications.
- **Safety and quality:** Questions about infection control, clinical governance, and how you maintain patient safety.
- **Communication and counselling:** Questions about how you discuss sensitive topics, obtain informed consent, and support patients and families.

The interview process often begins with a panel interview including the head of department, a senior consultant, and a human resources representative. You may be asked to complete a clinical skills assessment or a written case scenario. The interview typically lasts 45 to 60 minutes, covering your training, experience, and approach to patient care, followed by an opportunity for you to ask questions.

1. You are called to the delivery suite for a woman in labour with a non-reassuring CTG. How do you manage this situation?

Why they ask

This assesses your ability to recognise fetal distress, prioritise actions, and apply obstetric emergency protocols.

How to structure your answer

Use a structured approach: assess the CTG, consider maternal and fetal factors, initiate intrauterine resuscitation, and escalate as needed. Then explain your decision-making for delivery.

Example answer

“I would first review the CTG to confirm the non-reassuring pattern, noting any decelerations. I would assess maternal vital signs, check for cord prolapse or placental abruption, and position the woman on her left side. I would administer oxygen and IV fluids, and stop any oxytocin. If the CTG does not improve, I would prepare for an expedited delivery, either instrumental or caesarean, depending on the clinical situation. I would communicate clearly with the team and document everything.”

2. Tell me about a time you had to communicate difficult news to a patient or their family.

Why they ask

This explores your empathy, communication skills, and ability to handle sensitive conversations.

How to structure your answer

Use the STAR method: describe the Situation, Task, Action, and Result. Highlight your communication approach and the outcome.

Example answer

“I once had to inform a couple that their baby had a severe congenital anomaly detected on ultrasound. I ensured we were in a private room, sat down, and used clear, compassionate language. I gave them time to process and asked if they had questions. I arranged for a follow-up with a genetic counsellor and provided written information. The couple later thanked me for the support, and I learned the importance of pacing and checking understanding.”

3. How do you manage a difficult laparoscopic entry in a patient with previous abdominal surgery?

Why they ask

This tests your surgical judgement, knowledge of anatomy, and ability to adapt to intraoperative challenges.

How to structure your answer

Explain your approach step by step: preoperative assessment, alternative entry techniques, and when to convert to open surgery.

Example answer

“I would review the previous surgical history and imaging. I prefer an open Hassan entry or a left upper quadrant entry in patients with prior midline incisions. I would use a Veress needle only if I am confident there are no adhesions. If I encounter difficulty, I would not hesitate to convert to laparotomy to ensure patient safety. I always inform the patient of this possibility during consent.”

4. What steps do you take to prevent surgical site infections in your gynaecological surgeries?

Why they ask

This assesses your commitment to infection control and adherence to best practice guidelines.

How to structure your answer

Outline a systematic approach: preoperative measures, intraoperative precautions, and postoperative care.

Example answer

“Preoperatively, I ensure appropriate antibiotic prophylaxis is given within 60 minutes of incision. I screen for MRSA if indicated. Intraoperatively, I use sterile technique, minimise traffic in the theatre, and maintain normothermia. Postoperatively, I monitor the wound and educate the patient on signs of infection. I also audit my infection rates regularly as part of clinical governance.”

5. How would you counsel a patient requesting an elective caesarean section for non-medical reasons?

Why they ask

This explores your ability to provide balanced information, respect patient autonomy, and manage expectations.

How to structure your answer

Use a patient-centred approach: explore reasons, discuss risks and benefits, and support informed decision-making.

Example answer

“I would start by asking about her reasons and concerns. I would then explain the risks of caesarean section for both mother and baby, and the benefits of vaginal birth. I would discuss that while elective caesarean is an option, it is not without risks. I would offer additional support, such as a midwife or psychologist, and document the discussion. Ultimately, I respect her choice but ensure she has all the information.”

6. Give an example of how you have led a multidisciplinary team in an emergency situation.

Why they ask

This assesses your leadership, communication, and ability to coordinate care under pressure.

How to structure your answer

Use STAR: describe the emergency, your role, actions, and outcome. Highlight teamwork and clear communication.

Example answer

“During a postpartum haemorrhage, I took charge of the team, assigning roles clearly: one nurse to administer uterotonics, another to monitor vitals, and the registrar to prepare for possible surgery. I communicated with the anaesthetist and haematologist. We stabilised the patient and avoided the need for hysterectomy. Afterward, we debriefed to improve our response.”