Oral Pathologist interview questions

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What to expect

Oral pathology interviews in Australia are usually run by a hospital department, a diagnostic laboratory or a university, and they test diagnostic reasoning as much as they test your CV. Expect the panel to want evidence that you can reach a defensible diagnosis, communicate it clearly to clinicians, and supervise trainees without losing sight of quality and accreditation obligations.

- **Technical and diagnostic knowledge:** Questions on histological interpretation, immunohistochemistry selection, molecular testing and specimen handling, often built around a real or de-identified case.
- **Case-based reasoning:** A described specimen or clinical scenario where the panel listens for how you narrow a differential and where you would stop and seek a second opinion.
- **Behavioural:** Questions about communicating a difficult diagnosis, managing a disagreement with a treating clinician, or handling a heavy reporting load.
- **Scenario and judgement:** Pressure-testing questions such as a discordant frozen section result, an urgent case arriving late in the day, or a clinician pushing for a faster report.
- **Teaching and supervision:** Questions about supervising dental registrars and pathology trainees, giving feedback, and signing out cases they have reported.
- **Quality, safety and accreditation:** Questions on specimen labelling, incident reporting, external quality assurance and working to ISO 15189 and NATA requirements.

Most interviews run 45 to 60 minutes with a panel of two or three people: a senior oral pathologist or head of department, a clinical colleague such as an oral and maxillofacial surgeon or oncologist, and often a representative from human resources. You will usually be asked to talk through your training and specialist registration first, then move into case-based and technical questions, followed by behavioural and supervision questions. Some departments include a short slide or case review, a brief presentation on a topic of your choice, or a walk through the laboratory before the panel sits down. Bring your AHPRA registration details and Fellowship information, because they will almost certainly be checked or discussed.

1. Walk us through how you handle a specimen from the moment it arrives in the laboratory to the point a signed report goes out.

Why they ask

This is the core process question. The panel wants to see that your workflow is systematic, that you build in checks, and that you understand where errors can enter a diagnostic laboratory.

How to structure your answer

Give a sequential walk-through: accessioning and identity checks, gross examination and sampling, processing and staining, microscopy, ancillary testing where needed, reporting and authorisation, then communication of urgent or unexpected results. Pause at each step to name the check or record that protects the result.

Example answer

“When a specimen arrives, I start with accessioning: matching the request form to the pot, confirming the site and laterality, and checking the fixative and that the clinical history actually supports what has been asked for. If anything does not line up, the specimen is quarantined and the requesting clinician is called before I go any further. From there I do the gross examination, describe the lesion, and take sections that represent the lesion, the margin and any adjacent normal tissue. Routine processing and staining follow, and I review the slides at the microscope with the clinical and radiological

information in front of me. If the morphology is ambiguous, I order immunohistochemistry or molecular testing and note in the file that the case is pending those results. Once I am satisfied, I authorise the report with a clear diagnosis, a comment on margins and a recommendation for the treating team, and anything urgent or unexpectedly malignant is phoned through the same day rather than waiting for the report to be typed."

2. Tell me about a time you had to give a treating clinician a diagnosis they were not expecting.

Why they ask

Oral pathology sits close to clinical care, and the panel wants to know you can deliver bad news clearly, support the clinician, and keep the patient pathway moving.

How to structure your answer

Use STAR. Set the situation briefly, describe what you found and how you prepared, explain how you made contact and what you said, then give the result for the clinician and the patient.

Example answer

"A general dentist sent through an excisional biopsy of what looked clinically like a benign fibroma on the lateral tongue of a patient in their forties. Under the microscope the lesion showed features I was not comfortable calling benign, and after an immunohistochemistry panel I diagnosed a early squamous cell carcinoma with close margins. Rather than sending the report cold, I rang the dentist before it was released and walked through what I had seen and what it meant. We agreed they would contact the patient that afternoon and refer straight to an oral and maxillofacial unit, and I offered to speak to the receiving surgeon directly if it helped. The patient was seen within the week, had further resection, and the dentist later told me that having the diagnosis explained over the phone before the written report arrived made the conversation with the patient much easier to manage."

3. How do you decide which immunohistochemistry stains to add when the morphology is ambiguous?

Why they ask

This tests diagnostic discipline. The panel is listening for someone who uses ancillary testing to answer a specific question rather than firing off a broad panel and hoping something turns up.

How to structure your answer

Start with your reasoning approach, then give a concrete example from your own practice, then acknowledge the limits of staining and when you would escalate or refer out.

Example answer

"I start from the differential the morphology has already narrowed down, and I ask what single line of staining would separate the leading options. For an undifferentiated lesion in the oral cavity, that usually means a cytokeratin panel to confirm epithelial origin, then markers that distinguish squamous from salivary or lymphoid lesions, and if a spindle cell process is in play I add markers to exclude melanoma and sarcoma. I try to build the panel in a way that gives a definitive answer rather than an ambiguous one, and I keep the clinical history in view the whole time, because a stain result that contradicts the clinical picture needs explaining, not ignoring. I am also comfortable saying when a case has reached the limit of what a panel can resolve and picking up the phone to a tertiary centre or a colleague for a second opinion, which is faster and safer than repeating stains indefinitely."

4. A frozen section late in the day suggests malignancy, but the permanent sections two days later look equivocal. What do you do?

Why they ask

This is a judgement-under-pressure scenario. It tests how you balance patient safety, clinical communication and your own diagnostic certainty when the two results do not agree.

How to structure your answer

Work through it in order of risk: patient first, then communication to the treating team, then your own review and second opinion, then documentation. Be explicit about what you would not do, such as letting the discrepancy sit unexplained.

Example answer

“The patient comes first, so my immediate question is whether anything has been done on the basis of the frozen section that cannot easily be undone. If the surgeon has already proceeded, I contact them the same day, explain the discrepancy plainly, and make sure the patient's management is reviewed rather than left to drift. I then go back over both sets of slides myself, check the frozen section quality and whether the sampling explains the difference, and order deeper levels or ancillary stains. If I am still not certain, I ask a colleague for an independent opinion and record that I have done so. Whatever the outcome, I document the discrepancy, the review and the communication in the file, and if it points to a process issue in frozen section handling I raise it through the laboratory's quality system rather than treating it as a one-off.”

5. How do you handle a registrar who has missed an important finding on a case they reported?

Why they ask

Teaching and supervision is part of the role, and the panel wants to see that you can correct someone without crushing them, while still protecting the patient and the quality of the service.

How to structure your answer

Use a supervision framework: immediate safety action, then the conversation, then the learning step, then what you change in the sign-out process. Keep it specific to the registrar and the case rather than generic feedback.

Example answer

“First I make sure the patient is safe, which means the report does not go out until the case is corrected and, if a report has already been released, the treating clinician is contacted before anything else happens. Then I sit down with the registrar and go through the slides together, asking them to describe what they see before I point anything out, because I want to understand where their reasoning went off track, whether it was sampling, pattern recognition or simply rushing at the end of a long list. We agree on what they will do differently, and I might ask them to present the case at the next internal meeting so the whole group learns from it. If the same issue comes up again, I would look at whether the sign-out process is the real problem and change how cases are reviewed before reports are authorised.”

6. You notice that two specimen pots on the bench may have been mislabelled. What do you do?

Why they ask

Quality and safety questions are standard in accredited laboratories. The panel wants someone who acts immediately and follows the quality system rather than quietly trying to sort it out alone.

How to structure your answer

Give an immediate action, then the escalation and documentation, then the root cause and prevention step. Do not skip the part where the treating clinician and patient may need to be informed.

Example answer

“I stop processing immediately so nothing further is done to either specimen, and I quarantine both pots and the associated paperwork. I notify the laboratory manager and the supervising pathologist straight away, because this is a reportable incident under our quality system, not something to resolve quietly at the bench. We then trace both specimens back through accessioning, check the request forms and any handwriting or labelling against the original, and work out whether the tissue in each pot can be matched to a patient with confidence. If it cannot, the treating clinicians for both patients

are told before any report is issued, and in some cases that means a repeat biopsy, which is a conversation I would rather have early than after a wrong diagnosis. Finally, I write up the incident, contribute to the root cause review, and support any change to labelling or accessioning practice that comes out of it."