Oral Surgeon interview questions

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What to expect

Interviews for oral surgery roles in Australia typically combine a credentialing check with clinical reasoning, safety questions and a look at how you work with patients and junior staff. Panels usually include a clinical director or senior surgeon, and may include a practice manager or nursing lead.

- **Clinical and technical:** Questions that test your surgical knowledge, from extraction techniques to implant planning and trauma management.
- **Scenario and judgement:** Cases that put you in a pressured clinical moment, such as an airway emergency or a complex post-operative bleed.
- **Behavioural:** Questions that ask for real examples of how you have handled complications, difficult conversations or team conflict.
- **Safety and regulatory:** Questions about AHPRA requirements, infection control, WHS and NSQHS standards, and your understanding of scope of practice.
- **Patient communication:** Questions about explaining risk, gaining consent and managing anxious or vulnerable patients.
- **Supervision and teaching:** Questions about your experience with registrars, students or junior clinicians, and how you balance teaching with service demands.

The interview often starts with a panel introduction and a review of your registration and training. You might then move through a clinical case discussion, a set of behavioural questions, and a scenario or two. Some employers include a tour of the theatre or a meet-and-greet with the nursing team. Expect the panel to ask follow-up questions that probe your reasoning, not just your final answer.

1. Walk us through your approach to assessing a patient with a suspected mandibular fracture.

Why they ask

This question checks your clinical structure, your knowledge of anatomy and imaging, and whether you can prioritise airway and safety before definitive repair.

How to structure your answer

A clinical reasoning walk-through. Start with primary survey and airway, then history, examination, imaging choice, and a brief on management options and when you would involve other specialties.

Example answer

“First, I confirm the patient is stable. Airway is the priority, so I check for any obstruction, trismus or displaced fractures that could compromise breathing. If there's an airway concern, I involve anaesthetics and consider a definitive airway early. Once stable, I take a focused history: mechanism of injury, pain, malocclusion, numbness in the lip or chin. On examination, I look for step deformities, restricted opening, and intraoral haematoma. I order a cone beam CT or a facial CT depending on the injury pattern and the patient's presentation. If it's a simple, undisplaced fracture, I may manage conservatively with soft diet and analgesia. For displaced or unstable fractures, I plan open reduction and internal fixation, usually within a few days, and I coordinate with the maxillofacial team if the injury extends beyond the mandible. I always document the neurovascular status before and after any intervention.”

2. Tell me about a time you had to manage a serious post-operative complication.

Why they ask

They want to see how you recognise and respond to problems like bleeding, infection or airway compromise, and whether you stay calm and communicate well.

How to structure your answer
STAR. Situation, task, action, result. Keep the result focused on patient outcome and what you changed afterwards.

Example answer
"A patient I had treated with a surgical extraction returned the next day with a significant haematoma and increasing swelling that was starting to affect their swallowing. I assessed them immediately, secured their airway by sitting them upright and giving oxygen, and called the anaesthetic team. I arranged urgent imaging to rule out a deep space collection, took bloods, and started intravenous antibiotics and steroids. The patient was taken to theatre for drainage and made a full recovery over the following week. After that, I revised our post-operative instructions for patients on anticoagulants and added a routine phone check the next morning. We saw fewer unplanned returns after that change."

3. You are called to the emergency department for a patient with a deep space infection and airway compromise. What do you do?

Why they ask
This is a high-stakes scenario that tests your ability to prioritise, escalate and work in a team under pressure.

How to structure your answer
A judgement-under-pressure structure. State your first priority, then the steps you take in order, who you call, and how you decide on definitive management.

Example answer
"My first priority is the airway. If the patient is stridulous, drooling or unable to lie flat, I call for anaesthetic support immediately and prepare for a difficult airway. I keep the patient upright, give high-flow oxygen, and get IV access. While waiting, I do a rapid assessment of the infection: which spaces are involved, whether there's trismus, and whether they are systemically unwell. I order a CT with contrast and bloods including inflammatory markers. I start broad-spectrum IV antibiotics and ensure the patient is resuscitated. The definitive treatment is surgical drainage, so I book theatre urgently and coordinate with the anaesthetic and ICU teams. I would not delay drainage for imaging if the airway is worsening. After theatre, the patient goes to ICU for monitoring, and I review them daily with the team."

4. How do you ensure infection control and sterilisation standards are maintained in your theatre?

Why they ask
Oral surgery carries real infection risk. They want to know you follow the standards and lead by example.

How to structure your answer
A process and safety structure. Talk through the standards you follow, how you audit compliance, and how you handle breaches.

Example answer
"I work to the current NSQHS Standards and the Dental Board of Australia's infection control guidelines. In theatre, that means a strict sterile field, correct surgical hand hygiene, and single-use items where indicated. I make sure instruments are tracked through the sterilisation cycle, and I check autoclave logs each session. If I see a breach, I stop the case, address it immediately, and report it through the correct channel. I also run short refresher sessions with nursing and junior staff on hand hygiene and sharps safety. I think the key is consistency: everyone follows the same checklist, every

time, and we audit our compliance quarterly."

5. Describe your experience supervising registrars or junior staff. How do you balance teaching with patient safety?

Why they ask

Senior roles expect you to teach and supervise while keeping patients safe. They want evidence you can delegate appropriately and give useful feedback.

How to structure your answer

STAR or a description of your approach, with a concrete example of a time you stepped in or stepped back.

Example answer

"I have supervised registrars in both hospital and day surgery settings. I use a graded approach: I let them lead the parts of the case they are ready for, and I'm clear about when I will take over. For example, a registrar was performing a surgical extraction of a deeply impacted lower third molar. I watched them raise a flap and make good progress, but when the tooth started to move unexpectedly, I stepped in to complete the extraction safely. Afterwards, we debriefed and reviewed the radiographs together. I also run a monthly case discussion where registrars present complications and we talk through the decisions. That way, teaching happens without putting patients at risk."

6. A patient is anxious about undergoing a surgical extraction under general anaesthesia. How do you address their concerns?

Why they ask

Patient communication is a core skill. They want to see empathy, clear explanation, and a plan for shared decision-making.

How to structure your answer

A client-facing communication structure. Acknowledge the fear, explore it, provide clear information, and agree on a plan together.

Example answer

"I start by acknowledging that it's completely normal to feel anxious, and I ask what specifically worries them. Often it's the anaesthetic, the pain afterwards, or the thought of being asleep. I explain the process step by step in plain language: what happens before, during and after. I tell them what pain relief they will have and who will check on them. If they are still very anxious, I might offer a pre-operative phone call with the anaesthetist, or consider a short course of anxiolytic medication if appropriate. I make sure they have written information to take home and a number to call if they have more questions. The goal is that they feel in control and give informed consent."