Sexual Health Physician interview questions

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What to expect

Sexual health physician interviews test clinical reasoning, confidentiality and communication in roughly equal measure. Expect the panel to include a clinical director, a senior nurse or nurse unit manager, and sometimes a public health or allied health representative, because the role sits inside a multidisciplinary service.

- **Clinical reasoning and technical:** Questions on STI management, HIV care and syndromic approaches where the panel wants to hear how you think through differentials, testing and treatment, not just a list of drug names.
- **Communication and sensitive history taking:** Scenarios about patients who are reluctant, embarrassed, intoxicated, very young or from communities with reason to distrust health services. The panel is checking that you can get the information you need without pushing people away.
- **Confidentiality and legal obligations:** Questions on notifiable disease reporting, minors, contact tracing and what you do when a patient refuses to disclose to partners. These come up in almost every interview for this role.
- **Behavioural:** Past examples of difficult follow up, a missed result, a conflict with a colleague, or a patient you could not engage. Answer these with STAR.
- **Public health and teamwork:** How you work with public health units, counsellors, peer workers and GPs, and how you handle a surveillance or outbreak response on top of a full clinic list.

A first interview is usually a panel of two to three people, running 45 to 60 minutes, half clinical scenarios and half questions about your training, registration and how you work in a team. Shortlisted candidates often go to a second stage, which may include a case based discussion with a senior clinician, a simulated or observed consultation, and a walk through of the clinic. Credentialing, AHPRA registration and fellowship checks happen alongside or just after the interviews, so be ready to talk through your training pathway and supervision history.

1. Walk us through how you take a sexual health history from a patient who seems reluctant to discuss their sexual practices.

Why they ask

This is the core task of the role and the panel wants to see structure: how you build rapport, what you ask, and how you avoid missing risk information because the patient shut down.

How to structure your answer

Step by step walk through. Set the scene, then move through the stages in order: framing and confidentiality, general history first, then specific questions, then closing the loop. Give the reasoning behind each step rather than a script.

Example answer

“I start before any questions by explaining what the appointment involves and who will see the notes, because a lot of reluctance comes from not knowing who else finds out. I ask general health and social questions first, which gives the patient time to settle, and I explain that I ask every patient about sexual history so it does not feel like an accusation. When I get to the specific questions I use plain terms, ask about partners of all genders without assuming, and give people permission not to answer by saying we can come back to it. If a patient is still guarded, I ask about what they are worried about rather than what they have done, because that usually gets me the risk information I need to order the right tests. I finish by checking whether there is anything they wanted to raise but did not, and I make sure they know how results will be given and how to reach us.”

2. Tell me about a time you had to follow up a patient with an urgent or complex result.

Why they ask

Partner notification and urgent follow up are regular parts of the job, and the panel wants evidence you can chase something through to completion without breaching confidentiality or losing the patient.

How to structure your answer

STAR. Keep the situation and task brief, spend most of your time on what you actually did, and finish with the outcome and what you changed in your practice afterwards.

Example answer

“A patient had been tested at a drop in clinic and left only a mobile number. The result came back as infectious syphilis and the number was disconnected. My task was to get them treated and to start partner notification, but I had almost nothing to work with. I checked the file for any alternate contact, rang the GP they had listed with consent, and asked the clinic's public health nurse to try the health service they had attended previously. We reached them through a community worker they trusted, and they came in for treatment the next day. I also arranged testing for two partners through the clinic's contact tracing process. Afterwards I changed our intake so that we ask for a second contact and record how the patient prefers to be contacted, which has made this situation much less common.”

3. How would you approach a patient newly diagnosed with HIV in your clinic?

Why they ask

HIV care is central to the role and the panel wants to see that you can hold both the clinical and the human parts of a new diagnosis together, including the role of the broader team.

How to structure your answer

Structured clinical reasoning across time. Deal with the immediate conversation and safety first, then baseline workup and treatment initiation, then longer term monitoring and prevention, naming the people you would involve at each point.

Example answer

“First I would make sure the patient has time and privacy, and I would give the diagnosis plainly without softening it into confusion. I would check how they are taking it, ask about supports, and do a risk assessment for mental health and safety before anything else. Then baseline workup: confirmatory testing, viral load and CD4 count, resistance testing, hepatitis and STI screening, renal and liver function, and a pregnancy discussion where relevant. I would talk about treatment early, because starting antiretroviral therapy promptly and explaining that an undetectable viral load means HIV is not transmitted sexually is often the single most reassuring thing in that consultation. I would bring in the HIV nurse and a peer worker with the patient's agreement, set a follow up within a week or two, and cover partner notification and who else in their life they want involved.”

4. A 19 year old wants STI testing but does not want their GP to know and will not give a Medicare card. What do you do?

Why they ask

Young people, confidentiality and billing come up constantly in sexual health clinics. The panel is testing your judgement under pressure and your knowledge of how to keep a young person engaged without breaking the rules.

How to structure your answer

Judgement under pressure. Acknowledge the concern, clarify what they are actually worried about, explain the options and their limits honestly, then agree a plan and document it.

Example answer

“I would thank them for telling me and take the concern seriously rather than treating it as an obstacle. I would ask what specifically worries them about the GP knowing, because sometimes it is a family member working at the practice, or a parent on the same Medicare card, and that changes the options. I would explain what we can do without Medicare, what it costs, and that a pseudonymous service may be available depending on their circumstances. I would be clear about the limits up front, including what happens if a result is notifiable and what our obligations are if I am worried about their safety. If they can use Medicare but not their usual GP, I would offer to send results to another practice or to hold results here. Then I would document the discussion and the plan so the next clinician knows where things stand.”

5. A pregnant patient has a positive syphilis test. Talk us through your management.

Why they ask

Congenital syphilis is a live concern in Australian services and this question separates candidates who have real current practice from those giving a textbook answer.

How to structure your answer

Technical answer with a clear sequence. Confirm the diagnosis and staging first, then treatment, then the multidisciplinary and reporting steps, then follow up of mother and baby.

Example answer

“First I would confirm whether this is a new infection, a treated infection or a false positive by checking the serology pattern and treatment history, because staging changes everything. If it is untreated or inadequately treated syphilis in pregnancy, that is an urgent situation: I would arrange treatment with benzathine penicillin, check for penicillin allergy and manage it properly rather than substituting a less effective regimen, and be aware of the small risk of a reaction after the first dose. I would involve obstetric care and the infectious diseases team the same day, arrange partner testing and treatment, and notify the public health unit as required. Then I would set up the monitoring schedule for the rest of the pregnancy and make sure the paediatric team knows so the baby is assessed and followed up after birth.”

6. What do you do when a patient refuses to notify their partners?

Why they ask

This is the practical heart of sexual health work and the panel wants to see that you can balance patient autonomy, public health duty and the relationship you have with the patient.

How to structure your answer

Problem solving with escalation. Set out your first approach, the alternatives you offer, the point at which you involve the public health unit, and how you keep the patient on side throughout.

Example answer

“I would start by finding out why. Often it is shame, fear of a partner's reaction, family violence, or not knowing how to start the conversation, and each of those has a different answer. I would explain the options: they can tell partners themselves, we can send an anonymous notification that does not name them, or a public health officer can make contact without identifying the source. I would be honest that if the risk is serious and they will not act, I have obligations under public health legislation and would need to escalate, and I would tell them that before I did it. Throughout that I would keep the relationship intact, because a patient who feels reported will often disappear, and that is worse for everyone. I would document the conversation, the options offered and the outcome.”