Emergency Physician interview questions

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What to expect

Emergency medicine interviews test how you think under pressure as much as what you know. Panels want to see structured clinical reasoning, safe judgement when information is incomplete, and evidence that you can lead a team and supervise juniors on a busy floor.

- **Clinical reasoning and process:** Walk-through questions on how you assess, resuscitate and disposition common presentations such as chest pain, sepsis or trauma.
- **Behavioural:** Past examples of rapid decisions, conflict with a specialty team, or managing a clinical error using STAR.
- **Scenario and judgement under pressure:** Multiple patients, limited resources, or a deteriorating patient you have not yet reviewed. Panels watch how you prioritise and escalate.
- **Technical and procedural:** Difficult airway, procedural consent, or interpretation of an ECG, blood gas or ultrasound finding.
- **Supervision and leadership:** How you teach registrars, manage a struggling junior, or run a multidisciplinary team during a resuscitation.
- **Safety and quality:** Incident reporting, handover, and how you contribute to departmental improvement.

Most Australian emergency departments run a panel interview of a director of emergency medicine, a senior FACEM and often a nursing leader or medical workforce representative, typically thirty to sixty minutes. Expect opening introductions and a run through your training and ACEM progress, then a mix of clinical scenarios and behavioural questions, sometimes with a short written or simulation component. There is usually time at the end for your questions about roster, supervision structure, education program and departmental culture.

1. Walk me through how you approach an undifferentiated critically unwell patient arriving by ambulance.

Why they ask

This is the core of the job. The panel wants to see whether your assessment is structured, whether you verbalise your reasoning to the team and whether escalation happens early rather than late.

How to structure your answer

Use a chronological walk-through rather than STAR: pre-arrival preparation, primary survey with allocated roles, investigations and early treatment, then reassessment and disposition. Name where you would call for help and why.

Example answer

“It starts before the patient arrives. If the paramedic pre-alert suggests a time-critical presentation, I make sure the resus bay is ready, allocate roles to the nursing and medical staff present, and ask for the relevant specialty to be aware. When the patient comes in, I run a primary survey with the team working to their roles: airway with cervical spine consideration, breathing with oxygen and auscultation, circulation with IV access and bloods, then a quick neurological check and exposure. I verbalise my working diagnosis out loud so the team can follow and challenge it. Point-of-care ultrasound and an ECG run alongside the bloods if they will change what I do in the next few minutes. Once the patient is stabilised I reassess, decide whether this needs intensive care, theatre or a ward bed, and make those calls early rather than waiting for full results. Throughout, I keep the patient and family informed where I can, and I hand over clearly to whoever takes over care.”

2. Tell me about a time you had to make a rapid clinical decision with incomplete information.

Why they ask

Emergency medicine is decision making with partial data. The panel is listening for sound reasoning, appropriate risk taking, and whether you revisit the decision when new information arrives.

How to structure your answer

Use STAR. Keep the situation and task brief, spend most of the answer on the actions and your reasoning, and finish with the outcome and what you would do the same or differently.

Example answer

“I was on a night shift when a middle-aged patient presented with severe abdominal pain and early signs of shock, but the history was limited and imaging was not immediately available. The task was to keep them alive long enough to get a diagnosis. I started resuscitation, gave broad spectrum antibiotics on the presumption of a surgical or septic cause, and called the surgical and intensive care registrars early rather than waiting for a CT result. I also repeated my examination as fluids went in. The patient went to theatre within a couple of hours and the cause turned out to be a perforated viscus. The decision to treat presumptively and escalate before imaging was confirmed felt exposed at the time, but waiting would have cost the patient. I would make the same call again, though I would document my reasoning more explicitly for the surgical team.”

3. How do you manage a difficult airway in the emergency department?

Why they ask

Airway management is a defining skill of the role. The panel wants a structured plan, awareness of your own limits, and a clear fallback position if the first attempt fails.

How to structure your answer

This is a technical question, so give a step-by-step clinical plan: preparation and team briefing, optimised positioning, first attempt, and explicit escalation criteria. End with the rescue options you would call on.

Example answer

“I treat every intubation in the department as a planned procedure even when it is urgent. First I brief the team on roles, confirm the equipment and drugs, and check the monitor and suction. I optimise the patient's position and pre-oxygenate properly, and I consider whether this is a physiology problem as much as an anatomy problem, because a shocked or acidotic patient can arrest on induction. I plan the first attempt with the most experienced operator available and a clear plan for who takes the second. If the first attempt fails, I move to a supraglottic airway and call for surgical airway support rather than persisting. Afterwards I debrief the team and document the grade of view and what worked. Knowing when to stop and escalate is as important as the technique itself.”

4. You have three critically unwell patients arriving at once and only two resus bays. How do you handle it?

Why they ask

Resource pressure is a daily reality in emergency departments. The panel is testing prioritisation, delegation and whether you escalate to the hospital rather than absorbing the problem silently.

How to structure your answer

Use a judgement-under-pressure structure: take a moment to assess, allocate the scarce resource to the patient who most needs it, delegate, and escalate up the hospital chain early. Finish with what you would review afterwards.

Example answer

“I take thirty seconds to work out which patient is most time-critical and who can safely wait in the short term. The sickest patient gets the first resus bay and the most experienced team. The second

bay goes to whoever needs immediate intervention, and I ask a senior registrar or the second consultant on call to take the third patient in a monitored area rather than leave them unassessed. I delegate clearly, because standing in the middle trying to do everything myself helps no one. I also call the duty manager and the director of emergency medicine early, because three simultaneous critical patients is a hospital problem, not just my problem, and extra staff and a theatre or ICU bed may need to be arranged now rather than later. Once the situation settles I debrief the team and look at what we could have done faster."

5. How do you supervise and support a registrar who is struggling on shift?

Why they ask

Emergency physicians supervise junior staff constantly. The panel wants to see that you notice problems early, give useful feedback and escalate appropriately without humiliating anyone.

How to structure your answer

This is a leadership and supervision question, so structure it as: notice, check in privately, adjust the workload to keep patients safe, then put a plan in place with the registrar and the training director.

Example answer

"I pick up on it during the shift, usually through how they present cases or how slowly they are moving through the queue. I find a quiet moment and check in directly but without an audience, asking what is making today hard rather than telling them what they are doing wrong. Depending on the answer, I might shift them to a less acute area for the rest of the shift or pair them with a senior registrar so patients stay safe while they rebuild confidence. I give feedback on specific cases rather than vague impressions, and I make sure they know what a good outcome looks like next time. If it is a pattern rather than a bad day, I raise it with the director of emergency training so there is a proper plan, because it is not something to manage alone or leave undocumented."

6. Tell me about a time you made or witnessed a clinical error and how it was handled.

Why they ask

The panel is checking whether you are open about error, whether you follow the reporting and governance process, and whether you learn from it rather than becoming defensive.

How to structure your answer

Use STAR, but make the reflection a real part of the answer. Name the error plainly, describe the reporting and communication, then state what changed in your practice.

Example answer

"A patient I assessed for chest pain was initially treated as musculoskeletal because the ECG and initial troponin were reassuring, and I discharged them with a plan to return if symptoms worsened. They represented the next day with a confirmed cardiac problem. As soon as I heard, I reviewed my documentation honestly and discussed it with my consultant rather than waiting to be asked. We reported it through the incident system, and I spoke with the patient's admitting team so they had the full picture. The case went to our departmental morbidity and mortality meeting, where the discussion focused on serial testing and shared decision making in low risk chest pain. It changed how I counsel patients at discharge and how carefully I document my reasoning. I would rather the error be visible and learned from than quietly buried."