Gastroenterologist interview questions

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What to expect

Interviews for gastroenterologist roles typically assess clinical reasoning, procedural competence, communication and teamwork. You may face a panel including a clinical director, a nurse unit manager and a human resources representative. Questions often blend technical knowledge with behavioural and scenario-based prompts.

- **Technical and procedural:** Questions about endoscopy, ERCP, management of IBD and other core gastroenterology procedures and treatments.
- **Clinical scenario:** A complex patient presentation, such as acute GI bleeding or decompensated liver disease, where you explain your workup and management.
- **Behavioural:** Past experiences around teamwork, conflict resolution, communicating difficult news and handling pressure.
- **Safety and quality:** How you identify and manage risks in the endoscopy suite, including sedation safety, infection control and adverse events.
- **Supervision and teaching:** Your approach to training registrars, providing feedback and balancing service demands with education.

The interview usually takes place over one or two rounds. A first round may involve a panel interview of 45 to 60 minutes, with a mix of clinical scenarios, behavioural questions and a discussion of your procedural logbook. Some services include a separate practical assessment or a session with registrars. Second rounds may focus on leadership and service development.

1. Walk me through your approach to a patient with acute upper gastrointestinal bleeding.

Why they ask

This is a core emergency presentation and tests your ability to prioritise, resuscitate and make timely endoscopic decisions.

How to structure your answer

Use a structured ABCDE approach, then describe risk stratification, resuscitation, timing of endoscopy and post-procedure care. Finish with how you would communicate with the team and the patient.

Example answer

“I start with an ABCDE assessment, ensuring the airway is patent and the patient is breathing adequately. I check circulation, gain IV access and send bloods including a full blood count, coagulation profile and crossmatch. I resuscitate with crystalloid, transfuse if indicated, and start a proton pump inhibitor infusion. I use a validated risk score to stratify the patient and decide on the urgency of endoscopy. If they are haemodynamically unstable despite resuscitation, I activate the on-call endoscopy team and arrange urgent endoscopy within a few hours. If stable, I aim for endoscopy within 24 hours. I also liaise with ICU and the blood bank early. After the procedure, I document the findings and plan, review the need for repeat endoscopy and ensure the patient is started on appropriate therapy to prevent rebleeding.”

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

Why they ask

Gastroenterologists frequently deliver news of cancer or chronic disease, so empathy and clarity are essential.

How to structure your answer

Use STAR: situation, task, action, result. Focus on how you prepared, what you said and how you supported the patient afterwards.

Example answer

“I had a patient in their fifties who underwent a colonoscopy for iron deficiency anaemia. The findings showed a likely malignancy. I asked the patient to bring their partner to a follow-up consultation. I prepared by reviewing the histology and staging scans, and I booked a quiet room with tissues available. I started by asking what they already understood, then gave the news clearly and without jargon, pausing to let it sink in. I explained the next steps, including referral to the colorectal multidisciplinary team and the role of the cancer care coordinator. I offered written information and a follow-up call the next day. The patient later told me they felt supported and knew exactly what would happen next. I also documented the conversation and informed the GP promptly.”

3. How do you manage a patient with moderate to severe ulcerative colitis who is not responding to first-line therapy?

Why they ask

This tests your knowledge of IBD management, including when to escalate therapy and involve surgery.

How to structure your answer

Start with assessment of disease severity and extent, then step through evidence-based options in a logical sequence, involving the multidisciplinary team and discussing risks and benefits with the patient.

Example answer

“First, I confirm the diagnosis and assess disease extent and severity using clinical scores, inflammatory markers and recent endoscopy. I check for complications such as infection, including stool testing for C. difficile and cytomegalovirus. If the patient is on mesalazine and not responding, I consider adding a course of corticosteroids for induction. If they have moderate to severe disease, I discuss starting a biologic or a small molecule such as tofacitinib, after checking screening for hepatitis B, tuberculosis and other infections. I involve the IBD nurse specialist for education and support. I also refer to colorectal surgery early if there are signs of acute severe colitis or if medical therapy fails. I review the patient regularly and use treat-to-target principles, aiming for clinical and biochemical remission. Throughout, I involve the patient in shared decision-making, explaining the risks and benefits of each option.”

4. Describe a situation where you identified a safety risk in the endoscopy suite and what you did.

Why they ask

Safety and quality are critical in procedural areas, and this question assesses your vigilance and ability to act.

How to structure your answer

Use a safety-specific structure: identify the risk, act to mitigate it, and review the outcome. Mention communication with the team and any follow-up.

Example answer

“During a busy endoscopy list, I noticed that a patient with a known difficult airway was being sedated without the anaesthetist present and without the correct monitoring in place. I immediately paused the list and spoke to the nurse in charge. We confirmed that the patient required anaesthetic support and that the sedation protocol had not been followed. I ensured the anaesthetist was called and that capnography and full monitoring were applied before proceeding. After the list, I raised the issue at the quality improvement meeting and suggested a pre-procedure checklist that included airway risk. The checklist was introduced, and we had no further near-misses. I also provided feedback to the registrar involved in a supportive way, focusing on system improvement rather than blame.”

5. How do you supervise and teach registrars in a busy endoscopy list?

Why they ask

Gastroenterologists are expected to train the next generation while maintaining service delivery.

How to structure your answer

Explain your approach to setting expectations, providing feedback, and balancing service demands with training. You can use a brief example to illustrate.

Example answer

"Before each list, I set clear learning objectives with the registrar and discuss which procedures they will lead. I assess their competence and allow them to perform the scope with my hands ready to assist. I give feedback immediately after each procedure, focusing on one or two specific points. I ensure they understand the indications, risks and consent process. If the list is running behind, I may take over a difficult case to keep things moving, but I explain why and what I am doing. I also encourage them to attend outpatient clinics and IBD meetings to see the longitudinal care. I document their progress in their logbook and provide a formal mid-term review. I aim to create a safe learning environment where they can ask questions without fear."

6. What is your experience with ERCP and how do you manage a failed cannulation?

Why they ask

ERCP is a high-risk procedure that requires specific technical skill and judgement about when to stop.

How to structure your answer

Describe your experience, then talk through a stepwise approach, including when to call for help and how you prioritise patient safety over completing the procedure.

Example answer

"I have performed numerous ERCPs during my advanced training, including for choledocholithiasis, biliary strictures and post-operative leaks. If I fail to cannulate the bile duct after a reasonable attempt, I stop and reassess. I avoid repeated attempts that could cause pancreatitis or perforation. I may try a different technique such as a guidewire-assisted approach or a precut if I am experienced, but only if it is safe. I call for a more experienced colleague early rather than persisting. If the procedure is urgent, I consider alternative approaches such as percutaneous drainage or surgery. I always discuss the situation with the patient and their family, explaining the plan and the reasons for stopping. I document the attempt and the next steps clearly. After the procedure, I monitor the patient for complications and arrange follow-up."