Palliative Medicine Physician interview questions

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What to expect

Palliative medicine interviews are less about reciting guidelines and more about how you think when the clinical picture is messy and several people in the room want different things. Panels are usually made up of a palliative care physician, a nurse unit manager or clinical nurse consultant and sometimes an allied health or social work representative, because the role is fundamentally team based.

- **Clinical reasoning:** A case stem with uncontrolled symptoms, and follow up questions on opioid choice, rotation, adjuvant agents and when sedation is appropriate.
- **Communication and family facing:** How you break difficult news, run a family meeting, or handle a family that disagrees with the treating team about goals of care.
- **Behavioural:** Past examples of conflict, error, moral distress or a decision you would make differently, usually explored with follow up questions.
- **Judgement under pressure:** Overnight or after-hours scenarios where you are the most senior palliative voice available and the patient is deteriorating.
- **Leadership and teaching:** How you supervise registrars, run the multidisciplinary meeting and manage a full clinical load at the same time.
- **Credentialling and service fit:** Registration, scope of practice, on-call expectations, and how you would work within the service's model.

Most panels start with a short introduction and your reason for applying, then move to one or two case based clinical discussions where the panel will push on your reasoning rather than the final answer. Behavioural and communication questions usually follow, often drawn from your own examples rather than hypotheticals. Many services include a separate session with the nursing and allied health team, and some ask for a brief presentation, an audit summary or a morbidity and mortality style case discussion. You will usually get time at the end for your own questions, so ask about the on-call roster, community versus inpatient split, and how the service handles after-hours advice.

1. Walk us through how you assess and manage a newly referred inpatient with advanced cancer, severe pain and a prognosis of weeks.

Why they ask

This is the core of the job and the panel wants to see your reasoning sequence rather than a list of drug names. It also tests whether you work the psychosocial and family side into the same plan as the pharmacology.

How to structure your answer

A structured walk-through: history and pain characterisation, review of current analgesia and any toxicity, examination and relevant investigations, then a treatment plan with non-pharmacological measures, opioid choice and route, adjuvant agents, and finally the conversation with the patient and family about goals. Close on monitoring and who you hand over to.

Example answer

“I start by sitting with the patient and getting the pain story properly: onset, site, character, what makes it worse, what they have already had and what they are worried about. I review the chart for current opioids, any renal or hepatic impairment, and prior toxicity, because a patient who is drowsy on a background of renal failure needs a different plan to someone who is opioid naive. On examination I am looking for reversible contributors such as constipation, urinary retention, bony metastases or an undrained collection, because those change the plan entirely. If the pain is

nociceptive and they are opioid naive, I would start a low dose of immediate release morphine or oxycodone with regular breakthrough cover and review within a few hours, adding a laxative and an antiemetic. If there is a neuropathic component I would add an adjuvant such as gabapentin or a tricyclic, taking renal function into account, and I would consider a corticosteroid if there is capsular liver pain or bony disease. Alongside that I would ask the nursing team about positioning, heat, distraction and who the patient wants present. Then I go back and explain the plan in plain language, check what they understand about where things are heading, and document the goals of care so the night team is not starting from scratch. I would hand over directly to the after-hours nurse and arrange a review the next morning."

2. A patient on high dose subcutaneous morphine develops myoclonus and increasing drowsiness while their pain is still not controlled. What do you do?

Why they ask

This probes opioid toxicity recognition, rotation and the difference between sedation as a side effect and sedation as an intended treatment. It is a common real scenario on any inpatient unit.

How to structure your answer

A clinical reasoning sequence: recognise the problem, exclude other causes, act, then review. State your reasoning at each step and be explicit about what you would and would not do.

Example answer

"Myoclonus with drowsiness in someone on high dose morphine suggests opioid accumulation, so I treat it as toxicity until proven otherwise. First I check for other contributors, particularly dehydration, renal impairment, hypercalcaemia, infection and any recent dose escalation, and I review what else they are on, since a benzodiazepine or antihistamine can be adding to the sedation. I examine for signs of delirium and check the latest bloods. If I am confident this is opioid related, I reduce the total daily dose rather than stopping abruptly, because the patient still has pain and withdrawal would be worse for them. I would rotate to a different opioid, usually switching to subcutaneous hydromorphone, oxycodone or fentanyl depending on renal function, calculating the new dose carefully and prescribing breakthrough cover at roughly a tenth to a sixth of the daily dose. I would treat the myoclonus itself with clonazepam or midazolam if it is distressing, and make sure the nurses know what to watch for and when to call. I would review within a few hours, then again in the morning, and I would document the rationale so the next doctor does not reverse my decision without understanding it. If the patient remains distressed despite good symptom management, that is a separate conversation about what they want, not a reason to push doses further."

3. Tell me about a time when a family disagreed with the treating team about goals of care.

Why they ask

Conflict around goals of care is routine in this specialty and the panel wants evidence you can hold a position calmly without turning it into a contest. It also shows whether you can repair a relationship rather than just win the meeting.

How to structure your answer

STAR: situation, task, action, result. Spend most of your time on the actions you took and how you handled the emotion in the room, not on the medical detail.

Example answer

"Situation. I was asked to see a man in his eighties with advanced dementia and recurrent aspiration pneumonia. The medical team felt that further admissions to intensive care were not in his interests, but his daughter was adamant that everything be done, and she was the decision maker. Task. My job was to help the family reach a position they could live with, and to make sure the treating team understood what was driving her. Action. I rang her before the meeting rather than surprising her in a

room full of people. She told me she had not been present when her mother died and had carried that ever since. In the meeting I acknowledged that directly, then asked her what her father would have said about being in hospital again. I did not push a recommendation straight away. Instead I explained what intensive care would actually look like for someone at his stage, including intubation and the likelihood of not coming off the ventilator, and I was clear that we would not abandon him either way. We agreed on a plan that prioritised comfort, kept antibiotics for treatable infections and avoided intensive care, with a clear commitment that she would be called at any change. Result. She agreed to the plan and later thanked the team. The nursing staff told me the escalation calls stopped becoming arguments, because everyone knew what had been agreed and why."

4. You are the on-call palliative physician overnight and a nurse pages you about a dying patient with severe breathlessness whose family is distressed. What do you do?

Why they ask

After-hours judgement is a large part of the role and the panel is testing whether you can triage, act and communicate when you cannot see the patient immediately.

How to structure your answer

Judgement under pressure: settle the immediate safety issue, gather the essentials by phone, give clear instructions, then commit to a review. Say what you would delegate and what you would not.

Example answer

"My first move is to keep the nurse on the line and ask two questions: is the patient in distress right now, and what is in the drug chart that could be given immediately. Breathlessness is frightening to watch and the nurse calling me is often as anxious as the family, so I want to give them something concrete before we go further. If there is a parenteral opioid or midazolam ordered for breathlessness, I authorise a dose now, and I ask them to sit the patient upright, use a fan and keep the room calm rather than crowding it. I check whether there is a documented goals of care plan and whether the family knows the patient is dying, because some of the distress may be from not understanding what is happening. I ask the nurse to stay with the family while I review the chart remotely, then I attend. When I get there I do a focused assessment to exclude something reversible like a pleural effusion, pulmonary oedema or an anxiety component that would respond to a different approach. I adjust the regular orders so the next episode is covered before it escalates, and I speak to the family myself, in plain language, sitting down. I document what I did and why, and I hand back to the night nurse with a clear plan and my direct number."

5. How do you explain to a patient and their family that further disease directed treatment is no longer helping?

Why they ask

This is the conversation the specialty is built on and the panel wants to hear your actual words, not a description of a framework. It also reveals whether you can be honest without removing hope.

How to structure your answer

A communication structure: prepare and check who should be present, find out what the patient already understands, give information in small pieces and check it landed, respond to emotion before moving to planning, then agree next steps. Include the phrases you would use.

Example answer

"Before the conversation I check who the patient wants in the room and make sure we have enough time and no interruptions, and if there is an interpreter or a cultural support person needed, they are there. I open by asking what they have been told so far and what they are hoping for, because that tells me where to start. I use the word dying if that is what is happening, gently but plainly, because vague language leaves families more frightened, not less. Something like, I am worried that the cancer is now beyond what this treatment can control, and I do not think more chemotherapy will help

you live longer or feel better. I stop there and let it land. If someone cries, I do not talk over it. I acknowledge it: this is not the news you were hoping for, and it is a lot to take in. Then I move to what we can still do, which is usually a great deal, controlling symptoms, getting them home if that is what they want, and making sure the family is supported. I check understanding by asking them to tell me what they have taken from the conversation, and I offer a follow-up conversation because most people do not absorb it all the first time. I write a letter to the GP and document the discussion so everyone is working from the same position."

6. How do you supervise registrars and medical students while carrying a full clinical load?

Why they ask

Teaching and supervision are part of the position description and the panel wants a realistic answer, not an aspirational one. It also tests whether you understand that supervision is a safety issue, not just an educational one.

How to structure your answer

A prioritisation structure: what you do at the start of the day, what is delegated and what is not, how you make teaching happen inside the clinical work, and how you manage when the day collapses.

Example answer

"I start the day with a short handover and a plan for each patient, so I know which ones the registrar can manage independently and which ones I need to see myself. I am explicit about what must come to me: any request for palliative sedation, any conversation about withdrawing treatment, any patient who is deteriorating unexpectedly, and any family conflict I have not already been part of. Everything else I want the registrar to work through and present back to me, because that is where the learning happens. I use the work itself as the teaching. If we are at the bedside together I will ask them to commit to a plan out loud before I say anything, then we discuss it after we leave the room. If the day gets busy I do not cancel supervision, I compress it. A five minute check in at the end of the round is better than nothing, and I would rather move a teaching session than let a registrar carry a difficult case alone. I give feedback directly and close to the event, and I make sure they know that raising a concern about a patient, including with me, is expected rather than a sign of weakness. When I have students I give them a specific job for the day so they are useful and learning, usually focused on symptom assessment or communication."