# Radiologist interview questions

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## What to expect

Radiology interviews are usually panel-based and combine credentialing checks with real clinical reasoning. Expect to talk through images or cases, not just describe your CV, and expect questions on how you handle an on-call roster where you are the only consultant available.

- **Clinical reasoning and image interpretation:** You are shown or described a study and asked to talk through findings, differentials and what you would recommend next.
- **Technical and protocol:** Questions on protocol selection, contrast safety, radiation dose and when to escalate or recommend a different modality.
- **Safety and quality:** Discrepancy meetings, incident review, audit participation and how you respond when a report of yours turns out to be wrong.
- **Behavioural:** Structured questions on communication with referring teams, conflict with a colleague, and managing a heavy list under pressure.
- **Teaching and supervision:** How you handle registrars, feedback on draft reports, and your role in a training accreditation environment.
- **Professional and credentialing:** AHPRA registration, FRANZCR status, CPD compliance, scope of practice and teleradiology arrangements.

Most panels run for around an hour with a clinical director or head of department, one or two consultant radiologists and a practice manager or HR representative. The opening is usually introductions and a short walk through your training and fellowship path, then the bulk of the time goes to case-based discussion and behavioural questions. Many departments include a workstation or PACS session where you review a small set of anonymised studies and talk through your findings out loud. You normally get time at the end for your own questions, and credentialing documents are requested afterwards rather than during the interview.

## 1. You are shown a CT chest on an after-hours shift and the findings are not what the referral expected. Talk us through how you work it up.

**Why they ask**

This is the core of the job. The panel wants to hear structured image review, a working differential and a clear decision about who to contact and how urgently.

**How to structure your answer**

Use a clinical reasoning walk-through: systematic review of the study, name the findings, give a ranked differential, state the next step (further imaging, recall, direct call to the referring team) and how you document it.

**Example answer**

*“I start with a systematic read rather than jumping to what I expect to see, because the referral can anchor you. In this case the lung bases looked clear but there was a soft tissue density in the mediastinum that was not mentioned in the request, so I reviewed it on the lung and mediastinal windows and checked the prior study from two years earlier. The density was new and had mildly increased uptake of contrast, so my differential ran from a nodal process to a vascular or infective cause, and I wanted a dedicated contrast study to sort that out. I rang the treating registrar directly rather than waiting for them to read the report, told them what I had and what I thought was needed, and documented the call in the report along with the recommendation. I put the study on the list for the following morning's review so the finding was not lost if the patient deteriorated overnight.”*

## 2. Tell us about a time you had to give a referring team news they did not want to hear about a patient.

**Why they ask**

Radiologists deliver bad news by phone constantly. The panel is testing whether you can be direct, useful and respectful under pressure.

**How to structure your answer**

Use STAR. Set the situation, describe your specific action in the conversation, then the outcome for the patient and the relationship with the treating team.

**Example answer**

*“A surgical registrar had referred an abdominal CT for suspected diverticulitis in a patient in their forties. The scan showed a colonic mass with local nodal change, which pointed somewhere quite different. I called the registrar within the hour rather than letting them find it in the report, because they were about to decide on management. I led with the most important point, that this was not diverticulitis, then gave the findings in order and what I recommended: a gastroenterology referral and staging imaging. The registrar was initially flat about it, and understandably so, but they asked good questions and we agreed on the workup together. The patient was seen by the right team the next day, and I have used the same structure since, one clear headline first, then the detail.”*

## 3. You are the only radiologist on call and three urgent studies come through at once. What do you do?

**Why they ask**

On-call rostering means real resource decisions. The panel wants to see judgement rather than a rule recited from a textbook.

**How to structure your answer**

Use a prioritisation and communication structure: triage by clinical risk, decide what needs you now versus later, then communicate your plan to the people waiting and escalate if the load is genuinely unsafe.

**Example answer**

*“I triage on clinical risk rather than on the order the requests arrived. A suspected aortic dissection or a stroke thrombolysis decision outranks a query fracture that can wait an hour without harm. I read the highest-risk study first, keep the report short and actionable, and ring the treating team for anything that changes management. For the other two I give the referrer a realistic time and tell them what to do if the patient changes before I get there, which usually means they watch the patient and call me back. If all three were genuinely time-critical, I would contact the on-call consultant at the neighbouring site rather than let an unsafe backlog build, and I would log that escalation so the department can see what the roster was carrying.”*

## 4. How do you go about protocoling an MRI when the clinical question is vague and the patient has a possible contraindication?

**Why they ask**

Protocol decisions are where radiology adds value before the patient enters the scanner, and safety checks around implants and contrast are non-negotiable.

**How to structure your answer**

Walk through your process in order: clarify the question, check safety, choose the protocol, then document and communicate the decision.

**Example answer**

*“First I ring the referrer and ask what decision the scan is meant to change, because a vague request usually means the question has not been sharpened yet. Once I know that, I check the safety side properly: implant type and model, whether it is MRI-conditional, renal function if gadolinium is on the*

*table, and any previous reaction. If the implant information is incomplete I do not scan until it is confirmed, and I document that clearly. Then I build the protocol around the question, adding sequences that will actually answer it rather than running a generic study, and I brief the radiographer on what I am looking for so they can extend the study on the table if the first sequences are unclear. The patient gets told why there is a delay, and the referrer gets a short note about what I have decided and why."*

## 5. How do you balance your own reporting list with supervising registrars?

**Why they ask**

Teaching is written into the role and often the first thing to slip when a list runs late. The panel wants to know you take it seriously and have a workable method.

**How to structure your answer**

Give your approach as a set of principles, then illustrate with one concrete example of how you handled a clash between the two.

**Example answer**

*"I treat supervision as part of the list, not something that happens after it. In practice that means I book time for registrar review rather than leaving it to whoever is free, and I read their draft reports with them rather than correcting silently, so the reasoning gets discussed. When a list is running badly behind, I do not cancel the teaching, I shrink it: we go through the two cases that matter most instead of the full set. On one occasion a registrar was about to miss a subtle finding on a chest study, and talking it through on the day meant they picked up the same pattern unaided the following week. That is the outcome I am after, and it also improves the quality of what goes out under my name."*

## 6. A report of yours is picked up in a discrepancy meeting as an error that changed management. What do you do next?

**Why they ask**

Everyone misses something eventually. The panel is checking whether you can own it without defensiveness and turn it into a system fix.

**How to structure your answer**

Use a reflective structure: acknowledge the finding, outline what you did for the patient immediately, then the review and the change you made to your own practice or the department's process.

**Example answer**

*"My first step is the patient, not my own position. I would check whether the treating team has been told, contact them directly if not, and make sure the clinical plan has been reviewed in light of the corrected finding. Then I would go back through the study myself and be honest about what I missed and why, whether it was a perception error, a satisfaction of search issue, or a protocol that did not show the area well. In the meeting I would present it as my case rather than wait for someone else to raise it. After a similar miss earlier in my training, I changed how I read chest studies on the back of a long list, adding a fixed final check of the areas I know I under-read when tired, and I raised it with the department so the same pattern could be watched for across the roster."*