Intensive Care Specialist interview questions

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What to expect

Intensive Care Specialist interviews are consultant-level appointments, so panels expect technical depth, sound judgement under uncertainty and evidence you can lead a multidisciplinary team. Expect questions built around real ICU scenarios drawn from your logbook and references.

- **Clinical scenario and judgement:** A deteriorating patient or complex organ support case, where the panel watches how you reason through differentials, priorities and escalation.
- **Technical and procedural:** Questions on ventilation strategy, vasopressor choice, line insertion, ultrasound findings or interpreting blood gases and pathology.
- **Leadership and supervision:** How you run a ward round, support registrars, manage handover and handle disagreements within the team.
- **Safety, quality and governance:** Infection control, incident review, national standards and clinical documentation, often framed around something you changed in a unit.
- **Family communication and ethics:** Breaking bad news, goals of care discussions, conflict with families and treatment limitation decisions.
- **Role and career fit:** Why this unit, your procedural and non-clinical interests, roster expectations and how you intend to contribute beyond clinical duties.

Most appointments run as a panel interview with the ICU director, consultant colleagues, a nursing leader and sometimes a medical workforce representative, lasting around an hour. You will usually give a brief overview of your training and logbook, then work through several clinical scenarios, followed by leadership, safety and communication questions. Some units add a separate teaching or presentation session, and references and credentialing checks follow a successful panel.

1. Walk us through how you would manage a patient who becomes hypotensive and hypoxic four hours after ICU admission with severe pneumonia.

Why they ask

This is the bread-and-butter ICU scenario and tests whether your assessment is systematic or reactive under pressure.

How to structure your answer

Work through it in real time: immediate bedside assessment and ABCDE, what you rule in and out, the investigations you order, your initial interventions, then reassessment and escalation criteria.

Example answer

“I would start at the bedside rather than the notes. Airway and ventilation first: check the tube position if intubated, look at the ventilator waveform and whether the patient is fighting the settings, and confirm saturations with a blood gas. Then circulation: review the rhythm, blood pressure trend and perfusion, and check whether lines are patent and drugs are actually running. I would examine for asymmetry, secretions, a new murmur or abdominal distension, and get a bedside ultrasound of the heart and lungs to look for a new effusion, poor ventricular function or a pneumothorax. Alongside that I would send bloods, a lactate, cultures if not already taken, a chest X-ray and repeat gases, and discuss broadening antimicrobial cover with microbiology. If the picture suggests septic shock from a worsening pneumonia, I would optimise sedation, recruit what I can safely, start or escalate vasopressor support, and set a clear review point in the next hour with the registrar. If we were not improving, I would call for senior and cardiothoracic help early rather than waiting.”

2. Tell me about a time you changed a process or practice in an ICU to improve safety or quality.

Why they ask

Safety and quality work is part of consultant responsibility, and the panel wants evidence you finish what you start.

How to structure your answer

Use STAR: the situation and the risk you noticed, the task, the specific actions you took with the team, and the result measured in a way the unit actually felt.

Example answer

"On a previous unit we noticed that central line dressings were inconsistently documented after hours and lines were being reviewed later than they should. I raised it at the quality meeting, and rather than writing a new policy we built a short checklist into the existing nursing handover and added a line review prompt to the daily ward round. I worked with the clinical nurse consultant to trial it for a few weeks and adjust the wording, then rolled it out across the unit. Line review became a routine part of the ward round instead of something we chased, and the infection control team fed back that documentation was noticeably more complete at audit."

3. How do you approach a family meeting when the likely outcome is death or severe disability?

Why they ask

Family communication is a core part of the role and panels probe whether you can be honest and structured without becoming either evasive or blunt.

How to structure your answer

Describe your preparation, how you open the conversation, how you invite and respond to the family's understanding, and how you close with clear agreed next steps.

Example answer

"I prepare properly first: I know the clinical facts, I have spoken to the bedside nurse, and I have a clear view of what we are recommending and why. I ask who the family would want present and try to have the whole treating team aligned before the meeting. I open by asking what they already understand about how unwell their relative is, because that tells me where to start. Then I explain the current state in plain language, what support is doing for them and what we think is ahead, pausing to let them absorb it. If we are moving towards comfort-focused care, I say that directly and explain what it means in practice, and I check that they have understood. I finish by summarising what we have agreed, who will call them and when, and I document it clearly."

4. A registrar disagrees with your management plan in front of the team on a ward round. How do you handle it?

Why they ask

Leadership and supervision questions separate a consultant who builds a team from one who shuts it down.

How to structure your answer

Give a short, honest account of your approach: acknowledge the disagreement, protect the registrar's standing, resolve the clinical question on the evidence, and follow up privately if needed.

Example answer

"I would thank them for raising it, because a registrar who spots something I have missed is doing their job. If it is a genuine clinical difference, I would take a minute to hear their reasoning and explain mine, and if we still disagree I would set out why I am making the call and what review point would make me reconsider. What I would not do is turn it into a debate in front of the patient's bedside or the rest of the team. Afterwards I would check in with them privately, both to make sure they understood

the decision and to encourage them to keep speaking up. That is how registrars develop judgement, and it is safer for patients."

5. You have two deteriorating patients at once and only one senior doctor immediately available. How do you decide what to do?

Why they ask

This is a realistic capacity and prioritisation scenario, and the panel is listening for a clear framework rather than heroics.

How to structure your answer

Talk through how you triage: what clinical features make one patient more time-critical, what you delegate, who you call, and how you communicate the plan to both bedside teams.

Example answer

"I would triage on reversibility and time sensitivity rather than who shouted loudest. A patient with a rapidly correctable problem, say a tension pneumothorax or a reversible airway obstruction, gets me first because minutes matter and the fix is immediate. I would send the registrar or a senior nurse to the other patient with explicit instructions: what to check, what to start, and a firm time to call me back. I would ask the nurse in charge to call a colleague from another unit or the on-call consultant for support, and I would tell both bedside teams clearly where I am and when I will be with them. Once the first patient is stabilised, I would review the second myself and hand over properly. I would also flag the staffing pressure so it is on the record rather than absorbed silently."

6. Why this unit, and what would you bring beyond the clinical roster?

Why they ask

Units want a colleague who contributes to teaching, quality, research or service development, and who understands the specific setting.

How to structure your answer

Answer with a specific, honest reason tied to what you know about the unit, then a short account of the non-clinical work you actually do and could continue here.

Example answer

"I have followed the unit's work in [add a genuine, specific reason: a service, project or clinical focus you can point to], and the way the team runs its ward round and teaching fits how I like to work. Beyond the clinical roster, I have been involved in procedural teaching for registrars and in our sepsis and deteriorating patient reviews, and I would be keen to keep contributing in that space, including the nursing education side. I also supervised junior doctors through their ICU terms and found that the most useful thing I could give them was structured feedback after a shift rather than a lecture. I am realistic about roster demands, and I am interested in a unit where I can stay and build something over time."