Midwife interview questions

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What to expect

Midwifery interviews combine clinical competency checks with values-based and behavioural questions, since panels want to see both sound judgement under pressure and a woman-centred approach to care. Expect at least one scenario question that tests emergency decision-making, alongside questions about teamwork, communication and how you handle competing preferences between a woman's birth plan and clinical safety.

- **Clinical scenario:** Tests real-time decision-making in situations such as an abnormal CTG trace, postpartum haemorrhage or unexpected complication during labour.
- **Behavioural (STAR):** Explores past experience handling loss, conflict, or complex multidisciplinary cases, looking for evidence of resilience and reflective practice.
- **Client-facing communication:** Assesses how you balance a woman's autonomy and birth preferences against clinical recommendations and safety.
- **Safety and process:** Checks your approach to medication administration, documentation and escalation protocols in a busy ward environment.

Most midwifery interviews run as a panel with a senior midwife or clinical midwifery manager and sometimes a consumer or peer representative. They typically open with a general fit and motivation question, move into one or two detailed clinical scenarios, then cover behavioural questions about teamwork and difficult conversations, before finishing with your questions about the unit's model of care and rostering.

1. A woman's CTG trace shows late decelerations during the second stage of labour. Walk me through what you'd do.

Why they ask

This checks whether you can recognise a deteriorating fetal trace and apply the correct escalation pathway without hesitation.

How to structure your answer

Walk through your response step by step: what you observe first, immediate actions (repositioning, oxygen, stopping oxytocin if running), who you notify and when, and how you keep the woman informed throughout.

Example answer

“I'd first confirm the trace is accurate by checking the maternal pulse against the fetal heart rate to rule out a maternal signal. I'd reposition the woman, usually left lateral, and check for any obvious cause like maternal hypotension or an oxytocin infusion running too fast, which I'd stop immediately. At the same time I'd call for the obstetric registrar or on-call obstetrician and prepare the woman for the possibility of an assisted birth or caesarean if the trace doesn't recover. Throughout, I'd explain calmly what I'm doing and why, because clear communication reduces her fear and keeps her able to follow instructions during pushing.”

2. Tell me about a time you supported a woman through an unexpected complication or loss.

Why they ask

Midwives regularly face outcomes that don't go to plan, and panels want evidence you can provide compassionate care while managing your own reactions professionally.

How to structure your answer

Use STAR: describe the situation, your specific role, the actions you took to support the woman and family, and the result, including what you learned or how it shaped your practice.

Example answer

“During a postnatal shift, a woman I'd cared for antenatally was readmitted with signs of postpartum depression rather than settling into early parenthood as expected. My task was to reassess her wellbeing without making her feel judged. I sat with her, asked open questions about how she was coping rather than just clinical checklist items, and involved her partner in the conversation. I then referred her to the perinatal mental health team and documented clear follow-up steps for community midwifery. She engaged with the referral, and it reinforced for me how much postnatal checks need to go beyond physical recovery.”

3. How would you handle a situation where a woman's birth preferences conflict with what you believe is clinically safe?

Why they ask

This is central to midwifery practice and tests your ability to balance informed consent and autonomy against duty of care.

How to structure your answer

Describe your judgement process under pressure: how you'd listen, explain risk, document the conversation, and involve the wider team if the situation escalates.

Example answer

“I'd start by listening to why that preference matters to her, whether it's a previous birth trauma or a specific value she holds, rather than treating it as something to overcome. I'd then explain the clinical concern in plain language, using the partograph or CTG findings to show what I'm seeing, and offer alternatives that might meet her underlying priority in a safer way. If she still declines my recommendation and it's within her right to do so, I'd document the discussion thoroughly and keep monitoring closely, while looping in the obstetric team so everyone understands the plan and her wishes.”

4. What's your process for ensuring accurate medication administration and documentation on a busy shift?

Why they ask

Medication errors in maternity care carry serious risk for two patients at once, so interviewers want a concrete process, not a general assurance.

How to structure your answer

Walk through your standard process from checking the order to final documentation, noting where you build in double-checks.

Example answer

“I always check the medication against the woman's chart and allergy status before administration, and for anything high-risk like oxytocin or magnesium sulfate I get a second midwife to independently check the dose and rate. I document immediately after giving it rather than at the end of a task list, because delays are where errors slip through. If I'm interrupted mid-check, I stop and start the verification again rather than trying to remember where I left off.”

5. Describe a time you worked within a multidisciplinary team to manage a complex case.

Why they ask

Midwives coordinate closely with obstetricians, paediatricians and allied health, so panels want evidence you communicate well across disciplines.

How to structure your answer

Use STAR, with particular focus on how you contributed your midwifery perspective within the team decision, not just followed instructions.

Example answer

“I cared for a woman with pre-existing gestational diabetes whose labour needed close coordination between midwifery, the obstetric registrar and the neonatal team, given the higher risk of the baby needing extra monitoring after birth. My role was to keep continuous fetal surveillance and blood glucose monitoring on track while communicating changes promptly to the registrar. I made sure the neonatal team was briefed early rather than called in only at delivery, which meant they were ready immediately rather than scrambling. The baby needed brief monitoring for hypoglycaemia after birth, but because everyone had the same plan going into it, the transition was calm rather than rushed.”

6. How do you assess and support a new mother struggling with breastfeeding in the first 48 hours postpartum?

Why they ask

Infant feeding support is a core postnatal task and tests both clinical knowledge and educational approach.

How to structure your answer

Explain your clinical and educational process: what you assess first, how you tailor education to the individual, and how you know when to escalate to a lactation consultant.

Example answer

“I'd start by observing a full feed rather than relying on what the mother tells me, checking positioning, attachment and whether the baby is actually swallowing. Sore nipples or a baby who won't settle often point to an attachment issue I can correct on the spot by adjusting position. I'd also ask about her own expectations and any pain, since some mothers persist through significant discomfort without saying so. If there are ongoing concerns like tongue-tie, poor weight gain or persistent pain despite correcting technique, I'd refer to a lactation consultant or paediatric review rather than continuing to troubleshoot alone.”