



FREE PRACTICE · NO ACCOUNT NEEDED

Twenty FMProC sample questions

Worked examples across all four assessed attributes, in both rating and ranking formats — with the answer key, a rationale for every option, and space for your notes.

20 questions

4 attributes

2 formats

Created by **Dr. Mehrdad Anvar**, MD, LMCC

What's inside

[Browse online ↗](#)

Professional Integrity
Acting honestly and in the patient's interest

5

Empathy and Compassion
Understanding and responding to distress

5

Team Collaboration
Working well with patients and colleagues

5

Adaptability
Adjusting when the situation changes

5

1 Read and answer
Work through one case per page, using the scale or ranking boxes.

2 Check the key
Turn the page for the answer key and an explanation for every option.

3 Read the reasoning
Compare your thinking with the rationale and transferable principle.

ALSO INCLUDED

- ✓ Answer key and rationale for all 20
- ✓ A link to every worked page
- ✓ Rating and ranking formats
- ✓ Space for your own notes

THE FULL BANK

170 questions. Free after sign-up.

Attempt history and review-importance sorting included.

[Start practising ↗](#)

Unofficial study resource. Not affiliated with, endorsed by, or connected to the University of Calgary or the FMProC program. Scenarios are educational only and are not clinical or professional advice.

What's inside

Five samples for each attribute. Each case has a question page followed by its answer and rationale, and every entry links to the worked page online.

Professional Integrity			5 SAMPLES
01	Dr. Amara Okoye, a first-year Family Medicine resident on a General Internal Medicine ward...	b01 Rating	p. 03–04
02	Dr. Hana Yildiz, a family medicine resident, is running 40 minutes behind schedule in a busy...	b18 Rating	p. 05–06
03	Dr. Sarah Tremblay is a PGY1 family medicine resident rotating in a chaotic community...	v2021 Rating	p. 07–08
04	Dr. Nadia Farooq, a family medicine resident, is covering a busy evening shift at an...	b09 Ranking	p. 09–10
05	Dr. Maya Lin is finishing documentation in the clinic workroom when she notices her...	v2064 Ranking	p. 11–12
Empathy and Compassion			5 SAMPLES
06	Dr. Priya Sundaram is a family medicine resident at an urban community clinic. She is...	b02 Rating	p. 13–14
07	Dr. Liam Chen is conducting a six-week postpartum check with Danielle Taylor and her newborn...	v2023 Rating	p. 15–16
08	Dr. Noah Tremblay is completing a rural northern rotation at a remote nursing station. Elder...	v2034 Rating	p. 17–18
09	Dr. Callie Muir, a family medicine resident, is conducting a scheduled 30-minute home visit...	b10 Ranking	p. 19–20
10	You are a family medicine resident caring for Margaret MacIntyre, an elderly comatose patient...	v2096 Ranking	p. 21–22
Team Collaboration			5 SAMPLES
11	You are Dr. Yusuf Ahmed, a PGY2 family medicine resident on a community medicine rotation. You...	b05 Rating	p. 23–24
12	Dr. Danielle Ross is completing a rotation on a busy inpatient family medicine teaching ward....	v2010 Rating	p. 25–26
13	You are Dr. Julian Roy, a PGY2 Family Medicine resident in a busy academic community clinic....	v2045 Rating	p. 27–28
14	Dr. Ian Woods is a family medicine resident completing a rotation at a First Nations community...	b11 Ranking	p. 29–30
15	Dr. Al-Mansoor is examining Mr. Henderson, a 68-year-old patient with severe osteoarthritis...	v2094 Ranking	p. 31–32
Adaptability			5 SAMPLES
16	Dr. Priya Nair, a first-year family medicine resident, arrives for her scheduled outpatient...	b34 Rating	p. 33–34
17	Dr. Chloe Tremblay is a PGY1 resident completing a full daytime ward shift on the family...	v2048 Rating	p. 35–36
18	Dr. Evan Ross is a PGY1 Family Medicine resident on his first rural family medicine block. The...	v2059 Rating	p. 37–38
19	Dr. Hannah Cole, a family medicine resident on a long-term care rotation, is on-call overnight...	b07 Ranking	p. 39–40
20	You are a family medicine resident staffing an isolated northern nursing station when an adult...	v2097 Ranking	p. 41–42



Links are clickable. Open any question online for the interactive version, the answer key and the rationale for every option.

fmprocp.ca/questions

Professional Integrity

Rating

Hard

b01

Professional Integrity

Sample question 01 · Rating format

SCENARIO

Dr. Amara Okoye, a first-year Family Medicine resident on a General Internal Medicine ward rotation, is caring for Mr. Stein, a fully competent 68-year-old man recently diagnosed with locally advanced pancreatic cancer. During morning rounds, Mr. Stein's adult children, David and Sarah, intercept Dr. Okoye in the hallway and insist that their father must not be told the diagnosis directly. They explain that hearing such devastating news from a stranger would destroy him, asking that the clinical team allow them to disclose it gradually at home in their own way. When Dr. Okoye raises this with the attending physician, Dr. Vance, the attending remarks that the family knows the patient best and seems content to let them manage the information. Mr. Stein is scheduled for a discharge planning conference this afternoon and has just rung his call bell to ask for an update on his scan results.

YOUR TASK

How desirable is each of the following responses by Dr. Okoye in this situation? Consider each option independently; several may share a rating.

1 Very desirable

2 Somewhat desirable

3 Neither desirable nor undesirable

4 Somewhat undesirable

5 Very undesirable

OPTIONS

Circle one number per option

A Request an immediate clinical ethics consultation before discussing the diagnosis with Mr. Stein or his family.

1 2 3 4 5

B Agree to withhold the diagnosis from Mr. Stein permanently as requested by his adult children.

1 2 3 4 5

C Wait a few days to give the adult children an opportunity to disclose the diagnosis themselves.

1 2 3 4 5

D Tell Mr. Stein his cancer diagnosis immediately in his room, without any further family communication.

1 2 3 4 5

E Ask Mr. Stein privately about his preferences for receiving test results and involving his family.

1 2 3 4 5

F Meet with the adult children to explore their fears while explaining patient rights to disclosure.

1 2 3 4 5

G Discuss the ethical and professional obligations regarding truthful disclosure directly with the attending physician.

1 2 3 4 5

[Work through this question online](#)

Interactive version and related samples. The answer and rationale are on the next page.

fmprocprep.ca/questions/b01-professional-integrity

YOUR NOTES

Space for your reasoning

Professional Integrity

Rating

Hard

b01

Sample 01 · Answer & rationale

Professional Integrity · Scale: 1 Very desirable → 5 Very undesirable

ANSWER KEY

A 3

B 5

C 4

D 4

E 1

F 2

G 2

[Open online ↗](#)
A Request an immediate clinical ethics consultation before discussing the diagnosis with Mr. Stein or his family.

Key 3

This response is neither desirable nor undesirable because clinical ethics services are valuable resources for navigating irreconcilable moral impasses in hospital settings. However, mobilizing a formal ethics consult at this stage is premature, as basic clinical communication avenues—such as exploring the patient's preferences or having a focused discussion with the attending—have not yet been attempted. While not causing direct harm, it unnecessarily defers standard clinical responsibilities and delays care. It would become desirable if bedside dialogue and supervisory discussions reached an intractable stalemate.

PRINCIPLE Exhaust bedside communication and supervisory discussion before escalating to formal ethics.

B Agree to withhold the diagnosis from Mr. Stein permanently as requested by his adult children.

Key 5

This response is very undesirable because actively concealing a life-limiting diagnosis from a competent adult constitutes a critical failure of professional integrity, legal duty, and patient autonomy. Deceiving a patient or withholding essential prognostic information prevents them from participating in their own care decisions, planning their future, or providing valid informed consent for ongoing management. There is no ethical or clinical justification for completely subordinating a competent patient's right to information to the preferences of family members.

PRINCIPLE Never collude in withholding critical diagnostic information from a competent patient.

C Wait a few days to give the adult children an opportunity to disclose the diagnosis themselves.

Key 4

This response is somewhat undesirable because colluding in delayed disclosure to a competent patient without that patient's consent compromises informed consent and personal autonomy. While allowing families to share difficult news can occasionally be appropriate if requested by the patient, passively abdicating medical disclosure solely at the request of third parties leaves Mr. Stein uninformed during discharge planning. It also places the patient at risk of hearing the diagnosis accidentally from other staff. To be acceptable, this delay would require Mr. Stein's explicit instruction to delegate disclosure to his family.

PRINCIPLE Delaying disclosure on third-party requests breaches the obligation to competent patients.

D Tell Mr. Stein his cancer diagnosis immediately in his room, without any further family communication.

Key 4

This response is somewhat undesirable because, although it technically upholds the duty of truth-telling to a competent patient, delivering a devastating diagnosis abruptly and unilaterally lacks relational sensitivity. Disregarding the family's context entirely and failing to explore whether Mr. Stein desires support persons present can cause acute distress and fracture the therapeutic alliance. It prioritizes blunt contractual honesty over compassionate, patient-centred communication. To improve, the resident would first assess Mr. Stein's readiness and preferred support network before disclosing sensitive results.

PRINCIPLE Truth-telling must be delivered with relational sensitivity rather than blunt unilateralism.

E Ask Mr. Stein privately about his preferences for receiving test results and involving his family.

Key 1

This response is very desirable because competent adult patients possess the autonomous right to receive their health information and to direct how involved their family should be. Approaching the patient privately and exploring his preferred style of receiving information respects his autonomy without bluntly imposing unsolicited details or immediately creating conflict with his children. To lower this rating, the option would need to bypass the patient's agency or reveal information coercively.

PRINCIPLE Competent patients determine their own information disclosure and family involvement preferences.

F Meet with the adult children to explore their fears while explaining patient rights to disclosure.

Key 2

This response is somewhat desirable as it demonstrates compassion for the family's protective instincts while gently establishing professional and ethical boundaries regarding patient autonomy. Educating the family helps de-escalate tension and facilitates supportive disclosure rather than adversarial conflict. Nonetheless, spending time solely with relatives risks delaying responsiveness to Mr. Stein himself, who is currently asking for his results. To reach the top level, this conversation would need to support, rather than precede or supplant, direct communication with the patient.

PRINCIPLE Acknowledge family concerns compassionately without compromising patient autonomy or confidentiality.

G Discuss the ethical and professional obligations regarding truthful disclosure directly with the attending physician.

Key 2

This response is somewhat desirable because resident trainees should seek alignment with their supervisor when encountering conflicting clinical directions or ethical dilemmas. Engaging Dr. Vance directly addresses the attending's problematic passivity and reinforces shared accountability across the medical team. However, because it remains focused on internal team dynamics rather than addressing the patient who is currently asking for results, it does not fully resolve the bedside issue. It would be very desirable if paired with an active plan to assess Mr. Stein's disclosure wishes.

PRINCIPLE Address supervisory ambiguity collaboratively before initiating complex, contested patient communication.

Professional Integrity

Rating

Hard

b18

Professional Integrity

Sample question 02 · Rating format

SCENARIO

Dr. Hana Yildiz, a family medicine resident, is running 40 minutes behind schedule in a busy ambulatory clinic. Her preceptor, Dr. Craig Campbell, observes the backlog and quietly suggests that everyone in the clinic saves an hour by copying the previous visit notes forward for routine follow-ups. Dr. Campbell demonstrates this on Dr. Yildiz's computer, pulling forward an unedited previous physical examination template into an unexamined patient's open encounter. Dr. Yildiz has not yet seen or examined the two remaining patients on her morning schedule. She understands that while note-forwarding is common practice, clinical records must accurately reflect services actually rendered during the specific visit. Dr. Yildiz must decide how to proceed.

YOUR TASK

How desirable is each of the following responses by Dr. Yildiz in this situation? Consider each option independently; several may share a rating.

1 Very desirable

2 Somewhat desirable

3 Neither desirable nor undesirable

4 Somewhat undesirable

5 Very undesirable

OPTIONS

Circle one number per option

A Adopt Dr. Campbell's shortcut for today to catch up, intending to amend erroneous text later if needed.

1 2 3 4 5

B Thank Dr. Campbell for the tip while respectfully stating she prefers documenting findings after conducting her examinations.

1 2 3 4 5

C Copy forward historical background data but delete all physical examination and assessment text until after evaluation.

1 2 3 4 5

D Ask the clinic reception staff to rebook the two patients to avoid falling further behind schedule.

1 2 3 4 5

E Evaluate the patients fully and document only history and examination findings that she directly verifies today.

1 2 3 4 5

F Sign off the copied-forward clinical notes immediately to close the charts and keep clinic flow moving.

1 2 3 4 5

Work through this question online

Interactive version and related samples. The answer and rationale are on the next page.

fmprocprep.ca/questions/b18-professional-integrity

YOUR NOTES

Space for your reasoning

Professional Integrity

Rating

Hard

b18

Sample 02 · Answer & rationale

Professional Integrity · Scale: 1 Very desirable → 5 Very undesirable

ANSWER KEY

A 4

B 1

C 2

D 3

E 1

F 5

[Open online ↗](#)
A Adopt Dr. Campbell's shortcut for today to catch up, intending to amend erroneous text later if needed. Key 4

This response is somewhat undesirable (Rating 4) because leaving unverified clinical findings in an active chart creates clinical confusion and risks false record certification if amendments are forgotten. Charting ahead of time violates documentation standards. It avoids a 5 only because there is an intent to correct inaccuracies.

PRINCIPLE Documenting prospective findings with intentions of later amendment compromises chart integrity.

B Thank Dr. Campbell for the tip while respectfully stating she prefers documenting findings after conducting her examinations. Key 1

This response is very desirable (Rating 1) because it balances professional integrity with collegial diplomacy toward a supervisor. It clearly communicates her personal commitment to accurate charting while defusing hierarchy tension. It would shift downward only if the tone became argumentative.

PRINCIPLE Diplomatic boundary setting preserves documentation integrity within supervisory hierarchical relationships.

C Copy forward historical background data but delete all physical examination and assessment text until after evaluation. Key 2

This response is somewhat desirable (Rating 2) because carrying forward stable past history or chronic medication lists is legitimate, provided unverified objective findings are excised. However, doing this while rushed risks accidental retention of outdated information. It would be a 1 if followed by rigorous post-visit verification.

PRINCIPLE Carrying forward baseline chart data requires rigorous deletion of unverified objective findings.

D Ask the clinic reception staff to rebook the two patients to avoid falling further behind schedule. Key 3

This response is neither desirable nor undesirable (Rating 3) because while it prevents rushed or inaccurate charting, turning away scheduled patients inconveniences them and disrupts access. Rebooking should be reserved for true emergencies rather than routine delays. It would move down if the patients travelled far or had acute needs.

PRINCIPLE Cancelling appointments to manage documentation delays compromises access to patient care.

E Evaluate the patients fully and document only history and examination findings that she directly verifies today. Key 1

This response is very desirable (Rating 1) because it ensures patient safety and uncompromised medical record accuracy despite schedule pressure. Truth in clinical documentation is non-negotiable. It upholds the Professional CanMEDS role under challenging practice constraints without unnecessary confrontation.

PRINCIPLE Clinical documentation must accurately reflect patient evaluations directly performed during that encounter.

F Sign off the copied-forward clinical notes immediately to close the charts and keep clinic flow moving. Key 5

This response is very undesirable (Rating 5) because signing an unexamined patient's record containing fabricated examination data constitutes fraudulent documentation and compromises clinical safety. It exposes patients to diagnostic errors and the resident to disciplinary action. It represents a complete failure of integrity under time pressure.

PRINCIPLE Signing unverified clinical records constitutes fraudulent charting and threatens patient safety.

YOUR TAKEAWAY

One sentence you want to remember

Professional Integrity

Rating

Hard

v2021

Professional Integrity

Sample question 03 · Rating format

SCENARIO

Dr. Sarah Tremblay is a PGY1 family medicine resident rotating in a chaotic community emergency department during a surge in patient volume. Her senior resident, Dr. Dave Miller, dictates a formal inpatient admission note solely from the triage nurse's intake summary without evaluating the patient in person. Dr. Miller instructs Sarah to submit the electronic admission order set immediately so that emergency beds can clear before their shift ends. Sarah has not yet assessed or met the patient. Department policy requires an in-person physician evaluation prior to inpatient bed requests. Sarah feels substantial pressure from Dr. Miller to expedite bed turnover.

YOUR TASK

How desirable is each of the following responses by Dr. Tremblay in this situation? Consider each option independently; several may share a rating.

1 Very desirable

2 Somewhat desirable

3 Neither desirable nor undesirable

4 Somewhat undesirable

5 Very undesirable

OPTIONS

Circle one number per option

A Submit the admission orders as requested but document that the senior resident ordered them unassessed.

1 2 3 4 5

B State to Dr. Miller that she must conduct a brief bedside assessment before signing admission orders.

1 2 3 4 5

C Immediately report Dr. Miller's conduct to the department medical director without discussing the issue with him.

1 2 3 4 5

D Ask Dr. Miller to clarify the clinical rationale for admitting without performing an in-person assessment.

1 2 3 4 5

E Sign the admission order set immediately to avoid impeding flow during the departmental surge.

1 2 3 4 5

F Request that the triage nurse verify vital signs again before submitting the admission order set.

1 2 3 4 5

[Work through this question online](#)

Interactive version and related samples. The answer and rationale are on the next page.

fmprocprep.ca/questions/v2021-professional-integrity

YOUR NOTES

Space for your reasoning

Professional Integrity · Scale: 1 Very desirable → 5 Very undesirable

ANSWER KEY

A 4

B 1

C 4

D 2

E 5

F 3

[Open online ↗](#)

A Submit the admission orders as requested but document that the senior resident ordered them unassessed.

Key 4

This response is Somewhat Undesirable (4). Defensive charting does not protect patient safety from erroneous admission orders. While it attempts to preserve personal documentation accuracy, submitting unverified orders still enables unsafe care. To be rated higher, Dr. Tremblay must refuse to sign orders until an evaluation occurs rather than relying on charting disclaimers.

PRINCIPLE Protective charting does not excuse executing unsafe or unverified clinical orders.

B State to Dr. Miller that she must conduct a brief bedside assessment before signing admission orders.

Key 1

This response is Very Desirable (1). It directly addresses the safety issue and adheres to professional standards by ensuring an in-person evaluation occurs before committing orders. Dr. Tremblay communicates her clinical boundary respectfully without escalating prematurely. To be rated lower, it would have to deflect responsibility or cause unnecessary administrative confrontation.

PRINCIPLE Patient safety and verification precede administrative convenience and discharge efficiency.

c Immediately report Dr. Miller's conduct to the department medical director without discussing the issue with him.

Key 4

This response is Somewhat Undesirable (4). Bypassing direct communication with a colleague to escalate immediately to senior departmental leadership is disproportionate when the issue can still be managed locally. Immediate escalation might be warranted if there were malicious intent or imminent catastrophic harm that local intervention could not avert. To rate higher, Dr. Tremblay must first address the matter with Dr. Miller.

PRINCIPLE Attempt local resolution of professional disagreements before escalating to program leadership.

D Ask Dr. Miller to clarify the clinical rationale for admitting without performing an in-person assessment.

Key 2

This response is Somewhat Desirable (2). It invites dialogue and professional reflection, which may prompt the senior resident to recognize the oversight. However, it does not definitively state that Dr. Tremblay will assess the patient before placing orders. To achieve a 1, she would combine this inquiry with an explicit commitment to evaluate the patient herself.

PRINCIPLE Respectful professional inquiry encourages colleague self-correction while maintaining clinical standards.

E Sign the admission order set immediately to avoid impeding flow during the departmental surge.

Key 5

This response is Very Undesirable (5). It completely compromises professional integrity and patient safety in favor of administrative speed and shift handover convenience. Signing an admission order set without any physician evaluation risks serious diagnostic error and inappropriate inpatient bed utilization. There are no circumstances where clinical assessment should be entirely bypassed for throughput.

PRINCIPLE Throughput and flow pressures never justify abandoning foundational clinical assessment standards.

F Request that the triage nurse verify vital signs again before submitting the admission order set.

Key 3

This response is Neither Desirable nor Undesirable (3). While acquiring updated objective data provides some clinical reassurance, it inappropriately substitutes nursing re-assessment for necessary physician evaluation. It does not resolve the ethical breach of signing admission orders unassessed. It would move higher if linked to direct bedside evaluation, or lower if used as a complete substitute.

PRINCIPLE Auxiliary data collection cannot replace mandatory direct physician clinical assessment.

YOUR TAKEAWAY

One sentence you want to remember

Professional Integrity

Ranking

Hard

b09

Professional Integrity

Sample question 04 · Ranking format

SCENARIO

Dr. Nadia Farooq, a family medicine resident, is covering a busy evening shift at an after-hours clinic alongside her preceptor, Dr. Reiss. Over the past hour, Dr. Farooq observes Dr. Reiss give contradictory dosing instructions for the same standard antibiotic to two different adult patients, and notices him visibly swaying while standing at the charting desk. The charge nurse, Nurse Janet Gomez, approaches Dr. Farooq privately and whispers that she smells alcohol and is deeply worried about Dr. Reiss's fitness to continue seeing patients. Dr. Reiss has been an exceptionally supportive and kind preceptor throughout Dr. Farooq's rotation. Two hours remain in the clinic shift, and multiple complex patients are waiting in the reception area.

YOUR TASK

Rank in order the following actions for Dr. Farooq to take in response to this situation.

1 Most desirable

2

3

4

5 Least desirable

OPTIONS

Write a rank from 1 to 5 in each box

A Wait until clinic closes tonight to speak with Dr. Reiss privately about the observed dosing errors and physical instability.

RANK

B Speak privately with Dr. Reiss immediately alongside the charge nurse, advising him to step away from patient care tonight.

RANK

C Call the on-call clinic medical director immediately to report suspected acute impairment and request urgent supervisor coverage.

RANK

D Offer to take over seeing all remaining clinic patients tonight while advising Dr. Reiss to rest in his office.

RANK

E Cross-check every prescription and chart Dr. Reiss writes for the remainder of the shift before patients leave.

RANK

Work through this question online

Interactive version and related samples. The answer and rationale are on the next page.

fmprocprep.ca/questions/b09-professional-integrity

YOUR NOTES

Space for your reasoning

Professional Integrity

Ranking

Hard

b09

Sample 04 · Answer & rationale

Professional Integrity · Scale: 1 Most desirable → 5 Least desirable

ANSWER KEY

A 5

B 1

C 2

D 3

E 4

[Open online ↗](#)
A Wait until clinic closes tonight to speak with Dr. Reiss privately about the observed dosing errors and physical instability.

Rank 5

Rank 5. Postponing action until after the shift permits an acutely compromised physician to continue treating patients for two more hours. Loyalty and personal discomfort must never override imminent patient protection. It represents the least acceptable choice because it accepts active patient risk to avoid immediate conflict.

PRINCIPLE Never delay intervention when immediate patient safety is actively compromised.

B Speak privately with Dr. Reiss immediately alongside the charge nurse, advising him to step away from patient care tonight.

Rank 1

Rank 1. This action prioritizes immediate patient safety while treating the colleague with dignity and ensuring an objective witness is present. It addresses the acute hazard directly before any further patients are exposed to potentially compromised care. It would move down if handled confrontationally in front of patients.

PRINCIPLE Address acute colleague impairment immediately and privately to safeguard patient welfare.

C Call the on-call clinic medical director immediately to report suspected acute impairment and request urgent supervisor coverage.

Rank 2

Rank 2. Escalating directly to clinical leadership is a sound, responsible action that mobilizes institutional authority and backup coverage. However, it ranks just below direct intervention because waiting for leadership action may create a brief delay while the supervisor remains in active practice. It would rank higher if the supervisor had already refused to step down.

PRINCIPLE Escalate suspected impairment to administrative leadership to ensure safe clinic coverage.

D Offer to take over seeing all remaining clinic patients tonight while advising Dr. Reiss to rest in his office.

Rank 3

Rank 3. While this option protects patients from the supervisor and shows initiative, it exceeds the resident's legal and training scope to manage an urgent clinic entirely without staff supervision. Furthermore, it informally conceals potential impairment rather than addressing it through proper channels. It ranks above passive monitoring because it removes the compromised physician from direct care.

PRINCIPLE Do not practice beyond educational scope to shield an impaired colleague.

E Cross-check every prescription and chart Dr. Reiss writes for the remainder of the shift before patients leave.

Rank 4

Rank 4. This is a well-meaning attempt at damage control, but it leaves an impaired clinician actively delivering care and assessing patients. It is practically unfeasible during a busy shift and fails to prevent verbal misinformation, missed diagnoses, or procedural errors. It would rank lower only if no safety measures were taken at all.

PRINCIPLE Harm mitigation cannot substitute for removing an active safety hazard.

YOUR TAKEAWAY

One sentence you want to remember

Professional Integrity

Ranking

Approachable

v2064

Professional Integrity

Sample question 05 · Ranking format

SCENARIO

Dr. Maya Lin is finishing documentation in the clinic workroom when she notices her co-resident, Dr. Jordan Reed, updating his official residency procedural logbook. Jordan logs independent procedural credit for three knee joint arthrocenteses performed earlier that morning. Maya personally assisted on all three cases and knows Jordan merely observed the attending physician perform the procedures from across the examination table. When Maya privately asks about the entries, Jordan dismisses her concern, claiming that everyone logs observed procedures as independent to fulfill mandatory program quotas before CaRMS and graduation deadlines. Maya knows the residency program requires honest logging to certify clinical competence for independent practice.

YOUR TASK

Rank in order the following actions for Dr. Lin to take in response to this situation.

1 Most desirable

2

3

4

5 Least desirable

OPTIONS

Write a rank from 1 to 5 in each box

A Explain clearly to the colleague why false logging compromises safety, urging him to correct the entries himself.

RANK

B Warn the colleague that she will report the falsified logs to program leadership unless he corrects them.

RANK

C Report the fraudulent logbook entries immediately to the residency program director without further discussion with the colleague.

RANK

D Advise the attending physician who performed the injections that the colleague logged them as independent credit.

RANK

E Ignore the conversation and mind her own logbook, viewing peer logging practices as the program's responsibility.

RANK

[Work through this question online](#)

Interactive version and related samples. The answer and rationale are on the next page.

fmprocprep.ca/questions/v2064-professional-integrity

YOUR NOTES

Space for your reasoning

Professional Integrity

Ranking

Approachable

v2064

Sample 05 · Answer & rationale

Professional Integrity · Scale: 1 Most desirable → 5 Least desirable

ANSWER KEY

A 1

B 2

C 3

D 4

E 5

[Open online ↗](#)
A Explain clearly to the colleague why false logging compromises safety, urging him to correct the entries himself.

Rank 1

This is rank 1 because it addresses the ethical breach directly, collegially, and non-judgmentally at the peer level before formal escalation. It offers the co-resident an immediate opportunity to rectify the dishonest entry while underscoring the serious implications for patient safety and professional standards. To rank lower, it would have to be confrontational, passive, or prematurely punitive.

PRINCIPLE Address peer ethical breaches directly and collegially, providing opportunity for voluntary correction.

B Warn the colleague that she will report the falsified logs to program leadership unless he corrects them.

Rank 2

This is rank 2 because it establishes clear, uncompromising professional boundaries and gives the colleague a final chance to uphold integrity before formal institutional intervention occurs. While slightly more adversarial than an educational first conversation, it appropriately prioritizes patient safety and accountability. It ranks below Rank 1 because constructive dialogue is preferable to an immediate ultimatum.

PRINCIPLE Set firm accountability boundaries with transparent consequences when addressing documented peer dishonesty.

C Report the fraudulent logbook entries immediately to the residency program director without further discussion with the colleague.

Rank 3

This is rank 3 because, while it upholds program standards and ensures institutional awareness of dishonesty, escalating immediately without attempting a firm peer-level discussion damages collegial trust. Direct local resolution should be attempted first unless severe patient harm is imminent. It would rank higher if the colleague had already adamantly refused to correct the fraudulent record.

PRINCIPLE Reserve direct program escalation for unrectified ethical breaches following transparent peer discussion.

D Advise the attending physician who performed the injections that the colleague logged them as independent credit.

Rank 4

This is rank 4 because it involves an intermediary clinical supervisor who is not directly responsible for residency curriculum governance, avoiding the proper formal channels. While informing the involved preceptor is relevant, doing so before clarifying the issue with the peer or approaching the residency director represents awkward, indirect escalation. It would rank higher if the preceptor signed the logs.

PRINCIPLE Utilize established academic accountability pathways rather than triangulating uninvolved clinical supervisors.

E Ignore the conversation and mind her own logbook, viewing peer logging practices as the program's responsibility.

Rank 5

This is rank 5 because willful blindness to fraudulent credentialing undermines the medical profession and directly risks future patient safety if an incompetent physician is certified. Professional self-regulation requires residents to actively challenge dishonesty rather than looking away. It would rank higher only if Maya were unsure of the factual basis of the fraud.

PRINCIPLE Uphold professional self-regulation by actively rejecting passive complicity in credentialing fraud.

YOUR TAKEAWAY

One sentence you want to remember

Empathy and Compassion

Rating

Approachable

b02

Empathy and Compassion

Sample question 06 · Rating format

SCENARIO

Dr. Priya Sundaram is a family medicine resident at an urban community clinic. She is currently seeing Joy, a 17-year-old patient who attended the consultation alone under the clinic's mature minor youth confidentiality protocol. While discussing her tension headaches, Joy becomes visibly distressed, begins to weep, and discloses that she is attracted to girls. Joy suddenly grabs Dr. Sundaram's sleeve and whispers, 'Please don't tell them, please,' expressing acute terror that her parents waiting in the parking lot will find out. Moments later, the clinic medical office assistant sends an urgent instant message stating that Joy's parents have texted requesting a written summary of the visit before driving home. Dr. Sundaram must determine how to handle Joy's immediate distress alongside the parents' request.

YOUR TASK

How desirable is each of the following responses by Dr. Sundaram in this situation? Consider each option independently; several may share a rating.

1 Very desirable

2 Somewhat desirable

3 Neither desirable nor undesirable

4 Somewhat undesirable

5 Very undesirable

OPTIONS

Circle one number per option

A Prepare a clinical summary limited to the headache evaluation and review it with Joy before release.

1 2 3 4 5

B Provide the parents with the full consultation notes to maintain total transparency with the family.

1 2 3 4 5

C Recite the provincial mature minor legislation to Joy without acknowledging her acute feelings of fear.

1 2 3 4 5

D Advise Joy that being honest with her parents today would be the best way to relieve her anxiety.

1 2 3 4 5

E Condition confidentiality on Joy agreeing to attend family counseling with her parents in the near future.

1 2 3 4 5

F Reassure Joy immediately that her personal disclosure is strictly confidential and will not be shared with her parents.

1 2 3 4 5

G Validate Joy's distress and collaborate with her on what headache details to include in the parental summary.

1 2 3 4 5



Work through this question online

Interactive version and related samples. The answer and rationale are on the next page.

fmproccprep.ca/questions/b02-empathy-and-compassion

YOUR NOTES

Space for your reasoning



Empathy and Compassion

Rating

Approachable

b02

Sample 06 · Answer & rationale

Empathy and Compassion · Scale: 1 Very desirable → 5 Very undesirable

ANSWER KEY

A 2

B 5

C 3

D 4

E 5

F 1

G 1

[Open online ↗](#)**A Prepare a clinical summary limited to the headache evaluation and review it with Joy before release.**

Key 2

Rating 2 (Somewhat desirable). This option responsibly protects confidential disclosures and appropriately seeks Joy's review before sharing documentation. However, it leans primarily on procedural action rather than offering immediate verbal empathy to address Joy's visible emotional distress. It would move to very desirable if Dr. Sundaram first comforted and reassured Joy.

PRINCIPLE Uphold privacy pragmatically while ensuring patient review, though prioritize emotional comfort.

B Provide the parents with the full consultation notes to maintain total transparency with the family.

Key 5

Rating 5 (Very undesirable). Disclosing a competent mature minor's confidential information against her explicit wishes represents a catastrophic professional and ethical failure. This breaches legal confidentiality standards and directly risks Joy's safety and well-being at home. Upholding confidentiality is non-negotiable here.

PRINCIPLE Never release confidential mature minor records without informed patient consent.

C Recite the provincial mature minor legislation to Joy without acknowledging her acute feelings of fear.

Key 3

Rating 3 (Neither desirable nor undesirable). The information provided is legally accurate and upholds confidentiality, which protects the patient from external breach. However, communicating via bureaucratic policy without personal warmth or empathy fails to address Joy's overwhelming vulnerability. It would move up significantly if paired with emotional validation.

PRINCIPLE Avoid clinical or legal detachment when patients require compassionate reassurance.

D Advise Joy that being honest with her parents today would be the best way to relieve her anxiety.

Key 4

Rating 4 (Somewhat undesirable). Pressuring an adolescent in acute distress to disclose her sexual orientation disregards her stated boundaries and psychological safety. While familial openness can be beneficial under supportive circumstances, urging immediate disclosure invalidates Joy's fear and damages the therapeutic alliance. It would move to very undesirable if disclosure were made mandatory.

PRINCIPLE Never pressure vulnerable adolescents to disclose sensitive identity details prematurely.

E Condition confidentiality on Joy agreeing to attend family counseling with her parents in the near future.

Key 5

Rating 5 (Very undesirable). Imposing conditions on a mature minor's confidentiality is coercive and contrary to medical ethics. This approach exploits Joy's heightened vulnerability, breaches standard consent principles, and destroys patient trust in healthcare providers. Unconditional respect for mature minor confidentiality is required.

PRINCIPLE Do not impose conditional terms on a mature minor's right to privacy.

F Reassure Joy immediately that her personal disclosure is strictly confidential and will not be shared with her parents.

Key 1

Rating 1 (Very desirable). Joy is experiencing acute panic that requires direct, compassionate reassurance to establish safety. Prioritizing immediate emotional containment while confirming mature minor confidentiality rights exemplifies patient-centred communication. This response would only lose marks if it deflected or postponed addressing Joy's terror.

PRINCIPLE Immediately alleviate patient terror by affirming absolute confidentiality rights.

G Validate Joy's distress and collaborate with her on what headache details to include in the parental summary.

Key 1

Rating 1 (Very desirable). This response explicitly acknowledges Joy's emotional state while actively restoring her sense of autonomy over her medical information. Engaging Joy in deciding how the parents' inquiry is answered resolves the practical dilemma collaboratively without compromising trust. It would move down if the resident drafted the summary without Joy's input.

PRINCIPLE Involve distressed patients collaboratively in decisions regarding external information sharing.

YOUR TAKEAWAY

One sentence you want to remember

Empathy and Compassion

Rating

Hard

v2023

Empathy and Compassion

Sample question 07 · Rating format

SCENARIO

Dr. Liam Chen is conducting a six-week postpartum check with Danielle Taylor and her newborn in the clinic. Danielle appears visibly exhausted and emotionally detached while her infant cries persistently in the car seat. When Dr. Chen asks how bonding is going, Danielle tearfully laughs and remarks that the infant would probably be calmer and happier with an adoptive family. Danielle immediately waves her hands, brushes off the remark as an exhausted joke, and asks to proceed with the infant's routine physical measurements. Dr. Chen observes significant distress and vulnerability despite her attempt to deflect.

YOUR TASK

How desirable is each of the following responses by Dr. Chen in this situation? Consider each option independently; several may share a rating.

1 Very desirable

2 Somewhat desirable

3 Neither desirable nor undesirable

4 Somewhat undesirable

5 Very undesirable

OPTIONS

Circle one number per option

A Proceed with measuring the infant while observing Danielle's maternal interactions before returning to her emotional well-being.

1 2 3 4 5

B Immediately notify child protective services regarding Danielle's statement about relinquishing her infant for adoption.

1 2 3 4 5

C Acknowledge Danielle's profound exhaustion and gently explore the feelings underlying her comment about adoption.

1 2 3 4 5

D Validate how overwhelming postpartum adjustments can be before offering to administer a validated postpartum depression screen.

1 2 3 4 5

E Reassure Danielle that all new mothers experience occasional self-doubt and feeling overwhelmed is completely normal.

1 2 3 4 5

F Advise Danielle firmly that joking about child abandonment suggests she needs immediate psychiatric hospitalization.

1 2 3 4 5



Work through this question online

Interactive version and related samples. The answer and rationale are on the next page.

fmprocprep.ca/questions/v2023-empathy-and-compassion

YOUR NOTES

Space for your reasoning

Empathy and Compassion

Rating

Hard

v2023

Sample 07 · Answer & rationale

Empathy and Compassion · Scale: 1 Very desirable → 5 Very undesirable

ANSWER KEY

A 3

B 5

C 1

D 2

E 4

F 5

[Open online ↗](#)
A Proceed with measuring the infant while observing Danielle's maternal interactions before returning to her emotional well-being.

Key 3

This response is Neither Desirable nor Undesirable (3). Respecting the mother's request provides temporary relief and gives the clinician time to observe mother-infant behavioral dynamics. However, failing to acknowledge her tearful comment in the moment risks signaling that such disclosures are uncomfortable or unwelcome. To improve, Dr. Chen should offer immediate verbal validation before shifting focus.

PRINCIPLE Deferring emotional inquiry to maintain appointment flow risks leaving parental vulnerability unacknowledged.

B Immediately notify child protective services regarding Danielle's statement about relinquishing her infant for adoption.

Key 5

This response is Very Undesirable (5). Reporting a mother to child welfare based on an ambivalent, exhausted disclosure without evidence of abuse, neglect, or immediate harm is completely inappropriate and punitive. It shatters the therapeutic alliance and weaponizes an expression of postpartum depressive struggle. Child welfare escalation requires actual imminent safety risk, not expressions of maternal grief.

PRINCIPLE Do not escalate to child welfare agencies based solely on maternal distress.

C Acknowledge Danielle's profound exhaustion and gently explore the feelings underlying her comment about adoption.

Key 1

This response is Very Desirable (1). It demonstrates exceptional empathy by validating her emotional exhaustion and delicately exploring a high-risk disclosure without inducing shame. By maintaining a supportive and non-punitive tone, Dr. Chen builds psychological safety for Danielle to reveal postpartum mood distress. To be rated lower, it would have to ignore the comment or react with alarm.

PRINCIPLE Acknowledge vulnerable emotional disclosures non-judgmentally to uncover underlying postpartum mood disorders.

D Validate how overwhelming postpartum adjustments can be before offering to administer a validated postpartum depression screen.

Key 2

This response is Somewhat Desirable (2). Normalizing early postpartum vulnerability followed by objective screening is clinically sound and compassionate. However, pivoting directly to a formalized questionnaire can feel slightly clinical and impersonal immediately following an intimate emotional revelation. To achieve a 1, Dr. Chen would spend more time in open-ended emotional exploration before introducing psychometric tools.

PRINCIPLE Supportive validation paired with standardized screening supports timely postpartum mental health assessment.

E Reassure Danielle that all new mothers experience occasional self-doubt and feeling overwhelmed is completely normal.

Key 4

This response is Somewhat Undesirable (4). While intended to comfort, generic reassurance minimizes the profound severity of Danielle's detachment and potential postpartum depression or bonding disorder. Labeling her comments as merely 'normal' risks invalidating her distinct suffering and prematurely closing clinical discussion. To rate higher, the resident must explore her specific feelings rather than offering blanket normalizations.

PRINCIPLE Premature generic reassurance trivializes severe psychological distress and hinders diagnostic disclosure.

F Advise Danielle firmly that joking about child abandonment suggests she needs immediate psychiatric hospitalization.

Key 5

This response is Very Undesirable (5). It is punitive, judgmental, and pathologizes a cry for help as an immediate psychiatric emergency requiring involuntary containment. Such a stigmatizing and aggressive response destroys trust, discourages future help-seeking, and misinterprets postpartum depressive detachment. Clinicians must respond to distress with curiosity and containment, never shaming threats.

PRINCIPLE Punitive and alarming reactions to emotional vulnerability destroy therapeutic trust completely.

YOUR TAKEAWAY

One sentence you want to remember

Empathy and Compassion

Rating

Hard

v2034

Empathy and Compassion

Sample question 08 · Rating format

SCENARIO

Dr. Noah Tremblay is completing a rural northern rotation at a remote nursing station. Elder Thomas, a respected 74-year-old community leader, presents with severe lobar pneumonia, hypoxemia, and hemodynamic instability requiring urgent medevac transfer to an urban tertiary hospital. Elder Thomas has intact decision-making capacity but adamantly refuses evacuation, explaining that he survived residential school and a previous traumatic medical transport where relatives died alone in southern cities. Furthermore, he emphasizes his duty to lead an upcoming sacred community healing ceremony this evening. Marie, the nurse, warns that without tertiary transfer, Thomas faces high mortality, but Thomas states he would rather die on his ancestral land surrounded by community. Noah must balance life-threatening medical urgency with profound cultural safety, trauma-informed history, and respect for patient autonomy.

YOUR TASK

How desirable is each of the following responses by Dr. Tremblay in this situation? Consider each option independently; several may share a rating.

1 Very desirable

2 Somewhat desirable

3 Neither desirable nor undesirable

4 Somewhat undesirable

5 Very undesirable

OPTIONS

Circle one number per option

A Declare Thomas medically incompetent due to acute hypoxia so the medevac team can transport him involuntarily.

1 2 3 4 5

B Tell Thomas that refusing transport is irresponsible to his community because his death would cause unnecessary sorrow.

1 2 3 4 5

C Offer to arrange for a trusted family escort to travel with Thomas on the medevac plane to the city.

1 2 3 4 5

D Ask Thomas if an immediate trusted family member or community leader can join the discussion at the clinic.

1 2 3 4 5

E Explore whether maximum station-level supportive care can be provided alongside local traditional ceremony participation if he stays.

1 2 3 4 5

F Acknowledge the historical trauma of medical evacuation and listen deeply to Thomas's ceremony commitments without rushing him.

1 2 3 4 5

[Work through this question online](#)

Interactive version and related samples. The answer and rationale are on the next page.

fmprocprep.ca/questions/v2034-empathy-and-compassion

YOUR NOTES

Space for your reasoning

Empathy and Compassion

Rating

Hard

v2034

Sample 08 · Answer & rationale

Empathy and Compassion · Scale: 1 Very desirable → 5 Very undesirable

ANSWER KEY

A 5

B 5

C 1

D 1

E 2

F 1

[Open online ↗](#)
A Declare Thomas medically incompetent due to acute hypoxia so the medevac team can transport him involuntarily.

Key 5

Rating 5 (Very undesirable). Overriding a capable patient's fundamental autonomy by fabricating or inappropriately asserting mental incompetence is unethical, illegal, and reenacts colonial violence. Thomas has demonstrated intact decision-making capacity and value-consistent reasoning. This is a severe violation of professional integrity and human rights.

PRINCIPLE Never mischaracterize decision-making capacity to bypass an autonomous refusal of medical transfer.

B Tell Thomas that refusing transport is irresponsible to his community because his death would cause unnecessary sorrow.

Key 5

Rating 5 (Very undesirable). Guilt-tripping a respected Elder using coercive emotional manipulation is disrespectful, patronizing, and culturally unsafe. It ruptures clinical trust and weaponizes his communal role against his deeply held personal convictions. It has no place in ethical medical communication.

PRINCIPLE Never use emotional manipulation or guilt to coerce patient consent for transfer.

C Offer to arrange for a trusted family escort to travel with Thomas on the medevac plane to the city.

Key 1

Rating 1 (Very desirable). The fear of dying alone in an unfamiliar southern institution is a central driver of medical evacuation refusal among northern Indigenous patients. Guaranteeing a family escort addresses the root cause of his hesitation while directly honoring his dignity and relational safety. It would drop to a 2 if presented as a rigid bargaining chip.

PRINCIPLE Mitigate medical evacuation fear by securing trusted family accompaniment on transport.

D Ask Thomas if an immediate trusted family member or community leader can join the discussion at the clinic.

Key 1

Rating 1 (Very desirable). In Indigenous healthcare contexts, decisions often involve relational and communal dimensions. Inviting family or community leadership into the circle respects Indigenous kinship models, enhances emotional safety, and helps Thomas weigh options with collective support. It would drop to a 2 if initiated without Thomas's explicit consent.

PRINCIPLE Support Indigenous patient autonomy by welcoming chosen family and community support into decision-making.

E Explore whether maximum station-level supportive care can be provided alongside local traditional ceremony participation if he stays.

Key 2

Rating 2 (Somewhat desirable). Exploring harm-reduction and station-level interventions (oxygen, parenteral antibiotics) paired with traditional practices respects patient autonomy and self-determination when transport is declined. However, transfer remains the gold standard for survival, so Noah must first ensure all culturally safe transfer options have been exhausted. It would be rated 1 if pursued after comprehensive transfer dialogue.

PRINCIPLE Integrate aggressive local medical harm-reduction and cultural practices when evacuation is refused.

F Acknowledge the historical trauma of medical evacuation and listen deeply to Thomas's ceremony commitments without rushing him.

Key 1

Rating 1 (Very desirable). Demonstrating cultural humility and taking time to validate the historical trauma of residential schools and forced medical transfers is foundational to cultural safety. Listening attentively establishes genuine trust and creates space to explore potential compromises. It would move down if Noah listened passively without subsequently discussing medical management.

PRINCIPLE Acknowledge historical trauma and prioritize cultural humility when addressing medical transport refusal.

YOUR TAKEAWAY

One sentence you want to remember

Empathy and Compassion

Ranking

Approachable

b10

Empathy and Compassion

Sample question 09 · Ranking format

SCENARIO

Dr. Callie Muir, a family medicine resident, is conducting a scheduled 30-minute home visit for Mrs. Okonkwo, a 78-year-old patient with multi-morbidity and declining mobility. Dr. Muir planned to introduce advance care planning today, but each time she broaches the topic, Mrs. Okonkwo politely deflects with 'not today, doctor'. Meanwhile, her adult son, Chidi, repeatedly speaks on her behalf and answers clinical questions before she can respond. Dr. Muir has approximately 20 minutes remaining in the visit. She wants to respect Mrs. Okonkwo's autonomy and comfort while addressing her care needs effectively.

YOUR TASK

Rank in order the following actions for Dr. Muir to take in response to this situation.

1 Most desirable

2

3

4

5 Least desirable

OPTIONS

Write a rank from 1 to 5 in each box

A Thank Chidi for his support, then redirect the conversation to ask Mrs. Okonkwo for her direct input.

RANK

B Ask Chidi to leave the room to determine if Mrs. Okonkwo feels pressured by his presence.

RANK

C Validate Mrs. Okonkwo's boundary on advance care planning and gently explore what matters most to her today.

RANK

D Proceed with discussing advance care planning goals with Chidi, accepting his answers on his mother's behalf.

RANK

E Provide written advance care planning materials to review together, offering to discuss them at a later visit.

RANK

[Work through this question online](#)

Interactive version and related samples. The answer and rationale are on the next page.

fmprocprep.ca/questions/b10-empathy-and-compassion

YOUR NOTES

Space for your reasoning



Empathy and Compassion

Ranking

Approachable

b10

Sample 09 · Answer & rationale

Empathy and Compassion · Scale: 1 Most desirable → 5 Least desirable

ANSWER KEY

A 2

B 4

C 1

D 5

E 3

[Open online ↗](#)**A Thank Chidi for his support, then redirect the conversation to ask Mrs. Okonkwo for her direct input.**

Rank 2

This is a desirable response as it gently reclaims space for the patient's voice while constructively acknowledging the son's caring intentions rather than alienating him. However, it ranks below Option A because it does not explicitly acknowledge Mrs. Okonkwo's stated reluctance to discuss advance care planning today. It would rank higher if it paired this communication realignment with a clear pivot away from the stalled topic.

PRINCIPLE Acknowledge supportive family while intentionally protecting the patient's central voice.

B Ask Chidi to leave the room to determine if Mrs. Okonkwo feels pressured by his presence.

Rank 4

This option is somewhat undesirable because abruptly asking a family caregiver to leave their own home without prior gentle redirection can alienate both patient and family. While ensuring the patient is free from coercion is a legitimate consideration, jumping to exclusion before attempting inclusive conversational management is disproportionate and disruptive. It would rank higher if there were clear indicators of abuse or if Mrs. Okonkwo had requested privacy.

PRINCIPLE Avoid abrupt exclusion of family without first attempting inclusive conversational redirection.

C Validate Mrs. Okonkwo's boundary on advance care planning and gently explore what matters most to her today.

Rank 1

This is the most desirable response because it respects the patient's autonomy, validates her reluctance without pressure, and centres the remainder of the visit on her self-identified needs. In advance care planning, pushing past explicit patient boundaries damages trust, whereas following the patient's pacing preserves the therapeutic alliance. It would be ranked lower if it entirely ignored the son's tendency to answer for her in subsequent exchanges.

PRINCIPLE Respect patient pacing and boundaries while exploring immediate patient-centred priorities.

D Proceed with discussing advance care planning goals with Chidi, accepting his answers on his mother's behalf.

Rank 5

This is the least desirable response as it completely circumvents the competent patient's autonomy and substitutes a surrogate's voice simply for administrative convenience. Advance care planning must reflect the patient's own values, and treating her reluctance as consent for her son to decide is ethically and relationally unacceptable. It could only be justified if Mrs. Okonkwo lacked decision-making capacity and had designated Chidi as her legal substitute decision-maker.

PRINCIPLE Never substitute family preferences for a capable patient's direct autonomous participation.

E Provide written advance care planning materials to review together, offering to discuss them at a later visit.

Rank 3

This option is acceptable as a pragmatic middle ground that avoids coercive conversation while still planting seeds for future discussion. However, it is an emotionally neutral, passive approach that misses the opportunity to connect with Mrs. Okonkwo's immediate concerns or address the communicative dynamic in the room. It would rank higher if paired with active exploration of her priorities today, or lower if it closed off future discussion entirely.

PRINCIPLE Informational deferral maintains future options but lacks active empathic engagement.

YOUR TAKEAWAY

One sentence you want to remember

Empathy and Compassion

Ranking

Approachable

v2096

Empathy and Compassion

Sample question 10 · Ranking format

SCENARIO

You are a family medicine resident caring for Margaret MacIntyre, an elderly comatose patient experiencing multi-organ failure in a rural hospital. Her clinical condition is deteriorating rapidly, necessitating an immediate and definitive goals-of-care determination. Arthur, her common-law partner of twenty years, tearfully conveys that Margaret explicitly wished never to be maintained on invasive mechanical life support, though no written directive exists. Her estranged adult son, Derek, suddenly arrives from another province, angrily asserting kinship rights and demanding aggressive invasive resuscitation while dismissing Arthur's standing entirely. The interpersonal conflict is escalating outside Margaret's room, causing severe distress to both men as clinical decisions loom. You must resolve this dispute in accordance with provincial substitute decision-maker legislation while supporting a grieving, divided family.

YOUR TASK

Rank in order the following actions for Dr. Vance to take in response to this situation.

1 Most desirable

2

3

4

5 Least desirable

OPTIONS

Write a rank from 1 to 5 in each box

A Request an immediate urgent ethics consultation and initiate temporary invasive resuscitation until legal clarification is formally provided.

RANK

B Instruct Arthur and Derek to settle their legal dispute outside the hospital before any care decisions are implemented.

RANK

C Reassure Arthur of his legal substitute decision-maker status while notifying Derek that his resuscitation request cannot be accepted.

RANK

D Convene a facilitated meeting with Arthur and Derek to clarify provincial statutory hierarchy and focus on Margaret's values.

RANK

E Meet privately with Derek to acknowledge his grief and explain the statutory hierarchy before facilitating a joint family discussion.

RANK

[Work through this question online](#)

Interactive version and related samples. The answer and rationale are on the next page.

fmprocprep.ca/questions/v2096-empathy-and-compassion

YOUR NOTES

Space for your reasoning

Empathy and Compassion

Ranking

Approachable

v2096

Sample 10 · Answer & rationale

Empathy and Compassion · Scale: 1 Most desirable → 5 Least desirable

ANSWER KEY

A 4

B 5

C 3

D 1

E 2

[Open online ↗](#)

A Request an immediate urgent ethics consultation and initiate temporary invasive resuscitation until legal clarification is formally provided.

Rank 4

Rank 4. Escalating to hospital ethics over-complicates an issue already clearly governed by provincial substitute decision-maker legislation. Furthermore, initiating invasive resuscitation contrary to known verbal wishes subjects the patient to non-beneficial, invasive bodily harm simply to avoid immediate interpersonal confrontation.

PRINCIPLE Avoid invasive clinical harm merely to defer statutory decision-making and interpersonal conflict.

B Instruct Arthur and Derek to settle their legal dispute outside the hospital before any care decisions are implemented.

Rank 5

Rank 5. This response completely abdicates clinical leadership and professional responsibility during an end-of-life crisis. Abandoning a dying patient and traumatized family members to resolve statutory conflict unassisted causes severe harm and delays necessary palliative care.

PRINCIPLE Never abandon vulnerable substitute decision-makers during urgent end-of-life decision-making.

C Reassure Arthur of his legal substitute decision-maker status while notifying Derek that his resuscitation request cannot be accepted.

Rank 3

Rank 3. Upholding Arthur's legal authority under common-law partner statutory hierarchy correctly honours legislation and the patient's known wishes. However, delivering this unilaterally to Derek without empathetic exploration will likely heighten his sense of alienation and hostility.

PRINCIPLE Legal statutory clarity must be delivered with empathy to prevent alienation.

D Convene a facilitated meeting with Arthur and Derek to clarify provincial statutory hierarchy and focus on Margaret's values.

Rank 1

Rank 1. This action combines professional clarity regarding provincial substitute decision-maker legislation with high empathy. Bringing both men together to refocus on Margaret's authentic voice addresses the legal reality while de-escalating interpersonal tension and fostering collaborative closure.

PRINCIPLE Focus substitute decision-makers collaboratively on the patient's authentic prior values.

E Meet privately with Derek to acknowledge his grief and explain the statutory hierarchy before facilitating a joint family discussion.

Rank 2

Rank 2. Meeting privately with Derek shows empathy by validating his emotional distress and clarifying legal frameworks without public embarrassment. However, addressing the family separately initially risks creating suspicion with Arthur and marginally delays collective alignment compared to an immediate facilitated joint discussion.

PRINCIPLE De-escalate distressed family individually before facilitating collaborative decision-making on goals of care.

YOUR TAKEAWAY

One sentence you want to remember

Team Collaboration

Rating

Hard

b05

Team Collaboration

Sample question 11 · Rating format

SCENARIO

You are Dr. Yusuf Ahmed, a PGY2 family medicine resident on a community medicine rotation. You are conducting a home visit with Rina Kowalski, an experienced public health nurse who has worked in this community for fourteen years. As you explain your proposed insulin titration schedule, Rina states flatly across the kitchen table that your plan completely ignores what was agreed upon at the prior care conference. This conference took place two weeks before your rotation began and utilized a different clinical protocol that you were not briefed on. Mr. Doiron looks visibly anxious and glances back and forth between you and Rina, waiting for guidance on what to do next. You must address Rina's concern while maintaining Mr. Doiron's trust and psychological safety in the moment.

YOUR TASK

How desirable is each of the following responses by Dr. Ahmed in this situation? Consider each option independently; several may share a rating.

1 Very desirable

2 Somewhat desirable

3 Neither desirable nor undesirable

4 Somewhat undesirable

5 Very undesirable

OPTIONS

Circle one number per option

A Apologize to Mr. Doiron for the confusion and reassure him that the team will confirm one unified plan.

1 2 3 4 5

B Clarify that the care conference occurred before your arrival and that your current protocol takes precedence.

1 2 3 4 5

C Acknowledge Rina's point openly to Mr. Doiron and propose aligning their care plans together before leaving.

1 2 3 4 5

D Pause the insulin discussion immediately and defer all medication changes until contacting the clinic preceptor.

1 2 3 4 5

E Advise Mr. Doiron to proceed with your proposed regimen while you review past notes back at clinic.

1 2 3 4 5

F Politely request that Rina discuss team disagreements outside the home after completing Mr. Doiron's visit.

1 2 3 4 5

G Ask Rina to outline the prior conference decisions so they can integrate them into today's recommendations.

1 2 3 4 5

[Work through this question online](#)

Interactive version and related samples. The answer and rationale are on the next page.

fmprocprep.ca/questions/b05-team-collaboration

YOUR NOTES

Space for your reasoning

Team Collaboration

Rating

Hard

b05

Sample 11 · Answer & rationale

Team Collaboration · Scale: 1 Very desirable → 5 Very undesirable

ANSWER KEY

A 1

B 5

C 1

D 3

E 4

F 4

G 2

[Open online ↗](#)
A Apologize to Mr. Doiron for the confusion and reassure him that the team will confirm one unified plan.

Key 1

Rating: 1 (Very desirable). This patient-centred option immediately validates Mr. Doiron's perspective and de-escalates his observable distress. It models professional accountability and collective responsibility without assigning blame to either provider. To be downgraded, it would need to blame Rina or leave the treatment path completely ambiguous.

PRINCIPLE Acknowledge patient distress promptly and commit to unified team consensus.

B Clarify that the care conference occurred before your arrival and that your current protocol takes precedence.

Key 5

Rating: 5 (Very undesirable). Defending oneself by asserting clinical dominance undermines interprofessional trust and damages Mr. Doiron's confidence in the team. Dismissing a nurse's established longitudinal experience alienates a key colleague and escalates bedside conflict. To become less undesirable, Dr. Ahmed would need to acknowledge the prior conference rather than defensively dismiss it.

PRINCIPLE Hierarchical defensiveness erodes interprofessional partnerships and compromises patient trust.

C Acknowledge Rina's point openly to Mr. Doiron and propose aligning their care plans together before leaving.

Key 1

Rating: 1 (Very desirable). This response defuses immediate tension, maintains transparency, and avoids patient confusion by committing to unified interprofessional care. It respects the nurse's clinical continuity while preserving Dr. Ahmed's role as a collaborative physician. To become less desirable, it would need to deflect responsibility or dismiss the nurse's input in front of the patient.

PRINCIPLE Preserve patient confidence by openly aligning interprofessional care plans collaboratively.

D Pause the insulin discussion immediately and defer all medication changes until contacting the clinic preceptor.

Key 3

Rating: 3 (Neither desirable nor undesirable). While this ensures safety and avoids conflicting guidance, abruptly deferring all management can increase Mr. Doiron's anxiety and leave his immediate clinical needs unmet. It prioritizes risk avoidance over resident leadership and collaborative problem-solving. It would score higher if Dr. Ahmed offered a provisional bridging plan while seeking supervisory input.

PRINCIPLE Avoid excessive paralysis when resolving interprofessional uncertainty at the bedside.

E Advise Mr. Doiron to proceed with your proposed regimen while you review past notes back at clinic.

Key 4

Rating: 4 (Somewhat undesirable). Pushing forward with an unverified plan despite credible safety or continuity concerns raised by an experienced team member is dismissive. It leaves the patient uncertain about whether the medication change is safe or aligned with prior agreements. It would improve if Dr. Ahmed actively reconciled the plan with Rina before directing the patient.

PRINCIPLE Never bypass valid interprofessional safety concerns to enforce unilateral authority.

F Politely request that Rina discuss team disagreements outside the home after completing Mr. Doiron's visit.

Key 4

Rating: 4 (Somewhat undesirable). Although addressing interpersonal disputes in private is a valid communication principle, this response shuts down collaboration in real time and leaves Mr. Doiron with unresolved mixed messages. It fails to address the substantive concern about the insulin plan while the patient is listening. To improve, Dr. Ahmed would validate the team goal before establishing process boundaries.

PRINCIPLE Do not suppress collaborative clinical input at the expense of patient clarity.

G Ask Rina to outline the prior conference decisions so they can integrate them into today's recommendations.

Key 2

Rating: 2 (Somewhat desirable). Inviting Rina to share the previous care plan values her institutional knowledge and keeps Mr. Doiron informed. However, discussing protocol discrepancies in detail at the bedside risks heightening the patient's worry regarding past miscommunication. To move to a 1, Dr. Ahmed would frame the inquiry explicitly around shared reassurance rather than highlighting an oversight.

PRINCIPLE Respect colleague continuity while preventing bedside disputes over procedural history.

YOUR TAKEAWAY

One sentence you want to remember

Team Collaboration

Rating

Hard

v2010

Team Collaboration

Sample question 12 · Rating format

SCENARIO

Dr. Danielle Ross is completing a rotation on a busy inpatient family medicine teaching ward. Over the past three days, Dr. Alan Foster, the off-site attending physician, contacts Danielle expressing frustration about receiving multiple phone calls during his outpatient clinic for routine order clarifications, PRN medication approvals, and diet upgrades. Dr. Foster stresses that managing these routine ward issues is squarely within resident scope. Danielle approaches Nurse Gary, the day charge nurse, to discuss the issue. Gary candidly explains that past residents took hours to answer pages, so nursing staff found it far more efficient to call the attending directly. Danielle needs to re-establish proper paging workflow and rebuild trust with ward staff without alienating the nursing team.

YOUR TASK

How desirable is each of the following responses by Dr. Ross in this situation? Consider each option independently; several may share a rating.

1 Very desirable

2 Somewhat desirable

3 Neither desirable nor undesirable

4 Somewhat undesirable

5 Very undesirable

OPTIONS

Circle one number per option

A Inform Gary that bypassing residents directly breaches hospital policy and report him to the nurse manager.

1 2 3 4 5

B Accept Gary's rationale and allow nurses to call Dr. Foster whenever the ward is busy.

1 2 3 4 5

C Request Dr. Foster refuse to answer calls from the ward and redirect nurses back to her.

1 2 3 4 5

D Apologize to Dr. Foster and assure him she will manage all future ward calls promptly.

1 2 3 4 5

E Acknowledge past responsiveness frustrations and agree on expected response times for ward pages.

1 2 3 4 5

F Propose scheduled mid-morning and mid-afternoon nursing check-ins on the ward to review non-urgent orders.

1 2 3 4 5


[Work through this question online](#)

Interactive version and related samples. The answer and rationale are on the next page.

fmprocprep.ca/questions/v2010-team-collaboration

YOUR NOTES

Space for your reasoning

Team Collaboration

Rating

Hard

v2010

Sample 12 · Answer & rationale

Team Collaboration · Scale: 1 Very desirable → 5 Very undesirable

ANSWER KEY

A 4

B 5

C 2

D 2

E 1

F 1

[Open online ↗](#)
A Inform Gary that bypassing residents directly breaches hospital policy and report him to the nurse manager.

Key 4

This is rated 4 (Somewhat undesirable). Immediately escalating to administrative authorities over an established ward habit creates resentment and destroys working relationships on the floor. While protocol adherence is important, informal peer problem-solving should precede punitive management reporting. It would be rated 5 if done without speaking to Gary first.

PRINCIPLE Premature formal escalation over workflow habits fractures frontline interprofessional partnerships.

B Accept Gary's rationale and allow nurses to call Dr. Foster whenever the ward is busy.

Key 5

This is rated 5 (Very undesirable). Abdicating core ward duties ignores explicit attending direction and sacrifices essential resident learning opportunities. It leaves the attending physician burdened with routine interruptions and confirms resident irrelevance. It demonstrates an extreme lack of accountability and professional initiative.

PRINCIPLE Abdicating clinical scope compromises medical education and overburdened attending staff.

C Request Dr. Foster refuse to answer calls from the ward and redirect nurses back to her.

Key 2

This is rated 2 (Somewhat desirable). Asking the attending to reinforce the communication chain of command aligns expectations and supports resident autonomy. However, relying on the attending to enforce boundaries is less effective than Danielle actively building rapport and demonstrating reliability herself. It would move to 1 if paired with proactive resident responsiveness.

PRINCIPLE Attending reinforcement of communication pathways supports resident scope but requires personal reliability.

D Apologize to Dr. Foster and assure him she will manage all future ward calls promptly.

Key 2

This is rated 2 (Somewhat desirable). Acknowledging the attending's frustration demonstrates professional accountability to a supervisor. However, a verbal assurance alone fails to address the root cause, which is nursing staff's lack of confidence in resident responsiveness. It would move up if accompanied by concrete action plans with nursing.

PRINCIPLE Supervisory reassurances must be matched with frontline systems changes to resolve workflow failures.

E Acknowledge past responsiveness frustrations and agree on expected response times for ward pages.

Key 1

This is rated 1 (Very desirable). Validating the nursing team's historical pain points demonstrates empathy and maturity while resetting operational expectations. Agreeing on realistic response benchmarks rebuilds trust and establishes functional accountability. It would move down if Danielle became defensive about previous residents' habits.

PRINCIPLE Validating team frustrations and agreeing on response benchmarks rebuilds collaborative trust.

F Propose scheduled mid-morning and mid-afternoon nursing check-ins on the ward to review non-urgent orders.

Key 1

This is rated 1 (Very desirable). Instituting structured, predictable face-to-face check-ins addresses the underlying problem of page volume and delay. It demonstrates leadership, adaptability, and proactive teamwork. It would move down if it added excessive administrative burden without resident availability.

PRINCIPLE Structured communication routines reduce interruption burdens and streamline inpatient workflow.

YOUR TAKEAWAY

One sentence you want to remember

Team Collaboration

Rating

Hard

v2045

Team Collaboration

Sample question 13 · Rating format

SCENARIO

You are Dr. Julian Roy, a PGY2 Family Medicine resident in a busy academic community clinic. The attending physician, Dr. David Sterling, has been delayed at the hospital for over an hour, causing afternoon appointments to back up severely. In the minor procedure room, Gail Simmons, a senior clinic nurse, is setting up a tray for a knee joint aspiration on an elderly patient with acute effusion. She instructs Chloe Martin, a third-year medical student, to perform the procedure independently right now, stating that doing so is the only way to keep the clinic on schedule and avoid cancelling appointments. Chloe looks nervous and pulls you aside into the hallway, whispering that she has only observed a joint aspiration once on a plastic model and feels completely unequipped to do it alone.

YOUR TASK

How desirable is each of the following responses by Dr. Julian Roy in this situation? Consider each option independently; several may share a rating.

1 Very desirable

2 Somewhat desirable

3 Neither desirable nor undesirable

4 Somewhat undesirable

5 Very undesirable

OPTIONS

Circle one number per option

A Inform Gail that Chloe cannot perform the procedure unsupervised and must wait for proper oversight.

1 2 3 4 5

B Encourage Chloe to attempt the procedure herself, assuring her that Gail can assist with technique.

1 2 3 4 5

C Supervise Chloe directly through the aspiration if your own clinical competencies and schedule allow.

1 2 3 4 5

D Phone Dr. Sterling to ask whether he approves of Chloe doing the aspiration with Gail.

1 2 3 4 5

E Reassure the patient and explain that the procedure will be slightly delayed until a qualified supervisor is ready.

1 2 3 4 5

F Reprimand Gail in front of the clinic team for pressuring a junior student into an unsafe action.

1 2 3 4 5


Work through this question online

Interactive version and related samples. The answer and rationale are on the next page.

fmprocprep.ca/questions/v2045-team-collaboration

YOUR NOTES

Space for your reasoning



Team Collaboration

Rating

Hard

v2045

Sample 13 · Answer & rationale

Team Collaboration · Scale: 1 Very desirable → 5 Very undesirable

ANSWER KEY

A 1

B 5

C 1

D 4

E 2

F 4

[Open online ↗](#)**A Inform Gail that Chloe cannot perform the procedure unsupervised and must wait for proper oversight.**

Key 1

Clear communication with nursing colleagues regarding learner scope and safety boundaries is essential. This firmly protects the patient from an uncertified invasive procedure while taking the pressure off the hesitant medical student. It maintains professional respect while establishing unambiguous safety limits.

PRINCIPLE Firmly enforce learner scope boundaries to protect patient safety regardless of workflow.

B Encourage Chloe to attempt the procedure herself, assuring her that Gail can assist with technique.

Key 5

Encouraging an untrained student to perform an invasive procedure without physician supervision violates patient safety standards and educational ethics. While nurses possess deep procedural knowledge, joint aspiration requires appropriate medical training and credentialed supervision. This exposes the patient to severe harm and infection.

PRINCIPLE Never push an untrained trainee to perform invasive procedures without qualified supervision.

C Supervise Chloe directly through the aspiration if your own clinical competencies and schedule allow.

Key 1

This response protects patient safety, supports the medical student's learning in a safe environment, and assists the clinic's workflow. It embodies excellent leadership by stepping in to bridge a staffing gap within the resident's scope. It balances clinical education with operational demands.

PRINCIPLE Support junior learner education and patient safety through direct resident supervision.

D Phone Dr. Sterling to ask whether he approves of Chloe doing the aspiration with Gail.

Key 4

Phoning an attending about whether an inexperienced student who explicitly stated they feel incompetent can do an invasive procedure alone is an abdication of on-site judgement. The resident already knows the safety standard is breached; escalating this question to an off-site attending wastes time and delays an obvious local safety intervention.

PRINCIPLE Intervene immediately on local safety hazards rather than seeking redundant remote permission.

E Reassure the patient and explain that the procedure will be slightly delayed until a qualified supervisor is ready.

Key 2

Transparent patient communication manages expectations and preserves trust without revealing internal team friction or blaming colleagues. It protects safety by delaying the procedure until proper supervision arrives. While very good, actively providing or arranging that supervision makes it even more complete.

PRINCIPLE Communicate procedural delays transparently to patients while securing appropriate supervision.

F Reprimand Gail in front of the clinic team for pressuring a junior student into an unsafe action.

Key 4

While Gail's directive was unsafe, public reprimands destroy interprofessional trust, humiliate colleagues, and worsen team conflict. Safety corrections should be firm, immediate, and direct, but delivered professionally and privately. It damages workplace psychological safety.

PRINCIPLE Correct unsafe interprofessional instructions respectfully without resorting to public shaming.

YOUR TAKEAWAY

One sentence you want to remember

Team Collaboration

Ranking

Hard

b11

Team Collaboration

Sample question 14 · Ranking format

SCENARIO

Dr. Ian Woods is a family medicine resident completing a rotation at a First Nations community health centre, with two weeks remaining. During an appointment for a nine-year-old child with poorly controlled asthma, Dr. Woods proposes scheduling weekly clinic appointments over the coming month for close monitoring. In front of the child's grandmother, Darlene, an experienced community wellness worker who coordinates local care, states, "We do not book visits like that. Families will not come three times a month for puffer checks." The grandmother nods in agreement with Darlene's statement. Dr. Woods wants to ensure adequate asthma control while respecting the community's context and care coordination norms.

YOUR TASK

Rank in order the following actions for Dr. Woods to take in response to this situation.

1 Most desirable

2

3

4

5 Least desirable

OPTIONS

Write a rank from 1 to 5 in each box

A Accept Darlene's recommendation in the visit, then meet with her privately afterward to discuss sustainable asthma monitoring.

RANK

B Explain the clinical goals of monitoring, then ask Darlene if community-based check-ins could replace frequent clinic appointments.

RANK

C Acknowledge Darlene's insight and invite her and the grandmother to co-design a realistic follow-up plan together.

RANK

D Proceed with booking the three visits, explaining to the grandmother that standard clinical guidelines require close monitoring.

RANK

E Defer scheduling follow-up until discussing Darlene's objection and local scheduling norms with the supervising physician.

RANK
[Work through this question online](#)

Interactive version and related samples. The answer and rationale are on the next page.

fmprocp.ca/questions/b11-team-collaboration

YOUR NOTES

Space for your reasoning

Team Collaboration

Ranking

Hard

b11

Sample 14 · Answer & rationale

Team Collaboration · Scale: 1 Most desirable → 5 Least desirable

ANSWER KEY

A 3

B 2

C 1

D 5

E 4

[Open online ↗](#)
A Accept Darlene's recommendation in the visit, then meet with her privately afterward to discuss sustainable asthma monitoring.

Rank 3

This response is neither fully desirable nor undesirable; it defers conflict in front of the patient and shows respect for Darlene's position, but leaves the child's immediate monitoring plan unresolved during the encounter. Postponing the discussion risks sending mixed messages to the family about the importance of asthma oversight. It would rank higher if a collaborative monitoring compromise were established before the patient departed.

PRINCIPLE Address clinical safety needs collaboratively during the visit rather than postponing them.

B Explain the clinical goals of monitoring, then ask Darlene if community-based check-ins could replace frequent clinic appointments.

Rank 2

This response is desirable because it articulates safety goals while collaboratively leveraging Darlene's knowledge of alternative local resources. However, it focuses on justifying the resident's clinical perspective before directly consulting the grandmother about feasibility. It would rank higher if it invited family and worker input before reiterating clinical needs.

PRINCIPLE Adapt clinical monitoring goals collaboratively using community-based interprofessional resources.

C Acknowledge Darlene's insight and invite her and the grandmother to co-design a realistic follow-up plan together.

Rank 1

This is the most desirable response because it actively validates the wellness worker's community expertise while empowering the family in shared decision-making. It strengthens interprofessional collaboration and builds trust without compromising patient care. It would only rank lower if an acute medical emergency required immediate, unilateral clinical intervention.

PRINCIPLE Respect community team expertise by co-designing care with patients and allied staff.

D Proceed with booking the three visits, explaining to the grandmother that standard clinical guidelines require close monitoring.

Rank 5

This is the least desirable response as it overtly dismisses the community worker's local knowledge and ignores the caregiver's agreement with her. Enforcing an unfeasible plan damages therapeutic rapport and significantly increases the risk of complete non-attendance, jeopardizing child safety. It would only be acceptable in an acute, severe medical crisis requiring mandatory in-person care.

PRINCIPLE Never dismiss interprofessional cultural expertise to enforce rigid, unfeasible care plans.

E Defer scheduling follow-up until discussing Darlene's objection and local scheduling norms with the supervising physician.

Rank 4

This response is undesirable because it halts decision-making and avoids constructive communication with the colleague and family present in the room. While seeking preceptor guidance on local practices is appropriate, failing to agree on any interim plan leaves the child vulnerable and undermines the resident's professional accountability. It would rank higher if an interim plan were initiated while awaiting supervision.

PRINCIPLE Do not stall patient care decisions when collaborative solutions exist within scope.

YOUR TAKEAWAY

One sentence you want to remember

Team Collaboration

Ranking

Hard

v2094

Team Collaboration

Sample question 15 · Ranking format

SCENARIO

Dr. Al-Mansoor is examining Mr. Henderson, a 68-year-old patient with severe osteoarthritis and limited mobility living on a guaranteed income supplement. Mr. Henderson reports that his publicly funded daily personal support and dressing changes were abruptly halted this week due to an unpaid fifty-dollar administrative enrollment fee. Without assistance, he cannot perform personal hygiene, and Dr. Al-Mansoor observes developing Stage II pressure injury breakdown over his sacrum. When Dr. Al-Mansoor phones the regional home care coordinator, Gail, she states agency fee rules are strictly enforced and services remain paused until payment. Dr. Al-Mansoor must address the acute clinical deterioration while advocating for systemic care resumption.

YOUR TASK

Rank in order the following actions for Dr. Al-Mansoor to take in response to this situation.

1 Most desirable

2

3

4

5 Least desirable

OPTIONS

Write a rank from 1 to 5 in each box

A Connect the patient with the clinic social worker to pursue hardship waivers while arranging clinic nursing dressing changes.

RANK

B Advise the patient to borrow money from personal contacts to pay the fee so essential services resume.

RANK

C Engage the clinic team to treat the wound while advocating directly with home care leadership for fee exemption.

RANK

D Provide wound dressing supplies and educational handouts for the patient to manage skin care independently at home.

RANK

E Instruct the patient to attend the emergency department daily for dressing changes until home services are restored.

RANK
[Work through this question online](#)

Interactive version and related samples. The answer and rationale are on the next page.

fmprocprep.ca/questions/v2094-team-collaboration

YOUR NOTES

Space for your reasoning

Team Collaboration

Ranking

Hard

v2094

Sample 15 · Answer & rationale

Team Collaboration · Scale: 1 Most desirable → 5 Least desirable

ANSWER KEY

A 2

B 4

C 1

D 3

E 5

[Open online ↗](#)

A Connect the patient with the clinic social worker to pursue hardship waivers while arranging clinic nursing dressing changes.

Rank 2

This is a strong, collaborative approach that utilizes multidisciplinary team expertise to navigate financial relief mechanisms while ensuring wound care. It ranks slightly below Option A because direct physician-to-program leadership advocacy often resolves administrative impasses more rapidly for critically deteriorating patients. It would rank first if the social worker had direct delegated authority over home care fee waivers.

PRINCIPLE Leverage interprofessional team members to navigate systemic financial barriers effectively.

B Advise the patient to borrow money from personal contacts to pay the fee so essential services resume.

Rank 4

This option shifts systemic institutional burdens onto an impoverished, vulnerable patient without exploring administrative hardship exemptions or community supports. It demonstrates poor empathy and ignores systemic health advocacy roles expected of family physicians. It would move down if no medical advice was provided at all.

PRINCIPLE Avoid burdening marginalized patients with systemic administrative fees without advocacy.

C Engage the clinic team to treat the wound while advocating directly with home care leadership for fee exemption.

Rank 1

This is the most desirable response as it concurrently addresses the patient's immediate medical danger and tackles the systemic administrative barrier through proper advocacy channels. Combining acute wound care in the clinic with supervisor-level advocacy demonstrates clinical responsibility and effective health advocacy. It would move down if systemic advocacy omitted immediate local wound stabilization.

PRINCIPLE Bridge acute clinical vulnerabilities while actively dismantling systemic care barriers.

D Provide wound dressing supplies and educational handouts for the patient to manage skin care independently at home.

Rank 3

Providing medical supplies offers some material support, but expecting a severely immobile patient with sacral breakdown to dress their own wounds is clinically unrealistic and unsafe. It fails to address the root cause of the service cancellation and leaves the patient isolated. It would move up if paired with home care reinstatement efforts.

PRINCIPLE Ensure patient self-care plans are realistically matched to functional capabilities.

E Instruct the patient to attend the emergency department daily for dressing changes until home services are restored.

Rank 5

This is the least desirable action because it inappropriately overutilizes acute hospital resources for basic chronic wound care, while imposing painful, impractical transportation barriers on a frail patient. It deflects primary care responsibility and does nothing to solve the underlying home care suspension. It would move up only if the wound exhibited systemic sepsis requiring hospital admission.

PRINCIPLE Do not offload primary care and social advocacy to emergency services.

YOUR TAKEAWAY

One sentence you want to remember

Adaptability

Rating

Hard

b34

Adaptability

Sample question 16 · Rating format

SCENARIO

Dr. Priya Nair, a first-year family medicine resident, arrives for her scheduled outpatient rotation only to be abruptly redeployed to a community respiratory assessment centre due to an acute viral surge. For the next two weeks, she will manage high patient volumes in an unfamiliar ambulatory environment rather than her anticipated elective. On her first morning, she is informed that she must navigate a new electronic medical record, follow an unfamiliar clinical triage protocol, and adhere to updated infection-control personal protective equipment procedures. Forty symptomatic patients are already queued for assessment, and staff appear stretched thin. Dr. Nair must determine how best to approach the start of her shift.

YOUR TASK

How desirable is each of the following responses by Dr. Priya Nair in this situation? Consider each option independently; several may share a rating.

1 Very desirable

2 Somewhat desirable

3 Neither desirable nor undesirable

4 Somewhat undesirable

5 Very undesirable

OPTIONS

Circle one number per option

- A** Request a brief orientation from the charge nurse covering essential triage protocols, safety, and PPE procedures. 1 2 3 4 5
- B** Refuse to see any patients until comprehensive formal training on all clinic systems is completed. 1 2 3 4 5
- C** Contact the residency program director to request reassignment away from the surge assessment centre. 1 2 3 4 5
- D** Ask to shadow an experienced clinician for the first few encounters to learn the assessment workflow. 1 2 3 4 5
- E** Focus solely on reviewing electronic medical record documentation guidelines before addressing infection-control protocols. 1 2 3 4 5
- F** Identify a designated supervising clinician on shift to consult for complex presentations and procedural questions. 1 2 3 4 5
- G** Begin seeing queued patients immediately while figuring out the unfamiliar electronic medical record during care. 1 2 3 4 5


Work through this question online

Interactive version and related samples. The answer and rationale are on the next page.

fmprocprep.ca/questions/b34-adaptability

YOUR NOTES

Space for your reasoning

Adaptability

Rating

Hard

b34

Sample 16 · Answer & rationale

Adaptability · Scale: 1 Very desirable → 5 Very undesirable

ANSWER KEY

A 1

B 4

C 5

D 1

E 4

F 1

G 4

[Open online ↗](#)
A Request a brief orientation from the charge nurse covering essential triage protocols, safety, and PPE procedures. Key 1

This is very desirable because securing a focused orientation on infection control and triage parameters ensures patient and staff safety prior to providing care. It demonstrates adaptability and professional initiative within a high-pressure crisis setting. It takes minimal time while preventing critical safety breaches.

PRINCIPLE Prioritize safety, infection control, and triage protocols when redeployed to unfamiliar settings.

B Refuse to see any patients until comprehensive formal training on all clinic systems is completed. Key 4

This is somewhat undesirable because demanding exhaustive, lengthy formal onboarding during an active community surge demonstrates rigidity and ignores crisis realities. While essential safety orientation is vital, a resident must adapt to concise, just-in-time training during emergencies. It obstructs urgent clinical care.

PRINCIPLE Balance necessary safety preparation with flexibility during emergency surge operations.

C Contact the residency program director to request reassignment away from the surge assessment centre. Key 5

This is very undesirable because attempting to evade a public health surge redeployment exhibits an acute lack of adaptability, social accountability, and resilience. Emergency redeployment is an accepted duty within Canadian medical residency during health crises. It places self-interest above community health needs.

PRINCIPLE Demonstrate professional adaptability and public accountability during emergency surge redeployments.

D Ask to shadow an experienced clinician for the first few encounters to learn the assessment workflow. Key 1

This is very desirable because rapid observational learning allows the resident to assimilate charting nuances and clinical flow efficiently without compromising care. It promotes team integration and builds clinical confidence in a surge environment. It balances safe practice with urgent operational needs.

PRINCIPLE Utilize brief peer shadowing to rapidly assimilate unfamiliar clinical workflows safely.

E Focus solely on reviewing electronic medical record documentation guidelines before addressing infection-control protocols. Key 4

This is somewhat undesirable because it inverts core clinical safety priorities during an infectious disease surge. Infection-control measures and clinical triage parameters must take precedence over administrative software proficiency. Administrative accuracy is secondary to immediate contagion containment and patient stabilization.

PRINCIPLE Prioritize clinical safety and infection control over administrative electronic record proficiency.

F Identify a designated supervising clinician on shift to consult for complex presentations and procedural questions. Key 1

This is very desirable because establishing supervisory oversight ensures Dr. Nair operates safely within her professional scope as a first-year resident. It guarantees rapid escalation channels for deteriorating patients in an unfamiliar clinic. It reflects mature clinical leadership and self-awareness.

PRINCIPLE Secure accessible supervisory channels to maintain patient safety when facing unfamiliar demands.

G Begin seeing queued patients immediately while figuring out the unfamiliar electronic medical record during care. Key 4

This is somewhat undesirable because rushing directly into high-volume clinical care without basic familiarity with safety protocols or software creates substantial medical error risk. While eagerness to decompress patient queues is understandable, safety must precede speed. Taking fifteen minutes to orient protects patients from systemic oversights.

PRINCIPLE Do not prioritize patient throughput at the expense of essential safety orientation.

YOUR TAKEAWAY

One sentence you want to remember

Adaptability

Rating

Approachable

v2048

Adaptability

Sample question 17 · Rating format

SCENARIO

Dr. Chloe Tremblay is a PGY1 resident completing a full daytime ward shift on the family medicine service. At 16:45, fifteen minutes before the scheduled handover, her co-resident Dr. Tariq Al-Mansoor receives devastating news of a sudden family crisis requiring his immediate physical departure out of town. Tariq is scheduled to complete a 24-hour overnight call shift covering the active ward and emergency consultations. The residency program's formal backup system is poorly outlined and lacks a clear designated on-call backup trainee for the day. Dr. Liam O'Reilly, the chief resident, approaches Chloe and requests that she step in and cover Tariq's entire overnight shift. Chloe has an important personal commitment that evening celebrating her sibling's long-planned graduation dinner, but she also recognizes that Tariq cannot safely remain on duty and that the ward cannot be left unstaffed.

YOUR TASK

How desirable is each of the following responses by Dr. Tremblay in this situation? Consider each option independently; several may share a rating.

1 Very desirable

2 Somewhat desirable

3 Neither desirable nor undesirable

4 Somewhat undesirable

5 Very undesirable

OPTIONS

Circle one number per option

- | | |
|---|---|
| A Agree to work the complete overnight shift without mentioning her personal commitment or seeking alternative solutions. | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| B Insist that Tariq stay on duty until the chief resident locates a formal replacement. | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| C Offer to cover the initial hours of the shift while the chief resident coordinates overnight relief. | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| D Refuse the request flatly, citing her personal graduation dinner commitment and the program's flawed scheduling. | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| E Encourage Tariq to leave immediately and reassure him that his patients will be safely looked after. | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| F Suggest contacting the formal residency program director to clarify the contingency protocol for unassigned backup shifts. | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |

Work through this question online

Interactive version and related samples. The answer and rationale are on the next page.

fmprocprep.ca/questions/v2048-adaptability

YOUR NOTES

Space for your reasoning

Adaptability

Rating

Approachable

v2048

Sample 17 · Answer & rationale

Adaptability · Scale: 1 Very desirable → 5 Very undesirable

ANSWER KEY

A 3

B 5

C 1

D 4

E 1

F 2

[Open online ↗](#)
A Agree to work the complete overnight shift without mentioning her personal commitment or seeking alternative solutions.

Key 3

Rating 3 (Neither desirable nor undesirable). Sacrificing personal commitments entirely to protect patient care solves the immediate clinical and staffing dilemma safely and protects Tariq. However, complete self-abnegation without even attempting to negotiate shared coverage, split shifts, or alternative backup fosters personal resentment and burnout. While clinically safe and noble, it represents a passive approach to personal boundary management. It would move to a 1 if no other realistic options existed after inquiry.

PRINCIPLE Balance altruistic professional dedication with proactive self-advocacy and personal boundary management.

B Insist that Tariq stay on duty until the chief resident locates a formal replacement.

Key 5

Rating 5 (Very undesirable). Forcing a severely distressed resident in acute personal crisis to remain at the bedside is deeply uncompassionate and creates major patient safety hazards due to cognitive distraction. Demanding that an impaired or emotionally overwhelmed colleague continue providing clinical care compromises medical decision-making. Colleague wellness and patient safety are inextricably linked here. To improve, Chloe would need to facilitate Tariq's departure and address the coverage problem constructively.

PRINCIPLE Never compel an acutely distressed colleague to deliver distracted patient care.

C Offer to cover the initial hours of the shift while the chief resident coordinates overnight relief.

Key 1

Rating 1 (Very desirable). Offering to provide short-term bridge coverage demonstrates exceptional teamwork, adaptability, and patient-centered responsibility while still advocating for personal well-being. It prevents immediate ward abandonment and allows Tariq to depart without delay, giving the chief resident time to mobilize long-term coverage from the wider resident roster. This strikes an ideal balance between compassionate professional duty and personal boundaries. To move lower, the option would need to leave the ward abruptly uncovered during handover.

PRINCIPLE Provide flexible interim coverage during crises while negotiating systemic long-term replacements.

D Refuse the request flatly, citing her personal graduation dinner commitment and the program's flawed scheduling.

Key 4

Rating 4 (Somewhat undesirable). While residents are entitled to their personal lives outside scheduled hours and the program's backup ambiguity is frustrating, an inflexible refusal in the middle of an acute peer crisis displays poor collegiality and adaptability. Simply walking away leaves patients and the chief resident in an acute bind fifteen minutes prior to shift change. Professionalism requires engaging in collaborative problem-solving rather than rigid, unhelpful refusal. To move lower to a 5, she would have to act maliciously or humiliate her colleague.

PRINCIPLE Avoid rigid, uncollaborative refusals when unexpected colleague emergencies threaten clinical coverage.

E Encourage Tariq to leave immediately and reassure him that his patients will be safely looked after.

Key 1

Rating 1 (Very desirable). Prioritizing a distressed colleague's acute well-being with empathy and immediate psychological safety is a fundamental professional responsibility. Reassuring him alleviates his guilt and allows him to tend to a genuine family emergency without fearing patient abandonment. This action addresses the human dimension of medical practice decisively before sorting out administrative logistics. To move lower, it would need to ignore the transfer of clinical patient responsibilities.

PRINCIPLE Support distressed colleagues in crisis promptly by facilitating immediate, safe relief.

F Suggest contacting the formal residency program director to clarify the contingency protocol for unassigned backup shifts.

Key 2

Rating 2 (Somewhat desirable). Seeking clarity from program leadership addresses the underlying systemic vulnerability of a vague backup roster and promotes institutional accountability. However, contacting the program director at 17:00 does not resolve the immediate bedside clinical risk on the ward over the next thirty minutes. While correct in principle, it functions best as a parallel or subsequent administrative step rather than the initial tactical solution. It would be a 1 if coupled with immediate interim patient coverage.

PRINCIPLE Escalate ambiguous contingency policies to educational directors while managing immediate risks.

YOUR TAKEAWAY

One sentence you want to remember

Adaptability

Rating

Hard

v2059

Adaptability

Sample question 18 · Rating format

SCENARIO

Dr. Evan Ross is a PGY1 Family Medicine resident on his first rural family medicine block. The clinic is running forty-five minutes behind schedule due to an earlier complex emergency. His preceptor, Dr. Callum MacIntyre, asks Evan to independently perform a knee joint aspiration and corticosteroid injection on Mr. Kenneth Walsh, an established patient with severe osteoarthritis. Evan has only observed this procedure once previously during medical school and has never performed it on a human patient. Before Evan can explain his lack of hands-on experience, Dr. MacIntyre pats him on the shoulder, says he has complete confidence in Evan's skills, and leaves the clinic room to manage another waiting patient, adding that he will review and sign the procedural chart note later. Mr. Walsh is waiting on the examination table with the injection tray already prepped by the clinic nurse.

YOUR TASK

How desirable is each of the following responses by Dr. Ross in this situation? Consider each option independently; several may share a rating.

1 Very desirable

2 Somewhat desirable

3 Neither desirable nor undesirable

4 Somewhat undesirable

5 Very undesirable

OPTIONS

Circle one number per option

- A** Proceed with the joint injection independently, following standard anatomical landmarks carefully to avoid causing delays. 1 2 3 4 5
- B** Explain his procedural inexperience to Mr. Walsh and ask if he is comfortable with Evan attempting it. 1 2 3 4 5
- C** Step out immediately to explain his lack of procedural experience to Dr. MacIntyre and request direct supervision. 1 2 3 4 5
- D** Review an online procedural video on his phone in the clinic room before performing the injection alone. 1 2 3 4 5
- E** Inform the clinic nurse that the injection is cancelled today due to time constraints and reschedule Mr. Walsh. 1 2 3 4 5
- F** Position the patient, review anatomical landmarks, and wait until Dr. MacIntyre is free to scrub in together. 1 2 3 4 5

[Work through this question online](#)

Interactive version and related samples. The answer and rationale are on the next page.

fmproccprep.ca/questions/v2059-adaptability

YOUR NOTES

Space for your reasoning

Adaptability

Rating

Hard

v2059

Sample 18 · Answer & rationale

Adaptability · Scale: 1 Very desirable → 5 Very undesirable

ANSWER KEY

A 5

B 4

C 1

D 5

E 4

F 2

[Open online ↗](#)
A Proceed with the joint injection independently, following standard anatomical landmarks carefully to avoid causing delays.

Key 5

Rating 5 (Very undesirable). Performing an invasive joint injection without prior hands-on competence or supervision risks severe complications, including joint infection or neurovascular trauma. Prioritizing clinic timing over patient safety and informed consent violates fundamental professional ethics. Practicing beyond competence is never justified by clinical schedule pressure.

PRINCIPLE Never perform invasive procedures beyond personal competence to accommodate clinic schedule delays.

B Explain his procedural inexperience to Mr. Walsh and ask if he is comfortable with Evan attempting it.

Key 4

Rating 4 (Somewhat undesirable). While transparency with patients is vital, transferring the burden of deciding clinical competency onto an anxious patient in an exam room is unprofessional and coercive. The resident has already determined the task exceeds their safety threshold, making patient consent to an unassisted novice inappropriate. Clarifying training limits directly with the supervisor is the required action.

PRINCIPLE Do not transfer the responsibility of trainee competence verification onto the patient.

C Step out immediately to explain his lack of procedural experience to Dr. MacIntyre and request direct supervision.

Key 1

Rating 1 (Very desirable). Patient safety and professional self-regulation demand that a resident decline to perform unsupervised invasive procedures outside their competence. Directly and politely stating limits to the preceptor protects the patient from procedural harm and preserves educational integrity. It would move down if the resident refused without offering to prepare the patient while waiting for supervision.

PRINCIPLE Assert clinical competence limits directly to ensure patient safety despite hierarchical pressure.

D Review an online procedural video on his phone in the clinic room before performing the injection alone.

Key 5

Rating 5 (Very undesirable). Watching a brief video does not establish procedural competency for an invasive joint injection in a novice learner. Proceeding to inject a patient unassisted based solely on a video when the preceptor is in the building represents reckless overconfidence and endangers patient safety. The resident must seek supervision.

PRINCIPLE Do not substitute digital learning materials for mandated physical supervision of invasive procedures.

E Inform the clinic nurse that the injection is cancelled today due to time constraints and reschedule Mr. Walsh.

Key 4

Rating 4 (Somewhat undesirable). Cancelling a needed clinical procedure unilaterally without consulting the preceptor or exploring solutions inconveniences the patient, especially in a rural setting where travel distances are large. While it prevents unsafe unassisted practice, it bypasses collaborative problem-solving entirely. Communicating with the preceptor to supervise or reschedule together would improve this score.

PRINCIPLE Avoid unilateral procedural cancellations without first attempting supervisor coordination or brief assistance.

F Position the patient, review anatomical landmarks, and wait until Dr. MacIntyre is free to scrub in together.

Key 2

Rating 1 (Very desirable). This demonstrates excellent adaptability, initiative, and patient-centered efficiency. By completing the preparatory steps within his competence (positioning, cleaning, reviewing anatomy), the resident saves valuable preceptor time while strictly ensuring the needle is inserted only under direct supervision. It would move down if the resident proceeded to puncture without waiting.

PRINCIPLE Maximize clinic efficiency within safe boundaries while awaiting direct supervision for unfamiliar procedures.

YOUR TAKEAWAY

One sentence you want to remember

Sample question 19 · Ranking format

Dr. Hannah Cole, a family medicine resident on a long-term care rotation, is on-call overnight covering a 120-bed facility. At 23:00, the central nursing call-bell system unexpectedly shuts down across all wings, leaving residents unable to summon assistance electronically. Moments later, a personal support worker informs Dr. Cole that an 84-year-old resident, Mr. Abebe, is acutely hypotensive with rapidly declining vital signs. Simultaneously, the floor nurse presents Dr. Cole with routine, non-urgent evening medication queries for two stable residents. Dr. Cole's supervising physician has not responded to an urgent page placed fifteen minutes earlier. With limited overnight staff and multiple competing demands, Dr. Cole must determine her immediate course of action.

Rank in order the following actions for Dr. Cole to take in response to this situation.

5 Least desirable

Write a rank from 1 to 5 in each box

- RANK

- RANK

- RANK
-
- 

- RANK
-
- 

- RANK
-
- 

fmprocprep.ca/questions/b07-adaptability

Space for your reasoning

Adaptability

Ranking

Hard

b07

Sample 19 · Answer & rationale

Adaptability · Scale: 1 Most desirable → 5 Least desirable

ANSWER KEY

A 1

B 4

C 2

D 5

E 3

[Open online ↗](#)
A Assess Mr. Abebe immediately while directing the floor nurse to institute hourly manual room checks across units.

Rank 1

This is the most desirable response because it simultaneously prioritizes immediate life-threatening instability and provides actionable leadership to mitigate facility-wide vulnerability. Dr. Cole addresses the unstable resident directly without delay while delegating floor staff to manage the call-bell outage. This option demonstrates high adaptability by triaging acute clinical deterioration alongside systemic risk.

PRINCIPLE Prioritize acute clinical instability while delegating system-level safety measures immediately.

B Contact the facility administrator on-call to report the system failure and preceptor unresponsiveness before seeing Mr. Abebe.

Rank 4

This response focuses prematurely on administrative escalation and blame mitigation while an unstable resident deteriorates without medical assessment. Although an unresponsive supervisor and infrastructure failure warrant escalation, administrative reporting does not protect the immediate life of Mr. Abebe. To rank higher, Dr. Cole would need to stabilize the patient before pursuing bureaucratic channels.

PRINCIPLE Defer administrative reporting until immediate life-threatening clinical emergencies are stabilized.

C Evaluate Mr. Abebe at the bedside while asking the nurse to defer medication queries and repage the supervisor.

Rank 2

This response is desirable as it promptly directs clinical attention to the deteriorating resident while eliminating low-priority cognitive distractions. It is ranked lower than Option A because it leaves the facility-wide call-bell system failure completely unaddressed, exposing other vulnerable residents to unmonitored risk. To rank higher, it would need to incorporate a delegation step for resident safety rounds.

PRINCIPLE Address deteriorating patients directly while filtering out non-urgent operational tasks.

D Review and resolve the two routine medication queries quickly with the nurse before assessing Mr. Abebe.

Rank 5

This is the least desirable response as it reflects task fixation on low-stakes routine administrative duties in the face of an acute medical emergency. Completing minor non-urgent chart reviews while a resident's blood pressure is crashing compromises patient safety. It demonstrates poor clinical adaptability and failed prioritization under high-pressure conditions.

PRINCIPLE Never delay emergent patient assessment to complete routine administrative requests.

E Direct nursing staff to establish facility-wide emergency watch protocols before going to assess Mr. Abebe at bedside.

Rank 3

This response demonstrates situational awareness of systemic safety risks across 120 residents but misprioritizes sequence by delaying bedside care for an actively crashing patient. While organizing unit safety is important, an acute hypotensive crisis requires immediate direct physician assessment. It ranks above administrative escalation because it still engages with real-time facility safety, but falls below direct bedside triage.

PRINCIPLE Do not delay active bedside resuscitation to coordinate broader facility logistics.

YOUR TAKEAWAY

One sentence you want to remember

Adaptability

Ranking

Hard

v2097

Adaptability

Sample question 20 · Ranking format

SCENARIO

You are a family medicine resident staffing an isolated northern nursing station when an adult patient presents with atypical chest pain. Severe blizzard conditions have grounded all medevac aircraft, halting regional laboratory transport and preventing tertiary transfer for at least twenty-four hours. When preparing point-of-care testing, the clinic discovers that the entire supply of troponin and blood gas cartridges expired yesterday. Nurse Campbell advocates running the expired cartridges to gather approximate biochemical trends, whereas Nurse Tremblay refuses, arguing that invalid tests create medicolegal liability and false clinical reassurance. The nursing staff are deadlocked and awaiting your direction while the patient remains symptomatic. You must adapt clinical workflows to manage acute diagnostic uncertainty collaboratively.

YOUR TASK

Rank in order the following actions for Dr. Lin to take in response to this situation.

1 Most desirable

2

3

4

5 Least desirable

OPTIONS

Write a rank from 1 to 5 in each box

A Insist the nurses run the expired cartridges and rely on those quantitative results to guide management.

RANK

B Defer any cardiac medication administration until regional lab specimen transport can be arranged when weather clears.

RANK

C Run the expired cartridges immediately as auxiliary data while treating the patient based solely on clinical evaluation.

RANK

D Review cartridge expiration specifications with the nursing team and tele-cardiology before deciding whether to run them adjunctively.

RANK

E Formulate a clinical management plan using serial examinations and electrocardiograms while consulting tele-cardiology regarding the diagnostic dilemma.

RANK


[Work through this question online](#)

Interactive version and related samples. The answer and rationale are on the next page.

fmprocprep.ca/questions/v2097-adaptability

YOUR NOTES

Space for your reasoning

Adaptability

Ranking

Hard

v2097

Sample 20 · Answer & rationale

Adaptability · Scale: 1 Most desirable → 5 Least desirable

ANSWER KEY

A 5

B 4

C 3

D 2

E 1

[Open online ↗](#)
A Insist the nurses run the expired cartridges and rely on those quantitative results to guide management.

Rank 5

Rank 5. Mandating reliance on expired laboratory cartridges forces nursing colleagues to breach professional dispensing standards and risks severe clinical mismanagement through false-positive or false-negative readings. It represents autocratic leadership and poor adaptability in resource-limited medicine.

PRINCIPLE Never force nursing staff to rely on expired, unvalidated point-of-care diagnostics.

B Defer any cardiac medication administration until regional lab specimen transport can be arranged when weather clears.

Rank 4

Rank 4. Withholding empiric treatment during an evolving acute presentation because laboratory access is delayed compromises patient safety. While avoiding unvalidated tests is correct, clinical inertia while waiting for unpredictable weather clearance is inflexible and dangerous.

PRINCIPLE Do not withhold timely empiric management while awaiting delayed transfer capabilities.

C Run the expired cartridges immediately as auxiliary data while treating the patient based solely on clinical evaluation.

Rank 3

Rank 3. Attempting to collect supplementary information reflects practical curiosity, but running expired biochemical reagents carries significant risk of uncalibrated error and cognitive bias. It also partially overrides valid nursing safety concerns without resolving diagnostic ambiguity.

PRINCIPLE Avoid utilizing unvalidated point-of-care tests that can introduce misleading clinical bias.

D Review cartridge expiration specifications with the nursing team and tele-cardiology before deciding whether to run them adjunctively.

Rank 2

Rank 2. Seeking specialist advice regarding manufacturer degradation windows and involving the team respects interprofessional expertise and addresses staff conflict constructively. It ranks slightly below immediate clinical stabilization because discussing equipment technicalities marginally delays active patient assessment.

PRINCIPLE Engage interprofessional team and specialist input before deploying compromised diagnostic resources.

E Formulate a clinical management plan using serial examinations and electrocardiograms while consulting tele-cardiology regarding the diagnostic dilemma.

Rank 1

Rank 1. This option exemplifies adaptability by optimizing validated clinical tools (serial exams, serial ECGs) and integrating specialist telemedicine support when technology fails. It avoids reliance on corrupted diagnostic inputs while providing proactive, evidence-based care within environmental constraints.

PRINCIPLE Prioritize validated clinical assessments and specialist consultation when point-of-care diagnostics fail.

YOUR TAKEAWAY

One sentence you want to remember

Answer key

For rating items, the number is the desirability rating. For ranking items, it is the position. Each sample links to its full reasoning online.

#	SAMPLE	FORMAT	KEY	
01	b01 Professional Integrity	Rating	A3 · B5 · C4 · D4 · E1 · F2 · G2	Open ↗
02	b18 Professional Integrity	Rating	A4 · B1 · C2 · D3 · E1 · F5	Open ↗
03	v2021 Professional Integrity	Rating	A4 · B1 · C4 · D2 · E5 · F3	Open ↗
04	b09 Professional Integrity	Ranking	A5 · B1 · C2 · D3 · E4	Open ↗
05	v2064 Professional Integrity	Ranking	A1 · B2 · C3 · D4 · E5	Open ↗
06	b02 Empathy and Compassion	Rating	A2 · B5 · C3 · D4 · E5 · F1 · G1	Open ↗
07	v2023 Empathy and Compassion	Rating	A3 · B5 · C1 · D2 · E4 · F5	Open ↗
08	v2034 Empathy and Compassion	Rating	A5 · B5 · C1 · D1 · E2 · F1	Open ↗
09	b10 Empathy and Compassion	Ranking	A2 · B4 · C1 · D5 · E3	Open ↗
10	v2096 Empathy and Compassion	Ranking	A4 · B5 · C3 · D1 · E2	Open ↗
11	b05 Team Collaboration	Rating	A1 · B5 · C1 · D3 · E4 · F4 · G2	Open ↗
12	v2010 Team Collaboration	Rating	A4 · B5 · C2 · D2 · E1 · F1	Open ↗
13	v2045 Team Collaboration	Rating	A1 · B5 · C1 · D4 · E2 · F4	Open ↗
14	b11 Team Collaboration	Ranking	A3 · B2 · C1 · D5 · E4	Open ↗
15	v2094 Team Collaboration	Ranking	A2 · B4 · C1 · D3 · E5	Open ↗
16	b34 Adaptability	Rating	A1 · B4 · C5 · D1 · E4 · F1 · G4	Open ↗
17	v2048 Adaptability	Rating	A3 · B5 · C1 · D4 · E1 · F2	Open ↗
18	v2059 Adaptability	Rating	A5 · B4 · C1 · D5 · E4 · F2	Open ↗
19	b07 Adaptability	Ranking	A1 · B4 · C2 · D5 · E3	Open ↗
20	v2097 Adaptability	Ranking	A5 · B4 · C3 · D2 · E1	Open ↗

About this key. The answer key reflects FMProC Prep's editorial review. It is not an official FMProC key and is intended for study, not for reproducing live exam material. Every option's rationale is available on its question page.

Keep practising

170 questions, attempt history and review-importance sorting. Free after sign-up.

[Create a free account ↗](#)