FOURTH EDITION

Cases for PACES

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WILEY Blackwell

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Foreword

Taking the MRCP PACES exam is a defining moment in most physicians' training life. PACES is undoubtedly a high-stakes exam both from the perspective of the implications for progression of training but also for the way an individual's knowledge and skills are placed under the spotlight. All physicians will have strong memories of their PACES experience; both good and bad. It is a stern test, but once completed it acts as a stamp of quality that is indelible and widely recognized. Getting through the exam successfully requires hard work, dedication and a pragmatic approach given the competing pressures of both clinical and home life.

This book can't replace hard work and dedication, but it does provide a well-proven and effective methodology for success. Thousands of physicians have benefited from the use of its wisdom and the fact it is now in its fourth generation is testament to how useful it has been for many. This latest edition takes into account the evolving design of the exam and should lessen the fear of the unknown that some have when approaching the exam. PACES will continue to evolve as medicine itself evolves, but it is striking how much the principles of clinical diagnosis remain constant. The advice to take time to think, look and gather oneself while the hand rub dries is one such principle. These principles are not just for the exam but when used in daily clinical practice will make life simpler and less stressful for the physician and result in better outcomes for the patient.

The breadth of internal medicine is wide and this book reminds us how much we have learned (or indeed still have to learn or relearn). It reminds us how fascinating medicine is and why many of us have chosen life as a physician – and given current clinical pressures such a reminder is always helpful. For those taking the exam, you will never again have such a wide breadth of knowledge and hopefully this book will help you keep much of that accumulated wisdom for all your professional life.

I wish you all the best for the exam and hope this book eases the journey through it. I suspect it will and if you have a hard copy you will keep it to refer to for many years to come. You may even read these words again in 20 years' time (he says as he looks at the dog-eared spine of the copy of its predecessor on the office shelf!).

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Past President of the Royal College of Physicians, London

Preface

PACES (Practical Assessment of Clinical Examination Skills) was initiated in June 2001 by the Royal College of Physicians as the final stage of the MRCP examination. The initial examination consisted of five stations in a carousel: Station 1: Respiratory/Abdominal (10 minutes each), Station 2: History Taking (20 minutes), Station 3: Cardiology/Neurology (10 minutes each), Station 4: Communication Skills and Ethics (20 minutes) and Station 5: Short Cases (Skin, Locomotor, Eyes and Endocrine: 5 minutes each). The format was refined in October 2009 by restructuring Station 5 into two 10-minute 'Brief Clinical Consultations'.

The PACES exam had a further major update introduced from Autumn 2023 that was badged PACES23. Many aspects of the exam remain the same as the old format and the standard required to pass PACES23 is also unchanged. There will still be a five-station carousel, with each station lasting 20 minutes and 5-minute intervals in between. Candidates will continue to be examined by two examiners, who will have calibrated the case and agreed the pass threshold before assessing and marking each candidate independently.

The assessment of seven key skills is also retained in PACES23:

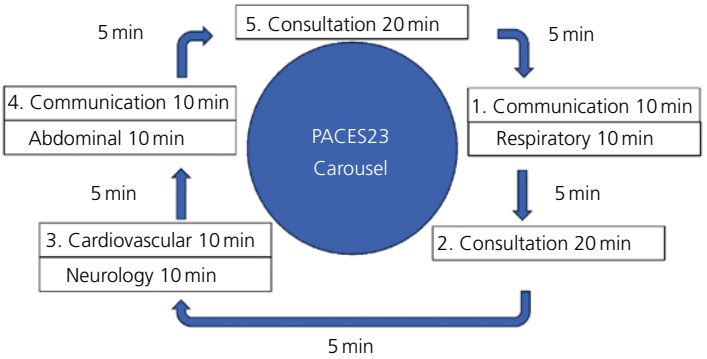
A. Physical Examination
B. Identifying Clinical Signs
C. Communication
D. Differential Diagnosis
E. Clinical Judgement
F. Managing Patient Concerns
G. Maintaining Patient Welfare

Candidates must achieve a pass in all seven key skills and reach a total mark above a set threshold to pass.

The four clinical encounters assessing Respiratory, Abdominal, Cardiovascular and Neurological systems, each in 10 minutes, with 6 minutes to examine and 4 minutes to interact with examiners, also remain the same. However, Station 2 – History Taking without physical examination was thought to be unrepresentative of current clinical practice and has been removed; Station 4 – Communication was believed to be too long, with examiner interaction of little value in assessing the candidate; and Station 5 – Brief Clinical Consultations was too short, although this station provided the best integrated assessment of all seven key skills that emulated real-life clinical practice. Stations 4 and 5 have now been redesigned, with more emphasis on the clinical consultation:

Old MRCP PACES		**New PACES23**
Station 2 – 20-min History Taking	→	Removed
Station 4 – 20-min Communication	→	2 × 10-min Communication encounter without examiner interaction
Station 5 – 2 × 10-min Brief Clinical Consultation	→	2 × 20-min Consultations: 15 minutes history and examination and 5 minutes examiner interaction

The five-station carousel has also been redesigned to accommodate these changes, with the two Communication encounters preceding the Respiratory encounter in Station 1 and Abdominal encounter in Station 4, two Consultation encounters (Station 2 and 5) and the Cardiovascular and Neurology encounters in Station 3 remaining unchanged:



Cases for PACES Fourth Edition prepares candidates for the current PACES23 examination. It mimics the new examination format and is designed for use in an interactive way. This fourth edition has a completely revised text that has been informed by recent successful candidate feedback. It has useful advice for the day of the exam and provides updated information on clinical, ethical and medicolegal issues. There are plenty of new scenarios and mock questions for candidates to practise themselves. The two Consultation stations, which assess all seven key skills in an integrated way that most closely reflects day-to-day practice, account for two-fifths of the exam marks and receive particular attention in this new edition.

Avoid further factual cramming at this stage – you know enough! Go and see medical patients on a busy acute medicine unit or outpatient department. This has always been the best way to prepare for PACES and will be particularly beneficial for the new Consultation stations. This book will assist you in self-directed ward revision in preparation for PACES23. Each section has clinical mark sheets guiding which of the seven skills are being assessed and what you need to demonstrate to pass; this should enable groups of candidates to practise 'under examination conditions' at the bedside.

Common cases that regularly appear in the exam, rather than rarities, have been deliberately chosen. We assume candidates who are well practised will be fluent in the examination techniques needed to elicit the various clinical signs. However, in this new edition we provide extra guidance on how to efficiently examine each system to identify and interpret those all-important clinical signs within the allotted time.

We provide discussion topics that a candidate could be expected to comment on at the end of the case during the 4 or 5 minutes of examiner interaction. Remember that the examiners are specifically assessing your knowledge of the differential diagnosis and organized clinical judgement and management, while addressing the patient's concerns and maintaining patient welfare throughout this interaction.

The detail in this book is not exhaustive but rather what is reasonably needed to pass and be a competent and safe Specialty Registrar practising medicine with minimal supervision. There is space to make further notes if you wish. The aim of this book is to put the information that is frequently tested in the clinical PACES23 examination in a succinct, exam-style format that will enable capable candidates to practise and pass with ease on the day.

We wish you the best of luck.

Stephen Hoole
Andrew Fry
Rachel Davies

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Abbreviations

AAA	Abdominal aortic aneurysm
ABC	Airway, breathing, circulation
ABG	Arterial blood gas
ABPA	Allergic bronchopulmonary aspergillosis
ABPM	Ambulatory blood pressure monitoring
ACE	Angiotensin-converting enzyme
ACh	Acetylcholine
AChR	Acetylcholine receptor
ACR	Albumin: creatinine ratio
ACS	Acute coronary syndrome
ACTH	Adrenocorticotrophic hormone
ADLs	Activities of daily living
ADPKD	Autosomal dominant polycystic kidney disease
ADRT	Advanced decisions to refuse treatment
AF	Atrial fibrillation
AFB	Acid-fast bacillus
AFP	Alpha-fetoprotein
AICD	Automated implantable cardiac defibrillator
AIDP	Acute inflammatory demyelinating polyradiculoneuropathy
AIH	Autoimmune hepatitis
A(I)NOCA	Angina (ischaemia) non-obstructive coronary artery
AKI	Acute kidney injury
ALP	Alkaline phosphatase
AMD	Age-related macular degeneration
ANA	Anti-nuclear antibody
APS	Anti-phospholipid syndrome
AR	Aortic regurgitation
ARB	Angiotensin II receptor blocker
ARNI	Angiotensin receptor/neprilysin inhibitor
ARVD	Arrhythmogenic right ventricular dysplasia
AS	Aortic stenosis
5-ASA	5-Aminosalicylic acid
ASD	Atrial septal defect
ASOT	Anti-streptolysin O titre
ATP	Anti-tachycardia pacing
AV	Arteriovenous
AVN	Atrioventricular node
AVR	Aortic valve replacement
AVSD	Atrioventricular septal defect
AXR	Abdominal X-ray
BAV	Balloon aortic valvuloplasty
BFT	Bone function test
BIPAP	Bi-level positive airway pressure
BiV	Biventricular
BM	Boehringer Mannheim (glucose)
BMI	Body mass index
BNF	British National Formulary
BNP	Brain natriuretic peptide
BP	Blood pressure
BPA	Balloon pulmonary angioplasty

BPPV Benign paroxysmal positional vertigo
BSO Bilateral salpingo-oophorectomy
BT shunt Blalock–Taussig shunt
CA Carcinoma
CABG Coronary artery bypass graft
CAD Coronary artery disease
CAP Community-acquired pneumonia
CAPD Continuous ambulatory peritoneal dialysis
CCB Calcium channel blocker
CCF Congestive cardiac failure
CCP Cyclic citrullinated peptide
CF Cystic fibrosis
CFA Cryptogenic fibrosing alveolitis
CFTR Cystic fibrosis transmembrane conductance regulator
CGM Continuous glucose monitor
CGRP Calcitonin gene-related peptide
CIDP Chronic inflammatory demyelinating polyneuropathy
CK Creatine kinase
CKD Chronic kidney disease
CLD Chronic liver disease
CMD Coronary microcirculatory dysfunction
CML Chronic myeloid leukaemia
CMR Cardiovascular magnetic resonance
CMV Cytomegalovirus
CNS Central nervous system
CoA Coarctation of aorta
COPD Chronic obstructive pulmonary disease
COMT Catechol-o-methyl transferase
CPET Cardiopulmonary exercise test
CRP C-reactive protein
CRT Cardiac resynchronization therapy
CRT-D Cardiac resynchronization therapy defibrillator
CSF Cerebrospinal fluid
CT Computed tomography
CTCA CT coronary angiography
CTEPH Chronic thromboembolic pulmonary hypertension
CTPA CT pulmonary angiography
CV Cardiovascular
CVA Cerebrovascular accident
CVID Common variable immunodeficiency
CVS Cardiovascular system
CXR Chest X-ray (radiograph)
DBD Donation after brain death
DBP Diastolic blood pressure
DCD Donation after cardiac death
DIOS Distal intestinal obstruction syndrome
DIPJ Distal interphalangeal joint
DKA Diabetic ketoacidosis
DM Diabetes mellitus
DM1 Dystrophia myotonica type 1
DM2 Dystrophia myotonica type 2
DMARD Disease-modifying anti-rheumatic drug
DNA-CPR Do not attempt cardiopulmonary resuscitation
DNAR Do not attempt resuscitation

DNase Deoxyribonucleic acid hydrolytic enzyme
DOAC Direct oral anticoagulant
D&V Diarrhoea and vomiting
DVLA Driver and Vehicle Licensing Agency
DVT Deep vein thrombosis
eGFR Estimated glomerular filtration rate
EBUS Endobronchial ultrasound
EBV Epstein–Barr virus
EC Ejection click
ECG Electrocardiogram
ECHO Echocardiogram
EEG Electroencephalogram
EF Ejection fraction
EMG Electromyogram
EP Electrophysiology
ERA Endothelin receptor antagonist
ERCP Endoscopic retrograde cholangiopancreatography
ESM Ejection systolic murmur
ESR Erythrocyte sedimentation rate
EtOH Ethanol
ETT Exercise treadmill test
EVAR Endovascular aortic repair
FBC Full blood count
FEV_1 Forced expiratory volume in 1 second
FFP Fresh frozen plasma
FH Family history
FSGS Focal segmental glomerulosclerosis
FSH Follicle-stimulating hormone
FSHD Facioscapulohumeral muscular dystrophy
FTA Fluorescent treponema antibodies
FVC Forced vital capacity
GA General anaesthetic
GBS Guillain–Barré syndrome
GCS Glasgow Coma Scale
GEP Gastro-entero-pancreatic
GGT Gamma-glutamyl transferase
GH Growth hormone
GI Gastrointestinal
GLP-1 Glucagon-like peptide-1
GMP Good medical practice
GnRH Gonadotropin-releasing hormone
GORD Gastro-oesophageal reflux disease
Gp Glycoprotein
GRACE Global Registry of Acute Coronary Events
GTN Glyceryl trinitrate
Hb Haemoglobin
HBPM Home blood pressure monitoring
HBV Hepatitis B virus
HCC Hepatocellular carcinoma
HCG Human chorionic gonadotrophin
HCM Hypertrophic cardiomyopathy
HCV Hepatitis C virus
HDU High-dependency unit
HF Heart failure

HGV Heavy goods vehicle
HIV Human immunodeficiency virus
HLA Human lymphocyte antigen
HOCM Hypertrophic obstructive cardiomyopathy
HR Heart rate
HRT Hormone replacement therapy
HSMN Hereditary sensory motor neuropathy
HSV Herpes simplex virus
5-HT 5-hydroxytryptamine
IABP Intra-aortic balloon pump
IBD Inflammatory bowel disease
ICD Implantable cardioverter defibrillator
IDDM Insulin-dependent diabetes mellitus
IGF Insulin-like growth factor
IHD Ischaemic heart disease
ILD Interstitial lung disease
INR International normalized ratio
IPF Idiopathic pulmonary fibrosis
IRMA Intraretinal microvascular abnormalities
ITP Immune thrombocytopenic purpura
ITU Intensive therapy unit
IV Intravenous
IVC Inferior vena cava
IVDA Intravenous drug abuse
JVP Jugular venous pressure
K_{co} Transfer coefficient
LA Left atrial
LAA Left atrial appendage
LAAO Left atrial appendage occlusion
LACS Lacunar anterior circulation stroke
LAD Left axis deviation
LDH Lactate dehydrogenase
LEMS Lambert–Eaton myasthenic syndrome
LFT Liver function test
LGE Late gadolinium enhancement
LH Luteinizing hormone
LMN Lower motor neurone
LMWH Low molecular weight heparin
LP Lumbar puncture
LQTS Long QT syndrome
LRTI Lower respiratory tract infection
LTOT Long-term oxygen therapy
LTR Left to right
LV Left ventricle
LVAD Left ventricular assist device
LVEDP Left ventricular end-diastolic pressure
LVEF Left ventricular ejection fraction
LVH Left ventricular hypertrophy
LVOT Left ventricular outflow tract
mAb Monoclonal antibody
MAO Monoamine oxidase
MCPJ Metacarpophalangeal joint
MC + S Microscopy, culture and sensitivity
MDM Mid-diastolic murmur

MDT Multi-disciplinary team
MEN Multiple endocrine neoplasia
MG Myasthenia gravis
MI Myocardial infarction
MIBI Myocardial perfusion (sestamibi) imaging
MLF Medial longitudinal fasciculus
MMF Mycophenolate mofetil
MND Motor neurone disease
mPAP Mean pulmonary artery pressure
MPTP Methyl-phenyl-tetrahydropyridine
MR Mitral regurgitation
MRA Magnetic resonance angiography
MRCP Magnetic resonance cholangiopancreatography
MRI Magnetic resonance imaging
MS Mitral stenosis
MSA Multisystem atrophy
MTPJ Metatarsophalangeal joint
MuSK Muscle-specific kinase
MV Mitral valve
MVP Mitral valve prolapse
MVR Mitral valve replacement
6MWD Six-minute walk distance
NG Nasogastric
NHSE NHS England
NIPPV Non-invasive positive pressure ventilation
NOAC Non-vitamin K antagonist oral anticoagulant
NSAID Non-steroidal anti-inflammatory drug
NSCLC Non-small cell lung cancer
NT-proBNP N-terminal prohormone of brain natriuretic peptide
NVD Neovascularization of the disc
NVE New vessels elsewhere
NYHA New York Heart Association
OA Osteoarthritis
OAC Oral anticoagulant
OCP Oral contraceptive pill
OGD Oesophago-gastro-duodenoscopy
OS Opening snap
Pa Partial pressure (arterial)
PACS Partial anterior circulation stroke
PAH Pulmonary arterial hypertension
PBC Primary biliary cirrhosis
PCOS Polycystic ovary syndrome
PCR Polymerase chain reaction
PCT Primary Care Trust
PCWP Pulmonary capillary wedge pressure
PD Parkinson's disease
PDA Patent ductus arteriosus
PDE5 Phosphodiesterase-5
PE Pulmonary embolism
PEA Pulmonary endarterectomy
PEFR Peak expiratory flow rate
PEG Percutaneous endoscopic gastrostomy
PEP Post-exposure prophylaxis
PET Positron emission tomography

PH Pulmonary hypertension
PICA Posterior inferior cerebellar artery
PIPJ Proximal interphalangeal joint
PLA2R Anti-phospholipase A2 receptor
PMH Past medical history
PMR Polymyalgia rheumatica
PPCI Primary percutaneous coronary intervention
PPI Proton pump inhibitor
PPMS Primary progressive multiple sclerosis
PPRF Paramedian pontine reticular formation
PPVI Percutaneous pulmonary valve implantation
PR Per rectum (rectal)
PRL Prolactin
PRN *Pro re nata*, when required
PS Pulmonic stenosis
PSA Prostate specific antigen
PSC Primary sclerosing cholangitis
PSM Pan-systolic murmur
PSV Public service vehicle
PTH Parathyroid hormone
PTHrP Parathyroid hormone-related peptide
PUVA Psoralen ultraviolet A
PV *Per vaginum* (vaginal)
PVD Peripheral vascular disease
PVR Pulmonary vascular resistance
QoL Quality of life
RA Rheumatoid arthritis
RAD Right axis deviation
RADT Rapid antigen detection test
RAPD Relative afferent pupillary defect
RAS Renal artery stenosis
RAST Radio-allergo-sorbent test
RBBB Right bundle branch block
RCC Right coronary cusp
RF Risk factor
RR Respiratory rate
RRMS Relapsing-remitting multiple sclerosis
RTL Right to left
RUQ Right upper quadrant
RV Right ventricle
RVF Right ventricular failure
RVH Right ventricular hypertrophy
Rx Treatment
SAH Subarachnoid haemorrhage
sAVR Surgical aortic valve replacement
SBP Systolic blood pressure
SCD Sudden cardiac death
SCLC Small cell lung cancer
SGLT2 Sodium-glucose co-transporter 2
SH Social history
SIADH Syndrome of inappropriate anti-diuretic hormone
S-ICD Subcutaneous implantable cardiac defibrillator
SLE Systemic lupus erythematosus
SOA Swelling of ankles

SOB Shortness of breath
SOL Space-occupying lesion
SPMS Secondary progressive multiple sclerosis
SSRI Selective serotonin reuptake inhibitor
SVCO Superior vena cava obstruction
SVT Supraventricular tachycardia
T_4 Thyroxine
T°C Temperature
TACS Total anterior circulation stroke
TAVI Transcutaneous aortic valve implantation
TB Tuberculosis
TEER Transcatheter edge-to-edge repair
TENS Transcutaneous electrical nerve stimulation
TFT Thyroid function test
THR Total hip replacement
TIA Transient ischaemic attack
TIMI Thrombolysis in myocardial infarction
TKI Tyrosine kinase inhibitor
TLC Total lung capacity
TL_{CO} Carbon monoxide transfer factor
TNM Tumour nodes metastasis (staging)
TOE Transoesophageal echo
ToF Tetralogy of Fallot
tPA Tissue plasminogen activator (alteplase)
TPHA Treponema pallidum haemagglutination assay
TPMT Thiopurine methyltransferase
TPW Temporary pacing wire
TR Tricuspid regurgitation
TSAT Transferrin saturation
TSH Thyroid stimulating hormone
TTE Transthoracic echo
tTG Tissue transglutaminase
TTR Time in therapeutic range
TV-ICD Transvenous implantable cardiac defibrillator
TWI T-wave inversion
U&E Urea and electrolytes
uACR Urine albumin: creatinine ratio
UC Ulcerative colitis
UFH Unfractionated heparin
UIP Usual interstitial pneumonia
UKHSA UK Health Security Agency
UMN Upper motor neurone
uPCR Urine protein: creatinine ratio
US Ultrasound
UTI Urinary tract infection
VATS Video-assisted thoracoscopic surgery
VEGF Vascular endothelial growth factor
VEP Visual evoked potential
VIP Vasoactive intestinal peptide
VQ Ventilation–perfusion
VSD Ventricular septal defect
VT Ventricular tachycardia
VTE Venous thromboembolism
WCC White cell count

Advice

Preparation

Practice makes perfect: it makes the art of eliciting clinical signs second nature and allows you to concentrate on what the physical signs actually mean. Practice makes you fluent and professional and this will give you confidence under pressure. We strongly encourage you to see as many patients as possible in the weeks leading up to the exam. Practise under exam conditions with your peers, taking it in turns to be the examiner, and use the mark sheets provided. This is often very instructive and an occasionally amusing way to revise! It also maintains your motivation as you see your performance improve. We encourage you to seek as much help as possible from senior colleagues too; many remember their MRCP exam vividly and are keen to assist you in gaining those four precious letters after your name.

The day before

Check that you have your examination paperwork in order with your examination number as well as where and what time you are needed – you don't want to get lost or be late. Also ensure that you have packed some identification (e.g. a passport) as you will need this to register on the day. Remember to take with you vital equipment you are familiar with using, particularly your stethoscope, although avoid weighing yourself down with cotton wool, pins, otoscope and so on. The necessary equipment will be provided for you. Punctuality is important and reduces stress, so we advise that you travel to your exam the day before, unless your exam centre is on your doorstep. Avoid last-minute revision and try to relax – you will certainly know enough by now. Spend the evening doing something other than medicine and get an early night!

On the day

Think carefully about your attire – first impressions count both with the examiners and more importantly with the patients. Broadly speaking, exam dress policy is similar to that required of NHS employees. You should look smart and professional, but above all wear something that is comfortable. Shirts should be open collar (not low cut) and short sleeved to enable bare-below-the-elbow and effective hand sanitation. Remove watches/jewellery (wedding bands are permitted) and dangling necklaces/chains that could be distracting or hit the patient. Facial piercings other than ear studs are not recommended.

Examination

You will have 16 mark sheets – two for each encounter. There will be a short problem-orientated clinical question with an instruction prior to starting the station encounter, for example 'This man has been inadvertently dropping things – please assess his upper limbs neurologically' or 'This woman has been complaining of breathlessness – please assess her cardiovascular system'. Use the preparatory time before each case wisely and remember to answer the question when presenting your findings.

When you enter the station encounter, hand the mark sheets to the examiners and remember to **HIT** it off with the examiners and the patient:

- **H**and sanitization (if available).
- **I**ntroduce yourself to the patient and ask permission to examine them.
- **T**ake a step back once the patient is appropriately uncovered/positioned and spend 20 seconds observing them closely. This is roughly the time it takes for hand sanitizer to dry. It can feel an extraordinarily long period of time when under exam conditions but it is time well spent. As soon as you start touching the patient, your focus becomes blinkered and you will miss vital peripheral clues to the case.

Remembering to HIT it off will help settle your nerves and then you'll be underway. The rest will follow fluently if you are well practised.

Rather like when looking in the rear-view mirror in a driving test, be sure to convey to your examiner what you are doing. Try not to move the patient excessively and repeatedly; your examiner will be expecting to see you do things in an efficient and familiar order and doing so looks systematic, practised and fluent. However, if you do forget to do something halfway through the examination, or you have to go back to check a physical finding, that's fine. It's more important to be comprehensive and sure of the clinical findings than just to try to be 'slick'.

Spend the last few moments of your examination time working out what is going on, what the diagnosis is and what you are going to say to the examiner. There's still time to check again. Most examinations can be completed by standing up and saying to the examiners a phrase like 'To complete my examination I would like to check…' and then listing a few things you may have omitted and/or are important to the case, such as blood pressure, urine dipstick and so on.

Presentation

Eye contact and a direct, unambiguous presentation of the case convey confidence and reassure examiners that you are on top of things. Avoid the phrases 'I'm not sure if it is…' and 'I think it is…' Be definitive and avoid sitting on the fence, but above all be honest. Don't make up clinical signs to fit a specific diagnosis (some cases may be normal to assess your ability to detect the absence of signs). Try not to present clinical signs that are inconsistent with the diagnosis or differential diagnosis.

There are two ways to present the case:

- State the diagnosis and support this with key positive and negative clinical findings – if (and only if) you are confident you have secured the correct diagnosis.
- State the relevant positive and negative clinical signs (it's often easier to do this in the order you elicited them) and then give the differential diagnosis that is consistent with these – particularly if you are unsure of the diagnosis.

Where possible, you should comment on the disease severity or disease activity. Consider complications of the diagnosis and mention if these are present or not. Know when to stop talking. Brevity can be an asset: it avoids you making mistakes and digging a hole for yourself! Wait for the examiners to ask a question and do not be pre-emptive – the examiners may follow you down the rabbit hole and possibly expose a gap in your knowledge.

Examiners

Prior to you examining the patient the examiners will have individually 'calibrated the case' to assess its difficulty and ensure that the clinical signs are present. This maintains the fairness and robustness of the exam and makes sure consistency exists in exam centre marking. There will be two examiners for every carousel station and usually one will lead the discussion with you. Both will have the mark sheets that you gave them at the start of the encounter and will mark you independently without collaboration. Contrary to popular belief, they both want you to pass. They are there because they are Fellows of the College in good standing and support the training and progression of the talented physicians of the future.

Mistakes happen

If you do make a mistake and realize it, don't be afraid to correct yourself. To err is human and the examiners may overlook a minor faux pas or mis-speak if the rest of the case has gone well. It's not uncommon to think that you have failed a case halfway round the carousel and that your chances of passing PACES have been dealt a fatal blow. We are often our own harshest critics, so don't write yourself off. Frequently, all is not lost. Don't let your performance dip on the next cases because you are still reeling from the last. Put any mistakes behind you and *keep calm and carry on*!