

YEAR 1 CLINICAL CONTACT IN PRIMARY CARE SESSION
Thursday 13th March 2025 – am or pm – group B (red stream)
Theme: Neurology and cognitive assessment
Cons skills: Explaining

Session plan		Suggested timings: AM	PM
Introduction	20min	09.00-09.20	14.00-14.20
Patient contact	1-hour 10min	09:20-10.30	14.20-15.30
10-minute break			
Debrief and discussion	40 min	10.40 – 11.20	15.40 – 16.20
Focus on cognitive assessment	30 min	11.20 – 11.50	16.20 – 16.50
Close	10 min	11.50 – 12.00	16:50 – 17.00

Please use this session guide in conjunction with the GP teacher guide [here](#) as needed.

The opportunity for students to have patient contact and practice clinical skills is the basis of the sessions.

The general format is the same as previous ones, though **the timings have changed** to allow for discussion about cognitive assessment. Half the group meet a patient (ideally with a neurological or cognitive problem) and half observe consultations with you, but the patient contact time is slightly less.

The main consultation skill focus is “**explaining**”.

The appendix contains further information extracted from the students’ digital notebook (OneNote) and resources to enable you to help the students make links between the patients they see and their university learning. There is also some information about the students’ creative assignment.

The session includes an activity discussing **cognitive assessment** as this is an important early part of the curriculum and an area where GPs have lots of experience. This discussion is based on a short consultation clip from *GPs: Behind Closed Doors* which the students will have viewed in advance and we ask that they watch again with you on the day. You can view this in advance if you wish or with the students before discussion on the day – see link and details on page 10 for instructions. The appendix contains info about different methods of cognitive assessment to support discussion.

Timings are approximate and flexible. Most important is patient contact with subsequent discussion and reflection. Patient contact ideally involves a mix of students observing/participating in consultations and meeting patients, in their own homes where possible. Please use your own clinical experiences to feed into the discussion. It doesn’t matter if you don’t cover everything, relevant alternative discussions or activities are fine.

Any problems on the day, please email phc-teaching@bristol.ac.uk or call 0117 4282987.

Central University teaching context

In **effective consulting labs**, the focus is on explaining. In pairs, the students will attempt collaborative discussion explaining information to their 'patient' using Check: Chunk: Check and Teach Back (you can read more about this in the appendix below). They will be focusing on ears and eyes.

Learning objectives

- Describe the importance of developing shared understanding in the clinical encounter
- Describe the structure and components of a well-rounded medical history including assessment of cognitive function
- Describe some of the features involved in explaining ideas and developing shared understanding (chunking, checking, clarity and the use of aids) in the clinical encounter
- Practice explaining clinical information to patients, relating this to information gathered, clinical formulation, and the patient's ideas, concerns and expectations.
- Describe the importance of eliciting and confirming the patient's understanding
- Describe how the patients' ideas, concerns and expectations inform health professionals explanation of clinical problems

GP advance preparation

- Read this guide: arrange a patient, ideally with a neurological or cognitive problem, to meet with half the students (at home or in the surgery).
- Arrange a short surgery (3/4 patients) for the others to observe.
- Watch the 5 min GPs Behind Closed Doors clip if time (details on page 10)

Welcome, catch-up and introduction (20 min)

09.00-09.20 or 14.00-14.20

Check in and pastoral review.

Run through session plan and learning objectives/task

You may like to

Brainstorm the importance of and aspects of explaining

Patient contact (1 hr 10 min.)

09:20-10.30 or 14.20-15.30

Patient interview

Ideally, this will be a patient with a current or past, neurological condition, dementia or dementia carer. Students should take it in turns to lead the interview and be prepared to feedback to each other on consultation skills (see the GP Teacher guide for practical information about this and a patient letter).

Observing consultations. Ask the students to practice and observe **communication skills**, for feedback and discussion in the debrief.

Specific tasks:

- Think about what information can be gathered from active, purposeful observation of patients
- Observe how the GP prepares for and opens the consultation (COGConnect template, available [here](#))
- Reflect on gathering information, the content and process and what questions worked well
- Can you identify the patient's agenda? What do you think were their ideas, concerns, and expectations about what was going on? What about impact and emotions as well?
- Did the patient agree with their doctors' perspective, or do they have a different perspective?

Regarding **explaining**, think about

- What information did the patient want and need to know?
- What is important to think about when you explain something to a patient? Does the patient have a good understanding of their condition?
- Check/chunk/check or teach back (*see observation tool for this in the appendix*)
- What resources help e.g. visual/decision-making aids or signposting online or to information leaflets?
- When was it important that a "shared understanding" was reached e.g. did the doctor have to ask additional information to understand terminology that the patient used? Did the patient and doctor agree on a plan of action?

10-minute comfort/toilet/stretch/tea break as needed

Debrief and discussion (40 min)**10:40 – 11.20 or 16:00 – 16.20**

Ask one student to summarise the patient's story from the **patient interview**.

Discuss and reflect on the patient's narrative — you may wish to use the reflective tool based on the 5C's of COGConnect to aid this — available [here](#).

Reflect on the experiences of having a neurological problem and how these impact on patients' and carers' lives.

Students present the patients from **observed consultations** to the group: debrief, feedback and discussion around any issues that arise

Discuss which communication skills and question types worked well with specific focus on gathering the history, and finding out the patients' ICE and **explaining** (refer to student consultation observation tasks above).

Focus on Cognitive assessment (30 min)**11.20 – 11.50 or 16.20 – 16.50**

As a group, watch the clip from *GPs: Behind Closed Doors*. See details on p10. Reflect on this consultation as a group (can use COGConnect template below)

- Discuss the challenges of cognitive assessment. GP teachers to share tips and experiences diagnosing dementia, differentiating from other causes of cognitive decline, overlap with depression etc.

Feedback and close (10 min)**11.50 – 12.00 or 16.50 – 17.00**

Spend time with your **group reviewing your sessions** together. What have they learnt? What did they like/what could be improved?

Remind students about their reflective log/ePortfolio.

GP tasks after the session

- Prepare for and consider appropriate patient to invite to the next session (with your other group) **Thurs 27th March 2025**, CBL fortnight: Gastroenterology. Cons skill focus: Activating
- Complete online **attendance data**
- Please complete our feedback questionnaire

Any questions or additional feedback, contact phc-teaching@bristol.ac.uk

This is a full session so it is unlikely that you will need any additional activities! Just in case, see below, as in the GP Teacher Guide.

- Activity practising patient introductions – see [here](#)
- Discussing recent cases you've seen relevant to their learning
- Students could observe you telephone consulting or participate if the patient consents.
- **Show and tell** with consulting room equipment. e.g. thermometer, sphyg, urine dip, swab. Hold one up and ask students to tell you what it is, how to use, what is normal etc.
- Discussing significant events that have occurred recently at the surgery

Also, the students can access **Speaking clinically**, which is a video archive of patients talking openly about their medical conditions. It is operated by the Medical Schools Council and all students can access it. These are not consultations but useful for self-directed learning about the patient perspective. You do not need to view this but if you wish to have access you can log in at <https://speakingclinically.co.uk/accounts/login/>. Use email as phc-teaching@bristol.ac.uk. Password: primcareGP1GP2

APPENDICES

Effective Consulting COGConnect

Clinical Communication

Gathering info

Explaining – some pages are extracted from the students' digital notebook (OneNote)

- Understand the patient perspective and ideas, concerns, and expectations.
- Jargon
- What the patient wants to know and needs to know
- Chunking and checking – and **observation tool**
- Teach back
- Shared understanding
- Use of visual aids and leaflets
- Observation tool for COGConnect

Assessing Cognitive function

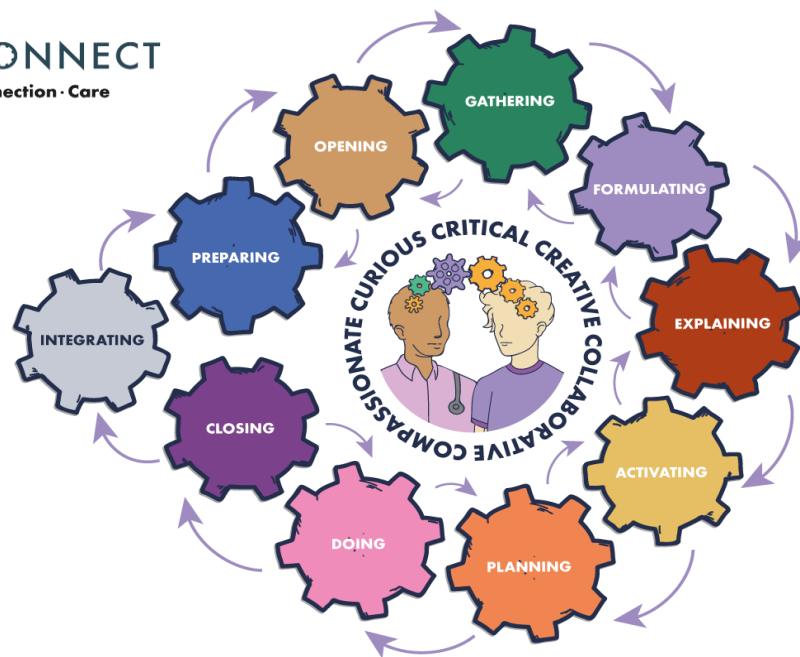
- Virtual Primary Care activity
- How to assess cognitive function

Creative assignment – for your info only

Effective consulting learning

Recap of COGConnect

The next page is an outline of the consultation model used to teach consultation skills in Bristol. Try using it to help the student reflect on their conversation. For instance, did the student open well? Did they bring their conversation to a satisfactory close? Was the student able to consider what was going on? Did the patient understand their condition, did they want an explanation?



PREPARING

Am I prepared?

- ⚙ Preparing oneself
- ⚙ Preparing the space
- ⚙ Checking the medical record

OPENING

Are we off to a good start?

- ⚙ Establishing the agenda
- ⚙ Establishing relationships
- ⚙ Initial observations

GATHERING

Have we covered all the relevant areas?

- ⚙ Sources of understanding
- ⚙ History
- ⚙ Clinical examination

FORMULATING

What is going and what is next?

- ⚙ Bias checking
- ⚙ Considering the options
- ⚙ Red flag signs and symptoms

EXPLAINING

Have we reached a shared understanding?

- ⚙ Chunking
- ⚙ Checking
- ⚙ Visual Aids

ACTIVATING

Is the patient better placed to engage in self-care?

- ⚙ Identifying problems and opportunities
- ⚙ Rolling with resistance
- ⚙ Building self-efficacy

PLANNING

Have we created a good plan forward?

- ⚙ Encourages contribution
- ⚙ Proposing options
- ⚙ Attends to ICE (IE)

CLOSING

Have I brought things to a satisfactory end?

- ⚙ Summary
- ⚙ Patient questions
- ⚙ Follow Up

DOING

Have I provided a safe and effective intervention?

- ⚙ Formal and informal consent
- ⚙ Due regard for safety
- ⚙ Skilfully conducted procedure

INTEGRATING

Have I integrated the consultation effectively?

- ⚙ Clinical record
- ⚙ Informational needs
- ⚙ Affective progressing

Clinical Communication: taken from students' resources

Gathering Clinical Information

As we foreground a holistic approach to GATHERING information from/with patients during clinical encounters, you may want to encourage students to consider the information they gather in the 3 domains:

- Nature of the medical problem
- Patient perspective on the problem
- Relevant background and lifeworld

Explaining

Drawing on the information gathered and formulated, describe how to develop a shared understanding with the patient of their condition, its causes, and next steps.

There are various points in the consultation that will require you to explain things to patients. You may explain:

- Your thinking during the consultation, especially what you think is going on: "Well, I don't think it sounds like your symptoms indicate anything serious, but I think we are going to have to do some further tests to make sure."
- Why you want to do something, such as an examination or get a blood test.
- The risks of a procedure to gain consent from a patient.
- How to do something, such as get a urine specimen
- What is likely to happen if you don't do anything. An example is explaining the natural history of a condition. For instance, a viral sore throat typically resolves within a week.
- Different options for treatment including not treating.

Patients should understand what the pros and cons of different treatment options are, and where there is uncertainty.

Understand the patient perspective and ideas, concerns, and expectations.

Explanation is not just telling the patient what is going on or what the options are and expecting them to sit and listen, it is a two-way process. The explanations you give for any of the above depends on what you have already discussed. It is based on your understanding of the patient's perspective.

Find out what the patient wants to know and decide what they need to know. Later on, when students learn more detail about various conditions it's common to hear them launch into lengthy explanations about the patient's problem before finding out what the patient wants to know.

Why should you find out what the patient wants to know: Suppose you are meeting a friend in town? You think you are nearly at the café you are meeting at, but you can't quite remember if you need to turn left or right so you consult a map. A kindly passer-by stops and presumes you are a tourist and that you need to know where you should go next. They start telling you about Bristol's road lay out, history and all the major landmarks you should visit and in which order. You can barely get a word in and feel a bit overwhelmed by all the information they give you. They leave and you realise you still don't know where the café is because they didn't ask what you needed to know.

A simple "Would you like me to tell you about..." or "I would like you to do a urine specimen, it's important it's done properly to avoid contamination, so can I talk you through how to do it?" works

well. It gives the patient the opportunity to say if they don't want/need the info. You never know, they might be a nurse on a urology ward and not need you to explain how to take a urine sample.

When you hear doctors give explanations to patients, listen to see if the doctor identifies the patient's starting point. An example would be: "From what you've told me and from examining you I suspect you have something called irritable bowel syndrome...if I say irritable bowel syndrome what does that mean to you?"

There are also numerous examples in medical practice of information that the patient needs to know but doesn't know that they need. They need to have been told the risks of a procedure before they can consent. They need to know what to look out for if their condition gets worse, what to do, and where and when to get help. You might hear doctors use signposting before they give information: "Having talked with you and examined you I think it is very unlikely that you have appendicitis, which is something you were concerned about. However, early on it can be hard to tell, and we need to discuss what to look out for..."

Remember to avoid jargon:

It's really important that you give explanations to patients in plain, straightforward language. Imagine you are talking to a family member who is not a doctor. Patient information leaflets such as those on www.patient.co.uk or patient support group websites for specific conditions are useful resources to look at to learn how to give simple explanations of sometimes quite complex problems. It can also be helpful to use the patient's own words.

Chunking and checking:

How we give patients information is important. Firstly, we need to check what information the patient wants and what their current understanding is.

We want to give information in a way that they will understand and recall. Particularly when we give a lot of information or complex explanations it helps to break it down into smaller "chunks".

"I am going to tell you 3 things about....The first is"

Also start with a simple "chunk" of information and check the patient has understood it before moving on. Checking is really asking the patient if they have any questions about what they are being told. One way to check if a patient has understood what you've talked about is to ask how they would explain it to their family or friends.

This is key to patient safety, key to patients' understanding treatment options, and key to patients making changes to their behaviour and self-care. One of the ways in which you can do this is through a method called (variously) 'teach back' or 'closing the loop'.

CHECK Identify and elicit the current situation before you proceed with the actual explanation.

a) your knowledge of the situation and information to be shared. Do you know what the result is and what that means clinically?

b) the patient's understanding of the condition/situation - what does your patient already know?

c) the patient's perception of the situation (ICEIE). Maybe they thought they might have cancer and being something else (however serious) could be a huge relief. Or maybe it will be devastating - they're an ice-cream taster and have a new diagnosis of a dairy allergy. Maybe they phoned and had the result already read out to them by an administrator?

d) the patient's ability to understand. This is key and will affect how you explain.

e) the patient's desire for information. For instance in some settings, some patients may actually not want excessive detail.

CHUNK. Here is where you actually explain the test result to the patient.

- a) deliver the information in appropriate-sized chunks of information that the patient can grasp
- b) do mini checks of understanding
- c) avoid technical language that most patients will not understand
- d) speak at a rate, pitch and volume that aids and at least does not discourage understanding
- e) try and weave into your explaining anything you picked up in the ICEIE.

CHECK. Here is where you check whether you have reached a shared understanding, based on your explanation.

- a) encourage the patient to ask questions, e.g. "was there anything that I said that you didn't quite understand?" or "could I clarify anything for you?"
- b) address any particular concerns divulged in ICEIE - e.g. "you told me you were worried about cancer - how are you doing with those worries now?" (notice use of open question).
- c) you could use teach back techniques here

Teach back:

In a non-blaming way, asking patients to repeat in their own words what they need to know or do. This is NOT a test of the patient, but of how well you explained a concept. A chance to check for understanding and, if necessary, re-teach the information. For more information see:

<http://www.teachbacktraining.org/using-the-teach-back-toolkit>

Shared understanding

When we talk about "shared understanding" with patients we are usually talking about shared decision making, helping patients understand their options and deciding together on the best way to proceed. All the way through an interview with a patient you want to check you are both "on the same page" i.e. you understand what the patient means, they understand what you mean, and that you encourage the patient to contribute or ask questions. The medical history is a meeting, not an interrogation! Part of a shared understanding is eliciting the patient's perspective and relating your explanations back to their understanding of the situation. It is also being sensitive to the patient's verbal and non-verbal reactions as you talk and checking in with them:

"I can see you look a bit puzzled. Have I confused you?" "Hmmm, I sense there is still something bothering you. Am I right?"

Use of visual aids and leaflets

Sometimes it helps to look at something together when giving explanations. A chart such as a Body Mass Index (BMI) chart clearly shows what is considered a healthy BMI and what isn't. It can be easier to show the patient where they are on the chart rather than verbal explanations alone.

Discussing stool consistency with patients can be helped by using the Bristol stool chart see here:

https://www.bladderandbowel.org/wp-content/uploads/2017/05/BBC002_Bristol-Stool-Chart-Jan-2016.pdf Likewise, patient information leaflets such as healthy diet sheets can be gone through together to back up your explanations.

Motivating patients to make lifestyle changes

Another reason we might give explanations to patients is to motivate them to make changes in their life. If patients understand that their nutrition, habits, or lifestyle are causing some of their symptoms or puts them at future risk they may be more motivated to make changes.

Observation tool for explaining

Tutors, if you are feeling brave, the students could observe any explanations you give to patients! The students also have this in their OneNote online. You could later reflect for CPD purposes.

Skill	Yes	Comment
CHECK		
The person who is doing the explaining: understanding of what is to be explained (nature and impact).		
Patient's <i>current understanding</i> of what is going to be explained (ICE IE)		
Patient's likely <i>ability</i> to understand		
Patients <i>desire</i> to understand		
CHUNK		
Deliver in appropriately sized <i>chunks</i> of information (leave gaps), using the voice well (tone, volume, breath)		
Use <i>language</i> the patient is likely to understand - avoiding jargon		
Speak at an appropriate <i>pace</i> - neither too fast nor laboriously slow		
Weave in aspects of patient's prior perspectives (? metaphor)		
Uses appropriate visual and other aids to understandings		
CHECK		
Offer patient opportunity to <i>ask questions</i>		
Enquire over any <i>specific concerns</i> (raised in ICEIE)		
Ask patient to <i>rehearse</i> their understanding		

Discussing assessing cognitive function

Virtual primary Care

The students have been asked to prepare in advance for this by viewing a 5-minute clip from *the GPs: Behind Closed Doors* series. Please see below for their instructions. If you are able, you can also watch this brief clip in advance:

<https://mediasite.bris.ac.uk/Mediasite/Play/759f68d8390d41139040ce2d4a4dbc8d1d>

Please ask one student to present the case and then discuss the consultation with the group. The table below is a useful guide for this. Please share and reflect upon your experiences of assessing cognition in various instances in clinical practice. It may be useful to have in mind cases which have been particularly interesting or challenging.

Instructions given to students in advance

Please watch this 5-minute video in advance of the session and use the Consultation Observation Questions on the next page to make some notes about each phase of COGConnect that you observe in this consultation. *Prepare to 'present'* this case to your group and to discuss with your GP tutor. You may watch this again in your session and there should be time to discuss it.

Watch the video a second time and identify the components of the memory screening test. Have a read of the GP COG Assessment here <https://patient.info/doctor/general-practitioner-assessment-of-cognition-gpcog-score>: and see how it matches up.

COGConnect Phase	Questions to consider whilst watching the video	Space for your notes
Preparing	Pause the video and look at the way the room is set up for consulting. What do you notice?	
Opening	How does the Doctor open the consultation? What do you notice about the patient's response?	
Gathering	<i>This consultation is edited for TV and is therefore shorter than a normal consultation and some of the memory assessment is missing.</i> Despite that, what do you notice about the information gathered? What are the patient's ideas about his memory problems (what does he think might be causing them)? What are the patient's worries about this situation? What aspects of a patient's lifeworld might be important where memory is a problem? How do we 'examine' memory? What other information gathering can you identify?	
Formulating	What does the doctor think is going on here?	
Explaining	Can you identify any explaining in this consultation? If so, does it take account of the patient's understanding?	
Activating	Do you notice any activating in this consultation? What aspects of lifestyle might be important for a patient with memory problems?	
Planning	Can you identify a clear management plan? What do you think the pitfalls might be?	
Closing	How does the doctor close this consultation?	

Integrating	<p>What does the doctor need to do now to appropriately integrate this consultation?</p> <p>How do patients integrate new information about their health, or new potential diagnoses?</p> <p>What might this patient do now?</p> <p>What might the emotional impact of this consultation be for the doctor?</p> <p>What might the emotional impact of this consultation be for the patient and his wife?</p>	
Generic Consulting skills	Note down the skills you observe being used in this consultation	

There is a lot of useful info here. <http://gpcog.com.au/index/frequently-asked-questions>. Read through the [FAQs](#) especially the bit about what to keep in mind when administering GPCOG.

Pre-reading given to students

You will cover in your case that it is common for patients to complain about memory impairment. Sometimes the patient presents with concerns about their memory, but often it is a family member who is worried. Mild cognitive impairment has many causes and should be tested for. This enables forward planning but also to look for reversible causes, as cognitive decline can put the patient and others at risk, for example leaving the gas on after cooking. Mild impairment can precede serious cognitive decline in dementia by many years. Causes include dementia, head injuries, Parkinson's, endocrine disorders e.g. hypothyroidism, metabolic e.g. hypoglycaemia, nutritional deficiencies e.g. folate and vitamin B12, sedative medication, depression, and infections.

There are different parts to assessing cognitive function, a history (including a collateral history), mental state examination, physical examination, and formal cognitive testing (a standardized test). The mini mental state examination is a commonly used test of cognitive function that scores out of 30. It tests orientation, short term memory, visuospatial and language skills and is thought to be sensitive (it picks up mild impairment) but is not suitable for making a diagnosis. It needs to be purchased and can't be reproduced.

The Montreal Cognitive Assessment (MoCA) is a rapid screening instrument for mild cognitive dysfunction. It assesses different cognitive domains: attention and concentration, executive functions, memory, language, visuospatial skills, conceptual thinking, calculations, and orientation. It scores out of 30 with 26 and above being normal. <http://www.mocatest.org/>

The GPCOG test was designed to screen for cognitive impairment in primary care. It has 2 parts: an assessment of the patient's cognitive function, then if their score is uncertain e.g. 5-8 there are further questions to ask someone who knows them (a collateral history or "informant"). <https://patient.info/doctor/general-practitioner-assessment-of-cognition-gpcog-score>

The "Six-item Cognitive Impairment test" (6CIT)¹ can be used to screen for cognitive impairment and is used in primary care. It is a little complicated to score (but computer versions available) but sensitive and still specific, and easy to translate to different languages and cultures.

SIX-ITEM COGNITIVE IMPAIRMENT TEST (6CIT) --Kingshill version 2000		Score if incorrect. (0= correct)
1	What year is it?	4
2	What month is it?	3
3	Give a 5-part address for patient to remember e.g. John Smith, 42 West Street, Birmingham.	
4	What time is it? (To nearest hour)	3
5	Count backwards from 20	1 error= 2 points 2 + errors = 4 points
6	Say the months of the year in reverse	1 error = 2 points 2 + errors = 4 points
7	Repeat address phrase	Score on number of errors 1 = 2 points 2 = 4 points 3 = 6 points 4 = 8 points All wrong= 10 points
SCORE	0-7 normal. 8 or more significant.	Total: 28

The abbreviated mental test score (AMTS) was introduced by Hodkinson in 1972² to assess patients for the possibility of dementia. You may see it in hospital, but it hasn't been validated for screening or use in primary care. It's simple and easy to score but over time the questions get adapted e.g. 2nd world war for dates and name the prime minister rather than monarch – so it is not very valid. In addition, questions often need adapting for patients depending on background and culture.

Put the following questions to the patient. Each question correctly answered scores one point, a score of 6 or less indicates dementia or delirium and indicates further testing.

	Abbreviated mental test score (AMTS)	Score if incorrect is 0 (Score 1 if correct)
1	What is your age?	0/1
2	What is the time? (to the nearest hour)	0/1
3	Give the patient an address, and ask him or her to repeat it e.g. 42 West Street (tell the patient you will ask them to remember it and ask them at the end of the test. No points for repeating—this is to check they've heard right)	
4	What is the year?	0/1
5	What is the name of this place? (the hospital or number of the residence where the patient is?)	0/1
6	Identification of 2 people. Can the patient recognize two of: family member, doctor, carer, etc.)	0/1
7	What is your date of birth? (day and month sufficient)	0/1
8	In what year did World War 1 begin?	0/1
9	Name of present monarch?	0/1
10	Count backwards from 20 down to 1.	0/1
11	Address recall	0/1
	Score: 6	10

1. Brooke P, Bullock R; Validation of a 6-item cognitive impairment test with a view to primary care usage. *Int J Geriatr Psychiatry*. 1999 Nov 14 (11): 936-40.
2. Hodkinson MH; Evaluation of a mental test score for assessment of mental impairment in the elderly, *Age and Ageing*, Volume 1, Issue 4, November 1972, Pages 233 – 238, <https://doi.org/10.1093/ageing/1.4.233>

Creative assignment – for GP tutor info only

You may wish to ask students about plans for their creative assignment. This is submitted to their EC Lab tutors (campus-based teaching groups) rather than to the GP, but students may choose to base their piece on a patient they have met either in primary care, secondary care or during their HCA shifts. If they complete a piece based on their GP placement, you may want to ask them to share it at a future session. This work is usually of high quality, lovely to see especially if based on a patient you know and facilitates interesting and useful reflection and discussions within the group. The remit for this is broadly the same as for previous years but there are some amendments to the criteria because of the impact of Covid. See the **guidance given to students** below: for info only.

*One of the key things we want you to experience in Effective Consulting is the chance to engage personally, and individually, with medical themes through creative work. An artistic approach gets us to focus on the individuality of the situation, and to deal with the emotional responses we often have to clinical situations. This approach can help us learn about ourselves, and about our patients and colleagues, and can also be a form of self-care helping us to manage the personal and emotional challenges of medicine. In the COGConnect model of clinical encounters which you will learn in EC this year, the final stage is **Integrating**. Whilst this includes some very practical things, like note writing and ensuring continuity of care, it also incorporates the ability to process our emotional responses to consultations. Some individual clinical encounters with patients will affect us deeply, for a variety of reasons, and it is this we want you to explore in your assignment for EC.*

Additionally, there are 5 Core values which we expect all Bristol Medical students to bring to each clinical encounter: compassion, curiosity, critical thinking, creativity, and collaboration.

Creativity will most usually mean developing creative and novel solutions, but we broaden this to its fullest meaning to include the arts in medicine. You may want to look at this article on [compulsory creativity](#) for more information. In Foundations of Medicine, you worked together as a group to develop creative work for the FOM Conference. Here, in EC, you have a unique opportunity to expand on this, and to explore your clinical contact with an individual creative piece which you will share with your EC colleagues.

Once you have chosen the clinical encounter you should consider and choose a way to extend your understanding using creative methods. You can produce your creative work in any media, including but not limited to photography, art, dance, music, poetry, creative writing, digital storytelling, video, drama, blogging, vlogging etc. Your creative work should be accompanied by a narrative of approximately 500 words.

Consent should be sought to use a patient's story as the basis of your creative work. This should be documented in your narrative or explained if impractical. All information should be anonymised.

Prizes and commendations are awarded for the best work in the EC Creative Assignment