An exploration of students' learning needs regarding the CanMEDS-role Health Advocate

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List of Abbreviations

CanMEDS	Canadian Medical Education Directives for Specialists
CEME	Community Engaged Medical Education
CRU+	Medical Education Utrecht – Patient-oriented Longitudinal Utrecht Study Programme
ECTS	European Credit Transfer and Accumulation System
NVMO-ERB	Dutch Association for Medical Education – Ethical Review Board

Abstract

Background/aim: The CanMEDS-role Health Advocate has been an important but undervalued part of the medical curriculum. There is a need for better integration of this role in the medical curriculum of the Utrecht University. The objective of this study was to gain insight into the learning needs of medical students regarding the CanMEDS-role Health Advocate and to research if Community-engaged medical education could be a fitting base for the new curriculum.

Method: This qualitative interview study utilised aspects from grounded theory. Six interviews were conducted with fifth- and sixth-year students of the Utrecht University medical program. The interviews were transcribed verbatim, forming the dataset. A thematic analysis was used to identify, analyse and report on patterns in the data.

Results: Four themes emerged from the data concerning the students' learning needs; (1) Retention of knowledge, (2) Practical skills (3) Students' competency and (4) Educational methods. With regard to Community-engaged medical education, attitude towards Community-engaged medical education appeared as a fifth theme.

Conclusion: This study highlights a deficit in knowledge retention on health advocacy themes among fifth- and sixth-year medical students, a need for more practical examples, more skills training throughout the program, and more opportunities to apply Health Advocate skills during their clerkships. The results suggest that the learning needs of the students of the Utrecht medical program could be fulfilled by instituting Community-engaged medical education within the curriculum.

Introduction

The Canadian Medical Education Directives for Specialists (CanMEDS) consists of seven different roles that address the various aspects of the physicians' daily activities (Frank et al., 2015). Each role has key competencies that describe the essential abilities of physicians. These could pertain to skills, attitude or knowledge. One of the seven roles, the physician as Health Advocate, has been an important but undervalued part of the medical curriculum (Boroumand et al., 2020; Damoiseaux & Soethout, 2017; Rademakers et al.,2007; Stutsky et al., 2012). As Health Advocates "physicians contribute their expertise and influence as they work with communities or patient populations to improve health. They work with those they serve to determine and understand needs, speak on behalf of others when required, and support the mobilization of resources to effect change" (Sherbino et al., 2015). The key competencies of the Health Advocate involve skills on the individual, community and population level. Firstly, the physician should posses the ability to address and implement the determinants of health and access to resources. Secondly, they should be able to advocate for system-level change to advance disease prevention, health promotion and surveillance. Lastly, the physicians need to be able to increase the opportunities to adopt healthy behaviours in patients and improve the health of the population.

Reasons for overlooking the Health Advocate role in the curricula might be a result of it being difficult to implement in the medical curricula (McDonald et al., 2019). This is mainly due to gaps in the knowledge of physicians, time constraints during clinical practice and the inability to recognise opportunities to teach about health advocacy. Nevertheless, the qualities of the Health Advocate are essential for modern day graduates of medical studies (Douglas et al., 2018).

Community engagement has been described as an educational principle to teach the key competencies associated with the role of Health Advocate (Boroumand et al., 2020). However, the different community-centred medical education curricula and the programmes themselves differ greatly between universities (Okayama & Kajii, 2011; Ellaway et al., 2016). In general, three educational concepts that address community engagement can be distinguished: Community-oriented medical education, Community-based medical education and the most recent conceptualization of Community-engaged Medical Education (CEME) (Strasser, 2010). In these programmes an increasing level of engagement with the communities was established throughout several decades.

With Community-oriented medical education, the educational content has a direct relevance to the health needs of the community in which the medical school is situated (Parekh et al., 2021; Magzoub & Schmidt, 2000). The learning activities are all conducted in a traditional academic setting and not in the community (Ellaway et al., 2012).

With Community-based medical education, the educational activities are transferred from the classroom into the community setting or health services in the primary and secondary care levels (Couper & Worley, 2017; Kristina et al., 2006; Kelly et al., 2014). Community-based medical education programmes contribute to the development of competencies such as shared-decision making, collaboration, effective communication, listening and observation skills (Claramita et al., 2019).

The call to make the medical schools more socially accountable encouraged the development of Community-engaged medical education. Here the community is actively involved in development of the medical curriculum (Boelen & Heck, 1995; Boelen & Woollard, 2011). This community-involvement and the need to establish a mutually beneficial relationship between the students and the community are core values of CEME (Strasser et al., 2015).

In the Netherlands the importance of Health Advocacy in medicine is underlined in different health policies and by recent changes in curricular standards (van der Pol et al., 2020). Due to stress on the affordability and accessibility of the Dutch health care system, emphasis is shifting towards a predominantly primary and preventative care focussed system (van Dijk et al., 2013). Therefore, an increasing number of doctors are needed in the fields of primary care, social medicine and public health (Advisory Committee on Medical Manpower Planning, 2019). This is reflected in the recently updated Medical Training Framework (van der Pol et al., 2020). This framework describes the final qualifications of medical training and serves as a guideline for all medical curricula in the Netherlands. The CanMEDS form the basis of this framework. The newest edition calls for a revision of medical training. One of the main objectives herein, is a more prominent place for the development of the CanMEDS-role Health advocate.

One of the medical curricula where CEME could be implemented is the current 'CRU+'-curriculum of Utrecht University (ten Cate et al., 2018). In this six-year program (360 ects) students on average only partake in a combined total of ten weeks of social medicine and primary care clerkships (see Box 1). In order to improve the medical education at Utrecht University, to provide the graduates with an additional foundation and to meet the requirements of the new framework of final qualifications, the University Medical Centre in Utrecht started a curriculum change project. This curriculum redesign offers an opportunity to give the Health Advocate role a more prominent position in the programme.

Box 1. CanMEDS- role Health Advocate in the 'CRU+'-Curriculum

Year 2: 10-week elective course 'Diversity in Health care', maximum 30 students.

Year 3: 4 hours, 'GZC III', lectures on Health Care system, occupational and insurance medicine.

Year 3: 5 hours, 'I&I', lectures on infectious disease control.

Year 4: 2 hours, 'Blok Rood', on the Youth Health Department.

Year 5: 1 week, 'Blok Geel', on the Determinants of Health, Public Health & Health Advocacy in the consulting room, vulnerable populations.

Year 5: 4 weeks, clerkship Public Health, for 50% of the students.

Identification of the learning needs of students is an important first step in curriculum change processes (Gonsalves et al., 2014; Hauer & Quill, 2011; Koren et al., 2008; Lockyer et al., 2005). By taking the students' concerns and learning needs into account in the curriculum development, student motivation and the chances of program success increases (Olmesdahl, 1999). Additionally, taking the learning needs of students into consideration, enhances deeper learning and intrinsic motivation of the students (Hofer, 2014).

The objective of this study is to provide input for the curriculum redesign process by gaining insight into the learning needs of medical students regarding the CanMEDS-role Health Advocate and to explore students' thoughts on Community-engaged medical education as a teaching concept within the new curriculum.

Method

This qualitative study used semi structured interviews to identify the learning needs of medical students of the Utrecht University, regarding the CanMEDS-role Health Advocate. A grounded theory approach was used to analyse the data (Cristancho et al., 2018; Kennedy & Lingard, 2006).

Ethical considerations

The research protocol has been approved by the Ethical Review Board of the Dutch Association for Medical Education (NVMO-ERB case number: 2022.5.6). Participants were informed about the aims of the research and their legal rights. Informed consent was obtained from all participants. Codes were used to ensure participants anonymity.

Subjects

The research population was composed of students of the Utrecht University medical program. As most public health training is being provided in the fifth-year of the curriculum, students were eligible to participate if they were in their fifth or sixth year and had completed their public health clerkship. To maximize the range of viewpoints, the included respondents had ambitions in differing fields of medicine. Ranging from an aspiring career in primary medical care to aspiring surgeons. Due to time constraints, six participants were interviewed.

Study design

Purposive sampling, convenience, and snowball sampling was used to reach participants. After acceptance of the invitation, informed consent was obtained and recorded. The interviews were conducted via videocall by the researcher in Dutch, as this is the native langue of the respondents and therefore resulting in more in-depth answers. Audio files of the interviews were recorded with permission from the respondents. A semi-structured interview guide based on an iterative process was used and was based on the following main concepts of the Health Advocate role: determinants of health, stimulating a healthy lifestyle, disease prevention (including health promotion and health surveillance), health equity and health advocacy. All the interviews started with open questions about their experience with the CanMEDS and their vision on the role of the physician in the community. Then the respondents were asked about their knowledge on and practical experience with each of the main concepts. On average, the interviews lasted 75 minutes.

Analysis

All audio files were transcribed verbatim. After familiarization with the transcripts, a coding frame was developed in three consecutive phases. First, codes were attributed to the respondents' answers by an open coding method. Second, through axial-coding these identified codes were grouped into categories forming the basis of the coding frame. The coding framework was enhanced as further transcripts were analysed. Finally, the overarching themes were identified through selective coding and used for further analysis. In regular meetings researchers LH and MJ discussed coding (sub)themes and interpretation of the data. NVivo was used to assist in the qualitative data analysis.

Results

From the data analysis four themes were identified concerning students' learning needs regarding the CanMEDS-role Health Advocate; (1) Retention of knowledge, (2) Practical skills (3) Students' competency and (4) Educational methods. The first three themes refer to problems the respondents signalled in the current curriculum, the fourth theme refers to their learning needs. With regard to the respondents view on Community-engaged Medical Education, attitude towards CEME, was identified as a fifth theme.

Retention of knowledge

Overall, most respondents had little understanding of the main concepts of the CanMEDS-role Health Advocate and were unable to give an accurate definition of these concepts. Upon prompting, most respondents were able to make an educated guess but there was no real knowledge retention. Their recollection of the topic 'healthy lifestyle' was the best, they mentioned examples concerning the risks of smoking, alcohol use, cardiovascular risk management and obesity. Furthermore, most respondents mentioned at least one of the four categories of the Determinants of Health as identified in the Lalonde report. Recollection of the topic 'health advocacy' was the worst. Most respondents stated this concept was completely new to them.

When discussing the theoretical background of each of the five main concepts of the CanMEDS-role Health Advocate, respondents solely provided answers and examples on the individual patient level. They did not understand the concept on a community or population level.

Respondents primarily linked the different topics to three parts of the curriculum; an elective course on diversity and inclusion in year two, 'Blok Geel' and a training on behavioural change and motivational interviewing in the fifth year. According to the respondents, almost every course gives at least some attention to the effects of lifestyle. The other four main concepts had received far less or no attention.

Practical skills

Results regarding practical skills can be divided into four subthemes; (1) Practical applications, (2) Role models, (3) Incorrect examples and (4) Position as a learner.

Practical applications

The curriculum lacks education on practical application of theoretical knowledge. This problem is twofold. Firstly, the emphasis on factual knowledge in the curriculum without teaching them how to apply that knowledge, hinders respondents' ability to effectively translate this to a clinical setting. Secondly, the respondents have not been given the opportunity to apply their knowledge and skills during their clerkships.

> *"Learned about… a long time ago. Applied? Definitely not. Well, applied once in 'Link Geel' for a mandatory assignment which was a part of the Social Medicine, there you fill it in once. And then during the course 'Blok Geel' we were taught about it once, and we were taught about in once during the Bachelor in a social course. The model of LaLonde. In year three I think." (Respondent #6)*

Respondents suggest that this could be due to the types of clerkship placements or due to the examples that were set by the physicians they worked with.

Role models

Respondents noted that they had not seen physicians model the competencies as stated in the CanMEDS Health Advocate role, especially not during the clerkships in a hospital setting. Because they did not have the opportunity to observe these skills being applied during their clerkships, they were not encouraged to practice these skills themselves. One respondent stated that in two of their clerkships, the outline of the patient interview they received as a guideline did not include any lifestyle markers:

> *"Because it, I have noticed, is not always something that is talked about. In ENT or dermatology for example. At the beginning of each clerkship, you get a format with a list of what you should ask about in the history taking, these specialties did not include smoking or alcohol use. Medication and medical history were included, but not those other things." (Respondent #1)*

Positive examples are experienced more often within the clerkships at the general practitioner's office. The general practitioners had more time to guide patients in the adaptation of healthy behaviours, had more insight into the socio-economic context of the patients and had more knowledge on where to refer the patient to with social- or financial problems.

Incorrect examples

Some respondents implied that the supervising physicians were actually setting an incorrect example. The respondents pointed out that they observed insufficient patient-communication styles and a disregard by physicians of the social determinants of health. The respondents seemed to judge the physicians negatively on these competencies. Furthermore, regarding communication with the patients, respondents stated that physicians, especially the older generation, did not accommodate their language to fit the abilities of the patient. They believed that this affected the patients' understanding of the medical information provided.

> *"Well, it is a bit of a…. maybe not an example, but it is just that in my experience the older generation just blurts out the information sometimes, which does not translate well to the patient. Because they either do not have the patience or the time to do that, or they do not think it is necessary." (Respondent #3)*

According to the respondents, the most notable reason these physicians were not modelling the Health Advocate role in their practice was time constraint. Furthermore, the respondents suggested that the physicians were unaware of the importance of the skills attributed to the Health Advocate role and that they were impatient. Respondents observed that when the topic of lifestyle change is discussed, the negative effects of the current lifestyle were communicated to the patient without subsequently providing them with applicable improvements.

> *"Well in the hospital little time, little… how do you say that, little, time, also for lifestyle changes. They do not talk about it. They mention it quickly, in the final conversation, well this and that is going on, this is the disease and this is the treatment, but also stop smoking, because that is bad for your blood vessels or whatever. But that is it, that is all. So, it is very short sighted, I think. But yes, that is also due to the time constraint." (Respondent #2)*

Position as a learner

Finally, some respondents expressed that they felt discomfort in applying their Health Advocate knowledge during their clerkships, even though they are aware of its importance. The respondents do not feel comfortable bringing up the social determinants in their conversations with patients due to their position as a learner. They were afraid that the patient would not accept and answer their questions or that the supervising physicians would disregard the information they had uncovered.

> *"Well, if I really did anything with it during my internships… that is difficult. No, I do not think so, no… And it is difficult in the position as a clerk, isn't it? Because... are you allowed to bring this up? That is also a little bit of a problem." (Respondent #2)*

Due to the assignment of tasks during their clerkships, respondents also felt they were not given the opportunity to practice advising patients on these subjects themselves. During a consultation, the respondents merely got to do the history taking and the supervising physician makes and shares the treatment plan with the patient, which hinders the opportunity to practice the skills of the Health Advocate.

Students' competency

When asked about their feelings of competency, most respondents indicated that they did not feel competent in the main concepts of the CanMEDS Health Advocate role. Especially not on the community and population level. The respondents declared they had only learned how to conduct the patient history taking about these themes and how to identify problems within the socio-economical context and lifestyle. However, they did not know how to provide any follow-up. Therefore, they did not feel competent to choose or provide the treatment plan or guidance for the patient, as one respondent said:

> *"I feel competent in asking questions, recognizing and defining the problem and also recognizing that something has to be done… But to solve it, to offer help, I certainly do not feel competent." (Respondent #6)*

Educational Methods

Two subthemes could be identified with regard to educational methods: 1) Theoretical knowledge, and 2) Skills training.

Theoretical knowledge

The respondents expressed a desire to learn more about the Health Advocate competencies on a community and population level, such as: contributing to health policies, navigating the healthcare landscape and medical activism to induce system level change. Respondents actively search for more learning opportunities about these concepts by reading articles, taking extracurricular or elective courses on lifestyle medicine and social medicine. One respondent stated that due to the uniformity of the student population, they feel a need for more attention to the diversity of the patient population:

> *"[…] I think that as a medical student I am pretty much in a bubble of highly educated people and therefore I may pay less attention to people with different living situations." (Respondent #5)*

The respondents expressed a need for linking theoretical knowledge to practical examples in order to enhance their long-term knowledge retention and their ability to apply their knowledge in their clerkships. They want to be able to "imagine a person to whom all these numbers and facts relate to". They suggested the incorporation of case studies, informative videos and real-life examples during lectures in furtherance of their ability to envision the practical use of this knowledge in the field:

> *"Yes, at the university it remains just a theoretical concept that we work with, where it is proven with scientific research that something works. But there is a human factor in it! And I think ... I think you can only incorporate that adequately if you practice it and gain a lot of experience. Especially, working on it." (Respondent #6)*

Skills training

Respondents shared their concerns about their lack of practical knowledge and skills. They stated that they have not received adequate practical training on the Health Advocate competencies. Therefore, they had not learned how to implement their knowledge in their clerkships for the benefit of the patient. Respondents urged that there is a necessity to actively practice these skills in an educational setting, for example through mock cases, simulated patient conversation and intercultural communication classes.

In addition, the respondents revealed a need to practice their skills in a clinical setting:

> *"I think it is mainly just practical experience, how do you talk about it in a good way, so the communication. And that can… maybe you need some theory for that, but I am someone who learns more by doing it, so I must do it more than once to feel skilled or competent at it." (Respondent #3)*

Regarding their clerkships, all respondents expressed that the amount of practice opportunities is highly dependent on the location the clerkship is taking place. Which is different for every student. Respondents said that they think they will get the most practice opportunities for the skills attributed to the Health Advocate role within the field of primary care or social medicine. However, the space in the clerkship-curriculum reserved for these specialties is currently limited.

Attitude towards Community-engaged medical education

With regard to CEME respondents had very little experience with this educational concept. They specified that the combination of getting the theoretical background from the university and the possibility to directly apply their knowledge to problems identified by the community were positive aspects of CEME. Respondents indicated that the lack of acceptation and the prejudice from the community would be an obstacle. They fear being seen as "outsiders, highly educated and privileged" and "just a youngster" and that this will hinder the creation of meaningful contact with the community members. Moreover, the respondents raise doubts about the current time-frame established for clerkships (max. 12 weeks) and the time it takes to build a relationship with a community.

Discussion

Respondents expressed an interest in the main concepts of the CanMEDS-role Health Advocate and recognized the importance of these skills for medical practice. Nevertheless, they were unable to recall most of the education provided about these main concepts and felt incompetent in executing the Health Advocate skills. The education provided was mainly focused on factual knowledge. Whereas the respondents stressed the importance of linking theoretical knowledge to practical examples, in order to improve their knowledge retention and to be able to practice their skills in both a training and a clinical setting.

This study shows that the respondents' theoretical learning needs predominantly center around additional information about the main concepts on a community and population level, real-life examples and practical application of theory in both an educational and clinical setting. In this sense, their learning needs are in line with Miller's pyramid of assessment in medical education (Miller, 1990). In this framework Miller states that students need to master not only the theoretical knowledge ('knows') but also the theoretical application ('knows how') and clinical application in an education setting ('shows how') in order to flourish in the highest pyramidal level and successfully apply the knowledge and/or skills in a clinical setting ('does').

This study also identified practical learning needs. Respondents underscored the need for more practice opportunities in an educational setting to develop their skills. Furthermore, there is an urgent need to get more clinical practice during the clerkships. These practice opportunities are now limited because the current clinical setting does not support the implementation of the Health Advocate skills and these skills are not being modelled by the supervising physicians. In addition, none of the competencies are being taught on a community or population level. These findings are in line with the study of McDonald et al. (2019) that states that in order to develop the necessary skills for health advocacy, a passive didactic approach is not sufficient. With their scoping review they researched how health advocacy is being taught in post-graduate medical education. Their results emphasize the importance of longitudinal, hands-on and immersive learning when designing a health advocacy curriculum.

To build a curriculum that addresses the CanMEDS Health Advocate role better than the current Utrecht curriculum, a change in educational approach is needed. Community-engaged medical education could partially fulfill the learning needs as stated by the respondents of this study. Particularly regarding the highest segment of Miller's pyramid of assessment ('does'), CEME provides students with a learning environment (the community) to sufficiently apply the knowledge and skills they acquired during the 'knows', 'knows how' and 'shows how' segments. In addition, CEME builds the socio-humanistic skills that are crucial to successfully fulfill the Health Advocate role (Claramita et al., 2019). Although CEME can also fulfill students' learning needs on the bottom three levels, other education methods that emphasize on real-life examples and application of knowledge such as Problem Based Learning would also be applicable here (Prosser & Sze, 2014).

Strengths and limitations

This small-scale study highlights the insights of six fifth- and sixth-year students from the same university. Therefore, the findings of this study might not be generalizable to the whole student population of the Utrecht University nor the entire Dutch medical student population. However, there is a lot of overlap in the input of each of the respondents, which might indicate data saturation.

The results seem to be largely signaling a need for more practical-oriented study materials. Therefore, these results might have been different, had the study been carried out at a university with a more contextual curriculum. Future research might replicate this study at a university that implements such a contextual curriculum. For example, the Maastricht University, which uses a Problem-Based Learning curriculum (Bergman et al., 2013).

All respondents disclosed an interest in the competencies as described in the Health Advocate role and sought out educational material on these topics on their own accord. This may have led to self-selection in the inclusion process as they were interested in these topics and therefore responded to the recruitment message. In addition, this could have influenced the results as the respondents might know more about Health Advocate competencies and attribute more importance to these topics than the average student.

The qualitative interview method ensured the collection of very detailed information on the vision of the students who are currently enrolled in the medical curriculum. The input of the students can directly be used in the ongoing curriculum reform of the Utrecht University. Future research is needed to analyze which communities would be suitable to host the students and to establish the educator's perspective on the applicability of CEME in the Utrecht Curriculum.

Conclusion

This study provides insight into the learning needs of fifth- and sixth-year medical students regarding the main concepts of the CanMEDS-role Health Advocate. The respondents indicated that they did not feel fully competent in any of the main concepts in both theoretical and clinical skills. More case studies, skills training and opportunities to practice during their clerkships are needed. Instituting Community-engaged medical education as an educational concept within the curriculum could facilitate the learning of the Health Advocate competencies.

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Conflicts of interest

The author declares that there are no competing interests.

Data

The data are deposited in a secured IT-system at the Julius Centre of the Utrecht University Medical Centre. They can only be accessed by the researcher of this study.

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Additional file 1

Translated English quote		***Original Dutch quote***
"Learned about… a long time ago. Applied? Definitely not. Well, applied once in 'Link Geel' for a mandatory assignment which was a part of the Social Medicine, there you fill it in once. And then during the course 'Blok Geel' we were taught about it once, and we were taught about in once during the Bachelor in a social course. The model of LaLonde. In year three I think". (Respondent #6)		"Van geleerd… lang geleden. Toegepast? Zeker niet. Ja toegepast een keer bij link Geel in een verplichte opdracht die er aan vast zit aan de sociale Geneeskunde, dan vullen we hem in. En dan tijdens blok Geel hebben we hem een keer gehad, en we hebben hem een keer gehad in de Bachelor tijdens een sociaal vak. Het model van LaLonde. In jaar 3 volgens mij." (Respondent #6)
"Because it, I have noticed, is not always something that is talked about. In ENT or dermatology for example. At the beginning of each clerkship, you get a format with a list of what you should ask about in the history taking, these specialties did not include smoking or alcohol use. Medication and medical history were included, but not those other things". (Respondent #1)		**"**Want het wordt, heb ik gemerkt, ook niet altijd uitgevraagd. Bij KNO en dermatologie bijvoorbeeld. Je krijgt aan het begin altijd een formatje van dingen die je moet uitvragen en daar stond bij deze vakken roken of alcohol niet bij. Medicatie gebruik of voorgeschiedenis wel maar niet die andere dingen." (Respondent #1)
"Well, it is a bit of a…. maybe not an example, but it is just that in my experience the older generation just blurts out the information sometimes, which does not translate well to the patient. Because they either do not have the patience or the time to do that, or they do not think it is necessary." (Respondent #3)		**"**Nou is een beetje een…. misschien niet direct een voorbeeld, maar het is gewoon dat de oudere Garde in mijn ervaring gewoon de informatie er uitgooit soms en niet aansluit op de patiënt. Omdat ze daar of het geduld niet voor hebben of de tijd niet voor hebben, of niet vinden dat dat hoeft." (Respondent #3)
"Well in the hospital little time, little… how do you say that, little, time, also for lifestyle changes. They do not talk about it. They mention it quickly, in the final conversation, well this and that is going on, this is the disease and this is the treatment, but also stop smoking, because that is bad for your blood vessels or whatever. But that is it, that is all. So, it is very short sighted, I think. But yes, that is also due to the time constraint." (Respondent #2)		**"**Nou in het ziekenhuis weinig tijd weinig… Ja, hoe zeg je dat, weinig, dus tijd ook voor leefstijl veranderingen. Ze benoemen het niet. Ze zeggen even hè, in het eindgesprek van nou dit en dit is gaande, dit is de ziekte en dit is de behandeling, maar stop ook met roken, want dat is slecht voor je bloedvaten of wat dan ook. Maar dat is het dan, daar blijft het bij. Dus het is heel kortzichtig, denk ik. Maar ja, dat ligt dus ook aan de tijd." (Respondent #2)

''Well, if I really did anything with it during my internships… that is difficult. No, I do not think so, no… And it is difficult in the position as a clerk, isn't it? Because... are you allowed to bring this up? That is also a little bit of a problem." (Respondent #2)		''Nou of ik daar tijdens mijn coschappen echt iets mee heb gedaan… lastig. Nee, ik denk het niet, nee… En het is ook wel lastig als positie van de co, hè? Omdat...mag je mag je dit wel op tafel brengen? Dat is ook een dingetje.'' (Respondent #2)
"I feel competent in asking questions, recognizing and defining the problem and also recognizing that something has to be done… But to solve it, to offer help, I certainly do not feel competent." (Respondent #6)		**"**Ik voel me bekwaam in uitvragen, het zien en benoemen van het probleem en ook wel zien dat daar iets mee moet… Maar om het op te lossen daar hulp aan te bieden zéker niet." (Respondent #6)
"[…] …I think that as a medical student I am pretty much in a bubble of highly educated people and therefore I may pay less attention to people with different living situations." (Respondent #5)		"[…] …ik denk dat als Geneeskundestudent ik wel redelijk in de bubbel zit van hoogopgeleiden en dus dat dat ik misschien minder aandacht heb voor mensen in andere leefomstandigheden." (Respondent #5)
"Yes, at the university it remains just a theoretical concept that we work with, where it is proven with scientific research that something works. But there is a human factor in it! And I think ... I think you can only incorporate that adequately if you practice it and gain a lot of experience. Especially, working on it." (Respondent #6)		"Ja het blijft bij de universiteit gewoon heel erg een theoretisch concept waarbinnen we werken waarop het op basis van wetenschappelijk onderzoek is aangetoond dat deze methodiek werkt. Terwijl; er zit een menselijke factor in! En ik denk dat … ik denk dat je dat alleen maar goed kan als je het doet en het veel ervaart. Juist er mee bezig zijn." (Respondent 6)
"I think it is mainly just practical experience, how do you talk about it in a good way, so the communication. And that can… maybe you need some theory for that, but I am someone who learns more by doing it, so I must do it more than once to feel skilled or competent at it." (Respondent #3)		"Ik denk dat het vooral gewoon praktijkervaring is, van hoe vertel je het gewoon handig, dus de communicatie. En dat kan… Misschien kan er dan iets van een theorie voor nodig zijn, maar ik ben meer iemand die al doende leert, dus ik moet het vaker gedaan hebben om me daar vaardig of bekwaam voor te voelen." (Respondent #3)