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Mentoring medical students as a means to increase healthcare assistant status: A qualitative study

Elizabeth Davison[1] | Joanna Semlyen[2] | Susanne Lindqvist[1,2]

[1]Faculty of Medicine and Health Sciences, Centre for Interprofessional Practice, University of East Anglia, Norwich, UK

[2]Faculty of Medicine and Health Sciences, Norwich Medical School, University of East Anglia, Norwich, UK

Correspondence
Susanne Lindqvist, Faculty of Medicine and Health Sciences, Centre for Interprofessional Practice, University of East Anglia, Norwich Research Park, Norwich, NR4 7TJ, UK.
Email: s.lindqvist@uea.ac.uk

Abstract

Aim: To offer a practical way in which the status of healthcare assistants (HCAs) can be increased by drawing on their experience, knowledge and skillset, whilst mentoring medical students during an HCA project.

Design: Qualitative, reflexive thematic analysis.

Methods: One-to-one semi-structured interviews were conducted between April and June 2019, with 13 participants. Participants included five healthcare assistants; three practice development nurses, two of whom were former HCAs; one registered general nurse and four clinical educators.

Results: Two themes were identified: HCAs as silent, invisible caregivers (theme 1) and the formation of an HCA identity through mentoring (theme 2). HCAs are often silent performers of complex patient care with limited opportunity to engage in the interprofessional team dialogue. Social perceptions of HCAs describe them as a marginalised, poorly understood, 'unqualified' group with 'lowly status'. Mentoring medical students allows HCAs to draw on their experience, knowledge and skillset by actively contributing to the learning and development of future doctors.

Conclusion: The mentoring of medical students gave HCAs an active voice within the interprofessional team, instilling their confidence and self-worth. Mentoring allowed HCAs to move from a homogenous, group-based social identity to a role-based one that enabled HCAs to reveal the true extent of their work whilst negotiating their place and identity within the interprofessional team.

Impact: Leaders in healthcare will see that a re-evaluation of HCAs as performers of basic, hands-on patient care is needed to breakdown ingrained beliefs, eliminating a 'us and them' mentality. Involving HCAs in the mentoring of medical students will impact on the personal development of both HCAs and medical students in the cultivation of a future, person-centred, inclusive and collaborative workforce.

Reporting Method: COREQ guidelines to enhance methodological rigour were strictly adhered to.

Patient and Public Involvement: There is no patient or public involvement.

KEYWORDS
healthcare assistants, hierarchical status, identity, interprofessional team, learning, medical students, mentoring, person-centred care, qualitative research

1 | INTRODUCTION

Healthcare assistants (HCAs) play a central part in patient care often carrying out many of the roles formerly undertaken by nurses (Fitzgerald et al., 2020). A study by Kroezen et al. (2018) examining the HCA role in 28 European Union (EU) Member States shows HCAs will become increasingly important in upholding a viable future healthcare service. Whilst awareness has grown, HCAs remain widely perceived as an 'unqualified' group not worthy of training nor development (Bach et al., 2012). As a consequence, HCAs lack 'voice' and hierarchical status within the interprofessional team, resulting in low confidence and self-esteem (Hewko et al., 2015).

HCAs also experience powerlessness, as organisational structures restrain them in positions with little influence (Rodger et al., 2019). 'Powerlessness' among HCAs is defined as excluded from wider moral dialogue when medical decisions are made that affect their patients (Rodger et al., 2019). This was discussed by Fryer et al. (2016) who noted instances where concerns made by HCAs, working in residential care facilities in New Zealand, were largely ignored, resulting in negative repercussions. It was suggested that this lack of acknowledgement was mainly owing to HCAs' 'non-specialist' status (Fryer et al., 2016). Canadian nursing staff similarly experienced higher levels of moral distress, associated with their low professional autonomy and limited opportunities to consult colleagues and express concerns (de Veer et al., 2013). Within the United Kingdom (UK), historical hierarchical perceptions of HCAs as 'unskilled labour' continue to perpetuate this culture, despite mounting evidence of their crucial role in sustaining a viable and efficient healthcare system (Fitzgerald et al., 2020).

According to Hewko et al. (2015), HCAs commonly possess low self-efficacy associated with the self-judgement of their own ability and value. Shrestha et al. (2021) agree that factors influencing a caring self-efficacy include an individual's self-esteem, job satisfaction and feeling worthy, which can all further the ability to perform better. Indeed, Kantaris et al. (2020) propose that one way of increasing the confidence and self-efficacy of HCAs working within psychiatric settings is through training HCAs in the management of aggressive patients. Whilst worthy in some respects, such interventions are limited in their impact on the wider perception of HCAs in raising awareness of their role, respect and valuable contribution to our healthcare service as part of the interprofessional team. Currently, HCAs are often not given an opportunity to contribute to the interprofessional team, despite calls to give them value and recognition (Hewko et al., 2015; Kroezen et al., 2018; Rodger et al., 2019).

In recent years, a shift towards more person-centred healthcare has become evident. This approach emphasises the importance of patient care that extends beyond clinical skills and recognises the need for holistic, respectful, compassionate care. This is an area that HCAs are very skilled at. However, work still needs to be done to realign systems and everyday practices around the needs of people and the humanising of healthcare, particularly in the education of healthcare students (Franco et al., 2022). One way of enacting such change is to create early opportunities in the curriculum that allow medical students to work in an HCA role whist also being mentored by an HCA (Davison & Lindqvist, 2019; Davison et al., 2021).

Mentoring is considered a valuable part of teaching and learning in the workplace (Gandhi, 2019). It can provide HCAs with an opportunity to work with medical students to raise awareness of the vital, holistic, person-centred work they perform on a daily basis. Additionally, mentoring may respond to the call to improve HCA self-efficacy and recognition within the interprofessional team, providing a voice, enhancing their confidence and pride in their work.

2 | BACKGROUND

Created in 1986, the role of a healthcare assistant (HCA), also known as nursing assistant, care assistant or auxiliary nurse, is situated within hospital or community settings working under the guidance of a qualified nurse or other qualified healthcare professional. It is estimated that 1.6 million HCAs are currently employed as front-line care providers, which is expected to double within the next 20 years (Wharrad et al., 2020). HCAs work closely with patients, providing personal and intimate care including feeding, washing and toileting. They also perform clinical work, such as monitoring and recording of patients' glucose levels, temperature, pulse, respiration, and weight. Within the UK, a heavily female-dominated HCA workforce now outnumber nurses by three to one, with approximately 60% of HCAs' time delivering direct and indirect patient care (Wharrad et al., 2020). Yet, recognition of the HCA role lags behind, remaining poorly remunerated and unregulated, which is in contrast to the EU, where the HCA role is regulated in 14 countries, and mandatory HCA education and training provided in 22 countries (Fitzgerald et al., 2020; Hewko et al., 2015; Kroezen et al., 2018).

Kessler et al. (2015) suggest HCAs possess 'soft skills' related to dealing with patients' emotions. They argue that the 'low status' and non-professional nature of the HCA role works to their advantage when interacting with patients, rendering them less intimidating. Associations made with hands-on duties being considered 'dirty work' and care work, with 'working-class' women further deepens the issue (Bach et al., 2012). Such prevailing views have influenced HCAs' identity formation and standing within the hierarchical structure, creating barriers and thus impeding attempts to revise common perceptions about the work HCAs perform.

A study by Lloyd et al. (2011) suggests that the very nature of the HCA 'close-knit in-grouping' acts as a barrier to them delivering collaborative care within the interprofessional team and in fact advances their marginalisation as they show solidarity to their own grouping. Such solidarity is believed to be a natural reaction to occupying a position 'at the bottom of the ward hierarchy' (Lloyd et al., 2011, p. 249). However, Moyo (2018) notes HCAs feeling disempowered when trying to raise important patient concerns within an acute medical unit. The author describes an 'us' and 'them' mentality, tensions and interprofessional subordination when considering doctor and HCA interactions, resulting in poor communication (Moyo, 2018).

Within Stets and Burke's (2000) discussion of identity theory (role based) and social identity theory (group-based), the authors note that people derive their identity and perception of self mainly from the social categories to which they belong. HCAs perceive themselves as part of a group-based identity that is more widely recognised as a uniformity of views where members work cohesively with each other. Stets and Burke (2000) further highlight the cognitive process in the social identity theory of depersonalisation where members view themselves as an embodiment of the group (the in-group). Indeed, this homogeneity could be interpreted as acceptable, with group members lacking the desire, or motivation, to move beyond the group network, as also discussed by Lloyd et al. (2011). Whilst HCA voices continue to be unheard however, HCAs may feel obliged to remain hidden within their own group. As a consequence, this may prevent them from interacting and negotiating their place and identity within the interprofessional team (or out-group), where their role may not be valued nor socially accepted.

Interventions that promote the possibility of cross-group encounters can enable the formation of new perspectives and greater clarity of roles. Understanding the common goal and the value of collaboration can have far-reaching benefits. Using an approach where representative members of the hierarchy who are traditionally at opposite ends come together in a safe environment, can transform aspects of the health service where every person involved feels valued. This paper draws upon qualitative data collected from a project designed to develop and harness medical students' relationship with and empathy towards patients. Existing findings show that medical students benefit from their role as an HCA and develop good understanding of the HCA role as part of the interprofessional team (Davison et al., 2021). As part of the project, the HCAs undertake a mentoring role whilst the medical students experience working directly as HCAs. Whilst mentoring has mutual benefits for both mentor and mentee, such as increased mentor recognition whilst imparting skills, values and wisdom to mentees (Burgess et al., 2018), in this study we focus specifically on the impact the mentoring aspect of the project had on HCAs themselves. Our research makes an important contribution to the emerging literature examining the HCA's knowledge, skills and contribution to the healthcare service, which has previously remained largely unexplored and offers a unique insight into the experience of the HCA as a mentor within medical education.

3 | THE STUDY

3.1 | Aim

To offer a practical way in which the status of HCAs can be increased by drawing on their experience, knowledge and skillset, whilst mentoring medical students during an HCA project.

4 | METHODS

4.1 | Context

The HCA project has been delivered within a medical school at a UK academic institution for the past seven years, working in collaboration with secondary care and local community hospitals and care and nursing homes. The project is a compulsory element of a Bachelor of Medicine, Bachelor of Surgery. (MBBS) Gateway Year (Foundation to Medicine) module and delivered on a voluntary basis for Year 1 medical students on the MB BS course. Students typically receive three days HCA training and a further three days working either 8- or 12-hour shifts as HCAs under the mentorship of HCAs in a hospital ward, care or nursing home setting.

4.2 | Design

We adopted a qualitative research methodology to explore participants' reflections on their role as mentors of medical students in the HCA project. In particular, we focused on how they perceived their own role in either training medical students during the three days of HCA induction, or whilst mentoring students on the wards.

Qualitative research is effective in examining experiences and motivation, in addition to investigating, as it allowed us to study the perspectives of research participants whilst also thoughtfully engaging with the data. We recognise the importance for researchers to identify which theoretical assumptions underpin their use of thematic analysis and why this is suitable for addressing their research questions (Braun & Clarke, 2021; Byrne, 2022). We selected a critical orientation to understanding the data, as this approach allows an interpretation of meaning that goes beyond that communicated by participants, making it possible for the wider social context to be examined as part of the analysis (Byrne, 2022).

4.3 | Participants and setting

A purposive sampling approach was used to collect data from participants to ensure heterogeneity within the sample. Participants were located within community hospitals, healthcare trust offices, the secondary care setting, care and nursing homes, sited in the East of England and had all taken part in the HCA project as either mentors; supervisors to mentors or in a clinical educator capacity (involved

in the HCA training of medical students) (see Table 1). As the HCA project has been running for the past seven years, some participants had been involved in the project from its onset, whilst others had become involved at a later stage.

4.4 | Data collection

Face-to-face, semi-structured individual interviews were conducted during April–June 2019. The interview schedule was flexible and open-ended, which allowed participants to expand on issues of importance that arose during the interviews. All participants were initially contacted by the first author (ED) via email, explaining the purpose of the study and inviting them to participate in an interview. Using snowballing, clinical educators and supervisors invited to take part were also asked to nominate HCAs who had worked in a mentoring capacity during the project with 10 HCAs being named. The named HCAs were consequently contacted, with five HCAs coming forward. Two of the supervisors who agreed to take part were also former HCAs. Subsequently, 13 interviews took place. Each individual interview was conducted by two researchers (an interviewer and a note-taker). A total of ten of the interviews were conducted by the first author (ED), with the other three interviews conducted by the third author (SL). Interviews lasted for approximately 45–60 min and took place at either participants' places of work, which were within local healthcare 'trust' (involved in the organisation and management of services) offices, community hospitals, privately run residential care and nursing homes, or at the researchers' own offices. All interviews were conducted in quiet, pre-booked rooms.

4.5 | Data analysis

Interview transcripts were analysed thematically using a critical orientation to understand the data (Braun & Clarke, 2006, 2021; Byrne, 2022). At the end of each interview the audio recordings were manually transcribed. Transcribed data were checked for accuracy by reading and rereading by the first author (ED) and initial notations were made (Braun & Clarke, 2006). The next stages of the analysis involved sorting and generating codes by the first author (ED) and making a note of any patterns or connections. A second round of coding subsequently identified themes that represented the complete data set. Repeated reading of the data and critical scrutiny of the themes by all authors aided and developed this study.

4.6 | Maintaining rigour

To ensure that methodological rigour was upheld throughout the study, all three authors collaborated to verify the accuracy of each stage of the process, thus adhering to COREQ guidelines (Tong et al., 2007). Member checking allowed participants the opportunity to verify transcripts to confirm the data were accurate representations of their statements, which also increase the trustworthiness of the data captured. Initial codes and themes generated by the first author were shared with the second and third authors, with a final consensus of the main themes being reached.

5 | FINDINGS

This qualitative study was conducted to offer a practical way in which the status of HCAs can be increased by drawing on their experience, knowledge and skillset, whilst mentoring medical students during an HCA project.

Two main themes were identified. In theme one, HCA perceptions as silent performers of personal and intimate patient care that often goes unnoticed and unacknowledged are described. In theme two, mentoring medical students allowed HCAs to look beyond their in-group and form their identity as members of the interprofessional team.

TABLE 1 Overview of the study participants.

Pseudonym	Job title	Place of work	HCA project role
Cheryl	Healthcare assistant	Hospital	Mentor
Colin	Healthcare assistant	Hospital	Mentor
Clive	Healthcare assistant	Community hospital	Mentor
Joan	Healthcare assistant	Community hospital	Mentor
Mary	Healthcare assistant	Residential nursing home	Mentor
Nicola	Practice development nurse and former healthcare assistant	Hospital	Supervisor to mentor
Paula	Practice development nurse and former healthcare assistant	Community hospital	Supervisor to mentor
Michelle	Registered general nurse	Residential nursing home	Supervisor to mentor
Sandra	Practice development nurse	Hospital	Clinical educator
Jenny	Clinical educator	Hospital	Clinical educator
Sara	Clinical educator	Hospital	Clinical educator
John	Clinical educator	Healthcare trust offices	Clinical educator
Wendy	Clinical educator	Healthcare trust offices	Clinical educator

5.1 | HCAs as silent, invisible caregivers

Seven participants identified HCAs as discreet, modest performers of private, personal care. HCAs considered themselves as part of the patient's zone by the bedside, with care often performed behind closed curtains. Frustration at doctors' lack of awareness of the need to respect patient privacy and dignity is evident here:

> … and sometimes they [doctors] do just barge in when curtains are closed, when you should be knocking, finding what's going on in there 'is that ok, ah, if I can come behind that curtain?'…
>
> (Colin, Healthcare Assistant)

> … carrying out personal care in a dignified manner and making sure the doors are closed, curtains are closed and covering everybody up…
>
> (Michelle, Registered General Nurse)

Consequently, the extent of HCAs' skills was largely concealed from the wider interprofessional team. Conversations between patients and HCAs were commonplace. Often participants stepped in from the onset to provide vital social support for confused, or bewildered patients when first arriving on the ward. Support could include seemingly simple tasks, such as helping a patient unpack their bag, or finding their glasses whilst chatting to them to discover key important social history. That rapport was continued throughout the patient's stay in hospital:

> … I know we're run off our feet, but when you're making a bed you can chat to the patient about their family about you know are they feeling ok is there anything we can help them with—we're the ones that really build that relationship with the patient…
>
> (Cheryl, Healthcare Assistant)

The level of HCAs' low self-worth and esteem was evident as participants modestly likened such important duties to 'small jobs', or 'just common-sense things'.

Whilst detecting any changes in patients' health was also viewed as part of HCAs' remit, affording them the opportunity to convey and discuss any key changes with the wider healthcare team was not straightforward. Nurses were HCAs' main channel of communication, acting as their interpreter and spokesperson to doctors:

> They [the doctors] tend to always ask us as registered nurses, and yes, I know, because they would be my patients. But, actually it's OK for them to have that interaction with healthcare assistants, because they would be the ones that could tell you, how they [the patients] walked to the toilet today. They [the doctors] ask me, and I'm telling them what the healthcare assistants have said sometimes…
>
> (Sandra, Practice Development Nurse)

HCAs demonstrated a deep sense of injustice and isolation, whereas a lack of recognition left them powerless to effect change. Doctors were often perceived as superior and elite members of the interprofessional team leading to a sense of remoteness and inaccessibility within the hierarchical structure for the HCAs.

When considering the doctor–HCA relationship, another HCA noted:

> I know we shouldn't, but perhaps we [HCAs] do think, 'ooh they're a doctor' and sometimes they [doctors] don't get that much communication between HCAs and doctors on [the] wards, it usually comes via nurses.
>
> (Colin, Healthcare Assistant)

HCAs talked of instances of dealing with the 'after-effects' of a doctor and patient encounter where patients went on to seek HCA help in deciphering the conversations. On these occasions, HCAs were able to discuss, reassure and translate medical jargon to patients. Despite providing vital patient support, some participants still felt compelled to share the extent of their frustration. Their perceived lack of respect and acknowledgement rendered them silent, hidden workers, prevented from gaining rightful recognition as part of the wider healthcare team. Consider here, for example, Cheryl's thoughts:

> This sounds awful, I can't think of another way to phrase it, but, like you know, you're just 'the lowest of the low', and that sometimes is how you're made to feel.
>
> (Cheryl, Healthcare Assistant)

One participant believed it boiled down to courage as to whether they dared step forward and voice their concerns to doctors, having acknowledged that HCAs were not established members of the interprofessional team. This was seen to be compounded by doctors' limited knowledge of the HCA role. As a result, speaking up could be difficult, as their relative obscurity meant such actions were unusual leaving HCAs uncertain of the response they might receive:

> Sometimes it can be quite scary speaking to doctors if you're not, you know, if you don't on a daily basis. That's what our bread and butter is, working as a team. But actually, for the healthcare assistants, it takes a long time for them, because they don't see their role as valued as others … I don't know why and not all of them, but I think sometimes it's quite hard.
>
> (Sandra, Practice Development Nurse)

Whilst HCAs were familiar, welcome faces for patients, their relative obscurity in the wider domain was picked up by a clinical educator who had previously worked as an HCA. This again reveals how HCAs are often forced to rely on a mediator when on the ward:

> So, just because they've [HCAs] not been to university perhaps, or anything like that, and vice versa, that we've all got a voice and they're going to be an advocate for the patients. So, then again the patient may have disclosed something to them and said 'I have said yes to that surgery, but I'm really actually worried and I'm not sure it's right for me'… So, they [HCAs] would be the best person to speak to the doctors to explain.
>
> (Nicola, Practice Development Nurse and former HCA)

Constrained within the boundaries of their role, HCAs were unable to effectively develop or in some cases easily recognise the skills they already had. Within their caring role, HCAs had limited opportunities to discuss or engage within a dialogue as part of the wider healthcare team. Consequently, it was only occasionally that their worth was revealed to them. Notably, Paula a practice development nurse, and former HCA, did recognise and take time to highlight to HCAs the value of their work:

> Some of the healthcare assistants as well it's intuitive stuff they've got, but they're not aware of it. You know, some of their abilities are really good. I was thinking about some of the most skilled I've seen, and you say to them 'you look at what you've got—look at the way you reacted to that person—look at how you connected with them'. [HCA] 'Oh I didn't realise. I was just doing what I do'.
>
> (Paula, Practice Development Nurse and former HCA)

HCAs welcomed the opportunity to explain and showcase the true extent of their responsibilities. Many were keen to reveal the true dynamics of responding at speed to patients' needs, and the resilience required to cope with 12-hour shifts with one, 30-minute, break. One participant pointed out that the HCA role has for some time now absorbed the work previously performed by state-enrolled nurses. Another participant described HCAs as responsible for executing the advice and instructions given by senior staff. However, HCAs described a sense of exasperation and of being constrained by their more visible, recognisable image likened by several to 'a bit of a pair of hands', performers of 'simple, easy' basic work and 'not just what you might see' of serving tea, washing patients and emptying commodes.

Others did attempt to elevate themselves and colleagues by associating HCAs with the embodiment of care work by describing HCAs as the 'eyes and ears for staff nurses' or 'the backbone of the NHS'. Nevertheless, participants felt such widespread labelling bore little resemblance to the reality of their work, which they portrayed as skilled, therapeutic, intuitive care often delivered to patients with demanding and complex conditions. It was whilst mentoring medical students that HCAs were able to begin to form their own identity, giving them professional standing and value as part of the interprofessional team.

5.2 | The formation of an HCA identity through mentoring

Assuming a mentor role was empowering for HCAs, allowing them to begin the process of claiming their place within the interprofessional team. Over three days, students completed their shifts working as HCAs. Significance was now placed on their knowledge and expertise to guide and mentor medical students:

> …I think that's [mentoring] given our HCA facilitators a bit of confidence … they didn't know, because they've never done this before, but I know that they were very worried about teaching them, because they, you know, 'they're medical students', but they don't know what you know, and what we know as teachers…
>
> (Sandra, Practice Development Nurse)

Another participant acknowledged the valuable contribution to student learning and awareness HCA mentors successfully conveyed:

> … and actually there is a lot of responsibility because if they [HCAs] got those obs [observations] wrong and they didn't report it, the patient could deteriorate so I think that kind of made them [medical students] realise you know … they [medical students] were saying that they would look at the paper [documented observations] and sort of read it, but they wouldn't have understood all the work that went behind it as such—so the knowledge I think—they were very surprised at the amount of knowledge that the healthcare assistants needed…
>
> (Nicola, Practice Development Nurse and former HCA)

Participants expressed a range of reactions when initially asked if they would like to mentor medical students. Whilst feeling excited at the prospect, deep-seated insecurities emerged around communicating with future doctors that were harboured in some cases by both HCAs and clinical educators:

> … I think it's really hard when they're introduced as medical students because um like myself I get anxious that I don't, can't, give them what they need and I want to give them the best service …
>
> (Wendy, Clinical Educator)

HCAs now had a legitimate reason to interact with medical students, which some found unnerving, compounded by perceptions of a 'us' and 'them' mentality. Inexperienced medical students were still

perceived as senior in both their knowledge and rank. Several participants talked of an existing 'stigma' around communicating with senior personnel:

> … yes I'd love to be able to talk to a doctor like anybody else on my team, but sometimes I don't feel that I can, um, you get snapped at sometimes, and I don't know whether that's because of the role that I have, or whether that's just how they are with everybody, but it feels sometimes like it's because well you're just an HCA…
>
> (Cheryl, Healthcare Assistant)

Consequently, some HCAs now doubted their own abilities and questioned whether they had any valuable knowledge to share with medical students, or indeed could take on the mentoring role. One participant recalled her conversations with HCAs who had expressed concerns:

> … I think there are things that I didn't expect. I didn't know they were anxious about teaching them at all, but they all secretly enquired, and said 'oh God you know what will it be like teaching medical students?' I said 'it will be like teaching every other healthcare assistant'.
>
> (Sandra, Practice Development Nurse)

It became clear that the HCA project and the importance of allowing medical students to learn from and experience working as HCAs had not been made clear to several HCAs prior their mentoring role. In some cases, the impact made on medical students', who had later expressed their gratitude and sense of privilege to have worked with HCAs, was not conveyed back to them:

> I think the HCA's always gain from being sort of a mentor or a coach or something, but I'm not sure whether or not they would have realised how much the medical students appreciate like learnt from that [learning from HCAs] experience, and that could be something that we need to work on, to make sure we get feedback [to HCAs].
>
> (Nicola, Practice Development Nurse and former HCA)

Several participants recalled 'light bulb' moments when mentees were able to talk through and make sense of their experiences of patient care from an HCA vantage point. Nicola's words show the key role HCAs performed over the three days of shifts in beginning a cognitive process that prompted students to question and explore patient care:

> … and understanding, um, so 'you're going to do it this approach', but you have to adapt your approach if you've got a different type of patient you know. It's if you've got a patient that's elderly with really frail skin, or you've got a patient who's got a learning disability; the approach is going to be different or depending on the results depends on how you action it. So, I think that was you can just start to see in a little time how it was like you know, almost like that bit of the thinking was coming along, um, so it's a bit of scaffolding really. You know, you start them off and then they [medical students] brought out more questions …
>
> (Nicola, Practice Development Nurse and former HCA)

Another participant viewed mentoring as a vital win–win situation that presented mutually important benefits to be gained by both HCAs and medical students. She believed the opportunity was a way of resurrecting and bringing into the limelight the work performed by HCAs to enhance and rejuvenate their public image. Notably, Mary also believed the experience would give medical students an awareness and appreciation of the HCA role, which would ultimately help HCAs in the formation of a mentor identity:

> It's sort of like saying to all us carers that the role that the carers and HCA play is still important, or very important, so much so that we're going to take our doctors and let them come and see how important that role is. So, yes it's good for us and it's good for the student doctors.
>
> (Mary, Healthcare Assistant)

Presenting a mentoring model where medical students were taught by HCAs promoted strong connections, and a new-found awareness and respect for HCAs. Allowing HCAs to mentor medical students required a range of attributes during which time HCAs demonstrated their organisational skills, knowledge and expertise in communicating with and caring for patients under demanding conditions. One participant explained that HCA mentors' main aim was to 'equip students with the skills that mark a day'. In doing so, Paula reveals the daily demands placed on HCAs working in a secure unit, which students witnessed and provided hands-on care with:

> … yes is really important and again seeing the pressures that are on, um you know, everybody you know I think mornings … 'must get people up and about and washed and dressed and make sure they've got food inside them'—all major meetings happen in the morning usually doctors turn up in the morning—afternoon's completely different perhaps a lot quieter, but then in the evening times when people are wanting to go home you know people with dementia thinking 'I've got to pick up my loved one it's getting dark outside am I staying here again' …
>
> (Paula, Practice Development Nurse and former HCA)

The mentoring process generated hope, energy, aspirations and a new sense of self within HCAs that opened communication channels between HCAs and medical students. After taking part, one HCA believed the mentoring of medical students would begin to foster new, vital connections between doctors and HCAs that ultimately benefitted both HCAs and medical students, eliminating an 'us' and 'them' culture:

> Yes, I really want it [HCA project] to bridge that gap between us and them I don't want there to be an us and them anymore I want it to feel like we're all a team … I'd just like it to feel like we're more of a team with them … I think it [HCA project] will be really valuable to everybody.
>
> (Cheryl, Healthcare Assistant)

Evidence of an emerging culture change and the breaking down of deep-rooted barriers was clearly demonstrated in this quote by a practice development nurse who was aware of HCAs who now had the courage to approach former medical student mentees, as well as those students who had since graduated as doctors. Furthermore, it shows HCAs belief in their self-worth and abilities, which appeared linked to the formation of a stronger identity, brought about from mentoring. HCAs were now confident that medical students and doctors were aware of their valuable contribution to patient care:

> I understand that they've [HCAs] seen them [medical students] on the wards, and been up and spoken to them, and say 'oh, you're still here and how are you getting on?' They're really small things, but actually for the healthcare assistants that's quite nice for them, 'that's the person that I worked with…they came to see what I did'. So, it's given them [HCAs] some more value, and that people do recognise what you all do. Even if we tell them every day, they don't necessarily believe it, and also a bit of confidence to tap them [doctor] on the shoulder, and say 'oh, you're a doctor now … remember when you …?' That's a nice thing. It's a good thing for them… so definitely a benefit.
>
> (Sandra, Practice Development Nurse)

Assuming a mentor role generated a new awareness and understanding of HCAs. Whilst some were initially anxious and reticent, HCAs embraced the opportunity to clearly articulate and demonstrate their work to medical students. Once into the role, HCAs' confidence grew, drawing at times on their life experiences of providing patient care, which further enhanced the formation of a HCA identity through mentoring. HCA mentors helped to give medical students, as one participant put it, 'the chance to release their human skills' on their future patients.

6 | DISCUSSION

6.1 | Wider perceptions of HCAs

This study confirms the feeling among many HCAs of being invisible caregivers who do not consider themselves valued and part of the interprofessional team. Importantly, by engaging HCAs as mentors to medical students during a relatively short yet impactful intervention, this study demonstrates that tradition can be reversed and used to heighten the much-deserved status and recognition of HCAs as key members of our workforce.

Findings show that HCAs are recognised as silent performers of personal and intimate patient care that often goes unnoticed and unacknowledged. Whilst some HCAs are aware and proud of their wide range of skills, likening themselves to 'the backbone of the NHS', others were not, until their abilities were pointed out by a fellow member of the healthcare team. Used to occupying a position on the periphery of the interprofessional team, HCAs diligently decipher information for patients, provide moral support and gather social data, whilst carrying out routine and advanced tasks under pressure.

However, although HCAs are often first-line responders for their patients, they feel devalued, thwarted in most instances from communicating their concerns direct to doctors, and obliged to use nurses as spokespersons. According to this study, many HCAs feel trapped and constrained by traditional hierarchical structures and prevailing stereotyping that describes them as unskilled, low-status workers frustrated that 'dirty work' is often assigned to them (Bach et al., 2012). HCAs' social standing, individual skills and qualities lie hidden within a group-based identity that damages their self-esteem (Stets & Burke, 2000). Collective references to HCAs as a 'marginalised group', with limited strategies at their disposal to assist in their development, places HCAs firmly within the bands of lower-paid, under-valued and care work (Bach et al., 2012; Woodhead et al., 2022).

6.2 | HCAs mentoring medical students

HCAs initially perceived the mentoring of medical students with anxiety, unsure of their own capabilities whilst acutely aware of their low social standing. However, the experience generated new connections between medical students that gave HCAs the confidence to approach previous mentees now working as newly qualified doctors on the wards. Bandura points out that the persistence in activities initially regarded as difficult, or hard to master, can reap the greatest benefits in terms of performance accomplishments (Bandura, 1977). Significantly, the performance accomplishments associated with taking on a mentoring role gave HCAs an active, first-person voice that is no longer diluted by and dependent on a mediator. Such progress raises HCA awareness and narrows the gap between HCAs' perceived roles and the reality of their capabilities, as suggested by Fitzgerald et al. (2020) and Just et al. (2021).

Mentoring medical students as part of the HCA project allows HCAs to move from a homogenous group-based social identity, where members view themselves as an embodiment of their in-group, which in this case is low on the hierarchy ladder, to a role-based identity that will increase their social standing. It enables HCAs to demonstrate their worth by revealing the true extent of their work whilst interacting with another group, the interprofessional team. Brown and Hewstone's intergroup contact theory highlights the potential that contact under the right conditions has in changing intergroup attitudes and thus reducing out-group stereotyping and prejudice (Brown & Hewstone, 2005). The authors discuss the importance of both interpersonal and intergroup dimensions for optimal contact conditions to occur.

Intergroup contact can foster empathy and new perspectives, leading to more positive intergroup orientation and ultimately better performance in the context of providing a healthcare service. In our study, Cheryl expresses her desire for the elimination of an 'us' and 'them' mentality. Medical students describe working with HCAs as 'eye-opening' and 'humbling' (Davison et al., 2021). Exposing both medical students and HCAs to direct contact with each other within a supportive educational setting where HCAs can take on the role of mentors can prove effective in fostering lasting attitude change. Brown and Hewstone (2005) agree that exposing people to extended contact prior to direct contact is a particularly powerful way of challenging prejudice. Students participating in the HCA project believe the early experience would influence their values as future doctors in respecting and listening to HCAs as part of the interprofessional team (Davison et al., 2021). Many opt to join the HCA bank afterwards and continue to work in this role throughout their course.

As this study illustrates, HCAs have been able to visibly and audibly both challenge and reject commonly held perceptions concerning their work that influences their identity. Findings presented here question claims that HCAs do little to promote themselves within the interprofessional team, often alluding to the importance of teamwork, but in fact failing to locate themselves within the wider team. As discussed by Lloyd et al. (2011) HCAs' identity acts as a barrier to them delivering collaborative care, in that HCAs perceive the wider interprofessional team as separate and outside of the notion of their 'team' (Lloyd et al., 2011). Such claims, however, imply that HCAs are responsible for their alienation owing to their solidarity to each other, and an identity born from not being and feeling valued.

This study confirms Moyo's (2018) findings that HCAs feel disempowered and ignored within the interprofessional team. Traditional, yet current, hierarchical structures drive HCAs to adopt 'a narrative of powerlessness', impeding them from raising important patient concerns, or revealing the true extent of their duties (Fitzgerald et al., 2020; Rodger et al., 2019). Consequently, a better societal understanding of the HCA role as part of the workforce and embracing them as part of the interprofessional team is essential in moving forwards (Hewko et al., 2015). Mentoring medical students offers HCAs an opportunity to reflect on their own performance and discover a deeper sense of self that recognised their occupational value. Indeed, Gandhi (2019) suggests upending the traditional perception of mentoring delivered by those occupying positions of power breaks down barriers that impede advancement.

This study highlights that HCAs are sometimes unaware of the positive impact their mentoring has made on medical students. As described by Nicola, other members of the team can help strengthen their status and sense of value further by making sure that HCAs receive the positive feedback from students. These findings therefore acknowledge the opportunity for all staff to role-model future practice. The HCA project allows students to question, reason, observe and practice good patient care first-hand from the HCAs. This is where training and ongoing support for HCAs becomes important so that they feel confident as mentors, whilst also appreciating the opportunity to use their power of influence.

6.3 | Limitations and further research

The benefits of involving HCAs as mentors for medical students shown here need to be explored across a larger sample of HCAs to understand their views of acting as mentors, whether this is something that should be part of their role and if so, what support they require. Investigation of the longer-term impact of this type of intervention on HCAs and medical students needs to be explored further to warrant the expansion of this project to include all medical students.

7 | CONCLUSION

This study finds that offering healthcare assistants (HCAs) the opportunity to mentor medical students during a relatively short educational intervention where they work as HCAs can have a very positive impact. It contributes to the knowledge gap that exists surrounding the HCA role by showing that HCAs continue to be a marginalised, undervalued, hidden and poorly understood workforce. Although performing vital patient care, HCA work is still widely perceived as menial, which damages their hierarchical status. Involving HCAs as mentors to medical students gives HCAs an opportunity to contribute to the education and advancement of future doctors. Notably, this small project has begun the psychological transition needed in order to change ingrained beliefs, and an 'us' and 'them' mentality. Such learning within the workplace will aid the development of both HCAs and medical students in the cultivation of a future, person-centred, inclusive and collaborative workforce where everyone feels valued and appreciated for what they contribute to the everyday care of patients.

AUTHOR CONTRIBUTIONS

All authors contributed to the design of the study. ED and SL undertook the interviews. Data analysis and interpretation of the data were accomplished by ED. SL and JS revised the analysis critically and made comments. ED drafted the manuscript. SL and JS read the manuscript for important intellectual content and provided

feedback. ED and SL addressed the reviewers' comments and feedback to further enhance the manuscript. All authors read and approved the final version of the manuscript and agreed to be accountable for all aspects of the work.

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CONFLICT OF INTEREST STATEMENT

The authors have no conflicts of interest to disclose.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ETHICS STATEMENT

The interviews were conducted after obtaining the Faculty of Medicine and Health Sciences Ethics Committee approval (201819-033). Participants were provided with an information sheet and written consent was obtained from each who agreed to take part. All participants were informed of the purpose of the study prior to the interviews and advised that they could withdraw up to the point of analysis. Participants agreed to be audio recorded and a copy of the transcript was sent for their comments to check and validate contributions (none were returned). Confidentiality and anonymity were assured by using pseudonyms.

ORCID

Elizabeth Davison https://orcid.org/0000-0001-8636-3635
Joanna Semlyen https://orcid.org/0000-0001-5372-1344
Susanne Lindqvist https://orcid.org/0000-0001-8598-6240

TWITTER

Joanna Semlyen Dr_Jo_S

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