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Tensions and Possibilities: A qualitative study of the views of nurse faculty training medical students to be Health Care Assistants

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Abstract

In the majority of pre-registration training programmes, early theory is supported by later clinical learning. Unlike nursing, midwifery and the allied health professions, medical training often offers relatively little early clinical patient contact, though this does vary by medical school. To overcome this, recently, some medical schools offer patient-facing nurse training for the Care Certificate (CC) in the first year, but as yet little is known about how this is being received by nurses. We report on the experiences and perceptions of nurse-led faculty who led a pilot for first year medical students to gain the CC in the academic year 2019-20, in one UK medical school. The qualitative study involved one-to-one, in-depth, semi-structured interviews with the course educators. Data were analysed using reflexive thematic analysis. Seven faculties participated, sharing their delight at students' willingness to embrace the CC. Five main themes arose: i) perceptions of doctors and nurses in the healthcare system; ii) affinity with the medical students; iii) benefits of the CC for medical students working as Health Care Assistants (HCA); iv) anxiety about teaching the medical students; and, v) uncertainty about whether this training should be compulsory. We discovered that nurses yearn for greater appreciation for their work by the medical workforce. These educators felt this could be realised through this change within first year medical training. Many benefits were perceived as an outcome of this training for medical students, all members of the clinical team and most importantly for patients.

Keywords: ***Health Care Assistant; interprofessional; nurse-led faculty; perceptions of medical students; qualitative research***

Introduction

Health and social care professional training has predominantly offered theory before practice, so students can appreciate the foundations of their chosen profession. Over time, this has resulted in theory-practice gaps and so faculties have derived methods to "bridge the gap" (Greenway et al., 2019). In pharmacy, the

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undergraduate programme has been dominated with science, leading to a re-think and subsequent development of a more clinical and patient-facing curriculum (General Pharmaceutical Council, 2019), while in nursing and midwifery, theory is integrated alongside practice with students entering clinical placements from the outset in supernumerary roles (Health and Care Professions Council, 2018; Nursing and Midwifery Council, 2018). In medical education, the Flexnerian (1910) demarcation between early science and later clinical placement learning, often remains stark. Little focus is given to the remarkable metamorphosis expected of medical students as they transition from secondary school [integrated courses] or university [more traditional courses] classroom-based teaching, into practice learning. Instantaneously, students are required to become a team member and be aware of systems, policies, practitioner roles and responsibilities, all of which may differ in different clinical settings. All healthcare students struggle to move seamlessly into front-line practice in educational, social and developmental contexts (Atherley et al., 2019); but, this is particularly true for medicine (Monrouxe et al., 2017; Monrouxe et al., 2018). Ten years ago, there were calls for the modernisation of medical education which asked for increased early immersion of medical students into clinical team working environments. These calls persist today (Frenk et al., 2010; Hamdy, 2018), with many arguing that early immersion is vital for safe practice (Hean et al., 2006; Makowsky, 2009; World Health Organisation, 2010; Haddara & Lingard, 2013; Rowland & Kitto, 2014; Anderson et al., 2016).

Despite the advent of interprofessional education (IPE), the professions overwhelmingly train in silos responsible to their respective professional bodies. While it is natural for students to socialise and study whilst staying within the social boundaries of, and in close proximity to, those with whom they have something in common, this can lead to the formation of in-groups and out-groups (Wackerhausen, 2009; Hall et al., 2013; Hean et al., 2013). Meanwhile in practice, we see a plethora of studies talking about the dominance of one profession over another, power games of access to resources, and students still facing the effects of their unspoken position in a hierarchy (Bainbridge & Purkis, 2011; Baker et al., 2011; Newton, 2014; Leedham-Green et al., 2019); and failure to recognise the value of the work patterns of each profession has also jeopardised patient safety (Lingard et al., 2002). Overall, in many more traditionally-structured medical courses, mechanisms of training have changed relatively little in recent decades, despite cries for patient–centred team working and collective competence. IPE, especially in practice, has been seen as the solution and is delivering change (Reeves et al., 2016) but remains hard to achieve throughout a curriculum because of the pressures of ever larger cohorts, timetabling complexities across different clinical programmes, and a lack of political will to change direction (Paradis & Whitehead, 2018).

Few have succeeded in offering the confidence gained by learning on training wards, as outlined in Sweden (Wilhelmsson et al., 2009). Another way forward is to re-think early learning of basic skills for clinical work. The UK Care Certificate (CC) offers a shared route for all health and social care practitioners to learn about the entry-level skills required in healthcare with similar training programmes in Europe (European Care Certificate, 2021) and North America (Skills for Care, 2015; Alberta Healthcare Aide Directory, 2021). Such competence and clinical exposure offers a platform for deeper appreciation of the clinical team and real experience that develops clinical confidence (Walker et al., 2017). Many nurses now use CC training as a straightforward way to work and be immersed into clinical practice as Health Care Assistants (HCAs) (Ferguson & Cerinus, 1996); this is also being considered in medical schools with early positive findings (Davison & Lindqvist, 2019). However, in the UK, the CC has led to concerns about standardisation and consistency of training across acute and community providers (Thomson et al., 2018).
There are additional benefits as the recent pandemic highlights, in having a flexible, motivated, and appropriately trained medical workforce able to go to the front-line when needed (Anderson & Patel, 2020). Reflecting on all these drivers, our medical school introduced the CC within early training, starting with a pilot group in 2019, using a partnership between the medical school and the local NHS acute care Trust. We set out to:

i) Increase medical student competence through clinical team-based exposure for patient contact and a deeper appreciation and value for caring work.
ii) Offer a training route to increase the local caring workforce to support clinical work in times of need.

It was recognised that this provided students with a chance to work and earn, whilst simultaneously supporting their learning.

A pilot for 30 first year medical students commenced in Induction Week 2019. Consenting medical students replied to a pre-enrolment invitation letter and were accepted on a first response basis prior to starting medical school. The partner hospital developed a nurse-led faculty to deliver the programme which consisted of classroom-based theory. This was followed by practical sessions scattered throughout the first semester pertaining to topics such as keeping patients warm, feeding them, taking account of their basic needs, and capturing basic observations. These students did not miss out on their core learning.

With little understanding of both the impact of integrating a CC into a medical curriculum and the nursing faculty experiences, we were keen to explore the meaning, impact, relevance and acceptability of this training, from the nurse faculty perspective. We report on the experiences and perceptions of this faculty training the first year medical students.

Methodology

We used a qualitative research approach. We aimed to generate data about the 'real life' experiences of teachers delivering the programme by listening to their perspectives (Kuper et al., 2008). The qualitative research paradigm for this study was constructivist concerned with understanding the making of meaning as it happens in the real world through the eyes of participants (Piaget, 1977).

The sample comprised of those who had delivered the programme including the two senior lead nurses, several specialist nurses and therapists. While we remain interested and are following the trajectory of the 30 medical students who participated, we will report on their progress in a future article.

Table 1:

Topic Guide for faculty interviews

Faculty Interviews
Introductory questions **Do you feel that medical students should train to gain a Health Care Certificate and become HCAs?** *Probe - If **Yes** why is this and if No – also why is this?* **Questions** ***I wish to talk to you about your experiences of supporting this training*** • What have been your greatest challenges over the last year? • What do you feel has worked well and what should we do differently? **How has this learning helped the medical students?** • What changes do you perceive in the students and can you give examples of these changes? *Probe – values of the NHS, patient-centred care, interprofessional values, skills, knowledge etc*. **How has this programme helped the NHS Trust?** *Probes* • ….early training of future doctors to shape their values and attitudes • … early training to become more familiar with systems and processes, such as how the ward works and the management issues led by the nursing team • … improving future doctors capabilities to communicate well with patients • …. Will these students be more resilient and understanding medical workforce **Are you aware of how many have worked shifts as HCAs?** *Probe* - Do you feel they will be a new workforce who can be called upon during periods of staff shortages? **Would you change in the way we set out this programme?** *What worked well; what could we have done better?* Do you feel this training should be compulsory for all medical students? *If yes why? If no why?*

The teaching faculty worked with the students from September to December 2019. The teachers were consented and invited to take part in one-to-one semi-structured interviews (see the topic guide in Table 1) at the end of the semester.

Recordings were transcribed verbatim and analysed using reflexive thematic analysis by KP, ES and SG (Braun & Clarke, 2019). All researchers read the scripts separately for understanding and completed the required steps to identify final themes. This process was completed using annotations in the script margins brought together through exploring the similarities and differences between participants (faculty members) in identifying evidence for coding. In the second step, we brought the codes together to agree a pattern of shared meaning for the interviews, capturing the main outcomes as themes, and agreeing on the clustering of themes to create sub-themes. In this way, we followed the six steps of; 'familiarisation; coding; generating initial themes; reviewing and developing themes; refining, defining and naming themes' (Braun & Clarke, 2020).

Results

Ten nurse-led faculty delivered the CC training; two acute care senior nurse leads, a specialist infection control nurse, a mental health nurse practitioner, a specialist nurse transfusion practitioner, a speech and language therapist, a dietician, a learning disabilities nurse specialist, and two IT systems support nurses. Seven were available for interview, including the two leads, while two were unavailable with professional commitments and one failed to respond. The call for thirty medical students was met, with only three students failing to complete the CC training due to their wishes to focus more on their formal course commitments.

The data from the faculty interviews coalesced around five main themes (Table 2); i) perceptions of doctors and nurses in the healthcare system; ii) affinity with the medical students; iii) benefits of the CC for medical students working as HCAs; iv) anxiety about teaching the medical students; and v) uncertainty about whether the training should be compulsory.

Table 2:

Faculty Themes and Extracts

Themes and Extracts	
Theme i) Perceptions of doctors and nurses in the healthcare system and hierarchy within modern healthcare delivery	
Subthemes	• **Outdated hierarchy** "I think the NHS is changing. I appreciate now that people do have different skill levels and we should embrace that." HCP 5 "My only reason I think it should be compulsory is that I think people that don't want to do it are probably the ones that should, because I think there's, I don't know whether there's some snobbery … you're going to be a medic but actually that's quite a high status job and why we being made to a low status," HCP 6. • **Lack of appreciation for other roles and skill sets** "I think it teaches them bedside manner. I think it teaches them the basic care skills that in my experience some medical staff do tend to lack a little bit." HCP 5. "But I don't think some of them appreciate all the other bits that are very useful to you in that capacity as a doctor… Yes, it is a very academic career, but you also need that other side of it, the more softer, the more caring, the people skills." HCP 5. "…understanding what we're able to do with patients… So an example would be we get a referral for somebody who has a suspected dysphagia but they're nil by mouth because they're about to go for a procedure, well we can't do anything" HCP 6.

	• **Lack of familiarity with junior medical students** "And really incorporating in the organisation, because I suppose for a lot of the time it's kind of like them and us, that kind of thing." HCP 2. "…because I think when you're training you kind of sit in a cocoon don't you." HCP 2. "It's difficult because I've not had a great deal of exposure to medical students to be fair. I mean we see them sort of in and around the hospital." HCP 2. "Well, I suppose as a doctor they'll be sort of deciding on the grand plan." HCP 7. "I mean hopefully, I don't know what's on further on in their medical [training]." HCP 7.
Theme ii) Affinity with the medical students	
Subthemes	• **Impressed with approach of medical students** **"…**help to continue to promote the positive values and attitudes that they have because that's pretty much all we've seen in everything that they've tipped up and divvied up and what they've done in the classroom." HCP 1. "So yeah, they've all really took it, they were lovely, they were really, they were delightful all the different characters and they all like really embraced like the myself and XX sort of as we got to know them a little bit by the end of the week." HCP 2. • **Students as individuals as well as future doctors** **"**It was a really tough week for them, moving into the Halls and some of them come in and they just look so tired. Obviously it's party heaven, Freshers week." HCP 2. "Yeah, all those things like, I don't know, any of them had thought about getting registered with a GP or a dentist or what I would call housekeeping." HCP 1. "Just really I think their lectures, trying to build in that Freshers, the awareness of just the Halls being very like, very tired sometimes, some of them are very young, some of them not as young as the others…" HCP 2. "I think they're probably younger than what I expected and probably a bit more down to earth. They were just normal young people." HCP 2.
Theme iii) Benefits of the Health Care Certificate training for medical students working as a HCA, NHS Trusts, team working and patient care	
Subthemes	• **Benefits for NHS trusts** "If we look at maybe, I think XX goal is to look at sixty eventually. That's a big chunk of people accessing our bank at times when sort of holidays and half terms and things when we're depleted with staff. So I think it will support recruitment, it can be a recruitment initiative" HCP 5 "…well I don't know how many HCAs shortages there are, because I'm assuming there's sort of a need for bank, there will be a need for bank. So if you've got people who are going to be motivated who want to go into the medical profession, who want to work in this environment. So I can imagine that being a positive." HCP 6. "…you'll have people committed to the Trust, don't necessarily move on or who value their experience and opportunities that they've been given. So in terms of kind of retention and those kind of things, people wanting to work in the Trust." HCP 6. • **Benefits for patient care** "…the basic care skills affect everybody in the NHS really. If you see a patient that needs help should you be shouting for someone at the bottom of the ladder if you like, or do you just get on and help that person?" HCP 5.

	"So by working at ward level in an HCA capacity I can see how they would see things from a different viewpoint and see the sort of more overarching care that the patient's receiving." HCP 7. "…people are afraid to question doctors, a certain generation of people are afraid to question doctors, they accept what they say. But I think when they see them in this more caring role maybe that will change and that's going to be for the better." HCP 5. • **Hands on** "…we're there to give them a real opportunity to get to grips with the equipment and a variety of pieces of equipment so that when they do go out there into clinical practice and they're asked to do a set of observations or to help move somebody, then they're equipped with the skills and knowledge to be able to do that adequately on a patient facing basis." HCP 1. "Which means they stand and watch and observe. Whereas as an HCA yes they will have some opportunity to have a supernumerary status, but they will still be getting involved, they won't just be standing and watching." HCP 1. "…throwing them in at the deep end I think that's a really good idea giving them that opportunity to be a basic ward member and settle in and actually meet some patients" HCP 4. "Well it's very hands on isn't it and I suspect that early on in medical training it can easily be not very hands on. So I can see that would be a benefit." HCP 7. • **Early exposure** "So I think being able to work on the wards and embed that before they actually need to use it, it's going to just be, by the time they come out it's going to be part and parcel of, they're going to know the systems" HCP 2. "They will also get to be exposed, on a repeated basis, to the language be it on the handover, the huddles, the paperwork that they're doing." HCP 1. "I think if they've worked as an HCA they will see how basic things like how things are ordered, inventories of the stock room, just the little things that they wouldn't ordinarily be concerned with when the supplies aren't there that they need for a particular procedure," HCP 5. • **Benefits for team working** "…maybe the HCAs will be unsure about something so they'll feel more confident to go to the doctor and share what they've learnt or what they know or get some advice from them." HCP 4. **"…**if we understand other people's roles then it makes it much more easy to work out what can and can't be done, how things should be done, how you communicate with different people." HCP 6. **"…**if the doctors know that the talents of the HCAs are to get patients to open up and engage then they can tap into that talent to say 'right, that HCA has got a really good rapport with that patient' get them to go and talk to the patient." HCP 4. **"**When they're coming through on the placement or even when they're qualifying they're going to be able to build on that learning in terms of the MDT and that's really beneficial for us in terms of our kind of the referrals we get." HCP 6.
Theme iv) Anxiety about teaching the medical students	
Subthemes	• **Fear of how to teach bright young people** "I suppose I did have in the back of my mind, is this information that a medical student really wants to be getting, because it can seem all very basic – eating meals, having snacks, it's all very, it's not rocket science, it's very basic stuff." HCP 7.

	"if you want to go and study to be a doctor it's not going to be everybody's choice to then be made to go and work as a Healthcare Assistant and I can fully appreciate why that would be. So yeah, I think some of them perhaps wouldn't be quite as willing to do that as others." HCP 5. "I did change some of the well I did review it because I looked at what we had in March of 2019 and I felt I needed to put on the title slide Medical Students HCA Training." HCP 3. "Sometimes I might have put the word "The spread of disease" and then in brackets put (transmission) and so using different terms and I used kept the work Microorganisms and I never put the word bugs in brackets." HCP 3. • **Concerns about medical students learning to be HCAs** "I'm sure they're very young and well educated and probably know more about IT skills than I've got. And they could probably teach me a few things." HCP 3. "Is there any other reason medical students might not be keen on doing the programme? I don't know, I don't know why. I mean I guess I feel like I should be saying ...because they're working up here, their goal is to be up here and not at the other end of the scale," HCP 2. "…they've (medical students) not made me feel like that's something that they feel (training to be up there and working down here) and we shouldn't be looking for that divide should we?" HCP2.
Theme v) Uncertainties about all medical students completing this training	
Subthemes	• **Preferential treatment for medical students** "And then they just and do they have to do a certain amount of bank work over the year…to maintain your pilot's licence you actually have to do so many hours a year don't you." HCP 3. "So it's not, I don't know that they need the full Care Certificate programme because we don't do that for student nurses." HCP 4. "So maybe that's a little bit unfair that the medics can join the bank before they've even done anything… a student nurse will have to have done a full placement, it's like 8 weeks." HCP 4. • **Expectation that working as an HCA would be unappealing to medical students** "Because quite rightly so you make your choice in life and you take a path and if you want to go and study to be a doctor it's not going to be everybody's choice to then be made to go and work as a Healthcare Assistant and I can fully appreciate why that would be." HCP 5. "But in reality I'm not sure that it would be something that appeals to a lot of medical students and should we take away that element of choice for them." HCP 5. "What you're asking them to do is a really hard job, it's not an easy job at all. So I can see there being issues in making compulsory." HCP 6. "My only reason I think it should be compulsory is that I think people that don't want to do it are probably the ones that should, because I think there's, I don't know whether there's some snobbery." HCP 6. "And also I can see that if you've got HCAs on a ward who don't want to be there and they're being forced to be there, then I can see that being a problem for a ward to manage." HCP 6. "I would say in an ideal world, yeah, I would say in an ideal world I can see how definitely the benefits of them doing it. I'd be disappointed I think if people didn't want to do it because that makes me wonder why." HCP 2.

	"…whether that's at interview that they're told about this programme that you're also going to be trained as HCAs and we expect you to do "X" number of shifts per year or whatever I don't know how that might affect your application process or number of applicants." HCP 3. • **Removing choice** "Because I think it just 'oh I've got to do it and oh and I don't want to do it'. Whereas if you say it's an integral part of the curriculum and as an added bonus I think people are much more willing to buy in." HCP 1. "I don't think it should be compulsory for everybody I think there should be choice... they choose to become medical students…" HCP 3. "I think in an ideal world that would be extremely beneficial. But in reality I'm not sure that it would be something that appeals to a lot of medical students and should we take away that element of choice for them?" HCP 5. "But if you force someone into doing something, I don't know whether that's always the best way." HCP 7.

The teachers held perceptions of doctors and nurses in modern healthcare delivery, which had predisposed them to assume that medical students might not come forward to learn and work as HCAs. These presented as underlying frustrations about an outdated hierarchy where medicine is perceived as more worthy than nursing. They felt that the hierarchy between medicine and nursing no longer reflected the changing skillsets of the members of modern patient-centred teams. HCP4 shared, *"*[doctors often fail to ask for help] I don't know, maybe it's that hierarchical egotistical thing," along with:

> There's a very good hierarchy in the NHS… job roles have evolved over the years but maybe attitudes haven't … there's a generation of people out there that still hold medical staff in this, not God like, but the older generation certainly do revere doctors … but we're all human. (HCP 5)

These frustrations extended to the lack of appreciation and knowledge doctors may have about the roles of other health care professionals, especially HCAs. The doctors' perspective of the HCA role was perceived as being work for low status individuals in the main, which was largely taken for granted. In addition, doctors were perceived to prioritise the scientific aspect of medicine at the expense of the 'softer' skills such as the 'bedside manner'. This was highlighted in comments by HCP2: "…you go and look at a patient in a bed knowing that you've [a doctor] got to actually cover them back over… not just lift the covers and then walk back out again." and by HCP5:

> It's things like compassion, just sitting down with somebody and talking to them, hand holding… I don't want to tar everybody with the same brush, but there are a lot of young medical students that do struggle with that kind of interaction. (HCP 5)

The nurse-led teaching faculty spoke of having had limited exposure to medical students, especially those who were early into their training, and so felt a lack of familiarity with these students. This, they felt, led to a silo mentality because there was little mixing between nursing and medical students in training, which was indicated by HCP2: "Them and us… you don't tend to see many of the younger medical students… It's difficult because I've not had a great deal of exposure to medical students to be fair."

The faculty felt the CC training programme had brought them a new affinity with the medical students. They were impressed by the way that the 'committed' and 'bright' medical students approached the programme. They believed that the importance of what they were teaching was being taken on board and not dismissed due to its intended use for work as an HCA. Several faculties commented on how the students didn't appear to fall into the stereotype of thinking the role was beneath them, including, "There's not many feel that it's beneath them or anything like that…they've been really quite positive," (HCP 2) and "Very, very committed, very strong work ethic from all of them… every one of them that turned up at 9 o-clock the morning after the [social event], that was impressive." (HCP1).

The faculty spoke about the students' positive approach and attitudes to learning. As they had spent the most time with the students, the two senior nurses spoke of seeing the students as individuals. They heard and considered the problems that the students were facing outside of the classroom: settling into a new city, being away from family, and building new relationships. They therefore perceived them differently to how they had expected. This was indicated in feedback: "I think they're probably younger than what I expected and probably a bit more down to earth. They were just normal young people." (HCP 2), and, "So they were tired. They were away from home for the first time and some of them were commuting." (HCP1).

The faculty discussed the numerous benefits for this initiative. An example of this for the local NHS Trust could be the availability of a larger bank workforce that could be called upon in times of demand. Ultimately, and importantly, they all spoke about benefits for patient care. HCP6 highlighted "…if we understand other people's roles then it makes it much more easy to work out what can and can't be done, how things should be done, how you communicate with different people." HCP3 also shared their thoughts:

> 'I know they [the trust] struggle to recruit enough healthcare assistants on the wards, so presumably by having medical students working on the bank that might ease pressure as well as providing them with the sort of opportunity and insight.' (HCP 3)

The faculty emphasised the enormous benefits for the students; gaining experience and having contact with the 'real NHS', and with the bonus of realising the importance of caring and becoming more patient-focussed.

> …it feels like a little bit relentless… like winter all year round. I think some people won't necessarily see that… they [medical students] will see the true NHS really, other than what the idealistic picture of how lovely it is to care for patients. (HCP 2)

> …the basic care skills affect everybody in the NHS really. If you see a patient that needs help should you be shouting for someone at the bottom of the ladder if you like, or do you just get on and help that person? (HCP 5)

They perceived that the benefits of teamwork would provide the students with a greater understanding of practitioners' roles and responsibilities, and an understanding of how teams work in healthcare. This included the value of speaking to other practitioners to gain deeper insights and understanding of their patients and the value of HCAs to the team. One suggested "…they will feel more confident to share concerns with other professionals and other colleagues if they've built up that basic rapport with the nursing staff." (HCP 4), whilst another included "There's an enormous amount of value in them going through the process… and understand what they (HCAs) have to go through and the level of input that's required to get them ready" (HCP 1).

Several presented anxieties at being asked to teach medical students. One member of faculty mentioned that these were '*young and well-educated*' bright young people, emphasising that most HCAs are not, hinting at the possibility of some trepidation of teaching medical students. Limited exposure to junior medical students left them concerned as they grappled with their own preconceptions of doctors and more senior medical students, and this meant that some nursing faculty were unsure about which level to present information at. One reflected that her teaching was too basic and another thought they overestimated what the students knew: "I suppose I did have in the back of my mind, is this information that a medical student really wants to be getting… eating meals, having snacks… it's very basic stuff" (HCP 7). Another spoke about changing her slides as it was important to use medical terminology in order to make the training more appropriate for the scientific background knowledge of the medical students: "…I never put the word 'bugs' in brackets… I'm sure they're very young and well-educated and probably know more about IT skills than I've got…they could probably teach me a few things" (HCP 3).

Some of the faculty held tensions and questioned whether it was right for medical students to complete this training. One faculty member questioned whether it was fair for medical students to be gaining

preferential treatment and a bespoke path towards HCA and bank working, without having done a single placement when compared to nursing students, for which these competencies are integral to their early curriculum. There were concerns that the medical students might unfairly be able to register on the bank before nurses who started training at the same time; "That's a little bit unfair that the medics can join the bank before they've even done anything… a student nurse will have to have done a full placement." (HCP4). Another faculty member raised apprehensions about medical student skill maintenance and progression, and how often they should be able to work in this role. The 'fast-tracked' approach was also thought to undermine the hard work that HCAs must complete during their training; "…do they have to do a certain amount of bank work over the year… because obviously to maintain your pilot's licence you actually have to do so many hours a year." (HCP3).

The faculty were concerned that making training as an HCA mandatory for all medical students would naturally instil a feeling of apathy or dislike for the programme, as shared by HCP6: 'I can see that if you've got HCAs on a ward who don't want to be there and they're being forced to be there, then I can see that being a problem for a ward to manage." There was also an expectation that some medical students would find training or working as an HCA unappealing and this would affect the quality of their commitment to the work or even their desire to study medicine, "…you make your choice in life… if you want to go and study to be a doctor it's not going to be everybody's choice to then be made to go and work as a Healthcare Assistant." (HCP5).

On the other hand, one faculty member commented that students who did not want to work as HCAs were perhaps the most important targets for intervention: 'My only reason I think it should be compulsory is that I think people that don't want to do it are probably the ones that should, because I think there's, I don't know whether there's some snobbery' (HCP 6).

While recognising that this cohort was self-selecting and as such possibly more motivated to work as HCAs, there were tensions and different perspectives between the faculty members on whether this training was right for all medical students. There were concerns about whether medical students who were training to be doctors would truly value training to be at the other end of the so-called hierarchy. For many this would raise the profile of what HCAs contribute to patient care but for others it was only a means to an end to give future doctors an enhanced skill set that might be achieved in other ways. However, there was almost complete agreement of the worth of raising the profile of HCA work in the medical cohort and for the need for doctors to gain hands-on caring, patient-contact roles and skillsets.

Discussion

A partnership between a medical school and a local NHS Trust established a nurse-led faculty who designed learning opportunities for medical students to achieve the competence standards for work as a HCA. Two senior nurses formed a team of teachers for the pilot. The local Trust accepted the medical school aims as a winning formula for their recruitment challenges and to enhance a future workforce with the relevant NHS values. The insights from the semi-structured interviews revealed deeply felt tensions which, on the one hand, resonate back to hierarchical issues between nursing and medicine, yet, on the other, reveal new possibilities from this alliance; most importantly respect for one another. The faculty were divided on whether this should be a compulsory programme.

Interviews raised multiple insights from nurses and allied health practitioners about their experiences of working alongside doctors, revealing worrying misunderstandings and tensions. While this is well understood and has been previously described in the literature (Nugus et al., 2010; Reeves et al., 2011; Matziou et al., 2014), it was disappointing to hear. These teachers reflected on the hierarchical low status position of HCAs; a rewarding patient facing role, essential in healthcare delivery and yet low paid. From a sceptical start and a place of unfamiliarity with little prior exposure to medical students, these teachers gained an affinity to the medical students. These new insights changed their views and led to respect and empathy, revealing the power of contact between professions to eradicate misunderstandings, and the development of mutual appreciation. This is seen as one of the theoretical reasons for developing 'practice-based IPE'; via the contact hypothesis which claims intergroup contact can reduce tensions (Allport, 1954). This, yet to be tested, future contact when working as HCAs, was also perceived as a route to important perceptual changes between doctors and nurses. There was delight that these students

were valuing their learning for this 'raw' clinical exposure and showed respect for the role and the nurse-led faculty. Such training might offer a new solution to some of the barriers and challenges for traditional IPE, by providing in-depth insights not just for nurses but for the whole clinical team through hands on patient caring work. The teachers craved closer working relationships with medicine and acknowledged that sadly, most nurses had little contact with medical students and their challenges as they start their training.

The competences for the CC were perceived to be important for doctors who occupy a front-line caring role. The faculty perceived this additional learning would not only enhance medical students' team working skills but would notably lead to more patient-centred compassionate care. There was an overlap with the majority of the CC competencies and the medical curriculum, just as there is a growing realisation of common learning across all healthcare curricula (Steven et al., 2017; Browne et al., 2021). Hands-on caring is often missing, especially in medicine, and despite frequent acknowledgement of the science-based intelligence of these students, the faculty were undeterred from teaching the core caring skills. They had aspirations that this training would give these future doctors new insights to enable them to step into a caring roles when required, to perhaps give a patient a drink or help when a patient falls.

Despite the positives benefits, some teachers had concerns about whether this programme was for all medical students and what a model of integration might mean. Paradoxically some of the nurse-led faculty implied concerns for medicine having preferential treatment and being fast tracked through this process. One faculty member felt it was unacceptable that this might give a step up to medical students over nursing students, many of whom seek to train and work as HCAs in their personal time. Indeed, there are warnings in the nursing literature that the advantages for earning and learning can be detrimental to academic achievement (Hasson et al., 2013). Nevertheless, the majority thought this training was a beneficial component and would support the move to a whole cohort, integrated approach, recognising the overlap of competence and the need for the additional caring competencies.

As a result of the positive enthusiasm of our students and of the local NHS trust for this work, we have established a partnership with the nurse faculty to integrate the care certificate competencies into the first year medical curriculum at Leicester Medical School. We will follow up this work by assimilating all stakeholder perspectives including student, faculty and employer outcomes. We can perceive a universal early shared curriculum for all healthcare students, which provides core elements of professional practice whilst simultaneously providing skills in hands-on caring.

As a one-centre study, involving interviews with only a small group of training faculty, this work has strengths and limitations. The medical students were volunteers and so may have been more willing to assimilate this additional learning within their heavy learning load. As a self-selecting group they could have provided the teaching faculty with a different experience to a cohort where the CC is a mandatory component of the course. The evaluation data concerning student learning, however, aligns with that of other studies (Walker et al. 2017; Davison & Lindqvist, 2019; Davison et al., 2022). The experiences of the nurse-led faculty were based on one iteration of the programme, so we cannot rule out a Hawthorne effect. Equally, the strength of an in-depth qualitative approach ensures a deeper appreciation of the lived experiences of these faculty members.

Summary

Whilst prior research has evaluated the responses of medical students training to be HCAs, this study focussed on the nursing perspectives of leading this new training programme in a medical curriculum. The results suggest that healthcare would benefit in various ways from having medical students who are able to improve staffing levels in an acute care trust in times of staffing stretch, whilst also creating future doctors who are able to collaborate more seamlessly. This work has highlighted that medical students acquiring the CC and working as HCAs is a means to advance their interprofessional understandings of care delivery and as a result, form better human relationships with their nursing colleagues and team members which are necessary for better team-based healthcare outcomes (Mitchell et al., 2011). This might form a less contested form of IPE which does not require the bringing together of a range of different students, but places one group within the working clinical contexts of others, requiring further research.

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Ethical approval

The study received ethical approval from the University of Leicester (27990-kgp2-ls: medicine).

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