**Moral distress in healthcare assistants: an overview with recommendations**

**Abstract**

**Background:** Moral distress can be broadly described as the psychological distress that can develop in response to a morally challenging event. In the context of healthcare, its effects are well documented in the nursing profession, but there is a paucity of research exploring its relevance to healthcare assistants.

**Objective:** This article aims to examine the existing research on moral distress in healthcare assistants, identify the important factors that are likely to contribute to moral distress, and propose preventative measures.

**Research Design:** This is a survey of the existing literature on moral distress in healthcare assistants. It uses insights from moral distress in nursing to argue that healthcare assistants are also likely to experience moral distress in certain contexts.

**Participants and Research Context:** No research participants were part of this analysis. **Ethical Considerations:** This article offers a conceptual analysis and recommendations only.

**Findings:** The analysis identifies certain factors that may be particularly applicable to healthcare assistants such as powerlessness and a lack of ethical knowledge. We demonstrate that these factors contribute to moral distress.

**Discussion:** Recommendations include various preventative measures such as regular reflective debriefing sessions involving healthcare assistants, nurses and other clinicians, joint workplace ethical training, and modifications to the Care Certificate. Implementation of these measures should be monitored carefully and the results published to augment our existing knowledge of moral distress in healthcare assistants.

**Conclusion:** This analysis establishes the need for more research and discussion on this topic. Future research should focus on evaluating the effectiveness of the proposed recommendations.

**Introduction**

Healthcare assistants (HCAs) describe a diverse group of the modern frontline healthcare workforce that provide assistance and support for health service users, healthcare professionals and their teams.[[1]](#endnote-1) They are instrumental in the provision of direct patient care, making up about a third of the UK healthcare workforce, and they can be found at nearly every level of care provision, providing routine and advanced tasks.[[2]](#endnote-2) There are many different roles performed by the non-regulated health and social care workforce. Here we will use the term HCA to describe non-regulated staff who provide patient care in the health and social care setting, although we appreciate that there are a number of different titles used to describe these types of support roles in various contexts. The HCA role has become increasingly malleable and in some cases are now performing tasks and fulfilling roles that have previously been within the domain of registered nurses or allied health professionals.[[3]](#endnote-3) In one large study, observational data indicated that HCAs in some contexts were spending twice as much time providing direct patient care than registered nurses.3

Andrew Jameton first coined the term moral distress over 30 years ago to describe the ‘painful feelings and/or psychological disequilibrium’ arising ‘when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action.’.[[4]](#endnote-4) Moral distress has been extensively explored in the nursing literature, and continues to be a topic of serious interest and concern, but its definition is still debated, and various accounts of moral distress have been developed. In McCarthy’s[[5]](#endnote-5) view, moral distress broadly describes the psychological, emotional and physiological suffering that arises from morally challenging situations, or what could be termed moral events.[[6]](#endnote-6) Fourie[[7]](#endnote-7) has argued that Jameton’s definition may be too narrow because it rules out cases of moral distress that encompass a broader range of causes, and assumes moral certainty. Here, we align with these broader definitions of moral distress.

Moral distress has been associated with an array of negative psychological and physical manifestations for individuals, as well as knock-on effects for patients, colleagues, health care providers and their profession. These include: a decrease in moral sensitivity,[[8]](#endnote-8) a decrease in the quality of patient care, headaches, guilt, anger, job turnover intent, and leaving the profession.[[9]](#endnote-9) [[10]](#endnote-10) [[11]](#endnote-11) In what follows we contend that HCAs, like nurses, can also experience moral distress and that of all the groups of frontline healthcare workers, HCAs are the least equipped to manage or identify it.

Nurses and other healthcare professionals have an interest in reducing moral distress among HCAs because it can contribute to and intensify their existing moral distress. Hart[[12]](#endnote-12) found that a negative ethical climate in the workplace could contribute to nurses considering leaving their current position. In some sectors of healthcare, attrition rates for HCAs are between 19-30%, 2 which is acutely high. We are not suggesting that these rates are solely reducible to moral distress but it may be complicit with other factors such as low-pay, high workload pressure, and increasing workplace demands. This is important to highlight because the highest intensity and frequency of moral distress has been associated with low and unsafe staffing levels.10

**Moral distress in HCAs**

We have noted that HCAs are increasingly performing tasks that were once the domain of nurses or allied health professionals, and consequently increasing their direct patient contact time. The length of time spent with patients in certain contexts has been strongly correlated with an increase in the severity and frequency of moral distress,[[13]](#endnote-13) and in fact providing patient care may be the predominant cause of moral distress[[14]](#endnote-14). This suggests that HCAs are being utilised in a way that may increase their risk of experiencing moral distress. Additionally, the known contributing factors that can cause or compound existing moral distress are also present in varying degrees for HCAs, such as differences in personal values, cultural background, role perception, long-standing relationships with patients, unsafe staffing levels and lack of resources.10 We will now examine some of the literature that describes moral distress in HCAs or details experiences that could be best understood as moral distress.

Caring for a dying patient and subsequently coping after their death can be morally challenging as well as emotionally and physically exhausting. It raises a number of questions surrounding respecting an individual's autonomy, preferences, and personal values, at a time when they may lack the capacity to communicate them.[[15]](#endnote-15) Fryer et al.[[16]](#endnote-16) describe the experiences of HCAs caring for dying patients in several different aged residential care settings. Although the topic of moral distress is not directly engaged with, there is evidence of psychological distress that is causally related to the deaths of their patients, which, in certain contexts, can qualify as a moral event. The focus group discussion describes experiences of powerlessness, an absence of organisational emotional support, the presence of a hierarchy that was perceived as obstructive to raising concerns about patients deteriorating health, and a repeated exposure to the death of patients that they had been treating “like they are part of the family”.16 Feelings of powerlessness, long-standing and close relationships with patients and their families, and subordination are common themes in the moral distress literature all of which can cause or contribute to moral distress. In a study by De Veer et al.14 high levels of moral distress were identified among staff working in nursing homes, providing home care or acute care hospitals. Furthermore, it was the Dutch equivalent of HCAs providing nursing care that reported the highest levels of moral distress.14

This has been corroborated in a study by Spenceley et al.[[17]](#endnote-17) exploring moral distress in nursing staff providing care in a Canadian residential home for patients with dementia. The majority of the participants in the study (38.9%) were HCAs, with many experiencing moral distress triggered by many of the factors that have been identified as causing and contributing to moral distress.17 These included powerlessness and organisational constraints from doing what they considered right, time constraints that they believed compromised patient care, poor staffing levels, failures in leadership support, and witnessing colleagues providing inadequate care.17 Feeling powerless to do the right thing and being excluded from decisions that affected patient care were also identified in Young et al.’s[[18]](#endnote-18) study of nursing staff providing end of life care. Their study found that HCAs experienced moral distress as a response to their powerlessness and inability to influence decisions they believed caused their patients greater suffering.18

In some contexts powerlessness could be experienced to a greater degree than some nurses because existing power structures mean HCAs are more likely to be in that position. Nurses are less likely than HCAs to be excluded from the medical decisions that affect the patients they are caring for. It could be argued that because HCAs have less responsibility than nurses that the degree of moral distress they experience is qualitatively different. However, the degree of responsibility will be wholly dependent upon the setting, experience and training of the individual HCA. The question of whether moral distress in HCAs is as extensive and experienced to the degree that nurses experience it is of secondary importance, and need not distract us from acknowledging that it is a legitimate problem.

Matthews and Williamson’s[[19]](#endnote-19) study explored the experiences of HCAs working in an inpatient adolescent mental healthcare facility. They found that HCAs ‘experienced tension between their personal moral code which orientate them towards empathy and support and the emotional detachment and control expected by the organization, contributing to burnout and moral distress.’.19 There are a number of clear moral themes in their analysis that demonstrate that the psychological distress experienced by the HCAs was triggered by a moral event, and hence qualifies as moral distress. For example, this is evident in cases where HCAs felt an incongruence between their personal moral values and having to let a patient self-harm at the request of a senior member of staff.

In each of the studies above there are explicit examples of some of the clinical situations and internal and external constraints that have been identified as some of the root causes of moral distress.[[20]](#endnote-20) Although more research needs to be undertaken, it is clear that moral distress is potentially a significant issue for HCAs as well as nurses. It is worth highlighting that our claim is not that all HCAs will inevitably experience morally distress - this will depend upon their role and type of patient care they are providing.

**Moral distress factors and HCAs**

We have demonstrated that evidence exists indicating that HCAs, like nurses, experience moral distress in certain clinical contexts, which is not unexpected given their shared responsibility for patient care. Why should HCAs be subjects of particular concern regarding moral distress? There are a number of factors differentiating HCAs from nurses that may entail they are more susceptible to and less able to manage the effects of moral distress. We discuss two of the most important factors below.

**Powerlessness**

We have noted that perceived powerlessness has been attributed as one cause of moral distress.20 HCAs typically occupy the lowest frontline positions in healthcare hierarchies, below that of nurses. They carry out decisions made by more senior medical staff, and inevitably at times these decisions will conflict with their intuitions about what action should be taken. HCAs’ lower position means that their perceived and actual ability to affect these decisions on patient care is often minimal. In the studies previously described, it is clear that the existing power structures mean that they are often excluded from discussions and decisions about patient care, which they feel that they could contribute to. Morley[[21]](#endnote-21) has rightly called for *nurses* to reject the narrative of powerlessness and to embrace the power they actually have. However, the narrative of powerlessness in the case of HCAs remains an accurate description for many of their experiences of moral distress.

**Lack of ethical knowledge**

Receiving training or education in ethics is an important component in learning to navigate the moral stressors that can develop into moral distress.[[22]](#endnote-22) Benefits include increasing the awareness of ethical violations, [[23]](#endnote-23) increasing moral sensitivity,[[24]](#endnote-24) [[25]](#endnote-25) and improving moral competence.[[26]](#endnote-26) Increased moral sensitivity has been shown to correlate with a reduction in the frequency of moral distress 24 and increased moral competence can help to manage the effects of moral distress.[[27]](#endnote-27) Lacking moral confidence, not feeling qualified and not knowing how to respond to a morally challenging event can make healthcare workers more susceptible to moral distress.[[28]](#endnote-28) Grady et al.28 describe how ethics education has been shown to help nurses and social workers increase their confidence and those without ethics education reported the least confidence in their moral judgements. Lang[[29]](#endnote-29) notes that Grady et al.’s findings imply that ethics education is an important tool in combating moral distress in nurses.

Amongst those working in frontline healthcare, HCAs are the least likely to receive any ethics education (although some HCAs will have received some form of ethics education as part of their education towards a foundation degree or a degree apprenticeship route into nursing whilst working as HCAs). In the United Kingdom (UK), nursing education includes a mandatory ethical component in their curriculum, which commonly includes lectures on ethical theory, codes of conduct and ethical decision-making frameworks;[[30]](#endnote-30) whereas there are no mandatory educational requirements for HCAs. However as we have noted, HCAs now commonly perform advanced clinical tasks that was once undertaken by nurses,2 and so are increasingly likely to encounter situations that may cause or compound existing moral distress. Consequently, any deficit in their ethics education seems likely to leave HCAs less able to cope with these situations than those colleagues who have received some form of ethics education.

Lack of ethical knowledge has other disadvantages, such as a lack of a shared moral vocabulary with colleagues in which to communicate moral concerns and to frame them in ethical terms.[[31]](#endnote-31) This means that HCAs may be less likely to engage in moral discussion. This ultimately could lead to another type of powerlessness - where HCAs are less likely to participate in the inter-professional moral dialogue, whilst experiencing some of the same morally distressing situations as their colleagues.

This ethical knowledge deficit also makes it less likely HCAs will benefit from existing ethical resources such as frameworks for ethical decision-making, which aid nurses in establishing that their moral judgments and actions are informed and well-reasoned. Deriving the intended benefits from these frameworks is predicated on a base of ethical knowledge (including a shared moral vocabulary) that is less likely to be present in HCAs. This is not to say that HCAs are unable to make good ethical decisions or engage in moral dialogue - only that they are currently disadvantaged, and therefore less likely to experience the benefits of doing so with respect to moral distress. Of course, it is possible that some HCAs may already have access to additional resources and support, and may be part of a healthy moral community. However, it seems likely that this may be the exception rather than the rule given the prevalence of moral distress across a range of professional boundaries such as occupational therapy[[32]](#endnote-32) and medicine9. It is likely that increased organisation support would help to prevent a number of the factors that can compound moral distress – too often it is not adequate or absent.

These factors imply that HCAs are likely to be particularly susceptible to experiencing moral distress in certain contexts. They do, however, point to some concrete measures that we suggest could mitigate the onset of moral distress as much as possible. We will now explore these measures.

**Reducing moral distress in HCAs**

We have noted that perceived powerlessness can cause moral distress, and so measures that reduce both the perception and the reality of powerlessness are likely to decrease moral distress in HCAs. Similarly, improving the ethical knowledge of HCAs should also be helpful in reducing moral distress for the reasons discussed.

One recommendation is to encourage better collaboration between HCAs, nurses and other healthcare professionals. Karanikola et al.[[33]](#endnote-33) describe how poor collaboration between nurses and physicians can contribute to moral distress, and suggest more participation of nurses in clinical decision-making, something that could be applied to HCAs. The need for improved ethical knowledge also suggests the possibility of joint ethics education for staff working in high risk areas for moral distress. Storch and Kenny[[34]](#endnote-34) have previously identified this as one way of addressing existing power structures in healthcare and to rediscover the provision of healthcare as shared moral work. However, rather than limiting joint ethics education to physicians and nurses, we suggest expanding this to incorporate the wider multidisciplinary team, including HCAs. There is evidence that steep hierarchies in healthcare can negatively affect patient care by hindering communication and teamwork.[[35]](#endnote-35) By encouraging joint ethics education that involves the wider multidisciplinary team the existing hierarchies can be flattened and their negative effects can be diminished. This would help to address some of the types of powerlessness many HCAs experience as the cause of their moral distress, and increase the type of ethical knowledge that can improve moral competence. This intervention helps to respect the existing relationship between HCAs, nurses and other healthcare professionals, encourages teamwork and collaboration and may increase the likelihood of HCAs of becoming more involved in decisions about patient care where they think they can contribute.

Browning and Cruz[[36]](#endnote-36) also describe how using regular ‘reflective debriefing’ sessions with intensive care nurses helped improve interprofessional collaboration and reduce moral distress. An obvious extension, where relevant would be to include HCAs, as suggested with joint ethics education, being inclusive of the wider multidisciplinary team. This would also contribute to building the type of healthy moral community that has been shown to mitigate moral distress.[[37]](#endnote-37)

There is also a good case for enhancing the ethical content provided in formal training of HCAs, which primarily consists of the Care Certificate, designed for those new to care. Although it is not mandatory, all health and social care providers registered with the Care Quality Commission (CQC) are expected to offer this to their non-regulated staff, and must demonstrate that their staff are competent in the standards.[[38]](#endnote-38) [[39]](#endnote-39) The current standards do engage with some ethical themes such as safeguarding, duty of care and confidentiality, but do not teach ethical theory or discuss moral distress. We recommend that the Care Certificate standards be broadened to include an appropriate introduction to ethical theory, which will equip HCAs with the moral vocabulary to express their moral concerns, to participate more effectively in interprofessional moral dialogue and utilise existing resources, such as ethical decision-making frameworks. Ideally, such training would also help HCAs become more aware of and comfortable with a degree of moral subjectivity regarding what is in their patients’ best interests.[[40]](#endnote-40)

Finally, specific training programs aimed at understanding and reducing moral distress such as the ‘4A Model’ have been shown to be effective with nurses.[[41]](#endnote-41) [[42]](#endnote-42) It seems likely these programs (or variants of) should also be effective with HCAs, and they should be trialled. As with ethics training, running such programs across multidisciplinary teams should help communication and collaboration in general as well as helping individuals deal with moral distress.

**Conclusion**

In this article we have sought to raise several important points. Firstly, HCAs in certain contexts are highly likely to experience moral distress, and this contention is supported by the limited literature available. Secondly, HCAs may be less equipped to manage moral distress than nurses and other healthcare professionals, even though they are increasingly being expected to fulfil tasks and roles that were historically within the domain of the nursing or allied health professions. This is because of certain factors that, while applicable to other healthcare workers, are of particular importance to HCAs: powerlessness and a lack of ethics education. Both of these factors have been shown to contribute to moral distress.

We propose a number of measures to begin dealing with these issues. Further research should be conducted that explicitly explores the moral experiences of HCAs in a variety of health and social care settings. Proactive steps should be taken to improve the ethical knowledge of HCAs, both through the current Care Certificate and regular staff training. This should also include training specifically for dealing with moral distress. It might be that programs aimed specifically at moral distress could be combined with broader ethical training.

Healthcare organisations should implement support structures that help protect and promote the wellbeing of their staff, such as regular reflective debriefing sessions that bring together care staff from across the professional spectrum, including HCAs, nurses and other clinicians. Together with joint staff training, these should serve to promote collaboration between these groups, helping them to manage and minimise moral distress. Further research should be conducted to evaluate the effectiveness of these measures.

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