

# Stigma experienced by hospital nursing assistants

## ✉ A qualitative study

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### Research Article

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# Abstract

## Background

Although indispensable to bedside care, hospital nursing assistants are often subjected to stigma—an experience that corrodes their professional identity, strains interpersonal relationships, and compromises psychological well-being. Nevertheless, empirical research has largely overlooked the daily manifestations of this stigma.

## Objectives

This study aims to investigate how hospital nursing assistants perceive and experience stigma in their daily work.

## Methods

A qualitative study design was employed. Semistructured interviews were conducted with 18 nursing assistants recruited from five hospitals. Data were analyzed inductively using Braun and Clarke's thematic analysis approach to identify patterns of stigma experiences.

## Results

Five interrelated themes were identified: bodily stigma, moral stigma, occupational stigma, cultural stigma, and coping strategies. Participants reported perceptions of uncleanness or contagion from intimate care tasks; moral discrediting via stereotypes of greed, laziness, callousness, theft, and abuse; professional devaluation through assumptions of low competence, servitude, and inferior status; and cultural marginalization due to perceived limited education and social standing. Coping strategies included passive endurance, intrapsychic regulation, mutual support through peer disclosure, and communication through consistent professional practice.

## Discussion

Stigma persists as a deeply embedded challenge for hospital nursing assistants, yet coping mechanisms remain predominantly individual and peer-based, with limited structural recourse. Multilevel interventions—encompassing anti-stigma campaigns, public awareness efforts, and organizational reinforcement—are imperative for strengthening professional recognition, safeguarding staff well-being, and ensuring the long-term viability of high-quality hospital care.

## Introduction

Stigma persists as a pervasive challenge in healthcare environments, influencing both healthcare workers' well-being and the quality of patient care [-]. It is conceptualized as a social process whereby individuals are labelled, stereotyped, and assigned to devalued social categories, leading to status loss and discrimination. [ ] Such processes are especially pronounced in healthcare because care work involves sustained interpersonal, bodily, and emotional engagement. Healthcare workers engaged in direct patient contact may be perceived as infection risks and consequently experience contamination-related stigma despite appropriate protective practices. [-] Likewise, prolonged exposure to heavy workloads, patient suffering, and death may generate psychological strain, which may itself be stigmatized as emotional instability, vulnerability, or professional incompetence. [-] These manifestations reflect broader processes of social evaluation in which healthcare occupations are interpreted not only functionally but also through moral and symbolic meanings.

Although stigma in healthcare settings has been extensively investigated, existing research has focused primarily on physicians and registered nurses, typically examining stigma in relation to clinical errors, burnout, and healthcare corruption. [6, , , ] In contrast, hospital nursing assistants remain comparatively overlooked. As indispensable members of multidisciplinary care teams, they provide continuous hands-on patient care and support essential hospital operations. [ , ] Despite this essential role, their stigmatization experiences have received limited empirical attention. Like physicians and nurses, nursing assistants are routinely exposed to demanding care environments and may also experience infection- or emotional labor-related stigma. At the same time, their subordinate position within healthcare hierarchies renders them susceptible to occupational devaluation and symbolic marginalization, and may also subject them to distinct forms of stigma rooted in hierarchical inequality and perceived incompetence. [ , ] Although several studies have examined stigma among hospital nursing assistants, most have focused on its consequences, including reduced job satisfaction, psychological distress, and maladaptive workplace behaviors [ , , ]. Little is known about how nursing assistants themselves perceive and experience stigma in their everyday work, especially stigma associated with their subordinate position relative to physicians and registered nurses.

Collectively, these gaps underscore the need for a more nuanced understanding of stigma among nursing assistants that extends beyond outcome-oriented perspectives to capture its lived, and subjective dimensions. Such knowledge is essential for advancing theoretical understanding of occupational stigma in healthcare and informing interventions to improve working conditions and promote the well-being of this indispensable yet frequently overlooked workforce. Accordingly, this qualitative study explores how hospital nursing assistants perceive and experience stigma in their daily work. Through semi-structured interviews and thematic analysis, it provides an in-depth account of the multidimensional nature of stigma experienced by hospital nursing assistants.

## **Research design and methods**

### **Study design**

This study employed thematic analysis to explore the stigma experienced by nursing assistants in hospital settings. [] The results are presented in accordance with the Consolidated Criteria for Reporting Qualitative Research [].

## Participant recruitment

Participants were recruited from five hospitals in Changji City, China, using purposive and snowball sampling strategies. [] The inclusion criteria were as follows: (1) current employment as a hospital nursing assistant, (2) a minimum of six months of work experience in the role, (3) direct interaction with patients, and (4) fluency in Mandarin or the Changji dialect, commonly used by nursing assistants in the region. During recruitment, potential participants were informed of the study's purpose and invited to participate if they met the inclusion criteria. Recruitment proceeded concurrently with data collection and continued until data saturation was reached. [] In total, 18 participants were enrolled between October and December 2025.

## Data collection

Face-to-face, semi-structured interviews were conducted following a comprehensive explanation of the study's purpose. A study-specific interview guide, developed based on the research team's expertise and contextual knowledge, was used. [] The guide included open-ended questions aligned with the study objective, encouraging participants to describe the various forms of stigma they had experienced in their everyday work. [] The English version of the interview guide is provided in Table 1. Two trained researchers conducted all interviews in Chinese, each lasting 45–60 minutes. Interviews were audio-recorded and transcribed verbatim by two researchers, with a third researcher independently cross-checking transcripts for accuracy, completeness, and interpretive fidelity.

Table 1  
Interview guide

| Section                                                       | Content                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|---------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Introduction</b>                                           | This study aims to explore your lived experiences as a hospital nursing assistant, with particular attention to how you perceive and experience stigma in daily work. We are interested in your reflections on your working environment, interactions with patients and colleagues, as well as experiences of respect, misunderstanding, or unfair judgment. Please speak freely based on your personal experiences.                    |
| <b>Demographics of participants</b>                           | <ul style="list-style-type: none"> <li>* Gender</li> <li>* Age</li> <li>* Education</li> <li>* Self-reported health status</li> <li>* Type of hospital</li> <li>* Employment status</li> <li>* Professional level</li> <li>* Years of working experience as a nursing assistant</li> </ul>                                                                                                                                              |
| <b>Work context and occupational role perception</b>          | <ul style="list-style-type: none"> <li>* Please describe your typical daily responsibilities in the hospital?</li> <li>* How do you define the role of nursing assistants within your hospital team?</li> <li>* How do you perceive your position within the institutional hierarchy relative to nurses and physicians?</li> </ul>                                                                                                      |
| <b>Interpersonal experiences in clinical work</b>             | <ul style="list-style-type: none"> <li>* How would you describe your routine interactions with patients and their families?</li> <li>* How would you describe your interactions with nurses and physicians in routine work?</li> <li>* Can you describe situations in which you felt respected, valued, or professionally acknowledged?</li> </ul>                                                                                      |
| <b>Stigma experiences and manifestations in daily work</b>    | <ul style="list-style-type: none"> <li>* How are nursing assistants generally perceived by others?</li> <li>* Have you ever experienced differential or inequitable treatment because of your occupational role?</li> <li>* What forms of stereotyping, labeling, or negative judgment do hospital nursing assistants commonly encounter?</li> <li>* How do you interpret the ways nursing assistants are treated by others?</li> </ul> |
| <b>Coping strategies and expectations for improvement and</b> | <ul style="list-style-type: none"> <li>* How do you typically cope with or respond to stigmatizing experiences?</li> </ul>                                                                                                                                                                                                                                                                                                              |

| Section                  | Content                                                                                         |
|--------------------------|-------------------------------------------------------------------------------------------------|
| occupational recognition | * What forms of support would help nursing assistants manage such experiences more effectively? |

# Data analysis

Thematic analysis was conducted following Braun and Clarke’s six-phase inductive framework. [18] Researchers first immersed themselves in the dataset through repeated readings of transcripts to gain a thorough and nuanced grasp of the content. Initial codes were then derived from data segments pertinent to the research question. Related codes were clustered into sub-themes and subsequently synthesized into overarching themes based on conceptual similarity. Preliminary themes and sub-themes underwent systematic review and refinement to ensure internal consistency, coherence, and faithful representation of the dataset. Overlapping or weakly supported themes were merged or discarded following team discussion. Each theme and sub-theme was then defined and labeled to capture its core meaning and analytical scope. Finally, the refined themes and sub-themes were integrated into a coherent interpretive narrative illustrating the various forms of stigma experienced by hospital nursing assistants. Representative quotations were incorporated to substantiate the analytic claims and were further contextualized through interpretive commentary.

# Trustworthiness

To strengthen trustworthiness, two researchers independently coded all interview transcripts. Efforts were made to verify that the generated codes adequately captured the breadth of the dataset []. Coding discrepancies were discussed until consensus was achieved []. To further uphold methodological rigor and minimize the risk of premature or partial interpretation, the researchers engaged in an iterative process of revisiting and re-evaluating the data throughout the analysis. This reflexive approach enabled continuous examination of emerging patterns and supported necessary refinements to codes, sub-themes and themes as warranted [].

# Results

Eighteen nursing assistants participated in this study, including 9 men and 9 women (Table 2). Participants represented a wide age range (20–65 years), with the largest proportion aged 51–60 years (38.89%). Educational attainment ranged from primary school to undergraduate level. Most participants worked in tertiary hospitals (66.67%) and were employed through outsourcing arrangements (88.89%). Professional ranks comprised elementary (n = 7), intermediate (n = 8), and senior (n = 3) levels. Nearly half had less than five years of work experience (44.44%), and overall self-rated health was favorable, with no participant reporting poor health. Thematic analysis generated five overarching themes and 15 subthemes.

Table 2  
Participant's characteristics

| Variables                          | n | %     | Variables                  | n  | %     |
|------------------------------------|---|-------|----------------------------|----|-------|
| <b>Gender</b>                      |   |       | <b>Type of hospital</b>    |    |       |
| Male                               | 9 | 50.00 | Tertiary                   | 12 | 66.67 |
| Female                             | 9 | 50.00 | Secondary                  | 5  | 27.78 |
| <b>Age range (years)</b>           |   |       | primary                    | 1  | 5.55  |
| 20–30                              | 3 | 16.67 | <b>Employment status</b>   |    |       |
| 31–40                              | 2 | 11.11 | Formal contract            | 0  | 0.00  |
| 41–50                              | 5 | 27.78 | Outsourced                 | 16 | 88.89 |
| 51–60                              | 7 | 38.89 | Temporary                  | 2  | 11.11 |
| 61–65                              | 2 | 11.11 |                            |    |       |
| <b>Education</b>                   |   |       | <b>Professional Level</b>  |    |       |
| Primary school                     | 6 | 33.33 | Elementary                 | 7  | 38.89 |
| Middle school                      | 4 | 22.22 | Intermediate               | 8  | 44.44 |
| High school                        | 5 | 27.78 | Senior                     | 3  | 16.67 |
| Undergraduate                      | 3 | 16.67 |                            |    |       |
| <b>Self-reported health Status</b> |   |       | <b>Years of experience</b> |    |       |
| Very good                          | 6 | 33.33 | within 5 years             | 8  | 44.44 |
| Good                               | 4 | 22.22 | 5–10 years                 | 6  | 33.33 |
| Basically good                     | 5 | 27.78 | 11–15 years                | 2  | 11.11 |
| Fair                               | 3 | 16.67 | 16–20 years                | 2  | 11.11 |
| Poor                               | 0 | 0.00  |                            |    |       |

## Bodily stigma

## Uncleanliness stigma

Hospital nursing assistants described how the intimate, physically demanding nature of caregiving was frequently equated with personal uncleanliness, generating pervasive bodily stigma. Despite adhering to rigorous hygiene practices, participants reported being labeled “dirty” because their work involved routine contact with bodily waste and secretions.

Participant 4 recalled the humiliation of such assumptions: *"Patients often ask questions that are deeply offensive. They ask, 'How often do you bathe?' 'How often do you trim your nails?' 'How many times do you wash your hands each day?' Some even rudely tell us that we should bathe more frequently and pay greater attention to personal hygiene. They simply assume we're dirty! If that isn't discrimination, what is? In fact, our personal hygiene practices are far more rigorous than those of most people."* Such encounters left participants feeling that the perceived contamination inherent in caregiving was unjustly projected onto their bodies and identities.

Although participants acknowledged bodily-fluid exposure as an inescapable occupational demand, they resented its interpretation as evidence of personal impurity. Participant 17 noted: *"Patients and their families often assume that we're somehow unclean. I can understand their concerns because of the kind of work we do, but I wish they understood that we adhere to exceptionally stringent hygiene and infection-control protocols."* Thus, participants located the stigma not in caregiving tasks per se, but in the devaluing meanings socially attached to them.

Participants further distinguished occupational exposure from personal cleanliness, emphasizing that contact with excreta was integral to their professional responsibilities rather than indicative of their lifestyle. As Participant 3 put it, *"Working as a hospital nursing assistant means helping patients with urination and defecation, suctioning sputum, and changing incontinence pads. Our hands and bodies inevitably come into contact with contaminated materials. That's part of our professional responsibility, not our personal lifestyle. Yet many patients and their families still think we're dirty and avoid us because of it."* By drawing this distinction, participants actively resisted the contamination meanings imposed on their occupational role.

## Contagion stigma

Beyond bodily uncleanliness, participants experienced contagion stigma, whereby patients and family members perceived nursing assistants as potential vectors of infectious disease because of their hospital-based work. Participants attributed these perceptions to the conflation of hospital environments with infection risk, which positioned bedside caregivers themselves as possible sources of transmission.

Participant 9 recalled: *"Hospitals certainly contain many germs, but some patients automatically assume we're virus carriers. It's difficult to believe, but some patients initially refused to let me feed them, while others would not even allow me to touch them because they feared I might infect them. What an extraordinary prejudice! We replace our gloves and masks every hour, have our temperature checked every day, and undergo comprehensive health examinations every three months. We may well be among the healthiest people in the hospital."* Such encounters conveyed to participants that the infectious risks associated with hospitals had been symbolically transferred to their occupational identities.

Participants were particularly distressed that strict adherence to infection-prevention protocols did little to dispel these assumptions. Participant 6 remarked, *"Patients and their families constantly suspect that*

*we have infectious diseases, and it is deeply distressing. More than one patient has insisted that I undergo a full medical examination before caring for them. Even when we showed them our health examination reports, they still didn't believe us. It's completely absurd."*

Several participants perceived that these concerns intensified during and after the COVID-19 pandemic, when heightened infection anxiety reinforced stigmatizing judgments toward those perceived as disease carriers. Participant 15 reflected: *"During the COVID-19 pandemic, some people maliciously labeled those who became infected as 'virus terrorists.' Even now, some patients and their families believe there are people like that among hospital nursing assistants. They suspect we are 'virus terrorists' who became nursing assistants to spread disease as revenge against society. Isn't that outrageous? Such accusations are incredibly malicious—they are judging us with the worst possible assumptions."*

## **Moral stigma**

## **Greed stigma**

Hospital nursing assistants frequently encountered moral judgments that characterized their work as excessively remunerated or financially motivated, despite its considerable physical and emotional demands. Participants reported that patients and families often focused on perceived earnings while disregarding the intensity and complexity of their daily responsibilities.

Participant 10 recounted, *"I often hear patients complain, 'Your fees are outrageous—you're practically robbing me!' or 'Is money all you care about?' But do they realize how demanding our work really is? We help patients turn over in bed, feed them, administer medications, clean their bodies, and assist with toileting. As long as the patient is awake, we are constantly working. Isn't 300 yuan (about US\$45) a day a reasonable return for such demanding work? If they think we're overpaid, why don't they try doing this job themselves?"* Such comments reflected a pervasive perception that nursing assistants derived undue financial benefit from vulnerable patients, which participants rejected by emphasizing the physically strenuous and emotionally taxing nature of their work.

This moral misjudgment was reinforced when others reduced their responsibilities to a series of simple tasks undeserving of higher pay. Participant 6 observed, *"Many patients simply cannot understand why we earn what we do and assume we're greedy. What a tremendous misunderstanding. They think all we do is feed patients and hand them a glass of water, yet we earn 300 or even 400 yuan a day (about US\$45–60), while they earn only 100–200 yuan (US\$15–30). What they don't see is how exhausting and unpleasant this work is. Without compassion and patience, no one could sustain this work. Every penny we earn is hard-earned, so there's nothing to envy."*

Perceptions of excessive remuneration also extended to other healthcare professionals, suggesting that such judgments were embedded in broader evaluations of nursing assistants' occupational standing. Participant 3 reflected, *"You know, it's not only patients who think we're overpaid—even some doctors and nurses think we're greedy. What they fail to recognize is the level of responsibility we carry. Patients cannot*

*fall or be injured, and if anything happens, we are held accountable. Our workload is often far heavier than that of nurses, and many nights we barely get any sleep. Isn't it reasonable that we might earn more than nurses?"*

## **Laziness stigma**

Beyond financial moralization, nursing assistants described recurrent accusations of laziness when briefly pausing during work, illustrating the persistent moral scrutiny surrounding their labor. Participants emphasized that even short periods of rest necessary to sustain physically demanding caregiving were interpreted as evidence of shirking.

Participant 9 recounted this experience: *"Every now and then we encounter particularly demanding patients. The moment they see us sit down to drink some water or take a short break, they accuse us of being lazy, slacking off, and taking money without doing any work. We're already extremely busy—we can't function like machines around the clock. When this happens, all we can do is silently endure it."*

Such judgments were intensified by stringent expectations from patients' families. Participant 16 explained, *"Some family members are incredibly demanding. They insist that we spend no more than five minutes using the restroom, no more than five minutes sitting down to rest, and they even forbid us from looking at our phones. We encounter situations like this all the time, and it's difficult to understand. They seem convinced that we're constantly looking for an excuse to be idle, so they supervise us like foremen on a construction site. Under these circumstances, how can we maintain the enthusiasm and emotional well-being to provide good care?"*

Laziness stigma further undermined participants' professional autonomy and dignity when family members attempted to regulate their movements and routines. Participant 4 described a similar experience: *"Some family members won't let us sit down or move around freely. They expect us to watch the patient every second because they're afraid we'll slack off. The moment we sit down to rest, they become unhappy and call us lazy people who take money without working. They say, 'We're paying you so much—why are you always trying to be lazy?' Situations like this leave us completely speechless."* Such encounters left participants feeling that their commitment to caregiving was persistently questioned and that they were treated as untrustworthy workers rather than legitimate healthcare providers.

## **Callousness stigma**

Callousness stigma arose when routine caregiving was construed as emotional indifference rather than professional care. Participants reported being repeatedly characterized by patients and families as uncaring or lacking compassion, despite viewing emotional regulation and professional boundaries as integral to sustaining their work.

Participant 15 articulated this tension: *"It's really puzzling. My colleagues and I are repeatedly criticized by patients' family members, who say we're nothing more than emotionless robots who only know how to take care of patients' bodies but not their emotional needs... But our job is to provide physical care, not*

psychological support—that's the responsibility of family members. Why do they have to make things so difficult for us?" Participants interpreted such criticism as reflecting expectations that they should provide emotional support beyond their perceived occupational remit.

Participants also felt that prolonged exposure to severe illness, suffering, and death was misread as emotional coldness, whereas they regarded emotional regulation as necessary for sustaining caregiving. Participant 7 reflected, *"You know, those of us who have been doing this work for many years have cared for countless critically ill patients. After seeing so many of these situations, we naturally become accustomed to them. Yet some family members think we're cold-hearted and lack compassion. They believe we can't empathize with patients' suffering. That's simply not true. We're more than willing to spend time talking with patients, but if we had to grieve and suffer emotionally over every patient we cared for, we probably would have broken down psychologically a long time ago."*

Such judgments became more pronounced during periods of intensive workload, when competing demands limited participants' ability to respond immediately to every patient need. As Participant 16 put it, *"There are times when our workload becomes overwhelming and several tasks require our attention simultaneously, making it impossible to meet every patient's needs immediately. At those moments, patients often accuse us of being cold, heartless, and unconcerned about them. It's incredibly frustrating."* These situations left participants feeling that unavoidable delays in care were interpreted as indifference rather than as consequences of competing clinical responsibilities.

## Theft stigma

Theft stigma represented another form of moral stigma in which hospital nursing assistants perceived themselves to be routinely treated as the "default suspects" whenever patients' or family members' belongings were misplaced. Participants viewed these suspicions as manifestations of entrenched occupational prejudice rather than evidence-based concerns. Participant 10 remarked, *"Whenever patients or their families can't find something, we're always the first people they suspect. There are four beds in a ward and countless people coming and going, so why am I the only one being asked whether I took their belongings? To me, that reflects a very deep prejudice."*

This presumption of dishonesty was reinforced by negative stereotypes portraying nursing assistants as inherently untrustworthy. Participant 8 recounted, *"I've worked as a nursing assistant for twenty years, and I've overheard patients whispering many times, 'You'd better keep an eye on those nursing assistants—some of them have sticky fingers.' How can they say things like that? Why are they so determined to see us through such prejudiced eyes?"*

Such suspicions sometimes escalated into direct accusations, causing substantial emotional distress even when misunderstandings were subsequently resolved. Participant 15 recalled an incident in which, *"Last week, one of my patients couldn't find something and immediately accused me of stealing it. Later she found it herself and apologized, but I still felt deeply hurt. It's so unfair. Whenever patients or their families lose something, we somehow become the first people they suspect. Why? In my opinion, it's*

*because they're prejudiced against us and simply don't trust us. I'm sure the next time something goes missing, they'll probably suspect me again."*

Some participants reported even more degrading experiences involving intrusive searches before any evidence of wrongdoing had emerged. Participant 1 described, *"I've been wrongly accused of being a thief several times, and those experiences were deeply painful. Last month I was caring for a 73-year-old woman who misplaced 600 yuan (about US\$90). She immediately demanded that I return the money and instructed her son to search my suitcase and bag. Later, her husband found the money in his own trouser pocket, and only then did the truth come out. Afterwards, all she said was a cold, 'I must have remembered it wrong,' without even apologizing. Incidents like this are heartbreaking. They trample on our dignity and self-respect."* Such encounters left participants feeling humiliated, demeaned, and fundamentally distrusted because of their occupational identity.

## **Abusiveness stigma**

Hospital nursing assistants characterized abusiveness stigma as arising when routine caregiving practices were misconstrued by patients and family members as deliberate harm. Participants believed these perceptions were reinforced by media portrayals and selective interpretations of caregiving incidents. As Participant 13 observed, *"Perhaps people watch too many short videos online. Patients and their families often assume that we're potential abusers. Isn't that strange?"* Such assumptions fostered generalized distrust toward nursing assistants before care was even delivered.

Participants further reported that unavoidable incidents during routine care were frequently interpreted as evidence of abuse rather than recognized as inherent clinical risks. Participant 8 elaborated, *"Because our workload is so demanding, occasional mistakes are inevitable. Yet these minor incidents are often exaggerated by patients or their families and interpreted as abuse. Once, while I was feeding a patient some rice porridge, she choked briefly. Her daughter immediately pointed at me and accused me of abusing the patient. Isn't that another form of discrimination against us?"*

Similarly, clinically necessary yet painful procedures were often perceived as abusive. Participant 16 recalled, *"I once cared for a patient who had suffered a stroke. Because he was severely constipated, I used a glycerin enema and subsequently provided manual assistance for bowel evacuation. He cried out in pain during the procedure, and his family immediately accused me of abusing him. I followed every step of the proper clinical procedure. How could that possibly be considered abuse?"*

Beyond physical care, participants reported that efforts to promote treatment adherence were sometimes construed as psychological abuse. Participant 17 clarified, *"Some patients are seriously ill but still refuse to cooperate with treatment. They won't take their medication or complete necessary examinations. In these situations, we have to remind them firmly and explain the consequences of refusing treatment. Sometimes, if we repeat these reminders too often, patients or their families accuse us of intimidating them or committing psychological abuse. But that isn't psychological abuse at all—it's simply our professional responsibility. Aren't we doing this because we want them to get better?"*

# Occupational stigma

## De-professionalization stigma

Hospital nursing assistants frequently perceived that their professional identity was undermined by persistent questioning of their qualifications, competence, and clinical judgment. Such doubts were experienced as de-professionalizing their occupational identity and undermining their standing within the healthcare workforce. Participant 11 stated, *"The question we hear most often from patients is, 'Are you actually professionally trained?' This is a real misunderstanding. Every nursing assistant who works here has completed formal training and obtained a professional caregiving certificate, just as teachers must earn a teaching qualification before entering the profession. We undergo rigorous training in patient care—administering medication, assisting with bathing, repositioning patients safely, preventing pressure injuries, and more."*

Participants also perceived a marked professional hierarchy in which the credentials of nursing assistants were scrutinized more readily than those of physicians and nurses. Participant 17 reflected, *"Over the years, I've been asked all kinds of strange questions: 'Are nursing assistants really qualified?' 'Did you graduate from medical school?' 'Do you actually have a professional license?' Doctors and nurses are never asked these questions, but we are. To me, that shows just how poor the public image of our profession still is. I strongly hope the government should do more to promote the nursing assistant profession and eliminate these stereotypes."*

Beyond credentialing, participants felt that their clinical recommendations were routinely accorded less authority than those of other healthcare professionals. Participant 5 observed, *"Although many patients accept our care, they never fully recognize our professional expertise. They listen carefully to every instruction given by doctors and nurses and follow it meticulously. But when we provide guidance, they often dismiss it as unimportant. It's a subtle kind of discrimination, but it still makes us feel that we are being treated differently."*

Distrust persisted even when participants demonstrated sound clinical judgment. Participant 7 recounted, *"I once cared for an woman who was scheduled to undergo knee surgery. After helping her back from the bathroom, I noticed that her hand felt unusually hot and suspected she had a fever. I told her that surgery should be postponed because patients with a fever shouldn't undergo an operation. Neither she nor her son believed me. They said, 'What would a nursing assistant know about that?' It wasn't until the doctor told them she needed to recover from her infection before having surgery that they finally accepted it. I've experienced this kind of disbelief more than once. Many nurses have praised me as an 'excellent nursing assistant,' yet while we can earn the respect of nurses, it is much harder to earn patients' trust."*

## Low-skill stigma

Hospital nursing assistants further described their work as being stereotyped as low-skilled and requiring minimal expertise, rendering their technical competencies largely invisible in everyday

interactions.

As Participant 1 reflected, *"I've worked as a nursing assistant for more than ten years, and I increasingly feel that the public fundamentally misunderstands our work. Many people think this job requires no skills at all—that's the biggest misconception. Massage therapy, chest percussion for sputum clearance, urinary catheterization, nasogastric feeding, rehabilitation exercises—which of these doesn't require professional skills? Take chest percussion as an example. It looks simple, but it actually requires considerable technique. You have to cup your hands correctly, avoid hitting the spine, and strike the patient's back at roughly 120 times per minute with just the right amount of force. It's nowhere near as easy as it looks. If the force is too light or the frequency too low, sputum won't be cleared effectively. If the force is too strong or too rapid, the patient will experience pain. Doesn't that require sophisticated skills?"*

Participants reported that such assumptions were often expressed explicitly by patients, reinforcing the perception that the specialized knowledge underlying their work was routinely devalued. Participant 7 recalled, *"One patient told me, 'All you do is feed me, give me my medication, and help me walk around. It's such a simple job that anyone could do it.' But how is this work simple? Repositioning patients, providing massage, administering enteral nutrition, suctioning sputum, inserting urinary catheters, and assisting patients with mobility all require specialized nursing skills."*

For some participants, these perceptions further reduced nursing assistants to a source of manual labor despite the technical complexity of many caregiving procedures. Participant 14 emphasized, *"Patients often treat nursing assistants as 'cheap labor,' assuming our job involves nothing more than repetitive tasks like wiping patients down or feeding them. Of course, anyone can hand someone a meal or help with basic hygiene, but procedures such as nasogastric feeding, tracheostomy care, and stoma care require genuine technical expertise. Anyone without proper training simply couldn't perform them. The professional care we provide is not something that family members can simply replace."*

## **Servitude stigma**

Servitude stigma emerged as a particularly degrading form of occupational devaluation. Participants described being treated as servants rather than healthcare workers, expected to comply with patients' demands rather than recognized as professionals delivering care.

Participant 3 stated, *"What I find most unbearable is when certain arrogant patients treat us like servants. They say, 'You, go and do this.' 'You, go and do that.' 'Are you deaf? Didn't you hear me calling you?' 'Come over here and help me turn over—now!' That kind of bossy, commanding attitude is incredibly humiliating. Why can't they simply speak to us with some basic respect? We are here to provide services, not to be their servants."*

Participants further described how derogatory language reinforced their perceived social inferiority. Participant 2 recalled, *"Many people look down on nursing assistants. They treat us like servants, ordering us around without showing the slightest respect. Once, a patient scolded me and said, 'You're nothing but a lowly servant. Your job is just to feed me and give me water. How dare you talk back to me?' That was*

*deeply hurtful. Why should anyone think that nursing assistants are somehow beneath everyone else? Every time I hear words like that, I feel upset for a long time. Sometimes it even makes me question whether I want to continue doing this job."*

Participants consistently rejected the servant identity, emphasizing that their relationship with patients should reflect professional service rather than subordination. As Participant 17 asserted, *"We are never servants—we are professional caregivers providing a service. Patients pay for our services, and we provide professional care. It should be an equal contractual relationship. Yet some patients and their families treat us like domestic servants, constantly ordering us around as if they were our masters. Patients need to understand that they are our clients, not our owners. They should respect the people who provide care for them."*

## **Low-status stigma**

Low-status stigma was closely associated with diminished professional dignity and limited social recognition. Participants perceived nursing assistance as a low-prestige occupation stereotypically associated with limited education, low ability, and social failure, positioning their work at the margins of occupational status hierarchies. Participant 7 argued, *"I think most people in society believe that nursing assistants are 'the losers of social competition'—that only people with limited abilities would take on this kind of cheap, low-status work. But doesn't our work have value? People shouldn't depend on our services while looking down on the very people who provide them."*

Even ostensibly sympathetic comments could reinforce perceptions that nursing assistance lacked social value. Participant 10 recalled, *"Many patients say things that sound caring on the surface but actually make me feel deeply disrespected. They ask, 'Why would you choose this kind of job? Every day you're cleaning people up after they use the toilet and helping them with such unpleasant things. Even if you do this for your whole life, what could you possibly achieve?' Others tell me, 'Almost any other job would be better than this one.' Whenever I hear comments like these, I can only force a smile, but the disappointment stays with me for a long time."*

In response to these pervasive stereotypes, some participants concealed their occupational identity to avoid anticipated judgment. Participant 6 disclosed, *"Society generally regards our work as inferior, and that leaves me feeling helpless. Thus, whenever people ask what I do for a living, I tell them that I'm a domestic housekeeper. I know it isn't right to lie, but I simply don't want people to look down on me."*

Similarly, Participant 4 concealed her occupation despite receiving formal workplace recognition: *"Last year I received the 'Outstanding Service Employee' award from my company, and all my colleagues congratulated me. Even so, I've continued telling my family and friends that I work as a security guard. Do you know why? Because society generally sees nursing assistants as people whose only job is to clean up patients' bodily waste—as if this were the lowest-status occupation imaginable. If they knew what I really did, they would look down on me."*

# Cultural Stigma

Hospital nursing assistants characterized cultural stigma as the stereotyping of their occupation and educational background as markers of being “uncultured,” which undermined both personal worth and professional credibility. Participants reported that patients and families frequently conflated limited formal education with a lack of cultural refinement.

Participant 14 argued, *“Many patients assume that, because nursing assistants generally have lower levels of formal education, we’re uncultured and lack sophistication. But does educational attainment really define whether someone is cultured? We live in the internet age. We all have access to much the same information and opportunities to learn, so the knowledge gap is not what it used to be. When it comes to communication, knowledge, and our outlook on life, many of us are no less capable than patients or their families. There’s no reason for them to look down on us.”*

Participants challenged this reduction of cultural status to formal educational attainment, emphasizing that being “cultured” also encompasses practical knowledge, professional expertise, and experiential learning. They felt that their capacity to acquire, apply, and continually expand nursing knowledge was obscured by occupational stereotypes. As Participant 5 maintained, *“Perhaps because nursing assistants generally have lower levels of formal education, many people assume we’re an uncultured group. But does attending university automatically make someone cultured? We have learned and mastered so much nursing knowledge and so many practical skills that genuinely improve patients’ well-being. Doesn’t that count for something? I sincerely hope more people will come to understand what our profession really involves.”*

Beyond individual misconceptions, participants interpreted cultural stigma as reflecting a broader social hierarchy that privileges intellectual and office-based occupations while devaluing manual caregiving. They described an enduring cultural logic in which physical labor was equated with limited education and inferior cultural standing. Participant 12 reflected, *“I strongly disagree with Mencius’ view that ‘Those who labor with their minds govern others; those who labor with their hands are governed by others.’ It seems that people automatically assume that anyone who works in an office is cultured, while anyone who does manual work is uncultured. Whenever people think about nursing assistants, they immediately assume we’re uncultured people who had no other choice but to make a living through physical labor.”*

## Coping with stigmatization

### Passive endurance

Passive endurance emerged as a common response to workplace stigmatization. Many participants tolerated and internalized stigmatizing experiences, viewing them as an inevitable and largely uncontrollable aspect of their work. Participant 18 reflected, *“Over the years, I’ve heard countless stigmatizing remarks, and all I can do is endure them. People are different, and different people inevitably*

*hold different opinions. I can't control what others think of me, so all I can do is accept it and bear it. If I endure it, eventually it will pass."*

Participants commonly perceived stigma as beyond their control and therefore prioritized emotional restraint over resistance. Participant 3 acknowledged *"When I encounter these stigmatizing comments, all I can do is remain patient and restrain myself. Most of the hurt I experience has to be dealt with on my own. I think endurance is something everyone in this profession needs. People who lack patience simply cannot last in this profession. Since I chose this career, I have to adapt to its challenges and learn to become more resilient"*

For some, endurance also reflected their limited structural power to contest stigmatizing encounters. As Participant 14 put it, *"When faced with this kind of stigma, all I can do is silently endure it. We are usually the weaker side, and whenever disputes arise, hospitals tend to side with patients. Sigh... I depend on this job to support my family. I can't simply leave because of these experiences. I have no choice but to keep putting up with these unfair comments."*

## **Intrapsychic regulation**

When confronted with stigmatizing discourse and social judgments, participants frequently mitigated their psychological impact through cognitive and emotional self-regulation. They reframed stigmatizing encounters through self-reflection, reinterpretation, and emotional acceptance, thereby reconstructing their meaning and reducing associated distress.

Participant 5 elaborated, *"After working in this profession for so many years, we've become accustomed to these stigmatizing remarks. I don't entirely blame people. If I hadn't spent so many years working as a nursing assistant, I might have held the same misconceptions myself. Ignorance is not a crime. Since I can't change what other people think, the only thing I can do is change myself by becoming more tolerant and open-minded."*

This cognitive reframing was further illustrated by Participant 3: *"I once came across a quote from Sartre on TikTok: 'People do evil half out of ignorance and half out of malice.' I think there is a lot of truth in that. Many misunderstandings and stigmatizing attitudes toward nursing assistants come either from a lack of understanding about what we actually do or from deliberately looking down on us. We should forgive those who are ignorant and disregard those who are malicious. Thinking about it this way helps me regain my emotional balance."*

Beyond cognitive reframing, participants also coped with emotional distress by focusing on supportive relationships with patients and their families. As Participant 11 shared, *"Whenever I hear stigmatizing remarks, I remind myself of the kind patients and family members I've met. They understand us, treat us like family, and even give us red envelopes (traditional monetary gifts during holidays) during holidays to express their appreciation. They make us feel respected and valued. Life is like a coin—it always has two sides. There are unpleasant experiences, but there are also warm and meaningful ones. When I think about the families who genuinely care about us, I gradually feel at peace again."* These positive relational

experiences served as an important source of occupational affirmation, helping participants offset experiences of stigma by reinforcing their sense of recognition, respect, and belonging.

## Peer disclosure and mutual support

In response to stigmatizing experiences, hospital nursing assistants also sought emotional support and validation from trusted colleagues. Sharing these experiences with colleagues who had encountered similar situations allowed participants to feel understood, reassured, and emotionally supported. Participant 11 recounted, *“I once cared for a patient who repeatedly accused me of abusing him. He frequently insulted me, saying that I had stolen his money... Whenever I feel distressed, I tend to confide in colleagues and share my grievances with them. Once I have expressed what has been weighing on my mind, I feel considerably more relieved.”*

The therapeutic value of peer support derived largely from shared occupational experience. Colleagues were able to recognize and validate stigmatizing experiences that outsiders might not fully comprehend. Participant 2 emphasized this shared understanding, *“When I hear stigmatizing comments, I usually talk with colleagues I am close to. After all, they have been through similar situations themselves, and they understand what I am going through. What they have experienced could easily become something I face in the future. No one understands our pain better than we do... Sharing our feelings with each other is the best way to ease the burden.”*

Through peer sharing and mutual encouragement, participants were able to release emotional burdens, regain emotional balance, and prevent stigma-related distress from carrying over into their work. As Participant 5 noted, *“Whenever I encounter such stigmatizing remarks, I usually turn to my colleagues for support. Sharing our experiences and encouraging one another helps me feel considerably more relieved. We need to regulate our emotions as quickly as possible and ensure that these negative feelings do not spill over into our work.”*

## Communication and witnessing

Some participants described using calm communication, transparency, and sustained professional conduct to challenge prejudicial assumptions and cultivate trust. When confronted with accusations or misunderstandings, they sought to clarify their actions, provide factual explanations when necessary, and demonstrate competence through consistent caregiving.

Participant 10 recounted an accusation of theft and his response through transparent communication and objective verification: *“A patient’s family member once suspected me of stealing their belongings. Rather than arguing with her, I accompanied her husband to obtain the hospital’s surveillance footage to establish my innocence. Once the truth came to light, they offered me a sincere apology. Although my role may appear insignificant, I still hope to gradually transform society’s stigmatizing perceptions of nursing assistants through my own actions. I believe that, over time, our reputation will improve.”* This account illustrates how evidentiary transparency could transform an encounter of suspicion into an opportunity for restoring trust and contesting occupational stereotypes.

For some nursing assistants, professional conduct became a way to contest stereotypes about their social background and professional competence. Participant 14 maintained, *“Whenever I encounter stigmatizing comments or misunderstandings, I respond patiently and calmly to patients or their family members and demonstrate my capabilities through the quality of my work. If we perform our duties well, family members will gradually come to recognize our efforts, and these misunderstandings will eventually fade.”* Through sustained professional practice and compassionate care, participants sought not only to resolve individual misunderstandings but also to gradually challenge broader stereotypes surrounding nursing assistants.

## Discussion

This qualitative study used thematic analysis to examine how hospital nursing assistants experience and interpret workplace stigma. Participants described a multifaceted stigma landscape rooted in their low-status occupational position, with bodily, moral, occupational, and cultural stigmas converging to shape professional identity and lived experience. These findings extend the literature beyond the more extensively studied stigma affecting physicians and registered nurses by illuminating the distinctive experiences of workers positioned at the lower end of the healthcare hierarchy.

Bodily stigma encompassed the attribution of uncleanness and contagion to nursing assistants because of their frequent contact with bodily fluids and contaminated materials. Comparable forms of stigma have been documented among healthcare professionals, particularly during infectious disease outbreaks, when physicians and nurses caring for infected patients may themselves be perceived as potential sources of infection. [ , ] However, our findings suggest a distinctive mechanism among nursing assistants: participants were stigmatized not primarily through association with particular outbreaks, but through the intimate and routine nature of caregiving involving urine, feces, sputum, wounds, and other bodily substances. This pattern accords with dirty work theory, which conceptualizes symbolic contamination as a form of stigma attached to occupations involving physical, social, or moral taint. [ , ] In this sense, the caregiving body itself becomes a symbolic marker of contamination, extending the meaning of “dirty work” beyond specific tasks to the social identity of those who routinely perform them. Because this symbolic contamination is embedded in the routine performance of everyday caregiving rather than exceptional infectious events, it may become normalized and continuously reproduced through daily interactions, making such stigma particularly persistent.

Moral stigma manifested through accusations of greed, laziness, callousness, theft, and abusiveness. Although physicians and registered nurses may also encounter moral scrutiny, including perceptions of self-interest, arrogance, or stereotypical expectations regarding their professional and moral conduct, [ , ] our findings suggest that moral stigma among hospital nursing assistants is qualitatively different. Rather than questioning their professional ethics or interpersonal conduct, patients and families often perceived participants as inherently untrustworthy. Particularly salient was the recurrent suspicion of theft and abuse, whereby structural occupational prejudice was translated into direct moral condemnation of individual workers. The intensity and breadth of moral stigma observed in this study

may be shaped by nursing assistants' relatively low occupational status and limited autonomy. This interpretation is consistent with research describing healthcare assistants as marginalized and undervalued within healthcare hierarchies, conditions that may render them particularly vulnerable to negative moral judgments and individualized blame. [ ] These findings extend existing stigma scholarship by demonstrating how occupational hierarchy shapes the moral valuation of healthcare labor, making workers in subordinate positions more likely to be perceived as inherently untrustworthy and consequently vulnerable to accusations of theft, abuse, and other forms of moral wrongdoing.

Occupational stigma was one of the most salient forms of stigma experienced by hospital nursing assistants, reflecting the persistent devaluation of their professional identity, expertise, and social standing within healthcare systems. Previous research shows that nurses may encounter occupational stigma through negative labels, devaluation, discrimination, and stereotypes that question their competence, autonomy, and professional status. [ ] Physicians may likewise experience reputational stigma following medical errors or professional misconduct. However, our findings suggest a distinctive form of occupational stigma among hospital nursing assistants, characterized not simply by the devaluation of their work but by the delegitimization of their occupational identity. Participants were positioned as "non-professionals," with the legitimacy of their role itself repeatedly questioned and their work presumed to require little knowledge or expertise. These findings build on previous research describing healthcare assistants as occupying marginalized positions within the division of healthcare labour by showing how occupational hierarchy may be translated into symbolic denial of professional legitimacy. [ ] The characterization of nursing assistants as "servants" further illustrates how occupational stigma intersects with the historical devaluation of caring labour. Nursing has long been associated with gendered expectations of care, and caring labour have often been represented as extensions of women's domestic work rather than as forms of specialized professional expertise. [ ] Taken together, our findings reveal that occupational stigma operates not only through the devaluation of caring labour but also through the denial of professional legitimacy to those who perform it.

Cultural stigma referred to perceptions that nursing assistants lacked culture, refinement, or intellectual sophistication because of their educational background and caregiving role. Healthcare occupations are structured by implicit status hierarchies in which formal credentials, specialized knowledge, and professional expertise contribute to occupational prestige and symbolic capital. [ ] Physicians occupy a particularly prestigious position within these hierarchies, reflecting the professional closure, educational requirements, and symbolic capital associated with medical expertise. [ ] Nurses, although increasingly recognized as autonomous professionals, have historically confronted stereotypes that associate nursing with caring and femininity, thereby obscuring its scientific knowledge and competencies. [ ] Our findings extend this perspective by showing how such hierarchies may be reproduced among nursing assistants, whose practical and experiential expertise may receive less symbolic value than credentialed academic knowledge. Stigma toward nursing assistants thus appears embedded in broader cultural narratives that privilege formal education and credentialed expertise while devaluing embodied caregiving as less intellectually demanding or professionally significant work.

Coping with stigma emerged as a dynamic process. Previous research similarly indicates that stigmatized healthcare workers adopt behavioral and cognitive strategies to manage stigma-related experiences. [ , ] During the COVID-19 pandemic, for example, healthcare workers reported coping with stigma by discussing their experiences with colleagues or family members, explaining their work to others, and reframing stigmatizing encounters as understandable reactions to fear rather than personal hostility. [ , ] Our findings, however, reveal several distinctive features of coping among nursing assistants. Participants frequently relied on passive endurance, perceiving stigma as an unavoidable occupational condition. This response may reflect the constrained occupational position of nursing assistants, as hospital-based nursing aides have been shown to experience greater job insecurity and lower influence within the hierarchical division of nursing work. [ ] Despite these constraints, peer disclosure emerged as an important protective resource, providing shared understanding and emotional validation that outsiders could not readily offer. Participants also engaged in identity-affirming practices by communicating their professional contributions and demonstrating competence through sustained caregiving performance. Rather than directly confronting stigma, they gradually challenged negative assumptions through everyday professional actions that made their expertise and value visible to others.

## Implication

Collectively, these findings indicate that hospital nursing assistants experience stigma that is more pervasive, personal, and structurally embedded than that typically documented among physicians and registered nurses. Such stigmatization extends beyond interpersonal prejudice, reflecting entrenched hierarchies that devalue intimate care work, marginalize intimate caregiving work, and reproduce cultural stereotypes. Addressing these inequities requires coordinated societal and organizational action, including formal anti-stigma policies, interprofessional education to strengthen role recognition and respectful collaboration, and public communication campaigns that challenge misconceptions about nursing assistants' competence and contributions. Healthcare institutions should also establish standardized procedures for workplace mistreatment, that provide evidence-based resources for managing stigma while cultivating respectful and inclusive workplaces. By delineating the complex stigma landscape surrounding nursing assistants, this study extends stigma theory by demonstrating how healthcare hierarchies institutionalize occupational devaluation and highlights the need to recognize the lived experiences of all caregiving professionals.

## Limitation

Several limitations warrant consideration. First, most participants worked in tertiary or secondary hospitals in China, potentially limiting transferability to nursing assistants in primary care, private hospitals, or healthcare systems with different organizational structures and workplace cultures. Second, all participants were Chinese, and stigma is shaped by cultural, institutional, and professional norms; thus, the findings may not fully reflect experiences in other national or cultural contexts. [ ] Third, the study focused deliberately on negative workplace experiences, particularly stigma, without

examining positive experiences, resilience, or sources of occupational fulfillment. The findings may therefore underrepresent the complexity and ambivalence of participants' everyday work. Fourth, although snowball sampling facilitated access to this relatively hard-to-reach workforce, it may have increased sample homogeneity and selection bias, limiting the diversity of perspectives captured. [] Finally, reliance on self-reported narratives introduced potential recall and social desirability biases. [] Future research should recruit more diverse institutional and cultural samples, employ broader sampling strategies, and examine both adverse and positive dimensions of nursing assistants' work to develop a more comprehensive account of their occupational realities.

## **Conclusion**

Hospital nursing assistants experience pervasive stigma across bodily, moral, occupational, and cultural domains, shaping their work experiences and prompting diverse coping responses, from passive endurance and intrapsychic regulation to peer support and communicative engagement. These findings underscore the multidimensional nature of stigma and its embeddedness within broader healthcare and social structures. Policy and organizational efforts should therefore prioritize stigma reduction, strengthen recognition of nursing assistants' professional contributions, and promote more inclusive, respectful, and equitable healthcare environments.

## **Declarations**

## **Ethics approval and consent to participate**

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. The study was granted ethical approval by the ethics committee of Changji University (CUEA-202578). All methods were used in accordance with the relevant guidelines and regulations. Written informed consent was obtained from all study participants.

## **Clinical trial number**

Not applicable.

## **Consent for publication**

Not applicable.

## **Declaration of competing interest**

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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## Author Contribution

Hongjuan Li: Methodology, Funding acquisition, Conceptualization. Meiyu LI: Formal analysis. Ruixin Wang: Investigation, Writing – original draft. Yiqing Lv: Investigation, Writing – original draft. Quan Zhang: Writing–original draft, Writing –review & editing, Supervision, Methodology, Funding acquisition, Formal analysis, conceptualization.

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## Data Availability

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

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