

Why First-Hand Accounts from Nursing Assistants Matter? Methodological Reflections on a Role Theory-Informed Qualitative Study [Letter]

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Dear editor

Nursing assistants (NAs) constitute the largest workforce segment in aged care and are regarded as the backbone of the long-term care system. They play a key role in expanding the supply of nursing services and ensuring the quality of patient care within institutions that provide integrated medical and elderly care services (IMECS).¹ We therefore value the descriptive qualitative study by Song et al that examined the roles and impacts of NAs in IMECS institutions.¹ Nonetheless, certain aspects of the study's methodology and interpretation of results merit further consideration.

Incomplete Application of Role Theory Due to Single-Sided Data

The study states that its research framework is based on Role Theory; however, data were collected only from registered nurses (RNs),¹ resulting in a partial application of the theory and limiting a comprehensive understanding of the NA role.

Role Theory posits that social roles emerge through interactions among different actors, and the theory involves several interrelated dimensions, including role expectations, role perception, and role performance.² Song et al elicited only RNs' expectations toward NAs,¹ omitting NAs' own perceptions—how they interpret and respond to external expectations. More importantly, without the participation of NAs, the study could not directly assess role performance. Descriptions of NAs' actions were derived from RNs' observations rather than first-hand accounts, and therefore might not fully reflect their actual behaviors, decision-making, or coping strategies.

This unilateral perspective also constrains examination of role conflict and ambiguity. Role conflict often arises from discrepancies among stakeholders' expectations.³ For example, RNs may expect NAs to undertake additional medical-support tasks (eg, pressure ulcer prevention or oxygen therapy care),¹ whereas NAs may view their primary responsibilities as activities of daily living, and family members of patients may hold yet another set of expectations. Data from RNs alone reflect RNs' view of expectation conflicts and cannot reveal the conflicts NAs actually experience when facing inconsistent expectations. Similarly, role ambiguity refers to individuals' uncertainty about the boundaries of their responsibilities,³ which only NAs themselves can accurately articulate.

We therefore recommend that future studies adopt a paired-sample design, collecting data from both RNs and the NAs with whom they directly collaborate. Practical challenges exist, particularly given that NAs may be reluctant to voice concerns due to hierarchical dynamics and that anonymity is more difficult to ensure in small units. These challenges can be addressed through separate interviews, robust confidentiality measures, and the use of independent researchers unaffiliated with unit management. Such a design would be both feasible and methodologically valuable, as it would



capture both role expectations and role perceptions, enabling comparative analysis of how each party interprets shared tasks and how these differences shape negotiation, compromise, or conflict in daily interactions.

Proxy Reports Leave NAs' Emotional Experiences Unheard

Under the sub-theme of “Suppressed Professional Enthusiasm,” the study identifies “occupational burnout” and “emotional exhaustion” among NAs, attributing these outcomes to the psychological toll of long-term care for elderly patients.¹ However, this conclusion is based entirely on RNs' observations rather than NAs' self-reports, raising concerns about proxy report bias.

Emotional experiences and professional passion are inherently subjective. Their nuances—intensity, origin, and expression—are best articulated by those experiencing them directly. It should be noted that we are not dismissing RNs' observations as invalid; rather, we recognize that they can offer valuable supplementary insights into NAs' external behavioral manifestations, such as silence, fatigue, and passive coping, particularly in certain situations. However, these indicators should not be equated with internal emotional states. Fatigue may be misinterpreted as diminished professional enthusiasm, and concealed or suppressed emotions may go undetected.

Moreover, NAs may consciously or unconsciously mask their authentic emotions when interacting with supervising RNs. Evidence indicates that, under unequal power dynamics, employees often display organizationally-desired emotions while concealing genuine feelings,⁴ including burnout and despair. Thus, relying solely on RNs' proxy reports—without triangulation with NAs' self-reported emotional experiences—risks an incomplete or potentially biased understanding, analogous to assessing employee satisfaction through managers alone or patients' pain via physicians' accounts.

Accordingly, future research must reposition NAs—the subjects of emotional experience—as the narrators of their own psychological realities. Methodologically, this requires: on one hand, employing in-depth interviews or emotion diaries to directly capture NAs' self-described experiences; on the other hand, incorporating participatory observation to establish sustained trust-based relationships, penetrating expressive barriers shaped by hierarchical dynamics.

Unverified Assumptions About IMECS-Specific NA Roles

The study repeatedly asserts in its *Introduction* that NAs in IMECS institutions differ from those in traditional nursing homes (TNHs), thereby warranting dedicated examination of their role positioning.¹ However, this central assumption appears insufficiently substantiated by empirical data in the *Results* and *Discussion* sections.

The four themes identified—role identity, high role expectations, role conflict, and low role authorization—lack comparative analysis between IMECS institutions and TNHs.¹ Consequently, readers cannot ascertain whether these findings are unique to IMECS institutions or represent universal challenges encountered by NAs across all elderly care settings. When the *Discussion* asserts that NAs in IMECS institutions “should be proficient in medical auxiliary techniques” and notes that NAs “have lower educational attainment and older age profile, which can constrain their professional development,” these conclusions are primarily derived from policy documents and prior literature rather than from the interview data generated by this study.¹ The study thus reiterates policy narratives rather than demonstrating actual differences.

The only evidence pertaining to “differences” is RNs' higher expectations for NAs—namely, stronger professional competence and faster adaptability.¹ Yet, these reflect subjective RN expectations rather than actual NA performance or role enactment. Whether this expectation gap translates into tangible role differences remains unclear. If so, in which specific work scenarios do these differences manifest? With respect to work tasks, responsibility boundaries, or participation in decision-making, what precisely distinguishes NAs in IMECS institutions from their counterparts in TNHs? The current data provide no answers.

Future research should employ comparative designs that include samples from both IMECS institutions and TNHs to more rigorously elucidate the unique features and role connotations of NAs within the IMECS context.

Team-Based Model Superiority Lacks Empirical Support

The authors explicitly assert in the *Discussion* that the team-based work model is superior to the one-on-one care model, presenting this as a key recommendation for optimizing management.¹ However, this conclusion warrants scrutiny.

First, the study reports that RNs perceive the team-based work model as fostering a “stronger sense of responsibility,” “facilitated information exchange,” and “convenience of mutual supervision” among NAs.¹ However, the *Discussion* occasionally frames these perceptions as objective advantages, stating for example that “...the team structure enhanced ..., allowing for earlier identification of ...”.¹ In reality, the qualitative data only support a more modest conclusion—that RNs, for management-related reasons, prefer the team-based model—and do not demonstrate its objective superiority. Thus, within a qualitative framework, future studies should present participants’ views as perceptions, not facts. To assess which work model yields better clinical outcomes, we recommend a mixed-methods approach that complements qualitative insights with quantitative measures such as patient outcomes (eg, pressure ulcer incidence, fall rates, patient satisfaction), NA turnover, and RN workload under the two models.

Second, the study fails to identify the managerial logic behind RNs’ preference. RNs favor the team-based model largely because it facilitates their management—centralized information, unified directives, and shared responsibility;¹ conversely, criticism of the one-on-one model stems from its disruption of RNs’ information monopoly and chain of command over NAs. Equating RNs’ managerial preferences with model superiority neglects the one-on-one model’s unique value in personalized care and NA-patient trust building.

Third, the study neglects the perspectives of patients and their families. In IMECS institutions, the one-on-one model often involves higher fees for exclusive services and emotional companionship.^{5,6} Based on our team’s previous research on TNH stakeholders, families often choose the one-on-one model due to concerns that the team-based model may dilute accountability or reduce individualized care. By evaluating the two models solely from the RNs’ managerial perspective, the study risks perspective bias.

Finally, the study does not account for key variables such as disease severity and care intensity. While the team-based model may suit elderly individuals with stable conditions and basic self-care abilities, families of patients with disabilities or dementia requiring 24-hour monitoring may prefer the one-on-one model.^{6,7} Without stratified analyses across different patient needs, the generalization that “team-based model is superior” is clinically unsound.

Practical and Economic Concerns in Training and Certification Policies

The article proposes establishing “a micro-certification training system”;¹ however, this policy recommendation lacks sufficient justification regarding practical feasibility.

First, the study does not report current training costs or quantify the relationship between NA turnover and training investment, making the economic rationale for standardized training difficult to evaluate. Given the high turnover among NAs (eg, “shortages during major holidays, unexpected resignations, or sudden absences”¹) and the reliance on external labor dispatch companies,⁵ institutions may face unrecoverable training costs if trained employees leave shortly thereafter, thus wasting resources. Under these conditions, questions arise regarding the cost-effectiveness of increased training and strategies to prevent the cyclical pattern of “training-turnover-retraining”—an issue that requires careful assessment.

Moreover, while a micro-certification system may enhance professional competencies, it may also alter the functional boundaries between NAs and RNs, potentially creating role conflicts. For instance, when NAs acquire certifications in specialized skills (eg., wound care or emergency response), how should their work boundaries be defined? Might RNs resist perceived encroachments on their professional domain? These operational details remain insufficiently addressed.

We recommend that future research incorporate health economic analysis to determine the cost-effectiveness of various training strategies, examine the interface between credentialing systems and NAs’ career progression and compensation mechanisms, and remain vigilant to potential unintended consequences of public health policy interventions.

Abbreviations

IMECS, Integrated Medical and Elderly Care Services; NA(s), Nursing Assistant(s); RN(s), Registered Nurse(s); TNH(s), Traditional Nursing Home(s).

Data Sharing Statement

Data availability is not applicable as no new data was generated or analyzed in this communication.

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Disclosure

The authors declare no competing interests in this communication.

References

1. Song A, Yan X, Yao L, et al. Roles and influence of nursing assistants in integrated medical and elderly care institutions: a qualitative study. *J Multidiscip Healthc.* 2026;19:576618. doi:10.2147/JMDH.S576618
2. Kumar P, Kaur P, Kalra RK. Role expectations, role perceptions and role performance of extension personnel. *Am Int J Res Human Arts Soc Sci.* 2013;4(1):6–13.
3. King LA, King DW. Role conflict and role ambiguity: a critical assessment of construct validity. *Psychol Bull.* 1990;107(1):48–64. doi:10.1037/0033-2909.107.1.48
4. Hideg I, van Kleef GA. When expressions of fake emotions elicit negative reactions: the role of observers' dialectical thinking. *J Organizational Behav.* 2017;38(8):1196–1212. doi:10.1002/job.2196
5. Pu FY, Yu LP, Shan HP. Training requirements and associated factors for nursing assistants in Jiaying City, China: a cross-sectional study in healthcare settings. *Front Med.* 2026;13:1710478. doi:10.3389/fmed.2026.1710478
6. Roche MA, Glover S, Luo X, Joyce M, Rossiter C. Extending the role of nursing assistants in mental health inpatient settings: a multi-method study. *Int J Ment Health Nurs.* 2021;30(5):1070–1079. doi:10.1111/inm.12859
7. Beccaria L, Hoey H, Towler H, et al. Employment of undergraduate nursing students for specialising of people with cognitive impairment: a pilot study. *Collegian.* 2024;31(2):84–91. doi:10.1016/j.colegn.2023.12.002

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