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Healthcare Stigma as a Dynamic Social Process: Moving From Individual Attitudes Toward Institutional, Cultural, and Identity-Based Mechanisms

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Abstract

Healthcare stigma is often approached as a problem of prejudicial attitudes held by individual professionals or members of the public. That perspective captures an important component of stigma but is insufficient for explaining how stigmatizing conditions are generated, reproduced, anticipated, internalized, resisted, or amplified across healthcare systems. This conceptual article argues that healthcare stigma is better understood as a dynamic multilevel social process whose effects depend on interactions among social classification, identity interpretation, interpersonal enactment, cultural meaning, institutional arrangements, structural inequality, and prior healthcare experience. The proposed account distinguishes stigmatizing attitudes from discrimination, anticipated stigma from enacted treatment, internalized stigma from identity threat, interpersonal interactions from organizational conditions, and structural constraints from individual choice. It further treats healthcare pathways as temporally connected rather than as isolated encounters and recognizes that patients may respond through avoidance, concealment, strategic disclosure, compensatory work, continued engagement, or resistance. Cultural and institutional environments shape both the meaning of stigmatized identities and the opportunities available for responding to them. The resulting dynamic multilevel model is presented as a theoretical synthesis rather than an empirically validated causal architecture. Its value lies in specifying testable cross-level relationships, identifying where attitude-focused explanations are insufficient, and matching potential intervention targets to the level at which stigma is produced. The framework also clarifies priorities for longitudinal, multilevel, intersectional, culturally comparative, organizational, and implementation research.

Keywords: Healthcare stigma, Structural stigma, Internalized stigma, Intersectionality, Healthcare discrimination, Health inequity

Introduction

Healthcare stigma is commonly described through negative beliefs, stereotypes, prejudice, or discriminatory responses directed toward people whose health conditions, identities, behaviors, bodies, or social positions are socially devalued. Yet contemporary stigma theory increasingly treats these phenomena as components of a wider system involving drivers, facilitators, manifestations, experiences, practices, and consequences operating at more than one level [1]. This broader perspective matters in healthcare because the same patient may encounter stigma through professional judgment, interpersonal communication, documentation practices, service eligibility rules, physical environments, institutional routines, or social expectations before any measurable negative attitude becomes clinically visible.

A central problem is therefore explanatory rather than terminological. Negative attitudes and discriminatory behavior are related but cannot be assumed to form a uniform causal sequence. A recent scoping synthesis of mental-health stigma research found substantial evidence

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concerning attitudes and discrimination while also emphasizing the relative scarcity of designs capable of establishing causal pathways from attitudes to downstream adverse outcomes [2]. Treating prejudice as the sole explanatory engine can consequently misidentify the level at which a stigmatizing process originates and can mistake association for mechanism.

Multilevel theories offer a more appropriate starting point because intrapersonal, interpersonal, environmental, and structural processes can reinforce or constrain one another [3]. Measurement practice, however, has not kept pace consistently with this conceptual expansion. Health-stigma instruments vary substantially in definitions, constructs, populations, and levels represented, with structural determinants less consistently operationalized than individual experiences or attitudes [4]. What researchers choose to measure therefore influences what stigma appears to be.

This article develops a proposed dynamic multilevel account of healthcare stigma. Its central claim is not that individual attitudes are irrelevant, but that their meaning and consequences depend on the social processes through which classification becomes enacted, interpreted, institutionalized, remembered, and carried forward across encounters. The analysis separates individual, identity-related, relational, cultural, institutional, structural, and intersectional processes while examining their possible interactions. The proposed model is intentionally bounded: it does not assume that every stigmatizing exposure causes avoidance, that every disadvantaged group experiences stigma similarly, or that the same mechanism transfers unchanged across illnesses, healthcare settings, cultures, or policy environments.

Limitations of attitude-based models of stigma

Attitude-based models are attractive because they locate stigma in a measurable psychological construct. A clinician can endorse or reject stereotypes; trainees can complete attitude scales; interventions can attempt to change beliefs. The limitation is not that these measures are meaningless, but that they capture only one potential carrier of stigma. Healthcare organizations may themselves alter what stigma means. Interviews with mental-health providers, for example, show that treatment settings can generate competing forms of stigma and risk categorization whose significance changes with institutional context [5]. Stigma is therefore partly produced within the organization of care rather than merely imported into it by prejudiced individuals.

The same problem appears in ordinary professional discourse. Healthcare staff can reproduce racialized classifications through routine talk that positions groups differently in relation to deservingness, responsibility, credibility, or appropriate treatment [6]. Such discourse cannot be reduced to a privately held attitude because its clinical relevance emerges through shared language, professional norms, and institutional authority. Social classification becomes consequential when it influences whose account is considered credible, what behavior is expected, or which deviations from professional expectations attract scrutiny.

Documentation offers an additional challenge to attitude-centered explanation. Comparisons between patient narratives and electronic records have identified discrepancies through which experiences of dismissal or stigmatization may become muted when translated into formal clinical documentation [7]. The record is not simply a neutral transcript of an encounter. It is a selective institutional representation that can privilege particular descriptions and suppress others.

Digital infrastructures can extend this process beyond a single consultation. Research with healthcare workers indicates that electronic health-management systems may participate in the production of structural stigma by making stigmatizing classifications persistent, portable, and available to future actors [8]. A patient may therefore encounter the consequences of a previous classification even when the next professional does not consciously endorse the original judgment.

These observations motivate what this article terms the proposed attitude-sufficiency boundary. On one side are phenomena for which an individual attitude may plausibly explain an important portion of behavior. On the other are processes transmitted through records, rules, resource allocation, institutional routines, professional discourse, or built environments. Crossing this boundary requires an explanation that identifies the carrier of stigma rather than attributing every adverse encounter to prejudice.

Because these non-attitudinal carriers create unequal opportunities to avoid, challenge, or repair stigmatizing encounters, the limitations are represented more efficiently as a constraint–opportunity landscape than as a sequence of isolated causes **(Figure 1)**.

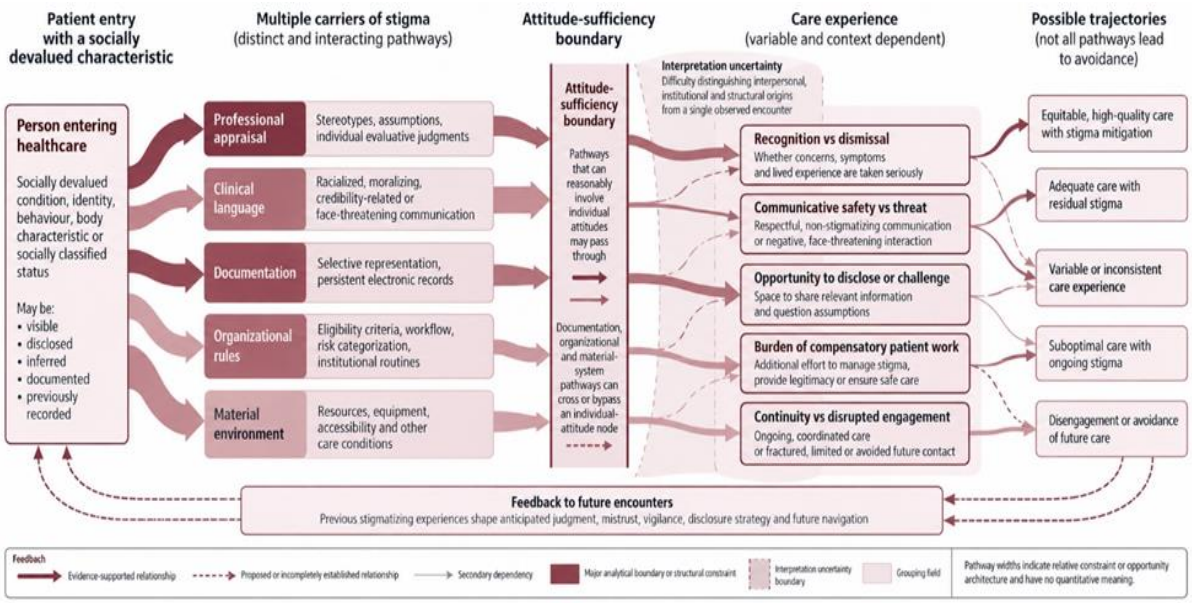

Figure 1. When prejudice is not the bottleneck: unequal routes through which healthcare stigma can be carried

Caption. The figure distinguishes an attitude-mediated route from routes carried through professional discourse, documentation, organizational rules, material conditions, and accumulated prior encounters. The central attitude-sufficiency boundary marks the point at which an individual-prejudice explanation becomes incomplete. Solid connectors denote relationships supported by the reviewed literature; dashed connectors denote the article's proposed cross-level or feedback relationships. Unequal pathway widths represent differences in available routes and constraints, not quantitative effect sizes. Boundary bands identify uncertainty about whether an observed care experience originates predominantly in interpersonal appraisal, institutional organization, or broader structural conditions.

Alt text. The diagram is read mainly from left to right. A patient-entry region leads into several unequally wide pathways representing professional appraisal, clinical language, documentation systems, organizational procedures, material care environments, and accumulated prior experience. A prominent vertical boundary labeled attitude-sufficiency boundary separates explanations that can plausibly be represented by individual attitudes from mechanisms that require institutional or structural analysis. Some pathways cross the boundary directly without passing through an attitude node. Lower dashed feedback routes return prior stigmatizing encounters to later expectations and care navigation. A surrounding uncertainty band indicates that the dominant mechanism may differ by patient, illness, setting, and institutional context.

Labeling, stereotyping, and social classification

A multilevel account must nevertheless retain the importance of labeling and stereotyping. The distinction is that classification is treated as an initial social operation rather than the completed mechanism of stigma. Major syntheses in mental health show that stereotypes, prejudice, discrimination, status loss, exclusion, and institutional responses need to be analyzed together rather than collapsed into a single attitudinal construct [9].

Within healthcare encounters, labels become consequential through language. Communication about body weight, for example, can generate face threat depending on how clinical advice is framed and delivered [10]. The stigmatizing potential of a classification therefore depends partly on interactional practice. Two professionals could recognize the same clinical category while producing substantially different interpersonal meanings.

Provider stigma toward people with substance-use disorders illustrates the same distinction at another level. Systematic evidence identifies stigmatizing attitudes among healthcare professionals and trainees, while evidence concerning stigma-reduction interventions remains heterogeneous [11]. Measuring stereotype endorsement may identify one intervention target, but it

does not establish that changing that score will automatically alter institutional practice or patient experience.

Digital narratives further widen the evidentiary lens. First-person accounts from people who use opioids describe stigma through encounters with healthcare and related institutions in ways that expose policies, routines, and social classifications that conventional attitude measures may miss [12]. Such accounts cannot estimate prevalence, but they can identify candidate mechanisms and locations where stigma is experienced.

The proposed theoretical sequence is therefore classification → contextual interpretation → enactment or institutionalization, rather than classification → inevitable harm. A label acquires stigmatizing force when social meaning, power, and opportunity allow it to alter credibility, communication, access, treatment, surveillance, or identity interpretation.

Identity threat and internalized stigma

Healthcare stigma also operates through how a person anticipates and interprets social evaluation. Anticipated stigma concerns expectations of devaluation or discrimination, whereas internalized stigma involves incorporating devaluing social meanings into self-evaluation. A systematic review found recurring associations between anticipated or internalized stigma and depression but also emphasized that longitudinal findings were less consistent than the cross-sectional literature might suggest [13]. Internalization should therefore not be treated as an automatic endpoint of exposure.

Concealment introduces another distinction. Among people with concealable stigmatized identities, active concealment was more strongly related to poorer quality of life than simple categorical "outness," indicating that ongoing management of disclosure may itself be burdensome [14]. In healthcare, this makes visibility an inadequate proxy for stigma: some identities are apparent, others disclosed strategically, and others inferred through records or clinical histories.

Healthcare-specific weight stigma illustrates how encounter-level experiences and internalized beliefs may intersect. Among women, weight stigma within healthcare and weight-bias internalization were associated with aspects of the patient–provider relationship and healthcare engagement [15]. Yet internalization remains analytically separate from the encounter that may contribute to it.

Healthcare stereotype threat similarly resists deterministic interpretation. In a national probability sample of transgender adults, healthcare stereotype threat and social support showed context-dependent relationships with access to gender-affirming medical care rather than a simple pattern in which greater threat invariably produced less care [16]. Anticipated judgment can lead to avoidance, but it may also prompt preparation, selective disclosure, seeking supportive providers, or greater effort to obtain necessary services.

Disability research provides another reason to preserve reciprocal and contextual interpretations. Associations among discrimination, depression, self-esteem, and disadvantage can be statistically organized into pathways, but modeled pathways within a specific social setting do not establish a universally causal sequence [17].

The identity-level component of the proposed model therefore contains multiple possible response states rather than a single "internalization" pathway. The following matrix separates those states from the contexts and uncertainties that determine their significance **(Table 1)**.

Table 1. Identity responses to healthcare stigma are conditional pathways rather than a single internalization sequence

Immediate interpretive process	Conditions that may redirect the pathway	Competing explanation or uncertainty	Important boundary	Potential care consequence
Identity response state — Anticipated judgment				
Expectation of devaluation before an encounter	Prior experience, provider reputation, social support	Concern may reflect realistic risk rather than distorted expectation	Anticipation is not enacted discrimination	Avoidance, preparation, selective provider choice, or continued engagement
Identity response state — Internalized devaluation				

Social judgment becomes incorporated into self-evaluation	Repeated exposure, identity meaning, available counternarratives	Distress may have causes independent of stigma	Association does not prove temporal direction	Reduced confidence, shame, or altered participation
Identity response state — Concealment management				
Active control of what is disclosed	Concealability, privacy, documentation requirements	Nondisclosure may reflect preference rather than stigma	Visibility and disclosure are different constructs	Cognitive burden, strategic disclosure, or delayed discussion
Identity response state — Healthcare stereotype threat				
Awareness that one's group may be judged stereotypically	Clinical context, support, prior treatment, perceived necessity	Threat can coexist with active pursuit of care	Threat does not predict uniform avoidance	Vigilance, compensatory effort, provider selection, or disengagement
Identity response state — Identity-protective resistance				
Rejection of stigmatizing meanings	Community resources, social support, alternative identities	Resistance may coexist with distress or institutional constraint	Absence of internalization does not imply absence of stigma	Continued engagement, challenge, advocacy, or care relocation

Interpersonal Enactment and Anticipated Stigma

Stigma becomes clinically relevant when social expectations encounter relationships in which power is unequally distributed. Direct discrimination is one route, but patients can also learn from observing or hearing about how similar people are treated. Evidence among transgender and gender-independent adults linked directly experienced or vicariously observed healthcare discrimination and erasure with mistrust and utilization-related behavior, although the observational design does not justify treating mistrust as an inevitable mediator for every patient [18].

Anticipation can create work even when care is ultimately obtained. Gay and bisexual men navigating HIV services have described the additional labor required to assess whether services are inclusive, anticipate judgment, manage disclosure, and locate acceptable care [19]. Such “patient work” complicates the conventional assumption that the principal behavioral consequence of stigma is nonattendance. Some people avoid care; others expend additional time, emotional effort, travel, information seeking, or communication work to remain engaged.

Interpersonal enactment should therefore be modeled as a branching process. A stigmatizing cue may produce mistrust, but it may also trigger vigilance, strategic disclosure, switching clinicians, seeking social support, confronting the interaction, or continuing care because the perceived medical need outweighs social threat. Conversely, an apparently respectful encounter does not prove the absence of structural stigma if restrictive eligibility rules, inaccessible environments, or stigmatizing documentation remain unchanged.

The relational level is consequently neither reducible to patient psychology nor separable from institutional context. Clinical authority affects whose interpretation prevails, while prior experiences affect how ambiguous communication is understood. These reciprocal influences become particularly important once stigma is embedded in cultural narratives that define what counts as normal, responsible, credible, dangerous, or deserving.

Cultural Narratives and Normative Meaning

Healthcare encounters take place inside cultural systems that supply meanings before a clinician or patient speaks. Narratives about personal responsibility, normality, productivity, sexuality, danger, self-control, family legitimacy, or deservingness can shape whether a condition or identity is interpreted primarily as illness, moral failure, social risk, difference, or legitimate variation. The same diagnostic or social category can therefore acquire different stigma meanings across settings.

Cultural context should not be treated as a fixed attribute of a national or ethnic population. Research on gender-affirming care in China, for example, shows that transnational medical norms are adapted through local family and institutional arrangements rather than simply transferred intact [20]. Culture operates through translation, negotiation, authority, and institutional fit.

Normative climate can also become geographically patterned. Australian evidence using variation surrounding the 2017 same-sex-marriage plebiscite linked more hostile structural environments with poorer health and wellbeing among lesbian, gay, and bisexual populations, while also indicating the relevance of social-support mechanisms [21]. Such findings support treating social norms as contextual exposures, but they do not imply that geographic political indicators capture every individual's experience.

The conceptual implication is that cultural narratives act as meaning translators between classification and action. A clinical label does not carry one stable interpretation. Its meaning is filtered through local narratives, professional norms, family expectations, institutional practices, and patients' own identity frameworks. Culture may amplify stigma, normalize it, contest it, or provide alternative meanings that weaken internalization.

The boundary conditions are substantial. Explanations based on culture can easily essentialize populations if within-group disagreement, institutional variation, migration, generational differences, socioeconomic inequality, and transnational influence are ignored. A useful theory therefore treats culture as a contested field of meaning rather than as a static group characteristic.

Table 2 registers these transfer boundaries explicitly before the cross-level relationships are represented visually.

Table 2. Boundary conditions governing when cultural narratives become stigma-relevant in healthcare

Cultural narrative	Stigma meaning	Transmission site	Care expression	Misreading risk	Boundary condition
Normative field — Responsibility narratives					
What becomes socially legible	Whether illness is framed as controllable or blameworthy	**Translating site**	Clinical conversation, public discourse, policy	**Where interpretation may fail**	Clinical risk discussion may be mistaken for moral judgment
Transfer boundary	Meaning varies by condition and social context	**Relevance to healthcare stigma**	Can alter blame, credibility, and communicative tone		
Normative field — Normality expectations					
What becomes socially legible	Which bodies, identities, or behaviors are treated as deviations	**Translating site**	Professional norms, family, community	**Where interpretation may fail**	Difference is not necessarily devaluation
Transfer boundary	Standards of normality are historically and culturally situated	**Relevance to healthcare stigma**	Shapes categorization and perceived legitimacy		
Normative field — Danger narratives					
What becomes socially legible	Whether a person is treated primarily as a risk	**Translating site**	Risk assessment, documentation, institutional procedure	**Where interpretation may fail**	Appropriate safety practice can resemble stigmatizing control
Transfer boundary	Risk must be evaluated separately from social stereotype	**Relevance to healthcare stigma**	May justify surveillance or restriction when left analytically unseparated		
Normative field — Deservingness judgments					
What becomes socially legible	Who is viewed as a legitimate recipient of effort or resources	**Translating site**	Triage, communication, organizational decision making	**Where interpretation may fail**	Resource limitation may have non-stigma explanations

Transfer boundary	Scarcity and policy context matter	**Relevance to healthcare stigma**	Can convert classification into differential treatment		
Normative field — Family legitimacy					
What becomes socially legible	Whose identity or care request is treated as socially acceptable	**Translating site**	Family involvement and consent processes	**Where interpretation may fail**	Family participation can support as well as constrain care
Transfer boundary	Family authority varies across legal and cultural settings	**Relevance to healthcare stigma**	Alters disclosure, advocacy, and care negotiation		
Normative field — Local adaptation of global norms					
What becomes socially legible	How imported clinical standards are interpreted in practice	**Translating site**	Institutions, professional communities, families	**Where interpretation may fail**	Formal policy does not reveal actual implementation
Transfer boundary	Transnational standards do not transfer unchanged	**Relevance to healthcare stigma**	Explains why formally similar services can produce different social experiences		

The interaction among cultural meaning, relational interpretation, and organizational implementation is sufficiently complex that a layered field is more informative than a linear cultural-exposure pathway **(Figure 2)**.

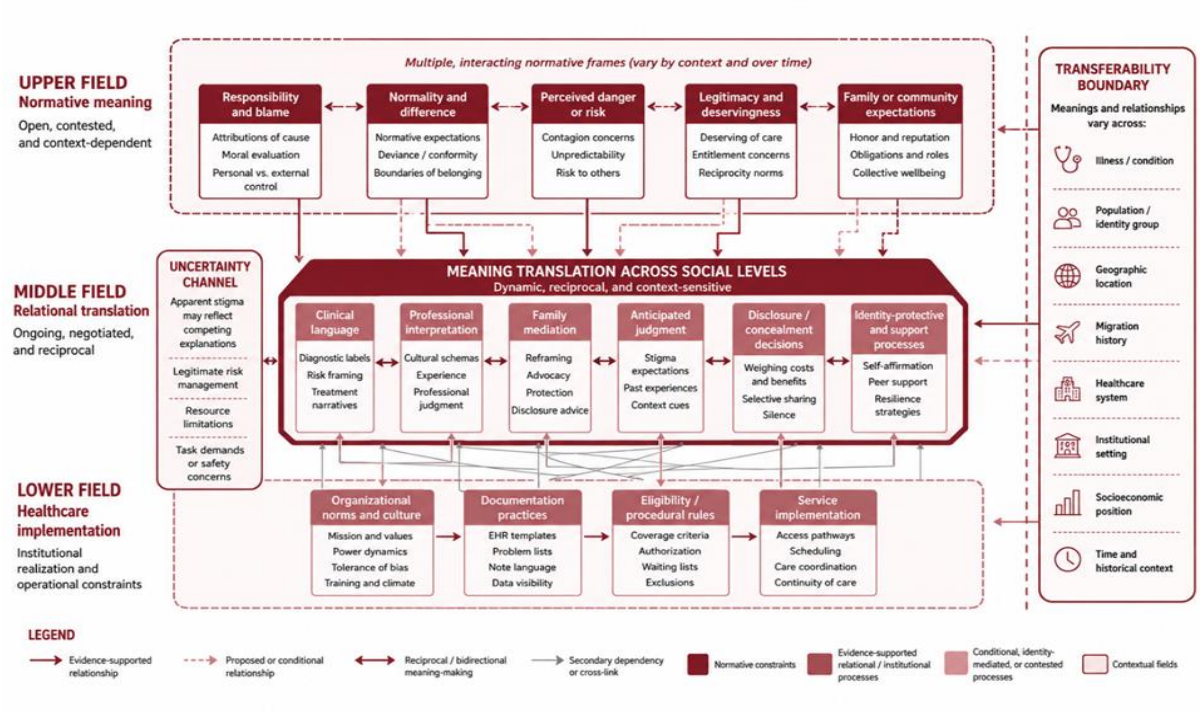

Figure 2. Normative meaning as a cross-level translator of healthcare stigma

Institutional and structural stigma

Institutional and structural stigma become analytically necessary when disadvantage is embedded in conditions that do not depend on a particular professional expressing prejudice. Structural stigma has been examined through laws, policies, area-level social climates, and institutional

arrangements associated with the health of LGBTQ+ populations [22, 23]. The importance of this literature is not that every association establishes causality, but that it identifies social conditions whose existence cannot be represented adequately as individual attitudes.

The construct itself remains methodologically heterogeneous. A recent scoping review found substantial variation in how structural stigma is defined and operationalized, including laws, policies, institutional practices, geographic indicators, and qualitative accounts [24]. "Structural stigma" should therefore not be treated as one homogeneous measurable exposure.

Healthcare offers concrete examples of why this distinction matters. Structural weight stigma in reproductive healthcare can be embedded in policies, insurance and funding arrangements, equipment, spatial environments, and service organization [25]. A clinician could hold relatively accepting personal attitudes while practicing in a system whose equipment, administrative procedures, or eligibility structures systematically disadvantage particular patients.

Health-facility research likewise suggests that stigma-reduction strategies may need to address individual, environmental, and policy-level conditions together [26]. This does not mean every multilevel intervention is effective. It means that interventions confined to knowledge or attitudes are mismatched when the relevant mechanism lies in workflow, infrastructure, documentation, staffing, governance, or institutional incentives.

The proposed model therefore allows a structural bypass: some stigma pathways reach the patient without requiring demonstrable individual prejudice at the point of care. Conversely, structural change can alter opportunity even when interpersonal attitudes change slowly. Maintaining this distinction is essential for both explanation and intervention design.

Intersectionality and multiple stigmatized identities

A multilevel account remains incomplete if it treats each stigmatized characteristic as an independent exposure that can simply be added to the others. Intersectional stigma scholarship instead emphasizes that identities and systems of power may interact, altering the meaning, visibility, consequences, and manageability of stigma [27]. The analytical question is therefore not merely how many stigmatized identities a person holds, but how particular configurations become consequential in a particular setting.

Mental-health-care research provides direct evidence of this complexity. A systematic qualitative synthesis found that people occupying multiple marginalized positions encounter discriminatory processes that can alter how they navigate services, although the evidence remains heterogeneous across populations and settings [28]. Such findings support intersectional analysis while cautioning against creating a universal hierarchy of multiply stigmatized groups.

The importance of power and resources is especially visible when weight stigma is examined together with race, gender, and socioeconomic position. Low-income Black women have described healthcare experiences in which body size cannot be separated cleanly from racialized treatment, affordability, resource constraints, and expectations about how they will be perceived [29]. Interpreting these experiences solely as weight bias would erase mechanisms operating through race and class.

Place can further modify intersectional experience. Qualitative evidence among Black sexual-minoritized men shows that belonging, exclusion, safety, and access to resources vary across social and geographic settings [30]. Place is therefore not simply the backdrop against which stigma happens; it can organize which identities become salient and which responses are available.

Intersecting health labels can also affect perception within healthcare. Experimental health-psychology evidence concerning mental and chronic physical disease indicates that combinations of stigmatized conditions may influence social judgments in ways that are not necessarily reducible to the independent contribution of either label [31]. At the lived-experience level, women living with HIV have similarly described HIV-related stigma as intertwined with gender, race, sexuality, socioeconomic position, and other social identities [27, 32].

These findings support an intersectional modification of the proposed dynamic model, but they do not justify converting intersectionality into a numerical "stigma burden." The model instead treats an intersectional configuration as a context modifier of pathway meaning. It can influence whether a classification is visible, how credible a patient's account is considered, what stereotype becomes salient, what resources are available for responding, whether concealment is possible, and which institutional constraints are encountered.

This approach also avoids inferring psychological states from demographic membership. A person occupying several socially disadvantaged positions cannot be assumed to experience internalization, mistrust, identity threat, or avoidance. Those are processes requiring evidence in their own right. Intersectionality identifies the organization of social positions and power relations within which such processes may occur; it does not predetermine an individual's response.

The theoretical consequence is substantial. Healthcare stigma cannot be modeled as a universal sequence beginning with a prejudiced attitude and ending with a uniform behavioral outcome. By the end of the first eight sections, the evidence instead supports a bounded architecture in which classification, identity interpretation, interpersonal enactment, normative meaning, institutional organization, structural conditions, and intersecting power relations remain analytically distinct while retaining the possibility of cross-level influence. The next stage of the analysis examines how those components accumulate across healthcare pathways, generate feedback between stigma and inequality, and can be integrated into the article's proposed dynamic multilevel model.

Stigma across healthcare pathways

Stigma rarely begins and ends within one clinical encounter. It can emerge before entry into care, during communication and assessment, through documentation and treatment decisions, or during follow-up and re-entry. A mixed-methods systematic review of type 2 diabetes stigma in healthcare settings illustrates this breadth: stigma was identified through communication, professional practices, anticipation and internalization, and features of the care environment [33]. A pathway perspective therefore asks not only whether stigma occurred but where it entered the care trajectory, what carried it forward, and whether later stages interrupted or reproduced it.

This distinction prevents several outcomes from being collapsed. Difficulty accessing a service is not equivalent to reduced utilization; utilization does not establish meaningful participation; participation does not establish adherence; and none of these automatically predicts clinical outcome. Previous evidence in this article also indicates that patients may remain engaged by undertaking additional work—screening providers, managing disclosure, travelling farther, contesting documentation, or preparing for anticipated judgment—even when the underlying environment remains stigmatizing.

Documentation creates particular temporal continuity. A stigmatizing interpretation recorded during one encounter may become available to future clinicians and thereby extend an earlier social classification into later care. Conversely, a supportive professional may interrupt an interpersonal pathway without removing structural constraints elsewhere in the system. Healthcare trajectories can therefore contain amplification, persistence, interruption, and partial repair simultaneously.

The proposed framework consequently treats each encounter as both an outcome of previous pathway conditions and a potential input into subsequent ones. **Table 3** makes visible how stigma carriers and patient responses may migrate between stages without assuming that every pathway terminates in avoidance.

Table 3. How stigma can migrate, accumulate, or be interrupted across a healthcare pathway

Stigma carrier entering that stage	Navigation response that may follow	What may be carried into the next stage	Interpretation that cannot be assumed	Possible interruption point
Care-pathway position — Before service entry				
Community narratives, previous discrimination, anticipated judgment	Delay, preparation, selective provider search, disclosure planning	Expectations about credibility, safety, or acceptance	Nonattendance necessarily reflects stigma	Accessible information, trusted referral, visible inclusivity
Care-pathway position — Initial contact				
Administrative language, eligibility rules, interpersonal classification	Continued engagement, withdrawal, strategic presentation	First impression of institutional safety	Polite interaction proves absence of stigma	Respectful reception and transparent procedures
Care-pathway position — Clinical assessment				

Stereotyping, face threat, credibility judgments	Vigilance, concealment, challenge, compensatory explanation	Perceived legitimacy of patient account	Diagnostic disagreement itself is discrimination	Collaborative communication and explicit uncertainty
Care-pathway position — Documentation				
Selective wording, inherited labels, persistent electronic records	Limited opportunity for immediate response	Prior classifications available to future professionals	Recorded information is socially neutral	Reviewable documentation and correction processes
Care-pathway position — Treatment and referral				
Resource restrictions, institutional routines, service availability	Acceptance, switching services, additional patient work	Unequal treatment burden or fragmented continuity	Every difference in treatment reflects prejudice	Mechanism-matched organizational review
Care-pathway position — Follow-up and re-entry				
Memory of earlier encounters plus continuing structural conditions	Return, conditional engagement, avoidance, advocacy	Reinforced or revised expectations of future care	One positive encounter repairs accumulated disadvantage	Continuity, repair, institutional learning

Feedback between stigma, avoidance, and inequality

A linear model would place stigma before avoidance and avoidance before adverse outcomes. The evidence assembled here suggests a more conditional structure. Anticipated or internalized stigma is frequently associated with psychological distress, yet longitudinal findings are less consistent than cross-sectional associations. Direct and vicarious discrimination may contribute to mistrust, while other patients remain engaged by performing additional patient work. Avoidance is therefore one possible transition rather than the defining behavioral consequence of stigma.

Longitudinal evidence among women living with HIV further supports treating stigma states as changeable. Intersectional stigma configurations and their associations with antiretroviral adherence can vary over time rather than remaining fixed properties of an individual [34]. Such findings do not validate a universal feedback mechanism, but they make a static model increasingly difficult to defend.

The proposed feedback account contains two distinct forms of recursion. Experiential feedback occurs when an encounter changes expectations brought to future encounters. Inequality feedback occurs when the resources required to manage stigma—time, money, mobility, social support, health literacy, alternative providers, or capacity to contest institutional decisions—are distributed unequally. Two patients exposed to similar social judgment may consequently face different feasible responses.

This interpretation also guards against blaming patients for disengagement. What appears behaviorally as "choice" may be constrained by prior experience, service availability, administrative requirements, financial resources, geographic access, or dependence on the same institution. Conversely, continued utilization cannot be interpreted as evidence that stigma was absent. Engagement may itself require substantial compensatory labor.

A dynamic multilevel stigma model

The evidence can now be integrated into the article's principal original contribution: a proposed dynamic multilevel stigma model. The model does not describe stigma as a substance that simply passes from society to patient. It describes a changing configuration of social classification, identity interpretation, interpersonal enactment, normative meaning, institutional organization, structural constraint, and prior experience.

Five propositions define the model. First, multiple entry points are possible: stigma can originate in attitudes, discourse, documentation, organizational routines, policies, material environments, or broader normative climates. Second, cross-level transmission is conditional: a stereotype becomes consequential only through a process capable of translating it into interaction, institutional practice, identity interpretation, or resource allocation. Third, structural bypass is possible: patients may encounter stigmatizing constraints even when no individual actor expresses demonstrable prejudice.

Fourth, responses branch rather than converge: anticipation can lead to avoidance, concealment, vigilance, compensatory work, resistance, provider switching, advocacy, or continued engagement. Fifth, states are revisable: subsequent encounters can reinforce earlier expectations, produce new forms of stigma, or partially interrupt and repair previous pathways.

Intersectionality modifies every proposition. Social positions do not simply add independent quantities of stigma; they can change which classifications become salient, how they are interpreted, and which resources are available for responding. Cultural meaning similarly operates as a translator rather than a fixed upstream variable. Institutional and digital systems can preserve classifications across time, giving some processes temporal persistence beyond the encounter in which they originated.

The model is not empirically validated as an integrated architecture. Its scientific purpose is to make competing explanations visible and generate falsifiable questions. **Table 4** therefore begins with situations in which an overly simple stigma model would fail.

Table 4. Failure cases that a dynamic multilevel theory of healthcare stigma must be able to explain

Patient or care-context state	Why a simple stigma sequence fails	Alternative process that must remain possible	What the proposed model must preserve	Validation requirement
Negative provider attitude without apparent discriminatory care	Attitude does not automatically establish enactment	Professional norms or safeguards may constrain behavior	Distinction between cognition and action	Observe attitudes and care practices separately
Respectful clinician within restrictive system	Positive interaction does not remove institutional constraint	Rules, equipment, eligibility, or documentation may carry disadvantage	Structural-bypass pathway	Measure institutional conditions independently of encounter ratings
Strong anticipated stigma with continued care	Threat does not inevitably generate avoidance	Necessity, support, preparation, or compensatory effort may sustain engagement	Branching behavioral responses	Longitudinally measure both expectations and navigation work
Absence of internalized stigma despite repeated discrimination	Exposure does not require self-devaluation	Resistance, counternarratives, community identity, or support	Identity-protective states	Separate enacted, anticipated, and internalized stigma
Single supportive encounter after accumulated adverse experiences	Repair may be partial rather than immediate	Prior expectations and institutional records may persist	Temporal memory and incomplete repair	Follow patients across repeated encounters
Similar classification with different consequences across settings	Labels do not possess fixed social meaning	Cultural, organizational, relational, and policy contexts modify interpretation	Context-sensitive translation	Comparative multilevel testing across settings
Multiple stigmatized identities with non-additive experience	Independent-risk summation misses interactions	One identity may alter visibility or meaning of another	Intersectional configuration	Test interactions without converting identities into a simple burden score

Intervention targets across levels

A dynamic account changes how intervention targets are selected. If the dominant mechanism is professional stereotyping or misinformation, education, reflection, or social contact may be appropriate. If stigma is carried through documentation, eligibility rules, inaccessible infrastructure, staffing practices, or policy, an attitude intervention alone is poorly matched to the mechanism.

Evidence supports cautious optimism rather than a universal intervention formula. A culturally grounded social-contact intervention in primary care demonstrated promising changes in provider-related outcomes within its particular implementation setting. By contrast, a cluster-randomized workplace intervention addressing HIV- and tuberculosis-related stigma showed mixed evidence, including a nonsignificant quantitative stigma

reduction despite informative qualitative findings [35, 36]. Intervention heterogeneity is therefore theoretically useful: it indicates that identifying "stigma" is not enough to identify the correct lever.

The model proposes a mechanism–target alignment principle. Intervention design should identify the level carrying the stigmatizing process, the actors or infrastructure capable of changing it, the pathway stage at which change is feasible, and the outcomes appropriate to that level. Success in changing attitudes should not automatically be presented as evidence of improved access or clinical outcomes; likewise, a structural policy intervention should not be judged solely through individual attitude measures.

Multilevel interventions may be necessary when several carriers operate simultaneously, but complexity itself is not a virtue. Each component should correspond to a specified mechanism and have an evaluable proximal outcome. Otherwise, a broad anti-stigma program risks becoming impossible to interpret when effects differ across populations, professions, institutions, or stages of care.

Results and Discussion

This article argues that the principal weakness of an attitude-centered understanding of healthcare stigma is not that attitudes are unimportant. It is that attitudes are too often asked to explain phenomena produced through qualitatively different social processes. The reviewed evidence spans individual expectations, interpersonal communication, professional discourse, electronic records, organizational arrangements, structural conditions, cultural translation, intersectional identities, and longitudinal change. Taken together, these literatures justify a broader explanatory vocabulary while not establishing one universal causal pathway.

The proposed dynamic multilevel model organizes that evidence around conditional transmission. Social classification must be distinguished from enactment; anticipated stigma from experienced discrimination; internalization from identity threat; interpersonal experience from institutional condition; and structural exposure from individual prejudice. These distinctions matter methodologically because measuring only one level can make another mechanism invisible. They also matter clinically because an intervention directed at the wrong carrier may alter a survey score without changing the condition through which stigma affects care.

Several apparent contradictions become more intelligible under this approach. Strong anticipated stigma can coexist with continued healthcare use because patients may compensate through additional work. Respectful interpersonal care can coexist with structural disadvantage because institutional rules can bypass individual attitudes. Conversely, negative attitudes need not produce observable discrimination when professional standards or organizational safeguards constrain enactment. Null or mixed intervention findings likewise need not imply that stigma is immutable; they may indicate mechanism mismatch, measurement mismatch, insufficient implementation, or context dependence.

The framework has important limits. Much of the evidence remains observational, cross-sectional, qualitative, population-specific, or dependent on heterogeneous stigma measures. Structural-stigma research varies substantially in operationalization, and evidence is concentrated in particular conditions and social groups. Intersectional research often provides rich accounts of context and power but remains difficult to compare using standardized designs. Digital documentation introduces potentially persistent institutional mechanisms, yet patient-level consequences cannot be inferred from the existence of electronic categorization alone. Longitudinal evidence is improving but remains insufficient to establish the complete feedback architecture proposed here.

The next empirical task is therefore not to search for one universal stigma score. Stronger tests would combine repeated patient-level measurement with encounter observations, organizational characteristics, documentation processes, geographic or policy indicators, and time-varying healthcare outcomes. Comparative designs should test whether the same classification travels through different mechanisms across illnesses, institutions, cultures, and policy environments. Intervention research should measure proximal outcomes at the level actually targeted and then test, rather than assume, downstream transfer.

A dynamic theory also changes the normative interpretation of patient behavior. Avoidance, delayed care, concealment, switching clinicians, extensive preparation, or continued engagement should not automatically be interpreted as stable psychological traits. They may represent context-sensitive responses to perceived opportunity and constraint. Making these alternatives visible is essential if healthcare systems are

to avoid converting structural or relational disadvantage into narratives of individual noncompliance.

Conclusion

Healthcare stigma is better conceptualized as a dynamic social process than as an individual attitude with predictable downstream effects. Attitudes remain one possible entry point, but stigma can also be carried through language, relationships, documentation, organizational rules, material environments, cultural narratives, structural conditions, and intersecting systems of power.

The proposed multilevel model preserves distinctions among exposure, interpretation, enactment, institutionalization, identity response, behavior, and healthcare consequence while allowing reciprocal and temporally changing relationships among them. It does not presume that stigma always causes avoidance, that multiple stigmatized identities combine additively, or that mechanisms transfer unchanged across populations and settings.

Its principal contribution is therefore explanatory discipline: identifying what carries stigma, at which level, under what conditions, and with what alternative pathways before selecting a measurement strategy or intervention. Prospective longitudinal, multilevel, comparative, and implementation research is required to determine which proposed pathways are reproducible, which are context specific, and where healthcare systems can most effectively interrupt rather than reproduce stigma.

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