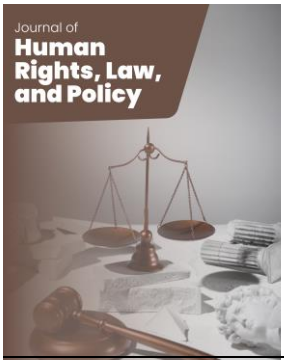

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Dimensions of Dignity in State-Provided Healthcare: A Qualitative Study of Patient Narratives

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ABSTRACT

This study aimed to explore how patients receiving care in state-provided healthcare settings in Tehran experience and define the concept of dignity during medical encounters. Using a qualitative phenomenological design, this study collected data through semi-structured interviews with 29 participants who had received care in public healthcare facilities in Tehran within the past six months. Participants were selected using purposive sampling to ensure diversity in gender, age, educational background, and treatment type. Interviews were conducted in Persian, audio-recorded, transcribed verbatim, and analyzed using thematic analysis supported by NVivo software. The data collection process continued until theoretical saturation was reached. The analysis followed a multi-stage coding process including open, axial, and selective coding to identify core themes related to patients' dignity experiences. Analysis revealed four major themes: (1) Respectful Communication—including active listening, clarity, and nonverbal cues; (2) Autonomy and Decision-Making—comprising informed consent, shared decision-making, and privacy; (3) Institutional Practices—encompassing physical environment, waiting time, bureaucracy, and treatment equality; and (4) Emotional and Psychological Safety—relating to empathy, emotional support, and minimization of shame. Participants described dignity as a multidimensional experience shaped by both interpersonal interactions and systemic healthcare conditions. Breaches in dignity were often linked to communication failures, lack of choice, and structural inefficiencies. Dignity in public healthcare is deeply relational and context-dependent, influenced by provider behavior and institutional structures. Ensuring respectful communication, supporting patient autonomy, improving institutional processes, and fostering emotional safety are critical to delivering dignity-preserving care in state-provided systems. These findings offer actionable insights for policymakers, healthcare professionals, and administrators aiming to enhance the quality and humanity of public health services.

Keywords: *Patient dignity; qualitative research; public healthcare; healthcare communication; autonomy; emotional safety; Iran; phenomenology.*

Introduction

The concept of dignity occupies a central place in ethical and humanistic frameworks of healthcare, representing both a philosophical ideal and a practical imperative in patient care. Within public healthcare systems, where high patient volumes, limited resources, and structural constraints often shape provider–patient interactions, preserving patients' dignity becomes a complex but vital concern. Dignity is not merely a theoretical construct—it is a lived, subjective experience that affects how individuals perceive their own worth and humanity during medical treatment (Jacobson, 2009). Particularly in state-provided healthcare systems, where patients may have less freedom of choice, the extent to which their dignity is protected or violated becomes a direct indicator of the quality and equity of the system itself (Leino-Kilpi et al., 2001).

Dignity in healthcare has been widely discussed in bioethics, nursing, and medical humanities. It is typically associated with respect, autonomy, personhood, privacy, and emotional safety (Gallagher et al., 2008). Nordenfelt (2004) famously distinguished between four types of dignity: the dignity of merit, of moral stature, of identity, and of human worth. In healthcare settings, "dignity of identity"—the sense of self as respected and valued—is especially salient, given the inherently vulnerable position of patients. Patients undergoing treatment often face physical exposure, loss of autonomy, and dependence on others—conditions that can heighten the risk of perceived indignity (Matiti & Baillie, 2011). Although numerous theoretical models of healthcare dignity exist, there remains a pressing need for context-specific, empirically grounded research that captures how patients themselves define and experience dignity—especially in settings where structural limitations may challenge ideal standards of care.

In recent years, patient-centered care has emerged as a guiding principle in healthcare reform, emphasizing responsiveness to patients' values, preferences, and needs (Epstein & Street, 2011). Central to this model is the recognition that dignity is not an abstract ideal but a relational and emotional experience shaped by communication, respect, and shared decision-making. Research shows that when patients feel respected, listened to, and involved in decisions, their treatment outcomes improve, and their satisfaction increases (Beach et al., 2006). Conversely, dignity violations—such as being ignored, rushed, disrespected, or inadequately informed—can lead to emotional distress, mistrust in the healthcare system, and even disengagement from care (Chochinov et al., 2002).

While dignity is universally relevant, its expression and perceived breaches are shaped by cultural, institutional, and social contexts. In many high-income countries, efforts to preserve dignity have led to the development of professional codes of conduct, patient charters, and legal protections (WHO, 2015). However, in state-provided systems within resource-constrained or developing contexts, such as Iran, the implementation of dignity-related principles is often inconsistently operationalized. Studies conducted in Iran have highlighted patient complaints about poor communication, insufficient privacy, discrimination, and bureaucratic hurdles—all of which contribute to perceptions of indignity (Shirazi et al., 2017; Abbaszadeh et al., 2014). Despite these concerns, few qualitative studies have directly explored the lived experience of patients with respect to dignity in Iran's public healthcare system. The present study addresses this gap by examining how patients receiving care in state-provided facilities in Tehran understand and narrate the concept of dignity.

A further complication arises from the structural characteristics of state-funded health services. State systems often prioritize efficiency and population-level outcomes, which can conflict with the individualized, emotion-centered demands of dignified care (Fenton & Hughes, 2009). For instance, in overcrowded hospitals, providers may lack the time or resources to engage in deep communication or emotional support, even if they recognize its importance. In such environments, dignity may be undermined not through intentional disregard but through systemic constraints. Understanding dignity as a relational and structural phenomenon allows researchers and policymakers to identify both micro-level (e.g., provider behavior) and macro-level (e.g., institutional design) factors that influence patients' experience.

Moreover, the emotional dimensions of dignity—such as feeling respected, valued, or emotionally safe—are often overlooked in administrative or biomedical evaluations of healthcare quality. Studies have shown that patients who feel emotionally supported are more likely to adhere to treatment and to report higher satisfaction (Sulmasy, 2007). In contrast, perceived emotional neglect can lead to long-term psychological impacts, including shame, helplessness, and a sense of invisibility (Wikberg & Bondas, 2010). This is particularly critical in contexts where patients may already experience marginalization due to gender, age, class, or disability. Therefore, a nuanced understanding of emotional and psychological safety as dimensions of dignity is essential to delivering humane care.

Communication practices are another key dimension of dignity. Research across diverse settings has emphasized the role of verbal and nonverbal communication in signaling respect and acknowledgment (Oosterveld-Vlug et al., 2013). Providers who use calm tones, maintain eye contact, avoid medical jargon, and allow time for patient questions are often perceived as treating patients with dignity. In contrast, hurried consultations, inappropriate language, or dismissive behavior can lead patients to feel devalued. In Iranian healthcare contexts, communication gaps have been widely reported, particularly in overcrowded public hospitals (Vahidi et al., 2016). This makes it imperative to explore how patients in these environments interpret communication as either enhancing or undermining their sense of self-worth.

Autonomy and participation in care decisions are also closely tied to dignity. While informed consent is a legal standard in many countries, its implementation varies significantly in practice. Research indicates that many patients, particularly in state-run facilities, do not feel fully informed or involved in treatment planning (Khosravi et al., 2018). Instead, hierarchical models of care often dominate, with physicians making decisions unilaterally. This can lead to patients feeling disempowered and invisible. In contrast, models of shared decision-making, where patients are encouraged to voice preferences and participate in planning, have been associated with enhanced dignity and trust (Charles et al., 1997). Within Iran’s healthcare system, the balance between traditional authority structures and contemporary patient-centered models remains unresolved and worthy of exploration.

Institutional factors—including the physical environment, waiting times, administrative processes, and consistency of care—also significantly shape the dignity experience. Studies have demonstrated that overcrowded wards, long waits, lack of privacy, and disorganized bureaucracies can signal to patients that their time and well-being are not valued (Lin et al., 2011). Continuity of care, whereby patients interact with the same provider over time, has been identified as an important facilitator of dignity, yet is often lacking in public systems. In Iran, institutional inefficiencies such as redundant paperwork, poor record-keeping, and poor interdepartmental coordination have been frequently cited as obstacles to patient-centered care (Tavakoli et al., 2019).

Finally, the psychological and emotional safety of patients plays a critical but underexplored role in perceptions of dignity. When patients feel emotionally safe, they are more likely to disclose personal information, adhere to care plans, and engage meaningfully with providers (Chochinov, 2006). Psychological safety includes being treated as a unique person, receiving emotional support during vulnerable moments, and being shielded from experiences of shame or judgment. This is particularly crucial for patients with stigmatized conditions or those undergoing intimate procedures. In public healthcare contexts where staff may be overburdened and training in emotional communication is minimal, ensuring psychological dignity becomes particularly challenging.

Given these complexities, this study seeks to explore the multifaceted dimensions of dignity as experienced by patients in Tehran’s state-provided healthcare facilities. Using a qualitative, phenomenological approach, the study focuses on patients’ subjective narratives to identify patterns, meanings, and contextual nuances surrounding dignity. By centering patient voices, the study aims to offer actionable insights for policymakers, healthcare providers, and administrators seeking to improve the quality of public healthcare not just in Iran, but in similar systems worldwide. The goal is not only to document violations of dignity, but to illuminate pathways for its preservation and enhancement within structurally constrained systems.

Methods and Materials

This study adopted a qualitative research design grounded in phenomenological methodology to explore the lived experiences of patients regarding dignity in state-provided healthcare settings. The phenomenological approach was chosen to capture the subjective meanings and perceptions that patients attach to their interactions within the healthcare system. A total of 29 participants were recruited from various public hospitals and clinics in Tehran, Iran. Purposeful sampling was employed to ensure the inclusion of individuals with diverse backgrounds in terms of age, gender, type of treatment received, and length of interaction with the public healthcare system. Inclusion criteria included: (1) age above 18 years, (2) receipt of care in a state-provided healthcare facility within the past six months, and (3) the ability to articulate personal healthcare experiences in Persian.

Data were collected through in-depth semi-structured interviews conducted in private and secure locations convenient for the participants. Each interview lasted between 45 and 75 minutes. An interview guide was developed based on existing literature on healthcare dignity and included open-ended questions such as: “Can you describe an experience in the healthcare system where you felt respected or disrespected?” and “What does dignity mean to you in your interactions with healthcare providers?” Follow-up prompts were used to encourage deeper reflection and elaboration. All interviews were conducted in Persian, audio-recorded with participants’ consent, and subsequently transcribed verbatim. The data collection process continued until theoretical saturation was achieved—defined as the point at which no new themes or insights emerged from additional interviews.

The transcribed interviews were analyzed using thematic analysis within the framework of phenomenological inquiry. NVivo qualitative data analysis software (version 12) was employed to facilitate systematic coding, organization, and retrieval of data. The analysis involved several stages: open coding to identify significant statements and initial categories, axial coding to establish connections among categories, and selective coding to synthesize overarching themes. To enhance the trustworthiness of the findings, strategies such as peer debriefing, member checking, and audit trails were employed. The researchers maintained reflexive memos throughout the process to account for personal biases and ensure the credibility and rigor of the interpretations.

Findings and Results

A total of 29 participants took part in this study, comprising 16 women (55.2%) and 13 men (44.8%). The age of participants ranged from 22 to 71 years, with a mean age of 43.6 years (SD = 12.4). In terms of educational background, 9 participants (31.0%) held a high school diploma or less, 13 participants (44.8%) had completed undergraduate education, and 7 participants (24.2%) possessed postgraduate degrees. Regarding marital status, 18 participants (62.1%) were married, 8 (27.6%) were single, and 3 (10.3%) were widowed or divorced. Participants received care for a variety of health issues, including chronic conditions such as diabetes and cardiovascular disease (n = 12, 41.4%), recent surgical procedures (n = 8, 27.6%), acute illness or injury (n = 5, 17.2%), and maternal or reproductive care (n = 4, 13.8%). All participants were residents of Tehran and had accessed public healthcare services within the previous six months.

Table 1. Extraced Codes

Main Theme	Subcategory	Concepts (Open Codes)
1. Respectful Communication	Active Listening	Eye contact, attentiveness, non-interruptive behavior, silence as empathy, nodding, verbal affirmations, patient-centered responses
	Tone of Voice	Calm tone, non-condescending speech, absence of shouting, friendly intonation, reassuring voice
	Language Appropriateness	Avoidance of jargon, use of lay terms, age-sensitive expressions, non-patronizing phrases, respectful address (e.g., “Mr./Mrs.”)
	Time Allocation for Questions	Allowing time for concerns, not rushing, pausing for understanding, repeating when asked
	Validation of Patient Concerns	“I understand your worry,” empathic statements, acknowledging distress, reinforcing concerns as legitimate
	Nonverbal Cues	Smiling, physical posture, nodding, calm facial expressions, gestures conveying openness
	Clarity in Explanations	Step-by-step clarification, visual aids, summarizing next steps, repeat-backs
2. Autonomy and Decision-Making	Informed Consent	Explaining procedures, offering alternatives, asking for permission, emphasizing choice, providing sufficient details
	Shared Decision-Making	Encouraging preferences, incorporating cultural values, involving families, balancing expert opinion with patient voice
	Opportunity to Decline Care	Right to refuse treatment, not coercing agreement, accepting hesitance, offering time to decide
	Control Over Daily Routines	Choice in visiting hours, food options, rest times, involvement in daily care planning
	Privacy in Discussions	Speaking in private rooms, avoiding public disclosures, asking if now is a good time to talk
3. Institutional Practices	Physical Environment	Cleanliness, quietness, personal space, presence of curtains, functional equipment, availability of basic necessities
	Waiting Time and Scheduling	Long delays, unexplained waits, lack of updates, rushed appointments, patient queuing experience
	Bureaucratic Obstacles	Repetitive paperwork, lack of digital records, miscommunication between departments, unclear referral paths
	Continuity of Care	Repeatedly seeing different doctors, lack of follow-up, no linkage across departments, fragmented communication
	Treatment Equality	Perceived discrimination, preferential treatment, unequal access to medications or tests, income-related disparities
	Accountability Mechanisms	Complaint procedures, responsiveness to reports, presence of patient rights posters, feedback boxes
4. Emotional and Psychological Safety	Being Treated as a Person	Recalling name, remembering details, treating beyond diagnosis, individualized care, respecting life history
	Emotional Support	Asking how patient feels, providing reassurance, acknowledging fear, offering hope, presence of counselor or chaplain
	Minimization of Shame	Avoiding moral judgment, not blaming patients for illness, gentle discussion of stigmatized conditions, respecting modesty
	Support During Vulnerability	Helping during physical exposure, presence during procedures, calming presence in emergency cases, talking through fear
	Consistency in Emotional Tone	No mood swings from staff, avoiding sarcasm, emotional predictability, reliable demeanor

1. Respectful Communication

Active Listening: Participants consistently emphasized the importance of healthcare providers’ ability to actively listen. Patients felt acknowledged when professionals maintained eye contact, responded without interruption, and demonstrated attentiveness through subtle cues like nodding or short affirmations. One participant shared, “The doctor just sat there and listened until I finished. It was the first time I felt someone was really hearing me, not just checking boxes.” This type of engagement helped establish emotional trust and signaled dignity in the interaction.

Tone of Voice: The tone used by healthcare staff significantly impacted patients' emotional comfort. Calm, respectful, and non-condescending speech was often perceived as validating and humane. As one patient explained, “She spoke gently, like I was someone who mattered—not a case file. That meant the world to me.” In contrast, raised voices or dismissive tones were described as humiliating and dehumanizing.

Language Appropriateness: Patients reported a sense of inclusion and respect when medical explanations were communicated in accessible, lay terms rather than technical jargon. Proper use of titles and respectful address were also highlighted. “He didn’t use complicated terms. He explained in my language and said ‘sir’—that showed respect,” one man remarked. Simplifying language without being patronizing appeared key to perceived dignity.

Time Allocation for Questions: Participants appreciated when providers allowed time for inquiries and did not rush consultations. This opportunity to express confusion or concerns empowered patients and affirmed their right to clarity. “She asked if I had more questions—even when her shift was almost over,” noted one woman. The absence of such time was perceived as a barrier to feeling respected.

Validation of Patient Concerns: Acknowledging patient emotions and concerns—even those not directly medical—was a strong indicator of dignity. “When I cried, the nurse said, ‘Your fear is valid,’ and that stopped me from breaking down completely,” a participant recalled. Validating distress gave patients the sense that their lived experience was meaningful to staff.

Nonverbal Cues: Nonverbal behaviors such as smiling, calm facial expressions, and open body posture played a subtle yet vital role in conveying respect. Participants linked these gestures to empathy and safety. “Her smile was calming. She didn’t even have to say much, I felt cared for,” shared one elderly respondent.

Clarity in Explanations: Participants valued when staff gave step-by-step explanations about procedures, potential risks, and next steps in care. One person mentioned, “He drew a small diagram and explained each part. I felt included, not just observed.” These efforts not only enhanced comprehension but also reinforced a sense of agency.

2. Autonomy and Decision-Making

Informed Consent: A major dignity-enhancing factor was the thorough communication of treatment risks and options. Participants felt respected when providers sought permission and explained implications clearly. “She didn’t just ask for my signature. She told me everything, then asked if I was okay with it,” said one participant, indicating the value of informed participation.

Shared Decision-Making: Many participants reported increased dignity when they were consulted in care planning. A patient described, “The doctor asked what I preferred—surgery or physical therapy first. It wasn’t just his call.” Including patients in decisions created a feeling of being respected as individuals with values and preferences.

Opportunity to Decline Care: Patients appreciated being able to refuse certain treatments without judgment. “I said no to sleeping pills, and the nurse just nodded and said, ‘That’s your choice.’ I didn’t feel pressured,” a respondent noted. Having the option to say no was seen as an affirmation of bodily and personal autonomy.

Control Over Daily Routines: Participants who were allowed to make small decisions, such as choosing when to rest or whom to have present during care, reported greater comfort and self-worth. One individual stated, “They asked if I wanted my husband in the room during the check-up. That gave me control in a vulnerable moment.”

Privacy in Discussions: Ensuring confidentiality and choosing private spaces for conversations was reported as fundamental to maintaining dignity. “He asked if I preferred to talk inside or in the hallway. That small gesture made a big difference,” one woman shared. Lack of privacy, in contrast, led to feelings of exposure and embarrassment.

3. Institutional Practices

Physical Environment: Patients frequently described the hospital's physical setting as reflective of how they were valued. Cleanliness, functioning equipment, and visual privacy (such as curtains) contributed to their perception of dignified care. "The curtain was always closed during exams. It felt like I had a space of my own," said a participant.

Waiting Time and Scheduling: Long, unexplained waiting periods were among the most commonly reported sources of indignity. "We waited four hours with no update—it made me feel invisible," one respondent explained. On the other hand, timely updates and apologies for delays were interpreted as respectful.

Bureaucratic Obstacles: Participants expressed frustration with inefficient administrative processes, which they felt diminished their importance. "I had to fill out the same form three times because different departments didn't talk to each other. It made me feel like a burden," one individual lamented. Such redundancy devalued the patient experience.

Continuity of Care: Seeing different doctors in each visit often disrupted trust and made participants feel like "a number." "Every visit, a new doctor. I had to repeat my whole story each time. It was exhausting and impersonal," one participant said. Consistency in caregivers was strongly associated with feeling acknowledged.

Treatment Equality: Several respondents noted disparities in treatment based on socioeconomic status or personal connections. "I saw someone jump the line because he knew someone. That's when I felt like I didn't matter," said one low-income participant. Fair and unbiased treatment was perceived as a core component of dignity.

Accountability Mechanisms: Awareness of complaint systems or visible patient rights posters gave participants a sense of safety. One interviewee mentioned, "When I saw the suggestion box and a patient rights chart, I felt like my voice could matter." Lack of such mechanisms was associated with powerlessness and mistrust.

4. Emotional and Psychological Safety

Being Treated as a Person: Patients deeply valued when providers remembered their name, past details, or personal preferences. "He asked how my daughter was doing—I didn't expect that," one participant noted. Feeling seen as a whole person beyond illness was central to preserving dignity.

Emotional Support: Acts of emotional reassurance—such as checking on patients' feelings or offering hope—were frequently mentioned. "The doctor didn't just treat my leg; he asked how I was coping with everything. That made a difference," shared one patient. This emotional attentiveness humanized the care experience.

Minimization of Shame: Avoiding judgmental language and treating stigmatized conditions (e.g., mental health, STDs) with sensitivity was noted as a key dignity-preserving behavior. "No one looked at me weird when I said I had HIV. That helped me hold my head up," said one participant.

Support During Vulnerability: Participants highlighted the importance of presence and gentle guidance during physically or emotionally vulnerable situations. "During the pelvic exam, she explained each step and didn't leave me alone. That helped me feel safe," recalled a female respondent.

Consistency in Emotional Tone: Unpredictable emotional displays from staff—such as sarcasm or abruptness—caused distress. In contrast, reliability in mood was linked to feelings of safety. "She was calm every time I saw her. That kind of steadiness calms your nerves too," one patient emphasized.

Discussion and Conclusion

This study explored how patients receiving care in state-provided healthcare facilities in Tehran experience and define dignity during their medical encounters. Four major themes were identified: Respectful Communication, Autonomy and Decision-Making, Institutional Practices, and Emotional and Psychological Safety. Each theme encompassed subdimensions that together illuminate the multifaceted and relational nature of dignity in healthcare. The findings reinforce the idea that dignity is not an abstract ideal but a lived experience, shaped by interpersonal behaviors, structural realities, and cultural expectations. The narratives reveal that patients interpret dignity as being treated as a person of value, having their voice acknowledged, and receiving care in a system that respects both their emotional and physical integrity.

The first theme—Respectful Communication—emerged as a fundamental element of dignity. Participants placed significant emphasis on behaviors such as active listening, appropriate tone of voice, respectful language, and clarity in explanations. These findings are consistent with prior research demonstrating that effective communication practices are central to patients' dignity perception (Beach et al., 2006; Oosterveld-Vlug et al., 2013). In particular, participants linked communication not just to understanding medical information but to feeling emotionally validated and humanized. This aligns with Chochinov's (2007) dignity-conserving model, which posits that respectful communication—especially in the form of acknowledgment and empathy—preserves patients' sense of personhood. The inclusion of nonverbal communication elements such as facial expressions, gestures, and physical presence further supports research highlighting the silent but powerful ways dignity is conveyed (Gallagher et al., 2008).

The second major theme—Autonomy and Decision-Making—reflects participants' desire to be included in their care rather than being passive recipients of treatment. Subcategories such as informed consent, shared decision-making, and the right to decline care were repeatedly associated with feelings of control and respect. These findings support the work of Charles et al. (1997) on the value of shared decision-making in fostering trust and patient satisfaction. In contexts where hierarchical models of care still dominate, such as in many public hospitals in Iran, autonomy is often compromised (Khosravi et al., 2018). The results of this study indicate that when patients are involved in decisions—even in minor aspects of their routine such as timing of care or who is present during examinations—they report a stronger sense of dignity. Importantly, participants also noted the symbolic value of being offered choices, even when they might not take them. This aligns with the findings of Matiti and Baillie (2011), who suggest that offering choice reinforces patients' sense of self-worth and agency, key components of dignified care.

The third theme—Institutional Practices—highlights how systemic factors impact patients' perception of dignity. Participants frequently described the physical environment, waiting time, bureaucratic inefficiencies, and continuity of care as indicators of how much they were valued by the system. These findings mirror the work of Lin et al. (2011), who found that institutional barriers such as long waits and fragmented care often erode the patient's experience of dignity, especially in under-resourced public settings. In the present study, the lack of consistency in caregivers and the presence of administrative hurdles were interpreted not only as logistical inconveniences but as moral injuries to the patient's self-worth. This supports Jacobson's (2009) argument that dignity in healthcare is deeply relational and can be either affirmed or undermined by institutional structures. The observed link between treatment equality and dignity—particularly around perceived discrimination or favoritism—also aligns with studies indicating that social justice is a core element of respectful healthcare (Leino-Kilpi et al., 2001; Shirazi et al., 2017).

The final theme—Emotional and Psychological Safety—underscores the importance of being treated with kindness, empathy, and respect for individual vulnerability. Participants described dignity as being seen beyond their illness, being emotionally supported during distressing procedures, and being shielded from feelings of shame or judgment. These findings resonate with Chochinov's (2006) work on dignity in terminally ill patients, which emphasizes the importance of identity, emotional connection, and psychological security. Even though the participants in the present study represented a broader patient population—not limited to end-of-life care—the importance of emotional safety was evident. Many respondents linked consistent staff demeanor, acknowledgment of feelings, and protection from emotional exposure as crucial to maintaining dignity. Wikberg and Bondas (2010) similarly found that when patients feel emotionally safe, they are more likely to engage with their care and express concerns, thereby improving both clinical outcomes and psychological well-being.

Notably, the study's findings also highlight the cumulative and interactive nature of dignity-related experiences. For example, respectful communication was often intertwined with emotional support, and institutional efficiency—or the lack thereof—impacted the perceived sincerity of interpersonal interactions. This complexity affirms the argument by Sulmasy (2007) that dignity in healthcare is not reducible to a single domain but is instead the convergence of ethical, emotional, structural, and cultural dimensions. In the context of Iranian state-provided healthcare, these dimensions are further influenced by the realities of high patient loads, limited resources, and culturally embedded power dynamics between patients and providers (Tavakoli et al., 2019).

Importantly, this study situates patient dignity not only within the behavior of individual healthcare professionals but also within the structural and organizational design of healthcare systems. Even when individual providers acted with compassion, systemic issues such as delays, lack of privacy, or administrative confusion could erode the sense of dignity. This suggests that dignity-preserving care must be addressed both at the micro-level (interpersonal encounters) and macro-level (institutional practices and policy frameworks). This duality is echoed in the World Health Organization's call for people-centered and integrated health systems, which place equal value on structural reforms and compassionate care practices (WHO, 2015).

Although the findings of this study provide valuable insights into the dimensions of dignity in state-provided healthcare, several limitations must be acknowledged. First, the study was conducted solely in Tehran, the capital city, which may not fully reflect the experiences of patients in rural or underserved regions of Iran, where healthcare resources and provider–patient dynamics may differ substantially. Second, the sample included participants who had accessed public healthcare within the past six months, potentially excluding the voices of those who had disengaged from care due to severe dignity violations. Third, all interviews were conducted in Persian and later translated for analysis, which may have introduced subtle nuances or losses in meaning during the translation process. Lastly, while the use of NVivo software supported the rigor of qualitative analysis, the inherently interpretive nature of thematic coding may still reflect researcher biases, despite efforts to maintain reflexivity and peer validation.

Future research should expand the geographical scope of this study to include diverse settings across Iran—particularly rural, border, or minority regions—where cultural norms, infrastructure, and access to care differ significantly. Comparative studies between public and private healthcare settings could also reveal how institutional ownership models influence the experience of dignity. In addition, longitudinal qualitative studies could capture changes in patients' dignity perception over time and across multiple points in the care continuum. Moreover, incorporating the perspectives of healthcare providers, administrators, and policymakers could provide a more comprehensive understanding of both barriers to and facilitators of dignity-preserving practices. Finally, intervention studies that implement communication training, structural improvements, or policy revisions based on dignity principles could offer evidence for practical reforms.

The findings of this study carry several implications for practice in state-provided healthcare systems. First, provider training programs should include modules on communication skills, empathy, and emotional intelligence, ensuring that dignity is understood not only as an ethical obligation but also as a clinical competency. Second, hospitals should institutionalize processes that uphold autonomy—such as protocols for informed consent and shared decision-making—especially in high-pressure settings where paternalistic models may dominate. Third, structural improvements are needed to address waiting times, continuity of care, and physical environment factors that shape patient dignity. Simple interventions—like better signage, private consultation spaces, or streamlined referrals—can significantly improve patient experience. Lastly, hospitals should actively collect patient feedback on dignity-related concerns and use it to inform policy and care delivery, ensuring that dignity becomes a measurable and accountable standard in public healthcare.

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Authors' Contributions

All authors equally contributed to this study.

Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

All ethical principles were adheried in conducting and writing this article.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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