Factors affecting patients’ rights practice: the lived experiences of Iranian nurses and physicians

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Background: The Iranian Ministry of Health and Medical Education published a ‘Patient’s Bill of Rights’ in 2001.

Aim: To gain insight into the perception and practice of patients’ rights in Iran. This paper reports on Iranian nurses’ and physicians’ perceptions and lived experiences of respecting patients’ rights.

Methods: A purposeful sample of eight nurses and five physicians working in a central teaching hospital in Tehran were interviewed during 2005–2006 for a qualitative study. Data were analysed using thematic analysis.

Findings: The emerging themes were categorized as ‘barriers to patients’ rights practice’ and ‘facilitators of patients’ rights practice’. Under these themes three subgroups were discussed: awareness, resources and accountability.

Conclusion: Healthcare professionals’ lived experiences are an important source of data if managers and policy makers are to make changes and legislate for protecting and promoting patients’ rights.

Keywords: Iran, Lived Experience, Nurses, Patients’ Rights, Physicians

Introduction

To provide ethical healthcare, it is important to consider patients’ rights as mentioned in different patients’ bills of rights or charters published in each country. Cultural differences, however, play an important role in individual attitudes and perceptions of rights in general and patients’ rights in particular. As culture and socio-economic contexts create different barriers and facilitators to respecting patients’ rights, a World Health Organization research group on patients’ rights and citizens’ empowerment suggested that each country should articulate its concerns and priorities according to its own cultural and social needs to promote and protect patients’ rights (WHO Regional Office for Europe 1999).

The Ministry of Health and Medical Education in Iran published a patients’ bill of rights in 2001 (Islamic Republic of Iran 2001) (see Appendix I). Many patients and staff, however, are not yet fully aware of its existence and content (Joolaee et al. 2006a). In addition, there is no comprehensively planned system in place for protecting these rights.

Most bills of rights, including the Iranian, are concerned with informed consent, autonomy, confidentiality and privacy. Professionals are expected to respect patients’ rights, but if they are not familiar with the contents of the bills of rights, or what they imply, problems can arise.
This study aimed to investigate the factors contributing to patients’ rights practice in Iran from the nurses’ and physicians’ point of view.

**Literature review**

A review of related literature published between 1996 and 2006 showed that patients’ rights have been investigated widely, mainly to ascertain compliance with rights (Barr 1996; Buetrow 1998; Leino-Kilpi et al. 2003; Williamson & Wilki 1997) and to determine the knowledge and awareness of the public regarding these rights (Büken & Büken 2004; Joolaee & Mehrdad 2003; Joolaee et al. 2006b; Kunjunmon 2006; Merakou et al. 2001; Mosadegh-Rad & Asna-Ashari 2004; Najafi-Pour et al. 2002; Zülfikar & Ulusoy 2001).

The findings of some studies indicate that healthcare providers have a high level of awareness about patients’ rights (Joolaee et al. 2006b; Mosadegh-Rad & Asna-Ashari 2004) but that patients have a low level awareness of these rights (Joolaee & Mehrdad 2003; Mosadegh-Rad & Asna-Ashari 2004; Najafi-Pour et al. 2002). However, Kunjunmon (2006) found nurses to have only a moderate level of patients’ rights knowledge, and Büken & Büken (2004) put healthcare providers into the category of people who are totally unaware of this concept in Turkey.

According to Büken & Büken (2004), establishing a patients’ bill of rights is a step towards protecting patients’ rights, but they report that violation of these rights is common in healthcare institutions in Turkey. Systemic and institutional obstacles, such as insufficient healthcare staff and inadequate purchase and maintenance of technological equipment, also play an important part in rights violations.

Albishi (2004) studied the concept in a multidimensional way in Saudi Arabia, exploring the patients’, physicians’ and nurses’ lived experiences with patients’ rights. He found that meeting the patients’ caring needs is the core concept for the meaning of patients’ rights in Saudi Arabia. He also found the lack of knowledge about the rights, lack of standard of practice among the hospitals and the impact of service pressure and subsequent lack of holistic care, as some of the barriers to patients’ rights practice in Saudi Arabia. However, in his findings, the patients, nurses and physicians were generally satisfied with the care they provided and patients received. However, because of the specific setting of that research, transferability of the findings is questionable. The King Faisal Hospital (KFH), where the research was carried out, is distinct from other Saudi Arabian hospitals because of its reputation for providing a high level of services.

There was no qualitative study conducted in Iran regarding patients’ rights. It was therefore considered that a qualitative study of the lived experiences of patients, their companions, nurses and physicians regarding patients’ rights in Iran would be the best means to investigate the phenomenon. Patients and their companions interpreted their rights in terms of caring needs, such as having their call-bells answered, soiled linen changed, intravenous lines checked, and their medications provided on time, as well as receiving adequate information about their health problem and effective communication. (Joolaee et al. 2006a). This paper reports the findings of the nurses’ and physicians’ data.

**Methods**

A large qualitative study, was undertaken between 2004 and 2007.

The main research question for the nurses’ and physicians’ group of participants was: ‘What are the lived experiences of nurses and physicians regarding the practice of patients’ rights in Iran?’

**Participants and setting**

The research was conducted in a central teaching hospital in Tehran, Iran.

The inclusion criteria were at least 3 years’ work experience in the particular hospital for nurses, and being in the second year of internship for physicians, as well as willingness to attend an interview and to explain their experiences, the need for being familiar with the hospital’s situation and its current regulations and policies.

**Data collection**

Semi-structured interviews with probing questions were used. The participants were asked to respond to questions such as: ‘What comes to your mind when you hear the expression “patients’ rights?”’ and ‘What is your own experience of practicing patients’ rights?’ Each semi-structured interview was tape-recorded and transcribed verbatim. Informal observation and writing field notes were other sources for collecting data. Data saturation was achieved after interviews with eight nurses and five physicians.

**Data analysis**

Data were analysed using thematic analysis as a way of seeking to identify and formulate themes (Benner 1994). A theme is a thread of meaning that penetrates all or few text parts and is seen as conveying an essential meaning of lived experience (Van Mannen 2006).

After each interview, the researcher (SJ) studied the transcribed texts to acquire a general understanding of the issues raised. Identifying general themes and similarities between different transcribed texts was carried out subsequently. The researcher then verified this understanding with some of the...
informants through complementary questions or further interviews. This was an opportunity to clarify any ambiguities by taking on board the more detailed explanations offered by the informants. Finally, the related themes were categorized into three clusters as described later.

**Trustworthiness**

To achieve the criteria of trustworthiness in the current study, data gathering methods were triangulated. In addition, member check for validation of interpretations and clarification of the interviews was conducted. Credibility of findings were established by having other researchers independently analyse slices of data and then compare themes and interpretations. All evidence and documents were securely saved to maintain audit ability.

**Ethical considerations**

The Nursing Faculty and Tehran University of Medical Sciences Research and Ethics committees approved the research proposal. All participants were provided with information about the research aims in a preliminary informal meeting and oral consent for audio-taped interviews was obtained. Confidentiality of data was assured, as were the rights of the participants to withdraw at any time.

**Findings**

Based on the data obtained from the nurses’ and physicians’ interviews, two main clusters of themes emerged: the factors that negatively affect patients’ rights and act as barriers; and those that are positive factors, facilitating patients’ rights practice.

Despite clustering the emerging themes into distinct groups, they overlap, so much so that they cannot realistically be considered and discussed separately and are therefore presented under three main subheadings: awareness of rights, resources and accountability. The following are some examples.

**Awareness of rights**

The ability to differentiate between what is just and what is unjust may be considered a precondition to demand one’s own rights. Nurses and physicians need to be aware what basic patient rights consist of, otherwise they cannot care for patients ethically or holistically.

Physician: The issue of ‘patients’ rights’ is a myth here. They (patients) don’t know what their rights are, so their rights are being violated frequently.

Physician: I have never seen the patients’ bill of rights. Have you? (Asking a colleague who responded emphatically: ‘no!’)

Nurse: Unfortunately people don’t know their rights and obediently accept everything that is told them or is done to them when they come into the hospital.

When the same issue (awareness) is pursued further in the participants’ lived experiences, a positive effect on patients’ rights practice is revealed as a facilitator for patients’ rights practice.

Nurse: The most important issue is public awareness. The more aware patients are, the more they demand their rights.

Physician: The media has an important role in educating people about their rights and information helps the people to ask.

The nurses and physicians saw patients’ rights as being something demanded by patients, rather than something that they are responsible for instituting and maintaining.

**Resources**

The nurses and physicians explained situations in which they were confronted with patients’ rights malpractice, but they could not stop this because of institutional inadequacies, such as staff shortage, time limitation and lack of facilities. They were committed to observing patients’ rights (informed consent, confidentiality, privacy and autonomy), but they also acknowledged that observing these rights needs prerequisites that are not available. Almost all informants noted that staff shortages and heavy workload (both for nurses and physicians) in conjunction with time limitations are important obstacles to patients’ rights practice. Examples include the following:

Nurse: There are not enough staff nurses. How can I know all 38 patients in the ward during one shift? I don’t have enough time even to listen to the last shift’s report, so listening to the patients’ concerns is a luxury.

Nurse: This is a teaching hospital with a lot of students. The wards are over-crowded. Look at the ward (pointing to the crowded ward corridor). There are many patients in each ward without enough staff, equipment and facilities. Not only the patients’, but also the staff’s rights are regularly ignored.

Disregarding nurses’ and other staff’s rights is apparent in the above quotations as a result of staff shortage, restricted time and other limitations on resources and facilities. Another example:

Nurse: I’m forgotten as a nurse. Who protects my rights, which are frequently being violated? I’m really exhausted. I need help to be able to help others, but who cares?

Some physicians also mentioned the nurses’ hard work and low morale:

Physician: I see they are too tired. They are working long shifts with a huge number of patients. Low salary and no respect make the problem worse. Nobody cares what they are doing. They don’t even get a rest during the night. Of course I believe
they can’t do better in this situation. Only their failings are usually talked about and criticized.

The physicians also talked about their workload in teaching hospitals as a factor that affects patients’ rights practice negatively. They explained that their shift was always a time of distress and exhaustion.

Physician: It’s really difficult. Imagine you are the on-call surgeon; you need to admit an emergency case in a critical situation. At the same time you hear the code alarm ring, someone is dying and needs you, so what happens if you leave this emergency and go to the other? What happens if you don’t go? Which one do you choose? I often think how stressful our job is, particularly in this context of limitations. We experience such situations frequently.

The limitations mentioned render nurses and physicians exhausted and dissatisfied with their job and this can negatively affect patients’ rights practice as well. They cannot provide quality healthcare. It makes patients find their own specific solutions, such as alternative advocacy mechanisms that are now utilized widely in Iranian hospitals. The presence of a ‘companion’ with the patients during their hospital stay is one such alternative mechanism:

Nurse: The patients’ companions play a significant role in meeting the patients’ basic needs and protecting their rights. We can never meet all the patients’ needs, especially during night shifts. Sometimes I’m not even able to bring a glass of water to a patient. I’m working all night, but the workload is constantly high. Someone needs to be with patients to meet their needs.

Nurse: Even though the presence of patients’ companions sometimes disturbs our work, they really help us to meet the patients’ basic needs.

The lack of time and facilities is interpreted as a detractor to maintaining patients’ rights, even though this may not directly affect such basic issues as consent, privacy, etc. Rather, lack of basic ‘care’ is seen as an issue that covers ‘rights’ generally.

Accountability

Nurses and physicians participating in this study explained how the overall accountability of the healthcare system should lead individual institutions and healthcare providers to be more accountable. It should lead institutions to reflect on their limitations and to develop, monitor and evaluate systems that assure patients’ rights practice. They believed that without accountability for the whole health system the individual institutions will not be accountable to staff and patients and, in such a context, the patients and their rights are all forgotten.

Nurse: I had a patient after an appendectomy in a surgical ward. He had some minor heart problems and needed to be monitored for potential arrhythmia. There were no empty beds in CCU and we didn’t have a monitor on our ward. I reported it to the hospital nursing office and the treating physician. No one responded to the problem. The patient was in a serious situation, but I couldn’t do any more. (Said with tears in her eyes.)

Physician: I prefer to work in a private hospital because I’m not given enough money or respect here. For the same surgical procedure I’m receiving more than 20 times more money in a private hospital, and that is in addition to better facilities than here. I like to work for people but I also have my own concerns and problems. No one listens to my concerns or does anything about them, but I have to be responsible for my family as well as the patients.

Accountability is seen here as the lack of management to take responsibility for the poor care given due to inadequate resources. The nurses and physicians believed that better accountability would lead to realistic patients’ rights practice.

Discussion

For a realistic discussion of patients’ rights practice, it is necessary that all stakeholders, especially patients and their relatives, nurses and physicians, can be involved in developing and evaluating regulations regarding patients’ rights. In this way they know both their rights and their responsibilities.

A lack of knowledge by the public, patients, nurses and physicians and unclear statements are very important issues when talking about patients’ rights. Most healthcare providers and patients who explained their experiences did not know that the Iranian Ministry of Health and Medical Education had published a patients’ bill of rights. This indicated that the process of informing healthcare providers and recipients has not been successfully implemented. The media plays a significant role in making people aware of their legal and social rights, but this requires planning at a high level of healthcare management systems. Informing the public about their rights as patients is part of promoting public awareness of human rights, which are important aspects of the Iranian Islamic culture. Using this context, Iran would be more likely to adopt patients’ rights practice successfully by referring to its valuable social and cultural traditions, as well as utilizing international experiences.

Given that some studies mentioned above indicated that healthcare providers have a high level of awareness about patients’ rights (Joolaee et al. 2006b; Mosadegh-Rad & Asna-Ashari 2004), but that others (Büken & Büken 2004; Kunjunmon 2006) found nurses to have only a moderate or low level of
patients’ rights knowledge, it is clear that knowledge is an important element in promoting and protecting patients’ rights.

This study’s findings also indicated that despite nurses and physicians agreeing that patients have rights and that they are committed to respecting these rights, they are rarely able to do this. They referred to knowledge and competence, time and resources such as staff, equipment and facilities as prerequisites for patients’ rights practice, which are often not available. The inevitable effects of these shortages on patients’ rights observation are the key points that need more attention.

Analysis of the participants’ narratives indicated that the nurses and physicians intended to spend more time with patients, listening to them and caring for them, informing them about the caring process and so on, but they cannot do so because of time constraints and heavy workload.

Insufficient numbers of healthcare providers and excessive numbers of patients are also reported in other studies (Alspach 2000; Büken & Büken 2004; Heather 2003; Hellwig et al. 2003; Joolaee et al. 2006b; Negarandeh et al. 2006), but the staff shortages have a different reason in Iran. There is not a true shortage of educated nurses, but rather restrictions in the absorption of nurses are to blame (Adib-Hajbagheri & Salsali. 2005). For some years, the Iranian Nursing Association has pushed parliament to change the present regulations for absorbing new healthcare staff and gaining more advantages, such as better salaries for nurses (Mirzabeigi 2003). These challenges brought about some positive changes, such as absorbing new nurses and ring-fencing nurses’ salary budgets.

In addition to lack of public knowledge, insufficient legal and managerial support and resource limitations, disregard of nurses’ and physicians’ own professional rights, such as adequate salary, proper staff/patient ratio and a safe work environment, and the significant role of the family were identified as other factors affecting patients’ rights practice. Albishi (2004) reported similar factors in Saudi Arabia; however, he did not report evidence that nurses’ and physicians’ rights were not observed there.

Providing more attention to a sick member of the family and supporting him or her during hospitalization and the passive role of the media in informing and educating the public regarding their rights, and the subsequent public unawareness, were found to be examples of positive and negative commonalities in this study as well as in Albishi’s.

The present study highlighted a number of issues that were also found in earlier descriptive work (Joolaee et al. 2006b), despite using a different methodology. This can also be seen as a kind of validation.

Other studies also found that workload pressure and staff discouragement led to an inability to provide the desired care for patients (Adib-Hajbagheri & Salsali. 2005; Dehghan-Nayeri et al. 2005). Jouybari et al. (2004) stated the same reasons for nurses’ complaints of being tired and unwillingness to care and lack of sympathy, compassion and respect. These are not shown to be barriers to observing patients’ rights in Albishi’s (2004) study because the care provider/patient proportion and subsequent workload of staff were approximately according to international standards in the KFH, where Albishi conducted his study.

Büken & Büken (2004) reported many problems in the healthcare sector in Turkey, a neighbour of Iran, listing in particular inadequate financial resources, the failure to use resources productively and effectively, the unbalanced distribution of employees and healthcare personnel in the region, problems of inadequate coordination and cooperation between institution, and the lack of a national health policy. All these problems reflect on observation of patients’ rights that in some aspects are very similar to the Iranian experience.

In a context where patients’ rights are not protected, patients look for alternative advocacy mechanisms to meet their needs and protect their rights. One of these mechanisms commonly used in Iran is being a companion alongside patients during hospitalization. This is not widely described in the literature in relation to patients’ rights; however, the role of the patients’ family was referred to in some studies, not for meeting the patients’ basic needs, but rather for providing emotional support (Albishi 2004). Jouybari et al. (2004) referred to patients’ companions as the ‘unknown soldiers for providing patient comfort’.

This enables the healthcare delivery system to work adequately without collapsing, despite the shortages of staff and equipment so prominent in the participants’ complaints. This also means that managers are not forced to look for formal strategies to counter the actual problems and therefore the inadequate cycle continues to run.

In summary, patients’ rights cannot simply be observed according to a patients’ bill of rights or individual actions of nurses and physicians. Protecting patients’ rights is the responsibility of the whole healthcare delivery system. It is a social concept that requires the full intention and commitment of every country, as well as a concerted international approach, for without this, no major system can continue to function in our global world. Healthcare policy makers and managers have a duty to listen to the voices of those who are maintaining and receiving these rights to be able to find realistic ways of promoting and protecting them.

The findings of this study cannot be generalized because of the nature of qualitative research approaches, but they contribute to sharing nurses’ and physicians’ experiences with factors affecting patients’ rights practice in Iran with colleagues around the world. The findings can also be compared to the situation of
patients’ rights practice and factors in different countries according to the healthcare professionals’ viewpoints.

Conclusion

Healthcare professionals are in a good position to identify and explain the factors that affect observation of patients’ rights. Their lived experiences are an important source of data if managers and policy makers are to make changes and establish legislation for protecting and promoting patients’ rights.

The findings of this study indicate that nurses and physicians are ready to exercise these rights but that they battle with factors such as staff shortages, limited facilities, low-competence staff, public unawareness and society’s poor attitude towards nurses, which effectively disable them from observing these rights. The participants mentioned, in particular, the lack of public awareness of rights, expert and competent staff, proper managerial policies, monitoring systems, accountability, patient-centred services, a clear definition of nursing responsibilities and tasks concerning patient care, and not providing patients with a copy of the bill of rights on admission are important barriers to the practice of patients’ rights. These factors would help to establish measures for protecting patients’ rights and providing a safer and more protective hospital environment for patients and staff. The information provided by this investigation will be of use to managers and decision makers as they hear and understand the voices of those who are mainly expected to observe and protect these rights in practice.

Limitations

The findings of qualitative studies are not expected to be generalized and their findings and should only be applied with caution and after adjusting them to each specific context. One study’s findings become useful when repeated in different situations and contexts. During the study period many positive changes have taken place in the policies of Iranian health and medical education in relation to patients’ rights. These changes may result in different findings in repeated studies.

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References


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Appendix I

Iranian patients’ bill of rights of the Ministry of Health and Medical Education, 2001 (A translation of shortened document by the authors)

The patient has the rights to:

1. Considerate and respectful care regardless of race, culture and religion.
2. Know the identity of physicians, nurses and other involved in his/her care.
3. Obtain from physicians understandable information concerning his/her diagnosis, treatment and prognosis, except in emergencies that would delay in providing urgent treatment that may threaten his/her life.
4. Request information related to the specific diagnostic procedures and treatments, the risks and possible alternatives.
5. Refuse treatment and/or be referred to another hospital except in cases of threats to community health.
6. Expect that all communication and records pertaining to his/her care will be treated as confidential by the hospital except in cases of public health hazards, when reporting is permitted or required by law.
7. Every consideration to privacy and confidentiality.
8. Accessibility to physician and other healthcare providers during hospitalization, transfer to other institutions and discharge.
9. Consent or decline to participate in research studies without any threatening consequences.
10. Be informed of hospital policies, charges and insurance coverage in addition to the care provider’s expertise in the current hospital and the hospital to be referred to.