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Research Article

Group Visit: A Challenge for Health System Responsiveness and Patient Rights

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Dear Editor,

Health is a fundamental and undeniable right of every human being, regardless of color, race, ethnicity, gender, literacy level, or social status. This right is also recognized by the Iranian Constitution. Historically, even in the Hippocratic Oath, physicians and other medical professionals have acknowledged health as an unquestionable right of humanity (1, 2).

The health system bears the primary responsibility for upholding this rightful claim (1). According to the World Health Organization (WHO), any organization whose primary and most significant objective is community health can be categorized as a health organization. Therefore, proper management of the health system is an essential and unavoidable principle to fulfill this vital governmental mandate (3).

In 2000, WHO outlined three fundamental goals for every health system: Better health (measured in terms of both the average level and equitable distribution of health among citizens), protection against financial risks when receiving healthcare, and responsiveness to the non-medical needs of individuals (4). In subsequent years, efficiency was added as a key goal (5).

Among these health system goals, responsiveness has received the least attention in research. Limited studies have focused on this area, indicating a need for further exploration (6). Responsiveness to non-medical needs is defined as addressing the legal expectations of potential customers of the health system regarding the non-medical aspects of care. These expectations may be either subjective or objective. According to WHO, responsiveness encompasses eight dimensions: Prompt attention, respect for people (dignity), clear communication, independence, confidentiality of personal information, the right to choose, quality and cleanliness of the environment (basic amenities), and access to a social and family support network (7).

As mentioned earlier, some of these dimensions are subjective, requiring specifically designed measures for evaluation. However, in certain instances, these dimensions are so self-evident that no scientific assessment is necessary. One prominent example in Iran is women's healthcare services, particularly those provided by gynecologists. In Iran, some gynecologists practice "group visits," where multiple patients are seen simultaneously instead of individually (8). It is evident how deeply private women's health issues can be, making it highly inappropriate to discuss them in the presence of other patients. This practice infringes on the "dignity" dimension of responsiveness and violates patients' rights.

Beyond potential risks such as the mismanagement of medications and care, this practice fundamentally violates the dignity and human rights of women. Additionally, due to cultural sensitivities in Iran that associate shame with discussing women's health issues, many women may self-censor and withhold critical details about their conditions. This can lead to misunderstandings, misdiagnoses, and potential malpractice. Such practices highlight the urgent need to address and reform healthcare responsiveness, particularly in the context of women's health services.

One of the key issues highlighted in Iran's health reform plan is the promotion of visit quality. A 20-minute session is considered the average visit time for specialists (9). While this standard stipulates that an average of 20 minutes should be spent on each patient, some

gynecologists and, in certain cases, women's urologists see three or four patients in less than 20 minutes through group visits (8, 10). This practice not only fails to meet the minimum requirements for a thorough and technical consultation but also significantly increases the likelihood of medical errors in prescribing medications and care. Moreover, the non-medical needs of patients are entirely overlooked in such a setting (11).

This practice violates patients' dignity and their right to choose, as they have no alternative to avoid such situations. The payment system, which incentivizes higher numbers of visits, suggests that physicians may act as economically rational agents seeking to maximize their income, as per basic economic theories.

On the other hand, given the rise of feminist movements and the growing emphasis on human rights, this approach may impose significant spiritual and intangible costs on the healthcare system. It risks eroding public trust in physicians as health ambassadors. Patients may begin to perceive that financial gain is prioritized over their needs and expectations, potentially undermining the credibility and ethical standing of the medical profession. In the long term, this could lead to irreversible damage to the trust and compliance that underpin the patient-physician relationship, disrupting the entire care and treatment process.

Considering these concerns, the "stewardship" function (12) of the health system mandates the immediate enactment of legislation and the implementation of strict monitoring mechanisms to address this issue of compromised responsiveness. Policymakers and health system planners must pay close attention to the legitimate and rightful demands of patients. Merely considering patient satisfaction rates is insufficient. Instead, a comprehensive approach that addresses all dimensions of responsiveness is necessary to enhance the quality of care provided.

One critical and immediate step could be the prohibition of "group visits," particularly in disciplines such as gynecology and women's urology, where such practices are especially detrimental to patient dignity, care quality, and overall trust in the health system.

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