Review Article

Practicing patients' rights in Iran: a review of evidence

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Abstract

Protection of patients' rights is critical in improving healthcare quality, and hence this study aimed at reviewing patient rights' practices in healthcare organizations of Iran.

Using systematic search, this review was conducted based on Preferred Reporting Items for Systematic Review and Meta-Analysis Protocols (PRISMA-P). Several keywords, including "patient rights", "patient bills of rights" and "patients rights' charter" were searched bilingually in the databases of SID, Magiran, PubMed, Scopus, and Web of Science from 2010 to 2021, and then, following a three-tier screening using the Critical Appraisal Skills Program (CASP) checklists, 76 articles were extracted.

The degree of compliance with the *Patients' Rights Charter* (PRC) in healthcare organizations was 60.88% on average. As to the observance of the PRC dimensions, respectively, the highest and lowest scores were related to the "right to privacy and confidentiality" (70.16%) and "right to access an efficient complaining system" (53.01 %).

Respect for patients' rights in organizations was assessed at a moderate level, and some aspects of patients' rights should be attended to immediately. Therefore, discrepancies in the dimensions of patients' rights and their implementation by organizations should be on the agenda of healthcare managers and policymakers.

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Introduction

All individuals need and use healthcare services throughout their lives, and hence the provision of health care services must be reasonably non-discriminatory and respectful of human rights and dignity (1). Patients' rights (PRs) are a set of norms derived from the bases and principles of medical ethics and human dignity, and professional commitments to patients are founded on these rights (2, 3).

Patients' Rights Charter (PRC) could improve the quality of healthcare, and protection of PRs might reduce irreparable physical, mental and social damages (4, 5). Accordingly, most countries have adopted PRs-relevant laws that healthcare providers must follow. The PRC aims to ensure that human dignity is respected by protecting patient health, especially in medical emergencies without discrimination of race, age, sex, or financial status, and with the provision of respectful and quality care (1). Although PRC is the first step in the realization of PRs, the development and proclamation of PRC alone cannot guarantee the implementation of PRs, and hence, to evaluate the degree of compliance with PRC, the execution and application of PRs should be persistently monitored.

In Iran, the first PRC (11 items) was launched in 2002, which was rudimentary and incomprehensible in expressing all the basic PRs. Therefore, a more thorough version was prepared via the participation of various stakeholders and announced in November 2009 by the Ministry of Health (MoH). The charter encompassed 37 articles and five dimensions including; "right to receive appropriate services", "right to access to desired and sufficient information", "right to choose and decide freely about receiving healthcare", "right of privacy and confidentiality", and finally, "right to access an efficient complaining system" (6).

Several studies were conducted on compliance with PRs in Iran and some other countries. For example, studies in Sudan and India reported that the degree of compliance with PRC was favorable and more than 70% on average (7, 8). In Iran, conversely, the results showed a relatively unfavorable situation on PRs protection in the hospitals of five provinces: 45% in Ilam (9), 18.5% in Kermanshah (10), 8% in Kerman (11), 63.2% In Yazd (5), and 14.59% in Mazandaran (12). In 2014, a reform was mandated, due to PRs challenges, in monitoring, supervision, and evaluation systems, expressed in article 2.6 of the General Health Policies announced by the Supreme Leader to legally strengthen PRs protection (13).

The current status analysis is assumed to be a prerequisite for initiating any improvement in healthcare practices. Therefore, several recent studies assessed the degree of PRs practice by healthcare organizations (HCOs) in Iran (14-21). Each of these studies presented the situation in a specific region of the country and failed to fulfill policymakers' and managers' requirements. Consequently, other researches aimed at providing a more comprehensive situation of PRs in the whole country by combining results via review studies in both Persian and

English languages (14, 22-24). However, these studies had limitations in terms of target groups (providers or patients), search keywords, and stand-alone places of study such as hospitals. Most of these studies were conducted five years ago; some also disregarded various PRC dimensions, did not provide a complete depiction of PRs protection in Iran and did not cover emerging studies after 2016. Therefore, scrutinizing current literature, this study aimed at reviewing the protection and observance of PRs and PRC dimensions in the Iranian HCOs at all three levels, i.e. prevention, curative and rehabilitation services from 2010 to 2021, delivered at health centers and hospitals.

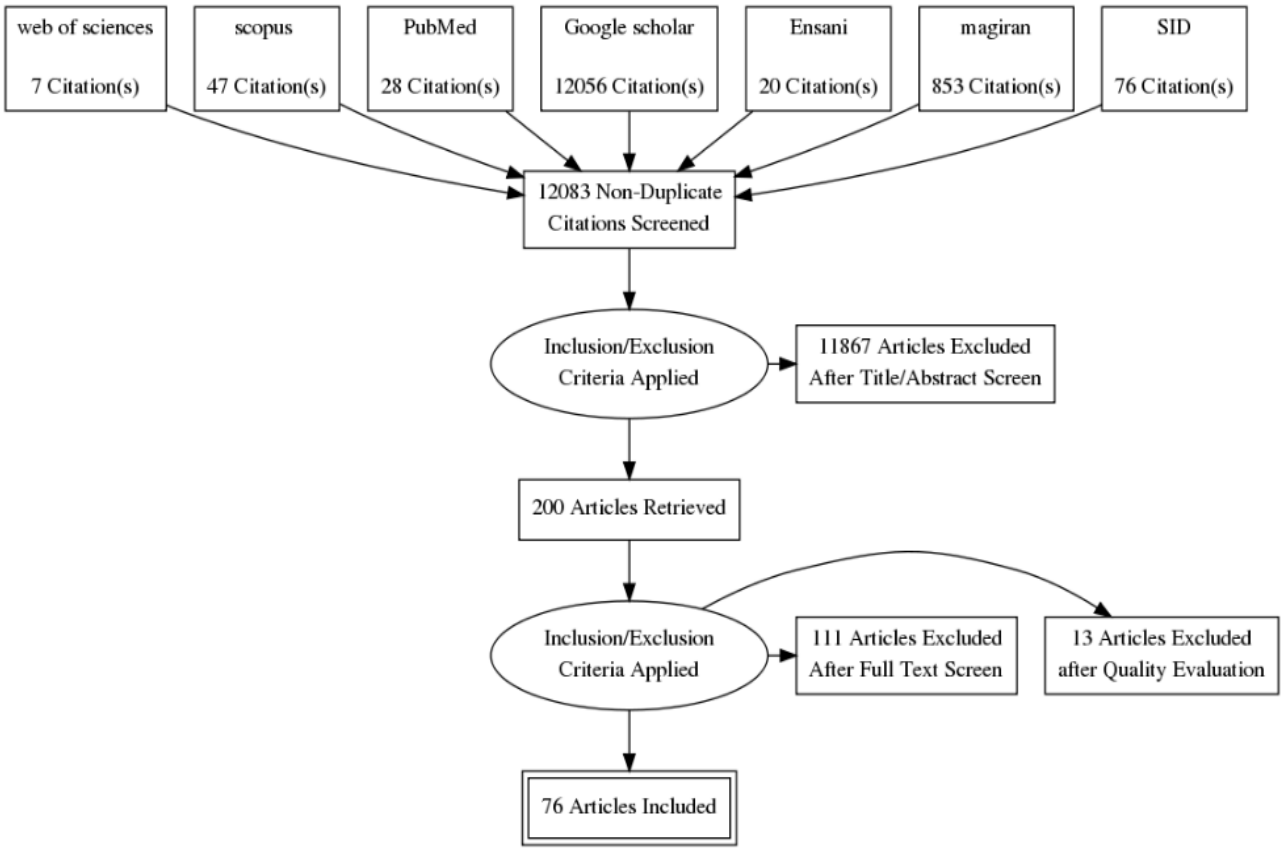
Methods

This systematic review study was conducted based on Preferred Reporting Items for Systematic Review and Meta-Analysis Protocols (PRISMA-P), a designed guide to develop and improve review reports and meta-analysis (25). Due to the heterogeneity of studies extracted and their use of different questionnaires, a meta-analysis was not feasible for the present work. Keywords included various combinations of "patient rights", "patient bills of rights", "patient rights' charter", "Iran", which were searched bilingually using medical subject headings (MeSH) in PubMed. The search was performed in English and Persian databases such as PubMed, Scopus, and Web of Science as well as SID[1], Magiran[2], and Ensani[3]. Moreover, the reference and citations lists were included (backward and forward tracing). The databases were searched using the following search strings: ("patient's rights" OR "patient bill of rights" OR "patients' bills of rights" OR "patient bills of rights" OR "patient right" OR "patients' right" OR "patient rights" OR "patient bill of right" OR "patient bills of right") AND ("Islamic Republic of Iran" OR Iran). As shown in the flow diagram 1, 12083 articles were identified after the search (28 in PubMed, 7 in Web of Science, 47 in Scopus, 76 in SID, in 853 Magiran, and in 20 Ensani).

Inclusion criteria entailed the articles published between 2010 and 2021 that reported PRs practice in Iran according to the viewpoints of both patients and providers. The present study also covered review studies conducted in 2010, including the studies before 2010. Qualitative studies and articles on PRs in other countries were excluded. Patient/Population, Intervention, Comparison, Outcomes (PICO) strategy was used for article selection, an evidence-based search strategy for indexing and retrieving scientific evidence (26). All articles were entered into the Endnote software. After duplicates checking and reviewing the titles and abstracts, 200 articles were selected and saved for full-text review. Eventually,

1. Scientific Information Database in Iran: www.SID.ir
2. specialized and general journals and newspapers Database in Iran: www.magiran.com
3. The Comprehensive Humanities Portal in Iran: www.ensani.ir

following a three-tier screening and using the Critical Appraisal Skills Program (CASP) checklists, 76 articles were extracted (flow diagram 1). CASP is the most commonly used tool for quality assessment in combining quality-related health evidence (27). Two authors independently searched for articles (TS and EJP), which were consistent in most cases, and minor discrepancies were resolved during joint meetings with other members of the research team (ESG and AMM).



PRISMA flow diagram 1-. process of entering studies in a systematic search

Result

Seventy-six articles (56 in Persian and 20 in English) were relevant to the PRs protection in Iranian HCOs from January 2010 to June 2021. The highest number of studies were conducted in 2015 (21%) and 2012 (14%) and the lowest number in 2020 (1.3%) and 2011(4%). Approximately 92% of the studies were observational (eight descriptive and 62 analytical), two interventional, and four review studies. The tools to measure the variables were questionnaires, mainly developed based on PRC dimensions.

Only one study was related to prevention services and one to rehabilitation services, and the rest (74 articles) were addressing curative services. Out of the latter, eight articles were on outpatient services

(including clinics and minor surgery centers) and 50 articles on inpatient services. As such, 10 articles examined the practice of PRs in the private sector, and 70 in the public HCOs, while some covered both groups. Fifty-six and 31 studies examined PRs practice from the perspective of services recipients, and providers, respectively. The research population mainly included patients, plus nurses, physicians, midwives, other staff, and medical students.

The studies were conducted in 26 provinces, out of which 30.26% were undertaken in the capital, Tehran (28-44). The provinces of Khuzestan (45, 46), Khorasan Razavi (16, 47-49), Kerman (11, 19, 50, 51), and Mazandaran (12, 52, 53) stood next.

The PRs practice in service areas

The degree of PRs practice in three levels of prevention, curative and rehabilitation services, was on average 77%, 58.3%, and 48.5%, respectively. Overall, the compliance with PRs in Iranian HCOs was 60.8%, more for the outpatient (65.67%) and less for inpatient (56.37%).

PRs protection: service providers and recipients' perspective

The providers and recipients believed that PRs observance levels by HCOs were 70% and 58%, respectively. According to the review studies (final four), PRs were moderately observed (14, 22, 23). The last review study, conducted in 2016, showed that the PRs compliance by the hospitals was not favorable (24). Chronologically, PRs protection has increased from 50.75% in 2010 to 69.6% in 2020 (Figure 1).

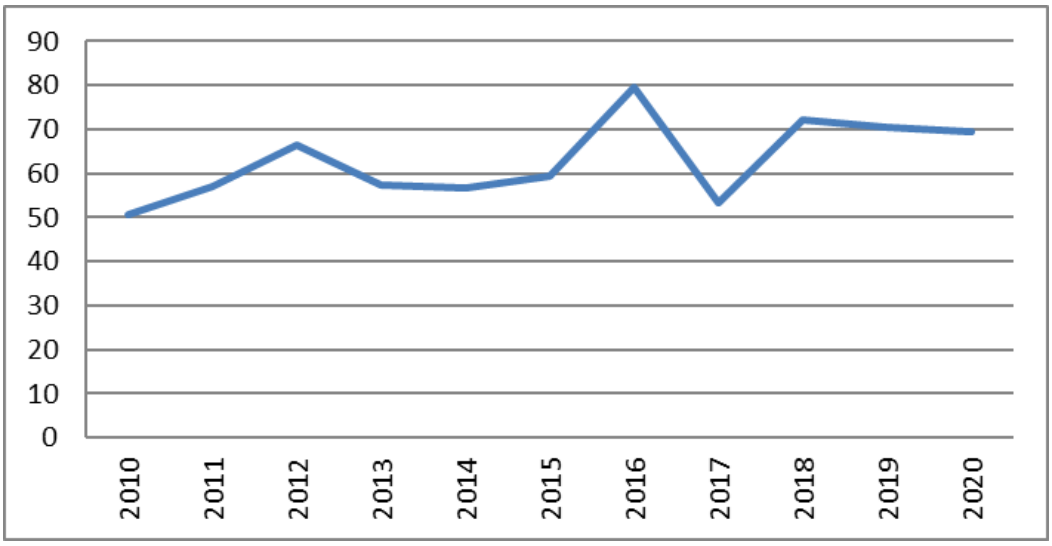


Figure 1- PRs practice in Iran from 2010 to 2021

As such, geographical dispersion of PRs practice was displayed in Figure 2.

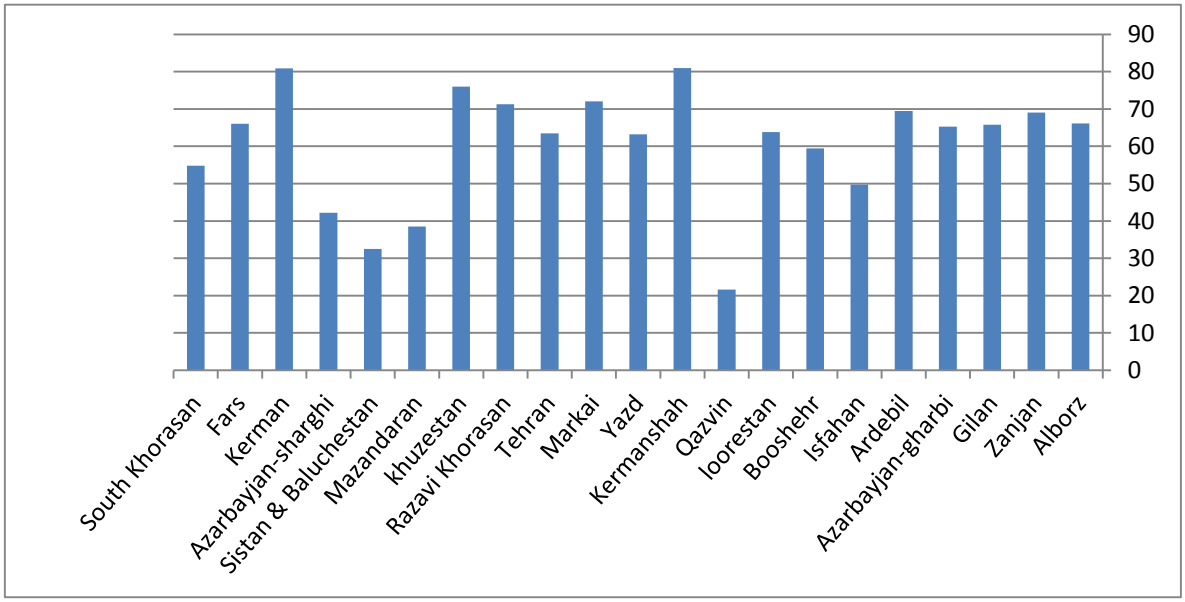


Figure 2- Provincial practice of PRs in Iran from 2010 to 2021

Compliance with PRC dimensions

The highest compliance among the HCOs was related to the dimension of "the right of privacy and confidentiality" (70.16%) followed subsequently by those of "right to receiving appropriate services" (66.94%), "right to access desired and sufficient information" (59.42%),"right to choose and decide freely on receiving healthcare" (57.33%), and finally "right to access an efficient complaining system" (53.01 %) (Figure 3).

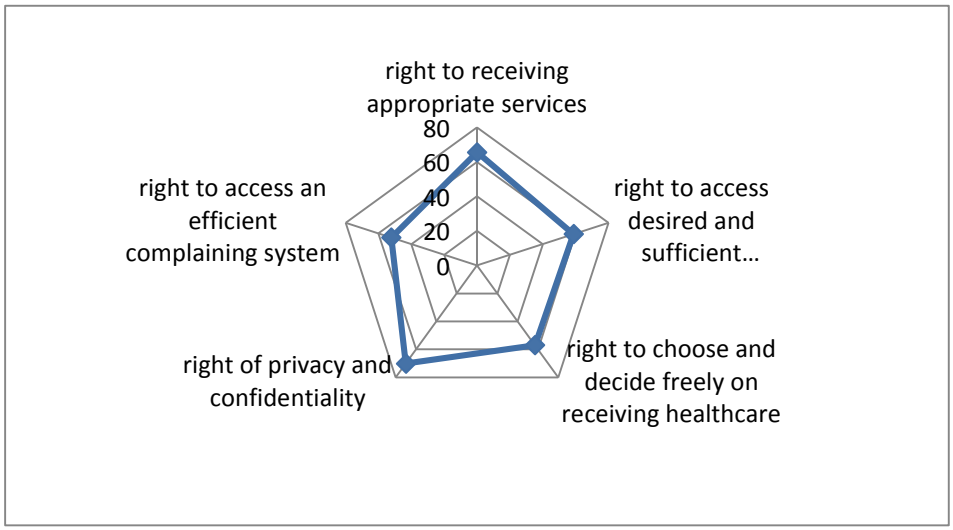


Figure 3- The observance of PRC dimensions in Iran from 2010 to 2021

PRs protection and related factors

According to 42.4% of the studies, PRs practice was significantly related to public awareness of PRs. Around 27% of studies reported that the level of patients' education was significantly related to their viewpoint

on the observance of PRs. A statistically significant association was observed between PRs practice and patients' age, gender, marital status, insurance type, experience and expectations, type of inpatient ward, length of hospital stay, living place, hospital type, and providers occupational group (P <0.05).

Discussion

PRC was moderately observed among Iranian HCOs and regarding PRC dimensions, the highest and lowest scores were related to the "right of privacy and confidentiality" and "right to access an efficient complaining system", respectively. The PRs protection in HCOs was evidently perceived higher from the perspective of service providers than that of the service recipients, as the former, i.e. the staff, are part of the organizations and might be biased towards their organization. The same results were reported in Egypt (54). This gap could be further adjusted by individuals' jobs, communication systems, expectations, and preferences (mental paradigms) (6). If the healthcare system aims to attend successfully to PRs, in conjunction with root cause analysis, organizational understanding should be improved about how an individual feels as a patient.

From 2010 to 2021, on average, the degree of compliance with PRs in the Iranian HCOs was around 61%, with fluctuations, and gradually improved during this period; this percentage is not considered within a high range (14, 23, 24). In some studies, in other countries, such as Egypt and Uganda, similar results were reported. For instance, in an Egyptian university hospital, only 0.5% of physicians and nurses abided by the PRs desirably, and 42% had moderate performance (55). In another Ugandan national reference hospital, limited observance of PRs was reported, in that 80% of the staff just protected a maximum of two-thirds of PRC (56). A report in 2016 demonstrated poor PRs compliance as a major challenge for six European countries: Croatia, Cyprus, Greece, Poland, Romania, and Slovenia (57). Only 51.2% of students in Poland and 38.5% of students in Slovakia believed that PRs were well-protected in their country (58). Nevertheless, according to the Indian studies, 74% of nurses performed well about compliance with PRC (59), and in Saudi Arabia, the mean score of patients' satisfaction with nurses in terms of respecting their rights was 90.67% (60). Such a high level of PRs observance, rarely was reported in other studies, could be due to the low level of expectations and economic status of patients, and could not necessarily be linked with the high quality of health services (7, 31). Therefore, PRs practice should be checked in conjunction with the treatment consequences, such as the patient's health status at discharge and the recurrence rate.

Chronological order of PRs practice

The majority of studies were conducted in 2015 (20%) and 2012 (15.4%), which could be attributed to the implementation of the *Health Transformation Plan* (HTP) in 2014 and to the formal initiation of Iranian mandatory hospital accreditation in 2012.

Protecting patients' dignity and their companions is a key aspect of the country's national accreditation and HTP (61, 62).

Although PRs practice has gradually improved in Iran since 2010, it has not grown as desired and does not have a promising prognosis. Accordingly, for the appropriate practice of PRs in HCOs, announcement, and communication of the instructions are not enough; in addition, training regarding PRC is required and PRC implementation should be strictly monitored. For instance, related training programs for healthcare providers on PRs, enacting laws and regulations to endorse PRs, implementing regulatory guidelines, tracking patients' rights violations (63), considering PRs observance in the employee appraisal, attending to the social and economic rights of staff, especially nurses, reducing staff's workload, creating a culture for PRs in the society and HCOs, and strong emphasis on the patient preferences could assist to promote PRs practice in HCOs (64, 65).

Geographical dispersion of PRs practice

The lowest score of compliance with PRC was related to Qazvin and Sistan-Baluchestan (SB) provinces. This finding resulted from the studies conducted in 26 provinces of the country over different years, but to adjust these results, the average of the findings of several studies in each province was used. Recent studies also showed that healthcare development in all provinces was not the same (66-68), which might influence PRs practice. SB is considered, in terms of health indicators, among underdeveloped provinces (66-68). Imbalanced access to healthcare resources could be crucial for improving PRs practice (69).

Protection of PRC Dimensions

The highest score was for the "right of privacy and confidentiality", which might be attributable to the importance of this issue in the religious teachings as well as to the implementation of the "plan for compliance of medical affairs with religious standards" in HCOs (70, 71). The lowest score was for "right to access an efficient complaining system", which could be due to the poor healthcare system's responsiveness and weak demanding skills in the country's cultural structure (72-74). In similar studies in Saudi and Ugandan hospitals, the lowest score was reported on the "right to compensation" (56, 75). In Finland, despite the authorization of the right to complain in law, and the presence of a patient ombudsman, the complaint process is difficult for patients, as the general public are practically lacking this right (76). The results were also presented in Egypt where in the hospitals under study, patients did not receive any information about the right to complain about physicians' abuse and malpractice or compensation, and they also did not know how to complain in case of dissatisfaction with the services (55). These results could be because physicians and nurses in these studies were afraid of the legal responsibility, and believed that disclosure of these rights to patients might lead to serious consequences (e.g., lawsuits and loss of their jobs). A study in France confirmed that the increase in the number of complaints related to medical issues between 1998 and 2004 was due to an increase in the

public awareness of medical errors after the enactment of the PRs act (77).

The second-lowest score was related to the "right to choose and decide freely on receiving healthcare". Similarly, Jozi et al. clarified that the "right to refuse" and "right not to participate in clinical trials" were the least important from the nurses' perspective (9). Ghanem et al. (55) also confirmed the necessity of reconsidering physicians' and nurses' viewpoints in "right to choice and decision-making". In the UK, expectations regarding the choice of hospital and physician were not met (78). In Belgium, physicians rarely complied with procedures such as informed consent (16.4%), and little demand of patients for their rights was observed (79). In Iran, the non-observance of PRs related to the choice presented as a general challenge for the healthcare system; the large difference between the private and public sectors tariffs could be an underlying reason (80, 81), as well as factors such as the increase in the number of hospitalizations, workload and staff shortage in hospitals leading to less time spent by hospital medical staff communicating with patients (82, 83).

PRs protection: Influential factors

The present study showed that the observance rate of PRs had a significant relationship with patients' awareness of PRC. For example, the highest level of awareness was related to the first dimension of PRC ("right to receiving appropriate services"), and the lowest was related to the third dimension ("right to choose and decide freely on receiving healthcare"), but the situation was inverse regarding satisfaction (32, 84). Therefore, the dimension with more awareness is more demanded and thus more practiced.

Moreover, the type of hospital had a statistically significant relationship with PRs practice, and this rate in teaching hospitals was lower than both public and private hospitals (1, 31, 85, 86). In Egypt, the performance of the university hospital was reported to be better than that of the general hospital (55). In Iran, however, in teaching and public hospitals, as opposed to other hospitals, attitudes towards PRs were notably inappropriate due to the high referral burden of patients, nursing work overload, insufficient knowledge of medical staff about PRs, the existence of different educational groups and students, and their lack of knowledge.

As a limitation in this study, access to the full-text of several relevant articles was restricted, which was solved through direct contact with their authors. Moreover, judgment on the PRs practice in the country was based on the existing studies and primary data was not sought.

Conclusion

Patient satisfaction can largely indicate the high quality of services and adequate response to medical needs and the realization of PRs. Hence PRC as a formal package of patient protection principles intended to serve this quality and responsiveness. According to the present study's findings, HCOs in Iran are

moderately respected PRs; hence, in conjunction with the efforts of authorities, the society and service providers should be fully informed, empowered, demanded, and monitored on the observance of all PRC dimensions. The "right to access an efficient complaining system" might be a basic requirement for the existing organizations and should be considered and targeted, because it has not previously been adequately addressed. The present study's findings, if receive sufficient attention from the authorities, can strengthen PRs protection at macro-level decisions by providing an overview of PRs practice status in the country and uncovering neglected dimensions of PRC.

To promote PRs, the following strategies can be adopted: (*i*) developing a process for providing sufficient information on PRs, (*ii*) considering the PRs indicators in medical and healthcare staff's evaluation, (*iii*) paying attention to the social and economic rights of the staff, especially nurses, (*iv*) reducing staff's workload, (*v*) creating a culture for realizing PRs in the society and HCOs, and (*vi*) patient activation and engagement via more emphasis on patients' preferences. In Iran, adopting a multi-level, multi-channel, and patient-centered approach in the development and implementation of laws to combine social services to realize PRs is lacking or non-existent. Similar studies in other provinces of the country, mainly qualitative, to investigate the causes of poor access to the desired level of PRs is recommended for future studies.

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Ethics approval and consent to participate

The approval of this study was granted by the Ethics Committee of Tehran University of Medical Sciences [The code of Ethics: IR.TUMS.SPH.REC.1398.190].

Competing interests

The authors declare that they have no competing interests.

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