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Iranian Women Perception of Patient's Rights: Inpatients' Attitude Toward Practice of the Iranian Charter

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Abstract

Background: Despite many studies, we are still in need of more investigations aiming at the implementation of patients' rights in Iran; this would be more important concerning vulnerable groups like women. In this way, we have tried to study how much are Iranian women justified about Iranian patients' rights charter and how much are their rights observed during hospitalization.
Methods: In this descriptive cross-sectional study, 150 competent in-patients were selected by simple random sampling. A previously validated (face, content, and construct validity) and reliable (Cronbach's alpha = 0.92) questionnaire was used to collect data. The questionnaire was designed based on the last version of Iranian patient rights charter and included four subscales. The data were analyzed by SPSS 21 using parametric statistics.
Results: Patients' rights charter was practiced weak (0.76 ± 0.24 out of 3) according to the patients. The weakest score was observed for the dimension of 'accountability and handling of complaints' (0.09 ± 0.27). Generally, the participants placed a relative importance (justified relatively well) for the charter (2.20 ± 0.46). Additionally, the "importance" of the rights was also significantly different regarding patients' educational ($P < 0.001$) and employment status ($P < 0.001$) and place of residence ($P < 0.001$). No significant correlation was determined between "Importance" and "performance" subscales.
Conclusions: According to the findings, more attempts should be implemented aiming at informing and sensitizing women about their rights. Therefore, establishing and/or supporting the following measures could be helpful: hospital and media-based advising programs for both patients and professionals, patients' rights movements, systematic controls and supervisions and carrying out patients' rights as a firm policy.

Keywords: Patient's Rights, Iran, Attitude, Women

1. Background

International growing concern about 'human rights violations' has made "patient's rights (PRs)" a framework for monitoring, documenting, and analyzing in patient care settings and creates a need for accountability for governments and some parties (1). Generally, providing an ethical healthcare necessitates respecting both fundamental and advanced rights of recipients of the health services (2, 3). Perception of patient's rights, however, might vary in different cultures and socio-economic statuses; both factors might play their specific role in the practice of PRs as facilitator or barrier (2, 3). In this way, despite being an international concern, world health organization (WHO) research group on PRs and citizens' empowerment suggested that each country should articulate its specific concerns and priorities according to its own cultural and social needs to promote and protect PRs (WHO Regional Office for Europe 1999). In spite of specific differences, however, top priorities of PRs in most countries include being respected as a human being, receiving health services and facilities in a high quality and non-discriminative way, respect for autonomy and informed consent, and respect for privacy and confidentiality (4).

The comprehensive definition of the health with its physical, mental, social, and spiritual aspects (5) has been also reflected in patients' rights charters worldwide. Now, PRs as an integral part of practicing modern medicine is perceived as a responsibility toward patients, (6) as a greeting to 'respect for autonomy' (7) and a concern for 'humanity' of patients. Moreover, outlining PRs as a fundamental basis for framing patient's care policies calls for it to be respected even in the lack of patient's express request (8).

Generally, an increasing attention of international community to human rights and specifically, patients' psychosocial and financial vulnerability made medical asso-

ciations to protect PRs through setting out charters or bills of rights, enacting policies, implementing guidelines, and issuing declarations. Following these, launching practitioner education, exercising firm policies and supervisions, all have helped guarantee the protection of the rights, especially during the last three decades (9-12). Aiming at determining the present status, patients' awareness of their rights, (3, 13, 14) providers' awareness of PRs, (4, 6, 13, 15, 16) and observance of the rights within health settings (16-19) have been investigated in lots of publications. Although some studies have shown that patients' awareness of their rights has raised noticeably (20), we are still in need of further investigations, especially regarding developing countries like Iran.

In Iran, "patient's rights charter" was first compiled in 2003, then amended and adopted in December 2009 by the ministry of health and medical education. Following that, Iranian Universities of Medical Sciences were obliged to work on the implementation of the charter at health settings; on this basis, hospital accreditation standards of Iran were also revised to support the charter (21).

Besides awareness, patient's perception and justification of the importance of their rights are also known as important in how PRs to be satisfied in the practice (22, 23). This importance would be bold with respect to vulnerable groups such as women, especially when their authority might be diminished in specific medical situations like pregnancy and labor. In this regard, we aimed to investigate the attitude of inpatient women regarding the importance of PRs and the quality of its observance by the health member professionals at OB/GYN wards of the two affiliated educational hospitals of Shiraz University of Medical Sciences (SUMS).

2. Methods

The data were collected using a previously validated questionnaire (Justification and practice of patient rights, JPPR) (23), which has been prepared based on the last version of Iranian patient's rights charter (2009) (21). The questionnaire consists of a demographic section and 30 questions categorized into four subscales. The tool assesses patients' attitude regarding two different dimensions: I- the "importance" and II- the "performance" (quality of the practice) of Iranian PRs charter in healthcare settings. The questions were categorized into four dimensions according to the results of a previously performed factor analysis; I-the right of choosing, education, and confidentiality; II- providing desired services; III- accountability and handling complaints, and IV- facilitating services (23). A four-point Likert scale was used for the scopes "importance" (from not important" = 0, "to "very important" = 3) and "performance" (Always = 3, often = 2, sometimes = 1, and never = 0) according to Narimani et al. Finally, mean values were calculated for total scale and the subscales (max mean = 3.00; min mean = 0.00). For providing a comprehensive understanding of the present status of our healthcare settings respecting PRs, the authors categorized the mean values qualitatively. In this way, the mean values between 2.01 and 3 considered as good, between 1.01 and 2 as moderate, and between 0.00 and 1 as weak.

The study was performed at OB/GYN wards of two educational hospitals affiliated to SUMS. All conscious and competent patients hospitalized in the wards could be a participant after receiving patient consent. The participants were selected continuously from visits to the hospitals every 3 - 5 days (Jun-May 2016). The questionnaires were proportionally distributed to a number of OB/GYN beds in each hospital. A sample size of 132 was determined using Cochran's formula (d = 0.05 and CI = 95%). The questionnaires were filled (#150) by the patients themselves. If the patient was illiterate, the researcher asked them questions and filled the questionnaire. Non-consented patients and those with unreasonable consciousness were excluded from the study. Ethically, patients were initially justified about the nature and objectives of the study, their freedom for participation, and researcher's commitment to confidentiality. Data analysis was carried out with SPSS software version 21 with parametric (T-test, ANOVA, and Pearson) statistics regarding the results of the normality and equality of variance (Levene's) tests.

3. Results

Reliability (Cronbach's Alpha) of the questionnaire respecting the "importance" (0.92) and the quality of PRs "performance" (0.82) was rechecked. All patients were female and married. For better analysis and interpretation, we categorized the patients into four subgroups based on their age (Table 1). Besides age, descriptive analysis of other demographic characteristics including educational status, employment status, and place of residence can be seen in this table. The statistical results related to the comparison of means have been also presented in Table 1 for the scales of "importance" and the quality of PRs "performance" separately. As Table 1 shows, where P values were significant, a Post Hoc test (Tukey HSD) was performed for providing information on the means, which are significantly different from each other.

Following the results of the ANOVA statistics, the results of the Post Hoc tests (Tukey HSD) regarding demographic characteristics including age, educational status, and place of residence are shown in Table 1. As can be seen, contrary to the age subgroups, mean differences between

Table 1. Demographic Descriptive Analysis of JPPR Questionnaire (N = 150)

Demographic Characteristics	No. (%)	Total Mean[a] ± Standard Deviation[b]	
		"Performance"	"Importance"
Age groups, y			
≤ 20	16 (10.7)	0.71 ± 0.28	1.98 ± 0.47
21 to 30	78 (52)	0.75 ± 0.24	2.21 ± 0.45
31 to 40	41 (27.3)	0.72 ± 0.17↑	2.21 ± 0.40
40 ≤	15 (10)	0.91 ± 0.26↑	2.07 ± 0.61
Between groups P value[c] (ANOVA)		0.049	0.231
Educational status			
Below Diploma	64 (42.7)	0.72 ± 0.22	1.94 ± 0.41↑
Diploma	34 (22.7)	0.86 ± 0.29	2.19 ± 0.40*×
Associate Degree	16 (10.7)	0.71 ± 0.23	2.51 ± 0.26×
Bachelor's Degree or higher	32 (22)	0.78 ± 0.20	2.53 ± 0.34↑*
Between groups P value (ANOVA)		0.062	< 0.001
Employment Status			
Housekeeper	124 (82.7)	0.75 ± 0.24	2.1 ± 0.44
Employee	26 (17.3)	0.8 ± 0.19	2.53 ± 0.4
Between groups P value (T-test)		0.315	< 0.001
Place of residence			
Shiraz[d]	64 (42.7)	0.77 ± 0.24	2.36 ± 0.4*×
Small cities of Fars	48 (32.0)	0.73 ± 0.22	2.0 ± 0.40↑×√
Villages of Fars	19 (12.7)	0.79 ± 0.30	1.72 ± 0.50↑*^
Other provinces	19 (12.7)	0.75 ± 0.24	2.35 ± 0.36√^
Between groups P value (ANOVA)		0.726	< 0.001

[a] Mean scores are out of 3.
[b] Symbols for showing significance (ANOVA) between two selected groups based on Tukey HSD Post Hoc test.
[c] Significance level: P < 0.05.
[d] Shiraz metropolis is the main city of Fars province.

other demographic subgroups are significant regarding the scope "importance". This is while in general, "performance" of PRs has not been significantly rated between demographic subgroups.

The mean and standard deviation regarding total scale and the subscales of the JPPR questionnaire are shown in Table 2. Conclusively, as Table 2 indicates, patients' rights charter was practiced weak (0.76 ± 0.24 out of 3) according to the patients. The weakest score was observed for the dimension of 'accountability and handling of complaints' (0.09 ± 0.27). In addition, the participants placed a relatively good importance (they were justified relatively well) for the whole charter (2.20 ± 0.46 out of 3). In this scope, the dimension "right of choosing, education, and confidentiality" rated the lowest according to the participants (1.87 ± 0.66).

Table 2. The Mean and Standard Deviation of the JPPR Questionnaire and Its Subscales Respecting Two Scopes of "Importance" and "Performance" of PRs (N = 150)

Subscales of the Questionnaire	Mean[a] and Standard Deviation	
	Importance[b]	Performance[b]
D1: right of choosing, education and confidentiality	1.87 ± 0.66	0.74 ± 0.33
D2: providing desired services	1.96 ± 0.52	0.91 ± 0.34
D3: accountability and handling of complaints	2.32 ± 0.74	0.09 ± 0.27
D4: facilitating services	2.56 ± 0.56	1.30 ± 0.50
Total score	2.20 ± 0.46	0.76 ± 0.24

[a] Mean scores are out of 3.
[b] Scopes of the JPPR questionnaire.

Having determined the correlation between mean values (Table 2), the Pearson correlation coefficients were calculated in Table 3 for the total and quad dimensions of the questionnaire respecting subscales "importance" and "performance". As Table 3 shows, generally there is no inter-subscale significant relationship regarding the mean values of total and quad dimensions of the JPPR questionnaire.

4. Discussion

We investigated how much women are justified with the importance of PRs based on the last version of the Iranian patient rights charter (2009). Moreover, we surveyed inpatients' opinion around the practice of the rights in two teaching hospitals having OB/GYN wards. The data revealed that women stressed weakly to moderately the importance of PRs. Moreover, they rated the quality of the practice of the charter as very weak.

As the results indicated, the quality of practice of PRs was construed as weak according to the ratings of the participants. This measure has been also reported in the published literature in a wide range from good (24-26) to moderate (6, 27) and weak (18, 28, 29). Moreover, according to the findings, the mean values of the practice of PRs are not

Table 3. Pearson Bivariate Correlation Coefficients and Their Significance Between Total and Quad Dimensions of the JPPR Questionnaire Respecting Subscales "Importance" and "Performance" of PRs (N = 150)

		D1I	D2I	D3I	D4I	Ts3I	D1P4	D2P	D3P	D4P	TsP
D1I	R	1	0.691	0.338	0429	0.815	0123	.018	-.117	-0.044	-0.007
	P		0.001	< 0.001	< 0.001	< 0.001	0.133	0.827	0.155	0.596	0.934
D2I	R		1	0.373	0.417	0.803	-.087	0.001	-.066	-.118	-.111
	P			< 0.001	< 0.001	< 0.001	0.291	0.995	0.419	0.152	0.175
D3I	R			1	0.259	0.702	-.010	-.059	-.127	0.088	-.014
	P				0.001	< 0.001	0.904	0.474	0.122	0.283	0.867
D4I	R				1	0.675	0.071	0.021	-.285	0.030	-.033
	P					< 0.001	390	0.799	< 0.001	0.719	0.686
TsI	R					1	0.037	-.011	-.197	-.005	-.049
	P						0.655	0.898	0.016	0.954	0.548
D1P	R						1	0.598	0.012	0.327	0.741
	P							< 0.001	0.879	< 0.001	< 0.001
D2P	R							1	-.021	.240	0.688
	P								0.797	0.003	< 0.001
D3P	R								1	0.091	0.330
	P									0.267	< 0.001
D4P	R									1	0.756
	P										< 0.001
TsP											1

Abbreviations: D1-D4, Quad dimensions of the JPPR questionnaire: dimension 1: right of choosing, education, and confidentiality; dimension 2: providing desired services; dimension 3: accountability and handling of complaints; dimension 4: facilitating services; I, subscale "Importance"; P, subscale "Performance"; R, Pearson Corelation; Ts, Total score.

significantly different among demographic groups except for one subgroup of the age. Commonly, this could indicate that the PRs charter is practiced regardless of patients' educational level, occupational status, and their place of living. Nonetheless, the assessment was rated significantly higher by women aged more than 40 compared to other age groups. Reasonably, this phenomenon could have happened based on the following assumptions: (A)- PRs were much respected for those over 40 by professionals with every reason or/and (B)- the viewpoint of those over 40 concerning respect of their rights has been more lenient than other age groups or so; Their "less expectation" could be for having a more comprehensive understanding of the specific conditions and limitations of a teaching hospital and also better understanding of their situation as a patient. However, both assumptions need more investigations before being confirmed.

Likewise, the relationship between the "quality of the practice" of PRs and demographic factors has been investigated in the relevant literature. Accordingly, statistical meaningful relationships have not been confirmed regarding demographic factors including age (22, 24, 28), education (24, 28), employment status (24), and place of residence (28) in most reports. Contrary to our results, a meaningful relationship has been reported in a limited number of publications concerning educational status of participants (22, 25).

Among four subscales of the questionnaire, the obtained mean for satisfying the third dimension - accountability and handling of complaints- was extremely low (mean = 0.09 $\pm$ 0.27). This weak point shows there is a critical need for increased professional accountability while handling women complaints. Moreover, according to the obtained mean values for the importance of the first dimension -choosing, education, and confidentiality- (mean = 1.87 $\pm$ 0.66), it seems that health-related autonomy as an international fundamental right of patients has not been an issue of the first priority for most participants. Additionally, based on the obtained mean values for the importance of the second dimension -providing desired services- (mean = 1.96 $\pm$ 0.52), it seems that generally, participants have not been enough familiar with their rights regarding the items of this dimension.

The same results have also been reported in the relevant literature; in some instances, participants believed that PRs regarding "complaints", (27, 28) "confidentiality", (28, 30) and "autonomy and right of decision making" (31) have been practiced weakly. Nevertheless, the quality of observance of "confidentiality" (25, 27, 31) and "education of patients" (giving information) (25, 31, 32) have been reported as moderate to good in some other studies.

There are influential factors reported in the literature with negative or positive effects on the realization of PRs in healthcare settings. According to our experience, lack or limitation of facilities, heavy workload, shortage of medical staff (2, 33) and low, out-of-date (33) and lack of appli-

cable (required) medical standards are among the main items that might also render violation of PRs in our health settings. On the opposite side, attempts are making for the improvement of the healthcare management, improvement of the effectiveness of health structures and processes, and development of professional knowledge and skills of the staff aiming at facilitating the implementation of PRs in our healthcare settings (34).

Generally, according to the findings, patients did not adequately justify the importance of the charter. This is while individual patients' awareness and solicitation of the rights could also play a critical role in the qualitative practice of the rights done by professionals (2, 22, 26, 33). Patients' awareness of their rights could be considered important as it might positively influence their satisfaction with health services (35). As one of the main goals of the market-based delivering, patients' satisfaction has been an indicator for assessing the efficacy and effectiveness of the health services especially in the last two decades (36, 37). Additionally, awareness of healthcare practitioners including physicians, nurses, trainees, and health managers and their positive view on the charter could also promote and protect satisfying the PRs (6, 15, 16, 18). Considering this fact is also important especially regarding medical trainees, they are playing a considerable role in our educational settings as members of patient' healthcare team while they have not been enough educated about PRs (15).

The findings also showed that the extent of "Importance" of the charter was not significantly related to the demographic characteristic of "age" but it was meaningfully related to participants' "occupation", "educational status", and their "place of residence". In this regard, the average score was higher in participants with academic education, the ones employed, and those who lived in Shiraz metropolis. Probably, higher education, having a job, and living in a bigger city are among factors that could develop patients' interpersonal relationships, increase availability and accessibility to informational resources, and cause confronting more various experiences; conclusively, these elements might enhance participants' health-related information and motivate their desire to participate in therapeutic processes more actively. Finally, all these conditions could have caused participants' expectation of the rights to be higher than their counterparts could.

These findings are likewise supported by the results of the publications which have studied patients' awareness of their rights regarding demographic factors including age, (24) education, (14, 17, 18, 38) occupation, (18) and place of living (14, 18). Nevertheless, the results are not supported based on the findings of some other reports regarding age (17) and education (39).

As bivariate correlation coefficients indicated, the mean values of "importance" are not generally a good predictor of the quality of "performance" of PRs at the bedside. Accordingly, only the mean values of the total ($r = -0.285$; $P < 0.001$) and the fourth dimension -facilitating services- ($r = -0.197$; $P = 0.016$) of the subscale "importance" could be used for prediction of the quality of "performance" of the third dimension of the JPPR questionnaire -accountability and handling of complaints. This could perceive that higher ratings of the importance of PRs especially regarding 'facilitating services' could have increased demands for accountability and decrease participants' satisfaction with the quality of handling complaints.

As a strength point, the study focused on a vulnerable group of patients (pregnant inpatients). Moreover, instead of patients' awareness of the rights, we went farther and investigated how much the rights were valuable and important for the participants. However, carrying out the study in an educational context could probably have imposed some limitations upon the results at least for two reasons: (A) generally, patients referring to teaching hospitals are often of disadvantaged groups. This fact might influence the generalizability of the results and, (B) medical trainees as important members of the healthcare team might not have a full awareness of the PRs, (15) which in turn could potentially lower the quality of the practice of the rights.

In sum, it seems that we are still in need of more attempts aiming at informing and sensitizing patients about their rights. Moreover, we are still in need of improving the concern of the members of healthcare team especially medical trainees about PRs. In this way, establishing and supporting the hospital and media-based advising programs, and supporting PRs movements and related NGOs could be helpful. Additionally, it is proposed that PRs could be implemented more strictly in everyday professional practice through employing continuous professional educations, systematic controls, and supervisions and carrying out PRs as a firm policy within the healthcare settings.

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