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Exploring patients' rights awareness and implementations amongst hospitalized patients in Northern Palestine: insights from a local perspective

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Abstract

Background and aim Promoting ethical medical practices and preserving human rights principles require an understanding of patient rights. Studies show varying awareness levels among patients regarding their rights. This study aims to assess the level of awareness among patients in Palestine about their rights and the compliance of healthcare professionals.

Methods A cross-sectional study was conducted between November 2023 and January 2024 in the Northern West Bank cities. Data collection was conducted by three trained medical students utilizing an interviewer-administered questionnaire. The association between participant characteristics and awareness was assessed using the Chi-square test, followed by a multivariate regression analysis to control for confounding variables.

Results Of 400 patients surveyed, 47.0% had good awareness of their rights. Multivariate analysis showed that awareness was associated with patients in the age group of 18–30 years and 46–60 years, having private insurance, more prior hospitalizations, non-governmental settings, and prior charter awareness. Awareness was highest for respectful care and lowest for staff introductions. Non-governmental facilities performed better than governmental on explaining procedures, alternatives, and costs, though both settings scored highly on non-discrimination and consent.

Conclusions Our findings underscore global gaps in ensuring adequate patients' rights awareness and implementation, with over half exhibiting inadequate knowledge. Significant deficiencies exist in involving patients in decision-making, informing about procedures/costs, and providing accessible complaint mechanisms, particularly in governmental facilities. Comprehensive, culturally-appropriate initiatives involving multisectoral collaborations are crucial to drive substantive reforms translating patient-centered care principles into consistent practice worldwide.

Keywords Patient rights, Awareness, Patient-centered care, Physician-patient relations

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Introduction

Patient rights refer to the legal and ethical entitlements of patients regarding their healthcare, encompassing access to care, the right to informed consent, confidentiality, autonomy in medical decisions, and the right to respectful and dignified treatment. These rights are rooted in the principles of human dignity, personal autonomy, and equality, which are essential for establishing a fair and ethical healthcare system [1]. Encouraging ethical medical practices and providing quality healthcare requires respecting patient rights. As a result, respect for patient rights is regarded as a critical component of health service quality improvement initiatives and serves as a foundation for establishing clinical service standards.

Patients' dignity can be enhanced by being aware of their rights, which also allows them to collaborate with doctors on decisions. Dignified care refers to treating patients with respect, empathy, and fairness, ensuring that their intrinsic value as human beings is honored. Providing dignified care fosters trust, enhances the patient-provider relationship, and can ultimately lead to better healthcare outcomes [2]. This can save costs, shorten hospital stays, and improve the quality of healthcare services. As such, determining whether patients are aware of their rights is crucial [3].

Since the United Nations (UN) passed the Universal Declaration of Human Rights in 1948, laws pertaining to patient rights have been enacted worldwide. It recognized "inherent dignity" and "equal and inalienable rights of all members of the human family" as the cornerstones of justice, freedom, and peace. The basic idea of intrinsic dignity and equality for all human beings, as set out in the declaration, underpins the development of a concept of patients' rights [4]. Additionally, the civil rights movements of the 1960s in the United States played a pivotal role in advancing the dialogue on human dignity and equality, particularly in healthcare [5]. Historians such as David J. Rothman have noted that the struggle for racial equality and the fight against segregation exposed disparities in healthcare access for marginalized groups [6]. This period also saw the emergence of bioethics as a field, driven by increased awareness of the ethical dimensions of medical care, including issues such as informed consent, the right to refuse treatment, and the protection of vulnerable populations. The intersection of civil rights and bioethics during this era significantly shaped contemporary discussions on patient autonomy and medical justice.

To advance and protect patients' rights, the World Health Organization (WHO) recommends that each country amend its legal framework to consider the distinctive cultural and societal norms of that country [7]. Countries all over the world have passed laws and regulations governing the moral treatment of patients. The Palestinian Ministry of Health accordingly introduced the patient's bill of rights, which has been in effect at all hospitals since 2004 [8]. Similarly, patients' bill of rights was included in Egypt's healthcare legislation in 2005 [3], and Sudan started introducing it in 2009 [9]. However, the WHO warns that the quality of healthcare is not enhanced by simply establishing patients' charters without accompanying efforts to raise awareness amongst patients.

The issues of patients' choice, the recognition of their values and preferences, as well as access to health care, are becoming more complex currently. Patients' expectations, including proposed procedures, treatments, and their alternatives, have increased with a desire for optimum care and active involvement in the decision-making process. In general, there is a growing awareness of human rights [10, 11]. However, there are still challenges, such as professional misconduct by some healthcare professionals and a lack of understanding about the rights of patients, despite these important advances. Different levels of awareness among patients have been found in studies in different countries, with many patients unaware of their rights [9, 10, 12–14]. This study aims to assess the level of awareness among patients in Palestine about their rights and to evaluate the patients' perceived compliance of healthcare professionals with these rights.

Methods

Study design, population, and sample size

A cross-sectional study was carried out between November 2023 and January 2024 to evaluate the awareness of rights among hospitalized patients and the extent of compliance with these rights by healthcare staff as reported by patients. The study population included all Palestinian adult patients. We included hospitalized patients in all governmental hospitals in addition to two non-governmental within the Northern West Bank cities. Seven governmental hospitals participated in the study, each with a patient population that was generally comparable. Although the hospitals differed in their bed capacity, this variation was taken into account when determining the sample size from each facility. We excluded patients under the age of 18, critically ill patients —defined based on clinician assessment as those exhibiting compromised vital signs, impaired consciousness, or other indicators of severity that precluded participation—, outpatients, those diagnosed with psychotic disorders, and patients with severe psychiatric conditions that prevented them from providing informed consent.

The sample size for the study was determined to be 382 patients. This calculation was based on a presumed 5% margin of error, a 95% confidence level, a response distribution of 50%, and an estimated total population of 50,000 patients. The sample size for each hospital was chosen in proportionate to its total capacity. To compensate for potential non-responses, we increased the calculated sample resulting in a total of 400 patients being included.

Ethical approval for the study was granted by the Institutional Review Board of An-Najah National University (Reference #: Med Oct. 2023/83). Additionally, official approvals were obtained from the Palestinian Ministry of Health and administrators of private hospitals. All participants were informed about the study's objectives, assured that participation was voluntary, and provided signed informed consent before data collection. To maintain privacy and confidentiality, no identifying information was collected, and hospital names were anonymized during analysis.

Data collection

An interviewer-administered structured questionnaire (Supplementary Information) was constructed from previous studies [13–16]. Two bilingual native Arabic speakers, one of whom also worked as a translator (non-medical background), translated the English questionnaire into Arabic. The Arabic text was then translated back into English by a native Arabic speaker who was also bilingual in English and Arabic. Prior to finalizing the Arabic version, the research team made several linguistic changes and compared it to the two English versions. To ensure ease of administration, timing, and clarity, two field experts evaluated the questionnaire. Following this, a pilot study involving 30 patients was conducted. The pilot study's findings were not incorporated into the original study's findings because the questionnaire underwent modifications to make certain questions clearer. Internal consistency for the study questionnaire was good, as Cronbach's alpha measured 0.844. Additionally, we conducted an Exploratory Factor Analysis to assess the construct validity (Supplementary Table 1).

Three trained medical students collected the data. We used a convenience sampling to select the sample from various wards. To control for inter-observer bias, they underwent training sessions on administering the questionnaire, asking questions, and responding to potential inquiries. Patients were approached face-to-face and given a brief verbal explanation of the study's purpose. Before being asked to complete the questionnaire, all patients who accepted to participate in the study signed an informed consent.

The questionnaire consisted of three parts. The first section included questions about sociodemographic information, including age, sex, marital status, place of residence, level of education, previous hospital admissions, length of hospital stay, and knowledge of human rights charter. In the subsequent section, the patients' level of awareness was assessed through the use of 17 questions, to which the responses could be "aware," "somewhat aware," or "not aware." Each question received a score of zero for the patient's lack of awareness of that particular right, one for their partial awareness, and two for their complete awareness. The scores for each statement were then added up to create an awareness score, which had a range of 0 to 34 points. The summative scores were converted to percentages, and the percentage mean score (PMS) was classified as a dichotomous variable. Based on the modified Bloom's cut-off point [17], a participant who scored ≥ 80% of the correct awareness questions (≥ 27.2 points out of 34) was considered to have "adequate awareness," and a participant who scored < 80% (< 27.2 points out of 34) was considered to have "inadequate awareness." The final section used 16 questions, each of which have a "yes" or "no" response, to evaluate patients' perceptions regarding the adherence of medical staff to their rights.

Statistical analysis

The collected data were summarized and coded before being input into the SPSS Windows V.26.0 software. The data were reviewed to check for any missing values or variables. Descriptive statistical analysis was utilized to demonstrate the characteristics of the participants, their awareness of their rights, and the practice of their rights by health care providers. The relationship between the characteristics of the participants and their awareness was evaluated using the Chi-square test. To account for any confounding variables, a multivariate regression analysis was conducted. The outcomes of the model were presented in the form of adjusted odds ratios (aOR) accompanied by their respective 95% confidence intervals (95% CI). For the practice of patients' rights, difference between governmental and non-governmental hospitals was evaluated using binary logistic regression while adjusting for gender, age, marital status, educational level, occupation, insurance status, and previous admissions. The False Discovery Rate (FDR) Correction, which was performed using the Benjamini-Hochberg technique, indicated no issues with multiplicity. The level of significance was set at 0.05.

Results

Sociodemographic characteristics

This study involved 400 patients, with a 91.0% response rate. Of these, 304 were from governmental hospitals, and 96 from non-governmental hospitals. Overall, males accounted for 52.5% (*n* = 210) of the respondents. Table 1 shows the patients' demographic characteristics. The study participants' ages ranged from 18 to 88 years, with a mean age of 42.2 ± 17.4. One-third (129, 32.3%) of all respondents were between 18 and 30 years of age. The majority were married (272, 68.0%), had an educational

Table 1 Socio-demographic characteristics of study participants, $n=400$

Variables	Frequency (%)
Sex	
Male	210 (52.5)
Female	190 (47.5)
Age	
18–30	129 (32.3)
31–45	114 (28.5)
46–60	80 (20.0)
> 60	77 (19.2)
Marital status	
Married	272 (68.0)
Not married	128 (32.0)
Educational status	
Primary education or less	109 (27.2)
Secondary education	136 (34.0)
University/college	155 (38.8)
Residency	
Urban	182 (45.5)
Rural	218 (54.5)
Occupation	
Employed	196 (49.0)
Unemployed	204 (51.0)
Insurance	
No insurance	74 (18.5)
Governmental	262 (65.5)
Private	64 (16.0)
Number of Previous Hospital Admissions	
Zero	120 (30.0)
Once - Twice	117 (29.2)
Three times and more	163 (40.8)
Duration of hospitalization in days *(Mean ± SD)*	5.2 (7.4)
Being aware of the patient rights charter	
Yes	137 (34.3)
No	263 (65.7)

level of secondary education or higher (291, 72.8%), and had a history of previous admissions (280, 70.1%). Unemployment was documented in 204 (51.0%) patients, and slightly more participants were from rural areas (218, 54.5%) than urban areas. The duration of hospitalization ranged from 1 to 100 days, with an average of 5.2±7.4 days. Only 137 patients (34.3%) were aware that there was a patient rights charter, despite the fact that 278 patients (69.5%) reported being aware of their rights.

Patients' awareness of their rights

This study explored patients' awareness of their rights. Out of all participants, only 188 (47.0%) had good awareness of their rights. Social media (48.0%) was the most commonly reported source of information on patients' rights, followed by doctors (34.5%) (Fig. 1).

Table 2 illustrates the findings indicating the levels of participant awareness. Notably, 92.8% of participants reported being fully aware of their right to receive respectful care. Additionally, 82.0% expressed awareness of their right to privacy during physical examinations, while 81.5% acknowledged their right to receive treatment and medical services devoid of discrimination based on age, color, religion, or sex. On the contrary, only a minority of patients demonstrated full awareness regarding some of their rights, such as the ability to designate a healthcare proxy (49.5%), request a second opinion from a different physician (48.0%), and engage in treatment decisions (47.7%). The lowest level of awareness related to the right to receive information about the identities and responsibilities of healthcare professionals involved in their care (36.3%).

Factors affecting patients' awareness of their rights

On univariate analysis, age, educational status, insurance coverage, number of previous hospital admissions, and being previously aware of the patient rights charter were found to be associated with awareness of patients' rights. Multivariable analysis showed that patients in the age group of 18–30 years [aP = 0.024, aOR = 2.24 (95% CI: 1.12–4.49)], and those aged 46–60 years [aP = 0.016, aOR = 2.43 (95% CI: 1.18–5.01)] were more likely to be aware of their rights compared to patients aged above 60 years. Patients with governmental [aP = 0.037, aOR = 1.89 (95% CI: 1.10–3.44)] or private [aP = 0.019, aOR = 2.49 (95% CI: 1.16–5.35)] insurance coverage were more aware of their rights than those without insurance. Patients with three or more previous hospital admissions [aP = 0.013, aOR = 2.00 (95% CI: 1.16–3.47)] were also more likely to be aware of their rights compared to those with no previous admissions. Furthermore, patients admitted in non-governmental healthcare settings [aP = 0.022, aOR = 1.85 (95% CI: 1.10–3.12)] and those who were aware of the patient rights charter [aP < 0.001, aOR = 3.10 (95% CI: 1.94–4.92)] had significantly higher awareness of their rights (Table 3).

Practice of patient's rights among health professionals from patients' perspective

Table 4 displays the degree to which physicians and nurses adhere to patient rights as perceived by patients. The multivariate analysis evaluated multiple rights across governmental and non-governmental facilities while adjusting for gender, age, marital status, educational level, occupation, insurance status, and previous admissions.

The rights most frequently upheld were non-discriminatory access to care (91% governmental, 94% non-governmental, aOR 1.3, 95% CI 0.52–3.5) and obtaining consent before examinations (84.5% governmental, 92% non-governmental, aOR 2.1, 95% CI 0.91–4.8), with no significant differences between governmental and non-governmental facilities.

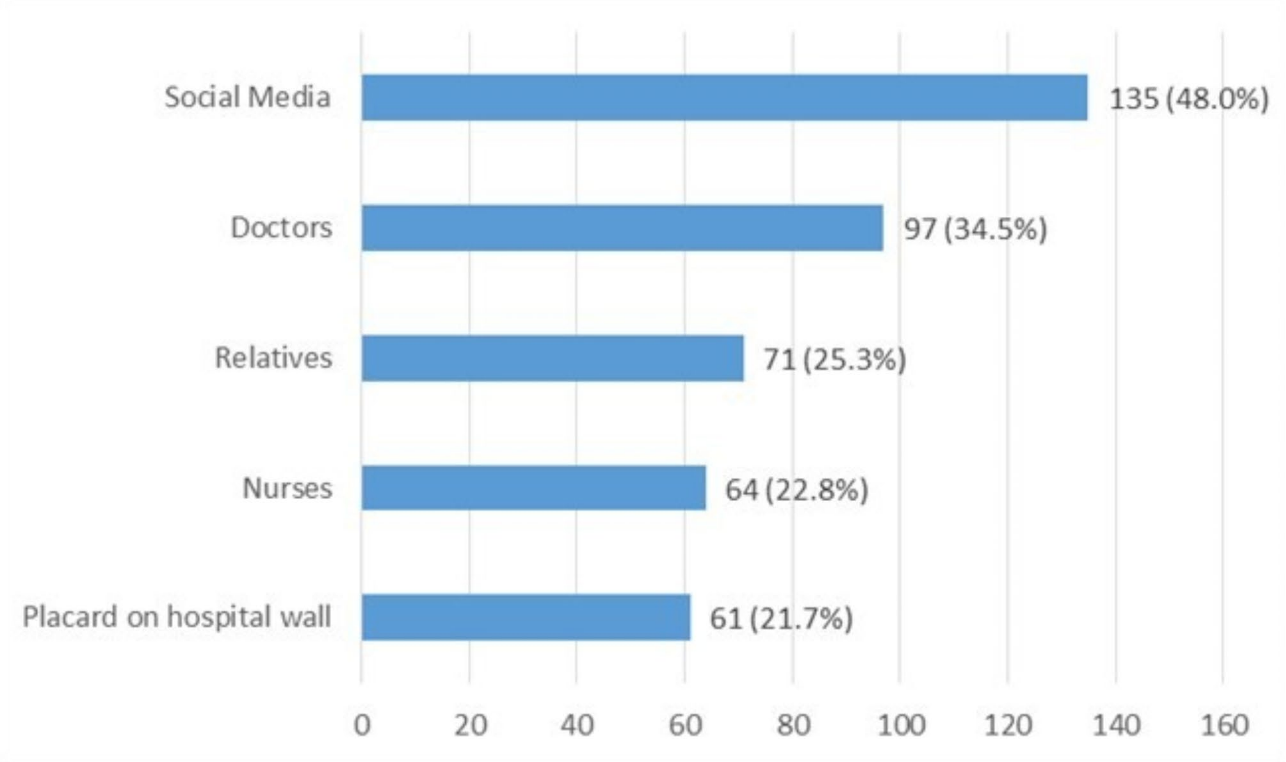

Fig. 1 Study participants' source of knowledge about patient rights, ($n = 400$)

Table 2 Assessment of patient's awareness regarding their rights, $n = 400$

Statement	Not aware at all (%)	Somewhat aware (%)	Completely aware (%)
To receive treatment and medical services without discrimination based on age, colour, religion, or sex	8 (2.0%)	66 (16.5%)	326 (81.5%)
To be informed about his/her rights and responsibilities in a manner he/she can understand	14 (3.5%)	79 (19.7%)	307 (76.8%)
To receive respectful care	2 (0.5%)	27 (6.7%)	371 (92.8%)
Privacy during the clinical examination	16 (4.0%)	56 (14.0%)	328 (82.0%)
To have a person of their same gender be present when they are examined and treated by a doctor of the opposite gender	54 (13.5%)	102 (25.5%)	244 (61.0%)
The information a patient reveals to a healthcare professional is private and there are limits on how and when it can be disclosed to a third party	56 (14.0%)	103 (25.7%)	241 (60.3%)
To receive a full explanation of his/her case and any unanticipated outcomes of care and treatments in terms that she/he can understand	18 (4.5%)	79 (19.7%)	303 (75.8%)
To know about the alternatives to the proposed treatment before consenting to treatment	39 (9.7%)	112 (28.0%)	249 (62.3%)
To seek a second opinion from another doctor	82 (20.5%)	126 (31.5%)	192 (48.0%)
To sign an informed consent form before any medical procedure	41 (10.2%)	76 (19.0%)	283 (70.8%)
To refuse or discontinue treatment after a thorough explanation by his/her physician about the consequences and/or outcomes of his/her decision	56 (14.0%)	96 (24.0%)	248 (62.0%)
To be informed names and functions of all healthcare professionals involved in patient care	122 (30.5%)	133 (33.2%)	145 (36.3%)
To participate in decisions relating to their care and in choosing the treatment plan	77 (19.3%)	132 (33.0%)	191 (47.7%)
To appoint a healthcare proxy who will speak on their behalf regarding the right treatment and make decisions	87 (21.8%)	115 (28.7%)	198 (49.5%)
To have a towel, toilet, clothes and storage space	45 (11.2%)	82 (20.5%)	273 (68.3%)
To know about the prices of services and procedures	39 (9.8%)	80 (20.0%)	281 (70.2%)
To file a complaint regarding your medical provider or facility without fear of reprisals	49 (12.3%)	123 (30.7%)	228 (57.0%)

Table 3 Factors affecting patients' awareness of their rights, *n* = 400

Variables	Awareness level		*P* value	Multivariate analysis	
	Good	Poor		aOR (95%CI)	aP-value
Sex			0.388		
Male	103 (49.0%)	107 (51.0%)		0.81 (0.52-1.25)	0.331
Female†	85 (44.7%)	105 (55.3%)			
Age			0.037		
18–30	66 (51.2%)	63 (48.8%)		2.24 (1.12–4.49)	0.024
31–45	55 (48.2%)	59 (51.8%)		1.72 (0.86- 3.41)	0.123
46–60	42 (52.5%)	38 (47.5%)		2.43 (1.18 5.01)	0.016
> 60†	25 (32.5%)	52 (67.5%)		1	
Marital status			0.372		
Married	132 (48.5%)	140 (51.5%)		--	--
Not married	56 (43.8%)	72 (56.2%)			
Educational status			0.014		
Primary education or less†	41 (37.6%)	68 (62.4%)		1	
Secondary education	61 (44.9%)	75 (55.1%)		1.27 (0.71- 2.26)	0.428
University/college	86 (55.5%)	69 (44.5%)		1.46 (0.80- 2.65)	0.215
Residency			0.272		
Urban	91 (50.0%)	91 (50.0%)		--	--
Rural	97 (44.5%)	121 (55.5%)			
Occupation			0.671		
Employed	90 (45.9%)	106 (54.1%)		--	--
Unemployed	98 (48.0%)	106 (52.0%)			
Insurance			0.006		
No insurance	25 (33.8%)	49 (66.2%)			
Governmental	124 (47.3%)	138 (52.7%)		1.89 (1.10–3.44)	0.037
Private	39 (60.9%)	25 (39.1%)		2.49 (1.16–5.35)	0.019
No of Previous Hospital Admissions			0.261		
Zero†	49 (40.8%)	71 (59.2%)		1	
Once - Twice	57 (48.7%)	60 (51.3%)		1.61 (0.92- 2.82)	0.098
Three times and more	82 (50.3%)	81 (49.7%)		2.00 (1.16–3.47)	0.013
Health Care setting					
Non-governmental	54 (56.3%)	42 (43.8%)	0.037	1.85 (1.10 3.12)	
Governmental†	134 (44.1%)	170 (55.9%)		1	0.022
Being aware of the patient rights charter			< 0.001		
Yes	88 (64.2%)	49 (35.8%)		3.10 (1.94–4.92)	< 0.001
No†	100 (38.0%)	163 (62.0%)		1	

†Reference group

However, lower scores were reported for certain rights with non-governmental facilities performed significantly better in these areas even after adjustment for confounding variable. Lower scores were seen for explaining physical exams [63.8% governmental, 78% non-governmental, (aOR 2.1, 95% CI: 1.2–3.7)], and discussing treatment alternatives [53.6% governmental, 71.9% non-governmental, (aOR 2.2, 95% CI: 1.3–3.7)]. The lowest scores involved informing about complaint processes [13.5% governmental, 34.4% non-governmental, (aOR 4.2, 95% CI: 2.3–7.6)] and summarizing rights (20.4% governmental, 25% non-governmental, aOR 1.3, 95% CI 0.74–2.4).

Discussion

The implementation of patients' rights is an important step towards improving health care practice and ensuring that patients, doctors, and nurses are aware of their own responsibilities [18]. It is essential for countries to evaluate and structure their healthcare systems to effectively address these issues. The practice of health care shouldn't be restricted by the implementation of patients' rights. Instead, it should foster a balanced sharing of responsibility between patients and healthcare providers. This equitable distribution is essential because when patients are aware of their rights, they become more engaged in their care, which can enhance the quality of healthcare outcomes. By promoting this mutual accountability, healthcare providers can deliver better care, and patients

Table 4 Univariate and multivariate regression analysis of health professionals' adherence to patients' rights, as perceived by patients, based on hospital type

Statement	Total	Governmental *n* (%)	Non-governmental *n* (%)	*P* value	*P* value (FDR correction)	aOR* (95% CI)	aP value	aP value (FDR correction)
The healthcare providers provided care respectfully	375 (93.7%)	282 (93.0%)	93 (97.0%)	0.147	0.200	2.0 (0.58 – 7.3)	0.268	0.335
Receive treatment and medical services without discrimination based on age, color, religion, or sex	366 (91.5%)	276 (91.0%)	90 (94.0%)	0.365	0.391	1.3 (0.52 – 3.5)	0.552	0.591
Permission was asked before the physical examination?	345 (86.2%)	257 (84.5%)	88 (92.0%)	0.077	0.116	2.1 (0.91 – 4.8)	0.082	0.123
Patient's privacy was protected during the physical examination	330 (82.5%)	243 (80.0%)	87 (90.6%)	0.016	0.028	2.6 (1.2–5.7)	0.017	0.036
An informed consent form was signed before treatment	331 (82.75%)	248 (81.6%)	83 (84.6%)	0.270	0.338	1.6 (0.78 – 3.1)	0.215	0.293
Functional bathing and toilet facilities, as well as any necessary personal items were available	292 (73%)	204 (67.0%)	88 (91.6%)	< 0.001	< 0.001	5.7 (2.6–12.6)	< 0.001	< 0.001
A storage space for personal material was provided	290 (72.5%)	201 (66.1%)	89 (92.7%)	< 0.001	< 0.001	6.4 (2.8–14.8)	< 0.001	< 0.001
Information about the recommended procedure, the associated risks, and any alternatives were given before treatment	273 (68.2%)	198 (65.1%)	75 (78.1%)	0.017	0.028	1.9 (1.1–3.2)	0.031	0.048
An explanation of the physical examination was given	269 (67.25%)	194 (63.8%)	75 (78.0%)	0.009	0.023	2.1 (1.2–3.7)	0.010	0.025
The financial costs of services and procedures were explained	255 (63.7%)	184 (60.5%)	71 (73.9%)	0.017	0.028	1.8 (1.1–3.1)	0.039	0.049
An explanation of the available alternatives was given before finalizing the treatment plan	232 (58%)	163 (53.6%)	69 (71.9%)	0.002	0.006	2.2 (1.3–3.7)	0.004	0.012
The healthcare providers introduced themselves by name and explained their function while showing their ID?	159 (39.7%)	102 (34.0%)	57 (59.4%)	< 0.001	< 0.001	3.0 (1.8-5.0)	< 0.001	< 0.001
The option to appoint a healthcare proxy who would speak on behalf of the patient regarding the right treatment was given	146 (36.5%)	108 (35.5%)	38 (39.6%)	0.472	0.472	1.1 (0.65 – 1.9)	0.718	0.718
A summary of the patient rights given	86 (21.5%)	62 (20.4%)	24 (25.0%)	0.338	0.390	1.3 (0.74 – 2.4)	0.329	0.380
The process of submitting a complaint regarding any concerns related to confidentiality or the quality of health care was explained	74 (18.5%)	41 (13.5%)	33 (34.4%)	< 0.001	< 0.001	4.2 (2.3–7.6)	< 0.001	< 0.001

*Adjusted to gender, age, marital status, educational level, occupation, insurance status, and previous admissions

can contribute more effectively to their own health management.

Patients' awareness of their rights

Our study demonstrated that less than half (47.0%) of the participants had a good awareness level about their rights, defined as scoring 80% or more. Participants were aware of their right to receive respectful care, the right to have privacy during physical examination, the right to receive treatment and medical services without discrimination based on age, color, religion, or sex, the right to be informed about his or her rights and responsibilities in respectful care,, and the right to be informed about his or her rights and responsibilities in a manner he or she can understand. These findings were similar to those found in studies done in Ethiopia [13], Egypt [3], Iran [19], and India [20]. On the other hand, participants were less aware of their right to appoint a healthcare proxy, seek a second opinion from another doctor, participate in treatment decisions, and be informed of the names and roles of healthcare professionals involved in care. This was parallel to the findings found in studies done in Pakistan [21], Egypt [3], Iran [19], and Iraq [22]. While this can be partly attributed to the paternalistic relationship between healthcare professionals and patients in these countries [23], other factors may also play a role. These include cultural norms that discourage questioning authority, and a lack of structured systems to promote patient participation in healthcare decisions.

Age was identified as a significant factor influencing patients' awareness of their rights. Specifically, the study revealed that individuals within the age groups of 18 to

30 and 46 to 60 exhibited notably higher levels of awareness compared to other age groups. The higher awareness in the younger age group (18–30) may be attributed to their increased access to digital platforms and educational opportunities, where healthcare rights are discussed. Meanwhile, individuals aged 46 to 60 may have greater awareness due to their extensive interactions with the healthcare system, either through personal experiences or caregiving roles. The associations between age and patients' consciousness of their rights varied across studies; while some studies indicated that older age predicted greater awareness [24], others suggested that younger individuals exhibited higher levels of awareness [9].

The frequency of prior hospitalizations is another contributing factor to patients' awareness of their rights. Patients who had been admitted to the hospital three times or more demonstrated significantly greater awareness levels. This can be attributed to the likelihood that individuals with a higher number of previous admissions encountered a variety of rights-related practices, thereby increasing their awareness of the expected standards of care in a hospital setting. Moreover, they are likely more motivated to explore facts about their rights and be familiar with the level of practice especially if they're readmitted to the same hospital. Being treated in a non-governmental hospital was associated with higher level of awareness compared to being treated in a governmental hospital, making health care-setting another factor that was significantly associated with the level of awareness. We believe that non-governmental hospitals often provide a less crowded environment, which allows for more individualized provider-patient interactions. This closer engagement can foster a better understanding of healthcare processes and patient rights, contributing to a higher level of awareness.

Participants who already knew about the "patients' rights" charter had a higher level of awareness; this is comparable to the study in Iran [25]. This indicates the importance of putting more efforts into efficient methods promoting "patients' rights" charter. Patients should receive written documentation (booklets or pamphlets) in addition to oral explanations upon admission.

The majority of patients (65.7%), according to this study, were unaware that a patients' rights charter that had been released by the Palestinian Ministry of Health. This is comparable to a study published in Pakistan where 65.5% of participants were not aware of the patients' rights charter, but still lower than those reported in studies conducted in Saudi Arabia [26] and Sudan [12], where 74.8% and 95.4% of participants, respectively, were found to be uninformed about the patients' rights charter. This variation can be explained by the absence of a dedicated information source, such as a website, directly educating the public about their rights within hospital settings. Notably, the Palestinian charter of patients' rights is embedded within a broad-ranging "Public health law," in contrast to the more focused and accessible dedicated sites found in Saudi Arabia.

Therefore, Palestinian healthcare authorities must prioritize the creation of educational campaigns specifically designed for the local population. Achieving this objective involves simplifying the charter of rights to ensure clarity and display it in the entrance of hospitals and patients' rooms to ensure more accessibility. After that, efforts should be made to launch awareness campaigns aimed at promoting understanding and recognition of these rights within different communities.

As for the type of insurance, participants enrolled in private insurance programs had a higher awareness level than those enrolled in governmental programs or had no insurance at all. This could be attributed to the differing levels of access to information and advocacy resources. Patients with private insurance often have greater financial means, which may afford them access to a wider array of educational materials, legal assistance, and advocacy groups dedicated to promoting patient rights. Additionally, private insurance plans typically offer more personalized customer service and support, including clearer explanations of coverage and rights [27].

Regarding the source of information about patients' rights, social media emerged as the leading source of information (48.0%); similarly, studies that showed comparable results were the ones conducted in India (58.0%) [28], South Egypt (89.4%) [29], and Ethiopia (28.3) [13]. However, in our study, doctors were the second source of information (34.5%). This was contrasted the findings in studies done in Riyadh, Saudi Arabia [30] and southern Egypt [3], where the greatest percentage of participants obtained their information from doctors and nurses.

The practice of patient rights

Our study found that, according to patients' perceptions, 92.5% of healthcare professionals adhered to providing respectful and non-discriminatory medical care, irrespective of whether the institution was governmental or non-governmental. This aligns with similar studies conducted in Egypt, which reported adherence rates of 96% in both governmental and non-governmental settings [3, 31].

However, concerning certain patients' rights, lower adherence rates were noted. While 88.3% of patients reported being asked for permission prior to physical examination, only 63.8% and 78% in governmental and non-governmental facilities respectively received an explanation of the procedure. Similar findings were observed in Sudan, with permission acquired in 87.1% of cases whereas explanation provided in only 69.2%

of cases [9]. These findings indicate that a significant number of patients undergo examination without being informed about the nature of the examination. This occurred significantly more in governmental versus non-governmental facilities. Therefore, healthcare providers, especially in governmental hospitals, must prioritize educating professionals to offer comprehensive explanations, even after consent is obtained.

Regarding treatment options, 53.6% of governmental and 71.9% of non-governmental hospital patients received explanations before finalizing care plans, surpassing rates found in other developing countries like Ethiopia (19.6%) [13], Egypt (10.3%) [3], India (44.16%) [31], and Sudan (62%) [9]. This relative improvement compared to other developing nations suggests modest advancement in decision-making practices in Palestine. Nonetheless, a substantial 18.3% gap exists between our governmental and non-governmental systems, with governmental hospitals lagging behind Sudan. Thus, legislators should introduce training programs to enhance shared decision-making, especially in governmental hospitals.

The most neglected practices by healthcare professionals were informing patients about the complaint submission process and providing a summary of patient rights. Shockingly, only 13.5% and 34.4% of respondents in governmental and non-governmental settings respectively were educated about complaint submission. Studies in Egypt and Ethiopia reported similarly low adherence rates of 16.5% and 1% respectively [3, 13. Insufficient education on this issue worsens the healthcare experience by leading to underreporting of patient complaints, which is crucial for improving quality of medical care provided. Similarly, only 22.7% of patients received a summary of their rights, with no significant difference between governmental and non-governmental hospitals, whereas in Ethiopia and Egypt, only 1% and 0% respectively were given a summary of their rights [3, 13]. Efforts should focus on improving these areas, as clearly defining the patients' rights would improve the patient experience and the services provided.

Strengths and limitations of the study

Our study is the first to explore patients' perceptions of their rights and how these rights are exercised in their care within our country. One potential limitation is observer bias, where a researcher's subjective judgments or expectations may influence data collection, potentially skewing the results. To mitigate this, we trained three independent data collectors who were not involved in the patients' care, ensuring a more objective data collection process. Another limitation of this study is the use of convenience sampling and the restriction of the study to the northern part of the West Bank, which may limit the generalizability of the findings. However, we believe that there are no significant sociodemographic or cultural differences between the various districts of the West Bank that would meaningfully impact our study's results. Additionally, the data relied on patient self-reports, it could be subject to reporting bias as patients may not provide accurate responses to avoid the embarrassment of admitting uncertainty. Collecting data from healthcare professionals would further improve this work, which was not feasible because of the high load on practitioners. Finally, the comparison between governmental and non-governmental hospitals should be interpreted cautiously, as differences in sample sizes may have influenced the results.

Conclusion

The findings underscore global challenges in ensuring adequate awareness and implementation of patients' rights across healthcare settings. While progress has been made in respecting fundamental rights like non-discrimination and consent, significant gaps persist in involving patients in decision-making, informing about procedures/costs, and providing accessible complaint mechanisms - particularly in governmental facilities. Over half of patients exhibited inadequate rights awareness, aligning with studies from other developing nations.

This highlights the need for comprehensive, culturally-appropriate initiatives to educate and empower patients worldwide. Recognizing that local cultures may sometimes be more paternalistic, it is crucial that these initiatives align with cultural values to foster acceptance and gradual empowerment. Governments should prioritize adopting localized patient rights frameworks in line with WHO recommendations. Multisectoral collaborations involving policymakers, providers, legal experts and patient groups are crucial to driving substantive reforms. Continuous monitoring and responsive interventions are vital to translate patient-centered care principles into consistent practice globally.

Supplementary Information

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Supplementary Material 1

Supplementary Material 2

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Author contributions

A.O, N.K, S.A wrote the main manuscript. Z.N prepared the tables and reviewed the manuscript comprehensively, with major edits to the manuscript. A.S reviewed the manuscript comprehensively, with major edits to the manuscript.

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Data availability

All the data used in this study can be obtained after reasonable request to corresponding author.

Declarations

Ethics approval and consent to participate

Ethical approval was granted by An-Najah National University institutional review board (Reference #: Med Oct. 2023/83), the Palestinian Ministry of Health, and private hospitals administrators. Signed informed consent to participate was obtained from all study participants prior to data collection.

Consent for publication

Not Applicable. No identifying images or other personal or clinical details of participants that would compromise anonymity are included in this manuscript.

Competing interests

The authors declare no competing interests.

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