Towards Patient Empowerment in Saudi Healthcare:

The Place of a Positive Patient Rights Culture

by

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Table of Contents

List of Figures

viii

List of Tables

Abstract

Background

Since the beginning of this century, a number of governments have legislated for the rights of patients and to protect these rights. This reflects the emergence of a new focus on consumers and promoting patient-centred care. Despite the large number of studies dealing with aspects of patient rights, few have examined the readiness of hospitals to implement patient rights concepts or establish a positive culture of patient rights.

Research aims

This research project aimed to establish the perceptions of key stakeholders (experts, managers, doctors, nurses, and patients) regarding the implementation of the Patient's Bill of Rights in public hospitals in Saudi Arabia. The specific objectives were to determine the factors facilitating and hindering implementation and examine the actual implementation of patient rights in selected Saudi public hospitals.

Methods

A "positive culture for patient rights framework" (PCPR) was developed and used as the conceptual framework for designing the research and discussing its findings. The framework reflects three levels of activity: macro (health system), meso (community and healthcare organisations) and micro (professionals and patients). A mixed-methods design was employed, comprising cross-sectional surveys and key informant interviews. A random sample of 292 doctors, 550 nurses, and 334 hospitalised patients were surveyed, using a self-administered questionnaire. The surveys were conducted in seven large hospitals in the capital, Riyadh. In addition, in-depth interviews with nine managers and experts in the field of patient rights were conducted. Survey data was analysed using descriptive and inferential statistics, with thematic analysis adopted for analysing the key informant interviews. Statistical and thematic analysis findings were integrated and discussed together.

Findings

Findings reveal shortcomings in public hospitals and among professionals, preventing effective implementation of the Patient's Bill of Rights. There was low commitment from hospital management, possibly reflecting the failure of the Ministry of Health to transfer their commitment to hospitals. Other shortcomings included the absence of publicity about the Bill, the low involvement of professionals and patients, and the failure to request their feedback. Obstacles to

professionals implementing the Bill include increased work pressure, low levels of job satisfaction, insufficient numbers of staff in public hospitals, lack of public awareness about the Bill, and the lack of authority given to staff of the Patient Rights and Relations Departments. Patient Rights and Relations Departments were seen as supporting the implementation of the Bill. The data highlighted the importance of managerial factors in success, such as creating a safe work environment, supporting teamwork values, publicising the Bill, clarifying the regulations, undertaking coordination between different organisations, creating an effective complaint system, providing advocacy services, and implementing an effective monitoring mechanism. The rights most respected were maintaining personal privacy, preserving patients' information, and treating patients in a safe environment. The rights least implemented were explaining the complaint procedures and giving patients copies of the Bill.

Conclusions

In the field of patient rights, this research is the first to examine different aspects of the implementation of the Bill in Saudi Arabia. The findings draw attention to the gap in commitment between senior management at the Ministry level and hospital management and revealed the ongoing difficulty of transferring commitment from one management level to another. The findings emphasise that creating a positive culture for patient rights requires more serious and effective managerial commitment, as well as the activation of the role of community. The current research was able to identify contributing and hindering factors, which provide clarity concerning options for improving the implementation process. The research provides solutions to address many challenges in the implementation process such as to legislate clear strategies that support and strengthen community participation, and insure the effective involvement of all stakeholders. It is necessary to increase the awareness of professionals, the public, and patients by providing training and education through the effective use of classic and modern media. Support from the Ministry of Health is crucial. More emphasis should be placed on policy implementation and evaluation on an ongoing basis. Effective collaboration between different governmental and non-governmental bodies is essential for promoting the Bill on multiple levels. Continuous improvements are recommended, including regular follow-up and evaluation.

Further research is recommended to examine the roles of educational institutions in promoting the implementation of the Bill, and to examine the perceptions of minority groups who have particular needs or illnesses.

Declaration

I declare that this thesis, presented for the degree of Doctor of Philosophy in Health Sciences under the supervision of Professor Ray Kirk and Associate Professor Pauline Barnett, has been composed solely by myself, except as acknowledged in the text, and has not been submitted for any other degree or professional qualification.

Faisal A Almutairi

Date: September 2017

Dedication

This thesis is dedicated to my loving parents, Abdulaziz and Sohailah, to my beloved wife Meshael, to my wonderful children, Abdulaziz, Bader, Fahad, Alreem, Deem and Mohammed, and to my great brothers and sisters. With all my love.

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<p dir="rtl">{وإن تعدوا نعمة اللّه لا تحصوها إن اللّه لغفور رحيم}</p>

In the Name of Allah, the Most Beneficent, the Most Merciful. All praise and thanks be to Allah, the Lord of the 'Alamin (mankind, jinns and all that exists).

At the beginning and the end, I am thankful to Allah for all his innumerable blessings upon me and for giving me strength, enabling me to conduct this work.

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Huge thanks to you, my lovely children – Abdulaziz, Bader, Fahad, Alreem, Deem and Mohammed. Without your co-operation, this study would not have

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Chapter 1: Introduction

1.1 Introduction

The subject of patient rights has recently become the focus of governments, international organisations, and health service providers. Over time many of the concepts in health services have changed. Since the beginning of this century, a number of governments have sought to legislate the rights of patients and force healthcare providers to pay more attention to patient rights. This concern has stemmed from the increasing number of cases of infringement on patient rights, which are understood to be a subset of fundamental human rights. The failure to protect patients in the medical context has compelled recognition of the size of the problem and the consequences of the absence of a legal framework that regulates the health professional-patient relationship to ensure full respect for the rights of patients in health settings.

The Kingdom of Saudi Arabia (hereafter Saudi Arabia) is a country that has paid a great deal of attention to patient rights issues in recent years and in 2006 introduced a Patient Bill of Rights. This research aims to determine the status of patient rights in Saudi Arabia and to identify the factors which facilitate and those that hinder the implementation of these rights through a study of the two largest governmental medical cities in Saudi Arabia. The term medical city is defined as a group of specialised hospitals and holistic healthcare centres located in one geographical location or related to the same academic affiliation (Nestel, Jolly, Kelly, & Watson, 2017; 195).

This chapter introduces the study and contains six sections. First, there is background information about Saudi Arabia, including demographic and economic situation, and the Saudi healthcare system. The next section (1.3) provides a general overview of the conceptual framework for this research. This is followed by an explanation of the significance of the topic and the motivation for the project (section 1.4), and the main objectives of the research (section 1.5). The last section (1.6) summarises the structure of the thesis.

1.2 The Kingdom of Saudi Arabia

In order to provide a context for this research, this section provides a brief summary of the geographical location, history, population, economic situation, and health system of Saudi Arabia.

1.2.1 Demographic and economic background

The Kingdom of Saudi Arabia (Saudi Arabia, and in some sources abbreviated to KSA), was formed in 1932 (Al-Rabeeah, 2003). Geographically, it is the 13th largest country in the world, the largest country in the Middle East, and lies at the intersection of three continents—Asia, Africa and Europe . The country is located in south-west Asia and covers approximately 2,000,000 square kilometres, representing about 80% of the Arabian Peninsula. It is bounded by eight Arab countries: Jordan, Iraq, Kuwait, Bahrain, the United Arab Emirates (UAE), Qatar, Oman, and the Yemen. Saudi Arabia is the home to two of Islam's holiest sites: Mecca and Medina. Islam is the main religion and Arabic is the national language, spoken by the whole population. The country is divided into 13 administrative regions as shown in Figure 1.2 and the capital city is Riyadh.

Figure 1.1 Map of Saudi Arabia and the 13 Provinces. (Source: Saudi Arabia Map Political Regional, 2016)

The General Authority for Statistics noted that the population of Saudi Arabia is estimated to be about 31 million, 57% male and 43% female. The total population of the country comprises over 67% Saudi citizens and 33% expatriate workers and their families. Of the Saudi citizens 50.24% are males and 49.76% females. Saudi Arabia has one of the world's fastest growing and largest young populations in the Middle East, with about 60% of the population under the age of 21 (General Authority for Statistics, 2016). Because of this the current annual population growth rate

in the country is 2.02% per annum and the total fertility rate was 2.69. The population over the age of 65 years is estimated at 2.93% and life expectancy has increased to 73.1 years for men and 75.7 years for women (Saudi Ministry of Health, 2014). United Nations predictions estimate that the population of Saudi Arabia will reach 40 million people by 2030 (United Nations, 2015).

Saudi Arabia has an oil-based economy, is one of the largest oil producers and exporters in the world, and is the world leader in the oil industry. A substantial proportion of the government budget (90%) and about 35.0% of GDP comes from oil sector revenues (Eid, 2015). In recent decades, the country has realised the importance of diversifying income sources to mitigate the negative consequences of a drop in oil prices on the growth of the national economy, and the need to ensure sustainable, balanced development for the security of the country and future generations. The non-petroleum sectors, such as the mineral and agricultural sectors, rely on the country's natural resources. The International Monetary Fund (IMF) stated that the non-oil sectors achieved a growth rate of 5.1% in 2014 (International Monetary Fund, 2015).

1.2.2   Saudi health profile

Health services in Saudi Arabia have developed and improved significantly over recent decades. The Basic Law of Saudi Arabia, Article 27 stated that "The government guarantees the right to healthcare for citizens and their families in cases of emergency, sickness, disability, and old age." Article 31 states that "the government is responsible for public health in the Kingdom and provides health services to every citizen" (Grote & Röder, 2016, p. 570).

The Saudi healthcare service began on a limited scale with small clinics. Prior to 1950, there was no single specialised organisation providing and monitoring health services in Saudi Arabia; however, some departments and hospitals provided a few services that had limited resources. The establishment of the Ministry of Health in 1951 led to the provision of health services across the country (Almalki, Fitzgerald & Clark, 2011). Since then, health services have been a top priority for successive governments. Saudi Arabia's strategic health plan emerged as part of the 5-year development plan adopted by the Ministry of Health after approval from the highest authority in the country. The first development plan was formulated in 1970 and focused on expanding the health services to provide healthcare to a large number of people in the country, while the most recent national development plan (2015-2019) aims to achieve high health standards, provide

accessible, comprehensive healthcare for the population, and support the private healthcare sector (General Authority for Statistics, 2016).

A comparison between the number of hospitals, beds, health centres, and human resources in 1970 and 2016 is shown in Table 1.1.

Table 1.1 Comparison of Number of Hospitals and Resources in 1970 and 2016

	1970	Rate (per 10.000)	2015	Rate (per 10.000)
Hospitals	47	0.081	462	0.149
Beds	9,030	15.57	69,394	22.01
Health centers	591	1.02	4952	1.60
Doctors	1,172	2.02	86,756	27.5
Nurses	3,261	5.62	172,483	55.64

Note: population in 1970; 5,800,000 and in 2015: 31,000,000

The overall figures have increased, especially in human resources. Large expansions were made in all hospitals and health centres so that they could provide more services and receive more patients.

The healthcare system in Saudi Arabia is primarily funded by the government and managed principally by the Ministry of Health. Expenditures on health services increased from 1.89% in 2008 to 3.49% in 2014 (The World bank, 2016) and the country has the highest healthcare outlay in the Middle East, with total expenditure of SAR 62,342,539 (USD 16,627,900) on the healthcare and social development sectors (12.9% of the government budget) (Saudi Ministry of Health, 2014). The Saudi health system was ranked 26th among 190 healthcare systems worldwide and among Arab countries second only to Oman (Tandon, Murray, Lauer, & Evans, 2000). The WHO report ranked the health system in 191 countries according to five performance indicators. These indicators were overall level of population health, health inequalities within the population, overall level of health system responsiveness, distribution of responsiveness within the population, and the distribution of the health system's financial burden within the population. However, the WHO ranking has been criticised by several experts, as it is not an objective measure of the performance of healthcare systems and includes factors that are misleading and unrelated to actual health performance (Frogner, Frech & Parente, 2015; Whitman, 2008). It gives different weight to

different components of each performance indicator, which play a key role in the ranking of each country and making the whole ranking process highly subjective, so that it relies on debatable assumptions, for example that there is a positive association between government involvement in healthcare and a better outcome. On the basis of this ranking, Saudi Arabia placed higher than the health systems of some western countries, such as Canada (30th), Australia (32nd), and New Zealand (41st).

The Ministry of Health is responsible for drawing up the strategic plan, establishing general rules and policies, and supervising all health services provided in the country (Al-Yousuf, Akerele, & Al-Mazrou, 2002). Health services are free of charge for all Saudi citizens and foreign workers in public facilities. Foreign workers are expected to have medical insurance provided by their employers or privately.

Health services are provided by three main entities: the Ministry of Health, the private sector, and other governmental agencies. These agencies include the universities, the Ministry of Defence, the Ministry of the National Guard, and the Ministry of the Interior. Each one of these providers service a portion of citizens and their final goals comply with the strategic goals of the Ministry of Health. About 60% of health services are provided directly by the Ministry of Health (Sebai, Milaat, & Zulaibani, 2011). Figure 1.2 shows the level of health services provided by the three main sectors.
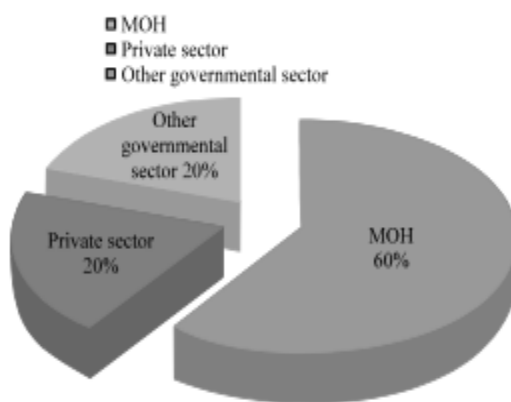
Figure 1.2. Percentage of health services provided by the three main agencies (Source: Almasabi, 2013).

The country is divided geographically into 13 health regions and each region has its own regional directorate of health affairs (Al-Yousuf et al., 2002). Each regional directorate supervises all public

and private hospitals and health centres located in its region. Health services are provided through 244 hospitals and 2,037 healthcare centres located both in large cities and in small towns across the country. However, the government encourages the private sector to invest more and increase its involvement in health services (Almalki et al., 2011). The government has established several initiatives to attract local and foreign private sector investment in healthcare across the country. These initiatives can be seen at two levels, local and international. At the local level, the Ministry of Health has established a health project loan system. The government supports local investors financially during the first stage and loans are repaid in instalments with no interest. At the international level, the Ministry of Health and the Saudi Arabian General Investment Authority have recently worked together to create a strategy that can support the establishment of an effective regulatory framework and develop a positive environment to attract foreign investors and private healthcare providers (Barrage, Perillieux & Shediac, 2007).

The Ministry of Health provides health services on three levels: primary (primary healthcare centres), secondary (general hospitals), and tertiary (specialised hospitals). The aim of the primary healthcare centres is to provide prevention, basic education, and the treatment of common diseases. Patients can be referred to the general hospital if they need further examination or more specialised care. The specialised hospitals are the most advanced healthcare providers with more specific specialities and highly developed equipment and facilities.

Despite the achievements of the Saudi health system in recent decades, there are several ongoing challenges, such as increasing costs, the high demand for services, shortage of qualified health professionals, and the near complete reliance on government support (Almasabi, 2013; Almalki et al., 2011). Alkabba, Hussein, Albar, Bahnassy and Qadi (2012) added some major ethical challenges such as patient rights, equitable distribution of resources, patient privacy, and professional ethics.

Although the government encourages the Ministry of Health to develop its services and meet any challenges it may encounter circumstances that lie outside its own specific responsibilities, hence overcoming some challenges requires the contribution of multiple parties. Because the health domain embraces much more than health alone and overlaps with education, the environment, law, and security, these challenges include ethical issues, crime, educational curricula and cultural

change. The government understands the magnitude of these challenges and supports the Ministry of Health to deal with them as the need arises.

The ethical challenges can only be met through the concerted efforts of all parties, including decision makers, planners, managers, supervisors, professionals, and patients. There is the additional need for supportive legislation and regulations that can control the relationship between parties to ensure each party's rights are protected. The growing global movement towards patient rights protection in addition to the high expectations of the public to receive high quality services as well as respect, make it very important for the Ministry of Health and hospitals to seek effective ways to implement the Patient's Bill of Rights.

The next section provides an explanation of the procedures of developing the conceptual framework for this research.

1.3   Developing a conceptual framework

A conceptual framework is used to visualise the relationship among the main variables in this study and to illuminate the interpretation of the study findings (Maxwell, 2005). Jabareen (2009) defines a conceptual framework as a set of interrelated concepts that create a comprehensive understanding of the topic under investigation and that generates a map for the study. To better visualise the interactions between the different elements at multilevel dimensions in the implementation of a Patient's Bill of Rights, it was essential to develop a conceptual framework showing the relationships among patients, health professionals, healthcare organisations, communities, and the entire health system.

In fact, there is a lack of literature presenting conceptual frameworks on the topic of the implementation of patient rights. As a consequence, this research offers an integrative framework derived from two different models that fit the context of the research. Two models were used to guide the construction of the new framework.

(1)   The Innovative Care for Chronic Conditions (ICCC) Model

The ICCC framework is an internationally recognised model for improving functional and clinical outcomes for patients with chronic diseases. This framework was developed in 1998 by the World Health Organization (WHO) in cooperation with the MacColl Institute for Healthcare Innovation

(Epping-Jordan, Pruitt, Bengoa, & Wagner, 2004), and originated from the Chronic Care Model (CCM), also known as Wagner's Chronic Care Model. It provides a flexible, comprehensive, evidence-based conceptual framework for integrating care for national public health systems and primary healthcare environments in developing countries (Epping-Jordan et al., 2004).

The framework focuses largely on modern principles, such as partnership, empowerment, participation, and tailoring healthcare to the unique needs of individuals. It also emphasises the necessity of moving patients and communities from a passive to an active role and of reforming health organisations and entire systems from a reactive to a proactive approach (Nolte & McKee, 2008). The ICCC framework contains three main levels—micro, meso, and macro—and each level has several subordinate elements: micro (patient and family), meso (healthcare organisations and communities), and macro (policy and financing) (Epping-Jordan et al., 2004).

The rationale for the selection of this framework for the current research is that it focuses on patient-centred care and emphasises several important, evidence-based care components to improve inter-action among the main stakeholders: patients, the community, health professionals, healthcare organisations, and the healthcare system. Such interaction will eventually improve healthcare service outcomes and create a positive environment. It may also initiate changes in health systems, improve the process of making decisions and strategic plans, and provide a solid basis for policy development (Epping-Jordan et al., 2004). Most importantly, the framework focuses on the importance of the presence of a positive policy environment that encourages supportive values and facilitates the general strategies of governments working to eliminate any burden on patients (Singh, 2008).

(2)   Patient Participation in Error Prevention (PPEP) Model

This model was developed by Longtin et al. in 2010 and includes the key influencing factors enhancing patient participation in preventing medical errors. It concentrates mainly on the micro level where the interaction between patient and health professional occurs. Factors relating to health professionals play important roles in patient empowerment as do factors relating to the patients themselves. Because these factors may facilitate or be a barrier to the process of patient participation, more attention must be given to enhancing the elements that facilitate and removing the barriers. Ensuring the success of this process is expected to lead to the emergence of positive feedback that improves healthcare outcomes and enhances safety in healthcare. This model was

selected based on its direct relationship with patient empowerment and its focus on the role of the key players in the success of that process.

For this research, the two frameworks described above were integrated to form a new conceptual framework. The result has been termed the positive culture of patient rights framework (Figure 1.3). The dimensions of the patient rights' culture framework were mapped on three different levels: 1) the macro level, 2) the meso level, and 3) the micro level. Each level has several important elements that were identified in the course of the literature review, on the basis of previous studies. Some dimensions were included because they were identified in the literature, even though they were not mentioned in the original models. In addition, some terms were changed to suit the context of the research. For example, "self-management support" was replaced by "empowering patients," "clinical information system" was replaced by "information technology," and "develop and allocate human resources" was replaced by "support." Each dimension, with its accompanying elements, is as follows:

(1)   Macro level

This is the health system dimension which covers the key roles of the Ministry of Health and senior management:

- Establishing one compatible complaints system and advocacy service
- Showing strong commitment towards patient rights' protection
- Strengthening partnership tools by various effective methods of coordination
- Promoting the concept of patient rights at the national level
- Implementing binding regulations and policies
- Monitoring and regularly evaluating the implementation process and outcomes
- Providing required resources, including financial and human resources, equipment and materials
- Offering ongoing support to each party to achieve the ultimate objectives

(2)   Meso level

The meso level comprises two dimensions:

a) - The health organisations' dimension, addressing the key roles of hospital management:
- Designing a delivery system
- Encouraging teamwork values

- Educating patients and the public about their rights
- Conducting training and education sessions for health professionals and other staff about patient rights and relevant legislation
- Empowering patients
- Promoting patient empowerment values among health professionals
- Showing a strong commitment to protecting patient rights, and
- Applying information technology supporting the protection of patient rights

b) The community' dimension, addressing the key roles of the public:

- Participating in all activities related to patient rights
- Providing free advisory services to patients
- Raising issues or concerns on the part of individuals or the public related to their rights in healthcare settings
- Providing another layer of monitoring of the implementation of patient rights in the community

(3)   Micro level

This encompasses health professionals; doctors and nurses, staff of Patient Rights and Relations Departments, and patients. This level is about the human interactions between these three groups. Because daily interaction occurred between patients and health professionals and staff of Patient Rights and Relations Department at the micro level, this level formed the central core of the framework, addressing the key role of health professionals and patients in the implementation process.

The major aims of developing a conceptual framework were to guide the analysis of the quantitative and qualitative data and to interpret the data collected. Because the new framework is based on relevant published literature, it may provide a significant contribution as a framework for future research in the field of patient rights. It may also help policy-makers and high level management to develop a broad understanding of the nature of the implementation of patient rights and the essential elements of a positive culture of patient rights. Moreover, the new conceptual framework is flexible enough that it can be applied in a variety of disciplines and is designed to be queried, examined, and perhaps improved, as it is used in practical study.

The integrative model of a positive culture of patient rights is shown in Figure 1.3 (Source: the author).
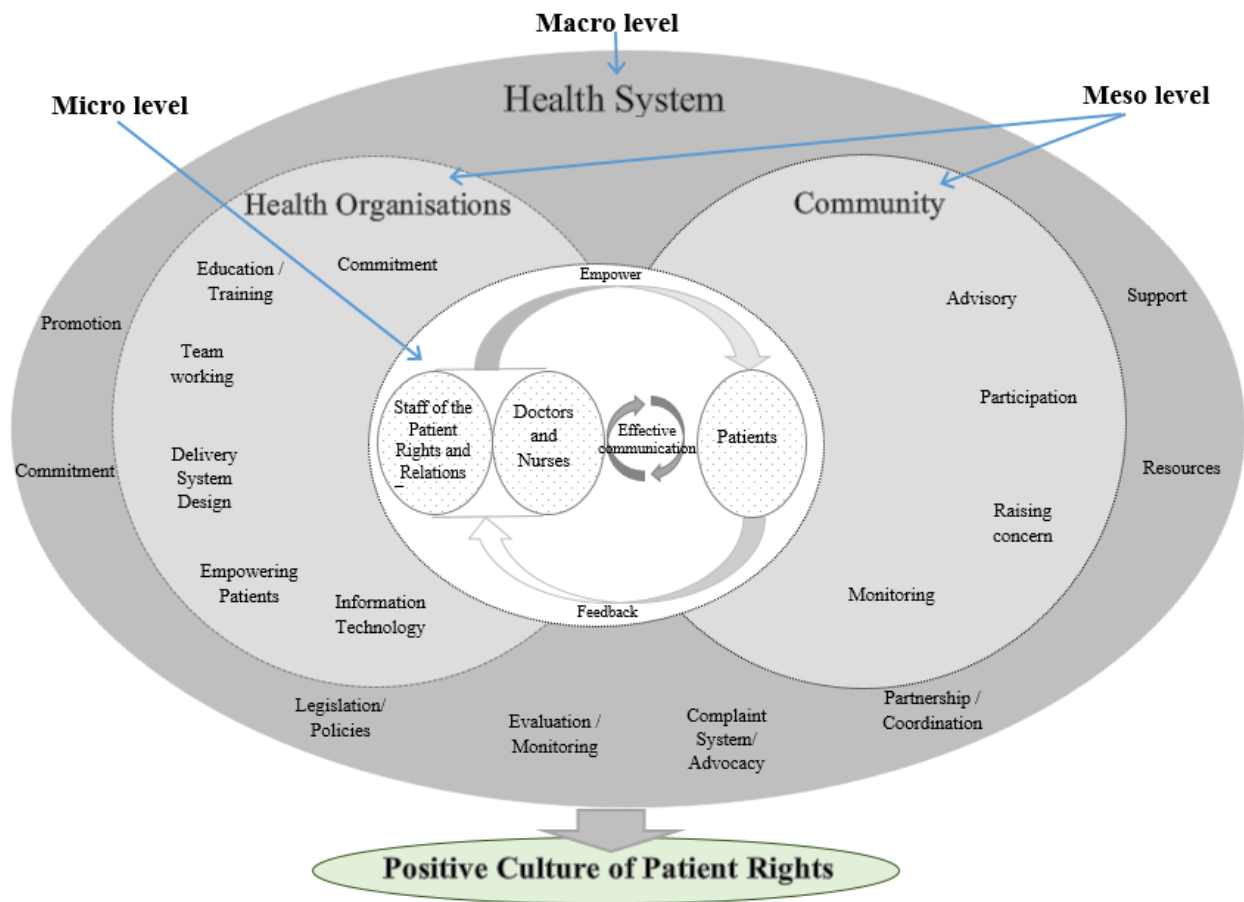
Figure 1.3. Conceptual framework for the study (adapted from ICCC & PPEP models).

1.4   Significance of the study

The number of studies concerning the rights of patients is increasing at a global level, as well as in the developing countries, especially Saudi Arabia. As will be shown in Chapter 2, however, there is a lack of studies concerned with aspects such as the availability of a suitable environment for the implementation of patient rights, the factors positively or negatively affecting the implementation process, the existence of the implementation on the ground, and the proper strategies to implement and protect patient rights. This is the case internationally and locally, for example, all of the studies conducted in Saudi Arabia focused more on the level of awareness among patients or health professionals about the existence of the Bill, and less on participants' views on the implementation of certain rights in hospitals or health centres. For this reason, the current research aims to fill this gap in the field of patient rights, especially in the Arab countries where such studies are few. It is hoped that this will add a significant step in the implementation of patient rights in Saudi Arabia. Saudi Arabia may benefit from the outcomes of the present research in its continuous attempts to improve the experience of patients in public hospitals. The outcomes may also be of value to other sectors in the country, such as private hospitals. The Ministry of Health may use the framework developed in this research to implement the Bill of Patient Rights throughout the country. The participants' insights and comments can be used to identify underlying issues associated with patient rights in both national and hospital management structures.

The outcome of this research may contribute to the knowledge base of the patient rights in healthcare.

1.5   Research objectives

The overall aim of this thesis is to contribute to the field of patient rights research both in Saudi Arabia and internationally. Findings from different perspectives can provide a broad understanding of the implementation of patient rights in selected Saudi hospitals and some of the influencing factors. To fulfil the objectives of the study, the following five main purposes were established.

1. To determine the readiness and ability of public hospitals to implement the Patient's Bill of Rights in two leading medical cities in Saudi Arabia.
2. To identify the factors that facilitate the implementation of the Bill in public hospitals in Saudi Arabia.

3. To identify the barriers to the implementation of the Bill in public hospitals in Saudi Arabia.

4. To examine the actual implementation of some selected fundamental patient rights.

5. To understand the different perspectives of the key stakeholders (patient rights experts, hospital managers, doctors, nurses, and patients) regarding the implementation of the Bill in public hospitals.

1.6   Outline of the thesis

This thesis is arranged into six chapters.

Chapter 1: Introduces the history of the concept of patient rights, its development and implementation in both western nations and developing nations. It also provides background information about Saudi Arabia includes its demographic and economic situation in addition to its healthcare system. It presents the conceptual framework of the research, the significance of the study as well as the research objectives, and outlines the structure for the remainder of the thesis.

Chapter 2: Focuses on the review of the relevant literature. The situation of patient rights in both western countries and developing countries is explained. A brief information about the policy implementation history, classifications, and development are included.

Chapter 3: Explains the research methodology, the research design, and the two phases of the research (cross-sectional survey questionnaire and interviews with key informants). It also clarifies the procedures of each phase including research sample, development of the instruments, data collection, reliability, and validity of the instruments, data analysis, and ethical considerations.

Chapter 4: Presents the findings from the results from the cross-sectional surveys.

Chapter 5: presents the findings from the key informant interviews. It illustrates the themes and sub-themes emerged from the analysis process.

Chapter 6: Reports the discussion of the findings to answer the research questions. It also provides suggestions, recommendations, and the conclusion.

Chapter 2: Literature Review

2.1 Introduction

This chapter provides an overview of previous research on patient rights to gain an understanding of their implementation in health settings. The structure of this chapter is as follows. First, a brief discussion of the search strategy is presented. A discussion of the concept of patient rights, in terms of its history, the development of the patient-doctor relationship, and the expansion of the role of patients in health services is followed by a classification of patient rights. This is followed by a review of findings from international studies, taking the opportunity to learn lessons from their experience. The discussion moves from patient rights in western countries and developing countries to the status of patient rights in Arab countries, mainly Saudi Arabia. The penultimate section describes the policy implementation process, followed by a brief conclusion.

2.2 Search strategy

The literature search was comprehensive and covered a range of medical, health, and social science electronic databases. The following databases were searched to identify the relevant literature: PubMed, CINAHL, Google Scholar, Ovid MEDLINE, ProQuest, PsycARTICLES, ScienceDirect, and searching by hand. Searching by hand provided an alternative option to find more studies because the database searches provided only a limited number of studies related to Middle Eastern countries. Manual searching provided an alternative method of finding more studies because the electronic database searches provided only a limited number of studies related to Middle Eastern countries. The table of contents of selected journals for relevant articles were reviewd in addition to searching the reference lists of the Arabic articles located by electronic searching to identify further relevant literature. Manual searching was performed to supplement electronic searching of the databases.

A range of keywords was used, such as "patient rights", "patient's rights", "patients' rights", "rights in hospitals", "rights in health", "rights in medical", "AND implementation OR exercise OR application OR observation OR protection OR awareness", "AND empowerment OR involvement OR participation", "AND charter OR bill OR legislation OR law OR Constitution OR act OR code OR ethics". The search was limited to material available in English and published between 2000 and 2017. In some cases, there was need to search particular reports

or documents beyond the inclusive criteria such the Nuremberg Code, the WHO, and United Nations reports.

The search of databases yielded 433 articles which related to the research: PubMed (119 articles), CINAHL (58 articles), Google Scholar (121 articles), Ovid MEDLINE, (28 articles), ProQuest (37 articles), PsycARTICLES (8 articles) and ScienceDirect (21 articles) and hand searching (41 articles). The abstract for each article was examined to eliminate any article that was obviously not relevant to the study. Finally, 115 of these articles met the inclusion criteria for this research, as shown below in Figure 2.1.
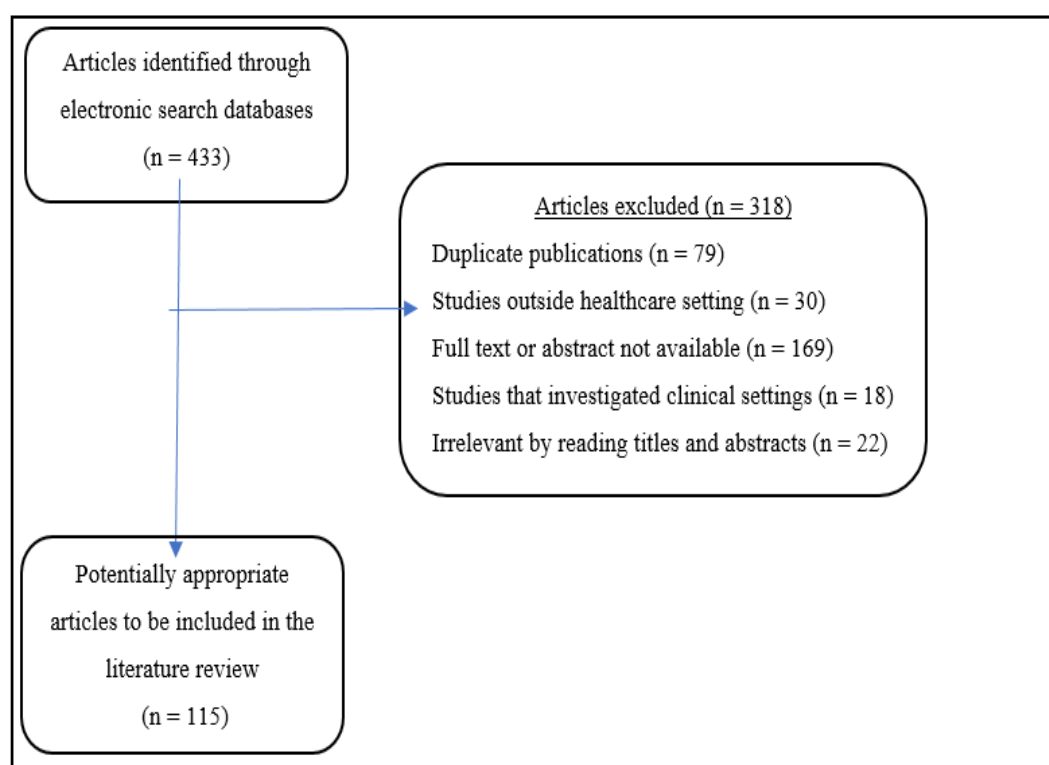
Figure 2.1 Flow chart of articles identified, included, and excluded in the literature review.

2.3   History of patient rights

Historically, the Hippocratic Oath, written in 400 BC, could be understood from a modern perspective to signal the beginning of the patient rights movement (Leino-Kilpi & Kurtittu, 1995). Although the oath consists of moral instruction directed entirely at doctors, it incorporates some fundamental human rights, such as treating all patients to the best of a physician's abilities, maintaining confidentiality, and of doing no harm. One of the earliest modern statements dealing with patient rights is the Nuremberg Code (1947) which lists a number of human rights to be observed during experimental research. It contains ten statements addressing some basic patient rights, such as informed consent, absence of risk, treatment by

qualified people and the right to withdraw from the research process (International Military Tribunal, 1949).

In 1948, the Universal Declaration of Human Rights was passed by the then named United Nations Organization. This declaration affirmed that everyone has the right to appropriate health and medical care (Kuzu, Ergin, & Zencir, 2006). Moreover, it included the right of patients to be treated as human beings. It is obvious that, within the modern context, patient rights have their official starting point with the Universal Declaration of Human Rights (1948), which states that "everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing and medical care and necessary social services" (United Nations, 1948, Article 25).

In 1964, the Nuremberg Code (the original statement of research ethics principles (1974)) was replaced by the Helsinki Declaration, adopted by the World Health Assembly. This declaration outlined many of the rights and responsibilities of health staff, and can be considered a formulation of medical-ethical standards and guidelines for any medical research (Krleža-Jerić & Lemmens, 2009).

The early emergence of the patient rights began in nations such as the United States (US) and United Kingdom (UK) in the late 1960s (Paasche-Orlow, Jacob, Hochhauser, & Parker, 2009; Mold, 2012). During the 1970s, the first movement towards patient rights began in the US (D'Oronzio, 2001) which is considered to have coined the term "patient rights" after the National Welfare Rights Organisation (NWRO) issued a Patient Bill of Rights (PBR) in 1970. By 1973, the American Hospital Association (AHA) adopted the first legal document called the Patients' Bill of Rights. In 12 points, it outlined fundamental patient rights that were later widely used as the basis for patient rights in the western world, for instance the right to respectful care, information that could be understood, participation in decision-making and privacy (Paasche-Orlow et al., 2009).

The literature indicates that the concept of patient rights derives mainly from broader ideas about human rights, such as the right to health, human dignity, freedom from discrimination, and privacy. Karaosmanoglu (2015) suggests that patient rights form one of the consequences of the third wave of the evolution of human rights, following the first wave, comprised of personal and political rights, and the second wave, comprising economic, social, and cultural rights.

Improvements in healthcare systems and the development of the health sciences, including medical ethics, changes in the physician-patient relationship (Kavari & Johari, 2006), and ease of access to medical information, have all played a major role in the emergence of the concept of patient rights (Merakou, Dalla-Vorgia, Garanis-Papadatos, & Kourea-Kremastinou, 2001). Roberts (1999) argued that the development of the concept of patient rights was the result of substantial changes in social attitudes and behaviours, giving more freedom to the individual to participate effectively in decisions that affect their destiny, including their health. These changes challenged doctors' authority and led patients to distrust this authority and demand that their own role in the health system be strengthened. These developments led to a transformation in the doctor-patient relationship from the paternalistic model, where doctors had absolute power over patients, towards a real partnership, where patients are considered active players in the medical decision-making process (Ilan & Carmel, 2016).

2.3.1 Patient-doctor relationship and patient empowerment

The relationship between patient and doctor has been considered vitally important since the earliest civilisations. In principle this relationship created obligations on the part of the doctor for the benefit of the patient and included the rights of the patient, enshrined in the regulations of medical literature and the laws governing the medical professions. In addition to basic human rights, these obligations formed the rights of the patient when receiving any health service.

The literature on the doctor-patient relationship focuses mainly on the power and authority of each party. There is no doubt that this relationship lies at the core of health services. Its success is an essential engine to effective interaction and communication between the two parties. In the course of history, this relationship between doctors and patients has changed markedly. During the 18th century, the physician-patient relationship was unbalanced. Doctors largely controlled this relationship and, for example, had the full right to make most medical decisions on behalf of patients without consulting them (Emanuel & Emanuel, 1992; Coulter, 1999; Kaba & Sooriakumaran, 2007). In the 1970s, the patient-physician relationship began moving more towards patient autonomy.

The relationship between patient and doctor has improved in comparison with what it was previously. This development has resulted from the evolution of rights movements at the end of the last century, from development in all medical fields, including medicine, genetics, biology, health informatics and research, and due to new concepts emerging in healthcare

services and law, as well as through community involvement. Patients become responsible partners and have active roles in this relationship with doctors so they can decide freely about their own treatment, based on accurate information provided by doctors. These developments have granted patients many rights. Several western countries have enacted appropriate legislation to formalise these changes.

Emanuel and Emanuel (1992) characterise the doctor-patient relationship using four different models: paternalistic, informative, interpretive, and deliberative. The first model is the *paternalistic* model, where one party has absolute power and the other has no authority at all. Doctors dominated passive patients who functioned simply as receivers of treatment.

The second, the *informative* model, is where doctors provide full information about the condition and the options available to the patient and the latter then decides which option they prefer. The concept of patient autonomy is prominent in this model, as patients exercise control over doctors through the choice of treatment. Third is the *interpretive* model, where doctors play advisory roles because they supply full information and help patients articulate and interpret their values. In this model, patients have complete control over the decision process. Fourth, the *deliberative* model, where the involvement of patients is encouraged through helping them to articulate and develop their values. In this model, both doctors and patients are involved in the medical decision.

More recent views, however, note that patients should be considered partners in health services (Stirrat & Gill, 2005). Berg, Appelbaum, Lidz and Parker (2001) suggest that the transformation of the doctor-patient relationship from the traditional paternalistic approach to the deliberative approach was for several reasons, including the development of medical technology, social movements such as the civil rights and women's rights movements, and research that revealed many cases of abuse and misuse of power over patients by staff.

Emanuel and Emanuel (1992) maintain that, in addition to the patient rights movement, the emergence of a business orientation in the medical field led to a change in the patient-physician relationship from the paternalistic to the informative model. This consultative approach is characterised by the integration of the physician's experience and skills with patient desires and values, and this gives patients the freedom to make their own preferential decisions with assistance from doctors (Vaisman, 2008).

In the same way, Abou Zeina et al. (2013) stressed that the emergence of the idea of patient rights has led to a transformation in which the medical decision process becomes a

collaborative effort between patients and professionals. The concept of patient rights creates some responsibility for the patient to contribute to the healthcare process. In modern medicine, it is expected that where possible, patients should be involved in decision-making, concerning their treatment.

Such collaboration is widely recognised as an essential factor promoting successful health outcomes, patient safety, patient satisfaction, and for increasing patients' feelings of dignity and autonomy (Davis et al., 2007). It is also strongly associated with the concept of patient empowerment (Delnoij & Hafner, 2013). Many recent studies have shown the importance of the participation of patients as active players in medical decisions (Davis, Jacklin, Sevdalis, & Vincent, 2007; Thomson et al., 2007; Arnetz, Winblad, Arnetz, & Höglund, 2008; Farrell, 2004). Because of this, many organisations in western countries have committed themselves to protecting patient rights and their involvement in their own care.

The modern form of the doctor-patient relationship resulted from the emergence of many healthcare principles, mostly focusing on the patient as the centre of health services. Patient empowerment is one of these principles and calls for the restructuring of the relationship between doctors and patients by adjusting the balance of power between the two parties (Roberts, 1999). Empowerment is the process of giving people a degree of autonomy and at the same time increasing their awareness, knowledge, and skills to be able to make decisions on their health-related issues (Lau, 2002).

It is important that patients be active partners in the healthcare system (Laverack, 2005). Such involvement, moreover, is a positive approach centring more on health than illness and on individuals' strengths rather than on their weaknesses (Sigurdardottir & Jonsdottir, 2008; Aujoulat, d'Hoore, & Deccache, 2007). As a basic concept, empowerment finds its roots in the social context of reaction against the social oppression of particular groups and the violation of their rights to freedom and social participation. These movements include the women's movement, the black power movement, and the disability rights movement (Gibson, 1991; Shearer & Reed, 2004).

Ocloo and Fulop (2012) stated that the term *empowerment* emerged in the literature for the first time in the 1970s and as a result of social action and political awareness movements then spread gradually in several disciplines in the social, educational, and psychological fields. Haddad (2013) stated that many movements employed this term to emphasise communal goals for these

groups, for example, the empowerment of people with AIDS, the empowerment of teachers, of students and of nurses.

Although the concept of *patient empowerment* has recently been widely considered a powerful tool to improve health outcomes, it is rooted in the 1970s in the United States and Europe. Earlier, during the civil rights movement, the WHO stressed the importance of individual and community participation in their own health affairs (World Health Organization and Unicef, 1978). Over time, the importance of the patient's role has increased in the field of healthcare and this has led to many calls to strengthen that role (Holmström & Roïng, 2010). In addition to the popular concept of patient empowerment, one encounters related emphases on patient centeredness, managed care, patient involvement, and patient participation. The idea of empowerment has begun to merge, along with the principles of health promotion and education, to become a holistic concept that addresses the relationship between patients and doctors (Shearer & Reed, 2004).

Roberts (1999) proposed that empowerment is a multilevel concept used at three levels: individual, organisational, and community. Feste and Anderson (1995) claimed that to change a patient's attitudes, empowerment must be achieved through a change at each of these three levels, including a patient's social environment and the organisations that influence their lives.

In fact, to define empowerment generally seems to be a complex matter because this principle takes many forms in different circumstances (Loukanova, Molnar & Bridges, 2007). Lau (2002) defined empowerment as "enabling process through which individuals or communities take control of their lives and their environment". Gibson (1991) redefined empowerment as "a social process of recognising, promoting and enhancing people's abilities to meet their own needs, solve their own problems and mobilise the necessary resources in order to feel in control of their own lives" (p. 359). He described it further as "a process of helping people to assert control over the factors which affect their health" (p. 359).
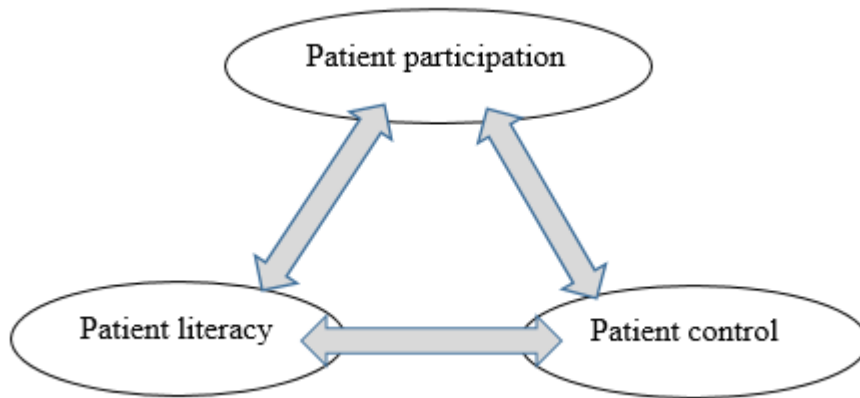
Figure 2.2. Dimensions of patient empowerment (modified from Ouschan, Sweeney & Johnson, 2000, p. 106).

In addition to the complexity of its definition, the term empowerment could be considered a multidimensional concept. Ouschan et al. (2000), as shown in Figure 2.2, proposed patient empowerment as having three dimensions. First, *patient participation* can occur when a patient is involved in the health service process, including decision-making and information sharing. The second dimension is *patient literacy*, including patient education, which aims to help patients to increase their awareness, knowledge, skills, and thinking, according to their needs. Last, *patient control* makes patients more responsible for their health situation.

Israel, Checkoway, Schultz and Zimmerman (1994) stated that empowerment is associated with community improvement. Based on that, there are three levels of empowerment: *individual or psychological empowerment* (when patients have full power to make decisions about their health situation), *organisational empowerment* (which integrates the processes that enhance individuals to increase their control over their health situation, and to influence policies and decisions), and *community empowerment* (when the whole society can select the best options for the life and health of their community).

Aujoulat, D'Hoore and Deccache (2007) suggested that the process of patient empowerment can be divided into two dimensions: intra-personal and inter-personal. Each one of these dimensions can stimulate the other and both are important for shaping the concept of empowerment. The *intra-personal dimension* includes the self-transformation of a patient, when power comes from within. This dimension can be enhanced through education and increasing patients' knowledge about their medical concerns.

In contrast, *the inter-personal dimension* covers all interactions between a patient and a health professional which may support the patient's self-esteem. In this way, power is transferred

21

from one party to another. In other words, the health professional empowers the patient through sharing information, knowledge, and decision-making. Thus, empowerment essentially relies on an expanded contribution from health professionals in empowering their patients.

Although the main role of healthcare providers is found in the inter-personal dimension, their contribution to the intra-personal dimension is crucial. Patients usually seem more willing to participate when they feel that there is a space available for them to be involved (Aujoulat, d'Hoore, & Deccache, 2007). In fact, the significant new role of healthcare providers requires a further change in their values, attitudes, behaviours, and beliefs in relation to the patient empowerment concept (Lawton & Armitage, 2012).

Many researchers have listed successful methods that can be used to strengthen the foundations of a suitable culture for empowering patients. These methods include management and leadership strategies, continuous improvement, health workers' engagement, health workers' development, training (Frampton et al., 2008), health workers' satisfaction, accountability, responsibility (Luxford, Safran, & Delanco, 2011; Frampton et al., 2008), and the development of complaints processes (UK Department of Health, 2009).

One of the most important factors that assists with implementing the concept of patient empowerment is the Patient's Bill of Rights. The existence of legislation protecting patient rights to participate in their healthcare is fundamental to creating empowered patients and communities. Stirrat and Gill (2005) maintain that the doctor-patient relationship is a cooperative relationship within hospitals among patients, doctors, nurses, and other healthcare staff. Many years ago, patients were the weakest part of the equation. Since then, they have acquired more support to enable them to recognise their rights and responsibilities, gain awareness of the proper ways to assert their rights, and protect themselves from violation while receiving health services.

This shift in the relationship between patients and doctors led to the emergence of many of the regulations that govern that relationship and protect the rights of both parties. Because doctors have had the benefit of power and support since the start of this relationship, most modern legislation is characterised by its concern for dealing with patient rights in terms of recognition and promotion, obligation, and protection. Accordingly, two of the main objectives in the implementation of patient rights are to empower patients by providing information and rights, and also to support equality in patient-healthcare provider relationships (Smith, 2002).

In addition, implementation has several other aims, such as developing trust between patients and healthcare staff, providing information on patient expectations, and increasing patients' awareness about rights in the healthcare system (Ammann & Bailey, 2011). Respect for patient rights is an indicator of the state of health services in a community of practice and serves as a basis for defining the standards of clinical practice (Joolahee & Hajibabaee, 2012). Abou Zeina et al., (2013) stated that a patient bill of rights provides patients with confidence in the fairness and equity of the healthcare system, confirms the importance of the relationship between patient and healthcare provider, and confirms the role of the patient in protecting their own health. By empowering patients to assert their rights, they can play an important role in elevating the standards of care they receive and also help to improve the overall healthcare system.

2.3.2 Classification of patient rights

Fundamentally, patient rights are major components of the general concept of human rights and so cannot be separated from them. In other words, patient rights are considered to be a direct reflection of human rights in medicine. Patient rights have been established to ensure that the fundamental rights of people seeking healthcare are met. Although there is no global standard definition of patient rights (Nys & Goffin, 2011), these can be defined as a set of fundamental principles that are either guaranteed by law or adopted by the health system to frame the relationship between providers and patients to protect the beneficiaries of the health services provided under that system. Although patient rights principles across the globe include similar major themes, such as autonomy, respect, and informed consent, the definition, and implementation of each of them vary from one nation to another, depending on a number of cultural, political, and economic aspects.

The literature indicates that patient rights can be classified in several ways, based on the types of rights, the nature of the patient rights, and the level of legal authority. Distinguishing successfully between different types of rights can be a better way to understand their implementation in each context.

The World Health Organization (2000) suggested that the rights of patients can be categorised into positive and negative rights. *Positive rights* involve the ability to enjoy some social or personal benefit or the provision of some good or service, which require action, obligate another to do something, and involve the expenditure of public money. For example, the right to health, right to a good death, the right of informed consent. Some positive rights can be

enforced only with difficulty because they require extensive resources. *Negative rights* are those that aim to protect the individual's power to make an autonomous decision, typically do not require action or obligate another to refrain from doing something, and there is no obligation to provide goods or services. For example, the right to refuse treatment, right to die, right to privacy. Most legal rights tend to be negative rights, such as the right to exercise one's religion freely. This does not mean that negative rights are more important than positive rights. However, the enforcement of positive rights can be more difficult to achieve. In particular, positive rights may require the allocation of resources. Consequently, some governments tend to give more importance to negative rights over positive rights. ; however, all positive and negative rights have the same degree of importance.

Starr (1982) proposed that patient rights could be broken into two main groups: "rights in healthcare" and "rights to healthcare". *Rights in healthcare* encompass the relationship between healthcare providers and patients, including the right to give consent that is informed, to have access to one's medical records, to refuse treatment, and to be involved in decision-making. In contrast, *rights to healthcare* cover patient eligibility to receive services from healthcare providers.

Nys and Goffin (2011) assert that patient rights can be general or specific. *General rights* are those that are applicable to all patients, whereas *specific rights* are those that serve various specific groups in hospitals, such as patients in mental wards, hospices, women, and children.

Hervey and McHale (2015) proposed that patient rights can be considered to be social or individual rights. *Social rights* concern the whole population, who have the right to enjoy public goods or services, such as the right to health protection, the right of access to health services, and the right to receive these services equally, whereas *individual rights* focus on individual people, their integrity, and privacy.

Raphaely (2009) suggested that patient rights can be divided into two types: rights of action and rights of recipience. He described the *right of action* as something that patients have the right to do, such as the right to make their own decisions. In contrast, the *right of recipience* is something patients have the right to receive, such as the right to privacy (Sim, 1995).

Focusing more sharply on the question, Boscheck (2004) suggests that patient rights can be formulated using three main categories: legal rights, quasi-rights, and non-legal rights. First, *legal rights* are those guaranteed by law for patients when they need healthcare service. If a healthcare provider fails to provide these rights, patients are entitled to appeal to judicial

authorities for compensation for non-compliance. Countries such as New Zealand and Finland have implemented patient rights in legislation. The health provider in these countries is legally accountable to provide or protect these rights. Second, *quasi-rights* are rights which healthcare providers must provide on condition of the availability of the necessary resources. Where these rights are concerned, the law cannot be invoked in the event of non-compliance. For example, in the UK, Australia, and France, such patient rights are set out in a national guide, bill, or charter. Third, *non-legal rights* are those which are considered to be moral duties that the healthcare provider is expected to fulfil. These can be seen in a number of countries where the rights of patients do not have legally binding force, as in most developing countries such as Pakistan (Masood, Mahmood-ur-Rahman, Mahmood, Nisar & Mohsin, 2016) and Ethiopia (Berhane & Enquselassie, 2016).

2.4   International experience of patient rights

Ethical issues play a prominent role in health services. As a consequence, improvement in the ethical aspects should be accompanied by the implementation of patient rights (Abdho, Saleem, & Elsayed, 2015). Increasing concern about the violation of patient rights in health sectors has led to calls on governments and health service providers to fulfil their responsibilities for the protection of patients. There are also ongoing invitations from international organisations and conferences to affirm international treaties and enact new local regulations to protect the rights of patients in all countries. The implementation of patient rights in healthcare settings is needed to adopt necessary legal regulations to reform the existing imbalance in the patient-provider relationship (Mizrahi, 1978, as cited in Mizrahi, 1992). To improve the relationship between patient and healthcare providers, many developed and developing countries enact ideas about patient rights in a variety of ways (Rider & Makela, 2003).

The promulgation of a formal document on patient rights is considered to be a serious step towards protecting patient rights in a country. Although patient rights concepts are essentially ethical and moral principles that reflect basic human rights, such as autonomy, privacy, and respect (Roberts, 1999), their implementation varies considerably from one nation to another in terms of the content of patient rights and their legal status (Nys & Goffin, 2011). Joolahee and Hajibabaee (2012) attribute this variation to the cultural norms and prevailing practices in healthcare systems.

Other factors, such as the level of transparency, corruption within governments, and financial issues in the health system, could delay any movement to implement these principles (Beletsky,

Ezer, Overall, Byrne & Cohen, 2013). Abdho et al. (2015) add that social and cultural values play a significant role in accounting for the difference among nations in their concept of patient rights but, Bantaş et al. (2015) declare that patient rights are universal values that can be further elaborated and implemented with respect to each nation's context, needs, and circumstances. Thompson, Melia, Boyd and Horsburgh (2006) argue that the implementation of ethical rights must be based not only on health professionals' values but on a set of universal principles; however, Beckett, Gilberston and Greenwood (2007) point out that despite the importance of the existence of common principles for the implementation of patient rights, these principles are usually unspecified and ambiguous.

Putting the theoretical concepts of patient rights into effect, however, has also been a challenge for health systems. The main reason for this is the lack of proper mechanisms to enforce these concepts in many different health systems (Vogel, 2010). Coulter (1999) claim that the modern participatory relationship between patients and doctors could achieve satisfactory results by using both parties' experiences and making decisions together. As a consequence, many healthcare systems have developed new legislation commensurate with the new situation for patients who have become customers and partners and therefore individuals with rights and duties.

The WHO encourages and supports countries around the world to take action and include some or all of these principles in their declarations. Despite some differences among countries in terms of cultural, economic, political, and other factors, there are still common methods which can be applied, based on each country's situation (World Health Organization, 1994). Typically, statements or declarations of patient rights cover five major areas: the right of access to medical care, the right to receive information about one's health situation, to be respected during treatment, to confidentiality, and the right to file a complaint (Karaosmanoglu, 2015). The main purpose of a Patient's Bill of Rights is to protect patients' dignity and integrity, outline a general framework for healthcare policies, maximise healthcare utilisation by minimising the negative impact of any problems that may occur, encourage patients to be more active in improving their own health outcomes, and promote an interactive, respectful, and beneficial relationship between patients and healthcare staff.

By reviewing previous research, I found that studies reporting patient rights can be divided into five types. First, there are studies concerned with measuring the existence of awareness of patients and the public as well as healthcare providers of the existence of a document dealing

with the rights of patients in health facilities. Second, there are studies that investigate whether patients or healthcare providers actually implement patient rights principles in their healthcare settings. Third, there are studies that examine the implementation of one or more specific rights when health services are provided, either from the viewpoint of service providers or beneficiaries or both. Fourth, there are studies that examine aspects of patient rights legislation and its legal and political association with human rights. Fifth, there are studies that focus on specific groups of patients, such as cancer patients, AIDS patients, psychiatric patients, or children, or that consider rights that are still under discussion and deliberation, such as the right of patients to die. There are, however, few studies in the literature that examine the entire implementation of patient rights law, bill, or charter. Most of the studies concerning the topic of patient rights examine the implementation of specific rights.

It should be noted that most studies conducted during the last 15 years in western countries do not focus on measuring the level of awareness among the public, patients, or healthcare providers of the existence of patient rights but deal rather with their legal status or the implementation of certain specific rights, such as privacy, dignity, or the right to die. It seems that the active role played by organisations that concentrate on individuals and human rights, in addition to the early emergence of terms such as rights, freedom, and autonomy, have made awareness of this topic something to be taken for granted. In western countries in recent years, most studies focus on the implementation of a specific right or rights in the health sector. In developing countries, numerous studies paid greater attention to basic principles of patient rights. These rights include the right to autonomy, privacy, dignity, informed consent, involvement, information about one's health status, and the protection of medical data.

2.4.1 Patient rights in western countries

Over recent decades, there has been an increase in the amount of global attention paid to the rights of patients. As a consequence, the concept of patient rights has become a fundamental element of most health legislation in modern healthcare approaches. Organisations such as the WHO and the World Medical Association have, in western countries, encouraged the implementation of patient rights, either by governmental or non-governmental organisations. In addition, these organisations have created and advocated for global patient rights standards, as is demonstrated by the Lisbon Declaration of Patient rights in 1981 and the Patient Declaration of the World Doctors Association in 1995 (Karaosmanoglu, 2015).

In western countries, the process of implementing a patient bill of rights in hospitals has been under way far longer than in developing countries but the means for protecting patient rights vary substantially. Most western countries have shown an increased commitment to empowering patients in their role by implementing the concept of patient rights. Although there are similarities between countries in the concept of patient rights, their application differs from one country to another, based on the values and culture of each community (World Health Organization, 1994). The majority of western countries have their own patient rights document that is consistent with the culture and needs of their communities (Leino-Kilpi & Kurtittu, 1995).

Although western countries have relatively strong rules in favour of patient rights and clear patient rights law, bill, or charter, they suffer from a low level of awareness of patient rights (Joolaee & Hajibabaee, 2012). In fact, continuing to raise awareness is one of the most important priorities of modern health organisations in improving the situation of health services and achieving a high level of patient satisfaction.

The next sections provide an overview of the development and implementation of patient rights charters and bills in the US, the European Union, the UK, Australia, and New Zealand.

2.4.1.1 *The United States*

The US has a unique healthcare system provided by the private sector and funded partially by the government through taxes and subsidies. The World Health Report 2000 noted that the US healthcare system was ranked 37th in overall performance among 191 nations and it is also considered one of the most costly.

Although the US was the first country in the world to develop a patient bill of rights and to support the concept of patient rights with legislation to provide a legal mechanism to enforce those rights, there is no national law protecting patient rights in the country (Vogel, 2010). It is the only western country that lacks a system of universal healthcare coverage (Rice et al., 2014; Davis, Stremikis, Squires & Schoen, 2014). There have been many attempts to enact a law safeguarding the rights of patients in the US health system (Binette, 2003, p. 689) and many states have enacted a patient bill of rights in their own state law, such as Texas in 1997, Georgia in 1999, and North Carolina in 2001 (Binette, 2003, p. 675-87). At the federal level, there have been a number of proposals aimed at enacting a law to regulate and protect patient rights in the US health system. Over the past years, all proposals failed to obtain the sought-

after legal status (Smith, 2002). Many proposals in the US focus on access to healthcare because it has not been available.

Patient rights principles benefitted from social movements across the US during the 1970s. The initial Patient's Bill of Rights in the US was issued by the American Hospital Association (AHA) in 1973 (Paasche-Orlow et al., 2009). The implementation of the AHA Patient Bill of Rights was voluntary but in time, several local states followed this lead and legislated these rights. The AHA Patient Bill of Rights was revised in 1992 and then replaced by the Patient Care Partnership in 2003, as a result of more emphasis being placed on the concept of partnership in healthcare.

In mid-2010, the US government enacted a new law called the Protection of Patients and Affordable Care Act, which is referred to more simply as the Affordable Care Act (ACA), or Obamacare. It includes statements confirming a new regulation to implement a patients' bill of rights. The new Act was projected to expand insurance coverage for US residents and terminate some of the patient abuse perpetrated by insurance companies (The US Department of Health and Human Services, 2010). The ACA/Obamacare is most likely to be repealed by the Trump Administration.

2.4.1.2 The European Union

In the European Union (EU), one of the first attempts to formulate the idea of patient rights was made by the European Parliament when it affirmed a resolution on a European Charter on the Rights of the Patient in 1984. The Convention on the Protection of Human Rights and Dignity of the Human Being in the application of biology and medicine was adopted in 1997 and was considered to be a major step towards promoting patient rights in EU countries (World Health Organization, 2000). The main aim of the Convention was to try to unite European nations under commonly agreed rights. To develop a general framework that could help European countries set out policies on patient rights, the WHO Regional Office for Europe defined six universal principles: human rights, information, informed consent, information confidentiality and patient privacy, care and treatment, and respect for rights. Although these principles have no legal force in any country, the Convention provides a moral document and a solid common framework for any legislation or law across the EU (World Health Organization, 1994).

The first formal draft of the European Charter of Patient rights was issued in 2002 and listed 14 patient rights:

- Right to Preventive Measures

- Right of Access

- Right to Information

- Right to Consent

- Right to Free Choice

- Right to Privacy and Confidentiality

- Right to Respect of Patients' Time

- Right to the Observance of Quality Standards

- Right to Safety

- Right to Innovation

- Right to Avoid Unnecessary Suffering and Pain

- Right to Personalized Treatment

- Right to Complain

- Right to Compensation (Lamanna, et al., 2011).

The Active Citizenship Network adopted the proposed charter in 2008. The European Charter itemised what a European patient anywhere in the EU could expect when receiving healthcare service in any EU country. On this basis, it can be considered a standard rather than a legally binding document. All member states of the European Union were required to include the European Charter of Patient rights in their national law; however, several writers have argued that even though the new directive uses the term patient rights in its title, it focuses on common values but does not provide an essential guarantee of many fundamental rights of patients (Nys, 2014).

Despite the directive concerning patient rights issued by the EU Parliament and Council in 2011, EU member nations have not adopted a unified approach to patient rights (Nys, 2014). Under EU law, each member nation must enact enabling legislation for the directive to take effect within that nation. The enabling legislation is also necessary because the directive imposes obligations only on member states with the national legislation necessary to extend patient rights obligations related to healthcare workers.

There are, however, some challenges faced by the directive, such as its ambiguous language concerning both cross-border healthcare and patient rights. The directive allows member states to protect local interests by limiting the outside use of health services, which undermines the right of access to healthcare. Another challenge is that it does not specify how relevant

information will be provided to patients or whether the information must be communicated in the primary language of the patient. In some member nations, information about the quality and the actual cost of health services to the patient, if any, may not be easily available to healthcare providers, and therefore cannot be communicated to the patient; however, patients cannot access information if they do not understand the language in which the information is communicated.

2.4.1.3 The United Kingdom

In the Patient rights Euro Scores, 2011, the UK was ranked first among the 21 European countries involved in the reform of patient rights (Lamanna, et al., 2011). The UK healthcare system was ranked first in terms of quality, efficiency, effectiveness, and safety of care among 11 industrial nations: Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the US (Davis et al., 2014).

As a citizen's right, healthcare is based on the entitlements of citizens to certain benefits from their government, a topic which was part of public discourse leading to the formation of the UK National Health Services (NHS) in 1948. One year later, the official UK patient rights movement established the Hospital Complaints Procedure Act, considered the earliest legislation in the world dealing with patient rights issues (Office of Public Sector Information, 1985).

Although the NHS was officially described as reflecting the duty of the government to provide healthcare, the public came to believe citizens were entitled to health services as an integral part of the welfare state. This view of health as a consumer right focused on the quality of the services provided by both public and private organisations. To some degree, the rights of consumers were similar to the rights of citizens. The recognition of consumer rights prompted the NHS to introduce changes during the 1970s to improve efficiency and quality in healthcare. As a result of serious concerns about the lack of consent from patients in teaching hospitals, the Patients Association tried to launch a formal bill of patient rights (Mold, 2012).

Mold (2012) identified three approaches informing the concept of health rights in the UK in the second half of the 20th century, consisting of *healthcare as a human right*, *the rights of citizens*, and *the rights of consumers*. Because of subsequent, increasing patient dissatisfaction with health services in the UK (long waiting times and the poor quality of services) the 1992 Patient Charter was formulated as one element of a national strategy to improve governmental health services (Smith, 2002; Council of Europe, 2001).

This Patient Charter consisted of 10 rights focused on the citizen's entitlement to care under the NHS and two sets of standards (Silver, 1997). *The National Charter Standards* provided a list of standards a patient could expect to have observed when receiving service anywhere within the NHS system. *The Local Charter Standards* were standards that local healthcare providers should meet or exceed and addressed such matters as wait times for procedures. The Patient Charter applied to all patients in the NHS system and so differed from the Patient Bill of Rights in the US that applied only to patients in hospitals. The Patient Charter, however, created significant problems for the NHS by raising the expectations of patients for services beyond the ability of healthcare providers to deliver (Vogel, 2010). Farrell (1999) also noted that the Charter faced criticism particularly from health staff who felt that it could be used against them. Further criticisms of the Charter concentrated on doubts about its usefulness. It was designed by people who had not worked with patients, created a blame environment, enhanced cheating behaviours (Smith, 2002), lacked clarity, and ignored patients' responsibilities (Council of Europe, 2001). Based on this review, in 2001 the UK Department of Health replaced the UK Patient's Charter with a new document called *Your Guide to the NHS*. This document identified patients' expectations and responsibilities (Smith, 2002).

Although each healthcare system in the four UK nations (England, Scotland, Wales and Northern Ireland) has its own patient rights charter, these have to follow the main principles of the National Health Services (NHS) in the UK. For example, the first draft of England's NHS Constitution was issued in 2008 and listed a number of patient rights, to empower and fulfil the needs of patients and NHS staff. It contained 26 rights for patients and the wider community, such as the right to accessible service, an acceptable level of service, the right to reject treatment, and freedom of choice about participating in research.

These rights cover seven areas:

- Access to health services
- Quality of care and environment
- Nationally approved treatments, drugs and programmes
- Respect, consent and confidentiality
- Informed choice
- Involvement in healthcare, and
- Complaint and redress

All these rights in the NHS constitution are protected by law and NHS and healthcare providers are legally obliged to follow these regulations. Because the NHS constitution is reviewed every 10 years, this period of time may give the UK Department of Health more time to review, monitor and evaluate current rights (National Health Service, 2015).

Because the NHS considers that the opinions of patients and the public are an essential part of the evaluation process, it has offered several channels through which to provide feedback. These include healthcare providers, primary care trusts, local advice, and liaison services. NHS patients can make complaints and comments approving or criticising the performance of NHS providers. The NHS has clear procedures for dealing with patient and community complaints. Patients can raise complaints with the healthcare provider or the local Primary Care Trust. If patients or their family are dissatisfied with the solutions offered, they can ask the Parliamentary and Health Service Ombudsman to review the case (National Health Service, 2015). The Ombudsman's main role is investigating patients' complaints regarding the care provided by the NHS (Parliamentary and Health Service Ombudsman, 2012).

In 2002, the Patient Advice and Liaison Service (PALS) was established to support patients and their relatives when using the NHS. PALS deals independently with all patient and relatives' concerns in all NHS and primary care trusts. Each year, PALS publishes a wide survey to investigate patients' and their relatives' perceptions about the NHS (The Patient Advice and Liaison Service, 2012).

2.4.1.4 Australia

The Australian healthcare system is a mixed system, funded by the Australian government, the six states and the two territorial governments, and delivered by both public and private healthcare providers. The federal government administrates Medicare, the universal healthcare coverage system, which offers free access to healthcare for Australian citizens in public hospitals and primary healthcare centres (Luxford, Piper, Dunbar, & Poole, 2010).

Prior to 2008, there was a variety of patient rights charters across Australia. Although most of them were relatively appropriate, they were not relevant to all healthcare settings, lacked consistency, and were not applicable to all providers of health services in the country. It was necessary to unify efforts and establish an agreed charter, binding on all parties. Developed by the Australian Commission on Safety and Quality in Healthcare in 2008 in consultation with government bodies, healthcare providers and health consumer groups (Dunbar, 2009), the Australian Charter of Healthcare Rights was accepted as the nationally agreed set of rights

providing a framework for patient rights in Australia and was endorsed by the Australian Ministry of Health for implementation nationwide.

The Australian Charter of Healthcare Rights outlines the rights of patients using Australian health services, emphasising seven main principles:

- Access
- Safety
- Respect
- Communication
- Participation
- Privacy
- Comment

The main aims of the Charter are to ensure a high level of safety and quality of the health services provided and to establish a basis for an effective partnership between patients and healthcare providers by creating a shared understanding of the rights of patients. It is clear that the Charter promotes the concept of patient-centred care by empowering patients and their role. Although it contains essential principles that every healthcare provider in the country must follow, these remain general and the Charter is still not a legal document (Dunbar, 2009). Consequently, each Australian state and territory must have its own patient rights charter based on Australian Healthcare Agreements and these charters are supported by the Australian Charter of Healthcare Rights (Smith, 2002; Dunbar, 2009).

Furthermore, the federal government has published the Private Patients' Hospital Charter which provides information about the rights and responsibilities of a private patient in public or private hospitals and outlines what patients can expect from their staff, hospital, and private health insurer. The Charter also provides information on how patients can complain about their care, their health provider, or private health insurance policy (Smith, 2002; Australian Government, 2012). In addition, each state and territory should have an independent organisation which deals with patients' complaints regarding health services in Australia. The Victorian Charter of Human Rights, which is a legal document, contains some rights that may be applicable in health services, such as the right not to be subject to medical or scientific experimentation or treatment without full, free, and informed consent, and the right not to have one's privacy, family, home, or correspondence unlawfully or arbitrarily interfered with.

Johnstone, Da Costa and Turale (2004) explored alarming ethical issues in the medical field in the Australian state of Victoria. The study used the Ethical Issues Scale questionnaire to survey 398 nurses registered with the Nurses' Board of Victoria. The results indicated that three of the five most frequently cited ethical issues reported by Australian nurses dealt with patient rights, specifically protecting patient rights and dignity, providing care with possible risk to the patient's health, and respecting/not respecting the right to informed consent to treatment.

An exploratory study was conducted by Henderson et al. (2009) at a large Australian acute care hospital in South East Queensland. A random sample of patients was interviewed using the convenience sampling technique. The purpose of the study was to examine threats to patient dignity and patients' perceptions of how their privacy and dignity were maintained. The study concluded that the majority of patients did not discern any threat to their dignity or privacy and were pleased with the way their dignity was respected during hospitalisation. The authors claimed that patients tend to feel that their dignity is maintained when they are treated with respect, given choices, or have control over their treatment. It also concluded that patients may excuse any deficiencies in the service if they feel that the hospital strives for the patients' best interests. This result may indicate that respect and positive interaction between patients and medical staff play a vital role in the observance of patient rights.

Walsh and Kowanko (2002) examined the perceptions of patients and nurses about respect for patients' dignity in a large hospital in Australia. Five patients and four nurses were interviewed and asked to describe their experiences and to say whether patients' dignity was maintained or neglected during hospitalisation. The large majority of nurses believed that the dignity of patients had been maintained at their hospital. If a violation occurred through some unexpected event, they attributed the incident to a lack of understanding between nurse and patient, or to work pressure, or a lack of interpersonal skills. Both patients and nurses agreed that patients' dignity includes privacy, respect, giving time, consideration, and advocacy. The study found that patients were satisfied that their dignity had been maintained.

2.4.1.5 *New Zealand*
Patient rights issues in New Zealand received widespread attention nationally in 1987 when it was discovered that without their knowledge, a great number of women were enrolled in experimental research at the National Women's Hospital in Auckland, some of whom died in consequence. After the investigation, the Cartwright Report (Cartwright Inquiry, 1988) confirmed the incident, leading to several changes in New Zealand law in the health sector to

protect patient rights (Bismark & Morris, 2014). The report revealed the poor support for patient rights in the law in the 1980s and that inequality in authority between patients and health staff was prevalent (Cartwright, as cited in Smith, 2002). This report brought about large-scale changes in the New Zealand health system, which began to reassess its ways of dealing with patients.

In 1994, all these factors led to the establishment of an independent officer called the Health and Disability Commissioner, tasked with determining and protecting patient rights. From that time, patients were no longer treated as weak, helpless people but became clients and partners, deserving of greater autonomy (Flood & Epps, 2004; Paterson, 2002). In 1996, the Code of Health and Disability Services Consumers' Rights (the Code) was adopted as official legislation protected under the authority of New Zealand law (Health and Disability Commissioner Act Commencement Order, 1996; Smith, 2002; Flood & Epps, 2004). The Code contains 10 rights:

- To be respected
- To receive care without discrimination
- To dignity
- To be treated according to agreed standards of services
- To effective communication
- To full information
- To give informed consent
- To be supported
- To consultation and right of refusal where research or teaching are involved, and
- To make a complaint (Smith, 2002; Flood & Epps, 2004; St. George, 2013)

All these are legal rights for each patient with any healthcare provider in New Zealand. For added protection, the Act gave the Health and Disability Commissioner significant authority and responsibility. In addition to the initial role of the Commissioner to establish the Code of Health and Disability Services Consumers' Rights and other significant responsibilities, including planning, reviewing, promoting, investigating, and making recommendations regarding the implementation of the Code, the Commissioner has the right to inform the Minister of Health about necessary action to protect patient rights (Smith, 2002).

Amendments to the new act in 2004 achieved three significant improvements: simplifying the complaints process, expanding the role of the Commissioner in resolving complaints, and developing the relationship with other bodies (St. George, 2013). In addition, patients in New Zealand can receive the help of independent advocates free of charge to listen and to help them lodge a complaint but they do not have a role in making decisions. Although some advocacy regulations can be issued by the Commissioner, the advocates remain independent of the Commissioner and health service providers (Paterson. 2002; Health and Disability Commissioner, 2016).

In countries such as New Zealand and Finland, the number of complaints increased as a result of the implementation of patient rights legislation. In New Zealand, it has been reported that the number of complaints increased 43% between 1996 and 2001 (Paterson, 2002). Similar findings were reported in Finland where there was a considerable increase in complaints between 2000 and 2004 (Kuosmanen et al., 2008). The increase in patients' and the public's awareness of their rights may constitute a factor in the increase in complaints.

2.4.2 Patient rights in developing countries

2.4.2.1 Overview

As western countries, have increased their concern for patient rights, developing countries have done the same, taking advantage of the experience of other countries in the patient rights field. The question of patient rights has become a hotly debated topic for most countries interested in the development of health services and the improvement of healthcare quality. As the nature of health services becomes more complex, it is necessary to delineate clearly the relationship between healthcare providers and patients. In this field, the United Nations and the WHO are making great efforts to consolidate and implement patient rights in developing countries. The existence of a law governing the health system would boost patient confidence in national health services in addition to preserving the rights of patients.

Research by the World Health Organization (2000) noted that the prevailing conditions in developing countries concerning the treatment of patients are more significant than any action by the government or professional organisations to establish a formal patient bill of rights. Some developing countries have established a patient rights charter or bill over recent decades, for example Iran in 2002 (Joolaee & Hajibabaee, 2012), Turkey in 1998 (Guven & Sert, 2010), and Saudi Arabia in 2006 (Almoajel, 2012). Most developing countries still lack awareness of

the importance of implementing patient rights and monitoring how health staff manage these in practice, rather than as merely theoretical knowledge.

Most of these nations copy the charters of international organisations or western countries in whole or in part. Using a patient rights charter developed by international organisations may be useful but that charter must be established and revised according to the social situation in the country in terms of culture, value, and beliefs (Leino-Kilpi & Kurtittu, 1995). In some countries, the charter becomes part of national law, as in Turkey, but in others it remains a general regulation within the health system, as for example in Saudi Arabia. Nevertheless, it has been demonstrated that the enactment of law and regulations alone without supervised practical implementation does not guarantee the success of the idea of patient rights (Güvercin & Arda, 2010).

Beginning in the late 1990s, some developing countries, such as South Africa, Ghana, Slovakia, Thailand, and Malaysia, began to implement patient rights. In South Africa, a patient rights charter was established in 1997. It included 12 rights for patients, such as the right to have a safe environment, to be involved in the decision-making process, and to have access to essential health services. The implementation of the charter was examined several times from various viewpoints. The findings of these studies revealed the failure of the implementation process in the country (Raphaely, 2009).

In Ghana, a patient rights charter first emerged in 2002, issued by the Ghana Health Service. This charter was based mainly on the Patient rights Charter in the UK and consisted of two parts: patient rights and patients' responsibilities. The implementation process in Ghana has faced a number of obstacles, since the charter was primarily an administrative document rather than a practical one and it was not legally binding (Abekah-Nkrumah, Manu, & Atinga, 2010).

In 1981, the Islamic Organisation for Medical Sciences, based in Kuwait, published the first Islamic code of medical ethics in harmony with the Islamic perspective, but patient rights are not mentioned in that code, because it deals with the duties of a physician towards a patient. The physician's duties, in most circumstances, are considered to reflect the rights of patients. Accordingly, this document provides a basic introduction to the principles of patient rights in Arab and Islamic literature (Mousavi, 2008).

The next section discusses the implementation of patient rights charters in two developing countries, Turkey and Iran. This discussion may give an initial insight into the situation of

patient rights in Saudi Arabia in light of the cultural, social, and background similarities among these countries.

2.4.2.2 *Turkey*

Although the healthcare system in Turkey still tends to be paternalistic, certain developments have moved decision makers towards a more patient-centred system. Since the adoption of a Patient's Bill of Rights in 1998, the Ministry of Health has shown more concern for the implementation of patient rights across the country (Guven & Sert, 2010). The prospect of being a member of the EU is the political incentive which supports this movement in the Turkish health system (Aydin, 2004; Hakan et al., 2009).

The Patient's Bill of Rights in Turkey is based on the 1994 Declaration of Amsterdam on the Promotion of Patient Rights in Europe (Zulfikar & Ulusoy, 2001). It contains such rights as access to health services, the right to be treated as a human being, to receive health services without any kind of discrimination, the right to privacy, to refuse treatment, informed consent, to receive visitors within regulations, and the right to complain (Kuzu et al., 2006). The initial targets of the Turkish Ministry of Health were to promote a culture of patient rights, especially the right to choose the physician, to provide comprehensive patient education around the country to inform the public about their rights as patients, and to create specialised departments for the care of patient rights in the healthcare organisations in the country (Guven & Sert, 2010).

In theory, patient rights in Turkey derived from the ethical principles of fairness and justice that are the foundation of healthcare practice in the nation. Patient rights include the right to know the identity of healthcare providers, to refuse treatment, and the right to be informed about costs and payment options for healthcare. The procedures for implementing various aspects of patient rights are based on previously enacted statutes, such as the law on the practice of the medical arts of 1928. The official enactment of patient rights regulations date back to 1998 (Güvercin & Arda, 2010; Aydin, 2004).

Zulfikar and Ulusoy (2001) conducted a cross-sectional study in a large 1650-bed hospital in Ankara, the Turkish capital. A total of 128 patients participated in the study, passing the criteria for inclusion: being hospitalised 3 weeks or more, between the ages of 18 and 65 years, and willing to participate. The findings showed that approximately 80% of participants were unable to identify their rights or were not sure about them. Moreover, 38% of patients were unaware of their diagnosis and 63% did not know what surgery they had had. The authors suggested

that the low level of education among patients might result in their inability to understand the explanation provided. Other reasons were suggested, such as work pressure, time limitations, and the paternalistic model of the doctor-patient relationship.

In 2001, Kuzu et al. (2006) conducted a survey on 166 patients in three large hospitals in Denizli, Turkey, using face-to-face interviews. The researchers deliberately selected two wards, internal medicine and general surgery, because patients in these wards are expected to stay longer and would therefore have enough time to gain significant experience. The participants were selected using a stratified random sampling technique. The findings revealed that more than 90% of patients were unaware of patient rights' regulations in these hospitals. Although patient rights' regulations existed in Turkey since 1998, the result of this study indicated an extremely low level of awareness. The authors attributed this to the long period of time between the study and introduction of the Bill in 1998, and also to the lack of effort by the government to promote the Bill to the public.

In another study, Özdemir, Ergönen, Sönmez, Can and Salacin (2006) carried out observational cross-sectional research to examine the awareness of patient rights' regulations among doctors working at seven teaching hospitals and two public hospitals in Izmir province, Turkey. The participants were selected randomly and a total of 567 doctors participated. The results showed that many of them managed to answer the survey questions about specific rights in accordance with the legislation; however, more than 60% of participants had not read any legislation related to patient rights in Turkey. The authors suggested that they responded either to previous information they had obtained or from their professional experience.

With regard to the importance of obtaining patients' informed consent, 95% of those working in public hospitals believed that informed consent from patients was required in all cases, whereas less than 50% of those working in teaching hospitals held the same view. This significant difference may be due to either being unaware of this or that the implementation of patient rights' principles is ignored in educational hospitals. In addition, more than 60% of doctors did not believe that patients have the right to review their medical records and less than 10% of participants considered the patient's prior consent to participate in experimental treatment a necessary prerequisite. This result showed the crucial need to promote patient rights legislation and educate professionals and patients about patient rights. The study also recommended that the establishment of patient rights units in hospitals may contribute positively to protecting patient rights and monitoring their implementation of their rights.

Aydin (2004) claimed that neither academic professionals nor the Turkish Medical Association was consulted during the planning stage of the patient rights legislation. There was a significant difference between the theory and the actual daily practice of health professionals in terms of respecting patients. To address some of the issues of adherence to patient rights, such as the lack of clarity for professionals' responsibilities and actually implementing the rights, the Turkish Ministry of Health issued a "directive for the implementation of patient rights in 2005. In 2014, the regulations were updated again to address many of the shortcomings in the enforcement of patient rights in the nation (Er, Ersoy & Celik, 2014).

The number and type of complaints may be considered clear indicators of the effectiveness of the patient rights programme in any nation. In Middle Eastern nations, relatively little research has examined the rate of patient complaints concerning their rights. In Turkey in 2003, the Turkish Ministry of Health adopted a regulation describing the mechanisms and procedures for complaints by hospital patients for perceived violations of patient rights, a step which supported the collection of data concerning complaints (Önal & Civaner, 2015).

The Turkish Ministry of Health (2007) reported that more than 40,000 complaints were received about violations of patient rights in 2006 (Güvercin & Arda, 2010). The overall rate of written and verbal complaints in the country gradually increased from 49.9% in 2005 to 50.6% in 2008 (Saracoglu, Tokuc, Guler, & Gul, 2010). The authors attributed the increase to the establishment of new units to deal specifically with patient rights' violations. Complaints also increased in frequency between 2005 and 2011 at a rate greater than the increase in the number of people treated in hospitals. It is possible that the frequency of complaints reflects the increase of patients' awareness of their rights (Önal & Civaner, 2015).

Over a 7-year period, from 2005 to 2011, Önal and Civaner (2015) conducted a descriptive study that dealt with the most violated rights and patients' expectations in Turkish hospitals, drawing on the databases of 54 public hospitals supervised by the Istanbul Health Directorate. All written and oral complaints submitted to the Patient rights Units were included and reviewed. Female patients were found to raise complaints more frequently than male patients (52.7% and 47.3% respectively) and approximately 60% of complainants were from people 40 years old and above.

The findings of the study showed that the three main reasons for patients' complaints comprised more than 65% of total complaints. Patients' top three complaints were that they though that they did not receive the treatment they required, were not treated with respect, and

were not given sufficient information. The high number of complaints related to patient rights shows the urgent need to implement a Patient's Bill of Rights that aims to improve patient outcomes and increase patient satisfaction, with the aim that this would eventually lead to a decrease in the number of complaints. Even so, an increase in the number of complaints is expected as patient and public awareness increases over time.

2.4.2.3 Iran

The 29th article of the law of Iran guarantees access to health services and treatment for all people without discrimination. This right of access to health services is one of the fundamental rights of patients in all international legislation. The Health Deputy at the Ministry of Health and Medical Education in Iran led in taking the country's first steps in medical ethics in 1994 by establishing the first specialised centre in the country. This was followed by the issuance of a Patient Bill of Rights in 2002 (Joolaee, Nikbakht-Nasrabadi, Parsa-Yekta, Tschudin, & Mansouri, 2006), which included 10 rights:

- To respectful care
- To know the identity of the health provider
- To understandable information
- To ask for information related to one's health situation
- To refuse treatment
- To confidential care
- To privacy
- To the accessibility of healthcare services
- To consent to participate in medical research, and
- The right to be informed of organisational and financial information

Health service providers and patients made no contribution to the construction of this Bill, which combines elements from western documents, and it did not reflect the social and cultural needs of Iranians (Joolaee et al., 2006). A number of surveys have shown that many patients and healthcare workers suffer from the inability to understand the Bill and complain of its vagueness and generality (Joolaee & Hajibabaee, 2012; Abedi, Azimehr, Rostami, & Mohammadi, 2012).

In Iran, it is not clear how the patients' bill of rights, established by the Ministry of Health, relates to the actual provision of health services (Joolaee et al., 2006). The rights of the patient

include the right to obtain information, to obtain care regardless of race, culture, or religion, to refuse care, to confidentiality of information, and to consent to or decline participation in research studies. The Iranian patients' bill of rights was strongly influenced by western concepts of patient rights and did not reflect the local cultural and social understanding of the rights of the individual with respect to healthcare. Qualitative research examining the implementation of the patients' bill of rights in Iran suggests that patients do not fully understand the scope and nature of their rights or how to assert them (Joolahee & Hajibabaee, 2012).

Yaghobian, Kaheni, Danesh and Abhari (2014) conducted a cross-sectional study among 336 patients from 4 teaching hospitals, to measure their awareness of patient rights and to assess the relationship between their education and awareness. The result found that a low level of general knowledge among patients of their rights in hospitals. More than 60% of respondents declared that they had not seen the Bill in hospitals. In addition, nearly half of patients indicated that they had poor level of awareness of patient rights.

Razavi, Khalili, Saiidi and Shidfar (2006) explored patients' and doctors' recognition of the elements of the Patient Bill of Rights. A questionnaire was administered to 140 patients and 70 doctors in the Emergency Department in Imam Khomeini Hospital, Tehran. The research found that about 60% of patients lacked awareness of the existence of a Patient Bill of Rights in the hospital. Moreover, more than three quarters of patients declared that the provisions of the Bill were not applied in the hospital. Two fundamental patient rights were the ones most violated in the hospital. The first was the right to have adequate, understandable information regarding their health situation, with 66% of respondents reporting the lack of such information. Second, the right to privacy during care was reported to be lacking by approximately 56%. With regard to the doctors' role, the results revealed that about 63% of doctors still made medical decisions on behalf of their patients. When a patient refused to be examined by a medical student, only 18% of doctors respected this choice. Lack of patient awareness of their rights usually leads to ongoing violation by workers in healthcare facilities. Researchers reported that the level of awareness of the Patient Bill of Rights two years after its implementation was still low. Furthermore, they believe that the relatively low level of patient awareness is expected to decrease their level of expectation from the services.

2.4.3 Patient rights in the Arab countries

2.4.3.1 Overview

In line with the global trend towards greater regulation and protection of patient rights, the situation of patient rights bills and charters in Arab countries is still under development and needs to be supported by government legislation. The principles of the rights of patients are still new in the health legislation of Arab countries, dating in Saudi Arabia to 2006, in the UAE to 2008, in Bahrain to 2010, in Kuwait to 2014, and in Oman to 2016; however, the first Arab country to make progress in this field was the Lebanon, which launched its Patients' Bill of Rights in 2004. Unfortunately, countries such as Egypt, Jordan, and Sudan have no unified national bill of patient rights.

The patient rights movement in Arab countries has taken one of two forms. The first has been a governmental initiative when the government leads the movement to support and enforce a law or establish a bill or charter of patient rights in health organisations, as for example in Saudi Arabia, the UAE, Kuwait, and Qatar. Despite the lack of legally binding regulations in many countries, there is considerable interest from non-governmental organisations in protecting patient rights.

The second form of the movement is seen where non-governmental bodies and civil society take the lead by asserting the rights of patients in the country. For instance, in mid-1999, the Law-Group for Human Rights in Jordan launched a national workshop and recommended that the Ministry of Health establish the National Charter for Patient Rights. The Sudanese Association for Patient rights Protection was formed in March 2009 (Sudanese Association for Patient rights Protection, 2009). Similarly, the Egyptian Initiative for Personal Rights leads a project for community-wide drafting of a patient rights charter in Egypt. Many of these community organisations have been established as a result of the increasing number of violations and incidents of abuse in health institutions in their countries.

The implementation of patient rights has suffered from the lack of a clear declaration of the patient rights among most health service providers in Arab countries. Some deliberately conceal those rights and others do not care about them. As a consequence, many patients lack knowledge about their rights, what they are, and how to obtain or claim them. Several studies have measured the knowledge of staff and patients about their rights in hospital and have found that many patients know nothing, or very little, about their rights. Although it is easy for health workers to find information, especially about policies and regulations, such as the terms of a

patient rights charter, a high percentage of them are still unaware of these regulations which have existed for years in the health sector. As a consequence, the percentage of patients who do not know about their rights in the health sector is expected to remain high. This makes it imperative for decision makers in the health system, including medical staff, patients, and the whole community, to focus more on raising people's awareness of patient rights bills or charters.

2.4.3.2   Saudi Arabia

In Saudi Arabia, Article 31 of the Saudi constitution states that the Saudi government is responsible for providing healthcare for citizens (Saudi Ministry of Health, 2012). Saudi Arabia sourced its Patient's Bill of Rights from the WHO and other international organisations, amended some rights and then attempted to apply the Bill in the national health system (Saudi Ministry of Health (2013). Alghanim (2012) reported that the Saudi Ministry of Health publicised a Patient's Bill of Rights in all health facilities supervised by the Ministry of Health in 2006 but Almoajel (2012) stated that the Bill in Saudi Arabia was distributed in 2001. Clearly, when referring to the date of the implementation of the Patient's Bill of Rights, Almoajel had in mind the date of the appearance of the Bill in hospitals, resulting from the efforts of hospital management. For this reason, the official implementation of Patient's Bill of Rights in Saudi Arabia was in 2006 (Almalki, Alzahrany, & Alharthi, 2016; Saleh & Khereldeen, 2013; Alghanim, 2012).

In 2009, the Saudi Ministry of Health formed the General Directorate of the Patient Rights and Relations Department. This department was established mainly to support the implementation of Patient's Bill of Rights and to work as a link between patients and healthcare providers in order to achieve a high level of satisfaction for patients and their families in Ministry of Health facilities. The Saudi Ministry of Health (2008) stated that the main objectives in creating the department were to consolidate the idea of patient rights, facilitate the mechanisms for implementation in health facilities, and protect those rights from any kind of violation.

The Saudi Patient's Bill of Rights contains the rights to good quality healthcare, respect of choice, autonomy, understandable information, privacy, health awareness, care with dignity, and religious assistance. This new development was expected to contribute to enhancing healthcare staff performance and improve outcomes in health organisations, as well as raising the level of patient and community satisfaction regarding health services provided by the Ministry of Health. Thus, the aspirations of the Ministry of Health are to develop and retain the

efficiency and quality of the health services and to follow recent developments in global healthcare. The Saudi Ministry of Health (2008) stated that the implementation of a Patient's Bill of Rights in healthcare organisations is an important step towards developing health services, improving their quality, and protecting patient rights.

All government hospitals in Saudi Arabia are required to create the Patient Rights and Relations Departments, according to the size of each hospital. The main role of this entity is to advocate for patients in the hospital, receive patients' complaints, and contact the Ministry of Health about any concerns. Moreover, hospitals are obliged to display a copy of patient rights in a visible place in hospital entrances, in waiting areas, and in patients' rooms, so it can be easily accessed by patients, companions, and visitors. The Ministry of Health's intention was also reflected in their planning and participation in a number of specialised events in the field of patient rights. For example, in November 2011, the Patient Rights and Relations Department sponsored the first international conference in the Middle East region dealing with patient rights with the theme "Patient First," and in May 2012, the First National Symposium on Patient rights was held (Saudi Ministry of Health, 2008).

There is little published literature concerning patient rights in Saudi Arabia and all of what is available aims mainly to investigate the level of patients' and health professionals' awareness of patient rights and examine the implementation of some specific rights in health settings.

In many respects, the Saudi health system still takes a patriarchal approach, whereby doctors have full control and the right to make most of the decisions in health organisations in the country. Patients in Saudi Arabia do not differ much from patients in other Middle Eastern countries in their full reliance on doctors' opinions. Patients' participation in decision making is one of their main rights and should be a key concern of the health system, including health professionals.

A study describing doctors' perspectives on the patient's role in the decision-making process was published by Khan, Al-Khudair and Al-Rayees (2012). They interviewed 337 doctors who dealt with approximately 60 to 70 patients every day. Most patients preferred to be passive partners in their own healthcare. That may result from a lack of awareness of the advantages of having a voice in their own medical care, or may be because many patients do not recognise their right to participate in medical decision-making.

However, Saleh et al. (2014) found that the two main reasons behind the lack of patient participation were the low level of patient education (72.1%) and time limitations (54.4%). In

fact, from the health professional's point of view, the absence of attention to patient rights is considered the main medical ethical problem that confronts Saudi health service providers (Alkabba et al., 2012). Alghanim (2012) claimed that patient rights are not often considered in Saudi Arabia, and only become important when a mistake leads to the death or disability of a patient.

Alghanim (2012) carried out a cross-sectional study in 2010 to investigate patient and staff awareness of the implementation of the Patient's Bill of Rights. The sample included 500 patients and 500 professionals in public and private primary healthcare centres in Riyadh. The study used self-administered questionnaires to collect data from participants, who were selected randomly using the stratified random sampling technique. Most of the patients participating were young, averaging 36.9 years of age, and were educated, more than 70% of them having completed high school or above. Over half (59.8%) of the health professionals were nurses and the remaining 40% were doctors, the overall average age being 38.2 years.

About 94% of patients and almost 66% of doctors and nurses had little or no knowledge of the existence of the Patient's Bill of Rights or its contents. Those results are practical indicators of the lack of success in the implementation of the Bill during the period prior to the study. When participants were asked whether they had noticed any improvement in the patient-doctor relationship over the last two years, more than 70% of patients and about 65% of professionals indicated that they had observed no change.

The findings also indicated that patients had lower expectations than health professionals about the improvement that would result from the implementation of the Patient's Bill of Rights. This result draws attention to the urgent need to educate patients and health professionals about the objectives of the Bill and what they can expect from its implementation in health services. Such a negative view also shows the level of effort required to change the entire community's attitude through effective implementation.

When respondents were asked to evaluate the degree of implementation of each right separately, they assessed the right to have their complaints taken seriously as the weakest right in actual practice in the hospital. This response shows the great importance of developing clear, effective procedures to deal with complaints immediately. To cope with the violation of their rights, many patients try to find alternative methods, such as using emergency services for non-urgent cases, a recourse considered improper (Siminski et al., 2005). Such actions harm not only the patient and the health organisation but the entire health system.

47

The authors concluded that in view of the low level of awareness of the Patient's Bill of Rights among patients and health professionals, urgent attention should be given to educating patients and health professionals about the Bill and its contents. The author suggested that the solution is to protect rights, satisfy patients, and make access to health services obtainable in respectful and appropriate ways; however, the study was limited to patients and staff attending the primary healthcare centres and did not include hospitals.

Another cross-sectional study was conducted by Saleh and Khereldeen (2013) to investigate the knowledge and attitude of doctors towards patient rights. The study recruited 246 doctors from two public hospitals in Mecca City, Saudi Arabia. The criteria for taking part in the study included that they worked the morning shift (8 a.m. to 4 p.m.), were employed by the hospital for more than 6 months, and worked in inpatient departments. The researchers used a self-administered questionnaire to collect the data. Most participants were male (82.9%), half had less than 5 years' experience, and a large proportion of them were from the surgery department.

From the results, it can be concluded that doctors considered that knowing the physician's name, being respected, privacy, confidentiality, informed consent, and being kept informed are very important rights that should be maintained for patients; however, only half of the doctors acknowledged the importance of the right of access to medical records, 36.6% of doctors endorsed the right to seek a second opinion, and 28.9% affirmed the right to refuse treatment.

When participants were asked to what extent these rights were implemented in their hospitals, all rights listed (16 rights) had a very high percentage of doctors who either did not know about or did not observe the implementation of these rights in the hospitals. The lowest ranked right was the right to be shown respect, with 99.25% of doctors admitting they rarely observed this right or did not know whether it was observed or not.

Surprisingly, the two rights that the doctors rated as unimportant, access to medical records (35.45%) and seeking a second opinion (27.15%), were the rights most observed. In contrast, in Alghanim's study (2012), the majority of both patients and professionals insisted that patients are treated with respect in hospitals. This result may be attributed to the fact that the Saudi Ministry of Health began the implementation of the Bill in hospitals and gave more attention to large hospitals than to health centres. It also may result from the excellent opportunities provided by education programmes for hospital staff.

The findings of Saleh and Khereldeen (2013) suggest that doctors are unwilling to show adequate consideration for the rights of patients. The findings indicate, moreover, that

professionals' theoretical knowledge alone cannot guarantee the implementation of patient rights. Because of this, the authors recommend the continuing education and evaluation of health professionals in addition to informing the public of their rights in healthcare settings. Patient awareness of their rights and the possibility of taking legal action for violation may encourage them to insist on their rights.

Further cross-sectional descriptive research has been carried out by Almoajel (2012) in Riyadh's King Saud Medical City, a public hospital with 600 beds. A questionnaire survey was used to collect data from 250 hospitalised patients. The researcher's objective was to explore the level of awareness of patient rights among patients. The findings showed that three quarters of the patients did not know about the Patient's Bill of Rights. Most patients were aware of their rights to respectful treatment, to be treated by qualified people, to give informed consent, receive information of the side effects when refusing treatment, discuss their treatment with the medical team, and to the guarantee of privacy and confidentiality; however, a great number of patients (63.4%) were unaware of their right to be fully informed of their diagnosis and treatment plan. Also, nearly 60% of patients were in doubt about their right to refuse participation in research and were unsure whether refusal would affect their treatment.

A comparison of these results with those from Saleh and Khereldeen's study (2013) revealed that about 30% of doctors ignored the right of patients to refuse treatment. It is clear that this area needs more attention and regular investigation to make sure both patients and professionals are aware of it. In addition, more than 35% of patients were not sure about their right to have a follow-up appointment and education when discharged and to have a medical report about their health condition. Saleh and Khereldeen (2013) stated that doctors believe patients cannot understand medical terminology. Added to that obstacle is the fact that hospital regulations may make it difficult for patients to request or gain access to their medical reports.

The main sources of information about patient rights were nurses, posters on walls, and doctors (33.33%, 31.75%, and 23.81% respectively). This may indicate an important role for nurses to educate patients about their rights in hospitals. In addition, well presented information in accessible, high-visibility locations can make a considerable difference in informing patients of the Bill.

Almoajel (2012) concluded that although the Saudi Ministry of Health established a Patient's Bill of Rights three years earlier, most hospital patients did not know of its existence. Almoajel (2012) claimed that the Ministry of Health failed to improve the awareness of health

professionals and the public about patient rights. He recommended the use of the mass media to inform people about their rights and to link these rights with prevailing social and cultural values. He also recommended that the Ministry of Health should include other governmental and community organisations in the implementation process and take advantage of international experience.

El-Sobkey, Almoajel and Al-Muammar (2014) carried out a study entitled "Knowledge and Attitude of Students in Saudi Health Professions Regarding the Patient's Bill of Rights" to explore the level of knowledge of medical students at the College of Applied Medical Sciences in Riyadh. Almost all the students believe that the principle of patient rights is important in medical care; however, only half of them were aware of the existence of the Bill, and less than 10% managed to identify some items of the Bill.

The authors had expected a full knowledge of the Bill and suggest the students based their answers on what they believed was ethically and morally acceptable rather than on their knowledge of the Bill. If this was the students' approach, it would explain the low level of student awareness. As can be seen in the results of Alghanim's study (2012), privacy and confidentiality were the rights generally acknowledged by the students, a finding that may be attributed to the fact that most students belonged to a religiously and culturally conservative society.

El-Sobkey et al. (2014) noted that about 95% of the students reported that their medical school did not have a course in patient rights nor was the topic of patient rights included in other courses. In view of the fact that these medical students will be future health professionals, it is essential to prepare them with adequate knowledge so that they can ensure patient rights are respected. The authors recommended that both the Ministry of Health and the Ministry of Education work together to institute a compulsory course, or courses, about patient rights.

A cross-sectional survey was conducted in 2011 by Halawany et al. (2016) among randomly selected patients from five regions of Riyadh. The aim of the study was to evaluate the level of awareness among patients about their rights in private and public hospitals. The findings showed that the majority of patients have an acceptable level of awareness about their rights. The results of this study were not in accordance with the results of studies conducted by Alghanim (2012) and Almoajel (2012). In addition, most patients did not demand two specific rights: the right to file a complaint and the right to decline participation in research.

This result concurred with that of Alghanim (2012), who asserted that the right to have a complaint taken seriously was the right least implemented in the hospital. The rights best observed, according to the majority of patients, were the rights to privacy and confidentiality. Alghanim (2012) and El-Sobkey et al. (2014) found a similarly high level of implementation of these two rights. The study reported a significant relationship between patients' levels of education and their level of awareness of their rights. More educated patients are expected to be more involved and understanding of their treatment and of health professionals' explanations.

Habib and Al-Siber (2013) carried out a cross-sectional study which included 625 of the public. For the study participants were recruited from public locations, such as malls and restaurants, using the convenience sampling technique. The majority of participants were young, under 40 years of age (66.4%), with the average age 35.75 years. Most were educated, with more than 40% holding a university degree and about another 40%, who had completed high school. The main aims were to explore people's awareness of patient rights and to identify the sources of their information about them.

The results revealed that only 1% could enumerate all 14 patient rights correctly and about one third (30.6%) knew of only 6 or fewer rights. This result accords with that of Alghanim (2012) and Almoajel (2012). The findings revealed a significant positive relationship between participants' education and their income, and their awareness of patient rights. There was also a significant negative relationship between the ages of participants and their awareness of their rights in hospitals.

In Habib and Al-Siber's study (2013), the main sources of information about patient rights were nurses (73.8%), doctors (62.1%), and other healthcare staff (41.1%). Because many patients get their information from more than one source the percentages do not add up to one hundred. This result was similar to the results of Almoajel (2012), who found that nurses and doctors were the main sources of information; however, in Almoajel's study, posters were the second main source, which is in contrast with Habib and Al-Siber's (2013) findings. Nearly half the patients in Almoajel's study were hospitalised for 2 weeks or more. Habib and Al-Siber (2013) did not include the length of hospitalisation or date of admission of the participants interviewed, and as a result, it is not possible to link length of hospitalisation with any benefit from information on posters. If patients are in hospital long enough, they have time to read posters so are likely to be more aware of their rights.

The majority of participants (73.2% in Almoajel's study (2012) had not completed high school whereas most of the participants (78%) in Habib and Al-Siber's study (2013) had a high school or higher education. It would be expected that better educated people depend at least as much on what they read as are told, whereas the less educated do not read as much and therefore depend on the opinions of people they consider to be experts. In addition, Habib and Al-Siber assumed that when patients come to hospital, they have neither the time nor the inclination to read booklets or posters on boards because their main concern is their treatment. This result may confirm the major role that health professionals can play in promoting the Bill in their organisations.

In spite of the great desire to achieve the highest levels of patient satisfaction with the services offered by hospitals and healthcare centres, actual practice in most health facilities ignores the importance of implementing patient rights and the significance of health workers' actual practice. Several researchers agreed that the Ministry of Health in Saudi Arabia has failed in the implementation of the Patient's Bill of Rights in hospitals and healthcare centres (Alghanim, 2012; Almoajel, 2012). Alghanim asserted that every healthcare department should be responsible for implementing and monitoring the Patient's Bill of Rights. He added that the process of studying the challenges and searching for solutions may delay full implementation of the Bill but it will lead to developments in the health services and a high level of patient satisfaction.

Alghanim (2012) and Almoajel (2012) reported that research in the field of patient rights in Saudi Arabia is still limited and they recommended exploring barriers that impede the implementation of patient rights, for example, the lack of knowledge about the Bill among patients and professionals, job dissatisfaction, staff shortages, inadequate facilities, workload pressure, and lack of resources (Alghanim, 2012). In particular, there is a need for research to create measures that can be used to guarantee the proper implementation of the Patient's Bill of Rights in hospitals (Alghanim, 2012). It is also necessary to ascertain the factors that facilitate the successful implementation of the Bill as well as those that hinder it. Scientific research remains one of the most trustworthy and useful methods to discover the strengths and weaknesses and find the appropriate tools to achieve the desired goals.

2.5   Policy implementation

The emergence of studies on policy implementation began in the US in the early 1970s. Policy implementation can be defined as a set of activities designed to achieve specific goals (Van Meter & Van Horn, 1975, as cited in Ham & Hill, 1993). Policy implementation refers to the process by which strategies and policies are translated into actions (Davies & Tavakoli, 2004). Policy implementation is important because it links the statement of the policy with its achievement and also with the evaluation stage (Ham & Hill, 1993)**.** An understanding of the gap between what the policies aim to do and the results can help policy-makers design effective implementation plans to achieve the best possible results. Moreover, this understanding may encourage policy-makers to anticipate barriers which in turn can lead to effective implementation.

Researchers have identified 10 conditions that contribute to creating an ideal environment for the successful implementation of policy. These conditions include the absence of external constraints, adequate time and resources, clear objectives, proper communication between all actors stakeholders, and the absence of resistance to policy-makers' directives (Hogwood & Gunn, 1984, as cited in Ham & Hill, 1993). Although aspects of these 10 conditions may seem unrealistic, policy-makers can use them as a guide in the implementation process.

In the literature, there are two main approaches to the policy implementation process: top-down and bottom-up. The *top-down* approach proposes that the ability of policy-makers to control resources provides them maximum opportunity to identify goals and implementation mechanisms and set up preconditions for successful implementation, with others complying with instructions to achieve those goals. In contrast, a *bottom-up* approach assumes that successful implementation can be achieved through those involved, participating in the policy-making process (Buse, Mays, & Walt, 2005).

In considering the progress made in implementing the Patient's Bill of Rights, it is important to acknowledge alternative theoretical approaches to policy making and implementation. There are many public policy models that have been developed and together they represent the development of policy implementation in practice. One of the most recent and useful models is the Public Policy Cycle Model developed by Bridgman and Davis (Bridgman & Davis, 2003). They elaborated the policy cycle in the public sector in the Australian context as a series of sequential steps (see Figure 2.3).
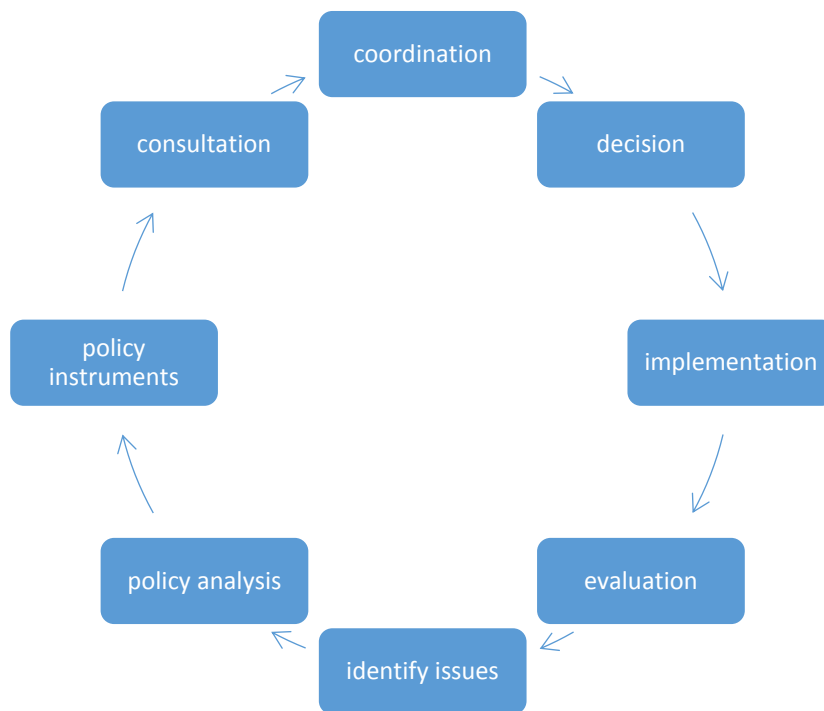
Figure 2.3. Policy cycle (The Australian Policy Cycle from Bridgman and Davis 2003).

The model contains eight steps which are presented in a circle to emphasise the importance of an ongoing and iterative approach (Figure 2.3). The ongoing inputs and gained experiences in this approach contribute to improve the policy over time. The steps of the policy cycle follow this order:

- Identify issues: involves understanding the issue that requires particular attention from the government and the community, which may consider setting a policy. Issues may emerge from research or needs' analyses.

- Policy analysis: involves using scientific evidence and experience-based knowledge to identify all available alternatives to the policy. During the selection process, the community should be engaged in making any decision on the appropriate policy.

- Policy instruments: involves the tools used to accomplish the desired outcomes for the public policy objectives of the selected policy, such as: legislation, incentives, building or infrastructure.

- Consultation: involves gathering information based on external and internal expertise to support the policy process development.

- Coordination: involves communication within the government and between the government and relevant agencies and institutions to remove any potential barriers.

- Decision: involves choosing the best policy option that can achieve the ultimate objectives of the policy process. At this stage, the policy is carried out by the appropriate person or body.

- Implementation: involves the process of translating a policy into practice.

- Evaluation: involves measuring, monitoring and evaluating the implemented policy.

The authors claimed that no one universal policy model can be applicable to all governmental institutions, as they are different in their requirements and needs. However, this approach can guide governments and public bodies to understand the broader picture of policy implementation. By using this approach, governments can develop their own policy according to their cultural, financial, and economic constraints.

Health policy is a subset of public policy that is formulated to address various health-related concerns, with the primary aim to protect and promote health of individuals, communities, and populations. Several aspects such as legal, ethical, and social concerns affect the formulation of health policy (Gostin, 1995). Health policy-makers must recognise the relationship between health policy and its final output through an understanding of each stage of policy, including the implementation process (Buse et al., 2005).

Walt and Gilson (1994), as cited in Buse et al., (2005), proposed a framework for health policy that contains four essential dimensions: content, context, process, and actors, as shown in Figure 1.5. The *content* dimension takes account of all policy details covered. The second dimension, *context*, comprises all factors that can affect any aspect of the policy. The *process* dimension contains the methods of making the policy, and the fourth dimension, *actors*, includes all individuals and groups that will be involved in the policy-making process. The internal relationship between these dimensions can be displayed as a model, as shown in Figure 2.4. Through the interaction of the various elements, this framework assists policy-makers to recognise important factors as they work out policy and plan implementation.
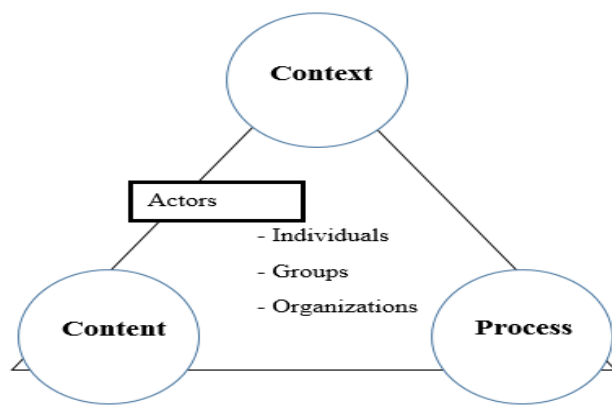
Figure 2.4. Health policy triangle from Walt and Gilson (1994), as cited in Buse et al. (2005).

In many healthcare disciplines, there is a growing concern about the gap between the findings from research and their implementation in practice (Evans, Snooks, Howson, & Davies, 2013; Tansella & Thornicroft, 2009). Tansella and Thornicroft (2009) described three phases that accelerate the translation process and identified different factors that facilitate or create barriers at the national, local, and individual levels. These three *translational roadblocks* are called: adoption in principle, early implementation, and persistence of implementation.

In the *adoption in principle* phase which reflects the intention to implement, policy priority is set. This phase is usually top-down, but local early adopters can come first and make it bottom-up approach. At the national level, this intention can be seen through activities such as advocacy actions, lobbying groups, or opinion leaders. At local level, the role of healthcare leaders becomes obvious by leading the change and developing a supported professional culture within their organisations. At individual level, a successful promotion for the new policy encourages and empowers individuals to be more demanding for that policy.

Next, the *early implementation phase* which includes boarder implementation strategies, including; making the implementation process flexible and feasible, providing resources, motivating staff, stakeholders active engagement, effective supervising, feedback system, highlighting the positive impact, education and training, and an information technology system.

In the *persistence of implementation*, it is important to maintain networks of implementation sites, required resources, staff training and motivating, feedback system, and systematic reviews to assess practice fidelity to the new policy to increase awareness of process.

Because healthcare is one of the most challenging and complex environments, it requires greater attention and proper concern to monitoring and evaluating the plan for the new policy before its implementation. The processes of implementing public health policy are considered

as complex and are influenced by several factors. For this reason, whether or not to implement public health policy is determined by several factors such the government target, local needs, and financial constraints (Evans et al., 2013).

The implementation of public health policy is influenced by many factors, including management approaches, support, explicit leadership support for the policy and its implementation, engaging stakeholders, health human resources, collaboration, relationship with higher authorities, funding, and resources available, in addition to the geographical, economic, and political factors (Valaitis et al., 2016). Cheung, Mirzaei and Leeder (2010) added some other factors such as evidence from research, allocation of scarce resources, ongoing funding, detailed health policy analysis and evaluation.

2.6   Conclusion

The literature clearly indicates the existence of great attention to the importance of protecting patient rights in medical practices. This importance arises from the fact that most of the ideas about patient rights originated from human rights, such as the right to dignity, respect, confidentiality, and freedom in decision-making. The growing global trend towards protecting the rights of patients and the steady acceleration of countries to enact specific legislation to protect these rights was an expected result of many of the violations and abuses received during healthcare experiences. Increased awareness among public and patients is crucial to the process of implementing patient rights' principles, as well as educating health professionals about patient rights and its implementation in daily practice. As a consequence, many studies have been conducted across a number of countries to measure the level of awareness of patient rights among several groups and their knowledge of the existence of documents that protect these rights. Despite an increase in studies about patient rights, it is still small compared to the importance of the topic. The majority of developing countries are still relatively behind in achieving the goal of the implementation of patient rights principles. The absence of effective strategies for implementation may be one of the major reasons for that. The experiences of developed countries could be used as an effective tool to achieve implementation, with the recognition of the importance of cultural compatibility in each country. The next chapter, Chapter 3, addresses the methodology that used in this research. It also discusses in detail the two approaches used, quantitative and qualitative, the rationale for the selection of the specific methods and strategies used to analyse the data. The ethical considerations of this research are also presented.

Chapter 3: Research Design and Methods

3.1 Introduction

This chapter details the research design and the methods used to achieve the research aims. It includes the aims and objectives, the rationale for the methods selection, the overall framework of the research, and an overview of the three main phases: exploration, implementation, and interpretation. Because this research used a mixed method approach, details of both quantitative and qualitative data phases are presented. These cover the study's setting and population, sampling strategy, sample size, sampling frame, and procedures for sampling and recruitment. The chapter describes the development of the data collection instruments for both quantitative and qualitative data, including the content, reliability, and validity of the instruments, and their pretesting. Information on data collection and analysis procedures are also provided. The chapter ends with the ethical procedures and considerations.

3.2 Research objectives

As introduced in the first two chapters, the overall aim of this thesis is to contribute to the field of patient rights research both in Saudi Arabia and internationally. Findings from different perspectives can provide a broad understanding of the implementation of patient rights in selected Saudi hospitals and some of the influencing factors. The overall aim was achieved through meeting the following six objectives:

- To determine the readiness and ability of public hospitals to implement the Patient's Bill of Rights in two leading medical cities in Saudi Arabia.
- To identify the factors that facilitated the implementation of the Bill in public hospitals in Saudi Arabia.
- To identify the barriers to implementation of the Bill in public hospitals in Saudi Arabia.
- To examine the actual implementation of selected fundamental patient rights.
- To understand the different perspectives of the key stakeholders (patient rights experts, hospital managers, doctors, nurses, and patients) regarding the implementation of the Bill in public hospitals.

3.3 Research design

3.3.1 Research design options

Research is a systematic practice that a researcher follows to find new knowledge (Creswell, 2012; Walliman, 2011). Research may be conducted for several reasons, such as to describe, predict, control, investigate, explain, evaluate, or understand a phenomenon. Research involves three parts: raising a question or questions, gathering relevant information, and providing answers (Creswell, 2012).

Research design is critical to research because it provides the plan that is followed in the course of research to collect and analyse data (Burns & Grove, 2009; Creswell & Clark, 2011). Polit and Beck (2014) describe the research design as "the overall plan for obtaining answers to the research questions and for handling challenges that can undermine the study evidence" (p. 51). The main function of research design is to create a logical link between the collected data and final conclusions to research questions (Denscombe, 2010; Yin, 2009).

In general, there are three main classifications of research design: quantitative, qualitative, and mixed methods (Conrad & Serlin, 2011; Creswell, 2013; Johnson & Christensen, 2012). *Quantitative* research design aims to explain the observed phenomena by using numerical data. It measures defined variables by using pre-structured data collection tools.

The second approach, the *qualitative* method, concentrates on exploring the underlying reasons for the phenomena and gaining an in-depth understanding of them. The qualitative research design tends to use a more subjective approach to the collection and analysis of data. Because qualitative design is more applicable to small populations or specific settings, results from this kind of research are less generalisable than those that adopt a quantitative research design.

The third design, the *mixed method* approach, integrates both quantitative and qualitative research methods in a single study (Creswell, 2012), and takes advantage of the strengths of both methods and compensates for their weaker aspects (Connelly, 2009; Yin, 2006). Johnson and Onwuegbuzie (2004) provide a formal definition of the mixed method approach as, "the class of research where the researcher mixes or combines quantitative and qualitative research techniques, methods, approaches, concepts or language into a single study" (p. 17). It can also be defined as an approach that aims to expand the understanding of the research problem by collecting, analysing, and combining both quantitative and qualitative data at some point during research development (Creswell, 2007).

Creswell and Clark (2011) point out that there are some instances where using mixed methods is a highly effective research strategy, with the variety of methods and multiple sources of data often leading to the achievement of the overall aims of the research. They cite six situations where a mixed method approach is appropriate: when data from a single source are inadequate, when primary outcomes need to be explained, when results need to be generalised, when one approach supports another, when a research framework calls for using both approaches, and when multi-stage or long-term research are required to create a link between results to reach the overall goal of the research (p. 7).

3.3.2 Rationale for using mixed method approach for patient rights research

The mixed method approach has become an increasingly popular design option in social research, such as in health sciences and health services research (Bowers et al., 2013; Creswell, Klassen, Plano, Clark, & Smith, 2011; Curry et al., 2013; Hassali et al., 2014; Leech & Onwuegbuzie, 2007; Miller, Crabtree, Harrison & Fennell, 2013). This trend may be attributed to the increasing complexity of problems addressed by health sciences researchers (Östlund Kidd, Wengström & Rowa-Dewar, 2011; Miller et al., 2013). Creswell et al., (2011) summarise the reasons why mixed methods may be an ideal choice for some health sciences research, namely that they draw information from multiple perspectives, take advantage of different types of information, and ultimately lead to an expanded understanding of the topic.

The rationale for selecting a mixed methods design reflects the multiple objectives of this research, which are to determine the readiness and ability of public hospitals to implement the Patient's Bill of Rights, to identify barriers to the effective implementation of the Bill as well as factors that facilitate it, and to understand the various stakeholders' perspectives in the implementation of the Bill in public hospitals in Saudi Arabia.

There are a number of advantages to using mixed methods in a single research project. First, mixed methods may counter any weakness in the use of a single method to address the research problem. Whereas the quantitative method can lack depth for understanding the context, the qualitative method is strong in this respect. In contrast, the qualitative method is weak in the generalisation of results but quantitative research usually overcomes this issue. For example, the quantitative method can answer questions about the most important elements that facilitate as well as the elements that prove barriers to, the implementation of the Patient's Bill of Rights but it cannot easily answer the why or how questions. In addition, there are other equally

important questions that can be elaborated on through face-to-face interviews, such as issues related to the implementation of the Bill in the Ministry of Health and in Saudi hospitals.

Second, with the many stakeholders involved in patient rights, a mixed methods approach makes it easier to bring a diversity of perceptions from different respondents and levels.

Third, it enhances the research findings by providing the ability to illustrate some results from one approach and other results from other approaches (Bryman, 2006; Johnson & Christensen, 2012).

Fourth, this thesis topic benefits from this type of research design because it is a relatively under-researched area. A mixed methods approach is the most appropriate to integrate the perspectives of doctors, nurses, patients, and key informants to address the research objectives.

Fifth, triangulation in mixed methods designs provides an important opportunity to improve the validity and trustworthiness of the research findings (Hall, 2008). Triangulation allows a researcher to examine the research question from multiple angles by using different data types and perspectives. Some authors claim that a mixed methods approach can benefit from the power of both quantitative and qualitative methods through strengthening the research findings and providing an improvement in the quality of the research information (Creswell et al., 2011; Johnson & Christensen, 2012).

Although there are many advantages to a mixed methods approach, there can be drawbacks as well. It is a time-consuming, costly, and more complex process than a single design method. The selection of a particular strategy, however, can mitigate these drawbacks.

3.3.3   Types of mixed methods strategy

Having chosen to use a mixed methods design, the selection of an appropriate strategy is crucial. A major challenge in choosing a mixed method design is the increasing number of potential designs that have emerged in recent decades (Leech & Onwuegbuzie, 2007). There are two broad approaches to mixed methods research: sequential and convergent (concurrent) strategies (Creswell and Clark, 2011).

In the *sequential* approach, priority is to either the quantitative or qualitative data depending on the nature of the research questions. The sequential strategies enable the researcher to gain different perspectives and over time to acquire further understanding of the phenomenon under investigation. This can be achieved by using the results from one analysis to assist in developing research for the next phase as well as helping to interpret the findings of the other

data. All the sequential strategies share the same weakness in that they usually require a considerable length of time to complete (Creswell & Clark, 2011; Gray, Grove, & Burns, 2013).

By adopting *concurrent* strategies, data collection and analysis for both methods can occur at the same time, independently of each other. There are three broad strategies: the convergent triangulation strategy, the concurrent (nested) embedded strategy, and the concurrent transformative strategy. Priority in the convergent triangulation strategy, the most popular mixed method strategy, is given equally to both the quantitative and qualitative data which are integrated in the interpretation phase. In contrast, in the concurrent embedded strategy, one method is dominant and the second is embedded within the main method. The data collected by this strategy are integrated during the analysis phase. In the last strategy, the concurrent transformative strategy, priority is given to either quantitative or qualitative data, or equal weight is given to both. The integration of both quantitative and qualitative data usually occurs during the analysis phase. These strategies typically develop well-validated findings in a relatively short time compared with that required for sequential strategies (Andrew & Halcomb, 2009; Creswell & Clark, 2011); however, there are two main limitations to the concurrent strategies approach. Great effort is required to manage the two different methods at the same time, and it can be quite challenging to compare results that are generated from two analyses using different datasets, especially if the results conflict with each other (Creswell & Clark, 2011; Terrell, 2012).

3.3.4 Rationale for selection of the convergent triangulation strategy

This research used the convergent triangulation strategy. The chosen design comprises two parallel methods. The first is a cross-sectional survey questionnaire for doctors, nurses, and patients. This helps to:

- Determine the readiness and ability of public hospitals to implement the Patient's Bill of Rights in two leading medical cities in Saudi Arabia.
- Identify the factors that facilitate the implementation of the Bill in public hospitals in Saudi Arabia.
- Identify the barriers to the implementation of the Bill in public hospitals in Saudi Arabia.
- Examine the actual implementation of some selected fundamental patient rights.

The second method is qualitative interviews with key informants, designed to explore their detailed experience of the implementation of the Patient's Bill of Rights.

This design allowed the application of both quantitative and qualitative methods to produce independent results that could then be combined for interpretation. The two approaches maximise the strengths and minimise the limitations of a single method. The combined approach yielded more information to help the researcher provide a broader perspective. There was no urgent need for a particular type of data to be collected or in any sequence but the different sources provided additional insight into the implementation of the Patient's Bill of Rights in public hospitals in Saudi Arabia and enhanced the data available in this generally under-researched field. Lastly, time limitations during the fieldwork phase of the research reinforced the selection of this strategy. Because both types of data were collected at approximately the same time and were not dependent on each other, a convergent triangulation strategy was efficient and well suited to the circumstances of this research project.

3.3.5   Research strategy and overall framework

A convergent triangulation strategy was used in this research (see Figure 3.1). As discussed in the previous section, this strategy was selected because it was considered the best way of fulfilling the research aims. The overall framework of this research consists of three phases: planning, implementation, and interpretation (Figure 3.1).
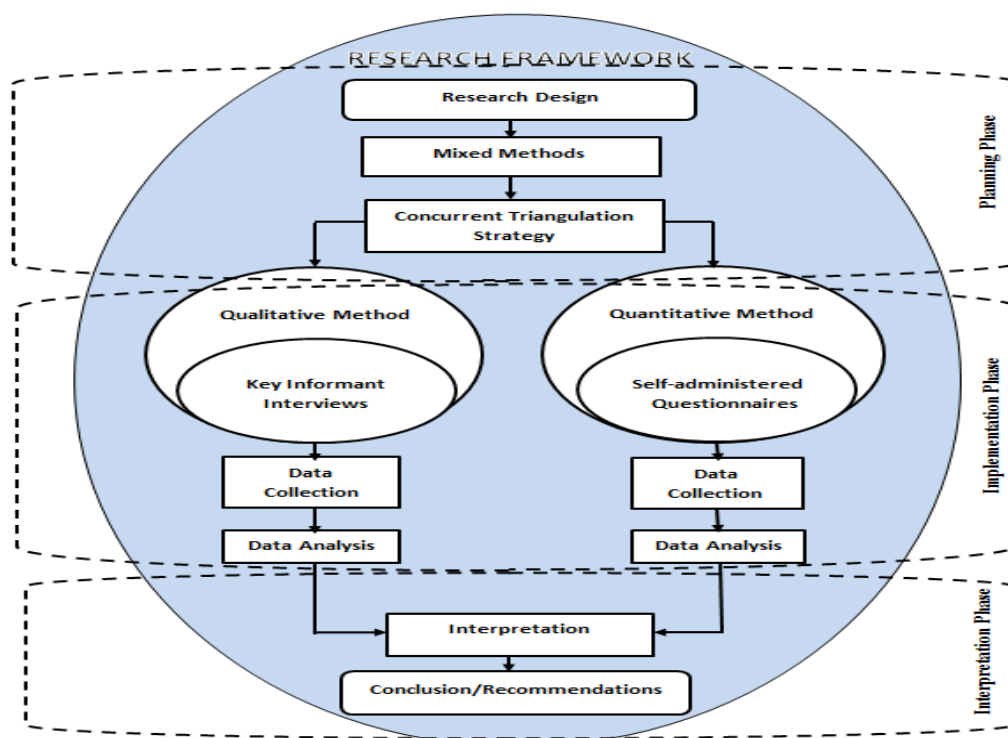
Figure 3.1. The overall framework for the research.

The first (planning) phase, as shown in Figure 3.1, concentrates on reviewing the literature, selecting the proper research design, identifying data sources, defining the participants, and

designing and establishing the data collection instruments and methods. The survey sample was a stratified random sample and the cross-sectional survey questionnaires were used to collect data from doctors, nurses, and patients in two large medical cities in Riyadh. In addition, key informant interviews were conducted to obtain qualitative data from a convenience sample of senior managers from the Ministry of Health, public hospitals, and the Patient Rights and Relations Department, as well as professional leaders. Figure 3.2 shows the linking of objectives and methods used in this research.

The second (implementation) phase was conducted concurrently using the cross-sectional survey questionnaire and key informant interviews. In this phase, a pilot study was undertaken in order to check the feasibility, clarity, and reliability of the questions and to gain feedback about the validity of the content of the questionnaires prior using them with the research participants (Hall, 2008). After a debriefing of the pilot study participants, revisions to the questionnaires were made prior to the main study data collection. Data collection comprised two concurrent processes as outlined previously: distributing the cross-sectional survey questionnaires and conducting the interviews.

After the surveys were collected and the interviews were conducted, the data were prepared for analysis by either quantitative or qualitative processes, as appropriate. The quantitative data were analysed using the Statistical Package for the Social Sciences (SPSS), Version 22. The qualitative data, gathered through key informant interviews, were transcribed and entered in NVivo Version 10 software for analysis to generate understanding and develop an interpretation of how the participants viewed the research topic. For the present research, the interviews were analysed using the thematic framework developed by Braun and Clarke (2006). This was chosen as most appropriate because of its flexibility and accessibility (Braun and Clarke, 2006); thematic analysis is free of theoretical assumptions and is commonly used in health sciences research (Pope and Mays, 2006).

The third phase was the interpretation phase (see Figure 3.1). This involved a discussion and linking of the research findings across sampled groups and methods. From this follows a series of conclusions, including recommendations for further research, and a set of suggestions to improve the implementation of the Patient's Bill of Rights in the Middle East, broadly, and particularly in Saudi Arabia.
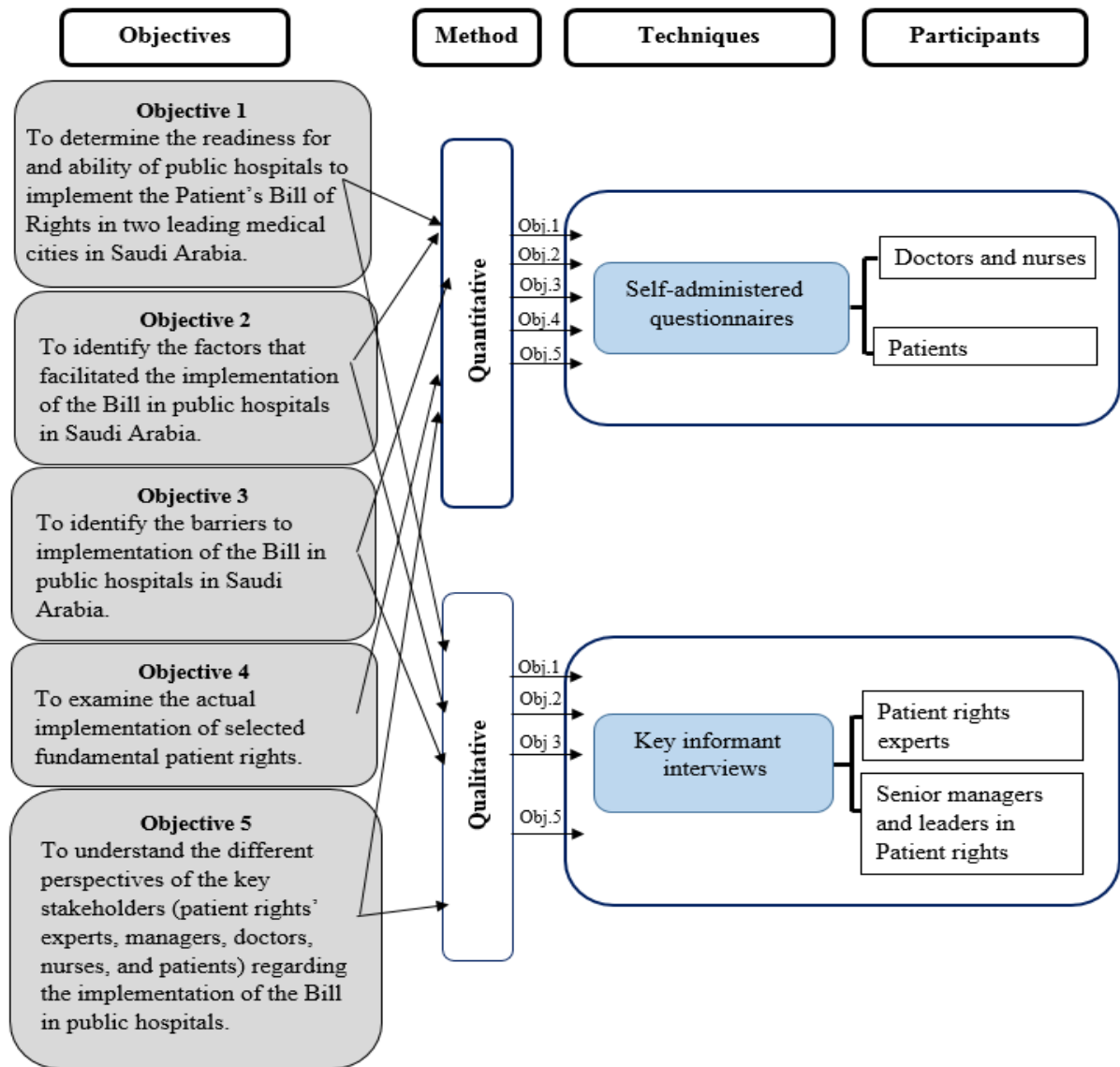
Figure 3.2. Overall research design and methods.

3.4 Phase I: Cross-sectional survey questionnaire for doctors, nurses, and patients

A self-administered questionnaire was used to gain information from a sample of stakeholders in two randomly selected Saudi medical cities. The questionnaire is a commonly used instrument for collecting quantitative data in social research (Hall, 2008; Rubin & Babbie, 2011) and health research (Marks & Yardley, 2004). Questionnaires offer a number of advantages. Data from a large number of participants can be collected over a short period of time with inexpensive tools (Burnard, Morrison, & Gluyas, 2011). The questionnaire provides access to information about respondents' behaviours, attitudes, preferences, and beliefs (Nardi, 2006). It allows the transformation of research data into a numeric format which can be subjected to statistical analysis. When the research topic is sensitive, a self-administered

questionnaire improves the reliability of responses from participants (Babbie, 2007). Lastly, and most importantly, it is preferable for busy participants (Hewison, McCaughan, & Watt, 2015).

There are, however, some disadvantages in using cross-sectional survey questionnaires, including the difficulty of designing the questions and controlling the response rate (Burnard et al., 2011; Seale, 2012). For this research, participants (doctors, nurses, and patients) were selected randomly, based on several criteria. To assist completion, the questionnaires were distributed to respondents in hard copy and were collected later for data entry and analysis.

3.4.1 Research setting and population

3.4.1.1 Research setting

The research took place in Riyadh, the capital city of Saudi Arabia from the middle of April 2013 to the end of July 2013. The Ministry of Health (2014) notes that they operate about 60% of hospitals nationwide, accounting for almost 54% of all inpatients and more than 60% of all beds. The population of Riyadh represents almost 25% of the total population of Saudi Arabia. The city was selected for the research because it comprises the largest health services district, containing about 20% of public health facilities.

The Ministry of Health is located in Riyadh and the research was carried out there as well. Riyadh is the capital city of the Kingdom of Saudi Arabia and all ministries except one are located there. There are both advantages and disadvantages in conducting the research in hospitals located in the same geographical area as the Ministry of Health. For example, the close proximity of hospitals to the MOH ensures greater conformity to the regulations because the hospitals are closely monitored by the MOH. This gives the research a position of strength from which to investigate the implementation of patients' rights in hospitals that actually apply the Bill according to MOH regulations. A disadvantage, however, is that the findings lack data from different parts of the country. Therefore, it is recommended that the current study be implemented in other cities to add further information to this field of research. Hence, it is recommended that potential future research investigate other locations so that the results can be compared. In addition, Riyadh district provides health services for both local residents and people from other parts of the country. The two leading medical cities in the country are in Riyadh: King Fahad Medical City (KFMC) and King Saud Medical City (KSMC). The two selected medical cities comprise a total of seven hospitals managed independently under the supervision of the Ministry of Health.

These two medical cities were chosen because of the variety of services, their size, and capacities, and also because they were the first hospitals in Saudi Arabia to implement the Patient's Bill of Rights. They are the leading health care providers in Saudi Arabia and have the major tertiary hospitals. These hospitals are the preferred destinations for patients from all over the country. Although they were designated to provide tertiary health care services, they also receive patients on referral who require a relatively low level of care. In general, both medical cities serve a full range of patients, including those requiring diagnostic and outpatient care, specialist care, or rehabilitation. For this reason, the findings from the current research should reflect the views of doctors, nurses, and patients across a wide cross-section of the Saudi population.

The first research site, KSMC, consists of three hospitals: general, paediatric, and obstetrics and gynaecology, as well as two specialised centres, the King Fahad Charitable Renal Centre and the Dental Centre. It receives referrals from all over the country and has a total capacity of about 1,400 beds (King Saud Medical City, 2014). KSMC provides a variety of secondary and tertiary health care services to people from different parts of Saudi Arabia.

The second institution, KFMC, is one of the most advanced health organisations in the Middle East. It consists of four hospitals: general, rehabilitation, paediatric, and maternity. The bed capacity is 1,095 and these are used by more than 50,000 inpatients annually (King Fahad Medical City, 2014).

3.4.1.2   Research population

A population can be described as all the individuals or objects that satisfy the inclusion criteria for the research (Burns & Grove, 2003). At the time of the survey, the total number of doctors and nurses employed in all Saudi public hospitals was 130,312 workers: 38,458 doctors and 91,854 nurses. In public hospitals in Riyadh, there was a combined total of 20,386 doctors and nurses: 7,099 doctors and 17,735 nurses (Saudi Ministry of Health, 2014). According to the Saudi Ministry of Health (2014), the national ratio of nurses to doctors in public hospitals was 2.4 nurses per doctor while the ratio in Riyadh was slightly higher, at 2.50 nurses per doctor. The total number of doctors and nurses employed in both medical cities during the survey period was 4,234 health professionals: 1,338 doctors and 2,896 nurses. The ratio of nurses to doctors in both medical cities was 2.16.

3.4.1.3 *Target population*

The target population may be defined as a particular group of people or objects, about whom the researcher aims to draw research conclusions (Kitchenham & Pfleeger, 2002). Identifying the target population is the first step in the sampling process. In the cross-sectional surveys of this research, there were two target groups. The first group (the professionals) consisted of all registered doctors and nurses working at KFMC or KSMC during the period of research. The second group comprised patients over 18 years of age who were hospitalised in KFMC and KSMC during the period of research. The main target group in the research was professionals who speak Arabic because they are more exposed to the community and to public media.

The researcher obtained a list of the target population of doctors and nurses from the Human Resources Department at KFMC and the Department for Administrative and Personnel Affairs at KSMC, and the number of hospitalised patients at each hospital from the Patient Rights and Relations Department in each medical city. The target population of the first group in both medical cities (4,234 doctors and nurses) represents 4.7% of the total number of doctors and nurses in Saudi Arabia: 5.1% doctors and 4.5% nurses (Saudi Ministry of Health, 2014). Table 3.1 indicates that the total target population for the research was 4,234 professionals and 1,625 hospitalised patients.

Table 3.1 Target and Accessible Populations According to the Type of Hospital

Medical city	Hospital	Target Population				Accessible Population			
		Doctors	Nurses	Total professionals	Patients	Doctors	Nurses	Total professionals	Patients
KFMC	General	208	442	650	413	168	378	546	265
	Maternity	65	150	215	208	50	109	159	146
	Pediatric	190	346	536	0	124	316	440	0
	Rehabilitation	30	100	130	124	22	68	90	78
	TOTAL	493	1038	1531	745	364	871	1235	489
KSMC	General	420	954	1374	746	283	638	921	425
	Maternity	140	310	450	134	88	165	253	112
	Pediatric	285	594	879	0	192	370	562	0
	TOTAL	845	1858	2703	880	563	1173	1736	537
TOTAL		1338	2896	4234	1625	927	2044	2971	1026

3.4.1.4 *Inclusion and exclusion criteria*

Burns and Grove (2003) define eligibility criteria as "a list of characteristics that are required for the membership in the target population" (p. 234). Eligibility in this research is defined by set inclusion and exclusion criteria for participation. For doctors, nurses, and patients, there were no restrictions regarding a participant's nationality, ethnicity, or gender.

The inclusion criteria for professionals in the study included all registered doctors and nurses who were working at either KFMC or KSMC hospitals during the research period, who provided any kind of medical service to patients, and who had direct contact with hospitalised patients. This excluded a considerable number of personnel who were in administrative or management roles. The total number of departments was 27 but 10 departments were excluded, five of these because their managers would not permit their participation. Two departments refused to be included because they were preparing for conferences and three refused with no stated reason.

The inclusion criteria for patients included people over 18 years old who were hospitalised patients in either KFMC or KSMC hospitals, having 3 days or more of hospitalisation before the distribution of the questionnaire, and who possessed the mental and psychological capacity to participate in the research. The researcher believes that patients who have more than two days of hospitalised care will usually have enough experience of hospital services to evaluate the patient rights situation properly.

The single exclusion criterion for patients was their inability to participate because of their current health situation at the time of distributing the questionnaires. Nurses in charge of each of the participating departments were asked to exclude any hospitalised patient whose condition made participation difficult, such as proximity to surgery, severe pain, life threatening conditions, being in an intensive care unit, having a mental health condition, or being illiterate.

3.4.1.5 Accessible population

The accessible population comprises all cases of the target population who meet the designated inclusion criteria (often called the eligible population) and who can be reached for invitation to participate (Grove, Gray, & Burns, 2014; Johnson & Christensen, 2012). As shown in Table 3.1, the accessible population comprised registered doctors and nurses totalling 1,235 professionals from KFMC (364 doctors and 871 nurses), and 1,736 registered doctors and nurses from KSMC (563 doctors and 1,173 nurses). A total of 1,026 patients (489 from KFMC and 537 from KSMC) made up the accessible patient population.

3.4.2 Sampling procedures

The main purpose of sampling in cross-sectional survey studies is to ensure that as far as possible, the characteristics of the selected sample represent the characteristics of the target population so that the findings of the research may be generalised to that population (Johnson, 2014; Rose, Spinks, & Canhoto, 2015). Burns and Grove (2003) define sampling as a deliberate procedure to choose a particular group in order to conduct a study. Sampling improves objectivity and the truthfulness of the research findings (Rubin & Babbie, 2011).

3.4.2.1 Sampling strategy

This study used a probability sampling method to ensure the representativeness of samples and minimise bias (Daniel, 2012). There are several types of probability sampling strategy, including simple random sampling, systematic sampling, stratified sampling and cluster sampling (Fawcett & Garity, 2009; Polit & Beck, 2014; Rose et al., 2015).

In this research, proportional stratified random sampling was used to sample subjects from each hospital in each medical city and to prevent the over-representation or under-representation of any hospital. The first step was to identify the appropriate number of subjects to be drawn from each stratum relative to the size of its population (Daniel, 2012). The diversity in the medical and nursing workforce in each medical city may result in a diversity of views in each hospital environment, indicating that stratified sampling was an appropriate technique for the research.

This type of probability sampling strategy is most useful when characteristics such as gender, age, and experience vary among the research population (Fawcett & Garity, 2009). Stratified random sampling is achieved by dividing the target population into mutually exclusive subcategories (strata) and drawing random samples from each stratum (Polit & Beck, 2011). Each hospital in both medical cities was stratified according to its speciality and then, using a simple random sampling technique, a representative sample from each hospital was drawn.

3.4.2.2   Sample size

Sample size is fundamental in ensuring the generalisability of research and refers to the total number of observations that will be sought (Collins, Onwuegbuzie, & Jiao, 2007). Several factors affect sample size, such as the research aim, questions, and design (Onwuegbuzie & Collins, 2007), population size, the risk of inappropriate sample selection, and sampling error (Israel, 1992). The process, therefore, of linking research design, goals, and questions with an appropriate sample size is a crucial step.

Appropriate sample size is based on three significant principles: the level of precision or sampling error, the confidence level, and the degree of variability. First, the *level of precision* is the difference between the predicted sample and the true value of the population. It is associated with balancing accuracy and resources and there are positive relationships between the level of precision, the sample size, and the cost to reach those samples. This means that to achieve a high level of precision there needs to be a large sample and significantly more time and money spent on the data collection process (Shenoy, Srivastava, & Sharma, 1988).

Second is the *confidence level* which expresses the degree to which a researcher is confident that the selected sample represents the target population. The third principle is the *degree of variability* which concerns the distribution of variables that will be measured within the population. An increase in target population homogeneity leads to a required increase in the number in the sample to identify differences (Israel, 1992).

Sample size can be determined by one of several techniques: using the whole population (for a small population), copying the sample size used in similar research, using published tables, or applying formulas to calculate a sample size (Israel, 1992). In this research, the sample size was calculated based on the simplified formula for proportions (Yamane's formula). A 95% confidence level and *p*-value = 0.5 are assumed for the formula (Yamane, 1967:886 as cited in Israel, 1992).

$$n = \frac{N}{1 + N(e)^2}$$

Where:

n = the sample size

N = the population size

e = the level of precision at 95% confidence level

The researcher decided to study the hospitals in both medical cities, giving a total of seven hospitals with a total of 1,338 doctors, 2,896 nurses and 1,625 patients, with a tolerable limit of error or level of significance at 0.05. Using this formula, the sample size would be determined as shown in Figure 3.3.

$$n = \frac{N}{1+N(e)^2}$$

Doctors:

$$n = \frac{1338}{1 + 1338(0.05)^2}$$

$$n = \frac{1338}{4.345}$$

n = 307.9

n = 308

Nurses:

$$n = \frac{2896}{1 + 2896\,(0.05)^2}$$

$$n = \frac{2896}{8.24}$$

n = 351.45

n = 352

Patients:

$$n = \frac{1625}{1 + 1625\,(0.05)^2}$$

$$n = \frac{1625}{5.0625}$$

n = 320.99

n = 321

Figure 3.3. Calculation of the sample size of each group.

Next, each hospital was considered as an independent stratum and multistage proportionate stratified sampling was implemented. The purpose of this technique was to ensure that participants were not over-represented or under-represented at any hospital. In proportionate stratified sampling, the size of the sample from each stratum has the same proportion as in the target population (Daniel, 2012). Accordingly, the researcher first grouped the doctors, nurses, and patients into seven strata, each based on their hospital. Then the proportional allocation of sample size to each stratum was determined by using the following formula:

$$nh = \left(\frac{Nh}{N}\right) \times n$$

Where:

72

nh = required sample size of a group in the stratum (hospital)

Nh = population size for a group in the stratum h

N = total population size of a group in the target population

n = the sample size of a group

The sample size was exceeded by supplying additional questionnaires when this was permitted. At KFMC, the nursing department asked for 100 questionnaires for the general and paediatric hospitals and 50 questionnaires for the maternity and rehabilitation hospitals. This over sampling aimed to compensate for expected non-response, refusals, or unreachable people (Israel, 1992).

The sampling process begins with determining the target population, calculating the accessible population, and lastly estimating the sample size. Table 3.2 shows the target population, the accessible population, and the sample size for each hospital in each medical city.

Table 3.2 Calculation of sample size and final distribution of questionnaires

Medical City	Hospital	Target Population*				Accessible Population**				Sample Size*** $nh = (\frac{Nh}{N}) \times n$			Distributed Questionnaires		
		Doctors	Nurses	Total Professionals	Patients	Doctors	Nurses	Total Professionals	Patients	Doctors	Nurses	Patients	Doctors	Nurses	Patients
KFMC	General	208	442	650	413	168	378	546	265	48	54	82	50	100	100
	Maternity	65	150	215	208	50	109	159	146	15	18	41	40	50	60
	Pediatric	190	346	536	0	124	316	440	0	44	42	0	50	100	0
	Rehabilitation	30	100	130	124	22	68	90	78	7	12	25	22	50	40
	TOTAL	493	1038	1531	745	364	871	1235	489	114	126	148	162	300	200
KSMC	General	420	954	1374	746	283	638	921	425	97	116	147	100	120	180
	Maternity	140	310	450	134	88	165	253	112	32	38	27	44	60	60
	Pediatric	285	594	879	0	192	370	562	0	66	72	0	70	100	0
	TOTAL	845	1858	2703	880	563	1173	1736	537	195	226	174	210	280	240
TOTAL		1338	2896	4234	1625	927	2044	2971	1026	309	352	322	372	580	440

Key*: Target population = the entire group of individuals to which a researcher is interested in researching and generalizing the conclusions
Key**: Accessible population= all individuals of the target population to which the researchers can reach and study
Key***:
nh= required sample size of a group in the stratum (hospital)
Nh= population size for a group in the stratum h
N= total population size of a group in the target population
n= the sample size of a group

3.4.2.3 Sampling frame

A sampling frame is defined as a body of information from which a researcher can draw samples, usually a complete list of all members of the target population (Currivan, 2004; Moule & Goodman, 2009), sometimes with extra information about each member (Malhotra, 2004). Permission to view the list of all registered doctors and nurses at each hospital was obtained from both the Human Resources Department at KFMC and from the Department of Administrative and Personal Affairs at KSMC. Another set of permissions to gain access to the patients' lists was obtained from the Departments of Patient Rights and Relations at both KFMC and KSMC.

The researcher followed the instructions given by the Department of Academic and Research Affairs at KFMC and all selected departments were personally contacted to ask if they would participate in the research. The hospital management was contacted regarding the doctors' questionnaires, the nursing department was contacted regarding the nurses' questionnaires, and the Patient Rights and Relations Department was contacted regarding the questionnaires for patients. At KSMC, the researcher consulted the management of each hospital regarding both the doctors' and the nurses' questionnaires, and the Patient Rights and Relations Department in regard to the patients' questionnaires. For the doctors' and nurses' survey, the Department of Academic and Research Affairs sent e-mails to all departments inviting them to take part in the survey. The departments that declined to participate in the research were excluded and removed from the list. The Patient Rights and Relations Departments were asked to designate the inpatient departments that could participate in the survey. The names of all patients who were admitted in non-participating departments were removed from the patient lists.

A reliable sampling frame was created from the remaining names on the lists. Each list was arranged in alphabetical order and each subject had a unique identification number. The lists contained some extra details such as professionals' specialty, contact number, and e-mail address, and the patient lists had details such as the date of admission, contact person, address, and contact number.

3.4.2.4 Sample selection

Because it was impractical to include the entire accessible population in the survey, a simple random sampling method was used to select the research samples. This method ensures that every unit from the sampling frame has an equal chance of being included in the survey. In this research,

75

random numbers were generated using an online sampling randomisation website (www.randomizer.org) so that sampling error would be eliminated. Table 3.2 shows the sample number required from each hospital for each group. When this was permitted, the number of samples was increased in each hospital to compensate for any unreturned or uncompleted questionnaires.

3.4.3 Cross-sectional survey questionnaire

3.4.3.1 Development of the instrument

After defining the information required to fulfil the research aims and reading through the relevant literature, two questionnaires were developed (one for doctors and nurses, and one for patients). The primary aim of the questionnaires was to explore the perspectives of the three key stakeholders: doctors, nurses, and patients, on the aspects of the roles of key players to implement the Patient's Bill of Rights in the designated hospitals (the first research aim), to identify factors that positively and negatively affect the successful implementation of the Patient's Bill of Rights (the second and third research aims), to obtain participants' views on the implementation of some fundamental patient rights in hospitals (the fourth research aim), and to provide recommendations for processes that will enhance the successful implementation of the Patient's Bill of Rights (the final research aim).

As a result of the lack of research in the field of the implementation of Patient's Bill of Rights both internationally and locally in Saudi Arabia, the researcher could not find either a generic or specific standardised questionnaire that could be used to answer the research questions. Most of the research in this field focuses on the awareness of patients or doctors and nurses, or both, on the presence of a charter or bill, or on the level of satisfaction about the implementation of the charter in hospitals. Because of this, it was necessary to develop a specific questionnaire for this study. The questionnaire design was guided by the research aims, the literature review, the advice of the supervisory team, and consultation with experts in patient rights in Saudi Arabia. When designing the questionnaires, considerable attention was paid to the Saudi culture and context.

The first version of the questionnaires was amended several times. Initially, the questionnaires were designed in English. Because the majority of the target population of this research speak and write Arabic rather than English, the questionnaires were translated into Arabic. To ensure the accuracy of the translation, the researcher translated the English version into Arabic and an

independent accredited translator translated the questionnaires back into English to compare both English versions. Some minor amendments were undertaken to both versions for greater accuracy and another forward and back translation was conducted to validate both versions. Another revision was made after pretesting the questionnaires on the basis of the feedback from the pilot study. This feedback led to further minor changes in some words. The English versions were kept for distribution if a participant preferred to have the English version.

3.4.3.2 Content of the questionnaires

The two forms of the questionnaire were similar but with differences related to their target audience (professionals and patients). Both followed the same format and consisted of five sections. Both questionnaires contained both open-ended and closed questions. The open-ended questions allowed respondents to be spontaneous while presenting their perceptions and viewpoints in their own words (Struwig & Stead, 2001). Lined text boxes were included at the end of each section to allow participants to add any further comments or explain their responses in greater detail.

A 5-point Likert scale was used in all sections of both questionnaires, apart from the first section requesting personal information (see Appendix 1, 2, 3 and 4). The Likert scale used in various sections in the questionnaires was as follows:

- In the second and fifth sections, the scales were similar and consisted of the following items: 4 – *great extent*, 3 – *moderate exten*t, 2 – *low extent*, 1 – *no extent*, 0 – *no information*.
- In the third section, the Likert scale consisted of: 4 – *very important*, 3 – *moderately important*, 2 – *low importance*, 1 – *not important*, and 0 – *no information*.
- In the fourth section, the scale consisted of the following items: 4 – *extreme barrier*, 3 – *moderate barrier*, 2 – *minor barrier*, 1 – *not a barrier*, and 0 – *no information*.

The questionnaire for doctors and nurses contains 76 questions (see Appendix 1 and 2) and that for patients contains 55 questions (see Appendix 3 and 4).

Section 1: Personal information

In the first section of the questionnaire, the doctors and nurses were asked to choose from listed elements related to some of their personal characteristics: sex, job title, age group, level of

education, and experience. The job titles of doctors were based the national classification of doctors inside hospitals and this mainly contains of three major titles: consultant, specialist, and resident. The professional classification of doctors in Saudi Arabia starts with the internship doctor who holds a bachelor degree in medicine. A doctor who has completed one year of internship and has not specialised in a field of medicine is called a *resident*. Resident doctors are key players in any medical team. They undertake most of the regular tasks in the departments where they work under the supervision of the consultant who supervises the team. Only after a resident has more than two years of experience and passes the examination for specialisation in that medicine field he or she becomes a *specialist*. Typically, this process takes four years. More than three years after obtaining the title of specialist, or completing postgraduate training in a main specialty, the doctor gains the title of *consultant* and is entitled to lead a medical team consisting of resident doctors and medical specialists (Saudi Commission for Health Specialties, 2014).

In contrast, the patients' questionnaires included the following personal details: sex, age group, education level, and length of stay (hospitalisation).

Section 2: The readiness and ability of public hospitals to implement the Bill

The second section focused on the roles undertaken by various groups of providers in public hospitals from the perspective of the aspects of implementing the Patient's Bill of Rights.

In the doctors' and nurses' questionnaires, there were 18 questions on the readiness and ability of public hospitals to implement the Bill. The questions in this section explored several areas, such as: management support; the availability of resources; promotion of the Bill; staff education and training; the commitment of professionals; knowledge, and positive behaviour towards patient rights; the contribution and cooperation of the staff of the Patient Rights and Relations Department; and the satisfaction of doctors, nurses, and patients with the implementation of the Bill.

In the patient questionnaires, 15 questions covered the readiness and ability of public hospitals to implement the Bill. The questions in this section explored several aspects, such as: the commitment of management, the patients' level of education, the availability of required resources, the commitment of professionals, the contribution and support of the staff of the Patient Rights and Relations Department for patients, and patients' satisfaction with the implementation of the Bill.

Section 3: Elements that facilitate the implementation of the Bill

The third section explored the factors that facilitate the implementation of the Patient's Bill of Rights.

In the doctors' and nurses' questionnaires, there were 18 questions dealing with several factors that have the potential to facilitate the implementation of the Patient's Bill of Rights. These factors included improving managerial support, rewriting and promoting the Bill, creating a safe work environment, providing recognition, education and training for health professionals, increasing professionals' job satisfaction, raising awareness of the Patient's Bill of Rights among patients and health professionals, separating the Patient Rights and Relations Department from hospital management, strengthening the roles of the department staff, and encouraging the presence of a patient's companion.

In the patient questionnaires, there were 14 questions on several factors that have the potential to facilitate the implementation of the Patient's Bill of Rights. These factors include a rewriting the terms of the Bill, promoting the Bill, providing the necessary resources, providing copies of the Patient's Bill of Rights to patients, raising the awareness of the Patient's Bill of Rights among patients, separating the Patient Rights and Relations Department from hospital management, strengthening the roles of department staff, increasing the number of staff, and encouraging the presence of a patient's companion.

Section 4: Barriers to the implementation of the Bill

The fourth section explored the barriers to the implementation of the Patient's Bill of Rights. The section listed several factors that can hinder the implementation of the Bill in hospitals.

In the doctors' and nurses' questionnaires, there were 27 questions about several potential barriers. These barriers included a failure by health professionals to appreciate the possible benefits of the implementation of the Bill, lack of management commitment, lack of education, training, and motivation among health professionals, low job satisfaction among professionals, failure to promote the Bill, an unsafe work environment, disregard for health professionals' own rights, poor performance of the staff of the Patient Rights and Relations Department, lack of authority given to staff in the Patient Rights and Relations Department, and the absence of patient's companion.

In the patients' questionnaires, there were 15 questions about several potential barriers. These include the ambiguity of some items in the Bill, the level of awareness among patients about the Bill, resources necessary to support the implementation of the Bill, the importance of treatment compared with the rights of patients, lack of encouragement of patients, the performance of the staff of the Patient Rights and Relations Department, lack of authority given to staff in the Patient Rights and Relations Department, and the absence of patient's companion.

Section 5: Actual implementation of patient rights

The fifth and final section tested the actual implementation of the Patient's Bill of Rights. The section consisted of 13 questions addressing what can be considered basic rights guaranteed to all patients by the Patient's Bill of Rights. In this section, the questions were identical in the questionnaires for doctors, nurses, and patients. The questions addressed rights such as giving patients copies of the Bill, giving high priority to patient rights, asking patients to sign a consent form before any treatment or procedures, and involving patients in the treatment plan. In this section, two terms are used that are commonly interchangeable: "privacy" and "confidentiality." In this thesis, "privacy" refers to protection from the physical presence of, or exposure of one's body to, unauthorized persons, whereas "confidentiality" refers to the protection of patient information from disclosure to unauthorized persons (Moskop, Marco, Larkin, Geiderman & Derse, 2005).

Using the PRES (Patient Rights Euro Score) scale, the value of each right was calculated to express the level of its implementation in hospitals, according to health professionals and patients. The labels used to assess rights implementation were as follows: not respected (0-50), hardly respected (51-60), partly respected (61-70), largely respected (71-90), and fully respected (91-100) (Lamanna, et al., 2011).

3.4.3.3   Distribution of the questionnaires
Questionnaires for doctors and nurses

Lists of the names of the randomly selected participants were provided to each department. Each participant received two envelopes: one sealed and the other unsealed. Each sealed envelope contained an information sheet, a consent form, and one copy of the questionnaire with a unique number at the top of each page. Once a questionnaire was removed from its sealed envelope, it was not possible to link it to a particular participant. This was to ensure confidentiality. The

unsealed envelope was a stamped addressed envelope without information, number, or code. These unsealed envelopes were provided to ensure the anonymous return of the questionnaires. In the accompanying letter, respondents were promised that in the report, their answers would not be linked to their name, department, or hospital. The names of participants were kept separate from the questionnaires by using code numbers for each questionnaire.

The researcher used a range of techniques to enhance the likelihood of professionals participating in this research, including asking department management to send reminder letters to all professionals three weeks after they had first received the envelopes. This approach brought success with several departments and professionals but was a notable failure with four departments in one hospital. After discussing the situation with the hospital manager, the researcher was invited to join several departmental weekly meetings to encourage doctors who had received the questionnaires to fill them out and return them. This too was unsuccessful but when the hospital management sent reminder e-mails, signed by the hospital manager himself, through the hospital intranet system to explain the importance of participation in this research, a high proportion of the questionnaires were returned within a short period of time and some doctors asked for replacement copies of the questionnaires.

Questionnaires for patients

After securing the necessary number of hospitalised patients, the departments that were not interested in being involved in the research were removed from the project. In total, 322 out of 1,026 patients were accessible to the research. The management of the Patient Rights and Relations Departments in the two medical cities advised the researcher to increase the number of distributed questionnaires among patients. This was based on their experience of the low response rate from patients to research. As a result, in KFMC 148 patients had been sampled originally to participate in research and 200 questionnaires were distributed. In KSMC, 174 patients had originally been sampled and the distributed questionnaires totalled 240.

The researcher was requested not to contact patients personally but to give the questionnaires to the Patient Rights and Relations Department for distribution. Each envelope contained an information sheet, a consent form, and a copy of the questionnaire. The envelopes were given to each patient and they were asked to return the completed questionnaires to the box provided at their ward reception or just to leave the completed questionnaire in their room. No name or mark

could be used to link a questionnaire to a particular participant. The respondents were informed that their participation in the research would not affect the services provided to them in any way. The researcher collected the completed forms from the various departments and from the Patient Rights and Relations Department.

3.4.3.4 Reliability and validity of the questionnaires

Reliability and validity are important indicators for evaluating the quality of the data collection instruments (Creswell, 2012; Kimberlin & Winterstein, 2008; Watson, Benner, & Ketefian, 2008). A poor level of reliability or validity of an instrument may increase the probability of error during the measurement procedure (Kimberlin & Winterstein, 2008).

Reliability

The term reliability in research refers to the dependability, trustworthiness, consistency, and repeatability of the measuring instrument (Pierce, 2008; Thyer, 2010). According to Creswell (2012), reliability can be estimated by different measures, including test-retest reliability, alternate forms of reliability, interrater reliability, and internal consistency reliability. The most frequently used measure is Cronbach's alpha test (Drost, 2011). The commonly acceptable level of alpha is 0.70 or above (Gerrish & Lathlean, 2015; Keele, 2011; Fain, 2013); however, Hair, Black, Babin, Anderson & Tatham (2006) and DeVellis (2003) suggest that the instrument is still reliable when the Cronbach's alpha score is greater than 0.60.

Validity

The second important indicator for evaluating the quality of the questionnaires is validity. An instrument is considered valid when it successfully measures what it is intended to measure (DeVon et al., 2007; Rattray & Jones, 2007). The literature reports a variety of tests that examine the validity of an instrument. The main types of validity tests are face validity, content validity, criterion validity, and construct validity (Craighead & Nemeroff, 2003; Engel & Schutt, 2005; Peat, Mellis, Williams & Xuan, 2002; Thyer, 2010).

Face validity is a method of considering whether the instrument measures what it is predicted to measure, based on its appearance, relevance, and clarity (Gerrish & Lathlean, 2015). With questionnaires, it is more common to use expert judgements than statistical techniques to assess face validity (Peat, et al., 2002). Expert perceptions are also used to assess content validity which

deals expert views on whether the instrument covers all aspects of each dimension in the research (Polit & Beck, 2008).

Whereas these two validity tests are based mainly on the judgements of experts (Peat et al., 2002; Watson et al., 2008), criterion validity and construct validity use statistical methods to test validity. Criterion validity examines the extent to which the findings of the current instrument are close to the findings from a previously validated instrument. This test usually uses the association coefficient. A high association coefficient indicates the high validity of the instrument (Engel & Schutt, 2005). Construct validity uses comparison with an established theory, often using factor analysis, when there is no gold standard available (Engel & Schutt, 2005). Because there was no previously validated questionnaire or established theory in this research, criterion validity was not applied.

For this project, the face validity and content validity of the questionnaires was obtained through examination by a panel of six experts, including experts in the field of patient rights and health care quality, professional leaders, hospital managers, and the researcher's supervisors. They were asked to provide feedback by e-mail on aspects of the questionnaires, including its layout, relevance to the research aims, relevance to the Saudi context, the clarity and wording of the questions, spelling or grammar issues, time suggested to complete the survey, and any other matters. None of the panel members was a participant in the research.

Those consulted provided valuable guidance, including additional details about patient's companion, the separation of the Patient rights Department from hospital management, removal of some items not applicable to the Saudi context, and changes to ambiguous and confusing words. As a result, four questions from the doctors' and nurses' questionnaires and five questions from the patients' questionnaires were dropped, and seven questions from both versions were rewritten. Most of their concerns related to the ambiguity of words and terms. Lined text boxes were added at the end of each section to give the participants space to provide their personal thoughts.

3.4.3.5 *Pilot testing*

A pilot test allows a researcher to gather necessary feedback from a small sample of respondents to improve the final questionnaire (Creswell, 2012) and data collection procedures. It helps to maximise the validity of the instrument and identifies possible improvements (De Vos, Strydom, Fouche & Delport, 2005; Hall, 2008; Polit & Beck, 2008; Watson et al., 2008).

The questionnaires were piloted in early July, 2010. They were tested on a small group similar to the target group to identify any ambiguities, check the wording of the questions, and confirm the time taken and the ease of completion. According to Grover and Vriens (2006), the pre-test sample size can range from 15 to 30 participants for each group. After the official letter of permission was obtained from the hospital management, a pilot study was carried out at two hospitals, involving a randomly selected sample of 35 registered health professionals (10 doctors and 25 nurses), and 40 patients. These professionals and patients were excluded from the full research.

The questionnaires were given to the nominated persons for completion and subsequent collection. Questionnaires were returned from 4 doctors, 25 nurses, and 31 patients. The results of the Cronbach's alpha reliability test, showed the internal consistency coefficient for all the items in the doctors' and nurses' questionnaire items was .932 and for the patient questionnaire items 0.967. All the Cronbach's alpha values exceeded the generally accepted minimum value of 0.70. Based on these results, it can be concluded that both questionnaires were reliable and had good internal consistency.

Finally, the pre-test questionnaires were reviewed and some minor modifications made. The time required to complete the questionnaires varied from 7–10 minutes for doctors and nurses and from 10–13 minutes for patients.

3.4.4   Analysis of survey data

The positive culture of patient rights framework (Figure 1.3) was used to analyse and interpret the information obtained.

3.4.4.1   Survey responses

The sample size needed and the response rates for each group are shown in Table 3.3.

Table 3.3 Response Rates for the Three Groups

Group	hospital	Accessible Population	Sample size*	Distributed	Returned	Usable	Response rate (%)
Doctors	KFMC	364	114	162	154	151	93.2%
	KSMC	563	195	210	162	158	75.2%
	Total	927	309	372	316	309	83.1%
Nurses	KFMC	871	126	300	281	274	91.3%
	KSMC	1173	226	280	273	259	92.5%
	Total	2044	352	580	554	533	91.9%
Health professionals		2971	661	952	870	842	88.5%
Patients	KFMC	489	148	200	180	162	81%
	KSMC	537	174	240	201	172	71.7%
	Total	1026	322	440	381	334	75.9%

*The sample size equation: Yamene's formula + 30%

Of 1,251 returned questionnaires, a total of 1,176 usable questionnaires were coded and entered into the SPSS programme. When that task was completed, the response rate of the health professionals and patients was calculated. Of a total of 952 questionnaires distributed to the doctors and nurses, 870 questionnaires were returned, but 28 of them were unusable. The majority of the returned questionnaires were in Arabic, which may indicate that the majority of participants were Arabic-speaking professionals.

Similarly, of a total of 440 questionnaires distributed to the patients, 381 were returned, with 47 of them unusable. The unusable questionnaires were either left completely blank or inappropriate answers were given, for example by the selection of the middle cell throughout the entire questionnaire. The overall response rate for professionals was 88% and for patients 76%. Kidder (1981) indicates that to be considered acceptable, the response rate in social research should not fall below 50% (as cited in Richardson, 2005). The high response rates for both groups in this research add value to the study.

3.4.4.2 *Data screening and preparation*
Prior to statistical analysis, data were screened for entry errors, response rate, missing values, outliers, normality, homogeneity, and multicollinearity. Next, the validity and reliability of the questionnaires were tested.

Missing values are a common feature in many aspects of social research. According to Hair, Black, Babin and Anderson (2009), if there are less than 10% of missing values in an individual's observations they can be ignored if they follow a random pattern. The missing data in this research were random, comprising less than 5%, and the study sample was relatively large, so no replacements were made. Using boxplot graphs, a visual examination of the data was made but no extreme values or outliers were found (Nuzzo, 2016). By performing Little's Missing Completely at Random (MCAR) test, the result was statistically significant (p<.001), which indicates the missing data was Missing at Random (MAR). Therefore, there was no need to replace the missing data. I understand that this sentence is rather confusing, so I have reworded it and added more explanation in the thesis.

3.4.4.3 Statistical analysis

The quantitative data in this research were analysed using SPSS version 22, drawing on various statistical techniques. Both descriptive and inferential statistical analysis were carried out in the data analyses.

Normal distribution and the homogeneity of data are two of the most important indicators for selecting the most appropriate statistical tests. The normality of the survey questionnaire results from professionals and patients was assessed using the Kolmogorov-Smirnov test. The results showed that the data from the questionnaires of both groups were not distributed normally, leading to the use of nonparametric tests. Next, the homogeneity of data was examined using the chi-square (χ^2) goodness of fit test. The categorical variables were then dummy coded to test for the presence of multicollinearity. The VIF values of variables showed that there were no multicollinearity concerns in this research because none of the variables had a variance inflation factor greater than 10.

Descriptive statistics

Descriptive statistical analysis was carried out to describe, summarise, and enable interpretation of the dataset and this assisted the researcher to convert a large amount of data into more easily understandable, meaningful information. Descriptive tests, recording percentages and frequencies, were used to provide an overview of the sociodemographic characteristics of the participants. Tables and figures interpreting selected results were presented and explained.

Inferential statistical analyses

A nonparametric method was employed because the data were not distributed normally, according to the Kolmogorov-Smirnov test. During the data analysis, the 5-point Likert scales used in the questionnaires were collapsed into a 3-point Likert scale because of the low number of respondents in some cells and to give greater clarity to the findings. Chapter 4.1 provides greater explanation of this process.

The chi-square test was applied to nominal and ordinal level data (Hair, Babin, Money & Samouel, 2003). For the purpose of this study, chi-square cross-tabulation and analysis were used to examine the association between the sociodemographic characteristics and the perceptions of each group. The resulting (p) value was compared to the 0.05 standard. A value below 0.05 is an indication of a statistically significant association between two variables and shows that they differ significantly among their groups; however, if the value is equal to or greater than 0.05, this indicates that there is no statistically significant association between the two variables. In order to compare the mean of more than two independent groups, the Kruskal-Wallis test was used.

3.5 Phase II: Interviews with key informants/stakeholders

The semi-structured interview is a widely used technique for collecting qualitative data in health services research (Al-Busaidi, 2008; Green & Thorogood, 2004; Jamshed, 2014) and is appropriate for exploring the perspectives of key stakeholders on the implementation of the Patient's Bill of Rights in public hospitals in Saudi Arabia. Key informant interviews can be used to achieve an in-depth understanding of the phenomenon under research and enable the researcher to discover new themes or findings. In addition, they provide the flexibility to explore non-verbal expressions and seek answers from people in different situations and from different backgrounds (Al-Busaidi, 2008; Bell, 2005. P. 157). In this research, key informant interviews were conducted with a number of key participants in the field of patient rights in Saudi Arabia, including experts from the Ministry of Health, hospital managers, Patient Rights and Relations Department managers, and professional leaders.

Using a semi-structured interview technique, the main goal was to understand how key informant stakeholders experienced the implementation of the Patient's Bill of Rights. The aims of these interviews reflected the overall research objectives:

1. To determine the readiness and ability of public hospitals to implement the Patient's Bill of Rights in two leading medical cities in Saudi Arabia.
2. To identify the factors that facilitate the implementation of the Bill in public hospitals in Saudi Arabia.
3. To identify the barriers to the implementation of the Bill in public hospitals in Saudi Arabia.
4. To examine the actual implementation of some selected fundamental patient rights.
5. To understand the different perspectives of the key stakeholders (patient rights experts, hospital managers, doctors, nurses, and patients) regarding the implementation of the Bill in public hospitals.

3.5.1 Participant selection

3.5.1.1 Selection strategy

The sampling strategies in qualitative research can be flexible and can be modified in order to answer the research questions (Creswell, 2012). Although a number of common sampling strategies are used in qualitative research (e.g., convenience sampling, purposive sampling, quota sampling, and snowball sampling (Creswell, 2012), because this research sought information on a specific policy implementation issue, purposive sampling was used to select key informants. In purposive sampling, the focus is on particular respondents who are deliberately selected for their detailed knowledge that may contribute to answering the research questions. This approach can help a researcher concentrate on rich sources of information and avoid lesser sources. The researcher deliberately selects appropriate participants who are experts or who have high levels of experience and can provide detailed descriptions and explanations of the phenomenon under investigation (Procter, Allen & Lacey, 2010; Punch, 2005; Silverman, 2005).

Because there are few experts in the field of patient rights in Saudi Arabia, the researcher identified and selected participants who had either knowledge of patient rights nationally or internationally (Burns & Grove, 2003; McCance & Mcilfatrick, 2008), or who first-hand experience of local implementation, or both.

The selection criteria used in this research for participant inclusion in the interviews were that they should be:

- In a position of responsibility for managing the implementation of the Patient's Bill of Rights, or

- A leader in charge of a team to implement the Bill in the hospitals, or

- A senior manager in the General Department of Patient Rights and Relations (this department is a Ministry level department) or on the General Directorate of Health Affairs in the Riyadh Region and has experience in the field of patient rights.

3.5.1.2 Sample size

The sample size in qualitative research is determined on the basis of the research aims (Wiersma, 2000) and of the resources and time available to the researcher (Silverman, 2001). Sample sizes may be small as long as the selection of participants receives careful consideration.

Marshall (1996) believed that the optimum sample size in qualitative research is achieved when the researcher has collected enough information to address the research aims, that is, when data saturation is reached. He added that, in practice, the proper number of interviews becomes clear during the research process at the point where no new data can be added. Thus, there is a strong relationship between sample size in qualitative research and data saturation.

Guest, Bunce and Johnson (2006) noted that a number of health science articles called for the use of theoretical saturation to determine the number of samples in qualitative research. This approach was used here. A literature review conducted by Guest et al. (2006) found that the majority of studies suggested that the optimal size for a qualitative research sample is a minimum of five participants and a maximum of 25. They concluded that the ideal sample size for interview techniques was 12 participants, because usually no new information is extracted from the data after the twelfth participant.

Only a small number of people have expertise in the field of patients' rights and the number of senior managers in patients' rights departments is limited as well since these are the newest departments in Saudi hospitals. The reseracher was able to collect 20 names of people who had the necessary experience to add value to the research. After the fifth interview, the reseracher began reviewing the questions and answers to check if the point where no new information could be added had been reached or not. After the ninth interview, it was found that data saturation was achieved because no new information was forthcoming.

3.5.2 Selection procedures

In key informant interviewing, the researcher aims to identify the key individuals or settings that offer a rich source of data (Procter et al., 2010). To increase the validity of the findings, the researcher is encouraged to choose the appropriate sampling strategy (Procter et al., 2010; Silverman, 2005).

In this research, the researcher used his experience in the field of patient rights in Saudi Arabia to identify potential participants who were well informed about the phenomenon. Initially 20 names were listed of people who matched the selection criteria for this research. These people were contacted, nine of them face-to-face, six by phone, and five by e-mail. They were given information about the research and asked if they were interested in being involved. More than half (12) expressed their interest in being interviewed and four asked to have more information about the research. Two of the potential participants, who agreed at first, did not respond further, excluding themselves from the research. At the next stage, one expert, who initially accepted, was very difficult to reach during the fieldwork. As a result, his name was excluded from the list. The final list of participants consisted of five people from the Ministry of Health, two managers from Riyadh district and hospitals, and two patient rights experts. The interviewed participants were all Saudis.

3.5.3 Key informant interviews

3.5.3.1 *Development of the instrument*

A literature review provides guidance in building theoretical foundations for developing questions for the face-to-face interviews (Bhattacharya, 2017). In this research, previous studies in the field of patient rights in the Middle East were the main source that contributed to the interview questions, with additional professional guidance from the researcher's supervisors. The interview questions originated predominantly from the relevant themes developed from the literature and the research questions. To ensure that the information provided by the interviews was clearly related to the specific research questions, the research aims were reviewed and the required qualitative information defined. Each question was related to an aspect of the implementation of the Patient's Bill of Rights in the Saudi health system. Some questions also emerged from suggestions that the researcher received during the questionnaire pilot study.

There were twelve questions topic areas. Each topic area started with broad questions which were then followed by more specific questions to gain further understanding of the participant's views on the topic. The flexibility of the semi-structured interview enabled follow up of unanticipated topics raised by the interviewees. Each main question had several follow-up questions for example, "Could you give me an example?" "Can you describe this for me?" "Please, tell me more about?" The twelve topic areas/questions are set out below. The questions and responses were all in Arabic, to be translated later on during the analysis process.

Question 1: "Could you please tell me about your experience in the field of patient rights, especially in the Saudi context? And briefly about the responsibilities you have for the implementation of the Patient's Bill of Rights in Saudi hospitals?" This question was intended as an icebreaker to start the conversation. It gave the interviewee an opportunity to show what came to mind about patient rights in Saudi Arabia.

Question 2: "From your point of view, what do you think is the rationale for the emergence of a Bill for patient rights in Saudi Arabia?" This question explored informants' personal perceptions of the reasons behind implementing the Bill in Saudi Arabia.

Question 3: "Could you tell me about the implementation stages of the Patient's Bill of Rights at the Ministry of Health and hospital level?" This question sought to explore the stages and process of implementation of the Bill at the higher level (Ministry of Health) and the secondary level (hospital level).

Question 4: "Based on your experience, how much effort or commitment is there from the Ministry of Health and hospital management to protect patient rights and implement the Bill?" This question aimed to assess the level of commitment from the decision makers and the managers towards the implementation of the Patient's Bill of Rights in hospitals.

Question 5: "How do you evaluate the support provided by the Ministry of Health to protect patient rights in hospitals? Could you tell me about your experience of stakeholders' involvement in the implementation process?" This question explored the support of the main stakeholders (Ministry of Health, professionals, managers, and patients) for the Bill and investigated how feedback on it was communicated to decision makers.

Question 6: "What is your evaluation of the implementation of the Patient's Bill of Rights at the Ministry of Health and hospital levels? Do you notice any positive or negative changes in the relationship between patients and health care providers during and after the implementation process?" The intention of the first part of the question was to investigate how informants assessed the implementation of the Bill at different levels. The second part aimed to explore any effect that implementation of the Bill had on the relationship between health service providers and receivers.

Question 7: "Based on your experience, what are the significant achievements of the Patient's Bill of Rights so far, if any?"

Question 8: "Could you explain briefly any lessons have been learnt from current achievements in the implementation of the Bill?"

Question 9: "What are the barriers to implementation of the Patient's Bill of Rights in Saudi hospitals? What are possible factors that may facilitate the implementation of the Bill?"

Question 10: "What conditions are needed for the successful implementation of the Bill in Saudi hospitals?" This question focused on the ways in which implementation of the Bill and could be enhanced.

Question 11: "What do you recommend to overcome challenges to implementation? What is your recommendation for both the Ministry of Health and hospitals to enhance the implementation of the Patient's Bill of Rights in hospitals?"

Question 12: "What else would you like to add? Please feel free to add any additional comments or information that we have not discussed already or that you think is important to the topic." This question was an opportunity to discover other interesting ideas and thoughts. It aimed to give the interviewee more opportunity to add information that may not have been covered during the conversation.

3.5.4   Pilot testing

The questions for the key informant interviews were pilot tested with two experts. The pilot test has many benefits for both the researcher and the research. The benefits for the researcher include testing the researcher's interviewing skills, estimating the time frame for the interview, and

providing practice for the pre-interview and post-interview requirements. Equally, the benefits for the research include ascertaining the face validity of the questions, discovering any unforeseen problems with questions, providing feedback on the wording and clarity, and suggesting any additions or changes to the research interview (Brink, 2006).

In the event, no major issues emerged from the pilot study, regarding the questions or the topics covered. Both experts explained their views fully; however, the researcher noted that unless the interviewee is asked not to receive telephone calls during the interview, some think it permissible to interrupt the conversation many times. Following the pilot test, no change was made to the questions and because the exclusion of these participants would limit the size and scope of the sample in the main research, the pilot study interviews were included in the main body of research.

3.5.5 Interview procedure

The researcher made sure that every step taken accorded with the pre-approval letter from the University of Canterbury Human Ethics Committee and with international standards on ethical issues. A detailed explanation of the ethical considerations during this research is provided at the end of this chapter. No risks to participants were identified and all information from them was treated and reported anonymously. Because the Ministry of Health and the main public hospitals are based in Riyadh, the interviews took place in that city.

The potential influence on the interviewees of the position of the researcher in the Ministry of Health was of particular concern. Consequently, the researcher employed two strategies to prevent role influence on the research. First, during correspondence prior to the interviews, the researcher made it clear that he had no current position in the Ministry of Health. In all communications he introduced himself simply as a researcher. Second, at the beginning of all interviews, the researcher stated explicitly that he had no current role in the Ministry of Health. It was clearly explained that the researcher had the role of interviewer only, and not any other role or position. However, the fact that participants knew the researcher was found to be an advantage for the research. As it turned out, the researcher's position facilitated and helped more than it hindered because it contributed to creating a positive climate of communication with interviewees. It also provided common ground in understanding and communicating with the participants in the interviews.

Based on the research aims and the literature review, an interview guideline was developed by the researcher to be followed before, during, and at the end of each interview. This guideline contains

the arrival process, introduction, setting up the recording device, the list of questions, and ending the interview. The key informant interviews were conducted from the middle of April 2013 to the end of July 2013. All interviews were conducted individually in Arabic, in a private room of the participant's choice, and at a time convenient for each participant. The following steps were followed.

Step 1. The researcher visited the organisation where the proposed participants work to introduce the research aims, needs, and to ask permission to interview some of their employees. The researcher received a cordial welcome and obtained verbal permission. The researcher believes that his previous relationship with these organisations accelerated the process of gaining permission.

Step 2. Invitations were sent to the 12 participants by e-mail, accompanied by the information sheet, the consent form (see Appendix 5 and 6), and the list of interview questions. Participants were asked to select a convenient time and place for their interview. The aims of this initial e-mail were to enhance the credibility of the research, improve the response rate, and acknowledge the importance of the informants' participation (Jones & Rattray, 2010). In addition, this approach enhanced ethical considerations and avoided any potential risks that could arise from their participation.

Step 3. Nine response e-mails were received during the first 5 days and only three reminder e-mails needed to be sent after 10 days. As a result of the reminder e-mails, two responses were received, but, even with the reminder, one potential participant did not respond. The researcher visited his office twice after the reminder e-mail but he proved unreachable. Because of the limited time frame for data collection, he was regarded as declining to be part of the research. All participants preferred the interviews to be carried out at their work offices.

Step 4. The interview began with a short conversation with the interviewee to help them feel comfortable and to establish a suitable atmosphere. The researcher managed a smooth shift from the informal part of the meeting to the more formal, more structured interview part. At the beginning of the interviews, the researcher thanked the participants for their valuable time, briefly introduced himself, then explained the purpose of the interview, why they were selected, and how the information would be recorded and kept safe. In addition, the voluntary nature of participation and the right of the participant to withdraw from the research were clearly emphasised. Six

participants signed the consent form. Three participants preferred not to sign the forms but gave oral approval to be interviewed. All interviewees accepted that the whole conversation could be tape-recorded.

Step 5. Interviewees were encouraged to explain further or clarify certain points. Although the researcher believed that his main role was to listen, he sought a deeper understanding by intervening to ask additional questions, such as what do you mean by this? Can you please explain more? Could you give me an example? or Do you want to add anything to this point? However, the researcher avoided leading questions or signals to make sure that no direction was given regarding the type of answer expected.

Step 6. At the end of the interview, interviewees were thanked for their participation and for their time. The researcher tried to cover the main points and finish the interview within the proposed time frame. The estimated time each interview was 40 minutes and the actual average time was 42 minutes. One interview lasted approximately 1 hour and 15 minutes because the interviewee asked to stop the interview three times to make important telephone calls.

3.5.6 Analysis of interviews data

The technique of thematic analysis was adopted for analysing the interviews. This method is commonly used for coding qualitative data, whether using a bottom-up or data-driven approach. Flexibility is one of the major advantages of the method. In addition to being free of theoretical assumptions, it provides the researcher with simple guidelines to generate understanding and develop an interpretation of how the participants' view the research. Most importantly, thematic analysis enables the researcher to include items of data in multiple themes, a crucial advantage in this research (Braun and Clarke, 2006).

The qualitative data analysis package NVivo 10 was used for organising, coding, and preparing the data for thematic analysis. The use of a specialised software package, such as NVivo, helps greatly in increasing the transparency, accuracy, efficiency, and trustworthiness of the process of analysis (Welsh, 2002).

By following the guidelines developed by Braun and Clarke (2006), the researcher identified, analysed, and reported the interview data. These guidelines involve six steps: (a) becoming

familiar with the data, (b) generating initial codes, (c) searching for themes, (d) reviewing themes, (e) defining and naming themes, and (f) producing the report (pp. 89-95).

3.5.6.1 *Steps in the analysis of interview data*

(a) Becoming familiar with the data

The researcher became familiar with the data by transcribing the interviews in Arabic and then translating them into English, and then reading, and re-reading the interviews. Reading the transcripts repeatedly assisted the researcher in becoming more familiar with the content. Once all interviews were fully and accurately transcribed into written form, the documents were imported into NVivo 10 software to make procedures more systematic.

(b) Generating initial codes

This step involves generating initial codes by noting themes that may be of interest and following up in light of the research questions. A code is a descriptor used to categorise a section of text based on some general features (Coughlan, Ryan & Cronin, 2013). As the initial codes began to emerge during the reading process, the researcher highlighted significant information according to its relation to the research questions. Later, these codes were checked, compared, and grouped by their focus to eliminate any obvious overlapping. It was very important to revisit the initial codes several times to ensure all possible themes were observed.

(c) Searching for themes

At this point, the codes generated in the previous step were checked and analysed to identify related codes that might create potential themes. A theme is considered to be a larger unit than a code and includes related codes representing one main idea in the data (Creswell, 2012). Broader themes were created by searching for relationships among the codes, then organising and grouping similar codes. Tables were used to separate and clarify themes from codes.

(d) Reviewing themes

After identifying the themes, a review process was conducted to rearrange and refine the themes identified. These were checked against the dataset to ensure that they were meaningful, significant, and related to the same content. For this step, a thematic map was used to compare the relationship between the themes and sub-themes and ensure the created themes were relevant to all the data and the research objectives.

(e) Defining and naming themes

At this stage, a further description of each individual theme was made to identify and analyse the relationship of the themes with the dataset and the research questions. Each theme was named to reflect clearly the codes it contained. Themes from the literature and previous research were reviewed and compared with the themes generated in the current research.

(f) Producing the report

Finally, the information obtained from the process of thematic analysis was written into a report of the research findings. The positive culture of patient rights framework (Figure 1.3) was used to analyse and interpret the information obtained. Relevant extracts and quotations were presented to support these findings. The direct quotations were validated using back translation procedures. The researcher translated the quotations from the original language (Arabic) into English, then a professional translator translated them from English into Arabic. The researcher compared the two resulting Arabic versions with the original interview. As a result, some modifications were made.

3.5.7   Establishing the trustworthiness of the research

For qualitative research, Guba and Lincoln (1994) suggest the term *trustworthiness* be used instead of reliability and validity, which are used in quantitative research. In Guba and Lincoln's work, trustworthiness has become an important concept in qualitative research (Ritchie & Lewis, 2003), with the primary aim to support the argument that the findings from the research are worth paying attention to (Lincoln & Guba, 1985, p. 290). The concept is an essential tool to increase the researcher's confidence that the research outcome reflects accurately the interviewee's perceptions (Lietz, Langer & Furman, 2006; Lincoln & Guba, 1985). Various techniques can be used to establish trustworthiness in qualitative research. Lincoln and Guba propose four criteria to increase the trustworthiness of qualitative research: credibility, transferability, dependability, and confirmability (Creswell, 2009; Giddings & Grant, 2009; Marshall & Rossman, 2006). Table 3.4 draws on these sources to show the strategies of each component used to ensure the trustworthiness in this research.

Table 3.4 The Components of Trustworthiness

	Component	Strategies
Trustworthiness	Credibility	Prolonged engagement
		Persistent observation
		Triangulation
		Peer examination
		Referential adequacy
	Transferability	Research context description
		Participants' experiences
	Dependability	External audits
		Peer examination
		Triangulation
	Confirmability	Detailed description of the methods used
		Triangulation
		Quotations

Source: modified from Lincoln & Guba, 1985.

The following section discusses the four criteria and related strategies that were used to increase the trustworthiness of the qualitative part of this research.

3.5.7.1 *Credibility (internal validity)*

Credibility is focused on improving confidence in the research findings. Lincoln and Guba (1985) argue that ensuring credibility is one of most important factors in establishing trustworthiness. Several strategies, listed below, were used to increase the credibility of the research findings (Polit, Beck & Hungler, 2001).

- **Prolonged engagement**. This requires being familiar with the culture and social aspects of the phenomenon by spending adequate time in the field. In this project, the researcher was familiar with the culture and the environment the participants work in. The researcher's previous experience in the field of patient rights in Saudi Arabia helped to create a relationship of trust with the informants, reinforced by sending the approval gained from the ethics committee, the information sheet, and the consent form to every participant.

- **Persistent observation**. The personal experience and professional background of the researcher in the Ministry of Health, in a number of hospitals, and in the field of patient rights provided him with an in-depth understanding of the phenomenon under investigation. Based on that experience, he was able to focus on the most relevant details.

- **Triangulation**. This involves using data from one or more sources in order to support findings from another source and provides an efficient strategy to create clear justifications for themes (Creswell, 2009; Giddings & Grant, 2009). In this research, both qualitative and quantitative methods were combined to ensure that the weaker aspects of one method could be mitigated by the other.

- **Peer examination.** This includes discussion with others to prevent bias and misrepresentation on the part of the researcher and develop new ideas about the interpretation of data. Peer critique was obtained through regular meetings with the researcher's supervisory team and with colleagues. Discussions covered aspects of the research, such as data collection, the process of analysis, findings, and obstacles encountered, and provided valuable feedback to the researcher.

- **Referential adequacy.** This strategy ensures that the data are documented and archived in a way that is traceable and easily rechecked at any stage (Lincoln & Guba, 1985). With the approval of participants, all interviews were audio-taped, transcribed, and translated by the researcher, who is bilingual and fully understands Saudi culture. Prior to transcription, the interview was checked in order to clarify any misunderstandings or identify any ambiguity in the interviewee's expressions. Every transcript was carefully read to make sure there were no points missing from the interview. Furthermore, relevant quotations from the interviews were included to support the participants' arguments.

3.5.7.2 Transferability

Transferability refers to the degree to which research findings are applicable to similar circumstances (Streubert, Speziale, & Carpenter, 2003). This criterion can be achieved by the thick description of the research context and the participants' experiences and their relation to the phenomenon under investigation. In the current research, this was achieved by purposive sampling from different organisations and departments, and from different levels of management

responsible for the implementation of the Patient's Bill of Rights. Five of the participants were from the Ministry of Health, four senior managers, and one consultant. In addition, two managers who involved in the implementation of the Bill at district level were selected, and two patient rights experts were interviewed. The variety of the informants in terms of their background, position, responsibility, and experience may enhance the results of the research.

3.5.7.3 Dependability

Dependability refers to the quality of the research process and the consistency of the results (Bitsch, 2005; Holloway, 2005). Dependability can be acquired through external audits, peer examination, and triangulation. In this research, dependability was ensured using the following techniques:

- **External audits**. The methods, data, findings, interpretation, and conclusions were discussed over the period of research with the researcher's supervisors. Their advice and feedback assisted the researcher to establish the dependability of the research.
- **Peer examination**. Many aspects of the research were shared with the researcher's colleagues and feedback was received. The discussions included such aspects of the research as data collection, the process of analysis, findings, and obstacles during the research.
- **Triangulation**. For this research, two methods were used to compensate for the weaknesses of a single method. This method is considered to be a powerful solution to strengthen the research design.

3.5.7.4 Confirmability

Confirmability refers to the degree of objectivity of the research results (Polit & Hungler, 2004). It aims to exclude researcher bias, interest, or beliefs from the research findings (Shenton, 2004). In this research, confirmability was obtained by following procedures in data collection and analysis.

- **Detailed description of the methods used.** This description allows external auditors to follow the research path and understand the rationale behind the researcher's decisions (Krefting, 1991). The methods for this research are described in detail in this chapter.

- **Triangulation**. The use of several methods can improve confirmability. In this research, two methods were used to compensate for the weaknesses of a single method, which provided a powerful technique that can enhance the dependability of the research.

- **Quotations**. The key findings from the data analysis were supported by selected quotations from the interviews.

3.6   Ethical considerations

Before it is conducted, research must take into account important ethical issues. The main relevant ones include informed consent, participants' protection, respect for the anonymity of participants, privacy assurance, and the rights of vulnerable people (Fouka & Mantzorou, 2011). DiCicco-Bloom & Crabtree (2006) list four items that any researcher should consider when conducting an interview: minimise unexpected risk, protect the participants' information, explain the overall aims, explain the research design and method, and minimise the possibility of information misuse.

The researcher believes that a number of ethical problems are avoidable prior to beginning the research. Awareness of the significance of these ethical issues is the first step in avoiding problems of an ethical nature. Anticipating and discussing this matter with the respondents and relevant authorities should be completed before commencement of the research in the field. In this research, ethical requirements can be classified into three stages: before, during, and after data collection.

3.6.1   Before data collection

Ethical approval was obtained from the Human Ethics Committee at the University of Canterbury (Appendix 7). This committee made sure that the research provided for appropriate emphasis on all participants' rights, including cultural values and ethical principles, which include justice, safety, truthfulness, confidentiality, and respect. In addition, the committee evaluated the consequences of the research methodology for any ethical or legal issues. After obtaining Human Ethics Committee approval, the researcher contacted the Ministry of Health in Saudi Arabia to get written permission to conduct the research (Appendix 8). Although permission for the research was acquired, the medical cities had to approve the time period for the distribution of the questionnaires. Letters seeking permission were given to all designated hospitals, with a copy of

the approval letter from the Ministry of Health. Finally, permissions were obtained by the management of each medical city, which also agreed on the timeframe for the data collection.

3.6.2   During data collection

The researcher took into consideration the following ethical concerns: informed consent, respect for the privacy of participants, and the need to keep risk at a minimum.

- Informed consent

All participants were provided with an information sheet about the research written in understandable language. In addition, the sampling method took account of each patient's personal health situation, the severity of their condition, and their competence to give consent, as has been mentioned in the section on inclusion and exclusion criteria. In the qualitative section, the researcher asked all interviewees to sign the form or to give verbal permission before any data were collected. Sometimes in Arab countries, for cultural reasons, people are reluctant to sign consent forms but they are willing to take part in an interview. In this case, with the approval of the Human Ethics Committee, the researcher signed the form, noting that a full discussion had been held. In addition, the researcher explained to all participants the following details:

- The researcher's contact details
- The research procedures
- The overall aim of the research
- How the information would be treated during and after the research
- A participant's right to withdraw from the research at any time with no need to explain the reason
- A participant's right to ask for a copy of the final result of the research
- Respect for participants' privacy

Regardless of the significance of the research results, any participant's right is the first priority for the researcher. The researcher fully respected the participants' confidentiality before, during, and after the research process and took full responsibility for protecting all participant identification and personal information at all stages of the research and in all circumstances.

During the questionnaire process, all information obtained from the returned questionnaires was coded numerically to protect the anonymity of participants. In addition, all identification symbols, numbers, labels, personal details, or other traceable information were removed. Furthermore, all paper-based data were stored in locked storage at the University of Canterbury, and all electronic data were saved on a password-protected hard disk.

- Reduced risk

The participants were not exposed to any kind of risk as a result of being involved in this research.

3.6.3 After data collection

The researcher is responsible for reporting all information honestly and accurately. All soft and hard copies, tapes, papers, and transcripts related to the participants' information will be destroyed after 10 years, in accordance with the policies of the University of Canterbury.

In addition, the researcher has provided a dissemination plan developed to involve key stakeholders and to implement the findings from the present research. (see Appendix 9).

3.7 Conclusion

This chapter has discussed the four principal sections of the research, namely the research design, methods, data collection, and ethical considerations, and has outlined the direction of the research process.

The chapter began with a description of the research aims and objectives and an overview of the research design. The choice of design and strategy was supported by an explanation of the reasons for each decision. This discussion was followed by an account of the research strategy and framework. The choice of the convergent triangulation strategy was based on the purpose of the research. Because two different methods were combined, each method was elaborated separately. The collection of the quantitative data was achieved by using a cross-sectional survey questionnaire. The research setting and population studied were described, followed by an explanation of the sampling procedure. Next, the development of the questionnaire and pilot test were discussed. This section concluded with a brief explanation of the techniques used to analyse the quantitative data.

The next section focused on the key informant interviews and outlined the sampling procedures, strategy of selection, sample size, and the selection process. The development of the key informant interviews and interview procedures were explained, as was the method of qualitative data analysis. A full explanation of the ethical considerations was provided, including the guidelines followed before, during, and after the research process. The next chapter focuses on data analysis and findings.

Chapter 4: Research Results from the Cross-Sectional Surveys

4.1 Introduction

The aim of the research was to determine the readiness and ability of public hospitals to implement the Patient's Bill of Rights in Saudi Arabia, to identify the factors that may facilitate the implementation of the Bill, and also those that are constraints and are, therefore, barriers to its implementation. A further, related, aim was to understand the different perspectives of health professionals and patients regarding implementation of the Patient's Bill of Rights, and to examine the actual implementation of some selected fundamental patient rights.

The cross-sectional survey questionnaires were used to meet the objectives of the research. There were two versions of the questionnaire: one was completed by doctors and nurses, while the other was completed by patients. Each section of the questionnaire attempted to achieve one of the research objectives.

This chapter is divided into five main parts. The organisation of the chapter is shown in Figure 4.1. In the first section, the characteristics of the participants are introduced. This section is followed by an exploration of the extent to which the public hospitals were ready and able to implement the Bill, which includes identifying the concerns most frequently reported by respondents. Section 4.3 identifies the factors that facilitate the successful implementation of the Bill. In section 4.4, the barriers to implementation are discussed. The fifth section observes the actual implementation of basic patient rights in public hospitals. Finally, a conclusion to the results from the quantitative research is presented.
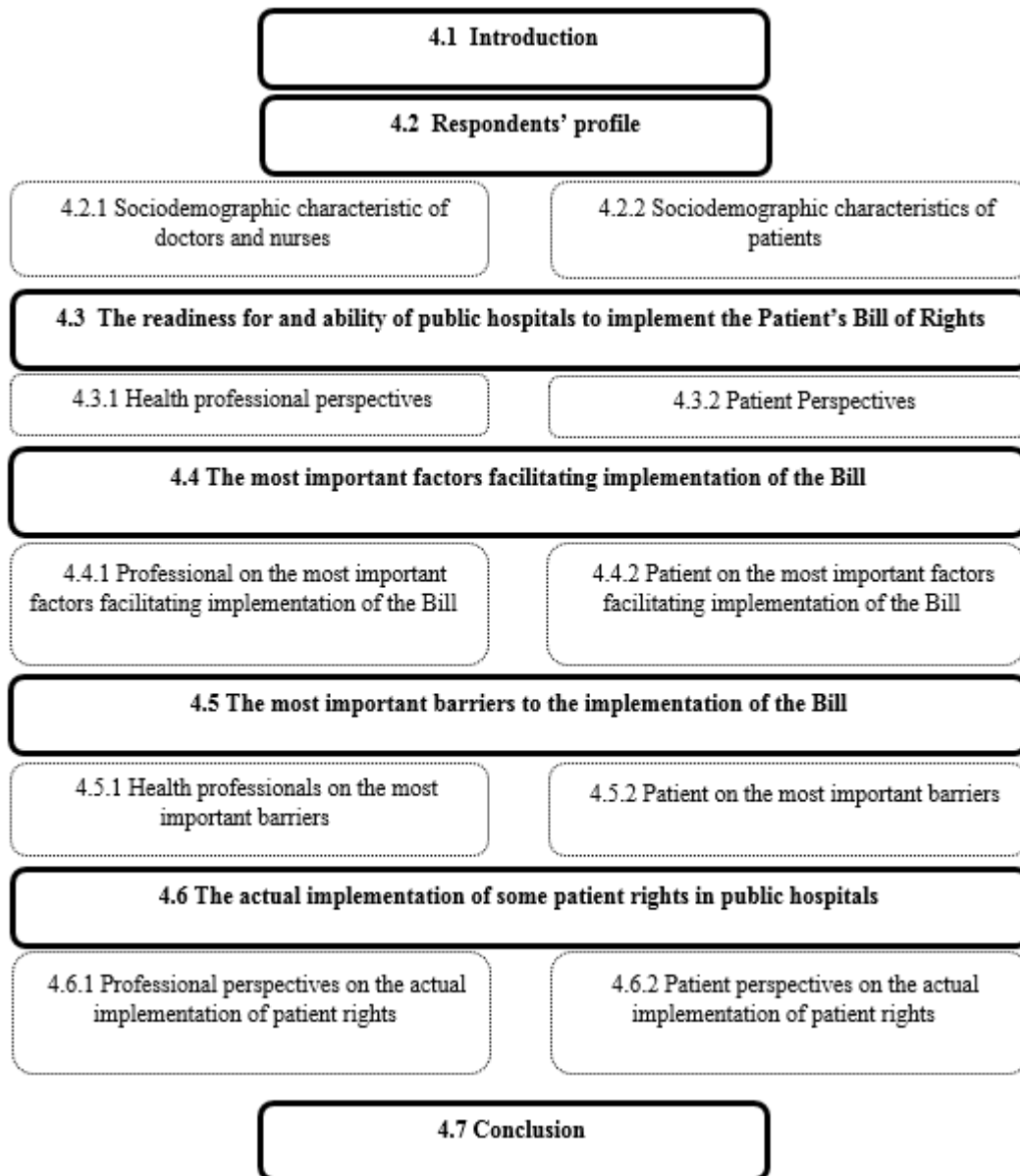
Figure 4.1. Outline of Chapter 4.

It was mentioned in Chapter 3 that the questionnaire was divided into five parts. The first covered sociodemographic variables. All variables in the other four parts of the questionnaire were scored on a 5-point Likert scale. The scale in Parts 2 and 3 was identical. As shown in Table 4.1, the answers on the 5-point Likert scale were merged into a 3-point scale for each variable in the questionnaire. This was done because of the low number of respondents in some cells and to give greater clarity to the findings.

Table 4.1 Amended Scale for the Doctors' and Nurses' Questionnaire

Section Number	Previous Scale	New Scale
Sections 2 & 5	4 – To a great extent 3 – To a moderate extent	3 – To a great or moderate extent
	2 – To a small extent 1 – No extent	2 – To a small or no extent
	0 – No information	0 – No information
Section 3	4 – Very important 3 – Moderately important	3 – Moderately to very important
	2 – Of minor importance 1 – Not important	2 – Of minor or no importance
	0 – No information	0 – No information
Section 4	4 – Extreme barrier 3 – Moderate barrier	3 – Moderate to major barrier
	2 – Minor barrier 1 – Not a barrier	2 – Minor barrier or not a barrier
	0 – No information	0 – No information

4.2 Respondents' profile

This subsection reports on the cross-sectional survey questionnaire of doctors, nurses, and patients. The sociodemographic characteristics of both the professionals and patients is summarised. The subsection has been divided into two main parts: the sociodemographic characteristic of doctors and nurses, and the sociodemographic characteristic of patients.

4.2.1 Sociodemographic characteristic of doctors and nurses

This part summarises the sociodemographic characteristics of the respondents. Table 4.2 shows the characteristics of the doctors and nurses based on sex, job title, age group, educational level, and experience. The main target group in the current research consists of professionals who speak Arabic because they are more exposed to the community and public media. Nevertheless, during the distribution of the questionnaire, the researcher was willing to give the departments the English version if they wanted it. In the end, the majority of the returned questionnaires were in Arabic, which indicates that the majority of participants were Saudi professionals. However, the effect of this on the results is unknown and future research may determine if this makes a significant difference or not.

Table 4.2 Professionals' Characteristics (Number and Percentage) (n=842)

Sociodemographic Variables		Doctors		Nurses	
		Number	%	Number	%
Sex					
	Male	212	73	78	14
	Female	78	27	467	86
	Total	290	100	545	100
Job title					
Doctors	Consultant	74	26		
	Specialist	147	50		
	Resident	71	24		
	Nurses			550	65
	Total	292	100	550	100
Age Group (years)					
	< 30	59	20	273	50
	30 – 40	100	34	160	30
	>40	132	46	110	20
	Total	291	100	543	100
Level of Education					
	Basic qualification*	10	3	246	45
	Post-basic degree**	122	42	221	41
	Postgraduate degree***	159	55	78	14
	Total	291	100	545	100
Experience (years)					
	≤ 5 years	99	34	225	41
	> 5 - 10	65	23	174	32
	>10	125	43	147	27
	Total	289	100	546	100

Key: * Basic qualification: for doctors, a Bachelor's degree; for nurses, a diploma (2 years of study after high school)

Key: ** Post-basic degree: for doctors, a Master's degree; for nurses, a Bachelor's degree

Key: *** Postgraduate degree: for doctors, a doctorate; for nurses, a Master's degree, or doctorate

Table 4.2 shows that a sample of 842 health professionals participated in this research: 292 (35%) doctors and 550 (75%) nurses, a ratio of 1.9 nurses per physician. The ratio of doctors to nurses who responded to the survey closely reflects the actual ratio of these health professionals in the two medical cities.

1) Sex

The data in the sex of respondents column given in Table 4.2 indicate that the majority of doctors were male (73%), whereas most nurses were female (86%). Hence, more women work as nurses than men, a typical finding worldwide. This result is close to the national ratio of doctors and nurses in public hospitals: male doctors total 75% and female nurses 79%.

2) Job title

With regard to job title, doctors included those with the title of consultant, specialist, and resident. The results show that half the doctors were specialists. The statistics indicated that of the 7,099 doctors in public hospitals Riyadh: 17% were consultants, 31% specialists, and 52% residents. Specialists formed the majority participating in this survey (Saudi Ministry of Health, 2014). This result was expected because even though the majority of doctors in hospital wards and departments were residents, these are the ones who usually do most of the daily work compared with consultants and specialists and, because they are busier than the other two groups, relatively few participated in the research. They are entrusted to carry out a variety of tasks, including the completion of the paperwork for patient admission and discharge, issuing medical reports, and examining patients in outpatient clinics and emergency departments.

3) Age group

The age of respondents in Table 4.2 was classified into three groups: under 30 years, from 30 to 40 years, and over 40 years. The table shows that of the three age groups, the over 40 year's age group was the one most represented among doctors (46%), whereas half the nurses were less than 30 years old. This may reflect the fact that it takes longer to train as a specialist doctor than it does to train as a nurse. Because of this, doctors (and those who are specialists requiring additional training) will generally be older than nurses. Another explanation may be that older nurses tend to leave their profession by taking managerial or administration roles.

4) Level of education

With regard to the respondents' level of education, the majority of doctors have a Master's degree, or higher qualification, while about half the nurses have a basic qualification. In the doctors' group, 55% had a postgraduate degree, about 40% had a post-basic degree, and just a few held only a medical Bachelor's degree. Among the nurses, in contrast, less than a quarter (15%) had a postgraduate degree, 40% held a Bachelor's degree, and almost half (45%) had

only a diploma. Less educated professionals tend to be younger, therefore, nurses are generally younger than doctors.

5) Experience

The level of experience among the doctor and nurse respondents varied. Most of the doctors had more than 10 years' experience, whereas 41% of the nurses had 5 years' experience or less. Because the majority of nurses had less experience, they tend to be younger than doctors. Overall, therefore, doctors were likely to be male, older, with more advanced qualifications and have greater experience than the nurses who participated in the survey.

4.2.2 Sociodemographic characteristics of patients

This part focused on the sociodemographic characteristics of patients and included the participants' sex, age, education, and length of hospitalisation. Table 4.3 shows the age distribution of patients' sociodemographic characteristics as a simple percentage.

Table 4.3 Patient characteristics (number and percentage) (n=334)

Sociodemographic Variables		Patients	
		Number	%
Sex			
	Male	169	51
	Female	161	49
	Total	330	100
Age Group (years)			
	< 30	139	42
	30 – 40	104	31
	>40	88	27
	Total	331	100
Level of Education			
	High school or less	160	48
	Diploma	67	20
	University degree	105	32
	Total	332	100
Length of Hospitalisation (days)			
	< 3 days	100	31
	> 3 - 10	104	33
	>10 days	115	36
	Total	319	100

During the implementation of this study, the total number of patients in both medical cities was 1,625 (745 patients in KFMC and 880 patients in KSMC) but, the total number of patients who participated in the survey was 334 (162 patients in KFMC and 172 patients in KSMC).

1) Sex

In general, the distribution of participants by sex was almost equal (51% male and 49% female). Because the researcher is male it was easy for him to have access to the male wards in the general and rehabilitation hospitals, whereas access to the female wards was very difficult for religious and cultural reasons. As a result, the number of male patients in the survey from these two hospitals was much higher than female patients. In contrast, in maternity hospitals, all the participants were female. A further difference occurred at the maternity hospitals because the male researcher, was not allowed to enter and the only possible way to distribute the questionnaire was through the nursing team.

2) Age group

The study contained a greater number of younger patients, aged 30 years or below (442%). About 30% of participants were between the ages of 30 and 40 years, and 27% of participants were 40 years or above (see Table 4.3). This is consistent with the fact that Saudi Arabia features a young population.

3) Level of education

Overall, the sample consisted mostly of respondents with high school qualifications or less. Table 4.3 reveals that 227 participants did not have a university degree, representing 68% of total participants and the remaining 32% of participants had obtained a university degree. This result is relatively similar to the national statistics; 19% of Saudi people has university degree while 52% of them has a lower education level. The remaining 29% are less than 18 years old and were, therefore, not included (General Authority for Statistics, 2016).

4) Length of hospitalisation

With regards to the length of hospitalisation, participants who had been hospitalised for more than 10 days made up 36% of the patients participating in this study. The next largest group was comprised of patients who had been hospitalised from 3 to 10 days, making up 33% of the total. Lastly, 100 patients were hospitalised for less than 3 days, representing 31% of the total number of patients.

4.3 The readiness and ability of public hospitals to implement the Bill

The purpose of this section is to determine professional and patient perspectives on the readiness and ability of public hospitals to implement the Bill in public hospitals in Saudi Arabia. Using the positive culture of the patient rights framework (Figure 1.3), the three different levels—macro (Ministry of Health), meso (hospital management) and micro (doctors, nurses and the staff of Patient Rights and Relations Departments) - were identified. The elements of community roles (the meso level) and patients' roles (micro level) were eliminated because there is no active roles for these two groups in the public hospitals in Saudi Arabia. This section covers the roles of the following four major groups (and levels) of providers: the Ministry of Health, hospital management, doctors and nurses, and the staff of Patient Rights and Relations Departments, as presented in Figure 4.2. The section also discusses the items most frequently reported by respondents, and the association between these items and sociodemographic variables to ascertain any differences in responses according to particular

characteristics. At the end of the section, there are items that assess the level of satisfaction of patients and health professionals with the implementation of the Bill in their hospitals.

Figure 4.2. The major groups recognised in the section.

This subsection is divided into two main parts. The first (4.3.1) addresses the perspective of professionals on the role of the key provider groups implementing of the Bill, and the second (4.3.2) reports the perspectives of patients on the roles of health provider groups.

4.3.1 Health professional perspectives

The items in this subsection can be classified into four roles: the Ministry of Health, hospital management, doctors and nurses, and the staff of Patient Rights and Relations Department. Figure 4.3 displays the various roles needed to implement the Bill in public hospitals.
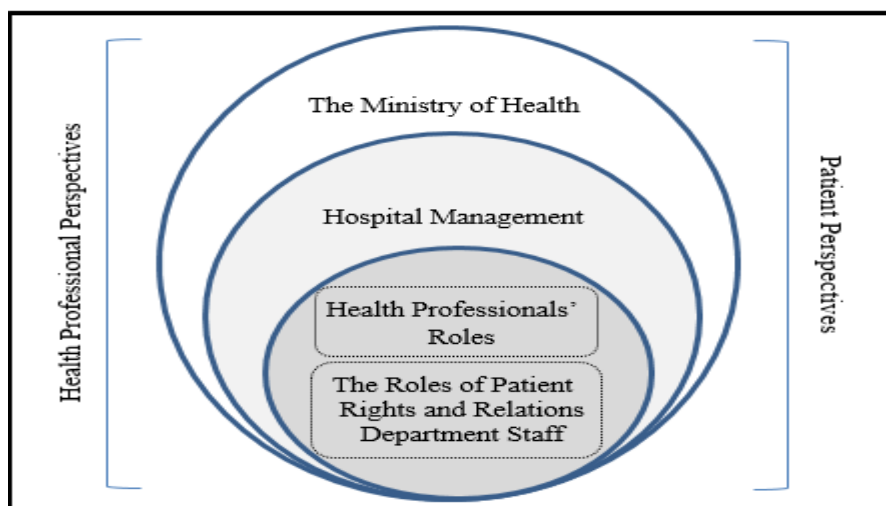
Figure 4.3. Important elements of the implementation of the Patient's Bill of Rights.

In Figure 4.3, the Ministry of Health roles represent the highest level of the implementation process. This is followed by the roles played by hospital management inside each organisation.

At the next level are the roles of two main actors for the successful implementation of the Bill; health professionals and the staff of Patient Rights and Relations Department.

Descriptive statistics for the variables relevant to each level, including the Ministry of Health, hospital management, health professionals, and the staff of Patient Rights and Relations Department, are presented in the Figures 4.4, 4.5, 4.6, 4.7, 4.8, 4.9, and 4.10. The relationships between selected items were tested using the chi-square test. Results in all figures and tables are presented as a percentage of respondents.

4.3.1.1 Perspective on roles of groups responsible for implementing the Bill
a) Ministry of Health role

With regard to the first level (Figure 4.3), the role of the Ministry of Health, there was a significant difference between doctors and nurses and the effective use of the media by the Ministry of Health that benefitted the implementation of the Bill. Figure 4.4 shows that the difference in response between doctors and nurses was statistically significant at $p<0.01$.

| | The Ministry of Health used the media effectively to increase awareness of the Bill at the local level** | | Senior management supports the implementation of the Patient's Bill of Rights | |
	doctors	nurses	doctors	nurses
to a great or a moderate extent	47.8	60.7	83.1	79.2
to a small or no extent	39.4	28.7	11.7	11.6
no information	12.8	10.6	5.3	9.2
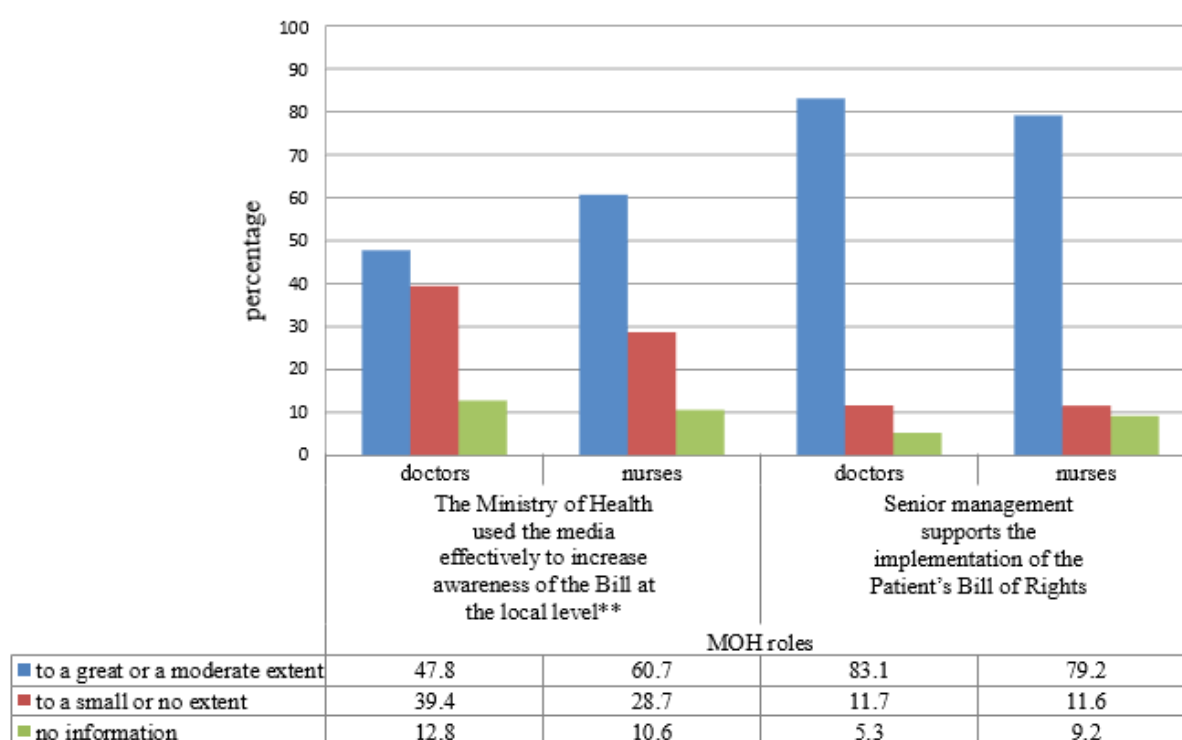
Key: * p< 0.05, ** p<0.01, *** p<0.001

Figure 4.4. Doctors' and nurses' assessment on roles of the Ministry of Health in implementing the Patient's Bill of Rights.

Figure 4.4 illustrates that over 60% nurses assessed the item as pleasant *to a great or moderate extent* while 47% of doctors had that view. In contrast, nearly 40% of doctors rated it poorly (*to a small or no extent*) compared with 28% of nurses who agreed. This result suggest that the

114

usage of media was hardly implemented by the Ministry of Health; however, doctors seemed to expect more effort from the Ministry of Health to use the media to promote the Bill. This makes sense because the more education people have, the greater their expectations.

In addition, 12.8% of doctors and 10.6% of nurses claimed to lack information on how effectively the Ministry of Health used the media. This clearly indicates the low effort made by the Ministry of Health to publicise the Bill. The result could also show the low involvement of health professionals in promoting the Bill in public.

In terms of the support from senior management at the Ministry of Health, both doctors and nurses rated it favourably (*to a great or moderate extent*). There was no significant difference between the respondents' views on the support from senior management. This suggests that the health professionals thought that there was a high level of support from the Ministry of Health to implement the Bill in public hospitals.

b) Hospital management role

With regard to the second level (Figure 4.3), hospital management, eight items were examined. As illustrated in Figure 4.5, six of eight items in the hospital management's roles showed a statistically significant difference between doctors and nurses. For all six items, nurses largely agreed in marking the items relatively highly (*to a great or moderate extent*), which sits in contrast with doctors. This may suggest that the courses provided early in the implementation phase to nurses make them more likely to notice the effort and the progress of the implementation of the Patient's Bill of Rights.

Figure 4.5 shows that nurses generally were more positive about most items than doctors, with one exception. Only one item was rated more positively by doctors than nurses – that the staff are qualified to implement the Bill. There was no significant difference between their views on this statement.

The extent of collaboration between hospital management and outside organisations in implementing the Bill was seen by over 65% of nurses and only about 45% of doctors as *to a great or moderate extent*. This result may give the impression that overall, doctors were unsure whether their hospitals collaborated with other local organisations or not. Another possible reason may be that many doctors were seeking a certain quality of collaboration; however, this item was the only one where a lack of information so high. This shows the low of involvement of both doctors and nurses in the implementation of the Bill.

	There are collaboration between hospital management and outside organisations in implementing the Bill***		Qualified staff required to implement the Bill are avaliable		There is sufficient number of staff to implement the Bill		There are sufficient supportive materials to implement the Bill**		Health Professionals are provided with information about the benefits of the implementation of the Bill***		Our department held regular discussions on issues relating to patient rights***		There are some kind of request for health professionals' feedback about the implementation of the Bill***		Health professionals know their roles and responsibilities in the implementation of the Bill***	
	doctors	nurses	doctors	nurses	doctors	nurses	doctors	nurses	doctors	nurses	doctors	nurses	doctors	nurses	doctors	nurses
to a great or a moderate extent	45.7	65.6	81.3	80.8	62.6	66.1	67.8	75.7	57.9	69.1	57.1	71.8	43.9	64.7	69.7	82.6
to a small or no extent	38.8	22.1	16.2	15.0	34.2	28.7	30.1	20.5	36.8	23.5	40.1	21.5	52.3	28.1	26.1	12.6
no information	15.6	12.2	2.5	4.2	3.2	5.2	2.2	3.8	5.3	7.4	2.8	6.7	3.9	7.2	4.2	4.8

Hospital management roles

Key: * p< 0.05, ** p<0.01, *** p<0.001

Figure 4.5. Doctors' and nurses' assessment of the roles played by hospital management in implementing the Patient's Bill of Rights.

There were three items that addressed the availability of required resources, the availability of qualified staff, the number of staff, and supporting materials. Of these items, the professionals showed a statistically significant difference for only one item. This was the availability of supporting material, which the majority of nurses (75.7%) rated favourably (*to a great or moderate extent*) whereas 67.8% of doctors indicated that; however, both groups of professionals had the same perspective on the remaining two items. Both doctors and nurses greatly agreed that the staff in their hospitals are qualified to implement the Bill. They were less confident that there were a sufficient number of staff required for the implementation process. The result also showed that nurses were more positive about the availability of supportive materials. The early workshops and lectures provided to nurses may make them more positive about this than doctors. Doctors may differ from nurses in what they consider sufficient and the quality required. This may relate to the differing levels of education between doctors and nurses.

Professionals believed that they had been well provided with information about the benefits of the implementation of the Bill (*to a great or moderate extent*) by about 70% of the nurses and 60% of the doctors. Conversely, there was a relatively large percentage of doctors (more than 35%) who assessed the information they received to be poor (*to a low or no extent*). This result may reflect the fact that at the beginning of the implementation of the Bill the focus was primarily on educating the nurses, rather than the doctors.

More than 70% of nurses reported that their department held regular discussions on issues relating to patient rights. This was only applicable to 57% of doctors, but 40% of doctors indicated that the presence of such discussion was small or non-existent. A possible explanation for this is that each professional team in every department has their own meetings. The result may support the possibility that nurses discuss more issues related to patient rights in their meetings, but that doctors concentrated more on treatment options and medical interventions than patient rights.

There was a significant difference between doctors and nurses with regard to the request for professionals' feedback. About 65% of nurses agreed that some kind of request for health professionals' feedback about the implementation of the Bill had been made *to a great or moderate extent*, whereas only about 45% of doctors shared this view. In contrast, more than half the doctors (52.3%) revealed that requests by hospital management for health professionals' feedback were minimal or non-existent. This result may reflect the presence of

some resentment towards the request for feedback before and during the implementation process and may indicate the doctors' reaction as they believed the importance of the role of health professionals was ignored by hospital management.

Education of health professionals is one of the main roles of hospital management. Over 80% of nurses but less than 70% of doctors assessed the knowledge that professionals have about their roles and responsibilities in the implementation process as present *to a great or moderate extent*. In contrast, more than 25% of doctors and only 12% of nurses indicated that health professionals' knowledge was small or non-existent. The differences between doctors and nurses in this item were statistically significant. This result also reflected the value of educating nurses at the first stage of the implementation of the Bill.

c) Health professionals' role

	doctors	nurses	doctors	nurses	doctors	nurses	doctors	nurses
	There is a serious commitment from health professionals to achieve the goals of the Bill		Health professionals have positive attitudes towards patient rights*		Health professionals confidently answer patients' questions about the Bill***		Health professionals show respect for the roles of the Patient Rights and Relations department**	
■ to a great or a moderate extent	75.4	82.2	77.7	82.8	66.6	80.6	75.0	84.3
■ to a small or no extent	17.3	11.4	17.5	11.0	30.3	12.8	19.8	10.2
■ no information	7.4	6.5	4.8	6.2	3.1	6.5	5.2	5.5

Key: * p< 0.05, ** p<0.01, *** p<0.001

Figure 4.6. Doctors' and nurses' assessment on roles of health professionals in implementing the Patient's Bill of Rights.

Figure 4.6 shows that nurses were more positive than doctors concerning all items that related to the roles of health professionals. For three of four items, there were statistically significant differences between doctors and nurses and only one item had no significant difference

118

between the two views – the presence of serious commitment from health professionals to achieve the goals of the Bill.

When doctors and nurses were asked about whether health professionals have positive attitudes towards patient rights, the majority of nurses (82.8%) reported that professionals *to a great or moderate extent* have a positive attitude towards the implementation of the Bill while 77.7% of doctors held the same view.

With regard to the confidence that health professionals have about their knowledge and skills in terms of patient rights, 80.6% of nurses stated that health professionals had a *great or moderate level* of confidence whereas 66.6% of doctors shared that view. In contrast, 30.0% of doctors and 12.8% of nurses indicated that the level of health professionals' confidence to be at a *low level or non-existent*. An explanation of these results may be that nurses received more introductory lectures and training at the beginning of the application of the programme. These measures resulted in nurses being better prepared and more familiar with the implementation process.

Doctors and nurses were asked about whether health professionals show respect for the roles of the Patient Rights and Relations Department. Nearly 85% of nurses indicated that health professionals respected the department was *great or moderate* while only 75% of doctors expressed the same point of view. On the opposite end of the scale, about 20% of doctors rated the respect as low *to a small extent or no extent* compared to only 10% of nurses, who shared the same opinion. The difference between doctors and nurses was statistically significant, possibly because nurses work closely with the staff of Patient Rights and Relations Department and are more aware of the work they do.

d) The role of Patient Rights and Relations Department staff

On the next level, dealing with views on the support and contribution of the staff of Patient Rights and Relations Department, there were statistically significant differences between the views of doctors and nurses in both items. Figure 4.7 shows that nurses were more positive than doctors concerning all items that related to the roles of the staff of Patient Rights and Relations Department.

	doctors	nurses	doctors	nurses
to a great or moderate extent	64.9	75.0	65.9	74.7
to a small or no extent	26.8	19.1	25.2	17.6
no information	8.2	5.9	9.0	7.8
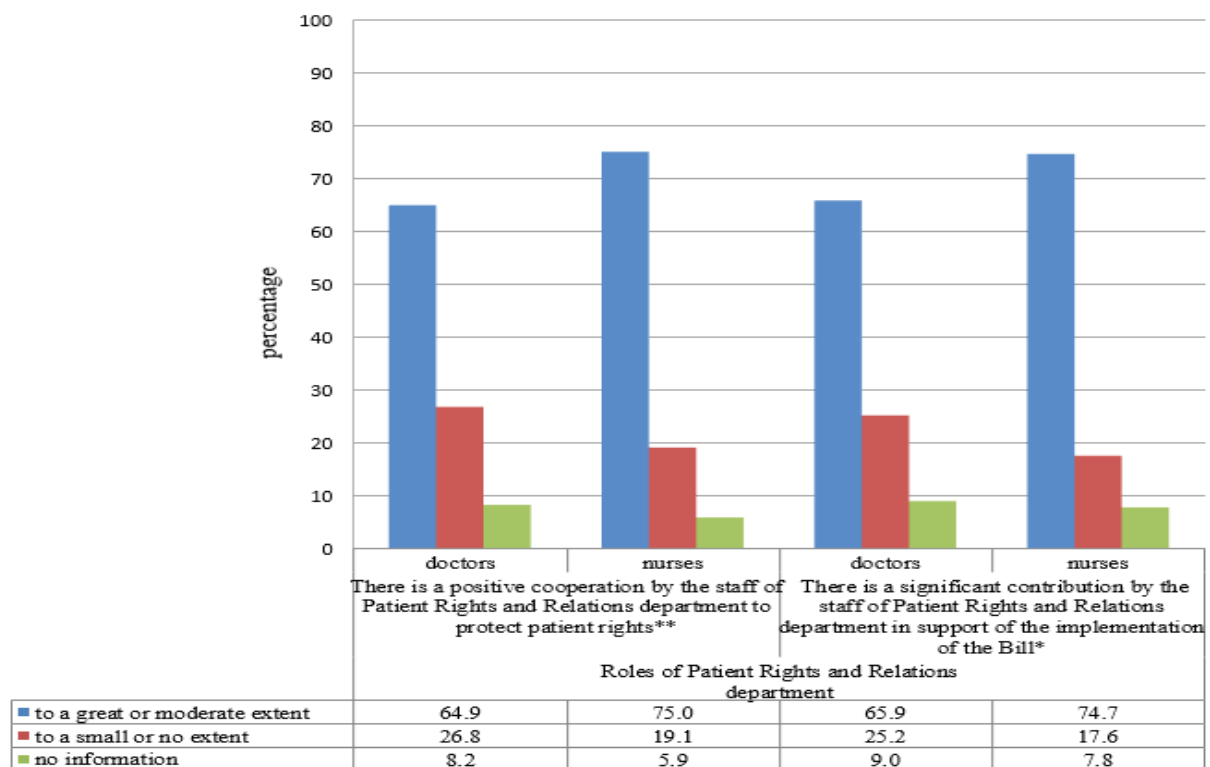
Key: * p< 0.05, ** p<0.01, *** p<0.001

Figure 4.7. Doctors' and nurses' assessment on roles of the staff of Patient Rights and Relations Department in implementing the Patient's Bill of Rights.

Nearly 75% of nurses rated the presence of positive cooperation by the staff of Patient Rights and Relations Department to protect patient rights as at a *great or moderate* level, whereas 65% of doctors had same view. However, a number of nurses and doctors (20% and 27%, respectively) stated that cooperation from them was *poor or non-existent*.

To the question whether the contribution of the staff of Patient Rights and Relations Department in support of the implementation of the Bill was significant, 75% and 65% of nurses and doctors, respectively, rated it as *great* or *moderate*. However, more than 25% of doctors and about 20% of nurses thought their contribution was *small or non-existent*. These findings reflect the perspective of professionals towards the value added by the staff of Patient Rights and Relations Department in the implementation process. The reason for the high ratio of nurses, compared to doctors, who believed the contribution of the staff of Patient Rights and Relations Department to be positive may be that nurses work more closely with the Department, giving nurses the opportunity to watch their performance closely. Although a significant number of professionals noted the positive contribution of the staff of Patient Rights and Relations Department, others indicated the opposite. The reason may be that the new administration, and perhaps the employees also, are still in the early years of their work in this department.

4.3.1.2 Perspective on professionals' assessment of the implementation

Doctors and nurses were asked to assess the overall satisfaction of health professionals and patients with the implementation of the Patient's Bill of Rights in their hospitals.

	doctors	nurses	doctors	nurses
	Patients are satisfied with the level of implementation of the Patient's Bill of Rights**		Health professionals are satisfied with the level of implementation of the Patient's Bill of Rights	
	Professionals and patients assessments			
to a great or moderate extent	62.6	74.1	67.9	72.7
to a small or no extent	23.9	16.9	24.1	18.6
no information	13.5	9.0	7.9	8.7
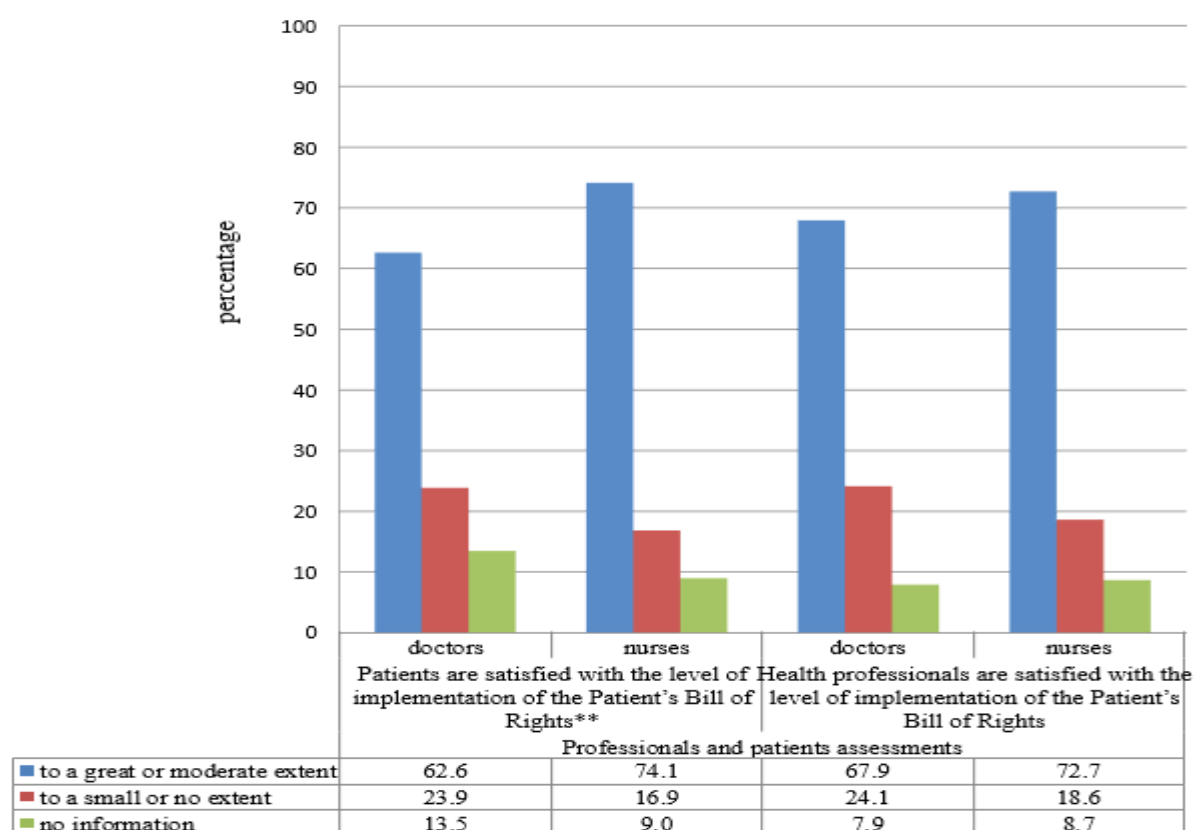
Key: * p< 0.05, ** p<0.01, *** p<0.001

Figure 4.8. Doctors' and nurses' assessment of the Professionals and Patients' satisfaction with the Implementation of the Patient's Bill of Rights.

As shown in Figure 4.8, the responses by the health professionals showed that most felt that both professionals and patients were slightly satisfied with the implementation of the Bill in hospitals.

When doctors and nurses were asked whether patients were satisfied with the implementation of the Bill, 74.1% of nurses and 62.6% of doctors indicated that was the case but 16.9% of nurses and 23.9% of doctors rated patient satisfaction at a low. This is a statistically significant difference between the views of doctors and nurses for this item. In contrast, doctors and nurses rated the level of health professionals' satisfaction about the implementation of the Bill at a *great* or *moderate* level but 24% of doctors and 18.6% of nurses had the opposite view.

121

4.3.1.3 Items most frequently reported by doctors and nurses

(a) Items most frequently rated as implemented to a great or moderate extent

Figure 4.9 shows the top four items according to both doctors and nurses. The four items most frequently assessed by professionals as perceived *to a great or moderate extent* were related to the health professional level (three items) and the hospital management level (one item).
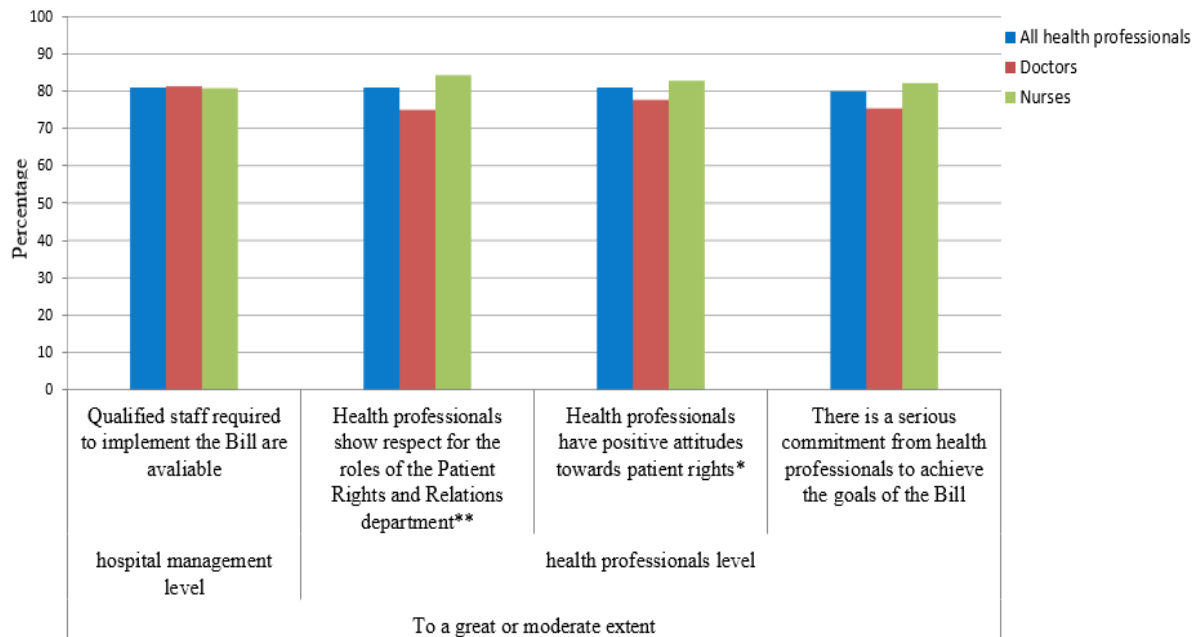
Key: * p< 0.05, ** p<0.01, *** p<0.001

Figure 4.9. Items most frequently rated by doctors and nurses as implemented to a great or moderate extent.

As shown in Figure 4.9, doctors and nurses rated the following four items *to a great or moderate extent*.

- The qualified staff required to implement the Bill are available
- Health professionals show respect for the roles of the Patient Rights and Relations Department
- Health professionals have positive attitudes towards patient rights
- There is a serious commitment from health professionals to achieve the goals of the Bill

The high scores given to the three items that relate to the role of health professionals show that they believe that current staff are qualified, committed, have a positive attitude, and they are also respectful of the role of the staff of Patient Rights and Relations Department. This result may show that the majority of respondents considered that health professionals are qualified to

apply the Bill. This result may also indicate that doctors and nurses believe that they are fulfilling their roles as required for most of the variables in the study and that the shortcomings, if any, can be attributed to other parties in the hospitals. There were statistically significant differences between doctors and nurses on their views about two items "Health professionals show respect for the roles of the Patient Rights and Relations Department" and the item "Health professionals have a positive attitude towards patient rights".

As shown in the bar graph Figure 4.9, nurses placed greater emphasis on those aspects related to professionals' attitudes, such as respect, a positive attitude, and commitment, whereas doctors placed more stress on the factors related to the availability of qualified professionals. These can be seen clearly in the spider chart below (Figure 4.10).
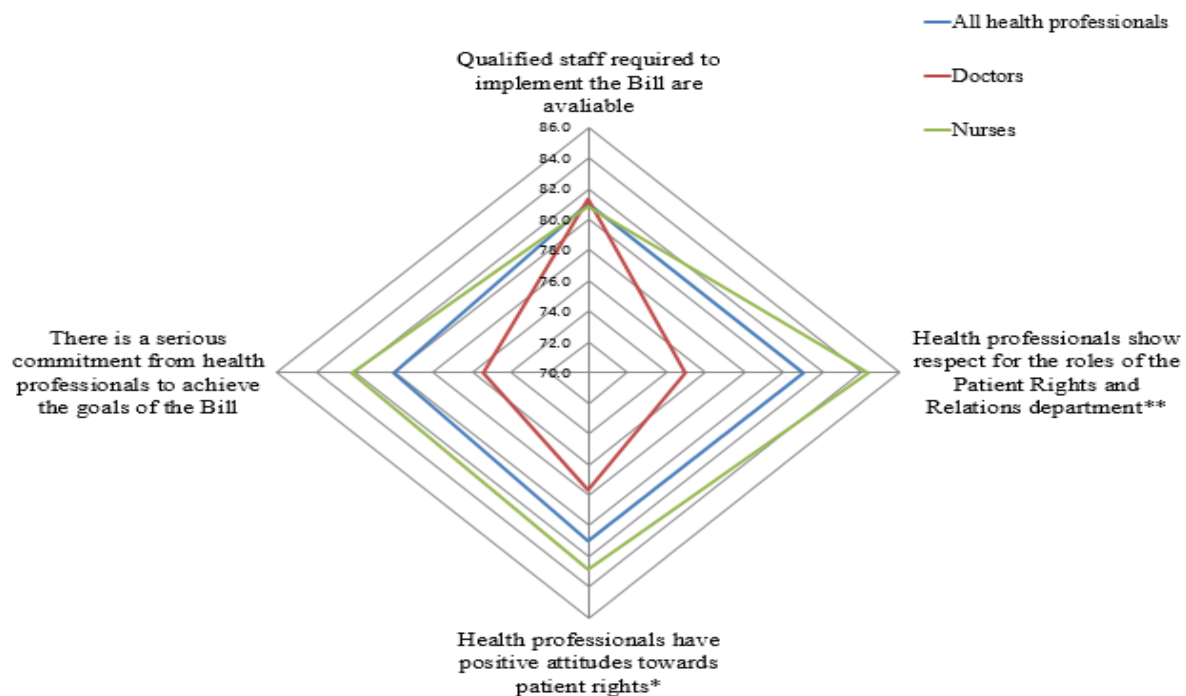
Figure 4.10. Spider chart showing a comparison between doctors and nurses for items most frequently marked to a great or moderate extent.

The spider chart (Figure 4.10) represents the viewpoint of doctors and nurses separately for the variables most frequently assessed as being present to a *great or moderate extent*. It clearly illustrates some discrepancies between doctors and nurses for three items. These items are related to the commitment from professionals to achieve the goals of the Bill, the respect of professionals for the role of Patient Rights and Relations Department, and the positive attitude of professionals towards patient rights.

There was no discrepancy between the views of doctors and nurses on one item, and that was on the availability of qualified staff to implement the Bill in hospitals.

123

Association between sociodemographic variables and key roles attributes

A chi-square analysis was performed to determine any significant association between the items most frequently rated *to a moderate or to a great extent* and the sociodemographic characteristics of respondents. The result confirmed that profession was the only variable that was significantly related to two of the items most frequently rated as implemented *to a great or moderate extent*. These two items and their associations with the respondents' job title are shown in Table 4.4.

Table 4.4 Chi-square Analysis of the Association between Respondents' Profession and their View of Items Most Frequently Rated as Implemented to a Great or Moderate Extent

Item	To a great or moderate extent	$\chi 2$	df	Sig.
	n (%)			
Health professionals show respect for the roles of the Patient Rights and Relations Department				
		14.755	2	.001*
Doctors	216 (75)			
Nurses	461 (84.3)			
Health professionals have positive attitudes towards patient rights				
		7.348	2	.025*
Doctors	226 (77.7)			
Nurses	451 (82.8)			

Key: * p< 0.05, ** p<0.01, *** p<0.001

The two items professionals most frequently rated as present *to a great or moderate extent* had to do with respect and having a positive attitude. A higher percentage of nurses than doctors assessed the two items highly *to a great or moderate extent*.

Almost 85% of nurses declared that they had *great or moderate* respect for the role played by the staff of the patient rights department. In contrast, 75% of doctors held the same view. The chi-square analysis result was statistically significant (χ^2 (2, N=835) = 14.755, p<.001). Although there was still a high level of respect by both doctors and nurses for Patient Rights and Relations Department, for nurses this respect was significantly greater compared to the doctors' reported viewpoint. This result may be due to the fact that both nurses and the staff of Patient Rights and Relations Department work closely with patients and are consequently more attached to them. This encourages a closer relationship between nurses and the staff of Patient Rights and Relations Department and promotes regular communication with them on a daily basis.

124

Furthermore, there was a statistically significant difference on the basis of profession for the item, concerning the attitude of professionals towards patient rights (χ^2 (2, N=836) = 7.348, p<.025). About 82.3% of nurses rated the positive attitude shown by health professionals relatively highly (*to a great or moderate extent*) whereas 77.7% of doctors held the same view. These results show that nurses assessed the attitude of professionals towards patient rights to be more positive than did doctors. This may be because nurses have a different perspective from that of doctors due to the Ministry of Health beginning the implementation of the Bill with a large number of intensive courses and programmes for nurses.

(b) Items most frequently rated as implemented to a small or no extent

There were six items which were most frequently selected by professionals and rated as present to a small or no extent. These items were associated with the Ministry of Health and the role of hospital management (Figure 4.11).
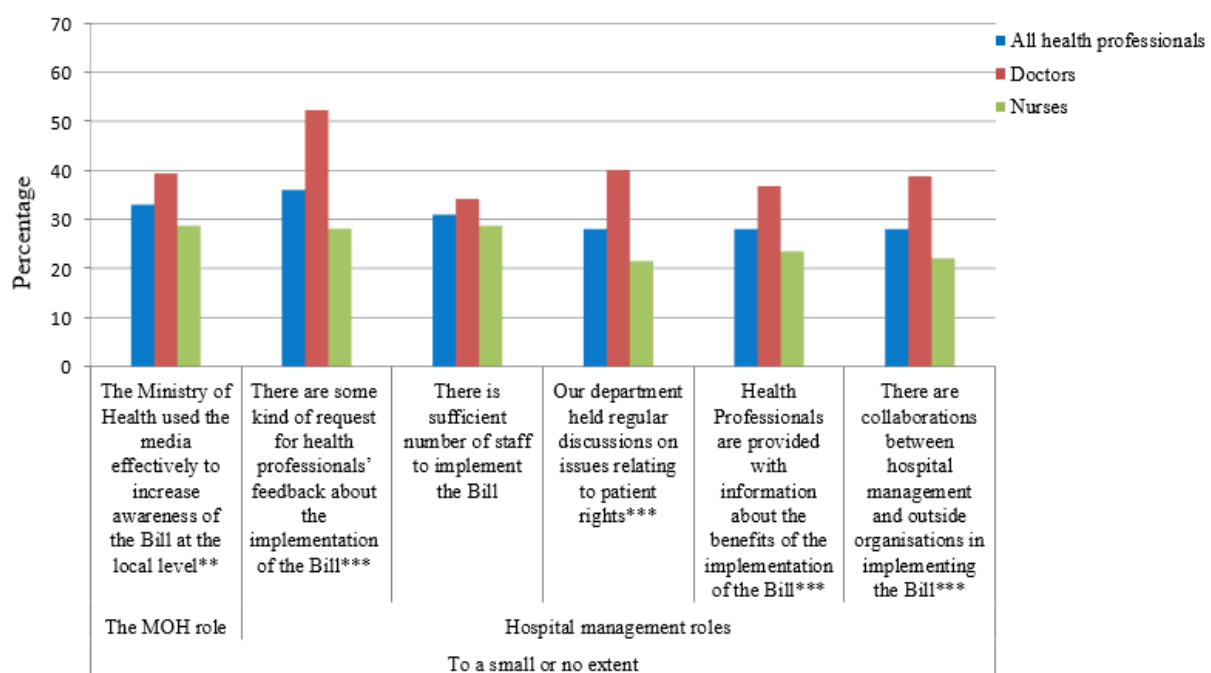
Key: * p< 0.05, ** p<0.01, *** p<0.001

Figure 4.11. Items most frequently rated by doctors and nurses as implemented to a small or no extent.

The following six items were given a low rating by health professionals (*to a small or no extent*) as shown in Figure 4.11.

1. The Ministry of Health used the media effectively to increase awareness of the Bill at the local level.
2. There are minimal requests for health professionals' feedback about the implementation of the Bill.

125

3. The number of staff required for the implementation of the Bill is inadequate.

4. Our department held regular discussions on issues relating to patient rights.

5. Health professionals are provided with information about the benefits of the implementation of the Bill.

6. There is collaboration between hospital management and outside organisations in implementing the Bill (e.g. community representatives, government and civic organisations).

The results show that the primary concern of health professionals was mainly with management behaviours and practice.

The following spider chart (Figure 4.12) shows a comparison between the viewpoint of doctors and nurses for the most frequent variables assessed as minimally present (*to a low or to no extent*). Compared to nurses, doctors, generally speaking, provide a higher proportion of responses across all variables, their line being consistently closer to the outer perimeter of the spider chart.
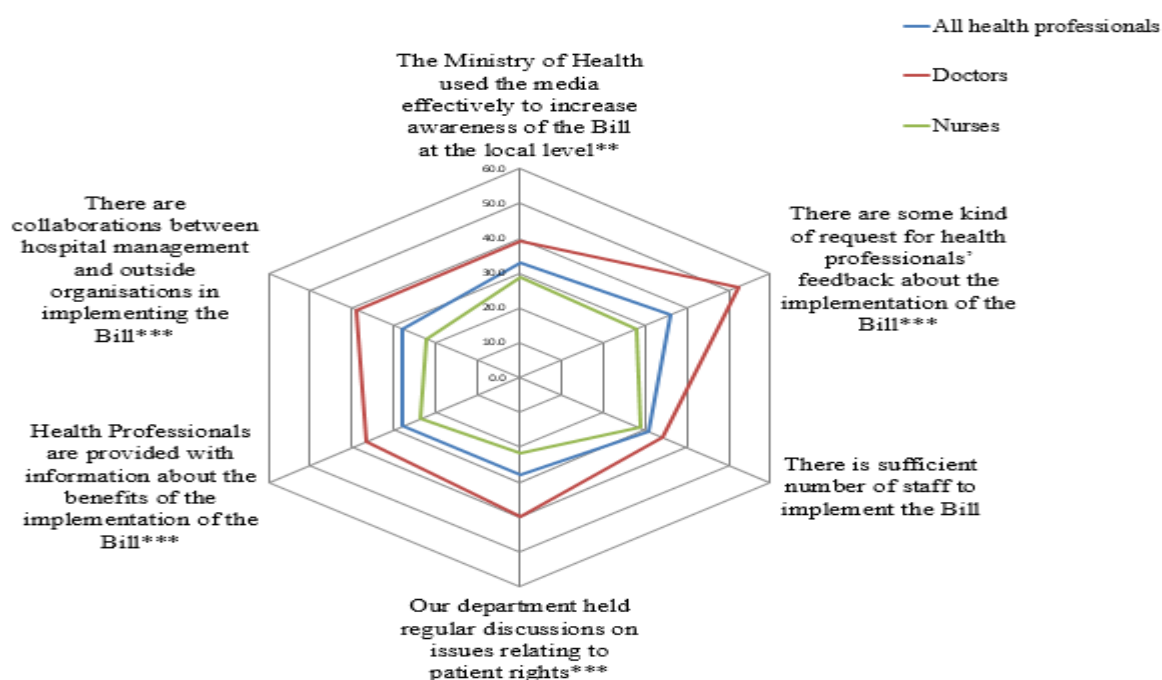
Figure 4.12. Spider chart of roles most frequently rated by doctors and nurses as implemented to a small or no extent.

The spider chart (Figure 4.12) represents the viewpoint of doctors versus nurses for the most frequent variables assessed as being present to a *small or no extent*. The figure clearly shows that the perceptions of doctors and nurses are mostly similar across all items. Overall, the average scores of professionals in this study were low for these items. There was one item for

126

which both doctors and nurses shared almost the same perspective; the number of staff required for the implementation of the Bill is inadequate.

Association between sociodemographic variables and key role attributes

The six most frequently reported items were examined to discover if there is any significant association between these items and the sociodemographic variables of respondents (sex, job title, age, education level, and experience). Chi-square tests show several statistical associations between five of the six items most frequently receiving a low rating (to a small or no extent) and health professionals' profession, level of education, and years of experience. These statistically significant associations are reported (Tables 4.5, 4.6, and 4.7).

Table 4.5 Chi-square Analysis of the Association between Respondents' Profession and Their View of the Items Most Frequently Rated as Implemented to a Small or no Extent

Item	To a small or no extent	χ^2	df	Sig.
	n (%)			
There are some kind of request for health professionals' feedback about the implementation of the Bill				
		47.476	2	.000***
Doctors	125 (44)			
Nurses	153 (28)			
The Ministry of Health used the media effectively to increase awareness of the Bill at the local level				
		13.174	2	.001***
Doctors	114 (39)			
Nurses	157 (29)			
Our department held regular discussions on issues relating to patient rights				
		35.403	2	.000***
Doctors	116 (40)			
Nurses	118 (21.5)			
Health Professionals are provided with information about the benefits of the implementation of the Bill				
		16.634	2	.000***
Doctors	105 (37)			
Nurses	128 (23.5)			
There are collaborations between hospital management and outside organisations in implementing the Bill				
		33.152	2	.000***
Doctors	112 (39)			
Nurses	121 (22)			

Key: * p< 0.05, ** p<0.01, *** p<0.001

Table 4.5 shows all five items had statistically significant associations with the respondents' profession. Nearly 45% of doctors revealed that requests for feedback by health professionals was minimal or non-existent compared with only 28% of nurses who had the same view. The chi-square result shows that there was a statistically significant difference between doctors and nurses (χ^2 (2, N=829) = 47.476, p<.000). This may reflect a general feeling among doctors that management underestimates their interest or role in the implementation of the Bill.

As shown in Table 4.5, the second item most frequently marked *to a small or no extent* or as being absent altogether was the promotion of the Bill through the Ministry of Health's use of the media. Approximately 40% of doctors gave the effective use of the media to promote the Bill a low rating (*to a small or no extent*). In contrast, fewer than 30% of nurses shared the same view. The chi-square result showed that there was a significant difference between doctors and nurses in their assessment of the Ministry of Health's role in promoting the Bill (χ^2 (2, N=836) = 13.174, p<.001). A large number of doctors indicated that they did not observe any success in the media campaigns to promote the Bill.

The third variable in the list focused on educating health professionals by means of regular discussion in each department about patient rights issues (Figure 4.11). Forty percent of doctors classified the frequency of discussions in their department about Bill issues to be minimal (*to a small or no extent*), compared with only about 20% of nurses. There was a statistically significant difference between doctors' and nurses' responses (χ^2 (2, N=839) = 35.403, p<.000). It is possible that discussion related to patient rights were minimal during doctors' meetings because these would often focus on patient cases and their treatment plans.

Table 4.5 sets out the fourth variable on the list of most frequently rated as implemented to a *small or no extent*: Health professionals are provided with information about the benefits of the implementation of the Bill (Figure 4.11). Thirty seven percent of doctors rated the information provided to health professionals about the Bill was *to a small or no extent*, whereas fewer than 25% of nurses expressed the same view. There was a significant difference between doctors and nurse perceptions of the information provided (χ^2 (2, N=827) = 16.634, p<.000). Doctors' assessment of the previous item about their low level of involvement is reflected in this. They report that they were not provided with information as to how the implementation of the Bill might have a positive effect on their work.

The last item that was reported to a *small or no extent* was about the presence of collaboration between hospital management and other organisations throughout the implementation process

(Figure 4.11). Doctors, more than nurses, assessed the extent of collaboration to be insignificant (*to a small or no extent*). Forty percent of doctors, compared with about 20% of nurses, stated that collaboration by hospital management with other organisations was minimal (*to a small or no extent*). The chi-square result shows that there was a statistically significant difference between the two groups (χ^2 (2, N=836) = 33.152, p<.000). This result can be linked to the absence of information concerning implementation and the lack of involvement reported by doctors in the hospitals.

Table 4.6 Chi-square Analysis of the Association between Respondents' Educational Level and Their View of the Items Most Frequently Rated as Implemented to a Small or no Extent

Item	To a small or no extent	χ^2	df	Sig.
	n (%)			
Some requests have been made for health professionals' feedback about the implementation of the Bill				
		16.224	2	.003**
Basic qualification	87 (34)			
Post-basic degree	110 (32)			
Postgraduate degree	105 (45)			
Mann-Whitney test	Basic qualification * Postgraduate			.024*
Mann-Whitney test	Post-basic degree * Postgraduate			.045*
Our department held regular discussions on issues relating to patient rights				
		12.665	4	.013*
Basic qualification	69 (27)			
Post-basic degree	80 (23)			
Postgraduate degree	85 (36)			
Mann-Whitney test	Basic qualification * Postgraduate			.021*
Mann-Whitney test	Post-basic degree * Postgraduate			.005**

Key: * p< 0.05, ** p<0.01, *** p<0.001

With regard to the level of education and the extent of the request for health professionals' feedback, Table 4.6 demonstrates the chi-square result, which shows that there was a statistically significant difference between professionals on the basis of their level of education (χ^2 (2, N=829) = 47.476, p<.000). Forty-five percent of doctors and nurses with a postgraduate degree indicated that generally speaking health professionals were asked for their feedback only *to a small or no extent*, while no more than 35% of doctors and nurses with less than a postgraduate degree held the same view. The result shows that professionals with a

postgraduate degree might have thought that a higher level of feedback would be desirable. Professionals with a high level of education may think they should play a greater role in the implementation process and the result may also reflect the level of disappointment in response to management's failure to involve them.

As shown in Table 4.6, the second item most frequently rated *to a small or no extent* was the extent of regular discussions about issues relating to the implementation of the Bill according to the education level of professionals, and these results showed a statistically significant difference. Mann-Whitney tests was used to assess whether two independent groups are significantly different from each other. More than 35% of professionals with postgraduate degrees indicated that there was some regular discussion of the subject to a small or lesser extent, whereas 27% or less of individuals in other groups shared this view (χ^2 (4, N=833) = 12.665, p<.013). From these results, it can be concluded that respondents with a higher level of education may have been frustrated with the low amount of regular discussion about the implementation of the Bill.

Table 4.7 Chi-square Analysis of the Association between Respondents' Experience and Their View of the Items Most Frequently Rated as Implemented to a Small or no Extent

Item	To a small or no extent	χ^2	Df	Sig.
	n (%)			
The Ministry of Health used the media effectively to increase awareness of the Bill at the local level				
		12.209	4	016*
5 years or less	119 (37)			
From 5 to 10 years	70 (29)			
More than 10 years	81 (30)			
Mann-Whitney test	5 years or less * from 5 to 10 years			.014*

Key: * p< 0.05, ** p<0.01, *** p<0.001

There was a significant difference between professionals who had less experience compared with those who had more. Nearly 40% of professionals with 5 years of experience or less rated the Ministry of Health's use of the media poorly (*to a small or no extent*), whereas only 30% of professionals with more experience held the same view. This result was statistically significant (χ^2 (4, N=829) = 12.209, p<.016). It may indicate that professionals with less experience want to see more use made of the media than is currently the case.

4.3.2 Patient perspectives

4.3.2.1 Perspective on the roles of groups responsible for implementing the Bill

The patients' perspectives were also sought on aspects of the roles the various groups played in the implementation of the Bill. The macro level (the Ministry of Health) was not assessed because in-patients have no direct contact with the Ministry level so are unable to evaluate. Therefore, according to the positive culture of patient rights framework (Figure 1.3), the remaining relevant two levels are the meso level (hospital management) and the micro level (doctors, nurses and the staff of Patient Rights and Relations Departments). Patients were asked about three groups: hospital management, health professionals, and the staff of the Patient Rights and Relations departments. One item was added to discover the assessment of patients concerning the readiness and ability of public hospitals to implement the Bill. Figure 4.13 shows the various important roles needed to implement the Bill in hospitals from a patient's perspective.
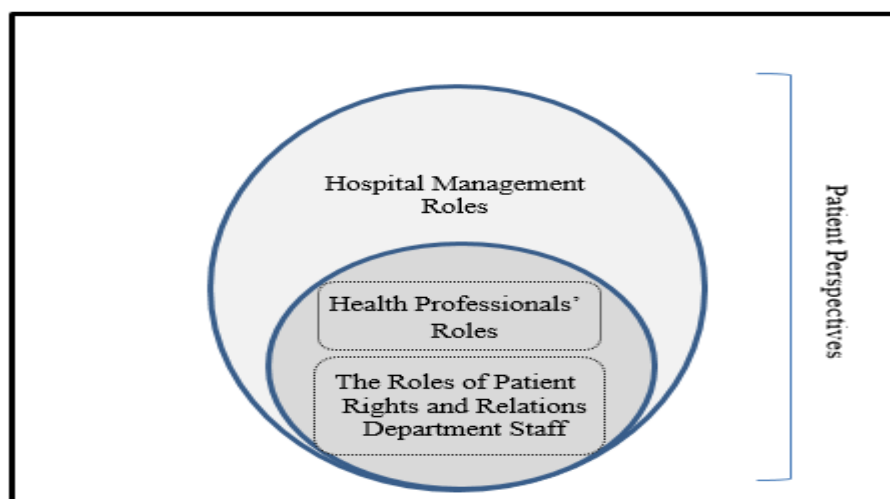
Figure 4.13. Key players with roles in implementing the Bill from a patient perspective.

Patients were also asked how they assess the extent of patients' satisfaction with the implementation process in the hospitals. Descriptive statistics for the variables for each group—hospital management, health professionals, and the staff of Patient Rights and Relations Department—in addition to the patients' assessment are presented in the following Figures 4.14, 4.15, 4.16 and 4.17. The items for this part were assessed using a chi-square test. Results in all three tables are presented as a percentage of respondents.

a) Role of hospital management

The management roles dealt with in the patients' survey included nine items (Figure 4.14). The first role was to assess the priority given by them to the protection of patient rights. The second

item dealt with the education of patients about their rights in hospitals. Seeking patient feedback was the third item, where patients are encouraged to take an active part and get involved in health services. The fourth item had to do with making information about the Bill available and accessible so patients can learn about their rights and responsibilities in hospitals. The next three items were concerned with providing qualified staff, adequate numbers of staff, and supporting materials. The eighth item, related to the knowledge of health professionals about the Bill because this boosts their confidence to answer patients' questions. The last item focused on the need to make it easy for patients to contact the Patient Rights and Relations Department in hospitals.

	The protection of patient rights is one of the top priorities in this hospital	Efforts are made to educate patients about their rights and responsibilities	Patients are asked about how well their rights are respected by health professionals	Patients can easily find information about the Bill	Qualified staff required to implement the Bill are avaliable	There is sufficient number of staff to implement the Bill	There are sufficient supportive materials to implement the Bill	Health professionals confidently answer patients' questions about the Bill	Patients can easily contact the staff of Patient Rights and Relations department
■ to a great or a moderate extent	0.0	40.0	41.8	52.0	53.8	48.3	48.3	51.1	52.0
■ to a small or no extent	36.1	56.4	53.6	43.5	37.8	40.2	42.5	41.1	43.5
■ no information	63.9	3.6	4.5	4.5	8.4	11.5	9.2	7.9	4.5

Figure 4.14. Patients' assessment on roles of the hospital management in implementing the Bill.

Figure 4.14 reveals that patients rated all items at a low level, only four items barely exceed 50%. These items are: the qualified staff required to implement the Bill are available (53.8%), patients can easily find information about the Bill (52%), patients can easily contact the staff of Patient Rights and Relations Department (52%), and health professionals confidently answer patients' questions about the Bill (51.1%). In contrast, the remaining five roles were rated poorly (*to a small or no extent*).

For the item dealing with the level of priority given by management to patient rights protection (Figure 4.14) not even one patient rated it highly (*to a great or moderate extent*). In contrast, more than 35% of patients rated it low (*to a small or no extent*). The majority of patients stated that they could give no information on the matter. The result may indicate that hospital

management placed little importance on publicising their commitment to protect the rights of patients. What is clear from the results is the substantial lack of information and knowledge among patients, concerning the priorities of the hospitals where they receive service.

Figure 4.14 shows that the majority of patients (56%) revealed that the effort to educate them was minimal (*to a small or no extent*). Conversely, 40% of patients evaluated relatively highly efforts to teach them (*to a great or moderate extent*). This result may indicate that the level of effort towards the education of patients is viable and less than what is needed.

Similarly, a majority of patients (54%) rejected that their rights were respected only to a lesser or no extent. Nearly 40% of patients evaluated the same item relatively highly (*to a great or moderate extent*). This result may be attributed to the low level of patient involvement in the Bill implementation process.

Participants were asked if patients could easily find information about their rights or not. Forty-three percent indicated that patients considered access to information about the Bill in hospitals to be poor (*to a small or no extent*). This result is a reflection of the minimal effort to educate patients already mentioned.

As shown in Figure 4.14, patients were asked about the availability of resources required to implement the Bill, namely; the availability of qualified staff, adequate numbers of staff, and supporting materials. Almost half of patients rated this item as relatively satisfactory (*to a great or moderate extent*) the other half disagreed (*to a small or no extent*). The result shows that, from the patients' perspective, there is a lack of necessary resources to meet the needs of the implementation of the Bill in hospitals.

With regards to the knowledge of health professionals about the Bill that enhances their confidence to answer patients' questions about the Bill, despite the majority of patients indicating that to be *high or moderate*, a large number of patients rated it as at a *poor or no extent*. This may indicate the low level of confidence among a large number of professionals because of the lack of education and involvement during the planning and the implementation process.

The last item displayed in Figure 4.14 relates to the ease of access for patients to reach the staff of the Patient Rights and Relations Department. Fifty two percent of patients rated this positively (*to a great or moderate extent*), compared with 43.5% of patients who evaluated it negatively (*to a small or no extent*). The high number of patients who gave low assessments

(*to a small or no extent*) may indicate that patients still felt isolated from the implementation process.

b) Role of health professionals

The second group addressed in the patients' survey was health professionals and their roles in the implementation process. Questions included matters relating to patients' perceptions about the commitment of health professionals, patients' confidence that health professionals could answer questions about the Bill, patients' sense of the respect health professionals showed for the efforts of the staff of Patient Rights and Relations Department, and how positive their attitude was towards the Bill.

	There is a serious commitment from health professionals to achieving the goals of the Bill	Health professionals show respect for the intervention by staff of Patient Rights and Relations department	Health professionals have positive attitudes towards patient rights
to a great or a moderate extent	55.4	51.5	50.1
to a small or no extent	38.2	38.9	37.4
no information	6.4	9.6	12.5

Figure 4.15. Patients' assessment on roles of the health professionals in implementing the Patient's Bill of Rights.

For all items related to the roles of health professionals (Figure 4.15), a larger proportion of patients evaluated the roles relatively highly (*to a great or moderate extent*), than patients who did not. In each instance, more than half the patients rated the level of commitment by professionals favourably (*to a great or moderate extent*). This may be taken as an indication that patients were more likely to believe that health professionals performed their roles well.

c) Role of Patient Rights and Relations Department staff

The third group considered in the patients' survey was the role the staff of the Patient Rights and Relations Department played in the implementation of the Patient's Bill of Rights, including an evaluation of their contribution and support for patients when needed.

	The staff of Patient Rights and Relations department contribute positively to support the implementation of the Bill	The staff of Patient Rights and Relations department support patients when any of their rights have been violated
■ to a great or a moderate extent	54.2	53.2
■ to a small or no extent	36.8	37.5
■ no information	9.0	9.3
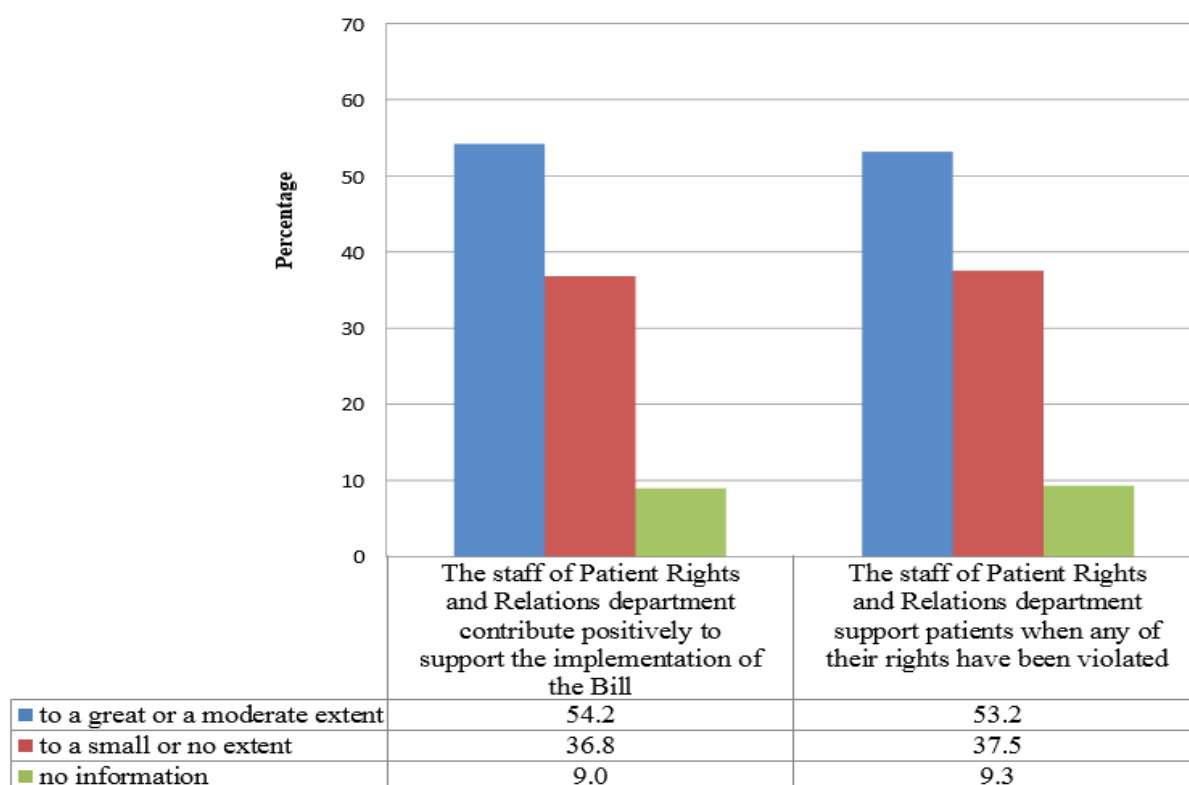
Figure 4.16. Patients' assessment on roles of the staff of the Patient Rights and Relations Department in implementing the Patient's Bill of Rights.

In regard to the staff of Patient Rights and Relations Department, as shown in Figure 4.16, nearly 55% of patients ranked favourably the contribution and support they received from the staff of Patient Rights and Relations Department (*to a great or moderate extent*). Overall, patients indicated that health professionals and the staff of Patient Rights and Relations Department make a valuable contribution to the implementation of the Bill and protect the patient rights.

135

4.3.2.2 Perspective on patients' assessment of the implementation

	Patients are satisfied with the level of implementation of the Patient's Bill of Rights
■ to a great or a moderate extent	51.2
■ to a small or no extent	43.7
■ no information	5.1
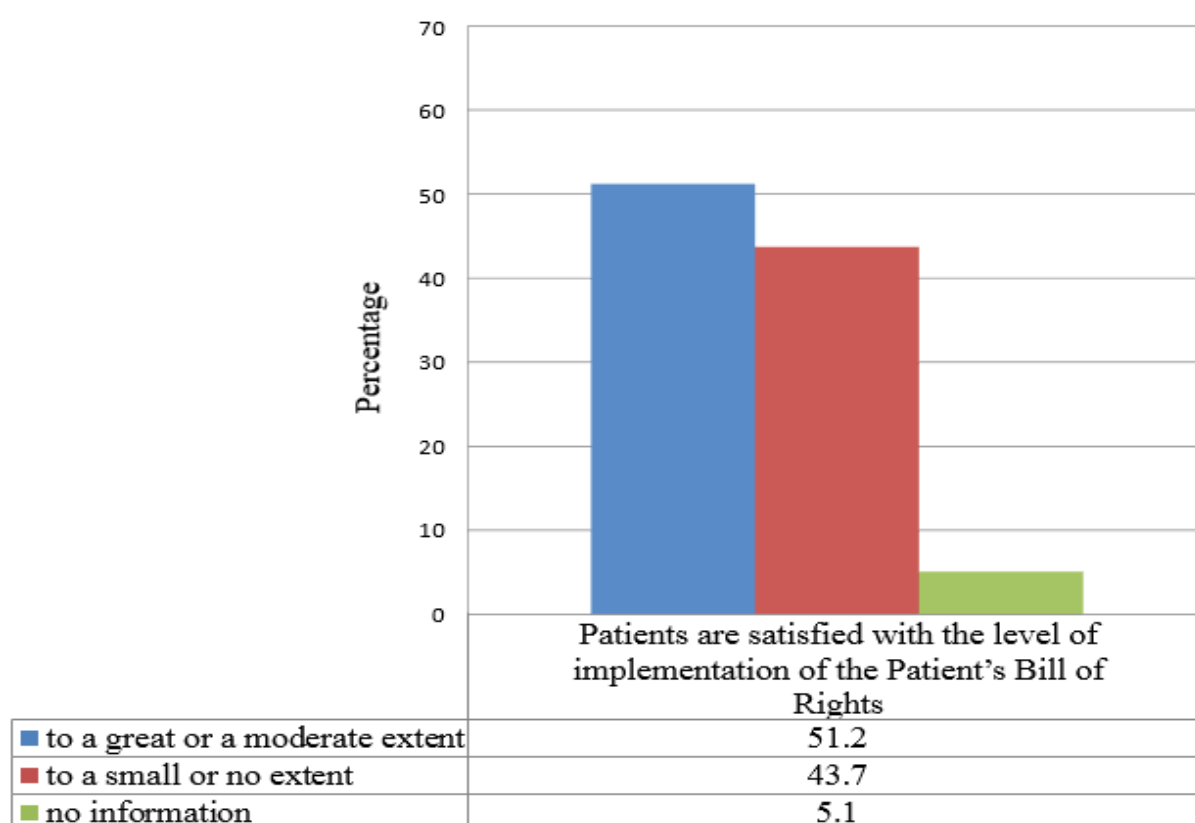
Figure 4.17. Participants' assessment of the patients' satisfaction with the Implementation of the Patient's Bill of Rights.

Figure 4.17 shows that overall patients participating in the survey were fairly evenly spread in their view of the satisfaction of patients with the implementation of the Bill. About half of participants reported they felt patients were satisfied with the level of implementation of the Patient's Bill of Rights (*to a great or moderate extent*) while nearly 45% of patients were dissatisfied (*to a small or no extent*).

4.3.2.3 Items most frequently reported by patients

(a) Items most frequently rated as implemented to a great or moderate extent

Figure 4.18 shows the five items most frequently rated favourably by patients (*to a great or moderate extent*). Of the items rated by patients, two belonged to the role of hospital management and two to the role of the Patient Rights and Relations Department, while the remaining one had to do with the role of health professionals.

	Hospital management roles		Health professionals roles	The staff of patients' relations department roles	
	Qualified staff required to implement the Bill are avaliable	Patients can easily find information about the Bill	There is a serious commitment from health professionals to achieving the goals of the Bill	The staff of Patient Rights and Relations department contribute positively to support the implementation of the Bill	The staff of Patient Rights and Relations department support patients when any of their rights have been violated
to a great or a moderate extent	53.8	52.0	55.4	54.2	53.2
to a small or no extent	37.8	43.5	38.2	36.8	37.5
no information	8.4	4.5	6.4	9.0	9.3

Figure 4.18. Items most frequently rated by patients as implemented to a great or moderate extent.

As shown in Figure 4.18, patients assessed the following five items with the label *to a great or moderate extent*

- The qualified staff required to implement the Bill are available
- Patients can easily contact the staff of Patient Rights and Relations Department
- There is a serious commitment from health professionals to achieving the goals of the Bill
- The staff of Patient Rights and Relations Department contribute positively to support the implementation of the Patient's Bill of Rights
- The staff of Patient Rights and Relations Department support patients when any of their rights have been violated

Generally, patients pointed out that there was an acceptable level of commitment from health professionals to implement the Bill. Patients indicated, furthermore, that the staff were sufficiently qualified to implement the Bill. In addition, these results show that patients stated that the presence of the staff of Patient Rights and Relations Department in hospitals was helpful. They also reported that the department was reachable and easily accessible for them and expressed their conviction that the staff of Patient Rights and Relations Department made a positive contribution to the implementation of the Bill. This may indicate that the role of the

new department's staff is particularly appreciated and acknowledged by patients. It may also indicate that patients have confidence in the staff of the Patient Rights and Relations Department as the protectors of the Bill inside hospitals.

Association between sociodemographic variables and key role attributes

A chi-square analysis was performed to determine whether there was a significant association between patient sociodemographic variables and the five items most frequently rated as implemented to a *moderate* or to a *great extent*. There were no statistically significant differences among patients according to sociodemographic background but sex did make a difference. Table 4.8 presents the items that most frequently showed a significant difference among the patients according to their sex.

Table 4.8 Chi-square Analysis of the Association between Patients' Sex and Their View of the Items Most Frequently Rated as Implemented to a to a Great or Moderate Extent

Item	To a great or moderate extent	$\chi 2$	Df	Sig.
	n (%)			
There is a serious commitment from health professionals to achieving the goals of the Patient's Bill of Rights.				
		7.124	2	.028*
Male	90 (54.2)			
Female	89 (56.3)			
The staff of Patient Rights and Relations Department contribute positively to support the implementation of the Patient's Bill of Rights.				
		8.667	2	.013*
Male	79 (46.7)			
Female	101 (62.7)			
The qualified staff required to implement the Patient's Bill of Rights are available.				
		6.601	2	.037*
Male	81 (49.4)			
Female	89 (58.6)			

Key: * p< 0.05, ** p<0.01, *** p<0.001

Table 4.8 shows that there was a modest statistically significant difference between male and female patients for three out of five items most frequently rated as relatively well implemented (*to a great or moderate extent*). The results may indicate that there is a significant difference between males and females concerning the extent of the commitment from health professionals to implement the Bill (χ^2 (2, N=324) = 7.124, p<.028). Women (56.2%) ranked the commitment from health professionals as existing *to a great or moderate*, compared with (54.2%) for men.

In contrast, more than 60% of women rated the contribution of the staff of the Patient Rights and Relations Department the Patient Rights and Relations Department favourably (*to a great or moderate extent*) compared with only about 45% of men who shared this view, χ^2 (2, N=330) = 8.667, p<.013). Lastly, there was a significant difference between the male and female participants concerning the availability of qualified staff required to implement the Bill, with women rating this more positively than men (59% compared with 49%; χ^2 (2, N=316) = 6.601, p<.037).

These findings show that women were more positive than men concerning all three items. Because male staff of the Patient Rights and Relations Department the Patient Rights and Relations Department deal with the male patients and female staff deal with female patients, it appears that the department's female staff have a more positive effect on their female patients than do their male counterparts on male patients.

(b) Items most frequently rated as implemented to a small or no extent

Figure 4.19 presents the items most frequently assessed by patients as being present to a *small or no extent*. All items are related to hospital management roles.

	Efforts are made to educate patients about their rights and responsibilities	Patients are asked about how well their rights are respected by health professionals	Patients can easily find information about the Bill	The protection of patient rights is one of the top priorities in this hospital
to a great or a moderate extent	40.0	41.8	44.9	0.0
to a small or no extent	56.4	53.6	50.3	36.1
no information	3.6	4.5	4.8	63.9

Figure 4.19. Items most frequently rated by patients as implemented to a small or no extent.

Figure 4.19 reports patients' low assessment (*to a small or no extent*) of the following four items:

1. Efforts are made to educate patients about their rights and responsibilities.
2. Patients are asked about how well their rights are respected by health professionals.

3. Patients can easily find information about the Bill.

4. The protection of patient rights is one of the top priorities in this hospital.

These results suggest that patients may have concerns about the role of hospital management to educate them and engage them in the implementation process.

Table 4.9 presents the results from the chi-square tests which showed that there was the only one significant relationship between these four items and the sociodemographic variables.

Table 4.9 Chi-Square Analysis of the Association Between Patients' Educational Level and Their View of the Ease of Access to Information About the Patient's Bill of Rights

Item	To a small or no extent	$\chi 2$	df	Sig.
	n (%)			
Patients can easily find information about the Bill				
		11.885	4	.018*
High school or less	68 (43)			
Diploma	36 (53.7)			
University degree	62 (59)			
Mann-Whitney test	High school or less * University degree			.034*

Key: * p< 0.05, ** p<0.01, *** p<0.001

As shown in Table 4.9, there was a statistically significant difference between the view of patients with high school education or less and patients with a university degree in their estimate of the ease of access to information about the Bill in the hospitals (χ^2 (2, N=330) =11.885, p<.034). The majority of patients with a university degree (about 60%) considered the ease of access to information to be poor (*to a small or no extent*), compared with only about 43% of those with a high school education or less who shared this view. This result may indicate that the higher the level of education, the higher the expectations people have of the presentation and content of the Bill.

4.4 Most important factors facilitating implementation of the Bill

This section contributes to addressing the second question in the thesis and reports on professionals' and patients' views on the factors considered to be the most important elements that facilitate the successful implementation of the Bill in public hospitals in Saudi Arabia. It is divided into two parts: professional and patient perspectives. At the start of each section there is a list of the top five most important factors that acted as facilitating elements, as nominated

by respondents. The association between sociodemographic variables and the selected factors was assessed with chi-square analysis.

4.4.1 Professionals on the most important factors facilitating implementation of the Bill

Health professionals were asked to indicate whether each of 18 factors was *moderately to very important* or *of minor or no importance*. Those who had no idea could select *no information*. The five factors rated most highly as the most important factors that facilitate its implementation:

- Create a safe work environment in the hospital
- Provide necessary resources to support the implementation of the Bill
- Increase awareness of the Patient's Bill of Rights among doctors and nurses
- Support teamwork values at the hospital
- Increase awareness of the Bill among patients

The tables presented in this section include only those items that were significantly different for each sociodemographic variable.

Doctors' and nurses' responses are reported as percentages in Figure 4.20.

	Create a safe work environment in the hospital	Provide necessary resources to support the implementation of the Bill (e.g. staff and materials)	Increase awareness of the Patient's Bill of Rights among doctors and nurses	Support teamwork values at the hospital	Increase awareness of the Patient's Bill of Rights among patients
	Hospital management level		Health professional level		Patient level
All health professionals	84.2	81.6	82.4	83.9	81.7
Doctors	85.8	85.2	84.3	85	84.3
Nurses	83.3	79.7	81.4	83.4	80.3

Figure 4.20. Factors rated most frequently by doctors and nurses as very or moderately important in facilitating the implementation of the Bill.

As shown in Figure 4.20, the factors that most facilitate the implementation of the Bill relate to one of three levels: hospital management, health professionals, and patients. The factors can

also be grouped according to three aspects: work environment, awareness, and resources. The two most reported factors were to create a safe work environment in the hospital (84.2%) and support teamwork values at the hospital (83.9%).

It should be noted that the large percentage of *no information* responses were for variables relating to the Patient Rights and Relations Department ("Separate Patient Rights and Relations Department from hospital management" 14%, i.e., 13% of doctors and 15% of nurses; and "Strengthen the roles of the staff of Patient Rights and Relations Department" 9%, i.e., 7% of doctors and 10% of nurses). This result may be an indication that a considerable number of doctors and nurses knew little about the role of the department or that a concentrated effort was made to promote the Bill but less effort was made to promote the role of the Patient Rights and Relations Department. In the Saudi health system, the Patient Rights and Relations Department is relatively new, and this may be the reason for the lack of information about the critical role it plays.

Table 4.10 presents each of the most frequently reported factors from the viewpoint of the doctors and nurses. Note that only the five factors most highly rated as very or moderately important are included in the table.

Table 4.10 Rank and Percentage of the Most Important Factors that Facilitate the Implementation of the Patient's Bill of Rights

Factor	All health professionals	Doctors	Nurses
	Rank (%)	Rank (%)	Rank (%)
Create a safe work environment in the hospital	1 (84.2)	1 (85.8)	2 (83.3)
Support teamwork values at the hospital	2 (83.9)	3 (85)	1 (83.4)
Increase awareness of the Patient's Bill of Rights among doctors and nurses	3 (82.4)	4 (84.3)	3 (81.4)
Increase awareness of the Bill among patients	4 (81.7)	5 (84.3)	4 (80.3)
Provide necessary resources to support the implementation of the Bill	5 (81.6)	2 (85.2)	5 (79.7)

Table 4.10 indicates that the two strongest elements that facilitate the implementation of the Bill relate to environmental safety and teamwork values (84% and 83.9% respectively). These results show the importance of these factors for both doctors and nurses in implementing or protecting the Bill and may reflect the significant role these factors play in the hospital environment and in teamwork (inter-professional) activities.

Factors relating to the need to increase the awareness about the Patient's Bill of Rights among health professionals and patients were also considered to be important factors that facilitate the implementation of the Bill. Increasing the awareness of health professionals was deemed highly important by 82.4% of respondents and increasing the awareness of patients also was considered highly important by 81.7% of the health professional participants. This may show that health professionals believe in the need to increase awareness to support the implementation process in hospitals.

More than 80% of professionals (85.2% doctors and 79.9% nurses) agreed in the importance of providing required resources for the implementation process. These resources included staff and materials required to accomplish the goal of the implementation of the Bill.

Association between sociodemographic variables and factors facilitating implementation of the Bill

A chi-square analysis was performed to determine if there were significant relationships between sociodemographic variables and the factors that facilitate the implementation of the Bill. Tables 4.11, 4.12, and 4.13 illustrate only those items that were significantly different for each sociodemographic variable.

Sex of health professionals

Table 4.11 presents factors most frequently rated as moderately to very important and that showed a significant difference among professionals according to their sex.

Table 4.11 Chi-square Analysis of Factors Most Frequently Rated as Moderately to Very Important According to the Sex of Professionals

Factor	Moderately to very important		χ^2	df	Sig.
	n	(%)			
Provide necessary resources to support the implementation of the Bill					
			6.032	2	.049*
Male	238	(85)			
Female	426	(79.8)			

Key: * p< 0.05, ** p<0.01, *** p<0.001

As shown in Table 4.11, there was a significant difference between men and women in their view of the importance of providing necessary resources to support the implementation of the Bill. Men (85%) more than women (80%) agreed that providing the necessary resources was one of the most important factors that may facilitate its implementation.

143

Health professionals by age group

Table 4.12 presents items most frequently rated as *moderately to very important* and that showed a significant difference among professionals according to their age group.

Table 4.12 Chi-square Analysis of Items Most Frequently Rated as Moderately to Very Important According to the Professionals' Age Group

Factor	Moderately to very important		$\chi 2$	df	Sig.
	n	(%)			
Increase awareness of the Bill among health professionals					
			14.433	4	.006**
Less than 30 years	251	(78.2)			
From 30 to 40 years	212	(83.1)			
Over 40 years	206	(87.3)			
Mann-Whitney test	Less than 30 * over 40 years				.004**
Increase awareness of the Bill among patients					
			14.271	4	.006**
Less than 30 years	254	(78.2)			
From 30 to 40 years	201	(79.8)			
Over 40 years	210	(88.6)			
Mann-Whitney test	Less than 30 * over 40 years				.001**
	From 30 to 40 * over 40 years				.005**

Key: * p< 0.05, ** p<0.01, *** p<0.001

Looking at the two items related to increasing the awareness of professionals and patients, it can be seen clearly that professionals aged over 40 years were more supportive of the importance of increasing awareness compared to younger professionals. For example, nearly 88% of participants over 40 years of age showed support for the importance of this activity compared to less 78% of participants less than 30 years of age.

Educational level of health professionals

Table 4.13 presents items most frequently rated as *moderate to very important* factors that showed a significant difference among professionals according to their educational level.

Table 4.13 Chi-square Analysis of Items Most Frequently Rated as Moderately to Very Important Factors by the Health Professionals' Level of Education

Factor	Moderately to very important		$\chi 2$	df	Sig.
	n	(%)			
Increase awareness of the Bill among health professionals					
			10.396	4	.034*
Basic qualification	188	(78)			
Post-basic degree	282	(83.2)			
Postgraduate degree	199	(85.4)			
Mann-Whitney test	Basic qualification * postgraduate				.034*

More than 85% of professionals with a postgraduate degree reported that increasing awareness of the Bill among patients was a very important factor.

4.4.2 Patients on the most important factors facilitating implementation of the Bill

This section aims to contribute to addressing the second question in the thesis, namely, identifying the factors that facilitate the implementation of the Patient's Bill of Rights in Saudi Arabia and it discusses patients' views on the factors considered to be *moderately or very important* factors for facilitating the implementation of the Bill in public hospitals. Respondents were asked to give their assessment for each factor in terms of its importance as a factor that facilitates the implementation of the Bill.

Figure 4.21 displays the distribution of the five factors most frequently considered to be moderately to very important by patient respondents. Only the five factors rated as very or moderately important are included.

	Encourage patients to exercise their rights	Clarify and simplify the complaint procedures for patients	Increase awareness of the Patient's Bill of Rights among patients	Encourage the presence of a patient's companion during hospitalisation	Train health professionals how to deal with patients properly
			hospital management level		
patients	73.2	70.4	67.7	64.7	64.4
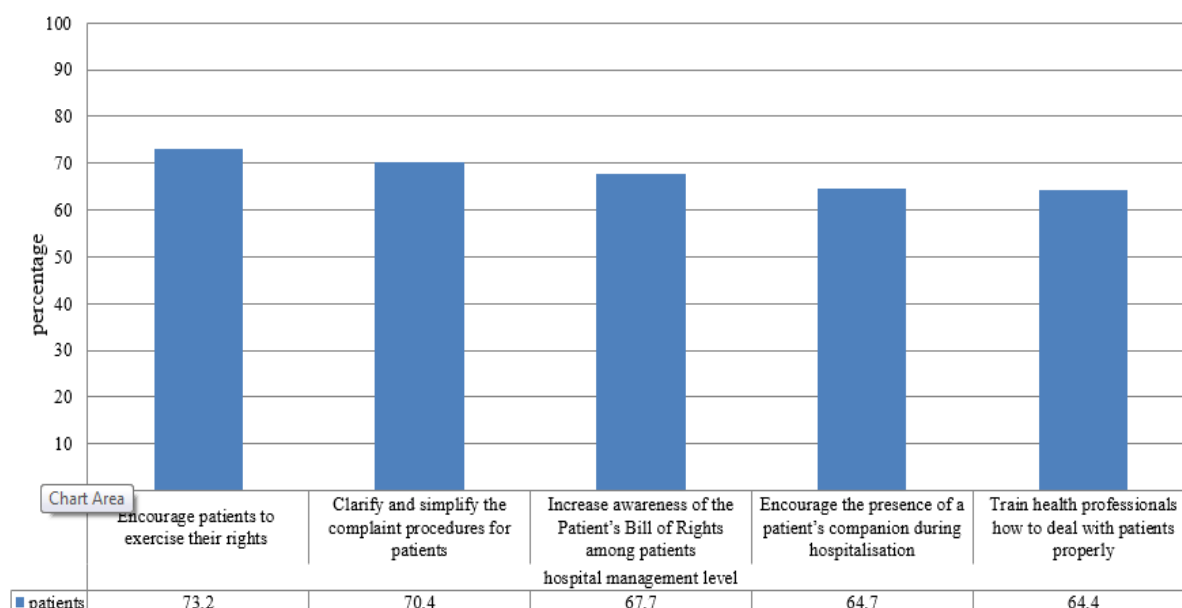
Figure 4.21. Factors rated most frequently by patients as very or moderately important in facilitating the implementation of the Patient's Bill of Rights.

As shown in Figure 4.21, patients generally reported factors related to hospital management as the most important factors that would facilitate the successful implementation of the Bill. Table 4.16 presents this data from the viewpoint of the patients. All five factors chosen by patients and included in the table are directly related to the roles of hospital management, giving the impression that hospital management is of great importance to the success of the implementation of the Patient's Bill of Rights. These five factors can be divided into three subgroups: the support for patients, the role of health professionals, and the role of other parties (specifically, patient's companion).

The first sub-group is composed of factors of the highest importance for patients and they are clearly interconnected. For example, 73.2% of patients indicated the importance of encouragement to exercise their rights. However, this encouragement cannot be achieved without teaching them their rights as guaranteed by the Ministry of Health, and 67.7% of patients indicated that increasing patients' awareness is very important. If patients are aware of their rights when visited by health professionals or hospitalised, they are more likely to claim those rights if they need to do so. This factor is strongly related to the clarification of complaint procedures in the event of any violation, with 70.4% who indicated that it is of utmost importance to clarify the complaint procedures for patients. Making the procedures easier and removing the bureaucratic burden may give patients greater confidence in the exercise of their rights.

Most patients (64.7%) also indicated that the presence of a patient's companion was *very or moderately important* in facilitating the implementation of the Bill. This links well to one of Saudi Arabia's social customs, where the presence of patient's companion gives them a greater sense of security, as well as moral and psychosocial support.

Lastly, patients noted that the actions of trained health professionals dealing with patients in the proper way was one of the most important enablers in the implementation process, with 64.4% of patients who indicated the *importance or moderate importance* of training for professionals. Patients may have found that health professionals were unready to deal well with the implementation of the Bill because it had only recently been established.

Association between sociodemographic variables and factors facilitating implementation of the Bill

A chi-square analysis was performed to determine whether or not there were significant differences between the sociodemographic variables and the factors that facilitate the implementation of the Patient's Bill of Rights. There were statistically significant associations between sex and one item, between age group and one item, between educational level and four items, and between length of stay and one item.

Tables 4.14, 4.15, 4.16 and 4.17 illustrate only those items that were significantly different for each sociodemographic variable.

Sex of patients

Table 4.14 reports only one sociodemographic variable and one item.

Table 4.14 Chi-square Analysis of Items Most Frequently Rated as Moderately to Very Important Factors by the Patients' Sex

Factor	Moderately to very important		χ^2	df	Sig.
	n	(%)			
Clarify and simplify the complaint procedures for patients					
			7.650	2	.022*
Male	107	(64.1)			
Female	122	(77.7)			

Key: * p< 0.05, ** p<0.01, *** p<0.001

Table 4.17 shows that patient views of the importance of the clarification of the complaint process differed significantly according to the patients' sex. Approximately 80% of women, compared to less than 65% of men, maintained that the clarification of the complaint

147

procedures for patients was a very important factor to the success of the implementation of the Patient's Bill of Rights. This result may stem from the fact that men in general can complain and raise their concerns more easily than women in a male-dominated culture such as in Saudi Arabia.

Age group of patients

Table 4.15 Chi-square Analysis of Items Most Frequently Rated as Moderately to Very Important Factors by the Patients' Age Group

Factor	Moderately to very important		$\chi 2$	df	Sig.
	n	(%)			
Encourage patients to exercise their rights					
			16.360	4	.003***
Less than 30 years	110	(79.1)			
From 30 to 40 years	78	(75.7)			
Over 40 years	53	(60.9)			
Mann-Whitney test	Less than 30 * over 40 years				.003**
	From 30 to 40 * over 40 years				.016*

Key: * p< 0.05, ** p<0.01, *** p<0.001

As shown in Table 4.15, a large majority (80%) of patients younger than 40 years of age stated that the encouragement of patients to exercise their rights was a very important factor for the success in implementation of the Bill, whereas only 60% of patients over 40 years of age shared the same perspective. This may indicate that younger patients like to be encouraged to assert their rights inside hospitals. Most patients over 40 years of age usually have a family member as a companion and because they feel safer, they may already feel well supported in exercising their rights.

Educational level of patients

Table 4.16 Chi-square Analysis of Items Most Frequently Rated as Moderately to Very Important Factors According to Patients' Educational Level

Factor	Moderately to very important		$\chi 2$	df	Sig.
	n	(%)			
Train health professionals how to deal with patients properly					
			15.300	4	.004**
High school or less	95	(60.1)			
Diploma	37	(55.2)			
University degree	80	(76.9)			
Mann-Whitney test	High school or less * University degree				.013*
	Diploma * University degree				.005**
Clarify and simplify the complaint procedures for patients					
			15.704	4	.003**
High school or less	101	(65.2)			
Diploma	41	(61.2)			
University degree	88	(84.6)			
Mann-Whitney test	High school or less * University degree				.001**
	Diploma * University degree				.001**
Increase awareness of the Bill among patients					
			14.928	4	.005**
High school or less	96	(60.8)			
Diploma	43	(66.2)			
University degree	82	(79.6)			
Mann-Whitney test	High school or less * University degree				.002**
	Diploma * University degree				.042*
Encourage the presence of a patient's companion during hospitalisation					
			9.631	4	.047*
High school or less	99	(61.9)			
Diploma	37	(57.8)			
University degree	77	(73.3)			
Mann-Whitney test	Diploma * University degree				.044*

Key: * p< 0.05, ** p<0.01, *** p<0.001

Table 4.16 reveals that four items showed a significant difference between patients with a university degree and patients with lower levels of education. These items were the training of

149

health professionals to deal with patients, the clarification of the complaint procedures, increasing awareness of the Bill among patients, and encouraging the presence of a patient's companion during hospitalisation.

Patients with a university degree consistently ranked the above four factors that facilitate the implementation of the Patient's Bill of Rights as more important than did patients with a diploma or lower qualification. For example, for the item related to the importance of health professional training, approximately 80% of patients with a university degree indicated that it was very important, while only 60% with less than a university degree shared the same view. Similarly, nearly 85% of patients with a university degree specified that the clarification of the complaint system for patients was *a very or moderately important factor* while only 65% of patients with a lower level of education held the same view. This may suggest that the educational level of patients has a considerable impact on patient perspectives on the importance of these factors.

Length of hospitalisation of patients

Table 4.17 Chi-square Analysis of Items Most Frequently Rated as Moderately to Very Important Factors by the Patients' Length of Hospitalisation

Factor	Moderately to very important		$\chi 2$	df	Sig.
	n	(%)			
Clarify and simplify the complaint procedures for patients					
			11.722	4	.020*
Less than 3 days	74	(75.5)			
From 3 to 10 days	77	(76.2)			
More than 10 days	71	(62.3)			
Mann-Whitney test	Less than 3 days * More than 10 days				.020*
	From 3 to 10 days * More than 10 days				.020*

Key: * p< 0.05, ** p<0.01, *** p<0.001

More than 75% of patients who stayed less than 10 days indicated that they considered the clarification and simplification of complaint procedures for patients to be *very or moderately important* whereas only about 62% of patients hospitalised for more than 10 days thought the same. This result could suggest that patients, who are hospitalised for a short period of time, need more support to assert their rights until they become familiar with the hospital environment.

4.5 Most important barriers to the implementation of the Bill

The most important barriers to successful implementation of the Bill are detailed in this section. It discusses both the professionals' and patients' views on important factors that hinder the successful implementing of the Bill in public hospitals in Saudi Arabia. The section has been divided into two parts: professional and patient perspectives. Each part starts with a list of the five most important barriers nominated by respondents. The association between sociodemographic variables and the selected factors was assessed with chi-square analysis.

4.5.1 Health professionals on the most important barriers

Professionals were asked to give their perspective on 27 listed factors, whether they considered them to be a *moderate or extreme barrier* to implementing or *minor or not a barrier*. If they had no idea, they could indicate they *lacked information*. The five factors most frequently reported as a *moderate or extreme barrier* to implementing the Bill, from the doctors' and nurses' perspective, are presented in Table 4.18.

Table 4.18 Rank and Percentage of the Most Important Factors Hindering the Implementation of the Bill

Factor	All health professionals	Doctors	Nurses
	Rank (%)	Rank (%)	Rank (%)
Increase in work pressure	1 (78.8)	1 (77.8)	1 (79.3)
Excessive number of patients to deal with	2 (70.8)	10 (70.5)	3 (70.9)
Time limitations	3 (70.1)	11 (70.5)	4 (69.8)
Low level of job satisfaction among health professionals	4 (69.8)	7 (70.9)	5 (69.3)
Insufficient number of staff	5 (69.6)	6 (71.5)	6 (68.6)

Doctors and nurses agreed that the most significant factor that hindered the implementation of the Bill was the increase in work pressure (79%). This may result from such matters as extensive work assignments, more responsibilities, and long hours. The second, third, and fifth most significant factors are almost certain to be related to increased work pressure. For example, more than 70% of doctors and nurses considered the excessive number of patients entering hospitals to *be a moderate or extreme barrier*, preventing the proper implementation of the Bill. Implementation of the Bill requires constant attention, but pressure work may mean that there is not enough attention given to patient rights.

In addition, inadequate staff numbers were also noted by about 70% of professionals as a *moderate or extreme barrier* to implementing the Bill properly. Insufficient staff numbers may

cause an increase in the workload which can augment the possibility of fatigue among staff. This fatigue may also function as a distraction from the effective observance of patient rights.

A low level of job satisfaction among doctors and nurses was reported by nearly 70% to be a *moderate or extreme barrier* to the implementation of the Bill. This may relate to high work pressure, working conditions, the reward system, lack of recognition, or low salaries. Approximately 70% of doctors and nurses affirmed that the low level of job satisfaction may hinder the implementation of the Bill in hospitals, suggesting that high job satisfaction among health professionals would assist the successful implementation of the Bill.

Four items related to the Ministry of Health and the Patient Rights and Relations Department returned a large percentage of *no information* responses. These are: "the Bill has unrealistic objectives", "the strategy for implementation is ambiguous", "lack of authority given to the staff of the Patient Rights and Relations Department", and "poor performance of the staff of the Patient Rights and Relations Department". This may suggest that communication between the Ministry of Health and health professionals is poor. The lack of information among health professionals concerning several aspects of the implementation strategy, plan, and goals may lead to the assumption that there is, as yet, no proper channel for the transfer of information to workers. In addition, the large number of *no information* responses to questions concerning the role of the Patient Rights and Relations Department may indicate that health professionals are still unaware of the department's role in the hospital.

Association between sociodemographic variables and hindering factors

A chi-square analysis was performed to determine whether there were significant differences between the sociodemographic variables and the most reported hindering factors. There was only a statistically significant association between educational level and one item, namely time limitations, as shown in Table 4.19.

152

Table 4.19 Chi-square Analysis of Items Most Frequently Rated as Moderately to Very Important Factors by Profession and Educational Level of the Respondents

Factor	Moderate to extreme barrier		$\chi 2$	df	Sig.
	n	(%)			
Time limitations					
By educational level			15.103	4	.004**
Basic qualification	166	(67.5)			
Post-basic qualification	252	(74.6)			
Postgraduate degree	156	(66.1)			
Mann-Whitney test	Basic qualification * Post-basic qualification				.031*
	Postgraduate degree * Post-basic qualification				.011*

Key: * p< 0.05, ** p<0.01, *** p<0.001

As shown in Table 4.19, there was a statistically significant difference between participants with a post-basic degree and those from other groups. The result showed that nearly 75% of participants with a post-basic degree indicated that time constraints were a *moderate or extreme barrier*, compared with about 65% of participants with postgraduate qualifications and 67% of professionals with basic qualifications who shared the same view.

4.5.2 Patients on the most important barriers

This section discusses factors considered to be the most important barriers to the implementation of the Bill in public hospitals from the viewpoint of patients. Figure 4.20 shows the distribution of variables most frequently rated to be a *moderate or extreme barrier* that may hinder the implementation of the Bill.

Table 4.20 Factors Hindering the Implementation of the Patient's Bill of Rights Reported by Patients as Moderate or Extreme Barriers

Factor	Patients (%)
Lack of public awareness about the Bill	(67.3)
Treatment is more important than rights for patients	(66.2)
Lack of specialised staff in the field of patient rights in the hospital	(60.2)
Lack of authority given to staff of the Patient Rights and Relations Department to protect patient rights	(59.7)
Lack of awareness of the Bill among patients	(58)

Table 4.20 summarises and ranks the most important barriers that hinder the implementation of the Bill. Although the four factors relate to three different levels of healthcare, they can be

also be seen as relating to two key stakeholders: patients themselves and the Department of Patient Rights and Relations.

The first group of items relate to the patient-centred perspectives: lack of awareness among the public, lack of awareness among patients, and the view that treatment is more important than rights for patients. For example, nearly 70% of patients indicated that the lack of public awareness is the most important barrier to the implementation of the Bill and more than 65% indicated that the assumption that treatment is more important than rights is the second biggest barrier. These factors may be linked. Because patients seem to be unaware of their own rights, they do not recognise patient rights in general as an important issue. This result may emphasise the strong relationship between the degree of importance of the Bill to patients and the level of awareness among patients of the Bill itself.

The second category has to do with the Patient Rights and Relations Department. Factors include the lack of specialised staff in the field of patient rights in the hospital and the lack of authority given to the staff of the Patient Rights and Relations Department to protect patient rights. This may indicate the high expectations patients have of this department to implement the Bill and protect their rights. Patients reported that the quality of the staff of this department and the level of the authority that they have are very important factors. For these reasons a lack of resources and lack of authority reflected in these two factors presents a serious barrier to the successful implementation of the Bill.

Association between sociodemographic variables and hindering factors

A chi-square analysis was performed to determine whether there were significant differences between the sociodemographic variables and the most important barriers. There were statistically significant differences between the educational level of patients and three factors, namely the lack of public awareness about the Bill, the lack of authority given to the staff of the Patient Rights and Relations Department to protect patient rights, and the lack of specialised staff in the field of patient rights in the hospital. Table 4.24 shows those factors where there was a significant difference between the reported levels of the barriers and the education level of patients.

Table 4.21 Chi-square Analysis of Items Most Frequently Rated as Moderate or Extreme Barriers by Educational Level of the Respondents

Factor	Moderate to extreme barrier		$\chi 2$	df	Sig.
	n (%)				
Lack of public awareness about the Bill					
			19.758	4	.001**
High school or less	92 (58.2)				
Diploma	43 (66.2)				
University degree	85 (81)				
Mann-Whitney test	High school or less * University degree	.000***			
	Diploma * University degree		.027*		
Lack of specialised staff in the field of patient rights in the hospital					
			15.769	4	.003**
High school or less	79 (51)				
Diploma	44 (66.7)				
University degree	72 (69.2)				
Mann-Whitney test	High school or less * University degree				.011*
Lack of authority given to the staff of the Patient Rights and Relations Department to protect patient rights					
			14.484	4	.006**
High school or less	81 (52.6)				
Diploma	39 (60)				
University degree	72 (69.2)				
Mann-Whitney test	High school or less * University degree				.023*

Key: * p< 0.05, ** p<0.01, *** p<0.001

As shown in Table 4.21, all the significant differences were reflected in the educational level of participants for the three items. Patients with highest levels of education are more likely than others to consider the importance of public education. For example, the majority (81%) of patients with a university degree reported that a lack of public awareness is one of the *moderate or extreme barriers* to the successful implementation of the Bill while only about 60-66% of patients with high school or less, or with a diploma, respectively, held the same view. This result may indicate that a high level of education favours the view that public awareness of the Bill is of great importance.

In the same way, patients with higher education are aware of the importance of the role of the Department of Patient Rights and Relations and the importance of increasing the authority of its staff. Approximately 70% of patients with a university degree stated that the lack of

authority given to the staff of Patient Rights and Relations Department to protect patient rights constitutes a *moderate* to *extreme barrier*, compared to about 50% of patients with high school or less holding the same view. Moreover, about 70% of patients with a university degree stated that the lack of specialised staff in the field of patient rights in the hospital is considered as a *moderate or extreme barrier*, while only about 50% of patients with high school or less held the same view. As with the previous results, this result may emphasise the value of the level of patients' education in understanding the importance of the quality of the staff of Patient Rights and Relations Department.

4.6   Actual implementation of some patient rights in public hospitals

The purpose of this section is to understand the extent to which some basic patient rights are implemented in public hospitals. The 13 rights listed in Table 4.25 below this section were selected because they were the main items guaranteed by the Ministry of Health to patients in Saudi Arabia.

4.6.1   Professional perspectives on the actual implementation of patient rights

Doctors and nurses were asked to rate the extent to which each right was implemented in their hospital. Table 4.25 shows the perceptions of the professionals with regard to the actual implementation of patients' fundamental rights.

Table 4.22 Professionals' Views on the Extent of Actual Implementation of Fundamental Patient Rights

Patient rights	To a great or moderate extent (%)	Overall assessment
To personal privacy	85.6	largely respected
To the confidentiality of their information	85.3	largely respected
To be treated in a safe environment	85	largely respected
To be asked to sign consent forms	84.7	largely respected
To be treated with respect	84.4	largely respected
To respect for choices they make	82.7	largely respected
To have their complaints treated seriously	80.6	largely respected
To have high priority given to their rights	80.4	largely respected
To have accurate information	79.8	largely respected
To be involved in their treatment plan	78.9	largely respected
To know the medical team by their name and specialisation	76.5	largely respected
To receive an explanation of complaint procedures	68.6	partly respected
To receive a copy of the Bill	56.7	hardly respected

Although the majority of patient rights were reported to be implemented at a relatively high level, two rights were rated with relatively high scores as being implemented only to *a partly or hardly respected*.

Doctors and nurses noted that the top three most implemented rights (reported by 85% or more) − patient privacy, confidentiality of information, and the right to be treated in a safe environment − were reported to be observed to *a great or moderate extent*. The doctors and nurses seem to believe that privacy and confidentiality in public hospitals are given particular attention and are respected by health professionals. They also indicated that the environment inside public hospitals was safe for patients. Safety includes reducing any avoidable risks and protecting patients from any physical or psychological harm. A large number of doctors and nurses (84.7%) reported that the right to be asked to sign consent forms before any medical intervention was largely respected. By ranking it at the top of the list, the doctors and nurses indicated that their commitment to have consent forms signed by patients is honoured at a high level. The fifth right observed at a high level was the right of patients to be treated with respect.

More than 84% of doctors and nurses agreed that the right to treatment with respect was largely respected.

The second group comprised only one patient right, to receive an explanation of the complaint procedures, a right which was rated to be *partly respected*, as reported by the health professionals. This result can be related to the previous finding about patients not receiving a copy of the Bill. Both could be considered crucial tools for educating patients and allowing them to assert their rights in the hospitals.

Lastly, with regard to the third group, there was one right that had that had the lowest rating on the patient rights list. According to health professionals, the right to be given a copy of the Bill was *hardly respected* in their hospitals. Giving a copy of the Bill to patients is considered an important way to spread the culture of patient rights and also to educate patients about their rights guaranteed by the hospitals.

Association between implementation rating of items and sociodemographic variables

Chi-square tests were conducted to determine any significant difference between the implementation ratings of items and the sociodemographic variables. The results showed that there were several statistically significant differences between the implementation rating of items and the sociodemographic variables.

Table 4.23 shows those factors where there was a significant difference by sociodemographic variable and the items.

Table 4.23 Chi-square Analysis of the Implementation Ratings of Items by Sociodemographic Variables

Right	To a great or moderate extent	To a small or no extent	No information	χ2	df	Sig.
	n (%)	n (%)	n (%)			
Patients' personal privacy is maintained						
By profession				6.366	2	.041 *
Doctors	239 (84.8)	35 (12.4)	8 (2.8)			
Nurses	456 (86)	44 (8.3)	30 (5.7)			
Patients receive explanation of the complaint procedures						
By profession				31.778	2	.000***
Doctors	158 (56)	101 (35.8)	23 (8.2)			
Nurses	402 (75.3)	107 (20)	25 (4.7)			
Health care is provided in a safe environment for patients						
By sex				8.221	2	.016*
Male	228 (80.6)	41 (14.5)	14 (4.9)			
Female	460 (87.5)	43 (8.2)	23 (4.4)			
Patients receive a copy of the Patient's Bill of Rights before being admitted						
By profession				23.219	2	.000***
Doctors	129 (45.3)	127 (44.6)	29 (10.2)			
Nurses	340 (62.7)	165 (30.4)	37 (6.8)			
By experience				11.769	4	.019**
5 years or less	164 (51.6)	125 (39.3)	29 (9.1)			
From 5 to 10 years	151 (65.1)	70 (30.2)	11 (4.7)			
Over 10 years	149 (55.2)	96 (35.6)	25 (9.3)			
Mann-Whitney test	5 years or less * from 5 to 10 years					.004**

Key: * p< 0.05, ** p<0.01, *** p<0.001

As shown in Table 4.23, the chi-square result for the first right (patients' privacy is maintained) shows that there was a significant difference between doctors' and nurses' perspectives on the level of implementation of the right to privacy (χ^2 (2, N=812) = 6.366, p<.041). Although a similar percentage of doctors and nurses considered the right to privacy as observed *to a great or moderate extent*, approximately 13% of doctors indicated that maintaining patient privacy in their hospital was *not implemented or implemented only to a small extent*, compared to only

159

8% of nurses who shared the same view. Nurses believed more than doctors that patients' privacy was protected.

Next, 75% of nurses, compared with about half of the doctors, reported that the explanation of complaint procedures was usually available to patients (*to a moderate or great extent*) (χ^2 (2, N=816) = 31.778, p<.000). This result may indicate that doctors and nurses believed that patients were not taught as much as they should be about the complaint process. It may also indicate that the complaint procedures were not available in written form or were not explained clearly as a great number of doctors were not aware of it. In the normal course of events the complaint process may be explained verbally and because nurses work much more closely with patients than do doctors, nurses reported that patients are given the necessary explanation The overall assessment of the implementation of this right (Patients receive an explanation of the complaint procedures) received a lower rating.

There was a significant difference between male and female respondents, concerning the right to be treated in a safe environment (χ^2 (2, N=809) = 8.221, p<.016). Fifteen percent of the men reported that the patient's right to receive treatment in a safe environment is observed only to *a small extent or no extent* while only 8% of female respondents held the same view. Almost all females and most males believed that the right to be treated in a safe environment was maintained.

The chi-square results in Table 4.26 show that there were statistically significant differences between doctors and nurses with regard to the right to receive a copy of the Bill. More than 60% of nurses reported that patients in their hospitals receive copies of the Bill but only 45% of doctors believed that happened to *a great or moderate extent* (χ^2 (2, N=827) = 23.219, p<.000). These differences between doctors and nurses may be due to the fact that when patients are admitted, the health professionals they meet and have most to do with are nurses. Accordingly, nurses observe whether copies of the Bill are given to patients. Nevertheless, a significant number of both doctors and nurses (45% and 30%, respectively) reported this right to receive a copy of the Bill was observed only to *a small extent or no extent*. In addition, professionals with more experience are most likely to note that patients receive a copy of the Bill. For example, 55% and 65% of professionals with more experience reported that the right to receive a copy of the Bill was observed in their hospitals *to a great or moderate extent*, whereas about half of the health professionals with less than 5 years' experience had the same perspective.

4.6.2 Patient perspectives on the actual implementation of patient rights

The purpose of this section is to understand the extent to which some basic rights are implemented in public hospitals. Patients were asked to rate the extent to which each right was implemented in their hospital. Table 4.28 shows the perspective of patients with regard to the actual implementation of some basic rights for patients.

Table 4.24 Patients' Views of the Extent of Actual Implementation of Fundamental Patient Rights

Patient rights	To a great or moderate extent (%)	Overall assessment
To be treated with respect	63.1	partly respected
To be treated in a safe environment	63.1	partly respected
To be asked to sign consent forms	63	partly respected
To the confidentiality of their information	63	partly respected
To personal privacy	62.7	partly respected
To have accurate information	60.6	partly respected
To respect for choices they make	60.5	partly respected
To be involved in the treatment plan	58.6	hardly respected
To be given high priority to their rights	56.6	hardly respected
To have their complaints treated seriously	56	hardly respected
To know the medical team by their name and specialisations	55.3	hardly respected
To receive an explanation of complaint procedures	47	not respected
To receive a copy of the Bill	43.4	not respected

As shown in Table 4.24, patients reported the five most commonly implemented rights were the right to be treated with respect (63.1%), to be treated in a safe environment (63.1%), to be asked to sign consent forms (63%), to the confidentiality of their information (63%), to privacy (62.7%), to be given accurate information (60.6%), and to respect for choices they make (60.5%). The overall assessment of these rights by patients was that they were partly respected in public hospitals.

Next, there were four patient rights that were accorded little respect according to patients: to be involved in the treatment plan (58.6%), to be given high priority to their rights (56.6%), to have their complaints treated seriously (56%), and to know the medical team by their name and specialisation (55.35).

Lastly, patients asserted that two rights were not respected in hospitals. These two items usually relate to the role of hospital management, who are responsible for providing the Bill in several forms and to make sure there is a way to explain or clarify the complaint process to patients. The results reveal that patients expect more to be done to implement the Patient's Bill of Rights in public hospitals. The results also may illustrate the belief that efforts to educate patients fail to meet their expectations.

Chi-square test was performed to determine whether there was any significant difference in the implementation ratings of items and the sociodemographic variables. The results showed no significant difference in the frequency distribution by the participants' sociodemographic variables.

4.7 Conclusion

This chapter presented the results of the cross-sectional surveys of health professionals and patients. The results revealed that doctors and nurses believe in their ability and readiness to implement the Patient's Bill of Rights. They showed less confidence in the role played by the Ministry of Health and hospital management to implement the Bill fully in public hospitals. It was found, however, that nurses were more involved in the implementation process than doctors. Nurses also indicated that they were more aware of the role of the Department of Patient Rights and Relations. Correspondingly, patients expressed their appreciation for the role played by both the health professionals and the staff of Patient Rights and Relations Department. The study highlighted the lack of knowledge and involvement in the Bill among the public, including patients who, furthermore, showed some confusion in their general assessment of the implementation process.

With regards to the elements that facilitate and those that prove to be barriers to achieving the successful implementation of the Bill, the participation of doctors and nurses yielded similar results. The results indicated that the factors reinforcing the successful implementation of the Bill correspond significantly with the creation of a suitable work environment and teamwork inside the hospital and with providing the necessary resources for implementation. Health professionals also agreed that increasing awareness among health professional staff and

patients was one of the most important factors leading to the success of the Bill implementation process. The results also showed that nurses tend to consider the social and moral aspects as important, whereas doctors consider organisational factors and their own personal considerations to be more important. Doctors and nurses pointed to the importance of staff morale for health professionals in implementing the Bill.

Patients, in contrast, mainly emphasised three factors: encouraging patients to practice their rights, complaints clarification, and patient awareness. It can be observed that the increase in health professionals' and patients' awareness has a substantial positive effect on the implementation of the Bill. In the same way, the lack of awareness among patients and the public was the chief barrier to the successful implementation of the Bill. In addition, patients considered that the lack of specialists in patient rights and the weakness of the authority granted to the staff of Patient Rights and Relations Department were among the major barriers.

Finally, the results suggest that patients' privacy and the confidentiality of their information were maintained appropriately in public hospitals. Doctors and nurses believe that patients are treated in a safe environment and with a high level of respect; however, patients did not entirely share this positive assessment. Both health professionals and patients agreed that patients in public hospitals lack knowledge of complaint procedures and do not usually receive copies of the Bill.

The next chapter describes the results from the key informant interviews and discusses managers' and experts' views regarding the implementation of the Patient's Bill of Rights, with several key themes highlighting important issues that can contribute to addressing the research questions.

Chapter 5: Research Results from Key Informant Interviews

5.1 Introduction

This chapter presents the results of the thematic analysis, based on the key informant interviews. These interviews were carried out with experts in patient rights and the senior managers in the Ministry of Health and public hospitals in Saudi Arabia. Insights gained from exploring their perspectives provides rich, in-depth information that contribute to the main objective of this research.

The purposes of the key informant interviews were, (a) to determine the readiness and ability of public hospitals to implement the Patient's Bill of Rights so far, (b) to identify the factors that facilitate and also those factors that are barriers to the implementation of the Bill (c) to observe the key stakeholders' concerns in regard to the implementation of the Patient's Bill of Rights and the process of improving it in public hospitals, and (d) to identify recommendations that may assist in the implementation of the Patient's Bill of Rights in Saudi Arabia. This chapter is divided into five sections. The first section presents the profile of respondents in the research. The second section outlines the readiness and ability of public hospitals to implement the Bill. The third section demonstrates the factors positively affecting the implementation process. The fourth illustrates the factors that are hindering the implementation of the Bill, and the final section provides a brief conclusion to the chapter.

Quotations and extracts from interviewee stories are used to illustrate the themes and sub-themes. To ensure anonymity, participants have been assigned random numbers.

5.2 Respondents' profile

Semi-structured interviews were conducted with nine key informants in the field of patient rights in Saudi Arabia. There were two experts, four participants from high level management of the General Department of Patient Rights and Relations, one regional district manager, and two managers of Patient Rights and Relations Departments in hospitals. The profile of respondents is presented in Table 5.1.

Table 5.1 The Sex and Profession of the Nine Respondents

Variable	Category	No
Sex	Male	7
	Female	2
Profession	Doctors	4
	Other health disciplines	3
	Health management	2
Organisation	Ministry of Health	4
	Riyadh District	1
	Hospital	2
	Experts	2

Table 5.1 shows that the majority of respondents were male, reflecting the great number of men compared with women in administrative and supervisory positions in patient relations' departments in Saudi Arabia. This may be due to the male dominant culture of the country; however, several changes have taken place in recent years supporting and empowering women in leadership roles.

With regard to profession, the majority of respondents were health professionals (with a minority of specialists in health management). Approximately half the interviewees were from the General Department of Patient Rights and Relations because they are the key players in implementing the Patient's Bill of Rights across the entire country. Accordingly, they were chosen for their closeness to decision makers and because they are more familiar with the overall implementation of the Bill. Two experts, who do not work in organisations belonging to the Ministry of Health, were selected to obtain an alternative point of view. The remaining respondents were from the departments responsible for the implementation of the Bill in hospitals.

5.3   Key informants' perceptions of the readiness and ability of public hospitals to implement the Bill

By using the positive culture of patient rights framework (Figure 1.3), the three different levels were included - macro (the Ministry of Health), meso (hospital management) and micro (doctors, nurses, staff of the Patient Rights and Relations Department, and patients). Therefore, this section is divided into five main components covering various aspects of the readiness and ability of public hospitals to implement Bill.

165

The following individual components emerged as the major themes.

- Bill-related aspects
- Organisational aspects
- Aspects related to health professionals
- Aspects related to the Patient Rights & Relations Department
- Patient-related aspects

Figure 5.1 shows the relationship of each aspect of the three levels in the positive culture of patient rights framework (Figure 1.3).
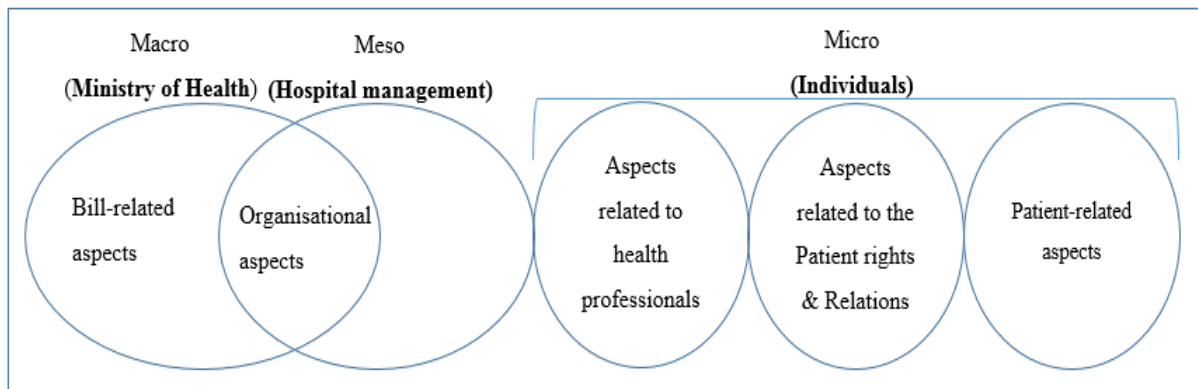
Figure 5.1 Relationship between levels and components

5.3.1   Bill-related aspects

Respondents spoke about the Bill in two ways: the existence of the Bill and the stages of implementation.

a) *Existence of the Bill*

Respondents spoke about their knowledge of the existence of the Bill in Saudi Arabia. Although the current Patient's Bill of Rights was preceded by a simpler version, most of the interviewees did not know of the existence of the earlier one at all. A few (3) knew of its existence but did not know its content. Lack of knowledge of the existence of the Bill can be attributed to the failure to make clear to staff what the expectations from them were. The Bill itself was not located in appropriate places and was poorly displayed in hospitals; however, as mentioned, very few people participants, even experienced people, indicated they knew about it. As one respondent explained:

> In theory, the Patient's Bill of Rights has been available since 2004 or 2005,
> though it dealt mainly with some small, minor aspects, such as covering the
> patient's body (nakedness) and preserving their dignity (Participant 3).

166

Participants who knew about the existence of the first Bill reported that it was simple compared with the current one, which is more comprehensive, and covers a wider range of rights. Most of the participants believe that the current Bill was developed on the basis of national and international experience. One expert maintained that this new movement towards patient rights was just "to keep up with developed countries." In general, it seems that there was little or no involvement from them in the development of the Bill. One of the respondents remarked:

> Patient rights in the health sector in the Kingdom of Saudi Arabia take their lead from the WHO and other international organisations as we interact with other parts of the world (Participant 8).

Two respondents emphasised that the implementation of the Bill was also a response to the emergence of internal pressure by the media and public who sought to highlight patient rights that were ignored in the country's health sector. Respondents thought that this pressure was the result of the large number of unresolved complaints and the frustration which forced people to turn to the media to publicise their stories. In response, the Ministry of Health established a new department dealing with the rights of patients and issued a Patient's Bill of Rights. Respondents also indicated that this pressure on the Ministry of Health led to a change in the way the Ministry of Health, as well as other health organisations, now dealt with every patient as a customer, not just a person in need. In contrast, another respondent revealed that his experience with the Bill only began with the establishment of the Patient Rights and Relations Department.

> Personally, I had not heard of anything called patient rights until the establishment of the Patient Rights Department in the Ministry of Health. We did not see it in the hospitals and no one talked about it in the past. Before the establishment of the Patient Rights Department in the Ministry of Health, I, and most other people, had not heard of the rights of patients (Participant 7).

Two respondents attributed the reason for the implementation of the Bill solely to the Minister of Health, who was determined to establish and implement it. One of the respondents said:

> I think it was the Minister's idea after he established a Patients' Relations Department at [name of an organisation] … He [the Minister] aimed to replicate the idea and transfer it from one institution to another. Potentially, a new Minister could come to the Ministry of Health and dissolve or merge this department, not as a response to international pressure or requirements, nor

167

the demands of insiders. The Ministry of Health does not pay attention to such pressure (Participant 7).

In fact, the establishment of the new department occurred at the Minister of Health's request: the Bill itself was already in existence as mentioned above. There is ambiguity in the implementation process, and therefore, in this case it is more likely to be based on the senior management desires of when and how to implement.

With regards to the content and preparation of the Bill, the two experts who participated in this research indicated that the current Bill needs to be rewritten and reformed entirely. One of them claimed that "the Bill is full of mistakes". Therefore, regular review is very important to ensure the clarity of the Bill to all stakeholders. The differing levels of education among patients and the public must be considered during the review process. Another participant expressed his view of the content of the Bill.

> I do not think that the Bill, in its current form, is comprehensive, adequate, or thorough. The dilemma is the size of the Bill; some articles are long and tedious, and others are fragmentary and do not give the correct meaning (Participant 6).

Four respondents believed that the Bill should be revised periodically. These revisions can include interpretation and shortening some long articles or it could possibly be distributed as a single page and make the full version available for those who wanted it.

> I think that the Bill in its current form is boring and does not induce or persuade anyone to read it. I think that it should be summarised in a single page and be published and distributed through modern means of technology, getting rid of old forms, including the brochures and manuals. It should be general and mention only general aspects of patient rights. The full versions should also be available for those who are interested in the details (Participant 9).

Most respondents emphasised that several features of the Bill may not help patients and may actually discourage them from continuing to read it. Improvements could include, for example, the place of presentation, font size, colour, and ease in reading so that the meaning is clear.

> I prefer other ways of presentation and distribution. The Bill might take the form of pictures, video clips, or something like that (Participant 6).

From my point of view, the Bill should be consolidated and codified and have clear standards in all hospitals. Most importantly, it should be brief and have an additional explanatory booklet for those who wish to know and understand more. Currently, as I observe many of the signboards here, when a patient stops and reads the first line, he immediately moves on, as they are long, boring, and written in small print (Participant 1).

There is some disagreement among respondents regarding the legal states of the Bill. This also clearly reflects the lack of awareness and involvement of staff in the development of the Bill. Five of the nine respondents highlighted the point that although the content of the Bill has a high level of importance inside hospitals, the legal standing of the document itself should be publicly recognised. Its status as a legal document would protect the Bill from infringement by any party in the hospitals. As one respondent explained:

No one will respect the content of the Bill [because] it has legal standing only inside the hospital but frankly speaking, I don't know whether it has any validity outside the hospital or not (Participant 9).

Most respondents supposed that without this move, the rights of patients in Saudi Arabia might not be protected by law. This could lead to further neglect in the implementation of the Bill by all parties, and eventually would result in making it a meaningless document. More than half the respondents believed that the Bill is unprotected by law. As one emphatically declared:

No extent. We don't have any laws or authoritative system of rules that force institutions to implement the Bill and abide by it (Participant 8).

Another respondent explained further:

The Bill is neither legal nor binding on staff, so I suggest linking it with a system such as the one used by practising medical professionals, which is considered legally binding for health services in Saudi Arabia. Yes, the current Bill is binding within the limits of the Ministry but not for other parties (Participant 4).

Some respondents had other opinions. One of them believed that since the Bill was approved and issued by a governmental body, this gave it legal standing. Another maintained that the establishment of the General Department of Patient Rights and Relations is clear evidence of its current legal status.

b) *Implementation stages*

With regards to the stages in the implementation of the Bill in public hospitals, respondents were evidently unsure, because they expressed divergent views. Five of the nine respondents indicated that the Bill was implemented in several stages. Conversely, three respondents believed the implementation had occurred in only one stage. The rest had no particular view of the matter, as one respondent explained:

> Honestly, at the beginning, the application was random because of the lack of particular policies and clear systems that could be followed by the emerging department. This situation lasted for about a year after the establishment of the department; however, after the issuance of an organisational manual for the department, there has been a clear path to follow in our work (Participant 7).

It is a critical in tailoring implementation process that the Bill is implemented in sequential stages, and the lack of this was clearly a problem for experts and mangers in the early stages of implementation. A need for continual communication with all stakeholders at all different stages is critical for achieving the ultimate goals of the Bill.

5.3.2 Organisational aspects

The organisational aspects cover two main areas: support from the Ministry of Health and support from hospital management.

a) *Support from the Ministry of Health*

Most respondents reported that the Ministry of Health had made a great effort to implement the Bill through their support for the General Department of Patient Rights and Relations. They all considered the establishment of the department to be a significant indication that this issue is a serious matter for the Ministry of Health. As one respondent explained:

> I can observe great interest from the Ministry. Over the previous short period of time, it has made rapid steps towards achieving great success in the process of applying the Bill (Participant 5).

These comments indicate that Ministry of Health senior management was very determined and highly committed to implementing the Bill in public hospitals. The Ministry of Health commitment to the successful implementation of the Bill and to attain its objectives was demonstrated by the respondents. As one respondent remarked:

> The commitment of the Ministry is very high, because the person in charge
> of this issue is the Minister of Health himself (Participant 2).

All respondents reported that the desire to implement the Bill was high at the Ministry of Health level. As one respondent explained:

> I think that the Ministry is interested in applying the Bill but it needs more
> commitment and work to be able to apply the Bill correctly. The drawbacks
> are always related to the capabilities. Having a strong desire and human
> support are key factors in achieving the desired difference (Participant 3).

All the respondents stressed the importance of connecting the General Department of Patient Rights and Relations directly to the Minister and said that this gave real support to the department and to patient rights. They added that this link gives the department power at the organisational level, linking it closely with decision makers and the highest authority in the Ministry of Health. Moreover, the new Departments of Patient Rights and Relations in the hospitals were linked to senior management in each hospital. One of the respondents confirmed this:

> I think that connecting the Department [of Patient Rights and Relations] with
> the top of the pyramid in hospitals can be considered a very important
> decision because the bureaucracy processing any complaint is not good, and
> moving the same complaint through many departments kills the whole
> process (Participant 1).

Although establishing the department and linking it to senior management was seen as evidence of commitment by the Ministry of Health, many respondents discovered several deficiencies. One is the unavailability of the resources required to support the process which is considered as a key element that facilitated the implementation of the Bill, and accordingly, the achievement of the objectives of the Bill depends on the availability, or the lack, of resources. A respondent confirmed his experience of lack of resources within a hospital.

> Moral support is there; however, financial, human, and technical support is
> hidden and hardly even exists (Participant 9).

Another deficiency aspect is the lack of skilled staff which was considered a main constraint. The negative impact of the lack of skilled staff in hospitals will affect the ability to fulfil the patient rights requirements, and in particular the lack of training courses for some stakeholders,

171

such as doctors and patients. Comprehensive training programmes are expected to improve all the performance of all those involved in implementing the Bill. Another area of deficiency was seen as the lack of financial support from the Ministry of Health.

> Financial support is completely absent. For example, a printed copy of the Bill was not delivered to the departments until 4 years after the establishment of the department. Human resources and logistical support are also absent. Training is at a very limited level and is not commensurate with a department that pursues success and excellence (Participant 7).

For example, one respondent was dissatisfied with the support given to patient rights. Even though there is a great show of support, the actual support is weak. He remarked:

> Frankly, there is only moral support. The Ministry just issues circulars and requests. Moreover, it does not even follow up on their implementation. All what the departments receive are circulars and inquiries about specific cases. In theory, the protection is there but in fact it is really weak (Participant 7).

Three respondents disagreed about the availability of sufficient training for health workers in the implementation of the Bill. It seems that the Ministry of Health is still giving patient rights a low priority. Combined with the low priority given to patient rights in public hospitals, providing sufficient training programmes and education activities is also another challenge. One respondent claimed that:

> Patient rights were not given the same attention as diseases such as obesity and diabetes. We hear about seminars and lectures, courses, and programmes related to those diseases, but nothing about the rights of patients (Participant 6).

The last of the deficiencies reported by most of the key informants was that no traditional or social media were used as a means to promote the Bill publicly, but rather there was only reliance only on the internal public relations department to do the task. All of the participants reported that the Ministry of Health never use any social media platforms, such as Twitter and Facebook, to promote the Bill. There are a number of benefits of using social media, including the ability to target specific groups, low cost, to reach people in their homes, and it is simple. Using traditional media is also a main vehicle to disseminate educational information to the public. Some participants reported poor use of traditional and social media for delivering of

information and for improving awareness among the public. This suggested that the Ministry of Health did not perform this duty as it should.

b) *Support from hospital management*

The hospital management is an important element in the successful implementation of the Bill. All respondents emphasised that the lack of interest on the part of hospital management leads in only one direction – the failure of the implementation process. The majority reported that they had experienced little support from hospital managers with regards to patient rights issues. Support from hospital management is essential to ensure the successful implementation of the Bill. Managers should use their leadership skills, in addition to their official authority, to motivate and monitor the implementation process.

Three respondents asserted that the Ministry of Health had established everything necessary for success in the implementation of the Bill in the Saudi health system but that hospital management was the reason for the poor implementation so far. The gap between the Ministry of Health and hospital management needs to be fixed and to improve to transfer the commitment from the senior management at the Ministry of Health down to the management at hospitals.

Most respondents believed that few hospital management staff follow the regulations for the implementation of the Bill and are just making their own way. The remaining staff either do not apply the Bill strictly or they apply only some of its stipulations, concerning simple rights. These different levels of implementation, from little to fully implemented, explicitly indicated that it depended on each individual's own commitment rather than the regulations. These situations are illustrated as follows:

One respondent argued:

> The Ministry is strongly committed to protecting patient rights but the problems are in the hospitals. Some of them are committed to the Bill and others have no interest in it at all. (Participant 6)

> Some decisions were made against the interests of the patients and these departments were informed about the problem but nothing changed (Participant 1).

One of the reasons for hospital management not providing support is the extra burden it places on hospitals.

> I think the Bill places an extra burden on hospitals and one has to bear in mind that some of its articles will cause problems for the hospital and its medical staff (Participant 1).

Some respondents noted that a hospital management that was keen to acquire accreditation usually had a high commitment to implementing the Bill. One of the main requirements of most international accreditation programmes is the implementation of patient rights. For example, one said:

> I have observed that hospitals that recently received their health certification and accreditation are the ones which have seen a distinct, positive change in the relationship between patients and their health care providers (Participant 3).

There are several indicators of the lack of interest on the part of hospital management, including lack of commitment to training and absence of educational materials. Regarding the lack of training for the staff of the Department of Patient Rights and Relations, one of the respondents explained his personal experience with regard to training:

> Can you imagine that there are some staff members who have not received any training over the last 4 years! (Participant 7)

Most respondents mentioned the lack of education for patients. One respondent reported:

> Actually, on almost all the hospital walls, we see many posters detailing patient rights written in small print; however, not everyone looks at them unless he/she notices them by themselves (Participant 1).

5.3.3 Health professionals' awareness

The most frequently mentioned feature that the public hospitals have and that needs to be enhanced was the high level of awareness of health professionals of the Bill. Continual education and training workshops were considered useful tools for improving the knowledge of staff about the Bill and its content. These activities should include appropriate strategies for engaging them in the planning and the process to acquire their loyalty to the Bill. All respondents stated that health professionals are aware of the existence of the Bill and its implementation, but varied in their commitment to learning more. One respondent said:

The medical staff's understanding of the Bill and its articles has developed significantly and reached a high level… [But] Some of the medical staff, especially doctors, have never had a look at the Bill, even when workshops and seminars were being held to educate them and draw their attention to it. Many doctors ignore the whole process, claiming that it doesn't matter whether they commit to the Bill and apply it or not (Participant 5).

Some participants felt that one of the reasons doctors were not interested in being educated about patient rights topics was that they thought it is job of nurses, or other staff, and that their focus was on clinical responsibilities. The heavy workload, in addition to the shortage of clinical staff, also contributed to the low interest from doctors to participate in the educational activities. Without an effective action plan to address this challenge, health professionals are unlikely to change their behaviour.

5.3.4 Patient Rights and Relations Department role

The Patient Rights and Relations Departments were established to enforce conformity by the hospitals and their workers to the Patient's Bill of Rights. The respondents reported that the presence of a staff member from the Patient Rights and Relations Department as a mediator between professionals and patients played the greatest role in developing patient-professional relationships. As a result of the department's presence, health professionals have changed their way of dealing with patients and are aware that there is a new department monitoring their behaviour with patients. For example, one respondent explained:

There is a significant effect. Workers in the health sector now tend to avoid clashes with patients because there is a special department that follows up on everything and takes care of these patients' problems as well (Participant 3).

Another participant noted:

The doctors and nurses have begun to realise that their behaviour and relations with the patients are being observed by a special department in the hospital. I think that this is not derived from their internal system of morality or self-reflection but rather a kind of fear they will be punished if they act in contravention of the regulations of the Bill (Participant 9).

Respondents reported that although Patient Rights and Relations Departments had been established five years ago, they still suffered from a number of major problems, such as

175

shortage of staff, lack of physical and moral support, and lack of offices for staff. Respondents who have experience working in the Patient Rights and Relations Departments claimed that the departments still lose talented employees from time to time due to the lack of protection for them and because of the lack of incentives. A respondent described the situation.

> The problem is that senior management doesn't care much, so long as the work gets done. They just assume that things are fine… [The reality is] the department loses some of its competent staff from time to time because there are no moral or physical incentives to induce them to stay under such pressure (Participant 1).

This lack of protection and incentives relates to the extensive control from hospital management over the Patient Rights and Relations Department. For this reason, the heads of department lack authority and cannot make decisions about their staff. When proper authority is given to the department, the heads of department could be more active in their roles. The current sole role for the department is focused on monitoring other departments but with no power or ability to take any corrective action. The head of department only has the ability to suggest and recommend or at most to raise the issue to a higher level of management. Giving the department authority in staffing matters, such as promoting, hiring, or firing, would increase the power and attractiveness of this department. It would strengthen staff loyalty and accountability for the objectives of the department. For example, one respondent stated:

> The department cannot protect itself or its employees, so how is it that the employee who is supposed to defend patient rights needs someone to defend their own rights in the hospital? (Participant 8).

There was some divergence of views, regarding the need for the Patient Rights and Relations Department to be independent of hospital management because they are supposed to monitor all work in the hospital, including that of hospital management. One respondent explained:

> Making this department independent of the hospital will give it greater power. Right now, for example, the staff of the Department [of the Patient Rights and Relations] cannot question a consultant in a rare specialty or blame him because a staff may lose his or her positions since that person has a powerful position at the hospital. (Participant 9).

But another respondent expressed the opposite view:

No, I do not see that. The department is supposed to be a part of the hospital but I think that its management should be appointed by the central administration which would control and supervise the department's work (Participant 7).

The Department of Patient Rights and Relations needs the cooperation of other departments if it is to perform its tasks of protecting patients from any violation, with any degree of success. Four respondents mentioned that at present, cooperation was based mainly on personal relationships.

The manager of the Department of Patient Rights and Relations can offer many things for patients simply if he or she has good or close connections with certain officials in other departments but if the relationship is poor, the manager might not be able to do these things (Participant 1).

Another added:

Every department depends on its own efforts and on its relations with hospital management and other departments inside and outside the hospital (Participant 9).

5.3.5 Patient awareness

All managers and experts agreed on the importance of awareness among the public, including professionals and patients. Community awareness of the rights of patients is a major responsibility of the Ministry of Health, and to this end they have established a department called the Public Relations and Health Media, which has strong connections with official government media, as well as with private media. The tools are available but the issue, as one expert explains, is how to use them effectively to serve your goals. The expert participant explained that the Ministry of Health cannot rely solely on traditional methods to promote its ideas but must diversify and modernise to keep pace with the aspirations of the community. The Ministry of Health needs to make changes in the form and content of its messages to reach its goal.

Most respondents said that patients had become more aware of the existence of their rights and affirmed that besides these changes in attitudes towards the existence of these rights, patients had begun demanding them in hospitals.

I feel that people in developed countries know their rights but in our country, only a limited number know about their rights in hospitals. The majority are not familiar with their rights. In fact, the concept of rights is absent in the wider society; however, I have noticed recently that some patients are beginning to ask about their rights and what they can demand (Participant 1).

Yes, I noticed a sense of awareness among patients that they have rights, and this was absent in the past. Whereas before, patients would ask for service timidly, now they are demanding it vigorously. This often happens with patients who are aware of their rights. Of course, not all patients are aware of them. Frankly, patients nowadays are feeling a sense of power, and the effect can be seen among service providers who have become more lenient and sympathise with patients in most cases (Participant 7).

5.4 Key informants on the most important elements facilitating the implementation of the Bill

This section explores and describes the perspectives of managers and experts concerning factors that facilitate the implementation of the Patient's Bill of Rights. The interviewees suggested a number of factors that can enhance the process of implementation. These elements facilitating the implementation of the Bill can be discussed on the levels suggested by the positive culture of patient rights framework (Figure 1.3). The framework suggested three different levels: macro (the Ministry of Health), meso (hospital management and community) and micro (health professionals; doctors, nurses, staff of Patient Rights and Relations Department, and patients).

Thematic analysis revealed four domains and ten major themes which positively influenced the implementation process (see Figure 5.1). In many cases, themes, and sub-themes were identified as being on more than one level because all levels are linked together. Interviewees identified a variety of factors related to one level or more that they felt enhanced the implementation process.
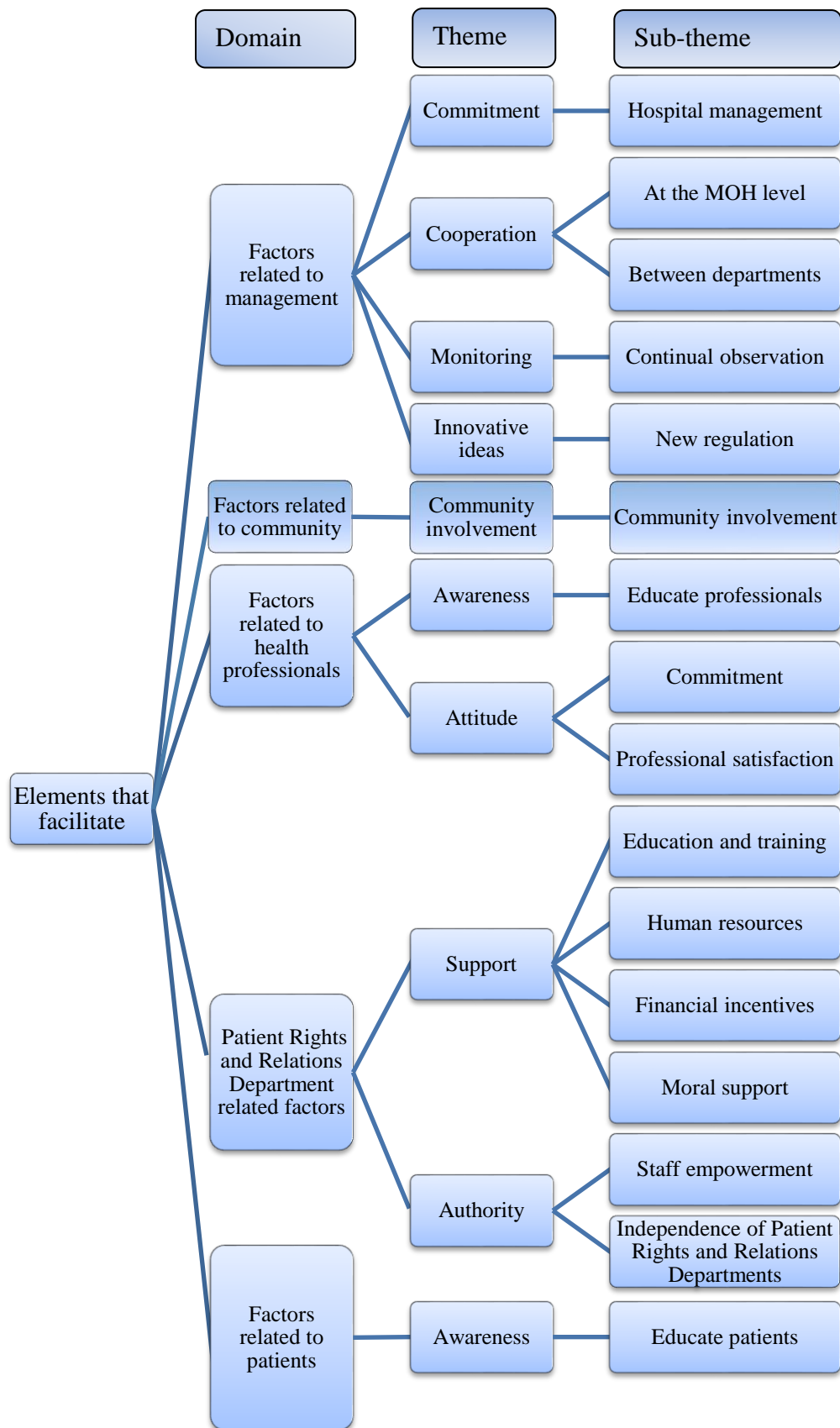
Figure 5.2. Domains, themes, and sub-themes of the elements participants perceived facilitated the Patient's Bill of Rights.

As shown in Figure 5.1, five domains emerged: (1) factors related to management, (2) factors related to community (3) factors related to health professionals, and (4) Patient Rights and Relations Department-related factors, and (5) factors related to patients.

5.4.1   Factors related to management (Macro and meso levels)

Both experts and managers judged that factors related to hospital management were important for enhancing the implementation of the Bill. These factors mainly include four major themes: (1) commitment, (2) cooperation, (3) follow-up, and (4) innovative ideas. Table 5.1 shows the codes and sub-themes for each theme. In many cases, themes that experts and managers identified as managerial-level factors were linked to factors in other domains.

a)   Commitment

Four respondents expressed the view that commitment is one of the main factors in the successful implementation of the Bill. The commitment of both the Ministry of Health and hospital management play a key role in ensuring that every actor has a clear understanding of the implementation process. It is expected that all parties will show a clear commitment and willingness to protect and promote patient rights and to address any problems that face patients in relation to their rights. The participants identified commitment as one of the elements that facilitates achieving the goals of the Patient's Bill of Rights. A participant illustrated this by saying:

> Senior management also, as well as the general supervisors (in the Ministry
> of Health), should show a strong commitment to the Bill (Participant 1).

It is not only the commitment among the Ministry of Health and senior management that is critical to the success of the implementation, but also the commitment by individuals. These individuals include health professionals, non-medical staff, managers at the hospitals, and departmental levels. One participant emphasised the importance of the commitment of doctors and the special need for intervention from management to "force" them to show their commitment to the implementation of the Bill in hospitals. The following quotation exemplifies his concerns:

> Hospital management should try hard to find ways to force doctors to
> understand the Bill and abide by it. Distributing and publishing the Bill means
> that the hospital should show a strong commitment to it, so how is it that the

hospital is committed to providing something that its staff does not adhere to? (Participant 1)

All the following themes relate strongly to senior management in the Ministry of Health or in hospitals. The commitment of management can be shown in proper cooperation, unlimited support, continued follow-up, and in encouraging innovation.

b) Cooperation

Most participants emphasised that the Ministry of Health and other governmental bodies, such as ministries and universities, should combine their efforts at the national level to protect patient rights and promote the implementation of the Bill. The cooperation of the Ministry of Health with the Ministry of Education could facilitate the inclusion of teaching about patient rights in the school curriculum and the Ministry of Health could encourage the universities to introduce new programmes or degrees in the field of patient rights. In cooperation with the Saudi Commission for Health Specialties, the Ministry of Health may propose adding questions concerning the rights of patients to the tests for health practitioners. Moreover, cooperation may include creating a new advocacy department and enforcing the Patient's Bill of Rights as law. These actions are expected to improve the implementation process.

All participants agreed that increased comprehensive cooperation between the Ministry of Health and the media is critical to promoting patient rights among the public. They mentioned the need to create a long-term relationship of trust with traditional media providers that can facilitate the implementation process. One participant explained:

> Strengthening the connection between the Ministry and the media and developing new methods to publish and distribute the Bill, such as writing a scenario of a specific problem and purposefully acting out a scene to show how it was solved, would further educate people and raise their awareness (Participant 1).

Two participants highlighted the importance of developing cooperation with international healthcare organisations to benefit from their experience in the field of patient rights. The cooperation with international organisations will promote high quality standards in the implementation process and evaluation. This action would yield substantial benefit to the Ministry of Health and hospitals by exchanging experiences, utilising best available expertise, improving global solutions, and developing proper approaches.

> Learning from international experience is very important. A field visit to one
> of the developed countries is very, very important for becoming familiar with
> the difficulties they face and how to overcome them, in addition to being
> aware of how to work in an appropriate and efficient way (Participant 3).

Several participants stressed that the media includes not only television and the press but also social networking sites that seem to attract people more, especially the younger generation. These can play a critical role in building more meaningful links with the public and engaging individuals in the process of implementation of the Bill.

With regards to cooperation between hospital departments, two respondents mentioned that such cooperation was essential to the successful implementation of the Bill. The most important cooperation they said was needed was a quick response to the Patient Rights and Relations Department or patients' concerns and complaints.

> The great facilitator is cooperation between Patient Relations staff and the
> different departments in the hospital to resolve the problems of patients and
> their companions (Participant 5).

c) Monitoring

Performing regular monitoring and evaluation of the implementation process is an essential factor enhancing the overall objective of the implementation of the Bill. Two respondents stressed that the Ministry of Health should take ultimate responsibility for the implementation of the Bill by following up closely with hospital management to ensure that the implementation process goes as planned. Continual observation and monitoring are required to investigate the actual situation of implementation of the Bill in hospitals. An effective monitoring system is needed to apply prompt response at an early stage so the corrective action can be taken on proper time. One respondent explained:

> The Ministry has all the statistics about the hospitals, their capacity, and the
> number of service recipients per day, so it should provide what is needed for
> each hospital and follow-up with its management to evaluate implementation
> of the Bill (Participant 1).

d) Innovative ideas

Most respondents stressed that the Ministry of Health should pursue the adoption of a number of new, creative ideas to support the implementation of the Bill. It is not the role of the Ministry

of Health alone but hospitals should gather innovative ideas from health professionals, other staff, and patients. The majority of the ideas related to the following topics: constructing new regulations or policies, adding services, or conducting research.

Respondents focused on promoting awareness among new staff and suggested adding the topic of patient rights to the recruitment policy to make sure every single new staff member knew the Bill well and perhaps was tested on it. For instance, one respondent recommended:

> Every new employee in Ministry hospitals should read the Bill before signing
> the contract (Participant 2).

With regard to current staff, four respondents recommended creating a punishment and reward system to control staff behaviour. They believed that could help foster good behaviour and discourage the bad.

> If we don't have any direct punishments, we will see no commitment or
> achievements at all. I think that focusing only on educating staff on what's
> there in the Bill will not be effective enough to achieve any concrete outcomes
> on the ground. Generally speaking, any Bill that is not directly linked to a
> penalty or punishment system will not be applied appropriately, except by
> those who have an internal deterrent that urges them to do good things and
> prevents them behaving badly (Participant 8).

Others, however, thought such a system would only be a "quick fix" that would not solve the problem completely and was not a long-term solution. Instead, they believed that if people found that certain behaviours were rewarded, they usually tended to adjust their behaviour accordingly. One respondent recommended:

> Incorporating the implementation of the Bill with health recognition systems
> for practitioners or health workers at the national level (Participant 4).

Another idea was to revise the complaint procedures so that they were unified and understandable for all parties.

5.4.2 Factors related to community (Meso level)

One of the main fundamental responsibilities of the Ministry of Health is provideg an opportunity for community involvement in the implementation process. Ministry of Health involvement in the implementation of the Patient's Bill of Rights is expected to increase the

chance of its success and to contribute to the reduction in violation incidents. Six respondents suggested that community involvement creates the sense of ownership necessary to facilitate effective implementation of the Bill. It also has a positive impact on the success of the implementation process. For example, one respondent said:

> The primary factors that led to good implementation are getting the local community involved in applying the Bill by meeting some of its spokesmen, in addition to setting up regular contact with them (Participant 4).

However, there are no active community groups or organisations in Saudi Arabia. This enlarges the responsibility of all government authorities to enhance the participation of the public in the services provided to them, including healthcare.

5.4.3 Factors related to health professionals (Micro level)

Themes in this part focus on factors influencing the awareness and attitude of the hospital staff, mainly health professionals. The experts and managers note that these factors are essential aspects which promote the success of implementation of the Bill.

a) Awareness

All respondents agreed that the most important element that facilitates the implementation of the Bill is building awareness among professionals and staff by educating them about the Bill and the steps for its implementation. The Ministry of Health and hospital management have a continuing role in educating professionals and promoting the Bill. This role should include educating them how to implement the terms of the Bill and how to ensure that all patient rights are fully respected and protected.

Several respondents stated that health professionals' awareness can be enhanced in many ways, including meetings, training workshops, and regular campaigns. One of them mentioned that it is very important to connect the training courses with some kind of recognition, and recommended:

> Holding more training and development courses to improve service and giving more opportunities to employees keen to develop themselves, bearing in mind that most employees are not interested in acquiring training certificates because they think they add nothing to them (Participant 9).

New technology such as Internet, social media, and smart phone applications can be used for teaching and informing purposes. A respondent suggested using technology to link professionals with the Bill.

> I see that the whole situation would be much better if the hospital were to send a daily e-mail to the doctors, put one of the patient rights on their computer screens as a reminder, hold workshops, or put banners at the entrance (Participant 1).

b) Attitude

Great effort should be made in activities that can change health professionals' practices and attitudes towards patient rights. The performance of health professionals is influenced largely by their attitude and responsiveness to patient rights' topics. Two respondents identified health professionals' own attitude towards the implementation of the Bill to be one of the most influential factors.

The positive attitudes from professionals are crucial for the creation of their accountability and commitment towards the Bill. Health professionals' commitment was the key factor enhancing the implementation process, as one respondent reported.

> Commitment – if all employees and staff, nurses, and doctors, committed themselves to whatever is specified in the Bill along with their rights and duties, it would succeed (Participant 1).

One of the most important factors that can improve professionals' commitment was their job satisfaction in hospitals. Increased satisfaction among professionals is most likely to lead to greater retention and performance inside hospitals, which in turn supports the implementation process. One respondent asserted that professional satisfaction was a factor in the success of the implementation of the Bill.

> The satisfaction of employees and how much they love their work are important factors as well (Participant 3).

5.4.4 Patient Rights and Relations Department related factors (Micro level)

a) Support

All respondents agreed on the significant role played by the staff of the Patient Rights and Relations Department and on their great need for support. Eight participants highlighted the

necessity of giving this department financial incentives, because most of the time they work under constant pressure. Patients or their companions who contact the department are always angry because of some problem they face. For this reason, financial support is strongly required by the department staff, one participant said:

> It is necessary to support the Patients' Relations staff with some financial benefits and understand that they are subject to various kinds of pressure: talking with angry patients, meeting patients with infectious diseases, getting assaulted by patients' families, enduring patients' insistence that they deal with their grievances and complaints throughout the day. Employees spend most of their time either looking for a doctor or telling patients what happened regarding their problems. At the same time, their colleagues in other sections and departments may be relaxing in their offices but receive similar salaries at the end of the month (Participant 9).

Three respondents reported that many of the staff of the Patient Rights and Relations Department leave the department after a short time because there is no benefit to be gained, only more headaches and stress. This is because many of the department's staff compare the effort they spend when dealing with the problems that they face, and with the benefit that they get in term of salary, incentives, and rewards. Another type of support that the staff of the Patient Rights and Relations Department need is moral support. The hospital management should provide moral support for each staff member to motivate and encourage them to overcome several challenges they face on daily base. In addition, the Patient Rights and Relations Department needs Ministry of Health and hospital management support to acquire resources, such as office premises, necessary equipment, materials.

b) Authority

The Patient Rights and Relations Department need a sense of power if they are to complete their roles successfully. Such official power can be obtained from management by strengthening the department's hold over other departments and over the department's own human resources. Lack of authority towards the staff of the department is one of the related factors affecting the voice of the staff themselves. Two participants remarked that the empowerment of the staff of the Patient Rights and Relations Department in hospitals had a great impact on the implementation process. One respondent reported.

I see that the Department of Patient rights is the right place in any hospital to defend the patient, so it should have full authority to follow through on its decisions. Its members need a measure of power to enable them work effectively (Participant 1).

One means to empowerment of the department as a whole is to secure its independence from hospital management. Four respondents supported the idea that independence would contribute positively to supporting the implementation of the Bill. One participant explained.

To strengthen the Patient Rights and Relations Department, it should be separate from hospital management. The best way to do that is by making it an independent committee (Participant 4).

Some respondents, however, were not convinced of the necessity to make the Patient Rights and Relations Department independent and preferred that the department remain part of the hospital at this early stage. For instance, one respondent declared:

Being separated from the general administration at this time will cause major problems due to the shortage of human and financial resources in the department. In future, however, when the department gets bigger, I think things will be more positive and this will support the Bill and strengthen those factors controlling its implementation, in addition to having more transparency in its work (Participant 6).

5.4.5 Factors related to patients (Micro level)

a) Awareness

A key element of the Ministry of Health's responsibility is raising awareness of implementation of the Bill. All respondents agreed on the vital role of the patient and public awareness in the implementation process and that the Ministry of Health should continue to promote the Bill and make every effort to raise the awareness of the public and patients. Several interviewees thought this role should be accomplished by hospital management as well as by the Ministry of Health. For instance, one participant said that:

Public awareness is very important. I believe that this role is part of the responsibilities of the Ministry of Health first and then hospitals (Participant 1).

Producing visual materials through the media, hosting famous people, distributing a copy of the Bill to every single patient, and organising regular conferences are some ways the respondents suggested would support the implementation of the Bill. The Ministry of Health ignored the role of educational organisations to raise the public awareness of the Bill. Educational organisations such as schools, colleges, and universities were mentioned frequently in the interviews. One participant pointed out:

> The importance of building knowledge about patient rights at school level to establish a knowledgeable, aware generation and in turn create a new generation with some good new values (Participant 5).

5.5   Key informants on the most important barriers

This section discusses barriers to the implementation of the Patient's Bill of Rights as assessed by managers and experts. Barriers encountered can be grouped into four domains: management related factors, health professionals' related factors, Patient Rights and Relations Department related factors, and patient-related factors. These barriers can be discussed on the levels suggested by the positive culture of patient rights framework (Figure 1.3). The framework suggested three different levels: macro (the Ministry of Health), meso (hospital management and community) and micro (health professionals; doctors, nurses, staff of Patient Rights and Relations Department. Key informants mentioned no barriers related to community roles, so this element was not included in this section.

Figure 5.2 displays the four domains and eleven themes. Further sub-themes were identified within each of these themes.

Domain	Theme	Sub-theme

Domain: Factors related to management
- **Theme:** Lack of conviction
  - **Sub-theme:** Lack of conviction about the importance of the Charter
- **Theme:** Ambiguity of the implementation process
  - **Sub-theme:** Weak implementation of the Charter
  - **Sub-theme:** Complexity of the complaint process
- **Theme:** Absence of collaboration
  - **Sub-theme:** Lack of collaboration from other departments
- **Theme:** Failure to use the media
  - **Sub-theme:** Low interest from media

Domain: Factors related to health professionals
- **Theme:** Lack of awareness
  - **Sub-theme:** Lack of awareness
  - **Sub-theme:** Lack of training
- **Theme:** Negative attitude
  - **Sub-theme:** Poor communication with patients
  - **Sub-theme:** Low moral competence

Domain: Patient Rights & Relations Department related factors
- **Theme:** Lack of support
  - **Sub-theme:** Lack of protection for the staff of Patient Rights and Relations Department
  - **Sub-theme:** Lack of financial incentives
  - **Sub-theme:** Lack of moral support
- **Theme:** Shortage of resources
  - **Sub-theme:** Shortage of human resources
- **Theme:** Weakness of the department
  - **Sub-theme:** Poor performance
  - **Sub-theme:** Intervention from senior management

Domain: Factors related to patients
- **Theme:** Lack of awareness
  - **Sub-theme:** Lack of awareness
- **Theme:** Patients' companions and relatives
  - **Sub-theme:** Presence of patients' companions and relatives

Figure 5.3. Domains, themes and sub-themes of the participants' perceived barriers

189

5.5.1 Factors related to management (Macro and meso levels)

Various barriers related to management were identified at all levels of the health system, including senior management at the Ministry of Health, management of the General Department of Patient Rights and Relations, hospital management, and patients. The main domain for the management-related factors comprises four themes: lack of conviction, ambiguity of the implementation process, absence of collaboration, and lack of use of the media.

a) Lack of conviction

The lack of clarity about the objectives for the implementation of the Bill and the feeling that the implementation process was too complex to understand could have created a lack of conviction among managers. About half the respondents agreed that one of the most important factors hindering the implementation of the Bill was the lack of conviction about its benefits. This arose as a serious concern when this lack of conviction about the need for the Bill occurred among senior management at the Ministry of Health or at the hospitals level. A participant said:

> Perhaps one of the barriers is hospital management's lack of faith in the importance of these rights (Participant 6).

Underlining this ignorance of the importance of patient rights, one manager was eager to give the Patient Rights and Relations Department due appreciation as a very important department in hospitals but was frustrated by the reluctance of higher management to approve.

> Some managers do not include the Patient Rights Department among their priorities. For me, I consider the Department of Patient Rights and Relations as the real interface not only for hospitals but also for the Ministry itself… The problem is that senior management doesn't care much, especially if the work is achieved, as they suppose that things are fine (Participant 1).

Half the respondents noted that hospital managers showed their support for the Bill in meetings and speeches but in practice they had no hesitation in violating patient rights. They mentioned that hospital managers expressed their confidence in the Bill but respondents claimed that this public confidence usually concealed a lack of conviction in what was being said. These activities indicate either a lack of conviction or confidence in their minds. A participant gave an example of some managers he noted in his experience.

It has been observed that the hospital directors or even some department directors believe theoretically in the importance of the Bill and say so but when it comes to implementation, they ignore many of its articles, giving trivial excuses such as not having the ability to achieve them. Actually, this is one of the problems (Participant 1).

These signals may reflect a significant lack of conviction in its importance and effectiveness among senior management. This lack of conviction may undermine their efforts and may also lead to a lack of commitment, which in turn may end with the failure of the entire implementation process. Participants believe that hospital management should be encouraged and persuaded because they cannot implement what they do not strongly believe in.

b) Ambiguity of the implementation process

Many respondents declared that the absence of clear implementation rules hampered the implementation process and placed hospital management in some uncertainty about the implementation of the Bill. As a result of this ambiguity, the ways in which each hospital implemented the Bill were inconsistent and some hospitals did not implement all of the Bill. Based on his own experience, one of the participants explained the problem with the implementation rules:

The General Department of Patient Rights and Relations has no clear rules of how to implement the Bill although it is the actual supervising body for the programme … Another problem is that there are some items and elements that the hospital doesn't apply; however, our aim should focus on bridging the gaps as much as we can (Participant 9).

Managers stated that the implementation process is a core element that ensures the success of the goal to implement the Bill. At the early stage of implementation, the Ministry of Health and hospital management focused their attention on the Bill's content rather than on the implementation process. One participant stated that senior management concentrated more on the Bill and its content rather than on the implementation process.

[They did] not pay much attention to the application stage. The problem with the Ministry and the General Department [of Patient Rights and Relations] is that they focused on the Bill and its content, and have forgotten how to take care of its implementation. Their tendency and plans focused on how to

191

publish and distribute the Bill and introduce it to the patients, forgetting all

about who is going to apply it (Participant 6).

Participants noted that the ambiguity of the complaint process is one of the main barriers to successful implementation of the Bill. Simplifying and promoting the complaint process and channels aids in removing the ambiguity of the process and helps patients and their families to feel safe and protected. Most managers and experts showed that they were unhappy about the length and complexity of the complaint process. An explanation of the process at the admission may resolve some concerns and ensure better understanding. One participant noted the lack of a clear mechanism to deal with complaints.

For example, the Ministry has given some phone numbers to call in the case

of having complaints, but without a clear mechanism. Unfortunately, there

are no clear paths for making complaints (Participant 7).

Overall, respondents indicated that they had no clear knowledge of how to make a complaint. The long, complex process for patients' complaints should be looked at carefully and with urgency to secure the successful implementation of the Bill. Implementation should be specific and planned step-by-step so that there is no ambiguity or complexity in the complaints process.

c) Lack of collaboration

The absence of collaboration among departments was one of the causes of high resistance among other department staff. Four of nine participants reported that the lack of collaboration between departments and across levels of the Ministry of Health and hospitals is responsible in part for the challenges facing the proper implementation of the Bill. Respondents reported that there had always been a poor level of collaboration between departments on patient rights issues. A culture of collaboration need to be established within each hospital. One of the respondents described failures of collaboration with one department:

I think that the most important factor is the lack of cooperation from the

admission desk. If the desk clerks gave a copy of the Bill to each patient, they

would contribute to solving the problems of patients' lack of knowledge of

their rights (Participant 9).

Some managers commented that departments and hospitals could learn more from each other if they would collaborate fully, acknowledging one another. According to the participants, several departments were unaware of the importance of this kind of collaboration or how to

implement it. The lack of collaboration between departments is more likely lead to disorganised utilisation of available resources and yield little change. Others mentioned the absence of direction or internal motivation impelling departments to encourage their staff to seek to work closely with other departments in the implementation process. One of them noted:

> There is a lack of interest and motivation of some departments, both in the Ministry and in hospitals, to publish the Bill and compel their staff to have recourse to it and get some training on what's covered in it (Participant 4).

Clearly, participants believe that the enhancement of collaboration between departments can make a substantial difference. These enhancements can be achieved through organisational regulations, meetings, and training for all departmental managers and staff concerned. An increase in the level of collaboration between departments in hospitals and the Ministry of Health would facilitate the implementation process and provide shared experience when some departments do not have it themselves.

d) Failure to use the media

The mass media play a significant role in increasing public knowledge about the implementation of new programmes, policies, or regulations. The failure to use traditional media can create a large gap between organisations and the public who are supposed to be the main beneficiaries of these new programmes or regulations. Most respondents agreed that the failure to exploit the media resulted in a lack of public awareness, which is a major barrier to the implementation of the Bill. A respondent explained:

> I think the Ministry needs to use the visual and written media more effectively to reach a larger slice of patients and staff, and this is what they actually need before the application. In the hospitals, we cannot reach all groups that have problems or inquiries; however, TV messages reach all segments of society, young and old, employees and patients, everywhere, in the city and village and so on. The message should be clear and contain only the rights and responsibilities of patients. The poor current relationship with the media is an obvious barrier. Everybody knows but no one officially says this (Participant 7).

One respondent suggested that perhaps the reason for the failure to use the public media is that the Ministry of Health has its own department which is responsible for health promotion, so it

has been anxious to use this department instead of the commercial media. Three participants explained that the media department within the Ministry of Health has no actual involvement in promoting the Bill or supporting the implementation process. This point can be linked with the previous factor, the lack of collaboration between departments. Another respondent stated:

> Unfortunately, there is not enough interest from the media in general regarding the Bill. The link is still missing between the Ministry and hospitals on the one hand and the media on the other. At this stage, moreover, senior management does not deal with the media outside the scope of the Ministry (Participant 2).

The media has had a negative relationship with the Ministry of Health, as two respondents pointed out. They mentioned that the media deliberately target the Ministry of Health's mistakes and amplify them, without mentioning achievements either by the Ministry of Health or its hospitals. A respondent asserted:

> One of the biggest obstacles is the media's reporting on health and communication in the Ministry of Health. They do not highlight the achievements of the Ministry. On the contrary, they keep reporting only the problems. The Ministry has not made much effort to cooperate with the media to publish the Bill through its various channels and means, so has been unable to highlight the correct form and manner of the Bill (Participant 6).

Another respondent emphasised the same point:

> The media have the negative tendency to publish accounts of problems and unlikely stories and they neglect to publish the response from the authorities. This leads to weakening people's confidence in health service providers (Participant 5).

5.5.2 Factors related to health professionals (Micro level)

It was suggested that there were several factors that constituted barriers in relation to health care professionals. Although health professionals have the major role in implementation of the Bill, some factors impede this. Factors that are a barrier that emerged from the interviews were a lack of awareness and a negative attitude.

a) Lack of awareness

The most important barrier reported by managers and experts was the lack of motivation among professionals to implement the Bill. Respondents noted that there was a general lack of awareness among professionals working in hospitals, especially doctors, and even if they knew about the Bill, they did not know how it could be implemented. One respondent declared:

> Therefore, it is necessary to make them aware of the importance of this issue and its sensitivity for the hospital. For example, they should know whether they are permitted to ask patients about certain issues or not. Unfortunately, doctors do not know the Bill and are not ready to read it and understand its articles (Participant 1).

The lack of awareness about the Bill among health professionals combined with the lack of awareness among patients can create general ignorance about the implementation process. When professionals have no information about the implementation of the Bill, they cannot provide patients with adequate information about the rights they can ask for. One respondent suggested:

> Lack of awareness about the Bill among patients and health care providers is an issue. The Bill was there but was not explicitly formulated. With the beginning of the implementation of the Patient's Bill of Rights in the Ministry of Health, it has become an official document to be followed by all health providers in Saudi Arabia. Unfortunately, the staff and patients are ignorant of the Bill (Participant 2).

This lack of awareness can include ignorance of the benefits, ignorance or misunderstanding about the Bill, and a lack of education and knowledge about the implementation process. Most respondents explained that when health professionals consider the implementation of the Bill unimportant, most likely they are unaware of its content and benefits.

b) Negative attitude

The negative attitude of health professionals regarding the implementation of the Bill was considered an important factor in the failure of the implementation process by four respondents. Barriers contributing to this attitude on the part of health professionals include lack of motivation, lack of self-reflection, loss of interest, and fears relating to the implementation of the Bill. This negative attitude may cause frustration and pessimistic feelings among

individuals. It leads to frequent criticism and refusal to change, as well as an insistence on persisting with previously held ideas, ignoring, rejecting, and criticising others. These negative attitudes on the part of professionals act as a barrier to the implementation of the Bill.

One respondent highlighted the point that in addition to a lack of self-reflection among professionals, the absence of firm regulations preventing any violation can lead to the creation of a culture of carelessness. This respondent reflected:

> When the individuals lack self-reflection, there will be no deterrent for them apart from imposing penalties and punishments imposed by laws and regulations (Participant 8).

Two respondents mentioned that a negative attitude towards the Bill is common among health professionals. Usually most people are comfortable with the working style they have adopted for many years, and therefore they strive to avoid change. It has become part of hospital culture and therefore requires more effort to change.

> The most important factor is related to what large numbers of workers have accepted from those who preceded them on how to work and deal with others. Yes, the main reason for this is that current workers inherited their methods and modes of behaviour from those who preceded them and therefore it is difficult to change them. In fact, it is difficult to change these people's culture and mentality simply by introducing a new system or programme but suitable motivation could induce change in some people in that group (Participant 4).

Some managers explained that many professionals are afraid that any initiative to implement the new Bill with patients may be used against them. This fear makes health professionals try to ignore, delay, or fail to mention the Bill to patients who do not know about it. As one participant pointed out:

> Some are afraid that if the Bill is given its proper place, they will lose some of their perks. For example, if the Bill is fully applied, they will not be able to come to work late as many of them do at present (Participant 1).

More than one respondent stated that attitudes are not permanent and can be acquired and changed by motivation and encouragement. One expert also suggested that by involving professionals and improving their knowledge of the Bill, their motivation, and interest in it increased.

5.5.3 Patient Rights and Relations Department related factors (Micro level)

Although various barriers were frequently noted as hindrances to the successful implementation of the Bill, factors relating to the Patient Rights and Relations Department were mentioned most often. There were three main barriers: lack of support, shortage of resources, and the weakness of the department. This result may show the important role the staff of this department play in the implementation process.

a) Lack of support

The Patient Rights and Relations Department, without sufficient support from hospital management and the Ministry of Health, cannot achieve its set goals. All interviewees reported that they had encountered one or more instances of lack of support for the Patient Rights and Relations Department and their staff. Two experts were convinced that this lack of support was the main indication of the failure of the implementation process. One manager, however, claimed that the Minister and the General Department of Patient rights and Relations had made a great effort to give support but the large number of departments that had been created in a very short time had caused these limitations in most hospitals. Lack of support is considered the most important barrier to implementation of the Bill, according to the experts and managers.

b) Lack of staff protection

The first area where support is lacking is in staff protection. The interviewees mentioned that the lack of protection for the staff of Patient Rights and Relations Department negatively affected them. The threat comes from the management they work for and also the patients they serve. Threats from management include changing the manager of the Patient Rights and Relations Department and meddling in the work of the department. One participant outlined the situation:

> Generally speaking, if you would like to have a loyal employee, you must be his/her boss. Currently, the hospital director selects the Patient Relations department manager. Since he/she [the manager of the Department of Patient Rights and Relations] is appointed by the director of the hospital, he/she is also assessed by the same person. He/she may be punished by the director of the hospital and moved to another place or position. The hospital director also is the only one who can grant or prevent that manager from obtaining financial incentives. On the one hand, the director cares mainly about showing the hospital in its best light but on the other, the Patient Relations director is the

one who may spoil this desired image, something they may not do because he/she is controlled by the director. So it is clear that the weakest link in the chain is the manager of the Patient Relations Department. Its staff are frequently required to deal with issues where they cannot guarantee their accuracy or integrity (Participant 8).

The second threat comes from patients and their relatives. One assumes that staff of the Patient Rights and Relations Department come to work without fear of any kind of violence or harassment from anyone. Managers revealed that staff of the Patient Rights and Relations Department have no protection from the patients they meet every day, who may be under stress or have psychological issues. In addition, there are the patients' relatives who usually cannot control their emotions and behaviour when they feel their loved ones have been violated or abused. The consequences of all this are unpredictable and may possibly lead to violent behaviour against the staff of the Patient Rights and Relations Department because they are always in the front line. The violation may take many forms, for example yelling, screaming, throwing items, or hitting staff members. As one participant pointed out.

There is no protection of any kind for the rights of the staff of the Patient Rights and Relations Department in a hospital, who must deal with very upset patients and relatives and various embarrassing situations with their colleagues in the hospital (Participant 1).

It is clear that the staff of the Patient Rights and Relations Department are among those who are more at risk than others. The respondents emphasised the importance of putting new policies and guidelines in place to protect the staff of the Patient Rights and Relations Department from both management and patients.

c) Lack of financial incentives

It seems that it is a common belief that the failure to offer financial incentives constitutes a considerable barrier to the success of the implementation of the Bill. Financial constraints can discourage the staff of the Patient Rights and Relations Department from making an extra effort in supporting the implementation process. The respondents complained that they face a lot of pressure and a heavier workload compared to others. One respondent illustrated how important it was:

To support the Patients' Relations staff with some financial benefits and understand that they are subject to various kinds of pressure: talking with angry patients, meeting patients with infectious diseases, getting assaulted by patients' families, enduring patients' insistence that they deal with their grievances and complaints throughout the day. Employees spend most of their time either looking for a doctor or telling patients what happened regarding their problems. At the same time, their colleagues in other sections and departments may be relaxing in their offices but receive similar salaries at the end of the month (Participant 9).

Three participants asserted that the department regularly loses good staff members as a result of the absence of any motivation that would induce them to stay on at the department. Participants have confidence that financial incentives would prevent staff from leaving the department and that furthermore, positions in the department would be in demand from outstanding workers.

d) Lack of moral support

Although most respondents maintained that financial incentives provide motivation, some suggested that other kinds of incentive can have a beneficial impact on motivation. One participant said:

Motivation might be financial, such as an increase of 10-30% of staff salary as an allowance for excellence. Motivation might also be psychological and take the form of moral recognition, for example putting the names of staff in a prominent place. This may lead to some change (Participant 4).

Moral support is a vital factor that improves an individual's sense of internal wellbeing and is also an indicator of a healthy relationship among staff. Respondents recommended that the staff of the Patient Rights and Relations Department be provided with appropriate moral support, such as appreciation and recognition. This can be done in several forms in weekly, monthly, or yearly gatherings and facilitated by the presence of the hospital manager or by someone from senior management in the Patient Rights and Relations Department. Based on personal experience, a participant described how important moral support is to staff.

Account should be taken that moral, that is psychological, motivation leads to positive results, and moral and motivational support may lead to greater

change. I will give you an example of psychological support. Some years ago, one of the hospitals decided to honour a distinguished employee and this led to a dramatic reduction in the number of complaints against service providers (Participant 8).

Two of respondents felt that most staff of the Patient Rights and Relations Department were not given appropriate moral support when they needed it. The absence of moral support led them to feel lonely and isolated in the hospital. They all agreed that moral factors are among the most basic needs for the staff of the Patient Rights and Relations Department.

e) Shortage of resources

A number of respondents reported that the staff of the Patient Rights and Relations Department occasionally experience a lack of essential resources, including personnel and supplies. This lack was observed mainly at hospitals with a large number of patients. One respondent commented.

> The problem with the hospitals has to do with the lack of good human resources and the absence of good material and financial support. Every department depends on its own efforts, and its relations with the hospital management and other departments inside and outside the hospital (Participant 9).

Participants believed that the main challenge was the short of qualified staff. The Patient Rights and Relations Department faced a constant shortage of resources during the year. Several staff members mentioned that some departments in rural hospitals were short of basic supplies, such as computers, an Internet connection, and space for staff, but they managed to cope with the situation because of their strong personal relationships. One participant described the difficulties.

> Most of Patient Rights and Relations Departments are shortage of personnel and this could negatively affect the performance of the employees because they work all day under intense pressure from the service recipient. Sometimes, four or five people come to our department at the same time. It should be considered that the employees also have to take calls and accomplish other (earlier) tasks. The patient relations staff are supposed to have their own offices because, generally speaking, most people who visit the

department are under pressure and are angry and worried about their patient relatives. So how can the employees calm them down and talk to them if there is no office to sit with the patient or the patient's relatives? (Participant 1).

f) Weakness of the department

All managers conceded that the biggest challenge was the weakness of the Patient Rights and Relations Department in the hospitals. These weaknesses include staff selection, staff management, staff protection, constraints on resources, and interference from hospital management. One manager suggested that the Patient Rights and Relations Department is not as strong as the other departments because of the weakness of the General Department of Patient Rights and Relations in the Ministry of Health. This department derived no benefit from its direct relationship with the Minister when it was first established, and its performance and presence at both ministerial and hospital levels has been very weak and limited.

> The department failed to exploit its direct association with the Minister and training has not been planned well, as shown in the very weak output of the early Patient Rights Department staff. As I said, all of this reflected on the employees and their poor performance (Participant 8).

The respondents reported that this powerlessness often puts more pressure on the managers and staff of the Patient Rights and Relations Department, resulting in an increase in employee carelessness, increasing the number of staff lost from the department, and staff evasion of responsibility. These can lead to ineffective action by the department and sometimes no action at all. One respondent explained.

> Honestly, some critical and unforgivable mistakes occasionally occurred from some critical, unforgivable mistakes occasionally occurred from important professionals in the hospital but no one can do anything, but can only hope that everything will go well… If the Department [of the Patient Rights and Relations] was independent, however, its staff could talk to anyone at the hospital, regardless of their position or prestige (Participant 9).

Furthermore, participants stated that interference from senior management in hospitals made the department weaker. It created a frustrating environment for the staff of the Patient Rights and Relations Department, as one participant explained:

I see that there is a willingness on the part of the Patient Rights and Relations Department and many other departments to respond to patients' requests but there are some obstacles which lie beyond the scope of our authority. For example, some of those obstacles may arise as a result of the intervention of hospital management. The General Department of Patient Rights and Relations asks them [the management of the Patient Rights and Relations Department] to find problems but others, including hospital management, ask them to hide the problems. This made for a frustrating environment and increase stress (Participant 1).

Another participant explained this further:

Paradoxically, the hospital administration is supposed to be monitored by the department; however, to this day managers order the staff to change and modify the numbers in order to improve the image of the hospital and show it in the best light, even though the reality is not good at all. The Department of Patient Relations is not supposed to be treated like any other service management since it is there to supervise, control, and measure the level of the provided service (Participant 7).

By controlling the Patient Rights and Relations Department, its conditions, its manager, and its employees, hospital management have gained full control over the Patient Rights and Relations Department, which is supposed to be independent. The director of the hospital has the power to move or isolate the manager of the Patient Rights and Relations Department from his position as well as favouring or elevating him. A respondent elaborated on this:

Its current status under the administration of the hospital director makes it difficult for its staff to work to the fullest, because the staff members sometimes has to choose whether to side with the patient against their manager [i.e. the hospital manager]. They might feel obliged to evade as he doesn't want to have any problems with his manager out of fear for his current and future position in the hospital. This may result in a conflict of interest in the duties and responsibilities of the Patients' Relations department. Moreover, reports prepared concerning any department in the hospital pass several stages before they arrive at the Ministry, and the Patients' Relations department cannot control any changes that may be made during this process.

It has to be recognised that, naturally, the hospital director, or general manager will not report anything they are not satisfied with (Participant 4).

5.5.4   Factors related to patients (Micro level)

There were only two barriers regarding patient factors, and these come from six participants; lack of awareness and a negative attitude on the part of some patients' companions towards medical staff.

a) Lack of awareness

A lack of awareness among patients was mentioned most frequently by respondents. This may indicate that this is a crucial barrier to the implementation of the Bill in public hospitals. The lack of awareness factor includes two important elements, namely lack of understanding and lack of interest. All respondents agreed that many patients and their families are not fully aware of the Bill or its current implementation. In addition, some patients who are aware of the Bill do not understand its content or its importance to them.

> The lack of awareness about the Bill among patients and health care providers is an issue. The Bill existed but was not explicitly formulated. With the beginning of the General Department of Patient Rights and Relations in the Ministry of Health, it has become an official document to be followed by all health providers in Saudi Arabia. Unfortunately, staff and patients are ignorant about the Bill (Participant 2).

This lack of understanding the Bill is a substantial barrier preventing people from exercising their rights in hospitals and can have a negative effect on the implementation process. One participant explained:

> In fact, the protection is there, theoretically speaking but in practice it is weak. In spite of the patient's knowledge of his rights, he cannot defend them or even secure some of them in some sectors, particularly the private ones. Patient rights are vague. For example, if a patient wants to complain, they will find that the whole matter is a little fuzzy. They will struggle and waste their time until they find the appropriate department to lodge their complaints and then they will keep following and tracking it from one administration to another till they get bored and tired, being obliged at the end to forget all about it (Participant 7).

They emphasised the importance of developing awareness of the Bill in the entire community and its importance to them and to the health system. The participants suggested a number of ways this could be achieved, such as developing educational materials and promoting the Bill in the media.

b) Patient's companion and relatives

With regard to religious and cultural aspects, it is evident that people in Saudi society always want to be close to their patient during his/her hospitalisation. This social custom can cause difficulties for medical staff, especially when companions and many relatives and friends try to intervene and inquire about the condition of the patient, as a way of their supporting him/her. These actions usually become a reason to delay the application of the Bill, as one respondent indicated.

> The large number of those who accompany the patient and keep asking about his or her condition adds negative pressure for professionals and causes confusion for them. This situation often leads to undermining the implementation of much of what is in the Bill (Participant 5).

The same respondent added an interesting point when he mentioned that there is a lack of understanding among patients' companion of the medical complications.

This situation again highlights the importance of whole community awareness and understanding of the content of the Bill.

5.6 Conclusion

In conclusion, the experts and managers described a variety of experiences and thoughts about the implementation of the Bill in public hospitals. The results from the qualitative data in this chapter show that the Ministry of Health strongly supports the implementation of the Bill; however, two vital factors are missing from this support, namely poor coordination with the media and preliminary training for hospital management.

One obvious result of poor coordination with the media was the lack of awareness among a large segment of patients and some hospital staff. The majority believe that the Patient Rights and Relations Department has had and continues to have a major role in the implementation process, with some limitations such as a lack of staff and lack of incentives. Overall, managers

and experts showed a level of satisfaction with what has been achieved, which can be considered a first step towards the desired success.

There was an almost total consensus about the importance of cooperation and collaboration between the Ministry of Health and other government agencies to promote and improve the implementation process at all levels, including cooperation with the media, universities, and schools. From the perspective of the respondents, diversification of the means of promoting the Bill and involving the community were necessary factors that facilitate its implementation. These two factors linked directly with one of the most important factors for a successful implementation of the Bill, namely an improvement in community awareness, including patients as well as health workers. Support for Patient Rights and Relations Departments and strengthening their roles and authority are extremely important for the success of the implementation process.

With regard to barriers to the implementation of the Bill from the viewpoint of managers and experts, a lack of conviction about the importance of the Bill among hospital managers was the most important factor. To this must be added the failure to take advantage of the media, which seems to be the most common factor at the various stages of implementation right from the outset. The weakness of Patient Rights and Relations Departments in hospitals and the failure to support them, seen especially in the lack of staff protection and the absence of financial and moral incentives for staff, have had a negative effect on the success of the implementation of the Bill.

The next chapter, the discussion, analyses the major themes and related sub-themes in more detail, and examines the findings in relation to previous findings in the literature.

Chapter 6: Discussion

6.1 Introduction

This chapter discusses the findings of the research to meet the research objectives:

1. To determine the readiness and ability of public hospitals to implement the Patient's Bill of Rights in two leading medical cities in Saudi Arabia.
2. To identify the factors that facilitate the implementation of the Bill in public hospitals in Saudi Arabia.
3. To identify the barriers to the implementation of the Bill in public hospitals in Saudi Arabia.
4. To examine the actual implementation of some selected fundamental patient rights.
5. To understand the different perspectives of the key stakeholders (patient rights experts, hospital managers, doctors, nurses, and patients) regarding the implementation of the Bill in public hospitals.

As noted in Chapter 3, in mixed methods research, the quantitative and qualitative findings are integrated in the interpretation phase (see Figure 3.1). It was expected that both types of findings would either overlap or complement one another, and hence this chapter discusses the study findings from this study in relation to the relevant literature and according to its objectives. The findings in this chapter have been structured and interpreted in light of the culture of the patient rights' framework established in Chapter 1 (Figure 1.3). After presenting the study findings, the strengths and limitations of the study are detailed. The implications for policy and practice in Saudi Arabia are then presented and recommendations which could benefit future research in the field of patient rights are discussed. This is followed by the conclusion.

The successful achievement of policy objectives lies in their implementation. The findings of the current research could enhance the understanding of various key stakeholders involved in the policy implementation process. Decision makers may benefit from the research findings to improve current policies related to patient rights in public hospitals. The suggestions derived from the findings help in making the implementation process more effective. Equipped with a knowledge of the current situation, an awareness of factors hindering and supporting the implementation process is important for recognising possible solutions to current and future challenges that affect successful policy implementation. The current findings also provide a

broad understanding of the reasons for failures in past policy implementation. The current research suggests that the Saudi health system can benefit from the the Public Policy Cycle Model developed by Bridgman and Davis (2003) and implement the plan and objectives in practical, sequential steps that comply with Saudi cultural, financial, and economic constraints.

6.2   Research objective 1

To determine the readiness and ability of public hospitals to implement the Patient's Bill of Rights in two leading medical cities in Saudi Arabia.

The findings of the thesis were somewhat disappointing in several major respects: there was low level of media usage to promote the Charter, the complex complaint system, the absence of advocacy services, lack of effective engagement of the public, poor support and commitment from hospital management, low level of awareness among both health professionals and patients, and the weak role of Patient Rights and Relations Departments. However, there were some positive aspects, such as the excellent support from the Ministry of Health, and positive attitudes and strong commitment from health professionals. In addition, the overall assessment of health professionals of the level of satisfaction among health professionals and patients was at a relatively good level. In contrast, the patients' overall assessment of their level of satisfaction with the level of implementation of the Patient Bill of Rights was low.

For hospitals to be able to implement the Patient rights Charter, there are several aspects that should be at least at a satisfactory level to ensure the success of the implementation process. Over the last decade, research has identified the level of implementation of patient rights, the factors affecting that implementation either positively or negatively, as well as the perception of health professionals and patients concerning implementation (Dilawari, 2016; Feyzipour, Mojarrab, Rayi & Javidmanesh, 2016; Toulabi, Kordestani-Moghadam & Pournia, 2016; Mastaneh & Mouseli, 2013; Alghanim, 2012; Joolaee, et al., 2006; Kuzu et al., 2006). However, there is a lack of research in the field assessing healthcare organisations' readiness and ability to implement the Patient rights Charter. To address this deficit, this research has adopted two different approaches to data collection, namely a cross-sectional survey questionnaire for health professionals and patients, and interviews with key informants.

Because hospitals are not isolated organisations but interact within their internal and external environment, the implementation of a new policy, such as the Patient's Bill of Rights, should consider all internal and external stakeholders. Implementing the Bill while ignoring the

surrounding environment is a sure step to failure. For this reason, the implementation of the Patient's Bill of Rights is not the sole responsibility of each hospital or the Ministry of Health but is a multi-level responsibility shared by key stakeholders. This responsibility can be discussed on the levels suggested by the positive culture of patient rights framework (Figure 1.3). The framework suggested three different levels: macro (the Ministry of Health), meso (hospital management and community) and micro (doctors, nurses and the staff of the Patient Rights and Relations Department). Investigating the role of each stakeholder should provide an in-depth understanding of the readiness and ability to implement the Bill in health organisations.

To ensure the successful adoption of the Patient's Bill of Rights at public hospitals, it is crucial that there is a general advance plan for implementation, preferably driven by national policy and approved and supported by all actors at all levels. All stakeholders expect to be involved in an effective manner in the process of implementation and to perform their roles successfully to build a positive culture of patient rights. There are five different levels of stakeholders: the health system (the Ministry of Health), the community, health organisations (hospital management), health professionals, and the staff of the Patient Rights and Relations Department. The main themes and sub-themes at the different levels are discussed in the following section.

6.2.1 Ministry of Health level (Macro level)

One of the most important factors supporting hospitals' readiness to implement the Patient rights Charter is the role of the Ministry of Health. If the Ministry of Health fails to fulfil its role, the whole implementation process could fail. Therefore, it was important to assess some of the essential tasks that need to be performed at Ministry of Health level. The Saudi Ministry of Health has responsibility for planning, coordinating, funding, and monitoring all programmes and services provided by public hospitals (Almalki et al., 2011). As a consequence, the role of the Ministry of Health is crucial for establishing a healthcare system that maintains the rights of its patients (Büken N. & Büken E., 2004). The findings of the present thesis were not very encouraging with regard to the Ministry of Health's role, in matters such as the poor usage of media, the complex complaint system, and the absence of advocacy services. However, the one positive aspect was that the Ministry of Health has shown great commitment to implementing the Charter in public hospitals. Because the Bill of Patient Rights had already been enacted, the role of the Ministry of Health in promoting it and improving public awareness of it through the mass media was examined to identify to what extent this

role was recognised. These roles can be categorised into four themes; commitment, regulations, promotions, and patient interface.

6.2.1.1 Commitment

The commitment of senior management at the ministerial level is a major aspect in the successful implementation of patient rights principles (Coney, 2004). Any effort to implement a new policy on a national scale necessarily involves a significant commitment from senior management. The Ministry of Health, as the main organisation in the healthcare system, plays a key role in leading the changes to build a culture of patient rights within the health system. Joolaee, Tschudin, Nikbakht-Nasrabadi & Parsa-Yekta (2008) stressed that patient rights principles cannot be implemented solely by organisations, or individual efforts, but should be promoted by action supported by the entire healthcare system, including the full commitment of the Ministry of Health. Therefore continual support from the Ministry of Health is needed at all levels to achieve the goals of the Bill of Patient Rights nationally (Njunga & Kasiya, 2006).

Indeed, requesting changes, delivering policies and regulations, and issuing guidelines cannot guarantee cooperation from healthcare organisations and individuals unless it is accompanied by real commitment from the Ministry of Health. In order to show the highest level of commitment, the Ministry of Health should guide healthcare providers in the right direction and show that it gives wholehearted support to implementing the Bill. To achieve a high degree level of implementation of the Bill, senior managers at the Ministry of Health should take seriously the responsibility to lead the healthcare organisations towards high performance objectives; however, the lack of commitment from the Ministry of Health was mentioned by Bourne, Neely, Platts & Mills (2002) as one of the causes for the failure in the implementation of a Patient's Bill of Rights.

In this research, generally, managers, experts, doctors, nurses, and patients made similar responses regarding the Ministry of Health's commitment. Most survey respondents agreed that there is a high level of commitment from the Ministry of Health to implement the Patient's Bill of Rights in public hospitals. They also believe that the Ministry of Health provides unlimited support for implementing the Bill. The Ministry of Health affirmed its strong commitment to translating the Patient's Bill of Rights into practice by establishing a superior Department of Patient Rights and Relations in the Ministry of Health and linking this new department directly to the Minister's office. In addition, the establishment of the General

Department of Patient Rights and Relations was followed by establishing a Patient Rights Department in every hospital and health centre. This gives an initial positive indication of the great attention and care the issue of patient rights has at the highest managerial level in the Ministry of Health.

Although the majority of respondents agreed that the commitment to ensure the successful implementation of the Bill was at a high level, the implementation process was not well planned. It appeared to be a short-term project and the high level of unlimited amount of support simply disappeared after the establishment of the departments at the Ministry of Health and in hospitals. The demands of the planning stage were underestimated and both before and during the implementation process, the entire project lacked certain important elements, such as the involvement of key stakeholders, at different stages. A natural follow on from this is to discuss the next fundamental role of the Ministry of Health in implementing patient rights principles: regulations.

6.2.1.2 *Regulations for implementing the Bill*

A very high level of commitment is not enough to protect patient rights unless the legislation is clear and the regulations are strong. In the same way, simply enacting regulations cannot guarantee the protection of the rights of patients in the health system (Momennasab, Koshkaki, Torabizadeh & Tabei, 2016; Joolaee et al., 2006; Kuzu et al., 2006). The strong enforcement of laws and regulations concerning patient rights would, however, constitute genuine progress and a critical milestone towards implementing a Patient Rights Bill in health settings (Guven & Sert, 2010).

The research revealed that the Ministry of Health's efforts to pass compulsory legislation aimed at implementing and protecting patient rights remains weak. As a consequence, the current Bill is treated as guidance rather than official law. The same situation was found in Turkey. Guven and Sert (2010) reported that Turkish regulation of patient rights tends to serve only as administrative guidance for health service providers. They suggested that this situation resulted from the precedence that other regulations took in the medical field over regulations around the rights of patients.

The current research also showed that in addition to the lack of strong regulations concerning patient rights in Saudi Arabia, the available guidelines also suffer from a lack of clarity. The current process for implementing the Patient's Bill of Rights was very uncertain and inconsistent with the reality found in hospitals. In fact, the absence of patient rights regulations

can negatively affect commitment at all levels and hinder the Ministry of Health and hospitals from carrying out enforcement activities under the law. Kuzu et al. (2006) indicated that the lack of patient rights regulations may lead to weakening the role of patients in the healthcare process and render them more passive. In contrast, the presence of these regulations is expected to improve the relationship between health professionals and patients (Krzych & Ratajczyk, 2013). Patients in a study in Egypt by Ibrahim, Hassan, Hamouda and Abd-Allah (2016) observed that the Bill of Patient Rights was implemented more systematically in private hospitals than in public hospitals. The researchers suggested that the strict regulations implemented by the management of private hospitals may play an important role here.

From the findings from the informant interviews in the present study, it can be observed that many health professionals respect the rights of patients as a matter of their own moral or professional ethics and not because they are observing existing, binding regulations. A study in Iran reported that the individual's commitment to patient rights plays a greater role in protecting these rights than do current regulations (Joolaee et al., 2006). Fallberg (2003) emphasised the importance of law to enforce obedience and suggested that the ethics of these health professionals should be made into health law in order to threaten offenders with litigation. Guven and Sert (2010) argued that a proper assessment and careful implementation of patient rights' legislation may improve the entire health system, including the relationship between health professionals and patients. In addition, Almalki et al. (2011) who wrote an overview article about the Healthcare system in Saudi Arabia indicated that it was necessary for the Ministry of Health in Saudi Arabia to develop legal regulations to protect the rights of patients in rural communities.

In addition, one of the vital regulations that needs careful consideration by the Saudi Ministry of Health was the monitoring system. The Ministry of Health has a substantial monitoring role, ensuring that patient rights are protected within the healthcare system. This role includes making sure that health professionals comply with regulations related to patient rights. Ethical codes alone cannot prevent the issues against patient rights but these should accompany effective monitoring and regular evaluation of the performance of health professionals (Momennasab et al., 2016; Joolaee & Hajibabaee, 2012).

The findings show that the Ministry of Health has authorised the General Department of Patient Rights and Relations to monitor the performance of hospitals and their staff in relation to patient rights. The monitoring role provided by the General Department of Patient Rights and

Relations has become increasingly important to ensure implementation of the Bill and to protect patient rights principles in the health system as a whole. Careful monitoring of the implementation of the Patient's Bill of Rights is required to identify any emerging issues at an early stage. Respondents suggested using the data and statistics collected to evaluate the progress of the implementation process. Rider and Makela (2003) suggested that collecting data from patients, their families and healthcare providers on a regular basis would help to evaluate the degree of compliance with the regulations at each hospital. They also recommended that the Ministry of Health develop indicators or measures for monitoring the progress of the implementation of the Bill in hospitals (Ghanem, Megahed & Mohamed, 2015).

To carry out this monitoring role in practice, the General Department of Patient Rights and Relations could assign the management of Patient Rights and Relations Departments in hospitals the task of comparing their hospital's performance against the requirements of the Bill. In practice, however, this course of action is ineffective because of the weakness of these departments compared to hospital management.

Surprisingly, the Patient Rights and Relations Department staff are responsible for monitoring, evaluating, and reporting to the General Department on the degree of implementation of patient rights in hospitals, and at the same time are employees under the jurisdiction of the hospitals they are supposed to evaluate. This situation puts department staff under considerable pressure because they must evaluate the performance of the management group that they report to and who are responsible for evaluating the performance of the staff of Patient Rights and Relations Departments. In many cases, they are required to report any violation to the General Department at the Ministry of Health. These reports may discuss cases in which hospital management is accused of a failure to act, or of acting poorly; however, hospital management is responsible for appointing the department's director and employees and is also entitled to dismiss them. It is claimed that the separation of the Patient Rights Department from hospital management is a direct way of strengthening the department's role in hospitals.

The absence of effective monitoring can lead to patient dissatisfaction, the violation of rights, health risks, as well as the destruction of the relationship between health professionals and patients (Abedi et al., 2012). Joolaee et al. (2006) reported that the absence of monitoring systems is a major barrier to the implementation of patient rights in hospitals.

6.2.1.3 *Promotion of Patient's Bill of Rights*

Health promotion has been described as a means as well as an ultimate goal in the literature of health services. Successful health promotion efforts are characterised by collaborative partnerships between organisations from different sectors. The Ministry of Health is responsible for protecting and promoting patient rights. One of the main, most frequently mentioned means was the public media. Using the media to promote the Bill is considered an effective approach to promote the idea of patient rights among the public (Aazami & Mozafari, 2015) and to influence healthcare providers to protect these rights and adhere to them through legislation and policy (Borovecki, Babic-Bosanac & Ten Have, 2010). The vital role of the media includes boosting broader public understanding, changing people's attitudes in a way that helps create new positive behaviours, and increasing public support for new policies (Joolaee et al., 2008). One effective method for making patient rights well known among the general public is a media-based campaign (Brazinova, Heydelberg, Koot, Rusnakova & Rusnak, 2006). Van Bekkum and Hilton (2013) maintained that the media, such as the Internet, newspapers, and television, wield influence not only with patients but also with health professionals.

The findings of this study show that only 60.7% of nurses and 47.8% of doctors acknowledged the effort made by the Ministry of Health to improve public awareness of the Bill through the media. Doctors, however, were more likely to rate that effort poorly.

This result may be explained by the fact that during the process of implementation of the Charter, nurses were more involved than doctors because they attended several training seminars and workshops. These had a poor reputation as a source of trustworthy information among health professionals, specifically doctors. Based on the views of both doctors and nurses, the Ministry of Health still needs to make greater effort to create a culture of patient rights within the entire community.

Although extensive research has been carried out on the use of the media in promoting patient rights charters, no single study adequately covers the essential factor of staff awareness of the importance of the new policy. This finding has significant implications for the need to involve and educate health professionals about the important role of the media. The finding also seems to be consistent with other research which reported a direct relationship between public awareness about health topics and media coverage of stories related to those topics (Patients Association, 2014; Joolaee et al., 2008). In agreement with this, Abou Zeina et al. (2013)

recommended that the management of the Ministry of Health should create a strategic plan to promote the Patient rights Charter and ensure effective supportive and supervision before using the media to promote awareness of patient rights.

In developing countries, government bodies, such as the Ministry of Health, have no strong relationship with the media and usually do not talk openly about topics related to patient rights. They leave this to hospital management or health professionals (Büken N. & Büken E., 2004). Hence the Ministry of Health needs to develop and implement a strategy for communication with/to the media, including a social media strategy. In most cases, Ministries of Health deal with the mass media as opponents; however, Joolaee et al. (2008) asserted that the effective use of the media should be planned and supported by high level management in the Ministry of Health to ensure continuous promotional campaigns and strong cooperation with local and national media. A government has the obligation to ensure the implementation of human rights, including patient rights, and make sure they are maintained, promoted, and respected (Beitz, 2009).

Several lessons can be learnt from the experience of the Slovak Republic in promoting of patient rights in Slovakia, which follows the successful Dutch model for the promotion of patient rights. They planned several public activities in cooperation with local media. These activities included training seminars, workshops, public lectures, media coverage for most of the activities, and television reports. One year later, a survey showed a marked increase in public awareness in several areas of patient rights (Brazinová, Janská, & Jurkovi, 2004). The UK Patients Association stresses the necessity of using media campaigns for educating the public and staff about the NHS Constitution. In addition, it suggested the NHS use schools and to have a social media strategy to promote the Constitution to the younger generation, including school-age children (Patients Association, 2014).

As the Joint Commission (2007) confirmed, it is very important to pay attention to the culture and preferences of the intended audience. The message conveyed by the media should be audience-centred and framed in a community context. According to a survey conducted by the UK Patients Association in 2014, about 65% of respondents stated that they wished to have their voice heard in the planning and promotion of campaigns for the Constitution (Patients Association, 2014).

6.2.1.4 Patient interface

The present findings are significant in at least two major respects: the complacency of the system and the need of an independent organisation to receive and treat complaints and to provide advocacy services. Patients want a fair, accessible, simple, and responsive complaint system (Veneau & Chariot, 2013).

Complaint System

Generally, there are two (independent) complaint mechanisms: internal and external. In the Saudi health system, only the internal complaint mechanism applies because the external mechanism remains very weak. Patients who believe their rights have been violated have one available channel for submitting their complaints, and that is through the Patient Rights and Relations Department at the hospital concerned. Some patients, however, do not trust the competence of this department to help them and try alternative channels, such as the hospital manager, the head of the district directorate in the region, or even the Ministry of Health or the Office of the Minister. According to the findings from informants' interviews, in Saudi culture, if someone has an issue with a service, they go to the most senior manager in the organisation to resolve it, otherwise their voice will not be heard. In the end, all these complaints are usually sent back to the Patient Rights and Relations Department at the hospital where they originated.

The findings from key informant interviews show that the complaint process is not clear and is complicated to follow, especially for patients who find themselves caught in an endless loop. Most patients give up on their complaints and do not follow up, which means that officially no further action is taken on them. This is likely to lead to the underreporting of complaints in the official statistics dealing with complaints. Önal and Civaner (2015) suggested that patients do not continue the complaint process when they expect no satisfactory solution to be offered or that no change would occur (Friele, Sluijs & Legemaate, 2008). Consequently, many patients usually search for other options to get the quickest, most effective response from the Ministry of Health. For instance, as reported by key informants, more patients in Saudi Arabia tend to submit their complaints to the management of hospitals or to the Minister's office. This move may be explained by the fact that patients and their families do not trust the staff to deal with their complaint seriously. This concurs with the suggestion made by Veneau and Chariot (2013) that there is a conflict of interest when a physician or a staff member is assigned to investigate complaints against their colleagues or their hospitals.

Another possible explanation for this pattern is that, based on their experience, patients find it an easy, fast way to have their problems solved. Alghanim (2012) indicated that when patients feel their rights are not protected, they tend to look for alternative mechanisms. In Saudi culture, it is popular belief that the fastest, most direct way to getting a problem solved is through the head of the organisation. This frequently adopted approach adds to the burden on management and the Ministry of Health in terms of time, effort and resources. However, the findings also indicate that patients are growing more familiar with the Department of Patient Rights and Relations, so an attitude of trust grows over time. When patients do not trust the fairness of the system, they usually go to the media to consider their story and to then report on their problems. The alacrity with which the hospitals or the Ministry of Health respond to the media leads others with similar experiences to resort to the media to solve their problems also. This result is in accord with a study conducted by Thi Thu Ha, Mirzoev and Morgan (2015), which indicated that people in high-income countries tend to use channels such as the media and the courts to draw public attention but this is not the case in low-income countries because of the cost of taking a complaint to a higher level.

The findings of the present research also indicate that there is a lack of regular communication with complainants, giving them feedback about their complaints. Putting the responsibility of following-up on patients and their families may increase their burden when added to their illness and the sequence of events that caused the complaint. Several key informants indicated that when patients received regular updates about the status of their complaint and certain corrective actions had been taken, they were likely to be more satisfied with the complaint process than others. The lack of feedback can provoke negative emotions, frustration and anger from patients against the entire hospital staff (Friele et al., 2008). Therefore, hospitals should have clear mechanisms and procedures for providing feedback about complaints, the outcome of the investigation, and the proposed action to be taken.

Advocacy Service

Patient advocacy services have the task of acting and speaking on behalf, or in support, of patients and their families against healthcare providers. The independence and accountability of advocacy services are essential to their success (Paterson, 2002). The Saudi health system provides no advocacy service to patients or their families. Although one of the objectives of establishing the Patient Rights and Relations Department is to protect the rights of patients, in reality, once the department sends a complaint report to management, they are not allowed to

hold further meetings with complainants. Joolaee et al. (2006) argued that the violation of patient rights in hospitals in Turkey results from the lack of an advocacy service for patients, which has led affected individuals to seek alternative advocacy. One example is the presence of patient's companions to advocate for their rights.

The findings of the present research also indicate that most respondents believe that it is very important to have a separate organisation and to strengthen its role to support patients, because the current situation hinders many of the department's main roles. Working under hospital management makes it difficult for department staff to fulfil their intended role of protecting patient rights in hospitals. This finding is broadly in line with a study conducted in France by Veneau and Chariot (2013) who point out that there is a conflict of interest when a patient is forced to submit their complaints to the same hospital staff they were complaining about, as the latter would be disinclined to admit the fault was theirs. This type of independent organisation which provide advocacy services are popular in many developed countries such as New Zealand and the UK.

Recently, the establishment of patient advocacy and patient ombudsman organisations are among the main efforts in European countries to improve their efforts in protecting patient rights in healthcare settings (Fallberg, 2003). Abekah-Nkrumah, Manu and Atinga (2010) assert that poor patients' advocacy groups, or the lack of them, can hinder the implementation of patient rights principles in the entire health system. Lau (2002) maintains that patient advocacy is one tool for ensuring patient empowerment in health services; however, many studies have argued recently that the advocacy role should be considered an important responsibility of the nursing profession (Abekah-Nkrumah et al., 2010; Iltanen et al., 2012; Joolaee et al., 2006). Joolaee et al. (2006) argued that the lacking advocacy for patients in developing countries led to the violation of patient rights in hospitals and affected individuals to seek alternative advocacy. One example is the presence of patient's companion to advocate for their rights.

6.2.2 Community level (Meso level)

Saudi Arabian culture encourages centralization and policy with a high level of respect for authority, making it easier for the Ministry of Health to promote patient rights in the community.

6.2.2.1 Partnership and collaboration

Like most developing countries, Saudi Arabia lacks effective engagement with the wider community in public services. This lack of engagement leads to a weakened role for community leaders and organisations in implementing or changing healthcare system regulations. Working with other governmental and non-governmental organisations was one of the main concerns of the respondents. The findings from this research shows that the Ministry of Health still needs to place more emphasis on collaboration with other organisations and on solid partnerships with them. In the same way, the second main challenge facing the Saudi healthcare system is the lack of coordination (Al-Rabeeah, 2003), which still has a negative effect on the Ministry of Health's efforts to implement the Bill successfully. In addition to the Saudi Ministry of Health, the 20 district directorates play an important role in supporting the implementation of the policies and coordinating with other agencies (Almalki et al., 2011). Successful implementation of the Bill at national level is characterised by collaborative partnerships between organisations from different sectors.

The findings of the present study indicate that the Saudi Ministry of Health has made several attempts to enter into collaboration with other relevant authorities, such as charitable associations, human rights organisations, the Ministry of Education, and the Ministry of Information.

Partnership can be achieved through various means, such as joint programmes, cooperation between organisations, and the involvement of other agencies in the planning and implementation stages. Slovakia provides an interesting example of involving other stakeholders in the planning stage. The Slovakian Ministry of Health wanted to benefit from the Dutch experience of implementing patient rights. A group of representatives from three different key stakeholders (the Ministry of Health and hospitals, patients' and consumers' organisations, and the General Health Insurance Company) was selected to visit relevant Dutch organisations. This strategy had a considerable effect on the implementation of Slovak patient rights (Brazinova et al., 2006). Saracoglu et al., (2010) recommended that the Ministry of Health work closely with universities and interested organisations to develop new policies for the implementation of patient rights. They advised that during this process, the public, patients, and health professionals should all be involved in order to increase their loyalty and improve their awareness (Joolaee et al., 2008). Such involvement can ensure that the regulations reflect the culture and needs of the community and are therefore suitable for it (Abekah-Nkrumah et al., 2010).

The findings from cross-sectional surveys indicated that there was minimal collaboration between hospital management and other organisations, such as community representatives, government, and civic organisations. Forty percent of doctors, compared with about 20% of nurses, were particularly sceptical that there was any collaboration at all. Their attitude may indicate that many of them sought a high level of cooperation that was lacking in the current situation. This result may give the impression that overall, doctors were unsure whether or not other parties cooperated with the hospital. The doctors' scepticism may also reflect the fact that the nurses, together with the staff of the Patient Rights and Relations Department, were the ones provided with education courses and workshops before and during the implementation process. This gave nurses the opportunity to acquire more information about the initial stages of the implementation of the Bill.

In addition, a large number of doctors and nurses in this study revealed that they had no information concerning collaboration between hospitals and outside organisations. Doctors reported that they had little or no information about any coordination taking place. This lack of coordination may have the result that health professionals are deprived of the opportunity to share their experiences with their peers in other organisations. This state of affairs reflects the absence of information among doctors concerning the implementation process for the Bill and a lack of involvement by the medical staff. Nurses, however, expressed more positive opinions on this matter than doctors, perhaps because nurses were the main target for education on the Bill and training by the Ministry of Health and hospital management. This training gave nurses the opportunity to acquire more information about the process of implementing the Bill.

6.2.3   Hospital management level (Meso level)

At the hospital management level, for the successful implementation of the Patient rights Bill, it was important for management to show its strong commitment by providing support, education and professional involvement.

6.2.3.1   Support

Ongoing support from management plays a critical role in implementing patient rights concepts and creating a culture of patient rights inside hospitals. It is difficult to implement a new regulation without the support of hospital management. Joolaee et al. (2008) demonstrated that managerial support in implementing patient rights is considered to be a major factor that facilitated its success. Support can take many forms, including human and financial resources, and physical and emotional support. The present findings concerning the role of hospital

management is disappointing because they suggest that hospital managers have performed poorly and accomplished little.

In this study, overall, most participants reported that hospital management did not provide sufficient support for the implementation of the Patient's Bill of Rights in hospitals. The majority of respondents indicated that the availability of qualified staff was at a *moderate to great* level but that the number of staff and the availability of supportive materials were inadequate.

The availability of qualified staff features as another important readiness criterion, as health professionals agree; however, just over half the patients ranked the available number of qualified staff as satisfactory (*to a great or moderate extent*) while 38% disagreed. This may be interpreted to mean that, relatively speaking, most patients have confidence in the quality of staff in hospitals. Extraordinarily, this item was the only one which a great number of patients evaluated positively (*to a great or moderate extent*), compared with patients who marked it negatively (*to a small or not extent*).

Britain's NHS Constitution highlights the importance of using qualified, competent staff, who have sufficient experience in performing services. The Constitution also requires staff to be registered with recognised professional bodies, such as the Nursing and Midwifery Council (National Health Service, 2015). This underscores how important it is for hospital management to ensure that the skilled, qualified staff are available to meet patients' needs. Alghanim (2012) reported that a lack of qualified staff with sufficient training in patient rights has a negative effect on the implementation of patient rights.

Despite the availability of qualified staff, all groups—experts, managers, doctors, nurses, and patients—complained of limited resources, including staff and educational materials. A large percentage of respondents pointed out that currently, both the quantity of staff and educational materials are insufficient. Many respondents revealed that the resources, if limited, were obtainable from the Ministry of Health but hospital management did not appear to be interested. For example, several Ministry of Health managers who were interviewed stated that a large quantity of educational resources were stored with the Ministry of Health because hospital management would not agree to receive them. Typical excuses given by hospital managers were "yes, we have them," or "we will organise them later."

Zakari (2011) concluded that support from managers in healthcare plays a vital role in creating a safe environment, establishing a positive culture towards safety and rights, and improving

patients' experience in hospitals. Managerial support also enhances the implementation process for any new policy (Sangster-Gormley, Martin-Misener, Downe-Wamboldt & DiCenso, 2011; Reay, Golden-Biddle & Germann, 2003). Insufficient support from hospital management may reflect the low level of their commitment to implement the Bill.

6.2.3.2 Commitment

Management commitment is needed to achieve better implementation of the Bill and would also significantly strengthen the commitment of other parties, including health professionals and non-medical staff. Lack of commitment from hospital management may be considered one of the main reasons for the failure of the implementation process. Resistance from hospital management may arise because they feel threatened by the implementation of a new Bill (De Waal & Counet, 2009).

Hospital managers may also lack the necessary information to change their scepticism about the benefits of the Bill to supporting its implementation. Commitment is an attitude that can be acquired when a person realises the benefits for hospitals and healthcare outcomes that are to be gained from implementation of the Patient's Bill of Rights. Senior management at the Ministry of Health level should communicate facts about the Bill and demonstrate their strong commitment to it through their own behaviour and actions. Commitment by hospital management is likely to be given when they see commitment from senior management and when they recognise the benefits to be gained from the Bill. Taking the long-term view, it is very important to promote the commitment of both senior management and hospital management for the successful implementation of the Bill. Although the senior management at the Ministry of Health is strongly committed, as mentioned in Section 6.2.1, hospital management does not have the same level of commitment. This clearly shows that management at the Ministry of Health failed to transfer their own strong commitment to middle management in hospitals. This finding raises the question whether the failure to transfer commitment was the fault of the approach by Ministry of Health management or whether that failure derived from the attitude of hospital management towards patient rights principles.

Thirty-six percent of patients believed that their rights were not a priority for hospital management, and this concurs with the viewpoint expressed by experts. The other 64% of patients indicated that they could give no information on the matter. This result shows the high degree of concern patients have about the level of protection for their rights in public hospitals. It also clearly reflects insufficient effort made to publicise the priorities of hospital management

among patients. As a result, when patients suffer from a lack of information, the level of their dissatisfaction with hospital services is likely to increase.

Another explanation for this situation is that the Ministry of Health and hospital management focus mainly on health professionals, with little attention given to patients. Patients may not see signs or brochures informing them of their rights or even receive a copy of them when they are admitted. It may also be the case that patients are unaware of the establishment of the new department to protect their rights and have the impression that the Department of Patient Rights and Relations was just a new name for the Department of Patients' Services Affairs. Overall, it is clear that patients suffer from a lack of information in hospitals.

6.2.3.3 Involvement of health professionals

Health professionals' involvement in designing, planning, and implementing the Bill positively affects their ownership, loyalty, contribution, and ultimately hospital performance and the quality of health services. It is anticipated that an involved health professional will feel ownership of the Bill. Having a strong sense of ownership is an essential factor that boosts the likelihood of implementation success. This strong sense of ownership derives from the health professionals' feeling that the Bill and its implementation were developed and implemented in a way that respects their opinions and preferences.

Although senior management at the Ministry of Health should foster the loyalty of major actors, including middle management, experts, hospital management, and the latter must also ensure the involvement of departmental managers and health professionals at every stage of implementation. This involvement can be achieved through organising teamwork activities, regular meetings, asking for feedback, and providing adequate resources and seminars. The full engagement of health professionals in the implementation process is a vital component for securing their support and is essential for the success of any implementation plan. Such involvement is expected to increase staff ownership of the new policy. People who are more involved in an implementation process would be more likely to show a high level of commitment towards the Bill (Ho, Oldenburg, Day & Sun, 2012). Middle managers can perform their role effectively when they get involved and play key roles in facilitating the implementation of any new policy within their healthcare organisation (Birken et al., 2015; Bourne & Walker, 2005). In hospitals, middle managers can provide substantial support for implementation by serving as a bridge between hospital management, and health professionals and frontline staff (Engle et al., 2017).

One of the major approaches to involving departmental managers and health professionals is through noting their opinions, comments, and feedback. The findings of the present study show that health professionals' involvement in the implementation process remains weak. The findings also show that little effort was made to request feedback from health professionals during the implementation process. Fifty five percent of doctors revealed that management asked them for very little or no feedback concerning the implementation of the Patient's Bill of Rights.

This result is consistent with an observational cross-sectional study conducted in Turkey, which reported that doctors were not adequately informed before the implementation of the Turkish Patient's Bill of Rights (Özdemir et al., 2006). If the role of health professionals is ignored this is likely to lead to a lack of interest among them towards implementation of the Bill, which may result in its eventual failure. Research conducted by Joolaee et al. (2008) explored the perceptions of health professionals in relation to the application of patient rights in Iran. They reported that health professionals hoped that advantage would be taken of their experience, and that their suggestions would be taken seriously and their voices heard. In the same way, Farzianpour (2014) recommended that feedback from doctors and nurses needs to be assessed on a regular basis to improve the implementation process.

The findings of this research found a significant statistical difference between doctors and nurses and also between professionals with a postgraduate degree and other professionals in terms of their views on the asking for their feedback. Doctors and professionals with postgraduate degrees regularly complained that minimal use was made of their feedback and that it was seldom requested. Clearly, they were disappointed with management's failure to take into consideration their role and wide experience and believed that these should be respected and their input requested by hospital management.

Health professionals would feel respected when they are provided with accurate information and engaged in plans to implement the Bill. The current lack of involvement and dearth of information are an obstacle to the whole implementation process; however, sharing information about the implementation process can secure their active participation and cooperation during all implementation stages. In contrast, the lack of accurate information provides a fertile environment for rumours and erroneous interpretations that could harm valuable implementation objectives. London (2005) reported that sharing information with managers at all levels about a policy to be implemented contributes positively to that policy's success. It is

very important that hospital management establishes effective communication strategies in the implementation process which will ensure that all stakeholders are informed and involved at all stages. This should be followed by continual assessment and the promotion of a strong interdepartmental relationship at the various levels for the successful implementation of the Patient's Bill of Rights.

The findings from the present research suggest that there is a large gap between management in hospitals and health professionals. This gap has resulted in a lack of involvement and an absence of information concerning the implementation of the Bill. Health professionals must be involved and aware of the development and implementation of the Bill, as they know best what is needed on the ground.

6.2.3.4 *Health professionals and patient awareness*

Achieving the laudable objectives of the Patient's Bill of Rights depends on the contribution of all stakeholders at all levels. Because health professionals and patients are the final beneficiaries of the Bill, more attention must be given to raising their awareness and knowledge of it. Oxford living dictionaries online defines awareness as "knowledge or perception of a situation or fact; concern about and well-informed interest in a particular situation or development" (Awareness, n.d.).

Health Professionals' Awareness

Awareness is an important element in implementing patient rights principles in a healthcare system. This awareness can include understanding the rights outlined in the Bill, in legislation and legal aspects, suitable approaches to applying them, and the appropriate reaction when a patient rights have been violated. Health professionals themselves describe awareness as an important factor in the implementation of patient rights (Iltanen, et al., 2012). El-Sobkey et al. (2014) assert that the lack of awareness of patient rights among health professionals has restricted implementation of these rights in the Saudi healthcare system. This lack is also expected to hinder health professionals from performing their role in promoting and advocating patient rights (Iltanen et al., 2012; Merakou et al., 2001). Lack of knowledge on the part of health professionals is likely to communicate to patients that their doctors, nurses, and hospital management is not interested in maintaining their rights. Thus, this may reflect negatively on the relationship between patients and health professionals, and between patients and the health system as a whole.

Numerous studies have highlighted the need to educate the staff of health organisations, particularly doctors and nurses, about their role, about patient rights, relevant regulations, and the implementation process (Halawany et al., 2016; Hopia, Lottes & Kanne, 2016; Farzianpour, 2014; Yaghobian et al., 2014; Parsapoor, Salari & Larijani, 2013; Dehghan, Dalvand, Haghgoo, Hosseini & Karimlou, 2013; Saleh & Khereldeen, 2013; Yakov, Shilo & Shor, 2010; Hakan et al., 2009; Kuzu et al., 2006). Protecting patient rights is one of the vital roles of health professionals (Er et al., 2014).

In addition, many studies in Saudi Arabia have stressed the urgent need to educate health professionals about patient rights in hospitals. Alghanim (2012) reported that one third of health professionals at primary healthcare centres were unfamiliar with the Patient's Bill of Rights in Saudi Arabia. In addition, half the health professionals who knew of the existence of the Bill had poor knowledge of its content. In another study, El-Sobkey et al. (2014) reported that although more than 95% of medical students believed in the importance of the Patient's Bill of Rights, only half were aware that it already existed in the Saudi health system. These results indicate a lack of knowledge about the Bill among health professionals and highlight the importance of reviewing the current method of informing staff about patient rights.

Saleh and Khereldeen (2013) suggested that health professionals' knowledge of patient rights should be evaluated and reassessed regularly and continuing education programmes should be provided. Departmental meetings, training courses and workshops, and educational campaigns were suggested as the best way to educate health professionals. Using technology to accomplish this goal was also recommended. A study conducted by Kagoya, Ekirapa-Kiracho, Ssempebwa, Kibuule & Mitonga-Kabwebwe (2013) reported that health professionals respect the rights of patients because of their personal moral standards and empathy rather than because of their awareness of the Patient's Bill of Rights. Well-informed staff have a positive effect on the implementation of patient rights because they are able to advocate for these rights and also educate patients and their families about them.

The findings revealed that most respondents agreed that among health professionals, there was minimal confidence in their knowledge of the Bill, little knowledge of their roles and responsibilities, little awareness of the Bill's benefits, and a lack of regular departmental discussion of subjects related to patient rights. This situation clearly points to a lack of effort in promotion and education provided to health professionals to train them in the new legislation.

In addition, most patients indicated that health professionals lacked both knowledge and confidence in answering patients' questions. Previous results clearly demonstrated that there was little familiarity among doctors and nurses about patient rights. This lack is likely to communicate to patients that health professionals and hospital management are not interested in maintaining their rights. All of this may reflect negatively on the relationship between patients and health professionals, and between patients and the health system as a whole.

These findings are consistent with research conducted by Alghanim (2012), who investigated the knowledge of health professionals and patients about the Patient's Bill of Rights in Saudi Arabia. He reported that about 65% of health professionals had knowledge of the Bill. Another survey study conducted by Abekah-Nkrumah et al. (2010) investigated the implementation of Ghana's Patient Charter and reported that nearly 60% of health professionals had a satisfactory level of knowledge of the implementation of the Bill.

In the same way, Iltanen et al. (2012) conducted a survey among health professionals in public health centres in Finland to evaluate the level of knowledge about patient rights among healthcare professionals. They reported that the majority respondents had poor knowledge of these rights. The results from the present research show that nurses had a significantly higher level of knowledge about the bill and its implementation than doctors did. This can be attributed to the fact that nurses benefitted from several workshops and training sessions at the beginning of the implementation of the Bill, a factor that would make a great difference in their level of knowledge of the Bill's content and the process of its implementation.

In general, nurses at the preliminary information sessions were more pessimistic than doctors concerning two matters, namely health professionals' knowledge of their roles, and confidence in their knowledge and skills. A possible explanation for this low awareness among doctors is that the hospitals focused mainly on educating nurses and involving them in the implementation process because the hospitals were only beginning to apply the Bill.

This research also indicated that doctors and nurses were not engaged or educated properly about their responsibility to safeguard patient rights. Doctors and nurses also suggested there is an urgent need for updated information regarding their role in the implementation process and any legal aspects involved. It is important to have written policies for health professionals to refer to concerning their role and responsibilities.

A descriptive, cross-sectional study conducted in Turkey by Akca, Akpinar and Habbani (2015) aimed to assess the attitudes of nurses towards patient rights and to create a suitable

educational programme. In this study, the majority of nurses believed that health professionals had the right to instruction about their roles and responsibilities in the implementation of patient rights principles. Another study in South Africa among student health professionals reported they had little information about their roles and responsibilities, regarding the protection of patient rights (Vivian, Naidu, Keikelame & Irlam, 2011).

Patients' awareness

Patients' awareness of their rights could be considered a decisive factor in the success of any plan to implement those rights. Many studies have been conducted and articles written about the positive effects for both the public and for individual patients from the provisions of Patient's Bill of Rights (Alhejaili et al., 2016; Ama-Amadasun, 2016; Abolarin & Oyetunde, 2013; Alghanim, 2012). A high level of patient and public awareness of patient rights offers numerous advantages, for example improvements in maintaining patient dignity (Ama-Amadasun, 2016), patient satisfaction (Farzianpour, Foroushani, Sadeghi & Nosrati, 2016), improving the quality of healthcare (Parniyan, Pishgar, Rahmanian & Shadfard, 2016), decreasing costs, speeding up the recovery period, shortening the length of hospitalisation, and minimising the risk of physical and spiritual damage (Mastaneh & Mouseli, 2013). A more informed patient is expected to be empowered to take a more active role in the treatment process; however, a high level of awareness of rights alone is not enough unless it is accompanied by a full understanding of how to demand their rights in a confident manner and put them into practice (Patients Association, 2014).

The findings in this research show that the effort made to educate patients about their rights was rated as minimal by the majority of patients (56%). This may indicate that patients in public hospitals did not observe any effort to provide them with proper education. This finding is in line with many national and international studies (Yaghobian, et al., 2014; Rajesh, et al., 2013; Abou Zeina, et al., 2013; Hojjatoleslami & Ghodsi, 2012; Joolaee, et al., 2008; Kuzu et al., 2006; Razavi, et al., 2006). Nationally, several studies were conducted in Saudi Arabia to evaluate patients' awareness of their rights (Alhejaili et al., 2016; Almalki et al., 2016; Almoajel, 2013; Habib & Al-Siber, 2013; Alghanim, 2012).

For example, Alghanim (2012) reported that only one fifth of patients knew about the Patient's Bill of Rights in the Saudi health system. Almoajel (2013) discovered that most patients (75%) did not know that the Saudi Ministry of Health had published the Patient's Bill of Rights. In another study, Halawany et al. (2016) reported that more than 84% of patients had not received

any kind of education about their rights in hospitals. By contrast, a study conducted by Almalki et al., (2016) indicated that more than 80% of patients were aware of their rights in military hospitals in Taif city, Saudi Arabia. A possible explanation for this discrepancy in results is that Almalki's study was conducted in military hospitals, which are operated by a military entity and not by the Ministry of Health. There may be some difference in the promotion and implementation process among different sectors.

Internationally, the level of patient awareness showed few differences, especially in developing countries, such as Iran, Turkey, and Egypt. Joolaee and Hajibabaee (2012) declared that the majority of studies indicated clearly that most patients have an inadequate awareness of their rights in healthcare institutions. Kuzu et al. (2006) reported that in Turkey, only 9% of patients were aware of the existence of patient rights. Abou Zeina et al. (2013) reported that in South Egypt, the majority of patients did not know about their rights. Another study conducted by Hojjatoleslami and Ghodsi (2012) in Hamadan, Iran, reported that more than 55% of patients lacked awareness of their rights. In Iran, Mastaneh & Mouseli (2013) indicated that only 10% of patients had a good level of awareness about their rights. Many of these studies reported that there were problems in the practical implementation of the charters, leading to this low level of awareness among patients about their rights. Mastaneh and Mouseli (2013) attributed this weakness in awareness to the failure to promote the Charter in the public media.

In the interviews conducted as part of this study, managers declared that they had observed a measure of improvement among patients in their knowledge of their rights. They blamed the Ministry of Health for the lack of publicity given to the Bill so far and stressed that hospitals also should take a more active role in their neighbourhoods. Educating patients is the responsibility of the Ministry of Health, the media (Almalki et al., 2016), hospital management, and health professionals (Verheijde, Rady & McGregor, 2007).

Many studies identified a number of methods for educating and informing the public and patients about their rights in the healthcare system. The media are one popular method for increasing people's awareness of their rights (Patients Association, 2014). Such publicity needs to be planned at the highest level of healthcare management systems (Almoajel, 2013). More practically, the Patient's Bill of Rights can be provided in written form to every patient on admission (Mastaneh & Mouseli, 2013). Providing reports and organising workshops and seminars for individuals and the public can also provide effective methods, together with distributing leaflets, displaying posters on the walls in healthcare settings, conducting formal

education in schools, and using modern technology, such as smart phone applications (Patients Association, 2014).

The best teaching strategies build on interactive relationships, educating patients by giving them information and instructions, and learning from them through requesting their comments and feedback on the content and implementation of the Bill. This approach, obtaining feedback from patients and the public, is likely to offer a valuable source of information to help hospital management plan for continual improvement (Abekah-Nkrumah et al., 2010).

In this study's findings, 55% of patients revealed that their perceptions were ignored, in that no one asked for their feedback. This appears to reflect the poor involvement of patients in health services and in particular in the implementation of the Patient's Bill of Rights. Several studies recommend that the healthcare system develop a systematic feedback mechanism that can collect data periodically from patients, families and staff to generate ideas for improvement and lessons learnt for educational purposes (Kuosmanen et al., 2008). Such a feedback mechanism can help to identify accurately some aspects of service that require change or improvement. The patient feedback mechanism could use a variety of tools, such as surveys, focus groups, web-based feedback, anonymous shoppers, suggestion boxes, and complaint databases.

Many of the managers interviewed indicated that hospital management tend not to make use of complaints as educational or improvement tools, and therefore mistakes continue without correction. It is essential that managers regard complaints as a valuable source for providing undiluted feedback from the experience of patients and their families. The feedback of patients and the public provide a rich, simple, and inexpensive source of valuable information (Coulter, 2012; Luxford et al., 2011). Information is at the heart of all healthcare service disciplines and projects, such as the legislation of patient rights in healthcare settings. Information about patient rights should be constantly available and accessible to all patients and the public. It is very important to ensure that high quality, accurate, meaningful information is available for the benefit of all stakeholders, including patients, the public, and also health professionals.

The findings of this study reveal that more than half of patients reported that access to information dealing with the topic of patient rights was *poor*. This result shows a strong correlation with the previous point concerning the minimal effort made to educate patients. There was a significant difference in response among patients, depending on their level of education. The more educated patients tend to complain far more about the accessibility of

information than do patients with low education. This may indicate that individuals with a low level of education also have low levels of expectation.

6.2.4 Health professional level (Micro level)

6.2.4.1 Attitude of health professionals

The attitude of health professionals has been identified as a major criterion of readiness to implement the Patient's Bill of Rights. As healthcare has been gradually transformed from being a one-sided relationship to an interactive one, the attitude of health professionals must keep pace with the new developments. Attitudes are influenced by many cultural, moral, educational, and organisational factors, for example lack of practice, lack of training, inadequate regulations, limited resources, and the absence of management support (Ghanem et al., 2015).

A negative attitude among health professionals was the most frequently mentioned barrier to the implementation of the Patient's Bill of Rights (Ibrahim et al., 2016; Yarney, Buabeng, Baidoo & Bawole, 2016; Er, Ersoy & Celik, 2014; Saracoglu et al., 2010; Fallberg, 2003). Hopia et al. (2016) highlighted that the root cause of many key ethical challenges in health services can be traced to professionals' attitudes, in addition to other factors such as the quality of healthcare and the safety of the work environment. Accordingly, many studies have emphasised the vital importance of a positive attitude on the part of health professionals in implementing patient rights principles (Berhane & Enquselassie, 2016; Saleh et al., 2014; Joolaee & Hajibabaee, 2012). They recommend that health professionals support patients to be active partners by maintaining a positive attitude at all times. As a consequence, the attitudes of health professionals and their perceptions of patient rights need to be monitored regularly to increase the understanding of them. El-Sobkey et al. (2014) suggested that teaching health professionals the importance of positive attitudes should occur early in medical school by improving the students' knowledge of the Patient's Bill of Rights and its contents. In the present study, doctors and nurses and, to a lesser degree, patients, affirmed that their attitudes were positive towards patient rights.

In this study, there was a statistically significant difference between men and women in their judgment whether professionals have a positive attitude towards the implementation of the Bill. The majority of nurses (82.8%) reported that professionals have a positive attitude towards the implementation of the Bill, compared with 77.7% of doctors who held the same view. This

result could be attributed to different perspectives about the desired attitudes that should be characteristic of health professionals.

It is to be expected that nurses would have a different view from that of doctors because the Ministry of Health began the implementation of the bill with a large number of intensive courses and programmes for nurses. An explanation for the difference between men and women in their perception of the attitude of health professionals may be that women are not treated in the same way as men and therefore their attitudes are likely to be different. Similarly, it can be argued that women have been conditioned to accept patronising treatment and therefore may not object to it where a man, given the same treatment, would object. Iltanen et al. (2012) made similar comments when they indicated that, generally speaking, there are differences between doctors and nurses in terms of their knowledge and attitudes in regard to medical ethics. It is also recognized that the high ratio of positive attitudes may cover many of the deficiencies in the implementation of patient rights (El-Sobkey et al., 2014; Kagoya et al., 2013).

In the interviews with experts and managers, they mentioned that a number of health professionals were not interested in learning about patient rights. The lack of interest among health professionals in learning about patient rights can be attributed to their busy schedules and work pressure (Zulfikar & Ulusoy, 2001) and their ignorance of the advantages of maintaining those rights (Siegal, Siegal, & Weisman, 2001). They may also believe the emphasis on patient rights is a new tool to restrict and control them as well as to weaken their authority in hospitals (Saracoglu et al, 2010).

Clearly, it is essential to update doctors and nurses when adopting new concepts such as those contained in the Patient's Bill of Rights. It is also necessary to provide them with full information of the implementation process to create a suitable environment for it. Such steps play a significant role in motivating health professionals to protect the rights of patients and to encourage patients to take an active part in the implementation process (Saleh & Khereldeen, 2013). This confirmed again that health professionals should be involved in the planning of patient rights and the implementation process (Baillie, Gallagher & Wainwright, 2008).

One of the major positive attitudes that health professionals must adopt is to show respect for the roles of the staff of the Patient Rights and Relations Department. In hospitals, this department is responsible for organising, coordinating, and supervising the implementation of the Patient's Bill of Rights and handling all patient complaints. If a patient feels dissatisfied or

believes his/her rights have been violated, the department acts as an investigator to solve the conflict at its first appearance. The department's role is vital for maintaining a balance in the relationship between health professionals and patients.

Participants in this study reported that, generally speaking, they respected the role of the staff of the Patient Rights and Relations Department; however, the results show a significant difference between doctors' and nurses' perceptions in relation to respect for the new department. Nearly 85% of nurses indicated that respect from health professional to the department was *great or moderate.* In contrast, 75% of doctors expressed the same point of view. The difference between doctors and nurses possibly because nurses work closely with the staff of the Patient Rights and Relations Department and promotes regular communication with them on a daily basis. These findings are supported by the results of a retrospective, cross-sectional study conducted by Saracoglu et al. (2010), who examined the status of the implementation of patient rights and the practical development of patient rights legislation in Edirne, Turkey. They reported that at the initial stage of the implementation of patient rights, challenges arose in practice as many doctors considered this to be an action directed against them. Evidently, the early involvement of health professionals, doctors in particular, is vital for resolving further complications that may occur as a result of a lack of awareness of their proper roles in maintaining patient rights.

As mentioned earlier, it is important to engage the help of health professionals to increase their commitment and understanding of the Bill and their roles during the implementation process. Health professionals, and nurses in particular, play a significant role in promoting and protecting the rights of patients because they often spend a large amount of time with them. This makes it very important to equip nurses with special training and education about patient rights. It follows that nurses should be required to recognise that advocacy is an essential role they must fulfil towards all patients and their families. Expert knowledge can help them to carry out their roles in the most efficient and effective way; however, the challenge for hospital management is to prepare nurses to accept advocacy as part of their role (Wellard, 2014).

6.2.4.2 Commitment of health professionals

Patients, especially hospitalised patients, need more support from health professionals and expect them to do their best to protect patients from any harm for this is one of the vital roles of health professionals (Er et al., 2014). In this, they need to be supported by hospital management through education, training, and encouragement to fulfil this role successfully.

Management actions can influence the commitment of health professionals towards patient rights either positively or negatively. The implementation of the Patient's Bill of Rights calls for the full intention and strong commitment of every health professional (Spratt, 2009). Lewkonia (2011) asserted that the wholehearted commitment of health professionals contributes to building a relationship of trust with patients, and in contrast Spratt (2009) notes that several factors such as unclear priorities, the absence of a system of rewards or incentives, limited support, and a lack of resources can undermine commitment among staff. The findings of this research indicate that the commitment of health professionals was assessed at a high level, as is evidenced by more than three quarters of the doctors and nurses, who indicated that they had a substantial commitment to the success of the Bill.

Similarly, the analysis of the data from patients in this study revealed that more than half believe that health professionals are committed to protecting their rights. Patients' assessment of the commitment of health professionals differed significantly between male and female patients. Sixty-five percent of women were more convinced than men that health professionals had a *moderate to great* commitment to the Bill. This discrepancy may be understood in light of the difference between hospitals, because the majority of female patients in this study were in women's hospitals where all nurses and most doctors were women as well. This result also shows a high level of solidarity among women, when they are given the freedom to do things more or less their way without the constant oversight of men.

6.2.5   Patient Rights and Relations Department level (Micro level)

The Patient Rights and Relations Department is an administrative body established by the Ministry of Health, in 2013, to ensure that patient rights in public hospitals are protected. Brazinova et al. (2006) indicated that the establishment of such a department was an important step for the Ministry of Health in the Slovak Republic. In a study in Turkey, it was reported that there is a positive relationship between awareness among health professionals of the presence of a Department of Patient Rights and their practice in preserving patients' privacy, ensuring patients' confidentiality, and obtaining informed consent (Utkualp & Yildiz, 2016). The presence of the Department of Patient Rights and ease of access to it are matters of great importance to patients. Usually, patients who seek out this department are those who feel that their rights have been violated.

The findings of present study suggested that the contribution and cooperation of the staff of the Patient Rights and Relations Department were still inadequate. This result may be due to the

recent establishment of these departments in hospitals, so that some health professionals are simply unaware of them. Similarly, Utkualp and Yildiz's (2016) study reported that eight years after the establishment of the Department of Patient Rights in Turkish hospitals, about 80% of health professionals at the Uludag University Faculty of Medicine, in Turkey were aware of the existence of the units but less than 65% indicated that these were functioning effectively.

The present study also indicated that more than half of the patients (52%) reported the department easy to contact; however, the remainder (43%) stated that this was not the case. This shows that great effort is still needed to make it easier for patients to contact the department when the need arises. These findings are consistent with research conducted by Dehghani et al. (2015), who reported that 44.5% of patients knew how to access the complaints' system. In contrast, Kuzu et al. (2006) concluded that the majority of patients did not have access to the complaint system. In New Zealand, Cunningham and Tilyard (2003), considered the multiple channels for registering complaints to be problematic. They suggested unifying the channels for complaints to establish a single point of entry to the system.

It seems that the new departments need more time and more effective promotion to become familiar to wider sectors of people in hospitals. In Saudi Arabia the Ministry of Health and hospital management have the major role to play in involving the new departments in most hospital activities and in helping them to present themselves in an appropriate way. Some key informants revealed that the cooperation of other departments with the Patient Rights and Relations Department is based mainly on personal relationships and friendships between managers.

The interviews conducted as part of this research suggest that the establishment of Patient Rights and Relations Departments in Saudi public hospitals has had a significant effect on the way health professionals deal with patients. Some interviewees suggested that the reason for this change is that health professionals feel there are new people and a new department who are watching their behaviour with patients.

Although the Ministry of Health has shown its commitment to protecting patient rights through the establishment of the Patient Rights and Relations Departments, interviewees report that the newly established departments suffer from a number of shortcomings, such as shortage of staff, lack of physical and emotional support, and lack of space for staff. These obstacles reduce the likelihood of hospitals benefitting from their presence and limit their ability to perform the work entrusted to them. It is the role of management at all levels to ensure that these new

departments have enough human and financial resources to be able to perform their role of promoting and protecting patient rights in all hospital facilities (Yarney et al., 2016).

Another challenge is encountered in the degree of authority given to these new departments. Many respondents revealed that the authority of the Patient Rights and Relations Departments over health professionals was relatively weak. The staff of the Patient Rights and Relations Department and managers felt undermined by officials at higher levels and had little confidence that they could perform their roles and achieve department objectives effectively. Brazinova et al. (2006) suggested that Patient Rights and Relations Departments should have more formal authority to supervise all hospital activities that may violate patient rights. They complained that being under the control of hospital management in regard to their activities, staffing, and reports, put their objectives in jeopardy.

The interviewees in the current research noted that the departments also suffer from the loss of skilled members because of the lack of motivation, the burdens placed on them, and their fear of being dismissed by hospital management. Saracoglu et al. (2010) mentioned the same issue in their study conducted to investigate the implementation of patient rights in Edirne, Turkey. They indicated that two of the main challenges facing patient rights units in hospitals were the selection of the unit manager, usually the chief consultant, and the selection of staff, usually from the nursing team. These selections harmed the independence of the units because of existing relationships and friendships between health professionals and unit staff. The separation of the department from hospital management was one of the solutions proposed by the Saracoglu's respondents.

6.2.6   Health professionals' and patients' assessment of implementation

The level of satisfaction of healthcare providers and end users is an important indicator for evaluating the success of the implementation of any new policy. It is expected that a successful implementation of the Patient's Bill of Rights will lead to improving healthcare delivery and increasing patient involvement and satisfaction (Alghanim, 2012). When patients find their rights are respected by health professionals, they will be more satisfied with the healthcare provided (Özdemir et al., 2009). Farzianpour et al. (2016) reported that there is a positive correlation between patients who observe that their rights are respected and patient satisfaction.

Respondents in this study were asked to assess to what extent there was a feeling of satisfaction with the implementation of the Bill among health professionals and patients in public hospitals. Doctors and nurses generally believed that there was a relatively good level of satisfaction

among professionals with implementation. As far as patients were concerned, the findings revealed that doctors and nurses rated the level of patients' satisfaction as more satisfactory than did the patients themselves. Among health professionals, 62.6% of doctors and 74.1% of nurses assessed patient satisfaction to be relatively good, compared to only 51.2% of patients who held the same view.

The findings in this research are consistent with the cross-sectional study conducted by Merakou et al. (2001) in the general surgical wards of six public hospitals located in the area of Athens, in Greece. That study reported that patients were relatively satisfied with the implementation of their rights in hospitals. In Pakistan, most patients were satisfied with the respect their rights were given in public hospitals (Tabassum, Ashraf & Thaver, 2016).

6.3   Research objectives 2 and 3

To identify the factors that facilitate and the barriers to the implementation of the Bill in public hospitals in Saudi Arabia.

Implementing new policies and projects alone cannot contribute to addressing challenges that the healthcare system faces unless that is accompanied by a better understanding of the underlying factors that affect the implementation process. As a result, ignorance of these factors may lead to the failure to reach the goals of these new policies. Although there are factors supporting the implementation of the Patient's Bill of Rights, so too there are factors hindering the implementation of the Bill; however, there is much overlap between several of these factors. Since many common factors may facilitate or hinder the implementation of the Bill, they will be discussed in one section.

By using the positive culture of patient rights framework (Figure 1.3), the original two levels, the macro (the Ministry of Health) and meso (hospital management and community) levels, were combined into one set of factors, termed "factors related to management," and the micro level was split into three groups of factors: factors related to health professionals, factors related to the Patient Rights and Relations Department, and factors related to patients.

Doctors, nurses, patients, and key informants, such as managers and experts, were asked about the factors that facilitated or hindered the implementation of the Patient's Bill of Rights in Saudi public hospitals and these factors were grouped under five major rubrics.

- Factors related to management: management commitment and support, regulations, cooperation, collaboration, and working conditions.

236

- Factors related to health professionals: awareness and attitude.

- Factors related to the Department of Patient Rights and Relations: support and authority.

- Factors related to patients: awareness and attitude of patients and the presence of patient's companion during hospitalisation.

6.3.1 Factors related to management (Macro and meso levels)

6.3.1.1 Management commitment and support

First, management commitment was mentioned by experts and managers as the most important factor that enhances the implementation of the Patient's Bill of Rights. The commitment of management at both the Ministry of Health and hospital level is critical in developing a positive culture of patient rights. To lead the transformation of the health system from a paternalistic healthcare model to a participation-based model requires full commitment from management (Meier, Pardue & London, 2012). It has been found that such commitment is highly effective in implementing any new policy (London, 2005). Senior management at the Ministry of Health level can signal their commitment to hospital management by clearly communicating the Ministry of Health's determination to protect patient rights and by allocating proper implementation policies and practices (Birken et al., 2015).

Joolaee et al. (2008) noted that management commitment can be seen in requiring health professionals to be more accountable and that the lack of this requirement can result in health professionals ignoring the Bill in Turkey. Such commitment and its influence on health professionals would show clearly the close relationship between management accountability and the application of the Patient's Bill of Rights in hospitals. It is also important that management takes full responsibility to discover patients' needs to eliminate problems related to the implementation of patient rights (Joolaee et al., 2006).

In addition, the commitment by hospital management can be shown through its support for all other parties in performing their roles. The provision of necessary resources is an important supporting role and is considered a significant factor that facilitates fostering the implementation of the Patient's Bill of Rights (Toulabi et al., 2016; Farzianpour, 2014; Dehghan et al., 2013). The findings of this study indicated that 85% of doctors and 80% of nurses believed that the availability of resources was one of the main prerequisites for the effective implementation of patient rights principles. This finding is in line with Joolaee et al. (2008). Elsayed, El-Melegy & Amaal (2013) reported that about 70% of nurses strongly

believed that the availability of resources, such as equipment and supplies, had a direct effect on the implementation of patient rights.

The improvement of organisational resources, such as human resources and hospital infrastructure, can improve the implementation of a Bill (Dehghani et al., 2015). Kagoya et al. (2013) asserted that the lack of resources, such as staff and financial support, was the main challenge in implementing patient rights in Uganda's hospitals. Rider and Makela (2003), however, commented that sometimes the concern should not be with limited resources but with the proper utilisation of them by many of the governmental bodies. The failure to use available resources optimally may lead to distortions in the health system and in the newly implemented regulations. In the Saudi health system, there is widespread waste of resources because of the lack of coordination and poor communication (Almalki et al., 2011).

The findings of the present study show that there is a high level of commitment by management to implement the Patient's Bill of Rights; however, the involvement of key stakeholders in the planning and implementation process left much to be desired. In addition, there were some additional barriers that were identified by the participants as very important hindrances to the implementation process. These barriers include the lack of conviction by hospital managers and poor promotion of the Bill. One of the greatest barriers to implementing the Patient's Bill of Rights is hospital management's lack of conviction of the benefits from the Bill. It is difficult to expect positive results for the implementation process without management conviction. Although the Ministry of Health showed its commitment to the Bill, as indicated by the establishment of a special department for the implementation of patient rights in every hospital, the participants in this study were of the opinion that the unsuccessful implementation of the Bill stemmed from hospital management's lack of conviction and failure to consider the importance of the idea of patient rights. Key informants in this research considered hospital management's lack of conviction to be one of the most important obstacles to the implementation of the Bill.

The findings of this study show that hospital management does not have a commitment strong enough to influence others in hospitals to take the issue of patient rights seriously. Slogans and rhetoric about the Bill will not lead to successful implementation unless these are linked to a real commitment which in turn derives from a strong conviction among senior management about the importance of the Bill. According to key informants, the implementation of the Bill is not a priority for hospital management. The reason for this may be that hospital management

faces many challenges that they consider to be greater and more important than patient rights, leading them eventually to ignore the implementation process of the Bill.

In fact, the absence of conviction by management could lead to undervaluing the implementation of the whole concept of patient rights, communicating to hospital staff that the Bill is not a serious issue for management. Thus, some staff may regard the implementation of the Bill as just a waste of time. This lack of managerial conviction could be attributed to a lack of understanding of the great advantages offered by implementation of the Bill. Management conviction about the benefits of the Patient's Bill of Rights is crucial and is most likely to be influenced by managers' knowledge of the content and benefits of the Bill. For this reason, hospital management education and involvement are two key factors expected to make a substantial difference in achieving a successful implementation of the Bill.

Promoting the Bill is one of the main roles of management at every level. The Ministry of Health is the first, most influential key actor responsible for promoting the Bill among the public. This promotion should be done in various ways. The main means of publicising the Bill mentioned in this thesis are traditional media. The findings of the present study show that a great number of health professionals and key informants remain unconvinced of the effectiveness of Ministry of Health efforts to use the media properly. Also, the lack of knowledge among health professionals concerning many aspects of the implementation strategy, plan, and goals could be considered additional significant evidence that no proper channels had been established for transferring information to health professionals.

6.3.1.2 Regulations for implementing the Bill

The two main regulations mentioned by participants in this study were the monitoring system and the complaint process.

Follow-up and monitoring system

A proper mechanism for monitoring and following up compliance with the Bill is a necessary ingredient to ensure the Bill moves towards its goals. The Ministry of Health and hospital management play an active role in fostering the inclusion of a monitoring system to evaluate the progress of implementation over time. Managers are responsible for developing a suitable approach as well as the means for conducting regular assessments of the performance of health professionals in the implementation of patient rights (Toulabi et al., 2016; Farzianpour, 2014; Dehghan et al., 2013) and to create a culture of patient rights in hospitals (Aazami & Mozafari, 2015). Monitoring the implementation process at multiple levels would provide an indication

of whether the rights of patients were protected or not. It would also allow management to identify areas of strength and weakness that need to be worked on and would assist in eliminating the possibility of the recurring abuse of patients. The monitoring process, including monitoring patient complaints, can be used as an effective tool for quality assurance systems and healthcare improvement (Mohammadi, Poursamad & Motlagh, 2016; Kuosmanen et al., 2008).

The findings of this study indicate that key informants believe that the implementation of patient rights in Saudi public hospitals needs close collaboration between the Ministry of Health and hospital management to establish a systematic monitoring system that would ensure that hospital staff follow Bill guidelines. They insist that the monitoring system should provide continual observation as part of the implementation process. This finding is supported by Momennasab et al. (2016) and Joolaee et al. (2006) who declared that ethics regulations and the personal moral values of health professionals alone cannot protect patient rights but a permanent mechanism for monitoring and evaluation should be considered in addition to legal arrangements. In developed nations, non-governmental organisations often provide an external monitoring system that can bring to focus a collective public voice, in addition to providing information and advice on various situations and practices (Coney, 2004). In countries where patient rights have been codified, information is collected on a regular basis from providers, patients, and their families to measure the level of compliance with regulations (Rider & Makela, 2003).

The complaint process

Complaints, typically made by patients or family members, are generally unavoidable in health service settings; however, a dispute within a healthcare organisation gives management an opportunity to discover and investigate a patient's negative experience and patient complaints can be considered a useful source of information for monitoring and improving health services. They also provide a valuable learning tool for management and health professionals. As a consequence, careful consideration should be given to complaints to discover imbalances and shortcomings that are not detected during the regular evaluation process.

In Saudi Arabia, following the Bedouin tradition, people feel they have the right to report their issues or concerns directly to the organisational leader, not to anyone else. This causes several problems in the health system when dealing with people's complaints. In this tribal tradition,

however, the system sometimes has recourse to tribal leaders' influence on their followers to mediate disputes.

The findings of this study reveal that 35.8% of doctors and 20% of nurses reported that patients received minimal explanation about the complaint process. As a consequence, the majority of patients (70.4%) regard simplifying the complaint process as the second most important factor that would facilitate the implementation of patient rights. This result paralleled that of Büken N. & Büken E. (2003) in their study in Turkey, who reported that patients considered the complaint process to be wasteful of time, effort, and money. In a cross-sectional study conducted in 12 teaching hospitals in Iran, Asadi et al. (2015) reported that 20% of managers were not satisfied with the complaint system and more than 30% said that lack of proper policy was one of the most important challenges in their hospitals. Similarly, Anbari, Mohammadi and Taheri (2015) reported that more than 60% of the patients in their study in Iran lack knowledge of the complaints process.

In the present study also, according to patients, feedback, and follow-up after lodging a complaint were unsatisfactory. Patients appreciate any effort from management to communicate and inform them about the progress of their complaints until a resolution is reached. Lack of follow-up was found to be the main reason for raising issues with senior management or even with traditional media.

Similarly, a general review conducted at the King Edward Memorial Hospital in Australia discovered several systemic and organisational deficiencies that needed to be addressed. One of these deficiencies was patient involvement, which included the customer complaint policy. The review reported that hospital policy had several problems related to the complaint system, including no clear explanation of the complaint process, lack of respect for the complainant, lack of coordination when responding to complaints, and insufficient feedback on complaints (Hindle, Braithwaite, Travaglia & Iedema, 2006).

The findings of the present study revealed that most patients prefer not to use forms and write complaints. A possible explanation for this reluctance may be their fear that a written complaint might be used against them or because of patient illiteracy. Or it may be that most patients think the expenditure of time and effort much greater than the probable returns. For these reasons, it is recommended that complainants be allowed to lodge complaints orally if they prefer.

Hospital management is expected to inform patients clearly about progress with their complaints (Parsapoor, Mohammad, Afzali, Ala'eddini & Larijani, 2012). The findings of the current research revealed that, in contrast with those who stayed longer, patients hospitalised for only a short time rated the clarity and speed of the complaint process as a very important factor. This indicates that on admission, patients are interested in learning how a complaint will be handled if they need to submit one. In Saudi culture, this step enables patients to feel more secure and gives greater confidence that hospital management cares about patient concerns. It is recommended that necessary explanations be given on admission or at the earliest suitable time for patients.

Simplifying the complaint process may include making it accessible, understandable, easy to follow, take only a reasonable time and effort, and not making threats. Using technology can make a valuable contribution to automating the entire complaint process.

The clarity of the implementation process is an issue to be addressed early in the planning stage. If the process of implementation does not have clearly specified steps, objectives, and assessment of progress, stakeholders will not be sure of their exact roles nor what is expected of them. It is highly likely that this very lack of clarity will form a major barrier to implementing the Patient's Bill of Rights. Many studies have indicated that the process of implementation is the most difficult aspect of implementing a new policy because it requires that all stakeholders to be actively and continually involved and commit to the implementation.

Key informants reported that the Departments of Patient Rights and Relations at the Ministry of Health and hospitals have no clear implementation plan or process. This made hospital management and health professionals unsure about the proper method to implement the Bill to meet its objectives. As a consequence, actual implementation in hospitals was inconsistent because each hospital implemented the Bill according to its own management's or health professionals' understanding.

One of the possible explanations for this situation is that during the implementation process, the Ministry of Health focused more on the Bill's content than on the process of its implementation. The most senior management at the Ministry of Health is considered by experts and managers to be the most important stakeholders in supporting the process of implementing the Patient's Bill of Rights. This finding is consistent with study by Abedian, Nesami and Shahhosseini (2015), who reported that the implementation process of the Patient Bill of Rights in Iran was not properly planned and conducted. As a result, health professionals

remained unaware of the content of the Bill and were not trained to deal with situations calling for ethical judgement. The authors recommended that the implementation process should be reviewed and reassessed to resolve all challenges hindering its success.

Patient Rights and Relations Departments at ministerial, regional, and hospital level should ensure that the implementation process is effective, comprehensive, and successful. To achieve this, they obviously require physical, human, and financial resources. Ovretveit, et al. (2012) show that senior management are usually required to drive the implementation process and provide guidance and establish the appropriate environment for implementation. Guidelines could be clear, with written regulations to ensure staff are committed to enforcing the Bill, and give significant support for the process of implementation of the Bill. A major step in the process is to convince hospital management and health professionals that the implementation of the Bill has great value for all parties and for the entire health system. Any problem or challenge occurring during the implementation process should be considered a learning opportunity opening the way to developing a new and better strategy (Butterfoss, 2006).

A lack of knowledge about the implementation process among health professionals could have a negative effect, which might lead to the failure of the whole enterprise. The involvement of all stakeholders, including health professionals, patients, and community leaders, could raise the sense of belonging and involvement in the process, which in turn could lead to maintaining interest and enthusiasm about the implementation of the Bill (Thurston et al., 2005). The involvement of stakeholders also creates a common understanding and shared values that enhance and foster the implementation process (Sangster-Gormley et al., 2011).

6.3.1.3 *Cooperation and collaboration*

To achieve their objectives, the Ministry of Health and hospital management should work collaboratively with a variety of governmental and non-governmental agencies as they seek to implement the Patient's Bill of Rights, a point supported by the findings of this study. Through medical and nursing schools, the Ministry of Health can ensure that future health professionals are well prepared to deal effectively with the Bill (Akca et al., 2015; Johnstone et al., 2004). In cooperation with the Ministry of Education, the Ministry of Health can teach the new generation of students all that is involved in patient rights. Toulabi et al. (2016) recommended that the Patient's Bill of Rights be included in the curriculum for medical and nursing students in order to create a generation familiar with its concepts and content in Iran.

In addition, community groups may be able to provide informal meetings and public support promoting awareness of the contents of the Bill. Effective cooperation with the media is expected to increase the whole community's understanding of patient rights. In the international context, the Ministry of Health could collaborate with recognised international healthcare organisations such as the WHO, Joint Commission International, or Europe's Active Citizenship Network, to benefit from their extensive experience of applying patient rights in a variety of contexts.

Almalki et al. (2011) explained that the Saudi Ministry of Health is required to build new strategies to guarantee effective cooperation with other sectors. In a similar vein, Büken N. & Büken E. (2004) noted that one of the challenges facing the healthcare system in Turkey is the lack of coordination and cooperation between different institutions. Cooperation among public hospitals and among departments within each hospital is vital for the successful implementation of the Bill. Hospital management should not rely on health professionals' sense of moral obligation to respect patient rights. Instead, their actual practice, regarding patient rights, should be closely monitored and evaluated (Momennasab, et al., 2016). According to the World Health Organization (2000), health professionals should collaborate to make the implementation of patient rights possible. A high level of awareness among patients and health professionals cannot ensure the successful implementation of patient rights unless there is effective collaboration among key stakeholders, such as health professionals, management, and policy-makers (Parniyan et al., 2016).

The findings of the present research suggest that management at the Ministry of Health, hospital management, and media governmental bodies, as well as community organisations should work together to strengthen the implementation of the Bill and to increase the level of knowledge about the Bill among the public; however, it is the role of the Ministry of Health to create appropriate strategies within and outside the healthcare system for improving this kind of collaboration (Alghanim, 2012). There should be a solid basis for establishing a collaborative relationship at all steps of the implementation process.

6.3.1.4 *Working conditions*

Working conditions include the physical, psychological, and social working environment, and each of these can have a positive or negative effect on staff (Jain & Kaur, 2014). Management are expected to create safe and healthy working conditions that positively affect staff attitudes towards their working environment. A good work environment motivates staff and helps them

to accomplish their organisation's goals. In contrast, poor conditions characterised by increasing work pressure, larger numbers of patients, lack of time, and lack of staff often lead to job dissatisfaction among staff.

In this study, both doctors and nurses emphasised that a good working environment, including good conditions and support are important factors, and experts and managers also agreed on this point. These key informants also indicated that improper working conditions hinder the implementation process. This result is in line with other studies, which indicate that poor working conditions, lack of staff, excessive patient numbers, lack of resources, and time constraints are all factors that negatively affect the implementation of patient rights (Dilawari, 2016; Abou Zeina et al., 2013; Elsayed et al., 2013; Alghanim, 2012).

Almalki et al., (2016) showed that an insufficient number of health professionals, heavy workloads, and time limitations can result in a low awareness among patients about their rights. A study conducted by Vivian et al. (2011) reported that excessive workloads, time limitations, and lack of staff were among the factors leading to the abuse of patient rights in South Africa. In the same way, Alghanim (2012) indicated that the situation in Saudi healthcare settings, especially health centres, reflects several challenges, such as lack of resources, lack of qualified health professionals, and excessive numbers of patients.

In fact, all these factors are interrelated and each one leads to the others. A lack of staff resources leads to increases in patient waiting times, which in turn leads to increasing the work pressure on staff. The eventual result is less time to perform the required work. It is expected that every patient will be given sufficient time to ask questions, understand and interact with their medical service providers but the factors mentioned force health professionals to shorten the time spent with each patient in order to maintain a minimum level of service (Joolaee et al., 2006). Joolaee et al., (2008) reported that even though health professionals indicated that they believe in the importance of patient rights, and are committed to protecting them, they also reported that they were often unable to do so because of their high workload and time constraints. By such comments, health professionals revealed that these factors led directly to the violation of patient rights (Joolaee et al., 2006).

Safe work environment

Establishing a safe working environment in healthcare settings, ensuring that all staff and patients feel physically, psychologically and emotionally safe, is one of the main responsibilities of hospital management (Farzianpour, 2014). The American Association of

Critical-Care Nurses (AACN) outlined six key elements that characterise a healthy work environment: skilled communication, true collaboration, effective decision making, appropriate staffing, meaningful recognition, and authentic leadership (The American Association of Critical-Care Nurses, 2005). A healthy and supportive work environment is a vital factor in making staff and patients feel more safe and secure.

In this context, the work environment includes interaction with others and the physical and emotional surroundings of the workplace, which may include building design, ventilation, amount of work, space, ventilation, tools, temperature, and safety (Aazami & Mozafari, 2015; Dehghani et al., 2015; Joolaee et al., 2006). It has been found that managerial support for staff makes them feel more valued, they consider their work environment healthier, and staff turnover is reduced (Sherman & Pross, 2010).

Evidence in the literature also demonstrates that a supportive environment is characterised by a high level of trust between management and staff, so that staff feel emotionally and physically safe (Shirey, 2006). A safe, healthy work environment has several beneficial effects on the performance of the entire organisation, the quality of healthcare service, the performance of staff and health professionals, and patient outcomes. A study conducted in Yemen reported that the level of respect for patient rights principles is higher when workplace conditions are satisfactory (Al-bardah, Shenouda, & Magdy, 2012).

The findings of the present study revealed that the factor considered most important by health professionals was the existence of a safe work environment in hospitals (85.5% of doctors and 83.3% of nurses), reflecting the essential role this factor has for health professionals in the hospital environment. This result is consistent with research conducted by Elsayed et al. (2013), who reported that 55% of nurses agreed strongly that a good working environment has a beneficial effect on patient rights. A safe environment is reflected in staff attitudes and behaviour in a way that benefits patient rights (Akca et al., 2015). Similarly, Abou Zeina et al. (2013) and Alghanim (2012) affirmed that an unsafe environment is one of the main barriers to the implementation of patient rights principles. A stressful working environment serves as an indicator of poor respect for the rights of patients (Fallberg, 2003).

Fair reward system

Creating a culture of patient rights in hospitals involves an understanding shared by all stakeholders of the value of these rights and the importance of their implementation. In addition, sufficient knowledge is required of the essential attitudes and behaviours, related to

patient rights, which are supported and rewarded. As a consequence, management should concentrate on encouraging desired behaviours and motivating health professionals to perform accordingly. A well-designed system of rewards is a powerful tool to create constantly motivated and encouraged staff. The main purpose of this tool is to motivate staff to show desired behaviour that aligns with agreed values. Rewards can be tangible, in the form of money, trophies, and gifts, or intangible, such as recognition, certification, or honour conferred (Miljković, 2007).

Generally, monetary rewards are those most frequently used and are preferred by most people. A study conducted in Nigeria found that there was a positive connection between monetary incentives and health staff performance (James et al., 2015). Money may be attractive but it is not always sufficient to motivate health professionals. Management should also consider non-monetary rewards as effective options (De Gieter et al., 2006). To motivate staff, Luxford et al. (2010) suggested several non-monetary approaches, such as acknowledgement of staff in a newsletter for their performance, an employee-of-the-month programme, sharing stories with the staff and management team, and a special acknowledgement or thank you from senior managers.

The present study's findings confirmed that a reward system can help to encourage health professionals to implement the Patient's Bill of Rights. Individuals who are excellent role models and contribute to the successful implementation of change should be motivated. Yaghobian et al. (2014) indicated that an effective method to motivate staff is by providing compensatory rewards.

The findings of this research emphasise, however, that a monetary reward system cannot provide a long-term solution because it is costly and, according to Herzberg's theory (Miljković, 2007), may lose its attractiveness over time. When changes are introduced, financial rewards may be used to encourage behaviour that makes the changes part of the culture of the organisation. In a similar Johnstone et al. (2004) recommended that managers boost the morale of health professionals through a fair, equitable reward system in different ways, including recognition, responsiveness, merit announcements, or citing an individual as a positive example. Most importantly, management should set up short-term achievable goals and link them to specific measurable objectives, because people tend to give up on unachievable or long-term goals (Hellings et al., 2010; Panozzo, 2007).

6.3.2 Factors related to health professionals (Micro level)

6.3.2.1 Awareness

Health professionals' awareness is one of the key enablers to achieving the goals of patient rights regulations (Dehghani et al., 2015; Farzianpour, 2014). Making health professionals and other staff familiar with patient rights is a significant responsibility of the Ministry of Health and hospital management. As healthcare has developed rapidly towards a greater focus on patients as active partners, health professionals also must adapt to this change and conform their practice to it. As a consequence, health professionals must learn and apply the principles of patient rights with a full understanding of their content as well as the legal aspects (Ansari, Abeid, Namvar, Dorakvand, & Rokhafrooz, 2013). Lack of knowledge about the Bill on the part of health professionals may be one of the most problematic matters for the implementation of the Bill process (Dehghani et al., 2015).

In this study, the findings show that all managers and experts considered awareness on the part of health professionals to be one of the most important factors that facilitates the implementation of the Patient's Bill of Rights in public hospitals. They believe the Ministry of Health and hospital management are responsible to teach them every aspect of the Bill (Farzianpour, 2014). In the quantitative part of this study, more than 80% of doctors and nurses believed that raising the awareness of health professionals was an important factor in facilitating the implementation of the Bill. This finding is supported by many studies that concluded that the awareness of health professionals plays a significant role in the implementation process (Parniyan et al., 2016; Sheikhtaheri, Jabali & Dehaghi, 2016; Aazami & Mozafari, 2015; Dehghani et al., 2015; Farzianpour, 2014; Parsapoor, Bagheri & Larijani, 2014; Dehghan et al., 2013; Joolaee et al., 2008).

The experts in this study also suggested that management can use new technology to improve the awareness of health professionals about the Bill. The compulsory introduction of the topic of patient rights in orientation programmes for new staff was recommended to promote a culture of patient rights in hospitals (Aazami & Mozafari, 2015). In addition, a reward system, discussed in the previous section, can be used to enhance health professionals' participation in educational events.

6.3.2.2 Attitude

One of the most important values addressed by managers and experts was securing a commitment from health professionals. The findings in this study show that health

professionals' commitment to the implementation of the Bill was the factor most frequently mentioned by experts and managers as essential to promoting the success of the implementation process. It has been found that staff commitment is usually influenced by a corresponding commitment on the part of management and leaders (Allen, Chiarella & Homer, 2010).

Although issuing the Bill shows a strong commitment from the Saudi health system to the protection of patient rights, this edict cannot be implemented in hospitals without a corresponding commitment from health professionals to adhere to its principles. Commitment from health professionals was one of 12 values that the High Committee of Medical Ethics of the Ministry of Health and Medical Education in Iran included in the ethical code required of health professionals to apply in healthcare settings (Momennasab et al., 2016).

Professional commitment may also play a major role in reducing the number of complaints from patients (Jabbari, Khorasani, Jafarian Jazi, Mofid & Mardani, 2014). Commitment to patient rights from health professionals can be enhanced by involving them in the planning and implementation process. It is recommended that management seek to understand the factors influencing health professionals' commitment in order to foster the desired moral behaviour and to create a culture of patient rights. One method for acquiring this understanding is by conducting staff satisfaction surveys and monitoring performance and experience.

Regarding teamwork, managers and experts confirmed that hospital management should establish teamwork values among health professionals to create a culture of patient rights in which all stakeholders share the responsibility to protect patient rights. Teamwork strategies could focus on improving teamwork, interdepartmental and staff relationships, cooperation, discussion, and effective communication. Teamwork values help minimise ethical conflicts between health professionals (Madsen, 2006) and therefore, teamwork should be encouraged within and between hospital departments and units.

In the current study, 85% of doctors and 83.4% of nurses agreed that teamwork was one of the main factors that facilitated protecting patient rights. Similarly, Pelzang (2010) suggested that efficient teamwork is one of the main requirements for the successful implementation of patient-centred care. Rathor et al. (2009) indicated that effective teamwork can play a significant role in the implementation process.

Another factor requiring a positive attitude and behaviour from health professionals is encouraging patients to assert their own rights and share in the decision-making process for their treatment (Ibrahim et al., 2016). Health professionals must adopt a positive attitude

towards patient rights and also the important concept of patient involvement and participation. Patients should be encouraged to raise any questions or concerns and to express their wishes or preferences directly, without fear of unfavourable reaction from anyone.

This study revealed that patients regard encouragement given them to exercise their rights as the most important factor in the implementation of the Patient's Bill of Rights. The findings also indicated that younger patients are more interested than older ones in exercising their rights in hospitals; however, a study conducted in Saudi public hospitals by Saleh et al. (2014) revealed that less than half the patients were encouraged to participate in the decision-making process.

In contrast, the job satisfaction of health professionals was shown to be an important concern of respondents, directly affecting the attitude they hold towards protecting patient rights. Professional satisfaction was considered to be a factor that facilitates the success of implementation of the Bill. Greater focus on improving staff satisfaction is significant in promoting the establishment of a culture of patient-centred service (Luxford et al., 2011).

Shortage of staff, heavy workloads, limited time, and low salaries are some of the causes creating staff dissatisfaction and have a negative effect on their performance in delivering quality health services (Alghanim, 2012; Joolaee et al. 2006). Job dissatisfaction may also negatively affect health professionals' motivation and commitment to patient rights (Ibrahim & Aly, 2014). Moreover as Khiavi, Dashti and Kishizadeh (2016) and Joolaee et al. (2006) contend health professionals cannot be expected to protect patient rights unless their own rights are respected and maintained.

This research indicates that the satisfaction of health professionals is an important enabler in the implementation process. Consistent with this finding, Asadi et al. (2015) reported that more than half the managers in Iran indicated that a high level of staff satisfaction is strongly linked with a correspondingly low level of patient complaints. In another study, Joolaee et al. (2006) reported that dissatisfaction among nurses and doctors was a key barrier to the implementation of the Patient's Bill of Rights. As a consequence, management should focus on staff satisfaction by considering health professionals' needs and make an effort to meet them to gain their support for the implementation of the Bill (Luxford et al., 2011). Involving health professionals in the planning and implementation process is expected to improve their satisfaction.

6.3.2.3 *Lack of training*

One of the most frequently mentioned barriers to the implementation of the Bill in this study was the lack of training. In fact, training is needed to satisfy the objectives of the Bill. The importance of training and continual education to support successful implementation of patient rights has been highlighted by many studies (Ama-Amadasun, 2016; Ibrahim et al., 2016; Barrera, Negrón, Barría & Méndez, 2015; Farzianpour, 2014; Parsapoor, et al., 2014; Erer, Atici, & Erdemir, 2008; Joolaee et al., 2006).

In the present study, the majority of participants were aware of the significance of the education and training of health professionals. Nearly 85% of doctors, 82.4% of nurses and 65% of patients rated educating professionals about patient rights as one of the most important factor that facilitates the implementation of the Bill. These results indicate how important respondents believed the education and training of professionals was to the success of the implementation process.

A quasi-experimental study conducted by Abedian et al. (2015) in an Iranian teaching hospital examined the effect of educational intervention on the practice and level of awareness among nurses regarding the implementation of patient rights. The study revealed that there were significant differences among nurses before and after the intervention; however, another study concluded that written educational materials have no significant effect on nurses with a university degree, unless these materials are accompanied by lectures or seminars (Yaghobian et al., 2014). Another study conducted in the US by Adams and Miller (2001) reported that more than 50% of the nurses they surveyed did not act on the basis of an ethical code or framework. The authors suggested that continuing education in ethical codes could improve their knowledge and influence their practice. An effective way of educating health professionals about ethical issues is for each department or unit to hold regular meetings to discuss and evaluate actual incidents that occur (Madsen, 2006).

Health professionals must learn the content of the Bill and its implications and also how to transfer their knowledge into practice by enabling patients to recognise their rights. This will involve appropriate education and training courses which include all hospital staff. Education and training efforts should be provided on a regular basis and using various approaches, such as lectures, workshops, seminars, as well as both formal and informal meetings.

6.3.3 Factors related to Patient Rights and Relations Departments (Micro level)

6.3.3.1 Support

Patient Rights and Relations Departments have been established for monitoring, training, and supervising hospital staff to ensure compliance with the Patient's Bill of Rights. Support from the Ministry of Health and hospital management is essential for these departments to meet their objectives. Department staff must be skilled and trained well to deal with ethical incidents in varying circumstances. This study indicates that Patient Rights and Relations Department needs support in several ways, including improved, ongoing education and training for staff, providing the department with human resources, a proven incentives programme for staff, and the provision of emotional support for staff.

Saracoglu et al. (2010) recommended that before the implementation of a patient rights bill, the relevant department's staff should be carefully selected and receive training in ethical topics. It was suggested that the staff of these departments be chosen from among social workers, psychologists, nurses, or related disciplines, and individuals who have received training in public relations (Önal & Civaner, 2015). Ongoing education for staff was identified as an important factor to empower staff who work as patient advocates (Johnstone et al., 2004).

With regards to human resources, Yarney et al. (2016) reported that public health authorities are required to provide sufficient staff to the departments in addition to other provisions, such as space, equipment, and materials. Managers and experts complained that these departments were unable to retain their staff, especially the most qualified ones. The high level of work pressure, in addition to the lack of emotional and financial incentives, resulted in losing more and more staff. Many expressed the view that there were no attractive features and no motivation for working in these departments. Many factors that could be seen as a hindrance were reported by participants in this study, including lack of protection for the staff of the Patient Rights and Relations Department, lack of financial incentives, lack of emotional support, and lack of human resources.

6.3.3.2 Authority

Because Patient Rights and Relations Department is new, compared to other departments in hospitals, it needs continued support from hospital management. That support should not be limited to financial, emotional, and structural support but must go beyond that to give the department broader powers to enable it to play its vital role in defending the rights of patients. Because of this, the staff of the Patient Rights and Relations Department should be empowered

252

by management to fulfil their role of protecting patient rights. Brazinova et al. (2006) recommended that hospitals offer patient rights unit's formal authority to perform their tasks effectively and intervene when patient rights were violated.

One means to empowering the department, suggested by managers and experts, is to separate it from hospital management. Saracoglu et al. (2010) revealed that the main problem facing patient rights units was the fact that the manager of these units was often the chief physician. This situation was found to weaken the role of the department because the manager would come under pressure from colleagues and the medical fraternity, which undermined the department's independence from hospital management.

This situation leads to a recognition of the next barrier, the weakness of the Patient Rights and Relations Department in hospitals. Many participants reported that other departments mistrust this new department because they assume that the purpose of the department is to spy on them or to strengthen the power of patients over them. An additional important barrier, mentioned repeatedly, was the frequent intervention from hospital management in the activities of the Patient Rights and Relations Department. This result may indicate that there was still considerable uncertainty among health professionals about the functions of the department and its purpose.

Because it was generally observed that patients may expect more from this department, about 60% of patients indicated that the lack of authority given to the staff of the Patient Rights and Relations Department was the third most significant barrier to the implementation of the Bill. As a consequence, the quality of the staff in this department and their level of authority were identified as factors likely to lead to the success or failure of the implementation of the Bill. The low level of these two factors presents a serious barrier to the successful implementation of the Bill.

6.3.4 Factors related to patients (Micro level)

6.3.4.1 Awareness and attitude of patients

Awareness

Awareness on the part of patients and the public is an important factor in the implementation of the Patient's Bill of Rights. Patient rights cannot be applied without the active participation of patients in the implementation process. The first line of defence against patient rights violations are the patients themselves. For example, when patients feel that their rights have

been violated, one assumes that patients or their families will ask questions and raise the issue in an appropriate way to address the incident. This response cannot take place unless patients, their families, and the public are aware of patient rights in health settings.

Numerous studies have indicated that patient and public awareness is the most important factor to facilitate the implementation of patient rights in hospitals (Ama-Amadasun, 2016; Ebrahimi, Sadeghian, Seyedfatemi, Mohammadi & Azizi, 2016; Feyzipour et al., 2016; Parniyan et al., 2016; Aazami & Mozafari, 2015; Yaghobian et al., 2014; Dehghan et al., 2013; Moghadam, Moghadam, Moslem, Ajam Zibad & Jamal, 2011; Joolaee et al., 2008). There are many advantages to educating patients about their rights. It improves their attitudes and motivation to participate (Ebrahimi et al., 2016) and increases the likelihood that they will demand their rights (Joolaee et al., 2008).

Patients and the public can be educated in many ways, traditional or modern. The traditional methods include educational courses, reading materials, signs on walls or boards, or giving out booklets or pamphlets on admission. However, Paasche-Orlow et al. (2009) noted that the Patient's Bill of Rights displayed in US hospitals was found to be difficult to read by the majority of adult patients. Similarly, Yaghobian et al. (2014) claimed that many patients were unable to benefit from reading materials for various reasons, such as low literacy rates, limited time, and the style of writing. However, technology has made a substantial contribution to patient education by making it simple, enjoyable, and accessible at all times. The modern methods include using social media, texting, and emails.

The present research shows that patients considered increasing awareness of the Bill to be an important factor that facilitated the implementation of their rights. Health professionals also indicated that this factor was very important for enhancing the implementation process. Patients with higher education were more in favour of promoting awareness, which reflects the role of education in supporting patients' participation and empowerment. Similarly, all managers and experts emphasised the vital role that public and patient awareness plays in the success of the implementation process. They believe the Ministry of Health, followed by hospital management, is responsible for raising awareness among the public and patients.

Attitude

Some patients have a negative attitude, which leaves them convinced that the exercise of their rights is a luxury and what is required from health professionals is simply to treat them, regardless of how they go about it. This attitude may be due to the nature of serious disease,

which reduces individuals to their weakest state and induces them to tolerate abuses in order to be treated at all.

This research confirms that a great number of patients assumed that treatment is more important than their rights as patients. That more than two thirds of patients said they held this view makes it the second most important barrier to the implementation of the Bill. A study conducted in Poland by Kaczyńska et al. (2004) reported that the majority of nurses indicated that patients often do not care about their rights. A possible explanation for this is that when receiving health service, most patients are unaware that they have rights. This ignorance leads to the weakening of their position in the health service.

The Ministry of Health and hospital management are responsible for developing mechanisms to empower patients and strengthen their roles through continuing education. Continuing education will lead to a new culture within hospitals that is concerned about patient rights. It is expected that this culture will teach patients to refuse health service in the absence of their basic rights, such as respect, justice, and confidentiality, and that the flouting of these rights is a violation and a serious matter punishable by law. For this reason, in such a culture, observing patient rights becomes a matter of top priority for patients.

6.3.4.2 *Presence of a patient's companion*

A patient's companion, sometimes more than one, is usually one of the patient's relatives and they divide the responsibility for the patient among themselves. Schilling et al. (2002) noted that whereas classic training for doctors and nurses focuses on interaction with patients as a second part of the treatment process, in actual practice there is usually a third key actor, the patient's companion. The presence of patients' companions is highly likely to affect the interaction between patients and health professionals. The patient's companion contributes significantly to improvement in communication between patient and health professionals (Ishikawa, Roter, Yamazaki & Takayama, 2005) and improves patient and health professional understanding as well as patient involvement (Clayman, Roter, Wissow & Bandeen-Roche, 2005).

Companions feel they have been delegated by the family to take responsibility for the patient's interests and therefore endeavour to be aware of all information relevant to the patient and to be a key part of the treatment process. Patients' companions usually act as advocates for the patient, and therefore they ask questions and raise concerns on behalf of patients. They also

provide assistance, company, and physical, and emotional support to their relatives who are patients (Chamsi-Pasha & Albar, 2016; Andrades, Kausar & Ambreen, 2013).

In Muslim culture, specifically Saudi, culture, where strong family bonds form a deeply rooted aspect of people's lives, patients' companions have significant influence on what patients choose and decide. Health professionals commonly accept this cultural norm and use patients' companions as a means to deliver news, including bad news, to patients and their families (Chamsi-Pasha & Albar, 2016; Al-Mohaimeed & Sharaf, 2013; Joolaee et al., 2006). In a Saudi study, most doctors (70%) preferred to discuss bad news with patients' companions rather than with the patients themselves (Al-Mohaimeed & Sharaf, 2013). In many developed countries, however, this practice would be considered a breach of the patient's privacy.

In this research, the findings show that the majority of patients consider the presence of companions to be the most important factor ensuring the successful implementation of the Patient's Bill of Rights in hospitals. The findings indicate that patients feel more secure, safe, and empowered when family members are present. Similarly, about 80% of nurses and 70% of doctors agreed on the importance of patients' companions during hospitalisation to facilitate the implementation of the Bill. Consistent with this finding, Abedian et al. (2015) noted that patients considered having a companion to be an extremely important means to maintaining and protecting their rights. The absence of patient rights advocacy services forces people to seek alternative mechanisms to protect their rights. One of the main alternative mechanisms in developing countries is the presence of patient's companion (Joolaee et al., 2008).

Despite this, a quarter of the doctors declared that the presence of patients' companions was of little or no importance in the implementation process. This high percentage may be the result of the following factors: doctors find that patients' companions argue, demand, or try to dominate decision making on behalf of patients; or the problem may be that doctors have inadequate training in dealing with patient's companion. This finding is consistent with those of Laidsaar-Powell et al. (2013) and Joolaee et al. (2008), who noted that for health professionals, the presence of patient's companion can present difficulties, such as disturbing the staff, wanting to make decisions for patients, or annoying other patients.

6.4 Research objective 4

To examine the actual implementation of some selected fundamental patient rights.

Patient rights are the most important principles that must be protected and maintained by health organisations and their staff at all times. The responsibility for protecting these rights does not lie with one department or its staff but with all health organisation staff at every level. Patient rights principles should be given priority and should be built into the healthcare system.

Using the PRES (Patient Rights Euro Score) scale, the value of each right was calculated to express the level of its implementation in hospitals, according to health professionals and patients. The labels used to assess rights implementation were as follows: not respected (0-50), hardly respected (51-60), partly respected (61-70), largely respected (71-90), and fully respected (91-100) (Lamanna, et al., 2011).

In the present study, patients generally rated the implementation of their rights at a significantly lower level than did health professionals. Overall, doctors and nurses perceived the implementation of the 13 rights in public hospitals to be *largely respected* (79.2%), whereas patients' overall perception was that they were *hardly respected* (57.9%). These findings may indicate that patients remain unconvinced that their rights are maintained at an acceptable level. The findings were in line with those of Alghanim (2012), who reported that few patients knew anything about the Bill and its implementation in primary healthcare centres, in Saudi Arabia. This result suggests that public hospitals in Saudi Arabia need to make more effort to enforce the Patient's Bill of Rights on the practical level by considering all factors that facilitate and all those that are barriers to its implementation. Every individual on the staff of healthcare organisations should be responsible for ensuring that patient rights principles are implemented as part of the organisation's culture.

6.4.1 Rights rated highly for degree of implementation

Although no single right was rated as *fully respected* (implemented), health professionals indicated that most rights were *largely respected*. Of the rights given this rating by health professionals, four were assessed *as largely respected* by 85% or more of respondents. These rights could be considered the most frequently implemented rights in public hospitals, according to health professionals. They were: the right to privacy (86%), to the confidentiality of information (85%), to be treated in a safe environment (85%), and to be asked to sign consent forms (85%).

In contrast with results obtained from doctors and nurses, results from patients showed that they did not rate any right as implemented at a higher level than *partly respected*. In order of their rating by patients, these rights are the right to be treated with respect (63.1%), to be treated in a safe environment (63.1%), to be asked to sign consent forms (63%), to the confidentiality of information (63%), and to privacy (62.7%).

6.4.1.1 Personal privacy

The concept of privacy is one of the key principles of human rights in several fields, including healthcare (Anbari et al., 2015). The Oxford Dictionary defines privacy as "a state in which one is not observed or disturbed by other people; the state of being free from public attention" (Privacy, 2014). The privacy of every patient must be should be given full consideration by all staff members during treatment, tests, and visits by health professionals. Observing a patient's privacy may include providing a private room, maintaining proper separations, using suitable curtains, and supplying appropriate clothing and blankets. It is always very important not to leave a patient without adequate dress or cover. Ama-Amadasun (2016) argued that continuing organisational and administrative evolution has had a positive influence on the protection of patients' privacy. Regular evaluation is expected to encourage health professionals to obey the regulations in hospitals.

The findings of the present study show that doctors and nurses agreed that the right to privacy was the right most frequently observed in Saudi public hospitals. More than 85% of doctors and nurses stated that patients' privacy was maintained at a high level. This finding is in line with Alghanim's study (2012), reporting that patients and health workers registered a high level of observance and that precautions are taken to ensure patients' privacy in healthcare settings in Saudi Arabia. Similarly, El-Sobkey et al. (2014) revealed that the patient's right most commonly recognised by student health professionals was the right to privacy and confidentiality. This result is consistent with recent studies, such as that carried out by Toulabi et al. (2016), which reported that most nurses (90.6%) believed that privacy was the right most respected in hospitals. In a study conducted by Utkualp and Yildiz (2016), most nurses (99.1%) indicated that health professionals maintain patients' privacy during all treatment processes. These findings could be attributed to the greater knowledge and growing awareness of ethical issues among health professionals.

In contrast, 62.7% of the patients in this study indicated that the right to privacy is only *partly respected*. Woogara (2005) conducted a qualitative study using fieldwork observation and

interview techniques to investigate the extent of respect of patients' privacy in three acute wards in healthcare settings in NHS trust. The findings revealed that patients reported their privacy was only partly respected in the public hospitals – findings that are consistent with this study. Similarly, Teke, Uçar, Demir, Çelen & Karaalp (2007) reported that the right least observed in teaching hospitals in Turkey was the patient's right to privacy.

6.4.1.2 Confidentiality of information

The two terms *privacy* and *confidentiality* are used interchangeably in several studies; however, each has a distinct meaning. Confidentiality in healthcare refers mainly to a patient's personal and medical information disclosed to healthcare providers to be used in the patient's interest (Moskop et al., 2005). This information must not be revealed to any other party without the permission of the patient. Confidentiality is one of the main principles of the Patient's Bill of Rights and aims to strengthen trust between patients and healthcare providers (Anbari et al., 2015). Lack of confidentiality usually makes patients reluctant to reveal private or sensitive information needed for their treatment, which may result in misleading information, improper diagnosis, and medical errors (Ama-Amadasun, 2016; Lin et al., 2013). All personal and medical information supplied by patients must be protected and kept anonymous by the entire healthcare team and only to be used for treatment purposes. However, Masood, et al. (2016) reported that 40.7% of hospitalised patients in Medicine and Surgery wards of Military hospital, Pakistan, believed that health professionals are allowed to use their medical records for any purpose with no prior consent.

In this research health professionals regard confidentiality as one of the most commonly observed rights. Eighty five percent of doctors and nurses indicated that the confidentiality of patients was respected in their hospitals. This result may indicate that even though health professionals assert that patients' information is mostly kept confidential, many patients do not believe them. In Canada, Vigod, Bell, and Bohnen (2003) argued that although most health professionals in hospitals are aware of the importance of the confidentiality of patient information, they find it difficult to put it into practice. The Vigod's study reported that breaches of patients' confidentiality happened when health professionals like to gossip about patients in public spaces in hospitals, it occurred most in hospitals' lifts. Ama-Amadasun (2016) revealed that the most common breach of confidentiality occurred among medical staff discussing a patient's condition in common areas, such as ward corridors, staff rooms, or when attending other patients. In the same way, Yakov et al. (2010) indicated that nurses in Israel

reported it difficult to cope on a daily basis with topics such as confidentiality, informed consent, and patients' quality of life.

In contrast to the 85% of health professionals who felt that patient confidentiality was well respected, only 63% of patients rated this right to be only *partly respected*. Anbari et al. (2015) had similar findings; most patients in 10 hospitals in Iran were dissatisfied with the protection of their privacy and confidentiality. In a cross-sectional study conducted in Iran which recruited more than 400 hospitalised patients, Hojjatoleslami and Ghodsi (2012) reported that about 75% of patients agreed that the confidentiality of their information was maintained. In Singapore, Tay (2005) conducted a survey among health professionals and reported that nearly 70% of patients indicated that they were sure of the confidentiality of their medical records.

With regard to the confidentiality of patients' information, Alkabba et al. (2012) stated that many Saudi hospitals lack policies concerning the management of this information. The handling of patients' medical records was often subject to the decision of doctors, who would use and share patients' information without their consent. The findings of the present study indicate that hospital management should monitor the confidentiality of patients' information. Breaches of confidentiality should be subject to strong disciplinary action to prevent its recurrence.

6.4.1.3 *Treatment in a safe environment*

Safety in health services plays a critical role and must be given high priority in all healthcare settings. A safe environment in hospitals depends on both service providers and the surrounding environment (Mazer, 2010). To be considered safe, a hospital environment should be free from all forms of physical or psychological threats against patients. As outlined in the Patient Care Partnership document, adopted by the American Hospital Association, patients expect to find a clean, safe environment during their hospitalisation (American Hospital Association, 2003). Wåhlin, Ek, and Idvall (2006) concluded that patients become more empowered when they experience such an environment.

After reviewing more than 600 studies, Zimring, Joseph, and Choudhary (2004) demonstrated that a safe physical environment in hospitals helps to minimise staff stress, and improve patient safety, patient and staff outcomes, and the quality of healthcare. The authors argued that designing better workplaces could help in improving staff performance, minimise medical errors, and increase staff satisfaction.

In the UK, the Patients Association conducted a survey to study patients' and public awareness of the NHS Constitution. In the survey, respondents were asked about the right they considered most important to them that they would like to be included in the NHS Constitution. The right to be treated in a safe environment and in a safe manner was the second most cited right (84%) (Patients Association, 2014). Even though the care provided in health settings seems to be safe, there are always opportunities to improve it and make it even safer. Henriksen, Battles, Keyes, and Grady (2008) argued that the design of the physical building is associated with several risks and hazards in healthcare settings. The design of hospitals contributes positively or negatively to the level of danger and risk that may occur (Zimring et al., 2004).

In the present study, 85% of health professionals stated that the right to be treated in a safe environment is *largely respected*. A descriptive cross-sectional study conducted in Turkey by Akca et al. (2015), which aimed to assess the attitudes of nurses in a large district about patient rights, reported that most nurses (98.1%) asserted that patients should receive health services in a safe environment. In another Turkish study, more than 90% of nurses believed that maintaining patient safety is essential (Kiyancicek, Dedeli, Yildiz & Senakin, 2014). From the patient's point of view, the right to be treated in a safe environment was rated as *partly respected*.

Management has a vital role in encouraging and supporting staff to ensure that the healthcare setting is safe for patients and staff by eliminating all potential hazards in hospitals (Farzianpour, 2014; Zakari, 2011; Kohn, Corrigan & Donaldson, 2002). All hospital staff need to be familiarised with possible hazards and the related regulations to help prevent risky occurrences. This is best achieved by ensuring that there is a full awareness of potential safety concerns as well as a strong commitment to deal with them immediately. For this reason, it is fundamental that all staff be well prepared and equipped with all safety training and resources needed.

Rose, Thomas, Tersigni, Sexton, and Pryor (2006) argued that health professionals either cooperate with or resist making the changes necessary to create safer environments, depending on the methods used to explain safety issues to them. In 2001, Brigham and Women's Hospital, Boston, USA, formed an integrated patient safety team to create the safest possible environment for patients and staff. The team found that the commitment of senior management was the main factor that enhanced the patient safety strategy and made the team more effective (Gandhi et al., 2003).

6.4.1.4   *Request to sign consent forms*

The concept of informed consent is an essential part of human rights and is a vital ethical principle in patient autonomy. All patients must be provided with adequate information before they are asked to give their consent. Giving necessary information is a prerequisite for any procedure and treatment to enable patients to make a decision in a fully informed, free manner. Even if a patient gives consent, they have the absolute right to withdraw their consent at any time. Simply put, a consent form is an oral or written document that expresses a patient's decision to give, or not to give, permission for health professionals to act in a certain way in their treatment. Consent forms must contain sufficient documentation and make provision for the counselling of patients (Satyanarayana Rao, 2008). To be valid, informed consent should include five components: voluntarism, capacity, disclosure, understanding, and decision (Del Carmen & Joffe, 2005). The patient should be an adult and competent to give consent. In some cases, such as with children, or incapacitated persons, consent must be obtained from parents or legal guardians or close family members.

The present study revealed that overall, doctors and nurses believed that the right of patients to be asked to sign consent forms was *largely respected* in hospitals, whereas patients rated this right as only *partly respected*. Hindle et al. (2006) conducted a comparative analysis of eight inquiries in six countries, including Australia, Scotland, England, Slovenia, New Zealand, and Canada. They reported that in most of the hospitals studied, patients, when asked to give consent, were not fully informed as they should be, particularly concerning surgical procedures. Another study in India reported that 75% of patients were unaware they had the right to give or withhold consent before any medical intervention (Rajesh, et al., 2013).

Özdemir et al. (2009) conducted a cross-sectional study among 150 midwives and 350 nurses working in universities, public hospitals, and village clinics in Turkey. The aim of the study was to examine the awareness of midwives and nurses regarding patient rights legislation. The findings showed that most participants (93%) believed that obtaining a patient's consent was necessary prior to any medical treatment, while only 7% stated that consent was only necessary prior to surgical procedures.

Almoajel (2013) concluded that many patients do not have sufficient knowledge, regarding the legal implications of consent forms. Informed consent was the seventh challenge facing the Saudi healthcare system (Alkabba et al., 2012). In addition to allowing family members to sign the consent form on behalf of patients, one of the major issues complicating this right was the

fact that many family members tended to sign the forms without first reading them carefully. This practice often led to problems for both parties.

In Saudi Arabia, Khan et al. (2012) indicated that the medical expressions used in informed consent documents and the way in which they were presented, in effect forced many patients and their family members to sign. In Poland, only 42% of patients were aware of their right to give or withhold consent (Krzych & Ratajczyk, 2013). However, most patients in Iran were unaware of the importance of their signing the consent form (Ebrahimi et al., 2016). In India, a study discovered that three quarters of patients lacked knowledge of the legal status of the consent forms for any medical intervention. Furthermore, about 90% of patients thought that they could not change their mind after signing the forms (Rajesh, et al., 2013). A recent study conducted by Ama-Amadasun (2016) claimed that a third of doctors in the healthcare institutions in Switzerland deliberately ignored some patient rights during treatment. Many doctors attributed this situation to the fact that the condition of some patients was urgent and did not allow for asking their consent.

These results indicate the urgent need to establish carefully explained procedures for informed consent, designing clear, specific informed consent forms, and promoting the informed consent process in each hospital department.

6.4.2 Rights with lower ratings for degree of implementation

In this research, among the rights least respected or implemented in public hospitals, two were singled out: the right to receive an explanation of complaint procedures and the right to receive a copy of the Bill. In the same way, health professionals also considered these two rights to be the ones least respected, rating the first as *partly respected* and the second as *hardly respected*. This coincidence shows how limited the implementation of these two particular rights was.

6.4.2.1 *Receive a copy of the Bill*

Upon admission, patients have the right to receive a copy of the Patient's Bill of Rights. Copies are also posted in many prominent locations in a hospital where it can be easily accessed by patients and the public (Joolaee et al., 2008; Kuzu et al., 2006). Other copies should be readily available in every department. If the Bill is placed in obscure locations out of the reach of patients, it loses its role and effectiveness. As a result, patients would remain unaware of their rights in health settings (Joolaee et al., 2006). It was found that 70% of health professionals at Fasa hospital in Iran believed that patients were entitled to be informed about their rights on admission (Kavari & Johari, 2006).

The findings of the present study indicate that patients believed this right was not observed. More than half of them rated respect for their right to receive a copy of the Bill as *low or non-existent*. More than 35% of health professionals rated observance of this right at only a slightly higher level, indicating that respect for it was low or partly-existent.

These findings are in line with an Australian study carried out by Rolfe, Sheehan, and Davidson (2008), using a survey questionnaire method to evaluate whether patients on community treatment orders were fully informed of their rights under the West Australian Mental Health Act. The study revealed that the right of patients to be provided with information about their rights was only partly implemented. Another cross-sectional study conducted in Spain by Mira, Lorenzo, Guilabert, and Pérez-Jover (2012) concluded that there was a low level of respect for these rights, according to most of the 790 discharged patients involved in the study.

In Iran, Ansari et al. (2013) reported that most patients indicated that they believed their right to obtain knowledge of the Bill at the time of admission was ignored. Yaghobian et al. (2014) conducted a cross-sectional study entitled "Association between awareness of patient rights and patient's education, seeing bill, and age: A cross-sectional study" to evaluate the rate of patient awareness of their rights and to examine its correlation with patients' background information. The study reported that there was a significant relationship between awareness scores and seeing the document in hospitals (r=0.809, p<0.0005). The authors estimated that about 65% of changes in the awareness scores were related to whether or not patients had seen the document in the hospital.

Several studies recommended the importance of providing written forms of the Bill to patients upon their admission (Dehghani et al., 2015; Yaghobian et al., 2014; Moghadam et al., 2011; Merakou et al., 2001). The failure to provide copies of the Bill to patients can hinder its successful implementation (Joolaee et al., 2008) but Merakou et al. (2001) suggested that health professionals failed to provide this right because of the lack of staff, time, and training. For this reason, Özdemir et al. (2009) suggested that hospital management hold training courses for health professionals to teach them proper methods of informing patients of their rights.

A study in the US conducted by Paasche-Orlow et al. (2009) pointed out that reading and understanding a patient rights document requires an advanced college reading level, which many patients lack, especially in developing countries. As a consequence, patients cannot be expected to learn from documents that they struggle to read or understand. This strongly

suggests that patients should be informed about their rights at the time of admission and in a way that they can understand.

6.4.2.2 *Explanation of complaint procedures*

Even if hospital management and health professionals endeavour to provide patients with a high level and quality of service, it is to be expected that patients will have some complaints about the service or behaviour of staff in hospitals. For this reason, hospital management are required to establish a complaints' resolution process or a system that enables patients to complain when they want to. The findings of the present study indicate that almost half of patients (47.6%) and a quarter of health professionals (25.5%) believed that respect for the patient's right to receive an explanation of complaint procedures was *low or non-existent*.

Several studies were consistent with these research findings. In Turkey, Joolaee et al. (2006) revealed that when patients encountered a situation where they needed to complain, there was no easy, clear mechanism to follow. As could be expected, this created a feeling that there was a failure to support and empower patients and their families inside hospitals. In Iran, Asadi et al. (2015) reported that 20% of managers assessed the complaints system as inadequate. In another study in Iran, it was estimated that 4 out of 10 patients were unaware of the complaints process (Anbari et al., 2015). Ansari et al. (2013) indicated that most patients did not know how to make complaints when they needed to, a situation which can lead eventually to patient dissatisfaction.

There are several major causes of an ineffective complaints' system, such as the lack of clarity for patients and their families about procedures, lack of respect for complainants, poor coordination of response to complaints, insufficient information provided to complainants in regard to progress or decisions about their complaints, a lack of a single filing system, and the failure to use complaints as improvement opportunities (Hindle et al., 2006). It is very important that public hospitals establish an effective complaint system and inform patients and their relatives about it (Parsapoor et al., 2012).

6.5 Conclusion

Given the high importance of the implementation of patient rights, it is essential to evaluate the actual implementation of these rights regularly and judiciously. By regular evaluation, hospital management can discover their strengths and weaknesses in the implementation of the Bill,

and will be able to improve training and education programmes to meet the needs in the relevant areas.

This section has discussed the overall assessment of the implementation of 13 fundamental patient rights in public hospitals. Doctors and nurses rated the overall implementation of patient rights as *largely implemented* (79.2%), whereas the overall response from patients indicated that they were *hardly implemented* (57.9%). There was agreement that four rights were most implemented: privacy, confidentiality of patient information, to be treated in a safe environment, and to be asked to sign consent forms. Both health professionals and patients rated these rights as respected more than all others; however, even though patients rated these rights as more commonly respected than others, they still rated the implementation of the Bill as only average. In contrast, both health professionals and patients considered the right to receive an explanation of complaint procedures and to receive a copy of the Bill as the rights least implemented in public hospitals.

These findings indicate clearly that the implementation of patient rights in public hospitals in Saudi Arabia remains below expectations, especially the patients' view. The findings of the present study are consistent with research conducted elsewhere in Saudi Arabia, which reports that according to ethics committee members, medical administrations, and academic staff, the 10 major ethical issues are: (1) patient rights, (2) equity of resources, (3) confidentiality of patient information, (4) patient safety, (5) conflicts of interest, (6) ethics of privatisation, (7) informed consent, (8) dealing with the opposite sex, (9) beginning and end of life, and (10) healthcare team ethics (Alkabba et al., 2012). It is, thus, essential for health professionals to be familiar with the content and implications of the Patient's Bill of Rights (Almoajel, 2012).

Chapter 7: Conclusions

7.1 Introduction

This chapter concludes the thesis by highlighting the main findings that have emerged from the entire project. This is followed by an account of the main contribution of the present research to the body of knowledge in this field. The chapter also includes the research strengths, limitations, and challenges that faced the researcher. At the end of the chapter, a number of implications for practice and research are outlined and discussed.

7.2 Overall conclusions

Over the last two decades, the topic of patient rights in health services has become a higher priority all over the world. Patient rights in the Saudi healthcare system also have received greater focus in recent years. The Saudi Ministry of Health issued the first official version of the Patient's Bill of Rights in 2011, followed by the establishment of the General Department of Patient Rights and Relations at the ministerial level. Later, Departments of Patient Rights and Relations were set up and established in all hospitals throughout the country. Since then, the Ministry of Health has been striving to create a new culture that respects the rights of patients within the Saudi healthcare system.

There has been a lack of research that explores whether Saudi hospitals and their health professionals were ready and able to implement the Bill and, in addition, a lack of research identifying the factors contributing to or hindering the process of implementation at various levels. This situation led to the direction taken in the present research, which examines whether the expected change was achieved at the desired level. Accordingly, this research project has investigated the readiness and the ability of hospitals to implement the Patient's Bill of Rights. Focus was also directed at the factors that facilitate or hinder the process of implementation, as well as the actual implementation of several fundamental patient rights in hospitals.

The objectives of this research were:

1. To determine the readiness and ability of public hospitals to implement the Patient's Bill of Rights in two leading medical cities in Saudi Arabia.
2. To identify the factors that facilitate the implementation of the Bill in public hospitals in Saudi Arabia.

3. To identify the barriers to the implementation of the Bill in public hospitals in Saudi Arabia.

4. To examine the actual implementation of some selected fundamental patient rights.

5. To understand the different perspectives of the key stakeholders (patient rights experts, hospital managers, doctors, nurses, and patients) regarding the implementation of the Bill in public hospitals.

All the objectives have been adequately addressed, as discussed in Chapter 6. The research has also offered a broad understanding of the implementation of the Bill at multiple levels, including those of the Ministry of Health, hospital management, health professionals, Department of Patient Rights and Relations, patients, and the public. The concurrent research methods design used in this research, namely, cross-sectional surveys for patients and health professionals and semi-structured interviews with experts and managers, has provided a solid foundation for the findings of the study. These findings provide rich in-depth data, in both quantitative and qualitative forms, from different stakeholders, including doctors, nurses, patients, experts, and managers. They also add significant material to the research literature which can be applied in many healthcare settings, not only in Saudi Arabia but also, by extension, to the international stage.

This research project offers an understanding of the current status of patient rights in the Saudi healthcare system. Investigation was made of the roles of the Ministry of Health, hospital management, health professionals, Department of Patient Rights and Relations, patients, and the public in the implementation of patient rights. An explanation of the challenges and recommended methods for improving the implementation of the Patient's Bill of Rights in public hospitals in Saudi Arabia was provided. In addition, this research highlights practical implications, and outlines possible future research to develop and improve the process of implementation in the Saudi healthcare system. Although the study was conducted and the data collected in Saudi Arabia, the rest of the process was undertaken in New Zealand, which provided the researcher a valuable opportunity to become aware of advocacy services, the complaint mechanism, and the process of implementing patient rights in New Zealand.

This study concluded that the majority of stakeholders who participated in the research received the strong commitment and support of the Ministry of Health management to implement patient rights in public hospitals. The perceptions of both experts and managers who were interviewed supported the survey results. Noteworthy contradictory findings were the low level of support and commitment from hospital management for the implementation of the Bill in public

hospitals. These findings make clear that management at hospital level is still isolated from the planning and decision-making process. Indeed, the research has shown that relying solely on the contribution and efforts of the Ministry of Health to encourage the creation of a patient rights culture in public hospitals is inadequate. To ensure the success of the process of implementation of the Bill, all levels of management must participate positively. Working together in this way allows for teamwork and growing experience to improve the planning, implementation, and monitoring of the Bill. Such cooperation contributes to promoting culture change in the hospital environment. The literature has shown that the involvement of management at all levels is critical to a successful process of implementation.

The findings, however, have also shown a lack of success on the part of the Ministry of Health in several areas, mainly in the involvement of the community in the process of planning and implementation. The failure to actively involve the community in the early stage of planning has limited the successful implementation of the Bill. Because the community was ignored in the early stages, this may also result in a rejection of the Bill's content or the method of implementation. Change in social culture cannot be achieved without the involvement of the people in a community and without paying attention to their voice. It is, therefore, critical that the Ministry of Health encourage and provide opportunity for community participation in activities related to patient rights. Ongoing neglect of the important role played by the community may lead to the withdrawal of community support and create obstacles in the way of implementing any new policy.

Other lack of success on the part of the Ministry of Health included the poor promotion of the Bill, the complex complaint system, and the absence of advocacy services. The poor promotion of the Bill among the public led to low awareness at all levels. Ministry of Health efforts to inform the public via mass media were considered weak by various stakeholders. Recognition of this failing leads to the conclusion that the Ministry of Health must pay more attention to this aspect. Promotion should not be limited to the mass media but should extend to include social media, public events, courses, and workshops.

The complexity of the complaint system makes it too difficult for patients and their families to follow and trust a system that purports to address complaints fairly but in fact usually fails to resolve them. In the end, the inadequacy of the system has led people to search for other ways to find solutions for their concerns or even simply answers. Accordingly, the Ministry of Health should establish a single, united, independent body to deal with patient complaints. That

independent body need to have a department or section in each hospital to resolve the complaints as closely as possible to patients. In addition, the existence of advocacy services will provide patients and their families with the reliable legal support they need. The experience of western countries in this regard features enough success stories to encourage the Saudi health system to recognise the need for this type of support service.

The findings suggest that staff qualified to implement the Patient's Bill of Rights are available but they suffer from a lack of resources required for successful implementation of the Bill. For example, there is a shortage of support materials, such as hard copies of the Bill, posters, booklets and brochures. The findings also revealed the low level of health professionals' involvement in the process of implementation because they were ignored by hospital management. It was just as surprising that the Ministry of Health failed to involve hospitals' management teams, who in turn made no effort to involve health professionals in the process. This situation makes clear that when applying new policy in the Saudi healthcare system, the idea of involving people concerned has not taken hold. Evidently, there is an urgent need to have clear policies in regard to the involvement of all parties at all stages in the implementation of a new project. The involvement of patients was also ignored by hospital management. The information acquired from patients' comments, their feedback and even complaints, are rich sources of valuable information that can be used to improve the process of implementation.

To a large degree, the awareness of health professionals and patients left much to be desired. The findings reported a low level of confidence among health professionals concerning the information available to them and their role in the process of implementation. Hospitals need to understand that raising health professionals' awareness of Bill content and implementation is an essential task that must be carried out properly.

The courses provided for nurses resulted in much greater awareness and confidence among the nurses than was found among the doctors. These results clearly suggest the promising effect of educational courses and workshops on the knowledge of health professionals and that contributes to supporting the implementation of patient rights in public hospitals. Similarly, the awareness of patients is as important as that of health professionals. When patients are aware of their rights, they can demand them and complain if they feel they have not been properly respected. Moreover, they can form their own assessment of the way patient rights in the healthcare system are implemented and monitored. As mentioned earlier, one aspect of the Ministry of Health's role in promoting the Bill includes the effort to educate patients. Other

methods can be used to increase patient awareness, such as scheduling events and courses in hospitals, as well as distributing brochures, posters, and booklets. In addition, hospital management should provide ready access to information about patient rights for all patients and their families.

From this research, it was clear that health professionals had positive attitudes towards the implementation of patient rights in public hospitals. The findings suggest that the contribution of the staff of the Department of Patient Rights and Relations could be greater. Poor performance was attributed to the lack of staff, support and authority given to the department. The Ministry of Health should support the department to allow it to achieve the goals for which it was established. Overall, health professionals gave the process of implementation so far a relatively good assessment but the patients were less impressed.

The second objective was to explore the factors contributing positively or negatively to the process of implementing the Patient's Bill of Rights. The findings reported several factors that facilitate, if they are present at a high level, but that hinder if they are at low level. Factors determined by management include working conditions, management support, and regulations. Factors that are important among health professionals were awareness and attitude. Factors significant for the Department of Patient Rights and Relations were support and authority. And last, factors of importance for patients include patient awareness, patients' attitudes, and the presence of patients' companions. Exploring these important factors will provide a baseline for the Ministry of Health and hospital management to take proper action to support them or prevent them from happening.

The third objective was to explore health professionals' and patients' perceptions of the actual implementation of some basic patient rights. The findings showed that, generally speaking, both groups of participants, health professionals and patients, agreed on the rights that were most implemented. These were the rights to privacy, confidentiality of information, treatment in a safe environment, and to sign consent forms. The rights least implemented were the right to receive a copy of the Bill and to be provided with an explanation of complaint procedures.

7.3 Contribution to knowledge

This study is the first in the field of patient rights to determine the readiness and ability of hospitals to implement a Patient Bill of Rights in Saudi Arabia. The research is also unique in its field in that it uses two research methods and investigates concurrently multiple stakeholder

perspectives on patient rights in Saudi Arabia (those of patients, doctors, nurses, managers, and experts). As a consequence, it provides an in-depth understanding of the status of the implementation of the Patient's Bill of Rights in public hospitals from a number of different levels. It also highlights the critical factors that enable or hinder the process of implementation, as well as examining the actual implementation of several fundamental patient rights in public hospitals.

The development of a conceptual framework for developing a culture of patient rights within a healthcare organisation is one substantial contribution of this research to the field of patient rights. The framework is also applicable to other disciplines where the aim is to apply a new policy to change or improve organisational culture. In this study, the framework was used to determine the readiness and ability of hospitals to implement the Patient's Bill of Rights.

Furthermore, this is the first time research such as this has drawn attention to the gap in commitment between management at the higher levels in the Ministry of Health on the one hand and hospital management on the other, as well as the difficulty of transferring the commitment from one management level to the other. A major contradiction was found between a management with a strong commitment to a policy and, a management with little or no commitment to the same policy.

This research is the first to discuss the role of the Department of Patient Rights and Relations in Saudi Arabia and has examined it from various perspectives. The study has highlighted the urgent need for these departments to receive support from qualified human resources and the appropriate authority to fulfil their role successfully.

The present research adds notable contributions to knowledge with regard to the implementation of patient rights in public hospitals from the Saudi perspective. Its findings are important for concerned stakeholders, namely, the Ministry of Health, policy-makers, hospital management teams, health professionals, hospital staff, patients, and the public. Implications of the present research for practice and policy were presented in the section discussing implementation for practice and further research.

7.4   Strengths, limitations, and challenges

Whereas most research in the field of patient rights focuses mainly on examining the factors affecting the implementation of Patient's Bill of Rights from the perspective of one or two stakeholders, this research views the broader picture and determine the readiness and ability of

public hospitals to implement the Bill. In addition, this study examines the contributing factors from various perspectives, including those of doctors, nurses, patients, managers, and experts. This variety of stakeholders adds to the results presented in Chapter 4 and Chapter 5. The results of this research add rich data that can feed into current knowledge of the implementation of patient rights in hospitals and also shed light on several new aspects useful to all who are interested in the topic of patient rights.

Because of the recent emergence of the topic of patient rights internationally and the lack of research in this area, this research provides a unique contribution to international literature in the field. In the Arabic speaking region and from a Saudi perspective, the very limited number of studies conducted in the field of patient rights makes this study a rich source of information as well as valuable additional experience, which contributes to the Arabic literature.

In the literature, little use has been made of mixed methods design in carrying out research on patient rights and using mixed methods. For the current research project, an extensive source of collected data was created, which has strengthened the research. Results are considered to be stronger when collected using a variety of methods (Johnson & Christensen, 2008). The mixed methods approach is common in healthcare research and it is used to determine and to explore complex problems in the healthcare system (Doyle, Brady & Byrne, 2009). The methods are complementary and are integrated in the discussion chapter (Chapter 6).

This research project is also unique in that it is the first to interview managers and experts outside the Ministry of Health in order to record their views about the Patient's Bill of Rights in Saudi Arabia. As a consequence, a further strength of this research is the fact that the perspective of informants outside the Ministry of Health is represented.

The results presented in Chapter 4 and Chapter 5 of this research are significant to all stakeholders because they provide baseline data on the current status of the implementation of patient rights in public hospitals and can be used as a rich source and reference for future similar research at both the international and national level.

The research does, however, have several limitations that should be acknowledged. First, the quantitative findings cannot be extrapolated to the wider population because due to time and resource constraints, they are limited to the public hospital in Riyadh city, and therefore, these data must be interpreted with caution. Riyadh, the city chosen, is the capital of Saudi Arabia, the largest city and with the highest population density, and it houses the largest tertiary and referral hospitals in the country. However, the doctors, nurses, and patients who participated in

this research do not necessarily reflect other health professionals and patients in other areas. Further research is, therefore, recommended to take into account other geographical areas where the population studied would be different, making it possible to confirm the findings of this research. It can also be argued that results similar to those obtained in the present study could be expected if the research methodology were replicated with a comparable group of participants elsewhere.

A second limitation is that because of insufficient time and resources, the research focused only on the public hospitals. For example, the primary care centres fell outside the scope of the current study. However, many people utilise their services and these centres are just as likely to ignore patient rights as hospitals. During the research, the Bill of Patient Rights was implemented only in hospitals and the primary care centres were not included. Because of the the huge number of primary healthcare centres across the country and the lack of strong supervision, the situation is likely to lead to continuing ignorance and disregard of patient rights. In addition, other medical institutions, such as private, educational, and military hospitals, were not included, nor were comparisons made with them. It is expected there are several differences in the implementation of the Patient's Bill of Rights in each type of medical institution as a result of differences in their senior management, organisational structure, regulations, and standards. It would make a significant contribution to future research to study the implementation of the Bill in these other institutions and then compare those results with the present research findings.

A third limitation relates to the sample group in the qualitative study. The number of participants selected for interview was limited, because of the lack of expertise in patient rights and a lack of experienced managers in Saudi Arabia. The initial plan was to interview up to 20 experts and managers but because of the limitations of time and resources, the number dropped to nine individuals; however, the results of the interviews would be weightier if the selected sample were larger, because it would enrich the description and enhance the credibility of the research.

A fourth limitation is the purposive sampling strategy that was used in selecting the interviewees, assigning each participant purposively. This non-probability sampling strategy allows for researcher bias in the selection process; however, the nature of the research led to the use of this strategy, which is recommended for a small sample size and restricted population (Battaglia, 2008). According to Kumekpor (2002), when using a purposive sampling strategy,

it is recommended that samples not be selected by random procedure but by deliberately choosing samples that are suitable for the study because the characteristics identified as meeting the selection criteria are not randomly distributed in the population.

The fifth limitation is that information regarding the ethnicity of health professionals was not included in the questionnaires, since the sample consisted almost entirely of Arabic-speaking professionals. However, including questions about ethnicity in future research is recommended in order to investigate further the differences between those who speak Arabic and those who do not.

Importantly, some challenges were encountered during the study project which need to be taken into consideration for further health research, especially in the field of patient rights. The first difficulty was the lack of sufficient literature available in the field of patient rights, especially in Arab countries. Because several of the factors and roles examined in their relation to the implementation of the Patient's Bill of Rights in Saudi Arabia have not been studied before, the results could not be critically compared or linked to any previous research. One of the main contributions of the present research is that it is the first in this field.

The second challenge was the process of recruiting participants for the interviews. One might think it would be easy to solicit the participation of academic staff and managers in such an important area but even though they showed interest in the topic, many were unwilling to participate. It was only with difficulty that participants made themselves available, with many cancellations and interruptions during the interviews. It is very important for future researchers to be aware of this situation and to be well prepared to adopt alternative plans if unexpected events occur. It is essential that the researcher expect to spend a great deal of time, effort, and resources in this endeavour, because social networking plays a major role in Saudi culture.

The third challenge was the distribution of the questionnaires to the doctors in the hospitals. In this research, it was the most frustrating task to complete it in the manner that had been planned. The oft-repeated excuses were, "we are busy", "we have no time now", "I will do it later", "come next week", "put it here and remind me later". These were some of the responses the researcher heard on a daily basis during the questionnaire distribution. Further complicating matters were that some doctors have offices and clinics, some have no physical office, and others have an office but do not use them often.

The researcher contacted each department manager to find an appropriate way to encourage doctors to participate in the research. Several pointed out that usually, doctors are eager to

participate only in topics related directly to their interests and specialties, and indeed the topic of patient rights is not attractive to them.

Finally, the researcher was invited to attend each department meeting and was given five minutes at the end of the meetings to introduce himself and his research, showing its importance and benefits for hospitals and health professionals, as well as patients. At the same time, the department managers promised to send to all staff e-mails encouraging them to participate in the research. After these two initiatives, the results were very promising and made a big difference to the response. Future researchers can use the same strategy to save themselves a great deal of effort, energy, time, and resources.

7.5 Implications for practice and research

In light of the discussion chapter (Chapter 6), it may be suggested that the findings of the present research are of great importance for various stakeholders, such as policy-makers, the Ministry of Health, educational institutions, healthcare providers, healthcare professionals, and the public. They can also provide a reliable basis for making strategic plans, projects and critical decisions in hospitals, as well as for changes in attitudes or steps to be taken by individuals. The research findings also provide a valuable addition to the body of knowledge in the literature as well as highlighting several areas and aspects for further research.

7.5.1 Implications in practice

The recommendations listed below can assist the Ministry of Health, other healthcare providers in Saudi Arabia, and others in similar situations, in addressing the challenges facing the implementation of the Patient's Bill of Rights.

Government
- Formulate patient rights regulations in Saudi law as a fully enforceable document. This will strengthen the position of the Patient's Bill of Rights and also empower the Department of Patient Rights and Relations.
- There is an urgent need for a national strategy to ensure effective collaboration between various public, private, and community organisations. The Ministry of Health needs major collaboration from the public media, the Ministry of Education, the public, and private universities to support the process of implementation for the Patient's Bill of Rights. A high level committee could be established, including decision makers, the Ministry of Health, educational institutions, healthcare providers, and the media to

work out a national strategy to educate the public about the Patient's Bill of Rights and its contents and create a culture of patient rights in the community.

- At the national level, there is a need to develop advocacy services to assist patients and their families when they need help with their complaints. The New Zealand experience of this type of service can be of benefit to others.

- The ethical and legal implications and impact of the implementation of the Patient's Bill of Rights in the Saudi healthcare system are often ignored at all levels. It is recommended that all aspects of the ethical and legal impact of the implementation of the Bill be researched, discussed and reinforced by policy-makers.

The Ministry of Health

- Instruction concerning the Patient's Bill of Rights should not limited to healthcare organisations but should be included in university curricula to equip future health professionals with the necessary knowledge. Similarly, health schools should modify current courses in ethics, or develop new courses, and topics to be taught to students who will be future health professionals. It is highly recommended that the topic of patient rights be included in medical school curricula. It can also be integrated carefully in other courses, according to the education level of the students.

- Saudi healthcare currently lacks a clear and effective complaint system. Because of this the Ministry of Health should be required to develop a united, fair, usable, and understandable complaint system. The system should be independent and not form part of the organisational structure of hospitals. It is very important to consider patients' complaints as a valuable source of information to develop the health services and to assess the implementation of the Bill.

- Establish a fair, regular, and effective monitoring system for the implementation of the Patient's Bill of Rights, not limited to large hospitals or cities only but extended across the whole country.

- It is necessary for the Ministry of Health to ensure that new private healthcare providers understand Saudi community culture, beliefs, backgrounds and the strengths of family relationships. This can be achieved through conducting workshops, seminars, conferences and developing educational materials.

- The Patient's Bill of Rights needs to be reviewed and updated on a regular basis by a group of experts from different fields, including medicine, law, public policy, and health management, together with the participation of community representatives.

- Senior management at the Ministry of Health needs to transfer their commitment to all levels of management, especially to hospital management. Formal and informal meetings can provide supporting and motivating activities helping to deliver this important message, and also to serve as an effective communication channel with hospitals to make sure that patient rights are considered a priority for hospital management. Middle management and hospital managers should be involved at all stages of the implementation of new policies. This involvement is expected to fill the current gap between management levels in the Saudi healthcare system.

- Ensure each hospital has proper resources and provides a safe, fair working environment for staff. Serious attention should also be given to health professionals' rights and the responsibilities of patients.

Other governmental departments

- Together with the Ministry of Education, the Ministry of Health needs to develop educational material that can be taught to school students in order to prepare the new generation to understand and absorb this culture at an early stage.

Hospital Managements

- Conduct ongoing health education programmes in public hospitals aimed at increasing the awareness of both patients and health professionals about patient rights. Professionals still need practical direction and training on the topic of patient rights. Ongoing training and educational programmes are essential to improve the knowledge and attitude of health professionals towards the Patient's Bill of Rights.

- Make information about patient rights accessible and available to all. This can be accomplished by distributing cards, booklets, pamphlets, and leaflets which explain patient rights clearly and simply.

- There is a serious need for a concentrated effort to address the problem of the shortage of qualified staff in the Department of Patient Rights and Relations, who can deal with patient rights violations and treat patients' complaint fairly and professionally. It is also very important to reduce the high turnover of competent staff in these departments, resulting from the lack of a reward system, poor support, and the lack of authority they wield. One practical solution would be to develop a reward system for the staff of Department of Patient Rights and Relations, a move which could be expected to improve staff retention in the departments.

- The staff of the Department of Patient Rights and Relations should have job descriptions that are clear, not only to themselves, but also to other hospital staff. Because it is a new department, much confusion has arisen over what it should and should not do. Clear job descriptions would also help department staff to avoid performing multiple roles in the hospital, a situation which leads to overlap with other departmental roles, such as those of the social department and sometimes the nursing teams. Department staff should be provided with follow-up training in the various implications of patient rights.

Community

- Community involvement is essential and should be fostered by the Ministry of Health, allowing people to share their experience and feedback concerning services and also share in decision making in some way. Community participation needs a great deal of support from various government bodies to involve the public in the process of planning, decision making, implementing, and monitoring public services. In healthcare, the situation is poor, because no effort has been made to encourage the public to be involved in the Ministry of Health's activities. The participation of the public in the healthcare system needs to be well planned and regulated. Literature from western countries has shown that the involvement of the community in the healthcare decision making process increases loyalty, adherence, and satisfaction.

7.5.2 Implications for future research

The present research has contributed to the body of knowledge regarding patient rights in Saudi Arabia. It formulates some important considerations for further research in the field of patient rights in Saudi Arabia and the entire Arab world. As a consequence, it can be used by researchers in these regions as a guide in conducting future research.

More research in the field of patient rights is recommended and should be supported financially and physically by governmental bodies, or private organisations, to investigate and find solutions for the challenges, issues, and problems facing the successful implementation of the Patient's Bill of Rights.

First, it would be advisable to replicate the present research in different cities and different institutions, such as private hospitals, military hospitals, and educational hospitals. More such studies in different settings would allow for making comparisons between different institutions

and different regions, which could be expected to add valuable information and enhance further understanding.

Another area that may be suggested for further research is investigating the contributions and roles of educational institutions in promoting and supporting the implementation of the Patient's Bill of Rights. Future professionals need to be equipped to deal properly with the ethical challenges they may face in their practice. The expected results from such research would make a significant contribution to the field of patient rights. Insights gained from exploring educational curricula and the perspectives of academic staff and students would improve the methods for teaching patient rights concepts and the Bill in Saudi educational institutions.

It can also be suggested that a further research topic is the perceptions of minority groups who have particular needs or illnesses, such as the elderly, prisoners, cancer patients, or those with HIV/AIDS. These groups are completely ignored in the literature, especially in studies conducted in Arab regions. Out-patients and primary care settings also are ignored in the majority of studies conducted in the field of patient rights.

It would be very interesting to explore the perceptions of discharged patients suffering from stress because of illness or from the fear of a negative reaction from staff, keeping them from expressing their real feelings. This kind of post-service assessment would help policy-makers, healthcare providers, and researchers gain more reliable information about the actual status of the implementation of the Bill.

A more extensive study should be carried out to explore the staff of the Department of Patient Rights and Relations because they are a rich source of information regarding patient rights in the hospitals. Discovering their experiences and concerns would be useful and add significant insight into the practical aspects of the implementation of the Patient's Bill of Rights in hospitals or healthcare centres.

A future study may need to explore the perceptions of other important stakeholders, such as the public, community organisations, and non-medical staff, to obtain a more holistic and judicious evaluation of the status of the implementation of the Patient's Bill of Rights in the country.

Further research can investigate the effect of the implementation of the Patient's Bill of Rights on the quality of healthcare and medical errors in Saudi Arabian hospitals. The results from

such research would provide in-depth understanding of the overall impact of the implementation of the Patient's Bill of Rights on the outcomes of the health services in the country.

Finally, the role of patients' companions in protecting patient rights is another area of research that should be explored in detail to understand the perceptions of these valuable advocates on whom patients in public hospitals rely heavily.

7.6   General conclusion

The topic of patient rights has grown over the last decade and has become a high priority for decision makers in international organisations, governments and healthcare institutions. Recently, Saudi Arabia has given this matter great attention and has established a general department that is responsible for the implementation of the Patient's Bill of Rights across the country. The implementation of patient rights in hospitals requires willing acceptance and strong participation from all stakeholders, including managers, health professionals and patients. Gaining rich, in-depth data from exploring the perceptions of main stakeholders toward the implementation of the Bill in hospitals in Saudi Arabia provides unique opportunities to the Ministry of Health to improve the implementation process, integrate patient rights into Saudi healthcare, maximise patient integrity, promote patient rights concepts, and minimise complications.

The purpose of this study was to determine the readiness and ability of public hospitals to implement the Patient's Bill of Rights in Saudi Arabia, to identify the factors that facilitate or hinder the implementation of the Bill in public hospitals, and to examine the actual implementation of some selected fundamental patient rights. Overall, the aims of the current study were successfully addressed. This study used mixed methods by surveying doctors, nurses and patients in public hospitals in two leading medical cities in Riyadh, and interviewing key informants—experts and managers from different sectors. The aim was to provide a thorough understanding of the current status of the implementation of patient rights in public hospitals in Saudi Arabia.

The results of the present study support a number of findings in the literature, in addition to yielding some distinct, innovative findings. In general, the situation in Saudi Arabia seems to be similar to the other developing countries. Although several positive aspects should be noted in the current implementation process, public hospitals need to make a greater effort to achieve

better implementation of the Bill. There is a gap between hospital management and higher management at the ministerial level, as well as health professionals in the hospitals. This gap must be fixed to ensure the successful implementation of patient rights.

Moreover, the overall level of awareness amongst health professionals, the public, and patients in regard to patient rights concepts and implementation is still limited, requiring further attention to education and promoting the Bill at the national level. The establishment of patient rights and relations departments in hospitals was a major step towards protecting patient rights. In addition, community participation is urgently needed as well as the creation of advocacy services for the public.

The study also identified a number of potential factors that would enable the successful implementation of the Bill as well as several practical barriers. The facilitating factors include establishing a safer work environment, supporting teamwork values, supporting hospitals with required resources, increasing people's awareness of the Bill, encouraging patients to practice their rights, and clarifying complaints procedures. Hindering factors include work pressure, the increase in patient numbers, staff shortages, the low level of job satisfaction among health professionals, the lack of specialised staff in the field of patient rights, and the lack of authority given to patient rights and relations departments.

It must be noted that this project is the first international research to establish a framework for the culture of patient rights. This framework was developed to assist health system leaders in understanding the various factors that influence the culture of patient rights at different levels: micro, meso, and macro. In addition, it is the only study in the Saudi Arabian context to pay heed to experts and to explore five different stakeholders in the area of patient rights. Consequently, this study provides key principles for further research that goes beyond assessing and evaluating patient rights in Saudi Arabia.

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Appendices

Appendix 1: Survey for Health professionals – English version

Study of action on patient rights in Saudi Arabia

Questionnaire for health professionals

Dear Participant:

My name is Faisal Abdulaziz Almutairi, a PhD student at University of Canterbury. I am pleased to invite you to participate to answer the questions in this questionnaire. This research aims to determine the extent of the implementation of the Patient's Bill of Rights charter in Saudi hospitals as an important tool to empower patients. You have been selected to represent the health professionals in this hospital. This questionnaire will require approximately 15-20 minutes to be completed. During this time you have the absolute right to refuse completing your participation at any time with no need to explain the reason. After you have handed in the questionnaire you will not be able to withdraw from the study because the questionnaire has no identifying details. All the information will remain confidential by saving it in a secure place and it will be destroyed based on the university regulations.

Your view is important to me; therefore I would kindly request your support in this survey. By participating and completing this questionnaire, you are agreeing to give your consent to this research. If you wish to have a copy of the result of this research or have any questions, please contact me through listed contact below.

If you are not satisfied with the manner in which this study is being conducted, you may report (anonymously if you wish) any complaints to my supervisors: Associate Professor Pauline Barnett: pauline.barnett@canterbury.ac.nz or Professor Ray Kirk: ray.kirk@canterbury.ac.nz or phone: 0064 3 366 7001 ext. 3692 or fax: 0064 3 364 3318.

> Instruction:
> Thank you for taking the time to share your experience. When you complete this questionnaire, please: Return this questionnaire to the person who gave it to you

Sincerely,

Faisal Abdulaziz Almutairi

faisal.almutairi@canterbury.co.nz

00 64 2155 6100 (New Zealand) -or- 00 966 505 251446 (Saudi Arabia)

Survey of the Patient's Bill of Rights: Health Professionals

Part 1: | **Sociodemographic Characteristics**

Please tick the circle that applies to you

1. **Sex**   ○ Male   ○ Female

2. **Job title**   Physician   ○ Consultant   ○ Specialist   ○ Resident   ○ Nurse

3. **Age group**   ○ Less than 30 years   ○ 30 years to 40 years   ○ More than 40 years

4. **Level of education**   ○ Basic qualification   ○ Post-basic degree   ○ Postgraduate degree

5. **Experience**   ○ Less than 5 years   ○ From 5 years to 10 years   ○ More than 10 years

319

Survey of the Patient's Bill of Rights: Health Professionals (continued)

Part 2:   **(The readiness and ability of public hospitals to implement the Bill)**

> To what extent do you think each of the following items reflects the current situation regarding the implementation of the Patient's Bill of Rights in this hospital?

	Please tick the boxes that best reflect your views:	No extent	To a small extent	To a moderate extent	To a great extent	No information
1.	Senior management supports the implementation of the Patient's Bill of Rights					
2.	Health Professionals are provided with information about the benefits of the implementation of the Bill					
3a.	Resources required for the implementation of the Bill of Rights in this hospital — a) Qualified staff are available					
3b.	b) Number of staff is sufficient					
3c.	d) Supportive materials (e.g. posters, brochures and leaflets) are available					
4.	There are some kind of request for health professionals' feedback about the implementation of the Bill					
5.	Our department held regular discussions on issues relating to patient rights					
6.	There are collaboration between hospital management and outside organisations in implementing the Bill (e.g. community representatives, government and civic organisations)					
7.	The Ministry of Health used the media effectively to increase awareness of the Bill at the local level					
8.	There is a serious commitment from health professionals to achieve the goals of the Bill					
9.	Health professionals have positive attitudes towards patient rights					

Please tick the boxes that best reflects your views:

		No extent	To a small extent	To a moderate extent	To a great extent	No information
10.	Health professionals know their roles and responsibilities in the implementation of the Bill					
11.	Health professionals show respect for the roles of the Patient Rights and Relations Department					
12.	Health professionals confidently answer patients' questions about the Bill					
13.	There is a positive cooperation by the staff of Patient Rights and Relations Department to protect patient rights					
14.	There is a significant contribution by the staff of Patient Rights and Relations Department in support of the implementation of the Bill					
15.	Health professionals are satisfied with the level of implementation of the Patient's Bill of Rights					
16.	Patients are satisfied with the level of implementation of the Patient's Bill of Rights					

If you have any other comment/s about the current processes or achievements of the implementation of t the Patient's Bill of Rights, please write it/them below:

Survey of the Patient's Bill of Rights: Health Professionals (continued)

(Facilitating factors for the implementation of the The Patient's Bill of Rights)

To what extent do you think that each of the following items can be considered an important factor in facilitating the implementation of the Patient's Bill of Rights in this hospital?

Please tick the boxes that best reflects your views:	No extent	To a small extent	To a moderate extent	To a great extent	No information
1. Rewrite the current Patient's Bill of Rights to make it easier for patients to understand					
2. Rewrite the current Patient's Bill of Rights to make it easier for health professionals to understand					
3. Separate Patient Rights and Relations Department from hospital management					
4. Use media effectively to assist in the implementation of the Patient's Bill of Rights (e.g. TV, radio and internet)					
5. Improve managerial support provided to health professionals					
6. Create a safe work environment in the hospital					
7. Provide recognition for those who do a good job of implementing the Patient's Bill of Rights					
8. Ensure effective distribution of the workload					
9. Make the policies for the implementation of the Patient's Bill of Rights explicit and provide them in writing					
10. Provide necessary resources to support the implementation of the Bill (e.g. staff and materials)					
11. Strengthen the roles played by the staff of Patient Rights and Relations Department					
12. Support health professionals' positive attitudes towards the Patient's Bill of Rights					

Please tick the boxes that best reflect your views:

		No extent	To a small extent	To a moderate extent	To a great extent	No information
13.	Provide continuing education and training in the field of patient rights					
14.	Increase the level of job satisfaction among health professionals					
15.	Increase awareness of the Patient's Bill of Rights among doctors and nurses					
16.	Support teamwork values at the hospital					
17.	Increase awareness of the Patient's Bill of Rights among patients					
18.	Encourage the presence of a patient's companion during hospitalisation					

If you have further comments related to the facilitator/s of the implementation of the Patient's Bill of Rights, please add it/them below:

Survey of the Patient's Bill of Rights: Health Professionals (continued)

Part 4: **(The barriers factors to the implementation of the The Patient's Bill of Rights)**

To what extent do you think that each of the following items can be considered a barrier to the implementation of the Patient's Bill of Rights in this hospital?

Please tick the boxes that best reflect your views:

		No extent	To a small extent	To a moderate extent	To a great extent	No information
1.	Failure by health professionals to appreciate the possible benefits of the implementation of the Bill					
2.	Some statements in the Bill are not easily understood by patients					
3.	Lack of commitment from hospital management to implement the Bill					
4.	Lack of motivation among health professionals to implement the Patient's Bill of Rights					
5.	Negative attitudes among health professionals towards the Patient's Bill of Rights					
6.	Lack of continuing education and training for health professionals concerning patient rights issues					
7.	Low level of job satisfaction among health professionals					
8.	Lack of awareness among patients of the Bill					
9.	Limited use of the media to promote the Bill					
10.	Unsafe work environment in the hospital					
11.	Absence of teamwork values in the hospital					
12.	Disregard for health professionals' own rights					
13a.	Lack of Resources required for the implementation of the Bill of Rights in this hospital — a) Lack of qualified staff					
13b.	b) Insufficient number of staff					
13c.	d) Lack of supportive materials (e.g. posters, brochures and leaflets)					
14.	Lack of awareness among health staff of the Bill					

		No extent	To a small extent	To a moderate extent	To a great extent	No information
Please tick the boxes that best reflects your views:						
15.	The absence of patients' companions during hospitalisation					
16.	Excessive number of patients to deal with					
17.	Time limitations					
18.	Increase in work pressure					
19.	Health professionals' fear of the Patient's Bill of Rights being used against them					
20.	The Bill has unrealistic objectives					
21.	The strategy for implementation is ambiguous					
22.	Treatment is more important than rights for patients					
23.	Lack of specialized staff in the field of patient rights in the hospital					
24.	Poor performance of the staff of the Patient Rights and Relations Department					
25.	Lack of authority given to the staff of the Patient Rights and Relations Department					

If you have further comments related to the barrier/s to the implementation of the Patient's Bill of Rights, please add it/them below:

Survey of the Patient's Bill of Rights: Health Professionals (continued)

Part 5:   (The implementation of the statements of the The Patient's Bill of Rights)

To what extent do you think each of the following statements is true in this hospital?

	Please tick the boxes that best reflects your views:	No extent	To a small extent	To a moderate extent	To a great extent	No information
1.	Patients receive a copy of the Patient's Bill of Rights before being admitted					
2.	Patient rights are given a high priority and respect					
3.	Patients receive explanation of the complaint procedures					
4.	Patients are treated with respect, regardless of their backgrounds					
5.	Health care is provided in a safe environment for patients					
6.	Patients are given accurate information about their condition					
7.	Patients know the medical team by their name and specialisations prior to any consultation					
8.	Patients information are kept confidential					
9.	Patients have their complaints treated seriously					
10.	Patients' personal privacy is maintained					
11.	Patients are being asked to sign consent forms before any treatment procedure					
12.	Patients are being involved in their treatment plan					
13.	Patients are being respect for choices they make to to refuse any care or treatment					

Survey of the Patient's Bill of Rights: Health Professionals (continued)

> What are your recommendation/s or suggestion/s for improving the implementation of t the Patient's Bill of Rights in hospitals?

> If you have any other comments related to the patient rights issues, please add them here.

Thank you for completing this questionnaire.

Appendix 2: Survey for Health professionals –Arabic version

<div dir="rtl">

(استبيان خاص بالطاقم الطبي) التاريخ: / / 1434

إلى: جميع المشاركين في هذا الإستبيان

عزيزي المشارك / ـه.

أنا أخوك الباحث / فيصل بن عبدالعزيز المطيري, طالب الدكتوراه في جامعة كانتربري بدولة نيوزلندا. يسرني دعوتك للمشاركة في الإجابة على أسئلة هذا الاستبيان. مع العلم أن الهدف من هذا البحث هو محاولة استكشاف الى أي مدى يتم تطبيق وثيقة حقوق المرضى في المستشفيات السعودية بإعتبارها أداة هامة لتمكين المرضى. وقد تم اختيارك كأحد من يمثلون المستفيدين من الخدمة الصحية في هذا المستشفى.

هذا الإستبيان يتطلب من 15 الى 20 دقيقة لإستكماله, مع العلم أنه يحق لك أن ترفض استكمال مشاركتك في أي وقت دون الحاجة لإبداء الأسباب. مشاركتك وتعبئة هذا الاستبيان تعتبر موافقة منك على المشاركة , وبعد تسليمك للإستبانة سيكون من الصعب استبعاد مشاركتك لأنه لا يوجد أي علامات قد تدل على استمارتك, مع العلم أن كل المعلومات سيتم المحافظة على سريتها بواسطة حفظها في مكان آمن وسيتم اتلافها فيما بعد حسب أنظمة الجامعة.

أخي المشارك/ ـه مشاركتك مهمة بالنسبة لي, لذلك أرغب منك دعمي في هذا الاستبيان.. إذا كنت ترغب في الحصول على نسخة من نتيجة هذا البحث أو كان لديك أي أسئلة بخصوصه، فيرجى الاتصال بالباحث من خلال وسائل الاتصال المذكورة أدناه.

وفي حال كنت غير راضٍ عن الطريقة التي يتم اتباعها في هذا البحث فيمكنك الرفع بأي إقتراح أو اعتراض أو شكوى (بدون ذكر أسمك إن رغبت في ذلك) الى المشرف على هذا البحث: البروفيسورة بولين بارنيت pauline.barnett@canterbury.ac.nz, او البروفيسور راي كيريك ray.kirk@canterbury.ac.nz
او الهاتف: 006433667001 والفاكس: 006433643318

ملاحظة:
شكراً لوقتك الثمين ومشاركتك بتجربتك في هذا البحث. عندما تُكمل تعبئة هذا الإستبيان, الرجاء إعادته للشخص الذي سلمه لك.

مع خالص التقدير،
فيصل عبدالعزيز المطيري

faisal.almutairi@canterbury.ac.nz

الإتصال: المملكة العربية السعودية (0505251446) – نيوزيلندا (006421556100)

</div>

☐☐☐☐☐☐

الجزء الأول: | المعلومات الشخصية

الرجاء أن تؤشر على الإختيار المتطابق معك:

1. **الجنس**   ○ ذكر   ○ أنثى

2. **المسمى الوظيفي**
   ○ استشارى
   ○ أخصائي
   ○ مقيم
   ○ ممرض/ـه

3. **الفئة العمرية (بالسنوات)**
   ○ أقل من 30 سنة   ○ من 30 إلى 40 سنة
   ○ أكبر من 40 سنة إلى 50 سنة   ○ أكبر من 50 سنة

4. **المستوى**
   ○ درجة الدبلوم   ○ درجة البكالوريوس
   ○ درجة الماجستير   ○ درجة الدكتوراه

5. **مدة الخبرة (بالسنوات)**
   ○ أقل من سنة واحدة   ○ من سنة إلى 5 سنوات
   ○ أكثر من 5 سنوات إلى 10   ○ أكثر من 10 سنوات

الجزء الثاني   (الوضع الحالي لتطبيق الوثيقة في المستشفى)

إلى أي مدى تعتقد أن كل فقرة من الفقرات التالية تعكس الوضع الحالي لتطبيق وثيقة حقوق المرضى في هذا المستشفى؟

لا أعرف	موجود إلى حد كبير	موجود إلى حد متوسط	موجود إلى حد ضئيل	غير موجود	الرجاء ضع علامة (√) في المربع الذي يعبر عن رأيك في كل عبارة:	
					ادارة المستشفى تدعم تطبيق وثيقة حقوق المرضى	1.
					هناك التزام واضح من الطاقم الطبي لتحقيق أهداف الوثيقة	2.
					أ — كفاءة العاملين	3.
					ب — العدد الكافي للعاملين	
					ج — المواد المساعدة (كالمنشورات, الكتيبات و البوسترات)	
					الطاقم الطبي دائماً يتم سؤالهم عن مرئياتهم حول تطبيق الوثيقة	4.
					الطاقم الطبي يشعرون بثقة في معلوماتهم عن الوثيقة عند التعامل مع المرضى	5.
					هناك انسجام بين إدارة المستشفى وغيرها من المنظمات (على سبيل المثال: الجمعيات والمنظمات الحكومية والمدنية) من خلال عملية تطبيق وثيقة حقوق المرضى	6.
					استخدمت وزارة الصحة وسائل الإعلام بشكل فعال قبل تطبيق الوثيقة لزيادة الوعي بثقافة حقوق المرضى على المستوى المحلي	7.
					ادارة المستشفى قدمت معلومات عن أهمية تطبيق وثيقة حقوق المرض للطاقم الطبي قبل عملية التطبيق	8.
					الإدارة/القسم الذي أعمل فيه يناقش بانتظام المسائل المتعلقة بتطبيق وثيقة حقوق المرضى	9.
					الطاقم الطبي يعرفون أدوارهم ومسؤولياتهم تجاه وثيقة حقوق المرضى	10.
					الطاقم الطبي يحترمون دور ادارة حقوق وعلاقات المرضى في هذا المستشفى	11.
					موظفو ادارة حقوق وعلاقات المرضى يتعاونون بشكل ايجابي مع الطاقم الطبي من أجل حماية حقوق المرضى في هذا المستشفى	12.

المورد الضرورية في تطبيق وثيقة حقوق المرضى متوفرة في هذا المستشفى مثل:

إلى أي مدى تعتقد أن كل فقرة من الفقرات التالية تعكس الوضع الحالي لتطبيق وثيقة حقوق المرضى في هذا المستشفى؟

لا أعرف	موجود الى حد كبير	موجود الى حد متوسط	موجود الى حد ضئيل	غير موجود	الرجاء ضع علامة (√) في المربع الذي يعبر عن رأيك في كل عبارة:	
					هناك تغيير ايجابي في سلوكيات الطاقم الطبي تجاه المرضى وحقوقهم	13.
					المرضى راضون عن كيفية تطبيق وثيقة حقوق المرضى في هذا المستشفى	14.
					ادارة حقوق وعلاقات المرضى ساهمت بشكل إيجابي في دعم تطبيق وثيقة حقوق المرضى	15.
					الطاقم الطبي راضون عن آلية تطبيق وثيقة حقوق المرضى	16.

إذا كان لديك أي إضافة حول موضوع التطبيق الحالي والمنجزات المتعلقة بتطبيق وثيقة حقوق المرضى في هذا المستشفى, أرجو كتابتها في الأسفل:

الجزء الثالث (العوامل المُيسرة لنجاح تطبيق وثيقة حقوق المرضى في المستشفى)

إلى أي مدى تعتقد أن كل محور من المحاور التالية يعتبر محور مهم في تيسير التطبيق الناجح لوثيقة حقوق المرضى في المستشفيات؟

لا أعرف	مهم إلى حد كبير	مهم إلى حد متوسط	مهم إلى حد ضئيل	ليس بمهم	الرجاء ضع علامة (√) في المربع الذي يعبر عن رأيك في كل عبارة:	
					تحسين الدعم من الادارة العليا للطاقم الطبي	.1
					إعادة كتابة عبارات الوثيقة بحيث تكون سهلة الفهم من قبل المرضى	.2
					إعادة كتابة عبارات الوثيقة حتى تكون أوضح للطاقم الطبي	.3
					تقديم التقدير المناسب للمتميزين في تطبيق وثيقة حقوق المرضى	.4
					دعم السلوكيات الإيجابية لدى الطاقم الطبي نحو وثيقة حقوق المرضى	.5
					توفير التعليم المستمر والتدريب في مجال حقوق المرضى	.6
					رفع مستوى الرضا الوظيفي لدى الطاقم الطبي	.7
					نشر الوعي بوثيقة حقوق المرضى لدى المرضى	.8
					نشر الوعي بوثيقة حقوق المرضى لدى الطاقم الطبي	.9
					استخدام وسائل الإعلام بشكل فعال لفائدة تطبيق وثيقة حقوق المرضى	.10
					وجود مرافق للمريض خلال فترة التنويم	.11
					خلق بيئة عمل آمنة في المستشفى	.12
					دعم مفاهيم العمل الجماعي في المستشفى	.13
					ضمان توزيع عبء العمل بين الطاقم الطبي بشكل عادل	.14
					عرض سياسات تطبيق وثيقة حقوق المرضى بشكل واضح وتوفيرها مكتوبه	.15
					توفير الموارد اللازمة لدعم تطبيق وثيقة حقوق المرضى (مثل وجود المؤهلين وكفاية الموارد البشرية وتوفر المواد المساعدة)	.16
					فصل ادارة حقوق وعلاقات المرضى عن ادارة المستشفى	.17
					تعزيز الادوار التي يقوم بها موظفو ادارة حقوق وعلاقات المرضى	.18

إذا كان لديك أي إضافة على العوامل المُيسرة للتطبيق الفعال لوثيقة حقوق المرضى في هذا المستشفى, رجاءً أضف تعليقك بالأسفل:

تابع) استبيان خاص بوثيقة حقوق المرضى : الطاقم الطبي

الجزء الرابع (العوامل المعيقة لإنجاح تطبيق وثيقة حقوق المرضى في المستشفى)

إلى أي مدى تعتقد أن كل محور من المحاور التالية يعتبر عائق أمام نجاح تطبيق وثيقة حقوق المرضى في المستشفيات؟

لا أعرف	عائق الى حد كبير	عائق إلى حد متوسط	عائق إلى حد ضئيل	ليس بعائق	الرجاء ضع علامة (√) في المربع الذي يعبر عن رأيك في كل عبارة:	
					عدم المام الطاقم الطبي بالمنافع المحتملة لتطبيق وثيقة حقوق المرضى	.1
					وجود عبارات في الوثيقة ليس من السهل أن يفهمها المرضى	.2
					عدم وجود دعم من إدارة المستشفى للطاقم الطبي لتطبيق الوثيقة	.3
					انعدام الحافز لدى الطاقم الطبي تجاه تطبيق الوثيقة	.4
					السلوكيات السلبية لدى الطاقم الطبي تجاه وثيقة حقوق المرضى	.5
					غياب التعليم المستمر والتدريب في مجال حقوق المرضى	.6
					انخفاض مستوى الرضا الوظيفي لدى الطاقم الطبي	.7
					انخفاض مستوى الوعي بين المرضى تجاه الوثيقة	.8
					محدودة الاستفادة من وسائل الإعلام لنشر الوثيقة	.9
					بيئة العمل غير الآمنة في المستشفى	.10
					غياب قيم العمل الجماعي في المستشفى	.11
					تجاهل حقوق الطاقم الطبي	.12
					أ – عدم كفاءة العاملين	.13
					ب – وجود عدد غير كافي من العاملين نقص الموارد اللازمة لدعم تطبيق وثيقة حقوق المرضى	
					ج – النقص في المواد المساعدة (كالمنشورات, الكتيبات و البوسترات)	
					انخفاض مستوى الوعي لدى الطاقم الطبي تجاه الوثيقة	.14
					عدم وجود مرافق للمريض خلال فترة تنويمة	.15
					ازدياد أعداد المرضى المطلوب التعامل معهم	.16
					عدم توفر الوقت	.17
					زيادة ضغط العمل	.18

(تابع) الجزء الرابع

إلى أي مدى تعتقد أن كل محور من المحاور التالية يعتبر عائق أمام نجاح تطبيق وثيقة حقوق المرضى في المستشفيات؟

الرجاء ضع علامة (√) في المربع الذي يعبر عن رأيك في كل عبارة:

لا أعرف	عائق إلى حد كبير	عائق إلى حد متوسط	عائق إلى حد ضئيل	ليس بعائق		
					إعتقاد بعض الطاقم الطبي بأن الوثيقة سوف تسخدم ضدهم	19.
					وجود أهداف غير واقعية في وثيقة حقوق المرضى	20.
					استراتيجية وزارة الصحة تجاه وثيقة حقوق المرضى غير واضحة	21.
					القناعة لدى المرضى بأن الحصول على العلاج أهم من الحقوق	22.
					قلة المتخصصين في مجال حقوق المرضى في المستشفى	23.
					ضعف أداء ادارة حقوق وعلاقات المرضى في المستشفى	24.
					ضعف السلطة الممنوحة لموظفي حقوق وعلاقات المرضى من أجل حماية حقوق المرضى	25.

إذا كان لديك أي تعليق يخص العوائق أمام التطبيق الفعال لوثيقة حقوق المرضى, رجاءً أضف تعليقك بالأسفل:

الجزء الخامس   (مدى تطبيق بنود وثيقة حقوق المرضى في المستشفى)

إلى أي مدى تعتقد أن كل فقرة من الفقرات التالية تنطبق على الوضع في هذا المستشفى؟

لا أعرف	موجود إلى حد كبير	موجود إلى حد متوسط	موجود إلى حد ضئيل	غير موجود	الرجاء ضع علامة (√) في المربع الذي يعبر عن رأيك في كل عبارة:	
					يحصل المريض على نسخة من وثيقة حقوق المرضى وذويهم ومسؤولياتهم عند دخول المستشفى	1.
					الطاقم الطبي يعطون أولوية عالية لإحترام حقوق المرضى	2.
					الطاقم الطبي يشرحون خطوات تقديم الشكوى للمريض	3.
					الطاقم الطبي يقدمون الخدمة الصحية للمرضى بإحترام بغض النظر عن خلفياتهم العرقية او المذهبية أو المناطقية	4.
					تتم الرعاية الصحية في بيئة آمنة للمرضى	5.
					الطاقم الطبي مستعدون لتقديم المعلومات الدقيقة للمرضى عن أوضاعهم الصحية	6.
					الطاقم الطبي يُعرفون بأنفسهم وتخصصاتهم بشكل واضح للمرضى قبل أي إجراء علاجي	7.
					الطاقم الطبي يحافظون على سرية المعلومات المتعلقة بالمرضى	8.
					الطاقم الطبي يتعاملون بجدية مع شكاوى المرضى	9.
					الطاقم الطبي يحافظون على خصوصية المرضى	10.
					الطاقم الطبي يطلبون من المرضى التوقيع على نموذج الموافقة قبل أي تدخل طبي	11.
					الطاقم الطبي يحرصون على إشراك المريض في الخطة العلاجية	12.
					الطاقم الطبي يحترمون رغبة المريض برفض أي نوع من الرعاية أو العلاج	13.

تابع) استبيان خاص بوثيقة حقوق المرضى : الطاقم الطبي

<div dir="rtl">

الجزء السادس

ماهي توصياتك ومقترحاتك لإنجاح تطبيق وثيقة حقوق المرضى في المستشفيات, رجاءً أضف ذلك بالأسفل:

_____
_____
_____
_____
_____
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_____
_____

الجزء السابع

إذا كان لديك أي إضافة أو تعليق, أرجو إضافته بالأسفل:

_____
_____
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_____

شكراً لك على إستكمال هذا الإستبيان.

</div>

Appendix 3: Survey for Patients – English version

Study of action on patient rights in Saudi Arabia

Questionnaire for patients

Dear Participant:

My name is Faisal Abdulaziz Almutairi, a PhD student at University of Canterbury. I am pleased to invite you to participate to answer the questions in this questionnaire. This research aims to determine the extent of the implementation of Patient's Bill of Rights in Saudi hospitals as an important tool to empower patients. You have been selected to represent the patients in this hospital. This questionnaire will require approximately 15-20 minutes to be completed. During this time, you have the absolute right to refuse completing your participation at any time with no need to explain the reason. After you have handed in the questionnaire you will not be able to withdraw from the study because the questionnaire has no identifying details. All the information will remain confidential by saving it in a secure place and it will be destroyed based on the university regulations.

Your view is important to me; therefore I would kindly request your support in this survey. By participating and completing this questionnaire, you are agreeing to give your consent to this research. If you wish to have a copy of the result of this research or have any questions, please contact me through listed contact below.

If you are not satisfied with the manner in which this study is being conducted, you may report (anonymously if you wish) any complaints to my supervisors: Associate Professor Pauline Barnett; pauline.barnett@canterbury.ac.nz or Professor Ray Kirk: ray.kirk@canterbury.ac.nz or phone: 0064 3 366 7001 ext. 3692 or fax: 0064 3 364 3318.

Instructions:

Thank you for taking the time to share your experience. When you complete this questionnaire, please: Return this questionnaire to the person who gave it to you

---

Sincerely,

Faisal Abdulaziz Almutairi

faisal.almutairi@canterbury.co.nz

00 64 2155 6100 (New Zealand) -or- 00 966 505 251446 (Saudi Arabia)

Survey of the Patient's Bill of Rights: Patients

Part 1:   **Sociodemographic Characteristics**

Please tick the circle that applies to you.

1. Sex ○ Male ○ Female

2. Age group
○ From 18 years to 30 years ○ More than 30 years to 40
○ More than 40 years

3. Level of education
○ High school or less
○ Diploma degree
○ University degree

4. Length of hospitalisation
○ Less than 3 days ○ 3 to 10 days
○ More than 10 days

Survey of the Patient's Bill of Rights: Patients (continued)

Part 2:   (The readiness and ability of public hospitals to implement the Bill)

To what extent do you think each of the following items reflects the current situation regarding the implementation of the Patient's Bill of Rights in this hospital?

Please tick the boxes that best reflects your views:

		No extent	To a small extent	Moderate extent	To a great extent	No information
1.	The protection of patient rights is one of the top priorities in this hospital					
2.	There is a serious commitment from health professionals to achieving the goals of the Bill					
3.	Efforts are made to educate patients about their rights and responsibilities					
4.	Patients are asked about how well their rights are respected by health professionals					
5.	Health professionals confidently answer patients' questions about the Bill					
6.	Patients can easily find information about the Bill					
7.	The staff of Patient Rights and Relations Department contribute positively to support the implementation of the Patient's Bill of Rights					
8.	Patients can easily contact the staff of Patient Rights and Relations Department					
9.	Health professionals show respect for the intervention by staff of Patient Rights and Relations Department					
10.	The staff of Patient Rights and Relations Department support patients when any of their rights have been violated					
11a.	Resources required for the implementation of the Bill of Rights in this hospital — a) Qualified staff are available					
11b.	b) Number of staff is sufficient					
11c.	d) Materials (e.g. posters, brochures and leaflets) are available					

Please tick the boxes that best reflects your views:

		No extent	To a small extent	To a moderate extent	To a great extent	No information
12.	Health professionals have positive attitudes towards patient rights					
13.	Patients are satisfied with the level of implementation of the Patient's Bill of Rights					

If you have any other comment/s about the currents process or achievement of the implementation of t the Patient's Bill of Rights, please write it/them below:

Survey of the Patient's Bill of Rights: Patients (continued)

Part 3: **(Facilitating factors of the implementation of the Patient's Bill of Rights)**

To what extent do you think that each of the following items can be considered an important factor in facilitating the implementation of the Patient Rights Charter?

Please tick the boxes that best reflects your views:

		No extent	To a small extent	To a moderate extent	To a great extent	No information
1.	Rewrite the current Patient's Bill of Rights to make it easier for patients to understand					
2.	Make it easy for patients to find the information they need about Patient's Bill of Rights					
3.	Provide a copy of the Patient's Bill of Rights to every patient					
4.	Encourage patients to exercise their rights					
5.	Improve health professionals' positive attitudes towards the Patient's Bill of Rights					
6.	Increase awareness of the Patient's Bill of Rights among patients					
7.	Use media effectively to assist in the implementation of the Patient's Bill of Rights (e.g. TV, radio and internet)					
8.	Provide the educational materials to support the implementation of the Patient's Bill of Rights (e.g. posters, brochures and leaflets)					
9.	Train health professionals how to deal with patients					
10.	Clarify and simplify the complaint procedures for patients					
11.	Increase the number of staff in the Patient Rights and Relations Department in hospitals					
12.	Separate the Patient Rights and Relations Department from hospital management					

Please tick the boxes that best reflects your views:

		No extent	To a small extent	To a moderate extent	To a great extent	No information
13.	Strengthen the roles played by the staff of Patient Rights and Relations Department					
14.	Encourage the presence of a patient's companion during hospitalisation					

If you have further comments related to the facilitator/s to the implementation of the Patient's Bill of Rights, please add it/them below:

Survey of the Patient's Bill of Rights: Patients (continued)

(The barriers factors to the implementation of the Patient's Bill of Rights)

To what extent do you think that each of the following items can be considered a barrier to the implementation of the Patient's Bill of Rights in this hospital?

Please tick the boxes that best reflect your views:

		No extent	To a small extent	To a moderate extent	To a great extent	No information
1.	Some statements in the Bill are not easily understood by patients					
2.	Lack of awareness of the Bill among patients					
3.	Limited use of the media to promote the Bill					
4.	Lack of educational materials to support the implementation of the Patient's Bill of Rights (e.g. posters, brochures and leaflets)					
5.	Hospital management does not take responsibility to protect patient rights					
6.	The Bill has unrealistic objectives					
7.	Health professionals do not encourage patients to read the Bill to claim their rights					
8.	Lack of public awareness about the Bill					
9.	Treatment is more important than rights for patients					
10.	Lack of specialised staff in the field of patient rights in the hospital					
11.	Poor performance of the staff of the Patient Rights and Relations Department					
12.	Lack of authority given to staff of the Patient Rights and Relations Department to protect patient rights					
13.	The Absence of patients' companions during hospitalisation					

If you have another facilitator/s to an effective implementation of the Patient's Bill of Rights, please add it/them below:

Survey of the Patient's Bill of Rights: Patients (continued)

Part 5: **(The implementation of the statements of the Patient's Bill of Rights)**

To what extent do you think each of the following statements is true in this hospital?

Please tick the boxes that best reflects your views:

		No extent	To a small extent	To a moderate extent	To a great extent	No information
1.	Patients receive a copy of the Patient's Bill of Rights before being admitted					
2.	Patient rights are given a high priority and respect					
3.	Patients receive explanation of the complaint procedures					
4.	Patients are treated with respect, regardless of their backgrounds					
5.	Health care is provided in a safe environment for patients					
6.	Patients are given accurate information about their condition					
7.	Patients know the medical team by their name and specialisations prior to any consultation					
8.	Patients information are kept confidential					
9.	Patients have their complaints treated seriously					
10.	Patients' personal privacy is maintained					
11.	Patients are being asked to sign consent forms before any treatment procedure					
12.	Patients are being involved in their treatment plan					
13.	Patients are being respect for choices they make to to refuse any care or treatment					

Survey of Patient Rights Charter: Patients (continued)

What are your recommendation/s or suggestion/s for improving the implementation of the the Patient's Bill of Rights in hospitals?

If you have any other comments related to the patient rights issues, please add them here.

Thank you for completing this questionnaire.

Appendix 4: Survey for Patients – Arabic version

(استبيان خاص بالمستفيدين من الخدمة الصحية)   التاريخ: / / 1434

إلى: جميع المشاركين في هذا الإستبيان

عزيزي المشارك / ــه.

أنا أخوك الباحث / فيصل بن عبدالعزيز المطيري, طالب الدكتوراه في جامعة كانتربري بدولة نيوزلندا. يسرني دعوتك للمشاركة في الإجابة على أسئلة هذا الاستبيان. مع العلم أن الهدف من هذا البحث هو محاولة استكشاف الى أي مدى يتم تطبيق وثيقة حقوق المرضى في المستشفيات السعودية بإعتبارها أداة هامة لتمكين المرضى. وقد تم اختيارك كأحد من يمثلون المستفيدين من الخدمة الصحية في هذا المستشفى.

هذا الإستبيان يتطلب من 15 الى 20 دقيقة لإستكماله, مع العلم أنه يحق لك أن ترفض استكمال مشاركتك في أي وقت دون الحاجة لإبداء الأسباب. مشاركتك وتعبئة هذا الاستبيان تعتبر موافقة منك على المشاركة , وبعد تسليمك للإستبانة سيكون من الصعب استبعاد مشاركتك لأنه لا يوجد أي علامات قد تدل على استمارتك, مع العلم أن كل المعلومات سيتم المحافظة على سريتها بواسطة حفظها في مكان آمن وسيتم اتلافها فيما بعد حسب أنظمة الجامعة.

أخي المشارك/ ـه مشاركتك مهمة بالنسبة لي, لذلك أرغب منك دعمي في هذا الاستبيان.. إذا كنت ترغب في الحصول على نسخة من نتيجة هذا البحث أو كان لديك أي أسئلة بخصوصه، فيرجى الاتصال بالباحث من خلال وسائل الاتصال المذكورة أدناه.

وفي حال كنت غير راضٍ عن الطريقة التي يتم اتباعها في هذا البحث فيمكنك الرفع بأي إقتراح أو اعتراض أو شكوى (بدون ذكر أسمك إن رغبت في ذلك) الى المشرف على هذا البحث: البروفيسورة بولين بارنيت

pauline.barnett@canterbury.ac.nz, او البروفيسور راي كيريك ray.kirk@canterbury.ac.nz

او الهاتف: 006433667001 والفاكس: 006433643318

ملاحظة:

شكراً لوقتك الثمين ومشاركتك بتجربتك في هذا البحث. عندما تُكمل تعبئة هذا الإستبيان, الرجاء إعادته للشخص الذي سلمه لك.

في الختام أشكرك على إسهامك بوقتك الثمين لمساعدتي في هذا البحث.

مع خالص التقدير ،

فيصل عبدالعزيز المطيري

faisal.almutairi@canterbury.ac.nz

الإتصال: المملكة العربية السعودية (0505251446) – نيوزيلندا (006421556100)

الجزء الأول: المعلومات الشخصية

الرجاء التأشير على الاختيار المتطابق معك:

1. | الجنس | ○ ذكر | ○ أنثى |

2. الفئة العمرية (بالسنوات)
   - ○ من 18 سنة إلى 30 سنة
   - ○ من 30 سنة إلى 40 سنة
   - ○ أكبر من 40 سنة إلى 50 سنة
   - ○ أكبر من 50 سنة

3. المستوى
   - ○ أقل من الثانوي
   - ○ الثانوية العامة
   - ○ درجة الدبلوم
   - ○ درجة البكالوريوس
   - ○ درجة الماجستير
   - ○ درجة الدكتوراه

4. فترة الإقامة حتى الآن
   - ○ أقل من 3 أيام
   - ○ من 3 إلى 10 أيام
   - ○ من 11 إلى 20 يوم
   - ○ أكثر من 20 يوم

| الجزء الثاني | (الوضع الحالي لتطبيق الوثيقة في المستشفى) |

| إلى أي مدى تعتقد أن كل فقرة من الفقرات التالية تعكس الوضع الحالي لتطبيق وثيقة حقوق المرضى في هذا المستشفى؟ |

لا أعرف	موجود إلى حد كبير	موجود إلى حد متوسط	موجود إلى حد ضئيل	غير موجود	الرجاء ضع علامة (√) في المربع الذي يعبر عن رأيك في كل عبارة:	
					حماية حقوق المرضى واحدة من الأولويات في هذا المستشفى	1
					هناك التزام واضح من الطاقم الطبي لتحقيق أهداف الوثيقة	.2
					هناك جهود لتثقيف المرضى حول حقوقهم ومسؤولياتهم في هذا المستشفى	.3
					المرضى يُسئلون عن مدى احترام الطاقم الطبي لحقوقهم في هذا المستشفى	.4
					الطاقم الطبي يُجيبون بثقة عن الأسئلة المتعلقة بوثيقة حقوق المرضى	.5
					المرضى يستطيعون بسهولة الحصول على المعلومات الخاصة بالوثيقة	.6
					وجود ادارة حقوق وعلاقات المرضى ساهم بشكل إيجابي في دعم تطبيق وثيقة حقوق المرضى	.7
					المرضى يمكنهم التواصل بسهولة مع ادارة علاقات المرضى عند الحاجة	.8
					الطاقم الطبي يُظهرون احتراما كبيرا للتدخل من قِبل موظفي علاقات المرضى	.9
					موظفو ادارة حقوق وعلاقات المرضى يساندون المرضى في حال تعرُض أي من حقوقهم لأي نوع من الإنتهاك	.10
				أ – كفاءة العاملين	الموارد الضرورية في تطبيق وثيقة حقوق المرضى متوفرة في هذا المستشفى مثل:	.11
				ب –عدد للعاملين		
				ج – المواد (كالمنشورات, الكتيبات و البوسترات)		
					هناك تغيير ايجابي في سلوكيات الطاقم الطبي تجاه المرضى وحقوقهم	.12
					المرضى راضون عن احترام حقوقهم في هذا المستشفى	.13

| إذا كان لديك أي إضافة حول التطبيق الحالي والمنجزات المتعلقة بتطبيق الوثيقة في هذا المستشفى, أرجو كتابتها في الأسفل: |

الجزء الثالث (العوامل المُيسرة لنجاح تطبيق وثيقة حقوق المرضى في المستشفى)

إلى أي مدى تعتقد أن كل محور من المحاور التالية يعتبر محور مهم في تيسير التطبيق الناجح لوثيقة حقوق المرضى في المستشفيات؟

لا أعرف	مهم إلى حد كبير	مهم إلى حد متوسط	مهم إلى حد ضئيل	ليس مهم	الرجاء ضع علامة (√) في المربع الذي يعبر عن رأيك في كل عبارة:	
					إعادة كتابة عبارات الوثيقة لتصبح سهلة الفهم من قِبل المرضى	1.
					تسهيل عملية الوصول إلى المعلومات التي يحتاجها المرضى بخصوص الوثيقة	2.
					توفير نسخة من الوثيقة لكل مريض	3.
					تشجيع المرضى على ممارسة حقوقهم	4.
					تحسين سلوكيات الطاقم الطبي تجاه وثيقة حقوق المرضى	5.
					زيادة مستوى الوعي لدى المرضى حول وثيقة حقوق المرضى	6.
					استخدام وسائل الإعلام بشكل فعال (مثل الإذاعة والتلفزيون والإنترنت) لتعريف الناس بالوثيقة	7.
					توفير المواد اللازمة لدعم تطبيق وثيقة حقوق المرضى (مثل الملصقات والكتيبات والنشرات)	8.
					تدريب الطاقم الطبي على كيفية التعامل مع المرضى بشكل مناسب	9.
					توضيح وتبسيط إجراءات تقديم الشكاوى للمرضى	10.
					زيادة عدد الموظفين في ادارة علاقات المرضى في المستشفى	11.
					فصل ادارة علاقات المرضى عن ادارة المستشفى	12.
					تعزيز الأدوار التي يقوم بها موظفوادارة علاقات المرضى	13.
					وجود مرافق للمريض خلال فترة التنويم	14.

إذا كان لديك أي إضافة على العوامل المُيسرة للتطبيق الفعال لوثيقة حقوق المرضى في هذا المستشفى, رجاءً أضف تعليقك بالأسفل:

....
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....
....
....

تابع) استبيان خاص بوثيقة حقوق المرضى : المستفيدون من الخدمة الصحية

الجزء الرابع (العوامل المعيقة لإنجاح تطبيق وثيقة حقوق المرضى في المستشفى)

إلى أي مدى تعتقد أن كل محور من المحاور التالية يعتبر عائق أمام نجاح تطبيق وثيقة حقوق المرضى في المستشفيات؟

الرجاء ضع علامة (√) في المربع الذي يعبر عن رأيك في كل عبارة:

لا أعرف	عائق الى حد كبير	عائق الى حد متوسط	عائق الى حد ضئيل	ليس بعائق		
					بعض البنود في الوثيقة ليست واضحة للمرضى	1.
					انخفاض مستوى الوعي لدى المرضى عن الوثيقة	2.
					ضعف الترويج الإعلامي لوثيقة حقوق المرضى	3.
					نقص الموارد اللازمة لدعم تطبيق الوثيقة (على سبيل المثال الملصقات، والكتيبات والنشرات)	4.
					عدم استشعار ادارة المستشفى لمسؤوليتها تجاه حماية حقوق المرضى	5.
					وثيقة حقوق المرضى فيها بعض الأهداف الغير واقعية	6.
					الطاقم الطبيلا يشجعون المرضى على استخدام الوثيقة	7.
					ضعف مستوى الوعي لدىالمجتمع عن وثيقة حقوق المرضى	8.
					وجود قناعة لدى المرضى بأن الحصول على العلاج أهم من الحقوق	9.
					قلة الموظفين المتخصصين في مجال حقوق المرضى في المستشفى	10.
					ضعف أداء ادارة علاقات المرضى في المستشفى	11.
					ضعف السلطة الممنوحة موظفي علاقات المرضى من أجل حماية حقوق المرضى	12.
					عدم وجود مرافق للمريض خلال فترة تنويمة	13.

إذا كان لديك أي تعليق يخص العوائق أمام التطبيق الفعال لوثيقة حقوق المرضى, رجاءً أضف تعليقك بالأسفل:

الجزء الخامس   (مدى تطبيق بنود وثيقة حقوق المرضى في المستشفى)

إلى أي مدى تعتقد أن كل فقرة من الفقرات التالية تنطبق على الوضع في هذا المستشفى؟

لا أعرف	موجود الى حد كبير	موجود الى حد متوسط	موجود الى حد قليل	غير موجود	الرجاء ضع علامة (√) في المربع الذي يعبر عن رأيك في كل عبارة:	
					يحصل المريض على نسخة من وثيقة حقوق المرضى وذويهم ومسؤولياتهم عند دخول المستشفى	1.
					الطاقم الطبي يعطون أولوية عالية لإحترام حقوق المرضى	2.
					الطاقم الطبي يشرحون خطوات تقديم الشكوى للمريض	3.
					الطاقم الطبي يقدمون الخدمة الصحية للمرضى بإحترام بغض النظر عن خلفياتهم العرقية او المذهبية أو المناطقية	4.
					تتم الرعاية الصحية في بيئة آمنة للمرضى	5.
					الطاقم الطبي مستعدون لتقديم المعلومات الدقيقة للمرضى عن أوضاعهم الصحية	6.
					الطاقم الطبي يُعرفون بأنفسهم وتخصصاتهم بشكل واضح للمرضى قبل أي إجراء علاجي	7.
					الطاقم الطبي يحافظون على سرية المعلومات المتعلقة بالمرضى	8.
					الطاقم الطبي يتعاملون بجدية مع شكاوى المرضى	9.
					الطاقم الطبي يحافظون على خصوصية المرضى	10.
					الطاقم الطبي يطلبون من المرضى التوقيع على نموذج الموافقة قبل أي تدخل طبي	11.
					الطاقم الطبي يحرصون على إشراك المريض في الخطة العلاجية	12.
					الطاقم الطبي يحترمون رغبة المريض برفض أي نوع من الرعاية أو العلاج	13.

شكراً لك على هذا الإستبيان

تابع) استبيان خاص بوثيقة حقوق المرضى : المستفيدون من الخدمة الصحية

ماهي توصياتك ومقترحاتك لإنجاح تطبيق وثيقة حقوق المرضى في المستشفيات, رجاءً أضف ذلك بالأسفل:

إذا كان لديك أي إضافة أو تعليق, أرجو إضافته بالأسفل:

شكراً لك على إستكمال هذا الإستبيان.

Appendix 5: Information sheet for interviews

College of Education
School of Health Sciences
Tel: +64 3 366 7001 ext 8691
Fax: +64 3 364 3318
Email: healthsciences@canterbury.ac.nz,
faisal.almutairi@pg.canurbury.ac.nz

UC
UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

Study of action on patients' rights in Saudi Arabia
Information sheet for interview

I am a PhD student at the School of Health Sciences, University of Canterbury. I am interested in understanding the current situation of the implementation of patients' rights charter in government hospitals in the Kingdom of Saudi Arabia. In this part of the study I will investigate the perceptions of experts, senior manager, professional leaders, health professionals and patients on the implementation of the charter in hospitals.

I would like to invite you to participate in this study. The interview will take approximately 40 minutes. The interview questions will include information about your job, your experience in patients' rights field, your role in regard to PRC implementation, the emergence of the charter in KSA, the Ministry of Health's activities related to PRC and the current achievement of the charter in national health sector. The interview will be taped with your permission.

Please note that your participation in this study is completely voluntary and you have the right to withdraw from this study at any stage with no penalty. If you withdraw up to the time of analysis, I will remove any information relating to you. Once your data has incorporated into the larger analysis it will not be possible to withdraw from the study.

I will take great care to ensure the confidentiality of all data collected from the participants in this study. The only persons with access to the data are the researcher and his supervisors. For the duration of the study, all the data will be kept in a locked cabinet and on a password secured computer at the School of Health Sciences, University of Canterbury. Once the study is completed the data will be kept in a secure storage facility at the School of Health Sciences, University of Canterbury for a period of ten years and then will be destroyed. For your anonymity, I will not mention your name or position in thesis or any reports. All data will be presented so that no particular person is identifiable.

The results of this study may be used to improve the current implementation of the patients' rights charter in government hospitals in the Kingdome of Saudi Arabia. Moreover, the results will be reported in international conferences and published in academic journals and will be available as a PhD thesis in the University of Canterbury Library, New Zealand.

If you have any questions about the study at any stage, or you would like to receive a report on the study, you can contact me on +966 5 052 51446 or email: faisal.almutairi@pg.canterbury.ac.nz or my supervisor Associate Prof. Pauline Barnett on email: pauline.barnett@canterbury.ac.nz or Professor Ray Kirk on email: ray.kirk@canterbury.ac.nz.

This study has been approved by the Human Ethics Committee of the University of Canterbury (Approval no. HEC 2013/17). If you have any complaints about this study, you can address it to the Chair of the University of Canterbury Ethics Committee, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz).

Thank you for assisting me in this study.
Faisal Abdulaziz Al-Mutairi

Appendix 6: Consent form for interviews

College of Education
School of Health Sciences
Tel: +64 3 366 7001 ext 8691
Fax: +64 3 364 3318
Email: healthsciences@canterbury.ac.nz,
faisal.almutairi@pg.canurbury.ac.nz

UC
UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

Study of action on patient rights in Saudi Arabia
Participant consent form for interview

I have been given full explanation of this study and have been given an opportunity to ask questions.

I understand what will be required of me if I agree to take place in this study.

I understand that my participation is voluntary and that I may withdraw at any stage without penalty.

I understand that any information or opinions I provide will kept in confidential to the researcher and his supervisors and that any published or reported results will not identify me.

I understand that all data collected for this study will be seen only by the researcher and his supervisors. It will be kept in a locked cabinet at the University of Canterbury and will be on a password protected computer. After completion of the study, it will be kept at secured facilities at the University of Canterbury and will be destroyed after ten years.

I understand that I can ask for receiving a report on the findings of this study.

I understand that if I require further information I can contact the researcher, Faisal Abdulaziz Al-Mutairi, if I have any complaints, I can contact the Chair of the University of Canterbury Ethics Committee, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz).

By signing below, I agree to participate in this study.
Name: ....
Date: ....
Signature: ....
Email address: ....

or

Verbal consent provided after full discussion of information sheet.

Researcher signature

....

Please select one of the next options:
☐ I would like to have a report of the findings on my Email or to the following address:
....
....

☐ I do not wish to have a report of the findings.

You may keep a copy of this consent form, and one copy will be returned by the researcher, Faisal Abdulaziz Al-Mutairi.

Thank you for assisting me in this study.
Faisal Abdulaziz Al-Mutairi
+966 5 052 51446

Appendix 7: Ethics Approval – The University of Canterbury

HUMAN ETHICS COMMITTEE

Secretary, Lynda Griffioen
Email: human-ethics@canterbury.ac.nz

Ref: HEC 2013/17

12 April 2013

Faisal Abdulaziz Almutairi
School of Health Sciences
UNIVERSITY OF CANTERBURY

Dear Faisal

The Human Ethics Committee advises that your research proposal "Study of action of patients rights in Saudi Arabia" has been considered and approved.

Please note that this approval is subject to the incorporation of the amendments you have provided in your emails of 13 March, 27 March and 11 April 2013.

Best wishes for your project.

Yours sincerely

Lindsey MacDonald
Chair
University of Canterbury Human Ethics Committee

Appendix 8: Ethics Approval – The Ministry of Health

المملكة العربية السعودية
Kingdom Of Saudi Arabia
وزارة الصحة
Ministry of Health
الإدارة العامة لبرنامج حقوق وعلاقات المرضى
General Directorate of Patient
Rights & Relation

سعادة / المدير التنفيذي لمدينة الملك فهد الطبية   المحترم

سعادة / المدير التنفيذي لمدينة الملك سعود الطبية   المحترم

السلام عليكم ورحمة الله وبركاته ....

تقدم الينا المبتعث/ فيصل بن عبدالعزيز المطيري، الدارس في جامعة كانتربري في دولة نيوزلندا لنيل درجة الدكتوراة في تخصص الادارة الصحية. وذلك بطلب عمل بعض المقابلات الشخصية الخاصة ببحثه عن حقوق المرضى في المستشفيات الحكومية في مدينة الرياض.

وحيث أنه لا مانع لدينا من ذلك على مستوى الوزارة والمستشفيات المذكورة ، فنرجو تسهيل مهمة الباحث في عمل المقابلات المطلوبة حسب الانظمة والتعليمات.

مع العلم ان الوزارة لا تتحمل أي مسئولية ولا أعباء مالية تجاه هذا البحث، ويلتزم الباحث بارسال ما توصلت له الدراسة بعد اكتمالها للوزارة والمستشفيات المذكورة.

شاكرين لكم اهتمامكم

و تفضلوا بقبول فائق التحية و التقدير ،،،،،،،،

مدير إدارة المتابعة والتنسيق
الإدارة العامة لحقوق وعلاقات المرضى

د يحيى بن محمد ابوحيمد

Kingdom of Saudi Arabia
Ministry of Health
General Directorate of Patient
Rights and Relations

الإدارة العامة

General Directorate of Patient Rights and Relations
Reg. /15/35423
11 Dec. 2012
Enclosures:

His Excellency: Executive Director of King Fahad Medical City
His Excellency: Executive Director of King Saud Medical City

Peace be upon you,

A scholarship student **Faisal Abdulaziz Almutairi**, who is studying at the University of Canterbury, New Zealand, to obtain a PhD Degree in Health Management, has requested to conduct some interviews and questionnaires relating to his research on patients' rights in governmental hospitals in KSA, Riyadh.

Whereas we do not have any objection against the conducting of this research at the level of the Ministry and the nominated hospitals, we would like you to facilitate the researcher's task of conducting the required interviews according to the hospital's internal policies and instructions.

It has to be taken into account that the Ministry does not assume any responsibility or financial burdens towards this research. Furthermore, the researcher is obligated to send a copy of this research results to the Ministry and the nominated hospitals.

Thank you for your attention,

With our best regards,

Follow-up and Coordination Directorate Manager

General Directorate of Patient Rights and Relations

Dr. Yahya bin Mohamed Abu Haidar

Official Seal and Signature

This is to certify
that the above translation
corresponds with the attached
....
.......08....1.....02.....1...2013...

Appendix 9: Dissemination plan

First of all, the research findings will be presented to the hospitals included in the study, as requested by the management of the two medical cities.

Next, the key players need to be persuaded to put the theoretical findings into action to enhance necessary change and improve the process of implementing patient rights.

Using his position in the Ministry of Health, the researcher will facilitate change in the process of establishing policies and regulations for enacting patients' rights in the Saudi health system. Also, a great deal of effort will be put into including awareness of patients' rights in the educational curriculum in the country's medical schools.