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Research Paper

Providing a Model to Protect the Rights of Service Recipients in Hospitals

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ABSTRACT

Background and Objectives: Service recipients in the hospital have rights due to unique physical and mental conditions. The increasing complexity of treatment systems, the increase in treatment costs, and the increase in awareness and expectations of service recipients have made it necessary to protect service recipients by the government and hospitals. This study was conducted to design a model to protect the rights of service recipients in Iranian hospitals.

Methods: This research was conducted using a mixed-methods approach (quantitative and qualitative). The questions of the researcher-made questionnaire were finalized after interviews with experts and two rounds of soliciting expert opinions using the Delphi method. The finalized questionnaire was then administered to service recipients who were hospitalized. Data were extracted and analyzed using SPSS software, version 19 and SmartPLS software, version 3 using exploratory and confirmatory factor analysis.

Results: Effective factors in protecting the rights of service recipients in Iranian hospitals were classified into ten main axes: strategic, information, patient-centered care, human resources, managerial, policy-making, physical resources, control, education, and insurance, along with 51 items. Among the results, the most crucial axis identified was strategy, with the sub-axis of legislation and drafting executive regulations to ensure the legal protection of the rights of service recipients.

Conclusion: Protecting the rights of service recipients in Iranian hospitals requires the provision of necessary infrastructures and mechanisms from the macro level to the hospital level. This issue will increase patient satisfaction and fulfill the government's obligations in this field.

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Introduction

The group of patients may be considered one of the most vulnerable social groups [1] because patients not only physically lose the ability related to their health during illness but also experience psychological, social, and economic pressures specific to this period [2]. The patient is the center and axis of all healthcare services, and hospitalization, disability, dependence on other people, unemployment, and the imposition of financial burdens reduce the family's economic power, creating new needs in all existential dimensions. Therefore, health service providers should know the needs and rights of patients well because failure to respect patients' rights can endanger the health and safety of patients [3]. The importance of legal regulations and the protection of patients' rights has grown with the development of medical science, as patients' expectations and demands about the quality and safety of medical care have increased [4]. Patients' rights are intertwined with four main principles of medical ethics: Beneficence, non-maleficence, justice, and autonomy. The patient's rights and the principles of medical ethics complement each other, and any deviation of the physician's procedure from medical ethics is often equal to violating the patient's rights [5].

The concept of patients' rights signifies a shift toward a balanced relationship between the recipient and the service provider, allowing the provider, as a clinical expert, to act in the protection of the active patient with greater independence and communication [6]. Until patients do not know their rights, they do not demand respect, and they cannot express their protest. Also, healthcare providers (physicians, nurses, etc.) should be aware of patients' rights and the consequences of not complying with them [7]. The patients' rights in different countries are different based on differences in laws, organization of healthcare services, and economic, social, cultural, religious, and moral values [8]. Strategies and policies designed to respect, protect, and fulfill the patient's rights are included in a specific social, political, cultural, economic, legal, and organizational context [5]. In many cases, the Holy Sharia of Islam has mentioned respecting the patients' rights. In these religious teachings, although the physician is often considered the main treatment element, the necessity of compliance by all medical staff members is undeniable [9]. In Iran, although the approval of the patient's rights charter is a valuable measure for realizing patient rights, the serious challenge is implementing and culturalizing it in Iran's health system. Respecting patient rights and implementing them not only requires political will at the national level but also providing education at the public and professional level is necessary to ensure patient rights' applicability in the healthcare system [10]. Meanwhile, the lack of hospital facilities and workforce leads to the non-observance of some provisions of the patient's bill of rights in hospitals, resulting in an increase in protests and complaints from the healthcare service provider system [11].

The results of integrated research regarding effective strategies to improve the management of patients' rights in Iranian hospitals showed that eight factors, including the existence of sufficient facilities and expertise, increase in personnel, decrease in patients (increase in the number of hospitals), patients' awareness of their rights in interaction with nurses, allocation of sufficient time to take care of the patient, empowering the executive and management system, familiarizing the patient with the treatment system, and not using planned forces in the primary treatment, are effective in this regard [12]. In another research, the practical solutions to improve the management of patients' rights in Iranian hospitals were investigated using the Delphi technique, and the results were categorized into four categories: Structure, human resources, process, and output. Structure-based strategies were recognized as vital strategies to improve the management of patients' rights [13].

Considering the importance of protecting the rights of service recipients in hospitals and the spiritual and moral emphasis regarding the treatment of patients in the religion of Islam and the role of protecting the rights of service recipients to create patient satisfaction and resolve their concerns and complaints on the one hand, and the commitment of the health system to respect and protect the rights for service recipients on the other hand, and the fact that the studies conducted in this field have not addressed the complete and comprehensive dimensions of protect the patient rights, this study was conducted to provide a model to protect the rights for service recipients in Iranian hospitals.

Methods

This study was applied objectively, and in terms of data collection, it was cross-sectional-descriptive, which was qualitatively and quantitatively conducted in 2021-2022. In the qualitative section, the research was conducted in the Ministry of Health, universities of medical sciences, Social Security, the Revolutionary Prosecutor's Office, and hospitals, and in the quantitative section, it was conducted in selected hospitals in Qom Province, Iran. The statistical population in the qualitative part of the

interview included 16 experts with executive or research experience in the study subject. In the second qualitative part, the statistical population included 40 experts in executive or research activities in the field of the research subject. In the quantitative part, the statistical population included 510 service recipients hospitalized in selected hospitals of Qom Province.

In the qualitative approach, 16 experts with executive or research experience in the study subject were selected through the snowball method, utilizing an interview tool and a semi-structured questionnaire. Interview recording and note-taking were used to record and collect data during the meetings. Collecting opinions and interviews continued until no new concepts were found. After the full implementation of the interviews and the extraction of concepts, in cases where there was ambiguity, the participants were referred for the second time and the ambiguity was resolved. After the saturation of the data, the essential criteria for protecting the rights of the service recipients were identified by the inductive content analysis method and using the MAXQDA software, version 10. Then, the results obtained from the interviews with the experts were designed as a researcher-made questionnaire using a five-point Likert scale (from completely agree to disagree). In the next phase, 40 experts with executive or research experience in the relevant field, who were working in hospitals, the headquarters of medical sciences universities, social security treatment management, the Revolutionary Prosecutor's Office, and as academic staff at universities, were selected, and the questionnaire was distributed to them. At this stage, the scores obtained for each option were extracted from a total of 5 points. If an option received 80% of the average score (equivalent to a score of 4 or higher), it was accepted. The questionnaire was distributed among the participants using the Delphi method in two stages. After reaching an agreement at this stage, a researcher-made questionnaire was prepared in the form of a 5-point Likert scale (ranging from completely agree to completely disagree).

The inclusion criteria for participants being interviewed and agreeing to participate using the Delphi method, having a research background regarding the rights of service recipients in hospitals, holding an executive responsibility in the Ministry of Health and Medical Education, treatment management, the social security organization, the justice system, or medical sciences universities related to this field, possessing a university education, and being a faculty member at medical sciences universities, as well as demonstrating a willingness to cooperate in the research. For service recipients, the inclusion criteria included being hospitalized patients or informed companions of the patients who were present in the hospital at the time of evaluation. The exclusion criteria at all stages included the unwillingness of participants to continue cooperation at any stage of the research.

A panel of 15 experts was used to confirm the content validity of the questionnaire. Experts were asked to answer one of the options "necessary," "not necessary but important," and "not necessary" for each of the questions to calculate the content validity ratio. The minimum required score to confirm validity based on the Lawshe Table is 0.49 [14], and all items scored higher than the value of this index. Regarding the content validity index, the experts were asked to respond to one of the four options "completely relevant," "related," "somewhat relevant," and "unrelated" on the Likert scale. The average content validity index of the questionnaire was >0.79. The reliability of the questionnaire was also calculated using Cronbach's α method, yielding a score above 0.70. Finally, the final questionnaire was prepared in two parts: demographic information and the second part containing 51 research questions.

In the quantitative approach, the final researcher-made questionnaire was distributed among the service recipients who were selected by simple random sampling from selected hospitals. Considering that the respondents were hospitalized patients or their informed companions, the questions were simplified as much as possible to ensure they were within the respondents' understanding. After providing explanations about the research objectives by the interviewers and obtaining the consent of the service recipients to participate in the study, as well as ensuring the confidentiality of the received information, the questionnaire was distributed among the service recipients. According to the researchers' recommendation in the field of factor analysis studies, the sample size should be 3 to 20 times the number of items [15]. Therefore, in this study, given the 51 items in the questionnaire and to enhance the quality of the data, the distribution of the questionnaire continued until a total of 510 responses were received.

Subsequently, the data were analyzed using the exploratory factor analysis method by SPSS software, version 19. KMO (Kaiser-Meyer-Olkin) statistical tests were used to check the adequacy of sampling, and Bartlett's sphericity test was used to check for a correlation pattern among the questionnaire items. The primary component method with varimax rotation was applied to extract the factors. Using confirmatory factor analysis and Smart-PLS software, the values of factor loading and t-values

for the indicators of each construct were determined. The results were validated using Cronbach's α method, combined reliability coefficient, and average extracted variance, and the final analysis was performed.

Results

In this study, 62% of the participants (service recipients) were women and 38% were men. Also, 27% of the participants were younger than 30, 47% were between 30 and 40, and the rest were over 40. In addition, 35% had been hospitalized once and 49% had been hospitalized twice. Table 1 presents other demographic information.

To begin the analysis, the main elements analysis method with vertical rotation and the varimax technique were used. The KMO index was calculated to be 0.0924, which indicates the sampling adequacy. This index should range between 0 and 1, and a value of 0.5 or high-

Table 1. Demographic characteristics of the study participants

Variables		No. (%)
Gender	Male	198(38)
	Female	327(62)
Education	Below diploma	117(23)
	Diploma	215(42)
	Above diploma	97(19)
	Bachelor's degree	67(13)
	Master's degree and above	18(3)
Age (y)	<20	18(3)
	20-30	122(24)
	30-40	241(47)
	40-50	82(16)
	>50	53(10)
Occupation	Freelancer	173(33)
	Employee	137(27)
	Housekeeper	82(16)
	Others	126(24)
Number of hospitalizations	Four times and more	18(3)
	Three times	65(13)
	Twice	250(49)
	Once	179(35)
Number of hospitalization days	Three days or more	113(22)
	Two days	220(43)
	One day	174(34)
	Less than a day	7(1)

Table 2. Factor loading and t-values obtained from the confirmatory analysis of the extracted items of each factor

Factor	Indicators	Factor Loading	t	P
Strategic	Holding meetings and special programs	0.599	18.097	0.001
	Evaluation and introduction of hospitals that protect patient rights	0.642	18.241	0.001
	Determining the score based on the rights of the service recipients in order to obtain the accreditation degree of the hospitals	0.675	20.004	0.001
	Standardization of the patient's informed consent forms	0.666	16.387	0.001
	Standardization of consent forms for patient participation in the research	0.677	15.832	0.001
	Compilation of comprehensive guidelines for handling complaints in the hospital	0.658	14.410	0.001
	Compilation of duties and responsibilities of the patient before hospitalization	0.706	18.799	0.001
	Elaboration of the bill of rights for medical service providers	0.660	12.942	0.001
Information	Holding a training course for newly arrived personnel	0.724	14.938	0.001
	Retraining of medical and paramedical groups	0.634	12.367	0.001
	Adding concepts of the right to receive service in the training courses of medical and paramedical students	0.703	15.755	0.001
	Informing the public about the service recipient's rights through mass media	0.629	14.642	0.001
	Informing all cases of patient's rights to the service recipient in appropriate ways	0.706	16.431	0.001
	Compilation and notification of all the information needed by the service recipient in the hospital	0.683	18.097	0.001
	Establishing patient communication centers in the hospital for consultation and providing the support needed by the patient	0.637	13.381	0.001
Patient-centered	Involving service recipients in decisions related to their health	0.676	14.431	0.001
	Creating facilities to support the patient's spiritual needs	0.667	13.358	0.001
	Creating facilities to provide emotional and psychological support to the service recipient	0.680	15.367	0.001
	Prevention of medical errors	0.662	15.085	0.001
	Identification and correction of identified medical errors	0.721	19.339	0.001
	Monitoring patient safety and correcting defects	0.643	15.472	0.001
	Monitoring the condition of patients who need follow-up after discharge	0.539	8.307	0.001
Human resources	Modifying the organizational chart of the hospital to improve the human resources situation	0.751	20.451	0.001
	Providing sufficient human resources in different job categories	0.722	19.660	0.001
	Increasing job satisfaction and solving livelihood concerns of employees	0.712	16.662	0.001
	Greater impact of respecting the rights of service recipients in evaluating and promoting employees	0.674	13.744	0.001
	Full coverage of professional liability insurance for health workers to compensate for possible damages	0.689	14.972	0.001
Managerial	Compilation of the code of ethics for medical service providers	0.726	19.926	0.001
	Compilation and monitoring of the operational plan for compliance with the rights of the service recipient	0.703	19.652	0.001
	Improving hospital work processes	0.724	16.520	0.001
	Maximizing the electronicization of information related to patient admission to discharge processes	0.703	13.755	0.001
	Provision of drugs, equipment and paraclinical services by the hospital or through the supply chain	0.672	12.462	0.001

Factor	Indicators	Factor Loading	t	P
Policy-making	Legislation and development of executive regulations to ensure legal protection	0.794	22.707	0.001
	Fair distribution of hospital resources based on the needs of different regions of the country	0.744	16.472	0.001
	Full implementation of family doctor and referral system	0.789	23.999	0.001
	Compilation and implementation of clinical guidelines in various diseases	0.720	16.089	0.001
Physical resources	Improvement and desirability of the physical spaces of the hospital	0.696	10.898	0.001
	Easy and safe access to different spaces and departments	0.715	17.238	0.001
	Improving patient hotel facilities	0.678	12.060	0.001
	Improving the welfare of service recipients	0.600	12.212	0.001
	Accurate information about referral locations and different hospital departments	0.667	13.137	0.001
Control	Ease of receiving complaints from service recipients	0.685	14.717	0.001
	Follow-up of service recipient complaints until results are obtained	0.707	17.078	0.001
	Obtaining the opinions of the clients regarding the observance of the rights of the service recipients and the correction of defects	0.690	15.594	0.001
	Periodic evaluation of the status of the service recipients and correction of deficiencies	0.647	13.197	0.001
	Periodic evaluation of received complaints related to service recipient's rights and correction of defects	0.718	16.474	0.001
Education	Teaching concepts of patient rights to service recipients	0.749	20.748	0.001
	Teaching the concepts of the right receiver to the personnel	0.724	16.559	0.001
	Teaching patient communication skills to staff	0.691	14.207	0.001
Insurance	Full coverage of basic universal health insurance	0.733	15.369	0.001
	Expansion of supplementary medical insurance	0.709	12.750	0.001

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er suggests that the data are suitable for factor analysis. Bartlett's test of sphericity was significant at the 0.001 level, which indicates the suitability of the correlation matrix for factor analysis of the data.

The exploratory factor analysis method is used to identify the underlying variables of a phenomenon or to summarize a set of data. The varimax method is the best way to achieve a simple orthogonal structure because the correlation between the factors is minimal enough to be ignored. After conducting an exploratory factor analysis and varimax rotation of the data, ten factors with a specific value greater than one were identified, which explains about 64.58% of the variance of the main structure, which is an acceptable value. Since the factor loading value of all the questions was calculated to be greater than 0.4, according to Table 2, this indicates that the questions were well loaded on the underlying variable, and there is no need to change or remove any questions from the questionnaire.

The results obtained from the software output of the confirmatory factor analysis, as shown in Figure 1, show that the standard regression coefficients were between 0.676 and 0.847, which is suitable for further analysis. Also, the results obtained from R^2, which illustrates the effect of an exogenous or independent variable on an endogenous or dependent variable and is represented by the blue circles in Figure 1, vary between 0.457 and 0.717. Based on another software output, which is shown in Figure 2, the factor load of each indicator with its structure had a t-value >1.96, which shows the necessary accuracy to measure that structure or latent attribute. The evaluation of the internal stability of the tool, as indicated by Cronbach's α coefficient, was between 0.724 and 0.861, according to Table 3, and the composite reliability was also between 0.714 and 0.861. The results

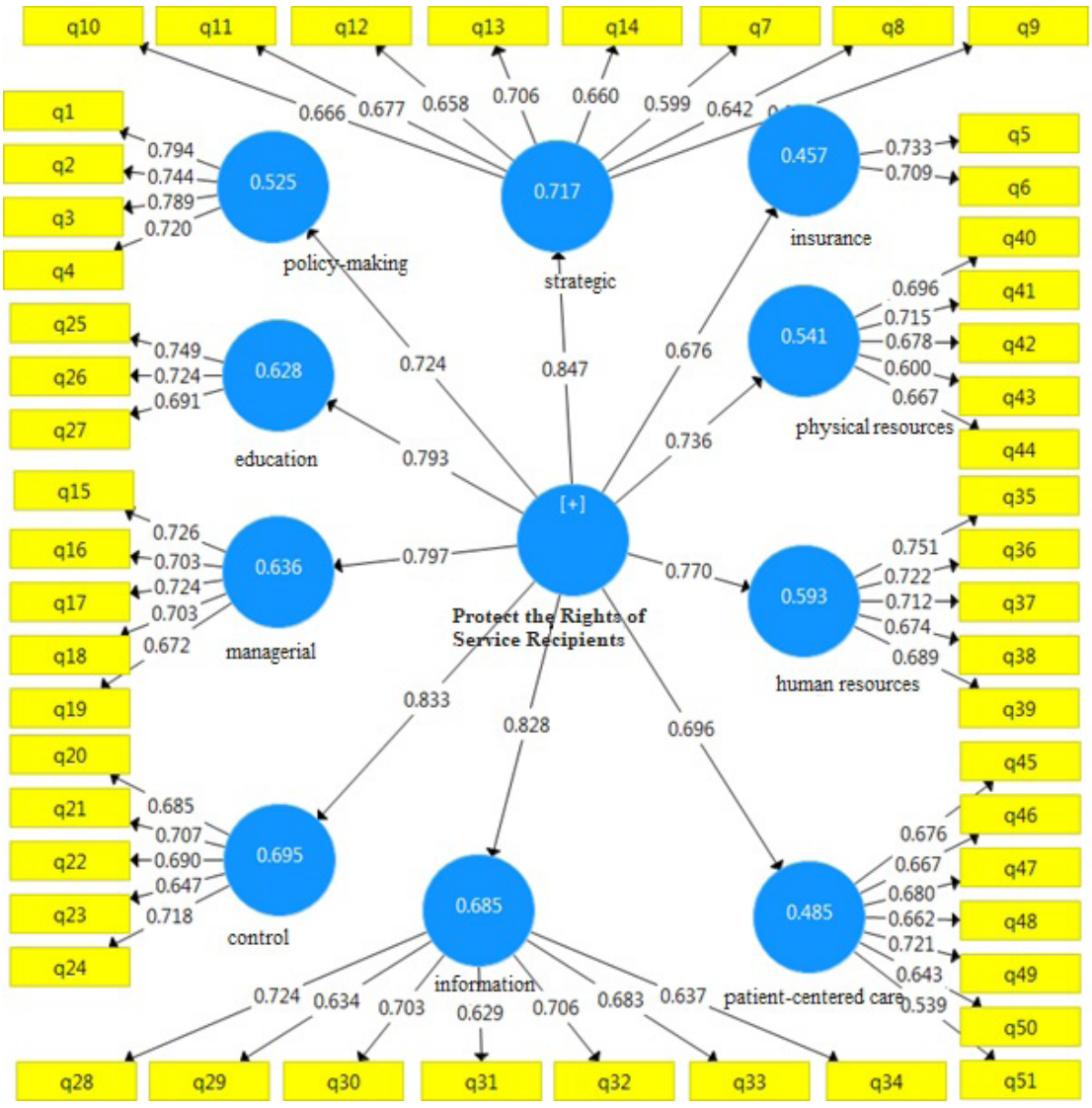

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Figure 1. The output of the software regarding the standardized path coefficients and the factor loadings of the effective factors in the model for protecting the rights of the service recipients

of the average variance extracted (AVE) of each variable with its questions were between 0.658 and 0.762.

Based on the results of the confirmatory factor analysis, as shown in Table 2 and the software output in Figures 1 and 2, ten main factors of the model for protecting the rights of service recipients in Iranian hospitals were obtained, which included 51 items. The first factor with eight items represents "strategy." The second factor determines seven items that represent "information." The third factor has seven items that represent "patient-centered care." The fourth factor with five items represents "human resources." The fifth factor defines five items that represent the "management" factor. The sixth factor consists of four items representing the "politicization" factor. The seventh factor with five items represents "physical resources". The eighth factor, which includes five items, represents "control." The ninth factor explains three items and represents "education," and finally, the tenth factor, consisting of two items, represents "insurance."

Discussion

This study was conducted to provide a model for protecting the rights of service recipients in Iranian hospitals using exploratory and confirmatory factor analysis methods. According to Liao et al. [16], factor loadings above 0.45 are significant and acceptable. According to Table 2, the factor loadings of the items varied between

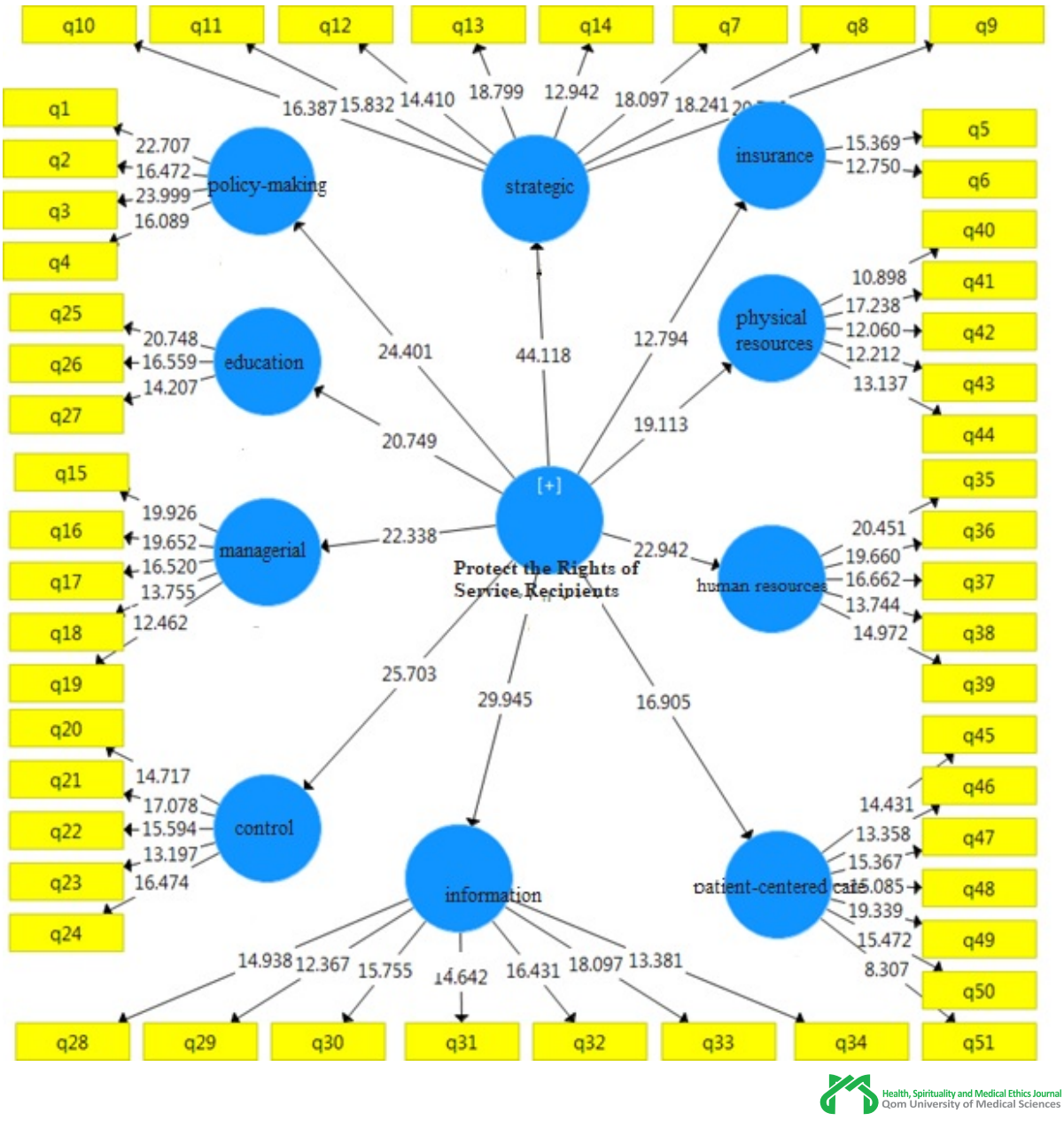

Figure 2. The output of the software regarding the t-value related to the model test of effective factors based on service recipients in hospitals.

0.539 and 0.794. Since the significant coefficients, or t-values, for all the sub-factors of each main factor, as shown in Figure 2, were >1.96, it can be concluded that the sub-factors estimate the relevant main factor well. Therefore, the factors and sub-factors can be included in the structural model of the research, and the structural equations do not need to revise any factors or sub-factors [17]. Reliability is one of the technical characteristics of the measuring instrument, which means that the measuring instrument must yield consistent results under the same conditions. Cronbach's α method is a conventional approach to assessing reliability, aimed at calculating the internal consistency of the measuring instrument, including the questionnaire. According to Table 3, the Cronbach's α coefficient for the constructs varied between 0.724 and 0.861, which is more than the acceptable level of 0.70, as the minimum suggested amount cited in the studies by Liao et al. and Ghaziasgar et al. [16, 18].

The composite reliability criterion is also used to check the reliability of the model. Unlike Cronbach's reliability, which considers the importance and weight of all items equally, in composite reliability, the reliability of that item is calculated according to the factor load of each item. According to Table 3, the composite reliabil-

Table 3. Validity, reliability, and AVE from the main components of the research

Latent Variables	Cronbach α	Composite Reliability	Average Variance Extracted
Strategic	0.861	0.861	0.661
Information	0.853	0.854	0.675
Patient-centered	0.839	0.832	0.658
Human resources	0.836	0.836	0.710
Managerial	0.820	0.832	0.706
Policy-making	0.846	0.847	0.762
Physical resources	0.804	0.804	0.672
Control	0.832	0.819	0.690
Education	0.766	0.765	0.722
Insurance	0.724	0.714	0.721

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ity obtained in this study was higher than the minimum value of 0.70 [19] for all variables, which indicates acceptable composite reliability. Also, the AVE >0.50 is recommended for the variables [20], which was higher than this value and acceptable in this study for all components.

In this study, the model for protecting the rights of service recipients in Iranian hospitals was identified across ten factors. In a study regarding the requirements for establishing patient rights in medical centers [21], the researchers concluded that the establishment of patient rights requires changes in seven areas, including university education, research, supervision, process management, physical space, organization, and management of human resources. The results of this study are consistent with the aforementioned study in the areas of management, education, physical resources management, and human resources management. In another qualitative study, the components of protecting the rights of service recipients in Iran's hospitals were identified in seven areas: policy, management, education, information, human resources, physical resources, and patient-centered care, according to experts These findings are consistent with seven out of the ten areas of this study [22].

This study examined ten main factors and sub-axis. The first factor obtained in the model for protecting the rights of service recipients in Iranian hospitals was "strategy." Strategy means setting goals and planning to achieve them. The results of this research are consistent with the study by Tsyganova and Svetlichnaya [23], which discusses holding special meetings and programs to protect the rights of service recipients. Heriani et al. [24] showed that protecting the patient's rights to improve the quality of public and medical services can be done through accreditation and certification or the quality improvement process. Regarding the sub-axis of accreditation, the results of this study are also consistent with those of Kusumaningrum [25], Engel [26], and Mousavi et al. [27]. Furthermore, the results of this study concerning informed consent are consistent with the findings of Karačić et al. [28].

The second factor obtained in this study was "information." The results of Tripathi's research [29] regarding the rights of service recipients in India showed that the role of medical humanities in medical education has yet to be determined, and it is urgently required to reform medical education. The results of Palm et al.'s study [30] examining patient rights in 30 European countries showed that although different countries have invested significantly in new modes to publish relevant information, the information needed to choose a provider is often unavailable. The results of these two studies are consistent with the current research regarding the information sub-axis.

The third factor extracted in this study was patient-centered care. Regarding the sub-axis of patient participation, the results of this study are consistent with those of Tsyganova and Svetlichnaya [23], who consider the ac-

tive participation of patients in related activities as one of the crucial factors in ensuring the protection of patients' rights. In another study, Akshay Mohan showed that the frequent collaboration with patients about their expectations of care and effective participation of patients in shared decision-making lead to reduced violation of patients' rights [31]. Mahmoudi et al [32] extracted six themes of patient-centered care, the results of which are consistent with the sub-axis of patient safety and spiritual care in this study.

The fourth factor in this study was human resources. In the study by Putturaj et al. [5], sufficient and competent human resources were considered necessary for executing patient rights, consistent with the present study. Anbari et al. [13] also considered human resources as one of the approved strategies for patient rights management in Iran. The mentioned factors and related items, which include selecting, hiring, and organizing suitable human resources based on knowledge and skills, creating work motivation and persistence mechanisms to encourage and reward employees, and establishing a competitive mechanism for employment, are consistent with the results of the present study. The results of this research regarding the items related to professional liability insurance for employees are also consistent with the studies by Tsyganova and Svetlichnaya [23] and Bielak-Jooma et al. [33].

The fifth factor in this study was management. The results of this research are consistent with the study by Fatahi et al. [12], who consider the empowerment of the management and executive systems in the hospital as one of the factors facilitating patients' rights. Anbari et al. [13] also concluded that the lack of electronic health records in Iran is an obstacle to establishing patients' rights in the hospital structure, particularly concerning the electronicization of processes. Also, the results of this study are consistent with those of Mozafari et al. [21] regarding items related to process management, designing a strategic plan centered on patient rights, correcting problematic processes regarding patient rights, and electronicizing client-related processes.

The sixth factor extracted in this study was "politicization". Mohan [31] considers the formulation of laws in this field to be one of the most essential tools for the government to protect the rights of service recipients. Rostami et al. [34] also regard the current charter of patient rights in Iran as having many gaps in protecting and guaranteeing patient rights, concluding that an independent law related to patients' rights should be designed and approved within Iran's legal framework. Both of these studies correspond to the legislative item in this study. The results of this study are also consistent with those of Johansson et al. [35] in Norway and Fedchun [36] in Ukraine regarding the development and implementation of clinical guidelines for the treatment of patients.

The seventh factor in this study was physical resources. Mousavi et al. [37] considered the availability of sufficient facilities as one of the factors facilitating patients' rights. Heriani et al. [24] also consider the facilities and infrastructure of care provided in the hospital as necessary to protect the patient's rights, and both studies are consistent with the results of the present study on the axis of physical resources.

The eighth factor was control. Control means monitoring activities to ensure that they are carried out according to plan and correct deviations. This study's results are consistent with those of Ghazanfari et al. [38], which consider systematic controls and supervision on executing patient rights as a decisive policy. Putturaj [5] also identified the availability of monitoring tools and mechanisms in the executive system of patient rights as one of the factors affecting the implementation of patient rights but categorized it under the axis of management resources.

The ninth extracted factor was education. Tanha and Hayat [7] consider education to be essential for respecting patients' rights in medical centers for both recipients and service providers. Waghmare et al. also emphasize the necessity of increasing patients' knowledge and awareness of their rights, and the results of both studies align with the findings of this study in the field of education [39].

The tenth and final factor was insurance. The results of this study are consistent with the research conducted in Ukraine by Bilyi [40] regarding the component of health insurance as one of the factors to protect the patient's rights. Also, the study by Gafurova and Babaev [4] showed that health and social insurance systems increase the financial support of patients by reducing the need to pay for medical services, leading to better health outcomes. Both mentioned studies are consistent with the results of this study on insurance agents.

Conclusion

It is necessary to protect the rights of service recipients in hospitals due to increasing awareness of these recipients, the specific complications governing the health

system, and the demands of the patients in this field. According to Article 29 of the constitution and national policy statement, the obligation to respect, protect, and implement these rights is considered one of the duties of the government. Implementing the results of this research can ensure the observance and protection of the rights of service recipients in hospitals by identifying the necessary infrastructure at the macro-level policy-making and executive levels within the hospital. This approach will also lead to satisfaction among service recipients in the hospitals while fulfilling the macro goals of the Ministry of Health and Medical Education.

Ethical Considerations

Compliance with ethical guidelines

This study was reviewed and approved by the Research Council of South Tehran Branch, Islamic Azad University, Tehran, Iran (Code: 162343550).

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Authors' contributions

All authors contributed to the preparation of this article.

Conflict of interest

The authors declared no conflict of interest.

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