Original Article

Contextual factors affecting autonomy for patients in Iranian hospitals: A qualitative study

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Abstract

Background: Consideration of patient autonomy is an essential element in individualized, patient-centered, ethical care. Internal and external factors associated with patient autonomy are related to culture and it is not clear what they are in Iran. The aim of this study was to explore contextual factors affecting the autonomy of patients in Iranian hospitals.

Materials and Methods: This was a qualitative study using conventional content analysis methods. Thirty-four participants (23 patients, 9 nurses, and 2 doctors) from three Iranian teaching hospitals, selected using purposive sampling, participated in semi-structured interviews. Unstructured observation and filed notes were other methods for data collection. The data were subjected to qualitative content analysis and analyzed using the MAXQDA-10 software.

Results: Five categories and sixteen subcategories were identified. The five main categories related to patient autonomy were: Intrapersonal factors, physical health status, supportive family and friends, communication style, and organizational constraints.

Conclusions: In summary, this study uncovered contextual factors that the care team, managers, and planners in the health field should target in order to improve patient autonomy in Iranian hospitals.

Key words: Autonomy, chronic disease, hospitals, inpatients, Iran, nursing ethics, patient, personal autonomy, qualitative research, qualitative study

Introduction

Autonomy is an essential human need and is important for human development.[1] It is mentioned in the "Code of Ethics for Nurses" as one of the four key principles of ethical practice in nursing care[2] Autonomy is mostly commonly defined as self-determination, individuals having the right and capacity to make decisions about their own lives.[3] Some psychologists consider it a cultural value.[4] In Islamic literature, it has been defined as performing one's duties within the knowledge and its power and without surrendering to anyone but God – having faith and trust in God does not imply low self-esteem – and making informed decisions based on rational, logical thinking and a sincere motivation to do what is necessary to achieve a goal.[5]

Patient autonomy is a key concern in the provision of individualized, patient-centered, ethical care.[6] It can be defined as the ability to make one's own decisions based on one's sound judgment and act on the basis of such decisions.[7] Patient autonomy conflicts with paternalism, which can limit the person's choices. Paternalism was the norm in the patient–physician relationship until the middle of the 20th century, but this changed in the latter half of the 20th century for various reasons including the increasing

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complexity of medical treatment, the development of medical ethics as a specialty, and the increase in litigation over the right to choose or reject medical treatment.[8]

To achieve autonomy, individuals must have achieved at least partial fulfillment of the universal needs: Adequate nutritious food, clean water and protective housing, a non-hazardous work and physical environment, appropriate health care and security in childhood, significant primary relationships, physical and economic security, appropriate education and (for women) safe birth control. Contexts are autonomy-supportive if they encourage the process of choice, and controlling if they exert pressure to behave in a certain way or work toward a specific outcome.[1]

The literature review revealed that there are internal and external factors related to patient autonomy. Internal factors that promote patient autonomy are often related to patients' cognition, such as self-recognition, self-awareness, perception of care, willingness to make decisions, and beliefs about one's long-term future. All of these factors can be influenced by the nursing staff. The most important external factors related to patient autonomy are nurses, the patient's family, social and organizational environment, the professionalism and respectability of the medical and nursing staff, and the legal system. When both internal and external autonomy-promoting factors are present, patients will be more likely to make sound autonomous decisions.[9,10]

Rahmani *et al*., in a quantitative study, showed significant statistical relationship between perception of health status, need for nursing care, and the age of patient, and their report of respect to their autonomy.[11] Masomi *et al*., in a study of older people, indicated that autonomy correlated with age, marital status, education, and illness.[12] Cullati *et al*.'s study in Switzerland in 2010 showed that factors associated with a higher desire for autonomy included being female, younger age, higher education, living alone, and reporting an excellent global health.[13] Proot *et al*. found in their study that the attitude of health professionals and family, and the nursing home could influence patient autonomy.[14]

Changes resulting from multiple impaired functioning in the body and mind in chronic diseases, as well as a negative image in society and negative effects of hospitalization challenge the autonomy in patients. These people do not have the energy to make good decisions or cannot make decisions without help.[15] There are certain actions such as neglecting someone's right to information or not asking for consent to perform daily activities or medical procedures, as well as more critical interactions, such as invasion of privacy and disturbing patients while they are asleep, which can lead to frustration in the patient and an increased dependence on others.[16]

One of the complaints of hospitalized patients is that doctors do not listen to them or do not care and do not agree with what they say. This is during the time hospitalized patients are dependent on doctors for a long term; this results in patients feeling devalued.[15]

There is also a link between culture and autonomy. Autonomy is viewed differently by different cultures.[9] Autonomy is a moral value which results from social construction within the network of meanings and practices of a particular society and culture.[17]

Like many other countries, the healthcare system in Iran has been affected by paternalism. Paternalism in the health system means that decisions are made by healthcare providers rather than patients and regardless of their own views.[18,19] Recognition that autonomy is an important right for Iranian patients implies that patient care should be patient-centered rather than paternalistic.[9,20]

Patient autonomy can be affected by internal or external factors. The nurse can have impact on all of these factors, while the autonomous patient can control these factors. Clear and comprehensive understanding of these factors can lead to a clearer picture of the situation framed within a qualitative study.

Qualitative research methods can be used to explore human interactions and other social processes and provide a complete theoretical description of the phenomenon under investigation. Researchers use qualitative methods to try to understand key social structures.[21] Because autonomy is culturally relative and is manifested in a social context and through interaction with others, and given that understanding of patient autonomy is limited, we chose to use qualitative research techniques. We found no published studies on contextual factors of patient autonomy in Iran. The main objective of this study was, therefore, to determine the contextual factors affecting patient autonomy in Iranian hospitals.

Materials and Methods

Design

This study used a qualitative research design, using semi-structured interviews and observation periods. Conventional qualitative content analysis was used in this study and coding categories were derived directly or inductively from the interview data.[22]

Setting and participants

This study was conducted in the medical wards of three university hospitals in Tabriz and Hamadan, Iran. Over a period of 10 months (from March 2014 to Jan 2014), 34 participants (23 patients, 9 nurses, and 2 doctors) were selected using purposive and theoretical sampling. The inclusion criteria for participation were: Medical diagnosis of a chronic illness, age over 18 and under 60, able to speak Persian, capable of describing personal experiences, having adequate mental capacity, hospital stay of over 3 days, not in an emergency condition, and willing to participate in the study. The inclusion criteria for the medical team were: Proficiency in Persian language, work experience of at least 1 year in internal medicine ward, and ability to communicate and explain experiences, emotions, and reactions to the researcher [Table 1].

Ethical considerations

This research was approved by the Institutional Review Board of the Tabriz University of Medical Sciences (IRB approval number: 5/4/3845). The researcher provided participants with essential information about the research, e.g. interviews would be recorded and information would be treated as confidential. The participants were also informed that they were free to discontinue participation in the research at any time and without giving any explanation or justification. Written informed consent forms were obtained from them. Observation was overt and permission was sought before these periods began.

Data collection

Semi-structured interviews with open questions and unstructured observation data were collected and analyzed by the principal investigator. The length of the semi-structured interviews ranged from 20 to 65 min. All interviews were conducted by one of the researchers in Persian. The time and location for interviews were chosen in consultation with the participant. All interviews were conducted individually in a quiet and private room at the hospital. The interviews started with the request that the participant describe a typical day during their work or stay in the hospital, including any interactions and incidents. Follow-up questions were used to achieve a better understanding: "Can you explain that for me?," "Can you give an example to clarify what you are saying?." and "Can you elaborate on that?"

During the periods of unstructured observation, the researcher frequently observed the behaviors and interactions of nurses and doctors with the patients, after coordination with the ward chief. The observations were noted in real situations and were recorded in detail at the end of the day. Field notes from interviews and daily informal conversations between the researcher and the participants were also recorded on paper.

The initial interviews and preliminary data analysis were used to develop additional questions for use in subsequent interviews. Three participants were interviewed for a second time to verify and clarify initial interpretations of the data and emerging research findings. Criterion for determining the number of participants was data saturation (saturation of data occurs when additional sampling provides no new information, but only redundancy of previously collected data[23]). Data collection ended when further interviews ceased to provide new information and the data became repetitive. Data saturation was achieved after 30 interviews and the last 4 interviews provided no new information.

Data analysis

A conventional content analysis was used to analyze the collected data. All interviews were tape-recorded and transcribed verbatim. Data were subjected to conventional content analysis using MAXQDA software 2010 version. Data analysis was conducted in Persian and was performed concurrently with data collection, beginning shortly after the first interview. All interview transcripts were read more than once and coded line-by-line to provide a comprehensive

Table 1: Demographic characteristics of participants

Item	Patients	Nurse	Physician
Sex	15 male, 8 female	7 female, 2 male	1 Male, 1 female
Age	20-60 years (Mean: 33.2)	23-35 years (Mean: 29.4)	Mean 32.5 years
Marital status	12 married, 11 single	5 married, 4 single	
Education	Primary school to BS	BSN	
Length of hospitalization	4-30 days (Mean: 8.5)		
Length of illness	1-7 years (Mean: 6.5)		
Number of hospitalization	1-14 times		
Wards	2 Orology, 5 Hematology, 6 Nephrology, 3 Endocrine, 2 Respiratory, 1 Gastroenterology, 1 Kidney transplantation, 3 General		
Working experience		1-12 years (Mean: 6.3)	Mean: 6.5 years

BSN: Bachelor of science in nursing

description of contextual factors influencing patient autonomy. The key concepts in sentences and paragraphs were identified and assigned a code. The codes were then compared and those with similar meanings were placed in the same category. In this way, themes and categories were generated inductively from the data.[22] The notes from observation and filed notes were transferred to and analyzed with MAXQDA-10.

Several methods have been used to determine the rigor of this type of analysis, including prolonged engagement, persistent observation, within-method triangulation, peer checking, and member checking.[21]

To ensure methodological triangulation, data were gathered by means of semi-structured interviews, observation, and field notes. Persistent observation means recognition of those characteristics and elements that are most relevant to the problem or topic under study and focusing on them in detail. Developing the codes, concepts, and category helped us examine the characteristics of the data. We constantly read the data, analyzed them, and reconsidered the concepts. We recoded and relabeled codes, concepts, and the categories. In this study, the participants were asked to confirm that the data and interpretations accurately reflected their experiences and opinions, as a member check.[21] The peer check consisted of asking two members of the qualitative researcher faculty and other expert colleagues who were involved in the study to approve the primary codes and categories. Providing rich descriptions of our data has enhanced the transferability of our findings, as readers will be able to judge the accuracy and appropriateness of our findings and assess whether they are applicable to their own context.

Results

Data analysis resulted in 979 codes and 16 subcategories from which five categories were derived. Categories, subcategories, and some codes are summarized in Table 2.

Intrapersonal factors

We uncovered five intrapersonal factors that affected patient autonomy: Age, knowledge about one's condition and treatment options, experience of illness and medical care, lifestyle, and beliefs.

Age

Participants' experience suggested that younger participants were more independent and made more effort than older people to maintain their independence. Although younger people, like the older people, may be dependent on the others in difficult conditions, such as when they are suffering severe pain, they try to find ways to become independent more quickly. They want to be less dependent on their families and the medical team and try to make decisions for themselves in many situations.

"Young patients are very independent and they like to be independent; the older they are, the more dependent they become, both physically and mentally."(Nurse 6)

Knowledge about one's condition and treatment options

The more knowledgeable an individual becomes, the more he or she seeks independence. Knowledgeable individuals use their knowledge and develop appropriate relationships with their care team. Some patients try to preserve their independence by reading the instructional materials on the boards or the notes stuck on the walls and try to improve their knowledge. The medical team takes account of the patient's knowledge level; if the patient appears knowledgeable, they listen, give information about the treatment process, and encourage involvement in the decision-making process; if the patient is not knowledgeable, the team involves the family in education and decision making.

"I think if I know, for example, that Lasix is for high blood pressure, I would definitely put one in my pocket, or I would have one with me. I want to have at least a little information. If I know about things like that, it will make me independent." (Patient 12)

Experience of illness and medical care

Some participants had previous experience of hospitalization; some experiences were positive and some were negative. Previous experience made the patients more independent; patients who had been hospitalized several times seemed more independent:

"As I was hospitalised before, I have some experience. Changing the IV cannula is painful, a bit more with some nurses, a bit less with others. I tell some nurses to change it, but not others." (Patient 1)

Lifestyle

Another factor in patients' desire and ability to remain independent was the degree of independence they were used to in everyday life. Patients who were used to being independent made more effort to preserve their independence in the hospital. For example:

"I was like this since my childhood, as I had no mother until I was 15 years old. They (patient's parents) had a problem with each other, and as we were doing our chores ourselves, we learnt to be independent." (Patient 8)

Table 2: Categories and themes of content analysis

Categories	Subcategories	Codes
Socio-demographic factors	Age	Older patient is more dependent
	Knowledge about one's condition and treatment options	More aware patients are more autonomous
Physical health status	Previous experience of hospitalization	Autonomous drug use by experienced patients
	Lifestyle	A person dependent on the family has low autonomy
	Beliefs	Belief to obedience of physician
Supportive family and friends	Physical health status	Ill patients are more dependent
	Duration of illness	Patients who have a longer disease course express their opinions
Communication style	Frequency of hospitalization	Patients who are frequently hospitalized select room and bed
Organizational constraints	Emotional support	Family helps patient with medication
	Instrumental support	Family gives hope to the patient
	The respect	Patient's request accepted by the nurse
	Paternalism	Selection of room by the patient
	Education in the context of respectful and collaborative relationship	Decision making for the patient by the doctor or the nurse
	Poor management of human resources	Insulin injection education to patient by nurse
	Insufficient physical resources	The doctor does not explain to the patient because he has no adequate time
	Restrictive regulations	Patient does not accept the room or bed because is not adequate
		Patient does not choose doctor because of regulations
		Patient does not choose bed because of routine

Beliefs

The participants' experiences indicated that having negative beliefs about the experience and knowledge of self about medical informations causes patients not to leave treatment's decision to physician. In addition, the person may believe that they have no power or knowledge to allow them to make decisions.

"Here, it is doctors who make decisions and I have had no role. I have to accept what they say because I do not have any information." (Patient 12)

Changes in health status and hospitalization

The participants' experiences indicated that physical health was an important factor in patient autonomy. We uncovered three physical health status and hospitalization factors relevant to patient autonomy: Physical health status, duration of illness, and frequency of hospitalization.

Physical health status

Patients who are not in good health at the beginning of their hospitalization are dependent on others such as family members, but as their health improves, they become more independent and they take care of their own daily hygiene routine on the ward.

"Now that I'm discharged, I can do my work because I feel really good physically." (Patient 16)

Duration of illness

Participants' experiences indicated that independence is affected by duration of illness. Long-term illness makes patients more independent.

"People who were sick longer express their opinion about medication, but the patients who take drug for the first time do not."(Nurse 6)

Frequency of hospitalization

Frequency of hospitalization definitely has an effect on independence. Patients who have been hospitalized more frequently try to maintain their independence.

"The patients frequently hospitalized choose their own doctor, or choose their own room and bed."(Nurse 4)

Supportive family and friends

Most patients stated that their family and other patients had supported them during hospitalization. We uncovered two categories of support: Instrumental support and emotional support.

Instrumental support

At the very beginning of the period of hospitalization, patients are supported by their family so that they will recover as quickly as possible. The family facilitates treatment; for example, families accept the responsibility

of ensuring that the patient takes the appropriate drugs to speed recovery. They supply medicines and equipment that are unavailable in hospitals. They are also responsible for some daily nursing care.

"Patients are told that such and such drug is not available. They accept and ask their family to follow up." (Nurse 1)

In the case of patients who are in low spirits, older, or illiterate, the treatment team may seek the family's support, for example, in obtaining written consent or training the patient to manage his or her condition. When a patient is physically hurt, family and friends help to take care of the patient.

"For example, to get a CT scan, it was my brother who helped me get there in a wheelchair." (Patient 7)

Emotional support

Families also provide emotional support. Family support gives patients a sense of security and a source of sympathy; the patient has someone to talk to. Frequent visits and conversation bring comfort and peace.

"In the evenings, one of the family members came and talking to me. We read books, watched movies and solved puzzles." (Patient 11)

Participants' experiences suggested that getting information from other patients also helped promote independence. Patients made friends with long-term hospital patients, talked to them, and used the information they gained to try to become more independent.

"I asked other patients who were staying longer than me for orientation. For example, what did such and such a physician do?" (Patient 11)

Communication style

This consists of three categories: Respectful relationship, paternalism, and education in the context of respectful and collaborative relationship.

Respectful relationship

Experiences of participants indicate constant communication between patients and medical staff. Routinely ask patients their requests and offer them opinions. A positive response to the request of the patient and their choices and decisions increased patient's confidence. Providing the necessary explanations to the patient, education, and showing respect to patient's comments were considered respectful; otherwise, their behavior was considered paternalistic.

"For sampling I asked them not to take the sample from the indicated site; they accepted this and took it from somewhere else." (Patient 8)

Paternalism

Some patients referred to experiences which threatened or limited their independence, in particular, not being allowed to make decisions and having their wishes overlooked. Patients felt they had to stay calm about this, but they considered that it postponed their recovery and increased their dependence.

"Nurses mostly make the decisions for us. Do this and do that. Don't go outside and similar things." (Patient 11)

Independence was also negatively affected when interns were given responsibility for care, and patients had no choice in the matter. Inexperienced interns tired patients with long information-seeking visits.

"Here, it is the doctors who make decisions and I have had no role. I have to accept what they say because I do not have any information." (Patient 12)

The experiences of participants of paternalism were that patients were not asked, their opinions were not taken, and no choice was given to them. For example, the opinions of patients about carers, treatment approaches, drugs, hospitalization, and discharge times were not taken.

"They have not asked me a question yet, for example, they did not ask whether the bed be positioned higher or lower." (Patient 1)

Sometimes medical teams do not give information about diseases and treatments to patients, while patients believed that medical information about disease and treatment possibilities is of fundamental importance for patient autonomy.

"I prefer to know what I'm taking, but nurses have no time to answer questions." (Patient 12)

Education in the context of respectful and collaborative relationship

Communicating with patients, giving them information, and helping them to familiarize themselves with the hospital routine promoted independence. In some cases, patients are offered the information they need to be more independent and self-sufficient from the very beginning of their stay until discharge. Some participants reported that materials such as patient education pamphlets and guidebooks were very helpful.

For example, the researcher, in one of his observations on the ward, observed that the nurse provided education about an insulin injection to an elderly woman and her son. After complete explanation was given about the insulin injection, the nurse asked them, "Do you have specific questions to ask about the insulin injection in practice?"

Organizational constraints

This theme was developed from three categories: Poor management of human resources, insufficient physical resources, and restrictive regulations. Most of the participants in this study emphasized the role of organizational factors in patient autonomy. They stressed that their autonomy was negatively affected by inadequate organizational practices.

Poor management of human resources

Poor management of human resources is a threat to patient autonomy. Participants frequently referred to the low staff-to-patient ratio.

"Given the restrictions on our time, we have to reduce our attention to patients. If a nurse only had to handle two, three or even five patients, things would be much better." (Nurse 3)

Another factor that prevents patients from being independent is being on a mixed-sex ward. One of the findings of this study was a sense of violation of autonomy because of the presence of patients of the opposite sex. Patients felt uncomfortable when they were left with patients of the opposite sex in rooms.

"One of the biggest drawbacks is being with men. We even have a common toilet." (Patient 4)

Insufficient physical resources

Factors such as lack of facilities and equipment, poor sanitation, and noise pollution may limit patients' independence and deprive them of decision-making power. Shortage of facilities and equipment is an obstacle to autonomy. Many participants believed that accessibility of resources is very important. The respondents described situations in which they were faced with a lack of the necessary facilities (e.g. private room). Crowded wards disturbed the autonomy of majority of patients. Participants were distracted mainly because of the noise coming from relatives' conversations and the electronic alarms on the equipment.

"When we want to watch TV, our roommate might want to sleep and we have to turn it down. Or accompanies' mobile rings… and we do not have a regular daily schedule." (Patient 4)

The participants insisted that cleaning of their environment was necessary for them to feel autonomy. Their experiences revealed their concerns about hygiene and lack of access to environmental sanitation and cleanliness.

"Poor sanitation is another problem on our ward. It is really dirty and there are cockroaches going up and down the walls. I do not let my little brother visit me because of the dirtiness." (Patient 2)

Participants were upset mainly because of the noise coming from the nurses' station and ward activities.

"At nights, our ward is so busy and noisy. I told the head nurse about the noise. I don't know how they expect the poor patients to have a good night's rest." (Patient 13)

Restrictive regulations

According to participants, some restrictive regulations and routines limit their independence and force them to accept an undesirable situation. When the patients' needs to return to their own habits and planning increase, the care routines limit their autonomy.

"There is no control over our nights. After dinner, I want to sleep, but we have to take serum and pills. So there is no alternative, but to stay awake and let the nurse do his or her job and then sleep." (Patient 1)

Discussion

This research uncovered the contextual factors that affect the autonomy of hospital patients in Iran. These contextual factors were: Intrapersonal factors, changes in health status and hospitalization, support from family and friends, communication style, and organizational constraints.

The experiences reported by participants in this study indicated that younger patients who were better informed, with previous experience of hospitalization, leading an independent lifestyle, and having a positive belief in their ability made more effort to retain their autonomy. This result is consistent with the results of other studies. They reported that greater autonomy was associated with younger age,[13,24,25] higher education,[13,24,26] independent lifestyle, instances where patients perceive and manage information about their condition, and their experience of treatment.[24,27] The results of some other studies do not concur with our study. For example, some studies reported that greater autonomy was associated with being female,[13,24,25,28] having paid employment and a higher income.[13] Another study reported that, in women, autonomy in decision making is positively associated with employment and number of

living children.[25] These differences may be the result of using different methodologies.

The second factor in patient autonomy was physical health status. Patients who were in better health, had been hospitalized for longer, or had experienced more hospitalizations were more independent. Similarly, Cullati *et al*. reported that a greater tendency to autonomy was associated with having made several medical decisions during the past 6 months, absence of chronic health problems, better general health, and practising preventive health behaviors. A sense of autonomy was not related to recent experience of health care, such as having visited a doctor or being hospitalized.[13] Patient's desire for autonomy was influenced by the experience of illness and medical care, diagnosis, and health status, and the type of decision involved.[24,25] Our finding is not consistent with the results of Rahmani *et al*. who reported that the number of days of hospitalization and number of previous hospitalizations did not correlate with patient autonomy.[11] This difference may be due to the difference in methodology.

The patients in this study valued support from family and friends in maintaining autonomy. Emotional support was particularly valued, but instrumental support also promoted autonomy. This result is consistent with the findings of Proot *et al*.[14,29] who indicated that the attitude of health professionals and family could influence patient autonomy. Instrumental support, such as support during home visits, transport, caring for the home, plants, and pets, shopping, delivering mail, laundry, help with managing finances, and preparing the discharge environment promoted patient autonomy. But overprotection by the family may inhibit autonomy and this is not consistent with our study, although this may be caused by the concept of autonomy being culturally dependent.[16] Dooley and Swords reached similar results in their conceptual analysis and showed that patient autonomy was significantly influenced by the presence and influence of the patient's family.[9] Qualitative research by van Kleffens *et al*. points to the same results and showed that the patients' relatives and friends influenced patient autonomy positively.[27]

Many of the participants' statements revolved around a third theme, communication style, including respectful relationship and paternalism. Seeking freedom may stress the relationship and negotiation process to establish autonomy. According to this view, independent functioning forms during dialog.[30] The participants' statement in the study also supported this dialog. Responsive communication was one of the categories generated by Moser *et al.,* which is formed through social interaction and includes reactions to thoughts, feelings, concerns, and habits of others.[31] Relational autonomy emphasizes that human beings act autonomously within the social context.[32] Relational autonomy,[33,34] which acknowledges the fact that people live within relationships, could be used as the models for health care decision making in chronic disease. The disclosure of information has even been supposed to be essential for autonomous decision making.[18,35] Patients should be encouraged to gather information from a variety of sources and to use this to support decisions that need to be made.[17] In our study, patients reported seeking information from a variety of sources to facilitate their autonomous action.

van Kleffens *et al*. reported physician interview data which suggested that medical information about one's condition and the treatment options is of fundamental importance for patient autonomy. Physicians indicated that they played an important role in patient decision making.[27] Proot *et al.* showed that a consistent approach by all members of the medical team greatly facilitated patient autonomy. Attentiveness to and respect for the patient, provision of support and therapy (supervision, instructions, aids), provision of information, and support in evaluating treatment options facilitate autonomy. Lack of information, lack of support in evaluating treatment options, and paternalism had a negative impact on autonomy.[14,29] Say *et al.* reported that patients' preference for autonomy was influenced by interactions and relationships with health professionals.[24] Pollak *et al.* reported that patients whose physicians made reflective statements had higher rates of high autonomy support than the patients whose physicians did not.[36] Adams *et al*. reported that perceived propensity for physicians to involve the patient in decision making about treatment was associated with preference for autonomy in decision making.[37]

Similar to our study, another study reported the healthcare system in Iran has been affected by paternalism.[18,19] According to the study by Proot *et al.,* paternalism (decision making for the patient) is one of the barriers to the patient's autonomy, while in the current study, patients accept paternalism.[14] In Moser *et al.*'s study, patients scarcely perceive problems with paternalism.[31]

According to the World Health Organization, patient education, not only technically but also for ethical reasons, is an essential part of care. Lack of patient education is synonymous with lack of respect, while educating patients is respectful; patient education is not only necessary but also essential.[38] The experiences of participants indicated that education is an element of autonomy. Nurses and physicians identify that education is one of the ways to promote patient autonomy, and accordingly, in a respectful relationship, the patient should be educated from admission

to discharge. Not providing appropriate education is acting in a paternalistic way. Results of a clinical trial study about the impact of autonomy in multiple sclerosis show that the patient education program led to more autonomous decision making in patients with relapsing multiple sclerosis.[39] Despite differences in the methodology between these two studies, the results of both were similar and indicated that education is important for patient autonomy.

The final category of factors influencing patient autonomy was "organizational constraints." Poor management of human resources, lack of physical resources, and restrictive regulations are obstacles to patient autonomy. Büken and Büken, in a Turkish study, refer to manpower, sources, and equipment shortage as obstacles to patients' rights.[40] Similarly, conceptual analysis by Dooley and Swords indicated that the main external factors that promote patient autonomy are the physical environment of the treatment facility and the legal system.[9] Lack of a team approach, care routines, lack of privacy, time constraints, and lack of access to familiar activities limit autonomy.[26,14,29] In a report of a study conducted in Iran, Joolaee *et al.* noted that nurses and physicians attributed patients' rights cases and malpractice cases to staff shortages, time constraints, and lack of facilities.[20] However, this study was limited to descriptions and experiences provided by inpatients in internal medicine wards, which does not allow the findings to be generalized.

Conclusions

This study has reported several internal and external factors that might be targeted to improve patient autonomy during periods of hospitalization. Nurses should pay attention to inpatients, respect their autonomy, and avoid taking a paternalistic approach to care. Effective communication and provision of information are important ways of promoting patient autonomy. Nurses should take the potentially supportive role of the patient's family into account and educate the patients and their families in order to prevent a decrease in autonomy. The number of patient complaints about organizational factors suggests that organizational constraints are one of the main obstacles to patient autonomy in Iran at present. Managers and planners in the health field should target organizational factors to achieve improvements in patient autonomy. The results of this study could be used to develop strategies for improving organizational practices and related guidelines and courses; these might include strategies for a whole-team approach to patient autonomy. Medical teams should actively seek ways to give patients access to a variety of activities to increase their autonomy. Education of staff, patients, and families is necessary to improve patient autonomy in Iran. Additional research in this area should focus on evaluating changes in care practice and the impact of this on patient autonomy.

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Conflicts of interest

There are no conflicts of interest.

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