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Barriers to patient education in Iran: A systematic review

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Abstract

Background: Patient education (PE) is a fundamental patient right and an essential tool for improving health outcomes and enhancing patient satisfaction. However, barriers to effective PE exist, and understanding these obstacles is crucial for addressing them.

Objectives: This study aimed to conduct a systematic review of the barriers to PE in Iran.

Methods: A systematic review was conducted to analyze published articles on the barriers to PE in Iran, available in both English and Persian. The search was performed across multiple databases, including PubMed, Science Direct, and ProQuest, and academic search engine of Google Scholar, and Iranian databases such as MagIran, SID, IranDoc, and IranMedex, covering the period from January 1, 2000, to January 1, 2022. Specific keywords such as "barrier", "education", "learning", "client", "Iran" and "patient" were employed, resulting in a total of 185 articles related to the topic. Ultimately, 47 studies were included in the review.

Results: The review encompassed 47 studies, comprising 32 descriptive, 9 qualitative, 3 intervention, and 3 review studies. The findings identified five categories of barriers: environmental barriers, nurse-related barriers, patient-related barriers, managerial barriers, and educational barriers removal.

Conclusion: Educating patients presents challenges due to various barriers. To address these obstacles, it is imperative for managers to support nurses by providing necessary resources, adequate funding, dedicated nursing personnel, suitable infrastructure, and training in innovative teaching techniques.

Keywords: Patient Education, Barriers, Iran.

Introduction

Patient education (PE) holds a critical role in healthcare, as it equips patients with information about their illnesses, treatment options, prognosis, and self-management strategies. Enhanced patient knowledge is associated with increased involvement in decision-making, improved treatment adherence, and greater satisfaction.[1,2] In the contemporary healthcare landscape, patients are actively engaged in their treatment process and recognize the importance of their well-being. Effective PE is pivotal for improving health outcomes, satisfaction, and reducing adverse events during hospitalization.[2,3]

Nurses, constituting over 70% of the healthcare team,[4] are instrumental in PE due to their extensive patient interaction and prolonged engagement with them.[5] Through education, nurses can positively impact patients' lives and effect long-term changes in their well-being.[2] Successful PE necessitates a blend of art and science, utilizing evidence-based techniques.[6] However, studies have indicated that Iranian patients often do not receive adequate and effective education, resulting in insufficient understanding of their diseases, care, and treatments.[7-9] Neglecting PE by nurses can lead to serious postoperative complications and hospital readmissions.[10]

Research on PE in various countries has identified several barriers to effective PE. Key obstacles include nurses' heavy

workload, absence of policies and guidelines, communication challenges, inadequate knowledge and skills among nurses, as well as environmental and managerial factors.[11-13] Identifying the root causes of PE failures is crucial for devising appropriate strategies to address these challenges.[14] While some studies in Iran have explored barriers to PE,[15-17] most have been descriptive and focused on the perspectives of nurses,[16, 18-20] managers,[21-23] or patients.[24] Although some studies have systematically examined barriers to PE,[11] these barriers have not been comprehensively evaluated from the viewpoints of all stakeholders.

Conducting a systematic review on this topic can consolidate findings and assist policymakers in formulating effective strategies to enhance the current situation. Therefore, this study aims to address the question: "What are the barriers to PE?"

Objectives

This study aimed to explore the barriers to PE in healthcare settings in Iran.

Methods

Study design

This systematic review was conducted following the PRISMA guidelines[25] and involved a search for articles published between January 1, 2000, and January 1, 2022.

Search strategy

We searched for relevant articles in 11 databases using the search strategies outlined in Table 1. Endnote software (Thomson Reuters, X8) was utilized to manage the studies.

Inclusion and exclusion criteria

The inclusion criteria for articles were publication in Persian or English, in national or international scientific journals, focus on PE, and access to their full text. Letters to the editor were excluded from the study. The PRISMA flow diagram for study selection is depicted in Figure 1.

Table 1. Databases and search strategies

Databases	Search strategy
Scopus, ERIC, Science Direct, and ProQuest, and academic search engine of Google Scholar	(Train*, Teach*, Educat*, Instruct* or Learn*), (Obstacle, Barrier, Obstruct*) and (Patient or Client (combined and using AND and OR intermediaries)
PubMed and ISI Web of Science	Composition (train* OR teach* OR educate* OR instruct* OR learn*) AND (obstacle OR barrier OR obstruct*) AND It was (patient OR client)
MagIran, SID, IranDoc and IranMedex	"Barrier", "patient education", "learning", "client"

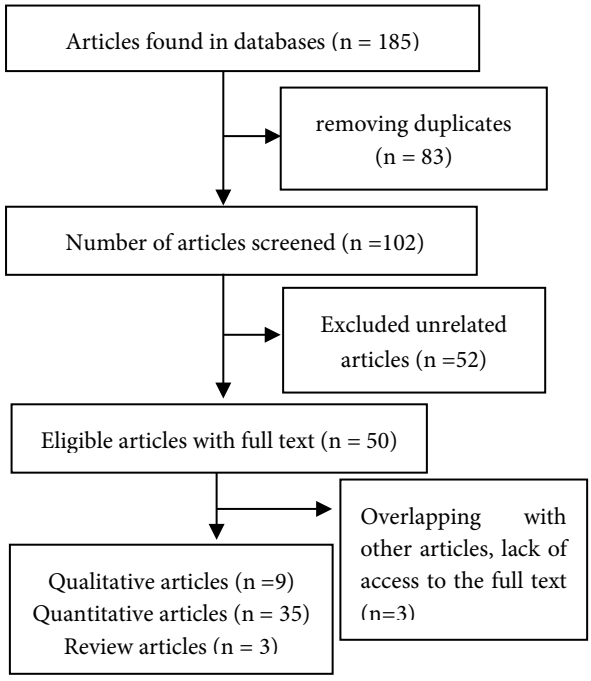

Figure 1. Search results and selection process of study articles

Quality evaluation

A 29-item STROBE checklist was employed to ensure the quality of the articles. The checklist assessed various sections of the articles, including the title (2 items), abstract (2 items), introduction (2 items), methods (10 items), results (8 items), discussion (4 items), and other information (1 item). Each item was rated as 0 or 1, and articles needed to score at least 15 to be considered acceptable.[26]

Data extraction

Two independent researchers (F.N., SH.D.) conducted the data extraction and quality assessment to minimize bias. In cases of disagreement between the two researchers, a third person reviewed the article.

Data analysis

The authors reviewed the results of each study separately, extracted data on barriers to PE, and categorized them into five categories through consensus. The search strategy yielded 185 studies [Figure 1], with 102 articles remaining after the initial screening. Following a detailed review, 47 articles were included in the final sample of this systematic review [Table 2].

Ethical considerations

The collected data in this study were used for scientific purposes, with respect for intellectual property in the reports. The authors avoided data manipulation, biased analysis, and data fabrication. This study was approved by the Ethics Committee of the Faculty of Nursing and Midwifery, Shahid Beheshti University of Medical Sciences, Iran, under the code IR.SBMU.PHARMACY.REC.1402.116.

Results

Study selection process

Among the reviewed articles, 38 (80.8%) were published in national journals, while 9 (19.2%) appeared in international journals. Of these, 32 were descriptive (68.1%), 9 qualitative (19.1%), 3 reviews (6.4%), and 3 interventional studies (6.4%). Study sample sizes ranged from 21 to 796 participants. Moreover, 10 studies (21.2%) employed random sampling methods, 22 (46.8%) utilized the census method, 7 (14.9%) convenience sampling, and 8 (17.1%) purposive and theoretical sampling. Of the total, 14 (29.8%) studies explored barriers from the patient perspective, while others involved nurses and managers. Notably, 33 (70.2%) studies employed researcher-made questionnaires, 8 (17.1%) used interviews, and the remainder employed various tools. Following analysis, five major barrier categories emerged: "environmental barriers," "nurse-related barriers," "patient-related barriers," "managerial barriers," and "removing educational barriers."

Environmental barriers

Among 47 studies, 11 (23.4%) identified the lack of suitable training locations as a barrier.[12,16,18,21,22,23,27,42,44,48,51] Nine studies (19.2%) noted insufficient resources and educational tools (e.g., whiteboards, monitors).[16,21,22,23,28,30,31,36,53] Cultural differences between educators and patients emerged as a significant environmental barrier in five studies.[12,17,21,27,42] Additionally, two studies (4.2%) reported nurses facing inadequate access to scientific and up-to-date resources.[18,28] Other challenges included language and communication differences,[17,40,45,55] long distances to medical centers for post-discharge follow-up,[45] and a lack of social acceptance of nurses as educators.[12,17,40]

Nurse-related barriers

In 17 studies (36.2%), the primary barriers to PE were a lack of time and high nursing workloads.[2,12,18,20,21,22,28,30,31,34,36,37,41,42,44,51,56] Thirteen studies (27.7%) cited inadequate nursing staff and patient-to-nurse ratios as contributing factors.[20,21,22,28,30,36,37,38,42,43,44,46,55] Seven (14.9%) studies mentioned a lack of motivation,[17,37,40,41,44,50,52] while 10 (21.3%) highlighted insufficient knowledge and scientific information among nurses.[12,17,19,20,21,40,44,51,52,56] Additional barriers included lack of evaluation,[18,37,42] failure to prioritize PE,[12,18,27,40,44] and nurses' disinterest in educational activities.[17,28,34,40]

Patient-related barriers

Seven studies identified unsuitable physical conditions and patients' lack of mental preparation (e.g., depression, stress) as primary barriers to effective PE.[12, 15,17,18,21,34,40] Other patient-related barriers included unwillingness to cooperate and accept education,[19, 21, 27, 40, 42] unawareness of nurses' educational duties,[12,40] failure to utilize provided training,[12,23] illiteracy,[21,23] short hospital stays,[12,17,21,27,40] lack of trust in nurses as information sources,[27,40] unawareness of rights,[21,23,30,40] disinterest in behavior change, [12,17,21] and embarrassment regarding sexual education.[17, 40]

Managerial barriers

In 12 studies (25.5%), managerial inattention, lack of support, and the system's failure to appreciate employees were identified as barriers to PE.[14,17, 18,21,22,27,36,40,41,42,44,53] In three studies (6.4%), issues such as lack of control, absence of a proper evaluation system, and insufficient encouragement from managers were also highlighted as barriers.[16,21,50] Additionally, eight studies (17.1%) pointed to insufficient budgets as a significant challenge.[12,16,21,23,27,40,41,44] Other managerial barriers to PE included lack of teamwork,[36] unclear rules,[20] ambiguous instructions,[11] poor management,[21,33] insufficient dedicated nursing staff, inadequate financial incentives,[31] bureaucratic procedures,[11] absence of standardized forms,[11] limited budgets, and insufficient training for nurses.[50]

Removing educational barriers

Only three interventional studies (6.4%) implemented strategies to address or mitigate barriers to PE.[8, 32, 38] Two of these studies advocated for optimizing the culture of PE,[8,38] while the third proposed a clinical supervision model.[32] According to these studies, enhancing nurses' educational skills and motivation, increasing the health system's commitment and accountability in implementing PE, and encouraging nurses to prioritize PE can significantly strengthen the culture of PE. The clinical supervision model has been shown to improve patient satisfaction by fostering meaningful educational interactions between patients and nurses. Additionally, the quality of PE records has improved since the implementation of this model.

Table 2. Characteristics of the articles included in the study based on barriers to patient education (PE)

Author/Year	Type of Research	Tool	Strobe checklist score	Results
Fattahi et al., 2002[27]	Descriptive	Questionnaire made by the researcher (QMR)	20	Lack of knowledge in nurses
Mardanian et al., 2005[28]	Cross-sectional	Hunan and Marcum questionnaire	22	Insufficient personnel, lack of time, and lack of resources and tools
Goudarzi et al., 2005[29]	Descriptive-analytic	QMR	23	Shortage of nurses, lack of proper place, time
Abbasi et al., 2007[30]	Cross-sectional description	QMR	21	Patients' lack of knowledge about nurses' educational duties, Inappropriate division of duties
Aziznejad et al., 2008[22]	Cross-sectional description	QMR	19	Lack of time and high concentration of nursing duties, lack of support and attention from managers.
Najar et al., 2009[31]	Cross-sectional	Questionnaire & Interview	24	lack of time, high workload, lack of educational materials, lack of nurses' motivation
Farahaniashgali et al., 2008[32]	Quasi- experimental	Spielberger anxiety and patient satisfaction questionnaires	20	The use of Culture Improvement Model of PE has motivated and changed the behavior of nurses in the direction of taking PE seriously and making the system more responsible and committed.
Ashghali-Farahani et al., 2009[33]	Qualitative research	Interview	33	Cultural beliefs may act as risk factors for, or serve to intensify, cardiovascular disease. Ineffective management, inappropriate organizational culture, cultural barriers
Vahedian Azimi et al., 2011[34]	Cross-sectional	QMR	23	Lack of nurse
Beiranvand et al., 2009[35]	Cross-sectional	QMR	19	Lack of nurses, lack of time and density of nursing duties, lack of attention and support from managers
Hakari et al., 2010[36]	Cross-sectional	QMR	22	Large number of patients, lack of nurse time, lack of teaching aids
Rostami et al., 2010[23]	Descriptive-analytical	QMR	24	Illiteracy of patients, lack of awareness of their rights, lack of budget, lack of educational space.
Mansourghanaei et al., 2011[19]	Cross-sectional	QMR	23	Lack of knowledge and skills of nurses, lack of physical preparation
Hadad et al., 2011[37]	Cross-sectional	QMR	25	Large volume of work tasks
Vahedian Azimi et al., 2012[20]	triangulation research	Interview	26	low scientific knowledge and information, shortage of nursing manpower, excessive workload,
Farahani et al., 2011[13]	Qualitative analysis	Interview	23	Lack of collegiality and communication between nurses and physicians
Heshmati Nabavi et al., 2012[38]	Quasi-experimental	QMR	24	This model can be useful for improving the knowledge and skills of nurses in the field of PE
Aghakhani et al., 2012[12]	Cross-sectional	QMR	25	Lack of patient adherence, failure of nurses' knowledge and skill level

Sultani et al., 2013[21]	Cross sectional	QMR	24	Inadequate opportunities for nurses, density of duties and the inadequacy of the nurse-patient ratio
Zareiyan et al., 2013[39]	Cross sectional Study	QMR	25	Heavy duties and lack of time, lack of communication and coordination
Dehghani et al., 2014[40]	Cross sectional	QMR	23	Lack of time due to workload density, lack of planning to educate patients in the daily work
Shirazi et al., 2014[24]	Cross sectional	QMR	21	Environmental barriers, management barriers
Mousavi et al., 2014[18]	Cross sectional	QMR	20	Insufficient satisfaction of nurses with working hours and shifts
Hasimi et al., 2014[8]	Quasi experimental	Spielberger anxiety and patient satisfaction questionnaires	23	organizational culture improvement model of PE will play an important role in the patients' health
Ezzatabadi et al., 2014[41]	Cross sectional	QMR	20	Lack of nurses working in the department and back-to-back work shifts
Ghorbani et al., 2014[42]	Descriptive	QMR	19	Heavy workload, inadequate time and lack of educational facilities
Taghizadeganzadeh et al., 2014[43]	Cross-sectional	QMR	18	Physical disadvantage, low literacy, shortage of the nursing
Saeidpour et al., 2014[44]	Descriptive	QMR	22	Shortage of nurses and lack of sufficient financial resources
Hamzehgardeshi et al., 2014[45]	Cross-sectional	QMR	22	Time constraint, Lack of family support
Arian et al., 2015[46]	Cross-sectional analysis	QMR	23	Lack of knowledge of nurses, illiteracy and illiteracy of patients, lack of cooperation of patients
Ramezanli et al., 2015[15]	Cross-Sectional	QMR	24	Nurses' insufficient knowledge, patients' physical and emotional unpreparedness
Karimi et al., 2016 [47]	Review of the literature	-	25	Nurse-related factors, shortage, unsupportive organizational culture
Badiyepeymaiejahromi et al., 2016[48]	Cross-sectional	QMR	24	Inadequate knowledge and skills of the nurse
Jahromi 2016[49]	Descriptive-cross sectional	QMR	23	Lack of appropriate educational facilities, time limitation, inadequate knowledge
Mirzaei-Alavijeh et al., 2016[17]	Cross-sectional	QMR	24	Lack of time, lack of educational planning, nurses' indifference, inability to communicate
Adib-Hajbaghery et al., 2017[11]	Review study	-	25	Lack of time due to the workload of nurses, unfavorable physical and mental condition of the patient
Saeedi Geraghani et al., 2017[16]	Descriptive	QMR	20	Patient contact with multiple nurses, shift work, lack of comfort facilities
Dahmardeh et al., 2017[50]	Descriptive	QMR	19	Managerial barriers to education had the highest average score
Khaleghparast et al., 2018[51]	Cross-sectional	QMR	18	Many duties of nurses, lack of sufficient time, lack of knowledge of nurses
Abbasi et al., 2018[52]	Qualitative study	Interview	21	Lack of motivation and willingness, lack of sufficient academic knowledge- Patients not demanding any education
Sedeki et al., 2020[53]	Qualitative research	Interview	23	Inadequate support of managers, lack of training conditions
Ghasemi et al., 2020[54]	Qualitative study	Interview	24	Inadequate organizational context, Patient-related, cultural barriers
Shahmari et al., 2021[55]	Domain browsing	-	23	There is a correlation between limited language skills and effective PE
Abedini et al., 2022[56]	Cross-sectional	QMR	21	Lack of knowledge and skills, lack of educator's time

Discussion

Studies on PE in Iranian hospitals have revealed a range of diverse and complex challenges. Over 75% of the studies utilized researcher-developed instruments for data collection. Analyzing and comparing the results of these studies is difficult when the instruments lack proper psychometric testing, particularly when considering the impact of organizational culture on the PE process. Human factors, patient interactions, family dynamics, and the care team all contribute to these challenges.[33,34] The use of valid, reliable, and culturally appropriate instruments is essential for assessing barriers to PE, and future studies should place greater emphasis on this aspect.

Our review also highlighted a significant gap in the literature regarding environmental barriers to PE. Future research should focus more on these obstacles. A lack of suitable locations for PE and a scarcity of educational resources and tools were identified as major challenges. In a study by Fereidouni et al., nurses recognized this as one of the most significant environmental barriers to effective PE.[5] Ahmed[57] and Kemppainen et al.[58] also noted that essential equipment and tools for PE are not readily accessible. Consequently, nursing managers bear the responsibility of providing appropriate spaces, educational resources, and tools to facilitate PE. Offering up-to-date materials, resources, and databases that are accessible to patients can support nurses and create numerous opportunities for both nurses and patients to teach and learn.[59] Addressing these issues can help resolve many of the educational challenges faced by patients.

Poor teamwork represents another barrier to PE that healthcare administrators must address to ensure optimal patient care. To fully understand the causes of poor teamwork, it is crucial to examine organizational culture and consider the perspectives of all healthcare team members, including physicians. Identifying both patient- and nurse-related barriers is imperative for improving PE. In the current study, lack of time and high workload emerged as significant nurse-related barriers to PE. These issues are likely rooted in the nursing shortage[60, 61] and can lead to physical and mental exhaustion. Managerial barriers, such as lack of support, attention, and low value placed on staff, can further diminish nurses' motivation for PE. Therefore, managers must provide adequate support and attention while considering the human and financial resources necessary for effective PE implementation. To overcome these barriers, it is essential for managers to prioritize adequate staffing in accordance with industry standards.

Our review revealed that nurses lack motivation for professional education, which may stem from inadequate management. To enhance nurses' motivation, we propose a six-step intervention that includes improving communication and fostering nurses' involvement in decision-making, goal setting, planning, implementation, and documentation. Additionally, implementing a clinical supervision model can improve organizational culture and enhance the quality of care and education provided by nurses.[62] This model fosters a mutually beneficial relationship between nurses and their supervisors, focusing on developing professional competencies and motivation as a means to improve care quality.[38,63]

In conjunction with addressing known organizational and managerial barriers to PE and tackling patient- and nurse-related obstacles, further research is essential to better understand these barriers and explore strategies for their elimination. Limitations of the current study include restricted access to certain international databases, limited advanced searching capabilities in some Persian language databases, and unavailability of results from some unpublished studies. Therefore, additional research is warranted to gain deeper insights into the barriers to PE. Moreover, developing indigenous tools to measure these barriers and designing intervention studies to test appropriate solutions will be beneficial in identifying both barriers and potential resolutions.

Although qualitative studies were not included in the systematic review, they were not excluded due to their value in enriching the data.

Conclusions

The findings of this study indicate that PE encounters challenges from nurses, patients, managers, and the organizational environment. Understanding these barriers can assist nurses, professional staff, and managers in effectively planning the educational process. Specific measures can be implemented to overcome these obstacles. Managers can support nurses by allocating resources, providing a conducive work environment, assigning dedicated personnel to PE, implementing continuing education programs, ensuring adequate staffing levels, and motivating nurses.

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Competing interests

The authors declare that they have no competing interests.

Abbreviations

Patient education: PE;

Questionnaire made by the researcher: QMR.

Authors' contributions

Study conception and design: F.N. and SH.D.; data collection: F.N. and SH.D.; extraction and quality assessment: F.N. and SH.D.; analysis and interpretation of results: F.N., M.GH., and F.P.; draft manuscript preparation: E.S. and F.N. All authors read and approved the final manuscript. All authors take responsibility for the integrity of the data and the accuracy of the data analysis.

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Availability of data and materials

The data used in this study are available from the corresponding author on request.

Ethics approval and consent to participate

This study adheres to the standards set forth in the Declaration of Helsinki. The Ethics Committee of the Faculty of Nursing and Midwifery at Shahid Beheshti University of Medical Sciences, Iran, approved this study under code IR.SBMU.PHARMACY.REC.1402.116.

Consent for publication

By submitting this document, the authors declare their consent for the final accepted version of the manuscript to be considered for publication.

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