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Nurses' experiences of discrimination in health care: A qualitative study in Iran

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Abstract:

BACKGROUND: Justice in health is one of the main concerns of health organizations, and discrimination in health care is one of the negative outcomes to achieving this goal. Hence, a full understanding of the phenomenon of discrimination in health care and adopting strategies to eliminate it is necessary. The present study was conducted to explore and describe the experiences of nurses of discrimination in health care.

MATERIALS AND METHODS: The present qualitative content analysis study was conducted between 2019 and 2020. Data were collected through semi-structured interviews with 18 participants (two physicians, three nursing supervisors, two head nurses, four clinical nurses, two nursing assistants, and three hospitalized patients) in one public and one private hospital in the city of Tehran. The participants were selected by purposive sampling, which continued until saturation of data. Data obtained were analyzed using the Graneheim and Lundman method.

RESULTS: Four main categories and 14 subcategories were extracted from data analysis: 1) habitual discrimination (everyday discrimination in health centers, ignoring patient rights, low levels of trust in medical staff); 2) interpersonal relationships (expectations of associates, respect for colleagues and friends, the possibility of the occurrence of similar situations, reciprocating people's favors); 3) shortage of health-care resources (shortage of medical equipment, heavy workload, infrastructure of medical centers, lack of access to physicians); and 4) favoritism (ethnicity, favoritism as a common method, and favoritism as the ultimate solution to treatment problems).

CONCLUSION: The present study revealed certain dimensions of discrimination in health care that remain hidden in many quantitative studies. It appears that health system managers will be able to move toward eliminating discrimination in health care. Thus, designing effective models to reduce discrimination in health care based on the underlying concepts of this study is recommended.

Keywords:

Content Analysis, discrimination, health care, justice, qualitative study

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Introduction

Justice in health is recognized as one of the principles of medical ethics and a primary patient right.[1] The International Society for Justice in Health defines this concept as follows: Justice in health means the absence of systematic and potentially resolvable disparities in one or more aspects of health in a population and economic, social, demographic, and geographical subgroups.[2] Accordingly, the opposite of justice in health care is discrimination, which has been recognized as one of the negative outcomes.[3] Discrimination in health care means non-provision, incomplete provision, or variable provision of health care to individuals, or groups of individuals, because of their personal and social attributes.[4] Discrimination in health care is a matter that is experienced by many

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people, but reported only by some,[5] who often belong to minority groups in terms of race, ethnicity, or having certain diseases or particular conditions such as physical and mental disabilities.[6] Many studies have reported various forms of discrimination in health care, such as discrimination based on gender,[7] race/ethnicity,[8] age,[9] disease type and nature, religion,[10] language,[11] and economic level and social status.[12] In all these cases, patients and visitors to medical centers have received partial, poor quality, or different health-care services compared to other patients.[7-12]

While explaining the current situation, Javier and Luis (2013) reported three common forms of discrimination in health care in the European Union (EU) member states, namely, age, sex, and disability discrimination. Among the European countries, Britain and Cyprus had the highest and lowest reports of discrimination in health care, respectively. Low income and high-school education were among the factors blamed for discrimination in health care.[13]

Piette *et al*.[14] stated that in the USA, almost one-third of patients visiting health centers had experienced discrimination in receiving health care during their lifetime. In van den Heuvel and van Santvoort's study (2011) investigating the experience of discrimination among older European citizens, 26% of 62-year-old citizens had experienced age discrimination occasionally and 11% had experienced it constantly.[15] In his study, Rodriguez (2017) reported that at least one in 10 Hispanic immigrants experiences discrimination in receiving health care.[16]

Discrimination in health care has significant consequences, and one of the most important of these consequences is visitor's and patient's loss of confidence in medical staff. Other important consequences include exposure to stress and experience of further tensions, with their specific complications, anxiety, depression, rising blood pressure, and even the risk factors for developing certain health problems such as obesity, breast cancer, and drug abuse.[4,6,17-19]

To accomplish justice and fight discrimination in health-care provision, various organizations, the World Health Organization (WHO) in particular, have designed and implemented various strategies. These strategies include continuous education of health-care providers on ethical principles, the constant review of health-care policies, and providing support to the public and stressing the need for people to report discrimination encountered in clinical settings.[11,20] However, discrimination in providing health care remains a major challenge and barrier.[21-24] The inadequacy of these policies and strategies suggests that strategies implemented have not been based on a comprehensive knowledge of the dimensions of discrimination in health care, and insufficient knowledge of the phenomenon of discrimination and its dimensions is probably one of the reasons for the inadequacy of such programs. Furthermore, most studies conducted on discrimination in health care have been quantitative and have reported its frequency and adverse consequences. The causes and subjective aspects of discriminatory behaviors of health-care providers have been less studied, and therefore, lack of qualitative studies about discrimination in health care was another reason for conducting this study. Moreover, the phenomenon of discrimination in health care is influenced by various sociocultural factors and is experienced differently by people in different societies.[25-28] Therefore, a full understanding of this phenomenon is necessary for adopting effective discrimination control and elimination strategies. Hence, the present study was conducted to explore and describe the experiences of nurses on discrimination in health care.

Materials and Methods

Study design and setting

The present qualitative study used the content analysis approach to explain the phenomenon of discrimination in health care using the experiences of nurses. The conventional content analysis approach was used to achieve the study objectives as it is a suitable approach for exploring and describing people's experiences.[29] The study setting comprised two hospitals in Tehran, the capital of Iran, one of which was a public teaching hospital and the other was a private, and not a teaching, hospital. Both hospitals provided specialized and subspecialty medical services.

Study participants and sampling

The participants included 18 people, of whom 15 were health service providers (physicians and nurses) and three were patients, who had been selected purposively sampling method (age, gender, work history, etc.). The first interview conducted for a nurse who had experiences about discrimination in health care during her work history (21 years), and she was asked to introduce other nurses who had experience and knowledge about this topic. The participants' demographic details and diversity are presented in Tables 1 and 2, respectively.

Data collection

Data were collected between June 2019 and July 2020 through semi-structured interviews, which started with general questions, such as "Have you ever acted unevenly toward patients? Please describe your experience" and "Have you ever experienced discrimination in receiving medical services?," and then, the next questions

Table 1: Demographic characteristics of the participants

Number	Age (years)	Gender	Marital status	Education	Position	Work experience (years)	Duration of interview (minutes)
P1	38	Male	Married	Master in nursing	Clinical supervisor	16	35
P2	32	Female	Single	Bachelor in nursing	Nurse of gynecology ward	8	20
P3	40	Male	Single	M.D.	Emergency physician	16	24
P4	53	Female	Married	Bachelor in nursing	Clinical supervisor	28	27
P5	52	Female	Married	Bachelor in nursing	Clinical supervisor	25	30
P6	33	Male	Married	Bachelor in nursing	ICU nurse	8	33
P7	32	Male	Single	Bachelor in nursing	ICU nurse	10	28
P8	35	Female	Married	Diploma	Nursing assistant	12	25
P9	38	Female	Married	Bachelor in nursing	Head nurse of surgical ward	15	23
P10	48	Male	Married	M.D.	Anesthesiologist	22	28
P11	36	Male	Married	Diploma	Nursing assistant	10	35
P12	48	Female	Married	Masters in nursing	Head nurse of medical ward	25	41
P13	42	Female	Single	Bachelor in nursing	Nurse of clinic ward	16	30
P14	39	Female	Married	Bachelor in nursing	Head nurse	15	24
P15	54	Female	Married	Bachelor	Patient	25	36
P16	41	Female	Single	Masters	Patient	16	33
P17	38	Female	Married	Masters	Patient	10	24
P18	40	Female	Married	Bachelor	Emergency nurse	16	23

ICU=intensive care unit

Table 2: Diversity of demographic characteristics of the participants

Demographic Characteristic	Description
Number of participants	18 people
Age (years)	Mean: 41 years, minimum: 32 years, maximum: 54 years
Gender	12 people (female), six people (male)
Education	Medical doctor: two people, masters: four people, bachelor: 10 people, diploma: two people
Work experience (years)	Mean: 16.3 years, minimum: 8 years, maximum: 28 years
Marital status	Married: 13 people, single: five people

were designed based on the interviewee's responses. Prior arrangements were made with the participants regarding the time and place of the interview. Interviews lasted between 20 and 41 min each, depending on the participants' conditions and willingness.

Data analysis

Data were analyzed by the conventional content analysis approach using the Graneheim and Lundman method.[30] All interviews were conducted and recorded in a private room in the hospital to ensure freedom for the participants. Eventually, the interviews were transcribed, reviewed, and coded and immediately analyzed by the researcher. Following the content analysis process, each interview was carefully studied several times to obtain an initial and comprehensive understanding of it, and then, important statements in it were highlighted. Next, to clarify the meaning, similar semantic units were extracted and assigned to categories and subcategories. In fact, data were analyzed continuously as they were being collected. To add further data, the process of data collection continued until saturation.[29]

Trustworthiness

For data validation, the Guba method (1981) was used. Accordingly, long-term engagement and contact with the participants helped the researcher to gain their trust and understand their experiences. Moreover, data credibility methods were used, through review of the transcripts by the participants (member check), to resolve any coding ambiguities. To this end, the researcher made parts of the interviews and codes available to the participants to reach identical concepts on their statements. Confirmability of the data was achieved through systematic data collection, researchers' impartiality, members' agreement on interviews, codes, and grouping of similar codes and categories, and comparison of the researcher's impression with what the participants had meant. Dependability of data was achieved by taking notes at the earliest, using peer check, and reviewing the whole data again.[31]

Ethical considerations

This study was approved by the Research Ethics Committee of Tehran University of Social Welfare and Rehabilitation Sciences (ethics code: IR. USWR. REC.1398.023). In addition, the participants read and signed the informed consent form for participating in this study. Before each interview, the participants were assured of the confidentiality of the information and that the participants could withdraw from the study anytime.

Results

The participants included 15 health service providers (two

physicians, three nursing supervisors, two head nurses, four clinical nurses, and two nursing assistants) and three hospitalized patients. The participants were aged between 32 and 53 years. Table 1 presents the demographic details of the participants. The results show four main categories: 1) habitual discrimination, 2) interpersonal relationships, 3) shortage of health-care resources, and 4) favoritism [Table 3].

Category 1: habitual discrimination

This category means that the phenomenon of discrimination in medical settings like hospitals is constantly experienced as a common and routine phenomenon, and health service providers and recipients consider it to be normal. This category consists of the following subcategories: 1) everyday discrimination in medical centers, 2) ignoring patient rights, and 3) low level of trust in medical staff.

Everyday discrimination in medical centers

This subcategory includes the discriminatory provision of medical services by physicians, nurses, and other health-care providers to patients with different conditions. In fact, health service providers declared this as a normal, and even inseparable, part of providing health care in medical centers. For example, participant 3 stated:

"*Discrimination happens in hospitals one hundred percent, and as a doctor, I differentiate between patients. My job is partly based on discrimination, and I consider various issues in my work.*"(P3)

Moreover, participant 4 said:

"*Is no discrimination possible at all? People and the structure of medical centers are such that discrimination is observed in many areas, and its absence is almost abnormal.*" (P4)

Ignoring patient rights

This subcategory is concerned with patients experiencing a lack of attention from medical staff during doctor's visits and in matters such as patient's condition and appointment time when patients attend medical centers and clinics to receive outpatient medical services. After such an experience, patients attempt to establish contact by searching for an acquaintance in these medical settings. One patient explained:

"Given my condition, I consider it right to resort to favoritism. Perhaps, if the clinic's appointment system worked properly, I wouldn't be so inclined to do that. I made an appointment at a clinic and was told to come at a certain time, but, after arriving there, I had to wait for two hours and 45 minutes; why? Why shouldn't they value my time? If that is the case, then I am forced to use favoritism, so that I can be seen quicker." (P17)

Lack of trust in medical staff

In this subcategory, the participants stated that until there is total trust between medical staff (including physicians and nurses) and patients, discrimination between patients will persist in medical settings. In fact, patients not trusting physicians' and nurses' performance look for a mediator to be assured of the performance of health-care providers. Participant 10 stated:

"*For example, they tell us to be more alert; and not to leave the operating room for one moment, or keep checking the patient's condition in ICU afterward; more accurate treatment and more checking; at the time of anesthesia, make sure that anesthetics are administered at the right dose, and the like.*" (P10)

A patient in the cardiac critical care unit (CCU) stated:

"I can say that the only reason I come to this hospital is that my good friend, who is a nurse, works here, and I know that she knows her job at the CCU well. My mind is at rest because my friend is here, and I am sure that the things she does are definitely right. She will tell me if something is wrong, and somehow, I am fully informed about the treatment process." (P15)

Table 3: "Discrimination in health care" with categories, subcategories, and open codes

Category	Subcategory	Open code
Involvement with discrimination	Habitual discrimination	Discrimination being routine in medical centers
		Ignoring patient rights
		Lack of trust in medical personnel
	Interpersonal relationships	Expectations of acquaintances
		Respect for colleagues and friends
		Likelihood of similar situations
		Reciprocating people's favors
	Shortage of health-care resources	Shortage of medical equipment and facilities
		Heavy workload
		Infrastructure of medical centers
		Lack of access to physician
	Favoritism	Discrimination in care due to ethnicity
		Favoritism as a common method
		Ultimate solution to treatment problems

Category 2: Interpersonal relationships

This category refers to instances where medical personnel favor their colleagues or family members of their colleagues and associates in providing health care because of their working relationships. This category consists of the following subcategories: 1) expectations of associates, 2) respect for colleagues and friends, 3) the possibility of the occurrence of similar situations, and 4) reciprocating people's favors.

Expectations of associates

In this subcategory, medical staff described their discriminating conduct toward patients because of previous acquaintances with some of them, as well as the expectations of these acquaintances to receive exclusive and more health services. Participant 12 explained:

"*Right now, I have a patient who is a young doctor from a province; she had gastrectomy, was taken to the operating room twice. She expects more as she knows more. She is a colleague after all. For instance, she asks for opioids, and at first, I tell her that she cannot have more, but she insists and I give her an injection in the end, but I worry about the risk of apnea. Or, colleagues come here and say that since they have been working in this hospital for so many years, they have certain expectations, and want them to be fulfilled.*" (P12)

Respect for colleagues and friends

In this subcategory, medical staff (physicians and nurses) cited their friendly relationships with colleagues and their desire to maintain mutual respect and relationship with colleagues as the grounds for discriminating between patients in particular situations. When colleagues or their family members were hospitalized, the staff treated them differently compared to other patients and argued that the reason for providing different health care to this group was that they wanted to show respect toward colleagues. Participant 3 stated:

"*For me, there is no difference between patients, whether I know them or not. But, when a colleague's father is admitted, I may check over him more frequently, since it is a friend's father after all, and we are in constant contact, and I am expected to attend to this patient more.*" (P3)

Possibility of the occurrence of similar situations

This subcategory concerns the possibility that medical staff or their family members may find themselves in a situation where their colleagues in other medical centers could provide them with preferential and different care compared to other patients. Bearing this possibility in mind, medical staff provide their colleagues with preferential care. This is because they think that the same could happen to them, physicians, and nurses. The medical personnel provide different and fuller medical and nursing care to their colleagues and their relatives, compared to what they do for ordinary patients. Participant 4 stated:

"*I attend more to a patient that is a relative of a colleague or a friend and attend to them with greater care and sensitivity. I do this because she is a nurse too, and one day one of my relatives can be hospitalized.*" (P4)

Reciprocating people's favors

According to this subcategory, medical staff show discriminatory behaviors in providing preferential care and services to reciprocate for favors they have received from their colleagues in the past. Participant 9 said:

"*I do this for my colleagues and friends, because of the friendship I have with them. I jump the queue to make an appointment for my friend's mother because she has done the same for me in the past or will do so in the future. It is like give and take. I make up for her trouble.*" (P9)

Category 3: Shortage of health-care resources

This category deals with the essential items needed for providing health care to patients and visitors, but the shortage of resources, which is seen and experienced by both recipients and providers of medical services, leads to discrimination between patients. This category includes the following subcategories: 1) shortage of medications and medical facilities and equipment, 2) heavy workload, 3) lack of access to physicians, and 4) medical centers' infrastructure.

Shortage of medications and medical facilities and equipment

In this subcategory, shortage of medical equipment such as ventilators and intensive care unit (ICU) beds and also vital medications, on which patients' health depends, creates a situation in which these services are provided preferentially to people who are in a particular condition or are associated with or recommended by a particular person or organization. The shortage of medical equipment also causes physicians and nurses to unintentionally differentiate between patients. For example, participant 6 explained:

"*Better care is provided in intensive care units than in regular wards because in the wards, I, as a nurse, have eight to ten patients to care for; one of them is intubated, and I don't have the time or even a monitor to constantly check the patient. There, I am forced to differentiate between patients, and can only attend for two hours of the entire 12-hour shift to this patient because I don't have the time or the necessary equipment.*" (P6)

Heavy workload

The shortage of physicians, nurses, and other health service providers leads to non-provision of the necessary

care and even reduced quality of services and subjects the medical staff to heavy workload. This forces them to discriminate in providing health care. Participant 9 stated:

"*As a head nurse, human resources are especially important to me. The quality of work drops when there is a shortage of manpower, and if there are some favored patients in the ward as well, a significant part of the human resources are spent on them, which affects the quality of care for other patients, and they are less attended to since there are only a few of us.*" (P9)

Participant 6 stated:

"*I have ten patients as the internal ward nurse, and one of them is intubated, how am I supposed to attend to all of them? I am forced to discriminate between them and attend more to those in better conditions. I have no choice because there are only a few of us.*" (P6)

Lack of access to physicians

In this subcategory, based on their experiences, nurses cited a lack of access to physicians as one of the reasons for discrimination between patients. Since the probability of a patient's family members meeting the physician is usually very low, they try to find other ways to be more in touch with the physician. Participant 8 said:

"*My brother had an accident and was hospitalized in this hospital. Because of my job and contacts, I was fully in touch with the ward and could meet my brother's doctor, and so they were more attentive and sensitive to his condition.*" (P8)

Also, participant 17 stated:

"*The anesthesiologist came to my bedside and asked me if I knew so and so person, and I said yes. So, he told me not to worry, and everything would be done perfectly. At the time of operation, when I was highly stressed, this was very reassuring. People's presence in the operating room helped me control my stress, and their treatment was different since they knew that I was an acquaintance of this person.*" (P17)

Medical centers' infrastructure

In this subcategory, serious deficiencies, mainly physical, in the infrastructure of medical centers were identified as a facilitator of discrimination in health care. Congestion of visitors seeking outpatient clinical and paraclinical services, caused by inefficient queuing systems, unsuitable physical conditions, and similar factors, drove visitors to seek medical services through other means. Participant 17 stated:

"*For example, why do they ask patients to be at the hospital at 6 o'clock? Why not ask one to come at 6.15 and so forth? When I see that my time is wasted and no one has any respect for my time, then I resort to nepotism and don't feel guilty about it.*" (P17)

Participant 16 stated:

"*I have a fear of MRI, so I asked to be anesthetized, but the staff at the imaging department told me that there was not such an option, while there was, but they did not want to go through the trouble. Thanks to recommendations from someone I knew, my MRI was done comfortably with anesthesia. I didn't want to resort to that at first, but I was forced to, and if I had no connections, perhaps I could not do the MRI at all.*" (P16)

Category 4: Favoritism

This category comprises favoritism as a common and almost unavoidable issue in providing health care, as knowing someone in a medical center is one of the main reasons for choosing that center. This category mentions that finding an acquaintance in a medical center is the main concern of the patients and visitors. This category includes the following subcategories: 1) discrimination in care because of ethnicity, 2) favoritism as a common practice, and 3) favoritism as the ultimate solution to treatment problems.

Discrimination in care because of ethnicity

In this subcategory, medical staff regard ethnicity as a factor in providing medical care and better services to people of their ethnicity. Participant 13 stated thus:

"*Where my patients come from is important to me, whether they are from the same region as me. If they are, then I feel that they have been deprived of their rights; they have spent so much money to travel from their hometown to here, and all in vain. I feel obliged to help them in any way that I can.*" (P13)

Favoritism as a common practice

This subcategory mentions favoritism by the staff, as well as by patients and visitors to health-care centers, as a common and normal way of receiving medical services, so that the first thing visitors do in order to be hospitalized and receive services is to find an acquaintance, who will ultimately accelerate the provision of health services. Participant 15 stated:

"*Since I am a friend of the head nurse, my work is done more rapidly, A few years ago, I had to be hospitalized in another hospital, where I knew no one, and therefore, I had to remain there for ten days. But I think if I knew someone like my friend there, things would have gone faster, and I would have been discharged earlier. Here, tests are done quickly, and the results come in, but it was not like that in the other hospital.*" (P15)

Participant 16 said:

"*Fortunately, I had no problems as I knew someone in the hospital who put in a word for me, and I was easily admitted, and things were done straight away. Surely it would not have been so easy otherwise. If you don't have a connection, things*

are delayed, or you are not hospitalized at all. It is usually like that, otherwise, I or a patient would be less attended to." (P16)

Participant 13:

"*There is discrimination and favoritism in admitting patients. A patient is admitted earlier, or someone rings at night to emphasize to pay more attention to a particular patient, or even comes to the hospital for the sake of that patient. But this is not done for a lot of patients. At the very most, they may ring or discharge the patient by phone. They would not visit the patient face-to-face. Another thing is ICU admission, which is highly nepotistic, and not just any patient is admitted to ICU. Some patients are admitted, and some are not.*" (P12)

Favoritism as the ultimate solution to treatment problems

This subcategory points out that recipients and providers of medical services consider finding an acquaintance a strategy and a solution to their problems. The patient and medical staff both believe that having an acquaintance could help them in medical settings.

Participant 18 stated:

"*As the emergency head nurse, I am frequently contacted when an intensive care bed is needed. I assess the patient and if they are likely to die, then I am not much inclined to admit them, so I tell them that there is no bed. An hour later, someone I know rings me on behalf of the patient, so I release the bed.*" (P18)

Also, participant 16 stated:

"*Overall, I think having an acquaintance is very necessary, particularly in the matters of treatment, and with the help of a contact, things progress much better and easier, both qualitatively and quantitatively. I was given more information because I knew someone. For instance, they asked the emergency doctor to write the MRI request on insurance forms, which reduced the costs a lot compared to the noninsured service. But this is not done for all patients.*" (P16)

Participant 17 stated:

"*I went to the clinic and I was already listed, so I was the first to be visited, which was excellent. For example, test results come in faster, or when I ring to book a time for the ultrasound, I am given a late appointment, but then I ring an acquaintance and I am the first in the queue. Ultrasound is terribly busy, but even there I am the first or second to be served. All this is because of having a friend at the hospital, otherwise, it will be exceedingly difficult.*" (P17)

Discussion

In this study, nurse's experiences of discrimination in health care were explained. The results showed four main categories, including "habitual discrimination," "interpersonal relationships," "shortage of health-care resources," and "favoritism."

The nurses' experiences showed that discrimination is normal in medical settings; hence, when visiting and receiving health care, patients had observed and experienced discriminatory behaviors on the part of health service providers. Medical staff, too, had experienced this phenomenon in providing health care to patients, as well as in the form of discriminatory behavior and provision of services of different quality to different people, as normal. Discrimination in health care in the form of discriminatory behavior of medical staff has been identified and explained in numerous studies conducted in various countries.[13-15,32,33]

Regarding discrimination being normal in health care, participants had experienced different dimensions, and ignoring patient rights was one of them. In fact, patients who had not received proper medical services for any reason, and considered this experience the result of ignoring patients' primary rights, sought medical services through discrimination in their next visits, and their experience suggested that they would receive insufficient health services without resorting to discrimination. Johnston[34] points out that fair access to medical services is one of the main patient rights, and patients and visitors to medical settings expect to receive these services without discriminatory behaviors. Accordingly, ignoring the patient's right to justice by medical staff leads to unethical and improper care, namely, discrimination in health care.[35,36]

According to the participants' experiences, the patient's and his/her family members' low levels of trust in medical staff is one of the reasons that propels patients and staff toward discrimination. In fact, this finding seems to suggest a lack of trust based on previous experiences of the visitors and the quality of medical services they received. Patients seem to distrust health-care providers and their performance because of their previous experience of discrimination.[37,38] Another reason for the patients' lack of trust in medical personnel is the high rate of errors committed by them. In a systematic review, Assiri *et al*.[39] reported errors in the administration of medications in 2%–90% and erroneous test results in 70% of patients.

According to the results of this study, interpersonal relationships of the staff was another dimension of discrimination. In medical settings, proper professional relationships are considered an effective factor in providing comprehensive and safe health care to patients.[40] According to the participants' experiences, because of their friendly relationships with their colleagues, physicians and nurses provide different

forms and qualities of medical services to patients associated with them. Medical staff cite colleagues' expectations, reciprocating colleagues' favors, or even the possibility of themselves or their family members getting into a similar situation as the reasons for such discrimination. This kind of professional relationship seems to result in neglect and discriminatory and unfair behaviors in some aspects of patient care. Medical staff's lack or low levels of support for a patient who has no connections among the staff suggests unfair treatment and unethical care and a failure to abide by the principle of justice in health care.[40] Patients who experience such injustice and discrimination lose their trust in the health system and medical staff.

Shortage of health-care resources is another dimension of discrimination in health care, as the results of this study showed. Participants stated that being faced with challenging situations at work, such as a heavy workload and the shortage of medical equipment, such as vital medications, they were forced to differentiate between patients and show discriminatory behaviors in providing health care.[41-43] The shortage of care resources such as workforce, equipment, medications, or physical infrastructure of medical centers has been the main concern of health organizations as a global challenge in recent decades. These shortages lead to problems such as physical and mental harm, job dissatisfaction, burnout, and more importantly, ethical challenges.[44,45] In fact, according to their professional responsibilities, health service providers are inclined to observe ethical principles in health care, but they are faced with the question, "How?" How can they provide a high quality of care according to ethical principles when health-care resources are scarce? They have no choice, but to ignore some of these principles in providing care because in the existing situation, physical care takes priority and the least attention is paid to ethical principles such as justice in care.

According to the results, favoritism is another dimension of discrimination in health care and a barrier to justice in providing medical services. In many countries, according to the patient rights charter, patients have the right to receive full medical services irrespective of ethnicity, culture, language, type of disease, and gender,[46] while the present study participants had experienced ethnicity as one of the dimensions of discrimination in health care. Discrimination based on ethnicity and the individual's origin is one of the most common forms of discrimination in health care and has been addressed in numerous studies.[47-49] It seems that health service providers feel closer to people of the same ethnicity and, on the other hand, exhibit discriminatory behaviors in providing care based on differences in appearance, such as skin color, language, culture, and religion, which ultimately leads to changes in the health behaviors of ethnic minorities.[50]

Furthermore, the participants had experienced favoritism as a common and normal method for receiving health services of a better quality. Favoritism in medical settings has been reported as one of the main barriers to the principle of justice in ethical care.[51] Favoritism is mainly enjoyed by people of a special status, such as the wealthy, those with a social or political station, and celebrities, or medical staff, such as physicians and nurses, themselves and their friends and family members. Favoritism takes the form of recommending an individual to the staff for receiving the best services in the shortest time possible.[52] Since favoritism is highly prevalent in Iran, fearing a repetition of their previous experiences of receiving insufficient care, patients and visitors to medical centers attempt to find someone they know in that center, so they can receive services through favoritism.[53]

According to the results, shortage of resources must be addressed by managers, because this is one of the important contexts of discrimination in health care. On the other hand, health system manager should develop new strategies to solve this problem. Moreover, health-care providers like doctors and nurses should reconsider their interpersonal relationships.

This study explores the experiences of nurses and other health-care providers about discrimination in health care and clarifies some contextual factors and reveals certain dimensions of discrimination in health care that remain hidden in many quantitative studies. But the study had some limitations. Discrimination is a social and cultural phenomenon, and so, some participants would not have shared all their experiences about this, and this can one of the limitations of this study. On the other hand, the qualitative studies cannot generalize the results; so, more studies need to be conducted in different countries.

Conclusion

The results showed discrimination in health care has four dimensions of habitual discrimination, interpersonal relationships, shortage of resources, and favoritism. The participants of the study stressed that discrimination happens in health care because of various factors such as a fear of receiving insufficient care, interpersonal relationships, shortage of equipment and facilities, and patients' ethnicity. The present study can help in elucidating the concept of discrimination in health care, and accordingly, it is recommended that health system managers use these results in planning and implementing the necessary measures to control and reduce discrimination.

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Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published, and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflicts of interest

There are no conflicts of interest.

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