PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	PATIENTS' AWARENESS OF THEIR RIGHTS, ASSOCIATED FACTORS, AND ITS PRACTICE BY HEALTH PROFESSIONALS FROM A PATIENT PERSPECTIVE AMONG ELECTIVE SURGICAL PATIENTS AT TIKUR ANBESA SPECIALIZED HOSPITAL, ADDIS ABABA, ETHIOPIA: A CROSS-SECTIONAL STUDY,2021.
AUTHORS	Dessalegn, Kaletsidk; Girma, Betelihem; Oumer, Keder; Hunie, Metages; Belete, Kumlachew

VERSION 1 – REVIEW

REVIEWER	Wang, Yuming Henan Provincial People's Hospital, Zhengzhou, Department of Scientific Research and Discipline Construction
REVIEW RETURNED	09-Feb-2022

GENERAL COMMENTS	7. If statistics are used are they appropriate and described fully? Please describe what confounding factors were adjusted for in binary logistic regression analysis. Table 4: please put the title at the top of the table. 8. Are the references up-to-date and appropriate? Please check reference 2 (Basic documents, 49th ed)? Please check references 15 and 16 (they are Figure 1 and Figure 2). Please check the format of all references, such as wrong author names (references 3, 17, 21, 22, 23, 25), or wrong publication year (reference 25), or lack of pages numbers (reference 25), or lack journal name (reference 22). 12. Are the study limitations discussed adequately? The authors focus their limitations on the lack of several paid papers. I suggest that they could investigate the awareness and the practice of patient rights from the health professionals' perspective in the future study. Moreover, this study was limited to only one large hospital in Addis Ababa. Future studies of other hospitals should be conducted.

REVIEWER	Dorey, Corine Mouton Univ Zurich, insitute of biomedical ethics and history of medicine
REVIEW RETURNED	13-Mar-2022

GENERAL COMMENTS	In the abstract please differentiate better results and conclusion. Προφφ˝ρεαδ τηε ενγλιση.

	Can you clarify in the discussion the cultural beliefs and norms you are talking about? On page 12, lines 7,12, 13 and page 13, line 41, you link the paternalistic model, the fear of loss of authority on the part of health care personnel, and the lack of information to the patient. Can you elaborate on the difference between cultural paternalism and medical paternalism? How can the variables of education, living in urban areas, and frequency of hospitalization lead to corrective actions for the lack of information and the improvement of the consideration of patients' rights? On several occasions, you seem to explain the deficits in information and communication by the overload of work of the caregivers in Tikur Anbessa hospital. This is not so much a problem of a paternalistic or authoritarian model of care, but rather a problem of the organization of the health system and of the means. In particular, the references cite neighboring countries such as Egypt, Sudan, Saudi Arabia or more distant countries such as India, Iran: are these comparisons based on comparable health systems, or comparable cultural norms?

REVIEWER	Eichner, Felizitas A. University of Würzburg
REVIEW RETURNED	20-May-2022

GENERAL COMMENTS	The overall question and scope of the study is understandable and important. However, the manuscript suffers from two major problems. First, the described methods and the presented results do not align. The authors are joggling with quite a few measurements such as Likert-scales and percentages, but the described methods used to assess understanding and the presented results do not align (e.g. in methods, a 4-point Likert scale is described, but I do not see that back in the results section). Second, the discussion section needs a major revision. The discussion suffers from many grammatically flaws making it almost impossible to understand what the authors want to convey. It is lacking the basic structure of discussing possibilities / reasoning why certain results were observed. Instead, hard statements are given, of which the reasoning can often not be followed as premises are missing. For example, you conclude that rural residents have less access to information about patient rights, but you only present the numbers of understanding. It is lacking how you derive from the lower understanding that the reason for this is lack of access. What could other reasons be your findings? The discussion section is also too lenghty. It is not necessary to discuss all aspects of the questionnaire in comparison to similar studies. Instead, focus on the major findings of your study. Also do not only compare this to other studies, but set it in an absolute context, e.g. why is finding xy a positive or worrying finding given the overall living and health care circumstances in Ethopia. Furthermore, ideas and suggestions how knowledge can be improved based on the study results is missing. Next to several smaller aspects, these two points need to be adressed in detail. I thus suggest the manuscript for major revision. Overal remarks

	1. Please re-read the manuscript with a focus of good readability for the audience. Especially the results section is uncommon in its structure, e.g. More than half of the respondents 217 (55.4%) were male. Suggestion: Either say „More than half of the respondents (N=217, 55.4%)“ or „Overall, 217 respondents (55.4%) were male“. Otherwise, this is impeding the reading flow. 2. Please align all percentages and numbers in the tables. There are extra spaces in some rows. 3. Please check for missing commas in the manuscript, especially before percentages. 4. Please reduce your decimals to a maximum of 2 in the whole manuscript. 5. Please check the whole manuscript again for grammatically correct English language.

VERSION 1 – AUTHOR RESPONSE

Detailed response for comments from reviewers.

First and foremost, we would like to express our gratitude to the editors and reviewers for their insightful criticism and support. We highlighted any comments that needed to be changed in the key documents. We carefully observed the writing, grammar, and discussion of the outcome. And since they will greatly advance our paper, we are happy to accept additional comments.

Comments from reviewer one

No.	Comments	Detailed response
	Study population	
1.	First, the described methods and the presented results do not align. The authors are joggling with quite a few measurements such as Likert-scales and percentages, but the described methods used to assess understanding and the presented results do not align (e.g., in methods, a 4-point Likert scale is described, but I do not see that back in the results section).	Response #1 Objective 01= The patient's awareness of their right was assessed using 14 questions, each of which had a score of 1, 2,3 and 4. The scores were calculated, and those who scores below 50% were deemed to have poor awareness, while those who scores 50% and above were deemed to be aware. Objective 02 = Patients were given 14 practice questions, to which they had to respond with one of the three options (*Yes, no, or don't know*). A cumulative score was then calculated; those who received a score of less than 50% were considered to be practicing poorly, while those who received a score of 50% or higher were considered to be practicing well.

2.	Please re-read the manuscript with a focus of good readability for the audience. Especially the results section is uncommon in its structure, e.g. More than half of the respondents 217 (55.4%) were male. Suggestion: Either say „More than half of the respondents (N=217, 55.4%) "or „Overall, 217 respondents (55.4%) were male ". Otherwise, this is impeding the reading flow.	Corrected in that way
3.	Please align all percentages and numbers in the tables. There are extra spaces in some rows.	Corrected in that way
4.	Please check for missing commas in the manuscript, especially before percentages.	Corrected in that way
5.	Please reduce your decimals to a maximum of 2 in the whole manuscript.	All decimals reduced to a maximum of two except the P-Value
6.	Please check the whole manuscript again for grammatically correct English language.	Corrected in that way

Comments from reviewer two

s. no	Comments	Responses
1.	What do you mean with psychological barrier to communication? Please re-write or give an example.	**Corrected as** *Patients with known and recorded in the patients chart psychiatric disorder such as (schizophrenia, depression, obsessive compulsive disorder (OCD)) was excluded from the study.*
2.	I would advise to adjust the structure of the methods section. The sample size calculation is normally found at the end of the methods.	corrected in that order
3.	Please define the primary outcome of your study first for which the sample size was calculated.	Response #3 = already mentioned in the operational definition, as **Awareness:** Refers to the knowledge of and ability to recognize the patients' rights; it can be determined by using the questioner's cumulative score of response.
4.	The authors say that they did not find similar study in Ethiopia, but the assumed proportion of 50% must be based on some assumption. Please give more details and/or references how the proportion of 50% was derived.	Response #4 = when the prevalence is not known with previous studies in the area, there are different assumptions to calculate the sample size. I. The first one is to undergo pilot study and which was not possible to be done in our condition due to time and money constraints. II. The second option is to use a proportion of 50% which can make p=0.5 and q=0.5 by which we can

		get the maximum possible sample size with single population proportion formula. In which we can get the most representative sample size. Also, Generalizability and possibility of finding outcome interest will be great when we take proportion of 50%.
5.	To speak of drop-out implies that there was a follow-up in the study which is not the case. If a patient does not want to take part in a study, he or she simply declines participation, but that is not the definition of a drop-out. Please explain what is meant by „drop-out “in your study. Instead of drop-out, I would recommend to report the expected participation rate prior to study conduct, i.e., which proportion of patients that were asked to take part in the study did you assume would agree to participate.	Corrected as “non-respondent”
	Data collection	
6.	Please state the length of the questionnaire and give more detail on the questions (e.g., refer to table 2 and 3).	Corrected in that way
7.	Line 37: Please rewrite this phrase: Within the 3 months, 806 patients were done What is meant with „done “?	Corrected as 806 patients were operated.
8.	Line 51: please state the references of these previously published studies that were used for questionnaire development.	we took use research done in Egypt and we cite it in current version of the manuscript. Here is the doi: 10.1093/intqhc/mzx182.
	Data Analysis	
9.	Please speak of missing values and not of missed values.	Response #9 = corrected in that way
10.	Please speak of „descriptive analysis “and not of „a descriptive analysis “.	Response #10 = corrected in that way
11.	Please specify: what do you mean by „after collection […] data were coded. What did you „code “in the data? To my understanding, no free-text was sampled thus descriptive analysis of the frequencies would be a sufficient suitable approach.	*Response #11 = Data coding in research methodology is a preliminary step to analyzing data. The data that is obtained from surveys, experiments or secondary sources are in raw form. This data needs to be refined and organized to evaluate and draw conclusions.* *So, in our case after we collected the data we enter and code it in SPSS and cleaned it to make it ready for analysis.*
12.	Please define the (binary) outcome that was modelled in the logistic regression model within the section of data analysis.	Objective 01 Binary outcomes =

		Aware < 50 cumulative score *Not Aware ≥ cumulative score*
13.	The section „Operational definitions “is rather confusing and needs more explanation or restructuring.	Response = corrected
14.	It is not clear to me how you can derive a cut-off of 50% if you assess all questions with a 4-point Likert scale, which is thus an ordinal and not a numeric scale. The same applies to the cut-off of <50%, 50-70% ect. for the definition of practice, where a 3-point Likert scale was used.	Response = Awareness = a total 14 awareness questions were administered which does have a value of1 to 4 which will give as a total of 56 which mean a score of 100 percent so patients total score was given its percentage. Practice = 14 practice questions were administered to the patients which does have one of the 3 answers which give as a total of 42 which is 100 percent and we calculate the percentage of each answer of the patient based on that. # a reason why we do take 50% as a cut point is based on cut points of previous study.
15.	Also, please give more detail on how you derived the cut-off of >=50% for „awareness “, i.e., why not a cut-off of 70%? Only being aware of 50% of my patient rights does overall appear to be quite low (equal to chance if I know a right or not).	Response = covered in the above response.
	Result	
1.	Line 12: Please rewrite this sentence so that it is grammatically correct: About 261 (66.6%) were lived in urban. This also appears at other places in the manuscript.	Response = corrected in that way.
2.	Line 14: Please also add a percentage here: About 188 patients knew the existence of a charter of patient rights	Response = corrected as About 188 (48%)
3.	Did you look at the specific types of elective surgery the patients were scheduled for? Please give some extra details on this. This is a wide range of interventions and the study populations tend to be different depending on the intervention. This might affect the interpretation of the results.	Response = we collect data from one government hospital in Ethiopia Black lion hospital, in which variety of surgical procedures were planned. But there is no health professional or patient variety which makes the research result hard to conclude on. By saying this patient who are included in this study were. General surgery - 126 Gynecology - 57 Orthopedics – 115 Urology – 42

		Gastro enterology – 22 ENT - 18 Cardiothoracic – 12 and *Total = 392 patients were included.*
4.	It is not clear to me why the results of awareness of patient rights including table 2 is presented as percentages instead of the results of the 4-point likert scale that was used. You even state in the operational definitions how you rate the awareness: average between 1-2 low, 2.01-3 moderate, and 3.01-4 good awareness. Please overall align the described methods and the presented results.	Response = removed and corrected in the previous way in a percentage.
5.	Please remove the „overall score“ from Table 2, this information is redundant.	Response = corrected
6.	Line 29: According to the methods section, you sampled this response as „yes, no, I don’t know“. Why are the categories presented here as „poor, moderate, good“? Please align the methods and results section on this part.	Response = corrected in that way.
7.	Line 41: You state that only 1% of patients said that a summary of patient rights was given. It is however not clear if doctors are (legally) obliged to make patients aware of all patient rights before an elective surgery. Please state in the methods or introduction section, what is the legal framework on this matter.	Response = the standard for medical practice by Ethiopian government state that “To receive from the patient's physician(s) or clinical practitioner(s) an explanation of his or her complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives in terms that the patient understands. If this information shall be detrimental to the patient's health, or if the patient is not capable of understanding the information, the explanation shall be provided to his or her next of kin or guardian and be documented in the patient's personal medical record;” and we state it in the method part.
8.	A major concern regarding the model is the small N in some of the categories (N<5). This gives you a very high uncertainty in your estimates, which you can also see in your huge confidence intervals. Furthermore, you have a lot of categories in educational status and occupation leading to a loss of power. Also, do not use „occupation == other“ as your reference in the model, as this is a very unspecific category. Please consider reducing/combining the categories (e.g. combine secondary education and university if they are comparable) and adjusting the refercence, then re-run the model.	Response= we check the frequency of both educational status and occupation categories, and no class of the category was less than 5%, which mean it’s in line with the assumption. And in Ethiopia education system you will join a university when you pass the entrance exam after secondary and preparatory school lessons So, we can’t say it’s comparable.
9.	Line 36: What is in your opinion the meaning of a 16.7 times higher awareness? Awareness is not something you can measure discretely (i.e., you cannot „count “it such as that I	Response = we try to correct it.

	have an awareness of 1 and another person has an awareness of 2). Please re-write this to an understandable interpretation of the effect size.	As the odds of good awareness in literates is 16.6 in comparison with the illiterates.
10.	Did you check if confounding was present between living area and education? I would assume that these parameters are highly correlated (i.e., higher educated people live in urban areas).	Response= we check the collinearity of those variables and the collinearity coefficient were 0.95, that shows as they are not hardly confounding.
	Discussion	
1.	Please limit the use of overall scores in the discussion such as the score of 33.37. This is very abstract, so what is the meaning of such a score? Rather discuss single items, which are important in your opinion or in the view of the patients.	Response =corrected in that way.

VERSION 2 – REVIEW

REVIEWER	Wang, Yuming Henan Provincial People's Hospital, Zhengzhou, Department of Scientific Research and Discipline Construction
REVIEW RETURNED	24-Jun-2022

GENERAL COMMENTS	NA

REVIEWER	Dorey, Corine Mouton Univ Zurich, insitute of biomedical ethics and history of medicine
REVIEW RETURNED	27-Jun-2022

GENERAL COMMENTS	The presentation, writing of this paper has been considerably improved. For the statistical part , the comments of the statistical reviewer have been taken into consideration but I let the statistical reviewer confirm it. The overall paper, especially the discussion, has been rewritten in a logical manner and in good English. There are two sentences that need to be corrected for English: page 12, lines 39-42 (that instead of since, and adding and) and : page 14, lines 12-13 (a verb is missing). The references have been corrected too. Once these very minor corrections are made, this publication can be accepted.

VERSION 2 – AUTHOR RESPONSE

First and foremost, we would like to express our gratitude for your insightful criticism and praise of our efforts. We are excited to share this journey with you.

The comments that need our response are addressed point-by-point below.

1	Please ensure that your abstract is formatted according to our Instructions for Authors:	Thank you for the comment

		Response: we ensure that the abstract is checked for meeting BMJ instruction for authors.
2	Please revise the 'Strengths and limitations of this study' section of your manuscript (after the abstract). This section should contain up to five short bullet points, no longer than one sentence each, that relate specifically to the methods. The novelty, aims, results or expected impact of the study should not be summarized here.	Thanks for the comment Response: corrected in the following way **Strength** ✓ The systematic random sampling method was used, which is a list of sampling methods that have the potential to be biased. **Limitation** ✓ Due to time and financial constraints, this is a single-center study.
3	In your ethics statement, please indicate whether or not participants provided informed consent	Thanks for the comment Response: corrected as follows After receiving clear and brief information about the study, each participant was asked to provide written informed consent.
4	Please work to improve the quality of the English throughout your manuscript. We recommend asking a native English-speaking colleague to assist you or to enlist the help of a professional copyediting service.	Thanks for the comment Response: we tried to correct the language of the manuscript one more time as you request, with online assistant.
5	Please include a copy of the full questionnaire as a Supplemental Information file, or include a citation if it has been published elsewhere. Please also thoroughly describe how the questionnaire was developed and validated before use.	Thank you for the comment Response: 1. questionnaire is added as a supplemental file by the latest revision submission. 2. The tool's validity was confirmed, and we also checked its internal consistency using the Cronbach's alpha, which came back at 0.75, indicating that it is internally consistent. 3. We cite where we found the questionnaire in the main document. And it's reference number 13.
Comments from reviewer 2		
1.	There are two sentences that need to be corrected for English: page 12, lines 39-42 (that instead of since, and adding and)	Thank you for the comment Response: corrected as One possible explanation is that Tikur Anbessa is a teaching hospital, and when health care providers

		teach their students, they may unintentionally reveal patients' privacy.
2.	page 14, lines 12-13 (a verb is missing).	Thank you for the comment Response: corrected in that way.
Comments from reviewer 1		
1.	NA	NA
Editorial comments regarding the responses to reviewer 3:		
1	The conversion of Likert scales to percentage scores is explained clearly in your response to the reviewer. As such, we recommend that you include this explanation in the manuscript itself ("Objective 01= The patient's awareness of their right was assessed using 14 questions, each of which had a score of 1, 2,3 and 4. The scores were calculated, and those who scores below 50% were deemed to have poor awareness, while those who scores 50% and above were deemed to be aware.	Thank you for the comment Response: written in the following way in the manuscript. **Awareness:** Refers to the knowledge of and ability to recognize the patients' rights; it can be determined by using the questioner's cumulative score of response. The percentage score is categorized as a dichotomous variable(11) (12) (14). <50%= Not aware ≥50%= Aware Based on the average of each of 14 elements(8).
2	Patients were given 14 practice questions, to which they had to respond with one of the three options (Yes, no, or don't know). A cumulative score was then calculated; those who received a score of less than 50% were considered to be practicing poorly, while those who received a score of 50% or higher were considered to be practicing well."	Thanks for the comment Response: That's how we do it. And the following is it's detail, Refers to behaviors regarding patients' rights during a health worker-to-patient health interaction (11). It is determined by the cumulative score of responses. Practice classified as poor if percentage score <50 %, and good practice ≥ 50%.
3	Please add the explanation for the 50% cutoff to the manuscript. Later in your point-by point responses, you note that you chose this cutoff as it is used in previous studies – please cite these studies if this is the case.	Thanks for the comment Response: Regarding to the reference of 50% cut point we state it as follows.

		Awareness: Refers to the knowledge of and ability to recognize the patients' rights; it can be determined by using the questioner's cumulative score of response. The percentage score is categorized as a dichotomous variable(11) (12) (14). <50%= Not aware ≥50%= Aware Based on the average of each of 14 elements(8). **Practice:** Refers to behaviors regarding patients' rights during a health worker-to-patient health interaction (11). It is determined by the cumulative score of responses. Practice classified as poor if percentage score <50 %, and good practice ≥ 50%(13). ❖ As it's explained in the above paragraphs both in the here and the manuscript reference 8 and 13 in the main document use 50% as a cut point.
4	Results, point 3: Please include details of the different kinds of surgery to the manuscript (General surgery – 126, Gynecology – 57, Orthopedics – 115, Urology – 42, Gastro enterology – 22, ENT – 18, Cardiothoracic – 12).	Thanks for the comment Response: corrected in the following way. A total of 392 patients participated in this study (General surgery - 126, Gynecology - 57, Orthopedics - 115, Urology - 42, Gastro enterology - 22, ENT - 18, Cardiothoracic - 12) with a 97.27% response rate.
5	Results, point 8: The reviewer asks that you do not use „occupation == other "as your reference in the model, as this is a very unspecific category. Please consider using one of the other categories as the reference.	Thanks for the comment Response: we understood the point and attempted to revise the main document; however, when we changed the reference, there was no significant difference in the outcome (association). So, when we checked all 40 jobs, we got a common name from the International Labour Organization definition under the group of others. They are known as Elementary occupations. The following is the definition: "Elementary occupations include cleaners and helpers who perform a variety of tasks in private homes, hotels, offices, hospitals,

		and other establishments, as well as in airplanes, trains, coaches, trams, and other similar vehicles, to keep the interiors and fixtures clean, and who hand-launder and press clothing and textiles.”
6	Results, point 10. Does this result not indicate confounding between living area and education? Please clarify.	Thanks for the comment Response: In our study, living area and education did not cofound one another. While examining their collinearity, we made this statement. *Our VIF was 4, and a VIF of less than 5 has a lower likelihood of being confounding.