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SYSTEM-LEVEL LEGAL KNOWLEDGE OF PATIENTS' RIGHTS AND RELATED OBLIGATIONS

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ABSTRACT

Patients' rights are a fundamental component of ethical and legally compliant healthcare, with professionals bearing primary responsibility for their implementation. This study aimed to examine healthcare professionals' knowledge of legally defined patients' rights and related professional obligations within the Croatian hospital system, to explore differences across sociodemographic and professional groups, and to assess whether distinct domains of legal knowledge can be identified.

A 2024 cross-sectional study in two Zagreb public hospitals used an anonymous online questionnaire with seven legally based clinical claims on patient rights and professional duties. Data were analysed descriptively and using nonparametric tests to examine differences across sociodemographic and professional groups, and Spearman's rank correlation to assess associations between claims.

Based on 197 complete and analysed responses, high levels of agreement were observed for well-established and routinely applied patient rights, such as the right to restrict visits, voluntary discharge with a written statement, and disclosure of professional identity. Substantial uncertainty and misconceptions were identified for claims involving conditional legal norms and procedural obligations, including research involving minors, documentation of intent to leave, and the obligation to provide a second medical opinion. Selective group differences were observed by gender, age, professional group, and professional experience. Correlation analysis primarily revealed weak associations among claims, with suggestive clustering around patient autonomy.

In conclusion, healthcare professionals' legal knowledge of patients' rights is fragmented and domain-specific rather than unified, underscoring the need for targeted, context-based legal education to support consistent protection of patients' rights in clinical practice.

KEY WORDS

patients' rights, legal knowledge, healthcare professionals, professional obligations, patient autonomy

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INTRODUCTION

Patients' rights are a key mechanism for protecting autonomy, dignity, and safety in healthcare and stem from a broader system of human rights and medical ethics. The fundamental ethical principles, autonomy, beneficence, nonmaleficence, and justice, form the basis of contemporary standards of patient rights, with healthcare professionals acting as their primary bearers and protectors [1]. In the international context, the Lisbon Declaration emphasizes the patient's right to information, free choice, a second opinion, self-determination, and refusal of treatment, while defining the physician's obligation to preserve the patient's dignity and act in the patient's best interests [2]. All healthcare professionals, including nurses, have a legal obligation to act in accordance with patients' rights and professional and ethical standards prescribed by applicable legislation [3]. According to data from the National Health Workforce Accounts, health workers form the foundation of health systems worldwide, with nurses representing the largest professional group and medical doctors forming a key part of the clinical staff [4], confirming their overall importance for direct health care and the implementation of patients' rights in practice.

In Croatia, the Act on the Protection of Patients' Rights [5] is the fundamental regulatory framework governing the rights to information, co-determination, access to medical records, privacy, and leaving the institution; however, while patients' rights are clearly defined, their obligations are fragmented and regulated mainly by the house rules of healthcare institutions, leading to variability and uneven application in clinical practice [3]. In addition, it has been emphasised that knowledge of patients' rights among healthcare professionals in Croatia has historically shown shortcomings, and that the degree of respect for these rights can be considered an indicator of professional culture and the democratic development of society [6].

The organisational characteristics of healthcare systems also influence the realisation of patients' rights. The OECD emphasises that transparency, quality regulation, availability of information, and institutional accountability strongly determine how effectively patients can realise their legal and ethical rights [7]. These characteristics confirm that the realisation of patients' rights is not only a matter of individual competencies among healthcare professionals but also of the structural conditions of the healthcare system.

Research reveals a persistent gap between prescribed patients' rights and their actual implementation. Notably, there are significant differences in how patients and healthcare professionals perceive this issue. Patients often report insufficient information, limited involvement in decision-making, and occasional breaches of dignity. In contrast, healthcare professionals typically believe that patients' rights are generally respected [8, 9].

Organisational barriers and a lack of competence support further complicate the consistent application of patient-centred care, despite healthcare professionals' understanding of the concept [10]. The medical ethics literature underscores that patients' rights exist only to the extent that they can be operationalised in clinical settings.

Empirical research supports these observations: earlier studies found that health professionals' knowledge of patients' rights was uneven, privacy and confidentiality were well understood, whereas legal and procedural aspects were less so [11]. More recent research has shifted from focusing on knowledge to attention to application, indicating that respect for patients' rights can remain stable even under challenging circumstances; nevertheless, inconsistencies in understanding and implementation persist [12]. This suggests that knowledge alone does not ensure the consistent application of patients' rights in everyday practice.

Direct European empirical studies on healthcare professionals' knowledge of patients' rights are limited; however, evaluation reports on the implementation of the EU Patients' Rights Directive indicate that a notable proportion of providers lack clarity about how patients' rights apply in practice, particularly in cross-border settings. This underscores gaps in professionals' awareness and communication of rights. Additionally, European health management organisations emphasise that healthcare professionals bear systemic responsibility to uphold and communicate patient rights within health systems. Comparative policy mapping confirms that professional duties are integral to rights frameworks across Member States [13-15]. Healthcare professionals need to understand the ethical and legal foundations to make safer, fairer, and more informed clinical decisions and to protect patients' autonomy and well-being effectively [1].

Given the complex legislative framework, varying legal literacy among healthcare professionals, differences in patient rights practices internationally, and the lack of empirical data in Croatia, a research gap exists. This study, therefore, examines Croatian healthcare professionals' legal awareness of patient rights and related obligations. Accordingly, the following research questions were posed.

RQ$_1$. What is the level of knowledge of healthcare professionals about legally defined patients' rights and the corresponding professional obligations of healthcare professionals?

RQ$_2$. Are there differences in the level of this knowledge among groups of healthcare professionals concerning gender, age, professional group, management position, and clinical experience?

RQ$_3$. Are individual aspects reflecting knowledge of patient legal protection and healthcare professionals' duties interconnected, and can distinct domains of knowledge be identified from their correlation structure?

METHODS

RESEARCH DESIGN AND SETTING

A cross-sectional observational study was conducted to examine health professionals' legal awareness of patients' rights and associated professional obligations. The study was conducted in the Croatian hospital health system at two public health institutions in the capital city of Zagreb in 2024. The study was conducted in accordance with ethical principles for research involving humans [16]. Approvals were obtained from the relevant ethics committees of the healthcare institutions involved in the study prior to the study's commencement. Participants were assured of anonymity and data confidentiality and informed of their consent to participate in the study.

TARGET POPULATION

The study's targets were health professionals involved in direct patient care, primarily medical doctors and nurses/technicians, representing various educational backgrounds, work experiences, and organisational roles, including management. This approach enabled the observation of legal awareness not only among individual healthcare professionals but also across different professional groups, experience levels, and organisational hierarchy, providing a systematic perspective on patient rights and professional duties. Initially, 200 respondents of diverse genders, ages, and professional backgrounds participated, including specialist doctors, residents, and nurses (from entry-level to master's degree holders), with work experience ranging from junior to senior and including those in management positions.

DATA COLLECTION

Data collection method

Data were collected using a structured, anonymous self-assessment questionnaire to examine healthcare professionals' knowledge of the legal protection of patients and their associated professional obligations. The questionnaire was distributed electronically using an online platform (Google Forms). The link to the questionnaire was forwarded to healthcare institutions, and further distribution was carried out through official communication channels (secretariats of clinics, institutes, and departments). Participation in the study was voluntary, and completing the questionnaire was considered informed consent.

Instrument and measurement structure

The instrument was developed in accordance with the relevant legislative framework of Croatia, primarily the Act on the Protection of Patients' Rights [5], drawing on previous research on patients' rights and the professional responsibility of healthcare professionals [8-12]. The instrument consisted of seven claims (items), each representing a specific clinical practice situation that requires knowledge of legally defined patient rights or healthcare professionals' obligations. Participants marked one of the offered answers (Disagree / Not sure / Agree) for each statement, enabling the assessment of the certainty and accuracy of their knowledge and the identification of areas of uncertainty. Each claim is conceptually related to one of the following areas: patient autonomy, informed consent and refusal of treatment, organisational-legal obligations of healthcare workers, professional responsibility, and ethical-legal standards of communication and transparency. Thus, the instrument enabled examination of knowledge not only at the level of isolated legal norms, but also in the context of their application in real clinical situations. An overview of the seven claims included in the instrument, together with their short labels and conceptual domains, is provided in Table 1.

Table 1. Claims included in the instrument and their conceptual domains.

Item	Short label	Long label (claim)	Conceptual domain
Q1	Restriction of visits	During hospitalization, a patient has the right to prohibit visits from specific individuals or groups.	Patient autonomy / Privacy
Q2	Refusal of life-saving treatment	A patient requires a medically necessary, life-saving intervention but refuses the procedure; the physician is obliged to respect the decision.	Informed consent / Refusal of treatment
Q3	Voluntary discharge (written)	A patient may leave a healthcare facility voluntarily only with a written statement.	Organizational-legal patient rights
Q4	Research involving minors	Scientific research cannot be conducted on a minor patient.	Research ethics / Vulnerable populations
Q5	Documentation of intent to leave	A healthcare professional may be fined for failing to record a patient's intention to leave the healthcare facility.	Professional responsibility / Legal obligations
Q6	Second medical opinion (misconception)	A healthcare professional is always obliged to provide a second medical opinion.	Misconceptions about professional obligations
Q7	Disclosure of identity	A healthcare professional is obliged to state their name upon the patient's request.	Ethical-legal communication / Transparency

STATISTICAL PROCESSING OF DATA

Statistical analysis was conducted to present the level of knowledge regarding patients' rights and health care workers' obligations, and to examine differences in responses by selected sociodemographic and professional characteristics of the respondents. Analyses were conducted in the Jeffreys's Amazing Statistics Program (JASP) software (version 0.95.4, JASP Team, University of Amsterdam), with the statistical significance level set at $p < 0{,}05$.

The sample structure was described using frequencies and proportions for categorical variables (gender, age group, professional group, level of education, and management position). Professional experience was expressed in years and reported using the arithmetic mean and standard deviation, the median, and the interquartile range (IQR), with minimum and maximum values presented.

The answers to each of the seven statements (Q1–Q7) were analyzed descriptively, showing the frequency and share of answers (Agree, Disagree, Not sure), which enabled an insight into the level of knowledge, the presence of wrong beliefs and the degree of uncertainty of respondents in relation to certain aspects of patients' rights and professional obligations of healthcare workers. For comparative analyses, the responses were coded as an ordinal variable (0 – Disagree, 1 – Not sure, 2 – Agree).

Given the ordinal nature of the responses and the non-fulfilment of the assumptions of normality, differences in responses to individual statements between two independent groups were examined using the Mann-Whitney U test. Comparisons were made according to the following parameters: gender (female vs. male), age (younger (less than 40 years) vs. older (40 or more years)), professional group (medical doctors vs. nurses), management position (yes / no), professional experience (junior – less than10 years; senior – 10 or more years).

In addition to p-values, for each comparison, an estimate of the difference with the corresponding 95% confidence intervals is shown, while the effect size is interpreted descriptively. In cases where the test was not applicable due to insufficient data variability, this circumstance is clearly indicated in the results presentation.

The mutual correlation of responses to individual statements was examined using Spearman's rank correlation coefficient (ρ) to identify patterns of association among different aspects of knowledge about patients' rights and the professional obligations of healthcare professionals. A correlation matrix heatmap visualisation accompanies quantitative data.

Statistical analyses were exploratory and aimed at describing and comparing patterns of knowledge, rather than testing pre-defined hypotheses.

RESULTS

SAMPLE CHARACTERISTICS

Of the 200 responses received, 197 complete cases were included in the analysis. Table 2 presents the detailed structure of the study sample ($N = 197$) together with the variables used for comparative analyses. The sample was predominantly female (67,5 %), with males accounting for 32,5 % of participants. Nurses constituted nearly two-thirds of the sample (64,5 %), while medical doctors represented 35,5 %. Age was broadly distributed across working-age categories, with the most considerable proportions observed in the 31-40-year (26,4 %) and 20-30-year (24,4 %) groups. Participants aged over 60 years accounted for a smaller fraction of the sample (5,6 %). For analytical purposes, age was dichotomised at 40 years, resulting in two comparably sized groups (less than 40 years: 50,8 %; 40 or more years: 49,2 %).

Within the physician subgroup, most participants were specialists (27,9 %), while residents accounted for 7,6 % of the total sample. Among nurses, participants were distributed across entry-level (22,3 %), bachelor's (27,4 %), and master's degree categories (14,7 %), reflecting heterogeneity in educational background. Professional experience ranged from 0 to 46 years, with a median of 17,0 years (IQR = 22,0). For inferential analyses, professional experience was dichotomised at 10 years, yielding groups of junior (< 10 years: 32,5 %) and senior (≥ 10 years: 67,5 %) healthcare professionals. A minority of participants reported holding a managerial position (15,2 %).

Overall, Table 2 illustrates a heterogeneous sample across age, professional role, educational level, and clinical experience, while clearly delineating the predefined grouping variables used in subsequent comparative analyses.

Table 2. Sample characteristics and grouping variables (*N* = 197). Values are presented as a number (percentage) of respondents. Percentages may not total 100 % due to rounding.

Variable	Category	*N* (%)	Used for grouping
Gender	Female	133 (67,5)	Yes
	Male	64 (32,5)	Yes
Age (years)	20-30	48 (24,4)	No
	31-40	52 (26,4)	No
	41-50	44 (22,3)	No
	51-60	42 (21,3)	No
	more than 60	11 (5,6)	No
Age (cut-off)	less than 40 years	100 (50,8)	Yes
	40 or more years	97 (49,2)	Yes
Professional group	Medical doctors	70 (35,5)	Yes
	Nurses	127 (64,5)	Yes
Professional role – medical doctors	Resident	15 (7,6)	No
	Specialist	55 (27,9)	No
Professional role – nurses	Entry-level degree	44 (22,3)	No
	Bachelor's degree	54 (27,4)	No
	Master's degree	29 (14,7)	No
Managerial position	No	167 (84,8)	Yes
	Yes	30 (15,2)	Yes
Professional experience (years)	Median (IQR)	17,0 (22,0)	—
	Range	0–46	—
Professional experience (cut-off)	less than 10 years	64 (32,5)	Yes
	10 or more years	133 (67,5)	Yes

RESPONSE PATTERNS ACROSS CLAIMS IN THE TOTAL SAMPLE

Table 3 presents the distribution of responses to the seven legal claims in the total sample (*N* = 197). High levels of agreement were observed for claims addressing clearly defined and routinely applied patient rights, including the right to restrict visits during hospitalisation (93,4 % agreement), voluntary discharge with a written statement (86,8 %), and the obligation of healthcare professionals to disclose their identity upon request (81,2 %).

Agreement was also relatively high for the claim concerning a patient's right to refuse a life-saving intervention (75,1 %), although a notable proportion of respondents disagreed with this statement (20,8 %). In contrast, responses to claims related to research involving minors and organisational-legal obligations were more heterogeneous. For the claim stating that scientific research cannot be conducted on a minor patient, responses were divided, with 52,3 % disagreeing and 36,5 % agreeing.

The highest level of uncertainty was observed for the claim concerning the documentation of a patient's intention to leave a healthcare facility, where 38,1 % of respondents selected Not sure. Similarly, responses to the claim regarding the obligation to provide a second medical opinion showed substantial dispersion across response categories, with approximately half of the respondents agreeing with the statement (50,3 %).

Overall, the distribution of responses illustrates marked variability across legal domains, ranging from high consensus on well-established patient rights to considerable uncertainty and divergent views on more complex legal and professional obligations.

Table 3. Distribution of responses in the total sample ($N = 197$). Values are presented as a number (percentage) of respondents. Percentages may not total 100 % due to rounding.

Item	**Disagree, *N* (%)**	**Not sure, *N* (%)**	**Agree, *N* (%)**
Q1. Restriction of visits	5 (2,5)	8 (4,1)	184 (93,4)
Q2. Refusal of life-saving treatment	41 (20,8)	8 (4,1)	148 (75,1)
Q3. Voluntary discharge (written statement)	20 (10,2)	6 (3,0)	171 (86,8)
Q4. Research involving minors	103 (52,3)	22 (11,2)	72 (36,5)
Q5. Documentation of intent to leave	59 (29,9)	75 (38,1)	63 (32,0)
Q6. Second medical opinion (misconception)	50 (25,4)	48 (24,4)	99 (50,3)
Q7. Disclosure of identity upon request	24 (12,2)	13 (6,6)	160 (81,2)

Following the descriptive analysis of responses in the total sample, group comparisons were conducted to explore potential differences across demographic and professional subgroups.

GROUP DIFFERENCES IN RESPONSES TO CLAIMS

Given the exploratory nature of the analyses and the number of comparisons performed across multiple legal claims and grouping variables, only statistically significant group differences are presented. This approach was adopted to enhance the clarity and interpretability of results, reduce redundancy, and focus on patterns with potential substantive relevance. Non-significant comparisons are available upon request.

Table 4 presents statistically significant group differences in responses to selected legal claims. No statistically significant differences were observed in any of the examined legal claims by managerial position. Concerning gender, female participants more frequently agreed with the legally accurate statement on voluntary discharge with a written statement (Q3; $p < 0{,}001$; $r_{(\mathrm{rb})} = -0{,}171$) and with the statement concerning research involving minors (Q4; $p = 0{,}019$; $r_{(\mathrm{rb})} = -0{,}185$) compared with male participants. Age-related differences were identified for two claims. Younger participants (< 40 years) showed higher agreement with the patient's right to refuse a life-saving treatment (Q2; $p = 0{,}020$; $r_{(\mathrm{rb})} = 0{,}145$), whereas older participants (≥ 40 years) more frequently agreed with the statement concerning research involving minors (Q4; $p < 0{,}001$; $r_{(\mathrm{rb})} = -0{,}298$). Significant differences were also observed between professional groups. Nurses more frequently agreed with the statements on voluntary discharge (Q3; $p < 0{,}001$; $r_{(\mathrm{rb})} = 0{,}212$) and research involving minors (Q4; $p = 0{,}003$; $r_{(\mathrm{rb})} = 0{,}234$), while medical doctors more often endorsed the incorrect statement regarding the unconditional obligation to provide a second medical opinion (Q6; $p < 0{,}001$; $r_{(\mathrm{rb})} = -0{,}336$). Regarding professional experience, participants with less than 10 years of experience more frequently agreed with the patient's right to refuse a life-saving treatment (Q2; $p = 0{,}005$; $r_{(\mathrm{rb})} = -0{,}187$). In contrast, participants with 10 or more years of experience showed higher agreement with the statement concerning research involving minors (Q4; $p = 0{,}001$; $r_{(\mathrm{rb})} = 0{,}255$) and with the misconception related to second medical opinions (Q6; $p = 0{,}002$; $r_{(\mathrm{rb})} = 0{,}248$).

Overall, the magnitude of observed group differences ranged from small to moderate, as reflected by the reported effect sizes.

Table 4. Group differences in responses to claims. Group differences were examined using the Mann-Whitney U test. Age was grouped as “less than 40 years” vs. “40 or more years”, and professional experience as “less than 10 years” vs. “10 or more years”. Effect size is reported as rank-biserial correlation ($r_{(rb)}$). Only statistically significant results are shown.

Grouping variable	Item (claim)	Direction of difference	*p* value	Effect size
Gender	Q3. Voluntary discharge (written statement)	Females > Males	< 0,001	−0,171
	Q4. Research involving minors	Females > Males	0,019	−0,185
Age	Q2. Refusal of life-saving treatment	Younger > Older	0,020	0,145
	Q4. Research involving minors	Older > Younger	< 0,001	−0,298
Professional group	Q3. Voluntary discharge (written statement)	Nurses > Doctors	< 0,001	0,212
	Q4. Research involving minors	Nurses > Doctors	0,003	0,234
	Q6. Second opinion (misconception)	Doctors > Nurses	< 0,001	−0,336
Professional experience	Q2. Refusal of life-saving treatment	Junior > Senior	0,005	−0,187
	Q4. Research involving minors	Senior > Junior	0,001	0,255
	Q6. Second opinion (misconception)	Senior > Junior	0,002	0,248

Table 5 presents Spearman correlations between responses to individual claims. Overall, the correlation coefficients were low to moderate, indicating limited interrelatedness between different aspects of knowledge concerning patient legal protection and healthcare professionals’ duties.

The strongest association was observed between the right to restrict visits during hospitalisation and the right to refuse a life-saving treatment (Q1-Q2; $\rho = 0{,}326$; $p < 0{,}001$), suggesting a modest clustering of responses related to patient autonomy. Beyond this association, most correlations were weak ($|\rho| < 0{,}20$), even when statistically significant. Several weak correlations were identified between claims addressing research involving minors and other legal domains, including the refusal of life-saving treatment (Q2-Q4; $\rho = -0{,}159$; $p < 0{,}05$) and voluntary discharge (Q3-Q4; $\rho = 0{,}155$; $p < 0{,}05$). These associations indicate partial overlap but do not suggest a coherent or firmly integrated knowledge domain. Claims related to organisational and professional obligations, such as documentation of a patient’s intention to leave and the obligation to provide a second medical opinion, showed minimal correlations with other items. In particular, the misconception regarding second medical opinions (Q6) demonstrated weak or negligible associations with all other claims, suggesting that this item reflects a distinct and largely independent area of misunderstanding.

Taken together, the observed correlation structure does not support the presence of a single, unified construct of legal knowledge. Instead, the findings indicate that individual aspects of knowledge related to patient rights and professional duties are only loosely connected, with limited clustering around specific themes such as patient autonomy.

Figure 1 visualises the inter-item Spearman correlation matrix as a heatmap, illustrating predominantly weak associations between individual claims and supporting the absence of a unified underlying construct of legal knowledge.

Table 5. Spearman correlations between responses to legal claims ($N = 197$). Values represent Spearman's rank correlation coefficients (ρ) based on ordinally coded responses (0 – Disagree, 1 – Not sure, 2 – Agree).

Item	Q1	Q2	Q3	Q4	Q5	Q6	Q7
Q1. Restriction of visits	–	0,326**	−0,103	−0,112	−0,097	0,131	−0,019
Q2. Refusal of life-saving treatment	0,326**	–	−0,075	−0,159*	0,041	0,073	−0,059
Q3. Voluntary discharge (written statement)	−0,103	−0,075	–	0,155*	−0,007	0,037	0,041
Q4. Research involving minors	−0,112	−0,159*	0,155*	–	0,126	0,063	−0,025
Q5. Documentation of intent to leave	−0,097	0,041	−0,007	0,126	–	0,048	−0,075
Q6. Second opinion (misconception)	0,131	0,073	0,037	0,063	0,048	–	0,114
Q7. Disclosure of identity upon request	−0,019	−0,059	0,041	−0,025	−0,075	0,114	–

*significant at the level $p < 0,05$
**significant at the level $p < 0,001$

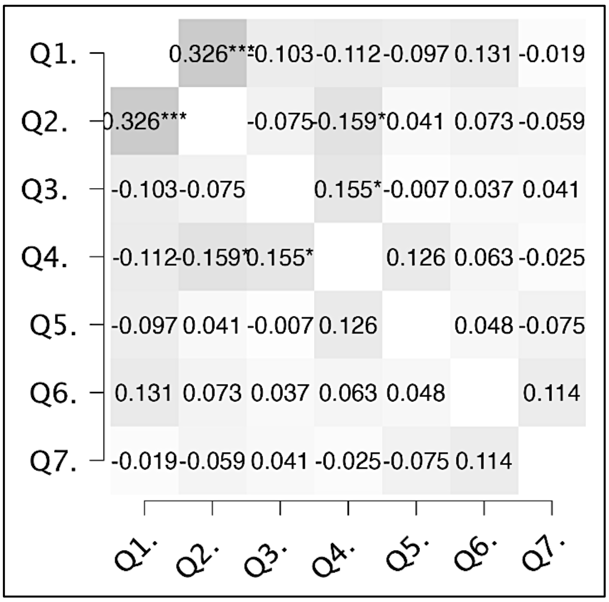

Figure 1. Spearman correlation matrix of questionnaire items Q1-Q7.

DISCUSSION

The findings of this research provide insight into the system-level legal knowledge of patients' rights among healthcare professionals in the Croatian hospital system and indicate patterns of knowledge, uncertainty, and misconceptions regarding patient legal protection and healthcare professionals' duties. In accordance with the set goal and research questions, the results confirm that knowledge of legally defined patient rights and associated professional obligations is heterogeneous, indicating a fragmented structure of legal knowledge within the healthcare system.

The first research question (**RQ$_1$**), which focused on the level of knowledge about individual rights and obligations, showed that well-established patient rights, which are clearly standardised and routinely present in everyday clinical practice, are relatively well recognised.

In contrast, rights and obligations that include conditional legal norms, procedural requirements, or ethical-legal exceptions (e.g., research involving minors, documentation duties, second medical opinion) are characterised by greater uncertainty and misinterpretation. This finding confirms that the formal existence of legal norms does not guarantee their equal internalisation among healthcare professionals, especially when their application is context- and situation-dependent.

The second research question (**RQ$_2$**) concerned differences in knowledge across sociodemographic and professional characteristics. The findings show that group differences are selective and limited to certain statements, with differences observed by gender, age, professional group, and professional experience, but not by managerial position. The absence of differences related to the organisational role is particularly indicative, as it suggests that a formal hierarchical position within the system does not necessarily imply a higher level of legal awareness regarding patients' rights. This implicitly calls into question the assumption that knowledge about patients' rights is systematically transmitted through organisational structures and management levels.

The third research question (**RQ$_3$**) addressed the interconnection of certain aspects of knowledge and the possibility of identifying distinct domains of legal knowledge. The correlation structure analysis showed that the connections between most statements are weak, indicating limited mutual integration of knowledge about patients' rights and professional obligations. Nevertheless, a small number of statistically significant, but low-to-moderate, correlations were observed, especially between claims related to patient autonomy (e.g., the right to limit visits and the right to refuse treatment), which may indicate partial, thematically limited clustering of knowledge. However, the absence of stronger, more consistent, and more widespread correlations, as well as of trend-level connections among the remaining statements, does not support the existence of stable or clearly differentiated domains of knowledge. Instead, the findings suggest that knowledge of patient rights and professional obligations consists of loosely connected, situationally conditioned elements, within which thematic connections emerge only sporadically.

The findings of this research largely align with previous empirical work indicating that health professionals' knowledge of patients' rights is uneven and domain-specific, rather than general and coherent [6, 11]. As in earlier research, rights directly related to routine clinical practice and ethical intuitions, such as privacy, the identity of a healthcare professional, or basic information, showed higher levels of recognition and agreement. On the contrary, claims involving conditional legal norms or procedural obligations, such as research involving minors, documentation of intent to leave, or a second medical opinion, were characterised by greater uncertainty and misconceptions. This pattern confirms earlier findings that legal aspects that require interpretation of exceptions, formal procedures, or knowledge of regulatory details are more prone to uneven understanding [10, 11].

In relation to existing research, this research additionally contributes to the literature by showing that the differences between professional groups and levels of experience are selective and limited to individual claims, with mostly small to moderate effect sizes. This builds on earlier work indicating differences between nurses and medical doctors in their approach to patient-centred care, while also showing that the professional role itself does not systematically explain differences in legal knowledge [8, 11]. The finding that managerial position is not associated with a higher level of understanding of patients' rights is particularly significant, as it was not often explicitly examined in earlier studies. This empirical evidence calls into question the assumption that knowledge about patient rights and professional obligations is automatically transmitted through the hierarchical and managerial structures of health institutions [3, 7].

Compared with previous research that primarily focused on the level of knowledge or perceptions of respect for patients' rights, this research provides additional insight by analysing the correlation structure among individual statements. Although some statistically significant connections were observed, especially within the patient autonomy dimension, their weak-to-moderate intensity does not support the existence of stable or clearly delineated legal knowledge domains. This finding extends existing knowledge by suggesting that knowledge about patients' rights functions as a set of partially related yet essentially independent elements, aligning with ethical literature that emphasises that patients' rights are realised through concrete clinical situations rather than as an abstract set of norms [1, 10].

In the broader European context, our findings are in line with evaluation reports on the implementation of the EU Patients' Rights Directive, which indicate insufficient clarity among healthcare professionals about how to apply patients' rights in practice, especially in situations that require procedural knowledge and active communication of rights [13-15]. Although the Directive is primarily aimed at cross-border healthcare, its emphasis on information, transparency, and professional responsibility is also reflected in national healthcare systems. The fragmented structure of knowledge observed in this research suggests that the challenges to the implementation of patients' rights identified at the European level are not limited to cross-border contexts but also present in everyday clinical practice within national systems.

Similarly, normative frameworks and basic bioethical principles (autonomy, beneficence, nonmaleficence, justice) set high standards for the protection of patients' rights. Still, our findings indicate a gap between these normative postulates and their operational application. This confirms that the formal adoption of international declarations and directives is insufficient to ensure the consistent application of patients' rights without systematic education and organisational mechanisms to support their implementation in concrete clinical situations. In this context, the results of this research can be placed in a broader normative and policy framework that includes the Sustainable Development Goals [17], the EU Patients' Rights Directive [15] and international declarations such as the Lisbon Declaration [2], because all these documents start from the assumption that the realization of the right to health and patient autonomy is not possible without clearly understood and consistently applied professional obligations within health systems.

This research contributes to the existing literature by empirically demonstrating that knowledge of patient rights and professional obligations is fragmented and domain-specific, rather than unique or coherent, and that legal knowledge does not spontaneously organise into stable domains. This further emphasises the need for targeted educational approaches that focus on specific clinical situations and conditional legal norms, rather than relying on general, declarative approaches to teaching patients' rights. In the context of the education of healthcare workers, the findings point to the importance of integrating case-based learning, profession-specific legal education, and explicit treatment of procedural obligations and ethical-legal exceptions in undergraduate, graduate, and continuing professional development programs. Strengthening legal literacy in these areas can contribute to safer clinical decision-making and more consistent protection of patient autonomy and patient dignity.

Several limitations of this study should be noted. The instrument included a limited number of statements, which does not allow for comprehensive coverage of all aspects of patient rights and professional obligations, and the cross-sectional design prevents causal inferences. Furthermore, the responses were based on hypothetical situations rather than observations of actual clinical practice, which may limit the ecological validity of the findings. Future research should include a broader range of legal and ethical domains, use mixed-methods approaches, and examine the relationship between knowledge, attitudes, and actual clinical application of patient rights. Longitudinal research could also provide insight into the development of legal knowledge over the course of professional education and clinical careers, and assess the effects of targeted education on the consistency of patient rights application in practice.

CONCLUSION

The results of this study show that healthcare professionals' knowledge of patients' rights and associated professional obligations is not uniform and varies by the type of right, professional role, and experience. Patients' rights that are clearly regulated and routinely present in everyday clinical practice are generally well recognised. In contrast, legal aspects that require contextual interpretation, procedural handling, or knowledge of legal exceptions are characterised by greater uncertainty and misinterpretation.

In terms of differences between groups, selective differences were found by gender, age, professional group, and length of work experience, and were limited to individual statements and mostly of low to moderate intensity. The absence of differences associated with management positions indicates that a formal hierarchical role in the healthcare system does not necessarily imply a higher level of knowledge of patients' rights, thus questioning the assumption of a systematic transfer of legal knowledge through management structures.

The analysis of the interrelationships among individual aspects of knowledge showed that the correlations between the statements were mainly weak, with only limited thematic clustering around the dimension of patients' rights related to autonomy. Such a pattern does not support the existence of a single or clearly structured domain of legal knowledge. Instead, it points to the fragmented and domain-specific nature of knowledge of patients' rights and professional obligations among healthcare professionals. Overall, the findings of this study highlight the need for targeted, contextualised, and professionally differentiated approaches to patient rights education that go beyond general normative familiarisation with the legal framework. Systematic strengthening of healthcare professionals' legal literacy is a key prerequisite for the consistent protection of patients' autonomy, dignity, and safety in everyday clinical practice.

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