The Rights of Persons with Intellectual Disabilities in Healthcare: Perceptions of Nursing Students from Poland – A Pilot Study

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ABSTRACT:

Awareness of the rights of patients, including those with intellectual disabilities (ID), among healthcare professionals is a challenge for healthcare professionals. People with ID are particularly vulnerable to marginalization and neglect, due to communication and cognitive problems, and low levels of knowledge among healthcare professionals about the specific nature of their needs and functioning. The lack of knowledge among healthcare staff about existing patient rights has a significant impact on the exercise or violation of these rights. The research aimed to analyze the views of nursing students (NS) from Poland on the rights of patients with ID. The study was conducted in a group of 120 NS using a survey questionnaire. Integral parts of the survey questionnaire were the Beliefs about Rights of Individuals with Intellectual Disabilities in Healthcare Scale (Beliefs Scale - BS), Social Distance Scale (Distance Scale - DS), and a sociodemographic questionnaire. The study showed that the relationship between views on the rights of people with ID and social distance towards them may play an important role in shaping the attitudes of future nurses towards this patient group.

Keywords: Intellectual Disability, Health Services, Nursing Students, Rights of People with Disabilities, Social Distance

INTRODUCTION

"Human rights are equated with natural rights, which, as inherent and inalienable, belong to all individuals. These rights are universal and equal; no distinctions among people can justify assigning different sets of human rights to any group" (Jankowska, 2012, p. 25).

Czajkowska et al. (2021) emphasize the necessity of ethical education provided at various stages of preparation for the medical profession, which incorporates an understanding of patients' rights, particularly their rights to dignity, privacy, access to information, healthcare services, and medical records. They further highlight that healthcare staff's insufficient awareness of these rights significantly influences whether patient rights are upheld or neglected.

People with intellectual disability (ID)[1] are one of the groups experiencing the greatest exclusion in having their needs met and their rights respected. At the same time, healthcare and the appropriate attitudes of health professionals appear to be crucial issues in terms of their well-being, given their higher exposure to diseases and comorbidities compared to the general population.

Medical rights are a crucial component of the human rights of individuals with ID, encompassing the right to the highest attainable standard of health as outlined in international treaties. Health-care systems aim to uphold this right through services such as health promotion, disease prevention, diagnosis, treatment, and palliative care, guided by medical ethics. Effective protection of these rights often involves a communication triad consisting of the patient, health-care provider, and caregiver, each playing a vital role in ensuring positive health outcomes. Ensuring the medical rights of people with ID involves providing optimal care, guaranteeing that healthcare providers avoid harm, empowering patients to have an autonomous voice in decision-making, and ensuring the fair and equitable distribution of medical services (Lunsky et al., 2009). Given these findings, we decided to investigate nursing students' views on the rights of people with intellectual disabilities to health care.

LITERATURE REVIEW

According to the Convention on the Rights of Persons with Disabilities (UN, 2006), persons with disabilities are entitled to the highest attainable standard of health without discrimination based on their condition. They must be ensured equal access to medical services and health rehabilitation, with attention to gender-specific needs. Equality and accessibility apply to all groups of persons with disabilities, including those with intellectual disabilities (ID). This encompasses the same quality, scope, and standard of services, delivered close to the communities in which they live. Article 25 of the Convention (2006) emphasizes the prohibition of discrimination in the field of social insurance. Medical professionals are required to provide persons with disabilities the same care as other patients, as well as to promote awareness of human rights, dignity, independence, and the needs of persons with disabilities. This is to be achieved through training and the dissemination of ethical standards in public and private healthcare systems (UN, 2006).

The Convention was ratified in Poland in 2012 (Ministry of Family and Social Policy, n.d). Domestic legal frameworks in Poland align with international standards for the protection of the health rights of persons with disabilities (Budnik, 2017; Mikołajczyk, 2020).

Despite legislative progress in the field, individuals with ID experience significant health disparities, including premature mortality and a higher prevalence of chronic diseases compared to the general population, as well as poorer access to healthcare services (Bright et al., 2018; CDC, 2022; Skuban-Eiseler et al., 2023; Larrabee Sonderlund et al., 2024). Health inequalities faced by individuals with ID often stem more from structural inequities and unmet healthcare needs than from cognitive or physical conditions themselves (Shakespeare et al., 2018; CDC, 2022; Clemente et al., 2022; Gréaux et al., 2023; Dunn et al., 2024).

Caring for people with ID involves ethical issues common to healthcare, as well as those specific to ID and their associated challenges. Common ethical dilemmas include respecting autonomy, privacy, confidentiality, lifestyle choices, social activity, access to genetic testing, participation in research, and the expression of sexuality. Additional dilemmas arise when patients refuse beneficial treatments they cannot rationally justify, or when restrictions on personal freedom or direct coercion are considered to protect the patient or others from harm. Resolving these dilemmas requires balancing patient rights with the ethical and professional duties of caregivers, emphasizing respect for human dignity, individualized care, and respect regardless of the nature or severity of the condition (Zurzycka & Radzik, 2016).

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[1] *Intellectual disability is a developmental condition characterized by significant limitations in both intellectual functioning (IQ approximately 70–75 or below) and adaptive behavior (conceptual, social, and practical skills), with onset before age 22 (Schalock et al., 2021).*

Furthermore, research confirms a lack of training for healthcare professionals, including nurses, in providing support to individuals with ID, while stereotypes and discrimination against this group persist (Pelleboer-Gunnink et al., 2017; Dunn et al., 2024). Stigmatizing attitudes toward patients with ID can negatively impact their integration into mainstream healthcare services. Studies highlight the importance of incorporating interactions and collaboration with experts in educational programs for healthcare workers to improve this situation (Pelleboer-Gunnink et al., 2017). As the research highlights, insufficient knowledge and training among healthcare providers are major barriers to effective care for people with ID. Patients often report negative experiences, such as being ignored, misunderstood, or treated disrespectfully by doctors, which undermines their care. This lack of training can lead to 'diagnostic overshadowing', in which symptoms are misattributed to disability, resulting in misdiagnosis and inappropriate treatment (Holland, 2000; Lunsky et al., 2009).

The World Health Organization (WHO) emphasizes that addressing health disparities requires the development of human resources, such as nursing personnel, to enhance access to services and support for marginalized and vulnerable populations, including individuals with ID (WHO, 2016). Nurses are widely recognized as having a significant impact on the health of individuals with ID in acute care facilities, community-based settings, and educational environments (Khanlou et al., 2023). Unfortunately, specialist nursing programs focused on ID are available only in the United Kingdom and Ireland at the undergraduate level (Sweeney & Mitchell, 2009; Jaques et al., 2018; Doody, 2023) and issues related to working with individuals with ID are occasionally included in general nursing programs in few countries, such as Australia, New Zealand (NZ), the United States (USA), and Canada (Doody, 2023). In Poland, there are no specialized nursing programs in the field of ID.

In Poland, medical professions are classified as professions of public trust. This designation requires individuals to demonstrate high levels of competence, complete higher education, and continually enhance their knowledge (Pomaranik, 2023). Medical education in Poland is publicly funded and adheres to established standards tailored to professions such as physicians, dentists, pharmacists, nurses, midwives, laboratory diagnostics specialists, physiotherapists, and paramedics (Regulation..., 2019). The overarching learning outcomes emphasize graduates' ability to establish respectful and empathetic patient interactions, prioritize patient welfare, and uphold patients' rights. Specific learning outcomes include evaluating patients' functional status, understanding the social ramifications of disabilities, recognizing socio-cultural barriers, and mastering effective communication techniques. However, there is a lack of focus on specific disability types, such as ID, both in the learning outcomes and in the names of subjects taught during medical education.

RESEARCH AIM

The study examined the perspectives of NS regarding the rights of patients with ID. Such an analysis can help identify the sources of difficulties and barriers experienced by individuals with ID in accessing healthcare services and contribute to improving the conditions of institutional care in medical facilities. The aim of the research was to analyze the views of NS from Poland on the rights of patients with ID, examining their beliefs, investigating the relationship between specialized ID care training and their perceptions of healthcare access rights, and exploring the connection between these beliefs and their social distance toward ID patients.

Three research questions were formulated:

1. What are the NS' beliefs about the rights of individuals with ID?
2. How does participation in training on the care and treatment of individuals with ID influence the NS' beliefs about the rights of these individuals to access healthcare services?
3. What is the relationship between NS' beliefs about the rights of individuals with ID and their social distance towards such patients?

METHODS

The study employed the diagnostic survey method. Data for analysis were collected through a self-authored online questionnaire in the form of a Google Form (Google, Mountain View, CA, USA). The study aimed to examine relationships between the analyzed variables, which necessitated the selection of methodological approaches based on quantitative data analysis. A quantitative research design was employed to obtain objective, measurable data amenable to statistical analysis. The research tools included in this survey were: The Beliefs about Rights of Individuals with Intellectual Disabilities in Healthcare Scale (Beliefs Scale), the Social Distance Scale (Distance Scale), and a sociodemographic questionnaire. Both measurement scales employed in this study were specifically developed for this research project by the authors, who formulated a set of statements concerning the rights of patients with ID and interpersonal situations related to functioning in the patient role. The content validity of the questionnaire was evaluated by four experts specializing in issues of rights protection, accessibility, and social inclusion. The instrument's reliability was established using Cronbach's alpha coefficient.

The Beliefs Scale (BF) was designed to assess the attitudes of medical students. Initially, it comprised 14 statements evaluated by respondents using a five-point Likert scale (1 – strongly disagree, 2 – rather disagree, 3 – hard to say, 4 – rather agree, 5 – strongly agree). During the validation process, the number of items was reduced to eight (items 3, 4, 6, 7, 9, 10, 13, and 14), explaining 63% of the variance in results. Using Cattell's scree test criterion, two factors were identified. The maximization of the variance of raw variable loadings for each factor was performed using the Varimax method. The Cronbach's alpha coefficient for the entire scale was 0.83.

The Distance Scale (DS) was developed to assess the declared willingness of NS to accept patients with ID in situations typical of hospitalization. As in the classic version developed by E. S. Bogardus (1959), the scale aims to determine the most comfortable social distance for respondents regarding individuals from another group (Aiken, 2002). Participants were asked to indicate their level of acceptance in ten interpersonal situations using a five-point Likert scale. The scale demonstrated satisfactory reliability coefficients. The Cronbach's alpha coefficient for the DS was 0.77.

To measure differences between independent groups (NS who participated in classes preparing them to assist individuals with ID and those who did not), the Mann-Whitney U test was applied. Effect size was determined using Glass's biserial correlation coefficient (r_g).

To assess the relationship between students' scores on the BRIIDHS scale and their interpersonal distance toward patients with ID, Spearman's rank correlation coefficient was used. All calculations were performed using Statistica software, version 13.3.

Respondents were recruited from Polish universities offering health professions education programs. Using a systematic sampling approach, five institutions were randomly selected from publicly available online registries of higher education institutions. Formal recruitment letters were subsequently dispatched to the administrative authorities of the selected academic units, detailing the study objectives, methodology, and requesting institutional cooperation in participant recruitment.

Data collection was conducted via an online survey platform between June 2023 and February 2024. Institutional coordinators distributed a secure web link to the study questionnaire, which was hosted on the Google Forms platform. The digital survey package included all research instruments accompanied by standardized completion instructions.

The study included 120 NS from medical universities in Poland, including 112 (93.33%) women and 8 (6.67%) men (Table 1). This represents the maximum achievable sample size obtained in the present study.

The majority of respondents (94.17%) were students aged up to 29 years and were enrolled in undergraduate programs or the first three years of five-year studies

Table 1. **Characteristics of the NS Study Group**

Group characteristic	n	%
Sex: - female - male	 112 8	 93.33 6.67
Age: - 18 - 29 > 30	 113 7	 94.17 5.83
Study year: - I - III - IV – V	 105 15	 87.50 12.50
Having a relative or friend with an ID: - yes - no	 40 80	 33.33 66.67
Participation in training on assisting a patient with ID: - yes - no	 30 90	 25.00 75.00

(87.50%). Most of them (66.67%) did not have an acquaintance or relative with ID and had never participated in training on caring for individuals with such a disability (75.00%). The study obtained approval from the Scientific Research Ethics Committee of the University of Warmia and Mazury in Olsztyn, Poland (Decision No 14/2023 dated 22/05/2023). Participation in the study was voluntary and anonymous, and students were provided with information about the study's purpose. The study was conducted in full compliance with the ethical principles outlined in the Declaration of Helsinki. Written informed consent was obtained from all participants prior to their involvement in the research. In accordance with data protection protocols, no personally identifiable information was collected throughout the study. Participants were explicitly informed about the voluntary nature of their participation, guaranteed complete anonymity, and advised of their unconditional right to withdraw from the study at any time without consequence.

RESULTS

Based on the preliminary analysis of the results (Table 2), a high level of acceptance of the rights of patients with ID was observed (M > 4.00). The surveyed students considered the right of individuals with ID to healthcare provided by well-trained staff to be particularly important (M = 4.83), as well as their right to health education (M = 4.69). The lowest level of acceptance was found for the statement that access to medical services for individuals with disabilities should be facilitated regardless of cost (M = 4.21).

Overall, the mean values of the surveyed students' responses to the various statements included in the scale indicate a predominance of positive responses among the surveyed students regarding the acceptance of the rights of patients with ID. It is also noteworthy that for beliefs with lower acceptance rates, a higher level of opinion diversity was observed (greater dispersion of results).

The highest level of acceptance was observed for Statement 6 (M=4.83), indicating a recognized need for specialized training in preparing to work with patients with intellectual disabilities. Conversely, the most challenging to accept was Statement 10 (M=4.21), which proposed that healthcare systems should prioritize accessibility improvements for individuals with intellectual disabilities, considering cost factors as secondary to equitable access. Although response variability was lower for Statement 6 (SD=0.60) compared to Statement 10 (SD=0.98), both statements elicited extreme negative (Min.=1.00) and positive (Max.=5.00) responses.

Further analysis of the BS results allowed for the identification of two factors within the structure of the examined beliefs:

Factor 1 (Recognition that patients with ID should receive professional support in healthcare) describes the right of individuals with ID to access medical services

Table 2. **Descriptive Statistics (N=120)**

The rights of patients with ID to use medical services	M	SD	Mdn	Q1	Q3	IQR	Min.	Max.
3. People with ID should have access to free preventive examinations.	4.29	1.05	5.00	4.00	5,00	1.00	1.00	5.00
4. People with ID should have access to universal vaccinations to prevent diseases.	4.55	0.93	5.00	4.00	5,00	1.00	1.00	5.00
6. Staff in public health care facilities should be trained to work with patients with ID.	4.83	0.60	5.00	5.00	5,00	0.00	1.00	5.00
7. People with ID should have the right to health education.	4.69	0.79	5.00	5.00	5,00	0.00	1.00	5.00
9. People with ID should have access to medical information (e.g., about reimbursed tests) in an accessible, easy-to-understand format.	4.66	0.68	5.00	4.00	5,00	1.00	1.00	5.00
10. Using health services should be made easier for people with ID, regardless of the cost.	4.21	0.98	4.50	4.00	5,00	1.00	1.00	5.00
13. People with ID should have the right to be informed about their health.	4.63	0.75	5.00	4.00	5,00	1.00	1.00	5.00
14. People with ID should have the right to privacy in medical care.	4.39	0.93	5.00	4.00	5,00	1.00	1.00	5.00

Notation: M – mean, SD – standard deviation, Mdn – median, Q1 – first quartile (lower quartile), Q3 – third quartile (upper quartile), IQR – interquartile range, Min. – minimum value, Max. – maximum value

Table 3. **NS' views on the rights of people with ID to access health services**

Rights of people with ID to access health services	NS who participated in training on assisting patient with ID (n=30)		NS who did not participate in training on assisting the patient with ID (n=90)		z	p	r_g
	Mdn	IQR	Mdn	IQR			
3.	5.00	1.00	5.00	1.00	-0.269	0.788	-0.03
4.	5.00	0.00	5.00	0.00	2.117	**0.034**	0.20
6.	5.00	0.00	5.00	0.00	1.040	0.299	0.07
7.	5.00	0.00	5.00	0.00	-0.256	0.798	-0.02
9.	5.00	0.00	5.00	0.00	0.718	0.473	0.07
10.	4.00	1.00	5.00	1.00	0.869	0.385	0.10
13.	5.00	1.00	5.00	1.00	0.37	0.592	0.05
14.	5.00	1.00	5.00	1.00	-0.407	0.684	-0.04

Notation: z – Mann-Whitney U test value, p – p-value, rg – Glass's biserial correlation coefficient

that take into account their specific needs regarding information about their health status, treatment process, and prevention, as well as ensuring privacy when required (statements: 6, 7, 9, 13, 14).

Factor 2 (Recognition that the prevention and treatment of individuals with ID may involve higher costs and greater workload for medical staff) reflects the economic context of treating patients with ID, particularly the willingness to acknowledge their right to free examinations and vaccinations (statements: 3, 4, 10).

Since the response profiles on the BS deviated from a normal distribution, non-parametric tests were applied in the subsequent analyses (Table 3).

The analysis of views on the right of individuals with ID to access medical services, as declared by NS who participated in medical assistance courses for individuals with ID (n = 30) compared to those who did not attend such training (n = 90), revealed a statistically significant difference in favor of the group of students who had not participated in the training. The results presented in Ta-

Table 4. **Relationship between NSI' views on the right of people with ID to receive medical services and their distance from patients with such disabilities in different professional situations**

The Distance Scale (DS)	BS (total)	BS (factor 1)	BS (factor 2)
1. I would accept a person with an ID as a patient in the hospital where I work.	0.38*	0.37*	0.24*
2. I would accept a person with ID as a patient in the ward where I work.	0.33*	0.37*	0.21*
3. I would accept a person with ID as a patient to whom I administer drugs.	0.38*	0.41*	0.24*
4. I would accept a person with an ID as a patient from whom I collect material for further research.	0.32*	0.34*	0.21*
5. I would accept a person with ID as a patient whom I help in self-service activities.	0.39*	0.42*	0.26*
6. I would accept a person with ID as a patient with whom I spend my free time (breaks at work).	0.30*	0.33*	0.21*
7. I would accept a person with ID as a patient to whom I pay more attention than others to ensure their well-being.	0.31*	0.36*	0.20*
8. I would accept a person with ID as a patient entitled to more privileges than others.	0.08	0.04	0.07
9. I would accept a person with ID as a patient who engages me more than other patients in terms of activities outside the scope of my duties.	0.18*	0.17	0.15
10. I would accept the need to improve my competencies in my free time from professional duties to better meet the needs of people with ID as patients.	0.29*	0.30*	0.20*

Notation: * - p<0.05

Table 5. **Results of the regression analysis between the overall distance score towards individuals with ID and views on the analyzed rights of individuals with ID among NS**

N=120	**Summary of regression analysis for the dependent variable: Distance Scale (DS.); R=,631; R^2= ,398; Adjusted R^2= ,388; F(2,117)=38,635; p<,001; SE: 5,160**					
	BETA	**SE (BETA)**	**β**	**SE (β)**	**t(117)**	**p**
(Constant)			9.504	3.834	2.479	0.015
Factor 1	0.563	0.082	1.238	0.180	6.861	0.000
Factor 2	0.121	0.082	0.347	0.235	1.477	0.142

KOuzn – overall assessment of competence in educating students with disabilities; R – coefficient of multiple correlation; Adjusted R^2 - is an adjustment for the Coefficient of Determination that takes into account the number of variables in a data set; R^2 – coefficient of determination; F – F-test value; p – p-value; SE - standard error of estimate; SE (BETA) - Std. error of BETA; SE (β) - Std. error of β; BETA – strength of the explanatory variable's relationship with the dependent variable; β – regression coefficient; t - Student's t-test value.

ble 3 indicate that students who did not complete specialized courses demonstrated a higher acceptance of the right of individuals with ID to receive routine vaccinations for disease prevention ($p = 0.034$).

However, the impact of completing such training on students' views regarding the rights of patients with ID was found to be very weak (all r_g values fell within the range of 0.00–0.30), suggesting that its practical significance should be considered low.

Regarding the structure of the identified factors, minor variations were observed exclusively in Factor 2 (Items: 3, 4, and 10). This pattern may indicate particular sensitivity to treatment cost issues, potentially reflecting concerns about excessive cost-intensity of medical services provided to patients with ID.

Additionally, the relationship between students' scores on the BS and their declared social distance (DS) toward patients with ID was analyzed (Table 4).

The analysis of correlation coefficients indicates a positive relationship between views on the analyzed rights of individuals with ID and social distance toward them among the surveyed students. This correlation is generally of moderate strength. The relationship is stronger in the case of recognizing that patients with ID should receive professional support in healthcare (higher r_s values) than in the case of acknowledging that the prevention and treatment of individuals with ID may involve higher costs and a greater burden on medical staff.

To estimate the significance of the impact of views on the rights of individuals with ID as patients (independent variable) on interactions with such individuals in professional settings (dependent variable), a multiple regression analysis was conducted (Table 5).

The model proved to be significant ($F_{2,117} = 38.635$; $p < 0.001$) and explained 39.8% of the variance in the dependent variable ($R^2 = 0.398$). The multiple correlation coefficient ($R = 0.631$) indicates a relationship between social distance toward patients with intellectual disabilities (ID) and all independent variables combined.

However, only Factor 1 - the recognition that patients with ID should receive professional support in healthcare - had a significant impact on the overall assessment of social distance in interactions with patients with ID ($\beta = 0.56$; $t = 6.86$; $p = 0.001$). This variable was positively associated with the dependent variable, meaning that an increased recognition of the rights of patients with ID in this regard is expected to contribute to a reduction in social distance in situations related to providing medical support ($B_1 = 1.238$).

Thus, NS' views on the rights of individuals with ID as patients may serve as an important resource in the context of providing medical assistance and influence the development of interpersonal relationships with patients with ID.

DISCUSSION

In addressing the first research problem concerning NS' beliefs about rights, it was found that the surveyed students demonstrate varied declared views regarding the right of individuals with ID to access medical services. This may be due to the complex ethical situation faced by healthcare professionals, as described in the literature. They often face the dilemma of balancing the avoidance of stigmatization and the promotion of equal rights for individuals with ID with the need to protect them from exploitation and harm (Pelleboer-Gunnink et al., 2017).

The second research question examined the relationship between participation in specialized training on the care and treatment of individuals with ID and the recognition of their rights to healthcare services. The results of our study showed that, paradoxically, greater knowledge and experience in caring for individuals with ID may lead to more diverse opinions and even a lower level of declared acceptance of their rights, particularly in the context of the practical limitations of the healthcare system. This may be influenced by the content covered in the courses. Students who participated in the courses may have spent more time on practical and clinical aspects, which are characteristic of the traditional medical model of disability, and less on broader ethical and legal considerations regarding equal access to healthcare, which are more prominent in the biopsychosocial approach to disability. In contrast, students without such courses may have based their views on more general, theoretical assumptions about patients' rights. This finding appears to contrast with Ryan and Scior's (2014) literature review, which indicates that most studies report a generally positive impact of interventions on medical students' attitudes. However, in the study by Sinai et al. (2021), completing a university module on ID was associated with increased knowledge but did not significantly influence students' attitudes toward the community inclusion of individuals with ID. This suggests that the effectiveness of such interventions may depend on the specific methods used. Supporting this idea, a recent comparative study (Ćwirynkało et al., 2025) found that although most medical students from three European countries (including Poland) had limited opportunities to interact with individuals with ID or learn about their needs, they still generally expressed positive attitudes - such as recognizing their rights.

The response profile indicates a predominance of positive reactions among the surveyed students regarding the acceptance of the rights of patients with ID. This is particularly important, as healthcare professionals (and NS who will soon become professionals) play a key role in implementing the principle of inclusion in mainstream medical services (Pelleboer-Gunnink et al., 2017). Awareness and recognition of these rights are essential conditions for ensuring healthcare accessibility for this population.

The surveyed students particularly acknowledge the right of individuals with ID to receive healthcare provided by well-trained personnel and their right to health education. Such an approach offers hope for improving the situation documented by Skuban-Eiseler et al. (2023), who report that, across Europe, individuals with disabilities continue to face barriers to healthcare access, including denial of information, refusal of insurance, and lack of reimbursement for medical expenses. The lower level of support for recognizing that prevention and treatment for individuals with ID may involve higher costs and increased workload for medical staff, as observed in this study, may stem from concerns about potential limitations in access to healthcare services for non-disabled individuals if such prioritization were required.

The study found that participation in courses or classes related to working with individuals with ID did not play a significant role in shaping stronger support for the rights of patients with ID among the surveyed students. However, completing such training could have a positive effect, potentially contributing to the overall equalization of the rights of individuals with ID as patients. This is confirmed by the analysis of the relationship between the recognition of patient rights and social distance in the context of the nursing profession. Regarding the third research question, which examines the relationship between the recognition of rights for individuals with ID and social distance, the results indicate that the more students acknowledge the rights of individuals with ID to specialized care, the lower their declared social distance—although this association is weaker when considering acceptance of treatment costs.

Careful selection of training content could better support the relationship between views on the rights of individuals with ID and social distance toward them, playing a crucial role in shaping the attitudes of future nurses toward these patients. The needs of different groups in this regard may vary significantly. This underscores the necessity of evaluating both the factors influencing attitude change and the outcomes of such changes, while also incorporating the results of preliminary assessments into the design of the training program. A positive impact of training participation on reducing social distance toward patients with ID was demonstrated in research by Kazanowski et al. (2024), while the need for such training - particularly in the areas of reasonable accommodations, effective communication with individuals with ID, and accessible health information - has been highlighted in studies by Dunn et al. (2024). Training in human rights can improve the well-being of healthcare workers and patients, increase engagement in the treatment process, and enhance satisfaction in mutual relationships (Picton-Howell, 2023). Research by Kazanowski et al. (2025) confirms that correlations between NS' self-assessment of competencies in caring for patients with ID, their recognition of these patients' rights, and their level of social distance suggest that attitudes and perceived preparedness may influence future professional behaviors. Previous studies have similarly indicated that greater awareness of patients' rights and reduced social distance are associated with more positive attitudes and higher self-efficacy in care provision (Aydoğan & Çetin, 2018; Desroches et al., 2022; Doody et al., 2023; Huskin et al., 2018; Rozani et al., 2024).

CONCLUSIONS

The study reveals diverse attitudes among NS toward the rights of individuals with ID to healthcare. While most students support their right to care from qualified staff and health education, concerns remain about higher costs and system strain. Training related to working with individuals with ID did not significantly influence attitudes, but may reduce social distance and improve relationships. It is recommended that training on reasonable accommodations, communication, and human rights be incorporated into curricula. Discussions on ethics and equity in healthcare can alleviate concerns about resource allocation. Training programs should be based on preliminary assessments of students' needs and attitudes. Continuous evaluation of training effectiveness is crucial for fostering inclusive attitudes. Through these measures, future nurses will be better prepared to ensure equitable healthcare for individuals with ID. The integration of disability rights education with practical experiences involving individuals with disabilities may help bridge the gap between theoretical knowledge and clinical practice, ultimately contributing to more inclusive healthcare standards.

LIMITATIONS

The results of this study must be interpreted with its limitations in mind. It should be noted that responses are declarative and may differ in reality. If respondents feel that they risk criticism or sanctions for their opinions about other groups, they may tend to limit SD and also have a more positive attitude towards the rights of patients with ID. Another limitation of the study is that it did not account for the content of courses addressing ID issues, particularly those delivered by nursing students enrolled in such programs. The study was limited by its sample size, which may restrict the generalizability of the findings. Additionally, the lack of detailed demographic data hinders a deeper analysis of influencing factors. Future research should include broader demographic variables and consider qualitative methods, such as in-depth interviews or focus groups, to explore students' awareness of disability rights, social distance, and preparedness for professional practice. These approaches could provide richer insights into educational needs and attitudes in nursing training.

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DECLARATION OF INTEREST STATEMENT

The authors reported no potential conflict of interest.

ETHICAL STATEMENT

The study was conducted in accordance with the Declaration of Helsinki, and the protocol was approved by the Ethics Committee of the University of Warmia and Mazury (Nr 14/2023) on 22 May 2023.

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