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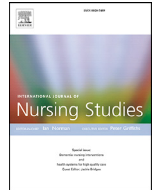

Entering forbidden territory - Value conflicts of female Muslim student nurses providing personal care to male patients: A qualitative study

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ABSTRACT

Background: Saudi Arabia is now facing a critical nursing shortage and is under considerable pressure to recruit more local nurses. However, attracting Saudi Arabian women into the nursing profession has traditionally been difficult due to religious and cultural barriers.
Objectives: The study was designed to provide insights into the research participants' experiences or awareness of conflicts between professional nursing values and the dominant religious and cultural values of Saudi Arabia.
Design: The research took the form of a qualitative case study.
Setting: The study was conducted at a leading university in Saudi Arabia.
Participants: The participants consisted of 24 female Muslim student nurses from the second and fourth years of study of the BSc Nursing degree and six female Muslim College of Nursing faculty members from the same university.
Methods: Data collection methods consisted of individual interviews and focus groups, and thematic analysis was used to analyse the data. The study used a theoretical framework based on Rokeach's (1973, 1979) theories of values and value change.
Results: All student participants were found to be experiencing conflicts between the nursing requirement to provide personal care to male patients, and their religious and cultural values relating to personal modesty. Faculty participants were aware of the presence of this value conflict, but it was not being formally acknowledged or addressed at the case study institution. The lack of official practice or policy guidance was found to be reinforcing the potential for the value conflict. Participants regarded religious values as fixed and mandatory, but cultural values as subject to change.
Conclusions: It was concluded that awareness-raising initiatives and open discussion of value conflicts should be conducted by the university to help realign the participants' culturally influenced values with the requirements of nursing. The available Islamic guidance should also be used to clarify the institution's official position on the provision of personal care to male patients by Muslim female nurses and improve understanding of the nursing tasks acceptable within Islam.

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What is already known

- Researchers have found evidence that value conflicts can arise when the professional values of nursing come into conflict with religious and cultural values, especially in Islamic countries.
- Previous studies in this area were mainly based on samples of qualified nurses in Islamic countries, not student nurses who are still in training for a nursing career.

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What this paper adds

- The study findings suggest that the value conflict which often arises when female student Muslim nurses are required to provide personal care to male patients is due at least in part due to cultural influences rather than religious values and beliefs per se.
- A lack of clear and non-conflicting guidance on this issue in the nurse education curriculum means that students in both year groups and even some faculty members are struggling to accept the responsibility for this type of nursing task.
- The paper indicates that value conflicts may be avoided if measures are taken to realign some of the nursing students' and faculty members cultural values with those of the nursing profession, and suggests ways of doing so.

1. Background

The Kingdom of Saudi Arabia is a conservative Middle Eastern Islamic country in which 100% of the native population are Muslim Arabs. In this setting, Islamic beliefs and laws as well as Arab culture strongly influence all areas of life including healthcare provision (Abudari et al., 2016). They relate particularly to gender roles, gender segregation, and protection of the modesty and privacy of individuals (Koenig and Shohaib, 2014; Uddin, 2017). The Islamic dress code of modesty requires that certain parts of the body, known as "awrah", should always be kept covered in the presence of unrelated people of the opposite gender. These include all parts of the female body except for the face and hands, and the male body area from the navel to the knee (Lovering, 2008; AlYami and Watson, 2014). Saudi Arabia also has a male dominated culture in which many Saudi women are not permitted by their male relatives to work outside the home, particularly in a mixed-gender environment. These religious and cultural factors can create considerable challenges in the healthcare context, especially when nurses and other healthcare professionals are required to deliver personal care to patients of the opposite gender.

Traditionally, Saudi Arabia has relied heavily on expatriate, non-Muslim nurses (Hassan, 2017; Mebrouk, 2018) to provide these forms of personal care to patients of the opposite gender. However, the Kingdom is increasingly facing a critical nursing shortage (Almalki et al., 2011; Ram, 2014; Keshk et al., 2016) and is under considerable pressure to recruit more local nurses. Demands for healthcare are rapidly increasing as the population expands by more than 3% annually and there is an increasingly large population of elderly people (AlYami and Watson, 2014; Ram, 2014; Khoja et al., 2017). To help reduce reliance on expatriates and encourage more Saudi nationals to enter nursing the government has implemented an indigenisation policy (National Transformation Program, 2016; Saudi Vision 2030, 2019). However, much of the resulting growth in the number of Saudi nurses has been accounted for by men, who reportedly account for around 50% of all Saudi nurses (Alboliteeh et al., 2017). It is becoming increasingly difficult to sustain gender segregation within healthcare in the face of the current nursing shortage (Alboliteeh et al., 2017; Hassan, 2017).

Historically, attracting Saudi Arabian women into the nursing profession has been difficult due to the religious and cultural barriers preventing inter-personal contact between unrelated people of opposite genders, and concerns about the requirement to expose the awrah of patients in nursing (Hassan, 2017). Many people in Saudi Arabia regard nursing as an inappropriate profession for Saudi women and hold negative attitudes towards those local women who do become nurses, perceiving their work to be distasteful and in conflict with Islamic beliefs (Lovering, 2008; AlYami and Watson, 2014). Studies indicate that there are high levels of attrition among Saudi women who do enter nursing, due to dissatisfaction with the work or difficulties in coping with the negative public image of nursing (e.g. Alboliteeh et al., 2017).

Despite this, the historical evidence is that nursing was traditionally regarded as an acceptable and valuable profession within Saudi Arabia and that Islamic beliefs and values are not incompatible with this profession. According to religious texts discovered in the 1980s, the first Muslim nurse Rufaidah Al-Asalmiya provided care to patients from the Muslim armies during the Holy Wars of the first century AD, working from a tent just outside the Prophet Muhammad's (Peace be upon him) own mosque (Almalki et al., 2011; Al-Osimy 1994). This suggests that the negative image of nursing that is now widely held in Saudi Arabia might be largely influenced by cultural values rather than Islamic values per se (Alboliteeh et al., 2017).

The article presents findings from qualitative research with a sample of female Muslim nursing students and faculty members at a leading university in Saudi Arabia. All data collection and analysis were carried out by the female researcher and author of this paper, who is of Saudi Arabian nationality and has qualifications and extensive work experience in nursing. Conducted within a theoretical framework focused on the concepts of values and value change (Rokeach, 1973,1979), the study was designed to provide insights into the participants' experiences or knowledge of conflicts between professional nursing values and the dominant religious and cultural values of Saudi Arabia.

Although previous researchers have reported that value conflicts can arise when the professional values of nursing come into conflict with religious and cultural values in Islamic countries (e.g. Hassan, 2017; Lovering, 2008), the few studies in this area have been mainly based on small samples of qualified nurses. By conducting research with student nurses, the researcher hoped to generate insights into value conflicts experienced at this early stage of training, so that suitable interventions can be developed to reduce the potential for value conflicts. Ultimately it is hoped that this will help Saudi Arabia address its nursing shortage by improving public perceptions of nursing and presenting it as a profession which is compatible and aligned with Islamic values.

2. Methods

2.1. Research design

The research used a qualitative case study design focused on a nursing degree programme at a university in Saudi Arabia. Data collection methods consisted of individual interviews and focus groups with students and faculty members, and a review of relevant documents. Case studies typically use multiple research methods, to achieve a comprehensive understanding of the phenomenon of interest, and to improve the overall validity of the findings (Crowe et al., 2011; Ritchie and Lewis, 2003; Creswell, 2013). The use of focus groups and interviews provided a means of examining the issue of value conflicts both in a group and in an individual setting, drawing on the relative merits of each approach. Interviews are especially useful when investigating personal or sensitive information that participants might not feel comfortable sharing in a group, while the interaction between participants in a focus group often generates information that might not have been provided spontaneously in a one-to-one interview setting (Morgan, 1997; Wood, 1996). The research was designed to investigate the ways in which student nurses at different stages of their training may experience value conflicts, and to understand how the attitudes and beliefs of faculty members might contribute to or help ease the potential for such value conflicts.

Before commencing the study, a research proposal was submitted to the University of Dundee's Research Ethics Committee

(SREC-UOD 2017031 Yaseen), and approval to proceed with the research was granted by the Committee in December 2017. Approval to conduct the research was also granted by the Research Ethics Committee at the Saudi Arabian case study institution and the clinical case study site in January 2018 and March 2018 respectively.

2.2. Theoretical framework

The study's theoretical framework was based on Rokeach's (1973, 1979) theory of values. Rokeach (1973) identified a wide range of factors that influence the values that an individual holds, including their cultural or religious background, education, and participation in social groups. He argued that many values develop in early childhood and remain relatively stable over time, but some change gradually or abruptly due to various life experiences. Rokeach (1979) identified multiple processes through which values can change. His theories were found to be helpful in the current study for understanding the ways in which conflicts between the personal and professional values of student nurses can arise, and how these might be reduced or resolved over time.

2.3. Sampling and participants

A multi-stage sampling design was used to select samples of 12 s-year and 12 fourth-year BSc Nursing students, as well as a sample of six faculty members. All second- and fourth-year students in the nursing department at the case study institution met the inclusion criteria of being female, Muslim and of Saudi nationality and were therefore eligible to participate. The researcher first delivered presentations about the study to these students and asked for volunteer participants. As a result, 41 s-year student nurses and 39 fourth-year student nurses expressed interest in taking part in the research. This represented 28% of all second-year students and 44% of all fourth-year students at the time. Due to the small number of married women in the available samples of volunteers, all of these were included in the final participant samples. The remainder of the participants were selected from the volunteers using random selection sampling software and allocated to individual interviews or focus groups based on their stated preference. The final samples of 12 students per year represented 8% of all second-year students and 14% of all fourth-year students on the nursing programme. All second-year student participants were aged under 20 and all fourth-year participants were aged between 20 and 25.

An invitation to participate in the research was emailed to all female Saudi faculty members of the Department of Nursing, but this initial approach only generated interest from one faculty member. The researcher therefore approached individual faculty members in person to explain the study and seek volunteer participants, and this resulted in an available sample of 13 eligible faculty members. A purposive sample of six faculty members was selected from this group in order to achieve diversity in terms of position, department and years of experience. This sample accounted for 20% of female Saudi faculty members at the time of the study.

2.4. Data collection

Face-to-face interviews were carried out at the university with 10 student participants (5 from each year of study) and 6 faculty participants. Two student focus groups, consisting of seven second-year students and seven fourth-year students were also conducted, all on university premises. The student interviews and focus groups both used a semi-structured guide covering similar issues. These included the participants' understanding of different types of values, their experience or awareness of conflicts that arise between personal and professional values, and their views on how the university manages such conflicts. The topic guide had been pilot tested in an earlier phase of research. The faculty interviews covered similar themes relating to the participants' perspectives of value conflicts experienced by students. One of the focus groups was attended by another nurse lecturer, who took field notes, but all other data collection was conducted by the main researcher alone, who took notes as well as recording the interviews. Each focus group lasted approximately 90 min and each interview approximately 60 min. No repeat interviews or groups were conducted.

All interviews and focus groups were conducted in Arabic, audio-recorded with the permission of the participants, transcribed and translated into English by the researcher before being analysed. The importance of retaining the intended meanings of the participants when translating and interpreting translated data has been emphasised in the literature (e.g. Van Nes et al., 2010). Previous studies have highlighted the risk of compromising the trustworthiness of qualitative data when the researcher is also the translator of the data, while also recognising the advantages of being fluent in the language of the participants and understanding any cultural nuances (Temple and Young, 2004; Al-Amer et al., 2015). In the case of this study, it is believed that the researcher's own fluency in both Arabic and English, her native knowledge of Saudi Arabian culture, and her first-hand understanding of the nursing context were more valuable than detrimental in improving the trustworthiness of the research. This follows the recommended approach of Al-Amer et al. (2015) including the use of an "insider" interviewer, who shares the language and culture of participants, and a translator who understands any specialist terminology or contextual information. In this case the researcher performed both roles. Additional measures which are believed to have enhanced the trustworthiness of the research included regular peer review of the ongoing research by academic supervisors and colleagues, "member-checking" of Arabic transcripts by some of the research participants, and the use of a professional translator to verify the accuracy of a sample of translated interviews.

2.5. Analysis

The translated interview and focus group transcripts were imported into NVivo 11 qualitative analysis software for the purpose of coding and thematic analysis by the researcher. No additional coders were used. A combination of a priori and inductive coding methods (Ryan and Bernard, 2003; Braun and Clarke, 2012) were used to identify the key themes and sub-themes relevant to the objectives of the study. The a priori coding methods helped provide structure to the early stages of coding and helped ensure that important themes from earlier literature were identified, while the inductive coding methods helped ensure that the final definition of themes accurately reflected the experiences and perceptions of the research participants. Field notes made during data collection were also used to guide the analysis process. However, participants were not asked to comment on the findings.

2.6. Ethics

The use of classroom presentations and face-to-face meetings by the researcher allowed students and faculty respectively to make a fully informed decision about whether to volunteer to participate. All research participants were given assurances that recordings and transcripts would be treated in complete confidence and that pseudonyms would be used when presenting the results. The focus group participants were asked to respect the confidentiality of information provided by other participants in their group.

Although there were no significant risks to individuals from participating in this study, it was acknowledged that some students or faculty might be emotionally affected when discussing potentially sensitive issues relating to value conflicts. All participants were notified that they could withdraw from the research at any stage and provided with information about the University Counselling team.

3. Results

This section sets out the primary research findings of the study, based on interviews and focus groups with a total of 24 nursing students and six nursing faculty members. The main findings are presented by the key themes identified from the analysis, and briefly discussed below with verbatim (translated) quotes.

3.1. Theme 1: Traumatic impacts of exposing male awrah

Nearly all the student participants in both years of study reported experiencing value conflicts when required to expose male awrah in nursing care. This was interpreted by the researcher as a conflict between the types of professional nursing values set out in nursing codes of conduct, such as those which prioritise the needs of patients, and the Islamic or cultural values dominant in Saudi Arabia that emphasise the importance of modesty and concealment of awrah. Many of the students expressed negative reactions and emotions arising from this type of conflict, such as shame, embarrassment, shock and trauma.

> *The idea itself is very embarrassing! (inserting urinary catheter for male) I mean it's too hard for me! Tough time on me! But what else I can do, it is helping him, this is my job! (Baraa, Year 2 Interview)*

> *When it comes to genitalia care this is…difficult, it will never work, I feel it is not ok to see. I am not comfortable, and also like afraid at the same time, ashamed, that's it. (Sawsan, Year 4 Interview)*

Some participants reported that they felt unable to share these aspects of nursing with close family members due to their expected reactions: "*I will not tell them! what am I going to say? I have exposed male awrah or seen his private area! No! (Baraa, Year 2 Interview)*". Even fourth year students who might be expected to have had more exposure to and familiarisation with this scenario in their clinical practice expressed similar views.

> *I would feel embarrassed because it is not normal. I cannot be exposed to male's private part without him being my husband or related to me. It is so abnormal in our culture it is a huge taboo. (Sanaa, Year 4 Interview)*

One of the fourth-year married students did have personal experience of this type of task and explained in her interview how it had made her reconsider her choice of nursing studies. In the following quote, she describes how traumatic it had been when required to give an injection in a male patient's buttock.

> *I felt suddenly the room is hot and I felt that I can't breathe because my scarf suddenly is too tight … That time my hand was really shaking I mean to the extent that I had to secure my wrist on the patient so I can insert it right … I mean honestly I was so ashamed. I felt so bad for myself and for him (Yara, Year 4 Interview)*

This and the other quotes cited above convey some of the most extreme forms of negative reactions to the conflict between the professional values of nursing and the Islamic requirements of modesty, and were expressed by many of the student participants. The next main theme relates to the participants' interpretations of why they have felt such negative reactions.

3.2. Theme 2: Religious and cultural influences on attitudes to exposing male awrah

Participants generally understood this type of conflict to be between the professional requirements of nursing and their religious values, as revealed by their use of terms such as "haram" (forbidden by Allah) to describe the tasks. Since most of their male patients were also Muslim, the student nurses perceived that these patients would also be embarrassed and upset by the requirement to expose their awrah to a female Saudi nurse. Some provided what they saw as evidence of this by referring to cases in which male patients had requested a male or non-Saudi female nurse to avoid embarrassment.

However, the findings also suggested a more complex influence of religious and other factors. For example, even though some participants expressed an awareness that Islam allows exposure of awrah for medical purposes, they still struggled to accept this.

> *I mean this situation is really embarrassing, if there is someone else to do it, why not? Why must it be me? … it's ethical - no not so much ethical, but I don't know, I feel its maybe religious! Even though in my mind it's not possible its religious. Because in religion, as God says, if there are excuses and necessity you can do it - even it was forbidden you can do it if you must, … it's complex, between ethics and religion, I don't know. (Kenan, Year 4 Interview)*

> *Nursing has existed since the Prophet Muhammad … (Peace and Blessings Be Upon Him), so I do not think there is anything that Islam forbids in nursing. I may have been raised that something like that is forbidden, but Islam does not forbid it. (Zaina, Year 4 Focus Group)*

Some participants also described situations in which other student nurses from very conservative families had found these types of tasks so unacceptable that they had left the nursing degree course. This suggests that the extent to which a value conflict is experienced may depend at least in part on the students' upbringing and family attitudes.

When discussing the meaning of values, many of the participants indicated that religious values are derived from Islamic texts and are firmly fixed, while cultural values are influenced by a range of factors such as family upbringing and education and can change over time. Since Islamic religious beliefs were in general shared by all the research participants, these cannot fully account for the differences in their experiences of value conflicts, but differences in cultural values and beliefs might.

3.3. Theme 3: Different responses to the value conflict as evidence of cultural influences

Participants fell broadly into three categories based on their reported responses to this type of value conflicts, a finding which indicates that cultural as well as religious factors may have an influence on the experience of value conflicts and responses to them. These categories were defined in the analysis as "reluctant acceptance", "outright refusal", and "willing acceptance" and are discussed in turn below.

3.4. Reluctant acceptance

Despite their discomfort about having to provide personal care for male patients, most of the student participants in both years of study accepted that this would become necessary in emergency

situations and indicated that they were prepared to tackle the challenge when necessary.

In our culture it is against our morals that a girl will do that especially for a male patient! But I have to do it because (of) professional value(s) and it is a duty and my work to do it. (Zaina, Year 4 Focus Group)

However, most of the participants who fell into this category also stressed that they would ask a male or foreign nurse to take over these types of tasks in non-emergency situations if possible, and only carry it out themselves as a last resort. This appeared to have become a widespread informal practice in the students' clinical work experience.

We are on a friendly agreement that I won't do it, someone else will … any other female nurse who is fine with it. (Kenan, Year 4 Interview)

If I was in the hospital and I have to do it to a male I can go look for male nurse, but if I am there and I have to act, I would not rely on male nurses. I learn it because there might not be a male nurse. (Nuha, Year 2 Focus Group)

Since most of the students had very little clinical practice experience, however, many of their comments were based on how they felt they would respond to hypothetical scenarios. Of those who discussed first-hand experiences or observations, some described feelings that suggested they were experiencing some desensitisation to the conflicts, or increased confidence in dealing with the tasks in which they arose.

In the beginning when we took only theory and studied inside the university, whenever they tell us we will deal with the male we feel like … No, impossible I mean I can't! But later when we went to the hospital and saw the nurses deal with them, we saw how the patient was in real need of us and to care for him. So this conflict we used to have and we say no to, I feel it is much less now and it's fine to deal with the other gender (Bushra, Year 2 Interview)

Things like cleaning or bathing might be weird for those in second-year but we already did it so now we feel like even inserting catheter is normal. We are already used to it. (Retal, Year 4 Focus Group)

Again these findings suggest that for some participants, the conflicts arise due to their cultural values, which are more amenable to change over time, than to immutable Islamic values and beliefs.

3.5. Refusal

A considerable number of participants, however, indicated that they could not accept the idea of exposing male awrah at all. Many of those who gave this type of response appeared to be under the impression that as Muslims they are not allowed to perform such tasks and that they are therefore permitted to ask someone else to take over.

Genital hygiene … I mean we don't do it here … I mean as Saudis and because this is our values … the foreigners are the ones who do it. Originally, they (the university) *said to us that we don't have to do it because we are not required to. (Sawsan, Year 4 Interview)*

I will say that I don't want to do it. It will not affect my evaluation or assessment. (Yara, Year 4 Interview).

In the case of this category of participants, it seems likely that religious rather than cultural values are the main influence on experiences of value conflict when required to provide personal care to male patients. However, religious values do not necessarily result in an insurmountable value conflict, as demonstrated by the third type of response discussed below.

3.6. Willing acceptance

A small minority of students, most of whom were in their fourth year of study, indicated that although they still found exposure of male awrah difficult they also viewed such tasks as an opportunity to demonstrate their care for patients. These students conceptualised this approach in terms of an Islamic approach to healthcare which did not therefore result in value conflicts.

I wanted to add to the bathing and cleaning discussion. Not only that it becomes a regular thing, now I feel it's important to the patient so I do it with love. (Zaina, Year 4 Focus Group)

When you see the patient in this condition I feel that all the values you have will change and your thinking will be about taking care of this patient because he cannot do anything! So you have to help him and take care of him in every aspect, regardless of anything. (Bushra, Year 2 Interview)

This approach helps demonstrate that exposure of male awrah by female Muslim nurses is not necessarily incompatible with Islam. It also provides important insights into the ways in nurse education might focus more on Islamic values relevant to the nursing context, to help overcome the value conflicts that other female Muslim student nurses are experiencing in such situations.

3.7. Theme 4: Faculty reinforcing potential for the value conflict

The research revealed an awareness on the part of faculty of the types of value conflicts experienced by students when required to provide personal care to male patients. However, most faculty participants appeared to be doing little to address or help reduce the potential for these conflicts. Indeed, some expressed personal beliefs that Muslim nurses are not allowed to provide this kind of care and reported that they will excuse students from doing so. The researcher could find no evidence of any formal policy supporting this approach. The interviews also revealed that at least some of these female Muslim faculty members also still experience their own value conflicts when required to expose male awrah even though they accepted the need to do so.

I mean we don't force them to do anything like this! And it is not our job to do this as long as there is male nurse and the male nurse is the one who do this stuff. (Alana, Faculty Interview)

It is even difficult for me … it is correct that I do not examine strict pudenda … I can do a full examination but those areas. If I have to do it, for example, an accident in the road and the person is bleeding then I will have to do what is necessary even near such areas. (Ekram, Faculty Interview)

Some of the faculty members indicated that their own nursing education had taught them that nurses are not allowed to expose male awrah and that they had therefore adopted this as their own approach when teaching students.

I never taught something related to the male, anything related to the genital areas. For example, when I have catheterization class I used to explain about the female only, the genital cleaning demonstration is on a female part. I never explained the male. Because I believe that we shouldn't do these things. (Shadan, Faculty Interview)

In the clinical they told us that Foley catheter we don't do it, in clinical as a student it is not a condition to do it for male patient.

The doctor could do it or one of the doctors or male nurse if there is no male nurse a doctor. (Alana, Faculty Interview)

These findings indicate that the nursing faculty, instead of helping to reduce the potential for student value conflicts, may be exacerbating them. Along with other institutional factors discussed in the next section, this is something which needs to be addressed by the university, perhaps through the use of awareness-raising workshops or other educational initiatives for faculty.

3.8. Theme 5: Istitutional factors contributing to the value conflict

A documentary analysis conducted by the researcher as part of the case study revealed no evidence of any formal policy relating to the exposure of male awrah by female Muslim nurses in use at this institution. Although two relevant government policy documents were identified in wider research, these provided conflicting information on whether it is acceptable for female Muslim nurses in Saudi Arabia to expose male awrah.

A Ministry of Health directive (2005) indicates that only healthcare providers of the same gender as the patient can expose their awrah. In contrast, the Saudi Commission for Health Specialties' Code of Ethics for Healthcare Practitioners (2014) acknowledges that in cases of necessity, healthcare professionals can expose awrah of patients of opposite gender if a professional of the same gender is not available. A religious fatwa (formal ruling by an Islamic scholar) was also located, but this only referred to care in the context of operating rooms. None of the faculty or student participants expressed awareness of any of these documents.

When asked in their interviews whether they felt that a religious fatwa covering exposure of awrah would be useful, most of the faculty participants agreed, and indicated that this would help remove any doubt about acceptability of this within Islam.

We connect our curriculum with Islam - of course you will convince the students in this way … Like the awrah, for example, if you work in a hospital and are told that you must do this … that is it … Fatwas are our reference and our guidance. (Shadan, Faculty Interview)

A few faculty members, however, expressed the view that fatwas are not likely to be very effective in reducing the scope for value conflicts. They explained, for example, that these do not always provide clear guidance as they are typically modified over time or can be subject to different interpretations.

We honestly always hear there is changes in the fatwas, there is fatwas from 10 years ago which prohibits something where nowadays it's allowed (Mayar, Faculty Interview)

I am a good Muslim and I am praying and doing religious matters but I feel that sometimes we should not mix things up. Because we will complicate it, I see in the end I'm here saving life! So I can do what I can without breaking religion or human being rights. (Alana, Faculty Interview)

This divergence in views on the potential effectiveness of fatwas in reducing the potential for value conflicts was mirrored to a large extent in the student interviews and focus groups.

Yes, of course, to know exactly what is required from me, what I am allowed to do, what is acceptable .... So, when the policy says that I am not require exposing male private area I feel good from not doing it without conflicting my professional values. (Baraa, Year 2 Interview)

Fatwas are not fixed at all times … we are still wondering whether it is forbidden or not .... Like driving, who knew that we might drive some day! (Nadeen, Year 2 Focus Group)

One of the factors contributing to value conflicts appears to be a lack of transparency at the outset of nurse training about the types of tasks that nurses are required to undertake. The findings even revealed that students and their families are often led to believe that Saudi student nurses will only be required to care for female patients.

We start or enter the program and we have things that we don't have any idea about … and did not think about. And … many parents let (their daughters) take nursing expecting that they will be working with females as they are studying in a female college (Yara, Year 4 Interview).

From the beginning of my studies they used to say that most male patients are treated by male nurses … They don't tell you how to deal with men and you have this idea in mind, it will be always caring for women. (Amal, Year 2 Interview)

It was also mentioned by both student and faculty participants that nursing students only ever practice on female dummies and receive very little training in the care of male genital area. This may therefore be contributing to the widespread belief that such tasks are not required of female Muslim nurses.

What they teach us is women catherization, for example, they didn't teach us on male. So I don't think it would be a thing for us, we are in Saudi and I think yes male nurse to handle it. (Kenan, Year 4)

Some of the faculty participants recognised that the students need more practical training but explained that this is hindered by the Nursing College's lack of access to suitable facilities such as the simulation lab used by medical students.

They don't have enough exposure yes, they need more. It is only 4 to 5 h which is not enough, perhaps the internship could help them more to change. (Alana, Faculty).

We do not have a dummy for male bodies but they study the procedure … It might be there in the simulation lab but even the simulation lab we cannot go there and that is another problem … It is mainly used by medical students. (Ekram, Faculty Interview)

Overall, there is considerable evidence from the students and faculty participants that the current teaching environment and practices of this nursing programme may be contributing to the experience of value conflicts by its Muslim student nurses. The following section discusses and considers the implications of the research findings.

4. Discussion

This study provides important insights into one of the main types of value conflict affecting female student Muslim nurses on a nursing degree programme in Saudi Arabia. There is evidence from this and previous studies that the dominant religious and cultural values of this society, specifically the Islamic principle of modesty which requires concealment of a person's "awrah, can come into conflict with the professional values of nursing. These nursing values specifically require the provision of the care needed by patients, which will often include personal care such as catheterization and bed-bathing.

The study revealed a lack of clear and non-conflicting guidance on this issue in the nurse education curriculum at this university. As a result, students and even faculty members struggle to accept some types of nursing responsibilities. A number of participants acknowledged that Islam allows them to perform such tasks in situations of medical necessity, though there was widespread confusion as to what constitutes necessity. As a consequence, a

widespread yet erroneous belief exists among the research participants that female Muslim nurses are not allowed to undertake these tasks. Informal practices have become widespread allowing student nurses to refuse or avoid these tasks, which are often facilitated or supported by faculty. This situation is only likely to reinforce the potential for value conflicts over time, as students are not gaining familiarity with or confidence in performing these tasks in ways that might contribute to a realignment of their values.

One of the most valuable insights of the study is that this form of value conflict appears to arise at least in part from cultural influences rather than religious values and beliefs per se. This conclusion is based on a number of findings from the interviews and focus groups, such as the differing value conflict responses of students from different family backgrounds, even though all participants were Muslim Saudi Arabians, and the ways in which some students had become more comfortable with such tasks over time. In general, the students defined religious values as fixed and mandatory throughout one's life, and cultural values as those which can change over time reflecting the experiences and learning that individuals undergo. This suggests that there may be scope for the university to introduce awareness raising and value-change initiatives to help students and faculty modify cultural values that are currently contributing to the experience of value conflicts.

Policies and guidance clarifying the types of nursing tasks that are permissible within Islam are needed to underpin such value-change initiatives. At present, the limited availability of official, non-conflicting guidance from religious, professional or governmental authorities is likely to be hindering the required value changes. Whether based on religious fatwahs, professional codes of practice or other types of guidance, such guidance will be critical in enabling nurse education institutions in Saudi Arabia to develop institution-level policies, practice and training that reduce the potential for value conflicts. An increased use of simulation techniques and expansion of the practical hospital-based training experience offered to student nurses at an earlier stage of their studies may also help to familiarise and gradually desensitize students to the tasks currently causing value conflicts.

New policies and guidance can form only part of the solution, however. Student nurses and faculty will also need to undergo certain psychological processes in order to reconcile deeply held beliefs and values with the conflicting requirements of their nursing roles. Rokeach's (1979) value change theory can provide a useful theoretical framework for initiatives intended to promote these changes by facilitating open discussion of value conflicts in a classroom setting. This theory postulates that value changes can occur when individuals acknowledge and understand the reasons for their value conflicts, while learning about and gradually internalising values that are better aligned with one another. Such initiatives might build on the experiences of those students who have been able to accept the tasks that create value conflicts in others, conceptualising them in terms of an Islamic healthcare approach. This argument is supported by previous research in Saudi Arabia and other conservative Islamic settings, which has shown how a focus on the spiritual aspects of care is an important component of the self-identities of some Muslim nurses (Atefi et al., 2014; Mebrouk, 2008; Ravari et al., 2012).

Nursing faculty will need to play a leading role in these awareness-raising initiatives in ways that help promote the alignment of students' personal and professional values. At present the findings of this study suggest that many of the faculty members in the case study institution, due to their own confusion or lack of knowledge about the nursing tasks permissible within Islam, may be reinforcing the potential for value conflicts among students. It is important for the university to ensure that nursing department faculty are provided with official guidance regarding the exposure of male awrah by female Muslim nurses, and helped to undergo their own value change processes, perhaps in faculty workshops in which the issue of value conflicts is openly discussed.

5. Limitations

Although the research was primarily intended to investigate value conflicts at a single case study institution, it has generated findings likely to be of interest and relevance to similar nurse education institutions in the region. However, it is not known to what extent the case study university and its student nurses and faculty are typical of others in Saudi Arabia or other Middle Eastern countries. This limitation must therefore be taken into account when considering the wider relevance of the findings. Another potential limitation was the use of self-selection procedures in sampling. Relatively high percentages of eligible students in each year group (28%; 44%) volunteered to take part in the study, and the final samples were selected using a mix of purposive and random sampling methods. This helped reduce the potential for self-selection bias. However, it is not known whether the student nurses who volunteered and were selected to take part differed from non-volunteers in ways that might have affected the research results. Finally, there are potential limitations involved in analysing translated data, relating to the possible misinterpretation of what was said by participants, or the loss of cultural nuances in translated data (van Nes F. et al., 2010). It is believed that the researcher's fluency in both English and Arabic and her direct responsibility for all stages of data collection and analysis helped minimise these types of risks.

6. Conclusion

The findings of this study help contribute to a more robust evidence base regarding the experience of nursing in Saudi Arabia, and the development of best practices in the management of these, which may ultimately help Saudi Arabia to successfully implement the Saudization policy and the Saudi Vision 2030 and thus contribute to overcoming its current nursing shortage.

The study also contributes to the wider body of research-based knowledge about the experience of value conflicts among female Muslim nurses in Islamic countries. These indicate that the types of nursing tasks which often result in value conflicts for student nurses may not be incompatible with Islamic values per se. Since many of the student nurses acknowledged that personal and cultural values can be changed over time, while religious values must remain fixed, this suggest that value conflicts might be reduced by the introduction of educational content and strategies which promote open discussion of value conflicts and the religious and cultural influences on these. In the longer term, the development and availability of formal guidance clarifying which types of nursing tasks and behaviours are acceptable within Islam are likely to be important in any conservative Islamic healthcare context in which female nurses are required to care for male patients.

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Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

CRediT authorship contribution statement

Hanadi Yaseen: Conceptualization, Methodology, Investigation, Writing – original draft, Writing – review & editing. **Karen Smith:** Supervision, Validation, Writing – review & editing. **Joan Cameron:** Supervision, Validation, Writing – review & editing. **Jane Fenton:** Supervision, Validation, Writing – review & editing.

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Supplementary materials

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