University of Dundee

DOCTOR OF PHILOSOPHY

Exploring and understanding the personal and professional value conflicts experience for undergraduate nursing students in Saudi Arabia

Yaseen, Hanadi Mohammed

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Hanadi Mohammed Yaseen

Thesis submitted for the Degree of Doctor of philosophy

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF APPENDICES

ACKNOWLEDGEMENTS

DECLARATION

I, Hanadi Yaseen, hereby declare that I am the author of the thesis. Unless otherwise stated, I have consulted all the references cited. I have carried out the work of which the thesis is a record and the work has not been previously accepted for any higher degree.

Signature: Date 26 July 2019

Hanadi Yaseen

All conditions stated within the Ordinance and Regulations of the University of Dundee have been strictly adhered to and fulfilled by the candidate, Hanadi Yaseen.

Supervisor's Signature: Date 26 July 2019

Dr. Karen Smith

GLOSSARY

Aib: Arab cultural term meaning "shameful"

Awrah: The parts of the body that should be kept covered in the presence of a 'stranger'. A woman must be covered in presence of any male apart from the mahram, except the face and hands (up to the wrists). A man must be covered "from the navel to the knee" in presence of any female apart from the mahram.

Fatwa: An Islamic religious ruling, issued by a recognised Islamic religious authority.

Haram: forbidden by Allah

Hadith: The documented words, actions or habits of the Islamic prophet Muhammad, used in developing Sharia law.

Hijab: The Islamic principle which relates to the need to protect the modesty and dignity of people. The term is used specifically to refer to the head covering worn by many Muslim women in the presence of non-mahram, and in broader terms to refer to modest clothing and behaviour.

Mahram: Any relative that a Muslim is not allowed to marry is mahram, if they are of the opposite sex and have reached puberty. These include blood relatives such as parents, grandparents, siblings and grandchildren, and also in-law relatives such as father-in-law, mother-in-law, stepfather/stepmother and stepson/stepdaughter.

Qur'an: The Muslim holy book and main religious text, believed to be a revelation from Allah (God), and used to develop Sharia law.

ABSTRACT

Background: Saudi Arabia is facing a nursing shortage, but it has traditionally been difficult to attract local Saudi Arabian women to this profession. Literature indicates that practising Saudi Arabian nurses experience value conflicts because of the poor status of nursing in this society and the ways in which their nursing roles conflict with religious and cultural values. Little research has been conducted, however, into value conflicts among female Muslim student nurses in Saudi Arabia; this is important so that value conflicts can be addressed at an early stage of their education and to generate information for use in improving the public image of nursing in Saudi Arabia.

Aims: The study investigated the experiences of value conflicts among a sample of female Muslim student nurses in a higher education institution in Saudi Arabia and to explore the awareness and views of faculty about these conflicts. It developed practical recommendations for the case study institution based on the findings.

Methods: An exploratory qualitative study used interviews and focus groups with second and fourth-year nursing degree students. The main study used a qualitative case study methodology. Interviews and focus groups were conducted with further samples of second and fourth year female Muslim student nurses, and interviews were carried out with a sample of faculty. A documentary analysis was also conducted.

Findings: All the student nurses were found to be experiencing value conflicts, most commonly between professional values, relating to the importance of providing the best patient care, and religious and cultural values which prohibit close contact between unrelated individuals of different genders and specifically the exposure of private areas of the body (awrah). Family background appeared to have an influence on the extent to which value conflicts were experienced, suggesting that these are influenced by cultural factors. Faculty were aware of the value conflicts, but were doing little to address them constructively; the documentary analysis revealed that the issue is barely covered in nurse education. There was confusion among students and faculty alike about the types of nursing tasks that are acceptable within Islam, and informal practices allowing students to refuse tasks causing value conflicts were

widespread. However, some of the student nurses reported avoiding value conflicts by viewing nursing as a way of demonstrating Islamic values such as love and care.

Conclusions: While there is a longer-term need for improved policies and guidance to clarify what types of nursing tasks are permissible within Islam, educational strategies and awareness raising strategies are also important. Rokeach's theory of value change was used to inform recommendations for classroom discussions intended to improve transparency and discussion of value conflicts and promote the adoption of new mindsets in which nursing is better aligned with Islamic values.

Key words: Values, value conflicts, Muslim, female, student nurses, Saudi Arabia, professional values, nursing, nurse education, Islam, culture.

CHAPTER ONE: INTRODUCTION

1.1 Introduction

The Kingdom of Saudi Arabia has traditionally relied heavily on expatriate nurses, with these reportedly still accounting for around 65% to 78% of the nursing workforce of the country depending on which estimate is used (Hassan, 2017; Mebrouk, 2018). This is despite the fact that there are now 36 government and private hospitals offering a bachelor's degree in nursing within the Kingdom (Hassan, 2017). This situation largely reflects religious and cultural factors. In particular, Saudi Arabia has a male dominated culture in which many Saudi females are not permitted by their male relatives to work outside the home, particularly in a mixed-gender environment, as well as public attitudes which view nursing tasks as incompatible with the conservative religious and cultural beliefs of Saudi Arabian society, and which can also prevent Saudi Arabians from receiving certain healthcare services from a healthcare provider of the opposite gender (Hassan, 2017).

However, Saudi Arabia is now facing a critical nursing shortage (Almalki, FitzGerald, and Clark 2011; Ram, 2014; Keshk, Mersal and Al Hosis 2016). As in the case of the other Gulf Cooperation Countries (GCC) in the region, healthcare needs are expanding as the population undergoes rapid growth and numbers of elderly people also increase due to demographic transition (AlYami and Watson, 2014; Ram, 2014; Khoja et al., 2017). At the same time there is a high rate of turnover and outmigration among expatriate nurses, many of whom return to their home countries after a period of time in Saudi Arabia (Abu-Zinadah, 2004; 2006) and, it has traditionally been difficult to attract local Saudi Arabian women to the nursing profession due to religious and cultural influences. This results in an increasing gap between the demand for and available supply of nurses. There are other important reasons why more Saudi nurses are needed within Saudi Arabia: for example, the population of this country is almost entirely Muslim and researchers have highlighted the ways in which local Saudi nurses are often better prepared than non-Muslim foreign nurses to understand and meet their specific healthcare needs, many of which are related to Islam and Arab culture (e.g. Abu-Zinadah, 2006; Alamri, 2012; Lovering, 2008; 2012; Hassan, 2017).

In recent decades, the Saudi Arabian government has been operating a "Saudization" policy, in which targets are set for the employment of Saudi nationals in various types of organisations throughout the economy, including healthcare (Saudi Vision 2030, updated 2019). The policy was implemented after the second Gulf War (1990), when many experienced expatriate nurses had left Saudi Arabia, which impacted adversely on the healthcare sector, and is also intended to help reduce the continuing high unemployment rates of Saudi nationals which reflect the historic reliance on foreign professionals in many sectors of the economy (Aljedaani, 2017). Within healthcare, initiatives to support the Saudization policy have included significantly expanding nurse education provision.

However, much of the growth in the number of Saudi nationals in the nursing profession has been among men, who reportedly now account for 50% of all Saudi nurses (Alboliteeh et al., 2017). Saudi Arabia still faces considerable challenges in attracting Saudi nationals, especially women, to nursing, since this has not traditionally been regarded as a desirable profession. This presents difficulties not only in terms of achieving the overall numbers of nurses required in a rapidly expanding healthcare sector, but also in terms of the provision of suitable nursing care for both male and female patients in this conservative Islamic society, due to the religious and cultural restrictions on receiving care from an unrelated person of the opposite gender. There are high levels of gender segregation in healthcare in this society, with designated female and male wards in many hospitals that are only staffed by individuals of the same gender as the patients (Alboliteeh, Magarey and Wiechula 2017; Hassan, 2017). However, it is becoming very difficult to sustain this gender-segregated care with insufficient numbers of Saudi nurses.

The limited available literature indicates that the difficulties of attracting Saudi females to nursing arise from a complex mix of religious, social and ethical factors (Hassan, 2017). However, little research has been conducted into these factors and the ways in which they may contribute to value conflicts among female Saudi Arabian nurses or student nurses. The available literature, much of which is now quite dated, indicates that these factors include Islamic principles such as those relating to interaction between the genders, and the requirement that certain parts of the body remain covered for the purpose of modesty (Lovering, 2008; AlYami and Watson, 2014). These have reportedly resulted in a situation in which many people in Saudi

Arabia regard nursing as a profession which is inappropriate for Saudi Muslim females, and hold negative attitudes towards those local women who do become nurses (Lovering, 2008; AlYami and Watson, 2014). Saudi women themselves may be reluctant to become nurses not just because of these public attitudes but because of perceived conflicts between their own religious and cultural values and those required of them as nurses, or between their personal values which are aligned with nursing and the wider values of the Islamic society. Among those who do enter nursing, studies indicate that there are high levels of attrition due to dissatisfaction with their working environment or due to the negative public image of nursing in Saudi Arabia (Alboliteeh et al., 2017).

This occurs despite evidence from religious texts indicating that nursing has a long history in Islam which dates back to the time of the Prophet Mohammed (Peace be upon him). According to religious texts, the Muslim nurse Rufaidah trained nurses, developed a nursing code of conduct, and cared for the wounded at the time of the Holy Wars, working from a tent just outside the Prophet's own mosque (Al-Osimy, 1994; Almalki et al., 2011). This indicates that, historically, nursing was regarded as an acceptable and valuable profession within Islam and that Islamic values are not necessarily in conflict with the professional values of nursing. It suggests that cultural interpretations of religious values may have an influence on public perceptions of the nursing profession and contribute to the dissatisfaction with their profession that is reportedly experienced by Saudi Arabian nurses (Alboliteeh et al., 2017).

In this context, understanding the nature of value conflicts that may be faced by Muslim nurses in Saudi Arabia is potentially complex, since religion and culture are closely intertwined in this Islamic society. It is important to do so, however, so that measures can be taken to reduce the potential for such conflicts and provide support to qualified and student nurses entering the profession to enable them to cope with such conflicts should they arise. Providing a deeper understanding of the ways in which nursing and Islamic values are compatible, as well as interventions intended to reduce value conflicts, may have the potential to attract more female Saudi nurses to the nursing profession.

This research study aims to address gaps in research and knowledge by first investigating the presence of value conflicts among a sample of second- and fourth-

year female student nurses in Saudi Arabia and, if found to be present, by examining their first-hand experiences of these and their understanding of why the value conflicts occur. It also explores the awareness and perceptions of student value conflicts among a sample of nursing faculty at the same institution. The research consisted of two distinct stages, an exploratory qualitative study using interviews and focus group that confirmed the presence of value conflicts among students, and the main study which explored these issues further using the same qualitative methods. The main study also included interviews with a sample of nursing department faculty.

The focus on a single case study setting in both stages of the study enabled the researcher to explore in detail how the issue of value conflicts is being experienced and addressed at one nurse education institution in Saudi Arabia and to develop recommendations tailored to the needs of this institution and its students.

The study was informed by the use of a theoretical framework based primarily on Rokeach's (1973) theory of the nature of values, which distinguished different types of values, the factors which influence these, and how values can come into conflict and change over time. By using a theoretical framework based on the concept of value conflicts, the study links with a wider body of international literature (discussed in Chapter 2) which has documented the impacts of various forms of value conflicts on newly qualified nurses and on their attrition from the profession (e.g. Forsyth and McKenzie, 2006; Takase, Maude and Manias, 2006). It contributes new insights to the understanding of this issue by examining the experience of value conflicts by female Muslim student nurses in the context of the conservative Islamic society of Saudi Arabia.

1.2 Background

Around the world, student nurses enter their undergraduate nursing education with a set of personal values, which for some may have contributed to their decisions to enter the nursing profession (Stacey et al., 2011). A range of factors including the individual's cultural or religious background, their education and the social groups they belong to, influence the development of personal values. Although some values are common to many student nurses internationally, such as altruism, a caring approach and concern for the dignity of individuals (Department of Health, 2000; Rogers, 2012), others will reflect their divergent backgrounds and experiences. For

example, in Muslim Arab societies such as Saudi Arabia, there is a strong emphasis on the family unit rather than the individual, and on respect for a patient's religious beliefs when delivering healthcare (Lovering, 2012). In contrast, student nurses who have grown up in Western societies are more likely to hold values relating to individual rights, privacy and freedom of choice (Lovering, 2008).

During their nurse education, students also learn about professional values, or the expected or required ways of thinking and behaving in this profession. These may be formalised in professional codes of conduct as well as the educational curriculum, or tacit and passed on by nurse educators and through the students' experiences of working with qualified nurses (Mackintosh, 2006), in a vicarious form of learning (Bandura, 1962). If these professional values are aligned with the personal values of the students, they will generally be internalised over time and will become closely intertwined with their personal values (Stacey et al., 2011).

Numerous studies have shown, however, that upon graduation and entry into clinical practice, nurses often experience difficult transitions and that emerging value conflicts may contribute at least in part to these. For example, conflicts may arise between the nurses' personal values or those learned during their nurse education, such as a focus on patient-centred care, and the professional values that they find to be dominant in the nursing workplace. These workplace values may relate, for example, to a hierarchical and prescriptive organisational culture or a focus on efficiency and productivity rather than patient-centred care (e.g. Boychuk Duchscher and Cowin, 2004; Forsyth and McKenzie, 2006; Maben, Latter and Macleod Clark, 2006; Takase et al., 2006; Boychuk Duchscher, 2008). Researchers have also found evidence that value conflicts can arise when the professional values of the nursing profession come into conflict with religious and cultural values. This may occur, for instance, when the secular and scientific approach dominant in Western models of medical education clashes with local cultural or religious beliefs about how to care for sick patients, which might for example include using traditional medicines or praying with them (Lovering, 2008), or when the religious or cultural beliefs prevent a patient from accessing crucial medical care in life-threatening situations (Hassan, 2017).

Researchers have found evidence of a wide range of psychological and physical impacts on newly qualified nurses arising from the value conflicts and other pressures

they face in the clinical practice environment. These documented impacts include, for example, "burn out" and exhaustion, disillusionment, reduced confidence or self-esteem, lowered resistance to illness and "moral distress" (Altun, 2002; Stacey et al., 2011; Brien, 2012; Solum, Maluwa and Severinsson 2012). According to research conducted in settings such as the United Kingdom and Australia, conflicts between nurses' personal and professional values often contribute to their decisions to leave the profession due to low job satisfaction (e.g. Forsyth and McKenzie, 2006; Takase et al., 2006). Conflicts between personal or cultural values and the perceived or actual requirements of nursing may also deter individuals from entering the nursing profession.

1.3 Rationale for the Study

The overall demand for nurses is increasing in Saudi Arabia and the country is facing a critical nursing shortage (Almalki et al. 2011; Keshk et al., 2016; Aljedaani, 2017). This significant and growing shortage of nurses in the Kingdom has resulted from a combination of factors.

First, nursing has not been traditionally regarded as a desirable profession for Saudi Arabian females, due to the perceived clash between what nurses are required to do and the values and teachings of Islam. As a result, it has been difficult to attract Saudi women to nurse education. As observed by the World Health Organization (WHO, 2013), Saudi Arabia relies heavily on expatriate nurses. Previous literature (Lovering, 2008; Almadani, 2015) suggests that the reluctance of Saudi Arabian females to enter nursing may be due to a mix of religious and cultural factors relating to gender segregation and beliefs about acceptable forms of contact between the genders.

Second, several studies (Lovering, 2008; Mebrouk, 2008; Alyami, 2014) have reported that practising Saudi Arabian nurses experience value conflicts or other pressures because of the poor status of nursing in this society and the ways in which their nursing roles and responsibilities conflict with their religious and cultural beliefs and those of their family, who believe for example that nursing is incompatible with the norms of Saudi Arabia's Islamic society (Hamdi and Al-Hyder, 1995; Al Mutair et al., 2014; Miligi and Selim, 2014; Rassool, 2015; Hassan, 2017). This may result in attrition from the nursing profession in Saudi Arabia; studies with qualified nurses have

indicated that a high percentage do not intend to remain in this profession (Alboliteeh et al., 2017).

Third, there is a high rate of turnover and outmigration among expatriate nurses (Abu-Zinadah, 2004; 2006), many of whom come to Saudi Arabia on short term contracts, to gain training and experience before moving home or to other countries (Alamri, Rasheed and Alfawzan, 2006; Alhusaini, 2006; AlYami and Watson, 2014).

Finally, overall demand for nurses is increasing in Saudi Arabia. The population is expanding by more than 3% annually (AlYami and Watson, 2014) and the country is undergoing significant socio-economic development. This not only increases demand for healthcare but also raises public expectations that this will be readily available. In response, the Saudi Arabian government has been investing heavily in the healthcare sector (Aldossary et al., 2008; Al Yateem, Al-Yateem and Rossiter, 2015), in June 2016 for example it was announced that 270 billion Saudi riyals (around £54 billion) would be invested into primary care and health information technology (IT) spending, and that total healthcare sector spending would be increased from the current 25% to 35% by 2020 (Sahoo, 2016).

Additionally, the government's "Saudization" policy is intended to increase the numbers of Saudi nationals employed in healthcare jobs (among other sectors) (AlYami and Watson, 2014). This is articulated in Saudi Arabia's Vision 2030, an ambitious strategy intended to diversify the economy of the Kingdom and reduce its reliance on oil by the year 2030. The strategy is also intended to reduce Saudi Arabia's reliance on expatriate workers and boost the employment rates of Saudi nationals in all sectors by setting targets and quotas, along with initiatives to help ensure that these can be achieved. In this context, Strategic Objective 5 of Vision 2030 is to "increase the attractiveness of nursing and medical support staff as a preferred career path" (National Transformation Program, 2016), demonstrating a recognition by senior authorities in Saudi Arabia of the recruitment challenges facing the healthcare sector.

Saudi Vision 2030 presents significant challenges to the healthcare sector, however, in terms of achieving Saudization targets and reducing dependence on foreign workers in a sector in which has traditionally relied heavily on this group. One of the main strategies to support this policy is expansion of nursing education within the Kingdom. However, Al-Mahmoud, Mullen and Spurgeon (2012) reported that half of the new

nurse education places were being taken up by males rather than females, and that these students were unable to progress in their careers due to a lack of degree-level nursing provision for male students. Even if degree level places for male student nurses were to be expanded, the numbers of male Saudi Arabians taking up nursing is still likely to be inadequate to solve the problems currently faced by Saudi Arabia's nursing profession without also attracting more Saudi Arabian females to this field.

The ultimate success of Vision 2030 regarding Saudization of the nursing profession in Saudi Arabia will therefore largely depend on the ability to understand the reasons why Saudi Arabian women have not traditionally been attracted to or retained in this profession. In this way, it can be determined why the Saudization strategy has not been more effective in increasing the number of Saudi women in nursing jobs, and the necessary measures can be taken to overcome the barriers that currently exist.

While religious and cultural influences on value conflicts can be difficult to overcome, an improved understanding of these is an important first step in providing the types of guidance, support and education necessary to help student nurses in Saudi Arabia and other Muslim countries cope with experiences of value conflicts or ethical dilemmas. However, the existing evidence base, especially with regard to student nurses, is minimal and many of the studies conducted with qualified nurses are somewhat dated (e.g. Lovering, 2008; Mebrouk, 2008). There is a need for in-depth, up-to-date research to provide a more robust understanding of value conflicts among female Muslim student nurses in Saudi Arabia. Research is also needed to identify the types of measures or support that might be implemented in this setting in order to help reduce the potential for value conflicts or enable student nurses to cope with them if they do arise.

1.4 The Nature of Values and the Theoretical Framework of the Study

Since the study is focused on exploring and understanding the value conflicts for the purpose of helping to reconcile value conflicts among student nurses in Saudi Arabia, it is important to ensure that it is grounded in a robust understanding of the nature of personal and professional values. The theoretical underpinning of the study is therefore based on Rokeach's (1973) theory of the nature of values, as well as other literature which has built on this theory. Rokeach's theory of values, which has been subsequently used by many other researchers including Rassin (2008) and Moyo et al.

(2015), was originally developed in the U.S. using empirical research with individuals from a range of ethnic and social backgrounds. This theory and related literature are discussed in Chapter Two. The key points of these in relation to their use as a theoretical framework for the present study are as follows.

Rokeach (1973) provided an insightful definition of a value as "an enduring belief that a specific mode of conduct or end-state of existence is personally or socially preferable to an opposite or converse mode of conduct or end-state of existence" (p. 5). He argued that a range of values, which can relate to desired goals (terminal values) as well as the means of achieving them (instrumental values) together comprise the value systems which are held by individuals and which influence their decision making, behaviours and assessment of the actions of other people. As other researchers have established, values often influence an individual's choice of career and the ways in which they carry out their work (Stacey et al., 2011).

The Rokeach Value System (RVS), was developed by Rokeach (1973) for use in measuring the priority that individual's give to different types of values. The use and validation of this tool by many other researchers (e.g. Graber and Kilpatrick, 2008; Moyo et al., 2015) has helped confirm that Rokeach's conceptualisation of values is a useful one for studying individual decision-making and behaviours (see Chapter 2). It is reported to have a high level of validity and to be highly reliable over time in measuring personal values (Rassin, 2008). The present qualitative study does not use Rokeach's tool to measure values quantitatively. Instead, his broader theoretical and conceptual approach to understanding values is used to underpin the study, along with other literature which identifies different types of values and the ways they can come into conflict It also uses Rokeach's conceptualisation of the ways in which values change to help understand how potential value conflicts might be resolved.

Rokeach (1973) and other researchers identified a wide range of factors that influence the values that an individual holds. These include, for example, an individual's cultural or religious background, their education, participation in different social groups and past experiences (Rassin, 2008; Shahriari et al., 2012).

Although Rokeach (1973) did not distinguish between different categories of values, other researchers have identified the influence that professional and religious/cultural values also have on the experiences and behaviours of individuals (Lovering, 2008;

Rassin, 2008; Crossley and Vivekananda-Schmidt, 2009; Lovering, 2012; Alfred et al., 2013; Shahriari et al., 2013). Professional values have been defined as the views or ideologies which guide professional conduct and reflect the ethics, practices, principles and other norms that are dominant within a particular profession (Crossley and Vivekananda-Schmidt, 2009). Cultural values are those which are formed by a community and not at individual level (Dyczewski and Slawik, 2016), but which influence the personal values of individuals. Religious values are those derived directly from religious texts such as the Qu'ran, Sunnah/Hadith and from the teachings that are based on these, and which also influence personal values. In societies such as Saudi Arabia where Islamic values influence all areas of life, it can be hard to disentangle religious and cultural values (Mebrouk, 2008). Researchers have identified ways in which incompatibilities or conflicts between personal and professional values often have negative impacts on nurses and student nurses (Altun, 2002; Lovering, 2008; Mebrouk, 2008; Stacey et al., 2011; Brien, 2012; Lovering, 2012).

Rokeach (1973) acknowledged that, although many of a person's values develop in early childhood and remain relatively stable over time, some also evolve over time or change abruptly as a result of life experiences. He explained that individuals may possess values which contradict one another, a fact that they are often unaware of. When these contradictions are brought to the attention of the individual (the self-confrontation method) this results in a sense of dissatisfaction which is necessary for change to occur and for more positive and congruent values to develop. This aspect of Rokeach's (1973) theoretical perspective on values is helpful as a means of interpreting the negative emotions that individuals might experience when their values come into conflict with one another.

In a later development of his theory, Rokeach (1979) identified ten different processes through which values can change. These are described in full in chapter two (section 2.4.2). These processes are helpful 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, particularly as the student nurses become increasingly socialised into their profession. For the purpose of the present study, of particular importance are the processes whereby values held by an individual change when they become incompatible with other more dominant values, or when new beliefs are developed which transform existing values.

Figure 1. Theoretical Framework for the Study
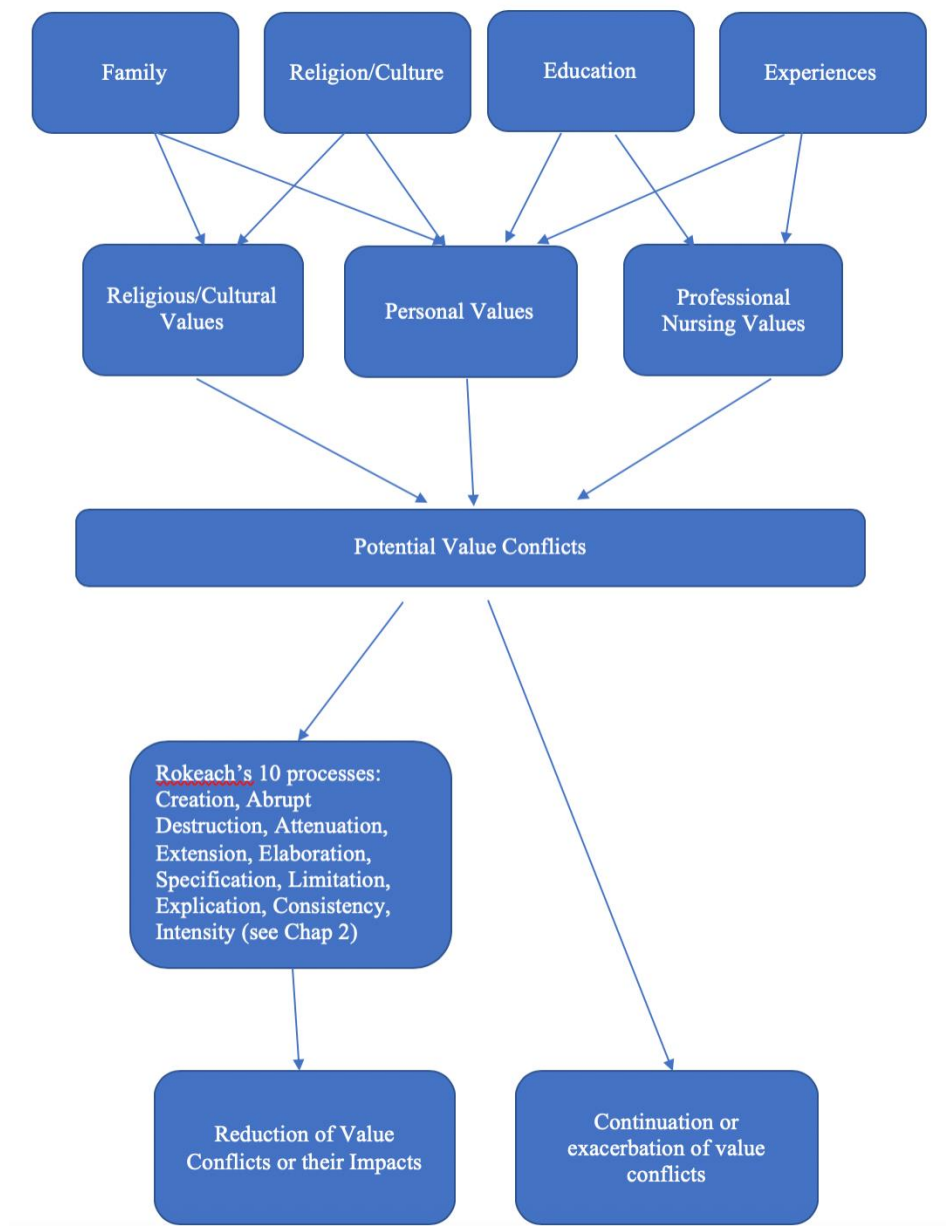
A visual representation of the theoretical framework of the current study, which has been adapted from Rokeach (1973,1979) and related literature (e.g. Altun, 2002; Lovering, 2008; Mebrouk, 2008; Rassin, 2008; Crossley and Vivekananda-Schmidt, 2009; Stacey et al., 2011; Brien, 2012; Lovering, 2012; Shahriari et al., 2012; Dyczewski and Slawik, 2016) is provided in Figure 1. Through the use of a framework grounded in a well-established theory and concepts which can aid in the interpretation of the researcher findings, the study is intended to provide new insights and understanding into the ways that conflicts may arise between the personal and

professional values of student nurses in an Arabic Muslim country and how the potential for such conflicts might be reduced.

1.5 Overview of the Study

An initial exploratory qualitative study, reported on in Chapter 3, investigated the presence of value conflicts among a sample of second- and fourth-year female Muslim student nurses at a higher education institution in Saudi Arabia. The main qualitative research study, conducted at the same case study institution, involved both student nurses and faculty. Like the exploratory study, it consisted of focus groups and in-depth interviews, and also included a qualitative review of the content of policy and training documents relevant to the possible experience of value conflicts by the student nurses.

This qualitative, case study approach enabled the researcher to gain detailed insights into the experience of value conflicts by female Muslim student nurses in a specific real-life context. The use of multiple forms of data collection also allowed examination of the issue from multiple perspectives as recommended in case study designs (Lauckner, Paterson and Krupa, 2012), and to strengthen and verify the findings of the study. The single case study design has enabled this research study to take into account the contextual factors specific to the case study site and geographical setting, and to explore the influences of multiple factors on these within this context. It also enabled the formulation of a number of practical, actionable recommendations tailored to the needs of students at this institution.

1.6 Aims and Objectives and Research Questions

The aims of the study were to investigate the presence and experiences of value conflicts among a sample of Muslim female student nurses in a higher education institution in Saudi Arabia; to explore the awareness of faculty about these conflicts and their views on the ways in which these might be reconciled, and to explore relevant documentation to provide further insights into the experience of value conflicts by student nurses at this institution.

The study also aimed to develop practical recommendations for consideration by the department of nursing at the case study institution, to help female Muslim student

nurses in this setting cope with experiences of value conflicts. The overall objectives of the research were:

- To provide an improved understanding of the experiences of value conflicts among female Muslim student nurses in years 2 and 4 of the Bachelor of Science in Nursing degree at a large public university in Saudi Arabia.
- To explore the nursing faculty's awareness and understanding of the value conflicts experienced by female Muslim student nurses.
- To investigate the views of student nurses and faculty regarding the measures or types of support that might be implemented to help female Muslim student nurses in this setting cope with or overcome their value conflicts.
- To identify whether and how content relevant to value conflicts in nursing situations is currently covered in policy, practice or training documents issued or used by the case study institution.

The exploratory study addressed the following research questions:

- What are the common values relating to their professional roles that are held by Muslim student nurses in the second year and the fourth year of the nursing degree?
- Is there evidence of the presence of conflicts between the student nurses' professional and personal values?
- If so, what are the commonalities and differences in these conflicts among the student nurses at different stages of their undergraduate education?
- What are the effects of these value conflicts on the student nurses?

Building on the findings from the exploratory study, the main study addressed the following research questions:

- What are the experiences of value conflicts among female Muslim student nurses at the case study institution?
- What factors contribute to the experience of value conflicts among female Muslim nurses at the case study institution, based on the primary research and documentary analysis?
- What are the effects of value conflicts on female Muslim students at the case study institution?

- What is the nursing faculty's awareness and understanding of the value conflicts experienced by female Muslim student nurses at the case study institution?

- What measures or types of support might be implemented to help female Muslim student nurses in this setting avoid or cope with value conflicts?

1.7 Significance of the Study

By focusing on a single institution, the study is not intended to be representative of the views and experiences of all female Muslim student nurses and nursing faculty in Saudi Arabia. However, the value of the case study approach is that it facilitated the investigation of these issues in depth within the context in which they occur in a single institution and the development of practical recommendations tailored to the needs of this institution and its students. In particular, the case study approach allowed for the investigation of the influence of contextual factors on the experiences of student nurses, within a higher educational institution located in the conservative Muslim society of Saudi Arabia.

The study is also expected to generate information that may be of wider interest and relevance to other nurse education institutions in Saudi Arabia and in other countries in which Islam is the main religion and in which the majority of the population are Muslim. Finally, it helps 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.

1.8 Structure of the Thesis

Chapter Two presents the findings of a two-stage review of literature relevant to the experiences of undergraduate student nurses when personal and professional values are in conflict. This is intended to provide a broader context for the topic, demonstrate a justification for the study and highlight its wider significance. The initial literature review covered relevant published research relating to value conflicts among student nurses in general, and the second stage structured review which focused more specifically on literature relevant to the experience of value conflicts among female Muslim nurses in Islamic societies.

Chapter Three presents the findings of the exploratory study, which explored evidence of conflicts between personal and professional values in a sample of student nurses in Saudi Arabia, for the purpose of generating initial evidence of the problem and informing the design of the main study. Chapter Four discusses the case study methodology used in the main study, offering justification for the research design and critically discussing the specific methods used. In particular, it provides information on how data was collected, analysed, and synthesised in order to generate the key findings of the research. Chapters Five and Six set out the results of the primary research findings from the main study, and Chapter Seven presents the findings of the documentary analysis regarding factors that may influence the experience of value conflicts by student nurses. Chapter Eight discusses the findings of the study in relation to the wider body of literature and the research aims and objectives. Finally, Chapter Nine summarises the most important findings of the study, considers their practical and theoretical implications and sets out recommendations tailored to the needs of the case study institution and its students. Chapter Nine also includes a summarising conclusion to the thesis.

CHAPTER TWO: LITERATURE REVIEW

2.1 Overview of Chapter

In this chapter the findings of an extensive two-stage review of relevant literature are presented. Overall, the two stages of the literature review generated a wide and varied range of literature and the identification of a range of relevant issues pertaining to value conflicts among nurses and student nurses. The first three themes draw mainly on the main literature review as described in section 2.2 and the later themes mainly report the findings of the narrower structured review described in section 2.3.

2.2 Stage 1 Literature Review Methods

2.2.1 Aims and Objectives

The aim of the main literature review was to identify and discuss any existing published research relevant to an understanding of values and value conflicts among nurses and student nurses. It was therefore much more broad-ranging in scope than the structured review, which was confined to the identification of empirical studies relating to the experience of value conflicts by Muslim nurses or student nurses in Islamic societies. It also used less systematic or structured methods of identifying relevant literature, as described below.

As Ridley (2012) observes, conducting a wider literature review at the outset of a research study helps to narrow the field of study, highlight where gaps in the literature exist, and develop an appropriate and specific research question for the study. The existing published research relating to value conflicts among student nurses was therefore identified in order to provide contextualisation for the topic and demonstrate a justification for the current study. This initial broad-ranging literature review also provided a conceptual framework for the subsequent structured review, which identified literature relating specifically to the experience of value conflicts by female Muslim nurses in Islamic settings. The research question addressed by the main literature review was:

What is the evidence from published research regarding the experiences of student nurses when personal and professional values are in conflict?

The process of engaging in a literature review using search terms related to the research question enables a researcher to generate relevant studies based on a wide range of methodologies (Merrill, 2011; Machi and McEvoy, 2012). Creswell (2013) points out that the selection criteria should ensure that the review includes studies that are aligned methodologically with the form of knowledge that the research aims to generate. In the case of the present study, both quantitative and qualitative research are important in understanding undergraduate nurses' experiences and perceptions of value conflicts and their responses to these. Qualitative studies can explore attributed meanings and subjective experiences from the personal perspectives of individual student nurses (Creswell, 2013). In contrast, quantitative studies can be useful in observing, measuring and categorising experiences in ways that minimise subjectivity but allow for comparisons between individuals and groups (Parahoo, 2011). The review therefore identified both qualitative and quantitative studies relating to the experiences of student nurses when personal and professional values are in conflict.

2.2.2 Search Terms and Strategies

For the main literature review, relevant studies were identified through utilising the university library portal to search the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline, British Nursing Index, Applied Social Sciences Index and Abstracts (ASSIA), SCOPUS, Science Direct, PubMed and Google Scholar. These databases provided access to a wide range of highly credible and peer-reviewed studies, that were identified using various combinations of relevant search terms. The selection of databases was intended to ensure that relevant peer-reviewed sources were identified from literature focusing on Nursing and Allied Health professions (CINAHL), the wider field of biomedicine (Medline), the social sciences (ASSIA) and academic literature in general (Google Scholar).

Key words used in the initial broad literature review included: nurses, student nurses, undergraduate nurses, newly qualified nurses, values, value conflicts, ethical conflicts, transitions, perceptions, experiences, clinical practice, organisational cultures, training, education, and clinical placements.

The reference lists from identified sources were then used to identify other important publications in this area in a "snowballing "process. These were then retrieved the online research databases cited above. Additional studies were also identified from the

recommendations of supervisors. The searches resulted in a wide and varied range of literature from reliable sources and the identification of a range of relevant issues pertaining to value conflicts among undergraduate nurses.

2.2.3. Results

Overall, 188 relevant sources were identified and included in the main literature review. These are included in the references list at the end of the thesis, along with the methodological sources cited in Chapter Four and at other points in the thesis.

2.3 Stage 1 Literature Review Findings

2.3.1 The Nature and Role of Values

In this section, content relating to the concept of values in general is presented, as identified from the literature review. This focuses first on values in general and then on personal, cultural/religious values and professional nursing values. The section includes a discussion, with examples, of the ways in which professional nursing values are incorporated into codes of ethics and codes of conduct.

Defining and measuring values

One of the earliest formal definitions of a value was put forward by Kluckhohn (1951) who defined a value as "a conception, explicit or implicit, distinctive of an individual or characteristic of a group, of the desirable which influences the selection from available modes, means, and ends of action" (p. 395). Rokeach (1973) defined a value as "an enduring belief that a specific mode of conduct or end-state of existence is personally or socially preferable to an opposite or converse mode of conduct or end-state of existence" (p. 5). He distinguished between two categories of values, those relating to behaviours, defined as *instrumental* values, and those relating to desired goals, defined as *terminal* values. For example, terminal values as defined by Rokeach included "inner harmony" (freedom from inner conflict); self-respect (self-esteem), and social recognition (respect, admiration), while instrumental values included ambition, obedience, forgiveness and being responsible (Rokeach, 1973).The values that individuals have are important because of their influences on decisions and behaviour, as Altun (2002) observes. According to Rokeach's (1973) theory, values are arranged within wider value systems, which are used to prioritise a person's

preferences about behaviours and desired end states on a continuum (Rokeach, 1973). They act as motivators for individuals to behave in particular ways, either in a social or professional context (Rassin, 2008). Beckett and Maynard (2005) emphasised the difficulty of making life choices without the guidance of values. Other researchers have also demonstrated that personal values effectively predict behaviour in many different settings (Kopandis and Shaw, 2013). As a result, values are often an important identifying factor, as pointed out by Mohr (1995): individuals and groups are recognised by the values they accept, and which are evident in their daily activities, choices, and decisions. As Safrit, Conklin and Jones (2003) argue, through their role in guiding behaviours, values have an important impact on the way people function not just as individuals or within their families, but also in the work setting. Values have been shown to be key determinants of the ways in which individuals practise nursing, for example (Stacey et al., 2011)

As well as directing behaviour, values are used by individuals to understand and evaluate their environment, including the behaviours of others (Güngör, cited in Kaya et al., 2012). Fritzsche and Oz (2007) highlight the importance of values in the ethical dimension of decision-making and explains that this takes the form of a process whereby values lead to the development of particular attitudes that result in specific decision-making behaviour. Ravari et al. (2012) also focuses on the ethical importance of values for individuals, describing these as a "launching pad from which their thoughts, attitudes, choices, decisions, behaviours, and actions are formed. Similarly, Williams (cited in Rokeach, 1979) explained values as the standards or criteria that not only guide action but "judgement, choice, attitude, evaluation, argument, exhortation, rationalization, and … attribution of causality" (Rokeach, 1979, p.2).

Rokeach (1973) developed a research instrument, the Rokeach value system (RVS) for use in measuring the priority that individual's give to different types of values. When completing this questionnaire, respondents are asked to arrange 18 terminal values and 18 instrumental values in ways which reflect their own personal priorities. The instrument has been tested by other researchers and is reported to have a high level of validity and to be highly reliable over time in measuring personal values (Rassin, 2008).

Some researchers have used Rokeach's theory to examine values at individual or organisational level. For example, Moyo et al. (2015) incorporated Rokeach's definition of values and the ways in which they influence behaviour, as well as the identification of specific types of values from Rokeach's work, when developing a new conceptual framework for their study of the personal and professional values of healthcare practitioners. Their approach thus overlaps with but also differs from the current study, which uses Rokeach's broad conceptualization of values and the processes of value change to collect and interpret data relating to the research questions of the study. Kopelman, Prottas, and Tatum (2004) examined the utility of Rokeach's theory along with three other theories of values in guiding the educational choices of graduates, though concluded that the theory had limited utility in this context. The review of literature indicated that healthcare researchers have mainly used Rokeach's theory only in their initial definition and explanation of values and not as an overall theoretical framework for their studies (e.g. Graber and Kilpatrick, 2008; Rassin, 2008; Farnsworth and Callaghan, 2013). The present study thus adds to the literature in this area by drawing on Rokeach (1973, 1979) as a theoretical framework.

Value formation and change

According to Rokeach (1973) values first develop in early childhood and remain relatively stable over time. However, values also evolve or change over time to reflect an individual's experiences, such as their interactions with other people. Some values will be reinforced by these experiences and become stronger, while other values weaken or change (Rokeach, 1973). Rokeach (1973) explained the value process change in terms of the self-confrontation method. This acknowledges that individuals may possess values which contradict one another, and that they are often unaware of this. When these contradictions are brought to the attention of the individual, this results in a sense of dissatisfaction which is necessary for change to occur and which can result in the development of more positive and congruent values, or alternatively if not addressed can result in the various negative impacts and discomfort associated with value conflicts (see Figure 1). In a further development of his theory, Rokeach (1979) identified ten specific processes through which values evolve or change over time. He defined these as:

- Creation, during which a new belief is developed and transforms an established value

- Abrupt destruction, a rare situation in which a major event changes previously accepted values

- Attenuation, or a gradual withdrawal of support for a value previously held

- Extension, or the application of the value orientation from specific objects or events to others

- Elaboration, which involves progressively rationalizing a value until it becomes embedded in a sociocultural context

- Specification, whereby a generalized value is increasingly defined within particular contexts in which it is defined, such as equality of opportunity rather than just equality per se

- Limitation, which occurs when a value is modified because of increasingly incompatibility with other dominant values

- Explication, or the tendency to make a previously implicit value more and more explicit

- Consistency, or the tendency for certain values to become more or less consistent

- Intensity, or the ways in which values either become intensely held and the focus of life in a particular society, or less intensely held over time, receding into the background of daily life.

Though not all of Rokeach's (1979) value change processes are necessarily relevant to the current study, as will be considered later in the light of the findings, the importance of his theoretical work on values and value change is that it can be used to understand the ways in which the values of student nurses develop and can come into conflict, and the ways in which these conflicts might be reduced or reconciled over time.

2.3.2. Types of Values

Although much of the literature discusses values in general terms, four main categories of values can also be identified, which are discussed in turn in the following section with specific reference to their influence in the nursing context. These consist of personal values, cultural values, religious values, and professional values. The impact

of religious values on healthcare, a vast topic in its own right, is considered here in the context of Islam specifically rather than other religions.

Personal values

Researchers have demonstrated that personal values are shaped by many different factors including an individual's cultural or religious background, their education, participation in different social groups and past experiences (Rassin, 2008; Shahriari et al., 2012). Blancett and Sullivan (1993) reported that friends, families, and religious persons/institutions all wield a significant influence on the development of personal values. The resulting choices and behaviours of individuals vary considerably as a result (Iacobucci et al., 2012). This extends to their choice of career; particular types of personal values have been shown to be associated with different professional groups, including nurses.

This was demonstrated in a qualitative study conducted by Stacey et al. (2011), based on interviews with twelve mental health nurse participants in the UK, in which the participants reported that their personal values did not develop as a result of their nurse education, but were established prior to this. Providing further evidence that this is also the case for other types of nurses, a quantitative study investigating the personal and professional values held by nurses in Israel (Rassin, 2008) reported evidence that these were influenced by a wide variety of factors including culture, education, age, length of work experience, position and field of expertise.

Personal values are key determinants of how nurses' practice, possessing the capacity to influence their actions and shaping the development of their professional identities, as well as the types of self-perception and understanding of one's role which develops over time as nurses internalise the values, norms and expectations of their profession (Stacey et al. 2011). Borawski (1994) noted that personal values denote nurses' ideas of what it means both to be and to act as a good nurse. Nurses apply personal values as valuable assets in taking decisions in practice as they interact with patients (Fagermoen, 1997). The types of personal values held by nurses and student nurses are also likely to influence their experiences and responses to professional values and models of care that they encounter during clinical practice and placements (Kaya et al., 2012).

A number of researchers have explored the types of values typically held by nurses and student nurses. The most frequently reported personal values among the mental health nurse participants interviewed by Stacey et al. (2011) were a commitment to person-centred care and the therapeutic relationship; an emphasis on the achievement of the client's own goals, and the improvement of services for the benefit of individual clients. In contrast, in a quantitative study of 323 Israeli nurses in which respondents were asked to rank the relative importance of 36 personal and 20 professional values (Rassin, 2008), the most highly rated personal values were found to be honesty, responsibility and intelligence. A review of previous literature by Altun (2002) concluded that the dominant values in nursing today include altruism, freedom, human dignity, justice, and truth.

In Saudi Arabia, Alboliteeh et al. (2017) conducted a quantitative survey of 741 male and female nurses in government hospitals in Riyadh between 2013 and 2014. The majority (75%) of respondents were female. They found that motivation to enter the nursing profession was mainly associated with altruistic values such as a desire to help people or help them cope with illness. These were found to be slightly more influential than values relating to a desire for job security or career advancement.

Relatively few studies have investigated the personal values of student nurses rather than qualified nurses. However, research conducted in the UK has revealed that many student nurses hold personal values which relate to helping, caring for and supporting the needs of patients; altruistic feelings and a nurturing and caring approach that is aligned with the person-centred model of care (Department of Health, 2000; Rogers, 2012). Similarly, Pearcey and Draper (2008) found that the key personal values held by student nurse participants in their UK study were caring, compassion and kindness. However, there is also some evidence from the literature that personal values held by nurses or student nurses vary between cultures, as discussed further in the following sub-section.

Cultural values

Because personal values reflect individual experiences and backgrounds, it is perhaps unsurprising that researchers have identified differences in dominant values between nurses in different cultural and geographical settings. Shahriari et al. (2013) reviewed literature on nursing ethical values and definitions from 1995 to 2010 and highlighted

the importance of values that originate from the cultural environment in which nurses have grown up, as well as their religious or spiritual affiliations and experiences. The authors did not discuss any changes in the dominance of different types of values among nurses over time.

Differences in the dominant values of nurses growing up in different cultural environments were also observed by Alfred et al. (2013), who conducted a study in which nurse educators in the United States and Taiwan collaborated in examining the values of their graduating students. Convenience samples of 94 Taiwanese and 168 American students were asked to rank values set out in the American Nurses Association Code of Ethics and the results were compared. The researchers found significant differences between the two groups. For the American students, the most highly rated value-related items were maintaining competence in one's own area of practice and acting as a patient advocate, while for the Taiwanese students the highest rated value-related items were maintaining confidentiality of the patient and safeguarding their right to privacy (Alfred et al., 2013).

Wros, Doutrich and Izumi (2004) found differences in the relative importance attributed to the value of truth by Japanese and American nurses. When caring for patients with serious diseases, the American nurses placed a high value on truth, seeing it as their obligation to inform patients of their condition. In contrast, the Japanese nurses regarded it as their duty to protect their patients by concealing their true condition from them or presenting it only in metaphorical terms.

Religious values

Illustrating the role of Islamic values are the findings of Lovering's (2012) ethnographic qualitative research with 14 Arab Muslim nurses caring for Arab Muslim patients in Saudi Arabia. Lovering (2012) observed that Islamic values, derived from the Qur'an and Hadith, provide guidance on in this setting on caring for health and looking after the body. Lovering (2012) distinguishes these from the inter-related cultural values of Saudi Arabia such as an emphasis on the role of the family (Lovering, 2012). She highlights the importance of tailoring healthcare to the religious and cultural values that are dominant in this Islamic society.

Shahriari (2012) explored the personal values of 28 nurses in Iran using focus groups and interviews and also reported that these reflected the influence of religious and cultural values, with an emphasis on preserving the dignity of the patient's family members and a high regard for his or her religious beliefs. In a similar way, Pang et al. (2009) found evidence of religious or spiritual influences on the values of nurses in China. Based on focus groups and interviews with 29 nurses, these researchers concluded that the dominant nursing values of their participants were largely based on Buddhist beliefs and principles, such as a focus on altruism, caring, reliability and dignity (Pang et al., 2009). Student nurses who have grown up in more secular Western societies, on the other hand, may be more likely to hold strong values relating to individual rights, privacy and freedom of choice (Lovering, 2008).

Professional values

Although Rokeach (1973) did not specifically distinguish between personal and professional values, other researchers have made this distinction and examined the influence of both types of values on human behaviour in various contexts (e.g. Rassin, 2008). Crossley and Vivekananda-Schmidt (2009) defined professional values as the views or ideologies which guide professional conduct and reflect the ethics, practices, principles and other norms that are dominant within a particular profession (Crossley and Vivekananda-Schmidt, 2009). Initially, new recruits may begin to incorporate the values of the profession during their formal education or training (Elfrink and Lutz, 1991; Eddy et al, 1994). This often draws on formal guidelines which set out these values. In the United States, for example, the American Association of Colleges of Nursing publication, The Essentials of Baccalaureate Education for Professional Nursing Practice (2008), identifies the values of altruism, autonomy, human dignity, integrity, and social justice as being fundamental to the discipline of nursing (American Association of Colleges of Nursing, 2008), and states that professional nurses require "the development and demonstration of an appropriate set of values and ethical framework for practice." (p.9).

The literature also indicates that professional values often become internalised and adopted as personal values, forming an important aspect of the self-identity of individuals within that professional group. For example, a group of mental health nurses interviewed by Stacey et al. (2011) discussed not only their pre-existing

personal values but also the importance of adhering to professional ethical principles as expected by governing bodies, which they had been taught during their academic nurse education. The nurses expressed these in terms of professional responsibility and organisational expectations of them, as set by governing bodies and their managers; Stacey et al. (2011) observe that although they were externally imposed values, the participants did not view them as such but expressed them as their own, demonstrating the ways in which professional and personal values often become intertwined. Similarly, a qualitative focus group study of 311 nurses from seven European countries (Tadd, Clarke and Lloyd, 2006) reported that most of the participants acted in accordance with their profession's code of ethics despite being unfamiliar with the detail of this code, because these professional values had become part of the professional identity of nurses and internalised by them.

Like personal values, professional values often differ between geographical and cultural settings (Weis and Schank, 1991; Martin, Yarbrough and Alfred, 2003). However, Snellman and Gedda (2015) identified commonalities across different cultural contexts and proposed a common value ground for the nursing profession based on principles of human value and the right to experience a meaningful life. Their conclusions were built on a review of literature published between 2000 and 2009, from which they identified trust, nearness, sympathy, support, knowledge and responsibility as the common values that should guide the nursing profession. These authors cautioned that the identified values are of equal status and not in hierarchical order of importance. Similarly, based on their review of previous studies, Jormsri et al. (2005) concluded that professional nursing values should be based on human dignity, social justice, altruism, autonomy in decision making, precision and accuracy in caring, responsibility, human relationship, individual and professional competency, sympathy, and trust. A systematic review of relevant international literature by Shahriari et al. (2013) identified ten ethical values in nursing: human dignity, privacy, justice, autonomy in decision making, precision and accuracy in caring, commitment, human relationship, sympathy, honesty, and individual and professional competency. A recurring theme relates to patient care. In other words, a core professional value for student nurses and nurses across all cultural contexts appears to be one geared towards delivering appropriate and effective care to patients.

At an international level, attempts are already being made to promote a consistent set of nursing values. For example, Directive 2005/36/EC provides professional, academic, practical and intellectual benchmarks for all nurses in the European Union (EU), an effort geared at introducing student nurses to similar professional values during the course of their education regardless of which EU country this occurs in. Hornberger et al. (2014) report on a collaborative effort between the EU and the U.S. aimed at developing a global nursing education, which will help overcome identified variations in curriculum, cultural differences, and differences in preparation as a specialist or general nurse upon graduation from the university.

Professional values are often set out in formal codes of ethics or codes of conduct, which represent a collective statement of the expected standards of behaviour of nurses and help define nursing responsibilities and obligations (Yancey, 1995). National codes of ethics issued by healthcare ministries or professional associations generally reflect the content of international guidance such as The International Council of Nurses' (ICN) Code of Ethics for Nurses (2012). This defines the values inherent in nursing as "respect for human rights, including cultural rights, the right to life and choice, to dignity and to be treated with respect." (p.1). Because professional nursing values are often defined in broad terms, however, codes of conduct often provide more detailed guidance on how these should be applied in everyday practice. For example, in 2015 the American Nurses Association issued a new *Code of Ethics for Nurses with Interpretative Statements* (American Nurses Association (ANA) 2015), with nine provisions identifying the main ethical obligations of nurses, and corresponding interpretive statements that provide guidance in how they should be applied. The first three provisions refer to the most basic nursing values, of respect for the patient and complete commitment to and protection of their health, rights and safety. The fourth provision relates to the accountability of the nurse in daily practice, while the remaining provisions relate to the duties nurses have towards themselves, to maintaining an ethical work setting, advancing professional knowledge, and in terms of collaboration with other nursing and healthcare professionals to promote health and ethical healthcare.

A very similar range of values and accompanying guidance is included in the UK's Nursing and Midwifery Council's (NMC) Code (Nursing and Midwifery Council 2018). A common factor in the Western codes of ethics that form the basis of nurse

education around the world is the priority given to patient care and safety, though the codes also emphasize the dignity and rights of patients. This is illustrated by the first principle of the UK's Nursing and Midwifery Council's (NMC, 2018) *Code*, which reads (italics inserted for emphasis): "You put the interests of people using or needing nursing or midwifery services first. *You make their care and safety your main concern* and make sure that their dignity is preserved, and their needs are recognised, assessed and responded to." In a similar way, the fourth provision of the ANA *Code of Ethics* (2015) relates to the accountability of the nurse for promoting patient health of the patient: "The nurse has authority, accountability, and responsibility for nursing practice; makes decisions; and takes action *consistent with the obligation to promote health* and to provide optimal care."

In Islamic nursing settings, codes such as the Nursing Code of Ethics – Saudi Arabia (2011), issued by the Ministry of Health, closely reflect the types of values set out in international and Western guidance. To demonstrate the range of values typically covered in professional codes of ethics, the key elements of the current UK and U.S. nursing codes are reproduced in Table 1, along with the Gulf Cooperation Council's (GCC) Code of Professional Conduct for Nursing's core values, key components of the International Council of Nurses' Code of Ethics, on which the GCC Code and the Saudi Arabian MoH's Nursing Code of Ethics are based. Overall, it can be seen that the nursing codes are very similar, though the guidance they provide is categorised under slightly different headings. All these codes of practice have a strong emphasis on patient-focused care and on values such as confidentiality, privacy and respect, on the professional responsibility and accountability of nurses in their everyday work and on upholding the standards of the profession. The MoH Code, the content of which could only be obtained via a nurse education document found online (author/organisation unknown), basically reproduces the ICN (2012) Code of Ethics, along with a statement of purpose and policy statements as reproduced in Table 1. The MoH code specifies that an inclusive approach should be taken in which nurses are culturally aware of and take account of the religious or socio-cultural needs of their patients when providing care.

Table 1: Coverage of Values in Selected International Codes of Ethics

NMC Code (UK)	ANA Code of Ethics (USA)	ICN Code of Ethics	GCC Code of Professional Conduct for Nursing's core values	MOH Code of Ethics (Policy statements)
Prioritise people: Treat people as individuals and uphold their dignity Listen to people and respond to their preferences and concerns Make sure that people's physical, social and psychological needs are assessed and responded to Act in the best interests of people at all times Respect people's right to privacy and confidentiality Practise effectively: Always practice in line with the best available evidence Communicate clearly Work cooperatively Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues Keep clear and accurate records relevant to your practice Be accountable for your decisions to delegate tasks and duties to other people Have in place an indemnity arrangement Preserve safety: Recognise and work within the limits of your confidence	**Provision 1:** The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person. **Provision 2:** The nurse's primary commitment is to the patient, whether an individual, family, group, community, or population. **Provision 3:** The nurse promotes, advocates for, and protects the rights, health, and safety of the patient. **Provision 4**: The nurse has authority, accountability, and responsibility for nursing practice; makes decisions; and takes action consistent with the obligation to promote health and to provide optimal care. **Provision 5:** The nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth. **Provision 6:** The nurse, through individual and	1. Nurses and people The nurse's primary professional responsibility is to people requiring nursing care. In providing care, the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected. The nurse ensures that the individual receives accurate, sufficient and timely information in a culturally appropriate manner on which to base consent for care and related treatment. The nurse holds in confidence personal information and uses judgement in sharing this information. The nurse shares with society the responsibility for initiating and supporting action to meet the health and social needs of the public, in particular those of vulnerable populations. The nurse advocates for equity and social justice in resource allocation, access to health care and other social and economic services. The nurse demonstrates professional values such as	Accountability: A nurse is answerable for actions concerning the patients and their interests. Decisions are based on professional knowledge, sound judgments, and technical skill. Dignity: The nurse understands and respect patient value systems, maintain patient dignity at all times; recognize and respect the uniqueness of patients; provide patients with accurate information and involve them in decisions regarding their own healthcare; supports patient's physical, emotional, and spiritual comfort; respect the patient's right to privacy and assist with relief of pain and suffering. Privacy and Confidentiality: Privacy involves limiting access to the physical and emotional aspects of the patient, while confidentiality means protecting all information concerning	Nurses are obligated to provide ethical and legal patient care that demonstrates respect for others. Nurses have four fundamental responsibilities: to promote health, to prevent illness, to restore health and to alleviate suffering. The need for nursing is universal. Inherent in nursing is respect for human rights, including the right to life, dignity and to be treated with respect. Nursing care is unrestricted by considerations of age, color, creed, culture, disability or illness, gender, nationality, politics, race or social status. Nurses render health services to the individual, the family and the community and co-ordinate their services with those of related groups. Remainder based on ICN Code of Ethics (2012)

Be open and candid with all service users about all aspects of care and treatment Always offer help if an emergency arises in your practice setting or anywhere else Act without delay if you think there is a risk to patient safety or public protection Raise concerns immediately if you believe a person is vulnerable or at risk Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies Be aware of, and reduce as far as possible, any potential for harm associated with your practice Promote professionalism and trust: Uphold the reputation of your profession at all times; Uphold your position as a registered nurse or midwife; Fulfil all registration requirements; Cooperate with all investigations and audits; Respond to any complaints made about you professionally; Provide leadership to make sure people's well-being is protected and to improve their	collective effort, establishes, maintains, and improves the ethical environment of the work setting and conditions of employment that are conducive to safe, quality healthcare. **Provision 7**: The nurse, in all roles and settings, advances the profession through research and scholarly inquiry, professional standards development, and the generation of both nursing and health policy. **Provision 8**: The nurse collaborates with other health professionals and the public to protect human rights, promote health diplomacy and reduce health disparities. **Provision 9**: The profession of nursing, collectively through its professional organizations, must articulate nursing values, maintain the integrity of the profession, and integrate principles of social justice into nursing and health policy.	respectfulness, responsiveness, compassion, trustworthiness and integrity. 2. Nurses and practice The nurse carries personal responsibility and accountability for nursing practice, and for maintaining competence by continual learning. The nurse maintains a standard of personal health such that the ability to provide care is not compromised. The nurse uses judgement regarding individual competence when accepting and delegating responsibility. The nurse at all times maintains standards of personal conduct which reflect well on the profession and enhance its image and public confidence. The nurse, in providing care, ensures that use of technology and scientific advances are compatible with the safety, dignity and rights of people. The nurse strives to foster and maintain a practice culture promoting ethical behaviour and open dialogue. 3. Nurses and the profession The nurse assumes the major role in determining and implementing acceptable standards of clinical nursing practice, management, research and education; The nurse is active in developing a core of	patients. The nurse ensures that the patient's physical and emotional privacy and confidentiality are protected at all time during health care procedures and the patient is not exposed unnecessarily. Patient's consent needs to be obtained when providing information relating to them required e.g. for research while patient's medical records are protected from unauthorized access.	

experiences of the healthcare system		research-based professional knowledge that supports evidence-based practice. The nurse is active in developing and sustaining a core of professional values; The nurse, acting through the professional organisation, participates in creating a positive practice environment and maintaining safe, equitable social and economic working conditions in nursing; The nurse practices to sustain and protect the natural environment and is aware of its consequences on health; The nurse contributes to an ethical organisational environment and challenges unethical practices and settings. 4. Nurses and co-workers The nurse sustains a collaborative and respectful relationship with co-workers in nursing and other fields; The nurse takes appropriate action to safeguard individuals, families and communities when their health is endangered by a co-worker or any other person; The nurse takes appropriate action to support and guide co-workers to advance ethical conduct.		

2.3.3. Experience of Value Conflicts by Newly Qualified and Student Nurses

Reasons for value conflicts

A substantial body of research evidence relating to newly qualified nurses has revealed that this group often experiences value conflicts when professional or workplace values are not aligned with their personal values (Forsyth and McKenzie, 2006; Takase et al., 2006; Stacey et al., 2011). Various studies have documented a wide range of psychological and physical impacts on newly qualified nurses and student nurses, arising from conflicts between personal or learned professional values and the values that they find to be dominant in the workplace.

During their education nurses are taught that certain values, such as a focus on person-centred care, are associated with nursing. Along with any pre-existing perceptions of nursing that they hold, these values often become part of their own self-identities (Stacey et al., 2011). In broad terms, this can be explained in terms of Rokeach's process 1 (creation) in which new belief is developed and may transform established values. After graduation, however, many nurses find that it is difficult to uphold these personal values in practice, due to organisational and other constraints such as workloads, negative role models and a lack of support in the transition from student to nurse (e.g. Bendall, 1976; Melia, 1987; Landers, 2000; Molassiotis and Gibson, 2003; Upton, 1999, cited in Maben, Latter and Macleod Clark, 2006). In particular, instead of the focus on person-centred care which is aspired to by many newly qualified nurses and inherent in professional codes of ethics and conduct, newly qualified nurses often find that organisational constraints such as a lack of resources, heavy workloads and limited time prevent them from acting in accordance with their values. Instead, the organisational values emphasise, for example, task-oriented working and goal achievement.

Fenwick et al.'s (2012) study of midwives demonstrated how personal values and the delivery of person-centred care were severely restricted in an organisational culture that favoured a different industrialised model of care, and in which risk-management as opposed to individual care was more highly valued by experienced professionals. Similarly, Edwards (2009) found evidence of situations in which respect for the autonomy of patients (a personal value) is frustrated by the non-availability of resources to provide the facilities or care they require (Edwards, 2009).

As a result, researchers have found that nurses often experience difficult transitions upon graduation and on entry into clinical practice, which result at least in part from the conflict between their personal or learned professional values and the dominant workplace values and role expectations (Boychuk Duchscher and Cowin, 2004). A term that has been widely used to explain the conflict between the anticipated and expected ideal roles of nurse is "cognitive dissonance", or a process in which individuals' existing pre-conceptions and understandings are challenged by new incoming information (Festinger, 1957; Hollywood, 2011; Fenwick et al. 2012). This often results in a feeling of mental discomfort which leads to a change in one of the conflicting beliefs or attitudes in order to restore a sense of well-being (Festinger, 1957), which reflects the process that Rokeach (1973) described in terms of the self-confrontation process.

Although there has been very little exploration of these issues among student nurses, some limited qualitative research indicates that student nurses on clinical placements often experience similar types of value conflicts to newly qualified nurses (Forsyth and McKenzie, 2006; Takase et al., 2006; Stacey et al., 2011). For example, in mixed methods research with final year student nurses in three educational institutions in the United Kingdom from 1997 to 2000, Maben et al. (2006) found that, within NHS settings, greater value is often placed on achieving targets and outcomes, as opposed to taking the time to deliver the kind of care that many new nurses aspire to. This was a robust study with a relatively large survey sample of 72 and interviews with 26 students. It is important in providing relatively robust evidence of the experience of value conflicts by student nurses, at least within the institutions covered by the study (Maben et al., 2006). A longitudinal qualitative study by Mackintosh et al. (2006), based on semi-structured interviews with a sample of 16 pre-registration student nurses conducted at two points during their nurse education, also provided evidence of a conflict of interest between the theoretically and politically promoted caring ethos of professional nursing and the organisational socialisation processes that student nurses experience in reality. Pearcey and Draper (2008) conducted semi-structured interviews with 12 first year student nurses in the UK following their first clinical placement and found high levels of disillusionment among the sample because their placement experiences had not lived up to their personal ideals and values regarding nursing. A common source of value conflict was the emphasis in clinical practice on targets, outcomes and paperwork, which was regarded by the students as being in conflict with patient-centred values (Pearcey and Draper, 2008).

In a study based on the analysis of journal material generated by 75 student nurses in Greece, Lemonidou et al. (2004) reported that the experience of ethical conflicts was the most challenging issue experienced by the student nurses during placements. One of the key findings of Lemonidou et al.'s (2004) research was that the participants had only became aware of their personal values through the process of delivering healthcare to and interacting with patients, while at the same time becoming aware of organisational barriers that made these values difficult to adhere to. The personal values important to the participants in this study were largely focused on caring and empathy as well as enthusiasm for nursing, and they were frustrated when the ability to apply these values in their clinical placements was hampered by the dominant values of the workplace, which they often regarded as promoting unethical behaviours.

Shoqirat and Abu-Qamar (2013) conducted focus groups research with 12 final year student nurses, including both males and females, in the Islamic society of Jordan. They found that the students had often experienced stressful situations on placement, largely arising from the perceived mismatch between their personal values and the organisational values experienced on their placements. For example, instead of experiencing good teamwork, the students often found that the worst, most tiring or most complex jobs were delegated to them by qualified nursing staff, resulting in feelings of disillusionment and sometimes incompetence.

Finally, Solum et al. (2012) conducted phenomenological qualitative research with ten student nurses in Malawi, a society in which traditional cultural beliefs often conflict with the principles of modern Western healthcare. The authors used conversational interviews to explore second- and fourth-year student nurses' experiences and awareness of ethical conflicts while on placement, and found that many had experienced multiple forms of ethical conflict. For example, student nurses reported a number of value conflicts arising from the needs of the patient and the wishes of their relatives and or guardian, which clashed with professional values and created ethical dilemmas for the student nurses.

The findings of these qualitative studies support those of Brien (2012), who undertook a systematic literature review of studies examining student nurses' transitions into professional practice. Based on a synthesis of the reviewed studies, the findings demonstrated that student nurses often experience stress, anxiety, and uncertainty during their initial clinical placement, that can contribute to such conflicts for student nurses. However, the research evidence presented above suggests that conflicts may not

necessarily be between personal values and the professional nursing values set out in codes of ethics and conduct, but to the difficulties of implementing both personal and professional values due to organisational constraints.

Impacts of value conflicts on individuals

Various studies have documented a wide range of psychological and physical impacts on newly qualified nurses arising from the value conflicts and other pressures they face in the clinical practice environment (Lemonidou et al., 2004; Pearcey and Draper, 2008; Solum et al., 2012; Shoqirat and Abu-Qamar, 2013). The reported impacts of these types of pressure on new nurses include "burn out" and exhaustion, disillusionment, reduced confidence and self-esteem and lowered resistance to illness (Altun, 2002; Stacey et al., 2011; Brien, 2012). Kumaran and Carney (2014) observe that newly qualified nurses' self-efficacy, confidence and personal values relating to patient-centred care are often swiftly challenged in the reality of clinical practice. Maben et al. (2006) reported that participants experienced anxiety when facing conflicts between idealised nursing practices and the expectations of real clinical environments, a finding common to many other studies (Gallagher et al., 2006; Jasper, Rosser and Mooney 2013). Whitehead et al. (2011) found that newly qualified nurses often face a need to renegotiate their knowledge, values and identity as a nurse, and that those who struggle with this transition to a new role and identity frequently experience disillusionment and other negative impacts on their well-being (Whitehead et al., 2011).

These experiences were conceptualised as long ago as 1974 by Kramer, who coined the phrase "reality shock" to describe the discovery that the professional values of the workplace are often very difficult to those developed during nurse education. Developing this concept and redefining it as "transition shock", Boychuk Duchsher (2009) highlighted in particular the different roles, responsibilities and performance expectations facing newly qualified nurses compared with student nurses, and estimated that the psychological impacts of this result in attrition from the profession of up to 30% of nurses during their first year of employment.

In as similar way, the term "moral distress" was first coined by Jameton (1984) to explain the uncomfortable psychological feelings that are experienced by nurses when institutional factors prevent them from acting in ways they believe to be in the best interests of patients. In a later refinement of the concept, Kalvemark et al. (2004)

discussed moral distress in terms of the stressful psychological impacts of situations with ethical aspects in which a nurse cannot reconcile the preferences or interests of all relevant stakeholders in a care situation, such as patient, their family members and medical professionals.

These impacts are not confined to Western healthcare settings; similar findings have been reported in studies conducted in countries including Turkey (Yildiz and Akansel, 2011), Jordan (Shaban, Khater and Akhu-Zaheya, 2012), and Taiwan (Sheu, Lin and Hwang, 2002). In a study based on in-depth interviews with 30 nurses in Iran, Ravari et al. (2012) observed that the more the core values of nursing, such as altruism, truth and human dignity are compromised, the greater the likelihood of negative effects on nurses such as emotional exhaustion and burnout.

Among student nurses, studies have provided evidence psychological and physical impacts of value conflicts that mirror those reported in research with newly qualified nurses (e.g. Maben et al., 2006). For example, these include weariness and burnout (Lemonidou et al., 2004); disillusionment (Pearcey and Draper, 2008); moral distress (Solum et al., 2012), and reduced confidence (Shoqirat and Abu-Qamar, 2013). These are worrying findings, indicating that student nurses are becoming weary and disillusioned with the profession even before they graduate and enter employment as qualified nurses. However, these negative psychological impacts are also consistent with Rokeach's (1973) theory, which proposes that mental discomfort may be necessary for the self-recognition of value conflicts, and eventual realignment of values through modification or change to overcome this discomfort. Recognition of the organisational or professional level impacts may also be necessary, however, if the necessary measures or support are to be provided to enable newly qualified nurses or student nurses to achieve this.

Impacts of value conflicts on the profession

According to the literature, conflicts between personal values and organisational constraints are factors contributing to nurses' decisions to leave the profession due to low job satisfaction. These have been reported in large-scale qualitative studies, such as interviews with 146 registered nurses in Australia with more than five years' nursing experience, conducted by Forsyth and McKenzie (2006). Other authors have also attributed the high levels of attrition from the nursing profession to the value conflicts experienced by newly qualified nurses (Forsyth and McKenzie, 2006; Takase et al. 2006).

In a Saudi Arabian study of 350 nurses of both genders which investigated the reasons for high turnover in the nursing profession, it was found that around 40% of the sample felt no pride in being a nurse (Aljedaani, 2017). Although this study did not specifically investigate the experience of value conflicts, it might be inferred that a lack of pride in one's profession might reflect the presence of such conflicts. Similarly, Alboliteeh et al. (2017) conducted a survey of 741 male and female nurses in government hospitals in the city of Riyadh. Around a quarter of all respondents (n=167) expressed an intention to leave the nursing profession within two years, with no significant differences between males and females in the likelihood of giving this response. More than a third of all respondents, both male and female, expressed strong agreement with statements relating to discomfort about dealing with patients or colleagues of the opposite gender.

2.3.4 Responses to Value Conflicts

Socialisation - adapting to value conflicts over time

For those individuals that remain in nursing, the value conflicts encountered on entering clinical practice are sometimes reconciled over time as they go through a process of "socialisation" (Simpson and Back, 1979; Benner, 1982; Du Toit, 1995; Fitzpatrick, While and Roberts 1996; Maben et al., 2006; Mackintosh, 2006; Whitehead, 2011; Dimitriadou et al., 2013). Although Rokeach (1973) did not use this term specifically in his values change framework, it can be inferred that many of his ten processes contribute to the socialisation process. For example, this might involve a reduced focus over time on the personal or ethical values that originally attracted nurses to the profession, which might be explained in terms of Rokeach's *attenuation* or *limitation* processes.

For instance, Ham (2004) compared ethical reasoning abilities between experienced registered nurses and senior baccalaureate student nurses, based on a self-completion survey tool shown to be valid and reliable, the Nursing Dilemma Test (NDT). The results demonstrated that the student nurses used higher levels of "principled thinking" than the qualified nurses when considering hypothetical moral dilemmas; and it was also found that the use of principled thinking declined with years of experience of nursing. These are worrying findings which indicate that there may be a decline over time not only in personal values but in the formal professional values held by nurses. On the other hand, other researchers have found evidence that nurses who try to reconcile their personal values with the reality of real-life working practice experience adverse impacts on their

well-being as a result (Stacey et al., 2011). These findings might suggest that the main options for nurses faced with value conflicts are to give up or compromise their personal values (or the professional values learned during nurse education) or hold on to these values and experience adverse effects on their well-being when they conflict with the dominant professional values of the workplace.

In contrast with this, however, and of particular relevance to the current study, are the findings of research by Lovering (2008) with Arab Muslim nurses in Saudi Arabia. Lovering (2008) identified the development of a distinctive care pattern in which professional nursing values were blended into the Muslim nurses' own cultural and religious belief systems. Spirituality is central to this model, with the spiritual needs of patients often taking priority over their physical needs. These took the form, for example, of praying with and for the patients, or accommodating their fasting practices during the holy month of Ramadan. Lovering (2008) found that it was often crucial for the nurses' own spiritual well-being to follow this approach, since they believe they will receive rewards from Allah (God) for doing so (Lovering, 2008).

Although Lovering's (2008) research with Arab Muslim nurses indicates that reconciling religious and professional values in this way enabled these nurses to cope with potential value conflicts, other studies indicate that conflicts between personal and organisational/managerial values may be more difficult to reconcile. Although some of the challenges faced may have been eased by new approaches to the education and support of newly qualified nurses, other studies provide evidence that newly qualified nurses frequently experience the types of conflict that result in stress, burn-out and demoralisation, and that contribute to high levels of attrition from the profession (Hollywood, 2011; Maxwell et al 2011).

Organisational responses

Various studies have shown that the environment and organisational culture in which newly qualified nurses work have a major effect on how they adjust and negotiate their new identity and adapt to the role of professional and qualified nurse (Whitehead, 2001; Mooney, 2007). The Nursing and Midwifery Council (NMC, 2006) has suggested that, in this period of vulnerability, new nurses require access to mentoring and preceptorship to facilitate adjustment to their new position. The research evidence provides support for the use of preceptorship in facilitating the transition of students and newly qualified

nurses into clinical practice and helping them develop a clearer understanding of their role and identity, thus enabling them to reconcile any value conflicts they may encounter (Maben and McLeod Clark, 1998; Mooney, 2007).

The review of literature also reveals that personal attributes of students, in particular confidence and self-esteem, enable them to more effectively manage the value conflicts that they encounter in clinical practice (Iacobucci et al., 2012). Maxwell et al.'s (2011) study revealed that newly qualified nurses who were more able to seek assistance in general terms were more proactive about identifying their own learning needs and negotiating more formal learning opportunities, and that this aided them in developing a positive nursing identity (Whitehead, 2011). Preceptorship and other forms of support have been shown to be effective in reducing negative or stressful experiences among student nurses and building these personal strengths. Brien's (2012) systematic review found that with appropriate support such as facilitating a new understanding of their role and greater acceptance within nursing teams, the anxiety of student nurses can be minimised and their confidence built (Brien, 2012). Similarly, in conducting research with newly qualified nurses in New Zealand, Adlam, Dotchin and Hayward (2009) revealed that the students' confidence could be raised by the provision of support through a graduate nurse programme. Newton, Billett and Ockerby (2009) conducted research with undergraduate student nurses during their studies and clinical placements and found an effective transition from education to practice was dependent on having supportive placements.

The literature in this area does not reveal, however, the specific impacts of student confidence on values, for example whether more confident students are able to retain their personal values and integrate these more effectively with the professional values required of them, or whether they are more inclined to change their personal values over time. Similarly, although the literature indicates that nurse education also has a major role to play in shaping the professional values of student nurses in ways that do not conflict with their personal values (Parvan, Zamanzadeh and Hosseini 2012; Dimitriadou et al., 2013), there is little evidence about how this occurs in practice.

Some information on this issue is however provided by Jonsén, Melender, and Hilli's (2013) qualitative study of the impact of support and preceptorship upon nurses' successful adaptation into clinical placements in Sweden and Finland. These authors examined three key aspects of initial placements: preceptors, theory and practice, and

reflection, among 22 student nurses following completion of their initial three to ten-week clinical placements (Jonsen et al., 2013). The student nurses in this focus group study reported that the availability of preceptorship facilitated a working environment that provided them with feelings of safety and security, while also promoting greater self-confidence and initiative. Preceptorship encouraged the students to reflect on their practical experiences and make connections between theory and practice, which in turn enhanced their practice and confidence (Jonsen et al. 2013). Critical reflection within nursing practice is a skill often utilised within theoretical education, which requires clinical practice to further such learning, echoing Jonsen et al.'s (2013) findings (Gibbs, 1998; Benner, 1982). As Benner (1982) states, such reflection is a vital skill that can facilitate the transition of nurses from the novice to a competent and professional expert. The self-reflection process can be equated to Rokeach's self-confrontation method, in which individuals need to become aware of value conflicts within them and experience a degree of mental discomfort about these in order to overcome them by modifying at least one of the conflicting values. However, this also indicates that students need to be provided with the necessary support to help them cope with and reconcile such conflicts.

Other studies conducted internationally emphasise the need for student nurses to be supported as they make their transitions and come to terms with their own expectations and those of the people they work with (Morrow, 2009; Pellico et al, 2009; Kelly and Ahern, 2008). For example, nursing student participants in Shoqirat and Abu-Qamar's (2013) research in Jordan made clear links between having good preceptors and positive clinical experiences. Whitehead (2001) and Whitehead and Holmes (2011), whose studies span more than a decade, examined such nurse transitions and recommended that newly qualified nurses should be able to access clinical supervision and support at any time, including whilst on shift. They found that many new nurses felt unsupported during their transition phase and that this was a significant factor contributing to high levels of anxiety. Unfortunately, recent studies have reported that effective mentoring and supervision is still not widely available. As a result, in many countries including the United Kingdom and Australia, newly qualified nurses are leaving the profession due to high levels of anxiety and work stress (Kumaran and Carney, 2014; Monaghan, 2015; Phillips, Esterman and Kenny 2015).

2.3.5 Cultural Influences on Healthcare

So far, the review of literature has addressed the issue of value conflicts as experienced by newly qualified nurses and student nurses in general. This and the remaining sections of the chapter discuss literature from the main review and the more narrowly focused structured review relating to the ways in which religion and culture can contribute to value conflicts among nurses and student nurses, especially in the context of Islamic societies. The section discusses ways in which perceptions and understandings of healthcare are not universal but are constructed in ways that reflect the religious or cultural beliefs of healthcare providers and their patients. As a result, there is potential for value conflicts to arise when the religious or cultural beliefs about care that are held by nurses clash either with those of their patients or with the dominant professional values of their nursing role.

The cultural construction of healthcare

According to Banks (1997), culture can be defined as "ideations, symbols, behaviors, values, and beliefs that are shared by a human group" (p. 8). A number of researchers have challenged the idea that there is a universal belief system about healthcare, and have instead argued that this is culturally constructed, reflecting the dominant beliefs of different societies (Holden and Littlewood, 1991; Rassool, 2000; Narayanasamy and Owens, 2001). The work of Kleinman (1978a; 1978b) has been particularly influential in explaining cultural differences in beliefs about healthcare. This author put forward the idea of explanatory models, defined as the belief systems that individuals hold about illness and healthcare treatments, and which reflect at least in part the cultures in which they live.

For example, the Islamic explanatory model of healthcare is an holistic approach which focuses on the interconnections between knowledge, health, the environment and God (Rassool, 2000), and does not recognise any separation between the physical and spiritual aspects of health (Lovering, 2013). As Al-Yousefi (2012) notes, traditional Islamic literature integrates religion and medicine, and Islamic care therefore focuses on both the physical and spiritual needs of patients, taking into account their beliefs about suffering, healing, and death. Muslims believe they are assessed on the health of their spirit or inner being, and regard spiritual disease as the cause of physical disease (Wehbe-Alamah, 2005). Spiritual health is seen as crucial in promoting physical health and preventing disease, while illness is viewed as an opportunity from God to purge sins and avoid being

punished for these in the afterlife (Wehbe-Alamah, 2005). Spiritual care is therefore defined in Islam in terms of the provision of activities to promote spiritual health and prevent spiritual disease as well as physical disease. This includes, for example, providing a patient with suitable conditions for prayer, enabling them to understand the concept of illness, and helping them to find hope (Marzband, Hosseini and Hamzehgardeshi, 2016). It is very important to Muslims that their non-Muslim caregivers respect their religious and cultural requirements which will include, for example, praying five times a day and fasting during Ramadan (Al Yateem et al., 2015; Padela and Pozo, 2011). Ultimately, spiritual health is always at the centre of this model, in contrast with the Western explanatory model of healthcare, in which spirituality and medicine are largely separated (Balboni et al., 2014).

It should be noted that this separation of spirituality and medicine is a relatively recent Western development; historically, religious orders of both males and females were involved in Western nursing and spirituality played a more central role. However, this largely dissolved with the emergence of the professional nurse role in the early 20th century (Lovering, 2008). Although spirituality remains an important component of certain Western medical concepts such as psychological wellbeing, many nurses and physicians view spiritual care as outside their direct sphere of responsibility (Balboni et al., 2014) and patients rely more on family and friends to provide this type of care (Ross, 2016). As Western medicine moves increasingly toward holistic models of care, some researchers are beginning to focus on the potential benefits of caring for patients' spiritual wellbeing (Best et al., 2015), and a spiritual dimension has been re-emerging as a component of care in many international and Western health models. For example, the International Council of Nurses' (ICN) Code of Ethics highlights the importance of the nursing role in promoting "an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected" (ICN, 2012, p. 2). However, this focuses on spiritual wellbeing generally, disease is not viewed as having spiritual or moral roots as in Islam, and spiritual care does not take priority over the physical needs of patients (Balboni et al., 2014; Best et al., 2015). Indeed, Lovering (2008) observes that there is no parallel in any other nursing tradition to the Islamic focus on spirituality. Even in Native American nursing, one of the closest comparable situations in which spirituality is one of seven themes regarded as the essence of nursing (Hunter, Logan and Goulet 2006), it is still not at the core of the belief system as it is in Islam.

However, nurse education in many Islamic countries is based on Western models and curricula. As a result, researchers have found that the explanatory models of healthcare that are held by medical professionals in these countries often incorporate their own cultural or religious beliefs about illness and healthcare as well as the beliefs or values taught in their education and training (Kleinman 1978a; 1978b). For example, Lovering's (1996; 2008) research with Arab Muslim nurses in Saudi Arabia revealed that these nurses held a culturally distinct belief system, in which professional models of health and healing were integrated with the nurses' cultural and religious beliefs and incorporated into their nursing practices. Lovering (1996; 2008) argued that this explained why these nurses often prioritised the spiritual needs of their patients over their physical needs, for example delaying preparations for surgery to give them sufficient time to pray. Similarly, based on in-depth interviews with five Saudi Arabian female nurses, Mebrouk (2008) found that the professional and personal identities of the research participants were closely inter-related, and could not be separated from Islamic values. The participants described various ways in which they incorporate spiritual practices into their nursing care, such as prayers and the use of Zamzam (holy) water.

In other Islamic settings a focus on the spiritual aspects of care also appears to be an important component of the explanatory models or self-identities of Muslim nurses. For example, Fooladi (2003) found evidence among Muslim nurses in Iran that conventional and spiritual nursing care are both seen as a single act of faith within the professional values of these nurses. Valizadeh et al. (2012) conducted research with 18 student nurses in Iran, with the objective of understanding how they experience spiritual care in this setting. The students reported using a range of spiritual care practices with their patients, such as praying with them and providing companionship and attention. Other researchers have also found that providing support and help to patients as they engage in Islamic self-care is seen by Muslim nurses as an important part of their role (Atefi et al., 2014; Marzband and Zakavi, 2015).

Relevant to this is the finding in some studies of associations between the job satisfaction of Muslim nurses in Islamic countries and the perceived spiritual value of their role. For example, Ravari et al. (2009) conducted semi-structured interviews with 25 staff nurses in university-affiliated and public sector hospitals in Iran and found that the participants sought job satisfaction from the contentment of patients and of God. From the Islamic

perspective held by the nurses, these could not be separated: the patient is seen as a reflection of God's image and caring is seen as a service to God.

Based on her observations about how Muslim nurses incorporate spiritual care in their work, Lovering (2008) argued that effective spiritual care requires that nurses and their patients share the same religious faith whatever that might be, a view shared by Halligan (2006). This is of course impractical and unrealistic in many healthcare contexts due to shortages of local nurses and the reliance on expatriate nursing staff. In contrast, Cockell and McSherry (2012) argued that effective spiritual care does not require that nurses and patients share a faith but that "a detailed understanding of that particular patient's situation and a relationship between the nurse and the patient, is necessary" (p. 963). One might argue that these requirements do not differ from the requirements of the nursing profession in Western cultures, where patient understanding, and relationship are also essential. However, in Saudi Arabia, there is a need to focus on these components to a greater degree, given the prevalence of non-Saudi and non-Muslim nurses and the greater risk that the spiritual care requirements of their patients, or the ways in which their fellow Muslim nurses address these, will not be understood. There is also a major difference in the Islamic context because religious laws and cultural expectations can make it very difficult for nurses to build "a relationship" with patients of the opposite gender or to provide personal care. The following section discusses some concepts which have been put forward to help inform the development of approaches to healthcare which are sensitive to the needs of patients from different cultures.

2.3.6. Cultural awareness and Culturally Appropriate Healthcare

Cultural awareness and responsiveness have become increasingly important as nurses face the challenge of providing care to patients from diverse ethnic and cultural backgrounds (Hammoud, White and Fetters 2005). These challenges are apparent in the United States and the United Kingdom (as well as many other countries) and across a broad range of different health care services including hospitals, doctors and mental health care services (Bhui et al., 2007, Gerrish and Papadopoulos, 1999). Despite the scale of the issue and the extent to which Western societies have diversified culturally and ethnically over recent decades, however, cultural responsiveness is an aspect of nursing education that has historically been under-emphasised (Dreher and MacNaughton, 2002; Neander and Markle, 2005). For example, Fahrenwald et al (2005) proposed a universal approach of including the five core values of human dignity,

integrity, autonomy, altruism and social justice in the nursing curriculum; however, scrutiny of these values reveals a lack of inclusion of the types of cultural and spiritual values advocated by Lovering to be important in transcultural nursing (2012).

There is a substantial body of literature that highlights the ways in which nurse education material has a cultural bias towards Western explanatory models of care, with little priority given to the religious and spiritual needs of the patient. In Saudi Arabia as in many other Middle Eastern countries, the nursing curriculum is largely based on the approach to care being used in Western countries, and most of the educational resources are in English because there are very few nursing texts available in Arabic (Lovering, 2008). As Nehring, 2003, cited in Felemban, O'Connor and McKenna 2014) explained:

> Saudi hospitals built on Western models, health care facilities and related educational institutions are becoming more westernised. It has become clear that one of the issues facing nursing education in the Arabian region is recognising how cultural bias is embedded in textbooks used within the courses. Even though textbooks reflect the importance of cultural diversity as a value, those available strongly reflect Western culture. (p.10).

The above quote suggests that materials used to educate Saudi Arabian nurses are not currently well aligned with the beliefs and values of Saudi Arabian nurses and their patients. Al-Shahri (2002) noted that, without adequate understanding of common cultural beliefs and practices, health care professionals might offend patients or overstep their boundaries. Al-Shahri (2002) noted that, in Saudi culture, women are supported and protected by their male relatives, so independence and autonomy may not be highly valued by all Saudi women. Therefore, female patients in Saudi Arabia may delegate decision making to a male relative, even if they are capable and legally able to make decisions on their own behalf. As another example, several medical interventions, such as blood transfusions, are religiously and culturally forbidden to individuals who are fasting, but non-Muslim nurses may not be aware of or understand the importance of this to Muslim patients (Al-Shahri, 2002). Felemban et al. (2014) suggest that inadequate cultural knowledge may lead to a lack of trust in the nurse and, subsequently, a decreased likelihood that the patient will comply with care instructions. Al Shahri (2002) notes that smoking is culturally unacceptable for females in Saudi Arabia, Islamic law forbids drinking alcohol, and all extramarital sexual contact is illegal. Therefore, during clinical assessment health care providers must be very careful in asking Muslim patients about these practices, because not only are such questions offensive in this setting, but admitting to these practices could have serious implications for the patients. Since the use of such

questions are normal practice in healthcare internationally, they have to be asked very sensitively by healthcare professionals in ways that are not likely to cause offence in this setting.

The concepts of cultural competence and cultural awareness gained academic attention in recent decades and have been seen as important in reducing the potential for value conflicts in the transcultural-nursing context. A cultural competence model originally developed by Papadopoulos and Lees (2002) for use in transcultural research, has also been heralded as a model for culturally competent healthcare practice (Byers, 2008). Papadopoulos and Lees (2002) distinguished between cultural awareness and cultural competence, both of which are crucial for effective transcultural research. According to the model, cultural awareness is present when an individual is able to examine their own personal value base and understand "how these values are socially constructed" (Papadopoulos and Lees, 2002, p. 260). In contrast, cultural competence incorporates not just cultural awareness but cultural knowledge and cultural sensitivity (Papadopoulos and Lees, 2002). Cultural competency assumes that a single approach to healthcare is not suitable for an ethnically and culturally diverse population, and that healthcare systems should provide the highest standards of care to all patients regardless of race, ethnicity, culture and language proficiency (Carpenter-Song, Nordquest and Longhofer, 2007). As Papadopoulos and Lees (2002) pointed out with regard to cultural competency, "the most important component of this … is the ability to recognize and challenge racism and other forms of discrimination as well as ethnocentricity" (p.262).

Since the publication of Papadopoulos and Lees's (2002) model, however, the concept of cultural competence has been challenged. For example, in the context of mental healthcare viewed from an anthropological angle, Carpenter-Song et al. (2007) argue that the concept of cultural competency simplifies the dynamic, emergent, and complex nature of culture, and that other factors such as age and gender may be more important to an individual's identity. They argue for the use of "culturally appropriate" (p.1365) care, which incorporates a more flexible approach to understanding a person's individual healthcare needs. Similarly, Thackrah and Thompson (2013) highlight several limitations of the cultural competence concept: including a lack of clarity about what this means and how it is used in practice, and a lack of evidence of the effectiveness of cultural competence strategies in healthcare.

While the specific concept of cultural competency has thus fallen out of popularity, the need to provide culturally appropriate healthcare has been highlighted in many studies conducted in different geographical and cultural settings. Hammoud et al. (2005), for example, illustrated the importance of cultural awareness and cultural appropriateness within nursing in the U.S. by pointing to the large number of areas in which Arab American and American Muslim patients expect and require culturally competent care, such as dress (in particular the *hijab*), privacy, modesty, staff gender (particularly in relation to women), dietary requirements, medication and birth control (Hammoud et al., 2005).

The model developed by Papadopoulos and Lees (2002) is valuable in settings such as Saudi Arabia where there are many expatriate nurses, because it offers a framework for developing cultural competency by furnishing nurses with a set of transferable cultural competence skills. However, new models of nursing care tailored to particular cultural or religious contexts have also emerged, which reflect the growing focus in the literature on the value conflicts that can arise when nurses are taught a Western model of care but required to apply this to patients in a non-Western cultural setting (e.g. Leininger, 2002; Høye and Severinsson, 2009; Lovering, 2012; Douglas et al., 2014; Almutairi et al., 2015).

As early as 2000, Rassool recommended the development of an Islamic nursing framework based on teachings about healthcare from the Holy Qur'an and the Hadiths (teachings of The Prophet) and the five pillars of Islam (faith, prayer, charity, fasting, and pilgrimage to Makkah). Motlagh, Karimi and Hasanpour (2012) also recommended that an Islamic care model should be formally included in the nursing curriculum of Islamic nations, in order to provide holistic care tailored to the needs of Arab Muslim patients and ensure that non-Muslim Western nurses are familiar with these needs.

In response to her findings of value conflicts experienced by Muslim student nurses in Saudi Arabia, Lovering (2012) recommended the adoption of a "Crescent of Care" (Figure 2) Islamic nursing model, in which nursing values are used to determine the spiritual, cultural, and clinical caring needs of the patient, and in which the patient and their family are the focus of nursing care. For example, in recognition of the central role of prayer in Islam, nurses are encouraged under this model to facilitate time for prayer, or by respecting the patient's wishes to join them in prayer. Similarly, the model

encourages nurses to incorporate religious words when performing procedures, to demonstrate spiritual caring or to use holy water for certain procedures (Lovering, 2012).

Figure 2: Crescent of Care Model (Lovering, 2012)

Lovering's Crescent of Care Model (2012) has been adopted by some hospitals in Saudi Arabia in recent years. However, the model is primarily focused largely on ensuring that healthcare professionals understand their patients' spiritual and cultural needs and tailor their care practices to these as appropriate. The review of literature revealed, however, that Muslim nurses in Islamic societies face potential for value conflicts related to religion and culture in ways that are much more complex than the situations addressed by these models. The explanatory models of healthcare discussed earlier, as well as the concepts of cultural awareness and cultural appropriateness are valuable as an overall framework for understanding this. The following sections draw on these to explain the religious and cultural influences on healthcare in Saudi Arabia, the setting for the current study.

2.3.7 Factors Influencing Healthcare in Saudi Arabia

Saudi Arabia is a conservative Middle Eastern Islamic country in which 100% of the native population consists of Muslim Arabs. Overall, the culture of Saudi Arabia is similar to that of neighbouring Islamic countries, but it differs in terms of its unique character and style (Bjerke and Al-Meer, 1993) especially the degree of Islamic conservatism. In describing some of the characteristics of Saudi Arabian society, Uddin (2017) notes that Islam determines all traditions, practices and obligations; that the family

is the strongest social unit with family interests prioritised over those of the individual, and that although women receive education and can join the workforce, their activities are determined by social and religious expectations about gender roles.

In general, religion plays a very important role in patients' values and beliefs in Saudi Arabian society, with attitudes toward illness and end-of-life experiences strongly shaped by these beliefs (Abudari, Hazeim, and Ginete 2016). Religious rulings (*Fatwa*) control many aspects of healthcare including fertility, resuscitation and organ donation (Baddarni 2010). *Hadith*, or the sayings of the Prophet Muhammad, provide extensive guidance on how to care for one's personal health and maintain the body in this society, such as reading verses from the *Qur'an* and reciting Islamic prayers. Islamic teachings have also become closely intertwined in Saudi Arabia with Arab cultural values and beliefs specific to this setting. For example, Muslims follow spiritual traditions affecting healthcare that have cultural as well as religious foundations, such as the use of "*Zamzam*" water (holy water from *Makkah*) for taking medication or wiping body parts (Mebrouk, 2008, Lovering, 2012).

Many of the dominant religious and cultural values in Saudi Arabia relate to issues such as gender segregation and protecting the modesty and privacy of individuals (Koenig and Shohaib, 2014). The Islamic dress code that requires covering of "*awrah*" (which is the parts of the body that should be kept covered in the presence of a 'stranger'. A woman must be covered in presence of any male apart from the *mahram*[1], except the face and hands (up to the wrists). A man must be covered "from the navel to the knee" in presence of any female apart from the *mahram*), and the ways in which physical contact between unrelated individuals of different gender are prohibited (Padela et al., 2011) creates a great challenge in health care delivery because, in hospitals and health care centres, it is often necessary for patients to be cared for by unrelated health care practitioners of the opposite gender. It also has an impact on the entry of unmarried Saudi females into the nursing profession, because the mixed-gender nature of the healthcare environment can influence their marriage prospects, due to the strict Islamic views on gender relations. It has been reported that many Saudi Arabian men are not interested in marrying women who interact with unrelated men as part of their jobs (Mirza, 2008), and a more recent

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[1] Any relative that a Muslim is not allowed to marry is referred to as mahram (e.g. parents, grandparents, siblings, in-laws.

study found that some Saudi nurses had to leave the profession in order to get married because their future husbands did not accept their career choice (Lamadah and Sayed, 2014).

Although the nursing profession has a poor public image in Saudi Arabia today, as discussed later in the review, this starkly contrasts with the spiritual origins of Saudi Arabian nursing. These origins were only recently discovered when in the 1980s a group of Saudi nurses investigated traditional Islamic texts and found evidence of the first Muslim nurse, Rufaidah Al-Asalmiya, who lived in the first century AD at the same time as the Prophet Muhammad. Like Florence Nightingale who lived much later in the West, Rufaidah reportedly treated patients from the Muslim armies during the Holy Wars, providing physical and emotional support to wounded and dying soldiers (Almalki et al. 2011; Al-Osimy 1994). It is even documented in the traditional Islamic texts that a nurse can provide essential care to male patients but did not give the right to expose their awrah, according to the Prophet (Almalki et al. 2011). It is also reported that after Rufaidah's death, many other Muslim nurses continued her work during both war and peacetime (Almalki et al. 2011). However, there appears to be little awareness of these spiritual origins of Islamic nursing in present day Saudi Arabia, either among the general public or among nurses and student nurses. As a result, considerable potential for value conflicts relating to both religious and cultural factors has arisen in the context of nursing in this society, which mirrors at least in part similar situations in other Islamic societies, according to the literature. These value conflicts and the factors contributing to them are discussed further in the following section.

2.3.8 The Experience of Value Conflicts by Muslim Nurses

Value conflicts in nursing in Saudi Arabia

The existence of different explanatory models of healthcare can create potential for gaps in care or conflicting beliefs, especially in transcultural nursing settings. In the case of Saudi Arabia, for example, local Muslim patients may be unhappy with the care they receive from non-Muslim nurses who do not share or understand their Islamic health beliefs, and Muslim nurses may experience value conflicts when the requirements of their nursing role, based on Western cultural models of nursing, do not directly incorporate the core focus on spiritual care which is so important in Islam generally and in Saudi Arabia in particular (Al-Shahri, 2002; Felemban et al., 2014; Abudari et al., 2016).

Almutairi, McCarthy and Gardner's (2015) interview-based research with 24 non-Saudi nurses in Saudi Arabia illustrates this. The researchers found that these nurses had experienced difficulties in understanding and responding appropriately to the cultural expectations of their Muslim patients, especially those relating to spiritual care. Similarly, Abudari et al. (2016) conducted research with non-Muslim nurses providing end of life care for Muslim patients in Saudi Arabia. They found that nurses often lacked awareness of their patients' spiritual care needs, and of cultural factors such as the close involvement of family members in decision-making in Islamic societies. Although family involvement in decision making is also important in Western societies, its importance in Saudi Arabia may transcend Western norms; for example, female patients may be unwilling to undergo examination or make decisions on their own behalf without a male family member being present (Al-Shahri, 2002).

Another potential form of conflict arises due to a clash between the professional nursing values taught to Muslim nurses and their personal religious or cultural values which are also shared by their Muslim patients and their family members (Lovering, 2008; Mebrouk, 2008; AlYami, 2014). For example, the western focus on the physical care and safety of patients is also often in conflict with the Islamic value of *hijab*, which relates to the need to protect the modesty and dignity of people. Although the values of privacy and dignity are also incorporated in other codes of practice as shown in Table 1, they are interpreted quite differently in many Islamic countries. For example, *hijab* requires that, when in the presence of unrelated persons of the opposite gender, a woman's body must be completely covered except for her hands and feet, and this even includes her face in the religiously conservative Islamic society of Saudi Arabia. The parts of the body that should not be exposed to members of the opposite gender under the principle of *hijab* are referred to as "*awrah*". This has led to expectations of gender specific care and avoidance of unnecessary physical contact between males and females in a medical setting in many traditional Islamic societies.

However, this can clash with the professional requirements of Western style nursing which not only require care for both genders but also close collaborative working between male and female healthcare professionals. For example, four principles of the ANA (2015) Code of Ethics refer to the collective or collaborative aspects of a nurse's responsibilities, and the UK's NMC code states: "You communicate effectively, keeping clear and accurate records and sharing skills, knowledge and experience where

appropriate". By requiring that female nurses interact as necessary with both male patients and colleagues (and male nurses with female patients and colleagues) to achieve this, such guidance can be regarded as incongruent with Islamic beliefs and therefore a source of potential value conflict for Muslim nurses.

It has been argued that these conflicts often arise due to cultural rather than religious factors (Lovering 2008; Mebrouk 2008), but religion and culture can be very difficult to separate in Saudi Arabia as in other Islamic countries, since Islam is a complete worldview that addresses all areas of life (Bester, Lovering and Arafat 2013). One of the participants in Mebrouk's (2008) study commented, "our culture depends on our religion, which is Islam" (p.157). Indeed, researchers have identified various cultural factors influencing the image of nursing and the experiences of Muslim nurses in Saudi Arabia. For example, despite the acceptance of nursing by the Prophet and the elevated status of nurses in Islam as represented in the story of Rafaidah, nurses are nowadays regarded as being of low status and poor moral standing in Saudi Arabia and other Middle Eastern societies (AlYami and Watson, 2014; Lovering, 2008). This is largely because of the association of nursing with tasks that seen as forbidden in Islam and Arab culture, such as exposing *awrah* and interacting with the opposite gender. In Saudi Arabia, this has created cultural barriers that deter many Saudi women from considering nursing as a profession, particularly as families are often opposed to this career choice for their female members (AlYami and Watson, 2014). These findings mirror those of other studies which have reported negative public impact of nursing in other Islamic societies such as Bahrain (Tawash and Cowman, 2015). A survey of Saudi Arabian citizens conducted by Saied et al. (2016) found that although the respondents perceived some aspects of nursing in a positive way, these perceptions did not translate into a desire to enter the nursing profession.

Other studies have also generated findings demonstrating a cultural influence on the image of nursing in Saudi Arabia. In research also reported from the structured review, Milig and Selim (2014) conducted a questionnaire survey of 152 female student nurses in Saudi Arabia, to investigate their attitudes toward the nursing profession. They found that those holding more negative attitudes were the younger members of the sample, aged under 20, and those originating from the North of the country. The North is a more religiously and culturally conservative region where it might be expected that the resistance to nurses conducting tasks which are considered to be against Islamic teachings

might be more extreme than in less conservative areas of the country. Further, quantitative research with male and female preparatory students by Keshk et al (2016) found that nearly two thirds of survey respondents did not consider nursing as a career choice because of factors such as the poor public image. Even among practising nurses, perceptions of professional image were found to be low, based on research by Zakari, Khamis and Hamadi (2010). These researchers conducted a quantitative cross-sectional survey of 346 nurses and nurse managers drawn from three healthcare sectors in Saudi Arabia and found that only a third of the sample reported a positive perception of nursing.

These studies demonstrate that though the negative public image of nursing affects both male and female student nurses, a more complex range of cultural factors affecting females. For example, Miligi and Selim (2014) found that main reasons why young Saudi females did not choose nursing as a career included the low public image of nursing, resistance from family members, long working hours, mixing with members of the opposite gender and the perceived risk to their prospects of marriage. There is evidence that the views and reactions of close family members have a significant impact on whether or not a Saudi woman chooses nursing as a career, reflecting the very important influence of the family in Saudi Arabian society (Hamdi and Al-Hyder 1995; Al Mutair et al., 2014; Rassool 2015). Felemban et al. (2014) noted that women may be deterred from nursing by the requirement that female nurses' employment applications be approved by their male custodians (usually male relatives), who may not approve of their entering the profession. According to Felemban et al., (2014, Pg11), "At times, the *mahrams* [male custodians] have been reported to react violently if nurses work night shifts, render care services to males, or attend to weekend assignments in the workplace".

Researchers have also identified practical barriers to the entry of Saudi women into the nursing profession, which relate largely to cultural expectations of gender roles and gender segregation. These include the challenge of how to travel to and from the workplace since, until very recently, Saudi women were not allowed to drive. Other reported barriers include the difficulties of finding suitable and affordable childcare, which is not readily available in Saudi Arabia, long working days, and the need to work shifts including night work (El-Gilany and Al-Wehady 2001; El-Sanabary, 2003; Lamadah and Sayed 2014; Aboshaiqah, 2016; Hassan, 2017). Lovering (2008) explains that the negative public image of nursing has been reinforced over time because most well qualified Saudi women do not choose nursing as a career due to the negative connotations

and it has been increasingly associated with low academic achievement. Nurses are also regarded as hand-servants of doctors who just carry out menial tasks, and there is little public awareness of the range of skilled tasks involved in nursing (Lovering, 2008).

Value conflicts in nursing in other Islamic countries

To help provide further insights into the ways in cultural as well as religious factors play a role, the literature review also examined the experience of value conflicts by nurses in other Islamic countries. The current study is concerned specifically with the issue of value conflicts among nurses in Saudi Arabia, who mostly belong to the Sunni school of Islam that is dominant in this country. However, as noted by Rassool (2015), there is considerably heterogeneity in the beliefs and practices of Muslims. These largely reflect the different schools of thought of the two main branches of Islam, Shi'a and Sunni, which account for the majority of Muslims worldwide, as well as many smaller sub-groups and sects (Bülow et al., 2008; Marzband et al., 2016). Most Islamic communities will defer to the opinion of their own recognized religious scholars on a range of issues including healthcare (Baddarni, 2010; Al-Awamer and Downar 2014; Wehbe-Alamah 2014). The literature indicates that, beyond the broad differences between the various Muslim schools of thought, country-specific cultural factors such as beliefs about gender segregation and the relative positions of men and women in society, have influenced the ways that religious teachers have interpreted the teachings of Islam (Lovering 2008; Mebrouk 2008). They also influence the development of cultural beliefs and traditions which are not strictly religious in origin but determine, for example, the types of jobs that are seen as suitable for women, suitable clothing for men and women, and acceptable ways of interacting with members of the opposite gender.

2.3.9 Responses to Value Conflicts among Muslim nurses

The literature also revealed ways in which Muslim female nurses in Islamic countries cope with the experience of value conflicts. For example, Lovering (2008; 2012) and others found evidence that Muslim nurses focus on the spiritual aspects of nursing in an attempt to reconcile the conflicts between their choice of profession and the negative public image of nursing. The nurses in Mebrouk's (2008) study indicated that they would not have become nurses if the profession was not supported by Islam (Mebrouk, 2008), while Alotaibi, Paliadelis and Valenzuela (2016) found that the perception of doing God's work and the expectation of rewards in the afterlife were important factors contributing

to job satisfaction. Similarly, the spiritual or religious values of Muslim nurses in Iran, such as the importance of providing spiritual care to their patients, and respecting their dignity and privacy, were found to contribute to high levels of job satisfaction. Nurses perceived their roles as a service to God and saw their patients as a reflection of God's image; they expected to receive rewards for their work in the afterlife. Importantly, a focus on spiritual values also enabled the nurses to develop a positive self-identity as a nurse, which helped them to deal with the challenges faced by the poor image of nursing in society (Ravari et al., 2012; Valizadeh et al., 2012).

There was also some evidence that Muslim nurses in Saudi Arabia use informal methods or coping strategies to deal with value conflicts when they arise. In particular, Mebrouk (2008) reported ways in which Saudi nurses reported strategies for developing caring relationships with all patients while maintaining their Islamic values relating to the privacy and dignity of patients. For example, when physical examinations were not acceptable to the nurses and their patients, potential problems were identified based only on conversations and not physical examinations and only later verified by the use of physical examination by male doctors (Mebrouk, 2008). Overall, there is considerable evidence in the literature of value conflicts and discomfort being experienced by Muslim nurses in Saudi Arabia and other Islamic societies, indicating that many have not been able to develop a professional self-identity or explanatory healthcare model that sufficiently reconciles the professional nursing role with their religious and cultural values.

2.4 Stage 2 Structured Review

2.4.1 Structured Review Methods

Aims and objectives

In contrast with the main literature review, which provided information on a wide range of studies relevant to values and value conflicts among nurses and student nurses, in general and within Islamic societies, the specific purpose of the structured review was to identify and examine the available primary research which has empirically investigated the experience of value conflicts by nurses or student nurses in Muslim countries, including those with different cultures to Saudi Arabia.

The purpose of this was intended to help provide understanding of the respective influence of religion and culture on value conflicts among student nurses in Saudi Arabia, by providing comparative information on the experiences of Muslim nurses in a range of different Islamic settings.

The structured review was guided by the following focused research question:

> "What information is available from peer-reviewed academic literature regarding the influence of culture and religion factors on value conflicts among Muslim Nurses in Islamic countries?

The structured review used a more tightly focused and structured approach to literature searches and retrieval. While a literature review uses fairly informal, less structured methods to identify relevant literature, often in a broad topic area, a "systematic" review is a "high level overview of primary research on a focused question that identifies, selects, synthesizes, and appraises all high-quality research evidence relevant to that question" (Kysh, 2013). It is particularly important to ensure that rigorous and systematic procedures are adhered to when conducting this type of review and that there is a clear audit of how the findings were obtained. This enhances the validity, trustworthiness and credibility of the review methods used and of the conclusions reached (Koch, 2006; Ridley, 2012; Creswell, 2013; Aveyard, 2014). An important objective of this section, therefore, is to provide a clear audit trail of all stages involved in conducting the review, as set out below.

Search terms, inclusion and exclusion criteria

The main databases searched for the structured review were CINAHL, Medline, ASSIA and Google Scholar. Again, this was intended to ensure that relevant peer-reviewed sources were identified from a wide range of academic literature. Only the first 100 or so Google Scholar results were included in screening due to the very large number of potentially relevant sources identified using this major online database. The following search terms were used:

nursing AND (role OR "role conflicts") AND culture AND (Islam OR Muslim OR Arab)

nursing AND (values OR "value conflicts") AND culture AND (Islam OR Muslim OR Arab)

nursing AND (role OR "role conflicts") AND religion AND (Islam OR Muslim or Arab)

nursing AND (values OR "value conflicts") AND religion AND (Islam OR Muslim OR Arab)

nursing AND (role OR "role conflicts") AND gender AND (Islam OR Muslim OR Arab)

nursing AND (values OR "value conflicts") AND gender AND (Islam OR Muslim OR Arab)

healthcare AND (role OR "role conflicts") AND (Islam OR Muslim OR Arab)

healthcare AND (values OR "value conflicts") AND (Islam OR Muslim OR Arab)

healthcare AND (role OR "role conflicts") AND (Islam OR Muslim OR Arab)

healthcare AND (values OR "value conflicts") AND (Islam OR Muslim OR Arab)

nursing AND (values OR "value conflicts") AND ("spiritual care" OR spirituality) AND (Islam OR Muslim OR Arab)

nursing AND (role OR "role conflicts") AND ("spiritual care" OR spirituality) AND (Islam OR Muslim OR Arab)

"Healthcare" AND ("ethical conflict" OR "moral dilemma") AND (Muslim OR Islam OR Arab)

"student nurse" AND ("qualified nurse" OR transition) AND ("role conflicts" OR "value conflicts") AND (Muslim OR Islam OR Arab)

Nursing AND ("role conflict OR "value conflict") AND ("culture OR religion") AND "Middle East"

Nursing AND ("role conflict OR "value conflict") AND ("culture OR religion") AND "Saudi Arabia"

Nursing AND ("role conflict OR "value conflict") AND ("culture OR religion") AND "Iran"

Nursing AND ("role conflict OR "value conflict") AND ("culture OR religion") AND "Egypt"

Nursing AND ("role conflict OR "value conflict") AND ("culture OR religion") AND "Indonesia"

Nursing AND ("role conflict OR "value conflict") AND ("culture OR religion") AND "Malaysia"

Nursing AND ("role conflict OR "value conflict") AND ("culture OR religion") AND "Turkey"

Nursing AND ("role conflict OR "value conflict") AND ("culture OR religion") AND "Israel"

Nursing AND ("role conflict OR "value conflict") AND ("culture OR religion") AND "Jordan"

Nursing AND ("role conflict OR "value conflict") AND ("culture OR religion") AND "Islamic country"

Studies were included in the review only if they met all the inclusion criteria defined as follows:

- Peer reviewed empirical studies (quantitative or qualitative) containing a description of methods and results
- Relevant to the research question: "What information is available from published academic literature regarding the influence of culture or religion on value or role conflicts among Muslim Nurses in Islamic countries?", with Islamic countries defined as those in which Islam is the official religion (even if other religions are also widely practised within the country).
- Published between 1950 to 2017 (because nursing formal nursing education began in 1954 in Saudi Arabia with a 1-year program. The first Bachelor of Science in Nursing (BSN) was established in 1976) (Alyami and Watson 2014).
- Published anywhere in the world and in any language.

Studies were omitted from the review if they met the exclusion criteria defined as follows:

- Grey literature such as academic dissertations and government reports, because the specific purpose of the structured review was to identify peer-reviewed journal articles based on empirical research with female Muslim nurses.
- Not based on empirical research.
- Not published in peer-reviewed academic journals.
- Published before 1950.

Screening and results

The structured review searches initially generated a total of 1928 results; these were listed in a spreadsheet that was then sorted alphabetically for the purpose of identifying and removing duplicates. The remaining 1309 articles were combined with 104 articles identified in the first stage literature review which appeared to be potentially eligible for inclusion in the systematic review approach. This resulted in a total of 1413 articles to be screened for eligibility.

The first stage of screening was based only on article titles and abstracts: in many cases this stage was sufficient to identify whether the article presented empirical research findings relevant to the experience of value conflicts among Muslim nurses in Islamic countries. However, to be certain that no relevant publications were omitted, the first stage of screening retained articles that were not primarily based on empirical research but which it was thought might contain reference to other empirical studies within their literature reviews. A total of 1227 papers were excluded from the review at this stage. The full text articles of the remaining 186 articles were then downloaded and skim-read, to determine whether they met the inclusion criteria. Based on this final stage of screening, 171 articles were excluded. This was because when the articles or their abstracts were skim-read, these were not found to report the findings of empirical research relevant to the experience of value conflicts among Muslim nurses in Islamic countries. Ultimately, just 15 were found to fall within the inclusion criteria and were included in the structured review. The results of screening at each stage are shown in the PRISMA diagram (Figure 3) (Moher et al., 2009), and a summary of the studies is shown in Table 2.

These studies covered a range of methodological approaches, including both quantitative and qualitative studies and observational research. Ten qualitative studies based on semi-structured or in-depth interviews with practising nursing or nursing students were included, and the remaining five consisted of quantitative survey-based research. Two of the qualitative studies also included field observations, and one consisted of the analysis of open-ended questions from a quantitative survey. The largest number of studies (N=9) reported on research conducted in Iran; four studies reported on research conducted in Saudi Arabia, and the two remaining studies were conducted in Egypt and Turkey respectively.

Figure 3: PRISMA flowchart, Search and screening results for structured review
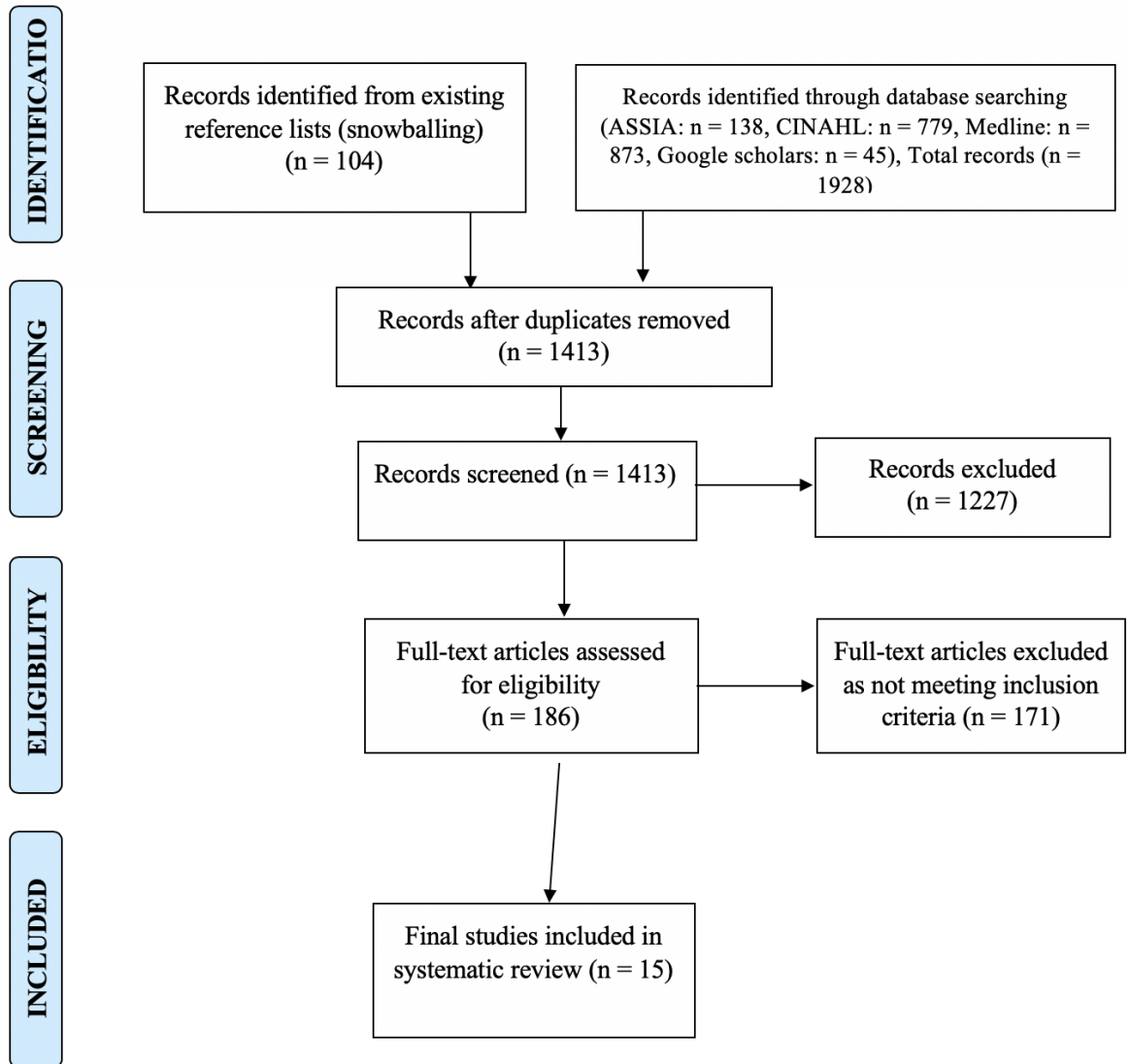
Table 2. Summary of Studies included in Structured Review

Reference	Country	Aims	Methods	Sample
Alotaibi J., Paliadelis P.S. and Valenzuela F.R. (2016). Factors that affect the job satisfaction of Saudi Arabian nurses. *Journal of Nursing Management 24*(3), 275–282.	Saudi Arabia	To determine factors influencing the job satisfaction of Saudi nurses.	Reports on qualitative analysis of 3 open-ended questions from a quantitative study.	553 nurses, self-selected from those meeting specific age and education criteria from 7 hospitals
Borhani, F., Hosseini, S.H. and Abbaszadeh, A. (2014) Commitment to care: a qualitative study of intensive care nurses' perspectives of end-of-life care in an Islamic context. *International Nursing Review, 61*(1), 140–147	Iran	To explore intensive care nurses' perspectives of the end-of-life care	Qualitative semi-structured interviews	12 intensive care nurses from intensive care units, recruited using purposive sampling.
El-Gilany, A., and Al-Wehady, A. (2001). Job Satisfaction of female Saudi nurses. *Eastern Mediterranean Health Journal, 7*(1/2), 31-37.	Saudi Arabia	To assess satisfaction of female Saudi nurses with their work and factors that would increase this satisfaction	Quantitative survey	Sample of 253 female nurses from governmental health facilities
Farrag, S., and Hayter, M. (2014). A qualitative study of Egyptian school nurses' attitudes and experiences toward sex and relationship education. *The Journal of School Nursing, 30*(1), 49-56.	Egypt	To examine how school nurses experience promotion of sexual health in an Islamic cultural setting	Qualitative in-depth interviews	13 school nurses from 13 different secondary and primary schools within a large city in Northern Egypt.
Fooladi, M. M. (2003). Gendered nursing education and practice in Iran. *Journal of Transcultural Nursing, 14*(1), 32-38. DOI: 10.1177/1043659602238348	Iran	To explore gendered nursing education and practice in Iran.	Qualitative interviews and field observations	6 nursing faculty and 5 undergraduate and graduate students recruited using convenience sampling methods
Hafizi, S., Koenig, H. G., Arbabi, M., Pakrah, M., and Saghazadeh, A. (2014). Attitudes of Muslim physicians and nurses toward religious issues.	Iran	To assess attitudes of physicians and nurses toward religion and impact of	Quantitative survey	Sample of 720 physicians, medical students and nurses

Journal of Religious Health, 53(5), 1374–1381.		socio-demographic factors on these		
Hajbaghery, M. A., and Salsali, M. (2005). A model for empowerment of nursing in Iran. *BMC Health Services Research, 5*(24). doi:10.1186/1472-6963-5-24	Iran	To inform the development of a model for empowering nurses in Iran	Qualitative semi-structured interviews and participant observation	Sample of 44 nurses
Mebrouk, J. (2008). Perception of nursing care: Views of Saudi Arabian female nurses. *Contemporary Nurse, 28*(1-2), 149-161. DOI: 10.5172/conu.673.28.1-2.149	Saudi Arabia	To examine nurse perceptions of their roles.	Phenomenological research design, using semi-structured, in-depth interviews	In-depth interviews with 5 nurses, selected using purposive sampling methods
Miligi, E., and Selim, A. (2014). Saudi nursing students' attitudes towards the nursing profession. *European Journal of Business and Management, 6*(29), 197-208.	Saudi Arabia	To identify nursing students' attitudes toward the nursing profession	Quantitative self-completion survey	Sample of 152 nursing students from a single college, selected using convenience methods
Ozcelik, H., Tekir, O., Samancioglu, S., Fadiloglu, C., and Ozkara, E. (2014). Nursing students' approaches toward euthanasia. *Omega, 69*(1) 93-103.	Turkey	To investigate undergraduate nursing students' attitudes towards euthanasia.	Quantitative self-completion survey	Sample of 383 nursing students
Rassouli, M., Zamanzadeh, V., Ghahramanian, A., Abbaszadeh, A., Alavi-Majd, H., and Nikanfar, A. (2015). Experiences of patients with cancer and their nurses on the conditions of spiritual care and spiritual interventions in oncology units. *Iranian Journal of Nursing and Midwifery Research, 20*(1), 25–33.	Iran	To explore nurses' and patients' views on spiritual care and spiritual interventions in the oncology units of Tabriz	Qualitative unstructured interviews	Sample of 10 patients and 7 nurses
Ravari, A., Bazargan, M., Vanaki, Z., and Mirzaei, T. (2012). Job satisfaction among Iranian hospital-based practicing nurses: examining the influence of self-expectation, social interaction, and organisational situations. *Journal of Nursing*	Iran	To examine the influence of self-expectation, social interaction, and organisational situation on job	Qualitative semi-structured interviews	Sample of 30 staff nurses who from university-affiliated and public sector hospitals.

Management, 20(4), 522–533		satisfaction among nurses.		
Ravari, A., Vanaki, Z., Houmann, H., and Kazemnejad, K. (2009). Spiritual job satisfaction in an Iranian nursing context. *Nursing Ethics, 16*(1), 19-30.	Iran	To identify and describe Iranian staff nurses' views on their spiritual job satisfaction	Qualitative semi-structured interviews	Sample of 25 staff nurses who worked in university-affiliated and public sector hospitals.
Shahriari, M., and Baloochestani, E. (2014). Applying professional values: the perspective of nurses of Isfahan Hospitals. *Journal of Medical Ethics and History of Medicine, 7*(1).	Iran	To investigate nurses' perspectives toward ethical and professional values in the clinical environment	Quantitative, self-completion survey	Sample of 150 nurses, generated using convenience sampling methods
Valizadeh, S., Tazakori, Z., Mohammadi, E., Hassankhani, H., Foladi, M. (2012). Spiritual Care Experiences of Iranian Nursing Students. *Journal of Hospice and Palliative Nursing, 14*(4), 268-273. DOI: 10.1097/NJH.	Iran	To provide greater insight into how nursing students experience spiritual care.	Qualitative, semi-structured interviews	18 nursing students from 3 universities, selected using purposive sampling methods.

Evaluation of research quality

As Aveyard (2014) discusses, it is common protocol within structured or systematic reviews to utilise hierarchies of evidence in order to identify and categorise the robustness of empirical research. Traditional hierarchies of evidence are commonly utilised to determine the efficacy or effectiveness of treatments and/or interventions, thus such methods are associated in particular with evaluating the quality of randomised controlled trials (RCTs) and case control studies (Petticrew and Roberts 2003; Glasziou, Vandenbroucke and Chalmers 2004). The majority of the studies covered in this structured review are qualitative in nature and therefore are not subject to the application of traditional hierarchies of evidence. However, as Aveyard (2014) states, there are also hierarchies of knowledge that can be utilised in the critical appraisal of qualitative studies. Appropriate evaluative frameworks for use in assessing quality include, for example, those developed by Bray and Rees (1995), Benton and Cormack (2000), Spencer et al. (2003) and Lee (2006). The review used the most recognised and widely used quality assessment tool, The Critical Appraisal Skills Programme (CASP, 2013) framework for qualitative research. This framework is built around ten key questions:

1. Was there a clear statement of the aims of the research??

2. Is a qualitative methodology appropriate?

3. Was the research design appropriate to address the aims of the research?

4. Was recruitment strategy appropriate to the aims of the research?

5. Was the data collected in a way that addressed the research issue?

6. Has the relationship between researcher and participants been adequately considered?

7. Have ethical issues been taken into consideration?

8. Was the data analysis sufficiently rigorous?

9. Is there a clear statement of findings?

10. How valuable is the research?

A slightly modified version of the CASP (2013) framework was used to assess the quality of all publications included within this review; this basically used the original CASP quality criteria but combined some of these for the purpose of producing a more concise data extraction table. The specific quality criteria used in this review were as follows:

1. Aims clearly stated?
2. Appropriate design and methods?
3. Appropriate recruitment and data collection?
4. Any issues of bias or ethics?
5. Rigour of data analysis methods and presentation of findings
6. Assessment of overall value of study to this review

Data Extraction

A systematic process of data extraction and interpretation was used for the purpose of extracting content from each article that was relevant to each of the evaluation criteria, and could be used for assessing the research quality of the studies, individually and as an overall body of literature. Data was extracted by reading each article in detail, and identifying methodological and other content relevant to the modified CASP framework headings. This was used to assess the quality and value of the research in terms of the specified criteria (e.g. methodological approach, rigour, bias) drawing on the researcher's

knowledge of research methodology and a consideration of how each article contributes to understanding of the issues being addressed in the current study.

Although a second researcher was not used to verify the searches and selection of sources, the researcher sought validation of the methods from supervisory team throughout the process by sending the search plan for approval as well as the search results and details of sources selected for inclusion. It is believed that the risk of bias in selection of sources was minimised since the inclusion and exclusion criteria were clear and objective, being designed only to identify only peer-reviewed empirical studies relating to the experience of value conflicts among Muslim student nurses.

2.4.2 Structured Review Findings

Findings relating to Research Quality

The identified articles are shown in the data extraction table attached as Appendix 1 along with relevant extracted material corresponding to each of the evaluation criteria.

First, it was confirmed that all of the studies included a clear *definition of their aims.* The ways in which these were defined accurately reflected the types of methods used in the research. For example, aims of the qualitative studies (e.g. Borhani et al., 2014; Ravari et al., 2012) were defined using terms such as "explore" or examine", especially in relation to the factors influencing the attitudes or experiences of nurses or nursing students. In contrast, the quantitative studies (e.g. El-Gilany & Al-Wehady, 2001; Miligi & Selim, 2014) used terms such as "assess the degree of satisfaction" and "identify attitudes", which reflected the ability of these studies to quantitatively measure these factors.

Based on the stated aims of each study, it was also determined that each used an *appropriate design and methods* for achieving the stated aims of each study. For example, a study concerned with assessing work satisfaction among female Saudi nurses and the factors contributing to this (El-Gilany & Al-Wehady, 2001) used a quantitative survey design that allowed investigation of the relationships between variables In contrast, a study intended to inform the development of a model for empowering nurses in Iran (Hajbaghery & Salsali, 2005) used a qualitative multiple methods research design and grounded theory analysis methods, which enabled the researchers to build a range of new understanding and knowledge essential for model development.

With regard to participant *recruitment and data collection methods*, most of the studies provided information which allowed the researcher to confirm that these were appropriate given the aims of the research. In a few cases, however, insufficient information was included in the articles on the recruitment and sampling methods to determine whether there were any weaknesses in these that might have influenced the outcomes of the research. This was particularly the case in a few of the qualitative studies based on relatively small samples of around 12 (e.g. Borhani et al., 2014; Farrag & Hayter, 2014). Although qualitative studies typically use small sample sizes, it is important to have sufficient information to properly assess the potential for *bias* in the findings which relate to the sampling and recruitment procedures, and in some cases this was lacking (Borhani et al., 2014; Ravari et al., 2009; Ravari et al., 2012). In other studies, the reported use of convenience or purposive sampling along with relatively small samples does suggest that a degree of sampling bias might have been present (e.g. Fooladi, 2003; Mebrouk, 2008; Rassouli et al., 2015; Valizadeh et al., 2012).

In contrast, some of the studies covered in the review were based on relatively large samples (e.g. n=44) and the diversity of participant characteristics in these is likely to have helped reduce the potential for selection bias, with methodological details on sampling procedures in some cases helping to confirm this (Hajbaghery & Salsali, 2005). In the case of the quantitative studies, relatively high responses rates ranging from 60/65% (Alotaibi et al., 2016; Ozcelik, 2014; Shahriari & Baloochestani, 2014) to 95.9% (El-Gilany & Al-Wehady, 2001) are likely to have reduced the potential for bias. However, at the lower end of this range it is possible that the findings may have been affected by bias in that non-respondents might have had different views and experiences than those taking part in the research. Further, the findings of those quantitative studies using non-random sampling methods (Miligi & Selim, 2014) may have been affected by sampling and respondent bias. The majority of studies (N=13) provided sufficient information on the analysis methods used to enable the researcher to assess these and confirm that they were sufficiently *rigorous*. These included both quantitative and qualitative studies. Two of the qualitative studies, both using thematic analysis methods, provided only broad information on these, and insufficient details to assess the rigour of these methods (Farrag & Hayter, 2014; Fooladi, 2003). The presentation of findings in all cases was clear and was deemed to be suited to the purpose and aims of the respective studies.

The final evaluation criteria based on the CASP framework was the assessment of overall *value of the studies* to this review. To recap, the purpose of the structured review was to help provide understanding of the respective influence of religion and culture on value conflicts among student nurses in Saudi Arabia, by providing comparative information on the experiences of Muslim nurses in a range of different Islamic settings.

The main limitation of this body of literature was that it covered only a small range of Islamic countries, with thirteen of the fifteen studies conducted either in Saudi Arabia or Iran, both conservative Islamic societies. Only two relatively moderate Islamic societies (Egypt and Turkey) were covered in the literature included in the structured review. This limited the possibilities for fully exploring the impact of culture on the experience of value conflicts, in terms of the interpretation of Islam in different societies. It also highlighted a gap in the literature on the experience of conflicts among Muslim female nurses in more moderate Islamic societies.

Despite these limitations, the overall body of findings from the studies included in the review has contributed value to the current study by providing additional supporting information regarding the experience of values conflicts, based on a range of different research methods and settings. This body of research evidence was in general deemed to be of high quality based on the evaluation criteria, but with a few weaknesses mainly relating to sampling and recruitment methods, or lack of adequate information on these, and the related risk of bias in some of the studies. The ways in which the overall body of literature contribute value to the current study in terms of substantive research findings are discussed in the following section.

Substantive Findings Relevant to the Current Study

Taking into account the limitations highlighted above, the findings of the structured review did suggest that Muslim nurses in a range of Islamic countries experience conflicts between their religious and cultural values on the one hand, and the professional values of nursing on the other. This seems to be the case even in countries such as Egypt and Turkey where a more moderate form of Islam is practised than in Saudi Arabia and Iran, for example where the dress codes for women and the requirements for gender segregation are less strict. Some common themes appeared in the literature relating to the

types of value conflicts or ethical dilemmas experienced by Muslim nurses in these settings mainly in the following three types of situations:

First, Muslim nurses frequently experience value conflicts or discomfort when required to provide nursing care for male patients. These appear to be related to the Islamic teachings that prohibit close contact between the genders, especially in the case of young unmarried women, and the ways in which these have been translated into cultural taboos about gender segregation in these countries. For this reason, the value conflicts of this type appear to be most extreme in the case of the more conservative Islamic societies of Saudi Arabia and Iran, despite conflicting findings that some nurses in Iran report nursing to be compatible with Islam (Fooladi, 2003). El-Gilany and Al-Wehady (2001) conducted research with a sample of 253 female Muslim nurses working in governmental health facilities in Saudi Arabia and found that 98.7% of the nurses could not accept the idea of working with male patients. Similarly, Alotaibi et al. (2016) reported on the qualitative analysis of three open-ended questions from a structured survey, completed by 533 nurses in Saudi Arabia, in which it was found that the majority of female nurses in the sample indicated a preference not to care for male patients. In Mebrouk's (2008) study in Saudi Arabia, although the nurses did not feel uncomfortable caring for male patients in general, they indicated that they could not expose the *awrah* of these patients. Instead they referred to ways in which they identified problems in this area based on conversation with the patient, to be confirmed later by a male doctor.

Unfortunately, the small number of more moderate Islamic countries, such as Egypt and Turkey, covered in this review of empirical studies, and the limited nature of the research in these settings, did not allow for an extensive comparison of this phenomenon between different Islamic cultures. In Saudi Arabia, where nurses are often expected to work on both male and female wards, the published research evidence indicates that female Muslim nurses find the lack of segregation especially difficult and that this often results in the experience of value conflicts between the religious and cultural beliefs about interaction between unrelated people of different genders and the requirements of their nursing role (El-Gilany and Al-Wehady, 2001; Mebrouk, 2008). Although some research participants were comfortable working on male wards, others expressed a reluctance to do so and all could not accept exposing male *awrah* in their work (El-Gilany and Al-Wehady, 2001; Alotaibi et al., 2016). In the case of Iran, in contrast, nursing is more gender-segregated, with one study reporting that the Iranian health system only allows

male nurses to care for male patients and female nurses to care for female patients and that there are higher levels of job satisfaction among female nurses as a result (Fooladi, 2003). More recent research (Valizadeh et al., 2012) indicates however that all nursing is not gender-segregated in Iran and that this results in the same difficulties and value conflicts for Muslim nurses as in Saudi Arabia. For example, both male and female Muslim nurses interviewed by Valizadeh et al. (2012) expressed concerns that they might be misjudged when providing spiritual care in the form of physical touch or verbal communications to patients of the opposite gender.

Second, value conflicts were experienced in different country settings when caring for end-of-life patients (Borhani, Hosseini and Abbaszadeh 2014; Ozcelik et al., 2014). This appears to be more directly related to the clash of religious and professional values. The nurse participants in the studies examining these situations reported feeling uncomfortable and inadequate when providing this type of care and identified conflicts such as being unprepared to switch off life support machines because Islam teaches that the time of a person's death should be the will of God alone. They appeared to disregard the fact that the use of a life support machine was already prolonging the patient's life unnaturally, and were unprepared to take the responsibility of ending the person's life because this conflicted too strongly with their Islamic beliefs. Conflicts in this area were reported in two of the articles reviewed. One was based on unstructured qualitative interviews with 12 intensive care nurses in Iran, a relatively conservative Islamic society (Borhani et al., 2014). The other was conducted in Turkey, a very moderate Islamic society, in which Ozcelik et al. (2014) conducted a survey of attitudes to euthanasia among 383 undergraduate student nurses. In general, the nurse participants in these two studies seemed to have little awareness of the situations that are interpreted as passive assistance and permissible by Islamic law: administering analgesic agents with the purpose of relieving pain, even if these might hasten death, and withdrawing ineffective treatment if family members agree (Aramesh and Shadi, 2007).

Third, there was evidence across the countries that nurses often felt uncomfortable in various aspects of their roles because of the perceived conflict between what they were required to do and the dominant cultural values of their country settings. This relates to the negative public image of nursing which appears to exist in all four Islamic countries covered by the review, and relates to the widespread perception that nurses perform unclean tasks and break gender segregation rules or taboos. Although these gender

segregation laws have their foundation in Islamic teachings, the differences in the ways they are experienced between the countries, and the apparent disregard by the public of the acceptance of nursing by The Prophet, as set out in the Hadith, indicates that these types of conflicts arise because of the ways that Islam has been interpreted in different country settings, as well as other cultural factors. Despite the perceived importance of providing Islamic nursing care to these participants, however, researchers have also reported that cultural beliefs and taboos in these societies often act as barriers to the provision of spiritual care. For example, the gender segregation rules in Iran prevented the nurses in Valizadeh et al.'s (2012) study from using touch or informal communications as forms of spiritual care with patients of the opposite gender. This was a source of frustration to both female and male nurses in the study, who feared being misjudged by others if they provided these forms of care.

This type of conflict is also illustrated, for example, by the discomfort experienced by school nurses in Farrag and Hayter's (2014) study in relation to sexual health education in Egypt. The findings indicated that the nurse participants in this study felt uncomfortable about being responsible for sex education, especially when teaching boys. Although this discomfort might not be unusual even in Western settings, the difference in Egypt appears to be the fear and worry expressed by the nurses that they might personally be judged due to this aspect of their roles and that it would have a negative impact on their reputation. This might be interpreted as a conflict between the nursing value of raising awareness of sexual health in order to protect young people from harm, and the Islamic value of female modesty. However, the article indicates that the discomfort felt by the school nurses largely reflects the cultural expectation in Egypt that women should be demure and sexually naïve.

In research with nursing faculty as well as undergraduate and graduate student nurses in Iran, Fooladi (2003) observed that women have historically been discouraged from taking paid employment in Iran, or encouraged to take "culturally and gender-appropriate" jobs, which according to this study includes nursing. This indicates that nursing is considered a more acceptable profession for women in Iran than in Saudi Arabia, even though both are conservative Islamic societies, and highlights the possible role of cultural differences in relation to female roles in these societies. However, a higher degree of segregation exists within Iran's health system, in comparison with Saudi Arabia, with nurses in some hospitals in Iran allowed to care only for patients of the same gender, which may explain

why the nurses in Fooladi's (2003) study cited earlier were more comfortable in their nursing roles. Other research conducted in Iran, based on semi-structured interviews and participant observation with 44 nurses (Hajbaghery and Salsali, 2005), provided evidence that nursing still has a poor public image in this country setting, as in Saudi Arabia. The researchers argued that high status of physicians in Iran has had a negative impact on the nursing profession, since uneven power relationships have developed between these groups. Although it might be argued that this is also true of the Western healthcare context, this is likely to be reinforced by the more patriarchal culture that is common to many Islamic societies, as well as the cultural taboos about communication between unrelated males and females and which can make it very difficult for nurses to fulfil their professional responsibilities in terms of teamwork.

Overall, the literature review findings of the structured review suggest that a complex mix of religious and cultural factors contributes to the experience of value conflicts by Muslim nurses in Islamic societies, which may help to explain the differences in the types and extent of value conflicts experienced. Several studies identified in the main literature review highlighted the ways in which religious or cultural beliefs of the Saudi Arabian population about gender segregation may have a negative impact on the public image of the nursing profession (El-Sanabary, 2003; Mebrouk, 2008; Alotaibi et al., 2016). However, cultural factors contributing to the perceived low status of nurses across the countries covered by the structured review include the image of nursing as menial work, long working hours which are difficult to reconcile with family responsibilities and the opposition of parents to daughters living away from home (El-Sanabary, 2003). Although these are often grounded in or attributed to the teachings of Islam, it appears that in practice they relate to the ways in which Islamic teachings have been interpreted in different cultural settings and have contributed to the evolution of social norms about gender relationships and the role of the family unit. In particular, Islam tends to be associated with very patriarchal societies in which females are expected to be submissive and modest.

Although the review did not allow for an extensive comparison of the experiences of female Muslim nurses in a range of Islamic societies, it provided considerable evidence of the experience of value conflicts among this group within Saudi Arabia and Iran, both conservative Islamic societies, and revealed ways in which these are being addressed in Iran through nurse education and organisational practices. In conclusion, the structured

review has generated findings which help contribute to the overall understanding of the experience of value conflicts in nursing within such Islamic societies, but this contribution is based mainly on research with qualified nurses rather than nursing students, and some of the studies reviewed were found to have methodological weaknesses or information gaps, making it difficult to confirm the rigour and quality of these studies. These conclusions help confirm the need for additional primary research into the experiences of value conflicts among female Muslim student nurses in Islamic societies.

2.5 Chapter Summary

The literature review has revealed considerable evidence that, after graduation and entry into clinical practice roles, many newly qualified nurses experience conflicts between their personal values and the professional values expected of them in the working environment. The reported findings relating to the experiences of value conflicts among student nurses have been based on a very small number of studies, but the limited evidence from these suggests that this group experiences similar value conflicts to newly qualified nurses, while on clinical placements.

The review findings indicate that that there are two main forms of value conflicts facing student nurses: one arising from the clash between the student's personal values relating to person-centred care and the dominant values of the real-life clinical environment, and the other arising from cultural issues encountered when applying models of nursing originally developed in Western environments without tailoring these to non-Western religious and cultural environments. The findings of the structured review, which focused on examining the experience of value conflicts among Muslim nurses in a range of Islamic societies, mainly revealed evidence of the second form of value conflict. The available literature also provides some evidence that student nurses, like newly qualified nurses, experience negative psychological impacts from these value conflicts.

The review has also demonstrated the central role of spiritual care within Islamic healthcare, and the importance to Muslim nurses of being able to reconcile their religious and spiritual beliefs with their professional nursing roles. The available literature has shown that Muslim nurses report higher levels of job satisfaction when this alignment, which might be conceptualised as "inner harmony" in terms of Rokeach's (1973) theory, can be achieved. It also demonstrates that value conflicts often arise when they are

required to undertake tasks which they believe are prohibited by Islam, such as exposing male *awrah*.

The findings of published research conducted in Saudi Arabia and other Islamic societies suggest that cultural factors have a significant influence on the value conflicts experienced by Muslim nurses. Although religious and cultural factors can be hard to separate in the context of Islamic societies, the empirical evidence indicates that nursing has a poor public image in Saudi Arabia largely due to a lack of awareness of its spiritual foundations and acceptance by the Prophet Muhammad. In the absence of this awareness, nursing has developed negative cultural associations over time, and is associated with low academic achievement, low skilled work and "unclean" tasks.

The review has also generated considerable evidence that the poor public image of nursing in Islamic societies, and the types of value conflicts that nurses face, are not only related to religious beliefs about gender segregation, but to cultural factors relating to the male-dominated nature of Islamic societies. These include, for example, family views about acceptable types of jobs for wives and daughters, and the expectation that women will play submissive and subservient roles in these societies, as well as practical considerations such as restrictions (until recently) on Saudi Arabian women being able to drive, and difficulties in finding suitable childcare or combining long shifts with family responsibilities.

The review of literature therefore suggests that both religious and cultural factors might have an influence on value conflicts among Muslim nurses and student nurses in Saudi Arabia, but none of the studies have specifically investigated this issues. Indeed, previous research on this topic, especially with regard to student nurses, is minimal and many of the studies conducted with practising nurses are somewhat dated. This indicates a need for the current qualitative case study, which incorporates data collection from individual interviews and focus groups as well as a qualitative analysis of related documentation in the form of training materials and policy documents. This is intended to generate a comprehensive, detailed understanding of the types of value conflicts experienced by female Muslim student nurses in their particular institutional context, the factors influencing these, and the types of support, guidance and training that are needed to help them cope with or overcome the conflicts.

In order to explore the feasibility of the research and to identify whether value conflicts do in fact exist among Muslim student nurses in the case study institution, the researcher first conducted a small-scale exploratory study in 2016, using qualitative research methods (focus groups and individual interviews). This was based on a sample of seven second-year and ten fourth-year female Muslim student nurses at the same governmental higher education institution in Saudi Arabia which subsequently formed the case study setting for the main study. The findings of this exploratory study are presented in Chapter 3.

CHAPTER THREE: EXPLORATORY STUDY

3.1 Introduction

The exploratory pilot study was intended to determine the presence or absence of value conflicts preliminary among a sample of female Muslim student nurses in Saudi Arabia, in order to determine the need for a full study to examine these issues in greater detail. The specific research questions of the exploratory study were:

1. What are the common values relating to their professional roles that are held by Islamic student nurses in the second year and the fourth year of the nursing degree?

2. Is there evidence of the presence of conflicts between the student nurses' professional and personal values?

3. If so, what are the commonalities and differences in these conflicts among the student nurses at different stages of their nurse education?

4. What are the impacts of these value conflicts on the student nurses?

3.2 Research Design and Methods

This qualitative exploratory study used two forms of data collection: focus groups and in-depth face-to-face interviews. It was based on a phenomenological approach that explored the lived experiences of individuals from their own perspectives (Laverty, 2003; Holroyd, 2007). The intention was to identify key themes and findings that captured these experiences and perspectives, which could then be used to help inform the design of the main study. Both the interviews and the focus groups were used to investigate the participants' perceptions of personal and professional values, and to identify and explore their experiences of conflicts between these values as a female Muslim student nurse in Saudi Arabia.

The total sample of 17 consisted of second-year (n=7) and fourth-year (n=10) female Muslim student nurses within a university in Saudi Arabia. The second-year students were selected for inclusion in the study, as this group had not yet been exposed to clinical practice nor influenced by the clinical training setting. In contrast the fourth-year student nurses could potentially have more experience and greater exposure to the clinical environment, and be more likely to have experienced or witnessed situations of conflict between their personal and professional values in nursing practice. The inclusion of both

groups in the study was intended to enable the researcher to investigate the ways in which student nurses at different stages of their education in this university become aware of and experience value conflicts, as well as identifying the factors that the participants in each year perceive to be influencing these value conflicts.

All 175 student nurses in the second (n=104) and fourth years (n=71) of study were eligible to take part in the study. A convenience sampling method based on initial self-selection was used, i.e. whilst all second- and fourth-year students were informed about the study and invited to take part, the sample was selected from those who volunteered to participate. Details of the overall population of student and the numbers and characteristics of those who volunteered to participate are shown in Table 3, along with the percentage of the all student nurses in each year that the sample represents, which was just over a third (36%) in each case.

Table 3: Exploratory Study - Characteristics of Population and Volunteer Sample

Characteristics of Population (N = 175)				
Target Population	Student Nurses in Year 2 and 4			
Gender	Female			
Target Population by Year	2nd year		4th year	
Number of students	104		71	
Expression of interest forms distributed	86		65	
Age group	Under 20		20 - 25	
Characteristics of Volunteers N=64				
	2nd Year		4th Year	
	Single	Married	Single	Married
Marital status	37	1	22	4
Focus group preference	25	1	16	3
Interview preference	11	0	4	1
No preference	1	0	2	0
Total participants and percentage of year group	38=36%		26=36%	

From those students that volunteered to participate (N=64), two second-year students and two fourth-year students were selected for one-to-one interviews, and five second-year students and eight fourth-year students were selected to take part in a focus group. Since there were relatively few married volunteers, they were all included in the final sample

of participants and were included a focus group or interviewed on a one-to-one basis depending on their expressed preference. The remainder of the focus group and interview participants were selected from the volunteers randomly using Dice random selection software (Random.org).

The focus groups and interviews were arranged with selected participants at mutually convenient times and conducted in the meeting room of the nursing faculty of the study institution. The researcher personally facilitated the focus groups and conducted the face-to-face in-depth interviews in Arabic, using a focus group guide and semi-structured interview guide. All interviews were audio-recorded and personally translated and transcribed by the researcher. An Arabic/English-speaking faculty member from the study site was asked to validate the accuracy of around a third of the translated transcripts, randomly selected. Member checking was also used in which one participant from each of the focus groups and some of the interviewees were asked to read the transcripts and to verify that these accurately represented what was actually said in the group or the interview.

The transcripts were imported into NVivo 11 qualitative analysis software for the purpose of the initial stages of coding and analysis using thematic analysis. The results are presented in this section by key themes and sub-themes relevant to the research questions and arising from the data, and their significance is discussed in relation to the research questions and the overall aim of the study.

Analysis of the data revealed four main themes and ten sub-themes, as shown in Table 5. In accordance with these themes and sub-themes, the findings section is structured as follows. First, the findings are reported relating to the participants' personal and professional values and the factors perceived to influence these. Their reported experiences of value conflicts are then discussed, including the types of value conflicts encountered, the reported impacts of these conflicts on the participants and the ways in these value conflicts are addressed in nurse education and by the individual participants. Findings are then presented on the ways in which the participants report they are changing and developing as a result of their nursing studies, and on how they expect to cope with future value conflicts in their work as qualified nurses. Findings relevant to the concept of cultural competency are then considered. A concluding section summarises the key findings and discusses their significance in the context of the existing literature in this area. Verbatim quotes from the interviews and focus groups are used to illustrate the

points being made, and to ensure that the research accurately conveys the participants' personal views and lived experiences.

Table 4: Exploratory Study - Themes and Sub-Themes

Main Theme	Sub-Themes
Personal and professional values	Personal values
	Religious versus cultural influences on values
	Impact of personal values on choice of study and nursing role
	Professional values
Types of value conflicts	Exposing private body parts (*Awrah*)
	Interaction of female nurses with male colleagues and patients
	Image of Nursing in Saudi Arabian Society
Dealing with value conflicts	Avoidance
	Distinguishing between religious and cultural values
	Growth in confidence over time

3.3 Exploratory Study Findings

3.3.1. Personal and Professional Values

The interviewees and focus group participants were first asked to describe and discuss their personal values as well as the professional values that they understand to be associated with nursing. The findings are very important not only in relation to the key objectives of the study, but also in adding to existing literature in this area by helping to clarify the nature of personal and professional values in an Islamic nursing environment and how these can be differentiated. The research participants were also asked about the ways in which their own values related to their choice of a nursing career.

3.3.2 Defining Personal Values

This research revealed the dominant role of religion and culture as major influences on the personal values of this sample of 17 Muslim student nurses in Saudi Arabia. However, the students recognised that personal values are also influenced by other factors, including education, life experiences and interactions with other individuals.

Although the students acknowledged that specific personal values may vary between individuals because of the influence of different family backgrounds or other factors, they also concurred that they share common religious values based on Islam, which is the foundation of society and culture in Saudi Arabia. All of the participants had therefore been brought up according to the principles of Islam, both within their families and in their education, and most – though not all - defined their own personal values specifically in religious terms.

> The religion is very important. Religion and the education are developing our personality, generally in our society religion is the foundation of our values. (Nada, Year 4)

> Our religious values are the main personal values, we are all from the same culture based on religion. (Hala, Year 4)

The participants identified two main types of Islamic values. First, they cited more general types of values, such as kindness, and caring for others, but highlighted that these are also Islamic values. Second, they mentioned values that relate to the teachings of Islam itself, such as values relating to interaction between the genders in Saudi Arabian society, or the ways in which women are required to cover their head with the *hijab*. In order to illustrate the ways in which they would never go against their personal values, one fourth-year student gave the example that, despite their long period of nurse education, they would still not be prepared to remove their *hijab* at work even if required to do so by the hospital.

> I will never change my value, for example I will wear my hijab in the operation theatre not because this my religion it my value and I should protect myself even if it is required by the hospital to take it off. (Hala, Year 4)

The student nurses discussed their religious values primarily in terms of the ways they guide their everyday behaviour and decisions, especially the limits they observe in interactions with male colleagues or providing care to male patients. Many of the participants referred to a "red line" defined by their Islamic values, which represents the boundaries that cannot be crossed.

> Based on our values I should not talk to a man, there should be some barriers and there are red lines not to go over … because our culture does not allow mixed environment and should not make relations with opposite sex. (Maha, Year 2)

> It is principles of each person, either something must not do and to go over the red line, or something must do. (Daad, Year 4)

As discussed later, there was considerable evidence from the study that these religious values are used to make decisions about which types of nursing tasks they are prepared to carry out, which gives rise to conflicts between these values and the professional values which demand certain tasks to be conducted in nursing.

Some of the participants expressed the view that personal values should be fixed and unchanging.

> Personal values are things that I organise my actions based on and must not compromise, it doesn't matter whether other people see it right or wrong. It is based on my religion, education and the way I think, interact with other people. (Suhair, Year 2)

> I feel the values and principles are the basics and foundation of a person and never change, and nothing should change my values, neither the environment surrounding me. (Layal, Year 4)

However, others indicated a belief that values can and do change over time, as a person is exposed to different experiences and ways of thinking. There were no notable differences in the responses of second- and fourth-year students in this respect.

> I think it depends on our understanding, our values when we are young it will change when we grow up, through the experiences I think our personal values develop, some become stronger and some could be changed. The more we grow the more we understand life, the more we understand then our values grow too. (Wafia, Year 2)

> It is the values that might be gained from the family, environment raised in, situations and circumstances, and this might vary from someone to another based on the family or school they studied in. (Maha, Year 2)

> I feel it is possible to change them if they were wrong, we might find ourselves wrong in something, so we change it. (Hala, Year 4)

3.3.3 Religious versus Cultural Influences on Values

Since Saudi Arabia is an Islamic society, the boundaries between religious and cultural values are often blurred, with religious values influencing all areas of life. However, some of the participants made a distinction between religious and cultural values that is relevant and important to the interpretation of their experiences of value conflicts and

their responses to these. These participants expressed the view that religious values are absolutely binding and are held by all Muslims in Saudi Arabia, as cultural values reflect the ways in which these religious values are interpreted and followed differently by groups and individuals within this society. Cultural values determine what is regarded as "aib" (shame) whereas religious values determine what is "*haram*" (forbidden by Islam). Unlike religious values, cultural values reflect how open-minded or strict a family is, for example with regards to interaction between men and women in the workplace, or between the practices of Saudi women in covering their whole face or just their hair with the *hijab*. Some of the participants who expressed this type of view explained that they can reject cultural values they do not believe in, but those based on religion must always be observed.

> Like hijab, it is different from person to another, someone covers all her face while another covers her hair only, some only expose their eyes. These values differ from one to another. It is standard religious value to cover, but the variations in the way they cover may be cultural as we said, depending on the family they came from or the school at which they studied. (Maha, Year 2).

> I don't believe that abaya should be black or that uncovering the face is prohibited "*haram*". I think this is cultural and it is a major issue in our culture. Also, in our speciality as health care providers or medical field some of us - and I am one of them - go out wearing lab coats without abaya. This is not accepted to some people in our culture. I see this as okay, it is okay to go out wearing lab coat as it is modest and covering like the abaya, so what is the difference? …. They think this is based on religion, but this is wrong, it is cultural far more than it is religious. (Suhair, Year 2).

These findings are in line with the conceptualization of cultural and religious values put forward by Lovering (2012), in her research with qualified nurses in Saudi Arabia. She identified relevant cultural values as "*aib*" rather than "*haram*" and observed that these differ from the religious values that provide guidance on caring for health and looking after the body, and on the use of Islamic prayers and verses from the Qur'an as healing methods.

Others in the exploratory study sample did not specifically make the distinction between religious and cultural values, but neither did they put forward an opposing belief; it seems more likely that they had not considered the differences between cultural and religious values.

3.3.4 Impact of Personal Values on Choice of Study and Nursing Role

Previous researchers have discovered that personal values often influence the choice of career among nurses, as well as the ways they carry out their day-to-day nursing roles. Many individuals who choose a nursing career have been found to hold values that are closely aligned with this type of work, such as caring for others, honesty, responsibility and respect for human dignity (Altun, 2002; Rassin, 2008; Stacey et al., 2011).

In this research it was notable that although the participants did identify with the types of values often held by individuals who choose a nursing career (Altun, 2002; Rassin, 2008; Stacey et al., 2011), relatively few had selected nursing as their initial choice of studies. Instead, they reported that they had pursued this field of study as a last resort because their exam results were not high enough to go into their preferred field such as medicine.

> I believe my choice has nothing to do with my values, I applied to the University for the Allied Medical Science which has different specialities and one of them is nursing … Based on my grades I was selected for nursing and I did not know what exactly nurses do. (Randa, Year 2)

It is not known how typical these are of other female Muslim Saudi Arabian student nurses, and therefore not possible to determine whether this finding was influenced by any bias resulting from the sampling procedure. In any case, many of these students also indicated that having commenced their nursing studies they were greatly enjoying these and recognised that nursing was well aligned with their personal values.

> First of all nursing was not my choice, I wanted to be a dentist, that's what I really like but I was not accepted by Dentistry College. So there were many choices to apply for and I decided to study nursing. I tried to see what is the best choice that really suits me. Nursing I felt that is a choice I can find myself in, helping people and a lot of physical activity as I don't like office work. Nursing has all this and lot of specialties. I prayed and selected it and I am comfortable and happy with my choice regardless of everything. (Suhair, Year 2)

For those who did take their personal values into account when deciding to pursue a career in nursing, these were often articulated at least partly in terms of religious or cultural values, such serving God and being a good Muslim. This is in line with the ways that most of the participants defined their personal values, as discussed above.

> I think my personal values have impacted my choice as I do really like to take care of others, very, very much and help people ... There might be religious values that influenced my choice, yes God will bless and reward us for this job but to be

honest I did not think about it from this point of view. My choice was mainly cultural as in our culture we believe in helping others and taking care of people who need it. (Suhair, Year 2)

Nursing was not my first choice from the beginning, I selected laboratory as a study choice. Then I thought since I am married laboratory will be difficult for me and my family in the future, better to take nursing so I will have two in one. First I will achieve my passion in helping people and this will be rewarded from God, it is never-ending rewards. Secondly, I will have a secured job and good income. So nursing will give me the chance that people I care for will pray for me - unlike in lab, no one from my patients will know me or pray for me like when I am a nurse. So I feel my own values make me select nursing. (Nada, Year 4)

3.3.5 Professional values

Professional values define acceptable or expected ways of thinking and behaving within a particular profession and have been defined as the views or ideologies which guide professional conduct and reflect the ethics, practices, principles and other norms that are dominant within a particular profession (Crossley and Vivekananda-Schmidt, 2009). Awareness of and commitment to relevant professional values is important in ensuring effectiveness in a job role and the ability to work smoothly with colleagues and others in a working environment. When these professional values are not aligned with an individual's personal values, however, the resulting value conflicts can have adverse effects on the individual and on their ability to effectively carry out their professional role and responsibilities.

As one of the Year 4 participants stressed, that it is important that personal and professional values are aligned in order to avoid the stresses arising from value conflicts. This participant was one of those holding the view that personal values can change and evolve over time, which suggests that they can be shaped by professional values and that this is important to avoid value conflicts and the negative impacts of these.

I believe our personality and personal values should be the same, at home and at work. To be someone else or wear a different mask because of the duties and job is difficult and creates huge stress. (Rola, Year 4).

Since the research examined value conflicts among students rather than qualified nurses, it was interesting to explore the extent to which the students are familiar with and relate to professional nursing values at this early stage of their careers, whether their awareness of professional values increases over time, and the potential for conflict between the personal and professional values of this group.

Most of the second-year student nurses claimed that they have little awareness yet of professional nursing values, and indicated that they are guided more by their personal values. Despite this, when asked to give examples of professional values, the types of answers they gave were similar to those cited by the fourth-year students and were closely aligned with what researchers (e.g. Shariari et al., 2013) have identified as the core common values in nursing, such as honesty, dedication and the utmost care and respect for patients. These also overlapped considerably with the examples the participants had given of their personal and religious values.

> I feel the most important thing at work is fidelity. When I go for training I see most of the people do their work and go. Not everybody has the fidelity at work and dedicated to do their job as it should be. I observed a lot and that make me believe strongly that when I work, I want to be dedicated to my work. This is the important thing I believe. (Suhair, Year 2)

> I feel that the main thing in my professional values is treating everyone in a fair, good way and protect their privacy. (Hala, Year 4)

> At work, for example, we should be honest and dedicated, we don't harm our colleagues to be promoted … nurses should be honest, this is a very important value. (Nada, Year 4)

> I feel there are some similarities between my personal religious values and professional ones. For example I have to treat all young and old patients the same, observing the right of all to be treated well and equally, for sure treating them with kindness, and respect … (Randa, Year 2)

Interestingly, participants from both the second and fourth years of study indicated however that their awareness of professional values derived more from their experiences and observations of clinical practice than from their education. This might suggest that there is insufficient emphasis on professional values in nursing education in Saudi Arabia, which could be one reason why value conflicts arise when student nurses begin to work in a clinical environment and are faced with the need to adopt professional values for the first time.

The types of value conflicts that are being faced by this sample of Muslim student nurses, as discussed in the following section, suggest that although the participants identify with core professional nursing values such as compassion, dignity and caring, their own values are less well-aligned with other dominant Western nursing values that prioritise the importance of the patient's physical health and well-being and the responsibility and accountability of the nurse to promote this above all else. In line with the research findings

of Lovering (2008), the results of this study suggest that the personal and religious values of these student nurses sometimes conflict with these types of professional values when they prioritize Islamic principles such as *hijab* (modesty) over the physical care needs of patients. The research evidence regarding the experience of value conflicts by this sample of student nurses is presented in the following section.

3.4 Experience of Value Conflicts

3.4.1 Exposing *Awrah*

It was clear that the most significant value conflict for these students nurses, and that which has the greatest impact on them, is between the professional nursing values which prioritise the importance of physical care and safety for patients and which often require intimate care, and the religious/cultural values that do not allow exposure of the areas of the body defined as "*awrah*" to unrelated individuals of the opposite gender (from the naval to the knees for men, and the whole body except for hands, feet and face for females).

Adherence to values which prioritise the importance of physical care and safety for patients, such as "you make (their) care and safety your main concern" (NMC, 2016) and "take action consistent with the obligation to promote health and to provide optimal care" (ANA, 2015) will often require nurses to undertake tasks such as catheterisation or giving bed baths to male patients, activities which conflict with the religious/cultural values of female Muslim nurses. Although not specifically mentioned by the research participants, the religious nature of these values is underpinned by a fatwa (Islamic religious ruling) issued by senior scholars around two decades ago which specifically prohibited female nurses from touching the bodies of male patients or seeing their genitals, except when extreme emergency situations arise and there are no male nurses available to deal with the emergency (Alifta.com). Although it may arguably be uncomfortable for any newly qualified female nurse to cope with exposure of certain areas of the male body in the early stages of her career, this is especially difficult, therefore, for Muslim student nurses since this is "forbidden" by her religion. A value conflict therefore arises between the requirement to carry out her role as a nurse and provide optimal health care to male patients, in line with the values of the profession as cited above, and the desire to observe her personal values, which require following the religious fatwa which forbids her to see the *awrah* of male patients.

A considerable amount of the discussion in the interviews and focus groups was focused on experiences of and responses to this kind of conflict, which all the participants experienced at least to some extent. The following quotes from a second and fourth-year student help to illustrate the sensitive nature of this type of value conflict in Saudi Arabian society, and illustrate the ways in which these value conflicts can hinder the ability of the student nurses to fulfil the requirements of their role in care provision and clinical assessment.

> Gender is very important here for example if I am a patient complaining about my private reproductive system I will talk to a female but not male. It is the same situation when (the patient) is a male and they (nurses) are females, there will be some embarrassment and difficulty in discussing it. (Nada, Year 4)

> I can't do full examination of him[2], our religion and culture is not allowing this. (Randa, Year 2)

The nurses indicated that they experience considerable psychological and emotional stress when in situations that conflict with their values in this way, even if they are only observing another nurse performing the task of providing intimate care to male patients or anticipating having to perform it in future. Their negative reactions to such situations were described in terms of "shame", "embarrassment", "shock", "fear" and "bad", and a number indicated they had a strong belief that they were not allowed to perform this kind of task, because of their religious beliefs. This therefore reveals the inner turmoil that the nurses often face when confronted with this type of value conflict. Although some of the most extreme reactions came from second-year students who were very new to this type of situation, fourth-year students also reported similar feelings, perhaps not surprisingly since their actual experiences of caring for male patients as students are still fairly limited.

> I will feel shy, and I feel it is wrong to do it because my culture says it is wrong, wrong, wrong. (Suhair, Year 2).

> One time I was in the male medical ward and required to do physical examination. I could not believe what I was going to do and I couldn't accept the idea of touching a male patient … Ok we studied how in class but when I got to the hospital I looked at him and thought "How I am going to touch you? I should not touch you, it is not right to touch you!" At the same time I have to do it, I am required to do it; the instructor will come to see me doing it and evaluate me. …

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[2] i.e. exposing awrah

> I started with his head then I stopped - I don't know why, but I could not continue and I left. (Maha, Year 2)

> Normally, when I am observing a nurse who is taking care for a male patient, and giving him a bed bath, I feel that I can't watch. I feel the difficulty that I might face later when I begin to work as a nurse. I know I should take care of them and their hygiene, but I don't know how I am going to deal with this. I tried to be brave and watch it but I could not, I can't. Because my professional value is telling me that I have to do it, I need to watch in order to learn and perform. I have to give a complete care and not to disregard something or part of it. But my personal values, naturally we are not dealing with men, beside I am a girl (single) this is not a normal thing to see or do, I still have not been exposed to such things. I can't, I am not coping with it. (Rola, Yr 4).

In many cases, it seemed the student nurses' feelings of discomfort and embarrassment related not just to the conflict created by personal values that make it difficult for them to provide intimate care to male patients, but to the shame and embarrassment this would cause their male patients. Some supported this with actual examples of male patients' reactions when being treated by female nurses.

> It happen to my friends that many times tried to take blood pressure for male patients and they refused saying "don't touch me, call the doctor" because he is male. (Suhair, Year 2)

> I was with one patient trying to take his blood pressure and he was not happy that I am a Saudi female will do it for him. He was refusing and I was confused what to do, I respect his value and I want to help him really as I understand his point but I have to do it for his sake. I was not sure what to do, I think this has stressed me a little. (Wafia, Year 2)

These conflicted feelings can also be related to the student nurses' personal Islamic values, which emphasise respect and dignity for others, and require that the patient's own religious and cultural beliefs are accommodated. As fellow Muslims who share the patient's values, many of the participants expressed great concern for their feelings, and reported experiencing a personal conflict between the need to respect and preserve the patient's dignity and the professional values that require them to carry out certain tasks in order to provide appropriate nursing care.

However, the majority of participants based their views on their personal perceptions of how male patients might react, or their own interpretation of the reasons for a male patient's hostility.

> I can feel that he is not comfortable, he is upset too. Even if the patient is not alert or unconscious; it is still not acceptable. This is his awrah. For the patients' respect and dignity… I can't do it. (Rola, Year 4).

> Bed making was an embarrassing experience for the patient and for me, from the way he was looking at me like he was trying to check out if I am Saudi or not as he was embarrassed completely by me … it was lower body bath and bed making at the same time … He will be very annoyed and embarrassed definitely, because this is private. It is a very sensitive situation. (Dalal, Year 2)

It is not always clear that these perceptions and interpretations are correct: for example, it might be the case that the patient who refused to have his blood pressure taken was just generally uncooperative, and not specifically opposed to a female nurse. Based on these somewhat ambiguous findings, it seems that the participants' definitions of acceptable nursing care in Saudi Arabia largely reflect their personal perceptions of religious/cultural acceptability which might well be correct but are not always grounded in evidence.

In one or two cases, however, the accounts of participants suggested that male patients might be willing to accept treatment from a female Saudi nurse. Although there were very few such accounts this does suggest that, at least in a minority of situations, barriers to effective nursing may arise from internal value conflicts that do not necessarily reflect the beliefs and attitudes of patients. For example, the student nurse who left the room half way through examining a male patient (see above), went on to explain:

> I think he was saying in his mind "what is wrong with her?" especially when I stopped I am sure that he knows that I have to complete and I did not finish. So when I said thank you that's it he looked at me and said ok …. I asked his permission and he is fine. I am sure he knew that I am student from the way I was stressed and uncomfortable. (Maha, Year 2)

In any case, although individual responses varied, all of the participants including both second and fourth-year students expressed extreme discomfort about these types of situations and most indicated that they would refuse to carry out tasks involving exposure of *awrah* unless they were absolutely necessary in an extreme emergency situation, such as the urgent need for catheterisation. The most common response seemed to be that they would try to find a male doctor or a non-Muslim nurse to carry out these tasks, but if no one were available they would reluctantly accept the responsibility, even though it would be difficult for them and would conflict with their personal values.

> We will not leave the patient without providing the care, I will go and find someone to do it, colleague or head nurse to allocate someone acceptable to do it. (Shadia, Year 2)

> If there is no one else available to do it, I will do it. I will not say no but preferably male for male and female for female in the tasks including their private areas. (Daad, Year 4)

> I feel it won't be a red line if there is nobody but me to do it… (Participant looked stressed and talked fast in a defensive way). If there is nobody else to do it, I will do it for sure. Beside that I knew before I start to work that I might be in this situation to do such a thing and I have to do it. In this I have no right to object and say no I will not do this. But yes it conflict with my personal values, I will not accept this inside me and I will not be happy about it. Because…I mean this is considered as one of the forbidden. (Layal, Year 4).

However, several of the student nurses in both the second year and fourth-year samples indicated that they would always refuse outright to perform that kind of task, even if they had to break hospital rules by doing so. Overall, therefore, the student nurses were divided between those who indicated they would refuse to carry out tasks involving intimate care of male patients, and those who acknowledged that this is an important and unavoidable part of their future role as nurses. In general, the fourth-year students were more likely than the second-year students to accept the future need to carry out these kind of tasks, but even these participants all stressed that they would only be prepared to do so in emergency situations or when there is no male or non-Muslim nurse available. Furthermore, there were no apparent differences in responses to the value conflicts that appeared to relate to the participants' family backgrounds, such as the extent to which their parents opposed their choice of career. Overall, the responses indicated that while the participants are student nurses, they can be excused from tasks that conflict with their religious and cultural beliefs; it is not clear, however, whether this will be the case when they are fully qualified nurses.

The views of participants were also divided regarding the question of whether they would feel more comfortable providing this type of intimate care to non-Muslim male patients. Among the fourth-year focus group participants who discussed this issue, some expected they would find this easier, while for others the same value conflict existed because it derived from their own religious beliefs and values, which prohibit seeing the male *awrah*.

> If the patient is not Muslim and he accepted me to insert it I will, I have no problem to insert as he has different religion and values … it will be less stressful, I will not feel resisting myself to do it as when the patient is Muslim. (Hala, Year 4).

> I will do it for non-Muslim patient in case if his condition is critical and I have to do it. But if his case is not an emergency I think no, I am not going to do it, I will refuse. (Zain, Year 4)

Again, these responses indicate that where value conflicts arise, these derive from the student nurses' own perceptions of and assumptions about Muslim and non-Muslim patients' beliefs and preferences and their personal values and beliefs, a point which was acknowledged by one of the fourth-year students:

> It has nothing to do with patient culture. It is all about my culture, I mean whether he is Muslim or not will make no different, he is still male and will go and I will never see him again. The problem will remain inside me: "how did I do this, I should not have done it, how did I touch it?" because my values forbid me to do this. (Daad, Year 4)

Several of the participants reported discomfort when required to expose the private body areas of female patients, but this did not emerge as a major value conflict in the same way as exposure of male awrah, and the reported impacts on the participants were not as extreme. Although exposure of female *awrah* by the student nurses is not regarded as "*haram*" or forbidden in the same way as situations that involve exposing male *awrah*, several student nurses did report feeling uncomfortable when they first had to expose the breasts of female patients, though some of the fourth-year participants indicated that this was an aspect of nursing which they had been more readily able to come to terms with and feel more comfortable with over time. Although their discomfort in this situation may at least partly be related to the cultural and religious emphasis on modesty and privacy in Saudi Arabia, these reported incidents may also reflect the student nurses' inexperience in general, and their shyness and embarrassment at having to undertake such tasks, but not to the same degree as when exposing male awrah.

> In our religion we should not expose this body part: it is modesty, and culturally it is not accepted for women to expose her breast. (Randa, Year 2)

> When I watched the video for breast examination I thought "What is this? Why will we expose the woman's breast?" Really, with time and practice I changed. Like the ECG - I have to expose the woman's chest including her breast to demonstrate and apply ECG, so I (became) used to it and with time I accepted it. (Nada, Year 4)

> My experience was with a female patient and I felt if I were the patient I will not accept this. I did not think of my situation or health condition. I thought of my right, I needed my privacy. The nurse should not ignore it or touch me, seriously I did not accept it and I did not do it properly, my instructor was not happy with

what I did. She said "What is this, you did not do anything complete?" I know
how to do it but I could not do it, I can't. (Shadia, Year 2)

It is also notable that these students are assuming that Muslim patients share their own
values and beliefs and that they will often prioritise the need for dignity and privacy over
the requirement for urgent medical care. Though this may well be the case, these findings
highlight the personal turmoil that the students face between their own mix of personal
and professional values in which Islamic principles such as *hijab* are mixed with
professional ethics that relate both to the provision of high quality medical care as well
as respect for the dignity and privacy of patients. In a western context, these professional
values will often be aligned and supportive of one another, whereas in the Islamic context,
the influence of *hijab* and prohibitions on exposure of *awrah* mean that the core nursing
values can often be contradictory, with the patient's need (or perceived need) for dignity
and privacy sometimes preventing them from receiving optimal care.

3.4.2 Interaction with Male Colleagues and Patients

Another type of value conflict reported by the participants relates to the need as a nurse
to interact with male colleagues, patients and patient's relatives. Interaction with patients
and their family members is crucial to achieve the core nursing values that relate to
putting patients first, and empowering them and their family members to participate in
decision making about care. This is articulated as one of the Nursing and Midwifery
Council's professional values in the format "All nurses must work in partnership with
service users, carers, families, groups, communities and organisations" (2015b).
Similarly, an important professional nursing value is to "work co-operatively", which
includes maintaining "effective communication with colleagues" (Nursing and
Midwifery Council, 2015a).

 In the Islamic society of Saudi Arabia, single women are generally prohibited from
mixing with and talking directly to males, and in situations where this is essential such as
in nursing, they must be very careful in their speech and body language in order to avoid
any misunderstanding of their intention. Having grown up with these prohibitions, it is
clear that the student nurses have internalised them as personal values that have a strong
influence on how they think and feel about interacting with males at work. A number of
the student nurses especially in the initial stages of their education indicated that they find

it difficult to talk to male colleagues and even male patients, and that this can sometimes hinder their ability to effectively carry out their nursing responsibilities.

> The issue is dealing with staff, I am not used to dealing with them or coping with it, when a male doctor or students ask me something I feel "no, no", I don't know what to say about it. I am not used to it yet. (Rola, Year 4)

> Personally I don't know how to deal with males at all (smiling) and my first experience with a male patient alone with no relative was not really good. (Wafia, Year 2)

Their responses indicated a lack of preparation in their nursing studies to deal with this aspect of their roles, but also again a dominance of their own religious and cultural beliefs when interpreting situations in which they face hostility from male patients.

> I was trying to extract blood in ER for one male patient and he was so aggressive. He said: "enough, stop it, stop it" then I found myself gathering my stuff and I left the room. I feel if she was a woman I could manage it better by talking to her and calming her down, I can ask her to give a chance and try to do it. But with the male I felt I can't, I could not argue with him … If I come and talk to him nicely, It will make it worse for the nursing image like "adding water to the soil" or adding "fuel to the fire". He will misunderstand me, he might get it wrong. (Rola, Year 4)

The accounts of the fourth-year students also indicated, however, that this is a type of value conflict that becomes easier to cope with over time, as they gain more experience of nursing and the ability to separate their professional and personal values. Even so, there is evidence that some of the student nurses, even in their fourth year of study, try as far as possible to avoid being in the types of situations that result in value conflicts for them, such as having to talk to male colleagues.

> I would like to say that nursing has changed me, now I am dealing with men, before I used to be very modest … There is male nurses in the study hospital and the head nurse in the male medical ward, I dealt and talked to them very comfortably. (Nada, Year 4)

> I feel different yes, I am not afraid like before. I became different in dealing with males, yes it is against our religion but I can control myself and override my personal values. I want to prove myself in the hospital at the same time I am trying as much as I can to put limits for myself to prevent any unnecessary contact with males. I feel by through the four years in nursing I became stronger. (Rola, Year 4).

3.4.3 Images of Nursing in Saudi society

The participants explained that because of the strong religious and cultural restrictions on interaction between the genders in Muslim society, as well as other beliefs about the types of tasks which are seen as "unclean" or "forbidden", individuals face a major conflict between their own choice of the nursing profession, and the negative image of nursing that is widespread in society. This can be interpreted as a value conflict for the Islamic student nurse participants because their "professional" choice of nursing as a career conflicts with the dominant religious and cultural values of their society, which underpin their own personal values.

Unlike non-Muslim nurses who may also feel uncomfortable performing "dirty" tasks, Muslim student nurses cannot be reassured by personal values which focus on doing the right thing in terms of the patient's healthcare and hygiene needs, because their personal values are strongly influenced dominated by Islamic values that make them feel guilty and wrong about performing these tasks. These feelings are reinforced by the reactions to their choice of career from relatives and others, as well as the negative stereotypes about nurses that prevail in Saudi Arabia, for example that nurses are of low class because they are prepared to undertake "unclean" tasks such as washing patients.

> A lot of people think negatively about anyone who works in a mixed working environment, they thinks that she is bad and lowering her own values. (Zain, Year 4)

> It is very, very, very rare that you find a female who studied nursing because she wanted to. It is all because the title, nurse as a title is not pleasant. Maybe because some people still think or view the naughty nurse image. In my friends some of their families still think that any nurse is naughty … They don't know what we are studying and what our role is in the hospital … (Suhair, Year 2)

In many cases, these negative images result in strong resistance to the choice of nursing studies even from close family members. Many of the participants indicated that nurses are generally regarded like inferior servants in Saudi Arabia, or using terms and images such as the "naughty nurse", or "sister', a term which has derogatory connotations in this context. Even the student nurses' own parents or other relatives had used these kinds of terms and images when conveying their dislike of their choice of career, according to the interviews and focus group discussions. Although they did not always refer directly to the ways that this made them feel, it can be expected that the students might have

experienced inner turmoil relating to their own desires to pursue a nursing career and the desire to please their parents and avoid causing them disappointment or shame.

> My mom is not happy because all my brothers are doctors and engineers and I am the only nurse. She is really disappointed in me when she sees me studying and says: "what are you studying at the end you are sister'… (Laughing) she is making a big deal of what others and friends will say about me. (Suhair, Year 2)

> The overall idea of being a nurse and the idea of cleaning wound… wound not anything else, wound management for a male, it is a big issue and hard to accept for my father. He is always screaming unhappy, kind of blaming me for doing wrong saying "you are cleaning men's wounds". I used to answer this a normal thing in my job, this is my duty to clean the wounds. This is the main problem I face especially with my father. (Rola, Year 4)

All of the participants were acutely aware of and had experienced impacts from the negative social image of nursing. However, the extent to which they had experienced direct resistance from family members varied. This seemed to depend mainly on whether there were other medical professionals within the family and their relatives' general level of awareness of the nursing role, there was little direct evidence that differences in open-mindedness or conservatism of the families had an influence.

Indeed, the majority reported at least some level of resistance and unhappiness from family members when they decided to take up nursing studies, and for many this resistance was severe and continuing. The participants mainly attributed these views to their relatives' concerns about what others in society would think, and the fact that they shared the view with others in society that nurses lower their values by carrying out "dirty" and "*haram*" tasks. Social status appears to be an important consideration for the families, since several of the student nurses reported that their parents wanted them to transfer to medicine and become a doctor, a profession regarded as being of higher status.

> When I knew the result of my application, that I am selected in nursing college, my parents did not show their feelings because they didn't want to upset me but I know that they were sad. Because my elder sister is a nurse they somehow did not reject it, but they wished I could have been accepted to anything else but nursing. They are wishing the best for me, better than nursing, although they are trying not to show it and they don't want me to feel it. But I feel it, I know they wish I were a doctor. (Shadia, Year 2)

> Not all my family are happy that I am a nurse. Like my mother said to me "all my children are doctors and engineers, how can I allow my only daughter to be a nurse?" Not only in the family, it is in our society, they look at nursing as nothing. (Suhair, Year 2)

Within the focus group discussions, the negative impact of being a nurse on the marriage prospects of a girl was also discussed, and one participant reported that she had actually had a marriage proposal withdrawn when her prospective fiancé's family discovered she was a nurse.

> It happened to me that one family proposed (marriage) to me and they asked about my study, when (the man's) mother discovered that I am nursing she asked if I can change my study or transfer. Pity my mother, she came and asked me if I can, or I want to do it and I refused. So they are gone, they did not accept me as a wife for their son because of my profession. Seriously, parents are afraid that we will never get married because of our profession. (Dalal, Year 2)

A family containing many other medical professionals, who threatened to throw the student nurse out of the family home, showed the most extreme reaction. As noted earlier, although most of the participants experienced resistance from family members, this was generally less extreme when there was a greater understanding within the family of the role of nurses, so this reported reaction was unusual in this type of family.

> There was too many pressure that they really refused and threaten me to leave the house, which is something not accepted in our culture and religion by itself anyway (Layal, Year 4)

In addition, many incidents were reported in which close family members made insulting and derogatory comments to the nursing student.

> One of my family members said one day to me "come and check my blood pressure please doctor" I said I am a nurse, I am not a doctor and sure I can check your blood pressure for you. Then he said "ok, take my stool and analyse it" and I answered that this is a laboratory job, nurses don't analyse stools. Then he said "ok, my urine then", and I explained this is also what a laboratory technician does, not me. He was so aggressive and said "what about my blood?" I answered laboratory again. So he said "what is your job then, only changing diapers?" This is really hurt. It hurt me a lot. (Wafia, Year 2)

> My brother was screaming when I decided to continue in nursing saying "Why my sister?" "What, all jobs are taken and nothing left except this?" That was too hard, I felt like I am doing a crime. (Maha, Year 2)

Despite feeling hurt and upset by the strong reactions of their family members, these participants expressed understanding of their perspective, especially their concerns about protecting the participants from the reactions of others, and from the value conflicts they

are expected to face in nursing. Interestingly, one reported that her brother would accept her working as a nurse overseas where she would not be judged in terms of Islamic values and culture, but not within Saudi Arabia.

> Our brothers are trying to protect us from being in such situations, they don't want to put us down or underestimating our abilities. But they are looking for the best for us … my family will accept any managerial position for me, anything, any promotion but not a bedside nurse dealing with patients. My brother said to me, if I am going to work outside Saudi Arabia he has no problem as no one knows our values and it is a different culture and no one will notice me. But here is too difficult to be against our culture. (Wafia, Year 2)

One of the fourth-year students reported that her family, most of whom are also medical professionals, are highly supportive of her.

> My family are very supportive; I am not the only family member who is in the medical field. They will receive it normally. My mother and my sister delivered by a male doctors. What is the difference? I don't think there is an issue with my family. (Suhair, Year 2)

Others also indicated that their family members are supportive of their choice of studies, though these were in the minority among participants without a medical family background.

> It is not an easy job, but my family accept for me now because they can see how happy I am in my study while I am still the same little girl in their eyes who they have to protect. (Lamees, Year 4)

> When I was accepted my father was supporting me and encouraging too, until now, thanks to God. I did not know about nursing before and it was not in my mind but I was admitted and my father supported me with more awareness of how precious a profession this is. I think he has the idea of the precious role of nurses in Prophet Mohammed's time. (Sadal, Year 4)

However, all of the participants indicated that they do not feel comfortable talking with their relatives about the types of nursing tasks that involve value conflicts such as exposing male *awrah*, even if these family members are also medical professionals, and many reported concealing aspects of their work from family members, such as exposing male *awrah*. They indicated that they would feel extreme embarrassment and shame that they were compromising their own values, and that their relatives would be shocked and angry, even if they are actually aware that nurses do perform these tasks. Some expressed

the belief however that their parents really do not realise that this type of work is required of a nurse.

> My father - if he heard or knew that I do catheterisation for male patient (laughing)… I don't know what his reaction might be and I expect that he doesn't know that I might do such a thing. He will not expect that studying nursing might put me in this situation. So it is too difficult to speak about it with my father. Also my husband - I did not tell him about it. (Nada, Year 4)

> My mother will say "how can you do such things?" - for sure I will not feel comfortable to tell her that I exposed male awrahs or observed urinary catheter insertion for male, It is very embarrassing to discuss it with her. But it will be easier to talk to my mother more than my father or brother. (Rola, Year 4)

> I cannot talk about it because it is my own values will not allow me to say that I did something against my values … This is against what I believe, so it will be reflected in my face when I talk about it, so I can't talk to my parents about it. (Randa, Year 2)

Although very few of the participants were married, the general consensus seemed to be that husbands would never readily agree to nursing as a profession for their wife. The participants explained that husbands would not be able to accept that their wives expose the *awrah* of male patients, and would be unhappy generally about them interacting with other male patients and working in a mixed gender environment, largely because of what other people would think. If nurses do marry, they stressed, it is very important not to talk to their husbands about what they do in their nursing role. One married participant reported that this causes severe tension in her marriage, explaining that she even has to hide her uniform from her husband for fear of upsetting him, a further form of concealment of aspects of the nursing role from family members. Despite this, she acknowledged that he does support her financially in her studies and believes these will provide her with future security in case they separate.

> I know his reason, that he doesn't want his wife to be a nurse because of what his family and friends might say about me, and might blame him for my job. But he said that his reason is "I don't want men to annoy you. The men harasses any women no matter if she is respectful or not, I am trying to protect you" … He criticises the way I look in the uniform just to irritate me, you know we as girls do care about the way we look. He used to say "you look like a man in this white uniform", he never criticises my look, but he knows that we are sensitive about our looks and I used to ignore him. So to avoid this every morning, I wear my abaya quickly before he notice what I am wearing. (Nada, Year 4)

Some of the participants reported receiving shocked reactions when telling other people they are studying nursing, and attributed these largely to the widespread lack of awareness about the nursing role, as well as stereotypical images that are derived from the media or films. When asked in the interviews and focus groups whether they had experienced potential or actual harassment from male patients or their relatives as a result of these images, most indicated they had little direct experience of this, although some had experienced or seen situations in which patients or their relatives had been insulting and disrespectful to the nurses.

> Sometimes patients are - I don't want to say aggressive but they treat nurses with some superiority as if they are servants. (Layal, Year 4)

> Some of the girls have been bothered by the looks, words, or actions of some of the patients' relatives. This is irritating, because we are trying to respect the place, respect the patient and still we find people under-estimating us. (Rola, Year 4)

However, the participants reporting such incidents were generally tolerant and understanding of the individuals involved even though they felt irritated and angry, recognising that the attitudes and behaviours towards nurses largely result from low levels of awareness.

3.5 Dealing with Value Conflicts

3.5.1 Avoidance

Previous studies have shown that the environment and organisational culture in which newly qualified nurses work has a major effect on how they adjust and negotiate their new identity and adapt to the role of professional and qualified nurse (Mooney, 2007; Whitehead, 2011). The research evidence provides support, for example, for the use of preceptorship in facilitating the transition of students and newly qualified nurses into clinical practice and helping them develop a clearer understanding of their role and identity, thus enabling them to reconcile any value conflicts they may encounter (Maben and McLeod Clark, 1998; Mooney, 2007; NMC).

The findings of this study indicate that a different approach is being taken to "protect" Muslim student nurses from value conflicts in Saudi Arabia. Instead of exposing them to situations required in nursing that may cause value conflicts, and providing the advice and support they need to cope with and overcome the conflicts, several of the participants indicated that as student nurses they are not allowed or required to carry out these types

of tasks. They reported that they are currently only required to care for female patients, and that even their academic education omits the types of teaching relating to tasks considered "*haram*" in Saudi Arabia. The second of the quotes below helps provide evidence of the perceived weight or burden of these conflicts on the students.

> The college is protecting us and makes limits for us. For example, when they teach us in class they focus on female cases only and not male patients. Like the urinary foley catheter insertions, they said I will not do it for male and many procedures similar to this they only teach us on females, so I did not face it ever … We are not allowed to do complete bed bath for male patients. (Suhair, Year 2)

> When we studied about the foley catheter the lecturer did not go into detail about male procedures and she said here we will not deal with male patients. That means male nurses will deal with male patients and female nurses will deal only with female patients. Seriously, this make me feels so comfortable and relaxed I felt the load taken away from my chest. (Shadia, Year 2)

The reactions of the students to this situation were mixed. Some expressed a general sense of relief and reassurance that they do not have to accept nursing responsibilities that cause value conflicts for them. It appears that the limitations in training may be giving these student nurses a false sense of security that they will never be required to undertake nursing tasks that involve exposing male *awrah*, and that they have the right to refuse such tasks.

> Even if it is necessary I will not do it. Because of my religion, my family, and myself, I can't do it. I will not accept doing it … When I refuse, I am sure there is a male nurse at the medical ward who can do it. So it is not an emergency and it is not necessary for me to lower my values and feel bad about myself, and it not fair for my patient knowing about the male nurse availability and disrespecting his awrah putting both of us under stress and pressure. Also if there are non-Muslim female nurses or non-Arabic female nurses who are ok to do it, then I will leave it for them to do if the patient accepts them. (Shadia, Year 2)

> If there are alternatives and someone else is available to do it why should we put ourselves in this situation?. (Dalal, Year 2)

A number of the participants also expressed concern that their education and training as nurses is inadequate because of the restrictions relating to the care of male patients, and acknowledged that they might not be protected in the same way when they were fully qualified nurses working in hospitals. These participants were worried that they would have considerable difficulty coping at that stage, because they would not be used to

dealing with these situations psychologically, and would lack the practical skills and experience to do so.

> Problem is, we are dealing with lot of females now, which creates a lack of confidence and lot of concern about how I am going to deal with males. This needs lot of effort after graduation. (Rola, Year 4)

> This is bothering me as I feel they must teach us everything, no exceptions. Personally, I feel if it is required from me to do it for males I will do it because if I went anywhere else I will be required to and I have to do it. (Suhair, Year 2)

To an extent, these challenges were already being faced by the fourth-year students who visit the university hospital for training and are required to carry out physical care on male wards, including face shaving and bed baths. Only one or two expected not to face these situations in future, for example by entering specialist field such as gynaecology or paediatrics. Others, including second-year students, anticipated that they would need to learn to cope with providing intimate care for male patients in future and were prepared to do so. One was critical of other students known to them who had entered nursing but could not accept this aspect of the role.

> I might feel more confident to do it, I will learn. Since I am a nurse this is my job and I have to learn, I believe I have to manage doing it for both males and females. I don't believe that males should be treated only by males as there are not many male nurses … Or if I worked outside this country I will have to do it, they cannot understand, what is the difference between male and female patients for me to take care of. It is a must to manage both, not to differentiate. In the end, they are both human, patients in need who should be treated equally. (Randa, Year 2)

> There are some students in my group saying that they are not going to accept dealing with males. I don't understand, patients are male and female and we will work with male and females, we can't be selective. They were lucky that we don't have male instructors in the college but before there were male doctors teaching the nursing students. How can they be studying in this major and expecting not to deal with males? I don't understand. Yes, those I believe will struggle a lot not only because of dealing with males but because not all men are alike. They might deal with good and bad ones and I don't know how they are going to manage it. I think if they know that their family will not accept this and they can't change it; this is not the right field for them to study. (Suhair, Year 2)

3.5.2 Distinguishing between Religious and Cultural Values

Several participants used their perceived distinction between religious and cultural values to justify the rights of female Muslim nurses to expose male *awrah* in emergency medical situations. These participants argued that although this would be "*haram*" or forbidden in

everyday nursing, based on the religious values of Islam, the teachings of Islam permit this in an emergency. In their view, the widespread belief within Saudi Arabian society that this is forbidden in all medical contexts is a cultural value defined as "*aib*" rather than "*haram*". This is indeed supported by the relevant fatwa (Islamic ruling), which specifically prohibits female nurses from seeing the *awrah* of male patients *except* in extreme emergency situations when no male nurses are available. To explain the difference between religious and cultural values, one of the participants described a case in which a female patient's husband refused emergency care from a male doctor, and commented:

> "They can't say haram, it is not haram. Families are confused between cultural and religious values. It is not haram. Interviewer: can you explain why it is not haram? Interviewee: because this is out of my hands, patient needs my help and I have to help him". (Rola, Year 4)

Making the distinction between religious and cultural values may help these student nurses to come to terms with the value conflicts they inevitably face in their nursing roles. In general, it seems that these nurses are more prepared to undertake tasks that are forbidden by culture rather than religion, such as emergency catheterization of a male patient, and they seemed reassured by the belief that exposing male *awrah* for the purpose of emergency medical care is not forbidden (haram) in Islam. Some participants also appeared more willing in general to undertake these types of sensitive tasks, perhaps reflecting subtle "cultural" as opposed to religious differences in values between the participants. One pointed out that these tasks are acceptable in Islam as long as the nurse is not alone in the room with the male patient.

> If this is my patient and there is an order to insert it, then I have to do it, but for sure I will call for assistance. It could be another female nurse because in our religion I should not be alone with a male in one room and this situation is more sensitive in my religion as I am exposing and doing task including his awrah, so I should not be alone with him, it is forbidden … So I will do it but with someone present in the room. (Randa, Year 2)

3.5.3 Growth in Confidence over Time

The review of literature reveals that personal attributes of students, in particular confidence and self-esteem, enable them to more effectively manage the value conflicts that they encounter in clinical practice (Iacobucci et al., 2012). Maxwell et al.'s (2011)

study revealed, for example, that newly qualified nurses who were more able to seek assistance in general terms were more proactive about identifying their own learning needs and negotiating more formal learning opportunities, and that this aided them in developing a positive nursing identity (Whitehead, 2011).

There was evidence from the exploratory study of an increase in self-confidence among the student nurses over time, which in some ways appeared to help them manage the value conflicts they encounter. This was demonstrated both by a comparison of the accounts of the second-year and fourth-year students, and by the ways in which the fourth-year participants specifically reported feeling that they had grown in confidence and in their ability to handle a wider range of nursing situations.

> I think everyone might change and we are changing, developing by time, knowledge and experience. I believe it is positive changing by nursing study. (Hala, Year 4)

> With nursing I became stronger and better, I feel more understanding and coping better with life factors and different situations. (Daad, Year 4)

Even some of the second-year students reported similar increases in confidence as they gained more experience. They also expressed the expectation that despite the challenges and value conflicts they currently face, they will be able to cope with these in future as their experience grows. Even for those who still find the value conflicts very difficult to cope with, there is a sense of being determined to learn more about nursing and to overcome these.

> We still have fear from being alone with male as we are not yet used to it … I feel maybe in the future we will get used to it and learn how to handle this fear, we will overcome this obstacle I believe. (Shadia, Year 2)

> We were both embarrassed knowing that I am a Saudi female single nurse going to examine or expose his private area for the first time. This is definitely hard for both of us, this is my first time to see a man awrah in my entire life. At the same time I want to learn because it is required from me as a nurse and I learned only in lab on a doll how to do it, and this is my time to practice on a real patient … It was not easy, it creates something inside me I don't know how to describe it. I felt bad. (Dalal, Year 2).

> I think my reaction when I was a second-year student was influenced by my personal values … I feel that my way of thinking has changed after studying for four years in nursing. Secondly, I have been through the experience myself: it was during my delivery and since then I put myself in others shoes to see if I'm needed, who would help, do they need me to do it … I feel like my values are developed;

that's why my perspective has changed, the way I look at it is changed. (Nada, Year 4)

For one second-year student, this was articulated in terms of a kind of dissociation, in which she expects to be able to gradually separate her personal and professional values. Indeed, she reports already beginning to develop this ability, which is providing her with a greater sense of pride and fulfilment in her work.

> Now I don't accept it, but in the future, when I am in the situation I will be under pressure. The patient is in need for the treatment so I have no choice but to accept it. I will not think of my own values or religion values, I will leave my values outside the patient room and do what I have to do … the professional nurse will go in and leave myself outside. I tried to do it before and I feel that I became a different person, became someone who wants to help and save the patient only, my professional values became so dominant, it was a good feeling that I did something I am proud of, the humanity I felt encouraged me to achieve my task. (Randa, Year 2)

Even without the types of external support that other studies have shown to be important in helping new nurses to handle value conflicts, such as effective preceptorship (Maben and McLeod Clark, 1998; Mooney, 2007), at least some of the participants seemed able to utilise their expanded experiences of nursing, as well as the personal and professional values that they hold, to develop greater resilience to situations that initially caused them considerable discomfort. Although this rarely extended to a full acceptance of the requirement to provide intimate care to male patients, it was exhibited for example in feeling more comfortable talking with male colleagues as long as their conversations are strictly work related and they watch their body language and facial expressions so as not to give the wrong impression. One Year 4 participant reported an increase in confidence in distinguishing between what she sees is wrong and doing the "right thing" as a nurse, which includes exposing female but not male *awrah*, a decision which is accepted in the context of her current nursing studies.

> I differentiate, I don't know how to explain it, but I differentiate between being ashamed and doing the right things. So now I see it's right to help a patient and do the urinary catheter, "female patient but not male patient" … I still refuse to do it for male. If I have the experience and I know how to do it for my patient I will do it for her. (Nada, Year 4)

3.6 Limitations of the Exploratory Study

The exploratory study has a number of limitations that should be taken into account when interpreting the findings. First, it is based on a relatively small sample of student nurses in a nursing programme at one university in Saudi Arabia. It is possible that the inclusion of different participants from this or other universities may have resulted in different or additional findings. It should be noted in particular that the institution's nursing programme has no male student nurses, and very few married students. Also, there were no mature students (older than 25) available for inclusion in the sample, as these are currently taught under a different programme. These characteristics of the nursing programme may have influenced the results. Second, the sample was self-selected from second-year and fourth-year students, who volunteered to take part. Although the final sample was mainly selected using purposive sampling techniques from the volunteers then random selection from the confirmed interested participants' long list, it is possible that the experiences of those who offered to participate may be different to the student nurses who did not volunteer. Finally, all interviews and focus groups were conducted in Arabic and translated into English. Although every attempt was made to ensure that the findings accurately represented the views and experiences of participants as they explained them in their own words, some unintended subtle changes in the power of meaning may have occurred.

3.7 Chapter Summary and Conclusion

The exploratory qualitative study was conducted to investigate whether a sample of student nurses at different stages of their nurse education in Saudi Arabia were experiencing conflicts between their personal and professional values, and how they were affected by such value conflicts. The findings confirmed that student nurses in this society, even at an early stage of their studies, were experiencing various value conflicts. All the research participants were apparently experiencing significant conflicts between their personal values, which are grounded in Islamic religion and culture, and some of the professional values and requirements of the nursing profession. The main forms of value conflict revealed by the exploratory study are shown in Table 5.

Table 5: Main Forms of Value Conflict Revealed by the Exploratory Study

Religious/cultural/personal values		Professional values
Cannot expose person's *awrah*	**Versus**	Maximising health and safety Prioritizing interests of patient
Modesty in interactions with male patients and colleagues	**Versus**	Communications, collaboration and effective working
Beliefs about dirty or "haram" nature of nursing		Beliefs about professionalism of nursing
Professional values		**Professional values**
Preserving rights, dignity and respect of patient	**Versus**	Maximising health and safety Patient rights and autonomy

These take various forms, with the most common being the conflicts between professional values relating to providing optimal healthcare and the religious/cultural values that prevent or strongly discourage the student nurses from undertaking any tasks requiring exposure of male *awrah*. The identification of value conflicts among participants in this exploratory study is important as this builds on and expands the existing literature on the issues that can arise when implementing western models of nursing, and western professional values, in an Islamic setting. In particular, as shown in Table 5, the conflicts faced by these nurses are not just between their personal (religious and cultural) values and the professional values of nursing, but between different types of professional values that are often contradictory in the Islamic context. Little direct evidence was found in this exploratory study of the other main type of value conflict identified in the literature review, which is between personal values or the professional values learned in education, and the dominant professional values of the real-life nursing environment which present barriers to the implementation of these.

Previous research in the Middle East has highlighted the need for culturally sensitive nursing that does not conflict with the Islamic values and beliefs of patients (Lovering, 2012). In Western settings, researchers have mainly investigated value conflicts among newly qualified nurses that relate to organizational pressures and constraints. In contrast,

this study has generated important new findings relating to the ways in which Muslim student nurses experience severe conflicts between their religious and cultural values which forbid them from undertaking certain tasks, and the professional values which require them to undertake these tasks in their roles as nurses. Additionally, it has revealed the ways in which these Muslim student nurses also face value conflicts relating to the negative social images of nurses in this society and the strong family resistance to their choice of studies.

First, the results revealed the nature of personal and professional values as experienced by the Islamic student nurses that participated in this study. Overall, it was very clear that the personal values held by these research participants were strongly influenced by the Islamic religious and cultural values of Saudi Arabian society, which they had internalised while growing up and being influenced by their family and educational background. Many of the student nurses claimed to have little explicit knowledge of professional nursing values or even of the types of tasks that are involved in nursing, and several confused or equated professional values with their own personal values. However, an implicit understanding of professional nursing values, such as the importance of prioritising the needs of patients, and of working cooperatively to deliver the best possible care, was evident in the ways the participants described the conflicts they were facing as nurses.

The research findings indicate that the student nurses are experiencing three main forms of value conflict. The most common type of value conflict, which largely dominated the interviews and focus group discussions, was between the personal/Islamic values that prohibit close contact between unrelated individuals of different genders, and the professional values that place a high emphasis on the medical and safety needs of the patient. These professional values often require nurses to conduct tasks involving the provision of intimate care to male patients, but are in conflict with personal values that are shaped by Islamic religion and culture and which therefore hinder the provision of patient care.

The second main type of value conflict reported by the participants relates to the need to interact with male colleagues, male patients and male relatives. In Saudi Arabia, single women are not generally allowed to mix with and talk directly to males, and it is clear that the student nurses have internalised this as a personal value that influences how they feel about interacting with males at work. However, this value conflicts with the

professional values that require nurses to work cooperatively with male colleagues and to talk to male patients and their relatives in order to understand the patient's needs and enable them to participate in decision-making about their care.

The final main form of value conflict identified in this study arises because the participants' "professional" choice of nursing as a career conflicts with the dominant religious and cultural values of their society, which underpin their own personal values. The discomfort arising from this value conflict was for most of the participants exacerbated by the resistance of close family members to their choice of career, based largely on what others in society would think of them, and the widespread view that nursing is associated with "dirty" or "haram" tasks especially the exposure of male *awrah*. Although most of the participants indicated that the attitudes of their relatives and others was not affecting their own abilities to perform well in their studies and clinical practice, this was clearly a significant issue for them, and they demonstrated evidence of struggling to reconcile these attitudes with their own adherence to the professional values of nursing. It seems very likely that the negative views of others, especially close relatives, may be hindering the ability of the student nurses to overcome the other types of value conflicts discussed above, since they are constantly receiving messages that their nursing role is in conflict with the basic principles and values of Islam and Saudi Arabian culture.

The issue of exposing male *awrah* is probably the most difficult area of value conflict for Muslim student nurses in Saudi Arabia, due to the existence of the *fatwa* which forbids exposure of male *awrah* to female nurses except in emergency situations, and the professional values of the nursing profession, as set out in the Codes of Conduct discussed in Chapter 2, which prioritise the rights of the patient (rather than the nurse) and focus on maximizing the health and safety of the patient whatever this involves. So the ICN Code (see Table 1) which forms the basis of the Ministry of Health's Code of Ethics notes that "the nurse's primary professional responsibility is to people requiring nursing care" and "In providing care, the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected.", but no mention is made of the beliefs and values of the nurses themselves.

Overall, the exploratory participants fell broadly into three categories based on their responses to the requirement to expose male awrah. The first group indicated that they would refuse outright to perform such tasks, for these participants their strong personal (Islamic) values take priority over the professional values of nursing. The second group

consists of those who expressed more uncertainty about how they will cope with these tasks in future, while acknowledging that they may be expected to do so. Some expressed the hope that they will be able to cope with these tasks as they gain more experience and grow in confidence, indicating a greater acceptance of professional values, but others in this group were more adamant that even with greater experience, their personal values would prevent them from accepting these tasks. The final group, including only a minority of participants, were more accepting that these tasks are part of their job and more determined to learn how to undertake them in future, indicating that they have begun to accept and internalise professional nursing values to a greater extent than those in the other categories.

There were few major differences between the second- and fourth- year student nurses in their responses to these value conflicts, some second-year students demonstrated a greater acceptance of professional values than the fourth-year students, and many of the fourth-year students continued to place great emphasis on their personal values in refusing to expose male awrah. It does not therefore appear to be the case that the participants are desensitized by repeated exposure over time to these value conflicts or the types of tasks that cause them. Instead, the main factor influencing experiences of and responses to value conflicts appeared to be the participants' family backgrounds, with those from more educated or more liberal families, or in which close relatives were also medical professionals, being more likely to indicate an acceptance of and willingness to overcome the value conflicts between their personal values and the values and related tasks required of them as a nurse. The student nurses' experiences of value conflicts relating to the negative images of nurses in Saudi society also mainly varied depending on their family backgrounds.

In the case of the value conflict arising from the need to talk to male colleagues and patients, on the other hand, there was some evidence that this became a little easier to cope with over time, as the students gained more experience of nursing and the ability to separate their professional and personal values. In this case a greater familiarity with or desensitization of the participants to situations involving interaction with males appears to contribute to their ability to cope with this form of value conflict. Many of the fourth-year participants reported feeling that they had grown in confidence and in their ability to handle a wider range of nursing situations, including some of those involving value

conflicts such as interaction with male colleagues and patients, but with the exception of those relating to the exposure of male awrah.

Some participants made an important distinction between religious and cultural values and used this to justify the rights of female Muslim nurses to expose male awrah in emergency medical situations. This is an important distinction which might be adopted by the nurse education system to promote greater understanding among student nurses of their rights and responsibilities in Islamic nursing, and to help them come to terms with the value conflicts they inevitably face in their nursing roles.

Overall, the findings of the exploratory study provide insights into this under- researched area and indicate the need for more extensive research to more fully understand experience of value conflicts among female Muslim student nurses in Saudi Arabia and what might be done to ease these conflicts and their impacts on the student nurses. The following chapter describes the research methods used to address this information gap in the main study.

CHAPTER FOUR: MAIN STUDY METHODOLOGY

4.1 Overview of Chapter

The previous chapters have provided an overview of the current study, set out the findings of a comprehensive review of relevant literature and presented the results of an initial exploratory project which confirmed the presence of value conflicts in student nurses and therefore the need for the main study. The present chapter discusses in depth the methodology used for the main study. It discusses the research paradigm used and the reasons for selecting this, and then sets out the specific research design and methods adopted with justification for their use. Subsequent sections discuss the sampling and recruitment strategies, data collection methods and analysis methods, and the processes used to ensure that the research was carried out to high ethical standards and high standards of research quality. This includes discussion of the issue of reflexivity and how this was used by the researcher to enhance the integrity of the research findings. First, the chapter reiterates the purpose and objectives of the study.

4.2 Purpose and Objectives of the Study

The aims of the study were to investigate the experiences of value conflicts among a sample of female Muslim student nurses in a higher education institution in Saudi Arabia and to explore the awareness of faculty about these conflicts and their views on the ways in which these might be reconciled in this setting. The study also aimed to develop practical recommendations for consideration by the department of nursing at the case study institution, to help female Muslim nurses in this setting reconcile or cope with experiences of value conflicts.

The study addressed the following research questions:

- What are the experiences of value conflicts among female Muslim student nurses at the case study institution?
- What factors contribute to the experience of value conflicts among female Muslim nurses at the case study institution?
- What are the effects of value conflicts on female Muslim students at the case study institution?

- What is the nursing faculty's awareness and understanding of the value conflicts experienced by female Muslim student nurses at the case study institution?

- What measures or types of support might be implemented to help female Muslim student nurses in this setting avoid or cope with value conflicts?

4.3 Research Paradigm

4.3.1 Ontology

When selecting the most appropriate research methods for a study, these should take account of the types of information that need to be generated in order to address the research questions or objectives of the study (Newell and Burnard 2011). However, the choice of research methods, as well as the overall design and objectives of the study, are also influenced by the epistemological and ontological perspectives of the researcher (Trochim 2006; Richards and Morse 2007; Kelly 2009). Together, these constitute the research paradigm, or the "conceptual lens through which the researcher examines the methodological aspects of their research project to determine the research methods that will be used and how the data will be analysed" (Kivunja and Kuyini 2017, p.26).

Ontology relates to the researcher's beliefs or assumptions about the fundamental nature of reality; for example, whether this exists independently and can be identified and measured in ways similar to the physical world, or whether it can only be identified and understood through the ways in which it is constructed in the minds of those experiencing it. The constructionist ontological paradigm, which was adopted in the current study, assumes that social phenomena have no objective and independent reality but are constructed through social processes and the meanings that individuals give to their experiences of them (Burr 2015; Seal 2012). This contrasts with the positivist or objectivist ontological paradigm, in which it is assumed that reality is objective and detached from individual experiences and perspectives, and that hypothesis testing or measurement of the relationships between social variables is therefore possible.

Crotty (1998) uses the simple example of a tree to differentiate between the main ontological approaches. Whereas the positivist ontology assumes that a tree is a meaningful phenomenon in its own right, whether or not individuals are aware of it, and we simply discover the meaning inherent within a tree when we become aware of it. In contrast, the constructionist ontology assumes that nothing really exists outside our

knowledge and the meanings that we as people attribute to it: "it is human beings who have constructed it as a tree, given it the name, and attributed to it the associations we make with trees" (Crotty 1998, p.43).

From the constructionist perspective, everything that happens in the world is therefore constructed, interpreted and experienced by individuals as they interact with one another and with wider social systems (Guba and Lincoln 1985; Merriam 1988). People therefore develop their own personal meanings and interpretations of the world based on the experiences that they have within it (Merriam, 1998; Seal, 1999; Creswell 2014).

From this perspective, value conflicts are experienced by individuals in their interactions with other rather than constituting an objective reality outside of human perception. A value conflict is something that occurs when a person holds different types of values which are in some way incompatible or difficult to reconcile and when they interpret or place meaning on this in terms which constitute a conflict. Although certain types of values may be held by social groups or professional groups as a whole, as discussed in Chapter 2, the constructionist perspective assumes that these are only really experienced and interpreted by individuals as they construct their own reality by allocating meaning to their experiences. However, this does not mean that all experiences are unique: social constructionism is based on the assumption that there are shared meanings and understanding between individuals within society (Young and Collin, 2004), and that factors such as language, culture and the environment have an influence on the ways in which individual make sense of the world and co-construct social reality (Berger and Luckmann, 1991). When conducting research within this paradigm it is important, therefore, to investigate the ways in which individuals experience social phenomena and the meanings they attribute to these experiences, as well as the factors that influence these interpretations. The epistemological approach associated with the constructionist ontological perspective is discussed next, in order to explain the choice of research methods for the present study.

4.3.2 Epistemology

In contrast with ontology, which refers to perspectives about the fundamental nature of reality, the term epistemology relates to the ways in which knowledge about a phenomenon can be acquired (Cooksey and McDonald, 2011). Like ontology, it consists of two contrasting paradigms: in this case interpretivism and positivism (Bryman, 2001).

The positivist epistemology assumes that since the social world has an objective reality outside of the perceptions of individuals, this can be studied in ways similar to the natural world. Quantitative research techniques are associated with this approach, such as structured questionnaire surveys and the use of statistical methods to examine and measure relationships between variables (Newell and Burnard, 2011). In contrast, the interpretivist epistemological approach, which is aligned with the constructivist ontological approach, assumes that social realities are multiple and subjective in nature, being socially constructed in the minds of the individuals who experience them, and reflecting the context in which they occur. According to this epistemological approach, which guided the design of the current study, social phenomena can only be understood by investigating individual experiences and perspectives within the specific contexts in which they occur, using qualitative methods such as in-depth interviews or focus groups (Bryman, 2001; Stake, 2006; Tuli, 2010; Newell and Burnard, 2011). Discussing the merits of this approach, Clarkson (2004) argued, "people cannot be understood outside of the context of their ongoing relationships with other people or separate from their interconnectedness with the world".

This extends to the role of the researcher, who it is assumed cannot be entirely objective or value free in conducting a study and interpreting the results (Al-Saadi, 2014). Walsham (2006) explains that "we are biased by our own background, knowledge and prejudices to see things in certain ways and not others" (p.16). Indeed, within the interpretivist perspective, the researcher is regarded as an active participant in their study, as he or she plays a role in interpreting the research participants' accounts of their experiences and attributing meaning to this. Howell (2013) further explained that the findings of a research study are "created through consensus and individual constructions, including the constructions of the investigator" p.87). Rigour is achieved in this process, according to Garcia and Quek (1997) by ensuring that the researcher's interpretations are "backed with quality arguments rather than statistical exactness" (p. 459).

4.3.3 Methodological Approach

An exploratory qualitative methodological approach was used for the study. As noted by Creswell (2009), qualitative research methods allow a researcher to investigate social issues in ways that allow exploration of unknown variables and patterns of experience,

and to provide deeper insights into the phenomenon of interest. Qualitative research also has other important features such as taking place in a natural rather than an experimental or quasi-experimental setting, which means that the phenomenon of interest is being studied as it exists in reality, without being manipulated by the researcher in ways that might influence the research findings (Creswell, 2005). It allows for the collection of multiple sources of information, and places value on the meanings that the research participants themselves give to their experiences of the phenomenon under study (Creswell, 2005).

The interpretivist approach assumes that meaning can only be attributed to social phenomena through the language used to describe them by individuals (Giroux, 1992). Therefore, the use of qualitative forms of data collection such as interviews and focus groups is important to enable research participants to describe and explain these experiences in their own words (Whitehead, 2002; Starks and Trinidad, 2007). In this way, the researcher can gain an understanding of how it really feels to participants to have these experiences, and the meanings that they place on them (Wood, 2006).

4.3.4 Research Design

It was decided to adopt a case study research design to allow for deeper exploration of the issue of value conflicts at a single institution. Case study research designs using a range of data collection methods are well aligned with the constructivist epistemological approach since they enable a researcher to examine a social phenomenon within its naturally occurring context, and to explore how this context influences perceptions or experiences of the phenomenon (Stake 2006). Using multiple research methods and data sources allows the researcher not only to understand the meanings that the research participants place on their experiences, but also to assist in the researcher's own interpretation of these in the analysis process. Carcary (2011) notes that:

"The case study is appropriate in situations where a single explanation cannot provide a complete account of the research topic. It is suitable for achieving in-depth, holistic knowledge of broad, complex phenomena and in understanding interactive processes, relationships, political issues and influence tactics within specific contexts" (p.12)

As Crowe et al. (2011) pointed out, the case study approach allows for "in-depth, multi-faceted explorations of complex issues in their real-life settings" (p. 1). It is used when

there is a need to gain detailed insights into a particular phenomenon in a specific real-life context, "especially when the boundaries between the phenomenon and context are not clearly evident" (Yin 2009, p.13).

Reflecting the ontological and epistemological perspectives described earlier, the study is based on the relativist-contructivist/interpretivist approach to case study research. This is one of the three main philosophical approaches to case study research identified by Harrison et al. (2017). It is distinguished from the realist-postpositivist approach (Yin, 2009), which relies heavily on quantitative data collection to test hypotheses, and from the pragmatic/constructivist approach (Merriam, 1998), which uses a combination of quantitative and qualitative methods and a very systematic approach to data collection and analysis. In contrast, the relativist-contructivist/interpretivist approach (Stake, 1995) focuses on individual experiences and the researcher's interpretation of these to build up understanding of a phenomenon inductively, or from the data itself (Harrison et al., 2017). It is especially helpful, as Darke, Shanks and Broadbent (1998) suggest, in areas of relatively new research when it is important to gain understanding of the context and dynamics within which a social phenomenon occurs. Although a review of previous literature provided the researcher with an understanding of value conflicts and related issues in the nursing context, and a broad framework for interpretation of the research data, the findings were primarily generated inductively using thematic analysis methods to explore the unique experiences of the research participants.

Stake (1995) defined three main forms of case study within the relativist-contructivist/interpretivist approach: an intrinsic case study, which is used to investigate a particular issue within a specific setting; an instrumental case study, which uses a particular research setting to understand a phenomenon that also occurs more widely; and a collective case study, in which multiple settings are studied to generate an even broader understanding of the phenomenon of interest. This research primarily constitutes an instrumental case study, as it was concerned with investigating the experience of value conflicts among Muslim student nurses in a specific organizational and geographical/cultural setting in order to contribute to the wider understanding of the phenomenon of value conflicts among female Muslim student nurses in conservative Islamic societies. There were also intrinsic aspects to the study. By exploring the experiences and perceptions of value conflicts among student nurses and faculty in a single research setting and identifying the specific influences on value conflicts in that

setting, the researcher was able to develop actionable evidence-based recommendations tailored to the case study organization and its members.

In this form of case study research, a case can be defined at any level or type: for example, an individual, organization, event or program (Harrison et al., 2017). The present research was based on a single case study, with the setting defined at organizational level as the nursing department of a higher educational institution in Saudi Arabia. This extended for the purpose of the study to include the hospital linked to this educational institution, in which the students gained experience of clinical practice. Although a multiple case study involving several institutions or other units of analysis can potentially generate more robust results by allowing for the exploration of a social phenomenon in a range of settings, it was not feasible in terms of time and cost to conduct a study of this type. This is a common reason why single case studies are used more frequently in social research especially by independent researchers (Yin, 2003). However, by focusing the research on a single qualitative case study, the researcher intended to generate rich data and insights for use in developing practical organization-specific recommendations while also contributing to the research-based understanding of the experience of value conflicts by Muslim nurses in Islamic societies. No previous studies had been identified in the review of literature which examined the experience of value conflicts by female Muslim nurses in Islamic societies using a case study approach of this type.

Case studies typically use multiple research methods, sometimes combining quantitative and qualitative research to achieve both breadth and depth of understanding of the phenomenon of interest, and to improve the overall validity of the findings (Stake, 1995; Ritchie and Lewis, 2003; Morgan, 2014; Creswell, 2015). Although the design of the present study did not incorporate quantitative data collection, the two forms of qualitative primary data collection (focus groups and interviews) provided a means of improving the robustness of the study and validity of the findings by examining the issue of value conflicts both in a group and in an individual setting, drawing on the relative merits of each approach as discussed in section 4.5.

The case study also included content analysis of documents such as published policies, codes of conduct or ethics and training materials issued by or in use within the case study institution. The main purpose of this stage of data collection was to provide contextual information for use in interpretation of the primary research data. For example, the documentary analysis was intended to identify potential influences on nursing practice

and the consequent experience of value conflicts by student nurses at this institution, including gaps or weaknesses in the provision of relevant information or guidance which might contribute to the experience of value conflicts.

Bowen (2009) notes that documentary analysis is often used to support and strengthen a research study, providing background information and enabling a researcher to contextualise their findings. It can also be helpful in providing additional relevant information that has not been available to, or has been forgotten by, the research participants (Bowen, 2009). In the context of the present study, for example, it was considered important to determine whether or not training or policy documents relevant to ethics, values and value contexts were in use at the case study institution, whether or not students and faculty were actually aware of them. Any gaps in knowledge or awareness of such documents among the research participants would be an important research finding in its own right.

Within documentary analysis, a document is defined broadly as any written text, written with a purpose by an individual or group and often reflecting the perspectives or assumptions of its author (Scott, 1990). An important aspect of documentary analysis, therefore, is to consider who authored particular documents, for what purpose and how the author's own perspective may have influenced its content or style. Documentary analysis is thus well aligned with the interpretivist epistemological approach which acknowledges that social realities are not objective and fixed, but are socially constructed and contextual. Documentary analysis also often forms an important component of case study research, which as Lauckner et al. (2012) explain, allow for the "exploration of complex situations, allowing for the gathering of multiple perspectives, from a range of sources, including contextual information (p. 4).

In the present study, for example, it was considered important to determine whether the issue of value conflicts is covered at all in policy and training documents, if so whether this translates into actual teaching or dissemination of the information to students, and if it is likely to help reduce the potential for value conflicts or provide support to student nurses who experience them. To achieve this, it is essential to interpret the content of documents in the context of how they were produced or used, and to consider not only their explicit but also their underlying meanings (Mogalakwe, 2006). In doing so it is often important to consider not just the existing text but also any content that might be expected to be in a particular type of document but is absent. In the case of the present

study, for example, the omission of information or guidance on value conflicts in policy documents or training materials might represent an important finding in its own right. As noted above, it is also important not only to identify potentially relevant information but to ensure that this is being effectively conveyed to the students. To address this point, the findings of the documentary analysis were considered in combination with the primary research findings, which provided information on the awareness of students and faculty about such policies, guidance or curricular content.

4.4 Research Methods

4.4.1 Selection and Characteristics of the Case Study Institution

It is important in case study research to provide a description of the case study site, so that the context of the findings is clear and their transferability to different settings can be assessed by others (Lincoln and Guba, 2013). In order to ensure the confidentiality and privacy of the research participants in the current study, however, the government higher education institution in Saudi Arabia which formed the case study setting is not named.

The organisation was chosen as the study setting for two main reasons, which are those cited in the literature as being most important in case study selection. The first reason is the suitability of the institution for enabling the researcher to address the research objectives, namely to explore experiences of value conflicts among female Muslim student nurses in a conservative Islamic society and the perceptions of faculty regarding these. Yin (2009) stressed in this respect that a case selected for study should be informative in ways relevant to the research questions of a study. Second, it is essential that the case selection should enable the researcher to gain access to the units of analysis that are important for answering the research questions (Crowe et al., 2011). Since the researcher is a Saudi Arabian nursing professional who graduated in 1998 from the case study institution, she was able to use personal contacts to negotiate access to this university and its members. However, the researcher has had little contact with the institution since then and has never worked in this university. She had little pre-existing knowledge or perceptions about the experience of value conflicts in this particular setting at the present time, reducing the potential for any researcher bias in data collection or analysis.

The university which forms the case study for this research first established its Department of Nursing in 1977, at which time the Department ran the first ever baccalaureate nursing program in Saudi Arabia. Formerly part of the Faculty of Applied Medical Sciences, the Faculty of Nursing was established in 2012. The Faculty now has Bachelor, Bridging and Post-Graduate programs, and three main departments: Public Health nursing, Maternity and Child nursing, and Medical and surgical nursing. Other smaller departments fall within these three main departments.

The Bachelor of Science in Nursing degree is a four-year academic program followed by a one-year hospital internship at the university hospital. It includes an initial preparatory year before three years of study in nursing and one year of training. Second-year students are required to attend an induction day in the clinical environment. The BSc. Nursing program covers a wide-ranging curriculum from the humanities, behavioural and basic sciences, including courses in maternity and woman's health, child health, and medical-surgical adult health among others. The faculty consists of three deanships for development, clinical affairs and graduate studies/scientific research respectively.

The Saudi Arabian setting in which the case study institution is located can be expected to have a significant influence on nursing and healthcare. As explained in Chapter 2 Saudi Arabia is a conservative Middle Eastern Islamic country in which 100% of the native population consists of Muslim Arabs, and in which Islam has a strong influence on all areas of life, including health and healthcare (Abudari et al., 2016). There are also very strong social and religious expectations about gender roles and gender segregation (Uddin, 2017). However, formal nurse education in Saudi Arabia has been largely based on the Western model of healthcare. These factors provide the general context for the study of value conflicts among student nurses at the case study institution.

Initial meetings with senior stakeholders were used to provide the researcher with additional background and contextual information about the case study institution and the nurse education process within this institution. This included a meeting with the Dean of the Nursing College in order to introduce and explain the study. Having given approval for the research to go ahead, the Dean advised that the Vice-Dean of Graduate studies and Scientific Research would act as the main contact for the study. This individual was very helpful in facilitating access to faculty members and to the three main Heads of Nursing who in turn introduced the researcher to the program coordinators who arranged access to the second- and fourth-year student nurses.

Meetings with these individuals was also invaluable in providing contextual information to help the researcher understand the responses of students and faculty in their interviews or focus groups. Some of the contextual details gained from the senior stakeholder meetings are included as findings of the study in Chapter 5.

4.4.2 Student Sampling and Recruitment Processes

The study used a multi-stage, non-random sampling strategy based on purposive sampling methods to select students for participation in the study. The use of non-probability sampling means that the findings of the research cannot be directly generalised to a wider population. However, this is not a limitation in the case of qualitative research since the objective is not to generalise to a wider population, but to investigate a phenomenon in depth based on the accounts of individuals with specific experience of this phenomenon (Tashakkori and Teddlie, 2003).

Purposive sampling is one of the most commonly used sampling method in qualitative research. This involves selecting participants based on pre-determined criteria. These inclusion criteria relate to the key characteristics of the target population that are relevant to the research question, such as demographic characteristics or geographic location (Lopez and Whitehead, 2013). In the current study, the inclusion criteria for the student sample were:

- Female
- Muslim
- A Saudi Arabian national
- A student in either the second or fourth year of study of the BSc nursing degree at the case study institution
- Giving voluntary consent to participate in the study

At the time of the research, all students in the nursing department at the case study institution were female, Muslim and of Saudi nationality and therefore eligible to participate in the study. Age was not used as an inclusion criteria and student nurses of any age who met the inclusion criteria were eligible to participate. As in the exploratory/pilot study, all students in the second year and the fourth-year of the Bachelor of Nursing degree were eligible to volunteer for participation in the main study.

As in the exploratory study, both second-year and fourth-year students were selected for inclusion in the main study, in order to reflect a range of experience. This enabled the researcher to investigate the ways in which student nurses at different stages of their training in this university become aware of and experience value conflicts. There was no danger of sample contamination through the inclusion of students who had participated in the exploratory study, since the original second- and fourth- year cohorts of students had since then moved into their third year of study or their internship year respectively.

It was decided to select sample sizes of 12 students per year (24 in total), with these split fairly equally between focus groups and interviews, in order to draw equally on the respective benefits of each of these data collection methods, as discussed in Section 4.5. There are no rules or standards regarding specific sample sizes in qualitative research (Patton, 2002); the main objective is to ensure that the sample is large enough to allow adequate in-depth investigation of the research topic (Mason, 2004). The concept of saturation is sometimes used in social research, in which the sample size is gradually increased until no significant new information is being generated (Richards and Morse, 2007). In the case of this study, although the total sample size of 24 was somewhat arbitrary, this was expected to provide sufficient numbers of participants to investigate a broad range of views and experiences, while also ensuring that the data collection and analysis workload would be manageable. Having pre-defined sample sizes rather than adding additional participants at a later stage also made it easier to plan and organise the interviews and focus groups without too much disruption to the case study organization.

All eligible students were informed about the research in a classroom information session held by the researcher and invited to participate. Information sheets (see Appendix 2) were subsequently distributed with the assistance of the students' team leaders, who also liaised with the researcher regarding the scheduling of the interviews and focus groups to ensure these would not have a negative impact on the student's studies. The information sheets distributed to all second- and fourth-year BSc student nurses set out the purpose and nature of the study and what would be required of participants, as well as the ways in which the confidentiality of the research data would be protected. Volunteers were asked to complete an initial expression of interest form with their contact details and hand this to the researcher in her designated office within a specified time period.

The expression of interest form also collected information on year of study, marital status and age (Appendix 3) for the purpose of the second stage sampling. The form also asked

volunteers to specify their preference, if any, regarding participation in an interview or focus group. The researcher had explained at the information session that expressing interest at this stage did not guarantee that a student would be included in the study, and also that the volunteers could withdraw their expression of interest at any time.

It was felt that marital status might influence the findings, with married women being more comfortable interacting with or providing care to male patients due to their experience of meeting and getting to know their husband. In contrast, single Saudi women are less likely to have experienced close contact with unrelated males. Since there were relatively few married volunteers in the available sample of volunteers, all married participants were therefore included in the final samples. The remainder of the participants were selected randomly from the volunteers using Dice random selection software (Random.org). This method was used in an attempt to achieve diversity of the final sample in terms of background and experiences.

The selected students were contacted by email personally by the researcher, confirming that they had been selected for participation in the study and proposing a date and time for their interview or focus group. The focus group dates were fixed in collaboration with the team leaders for each respective year group, but alternative interview dates and times were offered if those first proposed were inconvenient for any participants. The selected sample members were also given the opportunity to raise any further questions or concerns about the study, which were addressed by the researcher. At this stage, none of the selected students revoked their initial agreement to participate and the samples were confirmed.

4.4.3 Faculty Sampling and Recruitment

It was considered important to include faculty as well as students in the study, in order to gain a broader understanding of how and why value conflicts may be experienced by the student nurses and the ways in which the institution does or can influence these conflicts. While important to understand how it feels and means to the students to experience value conflicts, it was anticipated that faculty might be able to provide additional important insights from their knowledge and experience of the organisational context. Faculty had not been included in the exploratory study since the purpose of this had been only to explore the presence of value conflicts among student nurses. Since faculty were not

included in the exploratory study, the sampling and recruitment methods for this group were not tested in advance of the main study

In the case of the faculty sample, the inclusion criteria were:

- Female
- Muslim
- A Saudi Arabian national
- A faculty member of the Department of Nursing at the case study institution
- Giving voluntary consent to participate in the study

At the time of the research, all faculty in the nursing department at the case study institution were female, Muslim and of Saudi nationality and therefore eligible to participate in the study. Age was not used as an inclusion criteria and faculty of any age who met the inclusion criteria were eligible to participate. The nursing program includes some non-Saudi faculty members, but it was decided not to include these in the study. Although it might have been interesting to examine different cultural or religious perspectives on the experience of value conflicts by students, there were insufficient numbers of non-Saudi and non-Muslim faculty members to allow this.

As in the case of the student samples, purposive sampling methods were used to select a sample of six individuals for interview from the 29 female Saudi faculty members of the Department of Nursing (all faculty were female). This sample size was determined with the intention of generating a diverse range of views while ensuring that the data collection and analysis workload would be manageable.

An invitation to participate in the research was initially emailed by the Secretary to the Vice-Dean of Graduate Studies to all female Saudi faculty members of the Department of Nursing, along with a faculty version of the study information sheet and expression of interest forms (Appendices 4 and 5). The faculty expression of interest form collected information on position (e.g. Professor, Lecturer, Teaching Assistant), Department (Public Health Nursing, Department of Maternity and Child Nursing, or Department of Medical and Surgical Nursing) and number of years of professional experience, so that a diverse sample in terms of these characteristics could be purposively selected to participate. This was intended to help ensure that the issue of value conflicts faced by female Muslim student nurses could be examined from the viewpoints of faculty members with a range of professional backgrounds and length of experience. Hard copies of the

study information sheet and expression of interest form were also distributed to all nursing department secretaries who handed these personally to faculty members. The researcher verified that this distribution of information was completed so that all faculty members were known to have had an opportunity to learn about and volunteer to take part in the study.

These initial recruitment methods, which had not been tested in the exploratory pilot study, and which did not involve face to face contact between the researcher and prospective faculty participants, proved unsuccessful in contrast with the student recruitment methods. Initially, only one faculty member volunteered to participate. Since it was difficult in practical terms to organise an information session with all eligible faculty as a group, the researcher arranged through the Departmental Heads of Nursing to meet a number of faculty members individually, in order to explain the study in person and seek their willingness to participate. Care was taken not to coerce faculty members into taking part, and only to explain more fully the nature of the study and what their participation would involve. Faculty members were selected randomly for this direct approach, to reduce any possibility of selection bias, with meetings being arranged until the target sample size of six was achieved. This method proved highly successful, indicating that the face to face contact and interaction was effective in increasing levels of interest in the study and possibly also increasing trust in the researcher.

The selected faculty were contacted by email confirming that they been chosen for participation in the study and proposing a date and time for their interview. Alternative dates and times were offered if those initially offered were inconvenient for any participant.

4.5 Data Collection and Management

4.5.1 Individual Interviews

Face to face individual Interviews were arranged with the 10 student participants (5 from each year of study) and 6 faculty participants at mutually convenient times and conducted in the meeting room of the College of Nursing (the remainder of the student participants were allocated to focus groups, with the allocation based on the expressed preference of the students).

In-depth face to face interviews are most appropriate for use when the main research requirement is to provide in-depth understanding of individual experiences of a phenomenon and how these relate to other aspects of the participants' lives. Interviews are especially useful as a means of data collection when investigating personal or sensitive information that participants might not feel comfortable sharing in a group. It was felt that this might be the case with the student participants in the current study, since the issue of value conflicts is potentially sensitive. Individual interviews are also useful in qualitative research when the range of characteristics and experience of the research participants is expected to be very diverse, as was the case for the faculty sample in this study, who represented a range of job positions and areas, and vastly differing lengths of professional experience. There are also practical benefits to using individual interviews for busy professionals, since it can be difficult to arrange a focus group at a date and time convenient for the whole sample, when they have heavy workloads and may be based in different locations. Compared with focus groups, interviews also allow the interviewer to retain more control over the discussion and to collect more data about the experiences of individual participants (Morgan, 1997).

The study used semi-structured interviews, which are appropriate when the researcher knows enough about the topic to be able to develop relevant questions in advance but not enough that they can anticipate the answers (Richards and Morse, 2007). In contrast, unstructured interviews are more like informal conversations about a particular topic and have no predefined questions. This approach can be useful when very little is known about the phenomenon and the researcher seeks to learn about it primarily from the research participants (Richards and Morse, 2007). Semi-structured interviews are also most appropriate when it is important to be able to compare the experiences or views of participants, since the structured nature of the questionnaire enables the participants' responses to particular types of questions to be compared.

For interviews to be successful in generating rich data, a researcher must develop a good level of rapport with each interviewee in order to put them at their ease and ensure they feel comfortable enough to share information. The researcher took great care to put participants at their ease, creating a safe environment by stressing that all information would be treated in confidence, and by using appropriate verbal and body language to acknowledge the participants' views and feelings in ways which were non-judgemental.

4.5.2 Focus Groups

Two student focus groups, one comprising seven second-year students and the other comprising seven fourth-year students were arranged with the selected participants at mutually convenient times and conducted in the meeting room of the College of Nursing at the case study institution. One of the students initially selected for focus group participation was not able to attend, and was replaced by another from those who had originally volunteered to take part. The researcher personally facilitated the focus groups, and each focus group lasted approximately 90 minutes.

One of the main benefits of focus groups is that the interaction between participants in the group often generates valuable research data from participants that they might not have provided spontaneously in a one-to-one interview setting. This might include immediate evidence of differences and similarities in their views, that can enhance understanding of the issue (Morgan, 1997; Wood, 2006). This occurs for a number of reasons: a participant may feel more comfortable sharing their own views and experiences when others are doing the same, or the group discussion may trigger memories or thoughts that are then articulated by a participant. As explained by Rubin and Rubin (1995), "in focus groups, the goal is to let [participants] spark off one another, suggesting dimensions and nuances of the original problem that any one individual might not have thought of. Sometimes a totally different understanding of a problem emerges from the group discussion" (p. 140). As a result, focus groups often help the researcher to generate a more comprehensive understanding of the research issue (Vaughn, Schumm and Sinagub et al., 1996). An additional practical benefit of using focus groups is that these allow the researcher to collect data relating to a larger number of individuals more cost-effectively and in a shorter length of time (Halcomb and Davidson, 2006; Phellas et al., 2012).

One of the potential drawbacks of focus groups compared with individual interviews, however, is that they can inhibit discussion of sensitive topics. For this reason, student participants in the current study were given the choice of participating in an individual interview or a focus group. The focus group participants were also asked to treat the discussions in complete confidence and to respect the privacy of the other participants.

As in the case of the interviews, the researcher took great care to put participants at their ease using verbal and non-verbal communications.

Another nurse lecturer, who had also assisted with data collection in the exploratory study, was present at the 2nd year student focus group. This individual is an independent researcher who was not employed by the case study institution and was not known to the focus group participants. She has qualitative research experience and her main role in the focus group was to observe the non-verbal behaviour of the participants and take notes on these. She also made notes of the names of participants who made particular points in the interviews, which facilitated the identification of individuals when listening to the audio recordings. She helped in the management of the group by interjecting when some dominant participants were talking at length, and asking for the views of others. The researcher also discussed the group interaction with this colleague later and helped confirm that all participants had contributed to the discussion, and had also listened to and respected the views of others.

4.5.3 Research Instruments

In semi-structured interviews and focus groups, an interview guide or topic guide will generally be used which consists of a number of open-ended questions. However, since the purpose of qualitative research is to explore issues from the unique perspective of individuals, the interviewer does not need to stick rigidly to these questions, they can vary the order or specific wording in response to what is said by the participants. They can also probe and use additional questions to fully explore the research participants' experiences (Phellas et al., 2012). The research participants are encouraged to contribute any relevant information in their own words, which helps increase both the depth and breadth of information generated (Cozby, 2001; Groenewald 2004; Creswell 2005; Denzin and Lincoln 2011). This also helps ensure that the researcher can understand the overall context or background contributing to the participant's reported views and experiences. The use of semi-structured interview guides provided the researcher with the ability to adapt each interview and focus group to the emerging responses of the participants, while also generating comparable information about their views on and experiences of value conflicts.

It was decided to use semi-structured interviews for both students and faculty since the researcher had a broad understanding and direct personal experience of the Saudi Arabian nursing context in which the research participants might experience or observe value conflicts, as well as some knowledge of value conflicts and related issues in this context from previous literature and personal experience. However, the researcher did not know what the experiences of individual participants would be, or what meanings they would attribute to these. This enabled her to develop interview guides for the which were intended to generate data relevant to the objectives of the study while providing considerable flexibility to accurately capture the personal experiences of the research participants. In order to avoid influencing the likely responses of the participants and introducing researcher bias, questions were carefully designed to ensure that they were neutral in tone. The student versions of the guide were based on the earlier ones developed for use in the exploratory study, but refined to clarify some of the questions and expanded to address a broader range of issues as identified by the participants in this exploratory study. The questionnaires were not piloted, but were reviewed in detail by the researcher's supervisors and revised based on their feedback. The student questionnaires were very similar to those used in the exploratory study, in which they had proved to be effective as data collection tools.

Copies of the semi-structured interview guides used in interviews with student nurse and faculty participants and in the student focus groups are included as Appendices 7, 8 and 10 respectively.

4.5.4 Use of Vignettes in Faculty Interviews

A specific data collection technique included in the faculty interviews was the use of short vignettes describing value conflict situations which the faculty participants were asked to respond to with their views. Though often based on hypothetical or fictional characters, the vignettes used in the present study were developed from real-life experiences reported by student nurses in the exploratory study.

The use of vignettes is a method discussed by Richards and Morse (2007) as an indirect data generation strategy used to stimulate interpretations and responses to hypothetical situations. According to Finch (1987), vignettes are "short stories about hypothetical characters in specified circumstances, to whose situation the interviewee is invited to

respond" (p.105). Barter and Renold (1999) observed that vignettes are often used for three main purposes in social research: to investigate actions within a particular context, to help clarify the judgements of research participants and to provide a relatively impersonal and safe way of exploring sensitive issues.

There is little consensus in the research literature about the specific role of vignettes in qualitative research and how they should be developed (Kandemir and Budd, 2018). However, some best practice guidelines in the design of vignettes as documented by Barter and Renold (1999) are as follows:

- "Stories must appear plausible and real to participants
- Stories need to avoid depicting eccentric characters and disastrous events, and should instead reflect 'mundane' occurrences
- Vignettes need to contain sufficient context for respondents to have an understanding about the situation being depicted, but be vague enough to 'force' participants to provide additional factors which influence their decisions.
- Participant's ability to engage with the story may be enhanced if they have personal experience of the situation described." (Barter and Renold, 1999, section 4).

Three vignettes were generated based on themes generated from the exploratory study and described examples of value conflicts that that some of the student nurses had reported personally experiencing in their training or clinical practice. They were compiled using anonymised information from the student interviews in the main study, in order to protect the confidentiality of the participants. Since the purpose was just to provide examples of real-life situations and as they were based on actual incidents reported by participant in the exploratory study, no further testing or validation of the vignettes was carried out. The vignettes were read out to the faculty participants in their interviews and they were then asked a series of questions relating to their perceptions of why each value conflict may have arisen, their views on it, and how it might be avoided in future.

Since they were based on real situations, the vignettes met the Barter and Reynold (1999) requirements of being plausible, "mundane" (in the sense of occurring in everyday practice) and report situations which the faculty were likely to be able to relate to personally. Care was also taken to compile these in ways that included sufficient content to ensure faculty could understand them, while still being sufficiently vague to require

them to draw upon their own observations and experiences in order to respond or react to the situation. However, they did not form a major component of the interviews, they were introduced to help stimulate discussion about value conflicts. The three vignettes are shown in the faculty interview guide included as Appendix 8.

Vignettes were not used in the student focus groups and interviews, since these were mainly intended to encourage the student participants to discuss their own personal experiences of value conflicts or those of other student nurses based on their own observations of these.

4.5.5 Language and Translation

The researcher personally conducted all of the interviews and focus groups in Arabic, the first language of the research participants, to help ensure that they understood what was being asked and could fully express or explain their own views and experiences. These were audio-recorded with the permission of the participants, using a USB audio recorder. They were subsequently transcribed from the Arabic audio files to Arabic word documents and then translated into English.

Chen and Boore (2009) point out that translation of research documents relates to culture as well as language. The nuances of culture mean that concepts discussed in one language may have different meanings when translated to a different language (van Nes et al., 2010). Inevitably, some of the detailed nuances of intended meanings may be lost in the translation process. From an epistemological and a research quality perspective, it is important to provide transparency about the translation process, to enable readers to understand how this process may have influenced the findings of the study (Temple and Young, 2004). The interpretivist epistemological approach adopted in this research assumes that anyone involved in interpreting research data plays a non-neutral role in the construction of meaning from this data, and the processes involved must therefore be documented so that readers can evaluate the accuracy of the findings.

The researcher personally translated 50% of the Arabic transcripts to English for the purpose of data analysis, while a professional Arabic translator assisted in the translation of the remaining transcripts. The use of a professional translator as recommended by van Nes et al. (2010), as well as detailed review of the translated transcripts by the researcher, herself a fluent Arabic and English speaker, was intended to maximise accuracy of translation in this study. Two of the translated interview transcripts were verified

respectively by a professional translator in the university's research centre and by the relevant interviewee and both were confirmed to be accurate. A professional translator was also asked to validate the researcher's translation of the fourth-year student focus group and confirmed this to be accurate. Further, one of the Arabic interview transcripts from each student year sample was reviewed by the relevant participant to verify that it accurately represented what they had said. The focus group transcripts were also reviewed by two members of each focus group to verify that they accurately represented what was actually said during the group. This method is known as "member checking", and helps ensure the validity and reliability of data from qualitative research (Yin, 2015).

When reviewing the translating documents, some corrections were found to be necessary to achieve accuracy of translated concepts from a cultural as well as a language-related perspective. This is largely because many metaphors are used in the Arabic language and it is essential to capture the intended meaning of these when translating research data (Al-Amer et al., 2016). For example, when patients indicated that their "smile" might have been misunderstood by a patient, they are often referring not explicitly to their smile, but to their general demeanour towards the patient, which in the case of males might influence their understanding of the nurse's intention towards them.

Special care was also taken in the translation process in relation to the translated concept of value conflict. Word by word this might be taken to refer to "benefit" or "worth" of conflict (Seraat alqeema/qeemat al seraat in Arabic) instead of value conflict as intended in the study (seraat alqeiam in Arabic). It was important to ensure that the translator was provided with a good overall understanding of the study in order to maintain the correct meaning of such concepts in the translation process.

Very occasionally, it proved impossible to find a direct translation for Arabic terms. This was the case, for example, for the phrase "sidi", which is used in Saudi Arabia as a term of respect towards males. The closest equivalent in English is "master", but this is not an accurate translation as master conveys a sense of authority that is not associated with the term "sidi". In this case, the original term was retained in the translated document and in the results chapter and a footnote has been used to explain this.

Finally, a retired Lecturer in Nursing from the University of Dundee (formerly a member of the researcher's supervisory team) reviewed six of the translated interview transcripts (two faculty transcripts, two second-year student transcripts and two fourth-year student

transcripts). This person confirmed that the research had been conducted in an organised, consistent and methodical manner and that the six interview transcripts were felt to be sound and reliable. She also reviewed and approved the initial themes developed in the analysis process. The full report on the review of transcripts is attached as Appendix 9.

4.6 Research Ethics

4.6.1 Ethical Approval

Before commencing the study, a research proposal was submitted to the University of Dundee's Research Ethics Committee (SREC-UOD 2017031 Yaseen). Approval to proceed with the research was granted by the Committee in December 2017 and is attached as Appendix 10. 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 (Appendices 11 and 12).

4.6.2 Informed Consent and Care for Participants

The highest standards of research ethics were observed by the researcher throughout the study. The use of classroom presentations by the researcher as well as the distribution of an information sheet giving details of the study and the researcher's contact details allowed students and faculty to make a fully informed decision about whether to volunteer to participate. The information provided made it clear to potential participants that the participation in the study would be completely voluntary. The sheet also specified that the interviews and focus groups would be audio-recorded. Individuals who expressed willingness to participate were provided with a written consent form, which they were required to complete before their interview or focus group commenced. They were also notified that they could terminate their voluntary participation without giving any reason, and that they could refuse to answer any specific questions which they felt uncomfortable answering. Two faculty members withdrew their original expression of interest before the study commenced, but none of the student volunteers did so.

The participants were assured that any information they provided in the interviews or focus groups would be treated in confidence and that pseudonyms would be used when presenting the results in order to preserve their anonymity. The focus group participants were asked to respect the confidentiality of information provided by other participants in

their group and not to discuss this with any other students, patients or faculty members by name.

All research participants were required to complete and sign an informed consent form in Arabic before the process of collecting data began. They were given assurances that all recordings and transcripts would be treated in complete confidence and that the original data and transcripts would be destroyed two years after completion of the study.

The participant information sheets, expression of interest forms and consent forms were also translated into Arabic by a professional translator to ensure that the participants fully understood their content. The researcher, herself a fluent Arabic and English speaker, reviewed the translated documents to ensure that accuracy of content and meaning had been retained.

Although there were no significant risks to individuals from participating in this study, it was acknowledged that some students or faculty might have been be emotionally affected when discussing potentially sensitive or distressing issues relating to value conflicts. In view of this, information about the University Counselling team and the self-referral procedure were made available to all participants at the outset of the study. It is not known whether any participants made use of this facility.

4.6.3 Data Privacy and Security

Anonymity was preserved by the allocation of a pseudonym to each participant for use by the researcher when analysing the research data and reporting on the findings, and care has been taken not to disclose identifying information when presenting the results.

The audio recordings were initially stored on folders in a designated laptop, and the laptop and files were password protected. These were subsequently uploaded to a secure shared university folder, to which only the researcher and her supervisors have access. The transcriber had temporary access to the audio files via Google drive while working on these. All audio files and transcripts will be securely saved in the University of Dundee Data Archive following completion of the study, in an area that can be accessed only by the researcher and supervisors.

It was anticipated that ethical issues might arise when conducting the study, for example if participants were to disclose information about behaviours that contravene official policy on patient care. In order to meet high ethical standards of research and ensure that

confidentiality would be preserved, it was decided in advance that such incidents would not be disclosed unless the researcher perceived that a significant risk to patient safety was involved, and that the guidelines of the World Health Organization's (2013) Ethical Issues in Patient Safety Research as well as International Council of Nurses (ICN's) Code of Ethics for Nurses (2012) would be followed if necessary to determine whether participant confidentiality could reasonably be breached in the interest of patient safety. This information was not made available to the participants before the interviews as the risk of such incidents being disclosed was expected to be very small. In the event, no such incidents were disclosed in the interviews or focus groups.

4.7 Data Analysis

The interview and focus group transcripts were all imported into NVivo 11 qualitative analysis software (QSR International Pty Ltd., 2017) for the purpose of coding and analysis using thematic analysis. Four separate NVivo 11 files were created for the purpose of coding, which corresponded respectively with 1) the individual student interview data (2nd and 4th year students), 2) the individual faculty interview data, 3) the second-year student focus group and 4) the fourth-year student focus group.

Thematic analysis was defined by Braun and Clarke (2006) as a method for "identifying, analysing, and reporting patterns (themes) within the data" (p.79). In this process, the research data is systematically allocated to codes and sub-codes corresponding to key themes and sub-themes emerging from the data and relevant to the research questions. Although thematic analysis coding can be carried out manually, the use of qualitative analysis software can help facilitate the organisation and re-organisation of data by codes and themes during the analysis process. It is a flexible process which can be used in a variety of ways depending on the objectives of the study and the ontological and epistemological perspectives of the researcher.

Braun and Clarke (2012) set out six stages of the inductive thematic analysis process as follows:

1. Familiarisation with the data – which involves the researcher "immersing" him or herself in the data by reading and re-reading the transcripts.
2. Generating initial codes, which may reflect the language and concepts contained in the data (inductive approach) or the researcher's conceptual or theoretical frameworks (deductive approach), and allocating research data to these.

3. Searching for themes – which involves reviewing the coded data and actively seeking areas of similarity or overlap that might be defined as themes, and starting to explore relationships between themes.

4. Reviewing potential themes – a stage which involves comparing the identified themes with the whole dataset to determine if they accurately reflect this, and modifying them if necessary.

5. Defining and naming themes – or what Braun and Clarke (2012) refer to as the "deep analytic work involved in thematic analysis" in which the themes are articulated in writing, and extracts from the transcripts selected to illustrate them.

6. Producing the report – which Braun and Clarke (2012) stress is an iterative process in qualitative research, in which writing is interspersed with additional analysis.

In the present study 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 used to structure the presentation of findings. In a priori coding, some main themes are identified in advance, based for example on the research questions or key issues identified from relevant existing literature, and data from the research transcripts are coded against these themes. In contrast, inductive coding allows new themes to be identified from the data itself (Ryan and Bernard, 2003). Inductive coding is most often used in qualitative studies in order to ensure that the identified themes most accurately reflect the reported real-life experiences and views of the research participants (Ryan and Bernard, 2003). However, as Braun and Clarke (2012) point out, it is impossible to conduct completely inductive analysis as the researcher always brings some existing knowledge or understanding of the research topic to the process.

The advantages of combining a priori and inductive coding are that this helps provide structure to the early stages of the coding process and ensures that it incorporates consideration of relevant themes found to be important by other researchers, while also ensuring that the final definition of themes accurately reflects the experiences and perceptions of the research participants. However, it is important to ensure that the researcher does not unduly introduce bias in priori coding by ensuring that this is only used to identify broad, top level themes, and that these are revised if necessary in later stages of inductive coding to ensure that the final coding tree accurately reflects the data itself.

In broad terms, Braun and Clarke's (2012) stages of thematic analysis were applied for use in the current study. There was a need to modify the stages to allow for the synthesis or integration of findings from the various stages of data collection in ways that allowed for a coherent and meaningful discussion of each theme and sub-theme. The specific stages of coding and analysis that were followed in this study can described as follows:

1. The researcher was already familiar with the data as she had personally conducted all interviews and focus groups. However, the process of reading and re-reading the transcripts was found to be helpful as a reminder of the data collected, with this "immersion" invaluable in the process of identifying top level (a priori) themes.

2. Initial top-level themes (codes) were identified reflecting the researcher's existing knowledge of the research issue based on the literature review and exploratory study, and these were used as a top-level structure for each NVivo file. This was intended to help provide some consistency in the formulation of codes across datasets which would facilitate the integration of findings from different stages of data collection for the purpose of reporting on themes and sub-themes.

3. A process of inductive coding was then carried out which consisted of extracting each piece of relevant text (varying from a few words to multiple paragraphs) from each individual interview and focus group transcript, and giving this a label (code). In the first stage of inductive coding, a large number of codes are usually defined, many of which only have a small amount of data allocated to them. As the coding process progressed within each NVivo file, codes and their corresponding data were grouped into themes reflecting areas of overlap or similarity. In this stage, similar codes were merged into wider codes or themes, and codes or themes with lots of data allocated to them were broken down into sub-themes. The overall allocation of data to codes and themes was reviewed and refined several times to ensure that it accurately reflected the overall experiences of the research participants and that the identified final main themes could be coherent and meaningful in relation to the research questions.

4. The potential themes and sub-themes identified were then reviewed and compared with the whole dataset, to ensure that they accurately reflected the accounts of the research participants overall. This process also involved comparing the identified themes and sub-themes across the four datasets, and determining whether modifications might be made to improve consistency between them in order to

facilitate the final stages of analysis and reporting. Coding trees were then produced which are included in Appendix 13. These convey the final distribution of themes and sub-themes for each dataset.

5. In defining and naming themes, notes were made which articulated the meaning of each theme and sub-theme and extracts from the transcripts were selected to illustrate them. Since the research was concerned with exploring the experience and perceptions of value conflicts from the personal lived experience of the research participants, including personal narratives in the form of verbatim quotes was seen as an effective way of ensuring that the personal nature of these experiences were effectively conveyed when presenting the findings.

6. Finally, these were used to produce the findings chapter, an iterative process which involved revisiting the NVivo coding files while drafting each section, and incorporating any additional material necessary to fully capture the participants' views and experiences, and any relevant differences that emerged between the participants.

4.8 Documentary Analysis

4.8.1 Purpose and Objectives

The overall purpose of the documentary analysis was to identify any potential influences on the experience or perceptions of value conflicts by the samples of student nurses and faculty at the case study institution, in the form of policy, practice or training documents or codes of conduct. The analysis included documents issued by the university and the university hospital, as well as relevant documents issued by the Government of Saudi Arabia or by regional or international professional nursing bodies.

The documentary analysis had three main objectives:

- To identify whether and how the issue of value conflicts in nursing situations is covered in policy, practice or training documents issued by the hospital or university, or whether these documents may contribute to the development of value conflicts

- To determine how the issue of value conflicts is conceptualised or defined in hospital/university documents

- To identify whether reviewed hospital/university documents provide advice or information to help individuals respond to or cope with the experience value conflicts in nursing situations and the nature of this advice or information.

To identify any other key published documents which may influence the experience of value conflicts by student nurses at the case study institution.

4.8.2 Methods

Key literature on documentary analysis (Bowen, 2009; O'Leary, 2014; University of Northampton, no date) was utilised for the purpose of developing methods and a template for recording relevant information. The overall methodological approach to the documentary analysis followed the guidelines step out by O'Leary (2014) in the form of an 8- step process, as described below:

Gather relevant texts

The Vice Dean for Graduate Studies and Scientific Research and the Departmental Heads on the academic side, and the Deputy Directors of Nursing, Nursing Education and Development on the clinical side were very helpful and supportive in providing the required documents for review, such as policy documents and relevant Codes of Conduct.

A slight issue emerged when attempting to secure documents issued by the university hospital as this is considered a separate organisation and ethical approval had to be obtained to obtain these. This approval was obtained from the Bioethical Department and a number of relevant documents for review were obtained from the hospital.

Develop an organization and management scheme

Based on leading methodological literature on documentary analysis (e.g. Bowen 2009; O'Leary 2014) as well as the purpose and objectives of the current study, a data extraction template was developed for the purpose of recording relevant content from documentary sources. This included a number of categories consisted of: Title of Document; Type of document; Author; Date released/updated; Purpose/context; Target audience; Dissemination strategy; Relevant content re value conflicts; Purpose of content;

Information/guidance on dealing with value conflicts; Notes on 'latent" content (tone, style, bias, agenda, opinions etc.), and Other notes/observations (See Appendix 14).

Make copies of the originals for annotation

Although this stage was included in O'Leary's original (2014) documentary analysis process, it was not included in the present study. All the documents were reviewed in electronic format and the researcher worked in a "live" copy of the template, analysing the documents and inserting relevant information concurrently.

Assess authenticity of documents

Most of the documents were obtained direct from the University or hospital and were known to be authentic, so this stage was not needed in the case of the present study. Government and other documents such as policies and codes of conduct were obtained online, and could mostly be verified. However, in one or two cases (e.g. the MoH Code of Ethics) information was only available via secondary sources, and this is taken into account in the analysis.

Explore document's agenda or biases.

While reviewing each document, the researcher considered why it was produced and whether there were any underlying agendas or biases. Any relevant information was captured in the "latent" content category of the table. Additional notes or observations, for example regarding gaps in coverage relating to values and ethics, were also included in a separate category of the table.

Explore background information (e.g. tone, style, purpose)

In the case of each document, the researcher considered why it had been produced and for what purpose and audience, and recorded relevant information. This was important to understand whether addressing the issue of ethics and value conflicts was a specific objective of producing the document or what the broader/other objectives of doing so

were and how values/ethics relates to these. It was also essential to identify the target audience for the document so that its content could be considered in relation to this group, while also taking account of its impact on wider audiences.

Ask questions about document (e.g., Who produced it? Why? When?)

Similar to the previous stage, this involved identifying more information about the author of the document, their possible reasons for producing it and why it was issued at that particular time. This was intended to help the researcher identify any focus or interest in ethics and value conflicts on the part of various university/hospital stakeholders, and any factors or events that might have triggered the production of the document.

Explore content

In this final and main stage of the content analysis, each document was first skim-read in order to determine whether it contained information relevant to the issue of ethics and value conflicts in nursing. For those documents which contained no relevant information, basic data were recorded in the table. Those which did contain relevant information were scrutinised in more detail in order to enter key information and important details in the table, according to the categories listed in 4.8.2.2. The summarised results of the documentary analysis are presented in Chapter 6 with the fully completed data extraction table included as Appendix 14.

4.9 Chapter Summary

This chapter has discussed the overall research paradigm used for the study, and presented the detailed methods used for data collection, sampling and data analysis. It has also considered the ways in which ethical considerations were addressed when conducting the research, and the measures that were taken to ensure that high standards of research quality were achieved. The findings of the study are presented in the following three chapters. Chapter 5 and 6 presents the findings from the individual interviews and focus groups, and Chapter 7 presents the summarised findings of the documentary analysis.

CHAPTER FIVE: FINDINGS RELATING TO VALUES

5.1. Introduction

Chapters Five and Six set out the findings of the individual interviews and focus groups completed with student nurses and the interviews completed with faculty members at the case study institution. They form the main results chapters of the study, following which additional findings from the documentary analysis are presented in Chapter Seven.

The main findings chapters address the research questions of the study, as follows:

- What are the experiences of value conflicts among female Muslim student nurses at the case study institution?

- What factors contribute to the experience of value conflicts among female Muslim student nurses at the case study institution?

- What are the effects of value conflicts on female Muslim student nurses at the case study institution?

- What is the nursing faculty's awareness and understandings of the value conflicts experienced by female Muslim student nurses at the case study institution?

The primary qualitative research findings are presented by the main themes and sub-themes identified from the analysis. As discussed in Chapter 4, it was decided to integrate the findings from the student interviews, student focus groups and faculty interviews to provide a more comprehensive analysis of each theme and sub-theme from the different perspectives of students in different year groups and of faculty.

Reference to Rokeach's theories of value formation and change, as described in Chapter 2 and used as a theoretical framework for the study, is made where relevant throughout these chapters to interpret the findings. To recap, the key components of Rokeach's theories as they relate to this study are as follows.

Rokeach (1973) acknowledged that, although many of a person's values develop in early childhood and remain relatively stable over time, some also evolve over time or change abruptly as a result of life experiences. He explained that individuals may possess values which contradict one another, a fact that they are often unaware of. When these contradictions are brought to the attention of the individual (the self-confrontation

method) this results in a sense of dissatisfaction which is necessary for change to occur and for more positive and congruent values to develop.

Rokeach (1979) identified ten different processes through which values can change:

- Creation, during which a new belief is developed and transforms an established value

- Abrupt destruction, a rare situation in which a major event changes previously accepted values

- Attenuation, or a gradual withdrawal of support for a value previously held

- Extension, or the application of the value orientation from specific objects or events to others

- Elaboration, which involves progressively rationalizing a value until it becomes embedded in a sociocultural context

- Specification, whereby a generalized value is increasingly defined within particular contexts in which it is defined, such as equality of opportunity rather than just equality per se

- Limitation, which occurs when a value is modified because of increasingly incompatibility with other dominant values

- Explication, or the tendency to make a previously implicit value more and more explicit

- Consistency, or the tendency for certain values to become more or less consistent

- Intensity, or the ways in which values either become intensely held and the focus of life in a particular society, or less intensely held over time, receding into the background of daily life.

The present chapter presents the findings relating to the participants' understanding of the nature of personal, religious/cultural and professional values, and how these are perceived by the participants to have an influence on student nurses. Chapter Six will present the findings relating to the participants' experiences or perceptions of value

conflicts in the nursing context, their responses to these situations, and the ways in which they perceive that the university is or should be reducing the potential for such conflicts.

A detailed comparison of participants by personal characteristics has not been made, and specific numbers of individuals citing giving particular types of response are not generally provided in the analysis. Instead, a broad indication of prevalence is provided using terms such as "a small number" "some" or "the majority" of participants. This follows the Braun and Clarke (2006) approach to thematic analysis in which it is recognised that prevalence or frequency of a finding does not correspond in any straightforward way with the importance of the finding. However, the data was examined within key themes to identify any noticeable findings relevant to year of study or marital status, and these are reported. The characteristics of the student and faculty samples of research participants are first described.

5.2 Characteristics of Participants

5.2.1 Student Sample

The sampling strategy (see Chapter 4) resulted in 28% of all 147 second-year student nurses (n=41) and 44% of all 88 fourth-year student nurses (n=39) expressing interest in taking part after the initial information session. Of these, 12 second year students and 12 fourth year students were selected to take part using the sampling methods described in Chapter 4. In other words, the final achieved student samples represented 8% of all second-year students and 14% of all fourth-year students at the case study university. Of these selected participants, 7 second-year students and 7 fourth-year students took part in a focus group, and the remaining 5 second-year students and 5 fourth-year students took part in individual interviews. The characteristics of the population, volunteers and final participants by age group and marital status (single or "ever married") are shown in Table 6. Although a few of the students reported being separated or divorced, these have been combined with the married participants in the table to preserve anonymity.

5.2.2 Faculty sample

The faculty sample recruitment methods are also discussed in detail in Chapter 4. Sixteen faculty members from a total of 29 individuals (Saudi Arabian nationals) volunteered to take part in the study, but two of the 16 initial volunteers subsequently withdrew their expression of interest, and one did not meet the inclusion criteria as explained in Chapter

4, leaving 13 eligible volunteers. A purposive sample of six faculty members was then selected from this group, accounting for 20% of a total of 29 Saudi faculty members in order to ensure a relatively diverse sample in terms of position, department and years of experience. All of the faculty participants were married, the sample covered a wide age range (from below 40 to over 50), seniority and years of experience (from less than 5 to more than 20 years) and a diverse range of nursing areas.

Table 6: Characteristics of Student Population, Volunteers and Final Sample

Student Population				
Target Population by Year	2nd year		4th year	
Number of students	147		88	
Numbers of volunteers	44		39	
Age group	Under 20		20 – 25	
Volunteers				
	2nd Year		4th Year	
Number based on Marital status	Single 39	Ever married 5	Single 33	Ever married 6
Withdrew before interview	3	0	0	0
Final Sample				
Included in final sample	8	4	8	4
Total n and % of year group	12=8%		12=14%	

5.3 Development of Themes and Sub-Themes

As described in Chapter 4, the thematic analysis process used in this study included a combination of *a priori* and inductive coding methods (Braun and Clarke 2012; Ryan and Bernard 2003). In the a *priori* coding stage, some main themes were identified in advance from the research questions, the findings of the earlier exploratory study and existing literature. In general, the top level and second level themes were identified in this way. The sub-themes within these were identified inductively from the interview and focus group data. This approach helped provide structure to the coding and analysis process

while also ensuring that the findings accurately reflected the participants' accounts of their perceptions and experiences. However, since thematic analysis involves an iterative, ongoing coding process, some of the higher-level themes were also modified, removed or renamed before the coding tree was finalised. This also helped to minimise any potential researcher bias in the identification of themes by ensuring that these accurately represented the data itself rather than being pre-defined.

Using this process, a separate coding tree was created for each of the four separate datasets (student interviews, faculty interviews, second-year students focus group and fourth-year students focus group) showing the distribution of themes and sub-themes as defined in the final versions of the NVivo coding files. These are included in Appendix 13.

The use of inductive coding methods for sub-themes meant that the resulting coding trees were different for each of the four datasets. The results have been integrated in the findings chapters to provide a comprehensive understanding of each key theme or sub-theme from the perspectives of all groups of research participants. These themes, which emerged from the overall analysis process, have been used as headings throughout the chapters. The themes and sub-themes reported in the present chapter are also illustrated graphically within the sections. Verbatim quotations from the interviews and focus groups are included throughout the sections, with corresponding information in parentheses showing the participant's pseudonym, year of study if a student, and whether taken from an interview or focus group.

5.4 Understanding of Values

In the initial stages of the interviews and focus groups, the students and faculty were asked to discuss their understanding of what personal, cultural and religious values are, and the perceived purpose and role of such values. Since the aim of the study was to examine experiences and perceptions of value conflicts among Muslim female student nurses and female academic faculty, it was considered to be important to first enable the research participants' to provide information about their respective understandings and perceptions of values, and the ways in which they conceptualised and articulated these. Several themes emerged from the research data relating to the participants' understandings of values, which are shown graphically in Figure 4 and discussed in turn below.

5.4.1 Multiple influences on values

Regarding the perceived origins of values, the findings of the interviews and focus groups were largely in line with Rokeach's (1973) theory, which viewed values as mainly developing early in life from a variety of influences such as the family, education, religion and culture. According to Rokeach, although values can change as a result of later life experiences, those values which are developed in an individual's young formative years often remain strongly held throughout their life. The findings of the current study regarding influences on values therefore indicate that there may be significant challenges with regard to overcoming any value conflicts faced by the student nurses, if their personal values are formed early and are relatively intractable. These findings are illustrated by the following quotes from students and faculty.

Figure 4: Understanding of Values - Related Sub-Themes
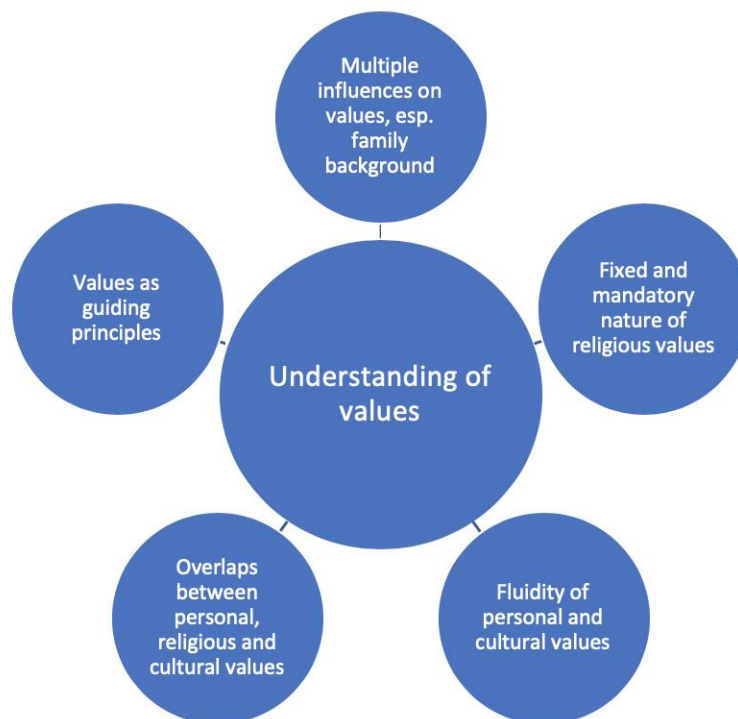
Values are what we have been raised on (Reham, Year 4 Focus Group)

My culture, of course, my environment that I live in and my family and their way of living! (Sanaa, Year 4 Interview)

> Basically it drives from religion and your family background. Then from the community surrounding, then from the nursing and from the hospital, but the foundation of course it always comes from home (Daad, Faculty Interview).

The participants identified a wide range of influences on their personal values, but most stressed that they originated first and foremost from family backgrounds, which were also influenced by culture and religion. Although the student sample was relatively homogenous in terms of being female, Muslim and of Saudi Arabian nationality, other findings discussed later in this chapter and the next reveal that differences in the degree of religious conservativeness in family backgrounds are relevant to an understanding of the experience of value conflicts by these student nurses. In this respect, Rokeach's theory is also shown to be helpful in explaining value formation, as this emphasised that values tend to form early in childhood, when families would be the main influence on them, and remain relatively stable over time. However, Rokeach's theory also acknowledged that values can also evolve or change. The identification of a range of influences on the formation of values by the participants might also help explain why these students have differing experiences of and responses to value conflicts, since although the sample is quite homogenous, individuals are also likely to have had different life experiences, for example in terms of education or exposure to other cultures.

5.4.2 Values as guiding principles

Participants defined and described their values in different ways which some referring to them as 'ethics' and 'principles'. However, the values were described, all participants agreed that they were important in guiding how they live and how they make decisions.

> My values and principles are what is directing me in my life … it is what helps me to take most of my decisions. (Baraa, Year 2 Interview)

> It is what give you the sense of what is right and what is wrong … basically it is what makes you a better person in treating and dealing with others. (Daad, Faculty Interview)

This interpretation of the role of values fits with Rokeach's theory (1973), which defined values in terms of beliefs that specific ways of behaving or outcomes are preferable to others. In general, the students conceptualised values in terms of those defined by Rokeach as "instrumental" values, or those relating to behaviours rather than desired end states, which he defined as "terminal values". As examples of these instrumental values,

students in both year groups described those which influence the ways in which they act towards other people, such as forgiveness, honesty, fairness and respect.

> I feel a personal value for me - and it is very important to me - is forgiveness ... Before I go to sleep, I always pray to God that I forgive all who is unjust to me and who spoke unfairly about me behind my back, and I can't live without it, without doing this every night. (Yara, Year 4 Focus Group)

> The things you see as right, like for example honesty - you feel it's something good ... devotion, these values which you feel should be in everyone. (Bushra, Year 2 Interview)

> Treating people the way I want to be treated (Kenan, Year 4 Focus Group)

Like the students, faculty members gave examples of personal values including transparency, honesty, and respect for all individuals. Daad, for example, gave the example of honesty, "*with yourself and with others*". The faculty findings also therefore suggest that participants viewed values in terms of what Rokeach defined as instrumental values, or the means of achieving goals, and not as goals in themselves, or what Rokeach called terminal values. The distinction is potentially important, as it suggests that there may be scope to influence the students' instrumental values in ways that avoid value conflicts but are just as effective in enabling them to meet their goals, such as the provision of high quality patient care.

Indeed, while many of the student and faculty participants discussed personal values in terms of behaviours towards other people in general, several related them specifically to nursing in terms of respect for patients and colleagues, demonstrating an awareness that personal values do affect the way that nurses carry out their roles. Their descriptions of these types of personal values appear in general to be well-aligned with the types of professional nursing values relating to patient-centred care that were identified in the codes of conduct discussed in Chapter 2, indicating that these types of values at least do not present the potential for conflict in the nursing context.

> To listen carefully and act not react accordingly considering their age and gender and their relation to me ... I must respect his psychological status, maybe he's been in the hospital for a while or something like that… (Arwa, Year 2 Interview)

> I respect both old and young people. It is my main principle to respect other people whether a young person or a doctor. (Maya, Faculty Interview)

In contrast to these types of perceptions of values, some of the participants instead cited behaviours such as adherence to rules and punctuality when asked about their personal values. This suggests that although these participants may have had a subconscious understanding of the role of values in their everyday lives, they did not conceptualise them as such but only understood them in terms of the ways they manifested in behaviours. For example, second-year student Arwa discussed the importance to her of dressing modestly in accordance with university requirements, as well as arriving on time to lectures, suggesting that she holds values such as modesty and integrity, but does not necessarily identify them as such.

> Respecting the rules; when I'm at the university I wear the appropriate clothing …. for example, punctuality in attending lectures and stuff like that. (Arwa, Year 2 Interview)

This point is reinforced by the discussions relating to religious values. When asked about their understanding of these, some of the student participants described religious values in terms of fundamental principles similar to their personal values, but others described religious values only in terms of their influence on behaviours, such as Islamic restrictions on diet and which hand to use when eating.

> I mean we do not eat pork, this is a religious value (Nahla, 2nd year Focus Group)

> I mean like I have to eat by the right hand and only from what is in front me, also this is from hadith. There is hadith about what to say before enters the toilet God bless you, that... In many things... (Sawsan, Year 4 Interview)

In a similar way, some of the faculty interviewees also religious values in terms of behaviours, for example relating to prayer and dietary restrictions.

> Religion means praying 5 times, believing that there is one God, not lying … honesty, giving a person his right, these are all religious values. (Alana, Faculty Interview)

> I think the things that are mentioned in the Quran and came from the Prophet (peace be upon him)… he explains it to us in a good way and direct like eating manners which is the food etiquette, the manners of everything: ablution, the prayer and these things. (Mayar, Faculty Interview)

One possible implication of this is that by conceptualising values in terms of behaviours rather than underlying beliefs or attitudes, some of the student nurses and faculty may

also lack awareness of the potential for value conflicts. Those student nurses who encounter such conflicts may then fail to understand the reasons for their negative feelings about such situations, and in turn will not be equipped to cope with these or seek appropriate support. Similarly, a lack of consciousness on the part of faculty members of the underlying values that drive behaviours, either personal or religious, may translate into a lack of sensitivity to the value conflicts that students may experience and a failure to offer the support they need.

5.4.3 Overlaps between Personal, Religious and Cultural Values

The participants identified a wide range of influences, including religion and culture, on the development of values. This meant that they often did not make clear distinctions between different types of value held by individuals. Rokeach's theory also did not distinguish between personal, cultural and religious values, and to a large extent this appears to be aligned with the perceptions of the participants, and the ways that values relate to the society of Saudi Arabia where Islamic values influence all areas of life. However, the lack of distinction between different types of values may also be a limitation of Rokeach's theory for use in understanding value conflicts and how to resolve these, as discussed later in the thesis.

Most of the participants in this study defined their religious values in terms of ethics, morals or principles, much in the same way that they had discussed personal values. The participants broadly concurred that, for Muslims, religious values provide the foundation and guidance for daily living and the ways in which individuals treat others, and are based on the Quran, hadiths (documented teachings of the Prophet Muhammad peace be upon him) or fatwahs (religious rulings issued by Islamic scholars). These values are seen as distinguishing Muslims from people of different religions, according to some of the participants, and as influencing many areas of daily life.

> The things that we have taught by the Prophet (peace and blessings of Allah be upon him)... Things in morality - this also can be ethical, but as we are Muslims it is religious first ... We treat people with kindness, and charity ... (Sondos, Year 4 Interview)
>
> Religious values are fundamental and if we don't have them we don't have morals. It is what makes us better humans. I think it is what gives us our principles that we follow. It is the reference we use if we are confused (Ayhan, Year 4 Focus Group)

Many of the participants also demonstrated a recognition recognised that in the fully Islamic society of Saudi Arabia, religious values largely determine or influence cultural values:

> I feel that the cultural values came from our religious foundations, in boundaries when dealing with people for example, we took from the religion, so like that I believe the cultural values came from the religion itself. (Kenan, Year 4 Interview)

> It may be that the cultural values we have in Saudi Arabia will be religious at the same time because the religion is always ordering us to do everything right and good (Baraa, Year 2 Interview)

When specifically asked to define and discuss cultural values, many of the participants gave responses indicating that they regard cultural values as being closely linked with, but not the same as religious values, since they may vary between different societies which follow the same religion. In this way, some defined cultural values in terms of habitual ways of doing things in a society, and as particular characteristics of a national or local culture. Both student and faculty participants emphasized that cultural values are primarily social traditions that are acceptable or required in society, but which vary even between different geographical regions of Saudi Arabia.

> Here in the hospital, you will find people not just from Jeddah, but also from the north; Medina and Makah, although it's the same country, each has their own culture. Things they do in their place. Things are usual to them, but to us they are not. And their way of speaking is different from us … (Ekram, Faculty Interview)

> Here in the Kingdom (of Saudi Arabia), we have the same culture, but when it comes to each city e.g. Riyadh, Jeddah or Eastern Province, you will find many (cultural) differences. (Nadeen, Year 4 Focus Group).

Some of the student participants identified cultural values that distinguish Saudi Arabia from some other Islamic or Arab cultures such as a strong focus on modesty, generosity and the overriding importance of the family.

> Decency and modesty Sure, I mean this is what distinguishes us...we are very strict in this more any other culture in general. (Baraa, Year 2 Interview)

> We have an example here in Saudi differentiate us in from others which is generosity. It is known about Arabs in general for their generosity but there is something also it is a very important one to differentiate us from the foreigners outside that we have the family is number one. They come first, meaning we can't live if we don't visit and see them minimum twice a week so they cannot survive without them. (Yara, Year 4 Interview)

These quotes seem to reflect a sense of the perceived distinctiveness and even superiority of Saudi Arabian culture compared with other Arab or non-Arab cultures. If this observation is accurate, the participants' sense of pride in their national culture may also have a strong influence on personal values, again reinforcing the point that there are close overlaps as well as differences between the different types of values. In relation to value conflicts, this finding may also mean that cultural values in which they feel a sense of pride might be strongly adhered to by the student nurses and might therefore be resistant to change if they clash with professional nursing values.

Conversely, cultural values perceived to be more detrimental in today's society were also identified, such as those that prohibit social interaction between unrelated men and women and the restrictions on women being allowed to drive (which have been lifted since this research was completed). The discussions reveal that values often associated with or attributed to the teaching of Islam are seen by at least some of the participants as being cultural or (socio-political) in origin, because they vary between Islamic societies or have changed over time and are not therefore based on the Quran.

> In Saudi Arabia, cultural principles are like that men and women are not to mix or to be in a social relationship. These are principles in Saudi Arabia that it is forbidden ... This idea still exists in Saudi Arabia. (Sanaa, Year 4 Focus Group)

> Like driving, for example, is not related to religion, it is not forbidden or anything like that, but we can say that government or politicians doesn't allow it. So, it is not related to religion but to politics (Warda, 4th Year Focus Group)

Some of the faculty interviewees also indicated that they do not necessarily agree with some of Saudi Arabia's cultural values which are not really based on religion. Illustrating this, Shadan for example gave the example of Islamic clothing requirements,

> Things that we do as customs and traditions, but it has nothing to do with religion ... Like wearing Abaya (the black cover) is a tradition only and we have to follow even if we are not satisfied with it ... of course there is a difference, there is a lot of things that religion tells us about and there are other things like cultural values - it makes you do things that are not in religion! (Shadan, Faculty Interview)

while Mayar referred to the conventions for addressing individuals within Saudi Arabian culture.

I call one lady by her name in a public place they consider it disgraceful, like they don't call you Hanadi – No, they will call you Yaseen's mother for example, it's disgraceful when I call some lady by her name! In fact this is my name and you are supposed to call me by it, so I think this is one of the cultural things I don't agree on but it's out there. (Mayar, Faculty Interview)

The overlaps between personal, cultural and religious values in Saudi Arabia as acknowledged by the participants suggests that it may be difficult to disentangle the impact of different factors on the experience of value conflicts in this setting, though important to do so in order to understand how to reduce the potential for these value conflicts. As noted above, these findings perhaps indicate that one of the main limitations of Rokeach's theory is its lack of differentiation between different types of values. The study may therefore be generating data which might be used in future modifications of this theory, especially to help explain value formation and change in Islamic societies where religious and cultural values dominate many areas of life.

5.4.4 Fluidity of Personal and Cultural Values

One of the differences that emerged between personal, cultural and religious values, based on the perceptions of the participants, was the extent to which these can change over time. First, a small minority of the student nurses expressed the view that all values are fixed and unchanging. In the case of personal values, one of the second-year interviewees explained, for example, *"that's my principle, I'm convinced about it. It will not change"* (Arwa, Year 2 Interview). However, many other second and fourth-year students acknowledged that personal values do change over time due to the life experiences of individuals or the context of their interactions. Their views were thus aligned with those of Rokeach, who argued that values in general which are established early in life tend to remain fairly stable over time but can also evolve or change abruptly as a result of various life experiences. As discussed in chapter 2, Rokeach defined ten distinct processes by which values can change over time (Creation, Abrupt destruction, Attenuation, Extension, Elaboration, Specification, Limitation, Explication, Consistency, and Intensity). The findings of the present study revealed many examples of value change among the student nurses which can be understood in terms of these processes, and these are highlighted where relevant in this chapter and the next.

In the second-year focus group, a general consensus emerged that personal values derive largely from one's family and upbringing, but that these can change later in life as a result

of other experiences. This is aligned with Rokeach's theory of value formation and change, since Rokeach acknowledged that personal values are not fixed but can change over time. Faculty member Alana similarly expressed the view that because of the range of influences on personal values, these vary considerably between individuals and can be formed or changed over the whole course of their lives:

> Personal values are values that are specific to a person, gained through his life, through his upbringing, from home, from the environment in which he grew up ... from religion ... (Alana, Faculty Interview)

In one example that is particularly relevant to the research questions of this study, second year student Baraa described how her life experiences have influenced her values over time, as she matured and particularly when she married. She explained this in terms of changing values regarding what is acceptable in terms of looking at attractive men.

> A long time before I got married, I had a point of view that it is normal to watch on TV or in the hospital nice looking men or doctors ... But after I got married I felt that this is cheating, even the eyes could cheat, I can't do it anymore. No matter what. I can't cheat on my husband with my eyes ... After I married my values strengthen, I became responsible more than before. Before, I was a girl who was still building up my values, growing my thoughts and developing my personality. (Baraa, Year 2 Interview)

It might perhaps have been assumed that after marriage the student nurses would become more comfortable interacting with male patients and colleagues than they were as single women with little experience of men other than their male relatives. Yet this quote illustrates the ways in which the personal value of modesty between the genders which is so important in the Islamic society of Saudi Arabia, can be strengthened after marriage and have the opposite effect. Again, illustrating the overlap between personal and religious values, the student discussed this as a personal value even though it clearly relates to this Islamic context. In relation to Rokeach's value change processes, Baraa's account might be conceptualised as falling within the *abrupt destruction* category, when a major event (marriage) has a transformative impact on existing values. Alternatively, it might be seen as a process of *limitation* when a value is modified because it has become incompatible with other dominant values, in this case the participant's respect for her husband.

The findings also revealed differences between the various categories of values in terms of participants' perceptions of whether they are fixed or more fluid over time. First, all of the participants indicated that they regard religious values as fixed, mandatory, and unchanging over time.

> You can't change religious values. Each religion has its own culture and it won't change even if the time or place had changed. It has the same core value since its existence and to this moment (Retal, Year 4 Focus Group)

> I agree with the others that the basis can't change. You can't say for example "It is okay to cheat today!" suddenly. There are foundations that can't change. (Warda, Year 4 Focus Group)

Most of the participants, however, indicated that cultural values, even those relating to religious conventions such as clothing or prohibitions on driving, can change over time: by definition, the fact that these can change appears to define them as cultural rather than religious values.

> There are some changes like how Hijab had changed with time and it became prettier. (Ayhan, Year 4 Focus Group)

Many explained this by explaining that cultural values as reflect the ways in which religious values have been interpreted and applied by others within Saudi Arabian society, and that they are therefore less critical to observe. Explaining the perceived difference between religious and cultural values in this regard, second-year student Amal stressed in her interview that although Muslims believe that basic religious values must be followed as a personal obligation, this is not the case for cultural values. She indicated that it is important to determine whether a cultural value is truly religious in origin when determining whether to do so.

> Religious values are constant and clear, obligated to follow – I mean to commit to it, there is no right or left it is fixed and straight and we don't have option to choose it … but cultural you are not committed to take it … The religious values sometimes correspond to cultural and sometimes they are not. In this case you go back to the origin of it, if its religious origin - continue and stick to it (but) if it's (of) cultural origin and that contradicts your personal values leave it. (Amal, Year 2 Interview)

Overall, the findings regarding the fluidity of values suggest that there may be scope for personal or cultural values to change if they come into conflict with the professional

values of nursing. The findings also demonstrate that, while the participants believe that religious values must be observed and do not change over time, some of the values commonly thought of as religious in nature may actually be cultural and therefore amenable to modification. nature. These findings have important implications for the development of recommendations for reducing the potential for or resolving value conflicts, since they suggest that there may be scope for the purposeful introduction of measures or strategies within nurse education which help ensure that the personal and cultural values of students are well-aligned with the professional values and requirements of nursing. They also have potential for informing future iterations of Rokeach's theories of value change, for example by expanding these to differentiate between different categories of values (personal, cultural, religious, professional) and to enable exploration of the inter-relationships between these.

5.5 Values in the Context of Nursing

In order to explore participants' understanding and perceptions of values in the specific context of nursing and the potential for value conflict in this setting, the research also investigated the student nurses' and faculty members' understanding of the nature of professional nursing values, and the ways in which their personal, cultural or religious values are perceived to have an influence on their roles as nurses. The sub-themes that emerged from the data in relation to this main theme are shown in Figure 5 and discussed in turn below.

Figure 5: Values in the Context of Nursing - Related Sub-Themes
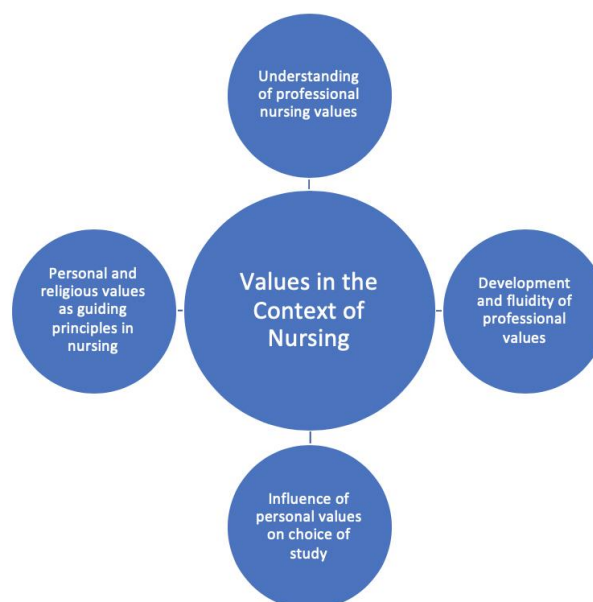
5.5.1 Understanding of Professional Nursing Values

The majority of student participants who discussed professional values described these in terms of nurse attitudes and behaviours towards patients, such as an emphasis on the rights of the patient in terms of privacy, confidentiality and respect:

> One of the professional values - I respect it honestly - which is respect (for) the privacy of the patient. I was shocked that even his name we should not mention it in the hospital, we should not talk about his condition outside his room. His file is not for anyone to see but his physician. (Amal, Year 2 Interview).

The student nurses and the faculty participants described professional values in broadly similar ways. Like the students, faculty participants emphasized the rights of the patient as being central to the professional values of nursing, and many of their responses indicated that they equate these with the ethics of the profession, such as confidentiality and honesty.

> First thing is the confidentiality …. The most important thing is to follow the ethics of the profession. (Shadan, Faculty Interview)
>
> Professionalism, satisfaction, autonomy, beneficence ... integrity, honesty … All of those are important in dealing with patients. (Maya, Faculty Interview)

It was noted by faculty member Alana that core nursing values are universally applicable to the profession, regardless of the geographical, cultural or religious context. Alana also argued that these are imposed on individuals working in this profession rather than developing within them as personal values do, a point which may suggest that there is often a weaker commitment to professional than personal values among nurses.

> International values that are specific professional values which we should follow. Like the honesty, the integrity, the cultural differences, the religious differences, the patients' preferences ... I am not the one who specified it, (it) may be specified by the environment of the clinical or whatever health sitting, but it is connected to the community and connected to the family and linked or related to the whole country (Alana, Faculty Interview)

These findings provide some evidence that the student nurses have an awareness of the types of professional nursing values as they are articulated in the types of codes of ethics or codes of conduct discussed in Chapter 2, although they did not refer specifically to

these codes and appear to have little knowledge of their existence, as discussed later in the findings chapters. The examples they gave were therefore very similar to those also identified as personal values, such as respect for others, but applied in the nursing context. Although reference to specific codes of professional conduct were lacking, fourth-year student Reham did refer to the role of policies in defining the professional values of nursing. She made the point that professional values must be prioritised these over personal values in the workplace:

> "The professional values are what we should always follow, the policies that we have to follow rather than the personal values" (Reham, Year 4 Focus Group),

It was not made clear by this student exactly which policies she was referring to, and it must therefore be inferred that she was speaking only in general terms. One implication of her comment, however, is that if students actually held this view about the priority of professional values in the workplace, there would be little scope for value conflicts to arise since professional values would always take priority. In fact, the evidence of value conflicts as reported in Chapter 6 indicates that the true situation is far more complex.

A further interpretation of these findings is that the strong focus on patient rights in many of the participants' conceptualisation of professional values may perhaps help to explain why value conflicts might arise when patient rights clash with the personal, religious or cultural values of nurses or their professional rights to administer care. This can be interpreted in terms of Rokeach's self-confrontation process, in which negative feelings arising in particular situations are the means by which an individual becomes aware that they hold value conflicts relating to that situation, and which are the necessary first stage in modifying or changing one or more of their values so that they are more congruent.

In a comment which might help to illustrate the existence of underlying value conflicts, faculty member Mayar highlighted that professional values are not always followed by all nurses; indeed, she indicated that she often sees examples of nurses failing to observe these values, an observation which perhaps suggests that they are not well aligned with their personal priorities and values, or alternatively that they do not hold values such as integrity and honesty which were highlighted earlier as being important to some of the student participants in this study.

> Some people will be like "ok I learned about it but in fact I don't apply it!" Like the confidentiality, caring for the patient's privacy, I mean everybody knows what

the privacy is and what the confidentiality is but they don't apply it! (Mayar, Faculty Interview).

5.5.2 Development and Fluidity of Professional Nursing Values

The faculty participants were also asked how the professional values of students change or evolve over time, to help generate insights into the relevance of Rokeach's value change processes as well as understanding of how positive processes of value change might be promoted.

Mayar explained that most students arrive on the course with very little knowledge or awareness of professional values, but that they come to understand these through the ethics training that is provided over time on their course. She also referred to a leadership course covering ethics that is delivered to students in the fourth year of training. This is an interesting finding, since her account of the ethics training delivered to students is somewhat at odds with the accounts of both students and other faculty members, and supported by the findings of the documentary analysis (Chapter 7) which indicate that very little ethics training is included in the nurse curriculum.

> In the second-year when the student comes they don't know what the ethical values are, nor do they know what the professional values are. So you start giving them little by little because after that in their fourth-year ... they will take a leadership course, it's a complete course about the ethical part ... we make her ready and prepared when she actually handles patients in the internship and after graduation. (Mayar, Faculty Interview)

More generally, the faculty participants broadly concurred in their interviews that students build professional values over the course of their studies, as a result of factors such as work experience, observing other nurses, and formal ethics training. Although Rokeach did not specifically distinguish professional from other types of values in his theory, the processes described by the participants were broadly in line with this theory, which acknowledged the influence of education and life experiences on value formation and change. In terms of his ten theoretical processes of value change, it might be inferred that creation, attenuation or limitation occur as students undergo their nursing education and are gradually socialised into this profession, with some of their existing values which are not well aligned with nursing being weakened, while new professional values are developed and strengthened.

One participant observed that as these professional values are adopted, some of the students who did not necessarily choose nursing voluntarily gradually come to enjoy their studies or career, while a faculty member also observed a similar process of value change among student nurses.

> In the first year, the student still has certain values as the personal values, when she goes to the hospital and know more about the job and the professional values, she will be changed by the fourth-year. (Maya, Faculty Interview)

> Some people do not love nursing, but while time runs they change and it turns out they love it. (Ekram, Faculty Interview)

These comments suggest that professional values can indeed play a key role in socialising students into the nursing profession, and highlights the importance within nurse education of teaching or demonstrating these professional values to students. Nonetheless, as reported earlier, the extent to which they are observed by individuals varies, perhaps as a result of the additional impact of personal values (which are also influenced by culture and religion) on nursing behaviour. If these professional and personal values are not well aligned, there will be potential for value conflicts as explored in the research findings that are discussed in Chapter 6.

5.5.3 Influence of Personal Values on Choice of Study

The student nurses also discussed the ways in which their values were perceived to relate to the nursing profession. One of the main themes which emerged was the influence of personal, cultural or religious values on their choice of nursing as a career, among those participants who had voluntarily chosen this field of study. Several emphasised ways in which they hold values such as caring and respect for others, which are well aligned with nursing and led them to choose this particular degree. For these students, it might be expected that the potential for a clash between their personal and professional values might be quite minimal. For example, one second-year student explained:

> I felt that it fits my personality and with my values .... I'm a person who likes to give, especially because I like taking care of things, which means I like giving care and attention, I felt it's the right role for me to be a nurse, I felt it fits and connects together in a lot of things - as we said, giving, respecting others (Basmah, Year 2 Interview)

In the fourth-year focus group, a general consensus also emerged that there is a connection between one's personal values and choice of nursing as a career and that most of the participants held values aligned with nursing, as illustrated by the following excerpts of the discussion:

> Yes, there is a huge connection! (Yes!) (Of course!) (Definitely!) (various participants) ...
>
> We won't choose this faculty if there was not a connection. (Zaina)
>
> Nursing is a humanitarian career! Morals and values are a necessity. (Warda)

Like the students, faculty participants also recognised that some students enter nursing because it is perceived to correspond closely with their personal values. Shadan explained why some students even choose nursing over other fields of medicine because of the opportunities this profession gives them to fulfil their personal values such as providing personal care to other people.

> There is small group that really loves nursing because she knows it is supporting her goals you know! That they want to give and care for people and love to serve people ... so they choose the nursing and do not choose medicine because of this! Because they feel that they are close, they will be closer to people more than when I am a doctor. (Shadan, Faculty Interview)

However, Shadan as well as several other faculty members also stressed that many students known to them do not enter nursing because of their personal values but are forced to do so because they have not qualified for other specialist areas of medicine or healthcare. Just one or two of the student participants in this study indicated that their decision to enter nursing had been a constrained choice, or that they had little awareness of what nursing would actually involve before enrolling on the degree course.

> Only available choice related to medicine (Sara, Year 4 Interview)

Despite this finding, some of the faculty members expressed the view that a large number of students on the nursing degree did not voluntary choose this degree.

> Most of them to be accurate are forced (into) nursing. It is not their choice. (Shadan, Faculty Interview)

There was relatively little evidence of this from the student interviews and focus groups, but it might be expected that students who are reluctantly studying nursing may have been less likely to have volunteered to take part in the research. Even Sara, quoted above, appears to be satisfied with her field of study and is now in the fourth year of her degree. Nonetheless, the student interviews and focus groups did provide further indirect evidence of this issue when the participants discussed their awareness of other students who had not voluntarily chosen nursing as a field of study. The following excerpt from second-year student Nada's interview reveals the ways in which this is perceived to manifest in the demeanour and in the actions of different nurses depending on whether their personal values are aligned with the profession:

> You always see for example two nurses, one does her work with love and kindness while another one does not and might mistreat her patient, she give without willingness. Her face, in short, not smiley this is for sure reflecting her values, maybe that what she is in all her life and this naturally will affect her profession. (Nada, Year 2 Interview)

These findings suggest that there may be two distinct categories of student nurses at the case study institution: one group whose personal values are well aligned with the professional values of nursing and who voluntarily chose this profession, and another group who entered nursing more reluctantly due to constraints on their career choices, and who might potentially encounter conflicts between their personal values and those of nursing. The scope to explore this specific point is limited since the findings relating to the second group are almost entirely indirect, based on secondary accounts about student nurses who were not participants in this current study. However, the data relating to the experience of value conflicts among the research participants also indicate that the true picture may be more complex than this dichotomous conceptualisation, as discussed in Chapter 6.

5.5.4 Personal and Religious Values as guiding principles in nursing

Findings also emerged from the student interviews and focus groups regarding the ways in which the students' personal or religious values have an influence on the ways in which they carry out their nursing roles, reflecting the ways in which Rokeach defined instrumental values as beliefs that certain ways of behaving are preferable to others. Their experiences might also be interpreted in terms of Rokeach's specification process, in

which specification, whereby a generalized (in this case, religious) value is increasingly defined within particular contexts in which it is defined (in this case, nursing).

Both second-year and fourth-year students commented that it is important to have strong values in general in order to work effectively as a nurse and give patients the care and respect that they deserve. Baraa, a second-year student, noted that this is especially important since nurses often work alone without supervision and their behaviours will therefore be guided by their values.

> When I have values I will give the patient his rights; there is no one with me in the room to watch me, be afraid for the patient and care about him …. Well sure I won't hurt him. I will not pass him infection, I won't give him medicine while I am not concentrating! (Baraa, Year 2 Interview)

A fourth-year student, Kenan, explained on the other hand that her values lead her to treat all patients as if they were a beloved member of her own family.

> (When) I'm with the patient and when I'm treating them … I always imagine - especially if they were elderly – like, God forbid, they are my mother or father. So for sure I'll treat them as I treat my family. (Kenan, Year 4 Interview)

In this context, examples of what were seen as Islamic values, such as an emphasis on honesty and integrity and on serving Allah at all times, were regarded by the participants as being closely aligned with nursing. These were perceived to have an influence on the way at least some of these student nurses perceive their roles, and in helping to ensure that they carry out their work in accordance with these religious values. The following interaction from the second-year student focus group illustrates the ways in which this is understood by the participants, with the key points being the awareness that everything they do is being observed by Allah and that it is crucial to do everything to the very best of their abilities in order to please him.

> The simplest thing I can say is that Allah sees us all the time… I would be more fair and honest. I would not discriminate and I will treat everyone with conscience so I can be satisfied with myself. (Samar, Year 4 Focus Group)

> First, one of the most important values in Islam is to try to perfect anything you do! That is a value that affects me and my relation with Islam. The second point is that I would not start something unless I can do it right. (Nadeen, Year 4 Focus Group)

I will apply beneficence. I will do everything like Allah… Yeah, like "worship Allah like you see him…" (Nuha, Year 4 Focus Group)

"If you do not see him, he sees you." (Nahla, Year 4 Focus Group)

So I want to apply that to all the patients and that would makes me do well. (Nuha Year 4 Focus Group)

The perception of nursing as a way to serve Allah and pursue religious values was also reflected in some of the individual interviews and provides strong evidence that these participants regard nursing as being congruent with Islamic values. For example as explained by second-year student Amal:

> This so linked to my personal and religious values … there is hadith[3] - I can't memorise it - but it means that you are rewarded even if you made a Muslim happy or smile, if you allow the happiness enter in their hearts. I mean as nurse you are not only making the patient happy, you are helping him in his hardest situation and time, being with him, treating and caring for him. (Amal, Year 2 Interview)

Indeed, many participants stressed the importance of Islamic values in distinguishing Muslim Saudi Arabian nurses from foreign nurses who do not share the religious and cultural values of their Muslim patients and are therefore unable to provide the same level and type of care. In the second-year student focus group, for example, Nahla gave the example of offering up Islamic prayers for a dying patient, something which foreign non-Muslim nurses are unable to do in this setting.

> Our personal values as Saudis differ from the foreign nurses .... Our relation with the patient or the staff will be different from them ... I will tell (the patient) to say the Muslim declaration of faith as these are our values in our religion, but those who come from abroad have no such a thing, so there is a difference between us and them. (Nahla, Year 2 Focus Group)

Several of the students also stressed that as Muslim nurses they personally benefit from the nurse-patient relationship through the prayers which their Muslim patients offer for them in return for nursing care, as explained by both Ayhan and Saja in the fourth-year student focus group.

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[3] Words and teachings of the Prophet Muhammad.

Filipino or other nurses want to work so they can send money back to their countries and that is not the case with us we treat patients not because we just need to and we have to go to another quick! You held her hand, she pray for you; you comfort them with a pat. We treat every patient like a part of family. (Ayhan, Year 4 Focus Group)

They (patients) pray for you and it motivates you to do more. (Saja, Year 4 Focus Group)

5.6 Chapter Summary

The findings discussed above have highlighted the ways in which the students' personal and religious values are perceived to be aligned with their role as nurses treating Muslim patients. They show that there is generally a close alignment at least among students who voluntarily chose nursing and that, as has been found in previous studies (e.g. Lovering, 2008), at least some of the student nurses largely define their nurse identities in religious terms. These are perceived to distinguish them from foreign nurses who they believe often give incomplete or insufficient care to Muslim patients, by not attending to their spiritual needs and providing the holistic care they expect. The importance of this finding with regard to the current study is that it demonstrates the compatibility of Islamic and professional nursing values and provides possible insights into ways in which conflicts between them may be overcome, as discussed later in the thesis.

The following chapter presents the findings relating to the experiences and perceptions of value conflicts by student nurses at the case study institution and the individual and organisational responses to these. It also notes, where relevant, how these relate to the theoretical framework of the study based on Rokeach's theory and the specific value change processes defined in this theory, points which are later expanded on in the discussion of findings in Chapter 8.

CHAPTER SIX: FINDINGS RELATING TO VALUE CONFLICTS

6.1 Introduction

This chapter presents the findings relating to the student and faculty participants' experiences or perceptions of value conflicts in the nursing context. First, the findings relating to their general understanding of value conflicts and the potential for these in nursing are presented, followed by discussion of the main types of value conflicts experienced by the student nurses that were identified in the study. After this, the various responses to these conflicts on the part of the students nurses and at organisational level are presented and discussed. Throughout the chapter, references are made to relevant aspects and components of Rokeach's theory of value change, where these were found helpful in describing or interpreting the reported experiences of the participants (for a recap of the main components of this theory as they relate to the present study, see pp. 140-141.

6.2 Forms of Value Conflict Experienced

At the outset of their interviews some students appeared to believe that their personal (cultural and religious) and professional values are well aligned in general, and did not have the perception that major conflicts would rise between their personal and professional values. For example, second-year student Amal said:

> Depending on the personal values if they are right then they will be compatible with the professional values. I mean honestly nothing in my mind to show where my professional value doesn't match my personal value... (Amal, Year 2 Interview)

This seemed to be particularly the case for second-year students who only had limited practical experience of nursing and had not yet encountered many situations in which value conflicts might arise. As the interviews and focus group discussions progressed, however, these indicated that most of the student participants actually did acknowledge that there might be times when their personal/religious and professional values might come into conflict in nursing. Additionally, many expressed an awareness that more severe value conflicts might be experienced by other Muslim student nurses from more conservative backgrounds than themselves. Some recognised that value conflicts could well arise later in their career when they would be faced with more challenging situations. In the second-year focus group, for example, Ruba observed:

> We (are) still at the beginning of our career. I do not think that everyone had faced those kinds of conflicts. The one that consumes you like you mentioned. (Ruba, Year 2 Focus Group)

Evidence of three main types of value conflicts experienced by the research participants emerged from the thematic analysis which appeared to have been extensively experienced by many of them. These related to 1) the provision of nursing care involving delivery of personal care to males; 2) the need to communicate with male patients and male medical colleagues; 3) conflicts arising from the poor image of nursing in Saudi Arabia. Additionally, evidence of two additional conflicts emerged which were less commonly reported.

The fourth type of value conflict identified in the study arose in relation to hospital practices or policies that the students do not agree with. Although reported by a minority of participants, this is reported here as it reflects the type of conflict widely reported among student nurses and newly qualified nurses in the literature.

The fifth type identified consisted of conflicts between personal and professional values among students who did not voluntarily choose nursing and are not happy in their studies. However, this form of value conflict was mainly reported indirectly by the faculty participants regarding students who were not participants in this study, and not from the direct first-hand experience of the student nurse participants.

The following sections present and consider the findings relating to each identified form of value conflict, followed by discussion of the ways in which students and the case study organization respond to such conflicts. Greater attention is paid to the first three types of value conflicts, which relate specifically to the situation of being a female Muslim nursing student in Saudi Arabia and are most relevant to the study's research questions. There was also a great deal more research data generated in relation to these than the final two types of value conflicts, which are discussed more briefly in order to consider their relevance in the context of previous literature and the research questions. The sub-themes which emerged from the data relating to the experiences of value conflicts in nursing at the case study institution are also shown graphically in Figure 6 below.

Figure 6: Forms of Value Conflict Experienced - Related Sub-Themes
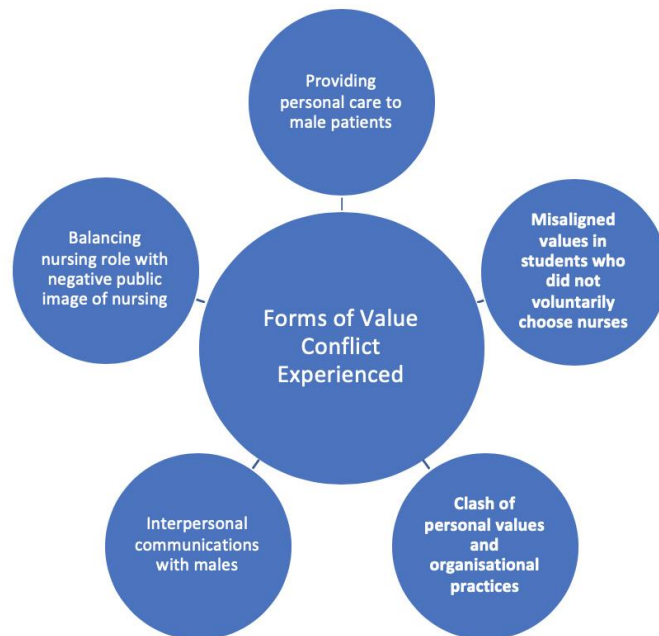
6.2.1 Providing Personal Care to Male Patients

Experiences of this conflict

The essence of professional nursing, as defined for example in the codes of conduct discussed in Chapter 2, involves the provision of the highest quality care for patients. Such care may often require exposure of all parts of the patient's body, including those private areas defined as "awrah" in Islam. All of the student nurses would at some stage be required to carry out such tasks, but their responses to this situation varied considerably.

Overall, exposure of male awrah was the most commonly cited situation causing a value conflict, which all of the student participants reported experiencing to at least some extent. The conflict arises between the religious/cultural values in Saudi Arabia that prohibit women from seeing the private parts of the opposite gender (*awrah*), and professional values of nursing (e.g. "*You make their care and safety your main concern*", NMC, 2015) which support giving the necessary care to a patient and may therefore

require exposure of male awrah, for example to insert a urinary catheter or bathe the patient.

The issue of exposing male awrah provoked quite extreme negative reactions and emotions from both 2nd and 4th year student nurses. The type of emotions or reactions that the student nurses reported experiencing in these situations included shame, embarrassment, shock, trauma, and shyness.

> 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)

Fourth year student Yara recounted an incident in which she had to give an injection in a patient's buttock while accompanying a more senior nurse and described how flustered and embarrassed she felt for both herself and the patient and how hard she perceived that the situation was for both of them. The example demonstrates the extremely negative emotional impact of this situation on the student nurse and how this conflict can affects the delivery of care to patients, even though there is no direct evidence that the patient actually felt the way imagined by the student nurse.

> I entered the patient room, I was embarrassed to be the nurse and that is the point that I forgot to introduce myself. I said I am the nurse and I will give an injection! She (senior nurse) was the one who told him that who we are exactly and what we are going to give him … Poor man he did not say anything but why I felt that embarrassment increased because of me. it was me who said it in Arabic, I told him to lower his trousers in Arabic … Poor man, he did but even it was not exposing the quarter that I should inject. So the nurse lowered it properly to expose the area where I suppose to inject and poor man he was holding his trousers but I said to him don't worry I will hold it for you, I mean, I will cover you and inject it quickly without you feeling. I was trying to ease the tension … how did I feel … I am stressed! Because 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, to that extent I was too nervous, my hand was shaking in an unbelievable way and the worse feeling was increased when I have to rub, I mean honestly I was so ashamed. I felt so bad for myself and for him. (Yara, Year 4 Interview)

Yara, a married woman, stressed the severely negative psychological impacts on her of even the idea of having to expose male awrah, to the extent that she might even consider withdrawing from her nursing degree. She also stressed that this situation is much more difficult for single nurses, who are not used to seeing male genitalia.

> It is not ok! It is not acceptable! Haram. Ok, so in our religion we are forbidden but it is my work! my work but I can't', I can't … for me it is a huge issue as married woman, I mean so difficult and how is it for the (single) girl who never saw or not… And required to do this thing? I mean I feel it is very, very hard for her .... I think it will have an impact on my psychology ... I don't know if I can tolerate it … I could have shock, it will give me a psychological shock and feel psychological trauma and I will change my mind about taking nursing ...   (Yara, Year 4 Interview)

These findings revealed the ways in which this situation presents a personal dilemma or conflict for these student nurses, in that they recognise that providing this type of care to males is sometimes inevitable in nursing, but also struggle with their personal feelings and the belief that Islam prohibits them from doing so. Use of terms such as "embarrassing", "hard", "tough" and "afraid" convey a real sense of the extent to which these participants are suffering mentally from the value conflict they face in this situation. However, though these findings highlight the negative impacts of value conflicts, they can also be seen as an essential aspect of the self-confrontation value change process described by Rokeach. As discussed in Chapter Two, Rokeach explained that individuals are often unaware that they possess values which contradict one another, and experience a sense of discomfort when this is brought to their attention, for example as in the case of the nursing students in this study who are for the first time required to provide personal care to males. According to Rokeach, the negative feelings experienced when individuals become aware of their conflicting values are necessary processes of change to occur which lead to more congruent and aligned values, in what is referred to as the self-confrontation method.

In most of these cases, however, it seems that the nursing students in this study were not yet aware that their negative feelings regarding exposure of male awrah were due to a value conflict. Although it may seem strange that the student nurses are having these kind of reactions to what might be seen as routine nursing tasks, this situation can arise because many Saudi women are not aware of what is actually involved in nursing until they begin their training, as discussed later in this chapter. Their experiences therefore might be

explained by the concept of "reality shock", as first used by Kramer (1974) to explain the difficult transition that many student nurses often experience when they discover what is actually required of them as nurses (see Chapter 2). Some students even reported that they were considering giving up nursing as a result. Any resulting attrition from the nursing degree would be serious not only in terms of the current nursing shortage but also the wasted resources that were invested in training students who subsequently leave the course or the profession, and in the potential impacts on the individuals who had already invested personal time and energy in the nursing degree program.

Evidence of these reactions to exposing male awrah were present both among relatively inexperienced second year students, and fourth year students who would be likely to have had more experience of such tasks. This suggests that exposure and familiarisation to the tasks is not necessarily effective as a means of modifying the cultural or religious values which come into conflict with professional nurses values in these situations. In other words, there is little evidence in these situations of the creation, attenuation or limitation value change processes defined by Rokeach, in which values are either developed in relation to a new situation or weakened or modified in the presence of more dominant values.

To an extent, it is perhaps unsurprising that the students are uncomfortable with such tasks, since even some of the faculty members mentioned that they also struggle with these requirements of their nursing role and will avoid exposing male awrah except as a necessity in emergency situations.

> 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)

This perhaps suggests that this type of conflict arises at least in part from cultural rather than religious factors per se, since Ekram is clearly aware that this type of care is allowed, at least in emergency situations, but remains uncomfortable when required to provide it.

Not all of the faculty members interviewed reporting feeling this way; others expressed a more pragmatic approach to dealing with this conflict. For example, faculty member Alana argued that there is a need for nurses to focus on the medical requirements of the patient and not over-think the situation in ways that consider cultural or religious factors

and are likely to cause internal dilemmas. At the same time, Alana also draws on religion to support her position, by stressing that there is nothing in Islamic teachings which indicate that carrying out such tasks are prohibited or punishable.

> The main problem is the over interpretation this what causes the conflict. I mean to sit and analyse the issue, is it halal or not, Haram or not, allowed to do for male or not, is this emergency or not. Is there an evidence in the Quran or Hadith to say if there is no male so female can do...? No, no, don't do this. This what I mean over interpretation. There is nothing to say if you didn't help a person you will be in hell or punished! Those who do over- interpretation are the ones who get tired and struggle! (Alana, Faculty Interview)

Factors contributing to this conflict

Although the fundamental reason for this type of conflict appears to lie in the clash between religious values and teachings, the research data revealed a more complex mix of factors which contribute to the experience of value conflicts in this area by the student nurses and the perception of these by faculty.

Sawson's mention of shame and Kenan's reference to embarrassment in the quotes included in the previous section suggest, for example, that the reactions of these students might be at least partly cultural rather than religious in nature, since shame and embarrassment generally reflect concern about the views of others in society.

On the other hand, Sawson's references to discomfort and fear may also indicate the influence of religion, since these emotions may reflect an unease at carrying out tasks which are prohibited (haram) under Islam and fear of the consequences of doing so. Likewise, use of the term "haram" (forbidden by Allah) by both Yara and Alana indicates that these participants are suggesting that the conflict is between religious and professional values. At the same time, by acknowledging how much harder this situation is for a single girl who has never seen male private parts before, Yara was also apparently indicating that part of the reason for the conflict is a lack of familiarity with the situation, rather than religious prohibition of the situation per se. These findings demonstrate how difficult it is to disentangle the respect impacts of religious and cultural factors on the value conflicts faced by the research participants, since religion and culture these are so closely interlinked in Saudi Arabia. The complexity is revealed further in the following extract from a fourth-year student's interview, who was first asked hypothetically whether they felt that a student's mother would refer to exposing male awrah as

"disgraceful" or "forbidden" (Haram). Having argued that she would say it is "disgraceful", Kenan went on to express her confusion in the following way, acknowledging that Islam allows the exposure of male awrah but that she still cannot accept it and cannot fully explain why.

> I mean this situation is really embarrassing, if there is someone else to do it, why not? Why it must 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, … meaning like it doesn't have to be religion, but I don't know how to tell you, it's complex between ethics and religion, I don't know. (Kenan, Year 4 Interview)

Comments made by many of the other student nurses and by some faculty participants also demonstrate an awareness that Islam does not prohibit the exposure of male awrah in the medical context, suggesting that cultural rather than religious factors are indeed playing a role in relation to this type of value conflict. Yet even these participants, while on the one hand acknowledging that the task is acceptable within Islam, also indicated in their interviews that they could not accept it for themselves.

> 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)

> I feel that it is not haram because I am helping him ... I feel shame more than it is haram, that I am not used to seeing this thing. But in religion it is ok, normal - I mean since he is sick and needs help ... In childbirth also it's normal that male doctors are helping women, in religion it's normal. (Sawsan, Year 4 Interview)

Once again, the types of negative feelings described by these participants may reflect the first stage of the self-value change process described by Rokeach, when individuals feel discomfort in situations in which their values come into conflict (see p.167), though the participants had apparently not recognised this in terms of the need to realign their values in order to overcome the value conflicts being experienced.

Another clue pointing to the influence of cultural factors on this value conflict is that some participants mentioned that other student nurses from strict or conservative families find this type of value conflict more difficult to deal with, and that some even leave nursing when they discover that it may be required of them. This suggests that it may be

a student's upbringing and the attitudes of their families and friends, rather than religious considerations per se, that influence their reactions to these requirements of their nursing role.

The research findings suggest that value conflicts are sometimes experienced by the student nurses in this type of situation not because of their own embarrassment but because they have an acute awareness or at least perception (which may not necessarily be accurate) of the feelings of their male patients about exposing their awrah to a Saudi nurse. Being from the same religious and cultural background as their patients, the student can relate to or imagine their perceived concerns or embarrassment. Incidents were reported involving tension in the patient-nurse relationship for this reason, or when patients refused to be treated at all by a Saudi nurse.

> There are so many (nurses) in the hospital … when the patients know we are Saudis they tell us that they want an Indian or Filipino nurse (Retal, Year 4 Focus Group)

> This area is private ... so we will be very embarrassed if someone has to deal with it or expose it. (Amal, Year 2 Interview)

According to the participants, some male Saudi Arabian patients prefer a nurse of a different nationality even if she is Muslim. Since the research did not investigate the attitudes of patients directly, it is difficult to interpret this accurately, but other findings suggested that discomfort often arises on the part of both male Saudi patients and female Saudi nurses since they share a culture and are familiar with its taboos relating to contact between the genders.

> I am the daughter of his town and he is sure knows that my religion is like his, we share the same values and expectations, he is a million percent sure about the way I feel is exactly the same he feels ashamed and not willing. You could imagine what would be the tension in the room and how much it is stressful for both of us. (Yara, Year 4 Interview).

Yara as well as second year student Amal explained that foreign nurses are likely to be more comfortable about exposing male awrah, and that their attitudes are more likely to put male patients at ease.

> If the nurse is foreign, he knows that she is not having the same religion or values and this is her job, he needs an injection then he might have been able to accept

> it. He will have half of the stress as he is not putting the nurse in the pressure to feel the struggle like his own country nurse …I mean yes we don't know how she feels but at least … she will not say Haram for example! (Yara, Year 4 Interview)

> Let us say that there is a patient and you are hesitant to deal with him because he is a man, he will feel it! This feeling is exchanged between us without talking. I mean I am hesitant and he feels it, both of us are not happy, he will be uncomfortable and (this) could make him refuse me, if there is a foreigner nurse he will prefer her of course because she deals with him naturally and more spontaneously. (Amal, Year 2 Interview)

Faculty member Daad observed that there are a range of possible reasons why Saudi Arabian men might refuse a Saudi nurse, but that these include awareness of a shared culture.

> Our native people they are not used to our Saudi nurses ... there is misconceptions, that you are under training maybe you don't know exactly how take the blood pressure. This is one option. The second one is that no you are Saudi and my country girl so call somebody else, the third one yes you are a female and I don't want you to touch me because of so, and I am not sick and I am not in emergency so ask somebody else! (Daad, Faculty Interview)

In Saudi Arabia "my country girl", the expression used by Daad, is a term often used by Arabs to show respect to women. Daad's second suggestion may therefore reflect the perception that male Saudi Arabian patients believe nursing is not an acceptable career for Saudi Arabian women. This point may also be relevant to Daad's third suggested reason, in that since the patient is not in an emergency situation it is not seen as necessary to accept care from a Saudi female nurse.

The type of value conflict experienced by female Muslim student nurses when required to expose male awrah can therefore be regarded as the other side of the coin to the finding reported in Chapter 5 about the advantages of sharing religious and cultural values with patients. The data indicated that the exposure of male awrah is a complex situation in which both nurse and patient are uneasy due to their knowledge of the religious and cultural barriers involved, and that their respective discomfort adversely affects the other.

Many of the students acknowledged, however, that a male patient's response to a female Saudi nurse will depend on his own level of need or characteristics. For example, they indicated that older patients or those in greater need of care are not likely to be so concerned about being cared for by female Muslim Saudi nurses.

> Depending on the patient, there (are those) who could find it ok and normal for them and there are people that (it is) not ok for them … Especially elderly people - it does not matter with them. (Baraa, Year 2 Interview)

> I feel like if he was too tired it will not make a difference for him, or if he was at the hospital for while of course he will be used to it, and it will not make a difference because thinking about his situation, about his sickness, I mean (if) he is in a bad condition, he won't be thinking there will be a female who will do the check-up …. (Arwa, Year 2 Interview)

This finding again demonstrates the impact of cultural rather than strictly religious factors on this type of value conflict, since the way in which it is experienced depends largely on the context and the individuals involved. It also reinforces the point that exposure of male awrah is understood by at least some student nurses to be allowed within Islam if there is a medical need for it. Promoting greater awareness of this might therefore be a way of reducing the potential value conflicts, as discussed in Chapters 8 and 9, though it must also be acknowledged that greater awareness of the tasks involved in nursing might also increase tensions between the student nurse and their family members.

A related issue which came up in fourth-year student Sanaa's interview was that a male patient's wife, rather than the patient himself, might not be happy with a local nurse providing personal care to her husband because of the religious and cultural restrictions relating to this.

> I think that his wife would not allow it. 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)

Sanaa explained this by initially referring to the Islamic rule that Muslim Saudi women are not allowed to see the genitalia of males other than their husbands or young children, yet went on to stress the cultural taboo rather than the religious prohibition. This again demonstrates how cultural and religious values overlap in Saudi Arabia and the difficulties of disentangling them in the minds of the student nurses, perhaps also demonstrating the need to build on Rokeach's theory with more advanced theoretical frameworks which distinguish between different types of values.

In contrast, however, second-year student Baraa, indicated that she felt this situation would not cause a problem since the patient's wife would just regard the actions of the

nurse as normal medical care, encouraged by the professional approach of the nurse herself. However, as a second-year student her comment was made hypothetically from a position of relative inexperience, it is not known to what extent she would indeed deal with the situation in a professional way in practice.

> First of all … I am a nurse and I will not be dealing with it as a private organ, no, as a normal body part, it is like a hand. Do you understand, this will make it something easy and she won't notice it… I will show her that this thing is normal/regular care. (Baraa, Year 2 Interview).

Indeed, both the student interviews and focus group discussions as well as the faculty interviews revealed that the university is not preparing or training students to deal with this type of situation or even to treat male patients in general. It emerged that not only do the student nurses have very little clinical exposure, especially in the early years of their training, but also that throughout their education they only practice on female dummies, and receive very little training at all in the care of male genital areas.

> They have not taught us accurately .... 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)

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

One faculty member highlighted in this respect the restrictions faced by the College of Nursing on access to university facilities such as the simulation lab, which are available to other medical students.

> 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)

6.2.2 Interpersonal Communications

Experiences of this conflict

The second type of conflict identified in the study arises because Islamic or cultural values in Saudi Arabia prohibit close contact or interaction between unrelated individuals of

different genders, while an adherence to nursing values require close interaction not only between female nurses and male patients but also between female nurses and male medical colleagues. Both the student nurses and the faculty participants indicated that this is a type of value conflict frequently experienced by the Muslim student nurses in this case study.

Many of the research participants expressed quite severe levels of discomfort and awkwardness at the idea or the reality of having to communicate either with male patients or with colleagues, again perhaps reflecting the first stage of the self-confrontation value change process described by Rokeach in which uncomfortable feelings are essential for acknowledging the existence of a conflict within oneself and eventually experiencing re-aligning of one's values to overcome this, in ways illustrated by Rokeach's ten value change processes (see Chapter Two, p.21). However, some of these participants were already in their fourth-year of training but still reporting these types of difficulties. The following interview quotes from fourth-year students Yara and Sanaa reveal the nature and severity of the internal conflicts that they face in relation to these aspects of their nursing role.

> I feel shy to enter the patient room. I don't know what to say! And what if I talked and he misunderstood, I am not confident of what to say and how. But who will do the job if I didn't. So that there is a struggle between me and myself to go or not, I have to take the blood pressure and his temperature. (Yara, Year 4 Interview)

> My environment does not allow me to do it, but my job requires for example interacting. So, it is a mental conflict ... To this moment I cannot really deal with the other gender. I do not speak fluently like I am talking to you right now. I get shy for a bit .... I think that it is the culture. The environment that I live in is not like that. So, I cannot overcome it easily. (Sanaa, Year 4 Interview)

Some were a little more comfortable about communicating with males, as shown by the following quote from a married second year student participant, who argued that as long as she remains professional, she feels confident about interacting with male patients and colleagues.

> I don't have a problem with mixing! I don't mean that what people think about mixing are wrong … I mean yes, there are some not so good people and those are the one sending the bad image, but ... my goal is I'm going to work, I mean I'm practicing my profession so I feel mixing won't have an effect, I'm wearing modest clothes. (Arwa, Year 2 Interview)

Although it is possible that the attitude of this student is linked to her marital status, as she would have experienced the process of getting to know a male who was not her immediate blood relative, there was no general indication from the data that married students were more comfortable interacting with men than single students.

However, family background does appear to have an influence on the experience of this value conflict, providing further support for Rokeach's theory in terms of the ways in which values are largely established early in childhood. Interviewees who indicated that they were expected to feel quite comfortable interacting with males discussed examples of other student nurses who find this difficult, either because of their lack of experience in doing so, or because their families could not accept this aspect of their work.

> It may be difficult for some girls to talk with men and to ease his pain or comfort him by talking ... I mean for me I don't face any conflict in this subject ... I didn't experience it, but I don't feel that I'll face it. But some people will ... because they are not used to it ... I mean if she's not used to meeting men all her life except for her brother and father ... it will be hard for her at the beginning to blend into a mixed environment. (Arwa, Year 2 Interview)

The majority of faculty interviewed indicated that they were fully aware that at least some of the Muslim student nurses were facing this type of value conflict; in some cases, they had been directly approached by students with a request to be released from any requirement to treat male patients during their nurse education, as illustrated by the following interview quote:

> Second-year students - the ones that go to the hospital right now - approached me. They came and told me "Miss we would like to change our faculty" and I would ask them why and their response would be "We are not comfortable dealing with a male patient" (Ekram, Faculty Interview)

Some of the students explained that the requirement for nurses to interact with males in their daily work is a factor which they believe deters many young Saudi women from entering this profession and that also contributes to high levels of attrition from nurse education and the nursing shortage in Saudi Arabia. This may be exacerbated by pressures from the student nurses' family members who regard it as inappropriate for them to work with men.

> I think that is why we don't have good number of Saudi nurses in our country. Because most of them doesn't want to work with men ... My friend's sister worked in a bank after graduating from nursing school because her husband does not want to her to work in a mixed environment. (Yara, Year 4 Interview)

Indeed, several of the faculty members explained that they too came from conservative family backgrounds and as a result had felt shy and awkward during their training when first required to interact with male patients and doctors:

> I was raised like this too and that is why when I deal with a male doctor I would be like…how do I say it… I would be like "God, I cannot speak at all" I do not know if he asked me for anything how would I talk to him? (Maya, Faculty Interview)

Another faculty member, Mayar, gave a graphic description of the ways in which she used to respond to this type of situation with unease, discomfort and avoidance early on in her nursing studies. She also explained, however, how her confidence in doing so had gradually increased over time and stressed how important this had been to her growing effectiveness as a professional nurse.

> With the patient in the second-year … when he ask me I'll try every way to not answer let's say I see him coming to ask me I'll turn the other way and pretend I didn't see him and pretend I have something else to do! That's me escaping this situation, another situation where he comes and ask me I answer in the shortest form while keeping my eyes on the file that's it! When I grow up in the third, fourth-year and the intern year I began to see that I'm a nurse and I have right and my voice must reach! With this shyness I'll not reach to my profession as a nurse. (Mayar, Faculty Interview)

The research findings revealed that one of the reasons for value conflicts is that Saudi Arabia's religious and cultural values relating to interaction between the genders can often result in a misunderstanding on the part of patients about what might be seen as normal nursing behaviour in other cultural settings.

> Therapeutic touching … I mean in the religious and our culture it is unacceptable. I mean even if they gave it the patient might perceive it wrong. (Shadan, Faculty Interview)

> Touching is normal abroad whether a male touches a female or vice versa, and they mean no bad intentions. Touching means support and things like that. It is

done universally, but here our religion and customs and traditions forbid that. (Ekram, Faculty Interview)

As a result of such restrictions, many of the student participants expressed confusion or frustration about how to fulfil their nursing role while still adhering to their religious or cultural values, and reported incidents in which they felt misunderstood by patients or feared that this would be the case. For example, Sondos, a divorced fourth year student and fourth year student Yara explained their concerns as follows, with Yara illustrating these with an actual example of a patient's misunderstanding of her intentions.

> I mean, I am not used to it. not used to deal with males ... I mean if I don't know when to draw a line ... Maybe it affects my reputation for example! I will give wrong impressions to the patient can lead to misunderstand me or the colleague can misunderstand me … Because I feel that I am too nice a character (Sondos, Year 4 Interview)

> Once I made a mistake with one of the patients... he told me how sorry he is as he was so dependant and demanding, I felt that I am tired… I told him don't worry Sir (*sidi*)[4]! He misunderstood my statement completely! I mean…I became so reluctant to enter his room again ... Sometimes we are caring more than it is necessary, men could misunderstand us. (Yara, Year 4 Interview)

The following extracts of discussion from the second-year students' focus group highlight further the confusion and the dilemmas that at least some of these Muslim student nurses face as they struggle to reconcile their perceived role as a nurse with their understanding of what forms of behaviour are allowed or prohibited by Islam rather than being culturally determined:

> For example, if the patient was an elderly and you tried to help them stand and held their hands or helped them or said "Sorry", sometimes you can't do that! It is wrong … They told us that we aren't allowed to here in college. But I feel like I was raised thinking it is alright because of my family culture. It feels like giving comfort. This pat before the surgery, telling them "You will be alright" "do not' worry" it will make them relaxed …. (but) because of the difference in the upbringing culture. It could be misunderstood. (Ayhan, Year 2 Focus Group)

> I think it is normal to console a male patient, but he will not see it that way. It depends on with whom I am dealing! I must think is this acceptable or not. Okay,

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[4] "Sidi" in Arabic is a word that used by women to describe/call close male relatives like a father or elder brother in a respectful caring way, and by men to call their close male friends. In this situation, its use was misinterpreted by the patient as indicating the existence of a perceived "special" relationship with the nursing student.

we agreed that I can console an old man, but a young male differs from an old person or a father. I also do not know what the patient has in mind. (Nuha, Year 2 Focus Group)

This type of concern was understood and indeed shared by the faculty, as illustrated in the following faculty interview quote which demonstrates the perceived risks of close contact or interaction with male patients or their relatives.

Sometimes if the patient feels comfortable with you, he refuses anybody else to deal with him but you. This makes me think, "what does he want exactly!" … Especially if it was not the patient, but the attendant who came with him ... the attendant keeps on asking things; what is your opinion, what is not your opinion, should I do that, and should not I do that … If there was close contact, I will think that "This is not right. I must not speak with him too much (or) get close to him too much. (Maya, Faculty Interview)

Factors contributing to this conflict

Some of the students who felt affected by this type of conflict attributed it primarily to religious rather than cultural factors. For example, the following student participants explained the conflict specifically in terms of the Islamic restrictions on making physical contact or light-hearted conversation with unrelated individuals of the opposite gender.

Religiously - for myself, it's not allowed to shake other men's hands. So for me there is boundaries in everything, so what's holding us back is the religion that's what I feel (Kenan, Year 4 Interview)

It is still also in our religion that I should not touch! I can't for example pat on his shoulder and say you will be fine, take it easy! This is not acceptable in our religion, it is not allowed for a woman to do such thing. (Yara, Year 4 Interview)

From the religious aspect, speaking to a foreign man is not allowed unless there was a necessity, for example: if the person was a patient, it does not make sense to laugh or joke, as this is forbidden. Here is the conflict, I must not speak, but in such cases I have to do what is necessary, but without touching. (Rasha, Year 2 Focus Group)

Ekram, a faculty participant, identified closely with the views of these students, indicating that she herself shared their difficulties in making physical contact with males as a result of Islamic rules which prohibit physical contact between the genders.

> We have been raised on these rules and Islam instructs us to this. It is difficult to accept touching between males and females. Really difficult! (Ekram, Faculty Interview)

However, the research findings also indicate that it may largely be cultural rather than religious values that determine a nurse's experience of this type of value conflict. Mayar referred to the ways in which males and females interacted at the time of the Prophet in order to emphasise the point that it is not religion per se which prohibits close contact; on the contrary, Islamic teachings provide guidance on how to act appropriately with people of the opposite gender.

> Islam give us the right thing on how I should deal with the person in front of me so he doesn't misunderstand me but it didn't say don't talk to them or don't deal with them! ... Let's say it depends on how I received this information on what is the Islamic point of view ... and how I were taught in in school or within the family after that … Let's go back to the time of the prophet (peace be upon him), they were not like that, they used to sit with good manners and respect, they used to go and ask the females and the prophet's wives so this is a proof that it is fine ... It's the culture … (Mayar, Faculty Interview)

Alana, another faculty interviewee stressed that in the nursing context it is not contact between the genders in itself that is prohibited, what matters is whether the nurse has good and appropriate intentions. To illustrate this, she discussed a hypothetical scenario of using the "therapeutic touch" to comfort an elderly male patient:

> Communication and contact is based on the situation! Based on the goal of communicating. I mean what is the intention, according to it we can say prohibited or not. I swear to God if my intention for communicate or contact is helping this person, I am treating and giving care to the human being! I don't think our God will not accept this …. Like a 70 years old tired patient, poor him, he feels lost, delirium or lost, he doesn't know where he is, nobody of his family with him. I can't say no he is male and I am female, I will touch him! I will tap on his shoulder to say you are ok, you are in the hospital, you are not alone it just not the visiting time, when the visiting hours starts your family will come or whoever visiting him. what does it cost me if I do this!... I am alone with this male patient in one room with the door closed, but what I am doing? Tracheal suctioning! Is this haram? I will not go to hell for this! … I mean we need to use our minds/brains… come on. What is the problem if I tap him or he hold my hand, forbidden!? I don't know, come on! it is OK! (Alana, Faculty Interview)

This faculty member appears to have strong feelings about the need to act on one's own initiative in the best interest of the patient. Interestingly, the same participant also later commented on the lack of adequate coverage of ethics in the nursing curriculum (p.74). Yet her own views do not seem to have been translated into teaching the students about these issues in the lack of formal curricular content on how to interact with male patients.

Despite their lack of formal training in this area, several of the second-year focus group participants, such as Suha, concurred that it is the nurses' intention that matters when making physical contact with male patients, and that well-intentioned touch is not prohibited by Islam. This participant referred specifically to the Islamic origins of nursing in Saudi Arabia, in which she argued that communicating and touching male patients was a normal aspect of nursing care by female nurses.

> I feel it has nothing to do with speaking to men from the religious prospective. I mean you can speak with men as Allah know your intention and purpose, so you talk with the patient or the doctor, whatever it was, even touching sometimes it for medical purposes. You will not touch him for something else .... It is about your intention and your thinking, and how you will speak with him…what is your intention? … I do not think that Islam might forbid such a thing, as I am helping other. In the age of the prophet Muhammad (peace and blessings of Allah be upon him) … They used to console the fighters and motivate them using words and touching and everything. (Suha, Year 2 Focus Group)

In relation to this type of value conflict, the influence of family background and upbringing again repeatedly came up in the interviews and focus groups as contributing factor. Mayar explained that many student nurses come from conservative family or education backgrounds in which they were taught only that they should not have contact with the opposite sex, and that it is these cultural aspects of their upbringing which give rise to the difficulties they experience in nursing when required to treat male patients or deal with male doctors. The comment of fourth year student Afnan is also revealing in that she stresses that her geographic region of origin has a negative influence on her ability to feel comfortable interacting informally with men.

> There are girls have issues … because she came from an environment or been taught at school that this person is prohibited or touch and to talk to, and it's not like that. (Mayar, Faculty Interview)

> I feel like since I am from the south that yes, it would affect it. Because he just want to speak without purpose. Unlike if it was a professional relationship that I would want him to agree on. Not talking without a purpose. (Afnan, Year 4 Focus Group)

Several other students also indicated that the ways in which Islam is interpreted between different families or different regions of the Saudi Arabia has a strong influence on whether value conflicts related to interaction with male patients and colleagues are likely to be experienced.

> If the culture was open to the interaction between men and women more open than this then it would have been okay … Culture, environment and upbringing are what bring conflicts. (Sanaa, Year 4 Interview)

> There are open-minded families and conservative families, that's what makes the difference. Like, open minded ... the whole family can sit together, male and females with or without covering, so she will be able to deal with a male just like any other person just like when she's dealing with a female. But if she was conservative maybe she will be faced with difficulties, she will be shy of males. (Arwa, Year 2 Interview)

Again, all these findings provide support for Rokeach's theory that values are largely formed early in childhood, though they can be influenced or changed either gradually or abruptly by subsequent events or life experiences, in a variety of processes defined in the theory (see Chapter 2, p.21). For example, illustrating perhaps the effect of Rokeach's "creation" process, in which a new belief is developed and transforms an established value, or the process of "attenuation" in which there is a gradual withdrawal of support for a value previously held, faculty member Maya argued that student nurses have become more open-minded about gender interaction over the years. Her comment also suggests that changing cultural interpretations of Islam, rather than strictly religious values, influence the likelihood of experiencing value conflicts in this area, even though there was relatively little evidence from the student participants of the attitudes that Maya reports:

> We see students that are open minded more than before. Like 10 or 12 years ago when I was still a student, it was the first time for me to work in a mixed place with men! So in the beginning this caused me umm … but the students nowadays are more open. (Maya, Faculty Interview)

The potential for this type of value conflict also appears to be exacerbated by a complete lack of male nursing teachers in the faculty, so that even during their nurse education the students remain largely within an all-female environment. This makes it difficult for the students to become confident and relaxed when dealing with male patients or male

colleagues since many have little experience of interacting with males generally, and indicates that there may have been few opportunities for Rokeach's processes of creation, attenuation or limitation to have occurred. A married fourth year student participant explained:

> We don't have men to teach us, so I don't know how to speak. I am very shy to talk to a doctor in the hospital! … Why is all the college females? … Now I am always with female doctors. So I am not used to talk to male doctors, I blush and can't ask them anything. (Sondos, Year 4 Interview)

Another institutional factor that may be exacerbating the potential for value conflict relating to interaction between the genders, and hindering value change processes in this area, consists of the informal university practices or policies that allow students to refuse to treat male patients. This was mentioned earlier in the context of the value conflict relating to exposing male awrah, but examples also emerged of students being released from the requirement to work on male units even to provide general care.

> We never try to force them to do something she is not happy to do. I remember one of the students She is refusing and rejecting completely to go to male units ... So we changed her rotation to female units ... (Shadan, Faculty Interview)

On one hand, this quote from Shadan demonstrates a sympathetic and caring approach to students facing value conflicts relating to gender interaction, but on the other it suggests that avoidance strategies are being adopted, as discussed later in the chapter. These are not only impractical to implement given the overall shortage of nurses in Saudi Arabia, may also reinforce the very cultural values and expectations about interaction between the genders which are creating the value conflicts in the first place instead of promoting processes of value change particularly those defined by Rokeach as creation, attenuation, or intensity. In these processes, support for previously held values are weakened while others become stronger, either at individual (creation and attenuation) or societal (intensity) level. Although Shadan stressed that the example of the student whose rotation was changed was an exceptional case, other findings from the interviews and focus groups suggest that there is an expectation on the part of many students that they can at least refuse to undertake certain nursing tasks for male patients and that this will be accepted by their supervisors, thus potentially hindering these types of processes of value change by legitimising the cultural values which prohibit interaction between the genders.

6.2.3 Balancing the Nursing Role with the Negative Public Image of Nursing

Experiences of this conflict

The third identified type of value conflict arises because of the clash between the student nurses' professional values and the religious or cultural values of their close relatives or the wider society. This relates to the poor public image of nursing that prevails in Saudi Arabia, despite the historical Islamic origins of the profession. This situation results in value conflicts because of the student nurses' desire to please their parents or other relatives, or alternatively to be accepted by others in society, while their professional values require them to undertake tasks which hinder or prevent this. The problem was observed by faculty member Shadan, who stressed that very few people in Saudi Arabia today are aware of the Islamic origins of nursing, instead receiving their information and perceptions about the profession from the media:

> From the days of the prophet there was Rufaida … They don't look to her and they are not referring to her or anything … the representation of nursing from TV shows is what sticks in their minds. The nurse is the one helping the doctor to wear his jacket, and whatever … (Shadan, Faculty Interview)

Other faculty participants also demonstrated an acute awareness of this value conflict. Daad and Mayar explained, for example, how negative media portrayals of nursing have become a major influence on how people see this profession within Saudi Arabia.

> The poor image which is in the media … nurses do not do anything but they are taking appointments! And getting files (Daad, Faculty Interview)

> Maybe the family still has the idea of the dark ages of nursing where everyone thinks nursing is a bad thing, there are families and people - till now they have the idea of "how can my daughter become a nurse? They are just maids" - sorry for this word! (Mayar, Faculty Interview)

Faculty members acknowledged that the negative image of nursing and the resulting resistance of some students' relatives make it too difficult for them to pursue nursing, even though their personal values may be well aligned with this profession. For example, Alana explained:

> Maybe the personal value is strong for some girls, but she is the one who puts it down as she has to follow family options and choices! Or maybe the image sometimes has an impact, like she says, "I love this thing and adore it but because of the nursing image...no I can't take it". (Alana, Faculty Interview)

Among the student nurse participants in this study, some indeed reported that they had experienced severe resistance from close relatives when they decided to embark on a nursing career. They attributed this mainly to the poor public image of nurses in Saudi Arabia and because of the ways in which they are required to interact with unrelated males, which is seen as unacceptable for Muslim females. Their comments suggest that the faculty's awareness of this issues, as reported above, is accurate, and that there is often resistance on the part of relatives to a student's choice of nurse education. Two of the fourth-year students, Sawson and Afnan, explained this as follows:

> My dad - from the day I started nursing - he has thought about nursing that I will be like a maid in the hospital... Also this subject of changing diapers … everyone, people, I mean when I tell them that I am a nurse they remind me of this point as if this is something wrong (Sawsan, Year 4 Interview)

> Even now he refuses the idea of me working in the male department and wants me to work with the females and to leave the males, as there must be somebody else to do the job. (Afnan, Year 4 Focus Group)

That this type of value conflict has a widespread negative impact on student nurses was highlighted by Yara, a fourth-year student. She expressed the view that it is inevitable that all Muslim nurses will face conflicts at work due to the poor public image of nursing as a low status occupation in Saudi Arabia, and expressed the view that this deters many Saudi women from entering this profession.

> We are all Arabs and we are all Muslims and all of us have parents and these are basic needs in our religion and in our country. So, I feel that each one of them will have to go through this situation like the others, all will have the same values, will face the same conflicts I believe. it is possible that there are girls who will say "this is my job!", but she will live in a conflict … I think that is why we don't have good number of Saudi nurses in our country. (Yara, Year 4 Interview)

Even one of the faculty members, Maya, recounted the ways in which she had faced resistance from her own family who were ashamed of her choice of studies when she first entered nursing.

> So I took nursing in the first year and I rushed through it. My family did not tell anyone that I win the faculty of nursing, but in the faculty of applied medical science. Why? Because they saw that nursing is very low class especially since our family had many doctors … I think that even within faculties they think little of nursing. We are the only faculty suffering. (Maya, Faculty Interview)

In relation to understanding the full experience and impact of this factor on student nurses, there are inherent limitations in the current project. Since the sample is drawn from students who were in the nursing degree at the time of the study and have therefore persisted with their choice of training despite any family resistance, it is not possible to generate information on the impact of this conflict on those who left the course as a result. It is also not possible within the scope of this study to examine the ways in which this type of value conflict might deter Saudi women from entering the nursing profession. Nonetheless, the student interviews and focus group discussions do provide a considerable amount of information on the effects of this conflict, including indirect evidence relating to the participants' perceptions of the experiences of other students.

Cultural influences on this conflict

The data indicates quite strongly that cultural factors rather than religious values contribute to this type of value conflict. When discussing the dilemmas they face in this area, participants rarely referred to the religious values of their family members or the general public, but emphasised instead the influence of the media on awareness and attitudes towards nursing. Explaining the impact of newspapers and TV on public perceptions of nursing, for example, the following students described these perceptions and attitudes as follows:

> It's not a good study field, not a good career, you help the doctor, your work is about dirt, long working hours … you work very hard and at the end you are just a nurse ... It is 12 hours a day and … at the end you are a nurse so it's nothing! They think the nurse only measures pressure, and injections and stuff like that. (Arwa, Year 2 Interview)

> They consider them as a housemaid but in the hospital ... Or they see her in the last rank of jobs in the health sector. (Basmah, Year 2 Interview)

The role of cultural factors was further revealed in the interview with Basmah, who reported that her family would be content for her to work as a nurse overseas where nursing has a more respectable public image, but not in Saudi Arabia.

> They encouraged me to study nursing overseas, the idea was that because of the viewpoint of the Kingdom's society is different for the nurses, but if I went to England for example they will respect you because the nurse there is a very good thing, they said "ok go to England and study nursing but not here in Saudi!" (Basmah, Year 2 Interview)

A number of the participants revealed that one of the factors apparently affecting the attitudes of family members or spouses to their choice of career is whether they have existing knowledge or experience of the medical profession.

> My husband - from the beginning, it is okay for him. I am not sure if this is because his sister is a doctor and his second sister a lab technician and this is normal for him. (Sawsan, Year 4 Interview)

> I was the one refusing, but my family asked me to stay. All of my family are nurses: my aunt, and my sisters both are nurses …. I took a course in forensic nursing. There is a need for this here in Saudi Arabia. It is very interesting, and it is the same as my ambition until now. So, my family supports it … they believe that this specialty is good (Reham, Year 4 Focus Group)

Moreover, though many of the student research participants indicated that this type of value conflict personally affected them at least to some extent, it was not reported by them all. Some indicated that their relatives were supportive of their choice of career and that they felt comfortable discussing the nature of their daily work with them. This appears to largely reflect the influence of individual personalities as well as the influence of cultural differences between families in terms of their degree of conservativism. The following quotes, for example, provide examples of relatively liberal parents (in the context of Saudi Arabia) who allowed their daughters considerable freedom in their choice of studies.

> My mother used to tell me that whatever you do is for yourself not us. What you want is what you will be. (Ayhan, Year 4 Focus Group)

> My father always says that we interfere only in choices that have to do with high school study, but the choice to apply in the university or not is yours. (Saja, Year 4 Focus Group)

The findings in this area also indicate that, if family members are open to learning about what their nursing responsibilities involve, these types of communications can play an important role in overcoming the potential for value conflicts. They might do so by

helping to change the family attitudes that can contribute to such conflicts, for example in ways that might be explained by Rokeach's attenuation value change process, or gradual withdrawal of support for previously held values based on increased knowledge about the nursing context.

> I tell them in detail. At first, there were some situations that shocked them, as I was in the beginning and it is difficult to see those situations. Later, you will see more, so try to use to it. They support me and encourage me. They do not say "no" or "it is wrong". (Suha, Year 2 Focus Group)

> Our father taught us how to trust each other. He told me that I have to tell everything … So I tell everything I do, as I prefer being respected than to hide something from him. (Retal, Year 4 Focus Group)

The important role of trust between family members in reducing the potential for this type of value conflict also emerged in the second-year focus group. When asked whether brothers, husbands or fiancés would accept it as normal for the students to interact with male colleagues, for example, several of the participants indicated that they would, since they would trust that the student nurses would behave in a professional manner and with good intentions.

> They know their daughters and they know how they raised them ... They trust me; trust that I would never let them down. If they were to see me they would know that it is for work and it is necessary. (Suha, Year 2 Focus Group)

> Yes, (they) think that what I am doing is work and not outside it. It is my job. (Suha, Year 2 Focus Group)

However, the responses were quite different when it came to the specific issue of exposing male awrah, indicating that the requirement for nurses to undertake this type of task remains one which is very difficult for people to accept in this society and which has a major negative impact on their image. The married or engaged student participants were particularly adamant that their husband or fiancé would find it hard to accept this aspect of their role and may expect them to give up nursing as a result. This again highlights the importance of differentiating between religious and cultural values when exploring how value change might be brought about, and the ways in which Rokeach's theory could be usefully expanded to incorporate different types of values.

> I expect that he will not accept… No, I mean, everything what I do in my general care is ok but ... when it comes to genitalia care this is...difficult, it will never work.(Sawson, Year 4 Interview)

> Maybe I'll not share the situation with them (fiancé). Because there will be rejection or … maybe they will feel, no, this is inappropriate … Maybe for example my fiancé will be sensitive about it and will say you don't need to continue in this job if you are doing this. Yea, it could reach to a point where I quit the job. (Bushra, Year 2 Interview)

It must be noted, however, that although the first of these students (Sawson) is married, both were referring to hypothetical situations and their perceptions of the attitudes of their husband or fiancé rather than being based on actual experience of this. Another married student expressed, in contrast, the hope that she may be able to persuade her husband to do accept her need to conduct such tasks by asking him to imagine himself or his own father in the place of the patient.

> I swear I think it will be difficult ... but I'll convince him at the end.... … I mean I feel it's difficult for any husband, I see that I won't force him at the beginning so he won't disagree…I wouldn't blame him, I mean I'm bathing men he won't understand it's a bed bath and he is unconscious they won't understand these things, if I explained in detail .... If you were in his place or your father, of course you will allow me to do this thing, put yourself in his place! (Arwa, Year 2 Interview).

One of the married participants indicated that their husband would not even be comfortable with the idea of them working on male wards. Although again based on perception rather than actual knowledge of her husband's views, this suggests that this participants' future nursing career options might be very limited if she is proved correct.

> It is ... possible that he will not accept to work at the male ward in the first place. (Sawson, Year 4 Interview)

Overall, these findings not only demonstrate the types of resistance from family members that many of the participants are experiencing as a result of the negative public image of nursing in Saudi Arabia, but they provide further support for the argument that cultural rather than religious factors per se are contributing to their experience of value conflicts resulting from this, and highlight the need to incorporate this distinction in theories of value change. The findings have also highlighted the complex interconnections between

the three main types of value conflict discussed so far: relating to the provision of personal nursing care for male patients; interaction between the genders and the nurses' perceptions of the public image of nursing (which are supported by findings of several other studies conducted in Saudi Arabia, e.g. Alboliteeh et al., 2017; Keshk et al., 2016; Zakari et al., 2010).

6.2.4 Clash of Personal Values and Organisational Practices

This is a more universal type of value conflict in which a nurse's personal or religious values come into conflict with the policies and practices she observes in the hospital environment. As noted in the literature, newly qualified nurses often experience value conflicts when the professional or workplace values they are required to adopt are not aligned with their personal values (Forsyth and McKenzie, 2006; Stacey et al., 2011; Takase et al., 2006). These have been shown to be associated with negative impacts on health and on mental well-being (Altun, 2002; Brien, 2012; Stacey et al., 2011). Value conflicts can also arise when the professional values taught during training, such as a focus on person-centred care, are not upheld in the workplace due to organisational constraints such as workloads, negative role models and a lack of resources (e.g. Landers, 2000; Melia, 1987; Molassiotis and Gibson, 2003; Upton, 1999, cited in Maben, Latter and Macleod Clark, 2006). Previous theorists have described these situations and their impacts on student nurses and newly qualified nurses in terms of concepts such as "reality shock" (Kramer, 1974) and "moral distress" (Jameton, 1984).

Since the present study was concerned primarily with exploring the specific conflicts associated with being a female Muslim student nurse in Saudi Arabia, these more general types of value conflicts were not investigated in detail in the interviews and focus groups. Nonetheless, evidence of these types of conflicts did emerge in both the second year and fourth year focus group discussions. This suggests that female Muslim Saudi Arabian nurses not only experience value conflicts specific to their own characteristics and working context, but also the more universal types of conflicts that are experienced by student nurses and newly qualified nurses around the world, exacerbating the potential overall negative impact of value conflicts on them.

This type of conflict can be conceptualised as occurring when hospital policies, or the actions of others, prevent these individuals from expressing or fulfilling personal values which are basic and universal in nature, such as kindness, care and honesty. In this sense,

it is a type of value conflict which transcends religious or cultural differences, and which can be perceived by the individuals involved as a violation of patients' rights.

Several of the student participants in this study reported situations in which they faced value conflicts or ethical dilemmas of this kind, reporting that due to hospital policies and regulations they were not always able to respond to situations in the ways aligned with their personal or religious beliefs and values.

> As a human being I love to give my best help, but because of the hospital's policy it is not my right to help as long as I have not the authorization. (Nadeen, Year 2 Focus Group)

One of the main types of policy-related situations reported to cause this form of value conflict was the use of Do Not Resuscitate (DNR) policies in situations where the student nurse did not regard them as being in the patient's best interest. The following fourth year students explained that they would find such situations very difficult if they were in the position of either being able to resuscitate a patient or to let them die if resuscitation appears futile, but were not allowed to do so in either case.

> There is a policy that I learned recently which is DNR, if the patients or their relatives didn't give us permission then we can't do anything. It is a professional … value that I should accept. I want to help this person, but I can't. That is the difference in my opinion. (Reham, Year 4 Focus Group)

> The one that trigger this the most are DNR cases. Watching someone dying and not doing anything to help them it is... too hard. Especially when the heart stops and I can do CPR and he will be back to life but I can't do it because of the policies and the rules and the other things that we mentioned. This is where I am always conflicted. (Retal, Year 4 Focus Group)

The first quote above indicates that, in Saudi Arabia, a DNR decision must be approved by the patient or their relatives, and that it is the clash of this policy with the student's own values on occasion that gives rise to a value conflict. It is notable that this contrasts with the situation in the UK where medical professionals are able to over-rule the wishes of family members based on their medical assessment of the patient's condition, and that this is perhaps therefore another example of the cultural influence on medical policy and practice in Saudi Arabia.

As another example of the Saudi Arabian cultural influence on this type of conflict, the participants also gave examples of being conflicted in situations when a patient's relatives

ask them to conceal from the patient how sick they are, for example when suffering from a terminal illness, and the nurse believes this is misguided but has to respect the family's request. This is because of the central importance of the family rather than the individual in Saudi Arabian culture, and the examples shown below show that, whether formally or informally, the views of relatives are often prioritised over those of the patient within healthcare. These situations are perceived by the participants to conflict with the basic human rights of patients, which are held as important personal as well as professional values by these student nurses.

> I had this elderly patient once, she had a colon cancer and her family and her grandchildren didn't tell her about it ... I felt like she should know about it but we get a note every Sunday that we shouldn't tell her because it would affect her mental state. I kept thinking should I follow that or should I tell her the truth? (Ayhan, Year 4 Focus Group)

> I had a patient that also has come and he didn't know. His son always told us "Make sure he doesn't know" and I felt like he had to know! It is his decision to do what he wants to do with his life. It is his life! ... He is in perfect mental state and he is an adult. It felt like they were lying and playing him and it felt so wrong! (Retal, Year 4 Focus Group)

Another commonly reported type of situation which causes this type of value conflict reportedly arises when the students observe another nurse or a doctor acting towards patients in ways they find objectionable, and which are also seen to contravene patient rights. In some situations these therefore represent a conflict between policy and practice, in which values such as integrity appear to be compromised.

> When I see the foreigner nurses' ways of dealing with the patients when they are handing them the medicines. It is wrong! They do not apply anything of what we have been taught. We learn about something completely different from what they do. (Ebtsam, Year 2 Focus Group)

In others, there is not necessarily a formal policy that is being contravened but the conflict is between observed practice and the student nurses' own personal values relating to nursing. In particular, these relate to an observed lack of respect for patients, as well as values such as kindness.

> I had a situation with two doctors who entered the room of a patient that is not theirs ... They just opened the door, they exclaimed "That not our patient" then left without even closing the curtain and without any respect. So it is not only nurses! (Nadeen, Year 2 Focus Group)

I personally saw a doctor that kept screaming at a patient "Why is that?" Not gently at all ... I started wondering if this is right? Should she be this strict with patients? It could be a conflict about what one should do. (Nahla, Year 2 Focus Group)

The quotes below illustrate the types of internal dilemmas that the student nurses expect that they would face in these situations, when they are torn between doing what they believe is right or following hospital rules.

In such cases, my professional values require me not to speak. However, my personal values require me to report such violations, and not to ignore it as I saw it happening ... So, I do not know what to do in those cases! .... Because it is not your right to say that a doctor made a mistake, or to tell to a doctor you are wrong. (Nuha, Year 2 Focus Group)

When you want to help a person but you have to follow the rules. I won't know if I should follow my morals or my career's rules. (Reham, Year 4 Focus Group).

Despite the dilemmas presented by these types of value conflicts, one of the participants mentioned in the context of discussion of them that they can have valuable aspects in terms of the learning gained, which might even have a positive knock-on effect to others that the nurse comes into contact with. This second-year student reported that she would reflect on the situation that caused the conflict and from this learn how to cope better in future.

I probably will not be able to live with something that I do not believe in ... So I will reach a conclusion which is acceptable for me as a person and for the place I work for, or live in as a student .... I will see something that everyone accepts even if it does not represent me, but it is right and everyone accepts. But I will never do something wrong, as this will not be me or this is not what I accept, so I will not live like that. So, I will meet halfway .... at first I will follow the hospital's rules, but when I go home I will think it again and review it in my mind to see if I have to live the same situation the rest of my life, will I do the same thing while I do not accept it? .... Conflict could help me gain value out of it and learn from it. Either it adds a new value or improves an already existing one. So, I could apply this value inside and outside work, depending on the value. There are some values that I would take home with me. It could influence for example, a friend who would see this and like it on me and she would starts applying it to her life as well. It could affect relatives, family and friends. (Nadeen, Year 2 Focus Group).

This student's reference to the way in which the conflict motivates her to re-evaluate her own values and ways of thinking indicates that this type of situation might be conceptualised as "abrupt destruction" as defined in Rokeach's ten value change processes (1979). The type of reflection which she refers to might perhaps even provide an example of ways in which the experience of more fundamental types of value conflicts identified in this study, such as those involving exposure of male awrah, might ultimately lead to the reconsideration and modification of values in ways which reduce the potential for such conflicts.

6.2.5 Lack of Interest in Nursing

The final identified type of value conflict was one which emerged from the data in an indirect way, based on the second-hand reports or anecdotes of faculty and some of the student participants. Although based on indirect evidence, it is discussed briefly here mainly because of its relevance to the issue of attrition from nurse education and thus to the nursing shortage in Saudi Arabia. This value conflict arises because of the misaligned personal and professional values of those student nurses who do not voluntarily choose to enter nurse education, or do so only because their choices are constrained. Although two of the student participants indicated that they originally fell into this category, their accounts suggested that they had adapted to and were enjoying their nursing studies, so these participants did not provide an opportunity to explore the experience of this type of value conflict directly.

Indeed, many of the faculty interviewees expressed the belief that a high proportion of Saudi Arabian student nurses enter nursing reluctantly because they have not qualified for other specialist areas of medicine or healthcare. Since admission to the nursing degree may be easier to achieve, this course of study may be regarded by these students or their families as an easier way to achieve a medical qualification and future job opportunities. As a result, the personal values of these students might not be well aligned with the professional values of nursing.

> Like the students wants .... to do medicine or dentistry as she see it as the best thing in the world and she is not accepted, so she is accepted in nursing. She could have heard that nursing girls have scholarship opportunities so in the future she could have her master and doctorate, or heard about the greater opportunities to find nursing jobs and salaries. She will be in an inner conflict all her life, in a struggle ... (Alana, Faculty Interview).

> The biggest and most of the conflicts that we have students who enter the specialty and they don't want to be in it …. until their fourth-year and they are still not interest in nursing. More than that until they complete their internship they are not interested to work as nurses. (Shadan, Faculty Interview)

According to the faculty members, this leads to many students leaving the course early in their training, or continuing but having little interest in their studies. The situation is exacerbated by the low levels of knowledge in Saudi Arabian society about what nursing actually involves, and their perceptions of the negative public image of the profession as discussed earlier.

> I think that girls do not apply on their own desire. They change their request after the first year, why? As they start practical training and know its details, as it is rarely to find a student know what this job is! Or what its values are that they can choose upon. (Maya, Faculty Interview)

> We already had - let's say 147 students in the second-year - around 10 to 20 will drop out ... They left because they are not convinced and their personal values affected them and it was stronger so they couldn't continue in the nursing field, but this let us say that it's a minority not a majority. (Mayar, Faculty Interview)

Although Mayar, as quoted above, indicated that only a minority of student nurses fall into this category, Shadan expressed the belief that the majority of student nurses fall into this category.

> Almost 80% of the girls that get into nursing are not interested to complete in nursing … It is sad enough to see! Really sad … And really if you saw the girls or talked to them you will find a small percentage that says I am satisfied and I am happy. (Shadan, Faculty Interview)

There was no direct evidence from this study that this misalignment of personal and professional values is widespread among student nurses at the case study institution, as none of the research participants revealed that they are unhappy in their nursing studies in general. However, since self-selection methods of sampling were used, it is perhaps less likely that students with lower levels of interest in nursing would have volunteered to take part in the study. Moreover, if there are actually high levels of attribution among those who entered the nursing degree reluctantly, this group would have been under-represented among the populations of second- and fourth-year students from which the samples were drawn. Since this was a qualitative study, the methods did not allow for

investigation of the prevalence of these types of attitudes among student nurses in general at the case study institution. Nonetheless, the strong if indirect evidence of these from the faculty interviewees indicates that this type of value conflict does exist among the wider population of study nurses at this institution and may potentially be quite widespread.

6.3 Responses to Value Conflicts

This section presents the finding of the interviews and focus groups relating to the ways in which the student participants reported responding to the value conflicts they experienced. It focuses primarily on the first three types of conflicts discussed in this chapter (relating to provision of personal care to males; interpersonal communications with male patients and colleagues, and family/public attitudes to nursing), which have been shown in the preceding sections to be closely inter-related and specifically influenced by religious or cultural factors. Although the remaining two value conflicts identified in the research (relating to hospital policies or practices, and those experienced by nurses who reluctantly entered this field of study) are no less meaningful or significant to student nurses who experience them, they are less directly relevant to the specific experience of being a female Muslim student nurse in Saudi Arabia and further discussion of these is considered to be beyond the scope of this study. Furthermore, only very limited or indirect information was collected relating these types of conflicts. In broad terms, student responses to situations resulting in the three main types of value conflicts have been categorised as follows based on the research findings: acceptance, acquiescence, avoidance/refusal, and concealment/hiding, as portrayed in Figure 7 and discussed in turn below.

Figure 7: Responses to Value Conflicts - Related Sub-Themes
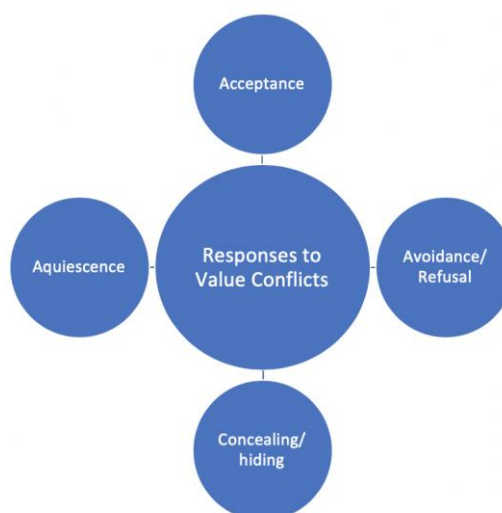
6.3.1 Acceptance

With regard to value conflicts relating to general interaction with male patients and colleagues, some of the participants accepted that these situations are an important aspect of their nursing roles. Although most demonstrated at least an awareness of the potential for value conflicts in this area, arising from their own attitudes and beliefs or those of their patients, they generally indicated that they accept these roles and expect to gain confidence in them over time. This might be regarded as reflecting Rokeach's elaboration process, or the progressive rationalisation of a value until it becomes embedded in a socio-cultural context. In these cases, the elaboration process might have been seen as relating to the ways in which the students increasingly rationalised the values relating to patient care as being those of greatest importance in the nursing context. Strategies for reducing the potential for value conflicts, such as appropriate clothing and behaving respectfully towards patients and colleagues were mentioned by several student interviewees. These were seen as important ways of demonstrating professional behaviour which is not likely to be misunderstood by the men with whom they are interacting.

> My goal is I'm going to work, I mean I'm practicing my profession so I feel mixing won't have an effect, I'm wearing modest clothes - it won't affect. (Arwa, Year 2 Interview)

> I think we will become more confident over time in communicating with male colleagues and patients ... I mean, if the girl is satisfied about her modesty and the way she is covering her body and she knows that he speaks politely ... In the beginning it will be hard but then this will change and it is good to have shyness to know her limits (Baraa, Year 2 Interview)

One of the fourth-year students described the process by which she had become more accustomed to and accepting of the need to interact with male patients and colleagues over the course of her studies, and the role that doctors and the university had played in this. The following extracts from her interview are particularly important in demonstrating the ways in which values can change over time, in the types of processes identified by Rokeach. This will be further examined in later chapters, but it is worthy of note at this point that the process described by this participant seems to fall within Rokeach's "limitation" process, in which a (personal) value is modified because of its growing incompatibility with other dominant (professional) values.

> When I was in my first year ... I didn't treat any male patients, I was like "no! .... Because in our customs we don't interact with each other … even in the shopping mall I don't talk to men ... But now it's fine, I feel I'm stronger and this thing is not something negative for me, but it's something positive … The doctors, they always put me with men, one time after another until I knew how to handle men…even outside of the work place, if I faced a situation with men, I will know how to handle it and I won't feel so shy and don't know what to do ... In the second year ... we used to tell them we don't want male patients and they kept telling us, no, we have to know how to handle male patients equally, whether male patients or male nurses we have to! ... So this was a huge help for us. I mean if the doctors told us it's fine, you will have only female patients every time, we will never get used to male patients! So I mean the doctors and my teaching as a nurse had the major role in changing my perspective, for myself the line between me and men was something huge. (Kenan, Year 4 Interview)

Some of the student responses conveyed the view that professional nursing values should be tailored to the context of an Islamic society in order for them to become compatible with their personal values. For example, they suggested that such professional values should support the idea of avoiding direct physical contact with the awrah of male patients. However, other participants did not agree with this, and indicated that by avoiding touching the patient in this way they may also be neglecting their responsibilities of giving the best possible care. These participants therefore also fell into the category of accepting the situations which potentially resulted in a conflict between religious/cultural values that prohibit physical contact between the genders, and professional values which support providing the most appropriate forms of care, including therapeutic touch as discussed earlier in the chapter.

> I mean when you see a patient in front of you in pain, I mean the least thing I could touch/tap his shoulder to support him and that's wrong! (Yara, Year 4 Interview)

Some of the interviewees were also asked about their expected reactions to the resistance of their husband, fiancé (in a hypothetical sense for those not yet engaged or married) or male family members to their choice of career, which meant working in a mixed-gender environment. Several stressed that they would be prepared to stand up to this resistance for the sake of their career, especially in the case of husbands or fiancés who would already have known when they first met that the participant was studying nursing. Their views contrast sharply with the account of the participant discussed earlier in the chapter who indicated that she would defer to her husband if he required her to give up nursing,

and this raises questions about whether these students would maintain these views in a real-life rather than a hypothetical situation.

> I will not agree because from the beginning, I mean everything was clear. I am studying nursing, I mean, what does he think I will work or where! I am for example in mixed work but I know my limits. I know how to speak with who, I know how to stop the one who exceed the acceptable limit, so if I know myself and know my values why I should afraid? Or why my family are afraid? I will make my values clear... If someone is afraid for me, I will feel unconfident and frustrated. It annoys me that they don't understand you or mistrusting you or that they even expect something could happen! (Amal, Year 2 Interview)

> The nursing is a part of me, if he didn't accept this part of me I'll not be able to remove it so you take me as a whole, so either this or no, just like that, no no bye. (Basmah, Year 2 Interview)

> The career does matter! I cannot stop because of it. I cannot stop for someone ... It is my life and my future .... Neither a fiancé nor a husband ... (Ruba, Year 2 Interview)

In relation to the specific task of providing personal care to males, relatively few of the students indicated complete acceptance of this aspect of their roles. One second-year student appeared to have no problem with this undertaking this task, but her explanation indicated a possible over-emphasis on professional rather than personal values in the sense of seeing the patient just as a medical case and not a person. Being in her early stages of training, this student is also unlikely to have had actual experience of this situation, so it is not known whether her attitude would remain the same in a real-life scenario.

> I don't feel there is a conflict, on the contrary because I deal (with) the patients as a patient I don't think about whether they are male or female, I deal with a case and I try to help. (Basmah, Year 2 Interview)

The fourth year focus group and some of the interviews also revealed that a minority of participants, while finding this kind of task difficult, saw it as an opportunity to demonstrate love for their patients by providing the care that they need, which they regarded as a specifically Islamic approach to healthcare. This is closely aligned with the findings reported earlier about the ways in which some of these Muslim nurses feel they can provide more complete, personal care to their patients than foreign nurses. It suggests that an increased focus on this Islamic approach to care might even paradoxically be a

way of helping students come to terms with the perceived religious restrictions on providing certain types of care.

> 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)
>
> Researcher: You do it with love? You are accepting of it?
>
> Very. (Zaina)
>
> Researcher: To man, woman, young, old, all?
>
> Yeah! (Zaina, Year 4 Focus Group)

This might be seen as reflecting the process of specification, as defined by Rokeach, whereby a generalized value is increasingly defined within particular contexts. In this case, the student nurses' Islamic values are being applied and defined within nursing. A related and important finding was that some students appeared to link these types of situations with their own personal values, particularly those relating to providing the best possible care for patients and doing their jobs to the best of their ability. This way of thinking appears to have enabled these students to overcome any potential value conflict by reconciling their personal and professional values.

> If I have to do a job I should complete it till the end. If I stop in the middle it means that I am not eligible or qualified! On the contrary this reduces my valuable position in the profession … I can't stop and ask someone to complete my job. (Amal, Year 2 Interview)
>
> 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)

In terms of Rokeach's theory, the scenario described in the second quote above might be seen as fitting with the "consistency" process, in which there is a tendency for certain types of values to "become more or less consistent" over time. In this scenario, the student still holds her personal or religious values about what types of tasks are acceptable to her, but becomes more willing to compromise these in certain situations where this is justified in terms of necessary patient care, perhaps in favour of more fundamental human values such as compassion.

Some of the students that were more accepting than others of the range of roles involved in nursing also acknowledged that they have an important role to play in helping to change stereotypical views about the nature of this profession, and by encouraging younger students to pursue a nursing career.

> I want to change people's perspective of nursing. They see nursing in a certain way, I want to change it by my values and ethics, and prove to them that the nurses - they don't all have these behaviours so don't judge people … Now it's in our hands to motivate the foundation year girls to apply for nursing or not! (Basmah, Year 2 Interview)

Several faculty members stressed that student nurses themselves can contribute to improving the image of nursing by talking with their own family members about their duties, demonstrating their care-giving skills at home, and simply involving them in discussions about their work. In the second quote below, Mayar gives an example of the way in which she had achieved this with her own mother.

> She must be an advocate, taking care of the elderly and giving their medications. The medication bag that the patient receives and does not know what to do with. A lot of patients they don't know how to deal with the medications bag that comes. Although everything is written on it, they still need explanation and follow up. She is the best to do this, she is their daughter, the one they love ... Look there's nobody, no family in Jeddah does not have a member without blood pressure high or low, diabetes .... (Daad, Faculty Interview)

> I used to tell my mother about everything. Why is that? Because I wanted to change her perspective on nursing … They need to talk with their families about their career. Tell them that it includes this and that. They should tell them about their experiences and ask for their opinion. I used to tell them "How should I act in this situation?" and she would be helpful and tell me what to do. (Mayar, Faculty Interview)

6.3.2 Acquiescence

The majority of the second- and fourth-year students indicated that although exposing male awrah made them uncomfortable due to religious and cultural factors, they also saw this task as an essential aspect of their roles as nurses and indicated that they were prepared to tackle the challenge when it arose.

> A sensitive topic which is bed bath or bed making and 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)

This type of response, indicating resignation to the necessity of conducting this type of task, was defined in the analysis as acquiescence. In terms of Rokeach's value change theory, it appears to be most closely aligned with the limitation process, which occurs when a value is modified because of increasingly incompatibility with other dominant values. Students who were responding to value conflicts in this way appeared to recognise that their religious and cultural values were incompatible with certain aspects of their nursing role, and therefore modified these at least in relation to the tasks which were causing conflicts.

Subtle but evident differences emerged between the student participants who gave this kind of response compared to the group discussed above who accepted the tasks more willingly. Many of those who were acquiescent regarding these types of tasks reported a sense of discomfort about undertaking them, while those in the group discussed above tended to exhibit a more positive attitude towards such tasks, seeing them as an opportunity for learning or for displaying their personal values in caring for patients.

Many of the students in both year groups acknowledged that although they would prefer not to undertake tasks involving exposure of male awrah, they accepted this as inevitable, at least in situations when a male nurse or female foreign nurse was not available to take over. However, it was notable that most of the student nurses, while indicating they would undertake this task if they had no choice, were also strongly inclined to let another nurse or doctor do so if they were available, especially if they perceived that the patient would prefer this.

> If there was someone available and can do it, I will call him a man...as he (the patient) prefers and wishes. (Amal, Year 2 Interview)

> I should look for solutions, but if there are none then I should do it. (Ruba, Year 2 Focus Group)

> 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)

It is of course difficult to determine whether peer pressure in the second-year focus group discussion influenced the responses of participants, and whether some might have given

different responses about their willingness to undertake such tasks in an individual interview situation. Nonetheless, many of the students in this group did indicate that, over time, they expect to become more confident and to resolve the value conflict that this type of situation initially presented them with.

Indeed, although few second-year students have had personal experiences of this type of task yet, some such as Bushra indicated that they were already gaining in confidence in this area. Her comment illustrates the process by which professional values are adopted by the student nurses over time and which can help overcome the influence of personal or religious values which hinder their ability to care for male patients. This might also therefore be interpreted as an example of Rokeach's "consistency" process in which a personal or religious/cultural value no longer takes precedence in every situation.

> 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 ... the hospital visits is what made me change my way of thinking and now I could help the other gender. (Bushra, Year 2 Interview)

This comment also suggests that the experience of these types of value conflicts is largely based on the perceptions of the students about how they would feel in these types of situations, rather than real experiences, and that their increased exposure to such situations may be a way of reducing the experience of value conflicts or their negative impacts.

Reinforcing these points, some of the fourth-year students also explained how they had also become more comfortable when dealing with tasks requiring the exposure of male awrah as they became more familiar with these tasks over time. Importantly, some of the student nurses from both the second and fourth-years of study indicated they would even experience a sense of personal satisfaction for overcoming something that they had found difficult to deal with at first.

> First of all, 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)
>
> I mean in the beginning I might be … confused, but one time after another it will be fine …of course I'll be happy that I could overcome something I was scared of

> … I used to say no, I can't imagine myself doing it - I accomplished something. (Arwa, Year 2 Interview)

This is an important point as it suggests that the experience of value conflicts is not completely negative, and can provide a learning and self-development opportunity for the Muslim student nurses if they are prepared to rise to the challenge, in ways that reflect Rokeach's self-confrontation process which is a key stage in value change. Doing so, however, will often require reconciling their religious beliefs and values about what types of nursing tasks are acceptable within Islam. Within the Rokeach value change framework, this specific process might therefore be explained in terms of "specification" or the process by which a general value is gradually defined within a particular context, a point that will be examined further in Chapter 8.

In this context, several of the participants highlighted their awareness that nursing care involving the exposure of a patient's awrah is allowed within Islam in emergency situations.

> "Like (when) there is no one else to help the patient and I'm there to help them. So, we are allowed to when necessary". (Reham, Year 4 Focus Group)

> I mean he cannot expose it unless it is a medical reason. So, for me it would not affect me ... I had a situation at the beginning and I was shocked, but I knew that it is my job and I have to accept it. (Suha, Year 2 Focus Group)

> There is no shyness in science. (Nahla, Year 2 Focus Group)

However, second-year student Baraa emphasized that she would need to protect the reputations of herself and her patient by getting approval of her line manager before being prepared to carry out such a task, revealing the extent of her fear for her own reputation and that of her patient, even if the measure she suggests is somewhat extreme and perhaps unviable.

> It has to be legal and signed/approved by my manager. In that way I am protecting myself and my patient, so no one will be harmed, it does not ruin my professional values too … If my patients really need it, it is emergency, I will take it after I settled all these precautions … to protect my patient and my back. (Baraa, Year 2 Interview)

Although many of the students were of the view that the need to expose male awrah may only arise in exceptional or emergency situations are exceptional, their comments also suggest that there is considerable confusion about what types of tasks are allowed within Islam, a point that will be discussed later in the thesis.

6.3.3 Avoidance or refusal

Avoidance of situations causing value conflicts or refusal to undertake tasks which gave rise to these was a common theme arising throughout the research. Many of the student participants reporting using these strategies when required to give personal care to male patients or to even to care for male patients generally. They often justified this response with reference to hospital policies or practices which they believed allowed them to be excused from such duties. Although the qualitative methods, particularly the use of focus groups, made it difficult to determine the prevalence of each type of response, the overall sense was that this was the second most commonly cited type of response, after reluctance acceptance, while willing acceptance of the tasks was least frequently cited by the student participants.

Indeed, a considerable number of the students indicated that they could not accept the idea of exposing male awrah at all, and indicated that in their current training they would refuse to care for male patients in this way. In terms of Rokeach's theory, this response might be interpreted as an example of the intensity process, as values held by some students which are incompatible with these nursing tasks become more intensely held over time as a result of being faced by these tasks. It may also be interpreted as indicating that processes of specification or explication are occurring in the case of these participants. In these, their existing cultural and religious values relating to modesty between the genders become more intensified and focused on the specific issue of exposing male awrah in the nursing context.

Many of these participants appeared to be under the impression that they are not required to perform such tasks and that the university would protect them from doing so.

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

> I know that the female nurse does not do it for male patient! … not allowed for us to insert for men! … I also heard that sometimes a situation becomes critical when the doctor is not available, and the nurse could do it, but it is not required from us. (Baraa, Year 2 Interview)

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

Indeed many participants – including fourth- as well as second-year student - apparently hold the misguided belief that under a formal university/hospital policy personal care such as full catheterisation can only be provided by individuals of the same gender as the patient.

I think that the university hospital have a policy that Saudi nurses do not put it (catheter) .... I think that the medical interns are the one responsible for it. ... Yeah, a new policy in the university's hospital. (Sanaa, Year 4 Interview)

Others referred to the use of informal arrangements whereby nurses are able to ask a male or a foreign non-Muslim nurse to carry out this type of task for them. The quotes below suggest that these student nurses do not acknowledge that such care is a part of their own nursing roles, and this viewpoint provides justification for their refusal to conduct such tasks.

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)

Some of the faculty participants also expressed the view that female Muslim nurses are not responsible for these types of tasks, supporting their arguments by reference to formal or informal policies or practices and claiming that these are effectively reducing the potential for value conflicts.

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)

The hospital have a policy that with the stuff that need very close contact with the patient, a male nurse will do it. (Maya, Faculty Interview)

The male catheterization is removed already from the nurses' tasks in the first place … New policy is that the physician is the one who should do it, if he is not available then a male nurse … same story with the bed bath .... Long time ago, yes we had students who have faced conflict and rejecting completely that she refuses to work with male … now we are preventing the student from this story. (Shadan, Faculty Interview)

It should be noted that no specific policy documents were mentioned by the student or faculty participants to support these arguments, however, and no evidence of such policies was found in the documentary analysis, with the exception of the hospital's Patient Rights document (2012), which gives patients the right *"to accept or refuse medical treatment"* and which, as noted in Chapter 7, may perhaps reinforce the possibility that male patients will refuse care from a female Saudi nurse, giving the nurses themselves a reason not to have to undertake such tasks. Indeed, the comment of one of the student nurses suggests that this participant is using the issue of patient rights as an excuse or justification for her own unwillingness to expose male awrah.

> I might talk to the university that I tried with a patient and he refused so can I just do it on a female! … If it saw that I tried more than once, and it didn't work, maybe the university will accept. (Zaahra, Year 2 Interview)

Married faculty member Mayar suggested that students should ask a male patient's wife or close relative to provide personal care to them, in order to avoid this type of value conflict. Indeed, this approach seems compatible with the Islamic approach to healthcare in which family members have a central role, although it still represents an avoidance of the task on the part of nurses. Several of the student nurses also referred to the option of asking a patient's wife to carry out this care for them, a strategy described by second-year student Amal as helping to ensure that all relevant parties are comfortable with the situation.

> You can ask the family to do the care by themselves … let's say in changing the diaper, for example ... I'll ask her, please change the diaper for your mom or for your father or brother. (Mayar, Faculty Interview)

> If I am the patient I will prefer my wife of course to do this care because she is the closest and she has the right to do it before anyone … We all want him comfortable whether I am a wife or as a nurse, it is the patient's right. (Amal, Year 2 Interview)

It was notable, however, that some of the participants who said they would refuse to expose male awrah appeared to experience an acute internal struggle, suggesting that this decision did not resolve their value conflict. The following quote from fourth-year student Sanaa's interview indicates that on the one hand she cannot possibly face undertaking

such a task, while on the other hand she acknowledges that she may have to do so if she is to continue in nursing. She therefore appears to be clinging to the hope that over time this type of task will become easier for her.

> Some would look at it as it is their job and they have to do (it) but me, I cannot do it and it is not my fault since I feel embarrassed. It is something that I have to get used so I might be able to overcome it in the future. (Sanaa, Year 4 Interview)

Some of the student participants highlighted the potential negative implications of this type of value conflict in terms of student retention. Referring to other student nurses from more conservative religious backgrounds, a theme which comes up many times in the research findings, they reported that these sometimes leave nursing altogether or change to a non-nursing program major after the second-year when they discover they are required to expose male awrah.

> There are some people who are very, very strict in the religion and ... so, she says that, "no I can't deal with the other gender, it cannot happen", maybe these are the people who quit or drop out of nursing. (Bushra, Year 2 Interview)

One referred to others who had dropped out voluntarily due to their own discomfort about this.

> There are people who continued but when they saw how nursing is, they just left by themselves ... I mean some of them say the care for this area is a "no" for me, it's too embarrassing for me and the mixed environment and the nursing and a lot of things, like they are against our principles ... so after the second year they changed their major. (Kenan, Year 4 Interview)

In the case of the participants in the current study, several in both the second and fourth-years of study indicated that although they plan to work as nurses in future, they intend to seek jobs in specialist areas that do not involve caring for adult males, such as paediatrics or obstetrics, and appear to have the expectation that this will be possible.

> Maybe when I am working these conflicts will not be there because I have my freedom to choose where to work. For example, … hopefully will be in the children unit. (Baraa, Year 2 Interview)

> Enshalla once I graduate, I will work in paediatric unit ... They didn't allow male nurses to work in this (children's) unit because of the mothers who are sitting with their patients. So few males enter the room …this is one of many things that makes

me consider paediatric unit to work as a nurse…I will be relaxed to work in this unit, I will not feel guilty to talk or see lot of males and this help me keeping my value of not cheating on my husband by eyes in my future working place. (Yara, Year 4 Interview).

The "cheating by eyes" reference in the second quote above is one discussed earlier in the chapter; this participant is one whose conservative personal and religious values appear to be strengthening over time, particularly since her marriage, and she feels that she is being unfaithful if she even looks at a man other than her husband. As a result, being married appears to exacerbate the potential for severe value conflicts when caring for male patients, at least for this participant. This type of value strengthening following marriage might be seen in terms of Rokeach's explication process, in which implicit values become more explicit, or in terms of intensity, or the way in which values become more intensely held over time. This might be occurring in response to the tasks they are being asked to carry out, making them realise that their values are not compatible with these and reinforcing their focus on these values rather than displacing them with new professional values.

Having personal experience of this type of value conflict or understanding the reasons for it meant that many faculty participants were quite sympathetic to the reluctance of second-year students to interact with the opposite gender or understood their inability to converse confidently with them. However, the faculty stressed that students need to gain confidence and accept these tasks over time if they are to succeed in the nursing profession. These views were demonstrated by the following reactions to one of the hypothetical vignettes presented to the faculty, in which a student nurse turned away in embarrassment from a doctor who asked her professional opinion about a patient.

> Imagine this girl come to work after graduation and tell you that I don't take male patients, or don't want to work in a male unit. All male patients need care, they need someone to give them morning care for them. If she said no, we can't say the Filipino or the Indian nurse will do it and you are not because you are Saudi … We have to be honest with her that they will face this. And they have to do it, they got to do it! Face it! .... Maybe if she is second year I will say it is ok as she still needs time to learn, it is too early for her and she still learning with very minimal exposure. But if she was a fourth year, it is disaster, she is going to internship, she won't be able to work! (Alana, Faculty Interview)

> If she was a second-year student … her reaction was normal that yes she doesn't deal with males … if she was a fourth-year student I'll say it's a big problem …

you have to know that your profession is mixed and we are a team whether male or female and we have to deal with both genders (Mayar, Faculty Interview)

She must get used to it because it is necessary to interact with those who around her because nurses work in teams. There is a doctor, social worker, and dietitian and … and everyone in the hospital. I cannot interact with some and not the others because the patient is above all of those things. (Ekram, Faculty Interview)

A number of faculty members mentioned the use of an informal practice of releasing students from the requirement to work in male units. The following quote explains that in some circumstances this practice becomes necessary in order to retain students within nursing due to family resistance. However, the faculty member also recognised that this approach can only be used in exceptional cases due to the need to provide adequate nursing cover.

We change it for her, we make all her rotations in the female units. I mean we try to solve these problems for those who we find that they are really trapped and struggling to move on with it … If is the student's problem, and she come on saying my husband forbid me and it is a matter of a divorce and nonsense like this. It is not worth it, we don't want this to happen, I mean it is not a big deal to force her, we will do what suit her and support her … I mean we try to solve these problems. … but we can't generalize it as rule or as policy to allow all the girls work with females only, this is very difficult! (Shadan, Faculty Interview)

Another faculty participant indicated that although they sometimes tried to accommodate the preferences of students who were uncomfortable about caring for male patients, there were not always enough male or foreign nurses to cover for them. In this situation, a request to be excused from such tasks would not be accepted regardless of the reasons given, according to one faculty member.

In their rotation we don't leave them without support or explanation, if there is catherization required there is a male nurse to do it, a male intern, a male resident but this is not an excuse when they say "because of my husband" - I am sorry, this issue is not our problem! ... I am sorry (but) you have to complete this rotation exactly as in the internship. (Daad, Faculty Interview)

Rokeach's theory of value change can also be used to help understand why these avoidance strategies are not likely to help overcome the experience of value conflicts among nursing students as a whole in the longer term. As noted above, the responses of students who avoid tasks which involve value conflicts by them can be explained in terms

of Rokeach's intensity or explication value change processes. The problem is that their personal, cultural religious values which clash with the professional values of nursing are likely to become strengthened rather than weakened over time, contributing to an overall nursing education environment in which it is legitimate to regard Islamic religion and culture as being incompatible with rather than aligned with the nursing role.

Conversely, some of the student participants who accepted the need to overcome such conflicts expressed the view those who cannot accept that they will have to interact with male patients and colleagues should not become nurses or must come to terms with these requirements.

> There are some girls till now they are not ready to talk ... with males or give care to male patients. I think these should not go into nursing! ... It is clear that nursing is a job requiring male interaction. (Baraa, Year 2 Interview)

> Once we had a survey about volunteering and whether it is ok that the team have male members .... Many put "No!" I was surprised that they are in nursing, I mean you are going to deal with male patients, doctors, male nurses! …. I mean they verbalized "I can't work with men"! I mean they are nurses and they are going to take care of male patients. (Sondos, Year 4 Interview)

One fourth-year student cited the example of a student nurse known to her who had successfully managed to avoid working in male units, but only after facing much resistance from her lecturers, and also at the cost of her full nursing qualification. Her account of this indicates that this participant at least understands the potential negative implications for student nurses of refusing to provide care for male patients and accepts that this is an unavoidable aspect of their role.

> They tried to convince her first that she should cover all those rotations to complete the course! But she refused, and we can see how much trouble, how much confrontation she faced. Finally, they gave her an exception to go to the female unit again and skip the male rotation. But we can't all do this …I mean they have to cover all clinical areas, all male and female units, it is obligatory. If she did not cover the requirement, she will not be issued the intern completion certificate! ... She will be graduated, yes, and will have her degree certificate but not the intern certificate, so she can't work without it. (Yara, Year 4 Interview)

However, it is notable that this type of case may encourage students to enter the nursing degree for the purpose of obtaining an academic qualification who have no intention of working as a nurse. Although it may well have been an exceptional situation, releasing

any nurses from their duties to treat all patients may also set a risky precedent that might reinforce the potential for value conflicts rather than helping to resolve them through increased exposure to the full range of nursing tasks. Such an approach is also likely to have negative financial and workforce implications for Saudi Arabia, due to the resources invested in training nurses who do not subsequently join the workforce, and the reduction in available places for potential recruits who would pursue this career on graduation.

6.3.4 Concealing or Hiding

As a variation on the avoidance response, and therefore categorised as a separate theme, the issue of hiding or concealing various aspects of the students' identities as nurses from their family members repeatedly came up in the interviews and focus groups.

Many of the students explained that they avoid talking to close family members about the details of their nursing tasks as a way of avoiding value conflicts, because they are aware these tasks are not acceptable to them or because they are embarrassed about these aspects of their jobs. In the case of tasks involving exposing male awrah, the majority of the participants indicated that their spouses or relatives would not accept that they carry out these tasks, and for this reason they would not consider talking about these tasks with them, though their comments appear to be based on perceptions of likely reactions rather than actual experiences of these.

> I will not tell them! what am I going to say? I have exposed male aura or seen his private area! No! (Baraa, Year 2 Interview)
>
> Just now I'm imagining my family and like that and they will not accept it, that's why I don't even tell them. (Kenan, Year 4 Interview)
>
> I will not tell my mother, she will get shocked! What will she tell me? She will tell me that "is not there anyone else"? What she will tell me! She will asked about the others, why me? Why there is not anyone else to do that job! If I am to tell anyone, it will be my friend. (Nadeen, Year 2 Focus Group)

Even among those students who are not facing resistance from their families or husbands to their choice of nursing studies, it appears to be quite normal practice to conceal from them the specific nature of the tasks they are or will be required to undertake, especially providing personal care to male patients. For example, Yara, who hopes to work in future in areas of nursing not involving these tasks explained:

This situation is what I did not tell my husband about ... he knows that I will take care of male patients but ... we are not talking about work in the home and thank God for this. This is a big relief, and that's what made me happy. I don't talk about the work a lot because - maybe if he knew that the patient is his father's age he might let it go, but if he knew that the patient is a young man he could say "why did not you ask somebody else to do it?!" ... After I finish my training and start to work in paediatric unit I will not be in this situation again enshallah (if God is willing). (Yara, Year 4 Interview)

Second year student Nadeen similarly explained that although she is prepared to be quite open with all her family members, including a future fiancé or husband, about some aspects of nursing, she would conceal from them what is actually involved in conducting fairly fundamental nursing tasks such as giving a bed bath to patients, reporting that this is something which she herself only discovered when she began her training.

They are my family and they have the right to know; fiancé, husband, sister, brother, mother, or a father. However, they would not understand the scientific way. For example, before I study nursing I thought that bed bathing would be that I take the patient to the bathroom and help them. But no! Bed bathing that we learned and did in the hospital in the first day is different! You held them, scrub, rub, and clean and that is the scientific way, not like what people think. My family knows about bed bathing but they do not have to know all the details. (Nadeen, Year 2 Focus Group).

In contrast, second year student Nahla indicated that she intended to be quite open about the nature of these kind of tasks, as she felt it was better for her family members to learn this from her rather than hear other people gossip about what she does. At the same time by stressing that she would not do so until she became more confident that she would continue in nursing as a career, this participant is also concealing aspects of her nursing identity from her relatives.

I have to tell my family about my work rather than avoiding it. .... they have to know about some stuff like bed bathing. They have to know what exactly I am going rather than hear it from someone else. I can convince them by showing them I do. They have to know! It does not have to be right now because we are all unsure. I should tell them when I know that I would continue it. (Nahla, Year 2 Focus Group)

Some faculty provided evidence of student nurses who have encountered extreme situations of family resistance to their choice of nursing studies and either go to the

extreme extent of lying to their families about what they are studying or ultimately leave the degree course because of their resistance. The following faculty participants even gave accounts of student nurses who were locked in at home to prevent them from pursuing their nursing studies, though it is not known whether this particular case relates to the same or different individuals:

> We are talking about the undergraduate girls who are still young and they are not able to deal with or know how to solve the conflicts that face them and their parents. Some of them can convince their parents - of course, the parents are open minded and they will say to them as long as you love this thing continue! But the people who are close-minded … yes they lie to their parents or must really stop and quit even if she loved this profession because of her family. Or she just lives with the conflict or the parents forbid her to come for her final exams! They locked her home, to prevent her from going to the college, because the mother or father are not convinced about this job. (Shadan, Faculty Interview)

> Something happened last year, a student's father would not let her to come …. Because after a year and half he finally found out that she studies nursing …She started to skip so many classes and was close to be dropped out. "My father would not let me get out because he did not know that I was taking nursing" … We have so many cases like this. (Maya, Faculty Interview)

Shadan went on to cite another example of a student who completed her whole nursing degree without the knowledge of her parents, as they believed that she was studying a different field.

> The student - after she enters, for example, the second year - she starts loving nursing! This conflicts with her family in that her parents do not like nursing! And they don't want her to continue in nursing, they want her to leave or transfer to another field, so this really puts the student is major conflict yes. I know one of the female students in the fourth year where she graduated, and her parents didn't know she was in nursing! (Shadan, Faculty Interview)

Although this is likely to be an exceptional and unusual case, this ultimate example of concealment might be expected to have had severely negative impacts on the student concerned in terms of stress, for example, and raises questions about how personal values such as honesty may have been compromised in order to avoid the clash of values with her family members. These types of issues will be considered in the discussion chapter.

Several other examples emerged of concealing one's identity as a nurse, most but not all were indirect rather than based on the direct experiences of the research participants. For example, it was reported that, for some families, a nursing degree is seen as a valuable

educational qualification, yet they would not want the student to actually enter nursing as a profession and do not even envisage the types of tasks that student nurses are required to undertake. In this type of situation, it was reported, the students sometimes lie to their families in order to preserve this distorted image of their studies.

> I know girls - their parents - basically they don't know for example that they go out to the hospital and such thing, because they are not imagining for example to see her without abaya .... They (parents) only wanted them to study and have the degree; it is just a certificate ... and be employed in another thing not nursing ... And some say, for example, "there aren't any men, we are not dealing with men, we are doing something else. (Sawsan, Year 4 Interview)

Sawsan also provided an account of a nursing student known to her who used to hide from her relative who is studying medicine at the same university, as her family were under the impression she was also studying medicine rather than nursing and she was afraid her secret would be revealed.

> ... When we were in second-year there was one with us who is hiding that she is studying nursing from her family and parents, to the extent that she is hiding from her relative who was studying medicine. When her relative appears, she runs away and hide from her because everyone in her family thinks she is a doctor. (Sawsan, Year 4 Interview)

Many of the findings regarding responses to value conflicts reinforce the earlier observation (page 87) that family background plays an important role in whether these Saudi Arabian Muslim female student nurses are likely to experience value conflicts. They also provide additional insights demonstrating that the family also has an important influence on students' responses to and ways of coping with value conflicts. These may depend, for example, on whether family members are supportive of and prepared to accept their nursing roles and responsibilities, issues which will be discussed further in Chapter Eight. Rokeach's theory of value formation and change is well suited to explaining these findings, as it showed that values formed early in life from one's family background often remain strong and stable over time, even though they can be influenced by other factors. According to the theory, however, a number of specific processes can take place which result in gradual or abrupt value change, and which can be used to help develop deliberate value change initiatives, as discussed later in Chapters Eight and Nine.

6.4 Organisational Factors

The research also investigated the student nurse and faculty participants' views on the ways in which the university is currently preparing student nurses to face their responsibilities and to reduce the potential for value conflicts. Overall, the findings indicated that, in the views of both student and faculty participants, the university is not adequately meeting its responsibilities in this area at present and may be contributing to the widespread experience of value conflicts among student nurses. Considerable confusion was revealed, even on the part of faculty, about the existence and use of particular policies such as those relating to single gender nursing, and the participants identified many areas in which there is scope for improvement or for the use of new initiatives to ensure that students have a better understanding of how to carry out their nursing responsibilities without encountering value conflicts when doing so. The specific findings are discussed by the sub-themes shown in Figure 8 which emerged from the data and are discussed in turn below.

Figure 8: Organisational Factors - Related Sub-Themes

6.4.1 Lack of Transparency about Nursing

Many of the research participants, including both students and faculty members, observed that there is a lack of transparency about what nursing entails in the early stages of nurse education.

> 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 who let them take nursing expecting that they will be working with females as they are studying in a female college ... They need more orientation and awareness of what nursing is about. This is from the first elementary year. First year of university too, so that the one can decides to what she wants to do, at the same time after all of that if she decided to complete in nursing, they have to support her and stand beside her in these situations and such conflicts. (Yara, Year 4 Interview).

This lack of transparency is likely to hinder the development of value change processes in which new professional nurses values gradually become stronger while any personal values not well aligned with nurses are weakened, as defined by Rokeach in terms of creation or attenuation, for example.

Some participants commented that students only really start to learn about nursing roles and responsibilities in their second-year, at which stage many experience shock at what they will be required to do, and leave the course because this conflicts with their religious or cultural values. Some of the second-year students indicated also that what they learn in the university is not currently well aligned with what they experience in the hospital, indicating that more realistic, transparent forms of teaching are needed.

> They would come to explain stuff but then when we go to the hospital we would see totally different thing. (Samar, Year 2 Focus Group)

> From the beginning of my studies they used to say that most male patients are treated by male nurses. For example, in the bed bathing ... They were saying that men will wash men ...They should not only teach us about women it is possible that a situation comes like this ... 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)

One of the faculty members, Maya, referred to a program delivered to the second-year students in which they can learn more about nursing, but acknowledged that this could be expanded to include more training about real-life nursing situations.

> We give the second-year a week of academic conciliation so they can learn about nursing program ... They get guest speakers that talk about their experience. How nursing affected their lives and all that. Maybe we should intensify it and add some parts about ethics and whatever. What would they find out as interns! Or when they finish their practical training. That could lessen it (potential for value conflicts). (Maya, Faculty Interview)

This participant also referred to the orientation sessions provided to second-year students, in which alumni and other guest speakers present information about their day to day work, which serves to increase awareness among the students of the mixed gender environment they will be working in.

> We teach the second-year students' academic guidance about the career. We ask people who have finished their studies to talk about their experience. We get guest speakers from Specialist hospital and university's hospital to talk about their career and their specialty and who do they work with. I think this makes them more aware that they are going to work in a mixed place so they start to learn. (Maya, Faculty Interview)

However, it emerged from the second-year focus group that some of the training sessions the students had participated in were delivered by educators from other countries, who had little awareness of the Saudi Arabian nursing context such as the cultural and religious influences on providing care to members of the opposite gender. The participant reporting this stressed that there is a need for the university to be more forthright and transparent with student nurses about what will be expected from them as nurses in this particular context, and that it is important that the training be delivered by local nurses who understand the Saudi Arabian context of nursing.

> The people who will teach is about the things that we will face in the hospital or tell us about nursing generally; they will be basically Saudi nurses who work in the hospital! ... They should come and tell us the real thing happening ... For example a doctor came from Britain and tells us that and this is like that in her country. Do not talk to us about your country, we are here in Saudi Arabia. (Ruba, Year 2 Focus Group)

On a related point, it was suggested that one of the best forms of training is leading by example by faculty who have considerable personal experience of nursing. Second-year student Amal stressed in her interview how effective she had found this approach particularly in reducing the potential for value conflicts when caring for male patients.

> For example, the instructor herself in the hospital she is giving us live example in front of us ... We were in the hospital and the instructor told us how to talk to the male, to talk well .... And we all understood this and applied it after that. ... She told us herself when you go to the male patients show them that you don't have a problem to reduce the distress, and embarrassment (Amal, Year 2 Interview).

One of the faculty members also stressed how important it is for the teaching staff to represent positive role models for the students by demonstrating how to interact with and talk to male patients. She explained how she does so in her own interactions with students and patients:

> I start the conversation in front of with them … and you know my voice is loud. I talk to the patients and talk to them as if I was in front of female … and let the student be encouraged to start talking with the male patient … It is according to the instructor who is with them. I mean there are some instructors who avoid males … Of course, when I am in the ward I have to deal with the males, (I) took this students group and I started the conversation with them and started to allow each one to ask a question. One by one until they feel used to talk to the male patients. (Shadan, Faculty Interview)

6.4.2 Insufficient Clinical Experience

Another aspect of the curriculum in which some of the students noted shortcomings is clinical experience, particularly in the early years of training. Because of this, and since all educators within the College of Nursing are female, this means that the students have very limited opportunities to interact with male staff or patients, and those from conservative religious backgrounds are not learning to overcome any potential value conflicts they may face. This again may hinder the development of Rokeach's value change processes of creation and attenuation, and in some cases increase the possibility that processes of intensity or explication will occur in which previously held values which conflict with nursing are strengthened or increasingly conceptualised in the nursing context. One option for helping to promote more positive processes of value change, through familiarisation, may be increasing numbers of male instructors, while the following quotes from second year students suggest also that by increasing the amount of clinical training that they receive and also ensuring that this covers nursing for both male and female patients, these value conflicts may be reduced:

> Best thing is to train us in clinical …this is more than enough, if we start to deal with men, male patient, male doctors, male units (Baraa, Year 2 Interview)

> They don't tell you how to deal with men and you have this idea in mind, it will be always caring for women. The nature and reality of your career not only with women, it is with them both men and women … Since this is what I am going to face in the reality and I will be in this situation they should give me the whole picture and not half of it! (Amal, Year 2 Interview)

However, at least one of the second-year students and one of the fourth-year students explained that they were gaining more experience of interacting with males since the hospital was now requiring them to work on male surgical and medical wards as part of their training; one also mentioned that the hospital had recently recruited more male nurses, which meant that the female Saudi nurses had to work alongside them in teams.

> They are trying to help us adapt. They do not send us to only female departments but also to men's departments. (Sanaa, Year 4 Interview)

> I feel they are already helping us on this side by allowing us to go (to) the … areas which is specific for male - like the male surgical and the male medical … also the university's hospital hired a number of Saudi male nurses, the foreign men putting aside their nationalities, there are male nurses so now we can deal with them. One of the responsibilities that was put for me that you have to deal with my male nurse in the daycare unit, he is the nurse you'll be working with, you have to deal with it, that's it! (Basmah, Year 2 Interview)

One of the faculty interviewees also argued that the since the nurse teaching materials are not gender-specific, they are used to teach students how to deal with all patients and colleagues, both male and female.

> In some of the material they are studying they are taught how to deal with the team, male physicians, male patients and whatever else. One of the outcomes of learning in the faculty is working with cooperation team. And I think that is also taught in all subjects, how to treat patients: females and males …. There is nothing separated or especially in dealing with the other gender. (Maya, Faculty Interview)

These measures may not have a major or immediate impact on the experience of value conflicts unless students are also provided with more specific training or support on how to interact with male patients and colleagues, or how to cope with providing personal care to males. However, the examples cited do suggest that the participants recognise that greater familiarity with these situations may help the students to adapt to their responsibilities and adapt their values so that they are more aligned with these. In terms of Rokeach's value change processes (1979), this can be conceptualised in terms of the gradual "creation" of new values or the "attenuation" process whereby individuals gradually weaken their support for an existing value.

However, it also emerged from the fourth-year focus group discussion that student nurses have very limited opportunities to use hospital equipment to learn about real life nursing

situations, and are instead relying mainly on videos, which does not appear to provide sufficient hands-on experience of caring for patients to make them more comfortable with these situations. As Retal explained:

> There is a section in the lab of the hospital where the medicine students use as they like but we need to make a reservation. We went once so we can use the shock wave therapy machine and they told us that we have to wait long before we can use it. It is supposed to be a university hospital that serves all the students ... It is a concern that we also don't have equipment and we need to learn so the hospital should put us in the schedule. (Retal, Year 4 Focus Group)

6.4.3 Lack of Ethics Education

The interviews also revealed that the current nursing curriculum currently includes very little content focusing on ethics, an area which might help raise awareness among students about types of value conflicts they may encounter and perhaps improve their ability to deal with these. The student interviews revealed very low levels of awareness of official documents such as the Nursing Code of Conduct and Ethics, which is unsurprising as these are not introduced until a very late stage of training. According to the research findings, the Code of Conduct and ethics teaching is only properly covered in the fourth-year of the nursing degree and students are only introduced to the hospital's Code of Ethics when they become interns in the fourth-year of study. The Code of Ethics is touched on only briefly in the Concepts of Nursing course taught to second-year students, as described by faculty member Mayar who teaches this course:

> In the basic concept material that I taught this year, there were lectures about communication and therefore we reached the point of how to handle situations. I gave them examples on what to do when you are in a hospital, as you will deal not just with patients, but with patients, doctors, physiotherapist, nurses and head nurse. They will deal with a complete team. Therefore we teach them how to deal with them and how to respect. I also gave them a lecture about patients' rights. These are the basic concepts … It keeps itself very simple. Just a little bit but, not to prepare the students to those issues or values and conflicts that will face them. (Mayar, Faculty Interview)

However, faculty member Alana argued that the ethics training provided to student nurses is inadequate and highlighted that this is provided in other areas such as the department of medicine but not in the nursing faculty. Including more coverage of ethical issues in the curriculum may help reassure the student nurses and enable them to better understand their experiences and feelings.

Ethics module is lacking! in the other specialties and colleges they do have it, but in nursing we don't have it ... We must have this subject to teach for the students... what I know and am aware of, these are a couple of words (paragraph) only in fundamental module about ethics in the second-year. There must be more about ethics, from my experience in another college there is a full semester condensed module about ethics... (Alana, Faculty Interview)

Faculty member Mayar also pointed out that, by learning about the ethics of nursing and the types of tasks involved at an early stage, students would be able to determine whether or not the profession is suitable for them, rather than wasting their time studying a course they later drop out of.

Our problem is the code of ethics which is very important and everything is based on it and we give it to them in the fourth-year! too late!... We should give it to them in the beginning, in the very start … tell (them) from the beginning so the girls knows what it is before wasting her time and years of studying (Mayar, Faculty Interview)

These points were supported by some of the student participants who also argued that they are not receiving enough ethics training, particularly training intended to prepare the students for the everyday challenges of nursing and how to behave in various situations they might encounter. As second-year student Baraa explained:

They added the ethics and the other values … But they did not teach us about what is expected from us like what to do and what not, what is acceptable and what not in relation to our values, so you understand? (Baraa, Year 2 Interview)

The second-year focus group participants referred to a lecture they had attended on medical ethics, but though some reported finding this helpful, most felt it was not sufficiently tailored to the context of nursing and did not reflect the reality of their situation. As in the case of earlier findings, this again indicates that many of the students are experiencing a form of reality shock when they discover what is actually required of them as nurses, compared to their expectations or the information initially received. In this focus group, Nahla explained:

He talked about nursing in a general way, its rights, what to do, and the nursing history and things like that ... They told us that we will not do that, and when we came we find ourselves doing it.. (Nahla, Year 2 Focus Group)

One of the faculty members (Daad) expressed surprise that the fourth-year student interviewees had not referred to the Health Commission's Ethics for Health Practitioners, which she explained had become mandatory in Saudi Arabia and had displaced the American Nurses Association Code of Ethics. This is apparently taught to fourth-year students but was not mentioned by them. It is not clear what the reasons are for this conflicting finding are, but regardless of these they demonstrate that a problem exists either in terms of students not receiving this ethics training or not recognising or remembering that they had done so, perhaps because it was not perceived by them to be useful. It therefore appears that this training is not currently effective in raising awareness of the student nurses about the ethics of nursing.

6.4.4 Lack of Clear Policies

The researcher determined that although there is no official policy in place at the university which specifies female to female and male to male personal care, this has become an accepted practice at the hospital as noted earlier, and has perhaps led to the widespread confusion about the tasks that students are allowed to refuse. The following quotes illustrate the types of conflicting perceptions and beliefs that exist among the students:

> There is one time I heard it when the doctor was giving a lecture here. She said the male nurses treat male patients and vice versa. (Kenan, Year 4 Interview)

> There is a point I am not sure about, that I am allowed to do for men or not (Baraa, Year 2 Interview)

> They let us … I mean with both gender… I mean there is no difference between the male and the female, but they encourage us by saying you must treat both if you were assigned to one you must deal with it. (Bushra, Year 2 Interview).

The faculty interviews revealed that student nurses are often given misleading advice by their lecturers that they are not required to provide this type of care to male patients, even though there is apparently no formal university policy to support this. In the case of some faculty members, it appears that their approach to teaching nursing is being influenced by their own religious or cultural beliefs which prohibit exposure of male awrah by females.

> 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)

Other faculty members including Ekram and Alana indicated on the other hand that their approach is influenced by what they had been taught in their own nurse education about not exposing male awrah. This suggests that such beliefs and practices are perhaps being reproduced over time in nurse education without having their accuracy or appropriateness questioned. They also indicate a need for more education and awareness raising among the nursing faculty so that their current attitudes and beliefs do not reinforce the potential for value conflicts among students.

> We can do a full-body physical examination of the patient … but areas like genital area or strict pudenda, she does not see it because the nursing and the religion do not allow. But here we are talking about the males (Ekram, Faculty Interview)

> In the clinical they told us that fully 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)

Another of the problems resulting from this avoidance of providing personal care to male patients was highlighted by a second-year student participant who argued that the student nurses are thus not being adequately prepared to work in other hospitals, even within Saudi Arabia, where there are different policies and practices in place regarding this type of care.

> I don't feel it would help me if I worked in another hospital, because in another Governmental hospital you can remove the catheter from the men! … There some different policies from one region to another in the Kingdom, for example like the Royal Commission in Yanbu you can do everything - it's ok, you're a nurse, it's fine you're allowed to do it. (Basmah, Year 2 Interview)

The faculty interviews also explored participants' views on the use of other types of formal policies and whether these would be helpful in reducing the value conflicts potentially faced by female Muslim student nurses. These included, for example, patients' privacy policies, communications policies, and patient and nurse' rights policies. In general, the faculty participants concurred that having more formal policies issued by the hospital or the university in these areas would be helpful and would start to help reduce the potential for value conflicts.

For example, when asked in their interviews whether a formal patients' privacy policy covering exposure of awrah would be useful, all of the faculty participants agreed that it would, and some claimed that this is already in place, even though the researcher could locate no firm evidence of this. The interviews did not explore, however, whether their response would remain the same if such a policy stated that female Muslim nurses were permitted to expose male awrah.

> Of course, it would help and it does exist in the university's hospital … the catheterization and any other thing that includes the private area should be done by male if the patient is male and a female by a female. (Maya, Faculty Interview)

> (There is a) new policy that the physician is the one should do it … if he is not available then a male nurse" (Shadan, Faculty Interview)

> Yes, of course, to know exactly what is required from me, what I am allowed to do, what is acceptable. Sure, sure, I will be relieved and heart comfort feelings will be great to know what my role is, especially the ones referring to our role as nurses will help me to accept and cope .... 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)

There was a general consensus among the faculty interviewees that a communications policy, which the researcher explained might provide guidance on verbal and non-verbal ways of contact and acceptable limits of communication with the opposite gender, would be useful. One explained that this would be particularly valuable in helping to guide communication between medical professionals of different nationalities and cultures. According to another of the interviewees, this type of information is already being taught informally to the student nurses, but has not been formalised as policy and therefore is not being properly followed.

> I think that it is very important. Especially in the hospital where miscommunication would happen and I noticed that it is between Saudis. Also, I noticed that a miscommunication would happen between a Saudi physician and a non-Saudi nurse. … Because the culture is so different … There was this one time where there was a Saudi and because there was a female nurse he would avoid communicating with the female nurse. (Maya, Faculty Interview)

> There are some things that we talk about like the tone, the volume, laughing, and the posture. Those we speak about but it should be written … Like the posture, the coat should not be tight or short. We talk about it but as long as nothing is written everyone will do whatever they want. (Ekram, Faculty Interview)

The faculty participants also mostly agreed that a statement of patients' and nurses' rights would be valuable, and again it was observed that these issues are being taught to students on a basic level at present but not in sufficient detail to provide real practical guidance.

> Sure, to know when and what the patient refuse and to respect. Also when the nurse has the right to say no and for what? (Alana, Faculty Interview)

> They learn about patients' rights within the subjects but they do not learn in a separate subject. They do not go deeper in details. They learn about it too in orientation in the hospital. (Maya, Faculty Interview)

Second-year student Amal emphasised the importance of the hospital's dress code in reducing the potential for value conflicts relating to interactions between men and women. She explained that observing the dress code helps the nurses to establish a formal relationship with patients by coming across as respectable and modest, and by discouraging inappropriate interaction which exceeds normal communications between a nurse and her patients.

> It explains the limits, and explains the professional values … often people judge us from the way we look … If there is a respectable person, there is no makeup, there is no tone in your voice it is clear, they will respect you … Maybe there is a patient that likes to talk, and he will feel free to talk with someone who wears makeup or not covering her hair, right?... For example, the university dress code to wear long lap coat, don't wear a lot of makeup this thing will prepare you. That you are going to work and you are not going, I mean not to socialise, not to build up friendship … no you are going to work. (Amal, Year 2 Interview)

The participants' views on the possible role of policies and formal practice in reducing the potential for value conflicts may well be justified, particularly in terms of clarification of the tasks that Muslim nurses are allowed to carry out, as well as the patients' rights to refuse care from them. However, the existence of policies alone is unlikely to have much impact unless these are also covered in nurse education. This is also the case for the next potential measure explored in the research, the use of formal Islamic guidance (fatwas) relating to nursing roles and responsibilities.

6.4.5 Mixed Views on Role of Islamic Fatwas

Overall, there was little consensus among the faculty members or students about the potential value of Islamic fatwas in reducing value conflicts especially relating to the provision of personal care for male patients.

Some faculty expressed a strong belief that these would be helpful especially for very religious students as they would remove any doubt about what is acceptable within Islam and provide a case for them to refuse certain tasks, or to convince their male patients that these are acceptable within Islam.

> Of course it would help. It would help a lot. I think that it would help religious ones, but most of the students feel like it is okay and normal. (Maya, Faculty Interview)

> It is very effective because … as an Islamic society we are controlled and ruled by Islam at the end … Islam is the one controlling us, so 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 to do this, you should do bed bath for a male and you should consider that you are cleaning for male genitalia, that is it. If there is no fatwa supporting you or policy based on this fatwa … But when you give me an advisory opinion like fatwa and say that even the female nurse shouldn't do something like this ... Fatwas are our reference and it is our guidance. (Shadan, Faculty Interview)

Other faculty members, however, expressed the belief that fatwas are not likely to be effective in removing ethical dilemmas as they are typically modified over time or are subject to different interpretations and therefore lose their significance. Some suggested that fatwas may detract from the important roles of nurses and are therefore not seen as appropriate in this context.

> We have different doctrines and within those doctrines there are differences so there are no direct fatwas, and we honestly always hear there is changes in the fatwas, there is fatwas from 10 years ago which prohibits somethings where nowadays its allowed … I'll not go through the fatwa I'll go based on my instinct and the right thing, I'll follow the Quran and Sunnah and what it says … but if someone give me a fatwa I'm sorry no. (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. If my patients does not accept me as a female it is up to him, it is his health and he is free to take his decision and choice. (Alana, Faculty Interview)

This divergence in views on the potential effectiveness of fatwas in reducing the potential for value conflicts was mirrored to an extent in the student interviews and focus groups, perhaps reflecting differences among the participants in their degree of Islamic conservatism. In the second-year focus group, for example, most participants agreed that fatwas could be effective in reducing value conflicts, yet some referred to the changes over time in religious fatwas relating to other issues, and indicated that they would might not be taken seriously as a result.

> 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)

Nonetheless, these findings raise questions about the role of such guidance in the context of the conservative Islamic society of Saudi Arabia, vis a vis the types of guidance issued by professional nursing associations internationally, which are often incorporated into local codes of conduct without consideration of the religious and cultural context of this society. These issues will be considered further in Chapter 8.

6.4.6 Inadequate Support for Students Facing Value Conflicts

One of the faculty participants stressed that it is the responsibility of all university staff to help students cope with value conflicts relating to family resistance to their choice of profession by encouraging and supporting them and helping to instil pride in their choice of profession. This is intended, for example, to help the students communicate more effectively with their relatives about their nursing responsibilities, rather than concealing these from them as discussed earlier in the chapter.

> Where does she get the support? From the academic advisor, from her doctors and professors in the university. She will feel strong we plant it in her every day that we have a decent profession! We have a decent profession and people need to understand that. (Mayar, Faculty)

Some of the faculty expressed the belief that support is already available for students experiencing value conflicts or other difficulties in their nurse education, for example in the form of their academic advisors as well as the student affairs counsellors, and in the clinical conferences that are held with students.

Difficulties in the study, difficulties in the college, psychological or anything, you go to your academic advisor and she will guide you to the right way … And ... in the post conference we always say please share your experience anything we could solve. (Mayar, Faculty Interview)

There is also academic conciliation. Every member of the teaching council has a certain number of students. If any of them have troubles they have to help her and counsel her and write a report about it … They should talk to all of the students. (Maya, Faculty Interview)

The faculty interviewees also reported however, that few students use these sources of help effectively and are often reluctant to speak up about the issues they may be facing.

We cannot do anything because the students would not speak up … The students need to speak up. (Maya, Faculty Interview)

The student interviews and focus groups did indeed reveal that few students were reporting their experiences of value conflicts or even acknowledged that the university should have a role in addressing these. One second-year student did report a positive experience of being able to talk about problems to a faculty member.

I was talking with professor about something private and she was listening, I was looking for advice and she advised me and told me you can go to the medical administration and they will guide you to the right place and she helped me. (Basmah, Year 2 Interview)

However, others indicated that they feared repercussions from doing so, such as a poor academic evaluation or being transferred to a different area of training, if they reported situations causing value conflicts.

I am not telling you that no one hears from us, for example if I went to my instructor she would listen for sure, the doctor is going to listen to me. But the fear is that I am afraid that it will affect my evaluation, or I will be under scrutiny … How will I know how they will take it, what if they asked me to transfer to another field? (Yara, Year 4 Interview).

Another of the fourth-year students expressed scepticism that the College of Nursing would take the concerns and issues of the students seriously, based on her previous experience, a point which other group participants concurred with. They referred to a survey questionnaire which the students are required to complete with their views before

receiving their grades, but expressed disappointment that no action was taken on the results.

> We talk every year and nothing happens. Every year we talk and meet with the college council and they ask what do you want? What are your problems? How do we improve for the next years and nothing changes ....
>
> They always say that it will improve and we fill all those surveys …
>
> Then we ask about the changes and no one say anything. (Various participants, Year 4 Focus Group)

These are serious points which indicate that the university needs to do more to reassure students that they can speak in confidence to staff about any value conflicts they face, without fear that they will be penalised for doing so. There is also a need to raise awareness among students of the support system available to them in the university, as will be discussed further in Chapters 8 and 9.

6.4.7 Perceived Need for More Male Nurses

Many of the students expressed the view that the best solution to their gender-related value conflicts would be to have recruit more men to the nursing degree, so that gender specific care could be provided. Those who expressed this view did not seem to expect that this would be problematic, since there are many Saudi men now have a diploma in nursing.

> It will lessen the problem a lot. I mean if there were male nurses, for example the male nurses will be assigned to male patients, and the female nurses will be assigned to the female section. (Zaahra, Year 2 Interview)
>
> A big percentage of diploma male nurses are working ... So, they should start recruiting a lot of males to study nursing, they would love to have the degree rather than stay in diploma. (Yara, Year 4 Interview)

Other participants saw an increase in male student nurses and nurses as a possible means of getting used to working with men which would help student nurses from more conservative backgrounds overcome their gender conflicts in this area, assuming that they were trained together on the nursing degree course as in other specialist areas.

> Other faculty like dentistry has both genders. So, they do projects together and so on and that can help them break this wall. They do presentations, events, or

whatever. But our faculty is only for females and we were not even taught by men. (Rameem, Year 4 Interview)

(Researcher: How will it be useful in your opinion?) In the communication that I'll be able to speak to the man … I got used to it, some girls maybe didn't have this experience so she may face difficulties because she cannot talk, so when the male doctor tells her something … she cannot talk she doesn't have the courage to talk (Basmah, Year 2 Interview)

6.4.8 Public Awareness-Raising

Finally, several of the students and the faculty participants suggested that the university might run seminars or conferences to help raise awareness among students, their families and staff about potential value conflicts and how to deal with them if they arise, including the types of support and help available.

> Maybe the university could do courses or seminars and like that, on how the girls face these conflicts … maybe reduce the numbers of girls quitting the nursing ... How can they face these conflicts ... what are the good professional values which you must follow, also I feel that they hav.e to talk about how the patient needs us so we have to continue to help the patient. (Bushra, Year 2 Interview)

> For example, there will be a conference in the university, and I wish everyone attends not only the nursing! All medical fields, we present on how to deal with the other gender, and talk about the values you told me about the personal, cultural, religious … let's say we do an awareness of things such as the most conflicting values they go through, we could one day talk to the students in the auditorium and the theme would be something like dealing about your conflicts in nursing, and we give a bonus for attending to motivate them. (Mayar, Faculty Interview)

Faculty member Mayar also proposed that the university should run sessions to help educate student nurses' families about the nature of nursing and its Islamic origins, in order to start changing the public image of nursing and also reduce the potential for conflict between the students' professional values and the religious or cultural values of their families.

> They should have a session for the family … education about the nursing and how it started? Which of the prophet companions were nurses? (Mayar, Faculty Interview)

Another of the faculty interviewees mentioned that the university has already made limited outreach efforts to help change the image of nursing, though Mayar's quote below indicates that others are not apparently aware of this. Overall, this indicates that there is potential for much more to be done in this area.

> The last time we went to a school for the deaf … and they were so happy about telling that they are nursing students. They were so satisfied that they did something, and everyone supported them and encouraged them to mix up and blend in the society to show their existence in the society … It is important to go out and show the society who we really are. This was a positive experience for the students, they felt happy to give and it benefitted their society, I believe this could make a huge change to the image. (Shadan, Faculty Interview)

> Actually the faculty does not provide anything right now but in the future they could spread awareness … they could do projects within the community to spread awareness about nursing profession in the malls and outside it. (Mayar, Faculty Interview)

6.5 Chapter Summary

Overall, the research findings presented in this chapter have confirmed that a range of value conflicts are being experienced by this sample of female Muslim student nurses at a university in Saudi Arabia, and that faculty members are broadly aware that such conflicts occur.

Although the analysis was conducted in an inductive way to allow themes to emerge from the data itself, the findings were found to be broadly very similar to those of the exploratory study reported in Chapter 3. The three main types of value conflict identified in the exploratory study were again found to be experienced by students in the main study, along with two additional types of conflict not identified in the earlier study.

First, the students reported experiencing conflicts between their religious or their cultural values (which overlap considerably in the Saudi Arabian context) and the professional values which may require them to provide personal nursing care to males, including exposing their private parts. Second, they reported experiencing conflicts between the religious/cultural values which prohibit close contact and interaction between unrelated individuals of different genders and the professional values of the nursing profession which require such interaction with male patients and male medical colleagues. Third, many of the students reported experiencing conflicts between their own personal or professional values relating to their choice of nursing studies and cultural values which

have resulted in a poor image of nursing in Saudi Arabian and family resistance to their choice of study. A more unique finding of the main study compared to the exploratory study is that a few students reported experiencing a fourth type of conflict which is predominantly between their personal and professional values and emerges when they observe hospital practices or policies that they do not agree with, and experience a form of reality shock as a result. These arise, for example, when they observe foreign nurses caring for patients in ways the students believe are not appropriate, or when nurses are forbidden to provide certain types of care, and are of the type widely reported in the literature to be experienced by newly qualified nurses in many countries. Although these were only mentioned by a few participants and were not a major focus of the research, the importance of this finding is that the Muslim student nurses in the case study institutions were experiencing multiple value conflicts including, for some, these universal types of conflict.

However, there were variations between individual student nurses in terms of the extent to which they experience different forms of value conflict and the ways in which they respond to them when they are experienced. There was no clear evidence that this depends on level of experience, since some of the fourth-year students apparently experienced value conflicts at least as much as the second-year students. The main factor influencing the experience of value conflicts by student nurses appears to be the degree of conservatism in their family background. According to the research findings, some of which were secondary accounts of other students rather than the participants' personal experiences, students from more conservative Islamic families appear more likely to struggle with a range of conflicts in which religious or cultural values, as well as the attitudes of family members to the nursing profession, clash with the professional values of the nursing role.

Faculty were asked about their awareness of and attitudes to value conflicts based on direct questioning about these issues and also by seeking their responses to a number of vignettes describing potential values conflicts among students. The findings confirmed that faculty are broadly aware of the types of value conflicts faced by students and provided additional insights into the perceived reasons for and implications of these value conflicts. However, faculty also varied in their attitudes and responses to the experience of value conflicts by student nurses. In very general terms, a slight difference emerged between the faculty with only a few years' experience and those with 20 to 30 years'

experience as lecturers. The researcher gained a general sense when conducting the interviews that the less experienced faculty often held the view that students must learn to cope with their role requirements while the more experienced were a bit more supportive and understanding of the value conflicts students can face. It is possible that this reflects a generational difference in attitudes, or differences in the training and experiences of faculty of different ages, but since the faculty sample size was so small the apparent difference may have emerged purely by chance.

The findings of the student interviews and focus groups as well as the faculty interviews provided a strong indication that the university is not currently doing enough to mitigate the potential for value conflicts or to support students that experience them. They revealed that there is limited knowledge and considerable confusion about various hospital policies and practices in this area even on the part of faculty. In this respect, the documentary analysis discussed in the following chapter provided an opportunity to explore the policies and other documents actually available to and in use by the case study university.

Finally, the presentation of findings in this and the previous chapter have confirmed that the theoretical framework of the study, based on Rokeach's (1973; 1979) theories of value formation and change, has proved helpful as a tool for describing and interpreting the research data. Many of the reported experiences of the research participants have been explained in the chapters either in terms of positive value change processes identified by Rokeach, such as creation, attenuation or elaboration, or in more negative processes such as explication and intensity (see pp. 140-141). The severe discomfort and other negative feelings reported by the participants when experiencing value conflicts were also interpreted in terms the self-confrontation process, which was regarded by Rokeach (1973) as an essential first stage in acknowledging the existence of value conflicts and beginning to modify values to make them more congruent, though it was observed that many of the students had not yet formally acknowledged that value conflicts were causing their discomfort. In the Discussion and Conclusion Chapters, the theoretical framework will be used to develop recommendations for deliberate value change initiatives which also build on the findings reported in this and the previous chapter.

CHAPTER SEVEN: DOCUMENTARY ANALYSIS

7.1 Overview of Chapter

As discussed in Chapter Four, this qualitative mixed methods study incorporated a review of documents that have been issued by or are relevant to the case study institution. To recap, the overall purpose of the study was to investigate the experiences of value conflicts among a sample of female Muslim student nurses in a higher education institution in Saudi Arabia and to explore the awareness of faculty about these conflicts and their views on the ways in which these might be reconciled in this setting. In order to provide contextual information for use in interpretation of the primary research data, the case study included a content analysis of documents such as published policies, codes of conduct or ethics and training materials issued by or relevant to the case study institution. This chapter presents the findings of the documentary analysis, including details of documents identified and included in the review, content identified, and a discussion of the overall outcomes and limitations of this stage of the case study research. First, the overall purpose and objectives of the documentary analysis are reiterated, followed by a summary of the documentary analysis methods as described in Chapter Four.

7.2 Purpose and Objectives of the Documentary Analysis

The overall purpose of the documentary analysis was to identify any potential influences on the experience of value conflicts by the samples of student nurses at the case study institution, in the form of policy, practice or training documents or codes of conduct. These included documents issued by the university and the university hospital, as well as relevant documents published by the Government of Saudi Arabia, national Islamic organizations, or regional or international professional nursing bodies. Previous literature on the experience of value conflicts by female Muslim nurses in Saudi Arabia has suggested that there may be a lack of organisational support or guidance available to this group in the event of ethical or value conflicts (e.g. Lovering, 2008) so the documentary analysis was intended to explore whether any documentation helps provide this at the case study institution. No previous studies were identified in the literature review (Chapter 2) which had investigated this in relation to student nurses in Saudi Arabia.

The documentary analysis had the following specific objectives:

- To identify whether content relevant to value conflicts in nursing situations is addressed in policy, practice or training documents issued by or used by the case study institution (university or hospital)

- To determine how the issue of value conflicts is conceptualised or defined in documents issued by or used by the case study institution

- To identify whether reviewed hospital/university documents provide guidance or information on possible ways of responding to the experience of value conflicts in nursing situations, and the nature of this information.

- To identify any other key documents which may influence the experience of value conflicts by student nurses at the case study institution

7.3 Scope of Searches and Retrieval of Documents

Searches were made for relevant documents issued either by the case study university, the hospital that is linked to this institution, or by government or religious organisations in Saudi Arabia. Searches were also made for relevant regional or international policies, professional guides of practice or other relevant documents issued by third party organisations.

It was considered important to include documents issued by the hospital as this institution is responsible for all clinical guidance issued to student nurses, and it is the setting within which clinical practice for students takes place. Ethical codes issued by government organisations such as the Ministry of Health (MoH) and Saudi Commission for Health Specialties (SCHS) or regional/international professional organisations were also considered important to include as these are used by individual hospitals in Saudi Arabia to develop their own codes of ethics.

Documents for analysis were initially identified by the researcher based on her own professional knowledge of the types of policy, practice and training documents used by the Faculty of Nursing. Further documents were identified from discussions at the exploratory study stage with academic and clinical faculty; these were intended to provide general insights into the nurse education process and identify any documents or policies used in this that might include content relevant to value conflicts. Online searches were also conducted for national, regional or international documents relevant to the issue of value conflicts faced by female Muslim student nurses in this educational institution.

Accessing documents at the University College of Nursing proved challenging. Even though ethical approval for the research was secured and a higher education memorandum was circulated to departments requesting their cooperation, some of the faculty members refused to provide documents for review. A different approach was therefore taken, whereby some of the nursing curriculum module coordinators were initially asked to check documentation in their area of the curriculum on behalf of the researcher to determine whether these included relevant content. Some documents were initially examined in this process but subsequently excluded from the documentary analysis since they focused exclusively on specific topics such as nutrition and did not address values or ethics.

Once potentially relevant documents had been identified in collaboration with the module co-ordinators, the researcher approached the Research Ethics Committee to negotiate full access to these documents. This strategy proved more successful and those responsible for delivering the modules provided their documents once they were made aware that the researcher had the approval of the Committee. It proved easier to secure relevant documents for review from the hospital, once written confirmation of ethical approval for the study was provided. Eventually, therefore, the researcher was able to secure all important documents that were identified as being relevant to the objective of the study and review these personally.

In total, 29 documents were included in the analysis, consisting of 12 university documents, 10 hospital documents, 5 Ministry of Health and other third-party documents and 2 regional/international professional association documents (shown in Tables 9 to 12 and Appendix 14). A further 17 university documents and 2 hospital documents were initially retrieved but excluded from the review as it revealed that they did not contain any content of relevance to the study (e.g. they were basic lists of subject areas, timetables, alternative timetables for the same course, or organisational charts).

7.4 Analysis Methods

Because of the limited relevant content that was identified, a conventional detailed content analysis of relevant material could not be conducted. Nonetheless, a systematic approach was taken to thoroughly reading each document, extracting any content which might be interpreted as having a potential influence on the experience of value conflicts, and presenting an overall analysis of this material in the present chapter.

The general methodological approach to the documentary analysis followed the guidelines set out by O'Leary (2014) in the form of an 8-step process, described in Chapter Four. Published literature on documentary analysis was utilised for the purpose of developing a data extraction template for recording relevant information (Bowen, 2009; O'Leary, 2014; University of Northampton (n.d.). In broad terms, the methods involved reading each document and extracting relevant information according to the categories defined in the template, following which the significance and implications of this material in relation to the research questions and objectives of the study were considered. The analysis identifies content which potentially has an influence on the experience of value conflicts by student nurses in the case study institution; considers the context in which it was developed as well as any latent content such as an underlying agenda or bias, and assesses the ways in which the documents might either reduce or exacerbate the potential for value conflicts among the female Muslim student nurses at the case study institution.

The template categories, developed from best practices identified in this literature, consisted of: Title of Document; Type of document; Author; Date released/updated; Purpose/context; Target audience; Dissemination strategy; Relevant content re value conflicts; Purpose of content; Information/guidance on dealing with value conflicts; Notes on 'latent" content (tone, style, bias, agenda, opinions etc.), and Other notes/observations (See Appendix 14). The range of categories was intended to ensure that the following types of information would be captured by the documentary analysis:

- Content explicitly addressing ethical and value conflicts in nursing in Saudi Arabia
- Content with implicit implications for ethical and value conflicts in nursing in Saudi Arabia
- Other content which might potentially contribute to the experience of value conflicts by female Muslim student nurses in Saudi Arabia
- Content which might help provide information and guidance for use in responding to experience of value conflicts in Saudi Arabia by the student nurses

The overall findings are presented and analysed below in sections respectively covering documents provided by the case study university; by the hospital attached to this

university; by the Saudi Arabian Ministry of Health or other third-party organisations, and by regional or international organizations. Key sources are discussed individually, along with an overall assessment of the availability and role of relevant documents within each provider category.

7.5 Findings

7.5.1 University Documents

Table 7. University Documents

Organisation	Title of Document	Type of Document
Case study university	Concept of Nursing Teaching Plan Table, 2nd Year Nursing (2016)	Academic timetable
	Course Syllabus Concept of Nursing NUR (211) (2017)	Academic syllabus
	An Introduction to the Foundation of Professional Nursing (I) NUR (222) (release date not known)	PowerPoint overview of course content
	Foundation of Professional Nursing (I) NUR (222) Course Syllabus (2015)	Academic syllabus
	Foundation of Professional Nursing Teaching Plan (2015)	Teaching plan and timetable
	Nursing Care of Adult (I) Clinical Objectives (release date not known)	Course objectives
	Nursing Care of Adult I Outcome Evaluation Form-1435 (release date not known) (2013)	Evaluation form
	Nursing Care of Adult (I) Course Portfolio (2013)	Course syllabus
	Critical Care Nursing – Course Portfolio Part 1 (2017)	Course syllabus
	Critical Care Nursing – Course Portfolio Part 2 (2014)	Course syllabus
	Critical Care Nursing NUR (427) - Field Experience Specification (2015)	Report to National Commission for Accreditation & Assessment
	Critical Care Nursing NUR (427) – Course Specification (2015)	Report to National Commission for Accreditation & Assessment

The documentary analysis provided evidence that the topic of values and ethics is included in the BSc Nursing curriculum from the 2nd year of training, though it is not clear whether the specific issue of value conflicts is covered. The Concept of Nursing

course, in particular, includes lectures on "nursing roles and Nursing in Islam" and on "values and ethics". Unfortunately, it was not possible to determine from the documents provided exactly what the content of these lectures are, or obtain copies of lecture notes or indicative content. However, the course overview indicates that it:

> "explores the evolution of nursing profession with emphasis on nursing in Saudi Arabia. It aims at raising student's awareness of the professional nurse roles in the health care system and promoting student's socialization into the role, values and behaviors of the professional nurse".

This appears to be the key early component of the BSc nursing curriculum which is intended (though not stated explicitly) to reduce the potential for value conflicts by teaching the students professional values and an understanding of their nursing role, within the Saudi Arabian context. However, the primary research interviews did not give any indication from the student nurses' perspectives that their early nurse education is preparing them to deal with or reduce the risk for value conflicts in their work, nor was much reference made to the Concept of Nursing course in this respect.

Similarly, the 4th year Critical Care Nursing curriculum indicates that upon completion of the clinical rotation, the student will be able to "*Explain how Islamic values, ethical and legal principles relate to decision making in a critical care environment*." Yet the interviews and focus groups indicate that value conflicts are widely experienced among both second- and fourth-year students, and provided little evidence that the students had achieved this particular learning objective, though this was not specifically investigated. These findings appear to be aligned with Lovering's (2008) findings that newly qualified nurses, who had completed the full nurse education curriculum of the nursing degree, were still experiencing value conflicts in their daily work, and indicate that the coverage of ethics and values in the nursing degree curriculum may not currently be effective in reducing the potential for these or helping nurses and student nurses to cope with them. No specific reference to values or value conflicts was identified in the remaining university documents examined during this review. However, other material was extracted into the template as being relevant to this study, because it was perceived to potentially result in value conflicts among female Muslim nurses in Saudi Arabia.

In particular, this consisted of course content and learning objectives which relate either to the physical examination of patients, or to the issue of communications with patients

or medical colleagues. It was noticeable that many of these appear to be based on nursing curricula adopted from non-Muslim countries such as the U.K. They were not modified to take into account the Islamic setting or any formal or informal policies or practices such those preventing student nurses from having to provide personal care (relating to genitalia) of male patients that were reported in the student interviews and focus groups. This is fairly unsurprising given that there no available clear guidance drafted from an Islamic perspective on what is permissible in these types of nursing situations.

As an example of such content, the 3rd year Nursing Care of Adult I Outcome Evaluation Form specifies among its Learning Objectives: *"Implement nursing care to different age groups/gender"*, and *"Treat clients equally regardless of race, sex, religion, nationality and socio-economic background"*. Similarly, The Nurse Internship and Training Program document issued by the hospital and included in Table 11, sets out *"specialized competency testing"* areas which include, e.g. *"bathing a patient"* and *"urinary catheterization"*, and note that surgical rotation should be 3 weeks male, 3 weeks female. The primary research findings indicated that formal or informal policies are operating within the hospital which conflict with these requirements in order to avoid situations in which female Muslim nurses are required to provide personal care to males. This is likely to reinforce the potential for conflicts between the student nurses' professional and personal values, as well as possibly affecting their overall performance and ability to meet the course and degree requirements.

In the case of other curricular content examined, it was unclear about whether the specified course content and learning objectives require giving care to male patients. For example, the 2nd year Foundation of Professional Nursing teaches students to perform physical assessments and also to obtain a health history of an individual using interviewing techniques and principles of communication. Topics covered include *"bed bath"*. *"health assessment: breast, axilla and genitalia"*, all based on lab demonstration and the use of dummies. Similarly, the Nursing Care of Adult I learning objectives indicate that certain tasks that could potentially give rise to value conflicts (in context of care for male patients) as a course requirement *"Provide basic physiological hygienic measures"* *"Obtain body fluid specimens as urine and stool samples, culture swab, drain and catheters tube tips, etc....."*. However, there is no mention of whether students are required to provide care for male as well as female patients. Greater clarity is needed in all course content so that students understand and can prepare themselves to deal with

situations that may potentially create value conflicts, and so that the university and hospital can provide appropriate support in these situations. Additionally, the documents discussed in this section demonstrate that there is also a need for the case study institution to re-examine its current outcomes/assessment criteria for student nurses, ensure that these are appropriately adapted to the Islamic Saudi Arabian context, and also incorporate relevant training and guidance into the nursing degree curriculum to ensure that students are adequately prepared to achieve the required outcomes.

The 3rd year Nursing Care of Adult I Outcome Evaluation Form includes learning objectives relating to more general interaction with male patients and colleagues: "*Communicate with various clients effectively*", and "*Discuss with colleagues and health care providers professionally pertaining clients' condition*". In a similar way, the 4th Year Critical Care Nursing report to the National Commission for Academic Accreditation & Assessment indicates that field experience objectives and course objectives include "*Communicate effectively with all the healthcare team members*" and "*Demonstrate confidence in dealing with the doctors and staff of the unit*". However, these professional requirements may be challenging for student nurses to achieve when their personal/religious values prohibit direct communication with non-related males. Although the existence of learning objectives of these types can perhaps be interpreted as giving permission to the students to communicate with patients and colleagues of the opposite gender, the problem appears to be the lack of more specific guidance on what styles or forms of communication are acceptable between female Muslim nurses and their male patients. The primary research interviews revealed some good practice examples of individual faculty members acting as informal role models in demonstrating acceptable forms of communication, but there was no evidence that communication styles or guidance on how to interact with patients and colleagues are included in the formal nursing curriculum or taught by other faculty members.

The existence of learning objectives of the types discussed above demonstrates the clear need for students to be better prepared and trained in order to be able to communicate and deal with male patients and colleagues, and to be provided with clear and consistent guidance and policies on issues such as exposing patients' awrah. At present there are evident gaps within nurse education at the case study institution between the learning outcomes that students are required to achieve, and the training or support provided to enable them to do so, including both ethics education and the types of practical

simulations that might help them to become more comfortable with the range of nursing tasks they are required to perform. For example, the primary research findings reported in Chapter 5 revealed that that ethics teaching is only properly covered in the fourth year of the nursing degree, just before the students become interns in their fifth year of training, and too late to be of practical help during earlier periods of clinical practice. Although some information about professional values and ethics is touched on in the Concepts of Nursing course taught to second year students, according to the accounts of the student and faculty research participants, there is no coverage at this earlier stage of training about value conflicts or ethical conflicts. Given the cultural and religious context in which they are living and working, it is perhaps unsurprising that this leaves scope for value conflicts to arise and remain unresolved, or for informal practices and policies to develop with the objective of avoiding these, but which may conflict with the professional requirements and values of the nursing role.

7.5.2 Hospital documents

Table 8: Hospital Documents

Organisation	Title of Document	Type of Document
Case study hospital	2nd Year Students Foundation of Nursing (II) (2018)	Memo
	Information Confidentiality (2008, updated 2014)	Policy Document
	Communication (2012, updated 2014)	Policy
	Nurse Internship and Training Program (2004, 2014)	Policy
	Hospital Code of Ethics (2012)	Guidance
	Hospital Orientation (student) PPT (release date not known)	PowerPoint presentation
	University Nursing Students' Orientation Program (2013)	Memo
	NUR-01-072 (03) Nursing Orientation Program (2004, updated 2017	Policy statement
	NUR-01-077 (03) Nursing Clinical Training (2013, revised 2017)	Policy statement
	Hospital Patients' Rights document (release date not known)	Policy statement

Relevant documents issued by the hospital linked to the case study university were also reviewed since these are likely to affect the student nurses' experiences of value conflicts when on clinical practice. Some documents relating to educational curricula were issued

by the hospital and included in Table 11; the other types of documents issued by the hospital and included in the review were in the form of communications and information policies and the hospital code of ethics.

Only the Code of Ethics (2004) was found to explicitly address the issue of value conflicts and provide any form of guidance to student nurses on dealing with these. However, the main source on which this document is based, the UK's Nursing and Midwifery Council Code of Professional Conduct (2002), is a Western, non-Muslim codes of conduct, and the guidance is not only very outdated, but is also not specifically tailored to the Islamic setting of Saudi Arabia. The document advises that "when facing professional dilemmas, your first consideration in all activities must be the interest and safety of patients" (p.7) and "You must ensure that all aspects of the relationship focus exclusively on the needs of the patient" (p.3).

The Code of Ethics may therefore be helpful to an extent in helping nurses facing value conflicts to decide on the most appropriate response based on the needs of the patient, but as well as being grounded in a Western approach to nursing, it is also very high-level and its practical value as guidance when facing value conflicts may be a little limited. On the face of it, the advice to put the interests and needs of the patients first seems straightforward; however, the primary research findings have revealed that this may not necessarily help to resolve situations in which the perceived or stated requirement of a patient (e.g. for a non-Muslim nurse or to avoid exposing awrah) conflicts with their medical need for nursing care. Furthermore, according to the faculty interviewees, students are only exposed to the hospital Code of Ethics after completion of the fourth year of training, when they begin their hospital internships. There may perhaps be scope for greater use of this document, from an earlier stage of training, as a means of stimulating discussion with students about how to apply the guidance in ways that are viewed as compatible with Islam.

Scrutiny of the hospital's Patient Rights document (2012) indicated that this includes a number of provisions which might increase the potential for value conflicts, but also others which may reduce this potential. First, the Patient Rights document stipulates that patients must "*observe and abide by all Government regulations, ethical laws, proper dress code, and good behavior*". Although the gender of nurses is not mentioned, this may encourage patients to accept care and treatment from student nurses, and indicates that inappropriate behaviour will not be tolerated. In theory, this may help reduce the

potential for conflicts between the religious/cultural and professional values of nurses, which arise when they are prevented from properly carrying out their responsibilities by the attitudes and behaviours of patients, such as refusing or being disrespectful to them as a Muslim nurse. However, the document is written in very general and non-specific terms and it is therefore not clear exactly which "regulations", "ethical laws" and examples of "good behaviour" etc. are being referred to. There is a sense that, although formally directed at patients with the purpose of raising awareness of their rights and responsibilities with regard to their hospital treatment, the document also has the latent objective of controlling the behaviours of patients in order to ensure that these do not have a negative impact on operational and healthcare processes in this institution. This might help reduce the potential for value conflicts by ultimately prioritising the need to comply with government regulations and laws, but the document seems too vague to have much practical relevance in clarifying the rights and responsibilities of patients in actual situations where such conflicts might occur.

The Patients' Rights document also states that "that "this is a university hospital where students of medical faculties and institutes are training and that they may examine patients". Unfortunately this only refers to examination of patients in general terms and it is not specified in the document whether this extends to the exposure of awrah for examination purposes. This appears to be missed opportunity to confirm the acceptability of this to both patients and nurses, and to help nurses avoid the experience of value conflicts arising from the perceived unacceptability of this to patients.

Finally, this document indicates that patients have the right "to accept or refuse medical treatment after consequences of refusal have been explained to you" and "To seek second medical advice without fear or threat of compromising care plan". These provisions may reinforce the current situation in which male patients sometimes request a non-Muslim nurse, giving rise to internal conflicts between the professional values of nurses and the personal/religious/spiritual values of the nurses which may be aligned with those of the patient.

Overall, therefore, the hospital's Patient Right's document appears to have some potential for both increasing and mitigating the potential for value conflicts, but also conveys some mixed or confused messages and is too non-specific to be of much practical value. As in the case of other documents discussed, however, the Patient Rights Document might be valuable as a tool for examining explicit value conflicts within the classroom, and

exploring how it can help clarify how best to respond to these in ways compatible with the guidance and with Islam.

The case study hospital's Communications Policy indicates that the "*Preferred*" approach to transferring care involves the use of face-to-face verbal communications; this may create value conflicts for inexperienced female Muslim student nurses when required to convey information to male doctors or other male colleagues. As noted with regard to the learning objectives discussed in section 7.5.1, this appears to be another example of a requirement in the nursing situation which of student nurses are not being effectively prepared to deal with.

The Information Confidentiality policy document (2014) is potentially relevant to the experience of the fourth type of value conflict identified in the primary research. This is the type of conflict that arises when student nurses observe hospital practices or policies that conflict with their personal values, for example when information about a patient's illness is withheld from the patient at the request of their family members. The policy states, for example, "information concerning a patient's condition and/or management or release of test results or procedure ... is provided ONLY to the patient or his/her guardian ...". Interestingly, the accounts provided by the research participants indicate that this policy is not currently being observed by the hospital at least in some situations, and suggests that the conflicts experienced are not between personal and professional values, but between personal values and informal practices or dominant organisational values. This is aligned with the findings of earlier studies (e.g. Maben et al, 2006; Stacey, 2011) conducted in Western countries, in which newly qualified nurses were found to experience value conflicts when the dominant values of the workplace were not as expected from their professional training.

Another document issued by the hospital with potential relevance to this study is the Nursing Internship and Training Program policy document, which sets out in some detail what tasks the nursing interns are required to cover and the competencies on which they are assessed. Again, any mention of values and ethics is notable for its absence in this document, and there is a lack of clarity regarding the types of situations that might give rise to value conflicts such as exposure of patient awrah. The document specifies, for example that rotations include male and female wards, and refers to the requirement for nursing interns to bathe patients and carry out urinary catheterization. However, it does not clarify whether they are required to do so for patients of the opposite gender. The

Nursing Internship and Training Program policy document does set out a dress code for interns, which if adhered to might at least help contribute to the development of professional and formal relationships between nurses and patients by ensuring that the nurses convey a professional and respectable image.

The other curriculum-related documents obtained from the hospital, such as the Nursing Students Orientation PPT and Memorandum, and the Nursing Clinical Training policy statement, were not found to include any content relevant to the issue of values and value conflicts.

7.5.3 Ministry of Health and other Third-Party Documents

Table 9: Ministry of Health and other Third-Party Documents

Organisation	Title of Document	Type of Document
Ministry of Health	Ministry of Health Manual of Nursing Policies and Procedures (2011)	Guidance including Code of Ethics
	Patient's Bill of Rights and Responsibilities (2010)	Guidance
	Ministry of Health rules and regulations of Observing the Decency of "Patients' Awrahs" (2005)	Rules and Regulations
Saudi Commission for Health Specialities	Code of Ethics for Healthcare Practitioners (2014)	Guidance
The Permanent Committee for Scholarly Research and Ifta'	Exposing Awrah in an operation room	Religious ruling

Online searches were also conducted for Saudi Arabian government or other third-party documents relevant to the issue of value conflicts faced by female Muslim student nurses in this educational institution. Relatively few documents of this type could be found online, with the exception of the five shown in Table 12.

The Saudi Arabian Ministry of Health's (MoH) Manual of Nursing Policies and Procedures (2011) provides detailed guidance to nurses and patients on a wide range of topics. Perhaps most importantly, this manual sets out a Nursing Code of Ethics.

However, this has not been developed specifically within the Saudi Arabian or Islamic contexts and most of the provisions are listed under the heading "International Code of Ethics", though it is not specified what specific code this is based on. The Code is patient-centred and specifies, for example:

> The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the name of health problems.

And:

> Based on respect for clients and regard for their right to control their own care, nursing care reflects respect for the right of choice held by clients.

There was no evidence from the primary research interviews or focus groups that the student nurse or the faculty participants were aware of this document or that it is being used to guide nurse education and practice in the case study institution. Such detailed guidance might help to clarify what is acceptable in situations currently giving rise to value conflicts, such as the refusal of a Muslim male patient to accept a female Saudi nurse. However, there still appears to be a need to tailor this type of document to the Saudi Arabian Islamic context, perhaps by specifying circumstances in which the patient's need for care constitutes necessity and can therefore take priority over their stated preference. This might help nurses to reconcile value conflicts in this area by endorsing the need to provide certain types of care on medical grounds, even if they are not seen as acceptable on cultural or religious grounds.

The MoH Patient's Bill of Rights and Responsibilities (2010) states:

> All workers in the health facility are committed to patients' rights and realize that they are MOH representatives. They have appropriate Islamic and social manners when dealing directly with patients and their families.

This is an important document in that it appears to go further than any of the others analyzed in acknowledging the need to provide healthcare that reflects Islamic beliefs and values. Furthermore, it specifically addresses the issue of exposing patients' private parts, stating that the patient and his/her family are entitled to "*Cover the patient private parts unless a medically urgent situation arose.*" The Bill includes a number of other relevant

provisions, including the right of the patient to refuse treatment or any aspect of it, and for their "cultural, psychosocial, spiritual and personal values, beliefs and preferences" to be respected. Indeed, this seems to be a key document which might be incorporated into nurse education in order to provide awareness and knowledge of the rights and responsibilities of patients, the situations in which the need for medical care can take precedence over patient preferences, and the rights and responsibilities of healthcare workers in relation to patient rights. The primary research did not reveal any evidence that this document is currently being used in this way in the nurse education curriculum. There is a pressing need, therefore, to raise awareness among students of the content of this document and ensure that they understand how this can help them to navigate ethical conflicts when they arise.

The internal memorandum on Administrative and Procedural Rules for Observing Decency of Patients' "Awrahs" was issued by another hospital in Saudi Arabia but based on a directive from the Ministry of Health, which is therefore cited as the original source in Table 12. This provides specific guidance on the religious and regulatory requirements relating to exposure of *awrah* but was issued in 2005 and no updated guidance from the MoH could be located. The 2005 document stresses that only healthcare providers of the same gender as the patient can expose their *awrah*, for example:

"If, prior to the performance of the operation, the male/female patient is required to expose his/her genitals, such as urinary catheterization or the necessity of causing the male/female patient to take a certain position for the operation, it must be ensured that no individual whose presence is unnecessary shall be present, and that such matter shall be performed by the female nurse for the female patient and by the male nurse for the male patient." (p.4).

The somewhat dated nature of this guidance which was published in 2005 may make it less relevant or helpful to current day Saudi Arabian healthcare, particularly in view of the increasing pressures on healthcare and nurse shortage, which may make it difficult to ensure that only nurses of the same gender of the patient can expose the patient's awrah.

In contrast, the Saudi Commission for Health Specialties' which was founded in 1992 to act as a supervisory body for all health care professions and the nursing board which joined the commission in 2002, published the Code of Ethics for Healthcare Practitioners in 2014. This is an important document which provides comprehensive guidance from an

Islamic perspective on healthcare ethics. Importantly, the Code of Ethics for Healthcare Practitioners (2014) acknowledges that healthcare professionals can expose *awrah* of patients of opposite gender if a professional of the same gender is not available. The guidance also states, however, that a person's awrah (awrah) should not be exposed under Islamic rulings unless there is a "necessity", the nature of which is not specified in the guidance.

"The principle in the religious ruling is the prohibition of exposure or examining of a person's Awrah, unless there is a necessity; in that event, it becomes permissible to expose only what is needed (to be exposed) for the purpose of diagnosing the patient (male or female) .... Men should not examine women and vice-versa, unless it is not possible to find an alternative technician of the same sex as of the patient to perform the tasks needed." (p.30)

It was clear from the primary research interviews that many of the student nurses and faculty were of the view that awrah can only be exposed by a nursing professional of the opposite gender to the patient in an emergency "life or death" situation, though some acknowledged that they would also do so in other medical situations when a nurse of the same gender of the patient is not available. The Code of Ethics for Healthcare Practitioners goes quite a long way, in comparison with other available guidance, in clarifying that awrah can be exposed for diagnostic purposes in certain situations, but still leaves gaps in clarifying the nature of these situations and whether they are restricted to medical emergencies or not. Perhaps more importantly, however, the available evidence from the research interviews and the overall documentary analysis indicates that although this is probably the most detailed guidance currently available on issues such as exposing male awrah, it is not currently being taught to student nurses within any of the modules in the nursing degree curriculum, and even faculty members did not appear to have knowledge of this document.

The primary research findings reported in Chapter 5 indicated that exposure of male *awrah* by female Muslim nurses is one of the main sources of value conflicts and associated distress for female Muslim nurses, but also that there is considerable confusion among students and faculty alike about what is allowed within Islam. It could not be determined whether the case study hospital has ever issued guidance based on the Ministry of Health rules or the Saudi Commission for Health Specialties' guidance. However, since these two documents are somewhat inconsistent in their guidance, with

the former stating that exposure of patient's awrah by a member of the opposite gender is not permissible and the latter indicating that it is allowed in certain circumstances, there is a need to consider how best to reconcile these differences, so that authoritative guidance can be prepared for members of the case study institution based on this. This is discussed further in chapters 8 and 9.

The Saudi Commission for Health Specialties' booklet also sets out guidance on interpersonal contact between the genders, including the healthcare practitioner-patient situation as well as interactions within the healthcare team, which might potentially be used by the case study institution to clarify acceptable forms of relationships in the Islamic healthcare context. The guidance specifies:

There is a natural relationship that is established between a healthcare practitioner and his/her patient(s), or the relatives. Such a relationship is maintained within three limits:

- The causing limit (i.e. the condition of the patient that caused him/her to need care)
- The location limit (i.e. within the healthcare institution)
- The time limit (the time of need of the healthcare).

There is a natural professional relationship among the healthcare practitioner, other colleagues, or interns. The rule is that the relationships remain within the three limits of cause, place, and time.

If the relationship of a healthcare practitioner with colleagues, patients or their relative extends beyond the previously mentioned limits; the healthcare practitioner should make sure that this relationship is permissible from religious and legal perspectives, as well as being customary and socially acceptable. (p.31)

However, the primary research interviews revealed that many of the student nurse participants, and even faculty members, struggle to determine appropriate ways of interacting with male patients and colleagues that are culturally and religiously acceptable. Since it covers a wide range of healthcare situations from an Islamic perspective, the Code of Ethics for Healthcare Practitioners (2014) is one of the most comprehensive that could be located which contains content relating to the types of value conflicts identified in the present study, and is potentially the most valuable document that might be adopted into nurse education at the case study institution. Drawing on the Quran and other Islamic texts, it sets out a range of guidance about how healthcare

professionals in general should act towards patients, colleagues and society. It might therefore prove to be very effective in helping to underpin and guide discussions about the ways in which nursing is compatible with Islam and how to undertake nursing tasks in ways that help avoid the risk of value conflicts.

If this or other documents discussed in this chapter are adopted within nurse education and practice in the case study setting, for example to guide classroom discussions about value conflicts, it might at least start to reduce some of the potential for value conflicts. For example, these discussions might be used to help clarify which types of actions and behaviours relating to inter-personal contact between the genders are permissible within Islam and which are prohibited, and how such forms of contact are rationalised in this context. Even if some nurses might reject the guidance if it were felt to conflict too strongly with their personal beliefs and values, others might find it helpful as a means of justifying to themselves and others the need for these forms of interaction in nursing.

In general, the documentary review did not include searches of Islamic rulings or laws; however, one key document of this type came to the attention of the researcher while conducting the study and was therefore incorporated. This is a Fatwa, or a religious ruling on a point of Islamic law, on the specific issue of "Exposing Awrah in an operation room". This was a significant discovery, since none of the research participants including faculty mentioned the existence of this, even when asked to discuss whether having relevant Fatwas could reduce the potential for value conflicts. This fatwa states "*It is not permissible for a Muslim to look at the 'Awrah (parts of the body that must be covered in public) of a patient unless it is necessary. Necessity is assessed according to its extent. Therefore a Muslim should only look at the part that requires treatment*". It also states, "*It is not permissible for a female nurse to see the 'Awrah of a man during treatment, unless in cases of necessity, such as when the hospital does not have male nurses.*" Due to the way in which it is worded, this fatwa could potentially be used to support the argument that nurses are not required to expose male awrah if a male nurse is available to do so; it is also unhelpful in that like other documents discussed above it does not clarify which types of specific situations would constitute "necessity". It must also be noted that the fatwa was developed specifically to cover operating room situations, and its applicability to other nursing situations such as bed-bathing and catheterisation has not been established. However, awareness of this fatwa might help nurses cope with situations in which it is necessary to expose male awrah, by clarifying that this is

acceptable as long as the medical professionals' deliberately avoid looking directly at any parts of the body in this area other than that being treated..

7.5.4 Regional and International Professional Association Documents

Table 10: Regional and International Professional Association Documents

Organisation	Title of Document	Type of Document
International Council of Nurses	Code of Ethics for Nurses (2012)	Code of Ethics
Gulf Cooperation Council	Code of Professional Conduct for Nursing	Code of Conduct

Searches were also conducted for regional or international documents relevant to the issue of value conflicts faced by female Muslim student nurses in this educational institution. This did not prove very fruitful as key national level guidance or policy documents are not readily available online.

For example, the Gulf Cooperation Council's *Code of Professional Conduct for Nursing* could not be readily located, although its core values have been reproduced in Nursing Practice Plans in Saudi Arabia as discussed in Chapter 2 (e.g. (KFSHRC, 2011). This code focuses on three main areas: accountability, dignity and confidentiality, and includes reference to supporting the "*physical, emotional, and spiritual comfort*" of patients, but there appears to be nothing specific about this code which is tailored to the Islamic societies of the GCC region and which differentiates it in this respect from Western or international codes of conduct. In this respect, such documents can provide a useful foundation for developing guidance for female Muslim nurses in Saudi Arabia but this guidance needs to be much more specifically tailored to this context in order to help reduce the potential for value conflicts.

Further online searches did not reveal any other regional or international guidance on ethics and values, with the exception of the International Council of Nurses' (ICN) *Code of Ethics for Nurses* (2012) discussed in Chapter 2. Again, this code is general in nature and there is a need to tailor its guidance to the Islamic context. For example, to reiterate from Chapter 2, the ICN Code highlights the importance of the nursing role in promoting "an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected" (ICN, 2012, p. 2). However, this focuses

on spiritual wellbeing generally and does not take into account the Islamic context in which disease is viewed as having spiritual causes and in which spiritual care can take priority over the physical needs of patients (Balboni et al., 2014; Best, Butow and Olver, 2015). Many of the student nurse participants in the current study indicated that they cope with the experience of value conflicts by conceptualising their roles in religious or spiritual terms, and it would seem therefore to be helpful to have more specific ethical guidance that recognises these spiritual aspects of nursing care. In any case, there was no evidence from the primary research that the regional and international documents discussed in this section are currently being used in the training of student nurses at the case study institution. Despite their shortcomings in terms of generality, the inclusion of such guidance in the nursing degree curriculum would be likely to raise awareness of ethics and values and how these relate to nursing tasks and communications. This might also provide the basis for discussions and learning about how value conflicts can arise and how the reduce the potential for them or cope with the experience of them.

7.6 Chapter Summary

This chapter has set out the main findings of the documentary analysis, with the full extracted content from documents included as Appendix 14. Overall, the findings of the documentary analysis were very limited with regard to the identification of content relevant to the experience of value conflicts by student nurses at the case study institution. Also, there was little evidence from the primary research that the available content relating to ethics and values is being actively used in the training of student nurses at the case study institution. It should be noted, however, that the limited nature of the findings is meaningful in its own right as this demonstrates significant gaps in the types of information and guidance which might help reduce the potential for value conflicts, as discussed further in Chapter Eight.

CHAPTER EIGHT: DISCUSSION

8.1 Overview of Study

This qualitative case study research has investigated the experience of value conflicts among a sample of Muslim student nurses in a large governmental university in Saudi Arabia. It also explored the awareness of a sample of faculty about these conflicts and their views on the ways in which these might be reconciled in this setting. A qualitative case study methodology allowed for exploration of the issue of value conflicts from multiple perspectives using a range of data collection methods, and because of the importance of understanding the detailed context in which such conflicts occur. This enabled the researcher to develop practical recommendations tailored to the case study organisation, which are presented in Chapter 9, while at the same time providing insights expected to be relevant and valuable in similar settings. The study also included a review of relevant documentation pertaining to values, ethics or value conflicts in the case study institution. This was intended to provide additional contextual information and further insights into factors contributing to or reducing the potential for value conflicts in this institution.

The specific objectives of the study were:

- To provide an improved understanding of the experiences of value conflicts among female Muslim student nurses in years 2 and 4 of the Bachelor of Science in Nursing degree at a large public university in Saudi Arabia.

- To explore the nursing faculty's awareness and understanding of the value conflicts experienced by female Muslim student nurses.

- To investigate the views of student nurses and faculty regarding the measures or types of support that might be implemented to help female Muslim student nurses in this setting cope with or overcome their value conflicts.

- To identify whether and how content relevant to value conflicts in nursing situations is currently included in policy, practice or training documents issued or used by the case study institution.

The study was conducted within a theoretical framework based on Rokeach's (1973) theory of the nature of values and value change. The purpose of the theoretical framework

was to help inform the design of the study and the ways in which values and value conflicts were explored in the interviews and focus groups, and to aid in the interpretation of the findings. The researcher investigated the ways in which the participants understood the nature of values, the influences on value formation, and the participants' perceptions of whether and how their values develop or change over time, for example.

The primary research findings from the interviews and focus groups were presented in Chapters Five and Six, along with verbatim quotes to illustrate each key point and help convey an accurate sense of the perceptions and experiences of the participants that are relevant to the research questions of this study. Chapter Seven presented the findings of the documentary analysis and highlighted the very limited and often unclear inclusion of ethics, values and value conflicts within policy, practice or training documents issued or used by the case study institution. This was identified as a possible factor contributing to the reported experience of value conflicts by female Muslim student nurses. In this chapter, the main findings and their significance are discussed more fully, in the context of the wider literature in this area as discussed in Chapter Two. The present chapter also includes a discussion of the strengths and limitations of the study, and a critical self-reflection on the role of the researcher.

8.2 Discussion of Findings by Key Themes

8.2.1 Overview of Section

Table 11: Main Themes covered in Discussion Section

Category	Themes
Experience of and types of value conflicts	Understanding of Values and Value Change Conflicts relating to: • Providing personal care to male patients – "Entering Forbidden Territory" • Interaction between Genders – "Rules of Engagement" • Public Image of Nursing in Saudi Arabia – "Overcoming the Stereotype" • Hospital policies and practices – To Object or not to Object • Other relevant findings • The role of faculty – helping or hindering students with value conflicts?
Factors influencing value conflicts	• Disentangling Religion and Culture • The Dominant Influence of Family Background • Spirituality at Work – a way of coping with value conflicts? • Shortcomings in University Policies and Practices

8.2.2 Understanding of Values and Value Change

Overall, the participants' understanding of how values originate and the influences on them were in line with Rokeach's (1973) theory, in which a value was defined as "an enduring belief that a specific mode of conduct or end-state of existence is personally or socially preferable to an opposite or converse mode of conduct or end-state of existence" (p. 5). Although a few of the participants were not able to articulate the nature of values except in terms of behaviours, most of the student nurse and faculty participants did exhibit a general understanding of the role of values, which they described in terms similar to "guiding principles" which help individuals make decisions and decide how to act in their lives.

Rokeach (1973) also argued that values first develop in early childhood and remain relatively stable over time. However, he acknowledged that values can also evolve over time or change abruptly, as a result of an individual's life experiences including interaction with others. In line with this, most of the participants in the current study argued that their values originate in and are largely shaped by their family backgrounds, but are also influenced by a range of other factors such as education and religion. There was, however, some apparent confusion about the distinctions between personal, religious, cultural and professional values, which seem to reflect the ways that these types of values are closely inter-related in Saudi Arabia. Since Rokeach (1973) discussed values in general and did not make a clear distinction between these categories, while recognising that individuals can hold conflicting values, his theory appears to be well suited to explaining the participants' understanding of values and experience of value conflicts.

Rokeach (1979) also explored the specific ways in which values evolve and change over time and identified ten processes through which this occurs. These are described in full in Chapter 2 and were defined by Rokeach as 1) creation; 2) abrupt destruction; 3) attenuation; 4) extension; elaboration; 6) specification; 7) limitation; 8) explication; 9) consistency, and 10) intensity. In the present study, examples of both value change were identified and presented in Chapter 6 in ways that appeared to be a good fit to several of the value change processes defined by Rokeach (1979). Rokeach's typology was therefore found to be a helpful explanatory framework in the analysis and interpretation

of the research data. Many of these examples are revisited and discussed at relevant points in the Discussion chapter.

8.2.3 Experiences of and Types of Value Conflicts

Overall, the primary research findings confirmed that value conflicts are indeed being experienced by this sample of female Muslim student nurses at a university in Saudi Arabia. But it should be noted that although the student nurses described situations that were interpreted by the researcher as value conflicts, and which clearly affected them in negative ways, they did not generally conceptualise these specifically in terms of value conflicts. Similarly, the faculty participants did not spontaneously discuss the issues faced by students in terms of value conflicts, unless prompted by the researcher to consider them in these terms. This has implications for the recommendations of the study which will be set out and discussed in the final chapter.

Three main types of value conflict were identified which appear to be widespread among these student nurses, and are discussed in turn in the present chapter:

- Conflicts between the student nurses' religious/cultural values and the professional values which may require them to provide personal nursing care to males, including exposing their private parts.
- Conflicts between the religious/cultural values which prohibit close contact and interaction between unrelated individuals of different genders and the professional values of the nursing profession which require such interaction with male patients and male medical colleagues.
- Conflicts between the student nurses' choice of nursing studies and the dominant cultural values in Saudi Arabia which have resulted in a poor image of nursing and often family resistance to their choice of study.

Greater attention is paid in the discussion chapter, as in the findings chapters, to these first three types of value conflicts, which relate specifically to the situation of being a female Muslim nursing student in Saudi Arabia and are most relevant to the study's research questions. Additionally there was some evidence from the findings of two other forms of value conflict which are discussed more briefly in the findings chapters:

- Conflicts that arise when student nurses encounter policies or practices in their nurse education or experience which conflict with their personal values.
- Conflicts between personal and professional values among students who did not voluntarily choose nursing

The first of these is a more universal type of value conflict that might be experienced by student nurses and newly qualified nurses in a wide range of geographical or cultural conflicts, and is less directly related to the specific situation of being a female Muslim nurse in Saudi Arabia. Some of the student nurses reported experiencing conflicts when they observed nursing policies or practices which were not aligned with their own values including, for example, situations in which when the hospital's DNR policy prevented them from resuscitating a patient or when a patient's relatives requested that information be withheld from them. Although this is a type of value conflict also experienced by nurses in Western countries (e.g. Edwards, 2009; Fenwick et al., 2012), some of the examples cited in the present study did relate specifically to the Saudi Arabian cultural context, for example when nurses were required to observe the wishes of family members and conceal information from patients. In contrast, in Western countries, it would be unusual for the preferences of family members to take precedence over those of the patient.

The second additional type of value conflict identified is perhaps more specific to Saudi Arabia culture, where it seems that a nursing degree is sometimes regarded as a fall-back option for those students who did not qualify for entry to study other fields of medicine. However, this is peripheral to the main findings of the study because it was reported only indirectly by the research participants when discussing other students, and is not therefore based on first-hand experience.

The finding that student nurses are experiencing multiple forms of value conflict is also somewhat in contrast with those of previous research into value conflicts among nurses in Saudi Arabia. Conflicts between religious/cultural values and the need to treat or interact with males were also identified by some earlier researchers in studies of qualified nurses (El Gilany and El Wahady, 2001; Mebrouk, 2008; Alotaibi et al., 2016), but these did not examine the experiences of student nurses, neither did they reveal any experience of the range of additional value conflicts reported in the current research. The findings

also differ from those of Lovering (2008; 2012) who found that local female Muslim nurses experienced value conflicts mainly because of the ways in which the Western approach to nurse education in this country conflicted with the Islamic approach to of health and illness. As a result, the demands of their patients for spiritual care as well as culturally sensitive physical care were in frequent conflict with the demands of their profession (Lovering, 2008; 2012).

The differences between the findings of these earlier studies and the current research may have arisen at least in part because the current study had a broader scope and focused more directly on revealing the range of value conflicts experienced, not just those arising from the need to apply a western model of care to Islamic patients. The findings of this study are therefore particularly insightful in demonstrating the wide range of value conflicts that are being experienced by student nurses in Saudi Arabia, and the ways in which they are influenced by religious and cultural factors in the case study setting. At least some of the student nurses appear to be experiencing multiple value conflicts, including those of the type faced by nurses worldwide and those that are more specific to the experience of being a female Muslim student nurse in Saudi Arabia, as discussed above.

The findings also included at least some evidence of these negative impacts of these conflicts on the student nurses, with their reactions and feelings about them being described in terms such as "afraid", "embarrassing", "psychological trauma" "stressed", and "mental conflict". A considerable body of previous literature exists on the psychological and physical impacts of various forms of work pressure on student nurses, including burnout, lowered self-esteem and reduced resistance to illness (Altun, 2002; Stacey et al., 2011; Brien, 2012). Some researchers have conceptualised this in terms of concepts such as "moral distress" (Kalvemark et al., 2004; Meltzer and Huckaboy, 2004; Fernandes and Moreira, 2013) and "reality shock" (Kramer, 1974) as discussed in Chapter Two. Many of the student nurse participants in the current study described struggling with a range of negative emotions when faced with various types of value conflicts, and their accounts also reflected a strong sense of confusion and uncertainty, particularly about what the types of nursing tasks and behaviours allowed within Islam, which contributed to their negative experiences. These did not just relate to the exposure of male awrah, though this type of conflict appeared to provoke the most extreme reactions, but extended for example to the use of therapeutic touch, a behaviour which is normal in non-Islamic

nursing contexts, and to more general forms of interaction with male patients and colleagues.

Few differences were apparent between the second and fourth year students in the experience of value conflicts, suggesting that students are not being taught or developing the abilities to avoid or cope better with them during the course of their studies. Also, no notable differences were identified between the participants in terms of marital status or age. There was, however, a strong indication that one of the main influences on experiences of value conflicts is whether or not the student comes from a relatively more conservative religious/cultural family background or a relatively liberal one. Such differences between family backgrounds are unlikely to be major since Saudi Arabia is a very conservative Islamic society. However, the differences that do exist between families within this context were mentioned repeatedly by the research participants as having an influence on whether or not students are likely to experience value conflicts and the expected impacts of these on them.

Almost all of the limited body of previous research on value conflicts faced by nurses in Saudi Arabia has focused on qualified nurses. The findings of the current study are therefore especially important in revealing that value conflicts are being experienced by student nurses from a very early stage of training, and in highlighting the types of value conflicts experienced and the factors contributing to these. Studies conducted in other cultural contexts have also identified negative impacts of value conflicts on student nurses (Lemonidou et al., 2004; Pearcey and Draper, 2008; Solum et al., 2012; Shoqirat and Abu-Qamar, 2013). However, few previous researchers have explored the impact on student nurses of conflicts involving religious or cultural values in the Islamic context. Although based on a case study methodology, the research findings therefore also provide important insights which may be of value in other similar nurse education institutions in Saudi Arabia and other Middle Eastern Islamic country settings. The findings relating to each of the three main types of value conflicts and the two additional forms of value conflict identified in the study are summarised and discussed in turn below.

Providing Personal Care to Male Patients – "Entering Forbidden Territory"

First, the students reported experiencing conflicts between their religious/cultural values and the professional values which may require them to provide personal nursing care to

males, including exposing their private parts. This was also a finding of Mebrouk's (2008) research in Saudi Arabia, in which most female Muslim nurses indicated that they could not expose the awrah of these patients.

This issue of exposing male "*awrah*" provoked extreme negative reactions and emotions from the majority of the student nurses in both years of study in the current research, indicating that this value conflict is one which affects many of them and causes considerable unease and discomfort. In general, the students did not identify exposure of female *awrah* as an issue causing value conflicts to the same extent, though some did stress the importance of preserving the modesty of both male and female patients. Their emphasis on the value conflicts relating to exposure of male awrah indicates that these reflect the religious and cultural values prohibiting any form of interaction between unrelated individuals of different genders in the Islamic society of Saudi Arabia. However, exposure of the private parts of male patients provoked much more extreme negative reactions in the student nurses than the second type of identified value conflict which relates to more general interaction and communications with male patients and colleagues, so it has been interpreted as being a distinct type of value conflict in its own right. Despite their negative reactions, some of the students accepted that providing this type of personal care to males is an unavoidable part of their nursing role which they must come to terms with, and even expected to experience a sense of personal satisfaction for something they had found difficult to deal with. However, others indicated that they could absolutely not accept doing so and believed that they were allowed to refuse to expose male awrah.

In relation to this value conflict, one of the key findings of the study is that there is a lack of clear policies and guidance at the case study institution regarding what is acceptable within Islam in terms of exposing the awrah of the opposite gender in the nursing context. This may reflect the absence of clear and non-conflicting official guidance about this from religious bodies or professional associations in Saudi Arabia, as well as the failure of the institution to address these issues to date in the nurse education curriculum. It is clearly stated in a religious fatwa as well as some of the other documents reviewed in this study that exposure of male awrah by women is prohibited in Islam unless it is necessary. But there is considerable scope for confusion and uncertainly as it is not specified in these documents what constitutes necessity. There is also a lack of awareness of the available guidance on the part of students and faculty alike. Despite the lack of clarity or

consistency in the documents, their inclusion within nurse education could help promote greater transparency and discussion of the issues. In this way, a more consistent and shared understanding can be developed within the case study institution about the situations in which it is regarded as acceptable to expose male awrah and when nurses can rightfully refuse to do so. There was virtually no evidence from the study that exposure and familiarisation to these types of tasks in particular promote the types of creation, attenuation or limitation value change processes defined by Rokeach, in which values are either developed in relation to a new situation or weakened or modified in the presence of more dominant values. Overwhelming, the Islamic values relating to the modesty and privacy of individuals and the perceived complete prohibition on exposure of awrah by a member of the opposite sex, are dominant for the research participants and any initiatives designed to reduce value conflicts by realigning values must therefore take this into account.

At present, the findings revealed that there is considerable confusion and misunderstanding on the part of the students about the hospital and university's policies on providing care to male patients, not only among students but also among faculty. It also appears that informal practices have developed that allow female Muslim students to avoid these types of tasks, which appear to have become established in the case study institution. Many students reported erroneously that the formal university/hospital policy is that care such as fully catheterisation should only be provided by individuals of the same gender as the patient, and referred to the widespread use of practices such as asking a male or foreign nurse to perform these tasks for them. However, no specific policy documents or religious fatwas relating to these practices were mentioned by the students. Based on the documentary analysis as well as the faculty interviews and initial meetings with senior stakeholders including the Vice-Dean of Graduate studies and Scientific Research, the researcher confirmed that no formal policy or official guidance is currently in place at the case study institution regarding exposure of awrah by medical professionals of the opposite gender.

Interaction between Genders – "Rules of Engagement"

Second, the female nursing students reported experiencing conflicts between the religious/cultural values which prohibit close contact and interaction between unrelated

individuals of different genders and the professional values of the nursing profession which require such interaction with male patients and with male medical colleagues. This interaction is necessary, for example, for the purpose of providing physical care, communicating medical information to patients and their relatives, and working effectively in a team with male doctors and other colleagues.

In fact, many jobs in Saudi Arabia now involve working in a mixed gender environment, and Islam does not prohibit verbal communication between unrelated men and women for professional purposes. Therefore, greater familiarity with these situations may help the students to adapt to their responsibilities and adapt their values so that they are more aligned with these. In terms of Rokeach's value change processes (1979), this can be conceptualised in terms of the gradual "creation" of new values or the "attenuation" process whereby individuals gradually weaken their support for an existing value while adopting new ones.

However, many of the students in the current study expressed a severe lack of confidence about interacting in this way with men, and some expressed uncertainty about what forms of verbal and non-verbal contact between the sexes are acceptable within Islam. Although a number of the second-year students said they expected to grow in confidence over time, some fourth-year students exhibited a similar lack of confidence and lack of knowledge about acceptable forms of communication, suggesting a significant need to introduce education and guidance on this within the nurse education program. In order to promote the process of creation of new values, therefore, there seems to be a need to expand their familiarisation with the situations currently causing discomfort.

However, some of the student nurse participants, including both second- and fourth-year students, reported that they had refused to work in male wards or referred to other student nurses who had refused to do so and had been released from this duty by the university. This approach would seem to do little to help resolve the potential for value conflicts of this nature, since the respective students are unlikely to be able to avoid working with male patients or colleagues completely and are not becoming sufficiently familiar with these situations to enable them to feel more comfortable. Likewise, a few of the students from each year who were extremely hesitant about interacting with men indicated that they intend to work in the future in specialist areas of nursing that do not involve caring for adult male patients, and appeared to have the expectation that this will be possible. It might have been expected that some difference would have emerged in this area between

single and ever married student nurses, either because those who had been married might be less troubled by such situations as they had become more used to male/female interaction, or alternatively more reluctant because of concerns about the views of their spouse regarding this aspect of their jobs. However, in broad terms there was no indication from the interviews and focus groups of any clear differences between the participants' responses to this type of value conflict based on marital status, and it appears more likely that family background and prior experience of interacting with unrelated males has a stronger influence on the experience of this type of value conflict by the student nurses.

Similar findings about the reluctance of female Muslim nurses to work with male patients have been reported in studies with nurses in Saudi Arabia dating back almost twenty years. For example, El Gilany and Al Wehady (2001) conducted research with a sample of 253 female Muslim nurses working in governmental health facilities and found that 98.7% of the nurses indicated that they would not accept working with male patients. Similarly, Alotaibi et al. (2016) found that the majority of a sample of 533 female nurses expressed a preference not to care for male patients. Although the current study findings indicate that a lower proportion of participants were very reluctant to care for male patients, which may reflect a change in attitudes over time, they are not strictly comparable with those of the earlier studies which were used quantitative, survey-based methods.

In the present study, some of the student participants were more accepting of the need to interact with males in their work. However, many examples were cited of situations in which the participants had experienced value conflicts not because of their own religious beliefs but due to their perceptions of the beliefs and views of their Islamic patients. The findings revealed that, based on the participants' perceptions, a mutual awareness of Islamic values regarding interactions between the genders often results in embarrassment or tensions in the patient-nurse relationship. Many of the students explained that they often felt uncomfortable when required to care for male patients, because they perceived that the patient would himself feel uncomfortable about receiving care from a Saudi female nurse or might misinterpret her actions. The students' expectations of these attitudes were exacerbated by the low-status image of nurses in Saudi Arabian society, which meant that they believed some patients expected nurses to behave in disreputable ways. As evidence of this, participants cited situations in which speaking kindly to a male

patient had been misinterpreted as being over-friendly or inappropriate. In this context, the participants also highlighted the difficulties of using in Saudi Arabia the "therapeutic touch", commonly employed in other cultural settings to comfort or reassure a patient. Some of the participants even recounted situations in which male patients had specifically requested a non-Saudi nurse, and in some cases this request had been complied with by the nursing staff. It seems that such avoidance strategies or practices may only exacerbate the potential for future value conflicts of this type to arise, since they fail to normalise situations in which Muslim female nurses are providing personal care to male patients.

Public Image of Nursing in Saudi Arabia – "Overcoming the Stereotype"

Closely inter-related with the second type of value conflict, the third identified type of value conflict arises from the ways in which dominant religious and cultural values in Saudi Arabia have caused a negative image of nursing to develop. As a result, students face conflicts between their own personal values which are aligned with nursing, such as a focus on caring for people, and the dominant cultural values of their society which are generally held by their family members, and relate for example to the unacceptability of interaction between unrelated people of different genders. The evidence from this and other studies indicates that nursing has gained a poor public image in Saudi Arabia and many people see this profession as associated with low academic achievement, low skilled work and "unclean" tasks. Previous researchers have found evidence that this often results in family resistance to the choice of nursing as a career by Saudi women, a point which is very significant given the important influence of the family in Saudi Arabian society (Hamdi and Al-Hyder 1995; Al Mutair et al., 2014; Rassool 2015). Others have found that even when Saudi Arabian citizens have a positive perception about nursing, this rarely translates into a desire to enter this profession (Saied et al., 2016).

Similar findings have been reported in other Islamic countries (e.g. Tawash and Cowman, 2015). In Motlagh et al.'s (2012) research with final-year student nurses in Iran, for example, student nurses reported challenges to their choice of career from family members due to its low status reputation in this country. Motlagh et al. (2012) also found evidence of negative attitudes to the profession on the part of the students themselves due to its poor image and reputation in Iran. In Saudi Arabia, researchers have found that many Saudi Arabian men are not interested in marrying women who interact with

unrelated men as part of their jobs (Mirza, 2008), and a more recent study found that some Saudi nurses had to leave the profession in order to get married because their future husbands did not find their jobs acceptable (Lamadah and Sayed, 2014).

Many of the students in the present study indeed reported experiencing conflicts between their own personal or professional values which influenced their choice of nursing studies or between their choice of profession and the values of their family members. Some indicated that they had experienced strong family resistance to their choice of study. The student participants also indirectly reported evidence of other students who had left the nursing program due to resistance from their spouse or families.

A key finding was that instead of trying to reconcile their personal and professional values when these came into conflict, some of the student nurses were instead exhibiting behaviours in which they seemed to be compartmentalising or separating different aspects of their identities in order to avoid such value conflicts. For example, one referred to leaving herself outside the patient's room and just taking on the identity of a professional nurse when she enters the room. In this way she was able to perform the tasks required of her without experiencing the degree of discomfort that might otherwise arise because they clashed with the personal, religious or cultural values that she held as an individual. In a similar way, this participant reported that even though her family members were supportive of her choice of profession, she avoided talking about her job at home. This suggests that the student nurse only felt a sense of identity with this profession at the hospital and this enabled her to avoid the value conflicts that might otherwise have arisen. In a related theme that arose from several of the interviews, student nurses described the ways in which they attempted to conceal their professional identify from family members; for example, one reported hiding her uniform from her husband and not wearing this at home, while another indicated that she did not want to be seen at the college by members of her family who were at the same institution studying medicine. As noted in Chapter Six, concealing or hiding their nursing role and responsibilities may represent a negative example of Rokeach's *limitation* process in which professional values are being suppressed in order to retain a focus on acceptable cultural and religious values outside the university and hospital environment, or alternatively the *consistency* process, in which the student nurses' focus on professional values is less consistent outside these environments. However, this does little to help change the image and reputation of nursing in ways that will ultimately help to reduce the value for value conflicts.

For Saudi Arabia to address its nursing shortage, and to reduce the potential for these types of value conflicts among current nurses and student nurses, there is instead an urgent need to raise public awareness about how nursing is compatible with Islam. When asked how the widely held negative reputation of nursing in Saudi Arabia might be overcome, several of the faculty participants stressed that one of the ways in which this might occur is by student nurses and qualified nurses providing more information to family and friends about what nursing actually involves. Other student and faculty participants discussed the need for public awareness raising campaigns, as discussed later in the chapter. Some commented on the need to revive awareness and understanding of the Islamic origins of nursing in the form of the nurse Rufaida who cared for the wounded at the time of the Holy Wars, in order to help raise the public reputation of nurses and demonstrate the compatibility of this profession with Islamic values. It must be noted, however, that efforts on the part of the nursing profession itself to improve its image are unlikely to be sufficient and may be unconvincing to those who already hold negative perceptions of nurses. Instead, actions to improve the image of nursing are also needed from others such as government departments, religious authorities and the media in Saudi Arabia. There may be scope for using the "Crescent of Care" Islamic nursing model developed by Lovering (2012) within both nurse education and public awareness campaigns, to help demonstrate how nursing is compatible with Islamic values. This model is mainly focused on ensuring that healthcare professionals understand their patients' spiritual and cultural needs and tailor their care practices to these as appropriate, but it also has potential value as visual and explanatory content for literature, presentations and media articles concerned with conveying the important role of nurses in this healthcare model. The model has already been adopted by some hospitals in Saudi Arabia to guide practice (Lovering, 2012) and one of them is collaborating with an overseas university to integrate the Crescent of Care model in the overseas university's nursing program. By demonstrating the ways in which healthcare is compatible with Islam, this may help to underpin a process of value realignment among student nurses in ways that reduce the potential for value conflicts relating to Islamic beliefs.

Hospital Policies and Practices – "To Object or not to Object"

Previous literature on value conflicts experienced by newly qualified nurses in Western countries has found that these often arise when the dominant organisational values clash with the nurses' personal values or the professional values they learned during training (e.g. Forsyth and McKenzie, 2006; Takase et al., 2006; Stacey et al., 2011). Previous researchers have discussed this and its effects in terms of concepts including virtue ethics (e.g. Lützén and da Silva, 1996; Arries, 2005;) and moral distress (e.g. Kalvemark et al., 2004; Meltzer and Huckaboy, 2004; Fernandes and Moreira, 2013), as discussed in Chapter 2.

Although this was not a widely reported type of conflict in the present study, reports of this type of conflict did arise in the second- and fourth-year student focus group discussions. A few participants in these described a number of real or hypothetical situations in which they felt they had been or would be prevented from responding to situations in ways aligned with their personal or religious beliefs and values. These included, for example, situations in which when the hospital's DNR policy prevented them from resuscitating a patient or when a patient's relatives requested that information be withheld from them. This created a conflict between these student nurses' professional values which required them to follow the policy, and their personal values such as honesty or the desire to save lives if at all possible. The participants also reported situations in which they had observed the practices or behaviours of other medical professionals which they felt were inappropriate or unethical and therefore clashed with their own personal values. These included incidents in which other nurses or doctors had treated patients unkindly but the student nurses did not feel confident enough or were not senior enough to intervene or object.

This type of conflict is somewhat tangential to the main focus of the present study, because it has been widely reported in a range of cultural settings (see Chapter 2) and is therefore not unique to the experience of being a female Muslim student nurse in Saudi Arabia. Other researchers have documented the negative impacts of these types of value conflicts on newly qualified nurses in Western countries and argued that support is needed to help them cope with them (Altun, 2002; Brien, 2012; Maben et al., 2006; Stacey et al., 2011). In the present study, this type of conflict appeared to be less commonly

experienced than the more pressing and complex value conflicts experienced by the female Muslim student nurses, and which reflect the influence of Islam and the closely related national culture of Saudi Arabia. However, the main relevance of these findings is that they demonstrate that these student nurses are actually experiencing a wide range of value conflicts, some of which are specific to their religious or socio-cultural situation and others which are more universal in nature. This may potentially exacerbate the negative impacts of the value conflicts on the study nurses. Indeed, evidence was found in the current study that at least some of the student nurses were experiencing psychological impacts such as stress and anxiety. Although these were inferred from the students' self-reported accounts of responses to value conflicts and not objectively measured, they do indicate that the case study institution needs to address the issue of value conflicts more effectively and also provide support for students who experience them.

Reluctant Nurses

Finally, anecdotes were provided by faculty members and some of the students which indicated the possible existence of a different type of value conflict, experienced by student nurses who entered this field of study reluctantly because they failed to qualify for other specialist areas of medicine or healthcare. This is not reported as direct evidence of a value conflict, as the information was obtained only indirectly about individuals who were not participants in the study. However, it is another issue which is relevant to the overall challenge of female nurse recruitment in Saudi Arabia, and which appears to be influenced by factors which are also pertinent to the main value conflicts that were experienced by the student nurse participants. According to the faculty participants, for example, this situation often arises because of the lack of public knowledge and transparency about what nursing actually involves. Students may enter nurse education with little understanding of this career, and if their personal values are not adequately aligned with nursing they may leave when they discover they are required to carry out tasks such as caring for male patients and assisting with personal hygiene. The resulting high level of attrition from nurse education, according to the perceptions of some of the faculty interviewees, has not been widely reported in previous literature but may be in turn reinforcing the negative reputation of nursing in Saudi Arabia. Attrition among student nurses and newly qualified nurses due to the impacts of value conflicts and other

pressures has also been widely reported in the international literature (e.g. Forsyth and McKenzie, 2006; Takase et al., 2006; Boychuk Duchscher, 2009).

None of the student participants appeared to fall into this category of disillusioned students, though several indicated that they had entered nursing involuntarily but had subsequently started to enjoy their studies. However, the researcher discovered in conversations with some of the participants that they or others had been initially suspicious of the study and concerned for example that it was intended to identify those students who did not really want to continue with the course. It is possible that this might have deterred such students from openly discussing any experiences of conflicts between professional nursing values and personal values that might not be well aligned with nursing. Furthermore, since the study used self-selection in the sampling procedures, it is likely that any students who were dissatisfied with their nursing studies and considering leaving the course would not have volunteered to take part in the study. In this respect, the study may have under-represented this type of value conflict, resulting in an element of sample bias, though it cannot be determined from the research data whether this was the case. Since it would not be ethical to coerce students to take part in the study, this is an unavoidable limitation.

The Role of Faculty – helping or hindering?

The inclusion of faculty in the study as well as student nurses was important in helping to reveal the existence of a wider range of value conflicts, particularly those which reportedly contribute to attrition from the nursing degree. This helped confirm the value of the research design and the range of data collection methods used. It also helped ensure that a more comprehensive understanding of student value conflicts, the potential reasons for them and ways in which they might be addressed, was generated from the study. No previous research with faculty in relation to the issue of value conflicts with student nurses or nurses in Islamic countries was revealed by the review of literature, so this research contributes an additional perspective to this issue. Faculty play a key role in socialising student nurses into the profession and in ensuring they are aware of relevant guidance or policies issued by the university or hospital. They also in theory have an important pastoral role which includes responsibility for supporting and helping students affected by value conflicts. However, the faculty interviews revealed relatively little

evidence that these roles are being effectively fulfilled at the case study institution, suggesting that faculty might at present be hindering the resolution of value conflicts rather than helping this process.

Overall, the findings showed that faculty were well aware of all three of the main value conflicts experienced by students. Indeed, a number of these female Muslim faculty members reported that they had experienced similar value conflicts when undergoing their own nurse education, but had overcome these over the course of their careers as they gained more experience of nursing, grew more confident and became socialised into the nursing workplace environment. This suggests that the student nurses might also overcome the value conflicts currently faced as they progress in their studies and careers, and provides clues as to the types of measures that might be used to facilitate or speed up this process, such as more practical experience or confidence-building techniques.

A few of the faculty participants, however, reported that they continued to face difficulties in exposing male awrah and would try to avoid doing so if possible. These reinforce the student-related finding about the influence of family background on experiences of value conflicts. Several of the faculty members also explained that they too came from conservative family backgrounds and as a result had experienced felt shy and awkward when first required to interact with male patients and doctors, though they had gradually gained in confidence over the course of their training. Such faculty members may be able to empathise with students experiencing value conflicts, but are at the same time perhaps more likely to release them from tasks causing discomfort, and are perhaps less likely to be able to role model the attitudes and behaviours necessary to overcome the conflicts. Over time, the use of avoidance strategies in particular may perpetuate the risk of value conflicts while also potentially resulting in staffing problems for the hospital when insufficient numbers of male nurses are available to provide care for male patients. They may also reinforce cultural beliefs about the need for gender-segregated healthcare and the poor image of nursing that currently prevails in this society, by helping to normalise the view that female nurses should not provide care to male patients, and that those who do so are disreputable. There was also considerable evidence from the faculty interviews of a widespread tendency to avoid addressing the whole area of value conflicts when teaching or interacting with students, a finding that is aligned with the theme of concealment and hidden information discussed earlier and which may also serve to legitimise the acceptability of refusing to care for male patients.

In very broad terms, a difference emerged between the faculty with only a few years' experience and those with 20 to 30 years' experience as lecturers. The less experienced and younger faculty participants, in general, expressed the view that students must learn to cope with their role requirements. In contrast, the more experienced (and typically older) faculty participants were, in general, more supportive and understanding of the ways in which cultural and religious values can result in value conflicts for the students, but therefore more likely to release them from certain duties, or avoid talking about value conflicts with them. At the same time, the "get on with it" mentality of some of the younger and less experienced faculty may be equally unhelpful in assisting students to acknowledge and learn how to cope with the value conflicts that they experience, unless adequate guidance and support are also provided to enable them to do so. In essence, to help students understand *how* to get on with it and *why* it is compatible with Islamic beliefs to do so, faculty need to share their own thinking and explicitly explore these issues in teaching.

The research findings did not reveal any particular reason for this apparent difference between the attitudes of younger and older faculty and, as noted in Chapter Six, the differences may simply have arisen by chance within the relatively small sample of faculty. They might also potentially be related to the family backgrounds of the faculty participants, with the older ones coming from more conservative family backgrounds and therefore also being more likely than the younger participants to have experienced similar value conflicts in their own nursing studies and careers. This does not necessarily correspond with cultural or religious developments in Saudi Arabia over time though, as the Kingdom followed a more moderate form of Islam around forty years ago than is currently the case.

A worrying finding was that many of the faculty, like the students, seemed to have incorrect beliefs about the existence of hospital policies and practices relating to tasks such as exposing male awrah. This was a surprising result which suggests that the lack of clear policies and practices in this area might perhaps be a significant factor contributing to the experience of value conflicts by female Muslim student nurses at this case study institution. As reported in Chapter 7, the documentary analysis revealed no evidence of any formal policy relating to the exposure of male awrah by female Muslim nurses at this institution. Further, the only two policies relating to this issue that were based on guidance issued by third party institutions (Ministry of Health; Saudi Commission for Health

Specialties) themselves provided conflicting information on whether it is acceptable for female Muslim nurses in Saudi Arabia to expose male awrah. A religious fatwa was located relating to this issue, but only in the context of operating rooms, and none of the faculty participants expressed awareness of this religious ruling.

Despite the lack of evidence that any clear guidance exists on the matter, some faculty participants referred (erroneously) to a formal policy which exempts Muslim nurses from providing personal care to male patients. In the absence of more extensive formal guidance or support mechanisms for students experiencing value conflicts, therefore, it seems that value conflicts may unintentionally be passed on and reinforced by faculty, either in the ways that they convey their own reservations about caring for male patients to students or by allowing students to avoid those tasks which cause such value conflicts based on an apparently incorrect belief that this is supported by policy.

A small number of faculty participants did report ways in which they try to help students overcome value conflicts in positive ways, for example by acting as role models and demonstrators of the ways in which to behave towards male patients in order to carry out their nursing roles effectively while avoiding any misunderstanding on the part of patients or contravening Islamic values. It is not possible to generalise about the characteristics of these individuals based on such a small sample and the qualitative methodology used. However, there was some indication that faculty members who fell into this category might themselves have had a less conservative upbringing than others, being more outgoing as well as more relaxed about interacting with male patients and colleagues and exposing male *awrah*. They provide examples of ways in which faculty members might help reduce the potential for value conflicts in future or provide support to students experiencing them, as discussed further in Chapter nine. Other faculty members described ways in which they encourage students not to overthink situations requiring, for example, exposure of male *awrah* and to take a more pragmatic approach to these type of nursing tasks. In fact, it might be suggested that in order to overcome the value conflicts, students should be encouraged to explicitly think through how carrying out these tasks might be compatible with Islamic values. Faculty could act as guides in this process by sharing their own thought processes in relation to reconciliation of tasks and values, and by using learning tools such as role play or vignettes, as discussed later. By not explicitly facing these issues in the classroom, however, it is possible that faculty taking this approach are deliberately or sub-consciously avoiding discussion of these issues, because of their

own discomfort or embarrassment, and are therefore reinforcing the potential for such conflicts to be experienced by current students.

8.2.4 Disentangling Religion and Culture

Influence of cultural factors on value conflicts

One of the most important findings of this study relates to the respective roles of cultural and religious factors in the value conflicts being faced by student nurses. As noted in Chapter 2, religion and culture can be very difficult to separate in Saudi Arabia as in other Islamic countries, since Islam is a complete worldview that addresses all areas of life (Bester et al., 2013). This helps explain why personal, religious and cultural values appear so closely intertwined in the participants' understanding of values, and also why they struggled to reconcile value conflicts because of the commonplace perception that Islamic values cannot be modified. However, it is important to at least attempt to disentangle religious and cultural values in order to identify how value conflicts might be overcome in ways that remain compatible with Islam. This is also demonstrated by the findings of AlYami and Watson (2014) that it is largely cultural barriers that deter many Saudi women from considering nursing as a profession, particularly as families are often opposed to this career choice for their female members.

The discussions of values in the interviews and focus groups revealed that, in general, the student participants regard religious values as fixed and unchanging, derived from Islamic texts and followed by all devout Muslims, and providing an important guide to decision-making throughout their lives. In contrast, they see personal and cultural values as influenced by a wide range of factors such as family upbringing and education, varying between individuals, and being subject to change over time. This is largely aligned with the findings of Lovering (2008) who defined Islamic values as those derived from the Qur'an which for example specify requirements for taking care of the body and one's health, and Saudi Arabian cultural values as those not specifically derived from the Qur'an, such as the dominant role of family relationships in this setting. Within the context of the very religious society of Saudi Arabia, this is a key finding of the study, which helps to reveal the extent to which it might be possible to transform some of the values of student nurses in order to ensure that these are more compatible with

professional values, while not compromising the core Islamic values which are so important to them.

The dominant influence of family background

The central role of the family in Saudi Arabian society was evident in many of the research findings, both in terms of shaping the personal values of students and also in influencing the extent to which they experienced the various types of value conflicts identified in the study. In particular, the research data indicated that students from more conservative Islamic families or more conservative regions of Saudi Arabia are more likely to experience a clash between their religious or cultural values and the professional values of nursing. This is aligned with the findings of quantitative research conducted by Milig and Selim (2014), which indicated that student nurses from the more religiously and culturally conservative northern region of Saudi Arabia were more likely to hold negative attitudes towards the profession.

The apparent differences in the experience of value conflicts between the participants, who were all local Saudi Arabian Muslim females, therefore indicate that value conflicts can arise not because of the clash between professional values and Islamic values, but because of cultural influences on the ways in which these are interpreted or followed. Many participants reported direct or indirect evidence indicating that family or local community background has had an influence on the extent to which they experience value conflicts or the impacts that these had on them. Some from less conservative backgrounds, for example, expressed understanding that Islam does not prohibit exposure of awrah for healthcare at least in emergency situations and an awareness that cultural interpretations of Islam have made this unacceptable in Saudi Arabia. In contrast, others from more conservative family backgrounds were of the view that this is not acceptable in any circumstances, since they had been brought up to believe that Islam prohibits such tasks.

Similarly, some of the students from relatively liberal family backgrounds were more comfortable interacting with male patients and medical colleagues, since their upbringing had involved a greater degree of contact with males outside of their immediate nuclear family, such as cousins or uncles, and they were more used to communicating with men. In contrast, others from more conservative backgrounds apparently experienced great difficulty and discomfort in doing so, since their upbringing has taught them that Islam

prohibits such interaction between individuals of opposite genders and they may not have ever been allowed to interact even with male relatives outside the nuclear family.

Few of the student nurses themselves reported that they come from very conservative family backgrounds, with just one or two exceptions such as one who reported that she grew up in the more conservative northern region of Saudi Arabia and still faced extreme difficulties in communicating with male patients and colleagues. Many of the findings on this issue are based on indirect evidence from the interviews and focus groups in which the student and faculty participants discussed other student nurses known to be from conservative backgrounds. This included one who had reportedly left nursing because she could not reconcile her traditional religious and cultural values with the reality of what she would be required to do as a nurse, including communicating with men. Nonetheless, Saudi Arabia is a very conservative Islamic society in general, so the differences between family backgrounds are merely a matter of degree. Overall, the findings indicated that most of the student nurses had experienced resistance from their close family members to their choice of study, which reflected the negative public image of nursing in Saudi Arabia. As a result, many reported that they avoided talking to their families about their nursing roles, indicating a possible element of shame or guilt which conflicted with their own personal values that were aligned with nursing or the professional nursing values that they were developing through their studies.

When more positive or liberal reactions from family members were reported, these generally reflected greater experience or understanding within the family of healthcare, with other family members sometimes holding positions as doctors or other medical specialists. Although there was some indication therefore that families were more supportive of the student nurses if they already had other members working in medical professions, this was not always the case: for example, one of the participants said that even though her mother is herself a doctor, she is uncomfortable telling her friends what her daughter is studying, and describes it as allied healthcare instead of nursing. This also suggests that even some doctors in Saudi Arabia have a poor understanding of the role of nurses and the knowledge and expertise they hold, and are influenced by the negative public image of this profession. However it is not possible to determine from this study how typical the participant's mother's views are. In other examples cited by the participants, family members are supportive of their studies and happy for them to

complete their nursing degree, yet still reluctant to see them actually enter nursing as a profession.

Spirituality at work – a way of coping with value conflicts?

It was found that students whose personal values are closely aligned with nursing often viewed their role in terms of complementing Islamic values rather than clashing with these. As a result, they were able to justify the carrying out tasks of which presented value conflicts to other nurses. For example, one of the student nurses willingly accepted the requirements to bathe both female and male patients by focusing on the importance of these tasks and viewing them as a way of serving Allah by demonstrating love and care for all her patients. Others gave examples of praying with dying patients and caring for patients as if they were members of one's own family. Transferring thoughts about their own family members to patients as a means of understanding the importance of their nursing role and of performing it willingly was mentioned by several of the student nurses. This seems to reflect not only an awareness of the spiritual needs of their Islamic patients who they could compare to their own father, brother or other family members, but also the emphasis on family relationships in Islam and specifically in Saudi Arabia. They represent examples of approaches to nursing which the participants indicated were not shared by foreign nurses in Saudi Arabia, especially non-Muslims but even some Muslim nurses from different countries with different cultures to Saudi Arabia.

This finding is aligned with that of Lovering (2008), who found that it was important for Saudi Arabian nurses' own spiritual well-being to blend their own religious and cultural beliefs into their nursing practices, by conceptualising their role in terms of seeking the pleasure of God at work. This enabled them to cope with the negative public image of nursing. Other researchers found similar evidence of Saudi Arabian nurses' reconciling their values in this way. For example, in a study of perceptions of nursing care among Saudi Arabian female Muslim nurses, the participants indicated that they could not be nurses if Islam did not support this, and described various ways in which they incorporate spiritual practices into their nursing care, such as prayers and the use of Zamzam (holy) water (Mebrouk, 2008). In other Islamic settings like Iran, a focus on the spiritual aspects of care has also been shown to contribute significantly to job satisfaction among Muslim nurses and appears to be an important aspect component of the self-identities of the research participants in these previous studies (e.g. Ravari et al. 2012; Atefi et al. 2014).

These examples help demonstrate that nursing is not incompatible with Islam as a religion per se, though Islam may be incompatible with certain nursing tasks such as exposure of male awrah by female nurses. It might be inferred that student nurses who are unable to accept tasks involving personal care for males might be effective at delivering spiritual care but not necessarily the physical care required by their male patients, in contrast with foreign or non-Muslim nurses. Nonetheless, a few did report using a focus on religious values to cope with this type of task. They explained that everything they do is being observed by Allah and that it is crucial to perform all their nursing tasks to the very best of their abilities in order to please him. This enabled them to cope with tasks that they would otherwise find distasteful, or which would be disapproved of by others in society such as providing personal care to male patients. To enable more student nurses to adopt this attitude, however, there is a need for better and clearer guidance regarding what female Muslim nurses are prohibited from doing and when exceptions to this rule are permissible.

The findings also indicate that it is the way that religious beliefs and values are interpreted by different individuals that has an influence on whether they contribute to value conflicts. Some students were apparently experiencing extreme value conflicts when faced by tasks seen as incompatible with Islamic values, while others cited an emphasis on Islamic values such as love and caring as factors which enable them to avoid value conflicts, since the expression of these values requires providing whatever forms of care are needed by patients. This indicates that such students may have undergone an internal transition, of the type suggested by Rokeach, in which the discomfort associated with value conflicts is transcended in order to reach a different state in which more compatible values are developed. Rokeach (1973) theorised that individuals can hold conflicting values of which they are unaware: when this comes to their attention they go through a process of self-confrontation, initially involving a stage of dissatisfaction and negative emotions which drive change and eventually result in the adoption of values that are better aligned or in which one of the conflicting values becomes dominant. As discussed in Chapter 6, many of the second- and fourth-year participants reported experiencing a range of negative emotions and psychological impacts as a result of the value conflicts they were experiencing, in ways that can be explained by Rokeach's self-confrontation concept. This was particularly the case with regard to the value conflicts arising from the requirement to expose male awrah or to engage in interpersonal communications with male patients and colleagues. While some of the students continued to struggle with these

forms of value conflict, the accounts of others suggest that they may have experienced such discomfort when initially faced with situations seen as incompatible with Islam, but made a conscious decision to focus instead on the importance of values such as love and caring. These are seen as Islamic as well as personal values, which apparently enabled these student nurses to come to terms with the situations they faced, and reconcile them with their Islamic beliefs. This provides important insights into the ways in which higher level values such as love and caring for patients, and the ways in which these relate to Islam, might be emphasised in nurse education in order to promote a similar process of value realignment among other student nurses.

The findings of the current study indicated, however, that many participants were confused about the distinction between Islamic values and cultural values, providing further support for the argument that more training and awareness-training about values should be provided to student nurses. For most of the participants, the perception of nursing as a means of serving God did not extend to a willingness to expose male awrah, which was seen as contravening Islamic laws and values, except in emergency situations. As noted earlier in the chapter, there is a pressing need for clearer guidance about how to define such situations so that student nurses can be encouraged to undergo a process of value re-alignment in ways that do not contravene the fundamental Islamic values relating to this type of task.

Shortcomings in Current University Policies and Practice

The findings of the various stages of this study indicated that the case study institution does not appear to be even acknowledging the issue of value conflicts at present, let alone addressing them. This argument is based on the results of the documentary analysis, which indicated that there is very little formal guidance available to students and faculty on issues that the research has shown to give rise to value conflicts, such as the provision of personal care to males and ways of communicating with male patients and colleagues. It is also based on many of the interview and focus group findings which revealed limited knowledge and considerable confusion about what is acceptable in these areas.

In the absence of formal policies and guidance, informal policies and practices have become entrenched, such as allowing students to refuse tasks involving exposure of male awrah, and in a small number of cases even excusing them from working on male wards.

However, the use of these appears inconsistent and is likely to be reinforcing the confusion and lack of clarity about what is permissible for female Muslim student nurses. As noted earlier, many students and even some faculty hold the belief that the formal university/hospital policy is that personal care such as catheterisation should only be provided by individuals of the same gender as the patient. However, no specific policy documents were identified by the participants to support these arguments, and the documentary analysis revealed that there is very little relevant and consistent content guidance issued by professional associations or religious authorities on these issues which might be used by the university in nurse education.

Of those documents that were included in the review, only one explicitly addresses the issue of value conflicts and provides guidance to student nurses on dealing with these. This is the hospital Code of Ethics which states "*when facing professional dilemmas, your first consideration in all activities must be the interest and safety of patients*" (p.7). However, the main references on which this document is based are Western codes of conduct. The guidance is not specifically tailored to the Islamic setting of Saudi Arabia where Muslim patients' "interest" may extend to religious and cultural requirements for same gender nursing care which conflict with their needs for safety, and therefore create ethical dilemmas or value conflicts for nurses. Also, this document provides only high-level general guidance and is unlikely to be of practical value in dealing with day to day value conflicts that may arise. Furthermore, there was also little evidence from the documentary analysis or the primary research that international or regional codes of practice such as the International Council of Nurses' (ICN) Code of Ethics for Nurses (2012) or the Gulf Cooperation Councils' (GCC) Code of Professional Conduct for Nursing's core values are being taught to student nurses in these institutions, and in any case these also only provide high level guidance which cannot be expected to be specifically tailored to the types of value conflicts being experienced by female Muslim student nurses in this setting. Nonetheless, the use of such documents in training might provide a foundation for the development of more specific guidance within the case study university, and to stimulate classroom-level discussions about the potential for value conflicts within various nursing situations and how this might be avoided.

Two documents issued by third party organisations in Saudi Arabia: the Ministry of Health and the Saudi Commission for Health Specialties, were found to provide quite extensive guidance on what is permissible within Islamic ethics in terms of patient care

and inter-personal contact between the genders, but no reference was made to these in the faculty or student interviews, suggesting that neither of them are being use for teaching purposes or the development of guidance at the case study institution. Furthermore, these two documents, though based on guidance issued by governmental authorities, provide conflicting guidance with one indicating that only healthcare providers of the same gender as the patient can expose their awrah, and the other acknowledging that healthcare professionals can expose awrah of patients of the opposite gender if a professional of the same gender is not available. This finding suggests that there is a wider problem within the nursing profession of Saudi Arabia in terms of contradictory guidance on issues which might result in value conflicts, which needs to be addressed at a higher level by Islamic religious authorities. If reconciliation of such conflicting guidance can be achieved, this will provide a more robust basis for institution-level policies, practice and training on values and value conflicts. In the meantime, the current documents might usefully be employed within the case study institution at least for the purpose of promoting discussion and helping faculty and students alike to explore perceptions of their meaning and how they can be used to help inform and guide their roles and responsibilities as nurses. This could form an important component of initiatives intended to help promote processes of value change among the students and overcome some of the potential for value conflicts, as discussed later in this thesis.

Another of the main problems with the current nurse education programs that emerged from the study is that these are not preparing students to care for male patients or to interact with these and male colleagues. Many of the participants, including students and faculty, explained that throughout the nursing degree students practice nursing procedures only on female dummies, so they do not build confidence in caring for males. Further, since there are no male faculty members or male students in the department, this makes it even more difficult for the students to become confident and relaxed when dealing with male patients since many have little experience of interacting with males generally. Many of the participants, especially the faculty members who commented about high levels of attrition from the course, observed that there is a lack of transparency about what nursing entails in the early stages of nurse education, and that students only really start to learn about nursing roles and responsibilities in their second year, at which stage many experience shock at what they are learning they will be required to do, and leave the course because these tasks conflict with their religious or cultural values.

Although ethics are not strictly speaking the same as values, they relate to accepted guidelines or principles for behaviour in a given society, and are likely to shape the values that individuals hold. Aspects of the nursing curriculum covering ethics are likely to be among the most suitable contexts for discussion of values and value conflicts. However, according to faculty, the Code of Conduct and Ethics is apparently touched on only briefly in the Concepts of Nursing course taught to second year students, and is only properly covered in the fourth year of the nursing degree. Further, they reported that students are only introduced to the hospital's own Code of Ethics when they become interns in the fourth year of study. Some student participants expressed the view that this limited coverage of ethics in their studies is insufficient, and that the current teaching does not include enough discussion of practical application of the code in their day to day work. Even the fourth-year students expressed low levels of awareness of these documents, indicating that teaching in this area may not currently be receiving enough prominence in the curriculum. Several participants stressed that they receive little guidance or training on what to do in specific situations that may cause value conflicts, and expressed the view that this should be included in training from an early stage. By exposing student nurses to the possibility of these situations through discussion of them, the participants argued, it would help them to get used to them psychologically and prepare themselves for real-life scenarios of a similar type.

In the wider international literature on value conflicts in nursing, the importance of organisational factors in helping reduce the potential for value conflicts or supporting individual nurses and student nurses to cope with them has been emphasised. As discussed in the literature review, various studies have shown that the environment and organisational culture in which newly qualified nurses work has a major effect on how they adjust and negotiate their new identity and adapt to the role of professional and qualified nurse (Whitehead, 2001; Mooney, 2007). Effective education and training have been shown to play an important role in socialising student nurses into the profession and in promoting the development of professional values (Dimitriadou et al., 2013; Keeling and Templeman, 2013). There is little direct discussion in the literature of the role of formal policies and guidance on ethics and values, but these might provide an important foundation for the development of education and training materials, and also as guidance for faculty and other institutional staff as they provide support to students.

Vignettes might also be usefully incorporated into student nurse education as a means of awareness raising, improving transparency of value conflicts, and stimulating discussion about these with the ultimate objective of transforming some of the values of the student nurses in ways that will reduce the potential for conflicts. The use of vignettes (see Appendix 8) to provide examples of hypothetical value conflicts for the purpose of discussion and reflection proved very effective in the faculty interviews. This may be because they provided concrete examples of the otherwise abstract concept of a value conflict, which helped the participants to formulate their reactions. They also provided a safe opportunity for the faculty participants to give their responses to the scenarios, without fear of any implications or repercussions on others, as might arise in a real life nursing situation involving named individuals. The researcher obtained informal feedback from staff that this approach had also worked effectively in the Crescent of Care workshops recently held at the hospital, in this case for the purpose of improving understanding of patients' cultural and spiritual/religious needs so that appropriate care can be provided to them.

With regard to support for students who have experienced value conflicts, the evidence from student and faculty participants was somewhat inconsistent. Some of the faculty expressed the view that sufficient support is available, for example in the form of the academic advisors, the student affairs counsellors, and the clinical conferences that are held with students. They reported however, that few students use these sources of help effectively and are often reluctant to speak up about the issues they may be facing. Possible reasons for this were revealed by some of the student participants. Although one student did report a positive experience of being able to talk about problems to a faculty member, others indicated that they feared repercussions from doing so, such as a poor academic evaluation or being transferred to a different area of training, if they reported situations causing value conflicts. This is a serious point which indicates that the university needs to do more to reassure students that they can speak in confidence to staff about any value conflicts they face, without fear that they will be penalised for doing so. Again the implementation of course content and strategies which promote open discussion of the nature of values and value conflicts and reduce any stigma associated with these is likely to help promote an organisational environment in which students feel more comfortable in reporting their experiences or concerns without fear of repercussion.

8.3 Implications of the Findings

The students' experiences of value conflicts appeared to largely reflect high levels of confusion about the types of nursing tasks that are acceptable within Islam. It seems that this whole issue has not been addressed either by the government or religious authorities, and that the educational establishment does not therefore have sufficient guidance for use in educating student nurses about this issue. This was reflected in the finding that even many faculty members were confused whether Muslim female nurses are allowed to expose the awrah of male patients for example. This is likely to be least in part because the available relevant documents are unclear or inconsistent, for example in clarifying what is meant by "necessity" when discussing the situations in which medical professionals can expose the awrah of patients of the opposite gender. There is a pressing need, therefore, for the development of clearer guidance to form the basis of nurse education in these areas.

This is particularly important because of the important distinction revealed by the research between the student nurses' perceptions of religious values, which are seen as fixed and mandatory throughout one's life, and cultural values, which can change over time reflecting the experiences and learning that individuals undergo. Within the conservative Islamic setting of Saudi Arabia, religious values were in general seen by the participants as those set out in the Qu'aran, Sunnah and Hadith, which are the main sources of Islamic teachings and law, while cultural values were seen to reflect the ways in which Islamic teachings have been translated over time by religious teachers and authorities. Clarifying in policies and guidance what nursing tasks are acceptable based on original religious values and teachings is therefore an important step in addressing value conflicts by providing a firmer basis of knowledge and overcoming the current confusion and inconsistency in beliefs.

New policies and guidance are likely to form only part of the solution, however, since student nurses still need to undergo psychological processes in which they achieve reconciliation of their existing religious and cultural beliefs and values with the requirements of their nursing roles. Such beliefs and values are likely to have been ingrained since childhood, and may be particularly strong in the case of those from more conservative family backgrounds. The findings of this study revealed that many of the students were facing discomfort in their roles not because of their Islamic beliefs per se

but because of cultural beliefs reflecting the negative image of nursing held by their family members, or the ways in which they had been brought up to believe that communicating with non-related males was culturally unacceptable in Saudi Arabia.

While clear policies and guidance are therefore needed in order to overcome the current confusion about what types of nursing tasks are permissible within Islam, educational strategies are also very important in order to promote changes in personal or cultural values that currently clash with the professional requirements of the nursing role, and to promote the adoption of new mindsets based on explanatory models of healthcare that are aligned with Islamic values.

Professional nursing values are learned by student nurses in several main ways: by being taught the content of formal codes of conduct, being taught such values as part of the nurse education curriculum and being passed on formally or informally as tacit values by nurse educators or by qualified nurses, through the student nurses' experience of observing and working with these. In order to ensure that these do not give rise to value conflicts, the channels of dissemination of professional values need to be adequately aligned with religious and cultural values of the student nurses, as well as consistent with one another, and in this way are more likely to be internalised over time, as the student nurses begin to confront their feelings of discomfort, increase their understanding of the reasons for them, and gradually adopt new values which are better aligned with one another, in the ways described in Rokeach's (1979) value change theory. Faculty must play a key role in these initiatives, disseminating nursing professional values and acting as role models to the students in ways that are currently not in evidence from the research. For example, faculty can demonstrate in their own teaching and actions how to behave in inter-personal communications with male patients and colleagues. Only one of the faculty participants mentioned that she currently takes this approach, and the research data from student nurses and faculty did not indicate that others are doing so. More formal strategies in which value transformation initiatives are incorporated into the curriculum are needed. Rokeach's theory of value change can be used to inform the design and content of these, as discussed in the next section.

8.4 Value Transformation Initiatives

Rokeach's theory has proved to be useful as a theoretical framework for examining the participants' understanding of values and the forms of value change which can occur in this nurse education environment. In the Findings and Discussion chapters, many of the reported experiences of the student nurses were interpreted in terms of specific value change processes as defined by Rokeach. However, while some reflected a positive realignment of values over time as students adapted to the professional nursing context, others were less positive and unlikely to be beneficial for the student nurses or the profession in the longer term. These included, for example, cases in which participants reported concealing or hiding their nursing role and responsibilities from family members. These were interpreted in the analysis in terms of Rokeach's *limitation* or *consistency* processes, when a value is modified because of increasing compatibility with other dominant values, or is held inconsistently depending on the context. In these cases, the professional values of nursing, which were applied by the students in the university and hospital environments, were apparently put aside at home where negative attitudes to the profession were dominant. It will be important that educational initiatives are designed to help promote more positive processes of value change as discussed in this section.

Another of the key findings of the study was the ways in which some of the student nurses overcame their own resistance to certain nursing tasks as well as the negative public image of nursing in Saudi Arabia, by reconciling these with their Islamic beliefs and viewing nursing as a way of demonstrating the Islamic values of love and care when dealing with their patients. This did not generally extend to acceptance of exposure of male awrah, which relates most closely to religious rather than cultural values, and must be addressed with clearer guidance as noted above. With regard to more general nursing tasks, however, the spiritual focus exhibited by some of the students provides insights into the ways in which value change might be promoted, by raising awareness of the ways in which Islamic values can be demonstrated through these tasks.

However, it is important to recognise that the transition from a situation in which a student nurse is experiencing severe and often multiple values conflicts, to one in which she has reconciled these and is able to view nursing as a way of serving God, is not likely to be an easy or straightforward one. Indeed, a certain amount of discomfort is an important

and inevitable part of achieving the cognitive and emotional shifts necessary for value change, according to Rokeach. He explained that this is caused by individuals recognising that they have conflicting values, an important precondition for the development of more congruent values.

It is therefore important for the case study institution to establish initiatives which promote positive processes of value realignment, while at the same time providing the necessary support to both students and faculty to ease this process as much as possible. Based on the findings of this study, one of the main factors currently contributing to the widespread experience of value conflicts is the avoidance of direct discussion of this issue. The topic of values and ethics is barely covered in the nurse education curriculum, let alone the issue of value conflicts. When these do arise, they are often dealt with using avoidance strategies, such as releasing student nurses from the types of situations causing them such as working on male wards, an approach which is only likely to exacerbate the problems in the long run, and do little to improve the public image of nursing in Saudi Arabia. Conversely, these female nurses most of which have very little previous experience of interacting with unrelated males, are receiving virtually no training or guidance from the College of Nursing in communication and behavioural skills relevant to the Saudi Arabian nursing context, and their resulting awkwardness with male patients and medical colleagues may be hindering the promotion of a positive professional image of nurses.

Even the most extreme form of value conflict reported, relating to the provision of personal care for male patients and which was experienced by all the student participants and many of the faculty, is apparently rarely discussed as part of nurse education. The lack of clear official guidance or teaching about whether and when this is permissible for female Muslim nurses has led to widespread confusion about this and the development of unofficial practices whereby male or non-Muslim nurses are generally asked to take over these tasks. This is only likely to reinforce rather than reduce the potential for value conflicts of this type, by encouraging the view among student nurses, other healthcare providers and patients that such care is unacceptable in any circumstances.

It is therefore strongly recommended that value change initiatives should be implemented that first promote open discussion of value conflicts in a classroom setting, In these, faculty should share their own experiences and views in order to encourage students to do so, and the content of relevant documents such as the Code of Ethics for Healthcare

Practitioners, the hospital's Patient Rights Document and the Ministry of Health's regulations regarding exposure of patient awrah should be explored in order to consider the implications of these for the nursing students. Such discussions are intended to help enable students to reflect on and consider the situations in which they have experienced value conflicts, share and learn from the ways in which other students or faculty have dealt with similar situations, become more aware of the available guidance and its implications, and gradually build a shared understanding of the nursing role that is compatible with Islam. Most importantly, by bringing the issue of value conflicts out into the open and with faculty sharing their own experiences of these, they are intended to gradually help reduce the embarrassment and awkwardness that students might currently feel in discussing these, promoting an environment for more constructive discussion about the situations causing value conflicts and ways of dealing with these, and teaching the students how to communicate with men in professional ways that are compatible with Islam.

In terms of Rokeach's conceptualisation of value change processes, the incorporation of more discussion and education about values and values conflicts within the nurse education curriculum might be expected to result in a *creation* process, in which new beliefs are developed over time and transforms previously held values. These are expected to include, for example, beliefs about the acceptability of interacting with male patients and colleagues in the nursing context without the current levels of awkwardness, and even an increase in willingness to provide personal care in cases of necessity, once an agreed definition of is reached within the case study institution through discussion of available religious and professional guidance. It may also take the form of an *attenuation* process, or the gradual withdrawal of support for a value previously held – such as the strong cultural values of Saudi Arabia which discourage inter-personal communications and interaction between unrelated individuals of the opposite gender. Alternatively, such discussions might be used to promote Rokeach's specification process, whereby a generalized value is increasingly defined within particular contexts in which it is defined. Using this process, the proposed discussions might be used to apply the students' religious values to specific nursing situations in order to understand how these can be conceptualised as ways of serving God, in the ways already being exhibited by some of the participants who might share their experiences of this approach to nursing.

These types of value change strategies also need to be combined, however, with more practical measures intended to address some of the underlying issues contributing to the experience of value conflicts that were identified in the research. Introducing more simulation techniques in training, for example, and expanding the practical hospital-based training experience offered to student nurses at an earlier stage of their studies may help to familiarise students with the situations currently causing value conflicts. Combined with the value transformation initiatives discussed above, these approaches may gradually desensitize situations currently resulting in value conflicts and reduce the negative impacts of these on the student nurses. A full range of recommendations for promoting value change and reducing value conflicts among student nurses at the case study institution is presented in Chapter Nine.

8.5 Strengths and Limitations of the Study

8.5.1 Critique of the Research Design and Methods

The completion of the initial exploratory study confirmed the presence of value conflicts in student nurses, and justified the need for the main study. It proved effective in testing the sampling and recruitment methods, identifying the types of issues to be covered in the main study, and confirming the suitability of the qualitative approach. The exploratory study was helpful not only as a means of testing and confirming the suitability of the research methods though, it also generated valuable data in its own right from a different group of research participants at the case study institution. It provided evidence, based on samples from different cohorts of student nurses, that these were experiencing significant value conflicts. As in the main study, the most common form of value conflict experienced by the exploratory study participants was between professional values relating to the provision of high standards of nursing care and the religious/cultural values that prevent the student nurses from undertaking any tasks requiring exposure of male *awrah*. There was also considerable evidence of the second main type of conflict revealed by the main study, relating to the need to communicate and interact with male patients and colleagues on a daily basis, and the third type of conflict, which arises because the participants' choice of nursing as a career conflicts with the poor public image of nursing and the attitudes of their family members to their choice of studies. Unlike the main study, however, the exploratory study sample provided little direct evidence of the type

of conflict that arises when student nurses are in disagreement with hospital policies and practices, or of value conflicts experienced by student nurses who did not voluntarily choose nursing.

In the main study as in the exploratory study, despite the potential sensitivity of the topic under investigation, the use of in-depth interviews and focus groups worked well in generating a range of rich qualitative data. Based on a case study design, the main study used multiple methods of data collection, consisting of student interviews and focus groups, faculty interviews and documentary analysis, and thus provided a broader range of information and richer contextual data than would have been achieved from a single method of data collection. It was particularly notable that including faculty as well as students in the research provided additional useful insights into issues into the ways that student value conflicts are manifested, information about current university practices and policies in relevant areas, and the role of faculty themselves in relation to the experience of value conflicts by students and how to address these.

The case study design also meant that recommendations could be developed for reducing the potential for value conflicts which were tailored specifically to this institutional setting. When developing detailed recommendations for an institution, it is essential to have a comprehensive understanding of the organisational context in order to identify which would be viable to implement and what the potential barriers might be.

By exploring the phenomenon of value conflicts from the personal perspectives of the research participants and within a specific case study context, findings were generated that demonstrated the wide variety of experiences and perceptions of value conflicts among both student and faculty research participants and helped identify the factors believed to be contributing to these. In particular, this provided opportunities for triangulation of the findings from the different groups of research participants as well as the documentary analysis results, in order to generate a comprehensive understanding of these taking into account their different perspectives. The commonalities and differences between the views of participants also helped enabled the researcher to identify the respective roles of culture and religion on value conflicts. The findings are used to develop recommendations expected to help reduce the potential for value conflicts among Muslim student nurses which do not contravene the strong religious values which are at the core of Saudi Arabian society and which underpin the personal values of the participants.

While providing useful information for the case study institution, the findings are additionally expected to prove useful in contributing to the overall evidence base regarding the experience of value conflicts by Muslim nurses in Islamic countries, and in helping to clarify the respective impacts of religious and cultural factors. In this sense, the research is also believed to provide a successful example of an instrumental case study, as discussed in Chapter 4. Throughout the discussion of findings in Chapter 7, the similarities between the experiences of the research participants and those of student nurses in other Islamic countries have been highlighted. Furthermore, the review of available literature as well as the empirical findings of the current study have suggested that the experience of value conflicts by female Muslim nurses vary depending on the ways in which Islam is interpreted and translated into cultural values. These findings about the respective impacts of religious and cultural values on value conflicts are likely to be of broader value and relevance in a range of organisational and country settings.

8.5.2 Evaluating Research Quality

The quality of qualitative research is often evaluated using the criteria proposed by Lincoln and Guba (1985). These consist of *credibility,* or whether the findings appear credible or reasonable; *dependability,* or whether similar findings would be generated if the study were to be repeated; *transferability*, or whether the findings could reasonably be applied to other settings, and *confirmability*, whether the findings appear to be objective and not biased by the researcher's existing beliefs (Lincoln and Guba, 1985). Research credibility and dependability can be enhanced by ensuring that a study is well grounded in existing literature or previous research to reflect a good understanding of the topic of interest. A thorough literature review as well as an initial exploratory study were carried out in order to ensure that this was the case in the present study.

One of the limitations of the instrumental case study method that has been discussed in the literature is the difficulty of generalising findings from a single case (Giddens, 1984; Yin, 2009). Although true generalisability is not the aim of qualitative research, well conducted qualitative single case studies can generate findings that are transferable to other contexts. Indeed many writers have argued that well-selected single case studies provide useful in-depth data for understanding a wider phenomenon and the ways in which contextual factors influence this, from investigation of a single case study site (e.g.

Kennedy, 1979; Flyvbjerg, 2006; Lincoln and Guba, 2013). Cronbach (1975, p.123) refers to this approach as "interpretation in context". Crowe et al. (2011) argue that selecting a "typical" case for study can help ensure that the research provides information about the phenomenon or issue of interest, and therefore has wider relevance beyond the immediate case study setting.

In the case of the present study, the selection of a case study site within a conservative Islamic country, and selection of a sample of second and fourth year female Muslim student nurses as well as faculty, means therefore that the findings potentially have some transferability to female Muslim student nurses in similar religious/cultural environments in other Islamic countries, or to other institutions within Saudi Arabia. The transferability of the study and its findings have also been enhanced by carefully documenting the research and analysis methods, so that the study can potentially be replicated elsewhere.

Confirmability was enhanced in this study by the use of multiple data collection methods as a means of triangulation to generate findings from different sources and perspectives (Lincoln and Guba, 1985). The researcher also employed a process of member checking, or respondent validation, in which participants are asked to read interview or focus group transcripts to confirm their accuracy. Further, an independent nursing research professional was asked to comment on the authenticity and veracity of the interview process based on a review of a sample of 6 translated interview transcripts. The reviewer confirmed that the transcripts were sound and reliable and that the interviews appeared to have been conducted in an organised, consistent and methodological manner. The reviewer's report is included as Appendix 9. Finally, all data collection and analysis techniques were well documented so that the study can be replicated by others if required in order to confirm the rigour of its methods (Morse et al., 2002).

8.5.3 Limitations of the Study

Although the case study design was to some extent successful in generating valuable insights both for the case study institution and other organisations, its effectiveness also proved limited. The documentary analysis, which was one of the data collection methods used to broaden the research from a purely qualitative study to a case study approach, proved limited in its effectiveness. This had been intended to provide a wealth of contextual information on the ways in which written content about values and value

conflicts is being taught or incorporated into policy guidance at this institution, with the interviews and focus groups being used to explore the participants' knowledge and views on this content or its dissemination.

In the event, the documentary analysis proved very limited for two main reasons. First, accessing documents at the University College of Nursing proved challenging. Even though ethical approval for the research was secured and a higher education memo was circulated to departments requesting their cooperation, some refused to provide documents for review. As an alternative approach, therefore, some of the main modules were reviewed on behalf of the researcher by cooperative module coordinators. It proved easier to secure documents for review from the hospital. Nonetheless, the researcher could not be fully confident that all relevant documents had been identified.

Another potential limitation of the study was the use of self-selection procedures in sampling. This should not be regarded as a weakness, since it would not have been appropriate to coerce individuals to take part in the study and doing so may have produced unreliable or less rich data. Overall, high percentages of eligible students in each year group – 28% of all 2nd year students and 44% of all 4th year students - volunteered to take part in the study, and the final samples were selected using a mix of purposive and random sampling methods, as explained in Chapter Four. This helped reduce the potential for self-selection bias. However, it is not known whether the student nurses who volunteered differed from those who did not volunteer and were therefore not included in the study, in ways that might have affected the research results. For example, it is possible that those who volunteered to take part, from which the samples of participants were drawn, were student nurses whose personal values are relatively well-aligned with nursing, more committed to their studies and therefore more interested in the research study, which may have introduced some bias into the findings. It is necessary to take this into account when interpreting the research results.

On a related point, several of the interviewees were more reserved and appeared less comfortable in answering questions at least at the outset of their interviews. On probing, the researcher discovered that a rumour had been circulating that the researcher was trying to find out whether they had been forced into nursing, in which case they would be asked to leave the program. Although this did not appear to have a major impact on the interviews, since the participants generally relaxed more in response to reassurances by

the researcher, it is possible that they may have held back certain types of information for fear of negative consequences.

It proved more difficult to attract faculty members to volunteer for participation in the study, despite disseminating information about this and attending a staff meeting to discuss the research. However, approaching faculty members individually to explain the study and the participant requirements proved far more effective as a recruitment strategy, increasing the number of volunteers from 1 to 16. Based on this experience, one to one recruitment methods for faculty members are recommended for use in similar research within Saudi Arabia in future. Despite their initial reluctance to take part, the selected faculty participants all appeared willing to discuss their views and experiences openly with the researcher.

Finally, the study is limited by its focus on a single nurse education institution in Saudi Arabia. It is not known to what extent this institution and its student nurses and faculty are typical of others in Saudi Arabia or the wider Middle Eastern region. Indeed, this is not a weakness of the study given its qualitative, case study design of the study and the objectives of the research. However, the study is also intended to contribute insights to the wider issue of value conflicts experienced by Muslim female student nurses in Islamic societies. In this respect it is important to take this limitation into account when considering the relevance of the findings for other organisational or country settings.

8.6 Role of the Researcher

In the qualitative approach adopted in this study the researcher was an active participant, playing a role in interpreting the research participants' accounts of their experiences and attributing meaning to this. However, it was essential to ensure that any researcher bias in the data collection and analysis process was minimised, and to demonstrate the integrity of the research by ensuring that my overall methods and thought processes were fully documented (Richards and Morse 2007; Balls 2009). For the purpose of transparency, this section therefore sets out my own thoughts and experiences while conducting the research, and critically considers my role in the research process.

I did not consider it would be possible to put aside completely my own knowledge and understanding of the research context, and that there would be value in using my own knowledge of this setting to understand and interpret the experiences of the research participants. For example, as a qualified nurse sharing the same religion, culture and

professional background, I was able to quickly grasp and understand some of the factual information provided, such as references to medical or nursing procedures and Islamic terms, which may have been more challenging for a non-medical specialist or a non-Muslim.

My background and experience as a Muslim nurse and a native Saudi Arabian, as well as the work conducted on the literature review and exploratory study, also enabled me to anticipate in broad terms the types of situations that student nurses might encounter in the setting of Saudi Arabia which might potentially give rise to value conflicts. This enabled me to develop and implement data collection processes and tools which were effective in exploring these types of situations while also allowing the participants to spontaneously contribute information about these or other issues and factors based on their personal views and experiences and in their own native language of Arabic, which I share.

In this sense, I believe that my "insider" understanding and personal experience of the Saudi Arabian nursing context in which the research participants contributed considerable value and improved the quality of the research. The benefits of an "insider" understanding have been documented in the methodological literature on reflexivity. For example, Pini (2004; 2005) emphasises that data collection, analysis and interpretation processes in research are all mediated by the various identities that a researcher holds, and as long as he or she is open and transparent about these to enable others to evaluate their potential influence on the findings, these identities provide access to participants, data and understandings that may not be readily available to those who do not share them.

One of the main challenges though is to set aside previous knowledge and preconceptions in order to also view the research data objectively from an "outsider" perspective. One of the issues encountered when carrying out data collection was that the participants often expected that, as a Muslim female nurse from the same culture, I would be familiar with and would identify with their views and experiences. In many of the interviews and discussion groups, comments were repeatedly made such as "you know why!", "you surely know", "as you know", and so on. I believe I was able to achieve an "outsider" perspective by reminding myself throughout data collection and analysis that I do not have up-to-date first-hand knowledge of the case study institution and should not make any assumptions about the intended meaning of statements made by the participants within this institution. I was constantly aware that I needed to reinforce my role as an objective and neutral observer, and always respond by asking them to explain their

answers more fully, using questions such as "why do you think that?", "why do you think that was? Or "how did that make you feel?". When reviewing the research data later, I realised that on a few occasions I had made assumptions about understanding a point because of being from the same culture. In these cases I used follow up telephone conversations with the relevant research participants in order to seek clarifying information. The types of questions involved related to the issues of why male patients could ask for foreign nurses, and why older male patients would be less likely than a younger male patient to object to having a female nurse.

The use of thematic analysis of the research data, which was based largely on inductive methods, also ensured that the identified themes emerged from the data itself rather than being pre-defined based on my existing knowledge or assumptions. When conducting the coding and analysis I was very mindful to acknowledge and step back from any preconceptions I might have had about the issues discussed and allow the research participants' own views and experiences to be dominant as I identified codes and combined these into themes, within the broad top-level themes/categories identified at the outset of the study. I believe that I was successful in remaining objective throughout this process and that my own pre-existing knowledge and beliefs did not have an impact. Attending a workshop helped me to decide exactly how to present my findings and why to adopt this approach. The workshop suggested that findings should either be organised by stages of data collection (student interviews, student focus groups, faculty interviews) or by concepts). I decided to present the findings by themes and sub-themes (concepts) in order to provide a more comprehensive analysis of each of these from the different perspectives of the student and faculty, and as I viewed this as the most effective way to help the reader to link these themes with those identified in the literature review as well as the objectives of the study.

I found it very helpful at various stages of my research to disseminate information about my study in a variety of forms to audiences with diverse academic and professional backgrounds and levels of research knowledge. Details and examples of conference and forum attendance, presentations and posters are included as Appendix 15. I believe that the constructive feedback received from these audiences, and reflection on this in discussions with my supervisory team, has resulted in considerable improvements to the study over time, particularly in the areas of methodology, analysis, ethics and administration.

8.7 Chapter Summary

This chapter has discussed the main findings of the study and considered these in the context of previous literature relating to the experience of value conflicts among nurses. The strengths, contributions and limitations of the study were identified, and the role of the researcher was discussed. Building on the findings of the study Chapter Nine sets out practical recommendations for the case study institution as well as recommendations for future research into the experience of value conflicts by female Muslim students. Finally, an overall conclusion to the study will be provided.

CHAPTER NINE: CONCLUSIONS AND RECOMMENDATIONS

9.1 Summary of Study

This study has examined the experiences of value conflicts among a sample of female Muslim student nurses in Saudi Arabia, a conservative Islamic country. It builds on previous research and an exploratory study which have suggested that student nurses may experience conflicts between their personal and professional values which have adverse impacts on them and lead to high rates of attribution from the profession.

The study is very topical and important as Saudi Arabia has traditionally relied heavily on expatriate nurses since it has been hard to attract local women into this profession. However, Saudi Arabia is currently facing a growing nursing shortage due to the ageing of the population, increased demands for healthcare in this society, and a high turnover of expatriate nurses. Further, the literature indicates that Muslim nurses are sometimes preferred by local Muslim patients since they share religious values and cultural traditions. The Islamic approach to healthcare has spirituality at its core, and Muslim nurses, unlike non-Muslim expatriate nurses, are able to understand the needs and preferences of patients and can provide the types of spiritual care needed, as well as understanding and respecting other religious or cultural requirements relating to the privacy and dignity of individuals. However, as revealed by the findings of this study, religious and cultural factors as well as the prevailing negative public image of the nursing profession in Saudi Arabia not only deters female Saudi Arabians from entering this profession, but can also give rise to value conflicts when local female Muslim nurses do enter nurse training and are faced with the reality of what this profession entails.

This study used qualitative methods within a case study design to explore whether a sample of female Muslim student nurses in a large public university in Saudi Arabia are experiencing value conflicts and has revealed that a range of conflicts relating to religious and cultural factors are indeed being experienced by these student nurses. The study has also provided further insights into the nature of these value conflicts, how they affect the nurses and how they respond to them, and the role that the university is playing with regard to mitigating the risk of such conflicts or helping to manage them if they arise.

An initial exploratory pilot study, reported in Chapter 3, identified three main types of value conflicts faced by Islamic student nurses at a large university in Saudi Arabia, and confirmed that the qualitative data collection methods consisting of interviews and focus groups were effective in generating in-depth information about the nature of these conflicts, their impacts on the student nurses and the responses to them. Building on and expanding this research, the main study provided more detailed insights into the experience of value conflicts by student nurses and included additional data collection to examine the awareness and perceptions of such conflicts on the part of a sample of faculty, as well as a review of available organisational documentation to help determine how well the university is reducing the potential for value conflicts or helping students to cope with them when they arise. The findings provided considerable evidence that experience of value conflicts among this group is widespread, and that faculty are broadly aware of these conflicts and indeed have experienced them themselves, but little evidence that the university has implemented adequate measures to mitigate the risk of value conflicts, in the form of policies, guidance or training materials. As a result, there is a widespread lack of awareness among students and faculty alike about what policies and guidance do exist in this area, and considerable confusion about what types of tasks and behaviours are permissible within nursing according to Islam.

9.2 Contributions of the Study

The study makes several important contributions to knowledge in this area. First, it contributes significantly to the existing body of research-based knowledge about the experience of value conflicts among female Muslim nurses in Islamic countries. Significantly, the study has generated a substantial body of qualitative evidence that religious and cultural factors are resulting in the widespread experience of value conflicts which are having adverse psychological effects on these student nurses and may therefore be hindering the effective delivery of nursing care. Specifically, these value conflicts are between professional values relating to the importance of providing the best possible care for patients, which also involve working effectively with all medical colleagues, and religious or cultural values which prohibit the exposure of certain areas of the body to individuals of the opposite gender and also prohibit social interaction between unrelated individuals of the opposite gender. Many of the student nurses were also found to be

experiencing value conflicts relating to the poor public image of nursing in Saudi Arabia, as discussed in the findings chapters.

In Saudi Arabia at least, much of the previous research had focused primarily on the ways in which the Western approach to nursing education conflicts with the spiritual understanding of health and illness within Islam, leading to value conflicts for nurses due to the conflicting demands of their profession and their patients. Lovering (2012) showed, for example, how qualified nurses were dealing with or overcoming these conflicts by incorporating spiritual care into their nursing practice and by conceptualising their own roles in terms of their religious beliefs and serving God. This can be interpreted in terms of the type of explanatory healthcare model discussed by Kleineman (1978a; 1978b). The present study provided some evidence in support of Lovering's findings, in that some of the participants also reported that they deal with some of the situations they might otherwise find difficult by viewing their nursing responsibilities as the work of God. As discussed in Chapter 8, this suggests that such students may have undergone an internal values readjustment process in response to the discomfort they might initially have felt when confronted with these responsibilities. They appear to be prioritising the Islamic values and care above the Islamic value of modesty, as the former types of values do not conflict with professional nursing values in the way that the latter often does. A focus on these types of values in some cases appeared to help the student nurses come to terms with some of the negative attitudes of their family members' towards their nursing studies, and to the requirement to interact and communicate with male patients and colleagues in their work. Although this process may have been a fairly sub-conscious one on the part of the participants who reported this approach, their examples might be used to construct a more deliberate strategy for evaluating and re-aligning values, based on classroom-level reflection and discussion of various types of Islamic values and their relevant and priority to nursing situations, perhaps informed by use of the Crescent of Care model and underpinned by clearer policies and guidance on what is permissible within Islam.

In particular there is an urgent need for clearer official guidance regarding what actually constitutes necessity in the case of exposure of male awrah or, in the absence of this, at least more discussion of this between faculty within the College of Nursing in order to develop more consistent approaches. However, the evidence of extreme psychological discomfort among students in relation to this tasks indicates that it would be inappropriate

to require them to undertake this type of task without any attempt to address the underlying value conflicts contributing to these feelings.

An important and relevant contribution of this study to the literature on value conflicts among Muslim nurses is the finding that these conflicts are influenced to at least some extent by cultural rather than religious factors per se. In the conservative Islamic society of Saudi Arabia, it can be difficult to disentangle the influence of religious and cultural factors since these closely overlap. However, the research revealed differences in the experience of value conflicts between different student nurses based on their family backgrounds, based both on the direct experience of the research participants as well as their accounts of other Muslim student nurses known to them. This suggests that cultural differences in the interpretation of religious values, for example within more or less conservative communities and families within Saudi Arabia, play a key role in whether or not such value conflicts are experienced.

The study thus contributes important insights to the existing but limited body of knowledge on the experience of value conflicts in Muslim nurses in Islamic societies. Most of these studies have examined value conflicts in qualified nurses (e.g. Lovering, 2008; Valizadeh et al., 2012). The current study demonstrates that student nurses are also experiencing value conflicts and that this occurs from an early stage of their studies. According to the findings from the faculty interviews, value conflicts may be contributing to high levels of attrition from the course especially among students who had little prior awareness of what nursing actually entails, although intentions to leave were not specifically mentioned by the student nurse participants. The study findings therefore demonstrate the importance of reducing the potential for value conflicts in the nurse education context and providing support for students who experience these, not only to reduce the negative impacts on them but to help prevent attrition from the nursing degree.

This findings 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 they arise from cultural interpretations of these. Since many of the student nurses acknowledged that personal and cultural values can be changed over time, while religious values must remain fixed, the findings suggest that value conflicts might be reduced by the introduction of educational content and strategies which promote open discussion of the scenarios contributing to value conflicts and the ways in which these are influenced by religious or cultural beliefs and values. The main purpose of these would be to promote

a process of value change, in accordance with the types of processes set out by Rokeach to explain how this can occur, which would be intended to help promote a new outlook among students in which Islamic values and professional nursing values are better aligned.

To support these measures, faculty might draw on available documents such as the The MoH Patient's Bill of Rights and Responsibilities (2010), Code of Ethics for Healthcare Practitioners (2014) and Saudi Commission for Health Specialties guidance (2014), as discussed in Chapter Seven. Although all these documents have shortcomings with regard to the extent and clarity of guidance they contain on what types of nursing tasks are permissible within Islam, their content might at least provide a useful starting point for discussion. Rokeach explained value change in terms of a process whereby individuals gradually become aware that they hold conflicting values because of the discomfort they feel as a result, and that this is the first step in modifying their values so they are better aligned. It can be therefore be hoped that encouraging open conversation and sharing of views and experiences about the types of situations causing value conflicts, in the ways already achieved in this research, might help reduce the stigma or taboos that currently exist among the student nurses in these areas, and help contribute to the development of new explanatory models or world views in which such their values are better aligned.

In the longer term, the development of more formal guidance clarifying which types of nursing tasks and behaviours are acceptable within Islam and which are prohibited will be important, and the university might usefully work with professional associations, religious bodies and the Ministry of Health in Saudi Arabia to inform the development of these. This might help reduce uncertainty among nurses and enable them to justify their actions in religious terms should patients, family members or other people question them. Section 9.3 sets out a number of suggestions and recommendations for the case study institution, based on the findings of this research.

More generally, the study is expected to be of interest and relevance to nurse education institutions in other Islamic societies where there is potential for conflict between the personal, cultural or religious values of nurses and the values of the nursing profession. Although the cultural values and other characteristics of such societies are likely to differ, the study provides a model research design and strategy for exploring these issues in other settings and developing recommendations tailored to these. In particular, it has been innovative in its use of a case study design rather than just qualitative methods to explore

the issue of value conflicts in an institutional setting. Although there were some limitations in this effectiveness of this approach, particularly with regard to the documentary analysis, the range of data collection methods used and the inclusion of faculty as well as student participants did provide broader insights into the experience of value conflicts by student nurses and the factors contributing to these in this institution.

9.3 Practical Recommendations

Based on the findings of the study, especially relating to the key themes reported in the previous section, the following recommendations are made for the higher education institution in Saudi Arabia in which this case study research has been carried out. Many of these recommendations may also be helpful and relevant to other nurse education institutions in Saudi Arabia and in other Islamic countries.

9.3.1 Relating to the Nursing Curriculum and Training

1. Consider restructuring the Bachelor of Nursing program so that students learn more about practical aspects of nursing and get more clinical experience from an earlier stage of their training, especially with regard to providing nursing care to people of the opposite gender.

2. Incorporate more formal education about values and ethics in the curriculum from an early stage of training. This should incorporate guidance from international and regional codes of ethics as well as the Ministry of Health documents discussed in Chapter 7, but clearly translated into the day to day situations that might be faced by students.

3. Introduce educational content and strategies in which students are encouraged to discuss value conflicts openly and reflect on their own values and the ways in which these reflect either religious or cultural influences. This would be intended to help modify cultural values held by the students which conflict with the values of nursing, and promote the adoption of a new explanatory model or world view in which Islamic values and nursing are well aligned. This would:

    a. Incorporate the use of vignettes or case scenarios into nurse education in order to raise awareness of various types of value conflicts and encourage reflection about how these might be avoided or managed.

b. Incorporate reference to and discussion of relevant Islamic fatwas or policies in teaching in order to raise awareness of the Islamic perspective on nursing and on the various types of value conflicts that can arise in this profession in an Islamic setting, and consider in particular the perceived meaning of "necessity" in relation to exposure of awrah to develop a shared understanding of this.

c. Incorporate the Crescent of Care Model (Lovering, 2012) in order to help students to better understand their own cultural and religious values and how these can be effectively aligned with the nursing profession.

4. Ensure that student nurses have access to the full range of medical training equipment and facilities such as male dummies for the purpose of simulated practice, or the use of videos to demonstrate the provision of personal care for male patients.

5. Formalise the informal role modelling being provided by some faculty, for example by including in the curriculum courses on how to interact and communicate with patients, especially males. These might usefully employ a range of teaching media such as the use of videos or role play, demonstrating how to interact with male patients and colleagues.

6. Ensure that faculty are adequately prepared and supported by the university so that they develop the knowledge, confidence and abilities needed to teach students about values, ethics and value conflicts. This might include encouraging faculty to discuss openly their own experiences of value conflicts and any methods they used to overcome these, so that they become effective role models for the students.

7. Hold seminars or conferences to help raise awareness among students and staff alike about potential value conflicts and how to deal with them if they arise, including the types of support and help available.

9.3.2 Relating to Policies and Practice

1. The hospital attached to the case study university should Review the MoH Bill of patients' rights, and develop corresponding guidance on nurses' rights, to clarify what is acceptable at the hospital particularly in the context of caring for the opposite gender, and also explore what nurses or patients can reasonably be allowed to refuse in order to incorporate this into the guidance.

2. The university and hospital should discourage the use of informal practices which allow students to be released from certain nursing tasks, such as those involving exposure of male *awrah* or working on male wards. This might be achieved by replacing these with formal policies which clearly set out what nurses are allowed to do or refuse, and stating clearly the alternative strategies to follow such as ensuring that male or non-Muslim female nurses, house officers etc. are available to provide cover if necessary.

3. The hospital and university should work together in developing recommendations to the Ministry of Health (MoH) and the Saudi Commission for Health Specialities (SCFHS) for:

   - A collaborative policy review of the Ministry of Health "rules and regulations of Observing the Decency of "Patients' Awrahs" document (2005) and an update to this policy document if determined appropriate, for example to clarify the types of situations in which exposure of patient's awrah is acceptable.

   - Following review and update, widespread distribution of the "Patients' Awrah" policy document to all healthcare organisations in Saudi Arabia, to raise awareness of and observance of agreed policy.

   - Improved future collaboration between the MoH and the SCFHS in order to avoid inconsistencies in their respective codes of conduct.

9.3.2 Relating to Student Nurse Recruitment

1. Consider developing a public outreach and awareness raising campaign, for example through nursing degree recruitment drives in shopping malls throughout Saudi Arabia. These might utilise literature stressing the Islamic origins of nursing in Saudi Arabia with the story of the first Muslim nurse, Rufaidah Al-Asalmiya as well as current day examples of best practice nursing care collected from interviews with patients.

2. Such campaigns should be transparent about the range of tasks involved in nursing, to avoid attracting recruits whose personal values may conflict with the professional values of nursing. Although this may have the effect of decreasing interest in nursing in the short term, it may help raise the overall status of nursing in the longer term, by attracting applicants who will be committed to and

enthusiastic about the profession, and who will convey a positive image of nursing to Saudi Arabian society.

3. Ensure that applicants to the nursing degree have a good understanding and realistic expectations of what the nursing profession involves and a positive attitude to these. This is likely to help avoid the problem of individuals entering the nursing degree involuntarily because they have not been accepted onto other courses, and will help ensure that the accepted applicants have personal values which are well aligned with nursing. Qualified Saudi Arabian nurses as well as student nurses might be encouraged to participate in recruitment activities in order to share their experiences of the reality of nursing with potential recruits.

9.3.4 Relating to the Image and Reputation of Nursing

1. Consider developing a public outreach and awareness raising campaign, for example through nursing degree recruitment drives in shopping malls throughout Saudi Arabia. These might utilise literature stressing the Islamic origins of nursing in Saudi Arabia with the story of the first Muslim nurse, Rufaidah Al-Asalmiya as well as current day examples of best practice nursing care collected from interviews with patients.

2. Current students should be encouraged to act as informal ambassadors for the nursing profession, by seeking opportunities to discuss their roles with friends and family and to emphasise how these are aligned with Islam, and by becoming directly involved in any formal outreach activities implemented by the university, as also noted in the previous sub-section. Although family resistance to their choice of studies was identified as a main factor contributing to value conflicts experienced by many of the students, some did cite examples of situations in which they discussed their roles with family members and had reportedly helped to change their attitudes.

3. As suggested by one of the faculty interviewees, consider running seminars or workshops to help educate student nurses' families and other interested parties about the nature of nursing and its Islamic origins, ideally working in collaboration with religious bodies in Saudi Arabia to legitimise and promote the messages more effectively. These initiatives should be designed to have a positive influence on the public image of nursing and to reduce the potential for conflict between the students' professional values and the religious or cultural values of

their families. It is recommended that religious bodies or leaders might be encouraged to participate in such events, and to incorporate content on the role of nurses in their own Islamic teachings.

9.3.5 Relating to Support for Students

1. Provide training to dedicated staff or faculty members to ensure they can provide the support needed by students experiencing value conflicts or ethical dilemmas.

2. Consider developing formal mentoring or preceptorship arrangements, which have been shown in previous literature to facilitate the transition of students and newly qualified nurses into clinical practice and help them develop a clearer understanding of their role and identity, thus enabling them to reconcile any value conflicts they may encounter (Clark and Maben, 1998; Mooney, 2007).

3. Disseminate information about the support or mentoring arrangements available to students, and ensure that they are not penalised in any way for reporting value conflicts.

9.4 Recommendations for Future Research

Additional case studies: It is recommended that the case study methodology developed in the current study should be applied in a wider range of nurse education institutions, either within Saudi Arabia or other Islamic countries and including those now accepting male student nurses. This will help provide a more comprehensive understanding of the types of values conflicts faced by female and male Muslim student nurses and the factors influencing these, and will highlight the ways in which these differ in different cultural or institutional contexts. As more case study research on the issue in a diverse range of settings is conducted, common findings may emerge which can provide the basis for the development of common best practices in reducing the potential for value conflicts, while also generating institution-specific recommendations.

Exit Interviews: A number of issues relevant to value conflicts and the problem of attrition from nurse education in Saudi Arabia arose indirectly in the research findings. For example, faculty and student participants recounted second-hand stories of student nurses who had left the profession because it did not meet their expectations, or because they had low levels of awareness of what is involved in nursing. Second hand accounts were also provided of student nurses who had left the degree or failed to take up nursing after graduation due to resistance from their husbands or family members. Future

qualitative research might therefore be designed to examine these issues more directly and to determine the extent to which they are actually contributing to attrition from nurse education and the nursing profession in Saudi Arabia. The findings of such research might be helpful in improving nurse education recruitment procedures or developing of initiatives for communications and awareness raising with family members about the spiritual aspects of nursing.

Quantitative research: The current qualitative study generated findings suggesting that certain student participant characteristics, such as family background and – to a lesser extent – year of study, were associated with different types of experiences of value conflicts. Similarly, some differences emerged between the attitudes and approaches of faculty members which appeared to be associated with their length of experience. However, the qualitative methods did not allow for a systematic comparison of participants by these characteristics, or by others such as marital status. Future quantitative research with a larger sample of female Muslim student nurses from the case study institution, or from a range of higher education establishments in Saudi Arabia, could provide further insights into the impact of socio-demographic characteristics on the experience of value conflicts and ability to cope with these.

Further Qualitative Research: The participants' experience of value conflicts as reported in this study reflected to a large extent their assumptions regarding the negative views of male Muslim Saudi Arabian patients about being cared for by a female Muslim Saudi nurse. Since the study did not collect any data from patients it is not possible to determine the accuracy of these perceptions. Further qualitative research might therefore usefully explore the perceptions of male Muslim patients in Saudi Arabia about being cared for by female nurses of the same religion and culture as themselves. If the student nurse perceptions of these are found to be accurate, this will provide additional evidence of the need for initiatives to help change the public image of nursing in Saudi Arabia; if on the other hand it is found that the patients are more receptive to being cared for by female Muslim nurses, this information might be included in the proposed educational initiatives intended to help promote value change among student nurses. Future qualitative research might also be conducted to explore the issue of public perceptions of nursing in Saudi Arabia and the factors influencing these, in order to provide more evidence-based insights that could help inform public awareness raising campaigns.

9.5 Concluding Comments

As noted in Chapter 1, the Kingdom of Saudi Arabia faces a pressing need to recruit more Saudi Arabian females into the nursing profession, to fulfil the requirements of the Saudization policy and to meet the rapidly increasing demands of the expanding and ageing population for healthcare. Previous literature and the findings of the current study demonstrate that this is likely to remain a major challenge for the Kingdom due to the poor public image of nursing and the widespread confusion both within the profession and in society about how the requirements of nursing are compatible with Islamic values.

This study has generated valuable information about the value conflicts that are faced by female Muslim nurses in this setting, and the factors influencing these. This is an important first step in helping to identify the types of measures and initiatives likely to be effective in reducing the potential for such conflicts and improving the public image and professional reputation of nurses. In particular, a range of measures have been identified from the research findings and developed into recommendations for the case study institution in this concluding chapter. Ideally, these require in the longer term the development of clearer guidelines and policies by government and religious organisations in Saudi Arabia, especially relating to acceptable forms of interaction between female Muslim nurses and male patients including tasks involving the exposure of male awrah. Such policies and guidelines need to be made widely available to healthcare and educational organisations so that they can be incorporated into the education and training of nurses and other healthcare professionals. Clear guidelines and policies regarding the rights and responsibilities of nurses and patients might also help improve the public image of nursing in Saudi Arabia and help attract and retain nurses in this profession. In this way, policymakers as well as nurse education providers, such as the university which formed the setting for this study, can play an important role in effectively implementing the Saudization policy and contributing to Saudi Arabia's achievement of the 2030 vision.

In the more immediate term, however, there is a need for the case study institution to address the value conflicts that this research has revealed are being experienced by many of its student nurses. These are having negative psychological impacts on these students,

and potentially affecting the efficiency and quality of nursing care within the hospital due to the prevailing use of informal practices such as releasing female Muslim students from the requirement to provide personal care to male patients. Overall, the study suggested that there is currently a tendency for the institution to avoid addressing these issues, as revealed by the very limited inclusion of them within the nursing curriculum, and the lack of clear understanding even on the part of faculty about what types of nursing tasks are acceptable within Islam, and how to deliver nursing care that is compatible with Islamic values. The findings were also very insightful, however, in revealing perceived differences on the part of the participants between cultural and religious values. These differences, which suggest that Saudi Arabia's cultural values consist of the ways in which religious values have been interpreted by others within this society and as such are subject to modification and change over time, unlike true religious values. This in turn indicates that measures can be implemented by the case study institution which are likely to be effective in modifying values in ways that promote new explanatory models of nursing that are compatible with Islam. By adopting the recommendations set out in this chapter, and helping to raising awareness of the compatibility of nursing and Islam, the case study university can ultimately provide a role model for similar institutions in Saudi Arabia, and contribute to addressing the nursing shortage within the Kingdom.

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Appendix 1: Structured Review Data Extraction Table

Source	Aims clearly stated?	Appropriate design and methods?	Appropriate recruitment and data collection?	Any issues of bias or ethics?	Rigour of data analysis methods and presentation of findings	Assessment of overall value of study to this review
Alotaibi J., Paliadelis P.S. & Valenzuela F.R. (2016). Factors that affect the job satisfaction of Saudi Arabian nurses. *Journal of Nursing Management* 24(3), 275–282.	To determine factors influencing the job satisfaction of Saudi nurses.	Part of a mixed methods study – this article reports on qualitative analysis of 3 open-ended questions from a quantitative non-experimental, descriptive research study, using thematic analysis.	All nurses who met specific age and educational level criteria from 7 hospital sites in different regions of the country were invited to participate. 553 nurses took part, representing a very good 65% response rate.	None apparent, though the findings may have been affected by non-response bias, i.e. non-respondents might have had different views and experiences to respondents.	A rigorous process of thematic analysis of qualitative data was used to generate and present key themes and sub-themes relating to job satisfaction. These are presented with narrative linking the findings to the objective of the study and verbatim quotes.	The findings of this study help provide support for the confirm that religious values and beliefs are important in the self-identity of nurses in Saudi Arabia, and that these enable them to reconcile their choice of profession with the negative public image of nursing.
Borhani, F., Hosseini, S.H. & Abbaszadeh, A. (2014) Commitment to care: a qualitative study of intensive care nurses' perspectives of end-of-life care in an Islamic context. *International Nursing*	To explore intensive care nurses' perspectives of the end-of-life care	The use of qualitative semi-structured interviews was appropriate for exploring participant perspectives of "end of life care".	12 intensive care nurses from intensive care units in Iran were recruited using purposive sampling. The article does not provide details about the selection procedure.	The lack of detail on sampling procedures does not allow for the identification of any sampling bias. No ethical issues are apparent.	Inductive coding was used to identify key themes from the interview transcripts. A number of methods for ensuring the rigor of methods are reported, including member checking and the use of thick	The study revealed evidence of conflicts between religious and professional nursing values relating to end-of-life care among Muslim nurses.

Review, 61(1), 140–147					descriptions of concepts.	
El-Gilany, A., & Al-Wehady, A. (2001). Job Satisfaction of female Saudi nurses. *Eastern Mediterranean Health Journal, 7*(1/2), 31-37.	To assess the degree of satisfaction of female Saudi nurses with their work and to investigate factors that would increase this satisfaction	The quantitative survey approach was appropriate for measurement of the relative importance of various factors influencing job satisfaction. In the absence of a validated measure of job satisfaction relevant to Saudi Arabia, this was measured as a subjective feeling of the nurse.	All 253 female nurses working in governmental health facilities were invited to participate, and a very high response rate of 95.9% was achieved.	None apparent	Descriptive statistical techniques were used and the chi-squared and Fisher tests were used to compare significant of differences between groups. These methods were appropriate given the objective of the study.	The study provided empirical support for the reluctance of Saudi Arabian Muslim female nurses to provide intimate care to male patients, and the impact of gender segregated care on job satisfaction.
Farrag, S., & Hayter, M. (2014). A qualitative study of Egyptian school nurses' attitudes and experiences toward sex and relationship education. *The Journal of School Nursing, 30*(1), 49-56.	To examine how school nurses experience promotion of sexual health in an Islamic cultural setting	The qualitative in-depth interviews used in this study were appropriate for investigating personal experiences of sexual health promotion in schools	13 school nurses were recruited from 13 different secondary and primary schools within a large city in Northern Egypt. There is a lack of detail on the specific sampling procedure.	The lack of detail on sampling procedures does not allow for the identification of any sampling bias. No ethical issues are apparent.	Thematic analysis was used, and the interview data was coded inductively in order to identify key themes. A lack of detail precludes a full assessment of rigour. The data are presented by key themes with illustrative verbatim quotes.	The study is important in revealing the value conflicts between cultural values and professional values/roles in a relatively moderate Islamic nation.
Fooladi, M. M. (2003). Gendered nursing education and practice in Iran. *Journal of Transcultural*	To explore gendered nursing education and practice in Iran.	Qualitative ethnographic methods – interviews and field observations were appropriate for examining gendered	6 nursing faculty and 5 undergraduate and graduate students were recruited using convenience sampling methods	The use of convenience sampling may have introduced some bias into the results	Thematic analysis was used to identify and triangulate common themes from the interview transcripts. This is a suitable	The study highlights the ways in which gender-segregated nurse education and practice has been effective in reducing value conflicts

Nursing, 14(1), 32-38. DOI: 10.1177/1043659602 238348		nursing education and practice from the perspectives of faculty and students			approach but the lack of detail precludes further assessment of research rigour.	and easing the nursing shortage in Iran. However, this is underpinned by cultural factors such as male dominance and the modesty of women.
Hafizi, S., Koenig, H. G., Arbabi, M., Pakrah, M., & Saghazadeh, A. (2014). Attitudes of Muslim physicians and nurses toward religious issues. *Journal of Religious* Health, 53(5), 1374–1381.	To assess attitudes of physicians and nurses toward religion and how these attitudes vary by education level and demographic characteristics.	Quantitative survey methods were appropriate for examining attitudes towards religion and comparing the results by factors such as age and education	A large sample of 720 physicians, medical students and nurses was achieved. Participation was voluntary but this represents a very high response rate, indicating the effectiveness of recruitment methods.	The very high response rate indicates that the findings are likely to be representative with little bias in terms of the target population. Respondents were recruited from a range of hospitals in Tehran. However, the findings may not reflect the experiences of similar groups in other regions of Iran.	The study used rigorous statistical techniques including descriptive statistics and linear regression.	The study is important in demonstrating how spiritual approaches in healthcare can decline over time if not supported in nurse training
Hajbaghery, M. A., & Salsali, M. (2005). A model for empowerment of nursing in Iran. *BMC Health Services Research,* 5(24). doi:10.1186/1472-6963-5-24	To inform the development of a model for empowering nurses in Iran	A grounded theory approach using qualitative – semi-structured interviews and participant observation were used to collect data. This was appropriate to inform the development of a new teaching model in ways that accurately reflect the experiences and needs of nurses.	44 nurses participated in the study; this is a large sample for qualitative research and helped to ensure that the findings were grounded in a wide range of perspectives and experience.	None apparent. The large qualitative sample helped to ensure that a range of views were represented in the findings. The use of multiple qualitative methods also enabled the researchers to triangulate the data to validate their conclusions.	Grounded theory is a very rigorous form of qualitative analysis which helped ensure that the conclusions fully reflected the views and experiences of participants.	The study is especially important in demonstrating the role of cultural factors, such as the power status held by physicians in Iran, in contributing to poor images of nursing.

Mebrouk, J. (2008). Perception of nursing care: Views of Saudi Arabian female nurses. *Contemporary Nurse, 28*(1-2), 149-161. DOI: 10.5172/conu.673.28.1-2.149	To examine nurse perceptions of their roles.	The use of a Heideggerian phenomenological research design, using semi-structured, in-depth interviews, enabled the researcher to explore participant experiences and their understanding of these in great depth.	The research was based on in-depth interviews with 5 nurses. Small sample sizes are common in phenomenological research to allow for depth of interviewing. However the small number of participants and the use of purposive sampling methods may have resulted in some bias in the findings.	Sampling bias due to the use of purposive sampling methods may have affected the results.	The study used Drauker's (1999) seven stages of qualitative data analysis. The use of a systematic approach provided rigour to the research methods and helped increase the validity of the findings, as they related to this specific sample.	The study was important in showing the ways in which Muslim nurses in Saudi Arabia conceptualize their spiritual role, and the ways in which they deliver spiritual care to patients.
Miligi, E., & Selim, A. (2014). Saudi nursing students' attitudes towards the nursing profession. *European Journal of Business and Management, 6*(29), 197-208.	To identify nursing students' attitudes toward the nursing profession	The quantitative methods based on a self-completion survey were appropriate for measuring attitudes and comparing these by demographic factors	A fairly large sample of 152 nursing students was achieved. However, convenience sampling methods were used to select participants from a single college of nursing in Saudi Arabia. It is not known to what extent the findings would represent the views of other Saudi nursing students.	None apparent, though the representativeness of findings are limited to the population of nursing students at the college from which the sample was drawn.	Simple descriptive statistical measures were used which were adequate to address the objectives of the study.	The study is important in highlighting the ways in which attitudes to nursing among Saudi nursing students vary by factors such as age and area of residence. This provides support for the impact of socio-cultural factors on value conflicts.
Ozcelik, H., Tekir, O., Samancioglu, S., Fadiloglu, C., & Ozkara, E. (2014). Nursing students' approaches toward euthanasia. *Omega, 69*(1) 93-103.	To investigate undergraduate nursing students' attitudes towards euthanasia.	Quantitative methods, based on a self-completion survey were appropriate for investigating attitudes and comparing the	A large achieved sample of 383 nursing students in Turkey; this represented a good response rate of 64%	Although a good response rate was achieved, there may have been some response bias – it is possible that non-participants may be those with different types of attitudes to euthanasia.	Simple descriptive statistical measures were used which were adequate to address the objectives of the study.	The study helped provide quantitative support for the existence of value conflicts among Muslim nurses which has largely been demonstrated from qualitative research. In this study, the existence

		results among different groups				of value conflicts is inferred from the feelings of discomfort experienced by the nurses when providing end-of-life care.
Rassouli, M., Zamanzadeh, V., Ghahramanian, A., Abbaszadeh, A., Alavi-Majd, H., & Nikanfar, A. (2015). Experiences of patients with cancer and their nurses on the conditions of spiritual care and spiritual interventions in oncology units. *Iranian Journal of Nursing and Midwifery Research, 20*(1), 25–33.	To explore nurses' and patients' experiences about the conditions of spiritual care and spiritual interventions in the oncology units of Tabriz	The use of qualitative unstructured interviews was appropriate for exploring personal experiences of receiving and providing spiritual care	A relatively small sample of 10 patients and 7 nurses was used. This is appropriate for in-depth qualitative research, but it is not known to what extent similar findings would be achieved using a different sample.	There is a possibility of sample bias in the findings due to the small numbers of participants	Systematic qualitative analysis methods were used to ensure rigour, and member checking was used to help validate the findings.	The study helps to highlight the importance of training in spiritual care, as a means of helping Muslim nurses reconcile their personal and professional values and provide the type of care needed by Islamic patients.
Ravari, A., Bazargan, M., Vanaki, Z., & Mirzaei, T. (2012). Job satisfaction among Iranian hospital-based practicing nurses: examining the influence of self-expectation, social interaction, and organisational	To examine the influence of self-expectation, social interaction, and organisational situation on job satisfaction among nurses.	The use of qualitative semi-structured interviews was appropriate to explore the types of factors influencing job satisfaction from the perspective of participants.	The sample consisted of 30 staff nurses who worked in university-affiliated and public sector hospitals. Little information is provided on the sampling procedure so the appropriateness of this cannot be assessed.	It is not known whether the sampling procedures may have introduced any bias into the findings.	Systematic qualitative analysis methods (content analysis) were used; the use of two coders helped to ensure the validity of the findings.	The study demonstrated the ways in which the spiritual values of Muslim nurses contribute to job satisfaction and help them overcome any value conflicts arising from the negative public image of nursing in Iranian society.

situations. *Journal of Nursing Management, 20*(4), 522–533						
Ravari, A., Vanaki, Z., Houmann, H., & Kazemnejad, K. (2009). Spiritual job satisfaction in an Iranian nursing context. *Nursing Ethics, 16*(1), 19-30.	To identify and describe Iranian staff nurses' views on their spiritual job satisfaction	The use of qualitative semi-structured interviews was appropriate to explore staff nurses' personal views on their spiritual job satisfaction.	The sample consisted of 25 staff nurses who worked in university-affiliated and public sector hospitals. Little information is provided on the sampling procedure so the appropriateness of this cannot be assessed.	It is not known whether the sampling procedures may have introduced any bias into the findings.	Systematic qualitative analysis methods (content analysis) were used; the use of two coders helped to ensure the validity of the findings.	The study provides insights into the ways in which Muslim nurses in Iran conceptualise and deliver spiritual care, and how this has many similarities with the experiences of Saudi nurses.
Shahriari, M., & Baloochestani, E. (2014). Applying professional values: the perspective of nurses of Isfahan Hospitals. *Journal of Medical Ethics and History of Medicine, 7*(1).	To investigate nurses' perspectives toward ethical and professional values in the clinical environment	The use of a quantitative, self-completion survey was appropriate for measuring nurse attitudes in order to achieve the research objective.	The research was based on a large achieved sample of 150 nurses, which represented a response rate of around 60%. The sample was generated using convenience sampling methods, which may have influenced the representativeness of results.	Some degree of respondent bias may have influencing the findings due to the non-random sampling methods.	A range of descriptive and inferential statistical techniques was used to explore the relationships between variables, ensuring the rigour of the study.	This study is important in identifying the types of values important to nurses in Iran, and how these are largely Islamic values. The study also highlighted the need for better training to support nurses in dealing with ethical dilemmas in their work.

Valizadeh, S., Tazakori, Z., Mohammadi, E., Hassankhani, H., Foladi, M. (2012). Spiritual Care Experiences of Iranian Nursing Students. *Journal of Hospice & Palliative Nursing, 14*(4), 268-273. DOI: 10.1097/NJH.	To provide greater insight into how nursing students experience spiritual care.	Qualitative, semi-structured interviews were appropriate for providing insights into personal experiences of providing spiritual care.	Purposive sampling was used to select 18 nursing students from 3 universities in Iran. This is a relatively large qualitative sample but it is not known whether a different sample would have reported different views and experiences	Some bias may have been introduced through the use of purposive sampling methods, though these are commonly used in qualitative research to identify participants with sufficient experience of the phenomenon of interest.	Systematic, grounded theory methods were used to ensure the rigour of the study and to develop findings that are firmly grounded in the research evidence	The study is important in providing insights into how spiritual care is conceptualized and delivered in the Islamic setting of Iran.

Appendix 2: Students Information Sheet

PARTICIPANT INFORMATION SHEET - STUDENTS

Exploring and understanding the experience of value conflicts by undergraduate nursing students in XXXXXX University, Saudi Arabia: student and faculty perceptions.

INVITATION TO TAKE PART IN A RESEARCH STUDY

You are invited to take part in a research study, which will investigate the experiences of value conflicts among a sample of Muslim student nurses in XXXXXX University, Saudi Arabia and to explore the awareness of faculty about these conflicts and their views on the ways in which these might be reconciled in this setting. My name is Hanadi Yaseen, and I am currently completing a PhD programme at the University of Dundee, Scotland, United Kingdom.

PURPOSE OF THE RESEARCH STUDY

This study aims to explore the issue of value conflicts between the professional and personal values of a sample of 1st and 4th year nursing students in the Arab Muslim setting of Saudi Arabia, and the awareness and views of faculty of these conflicts. Data will be collected using individual interviews and focus groups. The study will investigate these issues in depth within XXXXXX University and develop practical recommendations tailored to the needs of this institution and its students that aim to reduce the potential for conflicts or help students to cope with them if they arise.

TIME COMMITMENT

The study will require students to participate in either a single focus group with around seven other students or an individual face-to-face interview, depending on your indicated preference. The duration of individual interviews will be around one hour and the focus group is expected to last around 90 minutes. The focus groups and interviews will take place in a designated meeting room at XXXXXX University between December 2017 and January 2018, with specific dates and times to be arranged with the participants.

COST, REIMBURSEMENT AND COMPENSATION

Your participation in this study is voluntary. You will not receive any monetary support as a result of participating in this study. Light refreshments will be provided during both the interviews and focus group sessions.

RISKS

There are no significant risks involved in participating in this study. However, there is a small possibility that due to the potentially sensitive nature of the issues being explored, some issues raised may potentially cause individual participants some discomfort and/or

distress. Therefore information about the University Counselling team and the self-referral procedure will be made available to all participants at the outset of the study.

TERMINATION OF PARTICIPATION

You may decide to terminate your involvement without explanation at any time during the research process and you will not be penalised in any way. The researcher will not use any information you have already provided without your written permission.

CONFIDENTIALITY AND DATA MANAGEMENT

The data collected will be anonymised and will not contain any personal information about you. Pseudonyms will be allocated to all participants for use when analysing the data and reporting on the results, and you will not be identified by your own name in the research findings.

All focus group participants will be asked to respect the confidentiality of information shared by the other participants. The focus groups and interviews will be conducted in Arabic, audio-recorded, transcribed and translated into English for the purpose of analysis. The research data will be verified by asking at least one or two of the research participants to read their interview or focus group transcript and confirm the accuracy of this. Apart from this, the transcribed data will be seen only by the researcher, supervisors and a person appointed to check the translations and will not be made available to anyone else. The audio recordings and transcripts will be securely saved anonymously in University of Dundee Data Archive, which can be confidentially accessed only by the researcher and her supervisors.

The data will be analysed by identifying key themes from the interviews and focus groups, and these will be presented and discussed in the research report along with anonymous quotes to illustrate the points being made. No individual will be personally identifiable from the findings.

WILLINGNESS TO PARTICIPATE IN THIS RESEARCH STUDY

If you are willing to participate in the study, please complete the attached Expression of Interest form and return it to the researcher.

FOR FURTHER INFORMATION ABOUT THIS RESEARCH STUDY

If you have any questions about participation in the study then please do not hesitate to contact me, Hanadi Yaseen by email at h.yaseen@dundee.ac.uk or by telephone on:

0044 01382 388564 (UK, UOD)

The University Research Ethics Committee of the University of Dundee has reviewed and approved this research study.

Appendix 3: Students Expression of Interest Form

EXPRESSION OF INTEREST FORM – STUDENTS

Exploring and understanding the cultural/spiritual value and professional value conflicts experience for undergraduate nursing students in XXXXXX University, Saudi Arabia: student and faculty perceptions.

Please complete and sign this form in order to express your interest in participating in the study. Please note that expressing interest does not guarantee that you will be selected for participation: the information provided in this form will be used by the researcher to select a sample of participants, and you will be contacted if you are chosen as a sample member.

Please indicate your year of study:

First year / Fourth Year

Please indicate your marital status:

Married ☐ Single ☐ Divorced ☐ Widowed ☐

Please indicate your age group:

20 to 25 ☐   26 to 30 ☐   31 to 50 ☐   51 or over ☐

I am willing to participate in an interview   ☐
I am willing to participate in a focus group   ☐

Please provide your preferred email address and phone number for the purpose of communications about the study:

_____

_____   _____   _____

Name of participant   [printed]   Signature   Date

Thank you!

Project contact details for further information:

Name: Hanadi Yaseen

Phone: 0044 01382 388564   Email address: h.yaseen@dundee.ac.uk

Appendix 4: Faculty Information Sheet

PARTICIPANT INFORMATION SHEET - FACULTY

Exploring and understanding the experience of value conflicts by undergraduate nursing students in XXXXXX University, Saudi Arabia: student and faculty perceptions.

INVITATION TO TAKE PART IN A RESEARCH STUDY

You are invited to take part in a research study, which will investigate the experiences of value conflicts among a sample of Muslim student nurses in XXXXXX University, Saudi Arabia and to explore the awareness of faculty about these conflicts and their views on the ways in which these might be reconciled in this setting. My name is Hanadi Yaseen, and I am currently completing a PhD programme at the University of Dundee, Scotland, United Kingdom.

PURPOSE OF THE RESEARCH STUDY

This study aims to explore the issue of value conflicts between the professional and personal values of a sample of 1st and 4th year nursing students in the Arab Muslim setting of Saudi Arabia, and the awareness and views of faculty of these conflicts. Data will be collected using individual interviews and focus groups. The study will investigate these issues in depth within XXXXXX University and develop practical recommendations tailored to the needs of this institution and its students that aim to reduce the potential for conflicts or help students to cope with them if they arise.

TIME COMMITMENT

Faculty are invited to participate in an individual face-to-face interview. The duration of individual interviews will be around one hour. It will take place in a designated meeting room at XXXXXX University between December 2017 and January 2018, with specific dates and times to be arranged with the participants.

COST, REIMBURSEMENT AND COMPENSATION

Your participation in this study is voluntary. You will not receive any monetary support as a result of participating in this study. Light refreshments will be provided during both the interviews and focus group sessions.

RISKS

There are no significant risks involved in participating in this study. However, there is a small possibility that due to the potentially sensitive nature of the issues being explored, some issues raised may potentially cause individual participants some discomfort and/or distress. Therefore information about the University Counselling team and the self-referral procedure will be explained and made available to all participants at the outset of the study.

TERMINATION OF PARTICIPATION

You may decide to terminate your involvement without explanation at any time during the research process and you will not be penalised in any way. The researcher will not use any information you have already provided without your written permission.

CONFIDENTIALITY AND DATA MANAGEMENT

The data collected will be anonymised and will not contain any personal information about you. Pseudonyms will be allocated to all participants for use when analysing the data and reporting on the results, and you will not be identified by your own name in the research findings.

All focus group participants will be asked to respect the confidentiality of information shared by the other participants. The focus groups and interviews will be conducted in Arabic, audio-recorded, transcribed and translated into English for the purpose of analysis. The research data will be verified by asking at least one or two of the research participants to read their interview or focus group transcript and confirm the accuracy of this. Apart from this, the transcribed data will be seen only by the researcher, supervisors and a person appointed to check the translations and will not be made available to anyone else. The audio recordings and transcripts will be securely saved anonymously in University of Dundee Data Archive, which can be confidentially accessed only by the researcher and her supervisors.

The data will be analysed by identifying key themes from the interviews and focus groups, and these will be presented and discussed in the research report along with anonymous quotes to illustrate the points being made. No individual will be personally identifiable from the findings.

WILLINGNESS TO PARTICIPATE IN THIS RESEARCH STUDY

If you are willing to participate in the study, please complete the attached expression of interest form and return it to the researcher.

FOR FURTHER INFORMATION ABOUT THIS RESEARCH STUDY

If you have any questions about participation in the study then please do not hesitate to contact me, Hanadi Yaseen by email at h.yaseen@dundee.ac.uk or by telephone on:

0044 01382 388564 (UK, UOD)

The University Research Ethics Committee of the University of Dundee has reviewed and approved this research study.

Appendix 5: Faculty Expression of Interest Form

EXPRESSION OF INTEREST FORM – FACULTY

Exploring and understanding the cultural/spiritual value and professional value conflicts experience for undergraduate nursing students in XXXXXX University, Saudi Arabia: student and faculty perceptions.

By signing below and completing page 2 you are indicating that you have read and understood the Participant Information Sheet and that you agree to take part in this research.

Please tick the appropriate boxes	Yes	No
Taking Part		
I have read and understood the project information sheet.	☐	☐
I have been given the opportunity to ask questions about the project.	☐	☐
I agree to take part in the project. Taking part in the project will include being interviewed and recorded (audio) either during an individual or focus group interview	☐	☐
I understand that taking part is voluntary; I can withdraw from the study at any time and I do not have to give any reason why I no longer want to take part. If I withdraw from the study at any time, the researcher will not use the information I have already provided without my written permission.	☐	☐
I am willing to participate in an interview	☐	☐
Use of the information I provide for this project		
I understand that my words may be quoted anonymously in publications, reports, web pages, and other research outputs, and that a pseudonym will be used for this purpose	☐	☐
I agree that the data I provide can be stored in the University of Dundee Data Archive.	☐	☐
I understand that member of the researcher team will have access to this data only if they agree to preserve the confidentiality of the information as requested in this form.	☐	☐
I understand that members of the research team may use my words in publications, reports, web pages, and other research outputs, only if they agree to preserve the confidentiality of the information as requested in this form.	☐	☐
So we can use the information you provide legally:		
I agree to assign the copyright of any materials related to this project to Hanadi Yaseen.	☐	☐

_____   _____   _____

Name of participant   [printed]   Signature   Date

_____ _____ _____

Researcher   [printed]   Signature   Date

Please indicate your Role:

Academic ☐   Clinical ☐   Joint ☐

Please indicate your Position:

Professor   ☐

Associate Professor   ☐

Assistant Professor   ☐

Lecturer   ☐

Teaching Assistant   ☐

Demonstrator   ☐

Lab Technician   ☐

Please indicate your Department:

Department of Public Health Nursing   ☐

Department of Maternity and Child Nursing   ☐

Department of Medical and Surgical Nursing   ☐

Please indicate your religion:

Muslim ☐   Non-Muslim ☐

Please indicate your number of years of Experience:

Please provide your preferred email address and/or your telephone number for the purpose of communications about the study:

Thank you!   Project contact details for further information:

Name: Hanadi Yaseen

Phone: 0044 01382 388564

Email address: h.yaseen@dundee.ac.uk

Notes:

1. All audios and transcripts will be saved anonymously in University of Dundee Data Archive (Box), which can be confidentially accessed only by the researcher and her academic supervisors.

Appendix 6: Student Focus Groups Guide

FOCUS GROUPS GUIDE - STUDENTS

Thank you for agreeing to participate in this focus group. This study aims to investigate the experience of value conflicts among a sample of Muslim student nurses in XXXXXX University, Saudi Arabia and also to explore the awareness of faculty about these conflicts and their views on the ways in which these might be reconciled in this setting. My name is Hanadi Yaseen, and I am currently completing a PhD programme at the University of Dundee, Scotland, United Kingdom. Please remember that you are free to leave, if you feel you do not want to continue at any point during the interview.

Understanding of Personal and Professional Values and Value Conflicts

First, I'd like to explore your understanding of values and value conflicts.

1. What do you understand by the term "personal values"? Can you think of any and tell me about these? Prompt if necessary:

    a. Cultural values – what are these? Examples

    b. Religious or spiritual values – what are these? Examples

2. How do you think your personal values might be related to your profession as a nurse in training?

3. What is your own understanding of the professional values relating to nursing?

4. What do you understand by the term value conflicts?

5. Even if you have not experienced these personally, do you think there is scope for any value conflicts to arise between your personal values and the professional values of nursing?

6. Why do you think such conflicts might arise during nursing study or practice? What might influence or cause these conflicts do you think? And why?

7. If you were to experience value conflicts during your nursing study or practice, how do you think these conflicts might affect you? What other impacts do you think they might have, for example on your patients or co-workers?

Personal Experiences of Value Conflicts

1. There might have been times in your nursing practice when a conflict has arisen between your own personal and professional values. Can you think of any of these times and tell me about them?

2. How do you think Islam influences your role and duties as a nurse? Probe if necessary:

    a. For example Islam forbids a man exposing his body part/s to females and vice versa, do you feel this affects your role as a nurse? Please explain.

    b. As another example, Islam prohibits close contact between unmarried individuals of different genders. Do you feel this affects your role as a nurse? Please explain.

    c. Are there any other ways in which you feel Islam affects your role as a nurse? Please explain.

3. It has been suggested in the past that family members can influence career choices in positive or negative way because of their beliefs or values. What has your experience of this been? How do your close family members feel about your choice to become a nurse? Probe if necessary:

   a. What is the opinion of your close family members regarding exposure/contact with body parts of the opposite gender, as part of your duty as a nurse? Do you think this might have had any impact on your career choice?

   b. What is the opinion of your close family members regarding general contact and communications with members of the opposite gender, as part of your duty as a nurse? Do you think this might have had any impact on your career choice?

   c. How do you feel about discussing your role and duties as a nurse in training with your family?

4. If you were to encounter a conflict between your personal and professional values in your nursing role, how do you think you would respond? And why?

Role of the University

1. I am now going to read out a list of types of documents that are relevant to nurse training and practice in Saudi Arabia. For each one, please tell me whether you believe this contributes to or helps reduce the potential for value conflicts in nursing and explain your answer. (List to be finalised following the documentary review stage of the research):

   a. Codes of Ethics and Professional Conduct

   b. Nursing Practice Plans

   c. Nurse training materials

   d. Fatwas or other Islamic guidance documents affecting nursing practice.

2. Are you aware of any ways in which the University attempts to reduce the potential for value conflicts in nurse training or practice? Please explain. How effective do you feel these measures are?

3. Are you aware of any ways in which the University helps student nurses to cope with any value conflicts they may experience in their training or practice? Please explain. How effective do you feel these measures are?

4. Are you aware of any other ways in which the University provides support or assistance to student nurses who experience value conflicts in their training or practice? Please. How effective do you feel these measures are?

5. Is there anything else that you think the University should be doing to reduce the potential for value conflicts among student nurses? Please explain.

6. Is there anything else that you think the University should be doing to help students cope with value conflicts? Please explain.

7. Are there any other issues you would like to share or discuss at this time?

Thank you for participating, once the research findings have been analysed a summary of the results will be emailed to each of you. Please contact me if you have further questions or would like to contribute more information.

Appendix 7: Students Individual Interview Guide

INDIVIDUAL INTERVIEW GUIDE – STUDENTS

Thank you for agreeing to participate in this focus group. This study is aiming to investigate the experiences of value conflicts among a sample of Muslim student nurses in XXXXXX University, Saudi Arabia and to explore the awareness of faculty about these conflicts and their views on the ways in which these might be reconciled in this setting. My name is Hanadi Yaseen, and I am currently completing a PhD programme at the University of Dundee, Scotland, United Kingdom. Please remember that you are free to leave, if you feel you do not want to continue at any point during the group/interview.

Understanding of Personal and Professional Values and Value Conflicts

First, I'd like to explore your understanding of values and value conflicts.

1. What do you understand by the term "personal values"? Can you think of any and tell me about these? Prompt if necessary:

    a. Cultural values – what are these? Examples

    b. Religious or spiritual values – what are these? Examples

    c. Other types of personal values – examples?

2. How do you think your personal values might be related to your profession as a nurse in training?

3. What is your own understanding of the professional values relating to nursing?

4. (4th year students only): Do you believe that your personal or professional values have changed since you began your nurse training? If so, please describe these changes and explain why you think they occurred.

5. What do you understand by the term value conflicts?

6. Even if you have not experienced these personally, do you think there is scope for any value conflicts to arise between your personal values and the professional values of nursing?

7. Why do you think such conflicts might arise during nursing study or practice? What might influence or cause these conflicts do you think? And why?

8. If you were to experience value conflicts during your nursing study or practice, how do you think these conflicts might affect you? What other impacts do you think they might have, for example on your patients or co-workers?

Experience of Value Conflicts

The next section of the interview explores any personal experiences that you may have had of value conflicts in your nursing role.

1. First, have you personally experienced any value conflicts between your personal values and the values or requirements of your nursing role? (If no, skip to next section). If yes:

    a. Can you please describe what happened and how you became aware of a value conflict?

    b. Can you explain how this made you feel?

    c. Do you believe the value conflict had an impact on anyone else (e.g. patients, fellow students, family members)

    d. How did you deal with the value conflict (e.g. taking action, seeking support, doing nothing)

    e. Did the University do anything to help you with this conflict? If yes, please explain. How helpful was this?

    f. Do you think there is anything the University should have done to help you with this conflict? Please explain.

    g. Is there anything else you would like to tell me about this value conflict?

2. Do you think other student nurses at this University experience conflicts between their personal values and the values or requirements of their nursing role?

    a. If so, please describe any examples of these, and explain why you think they have arisen?

    b. Based on your own knowledge of the situation, did the University do anything to help the student nurses cope with the value conflicts they experienced? If so, how effective was this.

    c. Do you believe that the value conflicts experienced by other students had an impact on anyone else (e.g. patients, fellow students, family members)

Role of the University and other comments

1. Is there anything else that you think the University should be doing to reduce the potential for value conflicts among student nurses? Please explain.

2. Is there anything else that you think the University should be doing to help students cope with the experience of value conflicts? Please explain.

3. Finally, Are there any other issues you would like to share or discuss at this time?

Thank you for participating, once the research findings have been analysed a summary of the results will be emailed to you. Please contact me if you have further questions or would like to contribute more information.

Appendix 8: Faculty Individual Interview Guide

INDIVIDUAL INTERVIEW GUIDE - FACULTY

Thank you for agreeing to participate in this interview. This study is aiming to investigate the experiences of value conflicts among a sample of Muslim student nurses in XXXXXX University, Saudi Arabia and to explore the awareness of faculty about these conflicts and their views on the ways in which these might be reconciled in this setting. My name is Hanadi Yaseen, and I am currently completing a PhD programme at the University of Dundee, Scotland, United Kingdom. Please remember that you are free to leave, if you feel you do not want to continue at any point during the interview.

Understanding of Personal and Professional Values and Value Conflicts

1. First, please could you tell me what you understand by the term "personal values"? Can you think of any and tell me about these? Prompt if necessary:

   a. Cultural values – what are these? Examples
   b. Religious or spiritual values – what are these? Examples

2. How do you think personal values might be related to a student's choice of nursing as a profession?

3. What is your own understanding of the professional values relating to nursing? Can you give examples of the ways in which these are demonstrated in nurse training and nurse practice?

4. Do you think that Muslim nursing students' personal or professional values tend to change over time during their nurse training? If so, please describe these changes and explain why you think they occur.

5. What do you understand by the term value conflicts?

6. Do you think there is scope for any value conflicts to arise between a nursing student's personal values and the professional values of nursing? Please explain.

7. Why do you think such conflicts might arise during nursing study or practice? What might influence or cause these conflicts do you think? And why? Prompt if necessary:

   a. For example Islam forbids a man exposing his body part/s to females and vice versa, do you believe this can give rise to value conflicts in nurse study and practice? Please explain.

   b. As another example, Islam prohibits close contact between unmarried individuals of different genders. Do you believe this can give rise to value conflicts in nurse study and practice?

   c. Also, it has been suggested that the values or beliefs of a student nurse's family members regarding the nursing profession can contribute to value conflicts. Do you agree with this? Please explain.

   d. Can you think of any other reasons why student nurses might encounter value conflicts in their study or training? Please explain.

8. If nursing students were to experience value conflicts during nursing study or practice, how do you think these conflicts might affect them? What other impacts do you think they might have, for example on patients or co-workers?

Awareness or Experience of Student Value Conflicts

In this part of the interview, I'd like to explore whether you have personally witnessed or been informed about any experience of value conflicts among female Muslim nursing students.

1. Have you ever witnessed or been notified about situations in which students apparently experienced value conflicts of during their study or practice? (If no, skip to next section).

2. If yes, for each situation mentioned:

   a. Can you please describe the nature of the conflict and how you became aware of it?

   b. Can you describe your understanding of how and why this particular value conflict arose?

   c. How do you think the experience made the student feel? What makes you say this? (E.g. she described her feelings to me; my own observation, other).

   d. Do you believe the value conflict had an impact on anyone else (e.g. patients, fellow students, family members)? Please explain.

   e. Did you personally do anything to deal with the value conflict or support the student? If so, please describe this.

   f. Did the University take any other measures to deal with the value conflict or support the student? If so, please describe these.

   g. Is there anything else you would like to tell me about this value conflict?

3. Some of the student nurses who participated in an earlier pilot study described examples of value conflicts that they have personally experienced in their training or clinical practice. Three of these have been summarised in the form of vignettes, with the use of pseudonyms to preserve the students' anonymity and privacy. I will read these out in turn and ask you as series of questions about them.

   a. Vignette 1: Abida admitted that she finds it difficult to deal with work situations involving male colleagues, since she is not used to mixing with unrelated individuals of the opposite gender at home or college. She explained that when a male doctor recently asked her professional advice regarding a patient's care, she turned away in embarrassment and did not answer him.

      i. Why do you think this situation arose?

      ii. What are your views on how the student nurse handled the conflict?

       iii. Do you think the University should have done anything (or anything different) to help support the student?

       iv. How do you think this type of value conflict could be avoided in future?

b. Vignette 2: Shakila described a value conflict that arose when required to take the blood pressure of a male patient. The patient was not happy about a female nurse having direct physical contact in this way and refused the examination. Shakila called a doctor to take the patient's blood pressure but reported feeling that this undermined her own professionalism as a student nurse.

       i. Why do you think this situation arose?

       ii. What are your views on how the student nurse handled the conflict?

       iii. Do you think the University should have done anything (or anything different) to help support the student?

       iv. How do you think this type of value conflict could be avoided in future?

c. Vignette 3: Fazia reported that her close family members cannot accept the idea of her becoming a nurse since they believe this role is associated with "unclean" tasks and reflects badly on their social status. Although Fazia intends to remain in the nursing profession, she refuses to not talk about her job with family members and reports that they make her feel ashamed of some of the tasks she has to carry out.

       i. Why do you think this situation arose?

       ii. What are your views on how the student nurse handled the conflict?

       iii. Do you think the University should have done anything (or anything different) to help support the student?

       iv. How do you think this type of value conflict could be avoided in future?

Role of the University

1. I am now going to read out a list of types of documents that are relevant to nurse training and practice in Saudi Arabia. For each one, please tell me whether you believe this contributes to or helps reduce the potential for value conflicts in nursing and explain your answer. (List to be finalised following the documentary review stage of the research):

    a. Codes of Ethics and Professional Conduct

    b. Nursing Practice Plans

    c. Nurse training materials and program

    d. Fatwas or other Islamic guidance documents affecting nursing practice.

    e. Patients awrah and privacy policy

      f.   Communication policy

      g.   Patients and nurses rights

2. Are you aware of any ways in which the University attempts to reduce the potential for value conflicts in nurse training or practice? Please explain. How effective do you feel these measures are?

3. Are you aware of any ways in which the University helps student nurses to cope with any value conflicts they may experience in their training or practice? Please explain. How effective do you feel these measures are?

4. Are you aware of any other ways in which the University provides support or assistance to student nurses who experience value conflicts in their training or practice? Please. How effective do you feel these measures are?

5. Is there anything else that you think the University should be doing to reduce the potential for value conflicts among student nurses? Please explain.

6. Is there anything else that you think the University should be doing to help students cope with value conflicts? Please explain.

7. Do you think the University is currently doing enough to help reduce the potential for value conflicts among student nurses or to help them cope with value conflicts when they do arise?

      a.   If yes, please explain why you say this.

      b.   If no:

            i.   What else do you think the University should be doing?

           ii.   Why do you think this is not being done at present?

          iii.   What would need to happen in order for the University to implement the measures you suggest?

8. Are there any other issues you would like to share or discuss at this time?

Thank you for participating, once the research findings have been analysed a summary of the results will be emailed to you. Please contact me if you have further questions or would like to contribute more information.

Appendix 9: Review of Collected Qualitative Interview Transcripts

PhD study Hanadi Yaseen (Interviewer/PhD student)
School of Health Sciences, University of Dundee
By Dr Alison O'Donnell (Retired Lecturer in Nursing)

Background

I am a retired Lecturer in Nursing from the School of Health Sciences, University of Dundee, having retired in September 2014. From September 2014 until September 2017, I was part of the supervisory team with Dr Karen Smith and Dr Jane Fenton working with Hanadi Yaseen (PhD student). I then retired fully from September 2017 but agreed to be the reviewer for the qualitative interview transcripts which Hanadi had completed as part of the data gathering process of her PhD study. The study is broadly focussing on the values and influences which may cause conflict with some Saudi Arabian nurses whilst they undertake select nursing roles.

This report is compiled to review the authenticity and veracity of the interview process which I have ascertained whilst scrutinising the 6 completed interview transcripts Hanadi had sent for consideration.

Presenting information

In reviewing the completed interview transcripts, the following details were noted;

1. 6 interview transcripts were sent to me by email – given the nature of the in-country interview/collection procedure and the original language (Arabic) in which the interviews were conducted, I acknowledge that I had no audio recordings to consider
2. all 6 interview transcripts were emailed in Word.doc format, and thus only the written word was able to be read, which had already been translated into English and transcribed verbatim
3. the mean time for an interview, was 49.8 minutes in length
4. the median length of time for an interview, being 58 minutes in total
5. all the interviewees were female
6. there was a range of nursing student experience at undergraduate level, i.e. 1st, 2nd, 3rd years, in terms of where a student was in their nursing education course

7. 2 members of academic/faculty were also interviewed; 1 Lecturer and 1 Associate Professor

8. the interviews were completed within a short time frame from 13th February -6th March 2018

Process of review

<u>Consistency of approach</u>

Initially, I read all the transcripts through in one 'sitting' and took short hand-written notes. As I was reading, I was thinking and looking to see if the interviewer (Hanadi) had asked the same questions, in the same manner, in the same order and to consider if there was a consistency of approach with all the interviewees, regardless of status, or experience.

I would confirm that the interviewer was consistent throughout the 6 interviews, in her forming of the questions and in her time management of each of the interviews.   All the interviewees seemed to be at ease with the interviewer and responded with different information, interesting thoughts and some 'rich data' in terms of the same questions posed, but also with some similar and consistent information from interviewee to interviewee.

Some of the emerging themes which were interesting to read highlighted that there are possible differences, and in some cases conflicts, between a nurse's personal views, cultural values and religious beliefs when undertaking specific nursing care. Interviewees noted that, some of the reasons for these differing viewpoints arose from the current in-country cultural principles which dictate the type of close contact that males and females can or cannot have. The issue of the gender of a nurse, to and with, a patient and their family is explored in the interviews. Interviewees also noted that developing educational experiences and the adequate preparation of students for their role in a constantly differing care setting, is key for their future ability to care for patients.

<u>Veracity in interviewing technique</u>

From reading and re-reading the interviews more than once, it seems that Hanadi posed the interview schedule questions in an accurate and truthful manner to the 6 interviewees.

This said, I acknowledge that I was reading completed typed transcripts. I have no way of knowing if the initial collected audio taped information has been transposed to the final written format accurately - in terms of transcription, language accuracy and if the inherent language nuisances from Arabic to English have been considered appropriately.

However, I have no reason to think that the translation of these 6 interviews would not be wholly accurate, valid and authentic to the information given at point of interview. I would suggest that this modification which has had to be undertaken for the purposes of language understanding and interpretation, be acknowledged when Hanadi comes to discussing this section in her final thesis.

Mode of interviewees

Given the nature and organisation of this PhD study in Hanadi's home country, it is noted that all the interviewees were women – this will, I am sure, be acknowledged and discussed in the completed final thesis. It may be interesting to consider, that if this study was to be replicated in the future, to include interviewing men who are nurses in Saudi Arabia (if this was appropriate) – findings may well be different, and this could be for future study in any post-doctoral studies.

A range of different types of student nurse interviewees were recruited to the study, from 1st year through to 3rd year students at undergraduate level. As well as this, 2 faculty staff were also interviewed both with 12 years of experience in nurse education.
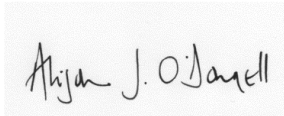
Time frame for interviewing

All the 6 interviews were undertaken from 13th February 2018 until 6th March 2018, as this is a relatively short time frame to conduct interviews, this ought to give a degree of soundness and consistency of approach to the process of managing the interviews.

In conclusion, taking all the above points into consideration, I am satisfied that the 6 interview transcripts are sound and reliable. I have found them to have been conducted in an organised, consistent and methodical manner. The interviewer seems to have approached each interview in a similar manner with a degree of accuracy and reliability. The interviews have generated a diverse and varied range of themes and thus a rich

selection of data has emerged – these findings will make for interesting debate and discussion within the final thesis.

I would like to thank Hanadi for allowing me to review these transcripts and wish her well with her final endeavours.

Alison O'Donnell (Dr) PhD, MSc, BA(Hons), RNT, RNCT, RNLD, RGN
11th July 2018

Appendix 10: University of Dundee Ethics Committee Approval

University of Dundee Schools of Nursing & Health Sciences and Dentistry Research Ethics Committee (SREC)

University of Dundee
Dundee
DD1 4HJ

14 December 2017

Dear Hanadi Yaseen

Application Number: 2017031
Title: Exploring and understanding the cultural/spiritual and professional value conflicts experience for undergraduate nursing students in ██████████ University, Saudi Arabia: student and faculty perceptions.

I am writing to advise you that your ethics application has been reviewed and approved on behalf of the SREC.

If your project data can be linked to an identifiable individual, you must notify the University Data Protection Officer, Mr Alan Bell a.z.bell@dundee.ac.uk.

Approval is valid for three years from the date of this letter. Should your study continue beyond this point, please request a renewal of the approval.

Any changes to the approved documentation (e.g. study protocol, information sheet, consent form) must be approved by this SREC. All revised documents must have an updated version number and date.

Yours sincerely

Andrew Symon

Dr Andrew Symon
Convenor, Schools of Nursing & Health Sciences and Dentistry
Research Ethics Committee

Appendix 11: Case Study University Ethics Committee Approval

KINGDOM OF SAUDI ARABIA
Ministry of Education

المملكة العربية السعودية
وزارة التعليم

...ch **Ethics committee**

Dear: Hanadi Yaseen

Title : Exploring and understanding the culture/Spiritual and professional value conflicts experience for undergraduate nursing students in _____ ,Saudi Arabia :students and faculty perceptions.

I am writing to you to advise you that your ethics application has been reviewed and approved by the University _____ research ethics committee in Nursing College.

Approval is valid for one years from the date of this letter. Should your study continue beyond this point, please request a renewal of the approval.

Yours sincerely

Vice Dean Of Post Graduate Studies And Research

Faculty Of Nursing

_____ **University**

Elha_____.edu.sa

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Encl . : .... : المرفقات   Date : .... : التاريخ   Ref . : .... : الرقم

Appendix 12: Case Study Clinical Site Ethics Committee Approval

DOM OF SAUDI ARABIA
Ministry of Education

Faculty of Medicine

المملكة العربية السعودية
وزارة التعليم

كلية الطب

رقم :
تاريخ :   /   /   ١٤٣هـ
المرفقات :

UNIT OF BIOMEDICAL ETHICS
Research Committee

Conditional Initial Approval

TO: Principal Investigator and Local Supervisor: ▮▮▮▮
(Vice Dean of Post Graduate Studies And Research Faculty of Nursing ▮▮▮
1st Investigator: Hanadi Mohammed Yaseen (PhD Candidate University of Dundee . Scotland)
Main – Supervisor: Dr.Karen Smith   Co – Supervisor: Dr.Jane Fenton   Co – Supervisor: Dr.Joan Cameron

From: Professor ▮▮▮▮
Investigator:Dr ▮▮▮▮

Date: Monday, March 19, 2018   CC:Vice-Dean, University /Hospital Director & Academic Affairs & File & Mentoring Committee
RE: "Exploring and understanding the cultural/Spiritual and professional value conflicts experience for undergraduate nursing students in ▮▮▮▮ Saudi Arabia: student and Faculty perceptions"
Non Intervention/Qualitative Research (Reference No 140-18)

The above titled research/study proposal has been examined with the following enclosures:
- Application for Research Unit of Biomedical Ethics. ▮▮▮ Form.
- Data Collection Sheet

The REC recommended granting permission of approval to conduct the project along the following terms:

1. The PI and Investigators are responsible to get NRC, Academic Affairs, hospital and departmental approval , according to bylaws they must get the administrative approval from organization collaborators outside ▮▮▮

2. Provide to committee" Continuing Review Progress Report "every 3 months.

3. The Investigators will conduct the study under the direct supervision Dr ▮▮▮▮

4. Any amendments to the approved protocol or any element of the submitted documents should NOT be undertaken without prior re-submission to, and approval of the REC for prior approval.

5. Monitoring: the project may be subject to an audit or any other form of monitoring by the REC.

6. The PI and Investigators are responsible for the storage and retention of original data of the study for a minimum period of five years.

7. The PI and Investigators are expected to submit a final report at the end of the study.

8. The PI and Investigators must provide to REC a conclusion abstract and the manuscript before publication.

9. To follow all regulations issued by the National Committee of Bio & Med ethics ▮▮▮▮ and Technology.
Kindly note that the committee does not disclose names of any of its members, however we confirm compliance with the above mentioned Saudi National Committee sections and we confirm that the PI is not part of the ethics committee.
The committee is fully compliant with the regulations as they relate to Ethics Committees and the conditions and principles of good clinical practice.
The Organization & operating procedure of the ▮ Faculty of Medicine - Research Ethics Committee (REC) are based on the Good Clinical Practice (GCP) Guidelines.
Please note that this approval is valid for one year commencing from the date of this letter.

Professor ▮▮▮▮

Chairman of the Research Ethics Committee

(HA-02-J-008) No of Registration At National Committee of Bio.& Med. Ethics.
Mohammed S. ALsearee (Reference No 140-18)

فاكس :
Fax ▮▮▮▮   ☎

Appendix 13: Coding Trees

Student Individual Interviews Coding: Final Themes and Sub-Themes

Understanding of Values	Personal values	Definitions or reported purpose of personal values	
		Examples of personal values	
		Influences on personal values	Family
			Life experience
			Religion or culture
			Reading
		Changes in values over time	Values change over time
			Values do not change over time
		Influence of personal values on nursing role or career choice	Values affect conduct as a nurse
			Values influenced choice of nursing as a career
			Values influenced choice of nursing specialism
			No influence - did not voluntarily choose nursing as a career
	Religious or cultural values	Cultural values	
		Religious values	
		Overlap between religious and cultural values	
	Professional nursing values	Understanding of professional nursing values	
		Examples of professional nursing values	
		Overlap between professional and personal values	
Understanding of and Scope for Value Conflicts	No experience of value conflicts		
	Scope for value conflicts		

	Understanding of value conflicts		
Conflict 1 – Relating to the Need to Expose Male Private Body Parts in Nursing	Impacts of this type of conflict	Personal experiences and feelings	
		Perceptions of how other nurses are affected by this type of conflict	
		Perception of impacts on patients	Role of foreign nurses in relation to this value conflict
		Perception of impact on patients' relatives	
		Views of nurse's family members and impacts of these	
	Responses to this type of conflict	Avoidance or refusal	Avoidance
			Refusal
		Acceptance	
		Does not experience this type of conflict	
		Gaining confidence over time	
		Reporting of conflicts caused by others	
Conflict 2 – Relating to Close Contact between the Genders in Nursing	Reasons for conflict	Cultural factors	
		Religious factors	
		Not used to working with males	
	Impacts of this type of conflict	Personal experiences and feelings	Concern about cultural misunderstanding
			Discomfort about interacting with males
		Perceptions of how other nurses are affected by this type of conflict	
		Deterring Saudi women from entering nursing	
	Responses to this type of conflict	Increase in confidence over time	
		Does not experience this type of conflict	
Conflict 3 – Relating to Public or Family Members' Perceptions of Nursing	Public perceptions of nursing as low status job	Role of nurses in changing image of profession	

	Views and influence of own family members		
	Own value conflicts about carrying out menial tasks		
Perceived Role of the University in Relation to Value Conflicts	Reducing potential for value conflicts	Nurse's knowledge or perception of current policies	Belief that student nurses are not allowed to expose male awrah
			Lack of knowledge or confusion about policies
			Relating to university dress code
		Training and preparation	Code of ethics and professional conduct
			Training materials and teaching
	Supporting students who experience value conflicts	Experiences or expectations of support	
		Lack of support	
		Concern about repercussions	
	Other measures		
	What else should the University be doing	To reduce potential for value conflicts	More male nurses or instructors
			More training or awareness raising
		To support students	

2nd Year Student Focus Group Coding: Final Themes and Sub-Themes

Understanding of Values	Personal values	Understanding of personal values
		Examples of personal values
		Influence of personal values on nursing role or career choice
		Overlap between personal and cultural/religious values
	Cultural values	Understanding of cultural values
		Examples of cultural values
	Religious values	Understanding of religious values
		Examples of religious values

		Influence of religious values on nursing role
Understanding or experience of value conflicts	Understanding of value conflicts	
	Personal experience of value conflicts in nursing	When seeing violation of personal values in nursing situations
		Relating to interaction with male patients or colleagues
		Relating to public perceptions of nurses
		Relating to hospital rules and regulations
		Limited or no experience of value conflicts
Perceived Impacts of Value Conflicts	Impacts on student nurses	Impacts of value conflicts reduce over time
		Positive impacts of value conflicts
	Impacts on nurses' family members	
	Impacts on patients	
Responses to Value Conflicts	Responses to conflicts relating to exposing patient's awrah	Initial shock
		Acceptance over time
		Seeking alternatives if possible
	Responses to conflicts relating to interaction between genders	Response depends on characteristics or condition of patient
	Responses to conflict relating to hospital policies	
Role of families on participant's nursing role	Influence of families on girls' career choices in SA	Restrictions on voluntary career choices of girls
		Influences depends on educational level of family
		Family influence declining in modern day SA
		Participant's family support their choice of nursing profession
	Whether they talk to family members about nursing tasks	Would not talk to family members about nursing tasks
		Would talk to family members about nursing tasks
		Would only tell certain family members about nursing tasks
Organisational ways of reducing potential for value conflicts	Avoidance	
	Code of Conduct/Code of Ethics	
	Policies	
	Nurse training	
	Fatwahs	

	Other ways university might reduce potential for value conflicts	Transparency and realistic information about nursing in KSA
		Raising family and public awareness about nursing

4th Year Student Focus Group Coding: Final Themes and Sub-Themes

Understanding of Values	Understanding of personal values	
	Understanding of cultural values	
	Understanding of religious values	Remain constant and unchanging
		A guide or reference in life
		Different levels of adherence
		Changing interpretations over time
Values Relating to Nursing	Connection between personal values and nursing career	
	Influence of religious values on nursing	
	Influence of cultural values on nursing	
	Understanding of professional nursing values	
Understanding or experience of value conflicts	Understanding of value conflicts	
	Relating to interaction with male patients or colleagues	Influence of culture on this conflict
		Influence of religion on this conflict
		Depends on characteristics of patient or nurse intention
	Relating to exposure of patient's awrah	
	Relating to withholding information from patients or their relatives	
	Relating to hospital rules and regulations	
	Impacts on student nurses	Discomfort

Impacts of Value Conflicts Relating to Caring for Male Patients	Perceived impacts on patients	Poorer quality of treatment
		Psychological impacts caused by reaction of nurse
		Embarrassment
Responses to Value Conflicts Relating to Caring for Male Patients	Willing or growing acceptance	
	Asking patient's relatives to help	
	Response depends on characteristics or condition of patient	
	Reporting conflict to University	
Influence of families on participant's nursing role	Whether families support choice of nursing career	Families are supportive
		Families are not supportive
		Families are partially supportive
	Whether they talk to family members about nursing tasks	Would not talk to family about nursing tasks
		Would talk to family about nursing tasks
Role of the University	Importance of written guidance in reducing conflicts	
	Lack of support for students	

Faculty Interviews Coding: Final Themes and Sub-Themes

Understanding of Values	Personal Values	Understanding of personal values	
		Examples of personal values	
	Cultural values	Understanding of cultural values	
		Examples of cultural values	
	Religious or spiritual values	Understanding of religious values	
		Examples of religious values	
Values Relating to Nursing	Professional nursing values	Understanding of professional nursing values	

		Examples of professional nursing values	
		Development or change in professional values over time	
	Influence of personal values on students' choice of nursing profession	Types of values associated with choice of nursing	
		Students not voluntarily choosing nursing	Impacts of students' lack of interest in nursing
			Actions taken to encourage students to stay in nursing
	Understanding of value conflicts in nursing context		
Value conflicts relating to exposure of patients' awrah	Awareness of this type of conflict	Awareness of conflict faced by students	
		Personal experience of conflict	
	Perceptions of this type of conflict	Perceived reasons for conflict	
		Does not recognize any value conflict in this situation	
	Responses to this conflict	Responses by students	Increase in confidence or acceptance over time
			Reporting conflict to University
		Responses by University	Avoidance of situation
			Exposure to situation
			Patient awareness raising
Relating to interaction with male patients or colleagues	Awareness of this type of conflict	Awareness of conflict faced by students	
		Personal experience of conflict	
	Perceptions of this type of conflict	Perceived reasons for conflict	Cultural factors
			Religious factors

			Patients' attitudes towards Saudi nurses
			Saudi women not used to mixing with men
		Does not recognize any value conflict in this situation	
		Impacts of conflict on nurses or patients	
	Responses to this type of conflict	Advice to students on dealing with this conflict	
		Own ways of supporting students	
Relating to family and public attitudes towards nursing	Awareness of this type of conflict	Awareness of conflict faced by students	
		Personal experience of conflict	
	Perceptions of this type of conflict	Perceived reasons for this conflict	Lack of awareness about nursing profession
			Poor public or media image of nursing
			Some nurses do not convey good image
Conflicts relating to choice of career	A. Perceived reasons for this conflict	a. Initial lack of experience of nursing	
		Whether entered nursing voluntarily	
	B. Perceived impacts of this conflict	a. Impact on University	
		Impacts on patients	
		Impacts on students	
Conflicts relating to hospital policies and practices			
Role of the University	Nursing curriculum and ethics training	Examples of current training	Teachers as role models
			Teaching of ethics and values
			Role of the University
		Perceived gaps in curriculum and training	
	Fatwas and religious guidance	Fatwas/religious guidance could help reduce conflicts	

		Fatwas/religious guidance unlikely to be effective in reducing conflicts	
	Policies and practices	|Views on patient privacy policy	
		Views on patients' and nurses' rights policy	
		Views on communications policy	
	Supporting students who experience value conflicts	Current support for students	
		Barriers to providing more support for students	
	What else should the University be doing?	Awareness raising for families and general public	
		More support for students	
		More training in ethics and values	
		Self-development/awareness raising workshops for students	

Appendix 14: Documentary Review Completed Template

UNIVERSITY DOCUMENTS	Concept of Nursing Teaching Plan Table, 2nd Year Nursing	Course Syllabus Concept of Nursing NUR (211)	An Introduction to the Foundation of Professional Nursing (I) NUR (222)	Foundation of Professional Nursing (I) NUR (222) Course Syllabus	Foundation of Professional Nursing Teaching Plan
Type of document:	Academic timetable	Academic syllabus	PPT overview of course content	Academic syllabus	Teaching plan and timetable
Author:	Faculty of Nursing	Faculty of Nursing	Faculty of Nursing	Faculty of Nursing	Faculty of Nursing
Date released/updated:	2016	2017	Not known	2015	2015
Purpose/context:	To provide 2nd year nursing students with Concept of Nursing timetable for 2016/17	Overview of Concept of Nursing course which is intended to "help the students understand evolution of nursing profession with emphasis on nursing in Saudi Arabia"	To provide students with information on the objectives, teaching methods, content and grading of the course.	Overview of Foundation of Professional Nursing course which is intended to ensure that students are "exposed to the most basic information and skills in nursing career" – focuses on clinical	Provides information on weekly course content by date

				knowledge and health assessment.	
Target audience:	2nd year nursing students	2nd year nursing students	2nd year nursing students	2nd year nursing students	2nd year nursing students
Dissemination strategy:	Not known	Not known	Not known	Not known	Not known
Relevant content re value conflicts:	3rd week lecture covers nursing roles and Nursing in Islam Week 14 lecture covers values and ethics	"This course explores the evolution of nursing profession with emphasis on nursing in Saudi Arabia. It aims at raising student's awareness of the professional nurse roles in the health care system and promoting student's socialization into the role, values and behaviors of the professional nurse. The concepts of human being, nursing, health and environment with which professional nursing interact are introduced. The legal and ethical	None in course overview	"you will attend and participate in clinical area through lab demonstration and practice on advanced simulation dolls in the 1st semester and hospital rotation and lab simulation in the 2nd semester." " Lab procedures are properly selected to be taught by demonstration, re-demonstration, audio-visual aids, and models (simulation dolls)."	Topics covered include "bed bath". "health assessment: breast, axilla and genitalia", all based on lab demonstration.

		aspects of nursing, nursing education, the value of research and nursing theories are presented."		Upon completion of this course, the student will be able to: 2. Obtain a health history of an individual using interviewing techniques and principles of communication. 3. Perform a physical assessment of an individual using technique of inspection, auscultation, palpation, and percussion.	
Purpose of content:	Not known	To provide an overview of a course which "aims at raising student's awareness of nursing profession and professional nurses' roles in the health care system and promoting student's	N/A	To provide basic clinical and health assessment skills in these areas	To provide information on specific subjects to be taught in this course

		socialization into the role."			
Information/guidance on dealing with value conflicts:	No guidance provided in this overview document	No guidance provided in this overview document	N/A	Not addressed in syllabus	None apparent
Notes on 'latent' content (tone, style, bias, agenda, opinions etc.):	N/A	N/A	N/A	N/A	There is no mention of gender specific nursing, not known from this document whether training covers giving care to male patients
Other notes/observations	Indicates that issue of values is covered in 2nd year nursing curriculum but it is not known if this addresses value conflicts	Indicates that issue of values is covered in 2nd year nursing curriculum but it is not known if this addresses value conflicts	N/A	Syllabus indicates that this is the course in which students begin to learn about aspects of nursing in which value conflicts may arise (e.g. physical examinations; interviewing patients) or which may contribute to later conflicts (e.g. practising only on	

					simulation dolls and not real patients). There is no evidence from the document that the issue of value conflicts is identified or addressed in the course.

Title:	**Nursing Care of Adult (I) Clinical Objectives**	**Nursing Care of Adult I Outcome Evaluation Form-1435**	**Nursing Care Of Adult (I) Course Portfolio**	**Critical Care Nursing – Course Portfolio Part 1**	**Critical Care Nursing – Course Portfolio Part 2**
Type of document:	Course objectives	Evaluation form	Course syllabus	Course syllabus	Course syllabus
Author:	Faculty of Nursing	Faculty of Nursing	Faculty of Nursing	Faculty of Nursing	Faculty of Nursing
Date released/updated:	Not known	Not known	2013	2017	2014
Purpose/context:	To set out learning objectives of course	Form for recording student grades against specified learning objectives	Overview of this course which is intended to provide students with "the knowledge which is used in applying the critical thinking approach and	Overview of this course which is intended to introduce students "to the use of the evidence base in the care of patients	Overview of this course which is intended to enable the student to "apply the nursing process in caring for individuals with complex,

			decision making in the healthcare medical and surgical settings. Also it helps in developing skills needed in nursing care based on Nursing process approach"	with acute and critical illness"	multisystem alterations in biophysiological functioning in critical care environments"
Target audience:	3rd year Nursing students	For use by lecturers	3rd year nursing students	4th year nursing students	4th year nursing students
Dissemination strategy:	Not known	Not known	Not known	Not known	Not known
Relevant content re value conflicts:	In this unit the student should be able to (e.g.) " Provide basic physiological hygienic measures " "Obtain body fluid specimens as urine and stool samples, culture swab, drain and catheters tube tips, etc….."	Learning objectives: 1c: "Implement nursing care to different age groups/gender 4a: "Communicate with various clients effectively" 4d: "Discuss with colleagues and health care providers professionally pertaining clients' condition"	None	" At the completion of the clinical rotation, the student will be able to: 1) Explain how Islamic values, ethical and legal principles relate to decision making in a critical care environment. 3) Explain responsibilities and accountability of professional nursing in a critical care environment,	Upon completion of this course, the student will be able to: 1) Explain how Islamic values, ethical and legal principles relate to decision making in a critical care environment. 3) Explain responsibilities and accountability of professional nursing in a critical care environment,

	"Provide psychological support and spiritual care as needed."	5d: " Treat clients equally regardless of race, sex, religion, nationality and socio-economic background" 5e "respect client's belief and value" 6a " Recognize the client's right" 6b "Maintain client's confidentiality" 6f: " Implement professional ethics when interacting with clients and healthcare providers"		which are congruent with professional standards. 4) Adapt communication strategies according to the needs of clients. 14) Provide appropriate patient teaching that reflects developmental stage, age, culture, spirituality, patient preferences, and health literacy considerations to foster patient engagement in care. 15) Provide psychological and spiritual support as needed. 16) Apply ethical and legal principles when caring for the client and/or family. Also includes student's reflection form, asking for a "description of the experience and related feelings.", areas of	which are congruent with professional standards. 4) Adapt communication strategies according to the needs of clients.

				improvement needed, and what they would do differently in future.	
Purpose of content:	Specific learning objectives	To specify areas of nursing on which student performance is evaluated	N/A	Specific learning objectives	Specific learning objectives
Information/guidance on dealing with value conflicts:	None addressed	None	None	None addressed	None addressed
Notes on 'latent' content (tone, style, bias, agenda, opinions etc.):	No mention of gender-specific care, it is not known whether the student nurses are required to provide this to males and females.	The potential for value conflicts in these key learning areas is not acknowledged.	N/A	No mention of gender-specific care, it is not known whether the student nurses are required to provide this to males and females.	No mention of gender-specific care, it is not known whether the student nurses are required to provide this to males and females.
Other notes/observations	The learning objectives suggest that knowledge of how to perform certain tasks that could potentially give rise to value conflicts (in context	This indicates that student nurses are being evaluated on key learning objectives which could give rise to value conflicts, but without	N/A	The learning objectives suggest that knowledge of how to perform certain tasks that could potentially give rise to value conflicts (in context	The learning objectives suggest that knowledge of how to perform certain tasks that could potentially give rise to value conflicts (in context

	of care for male patients) are a course requirement.	being given guidance and support to deal with these.		of care for male patients) are a course requirement.	of care for male patients) are a course requirement.

HOSPITAL DOCUMENTS	2nd Year Students Foundation of Nursing (II)	Information Confidentiality	Communication	Nurse Internship and Training Program	Code of Ethics
Type of document:	Memo	Policy	Policy	Policy	Guidance
Author:	Nursing Training Co-ordinator, Nursing Education, Training and Research Unit	Hospital Administration	Hospital administration	Nursing Department	Hospital
Date released/updated:	January 2018	2008/2014	2012/2014	2004/2014	2012
Purpose/context:	To inform Head Nurses of details of clinical training for 2nd year nursing students (dates,	To protect the legal rights of the patient/staff/ hospital from invasion of privacy & security as a result of indiscriminate	To ensure that all healthcare providers use a standardized approach to effectively communicate patient-specific	To set out policy for a planned and documented nursing internship program	To inform registered nurses of the standard of professional conduct required of them, and to inform the public of the

	names, clinical objectives)	and unauthorized access and disclosure of confidential information. Includes confidentiality agreement for signature of all staff.	information between or among providers (Situation-Background-Assessment-Recommendation)		standard of professional conduct they can expect of a registered practitioner
Target audience:	Concerned Head Nurses	All staff and patients	All hospital staff and contractees	Nursing Interns	Registered nurses and the general public
Dissemination strategy:	Direct communication	Hospital website and information system	Hospital web page and circulated memorandum		Not known
Relevant content re value conflicts:	None	None	None	None	"when facing professional dilemmas, your first consideration in all activities must be the interest and safety of patients" (p.7) "At all times, maintain appropriate professional boundaries in the relationship you have with patients. You must ensure that all aspects of

					the relationship focus exclusively on the needs of the patient" (p.3)
Purpose of content:	n/a	n/a	n/a	n/a	To provide guidance on how to deal with potential value conflicts that nurses may face.
Information/guidance on dealing with value conflicts:	None	None	None	None	As above
Notes on 'latent' content (tone, style, bias, agenda, opinions etc.):			"Preferred" approach to transferring care involves the use of face-to-face verbal communications; may create value conflicts when female nurses are required to convey information to male doctors or other male colleagues.	Sets out "specialized competency testing" areas to include, e.g. "bathing a patient" and "urinary catheterization" Surgical rotation: 3 weeks male, 3 weeks female No acknowledgement of potential value conflicts relating to opposite gender care	Main references (on which document is based) are Western codes of conduct, the guidance is not specifically tailored to this setting.

| Other notes/observations | Clinical objectives stated factually – no reference to gender of patients or potential for value conflicts in achieving them (e.g. assist in maintaining client's personal hygiene and morning care). | | | | Does not address specific types of values conflicts that may be faced by Muslim nurses in this setting, only gives general advice on prioritising needs of patients. However, this may be helpful to an extent for nurses dealing with value conflicts, as it may help them decide on the most appropriate response based on the needs of the patient. |

UNIVERSITY DOCUMENTS	Orientation (student) PPT	Nursing Students' Orientation Program	NUR-01-072 (03) Nursing Orientation Program	NUR-01-077 (03) Nursing Clinical Training	Patients Rights
Type of document:	PPT for use in student orientation session	Memo	Policy statement	Policy statement	Policy statement
Author:	Nursing Education and Research Unit	Coordinator, Nursing Education and Research Unit	Nursing Unit	Nursing Unit	Patient Affairs Office
Date released/updated:	Not known	August 2013	2004, revised 2017	2013, revised 2017	Not known
Purpose/context:	To provide new nursing students with an overview of the hospital mission, values, standards of nursing care and other guidelines.	To notify lecturers of Nursing Students' Orientation Program timing and content	To provide a planned process to orient new nursing employees.	To provide a planned process for Clinical Training of Nursing Under Graduate, Post-Graduate, Trainees and Interns.	
Target audience:	Nursing student entrants	Nursing Unit lecturers	New nursing staff	All undergraduate, postgraduate trainees and interns	Patients

Dissemination strategy:	Face to face (seminar)	Internal mail/email	Through hospital webpage.	Through hospital webpage.	Not known
Relevant content re value conflicts:	None	Sessions on Patient Rights, Patient Confidentiality and Patient Safety.	None	None	"To accept or refuse medical treatment after consequences of refusal have been explained to you" "To receive spiritual support if requested in accordance to laws and regulations of the Kingdom" "To seek second medical advice without fear or threat of compromising care plan" "To understand that this is a university hospital where students of medical faculties and institutes are

					training and that they may examine patients" "To observe and abide by all Government regulations, ethical laws, proper dress code, and good behavior".
Purpose of content:	N/A	Not known	To provide information on theoretical and practical requirements of orientation program.	To provide specific guidelines to conduct clinical training and competency assessment.	To provide patients with information about their rights and responsibilities
Information/guidance on dealing with value conflicts:	None	Content of sessions not known	None	None	None
Notes on 'latent' content (tone, style, bias, agenda, opinions etc.):	N/A	Not known	N/A	N/A	Content of patient rights may potentially support refusal of treatment or examination, resulting in value conflict being experienced by relevant nurse. Conversely they specify that patients have

					responsibility to agree to be examined by student nurses if appropriate – may reduce potential for conflict in this respect.
Other notes/observations	This overview directs students to other guidance documents but does not in itself address the issue of value conflicts.	N/A	N/A	N/A	

	Critical Care Nursing NUR (427) - Field Experience Specification	Critical Care Nursing NUR (427) – Course Specification
Type of document:	Report to NCAAA	Report to NCAAA
Author:	The National Commission for Academic Accreditation & Assessment / Faculty of Nursing	The National Commission for Academic Accreditation & Assessment / Faculty of Nursing
Date released/updated:	2015	2015
Purpose/context:	To specify field experience Program Learning Outcomes, Assessment Methods, and Teaching requirements for this course, based on the five	To specific course objectives, learning outcomes, assessment methods etc. for this course, based on the five NQF Learning Domains, and the responsibility of faculty in supporting these

	NQF Learning Domains, and the responsibility of faculty in supporting these	
Target audience:	The National Commission for Academic Accreditation & Assessment	The National Commission for Academic Accreditation & Assessment
Dissemination strategy:	N/A	N/A
Relevant content re value conflicts:	NQF Learning Domains include " Interpersonal Skills & Responsibility" and "Communication". Specific learning objectives include *Communicate effectively with all the healthcare team members"* *"Demonstrate confidence in dealing with the doctors and staff of the unit"* *" Apply appropriate theories of communication with clients and their families."*	i) *establish professional relationship with the entire healthcare team* ii) *communicate effectively with patients (as necessary), healthcare staff, and others that may be involved in the care of the critically ill* B. *exemplify the ethico-moral responsibilities in the clinical area.* *Respect clients of different age groups from diverse cultures and background*
Purpose of content:	To ensure that students communicate and interact effectively with patients and the healthcare team	To ensure that students communicate and interact effectively with patients and the healthcare team

Information/guidance on dealing with value conflicts:	None	None
Notes on 'latent' content (tone, style, bias, agenda, opinions etc.):	Does not address potential for value conflict in these areas	Does not address potential for value conflict in these areas. Learning objective focused on age and diverse cultures does not mention gender.
Other notes/observations	Field experience specified as being in lab and clinical settings, no mention of whether care is to be provided to male patients within these settings	*"2 office hours each Thursday from 10 to12 for advice."* Could this be used for students to discuss value conflicts?

MoH and other Third Party documents	Ministry of Health Manual of Nursing Policies and Procedures	Patient's Bill of Rights and Responsibilities	Ministry of Health rules and regulations of Observing the Decency of "Patients' Awrahs"	Code of Ethics for Healthcare Practitioners	Exposing Awrah in an operation room
Type of document:	Guidance	Guidance	Memorandum	Guidance	Islamic Fatwa
Author:	Ministry of Health	Ministry of Health	Another government hospital in Saudi Arabia	Saudi Commission for Health Specialities	The Permanent Committee for Scholarly Research and Ifta'

			based on Ministry of Health directive		
Date released/updated:	2011	2010	2005	2014	Not known
Purpose/context:	To provide detailed guidance to nurses and patients on a wide range of topics	To set out the rights and responsibilities of patients	To provides guidance on the religious and regulatory requirements relating to exposure of awrah	To provide comprehensive guidance from an Islamic perspective on healthcare ethics	To provide guidance on what is permissible within Islam with regard to exposing awrah in operation rooms
Target audience:	Nurses and patients	Patients	Healthcare practitioners	Healthcare practitioners	Healthcare practitioners
Dissemination strategy:	Not known	Not known	Not known	Not known	Not known
Relevant content re value conflicts:	No direct reference to value conflicts, but includes a Nursing Code of Ethics which could help clarify how to deal with issues potentially resulting in value conflicts	No direct reference to value conflicts, but Includes content on the rights of patients not to expose awrah unless in emergency.	No direct reference to value conflicts, but stresses that only healthcare providers of the same gender as the patient can expose their *awrah,* which could give rise to value conflicts if sufficient nurses of same gender are not available	No direct reference to value conflicts, but specifies that healthcare professionals can expose *awrah* of patients of opposite gender if a professional of the same gender is not available, but only in a "necessity",	No direct reference to value conflicts, but provides guidance confirming that female nurses are not permitted to expose male awrah if a male nurse is available, and the way in which to do so if a male nurse is not available. This may help reduce nurses by

				the nature of which is not specified.	clarifying that this is acceptable as long as the they deliberately avoid looking directly at any parts of the body in this area other than that being treated.
Purpose of content:	To provide guidance to nurses on ethical issues when dealing with patients	To clarify patient rights with regard to religious/cultural aspects of healthcare	To provide guidance on how to deal with specific situation (exposure of awrah) that could cause value conflicts	To provide guidance on how to deal with specific situation (exposure of awrah) that could cause value conflicts	To provide guidance on what is permissible within Islam with regard to exposing awrah in operation rooms
Information/guidance on dealing with value conflicts:	None	None specific, but helps to clarify issues potentially giving rise to value conflicts such as exposure of male awrah by female Muslim nurses	None	None specific, but helps to clarify issues potentially giving rise to value conflicts such as exposure of male awrah by female Muslim nurses	None specific, but may help nurses cope with situations in which value conflicts might arise by clarifying what is permissible
Notes on 'latent" content (tone, style, bias, agenda, opinions etc.):	Not developed specifically within the Saudi Arabian or Islamic contexts and most of the provisions are listed				

	under the heading "International Code of Ethics"				
Other notes/observations			Published in 2005 – less relevant to current day situation in which the increasing demands on healthcare make it difficult to provide same-gender care	Helpful in indicating that practitioners of opposite gender can expose awrah of patients in a necessity, but does not specify what constitutes necessity	The fatwa was developed specifically to cover operating room situations and its applicability to other nursing tasks is not clear

Regional and International Professional Association Documents	Code of Ethics for Nurses	Code of Professional Conduct for Nursing
Type of document:	Code of ethics	Code of conduct
Author:	International Council of Nurses	Gulf Cooperation Council
Date released/updated:	2012	Not known
Purpose/context:	To provide guidance on ethical conduct for nurses internationally	To provide guidance on ethical conduct for nurses in the GCC region
Target audience:	Nurses internationally	Nurses in the GCC region
Dissemination strategy:	Published document	Published document

Relevant content re value conflicts:	Specifies that the nurse's *primary* professional responsibility is to people requiring nursing care. This may result in conflicts when the requirements of patients conflict with the nurse's own values	No specific content relevant to value conflicts
Purpose of content:	N/A	N/A
Information/guidance on dealing with value conflicts:	None specific	None specific
Notes on 'latent" content (tone, style, bias, agenda, opinions etc.):	The code is general in nature and not tailored to the Islamic context	The code is general in nature and not tailored to the Islamic context

Appendix 15: Conferences, Forums and Poster Presentations

I believe that presenting my study at various stages to individuals from a range of professional backgrounds helped contribute to an overall improvement of my work. Below are listed the conferences and forums at which I have shared and presented my study.

Oral Presentations:

Yaseen, H. March, 2019. *Exploring and understanding Personal and professional value conflicts for student nurses in Saudi Arabia: Students and Faculty Perception* at the (PGRF) post graduate research forum «School of Nursing and Health sciences» University of Dundee, Scotland.

Yaseen, H. November 2018. *Exploring and understanding Personal and professional value conflicts for student nurses in Saudi Arabia: Key primary study findings.* Presented within the post graduate research conference at «School of Nursing and Health sciences» University of Dundee, Scotland.

Yaseen, H. November 2017. *Exploring and understanding Personal and professional value conflicts for student nurses in Saudi Arabia: Study Proposal.* Presented within the post graduate research conference at «School of Nursing and Health sciences» University of Dundee, Scotland.

Yaseen, H. October, 2017. *The influence of religious and cultural factors on value conflicts among Muslim nurses in Saudi Arabia and other Islamic societies: Structured literature review* at the (PGRF) post graduate research forum «School of Nursing and Health sciences» University of Dundee, Scotland.

Yaseen, H. February, 2017. *Personal and Professional Value conflicts in Student nurses in Saudi Arabia* at the UOD - LTC monthly research meeting. The findings of the exploratory study research conducted with Students.

Yaseen, H. November, 2016. *Personal and professional value conflicts in student nurses: do they exist? Exploratory Study Finfings* at the upgrade review «School of Nursing and Health sciences» University of Dundee, Scotland.

Yaseen, H. September, 2016. An *Exploration of the presence of value conflicts in student nurses at Saudi Arabia* at the Research student Forum (RSF) «School of Social sciences» University of Dundee, Scotland. The findings of the exploratory study conducted with students.

Yaseen, H. July, 2016. Exploring the Student nurses' experiences of Personal and Professional value conflicts in Saudi Arabia: a study plan and progress update at the (COC) Crescent of care Model research group, Nursing Education and Saudization meeting, KFSHRC-J, Saudi Arabia.

Yaseen, H. March, 2016. An *Exploration of the presence of value conflicts in student nurses at Saudi Arabia: Study proposal* at the UOD LTC monthly research meeting.

Yaseen, H. March, 2016. An *Exploration of the presence of value conflicts in student nurses at Saudi Arabia: Study proposal* at the Research student Forum (RSF) «School of Social sciences» University of Dundee, Scotland.

Yaseen, H. October 2015. *Focused systematic review exploring the experiences of undergraduate nurses when personal and professional values are in conflict.* Presented within the post graduate research conference at «School of Nursing and Health sciences» University of Dundee, Scotland.

Poster Presentation:

Yaseen, H. October, 2016. *Personal and professional value conflicts in student nurses in Saudi Arabia: Exploratory study findings.* Presented within the post graduate research conference at «School of Nursing and Health sciences» University of Dundee, Scotland.