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**Keywords**

Keyword; Keyword; Keyword

**Introduction**

Individuals from minority populations represent a growing percentage of the nursing and medical workforce. The Israeli Ministry of Health’s guidelines on linguistic and cultural accessibility of the health system recommends recruiting personnel from among linguistic and cultural minorities (Ministry of Health, Israel, 2011). Data regarding diversity in the Israeli health workforce refer only to the nationality of the workforce and ignore religious affiliation (Judaism, Islam, Christianity, etc.). Israel and many other countries increasing seek to have their nursing workforce represent the population. Based on an estimate of the number of graduating students from three nursing schools, ethnic and religious minorities are a growing percentage of Israeli nursing students (Ministry of Health, 2011). In Jerusalem, two of the three nursing schools are Orthodox Jewish, with the third one a general public one. Nonetheless, few data and little research are available regarding the influence of nurses’ religious and cultural backgrounds on their interactions with patients.

Attracting minority students to the nursing profession has not been accompanied by research about their own experiences and the influence of their backgrounds on their training—specifically, the subject of religious Jewish female nurses touching male patients. Research regarding touch between the sexes in a professional context refers mainly to male nurses touching female patients, but not the opposite situation.

Some studies have been conducted on the subject of female nurses treating Muslim male patients. A recent review examined stressors between nurses and Muslim male patients, but did not mention the male-female religious dimension (Oakley et al., 2019). Another article stressed the centrality of the modesty concept, but from the perspective of the patient (Muslim female), not the nurse (Mujallad and Taylor, 2016). An Iranian study described challenges and barriers to compassionate care; young female nurses reported that they had problems providing compassion-based care to male patients. They also indicated that the gender of the nurse was a cultural barrier to compassionate care, but again, the focus was on the patient, not the nurse (Babaei and Taleghani, 2019). Many studies deal with caring for Orthodox Jewish patients, but from the patient’s viewpoint, not that of the nurse. A further study reviewing the “conversion” of nursing by Jewish Orthodox women in Israel described religious nurses’ challenges from a historical point of view (Raz, 2017). Ten veteran nurses in that study were interviewed, but the subject of touch was described in only one paragraph, and these nurses had worked decades ago. Another study described the process of integrating Ultra-Orthodox Jewish men in academic nursing, but focused on technology literacy and learning skills (Haron and Azuri, 2015). No further studies about Orthodox Jewish female nursing students touching male patients were found.

This study introduces the issue of “touch” in the students’ culture (Orthodox Judaism), with the aim of enhancing empathy for and understanding of the students’ perspective. According to Halacha (Jewish law), touch between the sexes is totally forbidden. Touch between married couples and parents and children is permitted, but physical contact with people of the opposite sex who are not family is strictly prohibited. Under special circumstances, such as in a life-threatening situation, touch between non-familial members of the opposite sex is permitted. It is also allowed during medical treatment.

Most religious Jewish female nursing students have never had any physical contact whatsoever with unrelated men (this includes shaking hands and other types of touch considered innocuous by the general population). Married students have only touched their husbands, and even this is not in public. The clinical phase of their nursing studies is the first time in their lives that most these students have encountered the situation of being required to touch men.

This qualitative study conducted interviews among female Orthodox Jewish nursing students. The interviews focused on the subject of touching male patients and aimed to explore and understand the students’ perspective and experiences.

**Methods**

***Approach***

Quantitative methods can show trends and changes in the workforce and the reasons for them. One limitation of quantitative studies is that although they describe trends, they do not explain their consequences. In addition, to our knowledge, quantitative research has not been used to investigate the phenomenon of religious female nursing students touching male patients.

Qualitative research can address these limitations. Nursing is not only a technical profession, but also one that involves a wide range of human interactions, patient teaching, and ethical considerations. Cultural factors can strongly influence the patient–nurse encounter. Using qualitative methods to investigate this encounter may better reflect minority nurses’ point of view.

Qualitative methods can deepen the understanding of human experiences and interactions and enhance culture-dependent perspectives. The many dimensions of language, combined with a researcher who understands the fine cultural nuances of Orthodox Jewish practice and those of clinical nursing practice in a multicultural hospital department, can help provide new insights into the issues being examined (Malterud, 2001).

This study was guided by two main theories: Festinger’s cognitive dissonance theory and Bandura’s social learning theory. Cognitive dissonance theory is perhaps the best-known theory to emanate from social psychology. The theory was originally conceived by Festinger in the 1950s (Festinger, 1957) and is still the basis of active research programs today (McGrath, 2019). Cognitive dissonance occurs when a person has two or more contradictory [beliefs](https://en.wikipedia.org/wiki/Belief%22%20%5Co%20%22Belief), [ideas](https://en.wikipedia.org/wiki/Idea%22%20%5Co%20%22Idea), or [values](https://en.wikipedia.org/wiki/Value_%28ethics%29%22%20%5Co%20%22Value%20%28ethics%29), or participates in an activity that contravenes one of these, thereby experiencing [psychological stress](https://en.wikipedia.org/wiki/Psychological_stress%22%20%5Co%20%22Psychological%20stress). According to this theory, when two actions or ideas are not psychologically consistent with each other, people will do everything in their power to change them until they become consistent. The discomfort is triggered by the person’s original belief clashing with new evidence or [facts](https://en.wikipedia.org/wiki/Fact%22%20%5Co%20%22Fact), thus leading them to try to find a way to resolve the contradiction to reduce their discomfort. Orthodox female nursing students have grown up in a society that forbids any touch between the sexes. They start their clinical studies in a general hospital department where not only do staff members touch each other unintentionally, but more importantly, they touch male patients all the time. This creates a prime example of cognitive dissonance for these young women.

Albert Bandura (1997) developed the social learning theory and the concept of self-efficacy. He reconceptualised individuals as self-organizing, proactive, self-reflecting, and self-regulating, as opposed to the orthodox conception of humans being governed by external forces. Bandura suggested a social cognitive theory of human functioning that accords a central role to cognitive, self-regulatory, and self-reflective processes for human adaptation and change. For example, nursing students’ clinical studies will mainly affect them not as passive learners being shaped by their supervisors and lecturers, but as individuals developing their own personal resources and self-reflective processes. Faced with the absence of sociocultural mediators, students must fulfill the demands of their clinical studies and cope with dissonance as well.

***Procedure***

To find participants for this study, notices for Orthodox Jewish students were posted on the notice boards of several nursing schools. This was done after obtaining approval from the institutional review board of Lev Academic Center, Jerusalem, and from the school managers.

Further information and a consent form were sent to potential participants. Participants could choose to be interviewed by telephone or in person. All chose the in-person interview option. Recruitment and interviewing were done by the author and continued until saturation was obtained (i.e., no new data or themes were obtained from the interviews). Students were recruited using a snowball strategy over a two-month period and were interviewed during the following six months. Students were in the midst of the clinical phase of their studies, either in year three or four (final year) of their undergraduate studies. Owing to the diversity of Orthodox Judaism and the variance between educational approaches among nursing schools, a relatively large number of participants (for a qualitative study) were interviewed, with 40 Orthodox Jewish female students from four nursing schools (10 from each school) participating in the research. More specific details about the participants (age, marital status, motherhood, etc.) are available on request.

All interviews started by reconfirming participants’ written consent, which included permission to record and transcribe the interviews. Following transcription, each participant reviewed and approved her own interview. The participants were able to delete any part of their interview transcript. However, no participant chose to do so.

The interview guide was updated following each interview to emphasise the themes. Open coding of the transcripts was performed and recursively developed until a thematic-tree structure was generated. After the themes and their explanations were obtained, they were presented to the participants, who were then asked to comment on the preliminary results. Confidentiality was maintained throughout the process.

The themes from this study were then analyzed according to insights from cognitive dissonance theory and social learning theory and coupled with interpretations from existing literature in the field to build a model that attempted to explain how the cultural background of female Orthodox Jewish nursing students influences their experience of touching male patients during the clinical phase of their studies. A flowchart was developed to show the process they described and to explain further dimensions (Figure).

**Results**

Forty Orthodox Jewish female nursing students from four nursing schools (ten from each school) participated in the study. The nursing schools were from different geographic regions in Israel, and one was an exclusively Orthodox Jewish school. Three main Orthodox Jewish streams were represented (Ultra-Orthodox, Orthodox, and Modern-Orthodox). The students were in the clinical phase of their studies, ranging from the end of their third year to the middle of their fourth (final) year. After 36 interviews, no further themes emerged, with four participants (one from each nursing school) interviewed for confirmation. All participants preferred not to be involved with the data analysis, but they approved the results.

The themes emerging from the interviews related to several dimensions: personal feelings, sources of support, coping strategies, and reflective retrospection. Each theme was supported by most of the participants, regardless of their religious stream affiliation.

*Personal feelings*

***Loneliness and helplessness.*** Each student felt that they were the only one facing this issue. As one student (Student 12) said, “Everybody seems to get along well. What is the problem with me?” They felt that nobody in the world could help them, because their family did not understand their professional situation and their clinical supervisor did not understand their cultural background. “There is no one I can speak to,” bemoaned Student 23. “My husband, parents, and friends don’t even start to understand what I am doing, and my supervisor doesn’t understand the relationship between the sexes in my culture.”

***Sources of support.*** Students reported a total lack of support from the nursing school, the clinical supervisor, and their own communities. They did not attempt to obtain support from anyone, and were uncertain whether anyone would understand their unique circumstances. They also did not request support from other nursing students studying with them, as they were too embarrassed to speak about the subject. “I was afraid that if I were to say what I felt that they would laugh at me, or they would say that if I am unable to wash patients, then I am unsuitable for the profession and should quit, and so I was on my own with this problem” (Student 6).

***Bullying and abuse.*** Not only did the students feel they had nobody to support them, but almost half of the participants (19 of 40) spoke about feeling bullied by their clinical supervisors and other nursing staff. this. Student 9 described how her clinical instructor had told her, “You will only treat male patients until you get rid of your old-fashioned concepts.”

Another student (no. 34) told us, “My supervisor forced me to wash male patients even when the patient specifically asked for a male nurse, and at that time there was a male nurse available in the department. The clinical instructor said I have to get used to touching men.”

More than half of the interviewees (25 of 40) described a lack of respect from clinical instructors and staff regarding how these students behaved with male patients, including avoiding unnecessary contact, not shaking hands, and not giving friendly pats on the back. “They used to tease me, saying I am afraid of men,” recalled Student 15. “This was not true, but they did not try to understand.” The bullying the students spoke about was entirely connected to their experience of touching male patients.

***Cognitive dissonance.***

The students knew that the Halacha (Jewish religious law) allows them to touch male patients as part of medical treatment, but they nevertheless had strong feelings against this, as it was in direct contradiction to their upbringing and culture. “On the one hand, I knew exactly what the profession entails,” conceded Student 26. “I spoke to my Rabbi, and it is permitted and even important. But then I approach the patient and need to wash him [and] I just want to run away. How can I be a good nurse if I recoil from the patient?”

***Fears.*** Students were “afraid of losing the gentle feature of the soul” (Student 10), that they wanted to preserve. They also were “afraid of becoming desensitised towards a future husband” (Student 17). According to their viewpoint, a husband is supposed to be the one and only man whom they will touch. (This was even though the Halacha clearly permits touch in a nursing context.) They were afraid of “becoming desensitised towards touch between the sexes” (Student 33), which in their eyes was supposed to be a holy and special act, even though, as already mentioned, the Halacha clearly permits nurses to touch patients. Many of the students were afraid of “moving away or straying from the path of G-d because of too much involvement in earthly or mundane pursuits” (Student 36). All these expressions reflect Jewish religious concepts inherent to the students’ culture.

*Coping strategies*

More than half of the students (21 of 40) saw the situation as a test, just like when G-d tested Abraham (Genesis 12: 1–7). Hence, they thought they needed to find the inner strength to pass the test. Student 5 said, “It means that this is only a phase to becoming a better person, and it also means that I can do it, since G-d only tests those who are capable of withstanding the challenge.” According to Student 21, “I understood it was G-d testing me, to see if I can be a really good nurse. Well, I suppose I need to do my best.” The other 19 students perceived the situation as an opportunity to change themselves for the better. “If this is a time for me to work on my character, then I am supposed to become a better person afterwards,” said student 31. Student 9 explained, “I understood this is only a step on the long path of becoming a better person. I should ignore other people’s contempt and focus on doing it as best as I can, and then I myself will be a better person.”

***Reflective retrospection.*** Speaking of their feelings after several clinical placements, students expressed the feeling of coping well. They felt they had improved their sense of confidence and self-esteem. Their general satisfaction had improved. They all described a sense of reinforcement of their personal values.

**Discussion**

Analyzing the students’ coping methods indicated that they chose between two distinct paths. One was viewing the situation as a test, and the other was viewing it as an opportunity for self-improvement. These coping mechanisms led the students to undergo a significant process within themselves. Most of the students did not think that their supervisors had bad intentions, but, rather, that they were unaware. The students saw themselves as part of something bigger. Initially, they described feelings of loneliness and helplessness. After a few clinical placements, they felt differently, both empowered and enabled. They independently and actively shifted their points of view, reflecting highly significant process on their part. They knew in advance that they were entering a profession demanding daily physical interaction with men, yet they still chose this profession. The cognitive dissonance between their intellectual understanding and emotional feelings was clearly in this very choice. When the clinical phase of their studies started, this challenge needed to be faced. They saw their situation as a challenge, not a difficulty, and as a matter of choice, rather than as something immutable.

The expressions and concepts the students used to describe the process they underwent are deeply rooted in Jewish tradition, and represent a spiritual dimension of Judaism. The students superimposed these concepts onto their challenge of treating male patients. The second path could be identified from the main themes that emerged from the interviews. Unexpectedly, the students were apparently able to transform the source of their distress (their cultural background) into a source of power.

Bullying was one of the themes that emerged strongly from the interviews. Marked similarities but also marked differences can be seen when comparing the responses of students in this study with research about bullying of nursing students. Research has shown that bullying in nursing is a widespread phenomenon with negative outcomes on the learning experience of vulnerable nursing students, affecting them physically, mentally, and emotionally (Birks et al., 2018). A majority of students report that the experience of being bullied or harassed makes them feel anxious and depressed. Almost one-third of students indicate that these experiences negatively affect the [standard of care](https://www.sciencedirect.com/topics/nursing-and-health-professions/health-care-quality) they provide to patients, with many reconsidering nursing as their intended career (Budden et al., 2017). Symptoms commonly reported by students experiencing bullying include headache, bad temper, stomachache, backache, nervousness, difficulties in sleeping, dizziness, fatigue, and even angina (Hamblin et al., 2016). The effect of bullying is not limited to poor psychosocial adjustment and a lack academic achievement; it also lowers concentration, success, motivation, and self-confidence (Hoel et al., 2017). It has been found that bullying can even cause posttraumatic stress disorder (Tee et al., 2016). Individuals who have witnessed bullying behaviours in the workplace setting respond in a similar way to that of the actual victims (Cardoso et al., 2016).

The initial feelings and experiences the Orthodox Jewish female nursing students in this study expressed regarding bullying were similar to those described in previous studies, but the outcomes were diametrically opposed. None of the students in this study reported feelings of depression, anxiety, or other factors affecting the standard of care they provided to patients. Most of them reported that despite the internal conflicts they felt, they provided the best care they could. To the author’s knowledge, no similar coping mechanisms for student nurses have been described in the literature.

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The main limitation of this study is the possible bias of the author’s personal values and beliefs as an Orthodox Jewish female nurse. Bracketing and reflexivity techniques were used to minimisze the possible influence of this on the study results.

**Conclusions**

The students used their cultural background as a source of power. Their choice of a point of view and a way of coping can be traced directly to their cultural background, which could help these students to thrive in conditions where other students would fail. These findings are of relevance for nursing schools and health services where nurses come from traditional populations whose perspectives regarding the interaction between men and women are similar to those of this study’s participants.

In a world of changing populations and global immigration waves, understanding the influence of the cultural background of students’ feelings and behaviour is crucial for the training of future generations of nurses. These findings are of paramount importance for clinical instructors and other staff members who teach students from traditional backgrounds.

Future research should examine and contrast the factors affecting male nursing students and other minority groups. These next steps are already in progress.

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