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Original research article

Exploring the experiences and perceptions of male Saudi nurses working in hospital clinical settings

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Abstract

Background: Nursing in Saudi Arabia has traditionally been a female-dominated profession, resulting in social stigma for Saudi male nurses. However, recent health system reforms have led to an increase in the number of male Saudi nurses, reflecting changing societal perceptions.

Aim: To explore the experiences and perceptions of male Saudi nurses working in clinical hospital settings, focusing on the challenges and contributions they face in their roles.

Methods: A qualitative design was used, involving semi-structured focus group discussions (FGDs) with seventeen Saudi male nurses from a tertiary hospital in Riyadh. Data collected between May and July 2025 were analyzed using inductive content analysis.

Results: Three key themes emerged: (1) Gender-based barriers to nursing care delivery, (2) Perceptions of workplace inequality, and (3) Overcoming gender-based stereotypes.

Conclusion: This study reveals that gender dynamics significantly impact male nurses in Saudi Arabia, creating barriers in patient care and interactions. Cultural norms favor female caregivers, limiting trust. To improve this, healthcare institutions should promote gender inclusivity, equitable workloads, and challenge stereotypes, encouraging more men to join the nursing profession.

Keywords: Male nurse; Nurses; Nursing care; Qualitative research; Saudi Arabia

Introduction

In Arabic communities, male family members are often viewed as superior to females and are taught traditional masculine roles from an early age (Saleh et al., 2020). In Saudi Arabian culture, men typically occupy more powerful roles and are expected to work in "tough" jobs, which rarely include nursing (Saleh et al., 2020). Historically, nursing has been seen as a female profession in Saudi Arabia, leading to social stigma against men who pursue this career (Elmorshedy et al., 2020; Salvador and Mohammed Alanazi, 2024). However, significant changes are underway as the Kingdom reforms its health system, aiming to become a leader in nursing within the Gulf Cooperation Council (GCC) and globally (Saudi Health Council, 2019). Recent reports indicate that out of 213,110 Registered Nurses (RNs) in Saudi Arabia, 44% are Saudis and 56% are expatriate nurses. Out of 94,021 total Saudi RNs, 40% (37,898) are men, representing a 10% increase since 2018 (Ministry of Health, 2023). This rise in the number of male nurses is promoting greater acceptance of their roles in clinical settings. However, the experiences of Saudi male clinical nurses in Saudi Arabia have not been thoroughly explored amidst these changes. Little research has focused on how they perceive their roles in clinical practice. Globally, studies on male nurses discuss topics like professional identity and job satisfaction (Cañadas-De la Fuente et al., 2018; Chang and Jeong, 2021; Mao et al., 2020; Smith et al., 2020; Stanley et al., 2016), but most overlook the specific cultural context of Saudi Arabia (Saleh et al., 2020). Understanding the experiences and perceptions of Saudi male clinical nurses is crucial for developing effective strategies to support their integration and professional growth. This study aimed to explore the experiences and perceptions of Saudi male nurses working in clinical hospital settings.

Materials and methods

Study design

This study utilized a qualitative research design with inductive content analysis to explore the experiences and perceptions of Saudi male clinical nurses, following the Consolidated Criteria for Reporting Qualitative Studies guideline (Tong et al., 2007). This approach was effective in uncovering patterns in participants' perceptions, challenges, and insights within the Saudi healthcare context.

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Sample

Conducted at a tertiary hospital in Riyadh, the study focused on a diverse healthcare workforce, including a growing number of Saudi male nurses. Researchers used purposive sampling to recruit participants who could provide rich insights. A list of eligible Saudi male nurses was generated from the hospital's Enterprise Reporting System (ERS). After filtering by inclusion criteria (1) Saudi nationality, (2) male gender, (3) currently employed as a clinical nurse in a hospital setting, and (4) having at least three years of clinical nursing experience in more than one tertiary hospital in Saudi Arabia, 93 potential participants were contacted via email, with 68 responding. Phone screening confirmed that 35 had at least three years of experience in multiple tertiary hospitals. Ultimately, 23 nurses agreed to participate, with 17 being interviewed.

Data collection

Data were collected between May and July 2025 through semi-structured focus group discussions (FGDs) conducted in a private room within the hospital premises to ensure comfort and confidentiality. Despite the sensitivity of the topic, focus group discussions were chosen over individual interviews. This approach was particularly appropriate because experiences of gender-based stigma and workplace inequality are socially negotiated and embedded in professional peer interactions. The group setting enabled participants with similar backgrounds to engage in collective reflection and mutual validation of their shared experiences. An interview guide was developed based on the study objectives, with these questions:

- What are the positive and negative experiences you encounter as a male clinical nurse in your workplace?
- Can you tell us your specific experiences that highlight your clinical work as a male nurse?
- How do you describe your role as a male clinical nurse?
- What are the strengths and challenges of being a male clinical nurse in your workplace?

Each FGD consisted of 4–5 participants. Participants were informed in advance about the purpose and format of the discussion, showing respect for their time and contribution. To address confidentiality concerns in the group setting, several measures were implemented. At the beginning of each session, participants were explicitly reminded that all shared information must remain confidential and not be disclosed outside the group. Additionally, each participant was assigned a pseudonym and participant number to protect their real identity. Before the commencement of each FGD, participants were asked to complete a demographic sheet to provide their basic profile. The sessions were moderated by the lead researcher (LB), with the assistance of note-takers (LS and JJ), who documented nonverbal cues, group dynamics, and key points. A semi-structured discussion guide was used to facilitate the conversation, ensuring consistency across sessions while allowing for flexibility to explore emerging themes. Each discussion lasted approximately 60 to 90 minutes and was audio-recorded by FH or AK with participants' permission. The moderator encouraged equal participation and ensured that all voices were heard, while also maintaining a respectful and focused environment. Probing questions were used to elicit more in-depth responses and clarify points as needed. No other non-participant individuals were present in the FGD. Following the sessions, the recordings were transcribed verbatim, and the transcripts were reviewed in conjunction with the field notes to enhance accuracy and context for subsequent data analysis. Interviews were conducted in English and audio-recorded with the participants' consent. All participants were proficient in English and able to articulate their experiences without translation, with no switching to Arabic during the discussions.

Data collection continued until data saturation was reached – that is, the point at which no new themes or insights emerged from the discussions. Data saturation was achieved after four focus groups. Although 23 potential participants agreed to be interviewed, only 17 were interviewed, as data collection was stopped after saturation was reached.

Data analysis

The interviews were transcribed verbatim and analyzed using the content analysis approach described by Lindgren et al. (2020). The researchers, all experienced and knowledgeable in the field of nursing, utilized their expertise to gain a deeper understanding of the participants' experiences. LB, a male registered nurse, holds a master's degree in nursing, is a certified professional in healthcare quality, and has extensive experience in qualitative content analysis research. LS, a female registered nurse, holds a Bachelor of Science degree in nursing and has experience in qualitative research. JJ, a female registered nurse, holds a master's degree in business administration and has experience in qualitative research. FH and AK, male registered nurses, hold a bachelor's degree in nursing. All of the researchers were working in the same organization at the time of the study.

The analysis process involved the following steps: (1) Authors read the transcripts multiple times for immersion; (2) LB and LS identified the meaning units relevant to the research question; (3) LB and LS condensed the meaning units to shorten the text while preserving the core meaning; (3) LB, LS, and JJ independently coded the condensed meaning units without consulting each other initially. After independent coding was completed, LB, LS, and JJ compared their codes side by side, then discussed the differences. When the codes were similar, merging was performed. Differences in coding were resolved through dialogue, clarification of interpretations, and reaching a consensus on the final codes that best represent the data; (4) LB, LS, and JJ grouped the codes collaboratively into subcategories and categories; (5) After identifying the categories, thorough discussions took place between LB, LS, JJ, FH, and AK to reach consensus on three identified themes. The analysis was conducted manually to ensure deep engagement with the data.

Rigor and reflexivity

To ensure methodological rigor and trustworthiness, the study followed Lincoln and Guba's (1985) criteria. Credibility was established through member checking and peer debriefing, while dependability was assured by maintaining an audit trail and using a consistent interview guide. Confirmability was achieved through bracketing and reflective journaling to reduce researcher bias. Reflexivity was emphasized throughout the study. The lead researcher, a nursing quality improvement coordinator with clinical experience in Saudi Arabia, provided cultural insight but needed to remain aware of potential biases. Efforts were made during interviews to maintain neutrality and allow participants to express themselves freely on sensitive topics like gender roles and workplace dynamics. The interview guide was designed to avoid leading questions, and reflexive practices continued during data analysis to ensure findings were based on participants' narratives.

Results

Characteristics of participants

Table 1 shows the demographic characteristics of the participants.

Table 1. The demographic characteristics of the participants

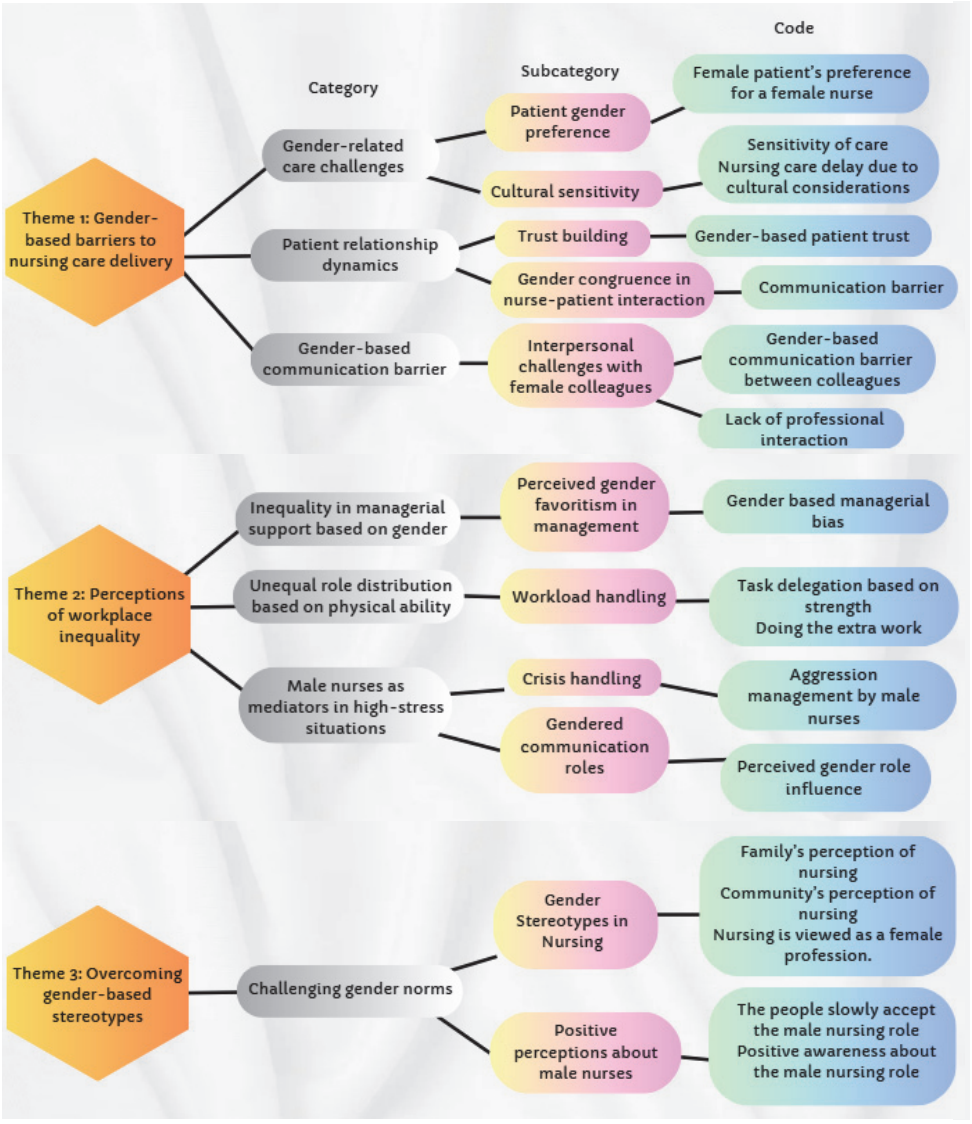
Demographics	Frequency number (*N*)	Percentage (%)
Highest educational attainment		
Bachelor	17	100.0
Place of work		
General ward	6	35.3
Ambulatory care	8	47.7
Procedural	3	17.6
Current position		
Staff nurse	17	100.0
Years of clinical experience		
3–5 years	7	41.2
6–10 years	6	35.3
11–15 years	4	23.5

Themes

Scheme 1 shows three main themes were identified from the analysis: gender-based barriers to nursing care delivery, perceptions of workplace inequality, and overcoming gender-based stereotypes.

Theme 1: Gender-based barriers to nursing care delivery

Participants described how gender norms profoundly shaped their clinical experiences, often creating barriers that influenced patient care. These barriers – manifested through patients' gender preferences, cultural expectations, trust-building challenges, and gender congruence in nurse-patient interaction – significantly impact the delivery of nursing care. Participants highlighted that navigating these barriers required constant professional adaptability and sensitivity to patient needs, underscoring the complex interplay between gender, culture, and patient care in clinical settings. Male nurses reported navigating these challenges while striving to deliver safe, respectful, and patient-centered care, frequently finding themselves in situations where they had to balance cultural sensitivity with professional responsibilities.



Scheme 1. Results showing the identification of the three main themes

Gender-related care challenges
The patient's gender preferences emerged as a significant challenge. Several participants reported that some female patients or their families sometimes refused care or requested female nurses for intimate procedures. These preferences not only delayed care but also required nurses to navigate sensitive situations while maintaining patient comfort and dignity. One participant shared:

"I face a big issue with some female patients in terms of providing care. They prefer female nurses most of the time as they do not want a man to see or touch the patient's skin during physical assessment or in any procedures" (FGD1:P1).

Cultural sensitivity further complicated care delivery. Male nurses described having to carefully respect their cultural and religious beliefs, which sometimes limited or delayed the care they could provide directly. One participant reflected:

"As the guys mentioned, the culture here is that sometimes if I need to enter a female patient's room for routine procedures, I have to knock and wait a little longer until she is fully covered before I can enter the room, or take a female staff member with me because a patient does not want me to go inside alone, which often delays my professional tasks" (FGD2:P5).

Patient relationship dynamics
Trust building was another key aspect of their experience. Participants explained that patients with the same gender as the nurse expressed trust more easily. Earning patient trust based on gender was highlighted as a central aspect of male nurses' experiences. Participants described that initial patient hesitancy often required extra effort to build rapport and demonstrate competence. One nurse explained:

"I feel that I have more trust from my male patients than my female patients. In my experience, they easily share more of their health issues or concerns with me than my female patients. I have to exert extra effort in establishing rapport with my female patients so that they are comfortable sharing with me their health issues or concerns for immediate interventions" (FGD1:P4).

Gender-based communication barrier
Gender congruence in nurse-patient interaction further influenced communication and care delivery. Male nurses noted that patient comfort and openness were often linked to the perceived appropriateness of a caregiver's gender. A participant emphasized:

"Male patients are more comfortable with me as a male nurse. Sometimes they were shy to ask something of the female nurse" (FGD4:P1).

Participants further described interpersonal challenges with female colleagues, often framed as gender-based communication barriers and limited opportunities for professional interaction. One nurse shared:

"I feel like there is a barrier between me and my female colleague. She feels shy about asking me and goes to another female nurse. Even when I am the charge nurse, this barrier exists between colleagues" (FGD4:P4).

Others described how communication barriers made collaboration feel strained, with expectations sometimes leaning toward stereotypical roles rather than equal professional exchange.

Theme 2: Perceptions of workplace inequality
Participants highlighted a persistent sense of inequality within their professional roles, often linked to gender-based assumptions and workplace expectations. These perceptions influenced their daily experiences, shaping how they viewed managerial practices, workload allocation, crisis responsibilities, and communication dynamics.

Inequality in managerial support based on gender
Several participants perceived gender favoritism in management, where female colleagues were seen as receiving more flexible schedules or greater understanding from supervisors. One nurse explained:

"Usually, the majority of staff here in the hospital, especially for nursing, are females. Even nursing managers are mostly female. We tend to see a pattern where females are getting what they want from management, such as a favorable work schedule and annual leaves, because they can speak to our managers easily" (FGD2:P1).

This perception fostered feelings of imbalance and suggested that gender subtly influenced managerial decisions.

Unequal role distribution based on physical ability
Workload handling was another area where participants reported experiencing inequality. Male nurses often found themselves tasked with heavier physical work or more labor-intensive duties, reinforcing gendered stereotypes about strength and endurance. A participant reflected:

"Female nurses always ask me for help, like emptying the heavy hampers and carrying heavy things" (FGD1:P1).

Another participant said: *"… if any of the female nurses need support (e.g., transferring a heavy patient from the bed), this will take up your time. You also need to complete a large number of assignments. So, we can say it is extra work. It is not your patient, but you will not say no. Maybe this is the most challenging thing you will see in my workplace"* (FGD2:P2).

The sense of unequal expectations extended to physical burden, where male nurses felt obligated to perform strenuous tasks, sometimes at the expense of their own well-being. They expressed concerns that these tasks were often not rotated among all staff members, reinforcing the perception that male nurses were expected to carry a disproportionate share of physical responsibilities.

Male nurses as mediators in high-stress situations
Male nurses also described being relied upon heavily during crisis handling, including situations involving aggressive patients, disruptive families, or medical emergencies. They felt this was based more on gender than professional training. One participant shared:

"In outpatient areas, what I find is that if someone is shouting, female staff come to you and expect you to be on the front line to tackle it. If she finds difficulty speaking with the patient/family, or if they are angry, and if you are behind her, she will be looking at you in that way. It feels as if being a man makes me responsible for controlling the situation" (FGD2:P6).

This expectation created additional pressure and sometimes placed nurses in physically or emotionally risky situations. Finally, participants discussed the gendered roles in communication, noting that they were frequently asked to mediate conflicts or de-escalate tense encounters. A nurse explained:

"… and I encountered a recent problem with the patient who was shouting at every female nurse. However, when the patient came to me and I was very clear and strict with him, he gave a different unexpected response with much humility, and he changed his behaviour" (FGD2:P1).

Theme 3: Overcoming gender-based stereotypes
Participants described their ongoing efforts to challenge and transcend societal and cultural stereotypes surrounding men

in the nursing profession. These stereotypes, often rooted in traditional beliefs that nursing is a female profession, influenced how patients, families, and the broader community perceived their roles. Despite these challenges, male nurses expressed resilience and a commitment to redefining their professional identity.

Challenging gender norms

Several participants shared experiences of encountering gender stereotypes in nursing, particularly assumptions that nursing is only a female job. One nurse stated:

"The community looks at male nurses with a feeling that nursing is for females. They thought that nursing is not suitable for a man. However, it is slowly getting better for the community, which is more open now and has started to understand the role of male nurses" (FGD2:P3).

Such perceptions sometimes resulted in feelings of professional marginalization, but also motivated participants to demonstrate competence, empathy, and clinical skill as a way of countering these assumptions. Family perceptions played a significant role in shaping how male nurses viewed their career choice, particularly during the early stages of their professional journey. Some reported initial resistance or concern from relatives, reflecting broader societal biases about gender and the nursing profession. One participant explained:

"At first, my family members used to tease me for being a nurse because they used to believe that nursing is suitable for females. Over time, they saw my dedication and the respect I gained at work, and their views changed" (FGD2:P6).

These shifts in family attitudes were often a source of validation, reinforcing the nurses' sense of purpose and commitment to their role. Participants also highlighted how actively confronting stereotypes fostered a sense of pride in their contributions to patient care. Many spoke about the satisfaction of demonstrating that nursing is a profession defined by skill, compassion, and critical thinking rather than gender. As one nurse reflected:

"It is important to let the male nurses work in all the units. Although it is challenging culturally, I think it is now improving. Every time I care for a patient who initially doubts me, only to thank me later, I know I am helping to change how people perceive male nurses. Now, there is a huge change in society, and they have started to know the role of male nurses better" (FGD2:P2).

Discussion

This study examined the experiences and perceptions of male Saudi nurses in Saudi Arabia, uncovering how gender-based dynamics influence patient care, workplace equity, and professional identity. Three interrelated themes – gender-based barriers to care delivery, perceptions of workplace inequality, and overcoming gender stereotypes – illustrate the complexity of navigating nursing practice within a context where cultural norms significantly influence gender expectations.

Gender-based barriers to nursing care delivery

The findings underscore the persistence of gender-based barriers to care delivery, particularly in relation to patient preference and cultural sensitivities. Male nurses described difficulty building trust with patients when gender incongruence existed, often resulting in delayed or refused care. These experiences mirror findings from a study across Middle Eastern contexts, where gender-congruent care is prioritized due to sociocultural and religious norms (Almutairi et al., 2014). Participants recounted encounters where patient preferences for female caregivers and cultural sensitivities undermined their ability to deliver care smoothly – particularly during intimate or culturally sensitive procedures. This aligns with quantitative findings showing that over 80% of Saudis prefer female nurses (Elmorshedy et al., 2020). These results align with broader regional patterns, where gender-congruent care is a strong cultural norm. At the same time, patient-centered care requires respect for cultural expectations, which can risk marginalizing the professional contributions of male nurses. This highlights the need for workforce strategies that reconcile cultural sensitivity with equitable care delivery.

Interestingly, male nurses in this study demonstrated a nuanced understanding of the cultural and religious traditions that prioritize gender-congruent care, particularly the preference for female patients to be treated by female healthcare providers. Participants acknowledged the legitimacy of patient preferences rooted in modesty and religious values. This reflexive awareness suggests they navigate a dual identity: as members of a society that uphold these traditions and as healthcare professionals committed to patient-centered care. However, this acceptance placed them in a paradoxical position, where their professional role sometimes conflicted with the very cultural expectations they personally endorsed, underscoring the complexity of practicing in a culturally conservative healthcare environment.

Importantly, while religion provides guidelines regarding modesty and gender interactions, individual interpretation varies considerably among male nurses. Some demonstrated greater flexibility in navigating gender-based care situations, while others adhered more strictly to traditional interpretations. This variation suggests that religious norms, though influential, are not monolithic and allow for personal interpretation based on professional context and individual values. Being a male nurse from the same religious background does not necessarily mean perceiving or responding to gender-based care expectations identically, underscoring the importance of recognizing individual agency within culturally conservative healthcare settings.

This study reveals that gender not only influences nurse-patient interactions but also significantly shapes communication among nursing colleagues. Participants described the presence of gender-based communication barriers within the workplace, particularly when interacting with female colleagues. In the Saudi Arabian context, where gender roles are socially and culturally defined, professional interactions between men and women are often influenced by broader societal expectations regarding modesty and gender segregation. Participants noted that some female colleagues appeared hesitant to communicate directly with male staff, particularly when discussions involved sensitive clinical matters or required assertive dialogue. This communication gap occasionally led to misunderstandings, slower teamwork, coordination, and emotional distance within the clinical environment. Similar findings have been reported in the Middle Eastern nursing study, where gender norms impact interpersonal collaboration and lead to communication asymmetries (Alshammari et al., 2019).

Perceptions of workplace inequality

Participants frequently noted differences in managerial support compared to their female counterparts. Many reported that female nurses were more likely to receive understanding and flexibility from managers regarding scheduling, leave, or interpersonal conflicts. This reflects a broader pattern of gender favoritism in nursing leadership, where male nurses

often feel marginalized and receive limited advocacy from predominantly female management structures (Bordelon et al., 2023; Sasa, 2019). Such disparities can lead to professional dissatisfaction and feelings of exclusion among male nurses (Ageeli and Alharbi, 2024). Another significant finding was the unequal distribution of physical workloads. Male nurses often received more physically demanding tasks, such as lifting patients, which some viewed as occupational stereotyping that reinforces outdated gender norms (Gauci et al., 2023). Interestingly, male nurses were often expected to handle high-stress situations, such as emergency codes or family disputes. While many took pride in this responsibility, others felt it added emotional and professional pressure. This expectation can reinforce gender hierarchies, suggesting that men are better suited for leadership in stressful situations, while women are seen as better for nurturing roles (Tuna and Kahraman, 2024).

Overcoming gender-based stereotypes

The experiences of male nurses in this study reveal a complex process of negotiating and overcoming persistent gender-based stereotypes embedded within the nursing profession and broader society. Participants described continuous efforts to challenge misconceptions that position nursing as a "female" profession, while simultaneously striving to earn respect and legitimacy from patients and families. Participants commonly reflected on the misconception that nursing lacks alignment with traditional masculine values. Many noted that their decision to pursue nursing was initially questioned by family members or peers, reflecting a deeply rooted social bias that associates caregiving and emotional labor with femininity. Similar findings have been reported in international studies, where men entering nursing often face stigmatization and are compelled to justify their career choice (Guy et al., 2022; Salvador and Mohammed Alanazi, 2024). Despite these challenges, participants expressed a strong commitment to their role, framing their work as a service to humanity and an opportunity to redefine professional masculinity through compassion and competence.

The influence of familial and cultural expectations emerged as a critical factor in shaping participants' experiences. Some described initial resistance from family members who perceived nursing as an inappropriate or low-status occupation for men. Over time, however, these perceptions often shifted as families witnessed the nurses' professional achievements and dedication to patient care. This finding aligns with earlier research indicating that increased visibility and success of male nurses help challenge traditional gender expectations and normalize male participation in nursing (Amin et al., 2025). The transformation of family attitudes in this study demonstrates how personal success stories can serve as catalysts for broader societal acceptance, gradually weakening the stigma surrounding men in nursing in Saudi Arabia.

Central to participants' experiences was the use of professional competence as a means of challenging stereotypes and earning respect. Many expressed the belief that consistent, high-quality patient care and calm performance under pressure gradually changed perceptions among both patients and colleagues. This reflects the notion that visibility of male nurses in clinical practice not only enhances professional legitimacy but also contributes to destigmatizing male participation in caregiving roles (Amin et al., 2025; Younas et al., 2022). By demonstrating clinical expertise and emotional intelligence, male nurses actively redefine nursing as a gender-neutral profession, grounded in skill and compassion, rather than solely in gender identity.

Collectively, these findings demonstrate that overcoming gender-based stereotypes involves both individual and systemic transformation. Male nurses in this study resisted gendered expectations by embodying professionalism, fostering collegial respect, and reframing caregiving as a universal human responsibility rather than a gendered task. This aligns with global calls for a more inclusive understanding of nursing identity, where diversity within the workforce is recognized as essential to advancing equitable, high-quality patient care (Carter, 2020; Stanford, 2020).

Implications

The findings of this study highlight several critical implications for nursing practice and education in Saudi Arabia. Firstly, it is essential to develop and implement training programs that address gender-based barriers in patient care delivery. These programs should focus on enhancing communication skills among male nurses, equipping them with strategies to build trust and rapport with patients, particularly in situations where gender congruence may be an issue. Secondly, nursing leadership and management structures should be re-evaluated to ensure equitable support for all staff, regardless of gender. This involves providing male nurses with the same level of flexibility and advocacy that female nurses reportedly receive, fostering a more inclusive and supportive work environment. Training for management on gender equity can help address biases and promote fairness in task distribution and professional development opportunities. Additionally, there is a pressing need for initiatives aimed at changing societal perceptions of nursing as a female-dominated profession. This can be achieved through outreach programs that challenge stereotypes and promote the contributions of male nurses, thereby encouraging more men to pursue careers in nursing. Collaboration with educational institutions to strengthen awareness of this issue at the entry level of nursing education would also be beneficial. Finally, creating a culture of respect and collaboration between male and female nursing staff can enhance teamwork and communication. Establishing regular interdisciplinary team-building exercises may help bridge gender divides, reducing misunderstandings and fostering a more cohesive working environment. Collectively, these implications aim to enhance patient care, professional satisfaction, and the overall effectiveness of nursing practice in Saudi Arabia.

Strengths and limitations

A notable strength of this study is its focus on an underexplored population: male Saudi nurses in Saudi Arabia, where cultural norms significantly influence healthcare delivery. The qualitative approach provided nuanced insights into the interplay between gender, culture, and professional identity.

Nonetheless, limitations should be acknowledged. Findings are drawn from a specific cultural and institutional context, which may limit transferability to other settings. The sample size, while sufficient for qualitative inquiry, may not capture the full diversity of male nurses' experiences across specialties or institutions. Further research should incorporate the perspectives of female colleagues, patients, and administrators to provide a more comprehensive understanding of the gendered dynamics in nursing in Saudi Arabia.

Conclusion

This study highlights the significant impact of gender dynamics on male nurses in Saudi Arabia, revealing barriers that

affect patient care and workplace interactions. Male nurses often face challenges due to cultural norms favoring female caregivers, which can hinder trust and effective care delivery. To address these issues, healthcare institutions must foster gender inclusivity through training programs that emphasize the contributions of male nurses. It's essential for nursing leadership to recognize and rectify perceptions of inequality by ensuring equitable workload distribution and managerial support, promoting a collaborative workplace environment. Lastly, challenging stereotypes associated with nursing as a female-dominated profession is crucial. By raising awareness of the valuable roles that male nurses play, healthcare systems can encourage more men to join the profession, ultimately benefiting both the nursing workforce and the patient populations served.

Ethical considerations

Ethical approval for this study was obtained on December 23, 2024, from the Institutional Review Board of King Faisal Specialist Hospital and Research Center, Riyadh (Reference # 2241401), before data collection. All participants were informed about the purpose and voluntary nature of the study. Written informed consent was obtained, and participants were assured of the confidentiality and anonymity of their responses. Data were securely stored and used solely for research purposes.

Conflict of interest

The authors have no conflict of interest to declare.

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