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Perceived Knowledge, Attitudes, and Self-Reported Practices of Clinical Fiqh Principles among Nursing Students: A Cross-Sectional Study.

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Abstract
Background: Clinical Fiqh plays an important role in guiding Muslim healthcare professionals in addressing religious and ethical considerations in patient care. In nursing practice, understanding Clinical Fiqh may support the provision of care that respects patients' religious needs while maintaining professional standards. However, evidence regarding nursing students' perceived knowledge, attitudes, and self-reported practices related to Clinical Fiqh remains limited. **Methods:** A cross-sectional study was conducted among 91 fourth-year nursing students at the Kulliyyah of Nursing, International Islamic University Malaysia. Data were collected using a researcher-developed, structured self-administered questionnaire assessing perceived knowledge, attitudes, and self-reported practices related to Clinical Fiqh principles. Descriptive statistics were used to summarise the study variables, while exact and chi-square tests, as appropriate, were used to examine associations between sociodemographic characteristics and the study outcomes. **Results:** Most respondents were classified as having good perceived knowledge (97.8%) and positive attitudes (97.8%) toward Clinical Fiqh principles, while 75.8% were classified as having good self-reported practice. No statistically significant associations were identified between the selected sociodemographic characteristics and perceived knowledge, attitudes, or self-reported practice ($p > 0.05$). **Conclusion:** Nursing students reported high perceived knowledge and positive attitudes toward Clinical Fiqh principles, while self-reported practice showed greater variation. As perceived knowledge and practice were assessed through self-report, these findings should not be interpreted as objective measures of factual knowledge or clinical competence. The findings provide baseline information that may inform further development and evaluation of Clinical Fiqh education, particularly opportunities for experiential learning and application during clinical training.

Keywords: *Attitudes and practices, Clinical Fiqh, Islamic nursing, perceived knowledge, nursing education, nursing students.*

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Introduction

Clinical Fiqh refers to the application of Islamic jurisprudence in healthcare practice, guiding Muslim healthcare professionals in addressing religious and ethical issues that arise during patient care. It includes various aspects of clinical decision-making such as facilitation of prayer for ill patients, exemptions from fasting, gender interaction during treatment, end-of-life care, and the permissibility of certain medications during emergencies. The integration of Islamic legal and ethical principles in healthcare is important in ensuring that Muslim patients receive care that aligns with their religious values while maintaining professional clinical standards [1,2].

In recent years, the importance of spirituality and religion in healthcare has received increasing attention. Research has shown that spiritual and religious beliefs significantly influence patients' coping mechanisms, treatment decisions, and overall well-being, particularly among individuals from religious communities [3,4]. Consequently, healthcare professionals are expected to possess adequate knowledge and skills in addressing patients' spiritual needs as part of holistic patient care.

Despite the growing recognition of spiritual care in healthcare, studies have reported that nursing students often feel inadequately prepared to address patients' religious and spiritual needs in clinical settings. Limited exposure to structured training related to spiritual care and religious considerations during nursing education has been identified as a major contributing factor [5,6]. As a result, there is a need to strengthen educational approaches that equip nursing students with the competencies required to integrate spiritual and religious considerations into patient care.

The International Islamic University Malaysia (IIUM) is among the few institutions that incorporate Clinical Fiqh as a specific course within its nursing curriculum. This course aims to equip nursing students with the knowledge and ethical understanding necessary to provide Shariah-compliant healthcare and to address religious issues encountered during clinical practice [7]. However, empirical evidence evaluating nursing students' readiness to apply Clinical Fiqh principles in clinical settings remains limited.

Therefore, this study aimed to assess perceived knowledge, attitudes, and self-reported practices related to Clinical Fiqh principles among fourth-year nursing students at IIUM, Kuantan. A secondary objective was to explore associations between these outcomes and selected sociodemographic characteristics. Given the exploratory nature of the study and the anticipated homogeneity of the sample, the study was designed primarily as a descriptive assessment rather than a hypothesis-testing study.

Materials and methods

Study design and setting

This study employed a cross-sectional design to assess perceived knowledge, attitudes, and self-reported practices related to Clinical Fiqh principles among nursing students. Cross-sectional surveys are commonly used in healthcare education research to examine characteristics and outcomes within a defined population at a specific point in time [8]. The study was conducted at the Kulliyyah of Nursing, International Islamic University Malaysia (IIUM), Kuantan Campus, where Clinical Fiqh is incorporated into the nursing curriculum as part of Islamic-integrated healthcare education.

Study population and sampling

The study population comprised 105 fourth-year undergraduate nursing students from Intake 211, academic session 2024/2025, at IIUM Kuantan who had enrolled in the Clinical Fiqh in Nursing course. Students absent or on academic leave during the data-collection period were excluded. The target sample size was 91 students, including an additional 10% allowance for non-response. Of the 105 students in the cohort, 91 consented and submitted complete questionnaires (86.7% of the cohort), resulting in a final analytical sample of 91 participants with no incomplete questionnaires.

Research instrument

The researcher-developed questionnaire was administered online through Google Forms with a participant information sheet, and consent form. Eligible participants were invited after ethical and institutional approval. Participation was voluntary, and responses were kept confidential. The instrument comprised of four sections and was based on Clinical Fiqh course content and relevant literature [1,2,9].

Section A collected sociodemographic information, including age, gender, prior Islamic educational background, and Clinical Fiqh examination results. Section B consisted of 11 items assessing respondents' self-reported knowledge of Clinical Fiqh principles. Rather than using objectively scored right-or-wrong questions, respondents rated their perceived level of knowledge across several Clinical Fiqh domains using a five-point scale ranging from very poor to very good. The items covered the application of Clinical Fiqh in nursing practice, ablution and dry ablution for sick patients, fasting exemptions, prayer modifications, medication permissibility and halal alternatives, abortion, end-of-life care, euthanasia, Hajj-related rulings, and spirituality in healthcare. For example, respondents rated their knowledge regarding Islamic rulings on ablution (wudu') and dry ablution (tayammum) for sick patients and prayer modifications for hospitalized or bedridden patients. The 11 items produced a total score ranging from 11 to 55, classified as good (41–55), moderate (26–40), or poor (11–25).

Section C comprised 10 items assessing attitudes toward the application of Clinical Fiqh in nursing practice. Items evaluated respondents' perceptions of the importance and relevance of incorporating Islamic principles into patient care. Responses were rated on a five-point agreement scale, yielding total scores ranging from 10 to 50. Attitude was classified as positive [37–50], neutral [24–36], or negative [10–23].

Section D contained 11 items assessing self-reported practices related to Clinical Fiqh principles during clinical training. Respondents reported how frequently they engaged in behaviours such as facilitating religious practices, considering Islamic guidance in patient care, seeking appropriate guidance when encountering Clinical Fiqh-related issues, and providing spiritual support. Responses were rated on a five-point frequency scale ranging from never to always. Thus, this domain measured students' reported frequency of practice rather than directly observed clinical behaviour or competence. Self-reported practice scores were classified as good [41–55], moderate [26–40], or poor [11–25].

Domain scoring

Total scores were divided into researcher-defined descriptive categories: Perceived knowledge and self-reported practice were classified as good (41-55), moderate (26-40), and poor (11-25); attitude was classified as positive (37–50), neutral (24–36), or negative (10–23. These cutoffs have not been externally validated and should not be interpreted as thresholds of factual knowledge, favourable clinical conduct, or competence.

Validity and reliability

Experts, including nursing educators familiar with Clinical Fiqh, reviewed the draft questionnaire for content relevance, coverage, and wording. Items were revised after their feedback. No item-level content validity index (I-CVI) and scale-level content validity index (S-CVI) were calculated. Eleven nursing students from the preceding cohort (Intake 201), who were excluded from the main analysis, piloted the questionnaire and provided feedback on unclear wording. Cronbach's alpha was 0.907 for perceived knowledge , 0.906 for attitude, and 0.860 for self-reported practice, indicating good to excellent internal consistency for that data set. Cronbach's alpha was used as an indicator of internal consistency, and it does not establish content validity, construct validity, or clinical competence. The questionnaire was administered in English without translation.

Data collection procedure

The questionnaire was distributed online, after permission from the relevant academic authorities. Participants were received study information and gave informed consent before completing the questionnaire. All 91 submitted questionnaires were complete and analysed.

Data analysis

Data were analysed using SPSS. Descriptive statistics, including frequencies and percentages, were used to summarise sociodemographic characteristics and the categorical levels of perceived knowledge, attitude, and self-reported practice. Given the exploratory nature of the study and the anticipated homogeneity of the sample, association analyses were considered secondary and exploratory. Associations between sociodemographic variables and categorical outcome levels were examined using Pearson's chi-square test when the expected-cell frequency assumptions were satisfied. Fisher's Exact Test was used for sparse 2 × 2 contingency tables, while the Fisher–Freeman–Halton Exact Test with the Monte Carlo method was used for larger contingency tables with sparse expected cell frequencies. Statistical significance was set at $p < 0.05$. However, it is important to note that the high homogeneity of the sample (with 97.8% of respondents classified as having good knowledge and positive attitudes) resulted in sparse contingency-table cells and limited statistical power to detect associations. Therefore, the absence of statistically significant findings should not be interpreted as evidence that no association exists.

Ethical considerations

Ethical approval for this study was obtained from the International Islamic University Malaysia Research Ethics Committee (IREC) with approval number IREC 2024 (UG)-037. All participants were informed about the objectives of the study and provided informed consent prior to participation. Confidentiality and anonymity of the respondents were strictly maintained throughout the study in accordance with ethical guidelines for research involving human participants [13].

Results

Sociodemographic characteristics of respondents

A total of 91 fourth-year nursing students participated in this study. As shown in Table 1, the majority of respondents were aged 22–24 years (92.3%, n = 84), while 7 students (7.7%) were older than 24 years. In terms of gender distribution, female students constituted the majority of the respondents (89.0%, n = 81), whereas male students accounted for 11.0% (n = 10). Regarding prior Islamic education background, nearly half of the respondents had previous Islamic educational experience (49.5%, n = 45) such as attendance at madrasah, tahfiz institutions, or Sekolah Menengah Kebangsaan Agama (SMKA). Slightly more than half of the respondents did not have prior Islamic educational background (50.5%, n = 46). With respect to the Clinical Fiqh examination results, the majority of students achieved excellent grades (A or A−) (90.1%, n = 82), while 9 students (9.9%) obtained good grades (B+, B, B−). None of the respondents obtained fair, poor, or failing grades in the Clinical Fiqh examination.

Levels of perceived knowledge, attitudes, and self-reported practice of clinical Fiqh principles

The levels of perceived knowledge, attitudes, and self-reported practice related to Clinical Fiqh principles among the respondents are presented in Table 2. Overall, most respondents were classified as having good perceived knowledge and positive attitudes, while self-reported practice showed greater variation.

In terms of perceived knowledge, 89 respondents (97.8%) were classified as having good perceived knowledge, while 2 respondents (2.2%) were classified as having moderate perceived knowledge. None were classified as having poor

perceived knowledge. These findings reflect respondents' self-assessment of their knowledge of Clinical Fiqh principles rather than objectively tested factual knowledge.

Regarding attitude, 89 students (97.8%) were classified as having a positive attitude, while one student (1.1%) had a neutral attitude and one (1.1%) had a negative attitude toward Clinical Fiqh principles.

Regarding the self-reported practice of Clinical Fiqh principles in clinical settings, 69 respondents (75.8%) reported good practice in applying these principles during clinical training, while 22 respondents (24.2%) were classified as having moderate self-reported practice. None of the respondents were categorised as having poor practice. These results indicate that although perceived knowledge and attitudes toward Clinical Fiqh are generally strong among nursing students, the reported application of these principles in clinical settings is comparatively lower. This difference may suggest a potential knowledge-practice gap.

Association between sociodemographic factors and KAP levels

The association between sociodemographic characteristics and the levels of knowledge, attitudes, and self-reported practice related to Clinical Fiqh principles among the respondents is presented in Table 3. The analysis showed that there were no statistically significant associations between age, gender, prior Islamic education background, and Clinical Fiqh examination results with the levels of knowledge, attitudes, and self-reported practice among the respondents ($p > 0.05$). However, given the high homogeneity of the sample—with 97.8% of respondents classified as having good knowledge and positive attitudes—these analyses were limited by restricted variability and sparse contingency-table cells. Therefore, the findings should be interpreted as exploratory and underpowered.

Discussion

The present study examined perceived knowledge, attitudes, and self-reported practice related to Clinical Fiqh principles among final-year nursing students at the International Islamic University Malaysia. Most respondents reported high perceived knowledge and positive attitudes toward Clinical Fiqh, while self-reported practice showed greater variation.

The high level of perceived knowledge indicates that most respondents considered themselves knowledgeable about Clinical Fiqh principles. However, because the knowledge domain was based on self-assessment rather than objectively scored factual questions, these findings should not be interpreted as demonstrating actual knowledge or theoretical competence. Notably, all participants had completed the Clinical Fiqh course, and 90.1% achieved excellent examination grades. While this educational background provides relevant context for interpreting the findings, the cross-sectional design does not permit conclusions regarding whether the Clinical Fiqh curriculum produced the observed outcomes. Nevertheless, knowledge of Islamic ethical and jurisprudential principles is important in preparing healthcare professionals to recognise and appropriately respond to religious and ethical considerations encountered in clinical practice [14]. Previous literature has also highlighted the importance of educational preparation in developing healthcare professionals' competence in providing culturally and religiously sensitive care [15].

Similarly, the findings of this study demonstrated that nursing students generally possess positive attitudes toward the importance of Clinical Fiqh in nursing practice. Positive attitudes among healthcare students are crucial because attitudes influence the willingness of healthcare professionals to incorporate spiritual and religious considerations into patient care. Studies on spiritual care education have reported that nursing students who receive training in spirituality and ethics tend to develop more

positive perceptions toward addressing patients' religious needs in clinical settings [16,17]. This suggests that integrating Clinical Fiqh within nursing education may foster greater sensitivity toward patients' religious beliefs and practices.

Although perceived knowledge and attitudes toward Clinical Fiqh were highly favourable, self-reported practice showed greater variation, with 75.8% of respondents classified as having good self-reported practice and 24.2% classified as moderate. This difference may suggest that students do not report applying Clinical Fiqh principles as consistently in clinical settings as their perceived knowledge and favourable attitudes might imply. However, the practice domain measured students' own reports of how frequently they engaged in Clinical Fiqh-related behaviours during clinical training. It did not involve direct observation, supervisor assessment, or other objective measures of clinical performance. Therefore, the findings should be interpreted as reflecting reported application of Clinical Fiqh principles rather than demonstrated clinical competence.

Several contextual factors may potentially contribute to this gap. Clinical workload and time constraints may reduce opportunities for students to attend to spiritual and religious needs alongside immediate clinical priorities [18]. Students may also require greater confidence, practical guidance, and role modelling when applying religious principles to situations such as facilitating worship for ill patients, maintaining appropriate gender interaction, or responding to religious concerns arising during care. Previous literature has highlighted the importance of clinical mentorship and experiential learning in translating spiritual-care knowledge into practice [19,23]. Within the Malaysian healthcare context, the Hospital Mesra Ibadah (HMI) initiative provides an institutional framework for integrating patients' spiritual and religious needs into hospital care. The Ministry of Health Malaysia identifies the provision of an ibadah-friendly environment and enhancement of healthcare personnel's knowledge and skills concerning patients' Islamic beliefs and practices as key components of HMI [24]. Nevertheless, students' exposure to and opportunities to apply these principles may vary across clinical placements. These contextual factors were not directly measured in the present study and should therefore be regarded as possible explanations rather than established determinants of the observed practice gap.

The present study found no statistically significant associations between sociodemographic characteristics and the levels of knowledge, attitudes, or self-reported practice related to Clinical Fiqh. However, these findings should be interpreted cautiously. Knowledge and attitude scores were highly concentrated, with 97.8% of respondents classified as having good knowledge and the same proportion demonstrating positive attitudes. Such limited variability results in sparse contingency-table cells and reduces the ability of inferential analyses to detect meaningful associations between variables. Therefore, the absence of statistically significant associations should not necessarily be interpreted as evidence that sociodemographic factors are unrelated to perceived knowledge, attitudes, or self-reported practices. Studies involving larger and more heterogeneous samples are needed to examine these relationships more robustly. Previous studies on spiritual care education have similarly reported that structured educational programmes can standardize students' competencies in addressing spiritual and religious aspects of care [20].

Overall, the findings of this study highlight the importance of integrating Clinical Fiqh education within nursing curricula, particularly in institutions that aim to provide Islamic-integrated healthcare education. Strengthening the practical components of Clinical Fiqh training during clinical placements may further enhance students' ability to apply these principles in real healthcare settings.

Implications for nursing education and practice

The findings of this study have several implications for nursing education and clinical practice. The high levels of perceived knowledge and positive attitudes indicate that respondents generally considered themselves familiar with and receptive to the religious and ethical principles addressed within Clinical Fiqh. Although the present cross-sectional study was not designed to evaluate curriculum effectiveness, these findings support continued attention to religious and spiritual dimensions within nursing education. Integrating such dimensions into healthcare education may contribute to the development of holistic and culturally sensitive care [21]. Future studies should incorporate objective knowledge assessments and observational, scenario-based, or supervisor-rated measures of Clinical Fiqh practice and competence.

The greater variation in self-reported practice suggests that further opportunities for experiential learning may be beneficial. Educational strategies such as case-based learning, simulation, and reflective practice may provide students with opportunities to apply Clinical Fiqh principles to realistic clinical scenarios. These approaches allow students to explore real-life ethical dilemmas and apply religious principles in healthcare decision-making [22].

Furthermore, clinical instructors and healthcare institutions play an essential role in facilitating the practical application of Clinical Fiqh principles during clinical placements. Supportive clinical mentorship and role modelling by experienced healthcare professionals can significantly influence students' confidence and competence in implementing spiritually sensitive care [23]. Strengthening collaboration between nursing educators and clinical mentors may therefore help bridge the gap between theoretical learning and clinical practice.

Limitations of the study

This study has several limitations. First, the study was conducted at a single institution and involved a relatively small sample of 91 final-year nursing students; therefore, the findings may not be generalisable to nursing students from other institutions or educational settings. Second, the study relied on self-reported responses, particularly for the practice domain, which may be subject to recall and social desirability biases and may not fully reflect students' actual application of Clinical Fiqh principles in clinical settings. Third, the knowledge domain assessed students' self-reported level of knowledge rather than objectively testing Clinical Fiqh knowledge using right-or-wrong questions. Consequently, the high proportion of respondents classified as having good knowledge should be interpreted as reflecting perceived knowledge rather than objectively demonstrated competence. Fourth, formal content validity indices (I-CVI, S-CVI) were not calculated during instrument development, and the classification thresholds were study-specific and not externally validated. Future studies should incorporate objective knowledge assessments and observational, scenario-based, or supervisor-rated measures of Clinical Fiqh practice and competence.

In addition, the distributions of knowledge and attitude were highly homogeneous, with 97.8% of respondents classified as having good knowledge and 97.8% demonstrating positive attitudes. The limited variability resulted in sparse contingency-table cells and reduced the ability of inferential analyses to detect potential associations between sociodemographic characteristics and KAP levels. Therefore, the absence of statistically significant associations should be interpreted cautiously. Finally, the cross-sectional design provides information at a single point in time and does not allow causal conclusions regarding the effects or effectiveness of Clinical Fiqh education.

Conclusion

This study assessed perceived knowledge, attitudes, and self-reported practice related to Clinical Fiqh principles among final-year nursing students at the International Islamic University Malaysia, Kuantan. Most respondents reported high perceived knowledge and positive attitudes toward Clinical Fiqh, while the proportion classified as having good self-reported practice was comparatively lower. These findings suggest that students generally perceived themselves as knowledgeable about Clinical Fiqh and expressed favourable attitudes toward its relevance to nursing care, although their reported application of these principles during clinical training was less consistent.

The difference between perceived knowledge and attitudes and self-reported practice highlights the importance of providing opportunities for students to strengthen the application of Clinical Fiqh principles in clinical contexts. Experiential learning, case-based discussions, simulation, and appropriate clinical mentorship may be considered to support the integration of these principles during nursing education.

Overall, the findings provide useful baseline information regarding perceived knowledge, attitudes, and self-reported practice related to Clinical Fiqh among nursing students in an Islamic-integrated nursing programme. However, this study should be considered exploratory and descriptive in nature. Perceived knowledge should not be interpreted as objectively demonstrated knowledge, and self-reported practice does not represent directly observed clinical behaviour or competence. Furthermore, the findings should not be interpreted as evidence of curriculum effectiveness because the cross-sectional design was not intended to establish the effects of Clinical Fiqh education. Future multicentre studies involving larger and more diverse samples are recommended. Future research should also incorporate objective knowledge assessments and observational or supervisor-rated measures of practice, while longitudinal, comparative, or pre–post intervention designs may be used to evaluate changes associated with Clinical Fiqh education. Additionally, future instrument development should include formal content validity assessment and, where possible, validation against objective performance measures.

Conflicts of interest

The authors declare that there is no conflict of interest.

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Authors' contributions

FTA contributed to the conceptualization of the study, data collection, data analysis, and manuscript drafting. MFMI supervised the research project, contributed to the study design, and critically reviewed and revised the manuscript. SZS contributed to the research methodology, data interpretation, and manuscript revision. All authors read and approved the final version of the manuscript.

Table 1. Sociodemographic Characteristics of Respondents (n = 91)

Variable	Category	Frequency (n)	Percentage (%)
Age (years)	22–24	84	92.3
	>24	7	7.7
Gender	Male	10	11.0
	Female	81	89.0
Prior Islamic Education Background (e.g., Madrasah, Tahfiz, SMKA)	Yes	45	49.5
	No	46	50.5
Result of Clinical Fiqh Examination	Excellent (A, A−)	82	90.1
	Good (B+, B, B−)	9	9.9
	Fair (C+, C)	0	0.0
	Poor (D, D−)	0	0.0
	Fail (E, F)	0	0.0

Table 2. Researcher-defined Categories of Perceived Knowledge, Attitudes, and Self-Reported Practices (KAP) of Clinical Fiqh (n = 91)

Variable	Category	Frequency (n)	Percentage (%)
Knowledge	Good	89	97.8
	Moderate	2	2.2
	Poor	0	0.0
Attitude	Positive	89	97.8
	Neutral	1	1.1
	Negative	1	1.1
Practice	Good	69	75.8
	Moderate	22	24.2
	Poor	0	0.0

Table 3. Associations between sociodemographic characteristics and Clinical Fiqh outcomes (n = 91)

A. Self-reported knowledge

Sociodemographic variable	Good, n (%)	Moderate, n (%)	p-value	Statistical test
Age (years)			**0.149**	Fisher's Exact Test
22–24	83 (98.8)	1 (1.2)		
>24	6 (85.7)	1 (14.3)		
Gender			**1.000**	Fisher's Exact Test
Male	10 (100.0)	0 (0.0)		
Female	79 (97.5)	2 (2.5)		
Prior Islamic education			**1.000**	Fisher's Exact Test
Yes	44 (97.8)	1 (2.2)		
No	45 (97.8)	1 (2.2)		
Clinical Fiqh examination result			**0.189**	Fisher's Exact Test
Excellent (A, A−)	81 (98.8)	1 (1.2)		
Good (B+, B, B−)	8 (88.9)	1 (11.1)		

B. Attitude

Sociodemographic variable	Positive, n (%)	Neutral, n (%)	Negative, n (%)	p-value	Statistical test
Age (years)				**1.000**	Fisher–Freeman–Halton Exact Test
22–24	82 (97.6)	1 (1.2)	1 (1.2)		
>24	7 (100.0)	0 (0.0)	0 (0.0)		
Gender				**1.000**	Fisher–Freeman–Halton Exact Test
Male	10 (100.0)	0 (0.0)	0 (0.0)		
Female	79 (97.5)	1 (1.2)	1 (1.2)		
Prior Islamic education				**1.000**	Fisher–Freeman–Halton Exact Test
Yes	44 (97.8)	1 (2.2)	0 (0.0)		
No	45 (97.8)	0 (0.0)	1 (2.2)		
Clinical Fiqh examination result				**0.185**	Fisher–Freeman–Halton Exact Test
Excellent (A, A−)	81 (98.8)	0 (0.0)	1 (1.2)		
Good (B+, B, B−)	8 (88.9)	1 (11.1)	0 (0.0)		

C. Self-reported practice

Sociodemographic variable	Good, n (%)	Moderate, n (%)	p-value	Statistical test
Age (years)			**0.353**	Fisher's Exact Test
22–24	65 (77.4)	19 (22.6)		
>24	4 (57.1)	3 (42.9)		
Gender			**1.000**	Fisher's Exact Test
Male	8 (80.0)	2 (20.0)		
Female	61 (75.3)	20 (24.7)		
Prior Islamic education			**0.667**	Pearson's χ^2 test
Yes	35 (77.8)	10 (22.2)		
No	34 (73.9)	12 (26.1)		
Clinical Fiqh examination result			**1.000**	Fisher's Exact Test
Excellent (A, A−)	62 (75.6)	20 (24.4)		
Good (B+, B, B−)	7 (77.8)	2 (22.2)		

Note: Values are presented as n (% within sociodemographic subgroup). Fisher's Exact Test was used for sparse 2 × 2 contingency tables. The Fisher–Freeman–Halton Exact Test with the Monte Carlo method was used for sparse R × C attitude tables. Pearson's chi-square test was used when expected-cell frequency assumptions were satisfied. Statistical significance was set at $p < 0.05$. No respondents were classified as having poor self-reported knowledge or poor self-reported practice. Given the homogeneity of the sample and the resulting sparse cells, these analyses should be considered exploratory and underpowered; non-significant findings should not be interpreted as evidence of no association.

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Clinical Fiqh Knowledge, Attitudes, and Practices Questionnaire

Questionnaire used in the study of final-year nursing students

Administration note. The questionnaire was administered in English. The wording and response options below reproduce the questionnaire contained in the study dissertation appendix. The knowledge domain represents self-reported/perceived knowledge rather than an objectively scored factual knowledge test, and the practice domain represents self-reported frequency of practice rather than observed clinical competence.

Part 1. Demographic Background

Age: ☐ 22–24 ☐ >24

Gender: ☐ Male ☐ Female

Prior Islamic education background (Madrasah, tahfiz, SMKA, etc.): ☐ Yes ☐ No

Result of Clinical Fiqh examination: ☐ A ☐ A− ☐ B+ ☐ B ☐ B− ☐ C+ ☐ C ☐ D ☐ D− ☐ E ☐ F

Part 2. Nursing Students' Knowledge About Clinical Fiqh Principles

Response options: Very good | Good | Fair | Poor | Very poor

No.	Item	Very good	Good	Fair	Poor	Very poor
1	I have a clear understanding of Clinical Fiqh principles and their applications in nursing practice.	☐	☐	☐	☐	☐
2	Islamic rulings regarding ablution (wudu') and dry ablution (tayammum) for sick patients.	☐	☐	☐	☐	☐
3	Islamic guidelines on fasting exemptions for patients during Ramadhan.	☐	☐	☐	☐	☐
4	Rulings on prayer (salah) modifications for hospitalized or bedridden patients.	☐	☐	☐	☐	☐
5	Islamic rulings on the permissibility of Haram medications (e.g., alcohol-based drugs, porcine-derived ingredients) in emergencies.	☐	☐	☐	☐	☐
6	Availability of halal alternatives to commonly used Haram medications.	☐	☐	☐	☐	☐
7	Islamic perspective on abortion under different medical conditions.	☐	☐	☐	☐	☐
8	End-of-life care in Islam, including withdrawal of treatment and Do Not Resuscitate (DNR) orders.	☐	☐	☐	☐	☐

No.	Item	Very good	Good	Fair	Poor	Very poor
9	Islamic view on euthanasia (mercy killing) and assisted suicide.	☐	☐	☐	☐	☐
10	Fiqh rulings on performing Hajj for patients with chronic illness or severe conditions.	☐	☐	☐	☐	☐
11	Role of spirituality in healthcare and patient care from an Islamic perspective.	☐	☐	☐	☐	☐

Scoring used in the original study: Items were scored from 1 (Very poor) to 5 (Very good), yielding a possible total score of 11–55. Study-defined categories were 41–55 = Good, 26–40 = Moderate, and 11–25 = Poor. These categories were not derived from an externally validated classification system.

Part 3. Nursing Students' Attitudes Toward Clinical Fiqh Principles

Response options: Strongly disagree | Disagree | Neutral | Agree | Strongly agree

No.	Item	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
1	Understanding Clinical Fiqh is essential for providing ethical nursing care.	☐	☐	☐	☐	☐
2	Nurses should respect and facilitate ablution (wudu) and prayer for Muslim patients.	☐	☐	☐	☐	☐
3	Patients should be provided guidance on fasting exemptions based on Islamic rulings.	☐	☐	☐	☐	☐
4	It is important to consider Islamic rulings when making decisions about end-of-life care.	☐	☐	☐	☐	☐
5	I feel confident and adequately trained to discuss Islamic medical ethics with patients and colleagues.	☐	☐	☐	☐	☐
6	Providing halal alternatives to Haram medications is important in healthcare.	☐	☐	☐	☐	☐
7	Euthanasia and assisted suicide should not be supported in medical practice from an Islamic perspective.	☐	☐	☐	☐	☐
8	Spiritual care should be integrated into routine nursing care to improve patient well-being.	☐	☐	☐	☐	☐
9	Patients who intend to perform Hajj should receive guidance on Islamic rulings for medical exemptions.	☐	☐	☐	☐	☐
10	I believe that integrating Clinical Fiqh principles into undergraduate nursing education will enhance patient care.	☐	☐	☐	☐	☐

Scoring used in the original study: Items were scored from 1 (Strongly disagree) to 5 (Strongly agree), yielding a possible total score of 10–50. Study-defined categories were 37–50 = Positive attitude, 24–36 = Neutral attitude, and 10–23 = Negative attitude.

Part 4. Nursing Students' Practices in Clinical Fiqh Principles

Response options: Never | Rarely | Sometimes | Often | Always

No.	Item	Never	Rarely	Sometimes	Often	Always
1	I ensure that Muslim patients can perform ablution and prayer when admitted.	☐	☐	☐	☐	☐
2	I discuss fasting exemptions with patients during Ramadhan.	☐	☐	☐	☐	☐
3	I follow Islamic guidelines on gender interaction while maintaining professional nursing care standards.	☐	☐	☐	☐	☐
4	I seek guidance from religious advisors or trained Islamic healthcare ethics consultants when faced with Clinical Fiqh dilemmas.	☐	☐	☐	☐	☐
5	I educate patients and their families about Islamic rulings on medical treatment when relevant.	☐	☐	☐	☐	☐
6	I provide or recommend halal alternatives to Haram medications when possible.	☐	☐	☐	☐	☐
7	I advocate for hospitals to stock halal-certified medications for Muslim patients.	☐	☐	☐	☐	☐
8	I support patients in end-of-life care decisions in accordance with Islamic principles.	☐	☐	☐	☐	☐
9	I acknowledge the role of spirituality in patient care and provide spiritual support when needed	☐	☐	☐	☐	☐
10	I help patients understand Islamic rulings on Hajj exemption due to illness.	☐	☐	☐	☐	☐
11	I apply Clinical Fiqh principles in my daily nursing practice.	☐	☐	☐	☐	☐

Scoring used in the original study: Items were scored from 1 (Never) to 5 (Always), yielding a possible total score of 11–55. Study-defined categories were 41–55 = Good, 26–40 = Moderate, and 11–25 = Poor.

Interpretive note. The knowledge responses are self-ratings of perceived knowledge and should not be interpreted as objectively demonstrated factual knowledge. Practice responses are self-reported frequencies and should not be interpreted as directly observed clinical performance or competence.