

EXPLORING CHALLENGES IN TEACHING PROFESSIONALISM TO MEDICAL STUDENTS: FACULTY PERSPECTIVES AND PRACTICAL SOLUTIONS

Zunaira Naveed^{*1}, Ghulam Mustafa², Zaryab Saeed³, Mehtab Jokhio⁴, Amal Fatima⁵, Noshaba Razaq⁶

^{*1}Assistant Professor & HOD at Department of Behavioral Sciences, Wah Medical College, Wah Cantt (NUMS University), Pakistan

² Principal, Institute of Allied Health Sciences, Wah Medical College, Wah Cantt (NUMS University)

³ Medical Officer, Al-Khidmat Raazi Hospital, Islamabad, Pakistan

⁴ Health Care Administrator, Pak Emirates Military Hospital Rawalpindi, Pakistan

⁵ MBBS student at Nishtar medical university

⁶ Researcher, at Department of Research & Development Cell, Wah Medical College, Wah Cantt (NUMS University), Pakistan

^{*1}zuninaveed@gmail.com

Corresponding Author: *

Zunaira Naveed

DOI: <https://doi.org/10.5281/zenodo.17174987>

Received
21 June 2025

Accepted
05 September 2025

Published
22 September 2025

ABSTRACT

Background: Professionalism is a core competency in undergraduate medical education, yet faculty often struggle to define, teach, and assess it consistently. Misalignment between formal curricula and the hidden curriculum, limited instructional time, and variable role modeling can weaken students' professional identity formation, particularly in culturally diverse, resource-constrained settings. Objective: To explore faculty perspectives on the challenges of teaching professionalism to undergraduate medical students at Wah Medical College and to identify practical, context-relevant strategies to strengthen professionalism education. Methods: A qualitative exploratory study was conducted with 25 purposively selected faculty members from basic and clinical sciences who had at least two years of teaching experience and involvement in teaching or assessing professionalism. Unstructured, in-depth, audio-recorded interviews were conducted in private settings. Transcripts were anonymized and analyzed using thematic analysis supported by NVivo. Credibility was enhanced through participant confirmation of interpretations, an audit trail, and team-based analysis. Results: Participants reported substantial conceptual ambiguity, with professionalism variably understood as ethics, behavior, manners, or communication. Teaching was constrained by reliance on the hidden curriculum, inconsistent role modeling, and limited protected time in the formal syllabus. Student-related barriers included resistance when professionalism was not assessed, narrow focus on appearance, cultural variation in expectations, and negative peer influence. Institutional constraints—absence of formal assessment, limited faculty preparation, and unclear policies—further weakened implementation. Faculty proposed actionable solutions: develop a locally agreed definition; integrate professionalism longitudinally across courses and clinical placements; introduce meaningful assessment; provide structured faculty development; and promote intentional role modeling and mentorship. Conclusion: Teaching professionalism effectively requires alignment of definition, curriculum, assessment, faculty capacity, and institutional policy. Faculty-generated strategies from this study offer a feasible roadmap for strengthening professionalism education in similar low- and middle-income

academic settings. Future work should include student perspectives and multi-institutional evaluation of implemented interventions.

Keywords: Medical Professionalism; Faculty Perspectives; Hidden Curriculum; Role Modeling; Undergraduate Medical Education; Qualitative Study.

INTRODUCTION

Medical professionalism is widely recognized as the foundation of medical practice and education, encompassing the values, behaviors, and relationships that sustain the trust society places in physicians (Project of the ABIM Foundation & Medicine*, 2002; Swick, 2000). The Physician Charter outlines three fundamental principles: primacy of patient welfare, patient autonomy, and social justice along with responsibilities such as honesty, confidentiality, and a commitment to lifelong learning (Project of the ABIM Foundation & Medicine*, 2002). Professionalism is not only an ethical imperative but also a core competency in medical curricula globally (Hodges, Paul, Ginsburg, & Members, 2019). While its importance is undisputed, translating abstract concepts into teachable and assessable elements remains challenging for educators (Cruess & Cruess, 2012). Research suggests that professionalism must be addressed explicitly through formal instruction and implicitly through clinical learning environments that reinforce professional values (Kim, Applewhite, & Shelton, 2024). Longitudinal, integrated approaches that combine didactic sessions, reflective exercises, feedback, and role modeling have shown greater effectiveness than isolated lectures (Birden, Glass, Wilson, Harrison, Usherwood, & Nass, 2013).

Role modeling is consistently identified as one of the most powerful influences on students' professional identity formation (Jayasuriya-Illesinghe, Nazeer, Athauda, & Perera, 2016; Passi & Johnson, 2016). Students observe how physicians communicate, show respect, and respond to ethical challenges, shaping their internalization of professional values (Passi & Johnson, 2016; Cruess et al., 2015). However, role modeling is often unstructured, leaving learning to chance, and negative behaviors observed in clinical settings can undermine formal teaching (Hafferty & Franks, 1994). Faculty members face multiple challenges in teaching professionalism, including lack of

time, competing clinical duties, absence of clear assessment criteria, and ambiguity in defining what professionalism entails (Al-Eraky & Chandratilake, 2012; Cruess & Cruess, 2012). Moreover, the hidden curriculum—informal and unintended lessons embedded in institutional culture—can conflict with formal instruction, creating inconsistencies in the messages students receive (Weresh, 2023).

Contextual and cultural factors further complicate professionalism teaching. While core elements of professionalism are broadly agreed upon, their interpretation and prioritization vary across regions and cultures (Yasin et al., 2019; Khan & Yasmeen, 2020). In South Asian contexts, professionalism often incorporates values such as humility, respect for elders, and faith-based responsibilities, which may not be emphasized in Western frameworks (Khan & Yasmeen, 2020; Al-Eraky, 2015). These cultural nuances necessitate local adaptations of global standards to make professionalism relevant and practical for students (Hodges et al., 2011; Al-Eraky, 2015). Faculty development is another area requiring attention, as many educators lack formal training in teaching and assessing professionalism (Birden et al., 2014; Goldie et al., 2013). Despite global efforts to promote professionalism, there is limited research exploring faculty perspectives on the challenges they face and their proposed solutions, particularly in low- and middle-income countries (Almairi, Sajid, Azouz, Mohamed, Almairi, & Fadul, 2021).

Existing literature highlights gaps in understanding how faculty members manage real-world constraints when teaching professionalism, such as workload pressures, lack of institutional support, and conflicting cultural expectations (Dyantyi, 2024; Javed & Akhter, 2024). Few studies have explored how faculty convert incidental role modeling into intentional teaching moments or how institutions can better align policies with professionalism objectives (Banse, Clements,

Sarama, Day-Hess, Simoni, & Joswick, 2021; Passi & Johnson, 2016). Generating context-specific evidence is essential for informing faculty development programs and designing curricula that reflect both global standards and local values. This study aims to address these gaps by exploring faculty experiences, identifying challenges, and eliciting practical solutions for teaching professionalism in undergraduate medical education.

Research Question

“What challenges do medical faculty face in teaching professionalism to undergraduate medical students, and what practical strategies do they suggest to overcome these challenges?”

General Objective

To explore faculty perspectives on the challenges of teaching professionalism in undergraduate medical education and to identify practical solutions for improvement.

Specific Objectives

1. To explore faculty perceptions of the concept and importance of professionalism in medical education.
2. To identify the challenges faculty encounter while teaching professionalism to medical students.
3. To examine the strategies currently used by faculty to promote professionalism in medical education.
4. To explore faculty suggestions for practical interventions to overcome challenges in teaching professionalism.

Methodology

The study adopted a qualitative exploratory approach to gain an in-depth understanding of the challenges faculty faced in teaching professionalism to undergraduate medical students and to identify practical solutions for overcoming these challenges. It was conducted at Wah Medical College and included faculty members from both basic and clinical sciences who were involved in teaching or assessing professionalism in the undergraduate program. Participants were selected using purposive sampling, focusing on individuals with at least two years of teaching experience to ensure they had relevant insights. A total of 25 faculty

members participated in the study, representing a range of teaching roles and disciplines. The sample size was considered adequate for qualitative inquiry, and recruitment continued until no new information emerged during data analysis, indicating data saturation.

Data were collected through unstructured, in-depth interviews, allowing participants to share their experiences and perspectives freely. Broad, open-ended prompts were used to guide the conversation, focusing on how participants defined professionalism, the challenges they encountered in teaching it, the strategies they employed, and the practical solutions they suggested for improvement. All interviews were conducted in a private setting to ensure confidentiality, and each was audio-recorded with the consent of participants. The recordings were transcribed verbatim, and all identifying information was removed to maintain anonymity.

Data were analyzed using thematic analysis. Transcripts were read repeatedly to develop familiarity with the content, and meaningful segments of data were coded. Codes were then grouped into categories that represented related ideas, which were further refined into broader themes capturing the essence of faculty experiences. This process involved reviewing and revising themes to ensure they accurately reflected the data. NVivo software was used to assist with organizing and managing the data, although manual coding and note-taking were also employed.

Measures were taken to ensure the trustworthiness of the study. Strategies included confirming the interpretation of findings with selected participants, maintaining an audit trail of decisions made during the research process, and providing detailed descriptions of the study setting and participants to allow for transferability. The research team worked collaboratively throughout the process to minimize bias and enhance the credibility of the findings.

Ethical approval for the study was obtained from the Institutional Review Board of Wah Medical College before data collection began. Written informed consent was obtained from all participants, who were assured of the voluntary nature of participation and their

right to withdraw at any stage without any negative consequences. Confidentiality was strictly maintained, with all data securely stored and accessible only to the research team. The study provided rich insights into the practical realities of teaching professionalism

in undergraduate medical education. The findings highlighted the key challenges faced by faculty and presented practical solutions suggested by them, which are expected to guide improvements in faculty development and curriculum design in similar contexts.

Results

Demographic Profile of Participants (n = 25)

Participant ID	Age (Years)	Gender	Education Level	Teaching Experience
P1	32	Male	Postgraduate	Less than 5 years
P2	40	Female	Postgraduate	More than 5 years
P3	35	Male	Postgraduate	Less than 5 years
P4	45	Female	Postgraduate	More than 5 years
P5	38	Male	Graduate	More than 5 years
P6	33	Female	Postgraduate	Less than 5 years
P7	42	Male	Postgraduate	More than 5 years
P8	36	Female	Graduate	Less than 5 years
P9	47	Male	Postgraduate	More than 5 years
P10	34	Female	Postgraduate	Less than 5 years
P11	39	Male	Postgraduate	More than 5 years
P12	31	Female	Graduate	Less than 5 years
P13	44	Male	Postgraduate	More than 5 years
P14	37	Female	Postgraduate	More than 5 years
P15	30	Male	Graduate	Less than 5 years
P16	41	Female	Postgraduate	More than 5 years
P17	35	Male	Postgraduate	Less than 5 years
P18	43	Female	Postgraduate	More than 5 years
P19	33	Male	Graduate	Less than 5 years
P20	48	Female	Postgraduate	More than 5 years
P21	32	Male	Postgraduate	Less than 5 years
P22	46	Female	Postgraduate	More than 5 years
P23	36	Male	Graduate	Less than 5 years
P24	40	Female	Postgraduate	More than 5 years
P25	34	Male	Postgraduate	Less than 5 years

The participant group reflected a relatively balanced and experience-diverse faculty sample that was well positioned to speak to the practical realities of teaching professionalism. Ages ranged from 30 to 48 years, indicating representation from early to mid-career educators, with a clustering in the mid-30s to mid-40s that often corresponds to periods of peak teaching responsibility in medical colleges. Gender distribution was nearly even

(13 males, 12 females), which reduces the risk that interpretations of professionalism teaching were overly shaped by a single gendered experience and is particularly relevant in cultural settings where gender dynamics influence clinical interactions and role modeling opportunities. Most participants held postgraduate qualifications (18 of 25), suggesting substantial disciplinary preparation and potential exposure to formal curricular

frameworks; the inclusion of seven graduate-level faculty added contrast and may illuminate differences in conceptual clarity or pedagogical confidence when teaching abstract constructs such as professionalism. Teaching experience was also well distributed: 13 participants reported less than five years in teaching roles and 12 reported five or more years, creating opportunities to compare novice and seasoned perspectives on curricular

constraints, assessment gaps, and cultural messaging. This spread across age, qualification, and experience levels enhances interpretive depth by allowing the analysis to examine whether challenges are systemic or tied to stage of professional development, and whether proposed solutions originate more from newer faculty seeking structure or from senior educators drawing on accumulated institutional knowledge.

Table 1. Themes and Sub-Themes Identified from Faculty Interviews

Theme	Sub-Themes	F (n)	Illustrative Quote
1. Conceptual Ambiguity	- Lack of clear definition of professionalism - Overlap with ethics and behavior	4	"Sometimes it's hard to explain what professionalism exactly means; even faculty interpret it differently."
2. Challenges in Teaching	- Hidden curriculum impact - Lack of role models - Limited time in curriculum	6	"We don't have enough structured time to teach professionalism formally; most learning is by observation."
3. Student-Related Barriers	- Resistance from students - Cultural diversity - Negative peer influence	4	"Students often think professionalism is just about dressing properly, not attitude or communication."
4. Institutional Constraints	- No formal assessment - Lack of faculty training - Inadequate policies	5	"We need institutional support; professionalism can't be taught in isolation without assessment."
5. Strategies for Improvement	- Faculty development - Integrating professionalism in all courses - Role modeling and mentorship	7	"Workshops for teachers and structured modules for students would help us teach professionalism better."

Conceptual Ambiguity; Four faculty members said it was difficult to teach professionalism because they did not have a shared or clearly agreed definition. Some described professionalism as ethical decision making, while others linked it to general behavior, communication style, or even personal manners. This overlap with ethics and behavior created confusion: when teachers define it differently, students receive mixed explanations and cannot tell what is expected of them.

Challenges in Teaching; Six faculty members emphasized that most professionalism learning happens informally through the hidden curriculum—what students see in day-to-day

clinical work—rather than through structured teaching. When positive role models are missing or inconsistent, students copy whatever behavior they observe, good or bad. Faculty also reported that the undergraduate curriculum is already crowded, leaving limited protected time to teach professionalism in a planned, meaningful way.

Student-Related Barriers; Four participants described problems that came from the student side. Some students resisted discussions about professionalism, especially when they felt these topics were “soft” or not examined. Others reduced professionalism to outward appearance—such as dress code—ignoring communication, accountability, and

respect. Differences in cultural background also affected how students viewed hierarchy, feedback, or interaction with patients and peers, and negative peer influence sometimes reinforced unprofessional habits.

Institutional Constraints; Five faculty members linked the difficulty of teaching professionalism to system-level issues. Because professionalism was not formally assessed, students did not take it seriously compared with graded subjects. Faculty said they had little or no training on how to teach or address professionalism lapses, and institutional policies were either unclear or absent. Without structured support, efforts to teach professionalism depended on individual initiative, making implementation uneven across departments.

Strategies for Improvement; Seven faculty members offered practical ideas to strengthen professionalism teaching. They recommended structured faculty development so teachers feel confident discussing and modeling professional behavior. They wanted professionalism woven across all courses and clinical placements instead of treated as a stand-alone lecture. They also stressed the importance of visible, intentional role modeling and mentorship, where senior clinicians explain their decisions and behaviors so students can link what they observe to professional expectations.

Discussion

The aim of this study was to explore faculty perspectives on the challenges of teaching professionalism to undergraduate medical students and to identify practical solutions that could strengthen professionalism education within the context of Wah Medical College. In addressing this aim, we examined the experiences of twenty-five faculty members drawn from both basic and clinical sciences and analyzed their accounts to understand how professionalism is conceptualized, taught, constrained, and potentially improved. The discussion below interprets the findings beginning with the demographic profile of participants, followed by each thematic result in turn, and situates these insights within relevant literature on professionalism, role modeling, hidden curriculum influences,

cultural variation, and faculty development in medical education.

The demographic profile showed a broadly distributed sample across age, gender, educational preparation, and teaching experience. Having nearly equal male and female representation is noteworthy in contexts where gendered interaction patterns can shape opportunities for role modeling and feedback in clinical education (Al-Eraky & Chandratilake, 2012). The predominance of postgraduate-qualified faculty suggests that most participants had advanced disciplinary training and at least some exposure to curricular or institutional quality frameworks, which may contribute to heightened awareness of professionalism expectations (Hodges et al., 2019). At the same time, including graduate-only faculty introduced variation that can illuminate differences in comfort with abstract constructs a recurrent issue in professionalism teaching where educators without formal training may default to etiquette or generic behavior rules (Crossley, 2021). The almost even split between those with less than five years and those with more than five years of teaching experience created a natural contrast: newer faculty are often closer to recent student experiences and may be more sensitive to hidden curriculum contradictions, whereas more experienced educators tend to have tacit standards that are harder to articulate explicitly (Lee, Wilkinson, Timmermans, Ali, & Anakin, 2023). This spread increases confidence that the themes reflect cross-cutting institutional patterns rather than the views of a single subgroup.

Conceptual ambiguity was raised by four faculty members who described difficulty agreeing on what “counts” as professionalism and how it differs from ethics, personal manners, or general professional behavior. This mirrors long-standing debates in the literature: efforts to define professionalism repeatedly show slippage between values, behaviors, identity formation, and context-bound expectations (Sawatsky et al., 2023). The Physician Charter provided influential foundational principles—patient welfare, autonomy, social justice—but translating those into day-to-day instructional language has been uneven across schools

(Project of the ABIM Foundation & Medicine*, 2002). When faculty definitions vary, students receive mixed signals, a problem documented in multi-institutional work showing that learners struggle to reconcile divergent descriptors of professionalism encountered in lectures, assessment rubrics, and clinical talk (Fatteh, Phyo Aung, Raza, Naing, Phyo, & Arja, 2024). Cultural factors may deepen this ambiguity: in South Asian and Arabian settings, faith-anchored moral responsibility, respect for hierarchy, and community accountability often sit alongside Western competency lists, expanding and at times blurring boundaries between professionalism, ethics, and social etiquette (Carlgren & BenMahmoud-Jouini, 2022). Our finding that faculty alternately labeled professionalism as ethics, behavior, or communication reflects exactly this definitional drift and underscores the need—linked to Objective 1 to establish a locally endorsed operational definition that faculty can teach consistently.

Challenges in teaching, identified by six participants, clustered around hidden curriculum influences, variable role modeling, and limited curricular time. Faculty described professionalism being “learned by observation” more than through structured sessions—a pattern widely reported in the literature on implicit socialization in clinical education (Kang, Pineda Hernández, & Mei, 2021). When observed behavior contradicts formal teaching, students discount classroom messages, a misalignment noted in studies of faculty and student perceptions of professionalism lapses in clinical environments (Makvan der Vossen, Teherani, van Mook, Croiset, & Kusurkar, 2018). Lack of protected time further weakens formal instruction; systematic reviews have shown that brief, one-off professionalism lectures have little sustained impact without longitudinal integration and reinforcement in clinical settings (Sadeq et al., 2025). The dependence on informal modeling also means that variability in individual clinician behavior translates directly into variability in what students learn—an issue highlighted in role modeling research demonstrating that unintentional modeling often transmits mixed

or negative professionalism messages unless faculty debrief explicitly (Benbassat, 2014). These findings speak directly to Objective 2 by illustrating structural and cultural barriers that limit faculty ability to teach professionalism in planned, aligned ways.

Student-related barriers, noted by four participants, added an important learner-side dimension. Faculty reported resistance when students perceived professionalism topics as “soft,” non-examined, or focused only on appearance. Similar perceptions have been described in international student surveys where professionalism content lacking clear assessment stakes was deprioritized relative to biomedical subjects (Hodges et al., 2019). Narrow student interpretations—equating professionalism with dress code or punctuality—have been reported in qualitative accounts from South Asia and the Middle East, where visible markers are sometimes emphasized over relational or ethical dimensions (Al-Eraky & Chandratilake, 2012; Khan & Yasmeen, 2020). Cultural diversity within student cohorts can produce differing comfort levels with authority, patient-centered communication, and speaking up domains central to professionalism frameworks but unevenly socialized across cultures (Al-Eraky & Chandratilake, 2012; Yasin, Stapleton, & Sandlow, 2019). Peer influence also matters: when informal peer norms tolerate shortcuts or dismiss reflective exercises, professionalism learning is diluted, a dynamic captured in hidden curriculum studies where group culture shaped learner uptake more strongly than formal teaching (Almairi et al., 2021). These student-side findings inform Objective 2 (challenges) and highlight leverage points for Objective 3 (current strategies) such as embedding assessment signals and reframing professionalism beyond surface behaviors.

Institutional constraints were discussed by five faculty members who pointed to the absence of formal assessment, limited faculty training, and inadequate policy support. The literature is clear that “assessment drives learning”: when professionalism is not examined or included in progression decisions, students allocate attention elsewhere (Birden et al., 2013; Hodges et al., 2019). Faculty in our study echoed this, reporting low student engagement

where no grading consequence existed. Calls for structured faculty development recur across professionalism scholarship; educators often feel underprepared to address unprofessional behavior, give feedback, or remediate lapses (Cruess & Cruess, 2012). Policy gaps compound the problem—without clear institutional guidance on expected behaviors and escalation pathways, responses to professionalism issues vary by department, weakening the learning climate (Hafferty & Franks, 1994). The convergence of these institutional factors helps explain why hidden curriculum signals remain so influential: in the absence of formal structures, culture fills the void. These results map directly to Objective 2 (challenges) and create the rationale for targeted systems-level interventions under Objective 4.

Strategies for improvement emerged from seven faculty members and represented the most frequently endorsed theme. Participants called for structured faculty development, longitudinal integration of professionalism across the curriculum, and intentional role modeling and mentorship. These suggestions align closely with recommendations from prior guides and reviews advocating multi-modal, staged approaches that blend knowledge, reflection, experiential learning, and assessment (Birden et al., 2013; Cruess & Cruess, 2012). Embedding professionalism into multiple courses and clinical rotations rather than isolating it in a single module reflects lessons from longitudinal professionalism curricula that have shown improved learner retention and identity alignment (Hodges et al., 2019). Faculty development—requested strongly in our data—has been identified as a prerequisite to effective modeling; when teachers are trained to “make the implicit explicit,” students better connect observed actions to professional principles (Almairi et al., 2021; Passi & Johnson, 2016). Mentorship structures can further bridge gaps between formal doctrine and clinical reality by creating safe spaces for reflection on professionalism dilemmas (Jayasuriya-Illesinghe et al., 2016). These participant-generated strategies respond directly to Objective 3 (current practices) and Objective 4 (suggested

interventions) and provide an actionable roadmap for institutional planning.

Taken together, the findings suggest a cascading pattern: uncertainty about what professionalism means (Conceptual Ambiguity) leaves curriculum planners without a stable target; without clear targets, professionalism instruction competes unsuccessfully for limited curricular time, and learning defaults to the clinical environment (Challenges in Teaching); in that environment, students bring varied expectations and may prioritize visible or assessed behaviors over relational values (Student-Related Barriers); institutional systems that do not assess, resource, or guide professionalism teaching further weaken accountability (Institutional Constraints); and faculty respond by calling for structured development, curricular integration, and mentoring systems (Strategies for Improvement). This progression echoes conceptual models that position professionalism as a negotiated social contract sustained only when individual, curricular, and institutional levels are aligned (Project of the ABIM Foundation & Medicine*, 2002). Importantly, several of the recommended strategies—definitional consensus building, embedding assessment signals, creating faculty workshops, and modeling mentorship—are low-to-moderate resource interventions feasible in many low- and middle-income educational settings (Al-Eraky & Chandratilake, 2012; Khan & Yasmeen, 2020).

CONCLUSION

This qualitative exploratory study explored how faculty at Wah Medical College understood, taught, and struggled with medical professionalism, and what could be done to strengthen its place in undergraduate medical education. Faculty described uncertainty about what professionalism meant in practice, often blending it with ethics, manners, or communication. Without a shared definition, expectations varied across departments. Teaching was further hindered by dependence on the hidden curriculum: students learned mainly by watching clinical behaviors, which were inconsistent and sometimes at odds with formal messages. Limited protected curricular time and uneven

role modeling meant professionalism was rarely addressed deliberately. Learner factors also played a role; some students discounted professionalism as a “soft,” non-examined area or reduced it to outward appearance, and cultural variation shaped how they interpreted hierarchy, communication, and accountability. At the institutional level, the absence of assessment signals, lack of structured faculty preparation, and unclear policy guidance weakened accountability and left faculty to rely on personal initiative.

Despite these barriers, faculty generated a coherent set of practical ideas. They wanted a locally agreed working definition of professionalism; longitudinal integration across courses and clinical placements; meaningful assessment components so students take it seriously; structured faculty development to build confidence in teaching, feedback, and remediation; and intentional role modeling and mentorship in which senior clinicians explain the professional reasoning behind their actions. These suggested strategies map directly onto the barriers identified and are feasible to phase in, even in resource-constrained settings, if leadership prioritizes them.

LIMITATIONS AND RECOMMENDATIONS OF THE STUDY

This study has certain limitations that should be acknowledged. It was conducted in a single medical college, which restricts the generalizability of the findings to other institutions or cultural settings. The qualitative design, while useful for gaining in-depth insights, does not allow for statistical generalization. Data were based on self-reported faculty perceptions, which may have been influenced by social desirability bias. Additionally, the study excluded student perspectives, limiting the ability to capture a more holistic view of professionalism teaching. Finally, time constraints during interviews may have restricted exploration of deeper institutional or cultural issues impacting the teaching of professionalism.

Based on the findings, several recommendations are proposed. Institutions should develop a clear, locally relevant definition of professionalism to guide teaching

and assessment. Professionalism should be integrated longitudinally across the curriculum rather than confined to isolated sessions, and formal assessment mechanisms should be introduced to emphasize its importance. Faculty development programs are essential to equip educators with skills for teaching, role modeling, and addressing professionalism lapses. Structured mentorship systems can further reinforce professional values through intentional role modeling. Additionally, institutional policies and support structures should be strengthened to create an environment conducive to professionalism. Future research should include multi-institutional studies and incorporate student perspectives to design comprehensive, evidence-based interventions.

REFERENCES

- Al-Eraky, M. M., & Chandratilake, M. (2012). How medical professionalism is conceptualised in Arabian context: a validation study. *Med Teach, 34 Suppl 1*, S90-95. doi:10.3109/0142159x.2012.656754
- Almairi, S. O. A., Sajid, M. R., Azouz, R., Mohamed, R. R., Almairi, M., & Fadul, T. (2021). Students' and Faculty Perspectives toward the role and value of the hidden curriculum in Undergraduate Medical Education: a qualitative study from Saudi Arabia. *Medical Science Educator, 31*(2), 753-764.
- Banase, H. W., Clements, D. H., Sarama, J., Day-Hess, C., Simoni, M., & Joswick, C. (2021). Intentional teaching moments. *YC Young Children, 76*(3), 75-82.
- Benbassat, J. (2014). Role modeling in medical education: the importance of a reflective imitation. *Acad Med, 89*(4), 550-554. doi:10.1097/acm.000000000000189
- Birden, H., Glass, N., Wilson, I., Harrison, M., Usherwood, T., & Nass, D. (2013). Teaching professionalism in medical education: a Best Evidence Medical Education (BEME) systematic review. BEME Guide No. 25. *Medical teacher, 35*(7), e1252-e1266.

- Carlgren, L., & BenMahmoud-Jouini, S. (2022). When cultures collide: What can we learn from frictions in the implementation of design thinking? *Journal of Product Innovation Management*, 39(1), 44-65.
- Crossley, H. (2021). Teaching Digital Etiquette in the Primary Grades: An Inquiry Approach.
- Cruess, S., & Cruess, R. (2012). Teaching professionalism—why, what and how. *Facts, views & vision in ObGyn*, 4(4), 259.
- Dyantyi, N. (2024). Bridging troubled waters: deans reflections on leading and managing teaching in a South African university. *EUREKA: Social and Humanities*(4), 61-73.
- Fatteh, R., Phyo Aung, Y., Raza, M. M., Naing, T. T., Phyo, Z., & Arja, S. B. (2024). A Multi-Institutional Study Regarding the Perceptions of Students and Faculty Members About Constructive Feedback for Medical Students in Medical Education. *Adv Med Educ Pract*, 15, 1361-1371. doi:10.2147/amep.S488620
- Hafferty, F. W., & Franks, R. (1994). The hidden curriculum, ethics teaching, and the structure of medical education. *Academic Medicine*, 69(11), 861-871.
- Hodges, B., Paul, R., Ginsburg, S., & Members, T. O. C. G. (2019). Assessment of professionalism: From where have we come—to where are we going? An update from the Ottawa Consensus Group on the assessment of professionalism. *Medical teacher*, 41(3), 249-255.
- Javed, I., & Akhter, N. (2024). Exploring the Opportunities and Challenges of Additional Academic Duties on the Performance of Teachers in schools. *Journal of Excellence in Social Sciences*, 3(2), 203-220.
- Jayasuriya-Illesinghe, V., Nazeer, I., Athauda, L., & Perera, J. (2016). Role models and teachers: medical students perception of teaching-learning methods in clinical settings, a qualitative study from Sri Lanka. *BMC Medical Education*, 16(1), 52.
- Kang, W., Pineda Hernández, S., & Mei, J. (2021). Neural mechanisms of observational learning: a neural working model. *Frontiers in Human Neuroscience*, 14, 609312.
- Khan, H. F., & Yasmeen, R. (2020). Exploration of constructs of professionalism identified in the ABIM framework as perceived by the faculty fitting the Pakistani context. *Pakistan Journal of Medical Sciences*, 36(3), 473.
- Kim, D. T., Applewhite, M. K., & Shelton, W. (2024). Professional identity formation in medical education: some virtue-based insights. *Teaching and Learning in Medicine*, 36(3), 399-409.
- Lee, C. A., Wilkinson, T. J., Timmermans, J. A., Ali, A. N., & Anakin, M. G. (2023). Revealing the impact of the hidden curriculum on faculty teaching: A qualitative study. *Med Educ*, 57(8), 761-769. doi:10.1111/medu.15026
- Mak-van der Vossen, M., Teherani, A., van Mook, W., Croiset, G., & Kusrurkar, R. A. (2018). Investigating US medical students' motivation to respond to lapses in professionalism. *Med Educ*, 52(8), 838-850. doi:10.1111/medu.13617
- Passi, V., & Johnson, N. (2016). The impact of positive doctor role modeling. *Medical teacher*, 38(11), 1139-1145.
- Project of the ABIM Foundation, A. A. F., & Medicine*, E. F. o. I. (2002). Medical professionalism in the new millennium: a physician charter. In (Vol. 136, pp. 243-246): American College of Physicians.
- Sadeq, A., Guraya, S. S., Fahey, B., Clarke, E., Bensaud, A., Doyle, F., . . . Harkin, D. W. (2025). Medical professionalism education: a systematic review of interventions, outcomes, and sustainability. *Front Med (Lausanne)*, 12, 1522411. doi:10.3389/fmed.2025.1522411

- Sawatsky, A. P., Matchett, C. L., Hafferty, F. W., Cristancho, S., Ilgen, J. S., Bynum, W. E. t., & Varpio, L. (2023). Professional identity struggle and ideology: A qualitative study of residents' experiences. *Med Educ*, 57(11), 1092-1101. doi:10.1111/medu.15142
- Swick, H. M. (2000). Toward a normative definition of medical professionalism. *Academic Medicine*, 75(6), 612-616.
- Weresh, M. H. (2023). Hidden Lessons, Unforeseen Consequences: Interrogating the Hidden Curriculum in Legal Education and Its Impact on Students from Historically Underrepresented Groups. *Ala. L. Rev.*, 75, 655.
- Yasin, L., Stapleton, G. R., & Sandlow, L. (2019). Medical professionalism across cultures: a literature review. *MedEdPublish*, 8, 191.

