

Faculty Approaches to Equitable Support for Underperforming Medical Students: A Qualitative Study

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ABSTRACT

Objective: To explore faculty members' perceptions and practices in supporting underperforming medical students and identify differences between the academic or emotional support they offered.

Study Design: A qualitative case study grounded in a constructivist paradigm.

Place and Duration of the Study: Department of Medical Education, Bahria University Health Sciences Campus, Karachi, Pakistan, from May to September 2025.

Methodology: A qualitative study involving 18 in-depth interviews, 2 focus group discussions, and reflective journaling was conducted among 47 faculty members at the Bahria University Health Sciences campus. Faculty members with at least five years of teaching experience in clinical or academic medical education settings were included. Faculty members with mostly administrative roles were excluded. A maximum variation purposive sampling method was employed to ensure diversity. Data were collected through in-depth interviews, focus group discussions, and reflective journaling, with thematic saturation reached after 18 interviews.

Results: Data were analysed using Braun and Clarke's six-step thematic analysis approach. Thematic saturation was achieved, with twelve major themes emerging across participants' perceptions of practices to support underperforming students: perceptions of ability, early identification of struggling students, tailored support, systematic barriers, faculty training, psychological support, emotional investment, institutional expectations, implicit bias, emotional labour of faculty, hidden curriculum of compassion, and student empowerment. Each theme revealed complex and, at times, contradictory attitudes towards underperforming medical students.

Conclusion: Faculty members play a critical role in shaping the academic journey of medical students; however, their support is often influenced by personal perceptions, emotional investment, systemic pressures, and implicit biases. To ensure equitable learning experiences, institutions should provide faculty with appropriate training, resources, and policies that promote consistent and fair support for all students, particularly underperforming students.

Key Words: Faculty bias, Underperforming students, Medical education, Qualitative research, Student support.

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INTRODUCTION

Underperformance among medical students poses significant challenges for academic progression and future clinical practice, requiring faculty to play a pivotal role in providing guidance and support while shaping students' academic and professional competencies. Since approaches vary depending on perceptions, culture, and resources, understanding faculty perspective is essential for designing effective remediation strategies and fostering resilience. While considerable research has been conducted on curriculum design, assessment, and student performance, less is known about how faculty members perceive and support students who struggle academically.¹

Faculty attitudes, perceptions, and practices are influenced by personal experiences, institutional expectations, and implicit beliefs, all of which can profoundly affect how students are supported or not through academic challenges. Students who underperform in undergraduate medical education are often at increased risk of academic dismissal, emotional distress, and long-term professional consequences. Faculty support is a critical factor in students' recovery and success. However, research suggests that faculty response may vary widely in how they interpret student performance and provide support to underperforming students. Underperforming students may not receive the same level or quality of mentorship, encouragement, or remediation as their high-performing peers. These disparities may be unintentional and driven by implicit biases, emotional fatigue, or institutional constraints that shape faculty behaviour.²

Emotional labour refers to the effort educators invest in managing their own emotions while supporting struggling learners, often balancing empathy with academic expectations.

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The hidden curriculum of compassion encompasses the unspoken norms, values, and caring behaviours that shape how support is delivered but are not formally taught. Little is known about how faculty emotionally invest in different learners, interpret student ability, or how systemic pressures influence their willingness and capacity to provide support. Understanding these dynamics is particularly important in clinical and academic settings, where faculty interactions can have lasting impacts on students' academic identity, confidence, and outcomes.³

There is growing awareness among educators of the social and cultural factors contributing to underperformance, with recommendations for evidence-based, individualised support plans.⁴ Some faculty members struggle with identifying and addressing underperformance due to a lack of training. This can lead to reluctance or inconsistent support.⁵ Faculty may sometimes refrain from formally addressing underperformance, either due to discomfort, lack of clear processes, or fear of negative consequences for students, resulting in underreporting or insufficient intervention.⁶ Multiple studies show effective remediation programmes and positive student outcomes.⁷ Barriers include lack of training, resources, and the failure-to-fail phenomenon. This study aimed to explore how faculty members in a medical college perceive and respond to underperforming medical students compared with high-performing students and to identify the underlying themes that influence their support practices.

METHODOLOGY

A qualitative study was conducted at the Department of Medical Education, Bahria University Health Sciences Campus, Karachi, Pakistan, from May to September 2025. The study explored perceptions and practices of faculty members. Inclusion criteria were faculty members with five years of teaching experience in clinical or academic settings. Excluded were faculty members with mostly administrative roles. The maximum variation purposive sampling method was employed to ensure diversity in department, teaching experience, gender, and clinical/non-clinical roles. Data were collected using in-depth interviews and focus group discussions. Reflective journaling was undertaken to record the researcher's thoughts, observations, and emotional responses throughout the research process. Reflective journaling serves as a tool to enhance reflexivity and examine the researchers' own biases to improve the transparency of the study. Data saturation was reached after 18 interviews. Theme saturation, meaning saturation, and theoretical saturation were reached after 18 interviews. An inductive and deductive approach was employed to ensure both data-driven theme generation and alignment with existing theoretical frameworks. Semi-structured in-depth interviews were conducted using an interview guide with open-ended questions. Focus group discussions and reflective journaling

were conducted to explore the diverse views of faculty members. Questions were grouped into themes such as perceptions of ability, emotional investment, institutional expectations, or implicit bias. An inductive and deductive approach was employed to ensure both data-driven theme generation and alignment with existing theoretical frameworks. Informed consent was obtained from all the participants.

Data Analysis was conducted using Braun and Clarke's six-step thematic analysis method. Coding was conducted using ATLAS.ti9. Confidentiality ensured that no identifying information was used in reporting. Voluntary participation, with the right to withdraw at any time and any stage of study, is allowed. Ethical approval is obtained from the institutional review board (IRB).

RESULTS

Data collected from 18 in-depth interviews, 2 focus group discussions, and reflective journaling were analysed using Braun and Clarke's six-step thematic analysis. Thematic saturation was achieved, with twelve major themes emerging across participants' narratives (Table I). Each theme revealed complex and, at times, contradictory attitudes toward underperforming *versus* high-performing students. As a medical educationist involved in this study, the researcher maintained a reflective journal throughout the data collection and analysis process. This journaling served to capture subjective impressions, contextual observations, and evolving interpretations, ensuring critical self-awareness in the thematic development (Figure 1).

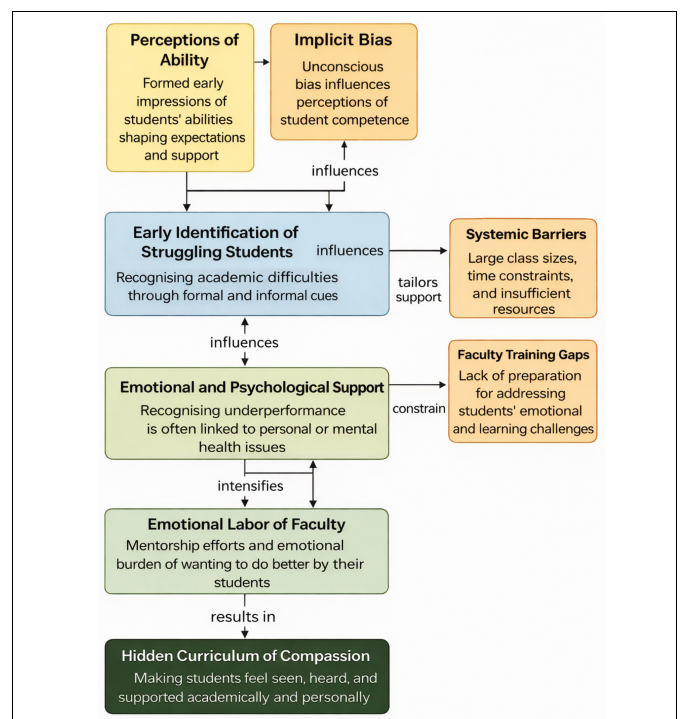


Figure 1: Relationship of emergent themes.

Table I: Summary of emergent themes across data sources.

Data source	Theme	Description	Representative quote
Interviews (n = 18)	Perceptions of ability	Faculty formed early impressions of students' abilities, shaping ongoing support and expectations.	Once you see a student struggling early on, you almost expect them to continue struggling. (faculty 6, clinical educator)
	Early identification of struggling students	Recognition of academic difficulties through formal and informal cues	Sometimes it is not their grades, but their silence in the classroom that tells you something is wrong. (faculty 12, basic sciences faculty)
	Tailored academic support	Personalised academic support based on specific student needs (e.g., content, time management)	No two students are alike. One may need content review, whereas another may need help with time management. (faculty 18, clinical educator)
Focus groups (n = 2)	Emotional and psychological support	It was recognised that underperformance is often linked to personal or mental health issues.	You cannot separate their personal struggles from their academic ones. We try to be as supportive as we can. (faculty 11, basic sciences educator)
	Shared frustrations with systemic barriers	Faculty cited time constraints, large cohorts, and insufficient resources.	I want to do more, but with 150 students, how do you give personalised help? (faculty 7, basic sciences educator)
	Faculty training and preparedness	Faculty felt ill-equipped to handle students' emotional and learning challenges.	We are clinicians, not counsellors. Some of us don't know how to deal with emotional distress in students. (faculty 1, clinical educator)
	Effective strategies from experience	Peer tutoring, structured remediation, and regular check-ins were seen as beneficial practices.	Weekly one-to-one meetings made a big difference for one of my struggling students. (faculty 40, clinical educator)
	Institutional policies and expectations	Policies and performance metrics limited faculty flexibility to support individuals.	There is pressure to move everyone along, but a limited support or time built into the system for individualised help. (faculty 3, department head)
Reflective journaling	Implicit bias	It was an acknowledgment that unconscious bias can influence perceptions of student competence.	Sometimes, certain students seem easier to work with; however, this does not always reflect true ability. (faculty 10, basic sciences faculty)
	Emotional labour of faculty	Faculty experience tension between the desire to support and institutional limitations.	Journal entry: Their frustration is not only just about workload; It is about wanting to do better for their students and not knowing how.
	Hidden curriculum of compassion Student empowerment	Faculty's supportive role operates informally and without recognition. Shift in focus from academic remediation to holistic student support	Journal entry: This is mentorship in its truest sense, yet it often goes unacknowledged. Journal entry: It is about making students feel seen, heard, and supported academically and personally.

DISCUSSION

This study explored the perceptions and practices of faculty members regarding their support for medical students, with particular attention to how underperforming students are perceived and treated. Four key themes—perceptions of ability, emotional investment, institutional expectations, and implicit bias—illustrate the complex interplay between personal, relational, and systemic factors in faculty behaviour. Findings suggest that faculty do not always provide equitable support to all students. High-performing students were perceived as worth the investment, reinforcing academic privilege and potentially widening performance gaps. These findings align with previous literature that highlighting the halo effect, where a positive and early impression causes preferential treatment and greater feedback or mentorship opportunities.⁸ Faculty described differing levels of emotional investment depending on students' performance and perceived responsiveness. Supporting struggling students often led to emotional fatigue, particularly in the absence of visible progress. These results are similar to studies on the emotional aspects of teaching in medical education, where faculty burnout negatively influences student engagement and learning outcomes.⁹

Institutional factors such as limited time, large class size, and the lack of formal remediation pathways shaped how and when faculty chose to support struggling students. This raises concerns about institutional accountability and highlights the need for systemic reform to ensure fair educational practices.

The role of implicit bias in shaping faculty-student interactions emerged as a particularly important finding. Faculty acknowledged that unconscious factors influenced their perceptions and support, even when they intended to be equitable. This reinforces the need for targeted faculty development initiatives focused on bias recognition, inclusive teaching practices, and equitable assessment strategies.¹⁰ Faculty development programmes should address unconscious bias, equity in student support, and strategies for emotional resilience.¹¹ Structured remediation pathways and institutional policies should ensure that struggling students receive timely, consistent, and evidence-based support.¹² Ongoing reflective practice, such as journaling or peer debriefing, may help faculty become more aware of biases and assumptions that affect their teaching behaviour.

There is empirical evidence of an academic tutoring programme enabling underperforming students to succeed through personalised intervention and support.¹³ Empirical evidence indicates that gender bias and social divide may affect the amount of support offered to underperforming students. The "failure" to fail literature exposes systemic and faculty-level barriers such as emotional burden, documentation challenges, and fear of litigation that hinder honest assessment and timely remediation of struggling medical students. A Q-methodology study in BMC Medical Education (2024) identifies distinct faculty viewpoints affecting decisions about failing underperforming students.¹⁴ Multiple dimensions, systemic, personal, and institutional, that collectively inhibit the effective support of struggling students. Findings of a recent research study suggested that medical students from ethnic minorities have negative

experiences that influence their educational experiences. Supporting such students is crucial for creating a safe educational and practical environment for ethnic minority students.^{15,16}

This study is limited by its focus on a single institution, which may affect generalisability. Additionally, social desirability bias may have influenced participant responses, particularly in discussions of bias or inconsistent support. However, triangulation through multiple data sources (interviews, focus groups, reflective journals) strengthens the credibility of the findings.

CONCLUSION

Faculty members play a critical role in shaping the academic journey of medical students; yet, their support is influenced by personal perceptions, emotional investment, systemic pressures, and implicit biases. To ensure equitable learning experiences, institutions must support faculty through training, resources, and policies that enable consistent and fair support for all students, particularly those who struggle.

ETHICAL APPROVAL:

Ethical approval was obtained from the Institutional Review Board of Bahria University Health Sciences Campus, Karachi, Pakistan (BUHS-IRB# 168/25; dated: 16 May 2025). All procedures adhered to standard scholarly and ethical practices.

PATIENTS' CONSENT:

Informed consent was obtained from all participants.

COMPETING INTEREST:

The authors declared no conflict of interest.

AUTHORS' CONTRIBUTION:

KF: Conceptualisation, literature search, data collection, interpretations, and drafting.

SNHH: Critical review, suggestions, and manuscript refinement.

Both authors approved the final version of the manuscript to be published.

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