



Barriers to Professional Development among Clinical Faculty Members: A Qualitative Study

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Abstract

Introduction: Faculty and professional development are intrinsically linked to organizational effectiveness and academic excellence. Understanding barriers to faculty development can help improve the institution. This study aimed to investigate some factors affecting the professional development of faculty members in the Faculty of Medicine, Shiraz University of Medical Sciences.

Methods: In this study, the qualitative content analysis method was used. 17 faculty members were recruited through purposive sampling and participated in semi-structured, in-depth interviews. Data collection continued until saturation was reached. The interviews were first recorded on tape, transcribed word for word, and later analyzed by applying Graneheim and Lundman's content analysis.

Results: Data analysis resulted in two major categories: organizational and cultural barriers. The organizational barriers consisted of lower salaries, a high workload, a non-supportive organizational system, lack of support for going abroad, inadequate incentives, inadequate access to resources, suppression of motivation, rigid promotion regulations, and poor infrastructure. Professional jealousy, preference for routine work, individual activities, and commercialization of medicine were the cultural barriers.

Conclusion: By recognizing the challenges that faculty members are facing in achieving success or development within the educational system, barriers can be overcome. Improving faculty development means the faculty is improved and contributes to student, organisation, and society development.

Keywords: Faculty, Medical, Staff development, Qualitative research, Organizational culture, Social environment

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Introduction

Faculty members are important pillars in the scientific, cultural, and social advancement of universities. These institutions play a pivotal role in societal and national advancement through excellence in teaching, research, and university-industry collaboration. However, the rapidly evolving educational landscape imposes multifaceted expectations, encompassing

rigorous standards in pedagogy, scholarly inquiry, administration, and collaborative engagement with both peers and students. Hence, a need for professional development to guarantee academic success and sustainability in higher education institutions has emerged (1-3). Professional development is an essential element in enhancing the knowledge, skills and competencies of faculty members to have the

ability to provide high quality health education and scientific research or to take part in the development of healthcare systems to serve the goals of the institution, and more specially in medical universities, which are central to the process of delivering healthcare services, supporting health promotion and training the next generation of health care workers (4-6). Furthermore, the rapidly evolving health-care environment dictates that health-care educators and clinical faculty members should continually add new knowledge, skills, and abilities to meet the many challenges of the future health-care environment to prepare the next generation of physicians. In this regard, several medical universities across the globe have initiated faculty development courses focused on enhancing the medical education skills and abilities in teaching, research, and clinical practice (7).

Given the substantial financial and temporal investments required, rigorous evaluation is essential to identify programmatic strengths and weaknesses, uncover opportunities for enhancement, and assess whether intended objectives are being achieved (8).

Option 1: Direct & Concise (Recommended)

“While many studies have examined professional development programs and interventions (9–11), existing literature remains largely quantitative and survey-based, often overlooking faculty members’ lived experiences and qualitative interpretations of these barriers

This gap is even larger in Iran, where particular cultural and structural circumstances influence professional development. Hence, this qualitative study is informed by the desire to gain a deeper understanding of these perceptions to give feedback to the policymaking process.

Faculty members are challenged on several fronts to develop professionally. Human and financial resource limitations, including salary and benefits constraints, research opportunities, and involvement in academic events, are significant challenges that often limit budgets (12). In addition, due to the fast pace of technological development, frequent recalibration of skills is required, but the modern tools to improve research and teaching are lacking (13, 14). Professional development is constrained by the lack of time for it due to heavy workloads, such as teaching, research, administrative tasks, and clinical activities (15, 16). Additionally, psychological pressures, unclear promotion criteria, lack of guidance or mentorship, and difficulties in achieving work-life balance further

obstruct development (17-19).

Previous studies have primarily focused on known barriers such as heavy workload and resource limitations, while less attention has been paid to the influence of organizational culture, career development, promotion expectations, and the way different barriers interact with and exacerbate one another. Such interactions reveal a multifaceted landscape of professional development that quantitative approaches often fail to capture (11, 20–22). Given this research gap and the need for a deeper understanding of professional development from the perspective of faculty members, this study adopted a qualitative approach. In-depth semi-structured interviews can provide rich insights into the experiences and perceptions of faculty members regarding barriers to professional development (23).

To better understand this issue, we used a qualitative content analysis approach and conducted in-depth semi-structured interviews with clinical faculty members at Iranian medical universities. We aimed to hear directly from faculty about their experiences and perspectives on what hinders their professional development. We chose this approach because it allowed us to explore these barriers openly, without imposing predetermined categories. This method is particularly suited to areas where existing theory or research is limited, as it allows themes and codes to emerge naturally from the participants’ own narratives (24). Ultimately, we hope the findings will offer practical, context-specific insights that can guide efforts to better support the faculty’s professional development.

Method

Design and participation

This study was conducted using a qualitative research design with a conventional content analysis approach. Qualitative methodology was selected to gain an in-depth understanding of faculty members’ experiences and perceptions regarding barriers to professional development within their academic context (24).

Settings

The study was conducted at the Clinical Faculty members of Shiraz University of Medical Sciences. Participants consisted of clinical faculty members with diverse academic ranks, disciplines, and years of teaching experience. Purposive sampling was employed to identify the participants who were most likely to provide relevant and valuable insights. We deliberately chose participants to reflect a wide range of academic ranks, specialties, and professional

backgrounds, rather than having an equal number of men and women (Table 1).

Data Collection

Data were collected from January to June 2023. The participants were recruited using a purposive sampling method. The third author, a medical education student with prior training and experience in qualitative interviewing, conducted all interviews.

To be included, participants had to be clinical faculty members at Shiraz University of Medical Sciences with at least two years of faculty experience and be willing to take part in an in-depth interview. We excluded the faculty members who were on sabbatical during the data collection period, as well as anyone who did not consent to be audio-recorded.

The interview guide included a short list of general questions posed to the faculty members: "Please describe your professional experience in the clinical setting." This was followed by inquiries regarding "The necessary competencies for faculty members in the clinical environment."

After the first three interviews, we refined the interview guide based on the participants' early responses. The key questions involved were: "What have been your professional development challenges and barriers, and what issues have slowed or impeded your progress and advancement with the University?" To draw out richer detail, we used follow-up prompts such as "How do you think these competencies are developed?", "What do you mean by that?", and "Please elaborate further on this matter."

All interviews were conducted in a quiet and private setting at a time convenient for the

participants. Each interview lasted between 40 and 70 minutes. With participants' consent, interviews were audio-recorded to ensure accuracy. Data collection continued until data saturation was achieved, defined as the point at which no new themes or insights emerged from the interviews (25). As we conducted the interviews, we monitored the data saturation. We considered saturation reached when new interviews stopped producing meaningfully new themes, and the themes we already had were detailed enough to address the research question. All interviews were recorded with a voice recorder and transcribed (verbatim) immediately.

Codes, subcategories, and categories were detected through an inductive process. Categories were formulated to reflect the participants' experiences. Two of the authors are faculty members at Shiraz University of Medical Sciences and expert in medical education.

To reduce potential bias, we held a 60-minute team discussion after each interview to review the emerging codes and challenge one another's interpretations. The first author also kept a daily journal, documenting personal assumptions, emotional reactions, and decisions made during coding and theme development. We saved every version of the coding scheme, memos, and analytical decisions to keep the process transparent.

Data analysis

Interviews were transcribed verbatim immediately after completion. Data were analyzed using the Graneheim and Lundman approach to content analysis (26). The analysis

Table 1. Demographic information of faculty members participating in the interview

Participant Code	Field / Specialty	Academic Rank	Gender
1	Infectious-adults	Associate Professor	Male
2	Pediatric Cardiology	Assistant Professor	Male
3	Internal Medicine - Special	Assistant Professor	Male
4	Internal Medicine - Special	Assistant Professor	Male
5	Vascular Surgery	Assistant Professor	Male
6	Medical Ethics(Clinical teaching role)	Assistant Professor	Male
7	Anesthesia (Adult Special Departments)	Associate Professor	Male
8	Pediatric Neurosurgery	Assistant Professor	Male
9	Neonatology	Assistant Professor	Female
10	Adult Neurosurgery	Assistant Professor	Male
11	Pediatric Internal Medicine - Special	Assistant Professor	Male
12	Pediatric Infectious Diseases	Associate Professor	Female
13	Cardiology	Professor	Male
14	Pediatrics	Assistant Professor	Male
15	Ear, Nose, and Throat (ENT)	Assistant Professor	Female
16	Dermatology	Assistant Professor	Female
17	Gynecology	Associate Professor	Female

process involved several steps: repeated reading of transcripts to achieve immersion in the data, identification of meaning units, condensation and coding of meaning units, grouping of similar codes into subcategories, and abstraction of subcategories into main categories. We interviewed 17 faculty members with semi-structured interviews, transcribed these interviews, and assigned them the code 'P01' to 'P17'. To ensure anonymity, all participant names were replaced with pseudonyms. All data were stored in separate folders, and all data were backed up successfully on an external hard drive. Interview transcripts were printed and coded by hand with colour coding.

Our research team consisted of faculty members whose special interests were medical education and a medical education master's student with a clinical background. The first author carried out a personal reflection journal to record the assumptions and analytical choices. All analytical memos and coding versions have been kept to support transparency (Figure 1).

Trustworthiness

Lincoln and Guba criteria were used to develop four critical criteria, which are credibility, transferability, dependability, and confirmability (27). Credibility was enhanced through repeated review of the transcripts and prolonged engagement in data collection and analysis over 5 months. We also applied member checking; that is, once we conducted the interviews, we selected certain quotes and added the initial code labels, and asked the participants, "Did we label this idea well?" Three of the participants were professors: one assistant professor, one associate professor, and one full professor who reviewed the final themes and confirmed that they were similar to their experiences.

To ensure transferability, we described the context, participants, sampling methods, interview processes, and data analysis in detail to allow the readers to evaluate the extent to which the results of the study can be transferred to other settings.

Peer debriefing and frequent analytical discussions were used to enhance dependability within the research team. In addition, the two independent peers reviewed our analytical process, further strengthening the credibility of the analysis. The other peer was a highly experienced associate professor of medical education from another medical school, and another one was an associate professor of nursing research at our own institution; they were particularly strong in qualitative methodology. They were most

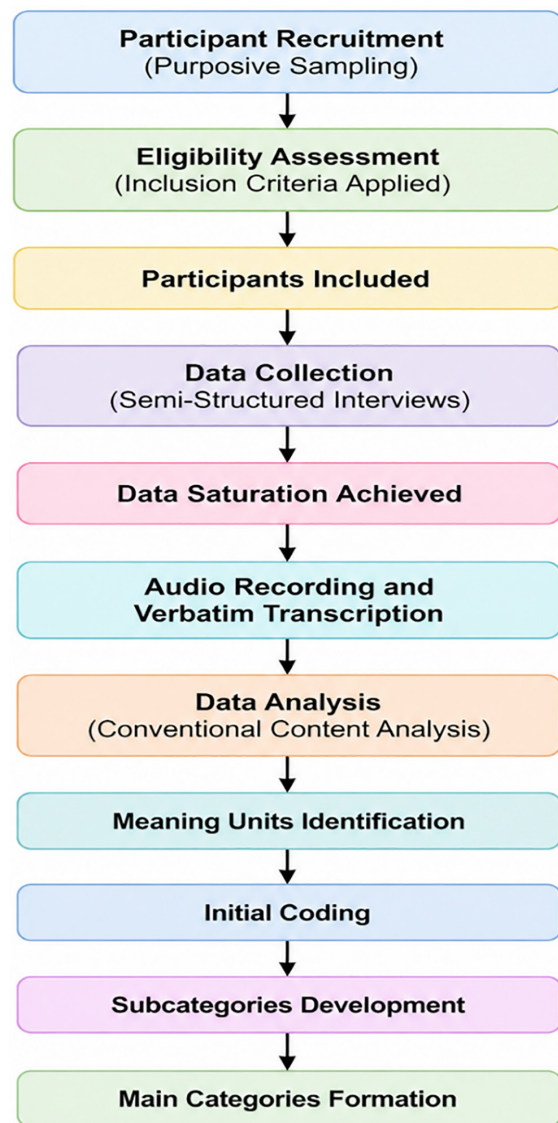


Figure 1. The overall process of the study

important in questioning our interpretation and coding of the data. Twice during the analysis period we met for peer debrief.

A comprehensive audit trail was maintained, which helped to improve confirmability. A detailed audit trail was kept during the process of data collection and data analysis. This involved audio recordings and verbatim transcriptions, handwritten codes, coding decisions, process notes, multiple drafts of final categories, and reflexive memos of researcher biases and assumptions. The authors also maintained a reflexive journal to record assumptions, methodological choices, and reflections on the analysis process throughout the course of the study, which served to reduce the possible impact of personal opinions on data analysis.

Ethical consideration

The participants were made aware of the aims

of the study, the voluntary nature of participation, and the confidential treatment of the data. Before they took part, written informed consent was secured, and anonymity was maintained during both the collection and reporting of data. The study received approval from the ethics committee of Shiraz University of Medical Sciences, with the code of IR.SUMS.REC.1401.642.

Results

Across 17 interviews, we identified 270 initial codes. Data analysis identified two main categories representing barriers to faculty members' professional development: organizational and cultural barriers. These categories were derived from the participants' experiences and perceptions and encompassed a total of thirteen subcategories (Table 2).

Organizational Barriers

Organizational barriers were the most frequently reported barriers, reflecting structural, managerial, and systemic challenges within the academic environment. This category comprised *nine* subcategories: insufficient salary, stressful system, high workload, lack of support for international participation, insufficient incentives, poor access to resources, and suppression of motivation, rigid promotion regulations, and poor infrastructure.

Insufficient salary

Inadequate financial compensation that fails to meet basic living expenses, creating economic pressure and reducing time available for academic activities, was identified as a major deterrent to

professional development. Operationally, this was reflected in participants' perception that their income was insufficient to cover living costs, which compelled them to seek additional employment and limited time for professional development. One participant stated that despite years of education and professional commitment, financial insecurity undermined motivation and long-term career planning.

"The salary I receive does not even cover my basic living expenses, so I am forced to work more, which gradually erodes my motivation for professional development" (Participant 4).

"...Until financial issues are properly addressed, professional development problems will not be resolved. It is financial matters that can create motivation" (Participant 10).

Stressful system

Psychological pressure arising from clinical responsibilities, high-risk patient care, and fear of losing professional position due to absence from the workplace was another prominent barrier, particularly in clinical settings where faculty members are responsible for high-risk patient care. Operationally, this was manifested in the participants' reports of constant anxiety related to patient outcomes, emergencies, and concerns about maintaining job security while pursuing development activities. Participants described constant psychological pressure associated with clinical responsibilities, emergencies, and continuous monitoring of critically ill patients, which adversely affected their capacity for professional advancement.

Table 2. Code, subcategory, class of barriers to professional development of clinical faculty members

Category	Subcategory	Extracted Codes
Organizational barriers	Insufficient salary	Low income (P4); financial insecurity (P2); need for additional employment (P6)
	Stressful system	Constant psychological pressure (P5); clinical responsibility (P5); work-related anxiety (P7)
	High workload	Multiple roles (P5); excessive clinical duties; lack of time for research (P1)
	Lack of support for international participation	difficulty getting approval for overseas (P2); high costs involved, which were not covered by the system (P17)
	Insufficient incentives	Unfair comparative reward system (P15); lack of motivation after repeated disappointment (P3)
	Poor access to resources	Unavailable or expensive lab kits (P12); disruption of academic work (P9)
	Suppression of motivation	Lack of recognition (P6); unfair reward system (P3); discouragement (P3)
	Rigid promotion regulations	Strict promotion criteria (P11); Emphasis on publications over teaching (P8); Limited recognition of teaching roles (P5)
	Poor infrastructure	Outdated equipment (P6); modern research facilities (P9); shortages of trained personnel (P10)
Cultural barriers	Commercialized view of medicine	Financially driven perception (P12); social pressure for wealth (P7)
	Preference for routine work	Resistance to innovation (P13); prioritization of repetitive tasks (P7)
	Inclination toward individual activities	Preference for solo work (P14); weak teamwork culture (P8)
	Professional jealousy	Lack of cooperation (P1); resistance to colleagues' success (P8)

"The nature of our clinical work is full of stress. We constantly worry about patients' conditions, even after surgery and during the night" (Participant 5).

"If a person feels that, for their own professional development, they have to attend a course and be absent from their workplace or position for a period of time, whether short-term or long-term, they may fear losing that job position. Or they may feel that all the effort they have put into achieving that position could be lost and no longer exist" (Participant 7).

High workload

Excessive professional demands from multiple simultaneous roles (clinical, teaching, research, and administrative) that leave insufficient time for professional development emerged as a significant challenge. This was characterized by the participants' experience of having inadequate time for quality teaching, research, and professional development due to overwhelming clinical and administrative duties. Faculty members reported that excessive clinical responsibilities reduced the quality of teaching and left insufficient time for research and professional development activities.

"With the current workload in treatment, we no longer have time for quality teaching, research, or professional development" (Participant 17).

"Due to the high clinical workload, we hardly have time to engage in professional development activities" (Participant 3).

Lack of support for international participation

The study found that institutional and systemic barriers to international academic mobility were recognized as a major hindrance, particularly in a context such as that of Iran. This is evidenced by participants complaining about their inability to get approval for training abroad as well as facing problems with visa issues and prohibitive expenses borne by their institutions. Faculty members also emphasized that while the courses used to be either free or inexpensive, now they have become unreasonably expensive, and very few individuals can afford to pay for them.

"There are several challenges with participation in these educational programs from foreign countries because gaining approval is difficult. Indeed, it is difficult to get permission to enter these countries from our state. Furthermore, these courses have become unaffordable expensive, notwithstanding that at some point courses were totally free or very cheap. The system does not pay out for participation in such courses, while paying for them privately is

impossible" (Participant 17).

Insufficient incentives

Another significant obstacle noticed is that there are no proper systems of recognition, reward, and encouragement assessing the contributions of different professors rather than counting publications. It may be related to the participants' perception of reward systems as something that takes into account only the best performers and neglects other people that decreased motivation. One of the respondents shared a remarkable example of this topic.

"If you have 20 publications in a year and someone else has 25, that second person is rewarded, but the first person receives no encouragement at all. In other words, rewarding the second person is a punishment for the first. After a while, the first person also becomes unmotivated and thinks, 'No matter how hard I try, I will never catch up to that person'" (Participant 3).

Poor access to resources

A lack of adequate physical, financial, and informational resources, including laboratory supplies, clinical equipment, and research databases, necessary for high-quality academic work was identified as a fundamental barrier that directly compromises the quality and integrity of academic research. This was reflected in the participants' reports of unavailable or expensive laboratory kits, outdated clinical equipment, and forced reduction of research scope. Participants provided concrete examples of how resource limitations force faculty members to scale down their research ambitions:

"A faculty member and a student needed to work on 7 microbes for a lab research project, but the required kits were unavailable or too expensive. They had to reduce the number from 7 to 3 items. These kinds of problems disrupt the work of academically oriented faculty members who cannot carry out their research as they would like" (Participant 12).

Suppression of motivation

Diminished professional enthusiasm and engagement resulting from lack of recognition, perceived unfairness in reward systems, and selective appreciation of faculty efforts was attributed to the absence of recognition. Operationally, this was reflected in the participants' reports of frustration, loss of enthusiasm, and reduced effort due to unrecognized contributions to education, research, and service. Several participants

expressed frustration that their contributions to education, research, and service were overlooked, leading to diminished professional enthusiasm.

"Many of our efforts are never seen or appreciated, and this gradually suppresses our motivation to grow professionally" (Participant 3).

Rigid promotion regulations

The criteria for promotion in the academic field have been described as rigid, focused on quantity, and disregarding the importance of teaching excellence and innovation and other important contributions to education, thus repressing creativity and stalling progress. This was evident in participants' accounts, which indicated that promotion processes were too rigid and that too much importance was attached to scholarly publications instead of the merit of teaching.

"The promotion rules are too strict and inflexible, and they do not value the quality of our academic work" (Participant 11).

Poor infrastructure

Inadequate physical infrastructure, apparatus, and institutional support that restricts research capacities, quality of education, and advancement opportunities has been recognized as a constraint. This is especially concerning in terms of obsolete equipment, absence of contemporary research infrastructures, and lack of skilled workforce. In practical terms, this was shown through the participants' statements on using out-of-date apparatus, friction of modern research facilities, misbalance of trained manpower, and lack of access to training programs. These limitations were reported to hinder both educational quality and research productivity, especially in specialized clinical fields.

"We lack essential equipment for education and research, and this has limited our professional development for years" (Participant 9).

Cultural Barriers

The second main category, cultural barriers, reflected prevailing values, attitudes, and norms within the academic and social environment. This category included four subcategories: commercialized view of medicine, preference for routine work, inclination toward individual activities, and professional jealousy.

Commercialized view of medicine

The societal perception of medicine as a pathway to wealth and financial success rather than academic commitment, which shifts professional priorities away from scholarly

development, was perceived as a cultural barrier that shifted attention away from professional development toward financial gain. Operationally, this was reflected in the participants' reports of societal pressure for physicians to achieve high financial status, which discouraged engagement in academic and professional development activities. Participants noted that societal expectations regarding physicians' financial status exerted pressure on faculty members and, in some cases, discouraged engagement in academic development activities.

"Medicine is seen as a path to wealth, and this mindset pushes doctors away from professional and academic development" (Participant 11).

"This has turned into becoming a physician who prints money, which requires putting aside professional development, and this is what is currently being observed" (Participant 7).

Preference for routine work

Resistance to change and innovation, favoring repetitive and familiar tasks over transformative professional activities, reinforced by systems that do not value creativity, was associated with resistance to change and innovation. Operationally, this was reflected in participants' perception that innovation and creativity were not valued by the institutional system, leading to prioritization of routine and repetitive tasks over professional development. Faculty members reported that the lack of institutional encouragement for creativity and development led to a tendency to prioritize repetitive and familiar tasks over transformative professional activities.

"When innovation is not valued by the system, people naturally turn to routine and repetitive work" (Participant 7).

Inclination toward individual activities

The cultural tendency to work alone, rather than collaboratively, reinforced by evaluation and promotion systems that reward individual achievements over teamwork and interdisciplinary collaboration was also identified. Operationally, this was reflected in the participants' reports that individual work is rewarded more than teamwork, leading to a weak teamwork culture, limited interdisciplinary collaboration, and reduced shared professional learning. This culture was perceived to weaken teamwork, interdisciplinary collaboration, and shared professional learning.

"Because individual work is rewarded more than teamwork, faculty members prefer to work alone rather than collaboratively" (Participant 5).

Professional jealousy

Interpersonal attitudes of resistance, non-cooperation, and unhealthy competition toward colleagues' success, which undermine collaboration, mentorship, and collective professional development, emerged as a cultural barrier that negatively affected cooperation among colleagues. Operationally, this was reflected in the participants' reports of a lack of cooperation, resistance to successful colleagues, and unhealthy competitive dynamics that hindered professional progress and team functioning. Participants described instances in which successful and productive faculty members faced resistance or a lack of support from peers, ultimately hindering their professional progress.

"Successful colleagues are sometimes faced with resistance instead of support, which discourages professional progress" (Participant 8).

"In team interactions, respect, familiarity, and hierarchical order all play a role, and all of these factors can prevent the system from functioning smoothly" (Participant 1).

Discussion

Our findings show that barriers to faculty professional development in medical sciences operate at both organizational and cultural levels. These barriers are not simply about individual limitations or a lack of resources; they arise from the way organizational structures and academic culture interact.

Organizational Barriers: Structural and Systemic Constraints

Study participants reported that the lack of a reasonable salary and institutional support were some of the significant impediments for them. This finding is consistent with other research in the area of higher education (28). Indeed, in their review of the academic literature, scholars admitted that the lack of financial incentives and access to funding can be considered one of the barriers to the professional development of educators, demonstrating that the lack of money not only limits the ability to attend conferences and training programs but also indicates that the institution does not prioritize continuous academic improvements in faculty members' minds. Moreover, in accordance with broader research in the field of medical education, respondents pointed to the terrible working conditions and heavy workloads in the field of medical education as significant impediments. The results of this research build on the findings from prior studies in the area of medical education, which claim that educational staff in this field are suffering from

problems in balancing the demands of research, teaching, and clinical work (29).

The convergence of the findings obtained in this research study and those in other countries indicates that workload strain may be regarded as a systemic problem linked to the clinical academics' model, due to the failure to provide meaningful participation in training initiatives caused by the serious time restrictions in the sphere. Rigid promotion policies that emphasize quantitative achievements over the quality and impact of teaching and scholarly work may also hinder professional development. This is supported by summary reviews conducted in Iran, which show that traditional promotion rules, in the majority of cases, ignore educational quality and contributions to creativity and may therefore discourage innovation and professional growth (30). In addition, unfitting infrastructures, such as out-of-date premises, lack of equipment and technology, and absence of research support, also restrict the pedagogical development of the staff. Similar observations were made in various research studies held in medical schools, where lack of modern technologies and research support leads to unfavorable conditions both for the specialists and for their professional development (31).

A recent study carried out by Khoshgoftar, et al. listed several individual, professional, educational, and management/organizational influencing aspects with regard to faculty participation in educational initiatives in medicine in Iran (32). We actually support this multiple approach on the issue at hand but focus on barriers that interfere with the professional development process, as well as the interaction of organizational and cultural limitations in the context of clinical education.

Cultural Barriers: Norms, Values, and Interpersonal Dynamics

Cultural factors also substantially influenced faculty engagement beyond institutional limitations. According to this study, commercialization in medicine indicates the social inclination toward monetary gain instead of commitment to academia. In line with this study conclusion, it can be inferred from the literature that cultural norms in academic medical settings have a strong impact on faculty focus, directing their attention away from the process of scholarly advancement (33).

The other cultural barriers that challenged development were resistance to change and preference for working according to routine. These trends echo the findings reported from the Saudi Arabian context where resistance to

innovation and risk-taking were identified as key individual constraints to the faculty development process (31). These tendencies can be viewed as the patterns that arise from fixed professional norms, which value steadiness over innovation and discourage the use of new learning methods and development opportunities. Interpersonal characteristics, such as individualism and professional jealousy, negatively influenced the development of collaboration and communities of practice. The findings regarding the impact of interpersonal behaviors on the process of faculty development correspond to the results of the scoping reviews indicating that the presence of collaborative culture and peer networks is of paramount importance for successful progress in faculty development in the field of medical education (34).

The “professional jealousy” we have detected is actually seen as a kind of envy with a negative meaning, which is characterized by various actions against the person, a colleague, in order to prevent his or her rise. Busari has recently pointed to the destructive consequences of malicious envy that may exist in the field of medicine, saying it can result in damaging one’s career and ruining various relationships within the field. This view of the phenomenon proves that the problem requires a more global approach, which makes sense regarding the findings of the research (35). Professional jealousy can be thought of not merely as a relationship problem but a cultural obstacle that leads to the corruption of relationships.

These results are also corroborated by Keshmiri, et al., who indicated inappropriate contextual conditions as well as interactions between individual and organizational factors as major difficulties in clinical education settings (36). In their work, the authors observe that professional development and professional identity cannot be separated from the environment in which the clinical faculty works.

Our study identified the commercialization of medicine as a significant cultural barrier. We observed that many faculty members shifted from an emphasis on patient care to the pursuit of profit. The findings indicate that even when clinical work significantly impacts income generation, academic mission is not necessarily weighed against clinical activities requiring effort. Leverence and others pointed out that the increase in salary based on productivity and focus on clinical revenues can cause the education and research to be jeopardized by being negatively affected by clinical work without appropriate acknowledgment of the value of

academic endeavors (37). Participants in our research mentioned that promoting the revenue-generating activities contributes to the loss of time dedicated to professional development and that commercialization serves as another cultural barrier to the development of the faculty.

Multidimensionality of Professional Development Barriers

Research revealed that professional development presupposed several interconnected components, including teaching, research, clinical practice, and leadership, and different barriers influenced them differently. Research suffers mainly due to financial difficulties and limited international support, which limits attendance at conferences and the availability of scientific resources. Teaching and educational innovations are impacted mostly by heavy clinical workload and interference from the educational system, which reduces the time spent on developing new courses. Access to resources as well as infrastructural issues are common for all areas, but they are experienced most in clinical and research areas. Issues attributed to culture, including individualism and professional envy, mainly limit collaboration and impede progress in leadership. These findings indicate that approaches to supporting the professional development of faculty members should consider different components of their work instead of relying on uniform approaches that work for every component of their duties.

Integrating Organizational and Cultural Perspectives

The interplay between organizational and cultural barriers suggests that faculty development efforts are unlikely to succeed if pursued in isolation. Structural modifications alone remain insufficient without a corresponding shift in the underlying culture. Thus, the findings underscore the need for a holistic approach that encompasses policy reform, cultural alignment, and individual-level support. Previous research suggests that providing protected time for faculty development can reduce workload-related barriers and signal institutional commitment to faculty development. In addition, it has been proven that the creation of communities of practice can facilitate collaboration and foster commitment on a long-term basis, providing answers to cultural and structural challenges (34). This integrated approach recognizes faculty development as both a systemic necessity and a cultural endeavor.

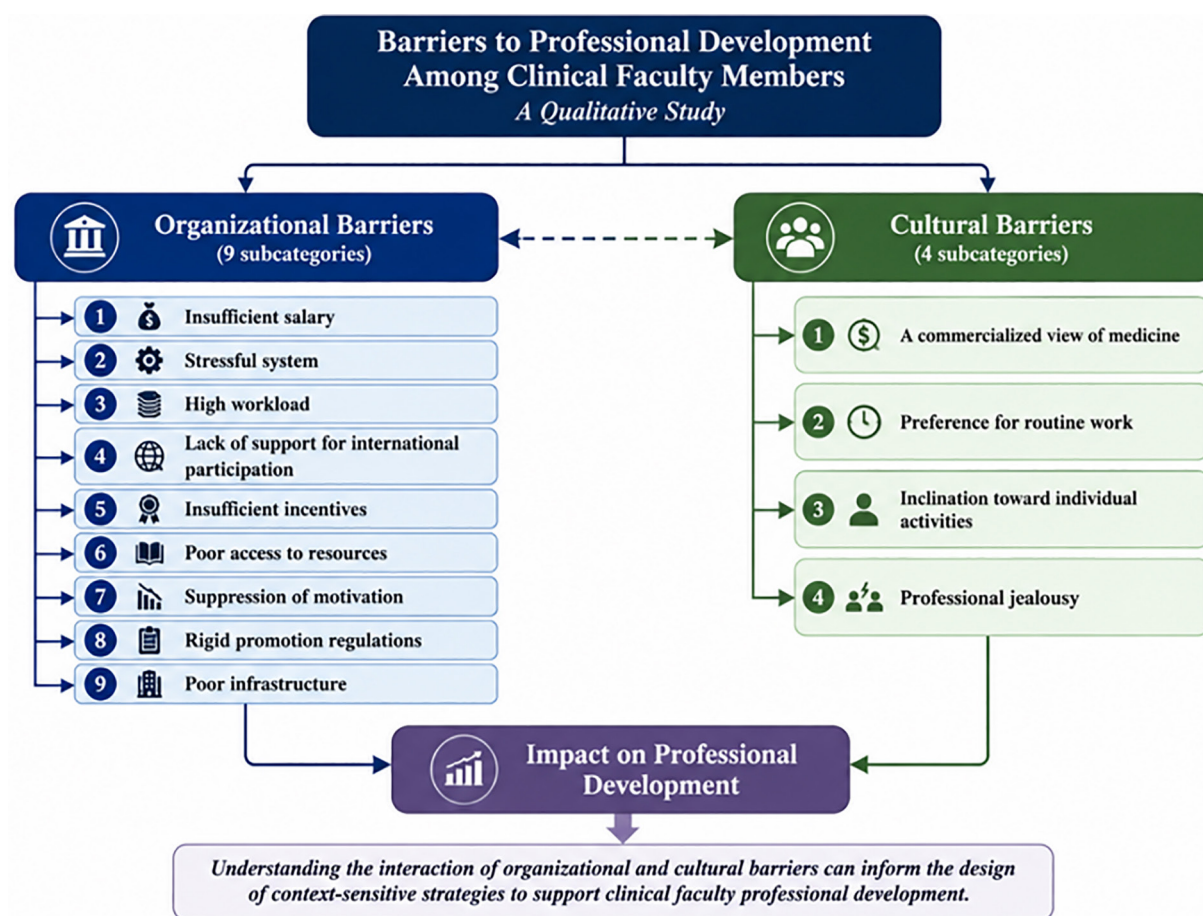


Figure 2. Conceptual of barriers to professional development among clinical faculty members.

Implications for Policy and Practice

The results of this research imply that leaders in medical education should do the following:

- Reform the criteria for promotion in such a way that quantitative outcomes are combined with teaching abilities, mentoring functions, and scientific work.
- Seek to develop the infrastructure to provide teachers with access to resources, modern technologies, and development opportunities.
- Encourage cultural changes, via leadership behavior, recognition systems, and peer initiatives that are designed to reduce routine-oriented work and professional isolation.
- Create time for development, taking into account working hours.

In this way, if systemic reforms are combined with the cultural background, it is possible to create an environment where development is seen as essential (Figure 2).

Limitation

This research has some limitations, which may affect how the results are interpreted. The first limitation is that certain faculty members hesitated to disclose the challenges facing their

organizations due to fear of potential repercussions in their workplace. Furthermore, since our sample consisted of only one full professor and four associate professors, our findings may not depict the experiences of senior members of the faculty fully. Further research should focus on involving more senior faculty members in the research in order to get their views on the barriers to professional development.

Second, the interviews took place during an economically unstable period in the nation, which may have had an impact on the participants' tendency to consider cost issues more important than any other types of organizational and cultural issues. Hence, some challenges might not be mentioned because they were overshadowed by particular circumstances. Third, even though the participants referred to mobility hindrances, they were not evaluated systematically in the interview. Future research could focus on sabbatical policies, restrictions on conference participation, and limitations on international collaborations. Finally, since this study was based exclusively on qualitative data from a single institution, the findings may not be generalizable to other universities or contexts.

Conclusion

The current investigation has examined different cultural and organizational constraints that obstruct the development of medical faculty. The results showed that organizational barriers, in the form of poor salaries, lack of adequate support from the administration, huge workload, and the strict regulations related to promotional processes, as well as cultural constraints like commercialization of medicine, reluctance for changes, and individualistic culture, oppose the development of faculty members.

In addition to the barriers which are often reported, there are no supportive measures for international involvement, and there is low motivation and lack of resources. The results could be connected to some general conditions in the Iranian academic milieu which include economic constraints and limitations in current international academic activities.

The environment of teaching hospitals creates a framework in which the complexity of various problems can be expressed. Members of the faculty have to cope with the problems created by heavy clinical workloads and educational and research demands that come into being at the same time. The necessity of implementing targeted solutions is illustrated by the conditions of this setting.

The multidimensional nature of barriers to professional development means that interventions should be adapted for each dimension, rather than employing a one-size-fits-all approach. The strategies that can mitigate existing barriers to professional development include providing enough time for engagement in development activities, promotion of areas of practice, and change in the promotion criteria with more emphasis on quality of teaching and development.

This study has important implications for policy as it underscores the need for re-thinking promotion criteria, investing in infrastructure and support units, and advocating for cultural change through leadership modeling and networking. In conclusion, the aim is to create a culture in teaching hospitals in which professional development is viewed as an important part of academic identity and the success of institutions, making professional development an integral part of academic institutions.

References

- Wynants S, Dennis J. Professional development in an online context: Opportunities and challenges from the voices of college faculty. *Journal of Educators Online*. 2018;15(1):n1.
- Matsika A, Nathoo K, Borok M, Mashaah T, Madya F, Connors S, et al. Role of faculty development programs in medical education at the University of Zimbabwe College of Health Sciences, Zimbabwe. *Annals of global health*. 2018;84(1):183.
- Shokpour N, Eslampanah N, Asadi V, O'Neill S, Dann C, Wang J. Iranian English as a Foreign Language (EFL) teachers' professional development needs in educational contexts: Exploring the challenge of reflective practice. *Journal of Advances in Medical Education & Professionalism*. 2024;12(4):261-71.
- Campos-Zamora M, Gilbert H, Esparza-Perez RI, Sanchez-Mendiola M, Gardner R, Richards JB, et al. Continuing professional development challenges in a rural setting: A mixed-methods study. *Perspectives on Medical Education*. 2022;11(5):273-80.
- Wilkerson L, Irby DM. Strategies for improving teaching practices: a comprehensive approach to faculty development. *Academic medicine: journal of the Association of American Medical Colleges*. 1998;73(4):387-96.
- Mir Mm, Al-Hazmi Ah, Abadi Am, Al-Shahrani Am, Alghamdi M, Alamri Mms, et al. Medical Education in the Gulf Cooperation Council: A Saudi Arabia Anchored Analysis from Expansion to System Alignment. *Journal of Advances in Medical Education & Professionalism*. 2026;14(3):207-19.
- O'Sullivan PS, Irby DM. Reframing research on faculty development. *Acad Med*. 2011;86(4):421-8.
- Uzorka A, Olaniyani AO. Leadership role and professional development of technology. *Educ Inf Technol (Dordr)*. 2023;28(1):713-23.
- Steinert Y, Mann K, Anderson B, Barnett BM, Centeno A, Naismith L. A systematic review of faculty development initiatives designed to enhance teaching effectiveness: A 10-year update: BEME Guide No.40. *Med Teach*. 2016;38(8):769-86.
- Arja SB, Paramban S, Ponnusamy K, Nayakanti ARJ, Fatteh R, Arja SB. The systematic approach to faculty development activities for biomedical educators. *Journal of Advances in Medical Education & Professionalism*. 2020;8(3):127-33.
- Ashwood N, Stanhope E, Lahart I, Dekker Ap, Hind J, Carmichael A. Teaching Professionalism during and Post Pandemic to Surgical Trainees: A Survey of the Impact of a Workshop on Trainers and Trainees. *Journal of Advances in Medical Education & Professionalism*. 2023;11(4):193-204.
- Kolomito K, Soleas E, Steinert Y. Developing Faculty Developers: An Underexplored Realm in Professional Development. *J Contin Educ Health Prof*. 2023 [Online ahead of print].
- Aydın N, Sayır MF, Aydeniz S, Şimşek T. How Did COVID-19 Change Faculty Members' Use of Technology? *Sage Open*. 2023;13(1):21582440221149720.
- Steinert Y, Cruess RL, Cruess SR, Boudreau JD, Fuks A. Faculty development as an instrument of change: a case study on teaching professionalism. *Acad Med*. 2007;82(11):1057-64.
- DeLuca J, Girand HL, Hilaire ML, Lindsey CC, Prescott WA, Jr. A Mixed Methods Study of Resources Available for the Professional Development of Mid-Career Faculty. *Am J Pharm Educ*. 2024;88(3):100661.

16. Steinert Y. Twelve tips for conducting effective workshops. *Med Teach*. 1992;14(2-3):127-31.
17. Huenneke LF, Stearns DM, Martinez JD, Laurila K. Key strategies for building research capacity of university faculty members. *Innovative higher education*. 2017;42:421-35.
18. Baran E. Investigating faculty technology mentoring as a university-wide professional development model. *Journal of computing in higher education*. 2016;28:45-71.
19. Girod SC, Fassiotto M, Menorca R, Etzkowitz H, Wren SM. Reasons for faculty departures from an academic medical center: a survey and comparison across faculty lines. *BMC medical education*. 2017;17(1):1-10.
20. Boamah SA, Hamadi HY, Havaei F, Smith H, Webb F. Striking a balance between work and play: The effects of work–life interference and burnout on faculty turnover intentions and career satisfaction. *International Journal of Environmental Research and Public Health*. 2022;19(2):809.
21. Roberts J. Future and changing roles of staff in distance education: a study to identify training and professional development needs. *Distance Education*. 2018;39(1):37-53.
22. Zodepy S, Sharma A, Zahiruddin Qs, Gaidhane A, Shrikhande S. Faculty development programs for medical teachers in India. *Journal of Advances in Medical Education & Professionalism*. 2016;4(2):97-101.
23. Brinkmann S, Kvale S. *Doing Interviews*. 55 City Road. London: SAGE Publications Ltd; 2018. Available from: <https://methods.sagepub.com/book/mono/doing-interviews-2e/toc>.
24. Hsieh HF, Shannon SE. Three approaches to qualitative content analysis. *Qualitative health research*. 2005;15(9):1277-88.
25. Roberts SJ, Abshire Saylor M, Ivynian S, DiGiacomo M. Data saturation and information power: Sample size in qualitative research—when is enough and how to assess? *European journal of cardiovascular nursing*. 2026;25(5):1069-74.
26. Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse education today*. 2004;24(2):105-12.
27. Lincoln YS, Guba EG. *Naturalistic inquiry*. London: Sage; 1985.
28. Okpalauwaekwe U, Holinaty C, Smith-Windsor T, Barton JW, MacLean C. From field of dreams to back to the future? Exploring barriers to participating in continuing professional development (CPD) programs. *BMC Medical Education*. 2024;24(1):106.
29. Lee CA, Wilkinson TJ, Timmermans JA, Ali AN, Anakin MG. Revealing the impact of the hidden curriculum on faculty teaching: A qualitative study. *Med Educ*. 2023;57(8):761-9.
30. Salajegheh M, Hekmat SN, Macky M. Challenges and solutions for the promotion of medical sciences faculty members in Iran: a systematic review. *BMC Medical Education*. 2022;22(1):406.
31. Algahtani H, Shirah B, Aldarmahi A, Alshawwa L, Tekian A, Norcini J. Barriers to Faculty Development Program for Medical Education: Experience from Saudi Arabia. *Dr Sulaiman Al Habib Medical Journal*. 2020;2(3):101-5.
32. Khoshgoftar Z, Khaledian S, Khani H. Factors Influencing Faculty Participation in Medical Education Development Programs: A Qualitative Case Study. *Journal of Medical Education and Curricular Development*. 2025;12:23821205251384382.
33. Montero L, Trivino X, Sirhan M, Moore P, Leiva L. Barriers for faculty development in medical education: a qualitative study. *Revista Medica de Chile*. 2012;140(6):695-702.
34. Kitto S, Fantaye AW, Ghidinelli M, Andenmatten K, Thorley Wiedler J, de Boer K. Barriers and facilitators to the cultivation of communities of practice for faculty development in medical education: A scoping review. *Med Teach*. 2025;47(10):1654-68.
35. Busari JO. The Harm We Cause: Spotlighting the Detrimental Consequences of Malicious Envy in Academic Medicine. *Clinical Medicine & Research*. 2026;24(1):1-8.
36. Keshmiri F, Farahmand S, Bahramnezhad F, Nedaei HHN. Exploring the challenges of professional identity formation in clinical education environment: A qualitative study. *Journal of Advances in Medical Education & Professionalism*. 2020;8(1):42.
37. Leverence R, Nuttall R, Palmer R, Segal M, Wood A, Yancey F, et al. Using organizational philosophy to create a self-sustaining compensation plan without harming academic missions. *Acad Med*. 2017;92(8):1133-7.