



PROFESSIONALISM IN PRACTICE: A QUALITATIVE ASSESSMENT OF RESIDENTS' TRAINING NEEDS IN MEDICAL LAW AND ETHICS IN TEACHING HOSPITALS OF KHYBER PAKHTUNKHWA

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Abstract

Background: Medical professionalism today requires more than clinical competence. Physicians must also understand legal responsibilities, patient rights, and ethical decision-making. In Khyber Pakhtunkhwa (KP), increasing regulatory oversight, patient complaints, and public scrutiny have made the medicolegal environment more demanding for postgraduate residents working in public sector teaching hospitals. However, structured and applied training in medical law and ethics remains limited during residency.

Objective: To explore the lived experiences of senior residents regarding medical law and ethics and to identify their perceived training needs within the public sector Medical Teaching Institutions of KP.

Methods: A qualitative phenomenological study was conducted from October 2024 to May 2025 across six public sector Medical Teaching Institutions representing Central, Northern, and Southern KP. Twenty-four senior residents (RT-3 and RT-4) were recruited using purposive sampling. Data were collected through semi-structured, in-depth interviews. Interviews were audio-recorded, transcribed verbatim, and analyzed using Braun and Clarke's inductive thematic analysis approach. Seventy-eight initial codes were generated and organized into 24 sub-themes and six overarching themes. Data saturation was achieved at the 21st interview and confirmed with three additional interviews.

Results: Six major themes emerged: The Legal Shadow, Socio-Ethical Dissonance, The Pedagogical Void, Systemic Barriers, Medicolegal Literacy Needs, and Professional Identity Formation. Residents

described practicing defensive documentation due to persistent fear of litigation and complaints. Cultural norms often conflicted with legal standards of patient autonomy. Training in medical jurisprudence was largely informal and shaped by observation rather than structured teaching. Infrastructure limitations and political pressures further complicated ethical practice. Participants strongly recommended case-based legal workshops, documentation training, conflict de-escalation skills, and institutional legal support systems.

Conclusion: Senior residents in KP practice in an environment of significant medicolegal vulnerability without adequate structured preparation. Integrating applied medical jurisprudence into residency programs is essential to strengthen professional accountability, reduce legal anxiety, and support ethical clinical practice. After surgery, in group A, after postoperative 2 cases had felt moderate anxiety, while in group B, 10 cases had felt moderate anxiety.

Keywords: Medical ethics; Medical law; Professionalism; Residency training; Qualitative research; Pakistan

Introduction

Professionalism in medicine has evolved significantly in recent years. Traditionally, professionalism was viewed as a moral obligation grounded in compassion, competence, and integrity. However, modern healthcare systems increasingly define professionalism as a measurable competency that includes ethical reasoning, accountability, communication skills, and legal awareness.¹ Physicians are now expected not only to deliver clinical care but also to function within structured regulatory and legal frameworks.

Globally, healthcare systems are experiencing increased transparency, patient awareness, and medicolegal scrutiny. Litigation related to medical negligence has shown a rising trend in several regions, including low- and middle-income countries.² Defensive medicine, in which clinical decisions are influenced by fear of complaints or legal consequences, has become increasingly recognized in contemporary practice.³ Although defensive strategies may provide psychological reassurance to clinicians, they can negatively affect patient-centered communication and trust.

Patients today are more informed and more assertive regarding their rights. Digital access to medical information and social media exposure have reshaped expectations from healthcare providers. Complaints, legal notices, and institutional inquiries are no longer rare occurrences in teaching hospitals. In such settings, postgraduate residents frequently serve as frontline decision-makers and communicators.

In Pakistan, the medicolegal environment has undergone structural changes in recent years. Provincial healthcare commissions, including those established in Khyber Pakhtunkhwa, have formalized accountability systems and complaint redressal mechanisms. While these reforms aim to enhance patient safety and transparency, they have also increased the perceived legal exposure of physicians working in high-volume public hospitals.

Public sector Medical Teaching Institutions in Khyber Pakhtunkhwa operate under significant workload pressures. Residents manage large patient volumes, obtain informed consent, document clinical decisions, communicate serious diagnoses, and respond to family concerns. Despite these responsibilities, structured and applied training in medical law and clinical ethics during residency remains limited.

Undergraduate curricula in Pakistan typically include forensic medicine and theoretical ethics. However, this instruction often emphasizes statutory definitions and medico-legal documentation rather than real-world ethical dilemmas encountered in clinical wards. As a result, residents may assume advanced responsibilities without adequate preparation for responding to legal inquiries, handling complex consent disputes, or documenting high-risk cases appropriately.

The hidden curriculum plays an important role in shaping professional behavior during residency. The hidden curriculum refers to the informal transmission of values and practices through workplace culture rather than formal instruction.⁴ In the absence of structured medicolegal education, residents

often learn documentation methods, consent practices, and communication strategies by observing senior colleagues. These learned behaviors may not always align with legal standards or best practices. Cultural context further complicates ethical decision-making. Western bioethical frameworks prioritize individual autonomy. However, in collectivist societies, family-centered decision-making remains common.⁵ In many cases, family members may significantly influence consent processes, especially for female patients. Physicians must balance cultural sensitivity with legal obligations. Without structured guidance, this tension may create uncertainty and stress.

Persistent exposure to ethical conflict and legal fear may contribute to moral distress. Moral distress occurs when clinicians recognize the ethically appropriate course of action but feel constrained by systemic or contextual barriers.⁶ Over time, such experiences may influence professional identity formation. Professional identity develops during residency through clinical exposure, mentorship, and institutional culture.¹ When legal anxiety becomes dominant, identity may shift from patient-centered professionalism toward defensive self-protection.

Recent medical education research emphasizes the need for applied ethics training, simulation-based learning, and case-based jurisprudence during residency.⁷ Experiential teaching methods, including mock trials and structured ethical case discussions, have demonstrated positive effects on learner confidence and preparedness.⁷ However, empirical evidence from Pakistan remains limited. Few qualitative studies have explored how residents perceive their medicolegal vulnerability or what specific competencies they believe are lacking.

Understanding residents' lived experiences is essential for meaningful curriculum reform. Qualitative inquiry allows in-depth exploration of perceptions, fears, and contextual challenges that may not be captured through quantitative surveys. In regions where sociocultural and systemic factors strongly influence clinical practice, phenomenological approaches provide valuable insight into how professionalism is experienced in everyday settings.

To date, no multi-institutional qualitative study has examined the medicolegal training needs of senior residents across public sector Medical Teaching Institutions in Khyber Pakhtunkhwa. Given the evolving regulatory climate and increasing public scrutiny, there is a pressing need to identify educational gaps and institutional vulnerabilities.

Therefore, this study aimed to explore the lived experiences of senior residents regarding medical law and ethics within public sector teaching hospitals of KP and to identify specific training needs that may inform curriculum development and institutional policy reform.

Methodology

Study Design

This study employed a qualitative descriptive design using a phenomenological approach. The phenomenological framework was selected to explore the lived experiences of senior residents regarding medical law and ethics within their clinical practice. Phenomenology is particularly suitable when the objective is to understand how individuals interpret and make meaning of their experiences in specific contexts.⁸

Study Duration and Setting

The study was conducted over eight months from October 2024 to May 2025. Data were collected from six public sector Medical Teaching Institutions (MTIs) located in the Central, Northern, and Southern clusters of Khyber Pakhtunkhwa. These institutions represent tertiary care referral centers with structured residency programs under provincial health governance.

The selected MTIs manage high patient volumes and serve diverse populations, making them appropriate sites for examining medico-legal and ethical challenges encountered during residency training.

Participant Selection

Purposive sampling was used to recruit participants. The inclusion criteria required residents to:

- Be enrolled in a recognized postgraduate residency program

- Have completed at least two years of residency training
- Be in RT-3 or RT-4 at the time of data collection
- Be willing to provide informed consent

Senior residents were selected because they have greater exposure to complex clinical scenarios, independent decision-making, and interactions involving consent, documentation, and conflict management.

Residents from four major specialties—Medicine, Surgery, Gynecology, and Pediatrics—were included to ensure variation in clinical exposure.

A total of 24 participants were interviewed. Recruitment continued until data saturation was achieved. Saturation was reached at the 21st interview, when no new codes emerged. Three additional interviews were conducted to confirm thematic stability.

Data Collection

Data were collected through semi-structured, in-depth, one-on-one interviews. An interview guide was developed based on literature review and study objectives. The guide explored:

- Experiences with informed consent
- Documentation practices
- Exposure to complaints or legal inquiries
- Ethical conflicts in clinical decision-making
- Perceived gaps in medicolegal training
- Suggestions for curricular reform

Interviews were conducted in English, as it is the medium of medical education in Pakistan. Each interview lasted between 35 and 50 minutes. Interviews were conducted in private spaces within hospital premises to ensure confidentiality and minimize interruptions.

With participant consent, interviews were audio-recorded. Field notes were maintained to document non-verbal cues and contextual observations.

Researcher Reflexivity

The primary researcher had academic exposure to health professions education and familiarity with residency structures. Reflexive journaling was maintained throughout data collection and analysis to minimize personal bias. The researcher consciously avoided leading questions and allowed participants to elaborate freely on their experiences.

Peer debriefing sessions were conducted with two senior qualitative researchers to discuss emerging codes and themes.

Data Analysis

Audio recordings were transcribed verbatim. Transcripts were reviewed multiple times to ensure accuracy and familiarization with the data.

Data were analyzed using Braun and Clarke's six-phase inductive thematic analysis framework⁹:

1. Familiarization with data
2. Generation of initial codes
3. Searching for themes
4. Reviewing themes
5. Defining and naming themes
6. Producing the report

Coding was performed manually to preserve closeness to the data. Seventy-eight initial codes were identified across transcripts. These codes were grouped into 24 sub-themes. Subsequently, six overarching themes were developed.

The analysis was inductive in nature, meaning themes emerged from participant narratives rather than being imposed from pre-existing theoretical categories.

Trustworthiness

To enhance credibility, prolonged engagement with data was ensured through repeated transcript review. Member checking was conducted with five participants, who reviewed summaries of findings to confirm interpretive accuracy.

Dependability was strengthened by maintaining a detailed audit trail documenting coding decisions, theme development, and revisions. Confirmability was addressed through peer review of codes and themes.

Transferability was supported by providing detailed descriptions of setting, participant characteristics, and contextual factors.

Ethical Considerations

Ethical approval was obtained from the Institutional Review Board prior to commencement of the study. Participants were provided with written information sheets explaining study objectives, confidentiality measures, and voluntary participation.

Written informed consent was obtained from all participants. Identifiers were removed during transcription. Participants were assigned codes (e.g., P01, P02) to maintain anonymity.

Data were stored securely and accessed only by the research team.

Results

A total of 24 senior residents participated in this study. Fourteen participants (58%) were male and ten (42%) were female. Thirteen residents (54%) were in RT-3, while eleven (46%) were in RT-4. Participants were equally distributed across Central, Northern, and Southern zones of Khyber Pakhtunkhwa. Specialties included Medicine, Surgery, Gynecology, and Pediatrics.

Table 1: Participant Demographic Characteristics (N = 24)

Variable	Category	n	%
Gender	Male	14	58
	Female	10	42
Residency Year	RT-3	13	54
	RT-4	11	46
Zone	Central	8	33
	Northern	8	33
	Southern	8	33
Specialty	Medicine	7	—
	Surgery	8	—
	Gynecology	5	—
	Pediatrics	4	—

Thematic analysis generated 78 initial codes. These codes were organized into 24 sub-themes and further consolidated into six overarching themes. Data saturation was achieved at the 21st interview and confirmed with three additional interviews.

The six overarching themes were:

1. The Legal Shadow
2. Socio-Ethical Dissonance
3. The Pedagogical Void
4. Systemic Barriers
5. Medicolegal Literacy Needs
6. Professional Identity Formation

The complete thematic framework is presented below.

Table 2: Themes, Subthemes, Codes, and Participant Quotes

Themes	Sub-theme	Codes	Participant Quote
The Legal Shadow	Defensive Documentation	Over-documentation; Fear of litigation; Self-protection writing	"I spend more time writing notes to save my skin than I do talking to the patient." (P02, Surgery)
	Legal Anxiety	Fear of recording; Fear of complaints; Suspicion culture	"Every time a patient records me on their phone, my heart sinks. Am I a doctor or a suspect?" (P08, Gynae)
	Ambiguity of Error	Unclear legal definitions; Fear of negligence label	"We don't know where mistake ends and crime begins." (P14, Medicine)
	Institutional Abandonment	Lack of legal backing; Fear of being scapegoated	"If something happens, the hospital steps back and we stand alone." (P05, Surgery)
2.Socio-Ethical Dissonance	Surrogate Decision-Making	Family dominance; Female autonomy challenges	"In Swat, the husband or father signs. The patient's signature is treated as a formality." (P06, Gynae)
	Paternalistic Truth-Telling	Non-disclosure requests; Cultural sensitivity	"Families beg us not to tell him it's cancer." (P02, Medicine)
	Gender-Based Ethics	Cultural hierarchy; Consent bias	"Sometimes the woman looks at her husband before answering." (P10, Gynae)
	Resource Rationing	ICU bed allocation stress; Ethical compromise	"Choosing who gets the last ventilator feels like playing God." (P09, Medicine)
3. The Pedagogical Void	Forensics–Ethics Mismatch	Theoretical overload; Lack of applied training	"I know how to identify a 3-day-old corpse, but not how to respond to a legal notice." (P03, Surgery)

	Absence of Integration	No interdisciplinary teaching; Curriculum gaps	"Ethics is in one book, practice is in another world." (P12, Pediatrics)
	Hidden Curriculum	Learning from seniors; Replicating mistakes	"I learned how to fill a death certificate by watching a senior who was doing it wrong." (P08, Medicine)
	Evaluation Deficiencies	No assessment of ethics; No OSCE in law	"We are never examined on how to handle consent." (P16, Surgery)
4. Systemic Barriers	Infrastructure Constraints	Overcrowding; Lack of privacy	"How do I maintain confidentiality when three patients share one bed?" (P07, Medicine)
	Political Interference	VIP pressure; Administrative calls	"If I follow the law with a VIP, I get a call from higher authorities." (P09, Medicine)
	Documentation Burden	Excessive paperwork; Time pressure	"Half my shift goes in paperwork." (P18, Surgery)
	Staffing Shortages	Fatigue; Ethical shortcuts	"When you are covering 40 patients, ethics becomes secondary." (P21, Pediatrics)
5. Medicolegal Literacy Needs	Case-Based Jurisprudence	Real court examples; Local case analysis	"Show us real court cases of doctors in KP." (P11, Medicine)
	Documentation Mastery	Legal wording; Proper charting	"Teach us what exactly to write so it stands in court." (P04, Surgery)
	Conflict De-escalation	Communication skills; Handling aggression	"Teaching us how to talk to angry families is more important than anatomy now." (P06, Medicine)
	Self-Protection Law	Rights of doctors; Legal boundaries	"We should know what rights we have as doctors." (P20, Gynae)
6. Professional Identity Formation	Role Ambiguity	Healer vs service provider; Legal identity shift	"The society sees us as healers, but the law sees us as service providers." (P05, Surgery)
	Moral Distress	Ethical compromise; Emotional burden	"Sometimes I know what is right, but I cannot do it." (P13, Medicine)
	Survival Mentality	Complaint avoidance; Defensive approach	"My only goal every shift is to finish without a complaint." (P02, Surgery)
	Future Intentions	Migration thoughts; Specialty reconsideration	"Many of us are thinking of leaving because of constant fear." (P22, Pediatrics)

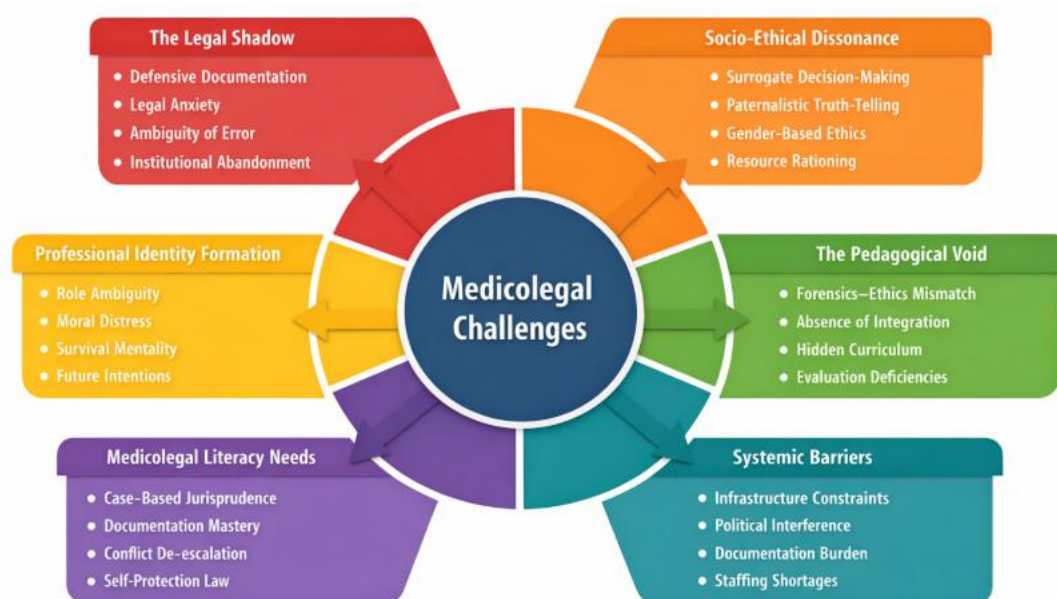


Figure 1: showing themes and subthemes

The results demonstrate that legal anxiety, sociocultural conflict, and systemic pressures are interconnected factors shaping residents' experiences. Defensive documentation practices were common. Cultural norms frequently influenced consent processes. Training gaps resulted in reliance on informal learning. Structural barriers intensified ethical compromise. These factors collectively contributed to evolving professional identity and survival-oriented clinical behavior.

Discussion

This multi-institutional qualitative study explored the lived experiences of senior residents regarding medical law and ethics within public sector Medical Teaching Institutions of Khyber Pakhtunkhwa. The findings reveal a complex interaction between legal anxiety, sociocultural tension, systemic constraints, educational gaps, and professional identity formation. Collectively, these themes highlight significant medicolegal vulnerability among residents and underscore the urgent need for structured curricular reform.

One of the most dominant findings was the pervasive sense of legal insecurity, described here as “The Legal Shadow.” Residents reported practicing defensive documentation and working under constant fear of complaints and litigation. This aligns with global evidence suggesting that defensive medicine is increasingly prevalent in environments with rising medico-legal scrutiny.³ Defensive practices, although protective in intention, may compromise patient-centered communication and reduce relational trust. Studies have shown that excessive documentation driven by fear may shift clinical focus from therapeutic engagement to self-protection.²

The uncertainty surrounding the definition of negligence further intensified residents' anxiety. Participants expressed confusion regarding where clinical error transitions into legal culpability. Similar concerns have been reported in low-resource settings, where medico-legal education does not adequately clarify professional liability standards.¹⁰ When clinicians lack clarity about legal thresholds, ambiguity may lead to risk-averse behavior and decision paralysis.

The theme of Socio-Ethical Dissonance highlights the intersection between cultural norms and legal principles. Residents described family-dominated consent processes and requests for non-disclosure of serious diagnoses. In collectivist societies, healthcare decisions are often shared among family members rather than centered exclusively on individual autonomy.⁵ However, modern legal frameworks increasingly emphasize informed consent and patient rights. This tension places residents in ethically complex positions. Research in similar sociocultural contexts suggests that culturally sensitive bioethics education is necessary to bridge the gap between universal ethical principles and local realities.¹¹

Resource rationing, particularly in high-demand settings such as intensive care units, emerged as another source of ethical stress. Participants described moral discomfort when allocating limited resources. Such experiences are consistent with literature on moral distress, where clinicians feel constrained by systemic limitations despite recognizing ethically appropriate actions.⁶ Persistent moral distress has been associated with burnout, disengagement, and compromised professional identity.¹²

The Pedagogical Void identified in this study reflects a disconnect between formal forensic medicine teaching and real-world medicolegal challenges. Residents reported that their undergraduate training focused on theoretical or autopsy-based knowledge rather than applied clinical jurisprudence. International medical education literature emphasizes the importance of experiential ethics education, including simulation-based training, case discussions, and mock legal proceedings.⁷ Without such structured exposure, residents may rely heavily on the hidden curriculum.

The hidden curriculum remains a powerful force in professional development.⁴ When residents learn consent documentation or death certification practices through observation alone, errors may be perpetuated across generations. This informal transmission of practice norms may normalize defensive strategies and incomplete consent processes. Strengthening formal assessment of ethical competencies, including incorporation into Objective Structured Clinical Examinations (OSCEs), may help counterbalance hidden curricular influences.

Systemic barriers further amplified ethical strain. Overcrowding and limited infrastructure compromised confidentiality. Political interference, particularly in cases involving influential individuals, created additional pressure. Such contextual factors demonstrate that professionalism cannot be viewed solely as an individual attribute but must be understood within institutional and structural frameworks.¹³ Organizational support systems, including legal advisory cells and clear reporting mechanisms, are essential to reinforce ethical practice.

The expressed need for case-based jurisprudence and documentation mastery reflects residents' desire for practical tools rather than abstract theory. Participants specifically requested exposure to real court cases involving physicians in their region. Evidence suggests that case-based learning enhances retention and contextual understanding of legal principles.⁷ Simulation of medico-legal scenarios, including mock trials, has been shown to improve confidence and preparedness in managing complaints.⁷ Incorporating such strategies into residency curricula may reduce anxiety and enhance accountability.

Professional identity formation emerged as a cross-cutting theme influenced by all other factors. Residents described tension between the traditional image of the physician as a healer and the contemporary perception of the doctor as a legally accountable service provider. Professional identity develops through repeated clinical experiences, mentorship, and reflection.¹ When clinical practice becomes dominated by fear of litigation, identity may shift toward defensive self-preservation.

The reported “survival mentality” is particularly concerning. When residents prioritize completing shifts without complaints over holistic patient engagement, professionalism may erode. Research indicates that environments characterized by fear and blame can weaken moral agency and reduce intrinsic motivation.¹² Addressing medicolegal anxiety is therefore not only a legal necessity but also a professional development imperative.

This study contributes novel insights by examining medicolegal training needs across multiple institutions within KP. Unlike single-site investigations, the multi-regional design enhances contextual depth and transferability. The findings underscore that legal vulnerability is not confined to a single specialty or hospital but is experienced system-wide.

Several implications emerge from these findings. First, forensic medicine curricula require reorientation toward applied medical jurisprudence. Second, structured workshops on documentation, informed consent, and communication during conflict should be mandatory components of residency training. Third, institutional legal counseling units could provide real-time advisory support, thereby reducing fear-driven practice. Finally, integrating reflective sessions on moral distress may strengthen professional identity resilience.

Future research should examine the impact of simulation-based medicolegal training on residents' confidence and complaint rates. Longitudinal studies may also explore how medicolegal preparedness influences burnout and career trajectories.

Strengths

This study has several strengths.

1. First, it included participants from six public sector Medical Teaching Institutions across Central, Northern, and Southern regions of Khyber Pakhtunkhwa. This multi-regional representation enhanced contextual diversity and strengthened the credibility of findings. The inclusion of multiple specialties, including Medicine, Surgery, Gynecology, and Pediatrics, allowed exploration of medicolegal experiences across varied clinical settings.
2. Second, the use of a phenomenological design enabled in-depth exploration of residents' lived experiences. The qualitative approach provided rich, narrative data that captured emotional, cultural, and systemic dimensions of professionalism that may not be measurable through quantitative tools.
3. Third, data saturation was achieved and confirmed through additional interviews, enhancing methodological rigor. Trustworthiness was strengthened through peer debriefing, member checking, reflexive journaling, and maintenance of an audit trail.

Finally, the development of a structured thematic framework with clear linkage between codes, sub-themes, and representative quotes enhances transparency and analytical clarity.

Limitations

Despite its strengths, this study has limitations.

1. First, it was conducted exclusively in public sector institutions. Findings may not fully represent the experiences of residents working in private hospitals or smaller district facilities.
2. Second, participants were senior residents (RT-3 and RT-4). Junior residents may experience medicolegal challenges differently. Their perspectives were not explored in this study.

3. Third, as with most qualitative research, social desirability bias cannot be excluded. Participants may have moderated their responses when discussing institutional weaknesses.
4. Fourth, the study relied on self-reported experiences rather than direct observation of practice. Therefore, reported behaviors such as defensive documentation were not independently verified.

Despite these limitations, the study provides meaningful insight into systemic and educational gaps within residency training in Khyber Pakhtunkhwa.

Conclusion

This study highlights that senior residents in public sector Medical Teaching Institutions of Khyber Pakhtunkhwa practice under substantial medicolegal pressure. Legal anxiety, sociocultural ethical conflict, infrastructural constraints, and insufficient structured training collectively influence clinical behavior and professional identity formation.

Residents described a shift from patient-centered engagement toward defensive practice strategies aimed at avoiding complaints. The disconnect between theoretical forensic instruction and applied medical jurisprudence further exacerbates this vulnerability.

Addressing these gaps requires urgent curricular reform. Residency programs must integrate case-based legal teaching, simulation exercises, documentation workshops, and structured conflict management training. Institutional mechanisms such as legal advisory support units are equally necessary to reduce fear-driven practice.

Strengthening medicolegal literacy is not solely a legal safeguard. It is fundamental to sustaining ethical integrity, protecting professional identity, and promoting safe, culturally responsive patient care.

Conflict of interest

The authors declare no conflict of interest.

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