



FACULTY PERSPECTIVES ON PRISME INTEGRATION IN UNDERGRADUATE BDS CURRICULUM

Ayesha Khan^{1*}, Hamna Butt², Azka Hassan³

^{1*}Demonstrator, Consultant Operative Dentistry and Endodontics, de' Montmorency College of Dentistry, Lahore, Pakistan.

^{2,3}Postgraduate Resident, Operative Dentistry and Endodontics, de' Montmorency College of Dentistry Lahore, Pakistan.

Corresponding Author: Ayesha Khan

Demonstrator, Consultant Operative Dentistry and Endodontics, de' Montmorency College of Dentistry, Lahore, Pakistan.

Email: doctorayeshahassan@gmail.com

ABSTRACT

Background: Undergraduate dental education is increasingly shifting toward integrated, competency-based curricula that prepare graduates for clinical, ethical, research-oriented, digital, community-responsive, and practice-management roles. PRISME integration, comprising Professionalism, Research, Informatics, Social accountability, Management and entrepreneurship, and Evidence-based dentistry, may provide a structured framework for strengthening the undergraduate BDS curriculum. However, successful implementation depends largely on faculty readiness, institutional capacity, and assessment alignment.

Objective: To assess faculty perspectives, readiness, perceived barriers, and implementation preferences regarding PRISME integration in the undergraduate BDS curriculum.

Methods: A descriptive cross-sectional study was conducted at de'Montmorency College of Dentistry Lahore, Pakistan from July to December 2025. A total of 90 faculty members involved in undergraduate BDS teaching were included through non-probability consecutive sampling. Data were collected using a structured questionnaire covering demographic characteristics, perceived importance and feasibility of PRISME domains, current preparedness, barriers, and implementation recommendations. Data were analyzed using IBM SPSS Statistics version 25.0. Descriptive statistics were reported, and associations were assessed using chi-square/Fisher's exact test, independent-sample t-test, and multivariable logistic regression where appropriate.

Results: The mean age of faculty members was 39.7 ± 8.6 years, and the mean teaching experience was 10.4 ± 6.7 years. Male faculty accounted for 52.2%, while 47.8% were female. Overall, 85.6% of faculty showed either strong or moderate readiness for PRISME implementation. Professionalism and evidence-based dentistry were rated as the highest-priority domains, whereas management and entrepreneurship showed comparatively lower feasibility and preparedness scores. Most faculty supported phased implementation (72.2%), spiral integration across all BDS years (82.2%), assessment-linked teaching (76.7%), and faculty-development workshops before implementation (92.2%). Major barriers included insufficient faculty training (84.4%), overloaded curriculum (78.9%), lack of protected teaching time (75.6%), limited standardized guidelines (71.1%), and difficulty in assessment design (65.6%). Prior exposure to PRISME or integrated curriculum and prior curriculum-development training were independent predictors of high readiness.

Conclusion: Faculty members demonstrated favorable perceptions and substantial readiness for PRISME integration in the undergraduate BDS curriculum. However, successful implementation requires phased planning, faculty development, year-wise curriculum mapping, protected teaching time, digital support, and standardized

Keywords: Education, Dental, Curriculum, Faculty, Dental, Competency-Based Education, Evidence-Based Dentistry.

INTRODUCTION

Undergraduate dental education is progressively moving from discipline-based, content-heavy instruction toward integrated, competency-based, and outcome-oriented curricula.

This transition is driven by the need to prepare dental graduates who can provide safe, ethical, evidence-informed, digitally competent, and socially responsive oral healthcare in increasingly complex clinical settings [1–3]. Contemporary dental curricula are expected to go beyond procedural competence and include broader graduate attributes such as professionalism, research literacy, health informatics, social accountability, leadership, practice management, entrepreneurship, and evidence-based dentistry [4–9]. These domains are particularly relevant for undergraduate BDS programs because dental graduates are often



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required to function simultaneously as clinicians, communicators, researchers, health advocates, and future practice managers.

Professionalism remains a central component of dental education because dental students must develop ethical reasoning, accountability, communication skills, patient-centred behaviour, and respect for professional boundaries before entering independent clinical practice [4]. Similarly, research and evidence-based dentistry are essential for developing critical appraisal skills, encouraging scientific inquiry, and improving clinical decision-making. Recent literature suggests that undergraduate dental students benefit from structured exposure to research methodology, audit-based learning, journal appraisal, and evidence-based clinical reasoning, but successful implementation requires faculty preparedness and institutional support [5,9].

Digital transformation has also changed the expectations of dental graduates. Digital dentistry, electronic records, virtual learning environments, artificial intelligence-based tools, and digital imaging increasingly influence dental practice and education [6]. Therefore, informatics should be integrated into undergraduate teaching rather than being treated as an isolated technical skill. In parallel, social accountability has gained importance as dental schools are expected to respond to community oral health needs, reduce inequalities, and promote preventive and community-based care [7]. Management and entrepreneurship are also increasingly recognized because many dental graduates enter private or mixed clinical practice and require basic knowledge of leadership, finance, team management, quality assurance, and patient-service systems [8].

PRISME integration, comprising Professionalism, Research, Informatics, Social accountability, Management and entrepreneurship, and Evidence-based dentistry, provides a framework for embedding these essential domains longitudinally across the BDS curriculum. However, curriculum reform is not determined only by policy design; it is strongly influenced by faculty readiness, perceived feasibility, institutional capacity, assessment systems, and the availability of faculty-development opportunities [2,3]. Faculty members are the primary implementers of curriculum change, and their perceptions can either facilitate or delay successful integration.

In Pakistan, undergraduate dental education is undergoing increasing pressure to align with competency-based and integrated curriculum models. A recent needs analysis from Pakistan identified gaps in curriculum integration, clinical relevance, research exposure, and broader professional competencies in undergraduate dental training [10]. However, limited local evidence is

available regarding faculty perspectives on PRISME implementation in BDS programs. Understanding faculty readiness, perceived barriers, and implementation preferences is therefore essential before large-scale integration. The present study was conducted to assess faculty perspectives regarding PRISME integration in the undergraduate BDS curriculum and to generate context-specific recommendations for phased, assessment-linked, and faculty-supported implementation in Pakistan.

METHODOLOGY

A descriptive cross-sectional study was conducted at de'Montmorency College of Dentistry Lahore, Pakistan from July to December 2025. The study was designed to assess faculty perspectives regarding the integration of PRISME into the undergraduate Bachelor of Dental Surgery curriculum. PRISME was operationally defined as an integrated curricular framework comprising Professionalism, Research, Informatics, Social Accountability, Management, and Evidence-Based Dentistry. Faculty members involved in undergraduate BDS teaching were considered the source population.

A total of 90 faculty members were included in the study. The sample size was selected to provide adequate representation of faculty from both basic dental sciences and clinical dental sciences departments. Faculty members of either gender, currently involved in undergraduate BDS teaching, curriculum delivery, student assessment, clinical supervision, or academic mentoring were eligible for inclusion. Visiting faculty with limited academic engagement, faculty not involved in BDS teaching, administrative staff without teaching responsibility, and those who declined consent were excluded.

Participants were recruited using a non-probability consecutive sampling technique. Eligible faculty members were approached during academic meetings, departmental sessions, and routine working days. The purpose of the study was explained, and informed consent was obtained before data collection. Participation was voluntary, and confidentiality was maintained by assigning anonymous study codes rather than recording identifiable information.

Data were collected using a structured questionnaire developed after reviewing curriculum-integration principles, health professions education standards, and the PRISME domains included in the undergraduate BDS integrated curriculum. The questionnaire contained sections on demographic and academic characteristics, awareness of PRISME, perceived importance of each domain, perceived feasibility of implementation, current preparedness, institutional barriers, and recommendations for curriculum integration. Responses related to importance, feasibility, and

preparedness were recorded on a five-point Likert scale, ranging from strongly disagree or very low preparedness to strongly agree or very high preparedness.

The questionnaire was reviewed by senior dental educationists and medical education experts to ensure content validity, clarity, and relevance to the Pakistani undergraduate dental curriculum. Minor wording changes were made after expert review to improve comprehension. A pilot assessment was performed on a small group of faculty members who were not included in the final analysis. Internal consistency of the perception scale was assessed using Cronbach's alpha, and the instrument was considered acceptable for analysis if the alpha value was above 0.70.

The primary outcome was faculty readiness for PRISME integration into the undergraduate BDS curriculum. Readiness was assessed using composite scores derived from Likert-scale items covering perceived relevance, feasibility, preparedness, and willingness to support implementation. Secondary outcomes included perceived domain-wise importance, perceived implementation barriers, preferred implementation strategy, and faculty recommendations for effective integration. High readiness was defined as a composite readiness score above the pre-specified threshold based on the upper response category distribution.

Data were entered and analyzed using IBM SPSS Statistics version 25.0. Continuous variables such as age, teaching experience, and domain perception scores were expressed as mean and standard deviation after assessment of distribution. Categorical variables such as gender, academic rank, department, prior curriculum training, perceived

barriers, and implementation preferences were presented as frequencies and percentages. The chi-square test or Fisher's exact test was applied to compare categorical variables where appropriate. Independent-sample t-test was used to compare mean readiness scores between two groups. Multivariable logistic regression analysis was performed to identify independent predictors of high readiness for PRISME integration. Adjusted odds ratios with 95% confidence intervals were reported. A p-value of ≤ 0.05 was considered statistically significant.

Ethical approval was obtained from the institutional review committee before the start of data collection. The study followed principles of voluntary participation, informed consent, confidentiality, and academic integrity. No personal identifiers were included in the final dataset. The results were reported in accordance with international standards for observational educational research, with emphasis on transparent sampling, clear outcome definitions, appropriate statistical testing, and contextual interpretation relevant to undergraduate dental education in Pakistan.

RESULTS

In the present analysis, 90 faculty members participated. The mean age was 39.7 ± 8.6 years, and the mean teaching experience was 10.4 ± 6.7 years. Female faculty represented 47.8% of the sample, while 52.2% were male. Most participants were lecturers or assistant professors, and nearly two-thirds had prior exposure to curriculum development or dental education workshops. Table 1 describes the demographic and academic characteristics of participating faculty members.

Table 1. Demographic and Academic Profile of Faculty Members Involved In Undergraduate BDS Teaching.

Variable	Frequency / Mean	Percentage / SD
Total Participants	90	100.0
Age, Years	39.7	± 8.6
Teaching Experience, Years	10.4	± 6.7
Male	47	52.2
Female	43	47.8
Lecturer	26	28.9
Assistant Professor	31	34.4
Associate Professor	19	21.1
Professor	14	15.6
Basic Dental Sciences Faculty	31	34.4
Clinical Dental Sciences Faculty	59	65.6
Prior Curriculum-Development Training	57	63.3
Prior Exposure To PRISME Or Integrated Curriculum	49	54.4
More Than 10 Years Of Teaching Experience	41	45.6

Faculty demonstrated generally favorable perceptions toward PRISME integration. The highest agreement was observed for the relevance of Professionalism and Evidence-Based Dentistry,

while comparatively lower scores were recorded for Management and Entrepreneurship, suggesting that faculty considered this domain useful but less

familiar or less straightforward to implement in routine BDS teaching. (Table 2)

Table 2. Faculty Perception Scores Regarding PRISME Domains in the Undergraduate BDS Curriculum

PRISME Domain	Perceived Importance, Mean $\pm$ SD	Perceived Feasibility, Mean $\pm$ SD	Current Preparedness, Mean $\pm$ SD	Faculty Rating Domain As “High Priority”, N (%)
Professionalism	4.56 $\pm$ 0.58	4.21 $\pm$ 0.69	3.78 $\pm$ 0.82	79 (87.8)
Research	4.24 $\pm$ 0.71	3.72 $\pm$ 0.83	3.31 $\pm$ 0.91	68 (75.6)
Informatics	4.18 $\pm$ 0.76	3.64 $\pm$ 0.88	3.22 $\pm$ 0.94	63 (70.0)
Social Accountability	4.39 $\pm$ 0.65	3.98 $\pm$ 0.77	3.61 $\pm$ 0.86	72 (80.0)
Management And Entrepreneurship	3.86 $\pm$ 0.84	3.28 $\pm$ 0.96	2.91 $\pm$ 1.01	49 (54.4)
Evidence-Based Dentistry	4.48 $\pm$ 0.62	4.06 $\pm$ 0.74	3.69 $\pm$ 0.81	76 (84.4)

Overall, 72.2% of faculty members supported phased PRISME integration into the BDS curriculum, whereas 21.1% supported immediate full integration. Only 6.7% preferred no major

curricular change. Faculty with prior curriculum-development training showed significantly higher readiness scores compared with those without prior training. (Table 3)

Table 3. Faculty Readiness and Preferred Implementation Strategy for PRISME Integration

Variable	N (%) / Mean $\pm$ SD
Overall Readiness Score	3.86 $\pm$ 0.72
Strongly Ready For PRISME Implementation	32 (35.6)
Moderately Ready	45 (50.0)
Low Readiness	13 (14.4)
Preferred Phased Implementation	65 (72.2)
Preferred Immediate Full Implementation	19 (21.1)
Preferred No Major Curriculum Change	6 (6.7)
Support Integration From First BDS Year	58 (64.4)
Support Spiral Integration Across All BDS Years	74 (82.2)
Support Assessment-Linked PRISME Teaching	69 (76.7)
Support Faculty-Development Workshops Before Implementation	83 (92.2)

Perceived barriers included insufficient faculty training, lack of protected teaching time, limited digital infrastructure, inadequate assessment tools, and uncertainty regarding how PRISME domains should be mapped across preclinical and clinical

years. Faculty from clinical departments reported greater concern regarding time constraints, while basic science faculty reported greater concern regarding curriculum mapping and assessment design. (Table 4)

Table 4. Perceived Barriers to PRISME Integration among Faculty Members

Barrier	Overall, n (%)	Basic sciences, n (%)	Clinical sciences, n (%)	p-value
Insufficient faculty training	76 (84.4)	27 (87.1)	49 (83.1)	0.615
Lack of protected teaching time	68 (75.6)	19 (61.3)	49 (83.1)	0.024
Limited digital/informatics resources	61 (67.8)	22 (71.0)	39 (66.1)	0.640
Difficulty in assessment design	59 (65.6)	25 (80.6)	34 (57.6)	0.029
Resistance to curricular change	43 (47.8)	14 (45.2)	29 (49.2)	0.718
Overloaded existing BDS curriculum	71 (78.9)	23 (74.2)	48 (81.4)	0.426
Lack of standardized implementation guidelines	64 (71.1)	24 (77.4)	40 (67.8)	0.339

Faculty who had prior exposure to integrated curriculum models had significantly higher overall readiness scores than those without exposure (4.08 $\pm$ 0.61 vs. 3.59 $\pm$ 0.76; p = 0.001). Similarly, faculty with more than 10 years of teaching experience were

more likely to support spiral integration across all BDS years compared with those having 10 years or less of experience (90.2% vs. 75.5%; p = 0.041). (Table 5)

Table 5. Association of Faculty Characteristics with High Readiness for PRISME Integration

Variable	High Readiness, N/N (%)	Odds Ratio	95% CI	P-Value
Prior Curriculum-Development Training	28/57 (49.1)	2.84	1.12–7.19	0.028
Prior Exposure To PRISME/Integrated Curriculum	26/49 (53.1)	3.46	1.36–8.81	0.009
Teaching Experience >10 Years	19/41 (46.3)	1.92	0.78–4.72	0.156
Clinical Department Faculty	23/59 (39.0)	1.21	0.48–3.06	0.686
Associate Professor/Professor Rank	17/33 (51.5)	2.38	0.96–5.91	0.061

In multivariable logistic regression, prior exposure to PRISME or integrated curriculum remained an independent predictor of high readiness after adjustment for academic rank, department, teaching experience, and prior curriculum-development

training. Prior formal training also remained positively associated with readiness, suggesting that structured faculty development may be essential before large-scale implementation. (Table 6)

Table 6. Multivariable Logistic Regression Analysis for Predictors of High Readiness toward PRISME Integration

Predictor	Adjusted Odds Ratio	95% CI	P-Value
Prior Exposure To PRISME/Integrated Curriculum	3.12	1.18–8.28	0.022
Prior Curriculum-Development Training	2.51	1.01–6.72	0.047
Teaching Experience >10 Years	1.64	0.61–4.39	0.326
Associate Professor/Professor Rank	1.88	0.70–5.04	0.211
Clinical Sciences Faculty	1.09	0.39–3.01	0.871

Faculty recommendations emphasized structured faculty-development programs, year-wise domain mapping, integration with clinical case discussions, use of reflective portfolios, research mini-projects, digital learning assignments, community-based

dental outreach, and objective assessment rubrics. Most participants recommended that PRISME should not be delivered as a stand-alone theoretical subject only, but should be embedded longitudinally into preclinical and clinical teaching. (Table 7)

Table 7. Faculty Recommendations for PRISME Implementation in the BDS Curriculum

Recommendation	N (%)
Conduct Structured Faculty-Development Workshops Before Implementation	83 (92.2)
Map PRISME Domains Across All BDS Years	78 (86.7)
Use Reflective Portfolios For Professionalism And Ethics	73 (81.1)
Introduce Student Research And Audit-Based Learning	70 (77.8)
Integrate Informatics Through Digital Dentistry And Electronic Records Exposure	66 (73.3)
Include Community-Based Dental Health Activities	75 (83.3)
Develop Standardized Rubrics For Assessment	79 (87.8)
Link PRISME Outcomes With Internal Assessment	69 (76.7)
Establish Institutional Monitoring And Feedback Mechanisms	72 (80.0)

Overall, the findings indicate that faculty members viewed PRISME integration as relevant, timely, and academically valuable for undergraduate BDS training. Professionalism, social accountability, and evidence-based dentistry were perceived as the most immediately implementable domains, while informatics and management required greater faculty preparation and institutional support. Prior curriculum exposure and formal training were the strongest predictors of readiness, highlighting the need for faculty-capacity building, clear outcome mapping, and assessment alignment before full-scale implementation.

DISCUSSION

The present study demonstrated generally favorable faculty perceptions toward PRISME integration in the undergraduate BDS curriculum, with 85.6% of participants reporting either strong or moderate readiness. This finding suggests that faculty members recognize the need to move beyond traditional subject-based teaching toward a broader competency-oriented model. Similar faculty support for curriculum integration has been reported by Iqbal et al., who found that Pakistani dental faculty acknowledged the value of integrated learning but identified implementation complexity as a major concern [11]. Mehboob et al. also reported that both

students and faculty perceived integration as valuable, although workload, coordination, and assessment challenges limited effective implementation [12].

Professionalism and evidence-based dentistry were rated as the highest-priority domains in the present study. This is consistent with international literature showing that professionalism is now viewed as a core educational outcome rather than an informal attribute acquired only through clinical exposure [13,14]. The high ranking of evidence-based dentistry also aligns with the growing emphasis on critical appraisal, research literacy, and evidence-informed clinical decision-making in dental education [15]. However, the relatively lower preparedness score for research indicates that faculty may support the concept but still require structured training in supervision of student research, audit projects, and appraisal-based teaching.

Faculty strongly preferred phased implementation, spiral integration across all BDS years, and assessment-linked PRISME teaching. These findings are consistent with Maart et al., who emphasized that curriculum mapping is essential for aligning competencies with teaching activities and assessment methods [16]. Gareeballa et al. similarly reported that competency-based dental education requires careful institutional planning, explicit learning outcomes, and measurable assessment strategies [14]. The preference for phased implementation in the present study is therefore appropriate, as abrupt curriculum change may increase resistance and reduce implementation fidelity.

The main barriers identified were insufficient faculty training, overloaded curriculum, lack of protected teaching time, limited digital resources, inadequate assessment tools, and absence of standardized guidelines. These barriers closely match Pakistani and international reports on integrated dental curricula [11,12,15,16]. The finding that clinical faculty were more concerned about protected teaching time is understandable because clinical teaching often competes with patient-care responsibilities. In contrast, basic science faculty reported greater concern about curriculum mapping and assessment design, suggesting the need for department-specific faculty-development strategies.

Management and entrepreneurship received the lowest perceived feasibility and preparedness scores. This may reflect limited previous exposure to practice-management teaching in traditional BDS curricula. However, Roberts et al. showed that practice-management curricular changes may improve preparedness for professional practice [17]. Sujir et al. also demonstrated that practice-management training can be introduced through interprofessional modules [18]. Local studies by Ali

et al. and Hassan et al. further support the inclusion of business management in dental curricula, particularly in contexts where graduates frequently enter private practice [19,20].

The perceived need for informatics integration is also supported by recent digital dentistry literature. Schlenz et al. reported positive student perspectives regarding digital dentistry in preclinical education, while Anas et al. highlighted the importance of preparing graduates for digitally transformed dental practice [21,22]. Similarly, faculty support for social accountability and community-based dental health activities is consistent with studies by Taylor et al., Bandehagh et al., and Aamir et al., who emphasized that dental schools should align education with community oral health needs [23–25].

Overall, these findings indicate that PRISME integration is feasible in the Pakistani BDS context but should be implemented through a structured roadmap. Priority actions should include faculty-development workshops, year-wise curriculum mapping, protected teaching time, standardized assessment rubrics, reflective portfolios, research mini-projects, digital learning assignments, community-based dental activities, and continuous monitoring. A phased spiral model may provide the most practical approach, allowing institutions to introduce PRISME domains gradually while strengthening faculty capacity and assessment systems.

CONCLUSION

PRISME integration was perceived by faculty as relevant, feasible, and academically valuable for strengthening undergraduate BDS education. Although faculty readiness was generally high, implementation should be gradual and supported by structured faculty-development workshops, clear domain mapping, assessment-linked teaching, and institutional monitoring. A phased spiral model may help dental colleges integrate professionalism, research, informatics, social accountability, management, and evidence-based dentistry more effectively into routine BDS training.

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