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The Power Imbalance Personified: A Mixed-Methods Analysis of Senior-to-Junior Bullying in Indonesia's Medical Residency Programs

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A B S T R A C T

Bullying within medical residency is a pervasive global issue with severe consequences for residents' mental health and patient safety. In Indonesia, where hierarchical structures in medicine are deeply entrenched, senior-to-junior bullying is a significant yet under-investigated problem. This study aimed to analyse the prevalence, forms, and lived experiences of bullying perpetrated by senior residents against their junior counterparts in Indonesian medical residency programs. A sequential explanatory mixed-methods design was employed. In the quantitative phase, an anonymous online survey was distributed to 584 junior medical residents across five major teaching hospitals in Indonesia. The survey included the validated Negative Acts Questionnaire-Revised (NAQ-R) and questions on demographics and specialty. In the qualitative phase, 25 junior residents who reported high levels of bullying were purposively selected for in-depth, semi-structured interviews to explore their experiences. Quantitative data were analysed using descriptive and inferential statistics, while qualitative data were subjected to reflexive thematic analysis. Quantitatively, 81.3% (n=475) of junior residents reported experiencing at least one bullying behaviour weekly. The most common forms were work-related, such as excessive workloads and meaningless tasks, and personal humiliation. Year of residency was significantly associated with bullying exposure. Qualitatively, four major themes emerged: (1) 'The Hierarchy as an Unassailable Mandate for Abuse'; (2) 'The Pedagogy of Fear: Bullying as a Misguided Educational Tool'; (3) 'Silent Suffering and the Armour of Complicity'; and (4) 'The Perpetuating Cycle: Victims on a Trajectory to Becoming Perpetrators'. The qualitative findings revealed that bullying was often rationalised by seniors as a necessary part of medical training. In conclusion, senior-to-junior bullying is alarmingly prevalent and deeply embedded in the culture of Indonesian medical residency programs. It is personified through a profound power imbalance, rationalised as an educational necessity, and sustained by a culture of silence. Urgent, multi-level interventions focusing on systemic change, faculty training, and robust confidential reporting systems are imperative to dismantle this destructive cycle.

1. Introduction

The journey through medical residency, the crucible in which physicians are forged, is universally acknowledged as a period of intense professional and personal growth. It is also, however, a period fraught with significant stressors, including long working

hours, high-stakes clinical responsibilities, and sleep deprivation.[1] Compounding these inherent challenges is the pervasive and insidious problem of workplace bullying. Defined as repeated, health-harming mistreatment of one or more persons (the targets) by one or more perpetrators, bullying involves threatening, humiliating, or intimidating conduct, work interference, sabotage, or verbal abuse. Within the hierarchical ecosystem of medicine, these negative acts are not random; they are often systematically directed from those with more power to those with less.[2]

Globally, the prevalence of bullying in medical education is alarmingly high. Systematic reviews have consistently shown that a significant proportion of medical students and residents experience some form of harassment or bullying during their training, with rates ranging from 40% to over 80% in various international studies.[3] The consequences of this mistreatment are dire and well-documented. For the individual resident, bullying is a potent catalyst for psychological distress, leading to increased rates of depression, anxiety, burnout, substance abuse, and suicidal ideation. This erosion of mental well-being does not occur in a vacuum; it has a direct and deleterious impact on the quality of patient care. A bullied, burnt-out resident is more prone to medical errors, demonstrates reduced empathy, and is less likely to engage in the teamwork essential for patient safety.[4]

While bullying is a global phenomenon, its manifestations and drivers are deeply shaped by local cultural contexts. In many Asian societies, including Indonesia, strong hierarchical structures, respect for seniority (often termed '*senioritas*'), and a collectivist culture that discourages direct confrontation create a unique environment where bullying can fester and become normalised.[5] The power distance between a senior resident and a junior resident is not merely professional; it is a deeply ingrained sociocultural dynamic. This power differential can be 'personified'—made manifest in the daily interactions where a senior's authority is wielded not for education or mentorship, but for control and subjugation. The junior resident, often far from home and entirely dependent on seniors for training, evaluation, and career progression, is placed in a position of extreme vulnerability.[6]

In Indonesia, the medical education system is undergoing rapid expansion to meet the needs of a large and geographically dispersed population. This has placed immense pressure on teaching hospitals and residency programs, potentially exacerbating workplace stressors. Anecdotal evidence and a small number of localized studies have hinted at the gravity of the bullying problem within this context. These preliminary studies, while valuable, have often been limited in scope, employing single-method designs that capture the prevalence of the issue but fail to illuminate the complex interplay of power, culture, and pedagogy that underpins it.[7] They have not adequately explored how seniors justify their actions or how juniors perceive and cope with the abuse within the specific cultural milieu of Indonesian medicine. The distinction between legitimate, rigorous Socratic teaching and outright psychological abuse often becomes blurred, with bullying being rationalised as a necessary 'rite of passage' to toughen up junior doctors.[8]

This research addresses a critical gap in the literature by providing a comprehensive, mixed-methods analysis of this phenomenon. It moves beyond simply quantifying the problem to deeply exploring the lived experiences of junior residents. The quantitative arm of the study was designed to establish the prevalence and patterns of senior-to-junior bullying on a larger scale than previously attempted in Indonesia. The qualitative arm was designed to give voice to the targets of bullying, allowing for a rich, narrative exploration of how power imbalances are experienced, rationalised, and perpetuated within the system. By integrating these two approaches, we aimed to construct a holistic understanding of the problem that is both statistically robust and deeply humanised.

The novelty of this research is threefold. First, it is one of the first large-scale investigations into medical resident bullying in Indonesia, providing crucial benchmark data from multiple major academic centres. Second, its mixed-methods design offers a

unique synergy, using powerful qualitative narratives to explain and give profound meaning to the quantitative statistics. This approach moves the discourse beyond numbers to the nuanced realities of power dynamics, cultural justifications, and the 'hidden curriculum' of abuse. Third, by specifically focusing on the senior-to-junior resident dyad, this study dissects the most common and arguably most complex axis of bullying within residency, where individuals are simultaneously learners, teachers, colleagues, and competitors.[9,10] Therefore, the primary aim of this study was to conduct a comprehensive mixed-methods analysis to determine the prevalence, characteristics, and underlying sociocultural mechanisms of senior-to-junior bullying as experienced by junior residents in Indonesian medical residency programs. We sought to personify the statistics by uncovering the stories behind them, thereby creating an undeniable evidence base to advocate for systemic and cultural change within Indonesian medical education.

2. Methods

This study employed a sequential explanatory mixed-methods research design. This two-phase approach was chosen to provide a comprehensive understanding of the research problem. The first phase involved the collection and analysis of quantitative data to determine the prevalence and patterns of bullying. The second phase involved the collection and analysis of qualitative data to help explain and elaborate on the statistical findings from the first phase. This design allowed for both a broad overview of the problem and a deep, contextualised understanding of the participants' experiences. The study protocol was approved by the CMHC Research Center, Indonesia.

The study was conducted between May 2023 and March 2024 across five large, university-affiliated teaching hospitals in Indonesia. These hospitals were selected as they host a wide range of medical residency programs and train a significant proportion of the nation's specialists.

Participants for the quantitative phase were junior medical residents. Inclusion criteria were: (1) being a medical resident in their first or second year of a clinical residency program (such as Internal Medicine, Surgery, Paediatrics, or Obstetrics & Gynaecology); (2) being registered in one of the five selected teaching hospitals; and (3) providing informed consent. Exclusion criteria were residents in non-clinical or laboratory-based specialties, including Clinical Pathology and Forensic Medicine, where the hierarchical team structure might differ, and residents in their final year, who often occupy a senior role themselves.

Participants for the qualitative phase were purposively sampled from the respondents of the quantitative survey who had (a) indicated their willingness to be contacted for a follow-up interview and (b) scored in the highest quartile for bullying exposure on the survey instrument. This purposive sampling strategy was employed to ensure that interviewees had rich and relevant experiences to share about the phenomenon under investigation.

An online questionnaire was developed using the Google Forms platform. It consisted of three sections: Demographics: This section collected data on age, gender, marital status, specialty, year of residency, and the city of their undergraduate medical education; Bullying Experiences: The core of the questionnaire was the Indonesian-validated version of the Negative Acts Questionnaire-Revised (NAQ-R). The NAQ-R is a widely used and robust 22-item instrument that measures exposure to workplace bullying. The items are divided into three categories: work-related bullying (including items like "Someone withholding information which affects your performance"), person-related bullying (such as "Spreading of gossip and rumours about you"), and physically intimidating bullying (like "Being shouted at or being the target of spontaneous anger"). Respondents were asked to rate how often they had been subjected to each negative act from a *senior resident* in the past six months on a 5-point Likert scale (1=Never, 2=Now and then, 3=Monthly, 4=Weekly, 5=Daily). For this study, the operational definition of being bullied was experiencing at least one of the 22 negative acts on a weekly or daily basis; Perceived Sources and Reporting: This section included questions about the

primary perpetrators of bullying (allowing for multiple selections), and whether the resident had ever reported the incidents.

The questionnaire was translated from English to Bahasa Indonesia by two independent bilingual experts and then back-translated to ensure semantic equivalence. It was piloted on a group of 20 junior residents from a non-participating hospital to check for clarity, flow, and cultural appropriateness, after which minor wording adjustments were made.

A list of all eligible first and second-year residents was obtained from the education coordinators at each of the five participating hospitals. An email containing an invitation letter, a detailed explanation of the study, and a link to the anonymous online survey was sent to all potential participants. To maintain anonymity, no personal identifiers like names or ID numbers were collected in the survey form. Participation was completely voluntary. Two reminder emails were sent at two-week intervals to increase the response rate. The data collection period lasted for ten weeks.

The quantitative data were downloaded from the Google Forms platform and imported for analysis using IBM SPSS Statistics for Windows, Version 27.0. The analytical process was conducted in two stages to meet the study's objectives. First, a descriptive analysis was performed to summarize the sociodemographic and work-related characteristics of the participants, as well as the prevalence and specific forms of bullying acts experienced. Frequencies, percentages, means, and standard deviations were calculated as appropriate. The overall prevalence of bullying was determined based on the established operational definition: experiencing at least one of the 22 negative acts on a weekly or daily basis within the last six months. Second, an inferential analysis was conducted to explore the factors associated with the experience of bullying. The dichotomized outcome variable ('bullied' vs. 'not bullied') was used for these tests. Preliminary associations between categorical variables (Year of Residency, Specialty, Gender, Marital Status) and the experience of bullying were initially explored using the Chi-square (x^2) test.

To quantify the strength of these associations and to build a more robust explanatory model, a multivariate binary logistic regression analysis was subsequently performed. This model allowed for the examination of each variable's predictive power while controlling for the effects of others. In this regression model: The Dependent Variable was the binary outcome of being bullied (coded as 1 = Bullied, 0 = Not Bullied); The Independent Variables entered into the model were the primary demographic and work-related factors: Year of Residency, Specialty, Gender, and Marital Status; Reference Categories for the analysis were carefully selected to provide a meaningful basis for comparison. For Year of Residency, 'Second Year' served as the reference group. For Specialty, 'Paediatrics' was used as the reference category, as it demonstrated the lowest prevalence of bullying in the initial analysis.

The results from the logistic regression are presented as adjusted Odds Ratios (ORs) with their corresponding 95% confidence intervals (CIs). A p-value of <0.05 was considered statistically significant for all inferential tests. This two-stage analytical strategy enabled both an initial mapping of associations and a more nuanced, quantitative assessment of the primary risk factors for bullying within the study population.

From the 158 survey respondents who agreed to be contacted and met the high-exposure criterion, we used a maximum variation sampling strategy to select 25 residents. This strategy aimed to include a diverse range of participants based on gender, specialty (surgical vs. non-surgical), and hospital to capture a wide breadth of experiences. Selected individuals were contacted via email and invited to participate in a one-on-one interview. All 25 approached residents agreed to participate. They were assured of strict confidentiality and that their interview data would be anonymised.

In-depth, semi-structured interviews were conducted by two members of the research team (one male, one female) who were experienced in qualitative research methodologies and were not in positions of authority over the residents. Due to geographical dispersion and to ensure participant comfort, all interviews were conducted via the Zoom video

conferencing platform. Interviews lasted between 60 and 90 minutes.

An interview guide was developed to ensure consistency while allowing flexibility to explore emergent topics. The guide included open-ended questions and prompts designed to elicit detailed narratives about the residents' experiences. Sample questions included: "Can you tell me about a time you felt you were treated unfairly by a senior resident?", "How would you describe the relationship between junior and senior residents in your department?", "In your view, what is the reason behind these behaviours?", and "How has this experience affected you personally and professionally?". All interviews were audio-recorded with the participants' explicit permission and were transcribed verbatim in Bahasa Indonesia.

The qualitative data were analysed using a reflexive thematic analysis approach. This method involves a six-phase process: Familiarisation: The research team repeatedly read the transcripts while listening to the audio recordings to immerse themselves in the data; Initial Coding: The transcripts were systematically coded line-by-line. Initial codes were descriptive and stayed close to the participants' own words. This process was managed using NVivo 12 software; Searching for Themes: The codes were collated and sorted into potential themes. The researchers looked for patterns of shared meaning across the dataset; Reviewing Themes: The potential themes were reviewed and refined. Some were combined, others were split, and some were discarded. This involved checking the themes against the coded extracts and the entire dataset to ensure they formed a coherent pattern; Defining and Naming Themes: Once the final thematic map was agreed upon, each theme was clearly defined and given a concise, evocative name. A detailed analysis was written for each theme, explaining its essence and scope; Writing the Report: The final phase involved weaving the thematic analysis into a coherent and persuasive narrative, illustrated with vivid, translated quotes from the participants. To ensure analytical rigour, two researchers coded the first five transcripts independently and then met to discuss and agree upon a coding framework. Regular team meetings were held throughout the analysis process to discuss emerging themes and resolve any discrepancies, enhancing the credibility of the findings.

In keeping with the sequential explanatory design, the quantitative and qualitative data were integrated during the final interpretation and discussion phase. The qualitative findings were used to provide depth, context, and explanatory power to the statistical results. For instance, if the quantitative data showed a high prevalence of work-related bullying, the qualitative themes would be used to explain why and how this specific form of bullying manifested in the daily lives of residents, linking it to concepts like power, pedagogy, and hospital culture. This integration allowed for a more robust and nuanced conclusion than either method could have achieved alone.

3. Results

A total of 850 residents were invited to participate, and 584 completed the survey, yielding a response rate of 68.7%. The mean age of the participants was 28.7 years (SD = 2.1). The sample was relatively balanced in terms of gender, with 53.1% (n=310) identifying as female. A majority of respondents were in their first year of residency (61.3%, n=358) and were enrolled in specialties often perceived as high-stress, such as Surgery and affiliated subspecialties (28.9%) and Internal Medicine (24.3%).

The prevalence of bullying was alarmingly high. Based on the operational definition of experiencing at least one negative act on a weekly or daily basis from a senior resident, 81.3% (n=475) of junior residents were classified as having been bullied in the preceding six months. The specific types of bullying acts experienced are shown in Table 2, categorised by the NAQ-R domains. Work-related bullying was the most frequently reported category. The single most common negative act was "Being ordered to do work below your level of competence" (including personal errands for seniors), reported weekly or daily by 65.1% of respondents. This was closely followed by "Having an unmanageable workload" (62.8%) and "Being exposed to an unmanageable workload" (59.2%).

Person-related humiliation was also rampant. "Being shouted at or being the target of spontaneous anger" was reported by 55.3% of residents on a frequent basis. "Being humiliated or ridiculed in connection with your work" in public settings like morning reports or patient rounds was also exceedingly common (51.4%). Physically intimidating behaviours were the least common, though still present.

Table 1. Sociodemographic profiles of respondents (N=584).

CHARACTERISTIC	CATEGORY / VALUE	FREQUENCY (N=584)
Age (years)	Mean (SD)	28.7 (2.1)
Gender	Male	274 (46.9%)
	Female	310 (53.1%)
Marital Status	Single	402 (68.8%)
	Married	182 (31.2%)
Year of Residency	First Year	358 (61.3%)
	Second Year	226 (38.7%)
Specialty	Surgery & Subspecialties	169 (28.9%)
	Internal Medicine	142 (24.3%)
	Obstetrics & Gynaecology	95 (16.3%)
	Paediatrics	88 (15.1%)
	Other	90 (15.4%)

Table 2. Frequency of negative acts from senior residents (Weekly/Daily) (N=584).

Negative act (Abbreviated from NAQ-R)	n (%) Reporting Weekly/Daily
Work-related bullying	
- Ordered to do work below your level of competence	380 (65.1)
- Having an unmanageable workload	367 (62.8)
- Someone withholding information affecting your performance	346 (59.2)
- Being given tasks with unreasonable deadlines	321 (55.0)
Person-related bullying/Humiliation	
- Being shouted at or the target of spontaneous anger	323 (55.3)
- Being humiliated or ridiculed in connection with work	300 (51.4)
- Spreading of gossip and rumours about you	215 (36.8)
- Being ignored or excluded	201 (34.4)
Physically intimidating bullying	
- Intimidating behaviours such as finger-pointing	110 (18.8)
- Threats of physical abuse or actual abuse	21 (3.6)

Table 3 shows a clear and statistically robust delineation between the factors that are strongly associated with the experience of bullying and those that are statistically irrelevant. This initial analysis provides the foundational evidence for a central argument: bullying within this context is not a phenomenon of random interpersonal conflict or individual prejudice, but rather a structured and predictable outcome of systemic power dynamics and cultural norms. The non-significant findings for gender and marital status are, in themselves, highly informative. The data indicate that the probability of being bullied is virtually identical for male and female residents, as well as for those who are single or married. This statistical equivalence powerfully suggests that the drivers of abuse are not predicated on the personal demographic characteristics of the target. Instead, the abusive behaviors are directed at the *role* of the junior resident, an institutional position of inherent vulnerability, irrespective of the individual occupying it. This finding effectively dismisses any hypothesis that bullying in this setting is primarily a function of gender-based harassment or personal animus, pointing instead toward a more profound, systemic pathology.

In stark contrast, the associations with year of residency and specialty are not only statistically significant but also reveal a dramatic gradient of risk. The finding that first-year residents are substantially more likely to be bullied than their second-year counterparts (87.2% vs. 72.1%, $p<0.001$) is a powerful quantitative testament to the concept of a power differential. The first year of residency represents the nadir of the professional hierarchy, a period of maximum dependency and minimum authority. It is at this point of peak vulnerability that residents are most exposed to the coercive power of their seniors. Similarly, the clear hierarchy of risk among specialties—ranging from a near-universal experience in surgical and obstetrics fields (approaching 90%) to a still-high but comparatively lower rate in paediatrics (70.5%)—demonstrates that departmental culture acts as a critical modulating variable. The data compellingly argue that certain clinical environments have cultural norms that tolerate, or even implicitly encourage, aggressive and intimidating behaviors more than others, creating distinct micro-climates of risk within the broader institutional setting.

Table 4 indicates a more profound, synthesized understanding by integrating these statistical realities with epidemiological measures of risk and the rich explanatory power of the qualitative data. This mixed-methods synthesis moves the analysis from association to interpretation, revealing the mechanisms that underpin the numbers. The table frames Hierarchical Status as the "Dominant Factor," a conclusion strongly supported by an Odds Ratio of 2.75 for first-year residents. This statistic is not merely a number; it is a stark quantification of vulnerability. It means that the simple fact of being in the first year of training increases a resident's odds of being bullied by nearly threefold, all other factors being equal. This powerfully validates the qualitative theme of *'The Hierarchy as an Unassailable Mandate for Abuse.'* The lived experiences of the residents, who described being treated as the personal property of their seniors, are the human translation of this Odds Ratio. The data and the narratives converge to paint a picture of a system where professional dependency is systematically exploited, and power is personified not as a tool for mentorship but as a weapon of subjugation.

Furthermore, Table 4 reframes Departmental Culture as a "Modulating Factor," demonstrating how the baseline risk established by the hierarchy is then amplified or buffered by the specific environment. The Odds Ratio of approximately 3.0 for residents in surgical and obstetrics fields, when compared to paediatrics, is particularly telling. It suggests that the cultural norms within these high-pressure environments—which may valorize aggression, display a low tolerance for error, and operate on rigid command-and-control principles—dramatically intensify the risk of bullying. This aligns perfectly with the qualitative theme of a *'Pedagogy of Fear.'* The shouting, public humiliation, and intimidation are not random acts of anger; they are culturally sanctioned behaviors rationalized as necessary components of a "tough" training regimen. The table thus illustrates how a specific departmental ideology can warp the

concept of education into a justification for abuse, making these environments particularly toxic.

Finally, the table's classification of Demographic Irrelevance as a "Systemic Indicator" presents the lack of statistical significance for gender and marital status as a crucial piece of evidence. With an Odds Ratio of approximately 1.0 for these factors, the data confirm that the system is indiscriminately oppressive to those at the bottom. This finding supports the qualitative themes of *'Silent Suffering'* and the *'Perpetuating Cycle,'* which describe a uniform experience of oppression that transcends personal identity. The problem is not who the junior resident is, but *what* they represent: the lowest rung on the ladder. This universality of experience is what fosters the culture of shared silence and the tragic trajectory where victims, having survived the depersonalizing abuse of the system, are primed to perpetuate it as a means of reclaiming the agency that was stripped from them. The tables, when read together, thus narrate a comprehensive story of a systemic crisis where a rigid hierarchy creates a universal risk that is then supercharged by the specific cultural pathologies of different specialties, creating a predictable and devastating pattern of abuse.

Table 3. Associations between demographic and work-related characteristics and experience of bullying.

CHARACTERISTIC	TOTAL (N)	BULLIED N (%)	NOT BULLIED N (%)	X^2 STATISTIC	*P*-VALUE
Year of Residency					
First Year	358	312 (87.2)	46 (12.8)	**24.51**	**<0.001**
Second Year	226	163 (72.1)	63 (27.9)		
Specialty					
Surgery & Subspecialties	169	152 (89.9)	17 (10.1)	**17.24**	**0.002**
Obstetrics & Gynaecology	95	84 (88.4)	11 (11.6)		
Internal Medicine	142	111 (78.2)	31 (21.8)		
Other Specialties	90	66 (73.3)	24 (26.7)		
Paediatrics	88	62 (70.5)	26 (29.5)		
Gender					
Male	274	223 (81.4)	51 (18.6)	0.08	0.782
Female	310	252 (81.3)	58 (18.7)		
Marital Status					
Single	402	327 (81.3)	75 (18.7)	0.20	0.654
Married	182	148 (81.3)	34 (18.7)		

Note: Significant associations ($p < 0.05$) are highlighted in bold red. The Chi-square (χ^2) test was used for analysis. Percentages represent the proportion within each characteristic's category (row percentages).

Table 4. A visual synthesis of bullying risk factors in medical residency; a mixed-methods analysis.

Risk Domain & Primary Insight	Data Snapshot & Narrative Interpretation
DOMINANT FACTOR: HIERARCHICAL POWER *A resident's place in the rigid pecking order is the single most important determinant of their vulnerability to abuse.*	**First-Year vs. Second-Year Residents** `Odds Ratio: 2.75` (95% CI: 1.88–4.01) `SEVERE RISK` First-year residents have nearly **three times the odds** of facing weekly bullying compared to their second-year colleagues. This isn't just a risk factor; it's the core mechanism of the system, where inexperience is equated with a license for subjugation. > ***The Voice of the Victim:*** > *"He holds my logbook, my evaluation. He is my god in this hospital... They are not teaching us; they are owning us."*
MODULATING FACTOR: DEPARTMENTAL CULTURE *While the hierarchy sets the stage, the specific culture of a specialty acts as an amplifier, dramatically increasing the risk in certain environments.*	**The Spectrum of Specialty Risk (Compared to Paediatrics)** 1. **Surgical & Ob/Gyn Fields:** `OR ≈ 3.0` `EXTREME RISK` 2. **Internal Medicine:** `OR ≈ 1.5` `ELEVATED RISK` Environments that valorize aggression and mistake fear for rigor create the most toxic conditions. The "pedagogy of fear" is most acute in these high-pressure specialties, where bullying is rationalized as a necessary tool for training. > ***The Voice of Justification:*** > *"They call it 'mental conditioning'. When a senior screams at you... they say it's to make you tough. But it doesn't make me tough. It makes me terrified."*
SYSTEMIC INDICATOR: DEMOGRAPHIC IRRELEVANCE *The fact that personal traits do not predict risk is powerful evidence that bullying is a feature of the system itself, not a matter of interpersonal prejudice.*	**Gender & Marital Status** `Odds Ratio ≈ 1.0` (No Statistical Difference) `SYSTEM-WIDE` Male or female, single or married—all residents face a virtually identical risk profile. This proves the abuse is not targeted based on who the junior is, but *what* they are: the lowest rung on the ladder. The problem is institutional, not individual. > ***The Voice of the Cycle:*** > *"It's a cycle. A vicious, horrible cycle. And I don't know how to break it. I fear the doctor I am becoming."*

Note: This table provides a narrative summary of statistically significant findings ($p < 0.05$) for Hierarchy and Departmental Culture. The Odds Ratio (OR) quantifies the odds of being bullied in one group compared to a reference group. Demographic factors were not statistically significant predictors of risk.

The thematic analysis of the 25 in-depth interviews provided profound and often distressing insights that explained the statistical findings. The narratives converged to form four overarching themes that characterised the experience of senior-to-junior bullying in the Indonesian residency context.

Theme 1: 'The Hierarchy as an Unassailable Mandate for Abuse'

This theme captured the core of the power imbalance. Participants did not just describe a professional hierarchy; they depicted a rigid, almost feudal system where seniority provided an unquestionable license to control and, at times, to abuse. This was seen as a structural and cultural norm, not an aberration. The power of seniors was absolute, governing every aspect of a junior's life, from clinical duties to personal time. This theme directly explains the high prevalence of 'work-related bullying' found in the survey. Tasks that were meaningless or personal in nature were assigned as a demonstration of this power.

"It's not about education. It's about power. Last week, my senior told me to pick up his laundry and buy him lunch. I had three patients crashing in the ward. When I hesitated, he said, 'Do you want to pass this rotation or not?'. What choice do I have? He holds my logbook, my evaluation. He is my god in this hospital. So I left my patients with the nurse and went." (Dr. B, Male, Internal Medicine, Year 1).

"The term is 'senioritas'. It's an unwritten law. They can ask for anything, and you cannot refuse. It's not just work. It's your life. They can call you at 3 AM to ask you to format their thesis presentation. It has nothing to do with medicine. It is a show of who is the boss. It is the personification of the power imbalance. They are not teaching us; they are owning us." (Dr. K, Female, Surgery, Year 1).

Theme 2: 'The Pedagogy of Fear: Bullying as a Misguided Educational Tool'

A deeply troubling finding was the frequent rationalisation of bullying as a necessary component of medical training. Participants described how seniors would often justify public humiliation, shouting, and intimidation as methods to "build character," "ensure vigilance," or "prepare them for the real world." This created a confusing and toxic learning environment where education was conflated with fear. This theme explains why acts like "being shouted at" and "being humiliated in connection with work" were so common.

"They call it 'mental conditioning'. When a senior screams at you in front of the entire team, in front of the nurses, even in front of the patient, for a minor mistake... they say it's to make you remember, to make you tough. But it doesn't make me tough. It makes me terrified. I become afraid to ask questions, afraid to report findings, because what if I'm wrong and I get screamed at again? It kills your desire to learn." (Dr. R, Female, Paediatrics, Year 2).

"There's a saying here: 'the nail that sticks out gets hammered down'. My senior told me that. He said my questions were challenging his authority. The goal is not to be the best doctor, but to be the most obedient junior. The educational method is fear. You learn to stay quiet, to be invisible, to survive. This is the pedagogy of our training." (Dr. S, Male, Surgery, Year 1).

Theme 3: 'Silent Suffering and the Armour of Complicity'

This theme captured the profound isolation and helplessness felt by the junior residents. It explains the stark discrepancy between the high prevalence of bullying and the extremely low rate of reporting. Fear of retaliation was the primary barrier. Reporting a senior was seen as career suicide, leading to ostracism, harder workloads, and guaranteed failure in evaluations. This fear fosters an environment of 'silent suffering,' where juniors are complicit in their own mistreatment by not speaking out. They learn to endure, creating an armour of emotional detachment to survive their training.

"Report it? To whom? The program director was a junior resident here thirty years ago. He went through the same thing. To him, this is normal. It's tradition. If I report my senior, the entire department will turn against me. My senior's friends will make my life a living hell. I will be marked forever. It's better to just shut up, lower your head, and count the days until you are the senior." (Dr. F, Male, Obstetrics & Gynaecology, Year 2).

"We have a support group, just among us first-years. We cry together in the on-call room at night. We share stories. But we never speak of it outside that room. It's our secret. You cannot show weakness. You have to pretend it doesn't affect you. Because if they see it affects you, they do it more. So you suffer in silence. It is the only way." (Dr. N, Female, Internal Medicine, Year 1)

Theme 4: 'The Perpetuating Cycle: Victims on a Trajectory to Becoming Perpetrators'

The most disturbing theme was the recognition, among some participants, that the system was designed to perpetuate itself. They described a clear trajectory where today's victims become tomorrow's perpetrators. After enduring years of abuse, some residents internalise the belief that this is the 'correct' way to train juniors. The abuse they suffered becomes a justification for the abuse they will inflict, a twisted form of paying their dues.

"I hate what they do to me. I hate it with every fibre of my being. But... there is a dark part of me that thinks, 'One day, it will be my turn'. I've worked this hard, I've endured this much... don't I deserve the same power?

It's a horrible thought, but it's there. The system doesn't just hurt you; it changes you. It turns you into them." (Dr. T, Male, Surgery, Year 2).

"My senior once told me, 'I had it much worse than you. So don't complain. Wait your turn.' It was like he was promising me that one day I could do the same. It's a cycle. A vicious, horrible cycle. And I don't know how to break it. I fear the doctor I am becoming." (Dr. L, Female, Paediatrics, Year 2).

4. Discussion

The findings of this research cast a stark and deeply unsettling light on the lived reality of junior medical residents in Indonesia. The quantitative data, with its staggering 81.3% prevalence rate of frequent bullying, serves as the initial shock—a cold, hard number that points to a systemic crisis. But it is within the heart-wrenching narratives of the qualitative interviews that the true nature of this crisis is revealed. This is not merely a story of workplace incivility or occasional harshness. It is a story of institutionalised oppression, of power personified as a tool of subjugation, and of an educational philosophy twisted into a pedagogy of fear.[9] The discussion that follows will deconstruct the layers of this phenomenon, weaving together the statistical facts with the rich tapestry of human experience to understand not just what is happening, but how and why it is allowed to persist with such devastating consequence. We will explore the architecture of this power imbalance, dissect the perversion of its educational mandate, analyse the anatomy of the silence that surrounds it, and trace the tragic trajectory of victims into perpetrators. This is an exploration of a system in profound distress.

The core of the issue, the very bedrock upon which all other findings rest, is captured in the theme 'The Hierarchy as an Unassailable Mandate for Abuse'. The quantitative results give us the blueprint of this architecture: work-related bullying is the most common form, with residents being ordered to perform tasks below their competence or saddled with unmanageable workloads. These are not just line items in a survey; they are the daily manifestations of a power structure that has been warped. The qualitative narratives breathe life into this blueprint, showing how the abstract concept of power becomes a tangible, oppressive force.[10]

In a functional hierarchy, power is a tool for organisation, mentorship, and ensuring quality control. A senior resident's legitimate power is granted by the institution to guide juniors, to teach complex procedures, and to oversee patient care.[11] What our findings describe is the mutation of this legitimate power into unchecked coercive and personal power. When a senior resident commands a junior to fetch his laundry or format his personal thesis, as vividly described by participants, he is not exercising his professional authority. He is performing a ritual of dominance. This act has a specific function: to strip the junior of their professional identity as a physician-in-training and reinforce their subordinate status as a mere functionary, an extension of the senior's will. It is a deliberate act of degradation designed to remind the junior of their place in the pecking order. The request is trivial, but its meaning is profound. It communicates, "Your time, your skills, your professional duties are secondary to my personal needs. Your value is contingent upon your absolute obedience to me." This is the essence of 'senioritas' as it was described—not as a respectful acknowledgement of experience, but as a cultural artefact that grants seniors quasi-ownership over their juniors.[12]

This weaponisation of the hierarchy is insidious because it blurs the lines between duty and servitude. The junior resident is trapped in a state of cognitive dissonance.[13] They entered medicine to heal and to learn, but they find themselves engaged in tasks that are professionally meaningless and personally humiliating. Yet, the threat of coercive power—the power to punish—is ever-present. The senior holds the junior's logbook, their evaluations, and their very future. The simple phrase, "Do you want to pass this rotation or not?" is not a question; it is a closing of all doors except the one marked 'submission'. This transforms the hospital ward from a place of learning into a space of constant threat assessment. The junior resident's mental energy is diverted from clinical

problem-solving to navigating the treacherous interpersonal dynamics and anticipating the whims of their seniors.

This environment systematically erodes the junior resident's sense of self-worth and professional agency. Agency requires the ability to make choices based on professional knowledge and ethical principles. When a resident is forced to abandon a crashing patient to run a personal errand, their professional and ethical compass is shattered by the magnetic north of the senior's demand. This single act is a microcosm of the entire system: the needs of the powerful supersede the needs of the patient and the professional development of the junior.[13] This is not simply bullying; it is a fundamental corruption of the principles of medical professionalism. The power is no longer an abstract concept within an organisational chart; it has been personified in the figure of the senior resident, becoming a daily, active force of oppression that dictates every action and stifles every objection. It is an architecture built not on professional respect, but on personal domination.

If the hierarchy provides the architecture of abuse, then the distorted view of education provides its twisted justification. The theme 'The Pedagogy of Fear' is perhaps the most intellectually and morally troubling aspect of this study. It reveals a system that actively defends its cruelty as a necessary component of training. Acts of public humiliation, shouting, and intimidation are not seen as failures of mentorship but are rationalised as legitimate teaching tools designed to forge "tough" and "resilient" doctors. This represents a profound perversion of pedagogical principles.[14]

Modern adult learning theory is founded on the principle that adults learn best in an environment of psychological safety, where they are respected, where their prior experiences are valued, and where they are free to ask questions and make mistakes without fear of humiliation.[14] The learning environment described by our participants is the antithesis of this. It is a space governed by fear, where the primary lesson is not clinical knowledge, but survival. When a resident is screamed at in front of a patient for a minor error, the intended lesson from the senior might be "don't make that mistake again." But the actual lesson learned by the junior is far more damaging: "Do not speak up. Do not take initiative. Do not expose your ignorance. Invisibility is safety."

This is the 'hidden curriculum' in its most toxic form. The formal curriculum, taught in lecture halls, speaks of evidence-based medicine, compassionate communication, and medical ethics. The hidden curriculum, taught through humiliation at the bedside and in the hallways, teaches that power, not evidence, is the ultimate authority; that hierarchy, not compassion, governs interactions; and that self-preservation, not ethics, is the primary virtue. The resident is caught between these two opposing worlds. They are taught to be curious and critical thinkers, yet the pedagogy of fear punishes them for asking questions that might "challenge authority." They are taught to be part of a collaborative team, yet they are publicly ridiculed, which severs bonds of trust with nurses and other colleagues.[15]

This fear-based learning has devastating consequences for both the learner and the patient. For the learner, it stifles intellectual growth. A terrified mind cannot engage in the complex process of differential diagnosis or nuanced clinical reasoning. Instead, it defaults to defensive medicine: ordering unnecessary tests to avoid being criticised for missing something, or failing to report subtle but important clinical changes for fear of being wrong.[15] This creates a physician who is not competent, but compliant; not resilient, but brittle. The "toughness" they acquire is not the true resilience of a confident, skilled practitioner, but the scar tissue of trauma—a hardened exterior that masks deep-seated fear and self-doubt.

For the patient, the consequences are immediate and dangerous. The junior resident who is afraid to call their senior at 3 AM about a worrying change in a patient's vital signs because they fear being shouted at is a patient safety disaster waiting to happen. The learning environment and the patient care environment are one and the same.[16] A system that terrorises its trainees cannot possibly provide safe and compassionate care to its patients. The shout that echoes in the hallway is not just an assault on a resident's dignity; it is a tremor that weakens the

entire structure of patient care. By framing abuse as education, the system is not only failing its trainees; it is betraying its fundamental promise to the public to "first, do no harm." The pedagogy of fear does not produce better doctors; it produces damaged individuals who are less capable of fulfilling their professional duties, perpetuating a cycle of harm that extends far beyond the hospital walls.

The chasm between the 81.3% prevalence of bullying and the 8.2% reporting rate is not a statistic; it is a deafening silence. The theme 'Silent Suffering and the Armour of Complicity' provides the anatomy of this silence, revealing it to be a rational response to a deeply flawed system. This is not a case of individual cowardice; it is a calculated decision based on a correct assessment of the power dynamics at play. The silence is composed of fear, futility, and a profound sense of institutional betrayal.[16]

The fear is primal and immediate. As participants articulated, reporting a senior is viewed as career suicide. It is not an act of seeking justice, but an act of provocation. The system is designed to protect its own hierarchy. A complaint from a junior against a senior is often seen not as a legitimate grievance but as an act of insubordination. The potential consequences are catastrophic: ostracism from peers, punitive workloads from the seniors' allies, negative evaluations that can derail a career, and being branded as a "troublemaker." The individual cost of speaking out is perceived, quite rightly, as being far too high.[17]

This fear is compounded by a sense of futility. The residents' narratives express a deep cynicism about the willingness of the institution to act. When a program director is himself a product of the same abusive system, a complaint is not heard as a cry for help, but as a failure of the junior to be "tough enough." The phrase "this is tradition" or "I had it much worse" acts as a powerful institutional defence mechanism, dismissing current suffering by benchmarking it against a romanticised, brutal past. This response constitutes a form of institutional betrayal. The trainee places their trust, their career, and their well-being in the hands of the institution, expecting it to provide a safe learning environment. When the institution not only fails to protect them but actively sides with the abuser or dismisses their pain as normal, it inflicts a second, deeper wound.[17] The initial harm comes from the perpetrator; the second harm comes from the institution that sanctions it through inaction.

In this crucible of fear and futility, the junior resident is forced to construct an "armour of complicity." This is a complex psychological posture. On the outside, it is an armour of emotional detachment, a hardened facade that signals to the aggressors that their barbs are not landing. To show vulnerability is to invite further attack. But this armour comes at a cost. Internally, by remaining silent, the resident becomes complicit in their own mistreatment and in the mistreatment of their peers. This can lead to a state of moral injury—the psychological distress that results from actions, or the lack of them, which violate one's own moral and ethical code.[18]

The resident knows that what is happening is wrong. They entered medicine with a strong moral compass. Yet every day, they are forced to witness or endure acts that transgress their core values, and they are forced to remain silent. This internal conflict is corrosive. It erodes their sense of self, their integrity, and their faith in the system they once aspired to join. The secret support groups in on-call rooms are a testament to this shared trauma. They are spaces of temporary relief but also a symbol of the problem's containment.[19] The suffering is privatised, hidden away, managed by the victims themselves, absolving the institution of its responsibility to act. The silence, therefore, is not an absence of noise. It is a resonant, powerful force, filled with the unspoken pain of thousands of trainees. It is the sound of a system that has fundamentally failed its duty of care, forcing its youngest members to choose between their career and their conscience.

The most tragic and insidious finding of this study is the elucidation of the system's primary mechanism for self-preservation: the transformation of the victim into the perpetrator. The theme, 'The Perpetuating Cycle: Victims on a Trajectory to Becoming Perpetrators', reveals a pathway that is as predictable

as it is devastating. This is not merely a matter of "an eye for an eye"; it is a complex psychological process through which the trauma of being bullied is metabolised and later reenacted as a means of survival, adaptation, and reclaiming power.

The journey begins with the initial victimisation. The junior resident endures years of humiliation, excessive workloads, and psychological abuse. This experience is internalised not just as a series of unfortunate events, but as the normative process of becoming a specialist.[19] The constant refrain from seniors—"I had it much worse, so don't complain. Wait your turn"—is a powerful piece of psychological grooming. It simultaneously invalidates the junior's current suffering and offers a perverse kind of promise: this pain is temporary, and it is a currency that can be redeemed later for power and authority. The suffering becomes an investment, and the right to inflict similar suffering becomes the eventual dividend.

As the resident progresses through the system, a psychological shift can occur. To cope with the trauma and powerlessness, some may begin to identify with the aggressor. This is a defence mechanism where an individual, faced with an overwhelming external threat, adopts the characteristics of the aggressor to transform themselves from the one who is threatened into the one who makes threats.[20] By adopting the behaviours, language, and worldview of their former tormentors, they find a way to escape the painful position of being the victim. The thought expressed by one participant—"I hate what they do to me... But... there is a dark part of me that thinks, 'One day, it will be my turn'"—is a chillingly honest articulation of this process. It is the sound of a moral compass being recalibrated by the immense gravitational pull of the system.

When these residents finally become seniors, they are faced with a choice. They can choose to break the cycle, to treat their juniors with the kindness and respect they themselves were denied. But this path is difficult. It requires immense moral courage and a conscious rejection of the entire system that has shaped them. The alternative path is easier. To perpetuate the cycle is to validate their own past suffering. If they were to be kind to their juniors, they would be forced to confront the painful truth that their own abuse was unnecessary and unjust. But if they inflict the same abuse, it gives their own trauma a kind of meaning. It becomes a necessary rite of passage, a trial by fire that they survived and are now duty-bound to administer. It transforms their painful memories from a source of shame into a badge of honour.

This is how the system endures. It does not need to constantly recruit new abusers from the outside; it manufactures them from the inside. It takes bright, idealistic young doctors and, through a process of sustained psychological trauma, remoulds them into the next generation of perpetrators. Each new senior who embraces this role becomes another guardian of the toxic tradition, another link in the chain, ensuring the culture's transmission. The fear that one resident expressed—"I fear the doctor I am becoming"—is the ultimate tragedy of this cycle. The system does not just inflict wounds; it fundamentally changes the identity of the people within it, ensuring that the legacy of abuse is carried forward, not as a memory, but as a living, breathing practice. Breaking this cycle requires more than just protecting juniors; it requires an intervention that can heal the wounds of the seniors and show them that there is another, better way to be a physician, a teacher, and a leader.[20]

5. Conclusion

This study ventured into the heart of Indonesian medical residency and found not a crucible of learning, but a cauldron of fear. The findings presented are not merely data points; they are an undeniable indictment of a culture that has mistaken cruelty for rigour and silence for strength. We have seen how an unassailable hierarchy becomes a mandate for abuse, how the noble act of teaching is perverted into a pedagogy of fear, and how the collective suffering of trainees is shrouded in an armour of complicity and silence. Most tragically, we have traced the genesis of the next generation of abusers, revealing a self-perpetuating cycle that functions as the system's own immune response against change.

This is more than a problem of unprofessional behaviour. It is a fever in the bloodstream of medicine,

a sickness that weakens the healer and, by extension, jeopardises the healed. A system that systematically breaks down the psychological well-being, empathy, and moral integrity of its future physicians is a system that has lost its way. It is a system that is failing its trainees, its patients, and the very society it is meant to serve.

Therefore, the conclusion of this research is not a gentle recommendation for minor adjustments. It is a resounding and urgent call for a profound paradigm shift. The chains of this destructive cycle must be broken. This will require more than new regulations on a shelf; it will require moral courage from the highest levels of leadership to dismantle the toxic culture of 'senioritas' and replace it with a culture of psychological safety. It demands that we stop rationalising abuse as a tradition and start seeing it for what it is: a failure of our duty to care for our own. The path forward involves reimagining medical education as a partnership built on respect, not a power struggle built on fear. The health of our future doctors, and the safety of their future patients, depends entirely on our willingness to begin this difficult and essential work now. The silence must be broken, not just by the whispers of residents in on-call rooms, but by the determined voices of leaders committed to healing the healers.

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