Enigma in Education
https://enigma.or.id/index.php/edu

e-ISSN: 3026-5827

ORIGINAL ARTICLE
Enigma in Education | Vol. 3, No. 1 (2025) | pp. 9–19

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

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ARTICLE INFO

Article history
Received: March 19, 2025
Revised: April 19, 2025
Accepted: May 14, 2025
Available online: May 27, 2025
Published: May 30, 2025

Keywords
bullying; Indonesia; medical education; medical residents; power dynamics; workplace violence

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ORCID
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DOI
https://doi.org/10.61996/edu.v3i1.92

ABSTRACT

Background. Bullying during medical residency harms residents' mental health and threatens patient safety. In Indonesia, where medical hierarchies are firmly entrenched, bullying of junior residents by senior residents has received little study.

Objective. To examine the prevalence, forms, and lived experience of senior-to-junior bullying in Indonesian residency programs from the perspective of junior residents.

Methods. A sequential explanatory mixed-methods design was used. An anonymous online survey including the Negative Acts Questionnaire-Revised (NAQ-R) was completed by 584 junior residents at five teaching hospitals. Twenty-five residents with high exposure were purposively selected for semi-structured interviews. Data were analyzed with descriptive and inferential statistics and reflexive thematic analysis.

Results. Of the respondents, 81.3% (n = 475) reported at least one negative act weekly or daily. Work-related acts and personal humiliation were the most common forms. Bullying was associated with year of residency (87.2% vs 72.1%) and specialty (70.5% in pediatrics to 89.9% in surgery), but not with gender or marital status. Four themes emerged: hierarchy as a mandate for abuse, a pedagogy of fear, silent suffering, and a perpetuating cycle.

Conclusion. Bullying by senior residents was highly prevalent, was often justified as training, and was sustained by silence. Systemic change, faculty training, and confidential reporting systems are needed.

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1. Introduction

Residency is the stage at which physicians are formed, and it brings real professional and personal growth. It also brings heavy stressors. Hours are long, clinical duties carry high stakes, and sleep is scarce.[1,2] Workplace bullying adds to the burden. It is usually defined as repeated mistreatment that harms the health of one or more targets and is carried out by one or more perpetrators, whether through threats, humiliation, intimidation, interference with work, sabotage, or verbal abuse.[3,4] In medicine such acts are rarely random. They tend to run from people with more power to people with less.[5–7]

Bullying in medical education is common worldwide. Systematic reviews report that many students and residents experience harassment or bullying during training, with rates from 40% to above 80% across studies.[5–7] The consequences are serious. They are also well documented. For residents, bullying contributes to depression, anxiety, burnout, substance abuse, and suicidal ideation.[6,8] Poorer well-being also affects patients. A bullied and burnt-out resident is more likely to make medical errors, shows less empathy, and takes part less readily in the teamwork that patient safety requires.[9]

Local culture shapes how bullying appears and why it persists. In many Asian societies, including Indonesia, strong hierarchy, respect for seniority (often called 'senioritas'), and a collectivist preference for avoiding direct confrontation allow bullying to take root and come to seem normal.[10–12] The distance between a senior and a junior resident is more than professional. It is sociocultural, and deeply ingrained. Power can be 'personified' here: it becomes visible in daily interactions where a senior's authority serves control and subjugation rather than teaching or mentorship. Junior residents are often far from home. They depend entirely on seniors for training, evaluation, and career progression, which leaves them very exposed.

Indonesia is expanding its medical education system quickly to serve a large, dispersed population. Teaching hospitals and residency programs are under heavy pressure as a result, which

may worsen workplace stress. Anecdotal reports and a few local studies point to a serious bullying problem.[10,13] These early studies are useful. They are also limited. They used single-method designs that measure how common bullying is without explaining the interplay of power, culture, and pedagogy behind it. They also did not examine how seniors justify their conduct, or how juniors perceive and cope with abuse in the Indonesian setting. The line between rigorous Socratic teaching and psychological abuse is often blurred, and bullying is excused as a 'rite of passage' that toughens young doctors.[14–17]

This study addresses that gap with a mixed-methods analysis. It goes beyond counting cases to examine the lived experience of junior residents. The quantitative arm aimed to establish the prevalence and patterns of senior-to-junior bullying on a larger scale than earlier work in Indonesia. The qualitative arm aimed to give voice to those who are bullied. Through narrative, it shows how power imbalances are experienced, justified, and passed on within the system. Combining the two approaches, we sought a picture of the problem that is statistically sound and also human.

We see the novelty of this work in three respects. First, to our knowledge, it is among the first large-scale investigations of resident bullying in Indonesia and offers benchmark data from several major academic centers. Second, the mixed-methods design lets qualitative narratives explain and give meaning to the numbers. It shifts attention from figures to the realities of power, cultural justification, and the 'hidden curriculum' of abuse.[11,18,19] Third, the study focuses on the senior-to-junior dyad, probably the most common and most complicated axis of bullying in residency, where the same individuals are learners, teachers, colleagues, and competitors. The primary aim was therefore to determine the prevalence, characteristics, and underlying sociocultural mechanisms of senior-to-junior bullying as experienced by junior residents in Indonesian programs. We wished to 'personify' the statistics by uncovering the stories behind them, and so to build an evidence base for systemic and cultural change in Indonesian medical education.

2. Methods

2.1 Study design and setting

This study used a sequential explanatory mixed-methods design.[20] We chose two phases to understand the problem fully. The first phase collected and analyzed quantitative data on the prevalence and patterns of bullying. The second collected and analyzed qualitative data to explain and extend the statistical findings. The design gave both a broad overview and a deep, contextual view of what participants had experienced. 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.

2.2 Participants, sampling, and eligibility

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, Pediatrics, or Obstetrics & Gynecology); (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.

2.3 Questionnaire and survey procedure

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).[21,22] The NAQ-R is a widely used 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 rumors about you"), and physically intimidating bullying (like "Intimidating behaviors such as finger-pointing"). 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.

We obtained a list of all eligible first- and second-year residents from the education coordinators at each of the five participating hospitals. Each person received an email with an invitation letter, a detailed explanation of the study, and a link to the anonymous online survey. No personal identifiers, such as names or ID numbers, were collected in the survey form. Participation was entirely voluntary. Two reminder emails were sent at two-week intervals to raise the response rate. Data collection lasted ten weeks.

2.4 Quantitative analysis

Quantitative data were downloaded from Google Forms and analyzed in IBM SPSS Statistics for Windows, Version 27.0. Analysis had two stages. First, we described the sociodemographic and work-related characteristics of participants, together with the prevalence and specific forms of bullying acts. Frequencies, percentages, means, and standard deviations were calculated as appropriate. Overall prevalence followed the operational definition: at least one of the 22 negative acts experienced weekly or daily within the last six months. Second, we examined factors associated with bullying, using the dichotomized outcome ('bullied' vs. 'not bullied'). Associations between categorical variables (Year of Residency, Specialty, Gender, Marital Status) and bullying were first explored with the Chi-square ($\chi 2$) test.

To quantify the strength of these associations and build an explanatory model, we then ran a multivariate binary logistic regression. The model examined each variable's contribution while controlling for the 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, 'Pediatrics' was used as the reference category, as it demonstrated the lowest prevalence of bullying in the initial analysis.

Results of the logistic regression are reported as adjusted Odds Ratios (ORs) with 95% confidence intervals (CIs). A *p*-value below 0.05 was considered statistically significant for all inferential tests. This two-stage strategy allowed an initial mapping of associations and a more detailed estimate of the main risk factors for bullying in the study population.

2.5 Qualitative sampling, interviews, and analysis

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 anonymized.

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 behaviors?", 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 analyzed using a reflexive thematic analysis approach.[23,24] This method involves a six-phase process:

Familiarization: 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 narrative, illustrated with translated quotations from the participants. To ensure analytical rigor, 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.

2.6 Integration of quantitative and qualitative data

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, because the quantitative data showed a high prevalence of work-related bullying, the qualitative themes were used to explain why and how this 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 nuanced conclusion than either method could have achieved alone.

2.7 Ethical considerations

The study protocol was approved by the CMHC Research Center, Indonesia (Approval number 2023/201) . Participation was voluntary, informed consent was obtained, and participants were assured of confidentiality. Interviews were audio-recorded with the participants' explicit permission.

3. Results

3.1 Participant characteristics

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 by 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%); Table 1 gives the full profile.

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 & gynecology	95 (16.3%)
	Pediatrics	88 (15.1%)
	Other	90 (15.4%)

3.2 Prevalence and forms of bullying

The prevalence of bullying was 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, categorized 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 "Someone withholding information affecting your performance" (59.2%).

Person-related humiliation was also frequent. "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 also common (51.4%). Physically intimidating behaviors were the least common, though still present.

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	
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 behaviors such as finger-pointing	110 (18.8)
Threats of physical abuse or actual abuse	21 (3.6)

Note. Ten of the 22 NAQ-R items are shown, grouped by NAQ-R domain; n (%) of 584 respondents reporting the act weekly or daily.

3.3 Factors associated with bullying

Table 3 presents the associations between respondent characteristics and bullying. Year of residency ($\chi^2(1) = 20.61$, $p < 0.001$) and specialty ($\chi^2(4) = 22.98$, $p < 0.001$) were significantly associated with bullying, whereas gender ($\chi^2(1) = 0.00$, $p = 0.98$) and marital status ($\chi^2(1) = 0.00$, $p = 0.99$) were not. Bullying was reported by 87.2% of first-year residents and 72.1% of second-year residents. By specialty, the proportion bullied was highest in surgery and subspecialties (89.9%) and obstetrics and gynecology (88.4%), followed by internal medicine (78.2%), other specialties (73.3%), and pediatrics (70.5%). The proportion bullied was 81.4% among male and 81.3% among female residents, and 81.3% among both single and married residents.

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

Characteristic	Total n	Bullied n (%)	Not bullied n (%)	χ^2 (df)	p
Year of residency				**20.61 (1)**	**<0.001**
First year	358	312 (87.2)	46 (12.8)		
Second year	226	163 (72.1)	63 (27.9)		
Specialty				**22.98 (4)**	**<0.001**
Surgery & subspecialties	169	152 (89.9)	17 (10.1)		
Obstetrics & gynecology	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)		
Pediatrics	88	62 (70.5)	26 (29.5)		
Gender				**0.00 (1)**	**0.98**
Male	274	223 (81.4)	51 (18.6)		
Female	310	252 (81.3)	58 (18.7)		
Marital status				**0.00 (1)**	**0.99**
Single	402	327 (81.3)	75 (18.7)		
Married	182	148 (81.3)	34 (18.7)		

Note. Significant associations ($p < 0.05$) are shown in bold. Pearson chi-square (χ^2) tests were used; percentages are row percentages within each characteristic. χ^2 values were recomputed from the printed counts at copyediting.

Table 4 combines these findings with the adjusted odds ratios from the logistic regression and with illustrative interview data. First-year residents had higher adjusted odds of bullying than second-year residents (OR 2.75, 95% CI 1.88–4.01). Compared with pediatrics, the odds were approximately 3.0 for surgical and obstetric fields and approximately 1.5 for internal medicine; for gender and marital status the odds ratio was approximately 1.0.

Table 4. Joint display of bullying risk factors in medical residency: quantitative results with illustrative interview quotations.

Risk domain and primary insight	Quantitative result and illustrative quotation
Hierarchical power. A resident's place in the rigid hierarchy showed the strongest association with exposure to bullying.	First-year vs second-year residents: OR = 2.75 (95% CI 1.88–4.01). Large association. First-year residents had nearly three times the odds of weekly bullying compared with second-year residents. "He holds my logbook, my evaluation. He is my god in this hospital… They are not teaching us; they are owning us."
Departmental culture. While the hierarchy sets the stage, the specific culture of a specialty may act as an amplifier.	Specialty risk compared with pediatrics: surgical and obstetric/gynecologic fields, OR ≈ 3.0 (large association); internal medicine, OR ≈ 1.5 (moderate association). Environments that valorize aggression and mistake fear for rigor may create the most harmful conditions; the "pedagogy of fear" was described as most acute in these high-pressure specialties, where bullying is rationalized as a necessary tool for training. "They call it 'mental conditioning'. When a senior screams at you… they say it's to make you remember, to make you tough. But it doesn't make me tough. It makes me terrified."
Demographic factors. Personal traits did not predict risk, which is consistent with bullying being a feature of the system rather than of interpersonal prejudice.	Gender and marital status: OR ≈ 1.0 (no statistical difference). Male or female, single or married, residents faced a virtually identical risk profile. This indicates that the abuse may not be targeted at who the junior is, but at the position they hold: the lowest rung on the ladder. "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 summarizes the statistically significant findings ($p < 0.05$) for hierarchy and departmental culture; the odds ratio (OR) compares the odds of being bullied in one group with a reference group. Gender and marital status were not statistically significant predictors. ORs are as submitted.

3.4 Qualitative themes

The thematic analysis of the 25 in-depth interviews provided insights that help explain the statistical findings. The narratives converged to form four overarching themes that characterized 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 helps explain 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 rationalization 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 may help explain 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, Pediatrics, 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 Armor of Complicity'

This theme captured the profound isolation and helplessness felt by the junior residents. It helps explain the 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 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 armor 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 & Gynecology, 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 tends to perpetuate itself. They described a trajectory where today's victims become tomorrow's perpetrators. After enduring years of abuse, some residents internalize 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 fiber 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, Pediatrics, Year 2)

4. Discussion

4.1 Interpretation of the quantitative findings

Table 3 shows a clear difference between the factors that were associated with the experience of bullying and those that were not. This pattern is consistent with the view that bullying in this setting is not a matter of random interpersonal conflict or individual prejudice, but reflects systemic power dynamics and cultural norms. The non-significant findings for gender and marital status are, in themselves, 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 suggests that the drivers of abuse are not predicated on the personal demographic characteristics of the target. Instead, the abusive behaviors may be directed at the role of the junior resident, an institutional position of inherent vulnerability, irrespective of the individual occupying it. This finding makes it less likely that bullying in this setting is primarily a function of gender-based harassment or personal animus, and points instead toward systemic factors.[6,25,26]

In stark contrast, the associations with year of residency and specialty were statistically significant and showed a 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 consistent with 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 pediatrics (70.5%)—demonstrates that departmental culture may act as a modulating variable. The data suggest that certain clinical environments have cultural norms that tolerate, or even implicitly encourage, aggressive and intimidating behaviors more than others, which may create distinct micro-climates of risk within the broader institutional setting.

Table 4 integrates these statistical findings with epidemiological measures of risk and with the explanatory power of the qualitative data. This mixed-methods synthesis moves the analysis from association to interpretation and suggests mechanisms that may underlie the numbers. The table frames Hierarchical Status as the "Dominant Factor," a conclusion supported by an Odds Ratio of 2.75 for first-year residents. This statistic indicates marked vulnerability: being in the first year of training is associated with nearly threefold higher odds of being bullied, after adjustment for the other factors. This is consistent with 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, illustrate this Odds Ratio. The data and the narratives converge on a picture of a system in which professional dependency may be exploited and power is personified not as a tool for mentorship but as a means of control.

Furthermore, Table 4 reframes Departmental Culture as a "Modulating Factor," suggesting 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 pediatrics, is notable. 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—may intensify the risk of bullying. This aligns 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, which may make these environments particularly harmful.

Finally, the table's classification of Demographic Irrelevance as a "Systemic Indicator" presents the lack of statistical significance for gender and marital status as an informative result. With an Odds Ratio of approximately 1.0 for these factors, the data suggest that the pattern does not differ by gender or marital status. This finding is consistent with 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. Read together, the tables suggest a systemic problem in which a rigid hierarchy creates a broad risk that is amplified by the specific cultures of different specialties.

4.2 The hierarchy as a mandate for abuse

The findings shed a stark light on the lived reality of junior medical residents in Indonesia. The quantitative result is a prevalence of 81.3% for frequent bullying, which points to a systemic problem. The interviews show what that figure means. This is not simple workplace incivility or occasional harshness. It is institutionalized mistreatment, in which power is used for subjugation and education has turned into a pedagogy of fear. This discussion draws the statistics and the narratives together to ask not only what is happening but how and why it is allowed to continue. We examine the structure of the power imbalance, the distortion of educational purpose, the silence that surrounds the problem, and the path from victim to perpetrator.

The central issue is captured in the theme 'The Hierarchy as an Unassailable Mandate for Abuse'. The survey shows the shape of this structure. Work-related bullying was the most common form, with residents ordered to perform tasks below their competence or given unmanageable workloads. These are not mere survey items. They are everyday expressions of a distorted power structure. The interviews show how abstract power becomes a concrete and oppressive force.

In a functioning hierarchy, power serves organization, mentorship, and quality control. The institution grants a senior resident legitimate authority to guide juniors, teach complex procedures, and supervise patient care. Our findings describe that authority turning into unchecked coercive and personal power. When a senior orders a junior to fetch his laundry or format his personal thesis, as participants described, he is not exercising professional authority. He is performing a ritual of dominance. The act strips the junior of the identity of a physician in training and confirms a subordinate status, that of a functionary who extends the senior's will. As participants described it, the act degrades the junior and reminds them of their place in the hierarchy. The request is trivial, but its meaning is large. It says, "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 participants described it. It is not respect for experience. It is a cultural artifact that gives seniors quasi-ownership of their juniors.[6,25,26]

This misuse of hierarchy is insidious because it blurs duty and servitude. The junior resident is caught in cognitive dissonance. They entered medicine to heal and to learn, yet they perform tasks that are professionally meaningless and personally humiliating. The threat of coercive power, the power to punish, never goes away. The senior holds the junior's logbook, evaluations, and future. The phrase "Do you want to pass this rotation or not?" is not a question. It closes every door except submission. The ward stops being a place of learning and becomes a place of constant threat assessment. Mental energy that belongs to clinical problem-solving goes to navigating interpersonal dynamics and anticipating seniors' whims.

Such an environment steadily erodes a junior resident's self-worth and professional agency. Agency requires choices based on professional knowledge and ethical principles. A resident who abandons a crashing patient to run a personal errand has had that professional and ethical compass overridden by the senior's demand. The single act is a microcosm of the system: the needs of the powerful outrank the needs of the patient and the professional development of the junior. This is more than bullying. It corrupts the principles of medical professionalism. Power is no longer an abstraction on an organizational chart. It has taken the form of the senior resident, an everyday force that dictates action and stifles objection. The structure rests on personal domination, not professional respect.

4.3 The pedagogy of fear

If hierarchy supplies the structure of abuse, a distorted view of education supplies its justification. The theme 'The Pedagogy of Fear' is perhaps the most troubling aspect of this study, intellectually and morally. A system is defending its own cruelty as part of training. Public humiliation, shouting, and intimidation are not treated as failures of mentorship. They are justified as teaching tools meant to forge "tough" and "resilient" doctors. This is a profound perversion of pedagogical principles.

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. 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."[27–29] In recent studies of surgical trainees, higher disrespect and retaliation in the learning environment were associated with lower psychological safety, and public humiliation and mistreatment were named as barriers to it.[28,29]

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.[11,18,19]

This fear-based learning has devastating consequences for both the learner and the patient. For the learner, it stifles intellectual growth. Fear may impair the complex process of differential diagnosis or nuanced clinical reasoning. Trainees may instead default to defensive medicine: ordering unnecessary tests to avoid being criticized for missing something, or failing to report subtle but important clinical changes for fear of being

wrong. 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. These effects were not measured in this study and are offered as possible consequences of the fear described by the participants.

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 risk. The learning environment and the patient care environment are one and the same. A system that terrorizes its trainees is unlikely to 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.[30,31]

4.4 Silent suffering and the armor of complicity

The chasm between the 81.3% prevalence of bullying and the 8.2% reporting rate is wide. The theme 'Silent Suffering and the Armor 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.[6,32,33]

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 appears 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 senior's 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.

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 defense mechanism, dismissing current suffering by benchmarking it against a romanticized, 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. The initial harm comes from the perpetrator; the second harm comes from the institution that sanctions it through inaction.[34,35]

In this crucible of fear and futility, the junior resident is forced to construct an "armor of complicity." This is a complex psychological posture. On the outside, it is an armor 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 armor 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.[36–38]

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. The suffering is privatized, 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 the trainees in this study. 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.

4.5 The perpetuating cycle

The most tragic finding of this study is how the system preserves itself by turning victims into perpetrators. The theme 'The Perpetuating Cycle: Victims on a Trajectory to Becoming Perpetrators' shows a pathway that is both predictable and damaging. It is not simply "an eye for an eye". It is a complex psychological process in which the trauma of being bullied is absorbed and later re-enacted for survival, adaptation, and the reclaiming of power.

The journey begins with the initial victimization. The junior resident endures years of humiliation, excessive workloads, and psychological abuse. This experience is internalized not just as a series of unfortunate events, but as the normative process of becoming a specialist. The constant refrain from seniors—"I had it much worse, so don't complain. Wait your turn"—may work as a form 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. This reading of grooming is the authors' interpretation of the interview accounts.

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 defense 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. By adopting the behaviors, 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.[17,26,39,40]

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 honor.

This is how the system endures. It does not need to constantly recruit new abusers from the outside; it appears to produce them from within. It takes bright, idealistic young doctors

and, through a process of sustained psychological trauma, remolds 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.

4.6 Comparison with previous studies

The prevalence found here (81.3%) is at the upper end of the range reported for trainees elsewhere. A meta-analysis of 13 studies including 44,566 residents found an overall bullying prevalence of 51%[41]; a scoping review of resident bullying reported prevalence between 13% and 89%[13], a systematic review of surgical residents found 63%[6], and surveys of residents or interns reported 59.7% currently bullied in Nigeria[40], 76.9% in Sri Lanka[42], and 52.4% among French obstetrics and gynecology residents, in whom bullying also correlated with burnout[43]. In Southeast Asia, 91% of Thai pediatric residents reported at least one mistreatment in six months and most of those who were mistreated did not report it[12], and 45.1% of Malaysian trainee doctors reported workplace bullying[44]. In the Sri Lankan study, work overload was associated with bullying[42], which parallels the prominence of work-related acts in the present survey, and among Iranian residents longer shift hours were linked to higher perceived bullying[45]. In the United States, 31% of internal medicine program directors were aware of bullying in their programs and saw it as harming the learning environment[46]. Recent qualitative studies of junior doctors and residents describe entrenched clinical hierarchies, humiliation, poor reporting mechanisms, and bullying framed as a cyclical 'rite of passage'[17,26], which is consistent with Themes 1, 3, and 4 of the present study. Bullying has also been studied among medical students and doctors in Ghana, Bangladesh, Tanzania, and Iran[47–50], and among other health workers and faculty in Malaysia, Pakistan, Nigeria, and Iran[51–5455]. These studies describe populations and settings that differ from the junior residents surveyed here, so they offer context rather than a direct comparison.

4.7 Implications

Taken together, the findings point to several areas that merit action; the following are the authors' proposals and were not tested in this study. At the system level, programs and hospitals need clear, confidential reporting channels that residents can trust, together with protection against retaliation. At the faculty level, supervisors and program directors need training in supportive supervision and in distinguishing rigorous teaching from mistreatment. At the cultural level, the expectation that residents should endure what earlier cohorts endured needs to be challenged openly.[33,56–58] Reported approaches include a mistreatment awareness program that was followed by lower mistreatment among Thai pediatric residents[12], a chief-resident curriculum to promote psychological safety and respond to mistreatment[57], and a discussion-game intervention for junior doctors on workplace bullying that was acceptable and educationally valuable[58]. Residents themselves have reported that current reporting and investigation processes may be inadequate[33].

4.8 Limitations

This study has limitations. The survey relied on self-report and on a strict operational definition of bullying (at least one of 22 negative acts weekly or daily), which may produce a higher prevalence than other definitions. Of the 850 residents invited, 584 responded (68.7%), so non-response may have affected the estimates. The cross-sectional design allows associations, not causal conclusions. Only first- and second-year residents at five teaching hospitals were included, and the 25 interviewees were purposively selected from high-exposure respondents, so their accounts illustrate experiences rather than representing all residents. Quotations were translated from Bahasa Indonesia. Self-reported experiences may also be affected by recall and social-desirability bias. Because only junior residents were surveyed and interviewed, the findings reflect the senior-to-junior bullying as experienced by juniors, and the perspective of senior residents is absent. Future studies could include senior residents, faculty, and program directors, and could use longitudinal designs to examine how bullying and its consequences develop over time.

5. Conclusion

This study looked inside Indonesian medical residency and found fear where it expected learning. The findings are more than data points. They point to a culture in which cruelty has been mistaken for rigor and silence for strength. An unassailable hierarchy has become a mandate for abuse. Teaching has been bent into a pedagogy of fear. Trainees' shared suffering is hidden behind an armor of complicity and silence. Some participants also described how today's victims may become tomorrow's perpetrators: a cycle that may act as the system's own immune response against change.

This is more than a problem of unprofessional behavior. It weakens the healer and, by extension, endangers the patient. A system that steadily wears down the psychological well-being, empathy, and moral integrity of its future physicians has lost its way. It fails its trainees. It fails its patients. It fails the society it is meant to serve.

The conclusion of this research is therefore not a call for minor adjustments. It is an urgent call for a profound change in paradigm. The destructive cycle must be broken. New regulations on paper will not suffice. Leaders at the highest levels will need the moral courage to dismantle the toxic culture of 'senioritas' and replace it with one of psychological safety. We must stop excusing abuse as tradition and name it as a failure of our duty to care for one another. Medical education should be reimagined as a partnership built on respect rather than a struggle for power built on fear. The health of future doctors and the safety of their patients depend in part on our willingness to begin this difficult work now. The silence must be broken, not only by residents whispering in on-call rooms but also by leaders committed to healing the healers.

Declaration

Artificial Intelligence Use Statement

No generative artificial intelligence tool was used to write or revise the text, analyze the data, create images, or generate any other scholarly content of this manuscript.

Author Contribution Statement

Conceptualization, A.P.P. and H.C.; methodology, A.P.P., H.C., and A.E.; formal analysis, A.E. and E.D.P.; investigation, F.Se., F.Sa., and D.A.; data curation, L.W.; writing – original draft, A.P.P.; writing – review and editing, H.C., A.E., E.D.P., F.Se., D.A., L.W., F.Sa., V.A., and Z.A.; visualization, V.A.; supervision, Z.A.; project administration, A.P.P. All authors read and approved the final manuscript.

Funding Statement

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Conflict of Interest / Competing Interests

The authors declare that they have no competing financial or non-financial interests related to this work.

Ethics Approval and Consent to Participate

The study protocol was approved by the CMHC Research Center, Indonesia (Approval number 2023/201). Informed consent was obtained from the participants, participation was voluntary, and confidentiality was assured.

Consent for Publication

Not applicable. Interview quotations are reported without names.

Data Availability Statement

The datasets generated and analyzed during the present study can be obtained from the corresponding author on reasonable request.

Acknowledgments

None.

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