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A Policy Brief

A Comprehensive Approach to Ending Bullying in Indonesia's Medical Residency Programs: A Policy Brief

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Introduction

Bullying is a pervasive issue in medical education and practice, affecting educators, residents, nurses, and students. In Indonesia, it has emerged as a significant concern, particularly within medical residency programs. Often described as a chronic problem, bullying in medicine negatively impacts patient care and is difficult to eradicate. It occurs both in professional settings and through digital platforms like WhatsApp and Telegram. Bullying in medical education takes various forms, including physical and non-physical, and often escapes the attention of faculty, universities, teaching hospitals, and victims' families. These acts, typically carried out by senior students in an organized manner, may be falsely perceived as part of the mentoring process, masking the harmful behavior.[1]

Current Situations

In Indonesian residency programs, reports of harassment, verbal abuse, and physical bullying by senior doctors or supervisors toward junior residents have surfaced, creating a toxic learning environment and severely impacting

mental health. A Ministry of Health survey involving 12,121 participants in residency found that 22.4% exhibited symptoms of depression. Among the 2,716 specialist doctor candidates practicing in Vertical Hospitals, 1,977 experienced mild symptoms, 486 moderate, 178 moderate-to-severe, and 38 severe. On August 23, 2024, the Ministry of Health recorded 234 reports of bullying, with the highest cases in the internal medicine residency program (44), followed by surgery (33) and anesthesiology (22).[2]

By early August 2024, 1,540 allegations of bullying among postgraduate medical students were reported, primarily from university and local government hospitals. The Director General of Health Services indicated that 25-30% of these cases had strong evidence of bullying, often involving non-physical forms such as excessive workloads. The situation gained widespread attention following the death of Dr. ARL, a Diponegoro University student, reportedly bullied by seniors, leading to a police investigation.[3]

A global systematic review estimated that 51% of medical residents experience bullying, with rates varying from 30% to 95%. Female residents and minority groups, especially from lower socioeconomic backgrounds, are at higher risk, with females nearly twice as likely to face bullying compared to males. In Ras Al Khaimah, UAE, 34.1% of healthcare students reported bullying, mostly verbal (44.4%) and cyberbullying (23.8%), both negatively impacting mental health. Similarly, 52% of final-year medical students in Pakistan reported bullying, primarily verbal abuse from consultants. Older students, males, and those attending colleges without anti-bullying policies were more likely to experience bullying.[4–6]

Several risk factors contribute to bullying in residency programs, particularly for female residents and those from minority or lower socioeconomic backgrounds. The hierarchical nature of medical training exacerbates power imbalances, making residents vulnerable, especially when a disparity in socioeconomic status exists. Attending physicians and co-

residents are frequently identified as perpetrators, with verbal bullying being most common. Fear of reprisal often prevents reporting, leading to severe emotional and psychological consequences. This underscores the need for systemic intervention.[5,7–11]

Four common forms of bullying are encountered in medical education: verbal, physical, social (manipulation of social relationships to harm or control the victim), and cyberbullying through digital platforms.[12,13] A survey in Thailand identified excessive workloads, often involving non-academic or trivial tasks, as the most common form of bullying in residency programs.[14] Bullying in residency is also embedded in the hidden curriculum, consisting of implicit, informal, and often unintentional values absorbed in these programs. This hidden curriculum fosters a negative learning environment, leading to burnout, loss of personal identity, and a teaching culture of humiliation.[15-1]

Research shows that bullying, regardless of the role, has lasting effects on emotional regulation and physiological responses, with victims at higher risk of depression, anxiety, and reduced self-esteem. These consequences are particularly severe in medical education, where the high-stress, hierarchical nature of residency makes trainees more susceptible. Up to 59% of medical trainees report experiencing bullying, often from senior colleagues, leading to increased burnout, medical errors, and thoughts of leaving the profession. This highlights the critical need for targeted anti-bullying initiatives in medical training programs.[18-21]

Bullying also significantly increases the risk of depression, a trend observed in both adolescence and medical residency. A 2024 study of 12,121 medical trainees in Indonesian hospitals found that 22.4% exhibited depressive symptoms, with high-stress specialties such as Pediatrics (14%) and Internal Medicine (12.9%) showing the highest prevalence, followed by Anesthesiology and Intensive Care (9.1%) and Neurology (6%). These findings emphasize the urgent need for mental health support and anti-bullying

initiatives, particularly in high-stress specialties.[22-23]

Policy Outcome and Implementations

Under Law No. 17 of 2023, residency program students providing healthcare services in Indonesia are protected from both physical and mental bullying.[24] Sanctions for bullying are outlined in Law No. 1 of 2023, covering defamation, physical abuse, and indecent acts, with possible prosecution under Article 1372 of the Civil Code.[2,25] The Medical Ethics Honorary Council (MKEK) and the Indonesian Medical Code of Ethics (KODEKI) are instrumental in addressing ethical violations related to bullying.[1,26] The Ministry of Health is committed to end bullying in residency programs, providing reporting channels and ensuring protection for victims and witnesses through Ministerial Instruction No. HK.02.01/MENKES/1512/2023.[27]

After this policy was issued, there was a significant increase in reported cases, with many successfully resolved.[28] However, the policy's effectiveness requires further evaluation, particularly in reducing incidents, changing behaviors, and improving reporting practices. This evaluation should involve both quantitative and qualitative assessments over time.

In the United States, residents in surgical specialties face frequent verbal abuse, lewd comments, and harsh criticism from supervisors and senior colleagues.[5,29] Similar trends are observed in Australia and New Zealand, where bullying is common in surgery and anesthesiology. In these regions, as well as Latin America and South Asia, cultural and institutional hierarchies exacerbate the problem, with residents often hesitant to file complaints due to fears of retribution or career jeopardy.[30] Many countries have implemented bullying prevention measures, including training programs to raise awareness. The United States and the United Kingdom have introduced interventions for workplace harassment and anti-bullying education, though results have been mixed. While reported bullying cases have declined, some measures have struggled to achieve long-term impact.

In Australia, anti-bullying initiatives have been adopted in hospitals, but the rigid, hierarchical culture in medical institutions remains a significant barrier.[5] These examples highlight the need for unified and comprehensive approaches to create safer, more tolerant work environments.

A systematic review found that 51% of medical residents experienced bullying, with verbal abuse being common.[5] In the UK, around half of residents reported similar experiences. In Western countries like the U.S., organizations such as the Accreditation Council for Graduate Medical Education (ACGME) have implemented anti-bullying policies and reporting systems to improve learning environments and ensure resident well-being.[7,31] These systems allow for confidential reporting without fear of retaliation. In contrast, Indonesia lacks structured frameworks for addressing bullying in residency programs. Addressing this issue requires the implementation of clear policies, confidential reporting mechanisms, and efforts to foster a respectful culture in the medical community. Further research on bullying in Indonesian residency programs is also critical.

Actionable Recommendations

To enhance the residency curriculum, it is recommended to integrate essential training modules such as emotional intelligence, assertiveness, communication, leadership skills, work-life balance, empathy, burnout prevention, conflict management, and stress relief. Each resident's performance in these areas should be evaluated. Emphasizing a "team-based culture" and promoting a "just culture" can help dismantle dysfunctional hierarchies. Academic priorities should shift toward fostering care in teaching rather than focusing solely on patient services. Standardizing and restructuring the learning environment is necessary to combat the hidden curriculum, with all levels of residents involved in curriculum design and evaluation, ensuring standardized feedback and reducing favoritism and bias. Faculty must take responsibility for daily resident activities, serving as leaders and role models to change the culture and eliminate the hidden

curriculum, which can develop without their awareness.

Collaboration between universities and governments is crucial to address residents' financial, well-being, and mental health needs. This includes offering affordable education fees, resident salaries, and mental health resources. Additionally, more medical and non-medical support personnel should be assigned to residents to mitigate overwork and prevent the assignment of tasks outside residents' competencies or curriculum. Periodic monitoring and evaluation of residency practices by external organizations can help prevent conflicts of interest. Flexibility in exit strategies, such as allowing residents to change programs or institutions, should also be supported.

A confidential whistleblowing system, managed by an independent body external to the medical faculty or program, must be institutionalized to ensure impartiality and protect the anonymity of victims. Misconduct should be addressed with specific terms like abuse of power, character assassination, or verbal harassment, rather than using the outdated term "bullying." Structural changes are necessary to break cycles of misconduct and protect current medical students from both internal and external threats, including those posed by alumni. Establishing a firm code of conduct, validated by external parties, along with random anonymous surveys conducted by unbiased organizations, can further ensure accountability.

The Ministry of Health should implement a standardized minimum salary for residents. Although Law No. 12 of 2013 mandates salary provision, the mechanism has yet to be clearly established. This uncertainty can lead to issues with the Badan Pemeriksa Keuangan regarding the legality of incentives. Establishing a clear, legal mechanism would alleviate financial stress, empowering trainees to focus on their education and report bullying incidents without fear, as both perpetrators and victims of bullying are less likely to come from high socioeconomic groups.[10]

Policies should also support flexible working arrangements, offer time off for self-care, and promote a culture that values work-life balance. Residents should be encouraged to set boundaries and prioritize their well-being, rather than feeling pressured to sacrifice their personal lives for their careers. Promoting mentorship relationships instead of oppressive senior-junior dynamics is essential. Clear timeframes and authorizations should be established to prevent the abuse of power, which is often perpetuated by hierarchical structures in medical training.

Conclusion

Bullying in Indonesian medical education, particularly residency programs, is a pervasive issue exacerbated by the high-stress nature of training and insufficient reporting mechanisms. Its harmful effects on mental health, including depression and anxiety, highlight the urgency of intervention. While legal frameworks and policies exist, more must be done to create a safe and supportive learning environment. Implementing anti-bullying policies, confidential reporting systems, and promoting a respectful, team-based culture are essential steps. Structural changes, financial support, and mental health resources will help break the cycle of misconduct. Ultimately, fostering mentorship, respect, and work-life balance will create a healthier, more inclusive medical training environment.

Competing Interest

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