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Specialist Medical Education Program (PPDS): A Phenomenological Study at the Faculty of Medicine, Sam Ratulangi University

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ABSTRACT

Bullying in clinical medical education has increasingly been recognized as a systemic problem that undermines learning quality, resident well-being, and ultimately patient safety. This study examines the dynamics of bullying within the Specialist Medical Education Program (PPDS), particularly Anesthesiology and Intensive Care, at the Faculty of Medicine, Sam Ratulangi University (FK Unsrat), and formulates a comprehensive management model for bullying prevention aimed at reducing residents' risk of depression. Using a qualitative phenomenological approach, data were collected through Focus Group Discussions (FGD) and in-depth interviews with purposively selected participants, including junior residents, senior residents, and consultants. Findings indicate that bullying is often "mild" in appearance yet persistent manifesting verbally (humiliating remarks, destructive criticism), socially (information exclusion), symbolically (non-academic errands justified as "tradition"), and administratively (unrealistic deadlines and punitive task allocations). These behaviors are normalized by a seniority culture, rigid academic traditions, and hierarchical structures, which create power imbalances and discourage reporting due to fear of retaliation and negative academic consequences. The study also reveals that existing prevention efforts remain largely normative: formal rules are not explicit about bullying, standard operating procedures (SOPs) are absent, and reporting mechanisms are unclear or distrusted. In response, this study proposes an integrated bullying prevention management model consisting of a dedicated SOP, an independent reporting and protection system, strengthened empathetic communication training, consultant mentoring development, organizational culture reorientation, and continuous monitoring and evaluation. The model positions

prevention as an institutional quality assurance agenda in clinical education linking humane supervision, ethical professionalism, and mental health safeguarding to improved learning outcomes and safer care.

Keywords: bullying, clinical education, depression risk, prevention management, qualitative phenomenology, residency program (PPDS), seniority culture.

INTRODUCTION

Bullying is not limited to primary or secondary education; it also emerges within high-stakes professional training, including clinical medical education. In residency programs, bullying often hides behind the rhetoric of "discipline," "tough training," or "character building," yet it can trigger sustained psychological distress that accumulates into chronic stress and depressive symptoms. In the PPDS context, power relations are sharply structured: junior residents depend on senior residents and consultants for supervision, evaluation, clinical opportunities, and progression. These structural conditions can intensify vulnerability, especially when "seniority" shifts from mentorship into domination.

Evidence from this study context (PPDS Anesthesiology and Intensive Care at FK Unsrat) shows that bullying is not always extreme; rather, it is frequently subtle, repeated, and socially legitimized. This is critical because subtle bullying can be harder to report and easier to normalize, allowing it to persist across cohorts. Over time, such patterns do not only affect educational climate but can impair residents' cognitive performance, motivation, and professional confidence—factors that are directly relevant to patient safety in clinical settings. The central problem is not merely identifying bullying forms, but understanding how bullying becomes systemic within clinical education and how educational management can intervene. This study therefore focuses on (a) the forms and characteristics of bullying experienced by residents, (b) cultural and structural drivers in hierarchical relations, (c) bullying's psychological impact related to depression risk, and (d) the effectiveness gaps in existing prevention management, culminating in a proposed optimization strategy and institutional model.

LITERATURE REVIEW

Bullying as a Power-Imbalance Phenomenon

Bullying is commonly conceptualized as repeated aggressive behavior involving a power imbalance between perpetrator and target. Olweus (1993) emphasizes repetition, intent to harm, and power asymmetry as core characteristics features that become especially relevant in hierarchical settings such as clinical education. This study's findings align with that conceptualization: bullying frequently appears in interactions between junior–senior residents and residents–consultants, where authority and evaluation power are concentrated.

In professional training systems, bullying may transform into "institutionalized mistreatment" a normalized pattern embedded in informal norms and socialization processes. Within clinical education,

the hidden curriculum can reinforce such norms: residents learn not only clinical knowledge but also coping behaviors, silence, and "acceptable" aggression as part of professional identity formation.

Depression Risk and Chronic Stress Pathways

Depression is widely framed as a mood disorder characterized by persistent sadness, diminished interest, impaired concentration, sleep disruption, and functional decline. In the clinical education context, repeated stressors especially those involving humiliation, exclusion, and perceived injustice can catalyze chronic stress responses and depressive symptomatology. In this study, bullying is explicitly linked to psychological pressure that may develop into chronic stress and depressive symptoms, which in turn can compromise academic performance and professional functioning.

A crucial insight from the FK Unsrat context is that "mild" bullying can still be psychologically damaging when persistent. Social exclusion (e.g., being left out of essential communication), symbolic domination (e.g., non-academic errands), and public criticism collectively erode self-efficacy and sense of belonging two protective factors against depression.

Management Perspective: Prevention as Educational Governance

From an educational management perspective, bullying prevention should be treated as part of institutional governance and quality assurance in clinical learning environments. Effective management frameworks typically emphasize planning, organizing, leading, and controlling (POAC), applied not only to academic outputs but also to learner well-being and ethical climate. The dissertation frames bullying prevention management as an institutional set of policies and mechanisms SOPs, safe reporting channels, mentoring systems, training interventions, and evaluation cycles designed to reduce bullying incidence and protect residents' mental health.

Importantly, there is often a gap between formal policy and lived practice. The FK Unsrat case demonstrates that when formal policy does not explicitly mention bullying and reporting procedures are unclear, informal culture becomes the dominant regulator sometimes reinforcing seniority-based domination.

Why a Phenomenological Approach Matters

Bullying in residency is frequently underreported due to fear of retaliation and stigma especially when "resilience" is culturally equated with silence. This study therefore benefits from phenomenology, which prioritizes lived experience and meaning-making, enabling the research to capture subtle, normalized forms of bullying and the psychological calculus behind non-reporting. The dissertation positions this integrative approach bullying + depression risk + prevention management as a theoretical and methodological novelty, since many prior studies separate prevalence measurement from management evaluation.

METHOD

This research employed a qualitative phenomenological design to explore the lived experiences of bullying and its mental health implications among residents, while also examining how institutional

management practices shape prevention and response. Data were collected primarily through Focus Group Discussions (FGD) and in-depth interviews. Participants were selected using purposive sampling based on involvement in PPDS hierarchical structures and direct experience with or knowledge of bullying dynamics.

The study involved three categories of informants: junior residents (years 1–2; n=5), senior residents (years 3–4; n=5), and consultants/teaching staff (n=3). All FGD and interview data were transcribed and analyzed thematically to identify recurring patterns and conceptual relationships across themes, including bullying forms, causal factors, psychological impacts, and management gaps.

RESULTS AND DISCUSSION

Forms and Characteristics of Bullying in PPDS

Findings show that bullying in PPDS at FK Unsrat is diverse and context-specific, often subtle yet repeated, and frequently legitimized as "tradition."

The most prominent forms include:

- Verbal bullying: humiliating remarks, sarcasm, and destructive criticism delivered publicly (sometimes in front of patients or peers).
- Social bullying: exclusion from essential information flows, selective silence, and marginalization within team communication.
- Symbolic bullying: assigning non-academic errands to junior residents, justified as "discipline" or a rite of passage.
- Administrative/structural pressures: unrealistic deadlines, punitive task distribution, and comparison practices that undermine residents' dignity.

A critical point is that these "mild" forms precisely because they are subtle can become routine, normalized, and therefore difficult to challenge. The dissertation explicitly concludes that even when not extreme, such bullying still requires serious attention because cumulative exposure becomes a significant psychological burden and perpetuates intergenerational cycles of injustice in clinical education.

Cultural and Structural Drivers in Hierarchical Relations

Bullying is shaped primarily by cultural seniority norms and rigid hierarchical structures. In FK Unsrat's PPDS environment, seniority can function positively as mentorship, but it frequently shifts into domination through "small commands" and everyday practices that position juniors as service providers rather than learning partners.

This reflects a broader institutional pattern: the hidden curriculum can implicitly teach that enduring humiliation is part of professional formation. Over time, residents may internalize the belief that bullying is "normal," lowering resistance and reinforcing silence. The implication for management is clear: policy solutions alone are insufficient unless cultural meaning is also transformed redefining seniority from domination into structured mentorship.

Bullying and Depression Risk: The Psychological Mechanism

The study identifies bullying as a significant psychological stressor that can progress into chronic stress and depressive symptoms. While residents may initially cope through personal strategies, persistent exposure especially combined with intense workload and evaluative pressure creates vulnerability. Importantly, social exclusion and public humiliation can reduce perceived support and self-efficacy, increasing depression risk pathways.

This finding is also consistent with the dissertation's framing that bullying impacts not only mental health but also academic performance, meaning that resident well-being and educational quality are inseparable outcomes in clinical education management.

Effectiveness of Existing Prevention Management: Formal vs Nonformal

A major institutional gap emerges in prevention management. The study finds that prevention efforts are not yet effective, mainly because existing mechanisms remain general and normative without specific operational guidance:

- No explicit anti-bullying SOP
- Reporting mechanisms unclear and distrusted
- No dedicated anti-bullying team
- No structured psychological support services for residents

A key comparison highlights the limited effectiveness of formal vs nonformal policies. Formal rules tend to rely on general academic codes and medical ethics, but they do not explicitly address bullying, while nonformal norms (mentoring traditions and senior-junior culture) dominate daily life and vary across supervisors.

Residents often do not know official complaint channels and avoid reporting due to fear of being labeled "weak" or facing educational consequences. As a result, residents default to personal coping rather than institutional support.

Proposed Model: Optimization Strategies for Bullying Prevention Management

Building on these findings, the dissertation proposes an integrated strategy that addresses both cultural and institutional dimensions. Core components include:

1. Reorienting seniority culture into mentoring culture
   Seniority should be reframed as structured mentorship, knowledge transfer, and professional character development not as legitimization for non-academic burdens. This requires leadership and empathetic communication training for senior residents.
2. Independent, safe, and confidential reporting system
   A reporting channel must be secure, anonymous where appropriate, and institutionally protected from retaliation. The dissertation recommends forming an independent unit (e.g., resident welfare committee) and adopting digital anonymous reporting to reduce psychological barriers.
3. Dedicated SOP for prevention and response
   A specific SOP should define bullying forms, reporting procedures, mediation steps, victim protection, and sanctions moving beyond general ethical statements into implementable pathways.
4. Transforming consultants' role into humane clinical mentorship

Consultants are not only assessors but also role models who shape academic climate. Training in mentoring and humanistic supervision is needed to disrupt intimidation-based teaching styles.

5. Continuous monitoring and evaluation (M&E)
   Prevention must be sustained through routine climate monitoring, annual evaluation of bullying reports, and resident well-being indicators, ensuring that prevention becomes part of academic quality assurance.

Notably, the dissertation even outlines a draft internal regulation/SOP structure defining bullying forms, prevention planning, and mechanisms such as a resident welfare committee and a digital anonymous platform. This strengthens the model's practicality because it translates findings into governance-ready instruments.

CONCLUSION

This phenomenological study demonstrates that bullying within PPDS at FK Unsrat is a systemic phenomenon reinforced by seniority culture and hierarchical structures, with repeated "mild" bullying forms that are often normalized as tradition. These experiences generate psychological distress that can progress into chronic stress and depressive symptoms, affecting learning quality and potentially patient safety.

The institutional prevention system is currently limited by non-explicit formal regulations, lack of operational SOPs, unclear reporting pathways, and weak protective mechanisms for residents. The study proposes an integrated prevention management model: SOP development, independent reporting and protection mechanisms, empathetic communication and mentoring training, consultant capacity building, cultural reorientation, and continuous monitoring and evaluation. This model positions anti-bullying governance as a strategic component of clinical education management and resident mental health safeguarding.

Practical Implications

- For Faculty Leadership: institutionalize anti-bullying SOPs and ensure independence of reporting and investigation mechanisms.
- For PPDS Program Management: standardize mentoring expectations and supervise senior-junior interactions through structured mentorship programs.
- For Clinical Teaching Staff: strengthen humane supervision competencies and shift feedback culture toward constructive, non-humiliating pedagogies.
- For Resident Well-being Systems: integrate psychological support and monitoring into routine academic quality assurance cycles.

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