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Original Article MEDICAL EDUCATION

Contextual reading and analysis of the team's narratives about the system in which clinical education and healthcare processes are experienced

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ABSTRACT

OBJECTIVE: Understanding the health system and the clinical and learning experiences from the perspective of complexity theory requires a reflective and contextual approach. The context in which experience takes place consists of multidimensional elements that influence each other, such as sociocultural environment, work/educational climate, stakeholders, educational/healthcare system. In this framework, it is important to read and analyze the parties' experiential narratives within their contexts. The aim of this study is to analyze the narratives of the team working in a surgical clinic about their clinical education and healthcare experiences in terms of the "institutional, clinical and national system" as one of the contextual elements in which the experience is lived. In line with this purpose, the research problems were identified as follows: (1) what are the experiences and narratives of the team regarding the system in clinical education and healthcare processes, (2) how do the parties relate to the system, and (3) what are the outcomes of different ways of relating?

METHODS: This narrative study was conducted in the surgical clinic of a university hospital. The voluntary participant group consisted of 31 participants, including clinical instructors (n=5), surgical residency students (n=5), medical students/interns (n=15) and nurses (n=6) working as a team in the clinic. The narratives obtained through in-depth interviews were analyzed using the "Three-Stage Contextual Theme Analysis" created for this study.

RESULTS: The themes that emerged from the analysis were grouped under three contextual categories: "clinical system: structure, functioning and workload", "clinical environment, climate and culture", "national, social environment and extra challenging situations". The themes related to the consequences of these contextual experiences were grouped under two categories: "ways of coping/not coping" and "consequences/effects".

CONCLUSION: The contextual dimension of the experience can cause parties to live experiences in their own way and to focus more on their context and not see enough of what others experience. This points to the importance of planning, conducting and evaluating clinical education, research and healthcare processes within their context, including the system.

Keywords: Clinical education; educational environment and climate; health system; narrative analysis.

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In complexity theory, a system is considered a "self-organizing complex social system". "Complex social systems" that constantly reorganize themselves through mutual interaction and transformation are context-dependent and therefore, the experiences of individuals, teams and organizations are evaluated in their context (local, historical, cultural, institutional, etc.) through a reflective and contextual approach [1–3].

This research forms a part of Merve Saracoglu's doctoral thesis.

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Understanding health and education systems as examples of complex systems and the experiences within these in their context requires addressing the interrelationships between the components of the system (subsystems, structures, functioning, arrangements, actors, materials, policies, etc.) together with their processes, contexts and outcomes. This is because complex clinical education and healthcare processes are experienced in the context of both institutional and national systems, and the outcomes that emerge from experience are framed by this intertwining of process and context. Clinical education processes are contextual and reflective developmental processes in which learners acquire the necessary professional/technical competencies and form physician identities with their own worlds of meaning and value. In this framework, it is important to read and analyze the experiences of the parties and their narratives within their contexts, and to formulate explanations and interpretations [3–6].

In general, the context of the clinic, the institution (hospital, faculty) and the society in which the healthcare or clinical education experience takes place can be categorized into three groups: (1) the environment, climate and culture of the institution/clinic, its sociocultural, emotional, relational, and professional environment; (2) the educational and health systems, policies, structures, functioning, automation, physical/technological environment at the national and institutional level; and (3) societal and local characteristics and culture. In one of the studies on how and in what way the "system" in which healthcare and clinical education experiences take place affects these experiences, the importance of qualified institutional learning climates for education and patient care was emphasized; supportive institutional (e.g. hospital) and clinical management and organizational system factors were shown to contribute positively to the development of these processes [7]. Health processes, especially in healthcare delivery services, have a complex nature as they involve many professional groups. Studies emphasize that the traditional hierarchical structure continues in the health delivery system. It has been stated that a healthcare system that supports effective teamwork can both improve the quality of patient care, eliminate negative causes of conflict that lead to emotional, motivational and behavioral consequences among health professionals, and reduce problems such as workload [8–10]. Studies on the economy-oriented healthcare system (performance system) indicate various negative outcomes. This focus can be associated with conflicts among staff, decreased acuity in patient care processes, and physicians' evaluations of whether to stay in the institution [11]. Cultural, semantic and individual value differences experienced in the interactions between clinical stakeholders may cause some problems in clinical functioning. Analyzing these value and meaning differences in the cultural context with ethnographic methods is one of the ways to improve clinical functioning processes, especially the system [12].

Highlight key points

- In health education and care service processes, intense clinical workload originating from national, institutional, clinical system may have negative physical, emotional and motivational consequences on clinical stakeholders.
- Disciplined, hierarchical functioning and environment in clinical climate and culture may create negative experiences for clinical stakeholders.
- The national, institutional and clinical system is experienced differently by the participant groups and their ways of relating and coping are also different.
- Local, social and cultural characteristics in which clinical processes take place play an important role in the experiences of clinical participants as a system.
- Due to national, institutional and clinical system-related factors, clinical education processes may be overshadowed by the dominance of health care.

Therefore, it is important to show through new research how context-dependent the experiences in clinical education and healthcare processes are and how they are framed by health and education systems. Through such research, it will be possible to demonstrate how processes can be experienced differently by each party in their own specific context and how the outcomes of the experience can differ between the actors. The aim of this study, which was designed within such a framework and thought to make a significant contribution to the literature, is to analyze the narratives of those working in a surgical department regarding their clinical education and healthcare experiences in terms of "institutional, clinical and national system", which is one of the contextual elements. In line with this aim, the research problems were identified as follows: (1) what are the experiences and narratives of the team regarding the system in clinical education and healthcare processes? (2) how do the parties relate to the system? (3) what are the consequences of different ways of relating?

MATERIALS AND METHODS

This qualitative research with a narrative design was conducted in the general surgery clinic of a university hospital in Eastern Anatolia, Turkiye. The team's narratives (qualitative data) were obtained using in-depth interview technique. The number of volunteer clinical team members participating in the study is as follows: 5 of 9 clinical educators, 6 of 13 nurses, 5 of 11 residents, and 3 students from each of 5 intern student groups rotating in the surgical clinic for 6 months, totaling 15 medical students/interns, (n=31).

Ethical Approval

Ethical approval was obtained from Van Yuzuncu Yil University, where this study was conducted (dated 15.01.2021, numbered 2021/01-13) and legal consent was obtained from the hospital and clinical department management. This research was conducted in accordance with the Declaration of Helsinki.

Contextuality and reflexivity: The institutional and social context of the research is a university hospital located in the Eastern Anatolia region of Turkiye. The population and geographical region served by the hospital employees show a collectivistic structure in which traditional rules and values are dominant. The cultural values and behaviors of the hospital staff are very similar to the population they serve. The surgical clinic, where the data of the study were collected, is the unit with the highest patient circulation in the institution. In addition, the hospital also accepts patients from nearby cities and undertakes the patient load of that geographical region.

The first researcher (MS) worked as an operating room nurse in a university hospital for 23 years. She is currently working as a doctor in the department of medical education and has a PhD in medical education. She is researching qualitative methods in health education research, the narrative paradigm, medical humanities and narrative medicine. This research forms a part of MS's doctoral thesis.

The second researcher (SYI), a psychologist, is an associate professor in the department of medical education and has a Ph.D in neurosciences. Her research interests include the relationship between emotions and decision-making, professionalism in medicine, emotions in the physician-patient relationship and reflection in education.

The third researcher (MAG), is a professor in the department of medical education. He works on qualitative research paradigms, organizational change and leadership dynamics and narrative medicine.

Research Design and Methodology

The narrative design is a qualitative research design based on the analysis, description, interpretation and/or re-narrating of individuals' oral or written narratives about their life experiences. This qualitative research design focuses on experience, the qualities of life and education, and the meanings of these experiences for those who experience them. The role of the researcher in the narrative design is to uncover the meanings implicit in individual narratives and interpret the meaning of the experience for the individual. At the same time, after the analysis of the data, the narratives can be re-narrated by the researchers in their own words. Re-narrating is the process in which the narrative is restructured to be analyzed according to time, place, space and situation. In narrative design, data can be collected through many methods and tools such as participant observation, in-depth interviews, narrative/reflective writings [13, 14]. In our study, personal narratives of the participants working as a team about the system were collected through one-on-one face-to-face in-depth interviews.

In-depth interview, one of the qualitative data collection techniques, is also referred to as "open-ended intensive interview" in the literature. The researcher initiates the conversation about the theme he/she wants to focus on with 1–2 initial questions. In the interview framed by the research questions, the researcher tries to provide focus and depth in the interview by going from general to deep in the natural flow of each interview. The aim is to reveal the participants' narratives about their experiences in detail and in depth [13]. In this study, 30–40 minute interviews were conducted with voluntary participants after obtaining their consent, in which they shared their clinical experiences. A voice recorder was used in the interviews after obtaining permission, and then the interview recordings were transcribed by the first researcher (MS).

The Process of Qualitative Analysis of Narratives

Data analysis in qualitative studies, as applied in this study, is a reflective and iterative process that usually starts with the data collection phase and continues with multiple readings. In the process, the transcribed text is read independently by at least two researchers; codes and themes are created on the text. Afterwards, consensus is

sought between the two people on the codes and themes that emerge and common themes and sub-themes are decided. In this order, a third person can be engaged as an expert both for consensus and, if necessary, for reorganizing the research questions and conceptual framework according to the analysis. In this way, themes and conceptual framework are revealed. The themes and conceptual framework are finalized by re-reading the text (validation) through the conceptual framework and themes. In the final stage, the main themes and sub-themes are associated with the research questions and the interpretation and reporting process begins [13, 15, 16].

Three-stage contextual analysis framework: In this article, the second of the three contexts listed above is selected and the results obtained by reading and analyzing the narratives of the team's experiences in health and clinical education processes through the "clinical education and healthcare system" are presented and discussed. In line with the Three-Stage Contextual Theme Analysis Framework, the analysis process was carried out as follows.

In the first stage, two researchers (MS, SYI) first analyzed the narratives independently and then together, and determined the codes and themes together with the contexts of the narratives. In the second stage, expert opinion was taken (MAG), the conceptual framework of the research was created based on the results of the first analysis (Fig. 1), and the research questions were revised. In the third stage, two researchers (MS, SYI) reanalyzed the data (verification) based on the revised research questions and the conceptual framework and finalized the framework and themes.

RESULTS

According to the results of the analysis of participant narratives in the context of the health and clinical education system, three sub-contexts emerged: "clinical system: structure, functioning and workload", "clinical environment, climate and culture", "national, societal environment and extra challenging situations". The themes related to the consequences of these contextual experiences were categorized under two dimensions: "ways of coping/not coping" and "consequences/effects". As seen in Table 1, between 3 and 8 themes were identified under three sub-contexts and between 2 and 6 themes were identified under two dimensions in the narratives of residents, nurses, faculty members and interns. In medical student/intern narratives, no themes emerged in the sub-context of "national, social environment and extra challenging situations" and in the dimension of "ways of coping/not coping".

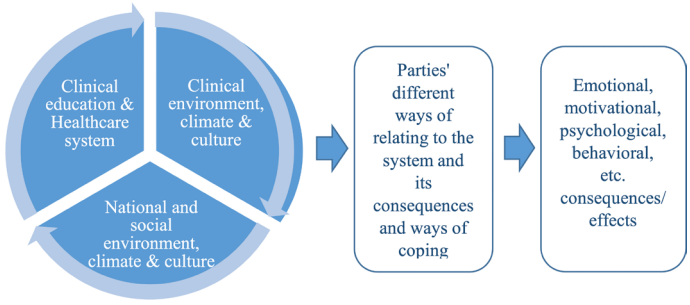

FIGURE 1. Conceptual framework of the analysis.

Clinical System Sub-context and Participants' Experiences

In the analysis of participant narratives, the first sub-context is related to the clinical system. It was revealed that the clinical system was mostly experienced in terms of structure, functioning and workload. In the analyses, the "clinical education system" did not directly appear as a sub-context, but rather was expressed through the clinical system.

The themes that emerged in the participants' narratives related to this first sub-context are mostly related to the dominance of healthcare service, clinical intensity, rapid patient circulation, discipline orientation and hierarchical functioning. In addition, "the current situation and difficulties related to the profession" in nurse narratives and "the lack of a specific, working program" in faculty member narratives emerged as separate themes. Sample statements related to these extra themes that emerged in the narratives of nurses and faculty members are as follows:

> *"Nursing is not a status that you can rise a lot, I mean, our branch is certain. After all, there is a question of position and status, I would not want to cross that line."* (N-4)

> *"There is no discipline here, and the main reason for the lack of discipline is that there is no control mechanism. Everything revolves around one person, there is no main branch of science, there is no organization."* (CI-1)

It was observed that the prominent issues regarding the dominance of healthcare service and intensive clinical workload were intensive workload, hustle and bustle and fast circulation.

> *"It is an education that requires being fast. The lecturer always wants the assistants to run, he always says they should run."* (R-3)

Table 1. List of sub-contexts, dimensions and related themes/sub-themes that emerged from the analyses of participant narratives

	Sub-contexts/dimensions	Themes and sub-themes
Residents (R)	Clinical system: structure, functioning and workload	1.Health service dominance, clinical workload, rapid circulation 1.1. Planning patient care processes 1.2 Weakness of scientific and educational dimension, decline in quality 2. Discipline-oriented, hierarchical functioning
	Clinical environment, climate and culture	1. Positive perception of the department and the head of the department 2. Family-like relationship, dedicated work environment 3. Humanly challenging, offensive, destructive environment
	National, societal environment and extra challenging situations	1. Shouldering the health burden of the region 2. National health system, performance system 2.1. Healthcare, economy orientation
	Ways of coping, ways of not coping	1. Fast, algorithmic solutions 2. Doing the job in a mechanized, emotionless way 3. Rationalization, acceptance
	Consequences/effects	1. Increased willingness to work and commitment to the department 2. Effects due to clinical overload and disciplined, hierarchical functioning 2.1. Thinking about leaving the department 2.2. Physical, emotional, motivational, psychological, behavioral consequences
Nurse (N)	Clinical system: structure, functioning and workload	1. Clinical intensity, rapid circulation, 2. Current status and difficulties of the nursing profession 2.1. Occupational perception, frequent interdepartmental mobility, inadequate employment 2.2. Interprofessional hierarchy and functioning 2.3. Unresolved material shortage
	Clinical environment, climate and culture	1. Positive perception of the department and the head of the department 2. Family-like relationship, dedicated work environment 3. Intra-team, interprofessional perceptions and relationships: 3.1. Hierarchical environment and interprofessional distance, conflict 3.2. Underappreciation and devaluation of the nursing profession 4. Work-orientated technicised working environment, poor social relations
	National, societal environment and extra challenging situations	1. Patient relatives; extended family structure, clan (local motif) 2. Changing perception of health workers in the society
	Ways of coping, ways of not coping	1. Quick, self-created, palliative solutions 3. Submission, acceptance 4. Managing, softening the reactions
	Consequences/effects	1. Effects of clinical intensity and rapid circulation 1.1 Motivational effects of work, resignation 1.2 Social impacts 1.3. Physical, emotional, mental, behavioral consequences 2. Declining quality of the relationship with patients

Table 1 (cont). List of sub-contexts, dimensions and related themes/sub-themes that emerged from the analyses of participant narratives

	Sub-contexts/dimensions	Themes and sub-themes
Instructors (CI)	Clinical system: structure, functioning and workload	1. Functioning without a definite, working programme: 1.1. Unplanned, disorganized 1.2. Lack of monitoring and evaluation 2.Health service dominance, clinical intensity, rapid circulation 2.1. Excessive burden on assistants 2.2. Weakness of scientific and educational dimension, decline in quality
	Clinical environment, climate and culture	1. Family-like relationship and local motifs (Teacher/Son) 1.1. Inability to be a team, inability to carry out work with a team 1.2. Unchanging, one-person dominant order
	National, societal environment and extra challenging situations	1. National health system, performance system 1.1. Health care, economy orientation 1.2. Lack of national planning 2. Cultural and regional characteristics, structures, relationships and behavioral patterns
	Ways of coping, ways of not coping	1. Acceptance, letting go 2. Finding by-pass/intermediate solutions, 3. Finding a solution on your own, getting it done
	Consequences/effects	1. Rapid change in interprofessional team members, weakness in social interaction due to resignation 2. Impacts due to a decrease in the scientific and educational dimension 2.1. Weakening of the instructor role of faculty members 2.2. Emotional, motivational effects 2.3. Effects on scientificity
Intorns (I)	Clinical system: structure, functioning and workload	1. Clinical intensity 1.1. Unfair excessive workload on assistants, which undermines their interaction with the residents 1.2. Preventing and hindering their education 2. Discipline-oriented, hierarchical functioning
	Clinical environment, climate and culture	1.Stressful, disruptive environment 1.1. Hardening of relationships, loss of human dimension 1.2. Aggravation
	National, societal environment and extra challenging situations	None
	Ways of coping, ways of not coping	None
	Consequences/effects	1. Negative feelings and loss of interest in the department, withdrawal from the department 2. Recognise the importance of positive interaction with the patient

"Employees do not last very long. We have a very fast circulation." (CI-2)

"This is a work-based service, it is a service loaded with work rather than teaching." (I-14)

It was observed that the findings related to discipline-oriented and hierarchical functioning were expressed in the narratives of nurses, assistants and interns as follows:

"There is a hierarchy. We are all part of this algorithm." (R-1)

"We know the subordinate-superior relationship. But this is disrespectful, offensive, insulting, humiliating; unfortunately, we have remained in such a system." (N-2)

Clinical Environment, Climate and Culture Sub-context and Participants' Experiences

The emerging themes related to the second sub-context were related to interparty and interprofessional relationships and perceptions, socialization and the work environment with its positive and negative aspects. Positive perception of the department, family-like relationships and self-sacrificing environment were identified as prominent themes in narratives other than interns, while inhuman, challenging environment was identified as the prominent theme in the narratives of assistants and interns. Two themes that also emerged in the nurse narratives were "intra-team and interprofessional perceptions and relationships" and "work-oriented working environment, poor socialization".

Examples of the participants' statements about the relationship with the department, family relationship and self-sacrificing environment are as follows:

"The chief model, the leading role is himself (head of the department of surgery). We treated the patients as he did. Our communication is like his. There is a brother-sister relationship in every environment." (R-4)

"It is a clinic where we work with devotion and hard work. We have a family structure here, in this way we can manage with a family concept." (N-3)

It is seen that the experiences of residents and interns regarding the humanly challenging, stressful and destructive environment are mostly emotional experiences that arise due to workload.

"In that intensity, there are also stress, tensions and breakdowns. It is a very stressful department." (R-3)

"You know, after a while, I think they lose their emotions, their sensuality. This puts them in a different human character category. They are a bit more like this, how should I put it, hard, with a hard temperament. They turn into people who can't fully adjust their bilateral relationship." (I-14)

In the nurse narratives, "negative interprofessional perceptions and relations" and "work-oriented environment and poor social relations" are mostly experienced together with the feeling of devaluation.

"Don't put me in the same category as an IV drip! We give more of ourselves by working selflessly. In return, we are valued as much as a dustbin." (N-2)

National, Social Sub-context and Participants' Experiences

The themes related to the social and national context were as follows: bearing the health burden of the region in the narratives of residents; national health system and performance system in the narratives of residents and faculty members; cultural, local characteristics, extended family structure and relationships in the narratives of nurses and faculty members; and the negatively changing perception of health professionals within the society in the narratives of nurses. In the intern narratives, no theme emerged in this context. An example of statements related to shouldering the health burden of the region in the assistant narratives is as follows:

"Our work here is very intense because it is a hospital with many cases and has to look after the Eastern Anatolia Region." (R-4)

In the narratives of assistants and faculty members, the national health system and the performance system, which are common themes, are expressed with their negative consequences.

"The system burdens you with so many patients... The assistant is actually the person who is sitting on a powder keg in university hospitals, the one who works the hardest, gets tired, whose labor and rights are not paid. The system stinks from the beginning." (R-3)

"University hospitals and teaching hospitals are obliged to make money. You have to take care of so many patients, you have to produce so much work. Where is our educational role?" (CI-5)

Cultural and local characteristics were expressed in the narratives of nurses and faculty members as follows:

> *"External factors tire us, too many relatives of the patients, there cannot be thirty people in front of one person, these tire people."* (N-2)

> *"I think it depends on our cultural structure, I think we cannot show this maturity, that is, to act as a team, due to our cultural structure and the environment we grew up in. I think these experiences are due to regional factors."* (CI-3)

One of the nurses' narratives about the recently changing social perception towards health workers in a negative way and the increase in violence against health workers as one of the most important results of this is as follows. The contextual factor that reveals this situation is expressed as excessive intensity/workload/high patinet circulation.

> *"All kinds of violence, psychological, verbal, sometimes physical, I have seen them. It is an action-packed place, it is definitely a very busy service, it does not come to stand idle for a moment."* (N-6)

The Consequences of Participants' Experiences in Relation to the System as a Contextual Factor

The results of the experiences that were lived within the system, structure, functioning and environments of the institution, clinic, region and national level presented above and framed by these contextual features were grouped under two dimensions through the analysis. These dimensions are "ways of coping/failing to cope" and "emotional, motivational, behavioral etc. consequences/effects".

In the dimension of ways of coping/inability to cope, the most prominent ones in the narratives of residents, nurses and faculty members were "producing quick, palliative, interim and individual solutions", "mechanization and desensitization", "rationalization, acceptance and management". Producing quick, palliative, interim and individual solutions is mentioned in the narratives as follows:

> *"When we have a problem, there are ways to solve it very quickly and easily. Practicalization, systematic and algorithmic settlement of this."* (R-1)

> *"The most important thing is to manage with peace and quiet, we are trying to be calm. We try to listen to both sides. You know, so that the incidents do not escalate, so that there are no problems, so that it does not reach the level of physical violence."* (N-3)

Two of the important consequences of contextual experiences for participants were identified as mechanization and desensitization. Sample statements in the narratives of nurses and assistants are as follows:

> *"The system puts you in charge. You have to behave like a robot. I don't have that luxury, you have to be as fast as possible. At that speed, you can allocate so little time, you have to do one job and move on to the next. Your brain is so fast and so far ahead of you. Your emotions are behind, they cannot keep up with the speed of the brain."* (R-3)

> *"Now you have to work like a motorbike, you have to convince them, the patients, with a beautiful language. You also let the patient blow off steam. You turn into an engine. With the sentences you have memorized due to the circulation, repeating the same sentences, we somehow manage to make everyone happy, flatter them and send them away."* (N-2)

Ways of coping such as rationalizing, accepting and managing were expressed by a resident in the following way, for example, in terms of disciplined, hierarchical functioning:

> *"As time passed and I gained seniority, I learnt that this discipline is the most important part of general surgical training."* (R-5)

The individual results and effects of the contextual experiences of the participants on themselves are, on the one hand, an increase in belonging to the profession in assistants, on the other hand, destructive effects that lead to disengagement from the profession. In interns, it is seen that decreased interest in the discipline and negative feelings about the department come to the fore. Emotional, motivational, psychological, behavioral, etc. effects in nurses and assistants are predominantly negative. In addition, weakness in social interaction in nurses and faculty members, impoverishment in scientific and educational dimensions in faculty members, and a decrease in the quality of the relationship with patients in nurses were among the results. Sample statements in this direction are as follows:

> *"I had difficulties, there were moments when I thought of quitting. I thought a lot about leaving the clinic I love, that is, if I were not married."* (R-5)

"I hate general surgery, I mean such a military hierarchy. I don't think we have to be in a military hierarchy, it bothered me a lot, I don't like this hierarchy very much." (I-7)

"I can't help the patients as much as I would like. No matter how good we are, we can't give them what they want because there are too many patients." (N-1)

"He (the residents) works for 3–5 months, finds it difficult due to intensity, resigns and leaves. That's why, you know one or two of them, then you get to know the third one and you realize that he/she has changed." (CI-2)

"There is no proper science in our clinic, we can be insufficient scientifically here, very insufficient." (CI-3)

DISCUSSION

According to the contextual qualitative analysis of the research data, the themes were grouped under three sub-contexts related to the system in which the experience was lived and two dimensions related to the outcomes/impacts that emerged from the participants' different relations with these contexts. The discussion is based on the parties' narratives of their contextual experiences, how they relate to the context and the consequences of different ways of relating.

The first sub-context is "clinical system: structure, functioning and workload". The themes that emerged in this context are: "health service dominance, clinical workload, rapid circulation", "disciplined, hierarchical functioning", "current situation/challenges of the profession" and "non-programmed functioning". Although the system was framed as both a clinical education system and a healthcare system in the research problems, "clinical education system" did not emerge as a separate sub-context in the analyses of their narratives. It was observed that education was experienced through the mediation of the clinical system and was mostly associated with the negative consequences of healthcare processes on education and research. At the same time, the results of the analyses reveal how differently the parties may experience the system in their specific contexts and how the outcomes may differ. For example, residents and educators experience the intensive work tempo in the clinic and the focus on healthcare services more in the form of inability to plan intensive health processes and as a result of this situation, weakening of education, research and scientificity. Nurses experience this situation as intense workload, trying to reduce the intensity, finding palliative solutions on their own, and this results in weakening of relationships with patients and the desire to leave the clinic.

Research shows that the dominance of healthcare service, clinical workload and experiences that are not sufficiently planned and programmed have multifaceted consequences on health professionals in clinical education and healthcare processes. These outcomes include emotional burden, negative motivational effects, and negative evaluations of the workplace environment. In a study conducted by Saygili and Celik [17] with allied health workers, it was shown that the participants evaluated the clinical environment and workload negatively, they were exposed to extra workload because their job descriptions were not clear and there were not enough employees according to the workload. In another study conducted with nurses, it was observed that stress caused by unfavorable working conditions and extra work frequently led to job dissatisfaction and burnout in them. Such stress factors create a tendency for employees to quit their jobs, to lose interest in patient care and to work in other jobs other than nursing [10, 18–21].

In this study, the disciplined, hierarchical functioning and environment in the clinic were mostly expressed as negative experiences by residents, interns and nurses. However, in terms of its consequences, this environment was rationalized by the residents as a necessity of clinical functioning and education over time, while the nurses interpreted this situation more as a devaluation of their profession. In the interns, this situation, which was experienced negatively emotionally, made them avoid the surgery in their choice of specialization. Research points to the devastating emotional consequences of excessive discipline, intra-team and interprofessional hierarchy on experiences in clinical education and healthcare processes. In the studies conducted with the participation of residents, it was underlined that the medical hierarchy is patriarchal in character and that it is re-reproduced by the seniors through emotional relationships. In a hierarchical environment, emotions such as intimidation, humilitation, anger, fear, frustration are experienced and the consequences of this situation can be very diverse: respect for hierarchy, adaptation, conflict avoidance versus acceptance behaviors; decreased quality of education, problems in team functioning, career reluctance, negative effects on patient care [22, 23]. In an ethnographic study conducted with medical students, they stated that the

clinical learning environment was disciplinary, hierarchical, that they had difficulty understanding excessive rules, and that they felt vulnerable to power [24]. Ravindra and Fitzgerald [25] also emphasized that students move away from the speciality due to the negative role model effect in surgical education. In studies conducted with nurses, it has been observed that power-oriented relationships in physician-nurse interactions affect the nurses emotionally negatively and create a sense of worthlessness as a professional [26, 27].

The second sub-context that emerged in this research is the clinical environment, climate and culture. The themes that emerged in this context are "positive perception of the specialty and the head of the department", "family relationship, self-sacrificing work environment" and "humanly challenging, offensive, destructive environment" in residents. In nurses, apart from the first two themes observed in the assistant group, the themes of "intra-team and interprofessional perception and relations" and "work-oriented, technical working environment and weak social relations", "family relationship, local motives" in trainers and "stressful and destructive environment" in interns emerged. Positive perception of the department, selfless environment and family-like relationship within the team were mentioned as positive experiences in the narratives of the parties. It was also observed that the healthcare service focus, intensive workload and hierarchy transformed the clinical environment into a humanly challenging, stressful and destructive environment for residents and interns. For nurses, the clinical environment was defined in terms of negative perceptions of the nursing profession, poor social relations and work-centeredness. Among the important consequences of such a description of the environment are feelings of worthlessness, being ignored, underappreciated and devaluation of the nursing profession, especially for assistants and nurses.

In the literature, studies on clinical education, healthcare environment and culture support these findings. Work environment and organizational culture have a significant impact on health employees' job satisfaction and motivation to work [28–30]. In a study conducted with the participation of nurses, it was shown that the management and conflict management system in the organizational culture was associated with motivation through positive or negative emotional effects in the work environment [31]. In the context of work environment climate and culture, negative communication between health professionals, intense work orientation and pressure to produce/perform work were identified as the main negative factors in the working and learning environment [32]. Especially in studies on physician-nurse relations and cooperation, it was emphasized that physician-nurse interaction is still problematic and that negative interaction reflects negatively on clinical processes and healthcare services [33–38]. Administrative processes that positively support teamwork and cooperation play an important role in keeping faculty members in the institution by positively affecting their institutional belonging [39]. In studies conducted with medical students, it has been pointed out that the attitudes, behaviors and personal characteristics of the trainers as well as the clinical environment, climate and culture have a significant effect on the dominant educator-learner dynamic in surgical education [40–43].

In this study, it was observed that the metaphor of "family" (being a family, brother-sister, father) emerged as a dominant narrative in the context of both clinical functioning and clinical environment, climate and culture; this metaphor found expression in different ways in the narratives of residents, nurses and faculty members. For example, while the assistants considered it more in terms of creating belonging to the clinic and department and professional role model, the nurses considered it as a socio-cultural feature in intra-team interaction and conflict management in the form of "the necessity to act conciliatory within the family". While the faculty members affirmed the "brother-sister" relationship as a local motif in the relationships with the assistants, they also emphasized the aspects of this relationship that undermine the professionalism of the team and negatively affect the administrative processes.

As a result of the analyses, the themes related to the societal national sub-context were bearing the health burden of the region, national health system, performance system, cultural and regional characteristics, and the changing perception of health workers in the society. It was observed that educators and residents evaluated the health system as economically oriented. Residents stated that they were not seen and their labor was not sufficiently appreciated in a system that overly focuses on healthcare services. The educators, on the other hand, emphasized that the economy-oriented health system overshadows education and research. In the studies, physicians have shown the negative effects of the economy-oriented working system on teamwork with various situations (such as ethical and im-

plementation problems) that arise in the functioning [44]. It has been observed that the economy-oriented performance system has negative consequences on the physician-patient relationship, negative perception of professionalism towards the profession and social interactions [11]. Faculty members stated that economy-oriented working systems negatively affect teamwork in terms of clinical education and research, create a hierarchical structure in the team, and cause loss of quality in patient care processes and resignation from the institution; thus, these systems have negative reflections on the institutional climate and culture [45].

In this study, cultural and regional characteristics were another theme that emerged in the narratives of nurses and faculty members. For example, nurses, as a local motif, stated that the extended family structure in the society increased the workload in the clinic and negatively affected their interactions with patients and their relatives. The nurses also stated that the perception of healthcare workers in the society has changed negatively recently and that this has been experienced more intensely especially for the nursing profession. It is observed that the characteristics of the region where the healthcare institution is located, institutional factors (technological, economic, organizational, etc.) and the characteristics of the clinical environment affect nurses' job satisfaction, workload, preferences to stay or leave the job and the quality of patient care service delivery [46–49]. Studies show that the duties, roles and responsibilities of nurses, their value and the standards of the nursing profession are not fully understood by the society and their work is still perceived as an auxiliary profession [50–53].

Finally, in this study, it was determined that the picture discussed above regarding the clinical system and environment and the national and social setting led to different consequences and effects on the parties. Considering the themes that emerged from the analyses, it was observed that the residents rationalized their experiences over time, produced quick solutions in clinical processes, and started to work in a mechanized and emotionless manner over time. The way of coping in nurses is mostly in the form of finding palliative solutions on their own, mechanizing, routinizing, becoming numb, submitting, accepting, managing and/or softening the reactions. Similar patterns were observed in the educators: finding solutions on their own, finding intermediate solutions, acceptance, letting go. The predominant patterns of the consequences of the system and these ways of relating to the system were as follows: negative physical and emotional consequences (worthlessness, lack of appreciation), motivational consequences (decreased interest, thoughts of leaving the job), weakening of social relations, decline in the quality of the relationship with patients, and the oppression of educational and research activities in the department under the pressure of healthcare requirements. Similar emotional and behavioral results, which were mostly negative, were also found in other studies, especially in studies conducted with nurses [54, 55].

Conclusion

One of the contextual elements in which clinical education and healthcare processes are experienced is the system. This study has shown how the lived experience is framed by the system, which is a contextual dimension, and how it can be differentiated in terms of processes and outcomes and different roles. Generally speaking, it is important to consider any educational or work-related experience as a contextual experience. This is because the context in which the experience is lived can transform the experience depending on both its qualities and how the parties relate to them. In addition, this may cause the parties to live the experiences in their own way, focusing more on their own contexts and not seeing the experiences of others sufficiently. At this point, a general suggestion that can be put forward is that clinical education, research and healthcare processes should be understood within their own contexts, and planning, execution and evaluation studies should be carried out within this framework.

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