Undesirable Knowledge Behaviours and Task Conflict in Hospitals: Effects on Quality of Care

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Abstract: Knowledge management systems in the healthcare context are designed to facilitate knowledge flows and to integrate ways of capturing, leveraging, and sharing knowledge effectively. However, knowledge management implementation is often challenging and driven by the complex and multifaceted nature of healthcare knowledge, albeit related to high performance healthcare outcomes. The social nature of knowledge brings forth additional complexities and managerial challenges that can be related to individual undesirable knowledge behaviours - such as knowledge hiding and knowledge hoarding. Undesirable knowledge behaviours reflect human-based activities that jeopardize decision-making and performance by consciously and unconsciously hindering knowledge flows inside organizations. Such loss of important information can promote disagreements surrounding allocation of resources, contributing to dissonant goals and perspectives that shape task conflict. To that end, the purpose of our work is to understand the influencing role of knowledge management systems, knowledge hoarding, knowledge hiding and task conflict as contributors shaping quality of care in hospitals. We follow a quantitative approach, using partial least-squares structural equation modelling (PLS-SEM) to test the relationships between variables from our original empirical model. Research data comes after a survey conducted to 318 healthcare professionals working in Portuguese hospitals. Main findings show that knowledge management systems positively contribute to knowledge hoarding behaviour, while also presenting a positive influence on the quality of care provided by the hospital. Additionally, knowledge management systems are negatively related to the existence of task conflict between healthcare professionals. Conversely, results show that knowledge hiding is positively related to task conflict–being the latter a negative predictor of quality of care. Moreover, results show that knowledge hoarding positively affects quality of care. Our research offers an original contribution to healthcare management by providing insight on the influence of knowledge related systems and behaviours and their influence on the quality of care provided by healthcare professionals. Theoretical and practical contributions driving future action and research are presented.

Keywords: Knowledge management systems, Knowledge hiding, knowledge hoarding, Task conflict, Quality of care, Mixed-methods, Healthcare

1. Introduction

Quality of care reflects dimensions of responsiveness, access, and patient trust, making it a core concern of healthcare practice (Anufriyeva et al., 2020). As such, quality of care results of a combination of factors that drive the core concern of healthcare services (Aiken et al., 2002). As healthcare development becomes increasingly complex, so do the conventional forms of measurement representing quality of care are being challenged (Hannawa et al., 2021). Structural aspects such as clinical practice knowledge, efficiency procedures, and techniques are important factors that influence quality of care (Karamitri et al., 2017; Kosklin et al., 2022). By extension, job and task related complexities are also drivers shaping quality of care (Anufryeva et al., 2020; Hannawa et al., 2021).

Despite the recognized importance of knowledge management practices and systems in the development of healthcare performance, knowledge management systems (KMS) remain underused in healthcare organizations (Hammoda et al., 2022). The implementation of knowledge management in healthcare faces many challenges and obstacles, as discussed by previous research (Karamitri et al., 2017)

Expanding on the knowledge difficulties (Hammoda et al., 2022) evidence suggests that the poor implementation of knowledge management systems and practices can act as a driver to power shift differences, marginalization of professionals and stratification through social isolation (Pandey et al., 2021). Such risks draw parallels from emergent literature in knowledge management literature focused on counterproductive forms of knowledge (Connelly et al., 2012). Knowledge hiding and hoarding are both motivated by power and psychological ownership of knowledge, and both are negatively related to knowledge sharing (Connelly et al., 2012; Oliveira et al., 2021). While research on the damaging effects of knowledge hiding in healthcare is limited, recent evidence suggests negative consequences at the individual level (Alam et al., 2021; Pandey et al., 2021). However, performance-based outcomes and consequences shaping the nature of healthcare work remain scarce in the healthcare literature. Expanding on such gap, this work aims to explore the role of knowledge management systems and counterproductive forms of knowledge behaviour

(knowledge hiding and knowledge hoarding), assessing their impact on the task conflict experienced by healthcare professionals and in the quality of care provided to patients.

2. Literature Review

2.1 Quality of Care

Quality of care is influenced by both structural aspects, such as clinical knowledge and procedures, and intrapersonal/individual characteristics, such as skill, learning, and teamwork (Anufryeva et al., 2020; Hannawa et al., 2021).

Therefore, it is necessary to explore the integration of both individual and organizational factors in promoting quality of care (Moen et al., 2021). Recent literature emphasizes the importance of self-assessment and individual input from healthcare professionals in measuring quality of care (Hannawa et al., 2022; Moen et al., 2021). By extension, it is of importance to consider the perspectives of healthcare professionals and patients to better understand the contribution of individual input to organizational preparedness in healthcare environments (Ayatollahi and Zeraatkar, 2019).

Achieving quality of care requires a focus on knowledge management at multiple levels, including infrastructural related sources (information technologies and systems), task oriented related sources (job complexity, task characteristics), and individual factors such as motivations and attitudes towards knowledge seeking and sharing (Anh et al., 2021; Savic et al., 2020). The healthcare industry can benefit from a transposition of such requirements to achieve innovative and competitive performance, mirroring in healthcare performance outcomes driven by knowledge related phenomena similar positive performance outcomes found in other knowledge intensive environments (Karamitri et al., 2017).

The integration of individual and organizational factors related to knowledge as an asset is essential in promoting quality of care in healthcare delivery (Hammoda et al., 2022; Karamitri et al., 2017; Pandey et al., 2021).

2.2 Knowledge Management Systems in Healthcare Organizations

KMS describe fundamental managerial process to improve individual and organizational outcomes in healthcare organizations (Karamitri et al., 2017; Kosklin et al. 2022). KMS rely on combinations of information infrastructures, technologies, as well as policies, processes and practices that can support the management of knowledge (Avali and Leidner, 2001).

The growing complexities in healthcare knowledge further justify the development of KMS in recent years, supported by the developments of new forms of technologies to support knowledge's potential in achieving proper forms of diagnostics and treatment to patients (Phan et al. 2022). As such, the role of KMS in healthcare should consider a two-folded approach to knowledge mobilization and knowledge use. The first, considering their potential to organize work, tasks and gain access to knowledge (Ayatollahi & Zeraatkar, 2019; Plaice & Kitch, 2003). The second, to ensure KMS design concerns on promoting social contact to attain higher levels of tacit knowledge only available at the individual level (Ayatollahi & Zeraatkar, 2019).

The implementation of KMS and practices can enhance interaction and reduce conflicts and professional tensions, therefore reducing uncertainty (Kosklin et al., 2022) – a proposition that mirrors the positive role of KMS in hindering task conflicts that arise from unclear visibility of the nature of work in other knowledge intensive environments (Semerci, 2019) or among working teams (Mu et al., 2021). Considering the advantages of KMS in the promotion of clearer venues of communication and knowledge flows in healthcare organizations (Alam et al., 2021; Karamitri et al., 20217; Kosklin et al., 2022), we propose that:

H1: KMS have a positive influence on the quality of care provided by healthcare professionals.

H2: KMS have a negative influence on the task conflict experienced by healthcare professionals.

Although deemed a knowledge intensive environment (Kosklin et al., 2022), healthcare organizations reliance on technology supporting knowledge management systems alone is insufficient if individuals fail to contribute or perceive these systems (Karamitri et al., 2017).

Of the risks related to mismanagement of knowledge management in healthcare settings, knowledge hiding and knowledge hoarding represent two counterproductive behaviours that can have life-threatening consequences, compromising the quality of care and the well-being of professionals (Pandey et al., 2021). These behaviours are driven by power dynamics and the perceived ownership of knowledge (Connelly et al.,

2012; Oliveira et al., 2021), acting more than an opposing force to knowledge sharing (Oliveira et al., 2021). Knowledge hiding reflects the intentional concealment of knowledge solicited by others, whereas knowledge hoarding reflects an unintentional accumulation of knowledge that is not shared with others for personal gain (Connelly et al., 2012; Gonçalves et al., 2023; Oliveira et al., 2021). Given the KMS focus on ensuring knowledge flows and knowledge availability in healthcare organizations (Alam et al., 2021; Kosklin et al., 2022), we argue that KMS hinders knowledge hiding behaviour. Nevertheless, we also propose that the availability of knowledge can promote accidental accumulations of knowledge and promote knowledge stickiness (Kim et al., 2012). Therefore, we hypothesize that:

H3: KMS have a negative influence on the knowledge hiding behaviour among healthcare professionals.

H4: KMS have a positive influence on the knowledge hoarding behaviour among healthcare professionals.

2.3 The Emergence of Counterproductive Knowledge Behaviours

Emerging as the more studied forms of counterproductive forms of knowledge behaviour, both knowledge hiding and knowledge hoarding represent two of the more conceptually developed and empirically studied phenomena in the literature discussing negative behaviours related to knowledge (Gonçalves et al., 2023; Oliveira et al., 2021; Silva de Garcia et al., 2021).

Literature suggests that knowledge hiding and knowledge hoarding research is focused simultaneously on both individual and organizational influences leading to such behaviours, and individual and organizational consequences stemming from them (Gonçalves et al., 2023). Nevertheless, empirical research is still scarce, with conceptual overlaps, still persisting in the operationalization of both knowledge hiding and knowledge hoarding (Gonçalves et al., 2023; Oliveira et al., 2021). Existing conceptual work proposes that knowledge hiding represents a deliberate intention to conceal information from others upon request (Conelly et al., 2012). On the other hand, knowledge hoarding represents an equal form of withholding of knowledge that is not shared to others after an accidental (and individual) accumulation of knowledge (Oliveira et al., 2021). Existing evidence in the literature suggests that job characteristics are related to knowledge hiding behaviours, with such forms of negative behaviours contributing to cycles of conflict grounded on psychological and power threats (Semerci et al., 2019). Nevertheless, there is little to no evidence on the role of knowledge hoarding as a form of behaviour that further leads to perceived conflicts in organizations. Given the complex nature of healthcare knowledge and the task related complexities representing knowledge assets in healthcare organizations (Hammoda et al., 2022), we propose that:

H5: Knowledge hiding behaviour has a positive influence on the task conflict experienced by healthcare professionals.

H6: Knowledge hoarding behaviour has a positive influence on the task conflict experienced by healthcare professionals.

Consequently, the difficulties surrounding the implementation of KMS in healthcare led to the development of healthcare management literature focused on the barriers, risks, and consequences of poor knowledge management inside healthcare organizations (Alam et al., 2021; Hammoda et al., 2022; Pandey et al., 2021). Expanding on the implementation of KMS and practices in healthcare organizations, knowledge management initiatives in healthcare are met with persistent and old-fashioned practices, as discussed in literature spawning more than a decade (Alam et al., 2021; Kim et al., 2012; Karamitri et al., 2017). Such evidence is of concern, in particular when considering both the life-threatening consequences from poor management of healthcare knowledge, and the potential for counterproductive behaviours stemming from erosion or knowledge devalue in healthcare organizations (Pandey et al., 2021). Pandey and colleagues (2021) argue that such lack of strategy or direction in the management of knowledge leads to power imbalances, stratification, and marginalization. This perspective aligns with current research on knowledge management, which has identified knowledge hiding and hoarding as negative or counterproductive forms of organizational behaviour related to knowledge as a resource (Connelly et al., 2012; Gonçalves, Curado and Oliveira, 2023). Adding to the identified risks of value destruction in healthcare through mismanagement of knowledge assets, counterproductive forms of knowledge behaviour are discussed in the literature as antecedents of both individual and team performance (Garg et al., 2022). Nevertheless, we argue that knowledge hoarding acts as a positive antecedent of quality of care, given the quasi-accidental nature of knowledge hoarding (Oliveira et

al., 2021) and its self-interest focus on individual development (Oliveira et al., 2021). Therefore, we propose that:

H7: Knowledge hiding behaviour has a negative influence on the quality of care provided by healthcare professionals.

H8: Knowledge hoarding behaviour has a positive influence on the quality of care provided by healthcare professionals.

2.4 Task Conflict in Healthcare Organizations

Task conflict describes a type of interpersonal conflict that arises from disagreements or conflicting views on how to approach and perform specific tasks or activities in the organizational context (Jehn et al., 1995). As such, task conflict differs from relationship conflict through the awareness of differences in interests and the incompatibility of interests pertaining the nature of work.

Research on task conflict represents a static nature of the phenomenon, often not acknowledging the cyclical pattern surrounding task conflict (Kuypers et al., 2018). Expanding on such view, literature suggests that the complex nature of task conflict presents a temporal pattern shifting from and to relationship conflicts (Guenter et al., 2016). Such evidence can draw a comparison with several propositions supporting the individual-centric nature of knowledge (Hammoda et al., 2022) by understanding individual behaviours and individual complexity. Expanding on this rationale, Kuypers and colleagues (2018) discuss that the role of task conflict should be viewed, not under its managerial complexities, but as a phenomenon related to human capital depletion (p. 1290).

Effective communication, open-mindedness, and willingness to compromise are key factors in managing task conflict in healthcare teams (Gittell et al., 2013; Mitchell et al., 2019). Additionally, clear role definitions, shared goals, and a focus on patient-centered care can help to minimize task conflict and facilitate the delivery of quality of care (Gittell et al., 2013). By extension, evidence also suggests that positive forms of commitment and communication between healthcare teams can also contribute to better quality of care when experienced task conflict is low (Mitchell et al., 2019). Therefore, we propose that:

H9: Task conflict experienced by healthcare professionals has a negative influence on the quality of care provided.

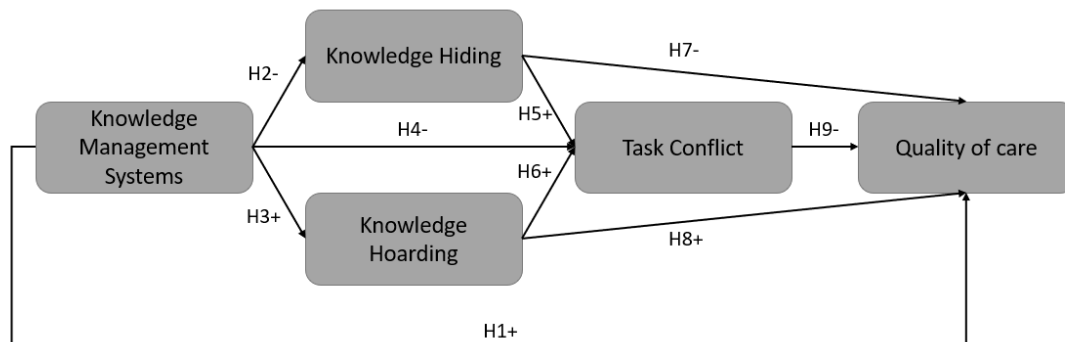Figure 1 presents the research model.

Figure 1: Research Model

3. Methods

3.1 Partial Least Squares Structural Equation Modelling

This study adopts a quantitative approach and utilizes a Partial Least Squares Structural Equation Model (PLS-SEM) to examine survey data collected from 318 healthcare professionals. The PLS-SEM is an estimation model that aims to evaluate and estimate the path models between latent variables and their connections. It is a suitable technique for smaller samples and can address limitations in researching complex variables (Hair et al., 2019).

3.2 Sample

The data comes from an online survey using QualtricsXM® sent to healthcare professionals working in hospital in Portugal. The research team contacted several hospitals (both private and public) who acted as a point of contact to ensure the internal distribution of the survey among healthcare professionals. The survey was internally validated by the Ethical Committees from the partnering organizations to ensure compliance. Measures come from different sources, previously validated in the literature. We conducted several ex-ante procedures to ensure data consistency and remove common-method and non-response bias. Participant anonymity and confidentiality was ensured. Items were randomized and counterbalanced. A team of six specialists representing several healthcare professionals provided insight on the survey to ensure further consistency and remove bias. The final sample comprises 318 responses. The demographic information of the sample is presented below (Table 1).

Table 1: Descriptive statistics

		f	%
Gender	Female	238	74.8
	Male	78	24.8
	Non-binary/Other	1	0.3
Age(years)	18-24	19	6
	25-34	74	23.3
	35-44	77	24.2
	45-54	72	22.6
	55-64	69	21.7
	65+	7	2.2
Profession	Certified therapists	27	8.5
	Hospital pharmacists	21	6.6
	Medical doctors	95	29.8
	Nurses	125	39.3
	Other allied health professionals (e.g. Technicians and technologists)	46	14.5
	Psychologists	4	1.3
Professional Experience(years)	0-1	23	7.2
	1-5	44	13.8
	6-10	41	12.9
	11-15	33	10.4
	16-20	55	17.3
	21+	122	38.4

3.3 Measures

We use previously validated measures coming from difference streams in the literature to ensure diversity and reduce common-method bias. KMS comes from Serenko and Bontis (2016). Knowledge hiding and knowledge hoarding comes from Connelly and colleagues (2012). Task conflict comes from Jehn (1995). Lastly, quality of care comes from Aiken and colleagues (2002). All measures were adapted following a seven-point Likert like scale system (1-Completely disagree/Very poor/Completely unconfident to 7-Totally agree/Excellent/Completely confident).

3.4 Measurement Model

The PLS-SEM approach requires a two-step analysis process (Hair et al., 2014; 2019). The first, centred in measures, relies on the calculation of the discriminant and convergent validity of the measures used in the

research. Following best practices, we calculate the convergent validity of the measures by inspecting the variance extracted (AVE), the Cronbach's alpha, and the resulting composite reliability (CR) (Hair et al., 2019) using the SmartPLS4® PLS-SEM algorithm. All measures remain above the recommended thresholds (AVE>0.5; CR>0.8). Regarding the discriminant validity, we follow three analyses (Hair et al., 2014; 2019). The analysis of outer-loadings, cross-loadings and the assessment of the heterotrait-monotrait (HTMT) matrix. All outer loadings for the items are above 0.5 (acceptable given the exploratory nature of the model (Hair et al., 2019)), ranging from 0.573 to 0.886. All outer loadings are higher than the cross-loadings, and the HTMT matrix presented values below the recommended threshold. The subsequent validation of the variance inflation factors (VIF) shows the presence of 2 items related to knowledge hiding (KH2 and KH10) with higher than recommended values (Hair et al., 2019), therefore being removed from the final model.

4. Results

The testing of the significance of the relationships in the structural model uses the SmartPLS4® bootstrapping algorithm. Results show that KMS has a positive impact on the quality of care provided by healthcare professionals (β=0.478;t=10.234;p<0.001) (H1). Conversely, KMS have a negative impact on the task conflict experienced by healthcare professionals (β=-0.275;t=4.782;p<0.001) (H2). KMS also have a positive impact on the knowledge hoarding behaviour (β=0.204;t=3.745;p<0.001), therefore confirmed hypothesis 3. However, no significative relationship was found between KMS and knowledge hiding behaviour (H4). Regarding counterproductive knowledge behaviours, results show that only knowledge hoarding has a significative and positive impact on quality of care (β=0.108;t=2.105;p<0.05)(H8), with knowledge hiding showing no effect on the outcome (H7). Conversely, while knowledge hoarding shows no significative impact on the task conflict experienced by healthcare professionals (H6), knowledge hiding has a positive and significative impact for the same outcome (H5)(β=0.223;t=4.531;p<0.001). Lastly, results show that task conflict experienced by healthcare professionals as a negative impact on the quality of care delivered to patients (β=-0.121;t=2.257;p<0.05). Figure 2 shows the main results.
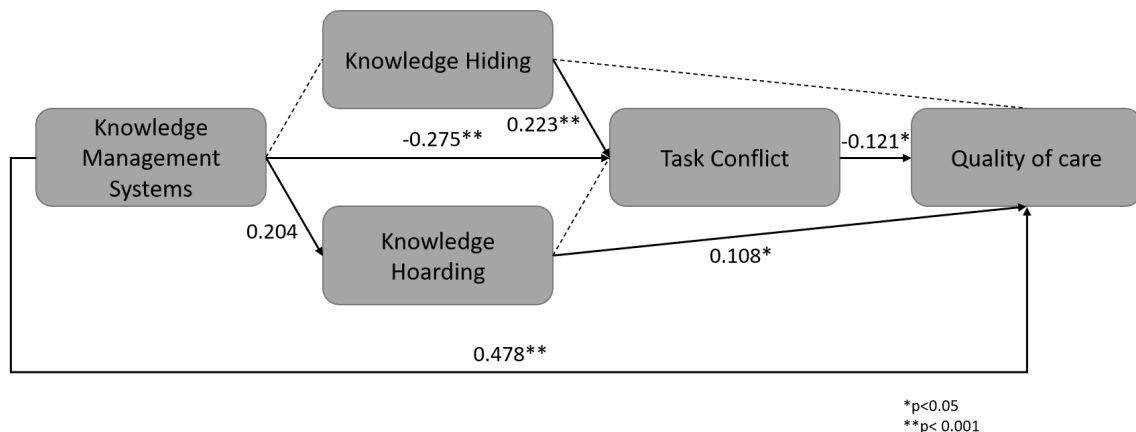

Figure 2: Quantitative Results

According to the structural model analysis, the results explain approximately 31% of the variance of data found for quality of care (R^2= 0.312), suggesting a medium explaining power of the model to the outcome (Hair et al., 2014). All significant relationships have effect sizes (f^2) above the recommended threshold (>0.05) (Hair et al., 2019).

5. Discussion and Conclusion

Our research expands on the importance of knowledge management in healthcare by exploring aspects related to the organizational capability to manage knowledge (KMS) and by expanding on a gap pertaining the consequences of counterproductive forms of knowledge in an understudied setting: that of healthcare organizations. Therefore, the work provides insight on current streams of research revisiting knowledge risks in healthcare (Hammoda et al., 2022), raising awareness to their consequences.

Regarding our hypotheses, results show that KMS have a positive influence on the quality of care delivered to patients (H1). Such findings reflect the importance of knowledge management implementation previously

discussed in the literature, relying on its vital role as a strategical tool to handle knowledge complexity and value creation through knowledge leverage in healthcare (Hammoda et al., 2022; Karamitri et al., 2017; Pandey et al., 2021). By extension, results also show that KMS have a negative influence in task conflict (H4), acting as an organizational structure that can reduce uncertainty and dissonances in healthcare tasks through the raised awareness on communication and cooperation (Karamat et al., 2019; Ayatollahi & Zeraatkar, 2019). Although KMS show no relationship with knowledge hiding in healthcare (H2), findings suggest a positive relationship between KMS and knowledge hoarding behaviour (H3). We argue that, by facilitating knowledge flows among healthcare professionals, KMS presents a quasi-paradoxical risk to knowledge stickiness (Kim et al., 2012) by nurturing behaviours of accumulation. Such novel findings advise caution and managerial implications. In the context of our findings, knowledge hoarding promotes quality of care – suggesting that the centralization and accumulation of knowledge in individuals can be beneficial to the development of healthcare performance (H8) (Karamitri et al., 2017). However, literature suggests that knowledge hoarding can lead to knowledge devalue and negative organizational consequences fostered not on task conflicts, but on relational forms of conflict that bypass the nature of the job (Connelly et al., 2012; Gonçalves et al., 2023; Oliveira et al., 2021).

Findings also suggest a positive relationship between knowledge hiding and task conflict (H5), and no relationship between knowledge hiding and quality of care (H7). Knowledge hiding has no direct effect on the quality of care provided to patients, however it does contribute to task conflicts experienced by healthcare professionals (H5), which in turn impact negatively on quality of care (H9). Similarly to the findings pertaining to knowledge hoarding, such evidence raises managerial concerns. We argue that knowledge hiding behaviours do not present a face value threat to quality of care given the growing concerns on team complexity design and vertical integrations in the healthcare process found in recent literature (Short & Ho, 2020). Expanding on the relationship between knowledge hiding and task conflict, although previous literature explores task conflict as an antecedent of knowledge hiding (Garg et al., 2021), we challenge that conceptualization by following a rational grounded on cyclical forms of conflict as discussed by Jehn (1995). Our findings suggests that task conflict is a consequence of knowledge hiding, relying on the promotion of knowledge mobilization strategies to support the current managerial challenges and difficulties in handling task conflict and its consequences (de Wit et al., 2012; Guenter et al., 2016; Kuypers et al., 2018). Lastly, findings corroborate previous evidence on the role of task conflict in healthcare organizations, suggesting that the lack of shared views in the nature of tasks has a negative impact on healthcare outcomes (Gittell et al., 2013; Mitchell et al., 2019) – here represented under quality of care.

Our work provides important theoretical and practical contributions. From a theoretical standpoint, this paper expands on the still limited empirical knowledge on counterproductive forms of knowledge behaviour in healthcare organizations. By extension, it provides an empirical effort to clarify the differences between different forms of negative behaviour, by addressing the effects of both knowledge hiding and knowledge hoarding – accommodating a theoretical approach suggested in recent literature (Gonçalves et al., 2023; Oliveira et al., 2021). Finally, it explores the effects of knowledge related phenomena in healthcare performance by responding to current challenges on the nature of quality of care (Hannawa et al., 2022) – centring its assessment on the individual input of healthcare professionals.

Regarding practical implications, the focus on both KMS and individual knowledge behaviours allows for managerial flexibility to nurture quality of care and to identify and act on knowledge risks, as proposed in recent literature (Hammoda et al., 2022). Managers and healthcare policymakers should understand and encourage the individual awareness behaviours aimed at the use of KMS in healthcare organizations to promote knowledge flows (Karamitri et al., 2017). However, we recommend that a focus should be given to ensure that the optimization of knowledge mobilization should rely on a cyclical and continuous activity, to deny behavioural tendencies focused on the individual accumulation and stagnation of knowledge. The promotion of reward systems and training should be deployed to raise awareness of the importance of KMS, but also to alert managers of the risks of knowledge concealment (Hammoda et al., 2022). We advise a managerial strategy with engaging leadership that entices cooperation and encourages self-learning of team members, focused on flexibility and team communication. Only through the individual engagement and focus on knowledge related phenomena can knowledge management truly thrive in healthcare organizations (Agrifoglio et al., 2021; Hammoda et al., 2022; Pandey et al, 2021).

6. Limitations and Future Work

This work is not exempt from limitation. We use a PLS-SEM approach to provide an innovative empirical insight on KMS and counterproductive forms of knowledge behaviour in healthcare. However, the research design follows a cross-sectional strategy, which limits causality. The limit geographical scope is also another limitation (Portuguese hospitals), presents risks of cultural influences as non-accounted effects shaping our findings. We recommend future research to contrast our research considering an increased geographical scope and assessing contrasting between professional groups. Lastly, we recommend the inclusion of knowledge complexity and knowledge fragmentation, as well as specific types of knowledge in future research. Namely behaviours pertaining to explicit knowledge and to tacit knowledge.

Acknowledgements

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