

Original Article

Quiet Quitting Threatens Healthcare Organizations and Services: Alarming Evidence from a Cross-Sectional Study with Nurses in Greece

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Abstract

Background: Quiet quitting has emerged during the COVID-19 pandemic and its consequences for healthcare organizations and services have been expected. **Objective:** To identify levels of quiet quitting among clinical nurses in Greece. Moreover, we examined the impact of demographic and job characteristics on quiet quitting.

Methods: We conducted an online cross-sectional study in Greece. We collected our data in February 2024. We obtained a convenience sample of nurses who have been working in clinical settings. We used the "Quiet Quitting" Scale (QQS) to measure levels of quiet quitting among nurses in our study. Moreover, we measured gender, age, educational level, job sector, understaffed workplace, shift work, and years of clinical experience.

Results: Applying the suggested cut-off point we found that seven out of ten nurses (68.2%, n=620) can be considered as quiet quitters, while three out of ten (31.8%, n=289) can be considered as non-quiet quitters. We found that males experienced higher levels of quiet quitting than females (adjusted coefficient beta = 0.216, 95% CI = 0.093 to 0.339, p-value = 0.001). Additionally, shift workers (adjusted coefficient beta = 0.182, 95% CI = 0.091 to 0.272, p-value < 0.001) and nurses who have been working in understaffed workplaces (adjusted coefficient beta = 0.134, 95% CI = 0.006 to 0.262, p-value = 0.040) showed higher levels of quiet quitting. Decreased years of clinical experience were associated with increased quiet quitting (adjusted coefficient beta = -0.008, 95% CI = -0.012 to -0.004, p-value < 0.001).

Conclusions: In our sample, nurses reported high levels of quiet quitting. Gender, shift work, an understaffed workplace, and clinical experience had an impact on quiet quitting. Healthcare organizations and managers should pay attention to quiet quitting in order to improve nurses' productivity and patients' outcomes.

Key-words: quiet quitting; nurses; engagement; satisfaction; burnout; healthcare services; healthcare organizations

Introduction

The global COVID-19 epidemic has placed significant strain on healthcare systems and professionals, with nurses serving as frontline healthcare workers facing heightened demand. Prior to the pandemic, health service organizations were already grappling with substantial organizational and operational deficiencies, which posed an especially arduous working environment for nurses. Over time, healthcare organizations have consistently faced the significant drawback of nursing understaffing, which has had a detrimental impact on the quality and safety of the care delivered, as well as the well-being of the nurses (Cho et al., 2020; Shin et al., 2018). Moreover, the nursing working environment is marked by a scarcity of material resources, nurses' exclusion from hospital decision-making processes, instances of aggression and bullying, and lack of organizational support as well as that of the immediate supervisor. The aforementioned factors have significant consequences for both the well-being of nurses and the quality of care they deliver (Hämmig, 2017; Labrague et al., 2018; Moisoglou et al., 2020; Sauer & McCoy, 2017; Zhang et al., 2017). Nurses in this professional setting often encounter elevated levels of occupational stress, anxiety, and depression (Kakemam et al., 2019; Maharaj et al., 2018), therefore impacting the overall quality of their work life (Barbagianni et al., 2023). Enhancing nurses' working conditions reduces the likelihood of burnout and ensures the provision of safe care (Moisoglou et al., 2021; Prezerakos et al., 2015). Amidst the COVID-19 pandemic, nurses faced exacerbated working conditions due to the combination of a heavy workload, intense work demands, fear of contracting the virus, extended work hours, limited resources, and insufficient specialized training related to COVID-19. Consequently, nurses encountered elevated levels of burnout, dissatisfaction anxiety, depression, and turnover intention (Galanis et al., 2021; Galanis, et al., 2023; Hu et al., 2020; Huerta-González et al., 2021).

During the pandemic, a novel phenomenon known as "quiet quitting" surfaced, referring to a new tendency in employee behavior

within organizations. Originally, this idea disseminated via the social media platform TikTok. Subsequently, it became evident that this was not a fleeting fad, but rather a behavior that was progressively gaining popularity, primarily within the business domain. A preliminary investigation in the US business industry revealed that over 50% of employees opted for a strategy known as "quiet quitting" to strike a balance between the escalating demands of their job and their personal lives (Harter, 2022). Quiet quitting is the phenomenon in which an employee deliberately decreases their job performance without legally resigning. Employees fulfill the job's essential requirements without putting in additional effort, working extended hours, or arriving earlier, and without exceeding the required level of performance (Scheyett, 2022). However, the phenomenon was not exclusive just to the business industry. Study on nursing staff has consistently demonstrated that over 60% of nurses choose quiet quitting, which actually surpasses the proportion observed among other healthcare professions (Galanis, et al., 2024). The investigation of the phenomenon of quiet quitting is still in progress, and not all the factors that predict its onset and consequences have been uncovered. Previous research has indicated that burnout and workplace bullying are the main triggers of quiet quitting (Galanis, et al., 2023; Galanis, et al., 2024), while a high degree of job satisfaction, moral resilience and emotional intelligence act as protective factors in the development of this organizational behavior (Galanis, et al., 2024; Galanis, et al., 2023; Galanis, et al., 2024). When nurses choose quiet quitting, they are more likely to declare their turnover intention (Galanis, et al., 2024).

As studies regarding the incidence of quiet quitting are limited, the aim of the present study was to identify levels of quiet quitting among clinical nurses in Greece and to examine the impact of demographic and job characteristics on quiet quitting.

Methods

Study design: We conducted an online cross-sectional study in Greece. We collected our data during February 2024. We obtained a convenience sample of nurses who have been working in clinical settings.

We created an on-line version of the study questionnaire by using Google forms. Then, we posted the study questionnaire in nurses' groups through social media.

We used the "Quiet Quitting" Scale (QQS) to measure levels of quiet quitting among nurses in our study (Galanis, et al., 2023). The QQS consists of nine items and three factors; detachment, lack of initiative, and lack of motivation. Answers are on a 5-point Likert scale from 1 to 5 with higher values indicating higher levels of quiet quitting. The factors and QQS score ranges from 1 to 5. There is a suggested cut-off point of 2.06 that distinguishes quiet quitters from non-quiet quitters (Galanis, et al., 2024). Moreover, we measured the following demographic and job variables: gender, age, educational level, job sector, understaffed workplace, shift work, and years of clinical experience.

Ethical issues: The Ethics Committee of the Faculty of Nursing, National and Kapodistrian University of Athens approved our study protocol (approval number; 479, January 10 2024). Moreover, we conducted our study in accordance with the Declaration of Helsinki (World Medical Association, 2001). We collected our data anonymously. Nurses gave their informed consent to participate in our study.

Statistical analysis: We use absolute frequencies (n) and relative frequencies (%) to present categorical variables. Moreover, we use mean, standard deviation (SD), and median to present continuous variables. The Kolmogorov-Smirnov suggested that the continuous variables followed the normal distribution. We performed simple and multivariable linear regression analyses to identify the demographic and job variables that affected quiet quitting. First, we performed simple linear regression analyses. Then we constructed a final multivariable model to eliminate confounding. In the multivariable model we applied the backward method. We calculated unadjusted and adjusted coefficients beta, 95% confidence intervals (CI), and p-values. We used IBM SPSS 21.0 (IBM Corp. Released 2012. IBM SPSS Statistics for Windows, Version 21.0. Armonk, NY: IBM Corp.) for the analysis.

Results

Demographic and job characteristics

Our sample included 909 nurses. Mean age was 39.7 years (SD; 9.7), while the mean years of clinical experience were 15.6 (SD; 9.9). Most of our nurses were females (86.5%). Among our sample, 67.5% possessed a MSc/PhD diploma and 60.5% have been working in shifts. Moreover, 82.3% have been working in the public sector and 86.2% have been working in understaffed workplaces. Detailed demographic and job characteristics of nurses are shown in Table 1.

Quiet Quitting Scale

Descriptive statistics for the Quiet Quitting Scale are shown in Table 2. The mean score for the QQS was 2.37 (SD; 0.67). Also, the mean score for the factors "detachment", "lack of initiative", and "lack of motivation" was 2.08, 2.36 and 2.97, respectively.

Applying the suggested cut-off point we found that almost seven out of ten nurses (68.2%, n=620) can be considered quiet quitters, while three out of ten (31.8%, n=289) can be considered non-quiet quitters.

Predictors of quiet quitting

Simple linear regression analysis between independent variables and quiet quitting is shown in Table 3. Moreover, multivariable linear regression analysis with quiet quitting as the dependent variable is shown in Table 4. We found that males experienced higher levels of quiet quitting than females (adjusted coefficient beta = 0.216, 95% CI = 0.093 to 0.339, p-value = 0.001). Additionally, shift workers (adjusted coefficient beta = 0.182, 95% CI = 0.091 to 0.272, p-value < 0.001) and nurses who have been working in understaffed workplaces (adjusted coefficient beta = 0.134, 95% CI = 0.006 to 0.262, p-value = 0.040) showed higher levels of quiet quitting. Decreased years of clinical experience were associated with increased quiet quitting (adjusted coefficient beta = -0.008, 95% CI = -0.012 to -0.004, p-value < 0.001)

Table 1. Demographic and job characteristics of nurses.

Characteristics	N	%
Gender		
Females	786	86.5
Males	123	13.5
Age ^b	39.7	9.7
Educational level		
University degree	295	32.5
MSc/PhD diploma	614	67.5
Shift work		
No	359	39.5
Yes	550	60.5
Employment in		
Private sector	161	17.7
Public sector	748	82.3
Understaffed workplace		
No	125	13.8
Yes	784	86.2
Years of clinical experience ^a	15.6	9.9

^a mean, standard deviation

Table 2. Descriptive statistics for the Quiet Quitting Scale.

	Mean	SD
Quiet Quitting Scale	2.37	0.67
Factor “detachment”	2.08	0.74
Factor “lack of initiative”	2.36	0.89
Factor “lack of motivation”	2.97	0.99

Table 3. Simple linear regression analysis between independent variables and quiet quitting.

Independent variables	Unadjusted coefficient beta	95% confidence interval	P-value
Males vs. females	0.202	0.076 to 0.328	0.002
Age	-0.010	-0.014 to -0.006	<0.001
MSc/PhD diploma vs. University	0.006	-0.087 to 0.098	0.905
Shift work	0.219	0.132 to 0.307	<0.001
Job in public sector	0.018	-0.095 to 0.131	0.756
Understaffed workplace	0.164	0.039 to 0.289	0.010
Years of clinical experience	-0.009	-0.013 to -0.005	<0.001

Table 4. Multivariable linear regression analysis between independent variables and quiet quitting.

Independent variables	Adjusted coefficient beta	95% confidence interval	P-value
Males vs. females	0.216	0.093 to 0.339	0.001
Shift work	0.182	0.091 to 0.272	<0.001
Understaffed workplace	0.134	0.006 to 0.262	0.040
Years of clinical experience	-0.008	-0.012 to -0.004	<0.001

Discussion

This study examined the effects of quiet quitting on nursing personnel working in clinical settings. The study's findings revealed that about 70% of the participants opted for the practice of quiet quitting as a form of organizational behavior. Furthermore, individuals employed in departments with insufficient staff, individuals working in rotating shifts, and those with limited years of work experience are more likely to be quiet quitters.

The correlation we found between inadequate staffing and employees quiet quitting, is consistent with the results of previous study (Galanis, et al., 2024). For many years, the Greek health system has had a shortage of nursing staff compared to other affluent countries. In Greece, the ratio of hospital employed nurses per 1,000 people is one of the lowest compared to other nations in the Organization for Economic Co-operation and Development (OECD). Additionally, there

has been no change in this ratio during the past two decades (OECD, 2021). Insufficient staffing is a significant contributor to nurses experiencing burnout (Lasater et al., 2021), which then affects the likelihood of them experiencing quiet quitting (Galanis, et al., 2023). Consequently, in order to enhance nursing staffing, it is crucial to implement interventions at the health policy level.

The present study's findings indicate that working a rotating shift is linked to the occurrence of quiet quitting. This result aligns with the findings of a research which employed Greek nurses (Galanis, et al., 2024). The task of working rotational shifts is arduous for nurses, exerting a toll on both their physical and mental well-being. In particular, shifts that involve rotation increase the likelihood of needlestick and sharps injuries, as well as other work-related mishaps. Night shifts and rotating shifts also elevate the risk of sleepy driving and motor vehicle crashes (Imes et al., 2023).

Furthermore, the practice of working rotational shifts has a direct impact on the quality of sleep experienced by nurses and also plays a role in the development of acute or chronic fatigue (Chang & Peng, 2021; Min et al., 2022). This burden on nurses from rotating shifts, which is probably exacerbated by understaffing, leads them to quiet quitting. Less experienced nurses who are younger may opt for a strategy known as "quiet quitting" to protect themselves from the adverse effects of chronic understaffing and working rotational shifts.

Conclusions: The current study emphasized the significant proportion of nurses who choose to quiet quitting, and identified characteristics such as inadequate staffing, working on rotational shifts, and limited work experience as predictors of this quiet quitting phenomenon. The choice of quiet quitting may negatively affect the quality and safety of the care provided. In many cases, nurses are already unable to complete all nursing tasks and provide comprehensive care. Through quiet quitting this situation may be exacerbated by significantly affecting the level of care of patients. Understaffing of health care organizations is perhaps the most important factor influencing the occurrence of quiet quitting, making it imperative to improve nursing staffing.

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