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ORIGINAL ARTICLE

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Illegitimate tasks in health care: Illegitimate task types and associations with occupational well-being

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Abstract

Aims and objectives: The aims of the study were to identify content categories of unreasonable and unnecessary illegitimate tasks and to investigate how unreasonable and unnecessary tasks relate to occupational wellbeing.

Background: Illegitimate tasks are a common stressor among healthcare professionals, and they have been shown to have negative associations with occupational well-being. Despite this evidence, research has not yet uncovered what kinds of tasks healthcare professionals consider illegitimate.

Design and method: The data gathered by means of an online survey consisted of 1024 municipal healthcare organisation employees. A theory-driven qualitative content analysis was used to analyse freely reported illegitimate tasks. For occupational well-being associations, a mixed-methods approach was used (ANCOVA and linear regression analysis). The STROBE statement—checklist for cross-sectional studies was used.

Results: Eight content categories were found for illegitimate tasks. For unreasonable tasks, these were (1) tasks outside one's occupational role (78% of all unreasonable tasks), (2) conflicting or unclear demands (9%), (3) tasks with insufficient resources (8%) and (4) tasks with difficult consequences (5%), and for unnecessary tasks, these were (1) impractical or outdated working habits (31% of all unnecessary tasks), (2) tasks related to dysfunctional technology (30%), (3) unnecessary procedures (27%) and (4) tasks related to bureaucratic demands (12%). Unreasonable and unnecessary tasks were associated with higher levels of burnout and lower work engagement and the meaningfulness of work.

Conclusions: Our findings support the theory that illegitimate tasks are an occupational stressor with negative effects on burnout, work engagement and meaningfulness of work.

Relevance to clinical practice: The study offers insights into the types of tasks health care employees see as illegitimate and highlights the importance of good job design in promoting occupational well-being in health care.

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KEYWORDS
burnout, illegitimate tasks, meaningfulness of work, nurses, work engagement

What does this paper contribute to the wider global clinical community?

- The qualitative approach expands existing knowledge about illegitimate tasks by describing what tasks are experienced as illegitimate in a large municipal health care organisation.
- The negative occupational well-being associations of illegitimate tasks highlight the importance of fair and practical work design in the healthcare setting.
- The categorisation of illegitimate tasks in health care offers healthcare executives and policymakers valuable insights that can be applied in the design of healthcare services.

1 | INTRODUCTION

Recent research has shown that illegitimate tasks are a common stressor among healthcare professionals (Änskar et al., 2019; Thun et al., 2018) and they have been shown to have detrimental effects on well-being (e.g. Björk et al., 2013; Fila & Eatough, 2018; Semmer et al., 2015; Thun et al., 2018). Work tasks are considered illegitimate if employees feel that they interfere with their core work roles and should not be part of their workload (Semmer et al., 2015). Despite the evidence of the high prevalence of illegitimate tasks in health care, research has not yet uncovered what kind of tasks health care professionals consider illegitimate. This is because previous studies of illegitimate tasks in healthcare settings (Anskär et al., 2019; Thun et al., 2018) have used a quantitative approach. This means there is a need for further research about the qualitative types of tasks healthcare professionals see as illegitimate.

To add to this kind of knowledge, it is essential to ask employees themselves what tasks they consider illegitimate in their work. The use of qualitative methods in addition to structured quantitative questionnaires can shed new light on the nature of illegitimate tasks. To our knowledge, only one study (Pindek et al., 2019) has studied the qualitative content of illegitimate tasks. However, as that study was conducted among engineers, it is not applicable in health care settings. Taken together, the aims of the present study are to gain further knowledge about (1) which tasks healthcare employees perceive as illegitimate, and (2) how different illegitimate tasks are related to their occupational well-being.

2 | BACKGROUND

Illegitimate tasks refer to tasks that employees feel that they should not have to carry out (Semmer et al., 2015). These tasks can represent occupational stressors and they have therefore drawn increasing interest in occupational stress research. Illegitimate tasks have recently been shown to be a unique stressor in several studies (Semmer et al., 2015, 2019). Illegitimate tasks conflict with normative role boundaries at work and violate what employees consider appropriate requirements in their professional role or position. Illegitimate tasks are thus in conflict with employees' core professional role and professional identity (Semmer et al., 2019).

Semmer et al. (2015), Semmer et al. (2010) name two reasons why employees can see job tasks as illegitimate. First, employees might see tasks as *unreasonable*, because they are not legitimate in terms of the employees' occupation and go beyond their occupational role boundaries. For example, a nurse can see cleaning duties as unreasonable, because cleaning is not part of what a nurse's work normatively includes. Semmer et al. (2010) describe a task as unreasonable if it falls outside of an employee's occupational role or status and should therefore be done by someone else. Also, a task might be considered unreasonable because it seems to be an unfair demand in relation to one's occupational role, or if it puts an employee in an awkward or difficult situation that the employee should not have gotten into (Semmer et al., 2010).

Second, employees might consider tasks *unnecessary* because they should not be done at all, or they could have been avoided altogether if the work had been better organised (Semmer et al., 2019). For example, a physician can perceive entering patient information in many different data systems as unnecessary because the organisation could replace the many systems with one, uniform system. According to Semmer et al. (2010), a task can be unnecessary if carrying it out serves no real purpose. A task might also be unnecessary if it needs to be done because of organisational inefficiency or supervisors' idiosyncratic demands (Semmer et al., 2010).

No task is illegitimate of itself. Semmer et al. (2015) underline that task illegitimacy is highly context dependent; the same tasks can be considered both legitimate and illegitimate under different conditions and by different employees. For example, a nurse might consider it legitimate to bring a glass of water to a bed patient, but would see it as illegitimate if the patient could have got the water by him- or herself. The difference is that in the latter scenario the nurse does not have a caring role, but rather the role of waiter or servant. Also, the legitimacy or illegitimacy of tasks depends on whether employees see the tasks as core or peripheral in their professional role: peripheral tasks are more likely than core tasks to be considered illegitimate, especially if they get in the way of performing the core tasks (Semmer et al., 2015). Nevertheless, core tasks can also be illegitimate (Semmer et al., 2015). For example, a physiotherapist may consider instructing uncommitted patients to do rehabilitative home

exercises to be illegitimate, even though prescribing home exercises is a core task for a physiotherapist.

According to previous research, what separates illegitimate tasks from other work-related stressors is that illegitimate tasks pose a threat to an employee's identity (Ma & Peng, 2019; Semmer et al., 2010, 2015). The concept of illegitimate tasks is based on the theory of Stress as Offence to Self (SOS; Semmer et al., 2019). As stated by Semmer et al. (2019), the central idea in the SOS framework is that people seek to achieve and sustain a positive self-image, so threats to one's personal or social self-esteem cause stress. The SOS framework helps to explain the mechanism between illegitimate tasks and stress by illustrating how illegitimate tasks pose a threat to an employee's self-image.

The SOS framework includes two pathways that can cause stressful experiences relating to self (Semmer et al., 2019). The first pathway is experiencing *stress through insufficiency* (SIN), which is tied to one's internalised standards of performance and the need to feel oneself capable of reaching those standards. Certain tasks can cause stress because they prevent employees from performing up to their internal standards and thus provoke feelings of inadequacy (Semmer et al., 2015). The second pathway is experiencing *stress as disrespect* (SAD; Semmer et al., 2019). Assigning tasks that are in conflict with an employee's professional role and professional identity may carry demeaning social messages of disrespect, and the perceived lack of appreciation can lower an employee's self-esteem and therefore threaten their psychological well-being (Semmer et al., 2015). According to Katz and Kahn (1978), professional roles are tied to the core tasks and responsibilities characteristic of different professions. Professional identity is affirmed by carrying out the core role activities of the professional role one identifies with (Katz & Kahn, 1978). Not being able to carry out the core tasks because of tasks that are expected illegitimately therefore lead to role conflict or role ambiguity.

Even though the theory of illegitimate tasks presents different ways of conceptualising these tasks, empirical studies on the qualitative nature of illegitimate tasks, especially as reported by employees themselves, are still scarce. In their study of American engineers, Pindek et al. (2019) found five different content categories of illegitimate tasks: (1) tasks that are unnecessary to do at all, (2), tasks that are due to poor work done by others, (3) tasks that fall under another employee's job description (not demoting), (4) tasks that fall under another employee's job description (demoting) and (5) tasks that are unethical or illegal. They identified the first category as unnecessary tasks and the others as unreasonable tasks, except for unethical or illegal tasks, which were not categorised in either of the sub-dimensions. In health care, no studies on the contents of illegitimate tasks have yet been made, even though illegitimate tasks are a common stressor among health care professionals (Änskar et al., 2019; Thun et al., 2018).

Illegitimate tasks are commonly measured with the Bern Illegitimate Tasks Scale (BITS; Semmer et al., 2015), which includes sub-dimensions for unreasonable and unnecessary tasks. However, it does not assess the content of illegitimate tasks. In this study, we use a mixed-method approach to study both the types of tasks health care employees see as illegitimate, and how having to do illegitimate tasks is associated with occupational well-being. In addition to BITS, we use an open-ended question about the tasks employees consider either unreasonable or unnecessary. By examining the associations measured with both of these, we can further explore how well BITS is able to capture the employee experience of illegitimate tasks.

2.1 | Illegitimate tasks in health care

Even though the number of clerical and support staff has been cut back in health care, the tasks carried out by these staff members have not disappeared. Rather, these tasks have tended to be transferred to nurses (Duffield et al., 2008), who can end up spending only one fifth of their work time on direct patient care (Institute of Medicine, 2011). In nursing practice research, tasks outside of core nursing work are called non-nursing activities (Sabo, 1990), and they are a common stressor in nurses' work (Motowidlo & Manning, 1986). Besides nurses, also physicians are affected by the strain caused by tasks that are not related to care (Melnick et al., 2020; Woolhandler & Himmelstein, 2014).

Studies about illegitimate tasks as a stressor in health care are still scarce. In their study of primary care employees in Sweden, Anskär et al. (2019) found that 27% of primary care physicians reported a high proportion of unnecessary tasks, and 8% of both physicians and nurses reported a high proportion of unreasonable tasks. Across all professional groups, the number of illegitimate tasks was highest among those with a high proportion of non-patient care-related administrative work. Also, having illegitimate tasks was associated with negative perceptions of the psychosocial work environment, suggesting an ineffective use of employee competence (Anskär et al., 2019). Thun et al. (2018) studied the prevalence of unreasonable illegitimate tasks among Norwegian physicians. They found that 7% of physicians reported that one third of their workload consisted of unreasonable tasks. In addition, half of the participants reported that 11% of their work could have been done by other hospital personnel. They also found that role conflict and a high number of administrative tasks were associated with unreasonable tasks and that unreasonable tasks were associated with higher stress and the probability of sickness presenteeism at work (Thun et al., 2018). These studies indicate that illegitimate tasks are a common stressor in health care and that they may negatively affect the occupational well-being of health care professionals. Let us now examine this more closely.

2.2 | Illegitimate tasks and occupational well-being

Illegitimate tasks have been shown to have a negative effect on occupational well-being (e.g. Fila & Eatough, 2018; Semmer et al., 2015; Thun et al., 2018) due to mechanisms presented earlier in the SOS model (Semmer et al., 2019). In this study, we measured occupational well-being via burnout, work engagement and meaningfulness

of work. As health care employees are already at high risk of burnout because of the emotional and social intensity of their work (Maslach et al., 1996), it is important to find out how illegitimate tasks as an individual stressor affect burnout levels in health care. Also, as work engagement and the meaningfulness of work can increase job satisfaction and decrease turnover in health care (Allan et al., 2019; Laschinger, 2012; Simone et al., 2018; Simpson, 2008), it is essential to study how illegitimate tasks relate to them.

Burnout is a syndrome resulting from prolonged work-related stress, with symptoms of chronic fatigue (*exhaustion*), negative work attitudes and lack of interest (*cynicism*) and feelings of incompetence (lack of *professional efficacy*) (Maslach et al., 2001). In this study, we focused on exhaustion and cynicism, because they are generally seen as the core dimensions of burnout (Schaufeli et al., 2004).

Work engagement is a positive work-related state of mind, and a feeling of fulfilment at work. It is characterised by high levels of energy (vigour), intense work involvement (dedication), and being deeply engrossed in one's work (absorption) (Schaufeli et al., 2002). Work engagement is linked to many positive work-related outcomes, such as positive emotions, and better mental and physical health and performance (Bakker et al., 2008).

Meaningfulness of work means experiencing one's work as significant, purposeful and motivating (Steger et al., 2012). Meaningfulness of work has been shown to have many positive outcomes, as it has been linked to higher levels of organisational commitment, self-rated job performance, work engagement and job satisfaction, as well as with lower levels of negative affect and turnover intentions (Allan et al., 2019).

Illegitimate tasks carry demeaning social messages and undermine one's identification with work (Semmer et al., 2015). They may therefore result in increased emotional exhaustion, cynical attitudes to work and disengagement. As care work is often seen as a calling (Prater & McEwen, 2006; Raatikainen, 1997), having to do irrelevant or useless tasks that undermine one's professional identity may also reduce its perceived meaningfulness. In previous studies, illegitimate tasks have been shown to cause strain (Björk et al., 2013; Kottwitz et al., 2013; Semmer et al., 2015) and emotional exhaustion (Fila & Eatough, 2018; Semmer et al., 2015). Schmitt and Ohly (2015) found that illegitimate tasks were also negatively related to work engagement. To our knowledge, no studies about how illegitimate tasks relate to the meaningfulness of work have yet been published.

Two theories that have been particularly useful in this study to explain the associations between illegitimate tasks and occupational well-being are the SOS theory (Semmer et al., 2007, 2019) and the Job Demands-Resources model (JD-R; Bakker & Demerouti, 2007). According to the JDR (Bakker & Demerouti, 2007), work stress is caused by a loss of energy and motivation due to excessive job demands or inadequate resources for the job. Illegitimate tasks can be considered as job demands because they create extra work for employees and are excessive in terms of their work roles. In the light of these theories, illegitimate tasks can be detrimental to occupational well-being in two ways. First, the strain caused by the threat to one's self-esteem can be a factor in the onset of burnout (Semmer et al., 2015). Second, as excessive demands, illegitimate tasks may reduce the employee's energy, their motivation for work engagement and the meaningfulness of work. The first view of illegitimate tasks as a stressor has dominated illegitimate tasks research, while their relation to positive aspects of occupational well-being has not received equal attention. By including work engagement and meaningfulness of work in our study, we have been able to broaden understanding of the adverse mechanisms behind illegitimate tasks in relation to the energy and motivation paths of the JD-R.

2.3 | Aims

Based on the aforementioned theoretical frameworks, this study had two main aims. First, we investigated what kinds of work tasks health care employees experienced as illegitimate (unreasonable and unnecessary), combining quantitative evaluations of illegitimate task frequency with qualitative descriptions of task content. Second, we examined how these different types of illegitimate tasks associated with the employees' occupational well-being (burnout, work engagement and meaningfulness of work).

3 | METHODS

3.1 | Data collection and participants

The participants in this study were employees of a large municipal healthcare organisation. We collected the data with an anonymous online survey, which we sent to all employees via e-mail in the fall of 2019. The employees were informed about the voluntary nature of their participation, confidentiality, as well as the fact that their personal data would be used in accordance with the GDPR. Before taking the survey, respondents had to check an item in which they gave their informed consent.

3.2 | Measures

Illegitimate tasks were assessed with the BITS (Semmer et al., 2015) and an open-ended question. First, the respondents read an explanation of what is meant by illegitimate tasks and their two subcategories, unnecessary tasks and unreasonable tasks. Then the respondents rated the items of the two sub-dimensions of BITS measuring unnecessary and unreasonable tasks. Unnecessary tasks were measured with four items, prompted by 'Do you have work tasks to take care of which keep you wondering…' followed by different statements, such as '…if they should be done at all'. Unreasonable tasks were similarly measured with four items, prompted by 'Do you have work tasks to take care of which you believe…' followed by different statements, such as '…should be done by someone else'. Response ranges for both sub-dimensions were from *never* (1) to *frequently* (5), high mean scores indicating a high prevalence of

illegitimate tasks. The BITS scale was followed by an open-ended question about which tasks they considered unreasonable or unnecessary in their work, phrased: 'If you feel that you have previously described tasks in your work that you see as either unreasonable or unnecessary, please describe those tasks freely.' We did not limit the length of the answer or the amount of illegitimate tasks they could mention. Previous research has indicated a good validity for BITS (Semmer et al., 2010, 2015). In the present study, the Cronbach's alphas were.89 for unreasonable and.89 for unnecessary tasks.

Burnout was measured with two dimensions (*exhaustion* and *cynicism*) of the Bergen Burnout Indicator (BBI-9; Salmela-Aro, Rantanen, Hyvönen, Tilleman & Feldt, 2011), a shortened version of the original BBI (Matthiesen & Dyregrov, 1992). The scale included three different items for both sub-dimensions, for example 'I am snowed under with work' (exhaustion) and 'I feel dispirited and I'm thinking of leaving my job' (cynicism), with response options from *completely disagree* (1) to *completely agree* (6), high scores indicating high burnout. The validity of this scale has been supported by previous research (Salmela-Aro et al., 2011; see also Feldt et al., 2014). In the current study, the Cronbach's alphas were .66 for exhaustion and .86 for cynicism.

Work engagement was measured with the Ultra-short Measure of Work Engagement (UWES-3; Schaufeli, Shimazu, Hakanen, Salanova, & De Witte, 2019) a shortened version of the original Utrecht Work Engagement scale (UWES; Schaufeli et al., 2002), which has been well-validated by previous studies (Schaufeli et al., 2019; see also Seppälä et al., 2008). The scale had three items representing the three sub-dimensions of work engagement: 'At work, I feel that I am bursting with energy' (vigor), 'I am enthusiastic about my job' (dedication) and 'I am immersed in my work' (absorption), with the response range from *never* (1) to *daily* (7), high scores indicating a high work engagement. In the present study, the Cronbach's alpha for work engagement was .82.

Meaningfulness of work was measured with the *positive meaning* sub-dimension of the Work and Meaning Inventory (WAMI; Steger et al., 2012; Cronbach's α .89). According to Steger et al. (2012), positive meaning is seen as a core dimension of meaningfulness of work, and it was therefore chosen as the only dimension for this study. The sub-dimension consisted of four items, like 'I have found a meaningful career', with response options from *completely disagree* (1) to *completely agree* (7), high scores indicating a high meaningfulness of work. The validity of the scale was supported by the study of Steger and colleagues (Steger et al., 2012). In the present study, the Cronbach's alpha for positive meaning was.82.

The background variables used in this study were *gender* (female/male), *age* (categorised as 25 or less, 26–30, 31–35, 36–40, 41–45, 46–50, 51–55, 56–60 and over 60, but it was used as a continuous variable), *weekly working hours* (an open-ended question about working hours used as a continuous variable), *doing shift work* (dichotomised as no/yes), *leadership position* (dichotomised as no/yes) and *profession* (an open-ended question about the respondents' professional title, coded into four main categories). Previous research indicates that these background factors may relate to experiencing strain at work (Brewer & Shapard, 2004; Jamal, 2004; Messias et al., 2019; Omansky et al., 2016; Park & Lake, 2005; Purvanova & Muros, 2010).

3.3 | Data analysis

To categorise the illegitimate tasks that the study participants mentioned in their open-ended responses, we combined theory-driven methods of content analysis with inductive elements (Cresswell, 1999). Our study is the first qualitative study on the subjective content of illegitimate tasks in health care, so we did not have applicable prior categorisations to use as a basis for our qualitative analysis. We used Semmer et al.'s (2010, 2015) theory of illegitimate tasks to categorise the responses as either unreasonable or unnecessary. To get deeper insight into their content, we also used Semmer et al.'s (2010, 2015) descriptions of typical unreasonable and unnecessary tasks and formulated subcategories for both.

At the start of the analysis, one researcher read the responses several times and formulated eight different preliminary categories based on the theory and the emerging themes. Then another researcher also read the answers and suggested changes that they considered necessary to the preliminary categorisation. The researchers discussed the changes together and revised the categories by mutual agreement. After the categorisation, the two researchers independently used the categorisation to code the responses. Each respondent was coded only once in each category. After the independent categorisation, the two codings were compared. Then, after discussing the codings together and consulting the organisations' liaison about unclear issues, the two coders agreed on the final classification.

Next, the quantitative analysis was carried out using IBM SPSS version 26. To analyse the correlations between background variables and study variables, we used Spearman correlation for categorical variables and Pearson correlation for continuous variables.

To see whether some professional groups were over-represented in some of the illegitimate task categories, we used cross tabulation with multiple response sets for both illegitimate task categories and professional group. Then, to examine the connection between freely reported illegitimate tasks and well-being, we used analysis of covariance (ANCOVA). Linear regression analysis was used for the illegitimate tasks measured with BITS. The assumptions of both ANCOVA and linear regression analysis were met. In the first step of the analysis, the background variables that correlated with the dependent well-being variables were added to the model. To increase the accuracy of the analysis, we then excluded the background variables without statistically significant associations in the first step of the linear regression analysis. In the second step, the unreasonable and unnecessary tasks were added to the model. Because of high correlations between unreasonable and unnecessary tasks, they were analysed separately. For the freely reported illegitimate tasks, we formed dichotomous variables of whether or not the respondent had mentioned unreasonable or unnecessary tasks. Because

our questionnaire did not include an option to check 'I do not have illegitimate tasks in my work', with the open-ended question about illegitimate tasks we cannot be sure if a respondent who left the question unanswered did so because they did not have any illegitimate tasks or for some other reason, e.g. they were pressed for time. To increase the validity of the analysis, we excluded respondents without freely reported tasks who scored high on unreasonable and unnecessary tasks measured with BITS (the median was used as the cut-off value). The total amount of excluded cases was 216 (21%). We also controlled for the background variables that correlated significantly with occupational well-being variables both in ANCOVA and in the regression analysis.

Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) Statement for cross-sectional study reporting (von Elm et al., 2017) was used to evaluate the reporting guidelines of our study (see Supplementary file 1).

4 | RESULTS

4.1 | Descriptive statistics

A total of 1024 employees participated in the survey. At the end of 2018, the total number of employees in the organisation was 3748 (N = 3748), which means that the response rate was 27%. Of the target group, that is, the total number of employees in the organisation in 2018, 83% were women, 52% were aged over 45 years, and the largest age group was 55- to 59-year-olds. Of the respondent sample, 85% were women, 52% were aged over 45 years, and the largest age group, 16%, was 51- to 55-year-olds. Of the respondents, 73% did patient care work, 44% did shift work, and 6% had leadership responsibilities. Of the respondents, 50% were nurses, 6% physicians, 12% other patient-care professionals (psychologists, therapists, social care workers) and 27% non-patient-care professionals (secretaries, maintenance workers, managers). Five per cent of the respondents did not want to reveal their professional title and were therefore not included in this study.

The professional background was assessed with an open-ended question about the respondents' professional title, which were analysed and coded into four subcategories. The professional titles were categorised as follows: (1) nurses (n = 511, 50%) (2) physicians (n = 65, 6%), (3) other patient-care professionals (n = 120, 12%) and (4) non-patient-work professionals (n = 271, 27%). If the respondent did patient care work and was previously coded under a nursing profession, he/she was placed in the *nurses* category (e.g. public health nurses, laboratory nurses, midwives, practical nurses). Similarly, if the respondent did patient care work and was previously coded under the profession of physician, he/she was placed in the *physicians* category (general practitioners, anesthesiologists, residents, dentists). If the respondent did patient care work but was coded as neither nurse nor physician, he/she was categorised under *other patient-care professionals* (e.g. psychologists, physiotherapists, social care workers). Finally, if the respondent did not do patient care work, he/she was categorised under *non-patient-care professionals* (secretaries, maintenance workers, IT-professionals, managers).

4.2 | Contents of freely reported illegitimate tasks

In total, eight illegitimate task content categories were found: four for unreasonable tasks and four for unnecessary tasks. Our results, as seen in Table 1, show that just over three quarters (77%) of all freely reported illegitimate tasks were unreasonable tasks *outside one's occupational role*. Thus, this category was strongly represented compared to all the other content sub-categories in both unreasonable and unnecessary tasks. The next largest unreasonable task content categories were tasks resulting from *conflicting or unclear demands* (9%), and tasks with *insufficient resources* (8%), while the smallest category was tasks that had *difficult or awkward consequences* for the employee (5%).

The largest content category for unnecessary tasks was tasks related to *impractical or outdated working habits* (15%). Close behind in size were tasks related to *dysfunctional technology* (14%) and *unnecessary procedures* (13%), while the smallest category was *tasks related to bureaucratic demands* (6%).

These results supported our expectations of what illegitimate task categories would emerge, as all three categories that were anticipated for both unreasonable and unnecessary tasks were found. However, two unanticipated categories also emerged: tasks with *insufficient resources* and tasks related *to impractical or outdated working habits*.

4.3 | Differences in freely reported illegitimate task categories between professional groups

The cross-tabulation results shown in Table 2 indicate that task categories differed between professional groups ($\chi^2(32) = 155.33$, p <.001). Nurses reported more unreasonable tasks outside their occupational role than other professionals did. Physicians reported more unnecessary tasks related to dysfunctional technology compared with all other professional groups. Finally, other patient-care professionals and non-patient-care professionals reported more tasks related to bureaucratic demands than nurses did. The results were mostly in line with our expectations of professional differences, except for professional differences in tasks related to bureaucratic demands, which we had not anticipated.

4.4 | Illegitimate tasks and occupational wellbeing

As a preliminary analysis for our regression analysis, we first calculated correlations between background variables and study

TABLE 1 Illegitimate task content categories

Illegitimate task categories	% (*n*)	Description of contents	Examples of illegitimate tasks
Unreasonable tasks			
1. Outside of one's occupational role	78 (357)	Tasks that should be done by someone else with a different profession or position	'A nurse has to often do the tasks of a cleaner, a physiotherapist and even a doctor'; 'The tasks that a supervisor should be interested in.'
2. Demands that are unreasonable, conflicting or unclear to the employee	9 (43)	Tasks that result from unreasonably strict, contradictory or unclearly stated demands	'The workload is not equally distributed and no one is doing anything about it'; 'I need to take responsibility for things I do not have the mandate to influence'; 'Taking care of the staff coffee room (that should be a task for everyone, but isn't)'
3. Tasks with insufficient resources	8 (37)	Tasks that have to be done without sufficient resources, e.g. time, training	'Many fancy projects and lists to fill out but without time given to do them'; 'It is expected that work goes on without proper professional guidance and training'
4. Difficult situations or tasks one considers unethical	5 (22)	Tasks that put the employee in a difficult position or require acting against one's ethics	'Difficult things in patient situations lacking the team's agreement, and having to make a difficult decision myself'; 'Getting into operations I wouldn't want to take part in'
	100 (459)		
Unnecessary tasks			
1. Impractical or outdated ways of working	31 (69)	Tasks that are the consequence of old, impractical habits in the workplace	'A lot of printing even though results are available digitally'; 'Too much overlapping work and different teams that don't know about each other'
2. Insufficient or dysfunctional information systems and other technology	30 (67)	Tasks that could be avoided with better technological solutions	'Many different digital systems that don't sync and take an unnecessary amount of work time'; 'Inoperative speech recognition'; 'Entering patient records in multiple systems'
3. Unnecessary procedures, operations and measurements	27 (61)	Tasks that make no sense and should not be done at all because they do not produce useful outcomes	'A doctor sends a patient to physiotherapy only when they can't come up with anything else'; 'All kinds of projects that occupy one but don't leave anything useful behind'; 'The treatment classification is completely pointless'
4. Bureaucratic demands, administration and organizational structure	12 (27)	Tasks that result from unnecessarily strict or rigid bureaucratic requirements	'Tasks due to the organizational structure that have led to various policies and procedures'
	100 (224)		

variables (Table 3). As seen from the results, many of the background variables correlated with illegitimate tasks and some with occupational wellbeing variables. Doing shift work correlated with all of the study variables, especially with higher amount of both unreasonable and unnecessary tasks and also higher levels of exhaustion. Being a nurse correlated with higher amount of both unreasonable and unnecessary tasks, whereas being a physician correlated with fewer unreasonable tasks but higher amount of unnecessary tasks and meaningfulness of work. Being other patient work professional or non-patient-care professional correlated with fewer illegitimate tasks altogether. Being other patient work professional correlated also with higher and being non-patient work professional with lower levels of meaningfulness of work.

As seen in Table 4, the results showed that freely reported *unreasonable tasks* were associated with a higher rate of both exhaustion and cynicism, and with a lower level of meaningfulness of work. In addition, freely reported *unnecessary tasks* were associated with higher levels of exhaustion. When measured with BITS (Table 5), both *unreasonable tasks* and *unnecessary tasks* were associated with higher rates of exhaustion and cynicism, and with lower levels of work engagement and meaningfulness of work.

The results showed that the associations of freely reported illegitimate tasks were parallel to those measured with BITS, albeit with fewer statistically significant connections. The results were in line with the expected negative associations between illegitimate tasks and occupational well-being.

TABLE 2 Professional background and freely reported illegitimate task categories

Illegitimate task category	Nurses (A) *n* = 511 *n* (%)	Physicians (B) *n* = 65 *n* (%)	Other patient workers (C) *n* = 120 *n* (%)	Non-patient workers (D) *n* = 271 *n* (%)	Total *n* = 1024
Unreasonable tasks					
1. Tasks outside one's occupational role, position or competence	232 (68)	19 (6)	35 (10)	56 (16)	343 A > D*** A > B, C**
2. Unreasonable, conflicting or unclear demands	24 (56)	2 (5)	5 (12)	12 (28)	43
3. Insufficient resources	24 (67)	5 (14)	0 (0)[a]	7 (19)	36
4. Difficult situations or tasks one considers unethical	13 (62)	1 (5)	4 (19)	3 (14)	21
Unnecessary tasks					
4. Impractical or outdated ways of working	30 (43)	6 (9)	13 (19)	20 (29)	69
2. Insufficient or dysfunctional technology	32 (52)	13 (21)	5 (8)	12 (19)	62 B > A*** B > C, D**
3. Unnecessary procedures, operations and measurements	37 (63)	6 (10)	9 (15)	7 (12)	59
4. Bureaucratic demansa, administration and organizational structure	6 (22)	2 (7)	6 (22)	13 (48)	27 D > A*** C > A*

***p <.000, **p <.01, *p <.05.

[a]Category not used in comparisons because its size is equal to zero.

5 | DISCUSSION

The aim of our study was, using a mixed-method approach, to gain insight into illegitimate tasks in health care by examining their qualitative content, looking at professional differences, and analysing how the experience of illegitimate tasks is related to occupational wellbeing. Despite the growing amount of research into illegitimate tasks during the past few years, the qualitative content of illegitimate tasks is still largely unexplored.

Based on Semmer et al. (2010, 2015) and their theorisation of illegitimate tasks, we expected to find two main types of illegitimate tasks, unreasonable tasks and unnecessary tasks, both of which emerged in the present data from health care employees. Building on their descriptions of unreasonable and unnecessary tasks, we also expected to find at least three subcategories for each task type. For unreasonable tasks, the expected content categories were (1) *outside one's occupational range*, (2) *conflicting or unclear demands* and (3) *difficult or awkward consequences*. For unnecessary tasks, the expected content categories were (1) *unnecessary procedures*, (2) *dysfunctional technology* and (3) *bureaucratic demands*.

All the expected categories were found, but also two unexpected categories emerged: *tasks with insufficient resources* for unreasonable tasks, *and impractical or outdated working habits* for unnecessary tasks. As regards the first of these, the theme of *insufficient resources*—mostly time—for expected tasks came up regularly, in the context of the task being an unreasonable demand. The theme that emerged is quite closely related to *conflicting or unclear demands*, but since it was so distinctive from the three expected unreasonable task categories, we decided to form a separate content category around it. As for the second unexpected category, in our analysis we found that several respondents reported their teams or units having *impractical or outdated working habits* that caused tasks

TABLE 3 Correlations between the background variables, illegitimate tasks and occupational well-being (N = 915–1024)

	Gender[a,c]	Age[b,d]	Working hours[b,d]	Leadership position[a,e]	Shift work[a,e]	Nurses[a,e]	Physicians[a,e]	Other patient-care[a,e]	Non-patient-care[a,e]
10. Unreasonable tasks	−.08*	−.02	−.06	.02	.18***	.19***	−.16***	−.14***	−.16***
11. Unnecessary tasks	.00	−.09**	−.06	−.03	.18***	.10**	.09**	−.08*	−.12***
12. Exhaustion	−.07*	.02	.01	.06	.15***	.05	.02	−.08*	−.04
13. Cynicism	.01	.05	−.04	−.06*	.09**	.02	−.02	−.05	.00
14. Work engagement	−.05	.04	−.01	.06*	−.08**	−.03	−.03	.06	.05
15. Meaningfulness of work	−.05	.07*	.04	.10**	−.07*	.03	.11***	.10***	−.13***

α = Cronbach's alpha.

***p <.001, ** p <.01, * p <.05.

[a]Spearman correlations.

[b]Pearson correlations.

[c]1 = female, 2 = male.

[d]used as a continuous variable.

[e]0 = no, 1 = yes.

TABLE 4 The connection between freely reported illegitimate tasks and occupational well-being (ANCOVA results)

	(1) No freely reported unreasonable tasks		(2) One or more freely reported unreasonable tasks				
Measure	*M*	*SE*	*M*	*SE*	*F*	*df*	Pairwise comparisons
Exhaustion[a]	2.75	.05	3.26	.05	48.14***	1	2 > 1
Cynicism[b]	2.28	.05	2.75	.06	33.98***	1	2 > 1
Work engagement[c]	5.64	.06	5.56	.06	1.02	1	
Meaningfulness of work[d]	4.01	.04	3.90	.04	.04*	1	2 < 1
	(1) No freely reported unnecessary tasks		(2) One or more freely reported unnecessary tasks				
	M	*SE*	*M*	*SE*			
Exhaustion[a]	2.92	.04	3.20	.08	8.91**	1	2 > 1
Cynicism[b]	2.46	.04	2.63	.09	3.15	1	
Work engagement[c]	5.62	.05	5.57	.09	.24	1	
Meaningfulness of work [d]	3.98	.03	3.91	.06	1.08	1	

***p <.000, **p <.01, *p <.05.

[a]Controlled: shift work and professional background (other patient work).

[b]Controlled: gender, shift work and professional background (other patient-care professionals).

[c]Controlled: managerial position and professional background (other patient-care professionals).

[d]Controlled: age, managerial position, shift work and professional background (physicians, other patient-care professionals and non-patient-care professionals.

that otherwise could have been avoided, and these did not fit into any of the expected categories of unnecessary tasks. The category that emerged resembles the category of unnecessary tasks related bureaucratic demands by executives (the vertical level) but is distinct from it because it covers impractical work processes and habits within one's team or unit (the horizontal level). We considered that the difference between vertical and horizontal levels justified its being a separate category of its own. The two unexpected categories make a valuable addition to the expected categories because they emphasise the importance of sufficient task resources and reasonable bureaucracy, both of which were clearly present in the data but would otherwise have been left invisible.

Our categorisations in healthcare organisations are in some ways different from the illegitimate task categories found by Pindek et al.

TABLE 5 The connection between illegitimate tasks measured with BITS and occupational well-being (linear regression analysis; all results from the 2nd step of the analysis)

	Exhaustion			Cynicism			Work engagement			Meaningfulness of work		
Predictors	β	R^2	ΔR^2	β	R^2	ΔR^2	β	R^2	ΔR^2	β	R^2	ΔR^2
Unreasonable tasks												
Step 1: Control Variables[a]		.02	.03***		.01	.01*		.00	.00		.06	.06***
1. Gender[b]	−.03			—			—			—		
2. Age[c]	—			—			—			.10**		
3. Managerial position[d]	—			—			—			.13***		
4. Shift work[d]	.07*			.01			−.03			−.02		
5. Physicians[d]	—			—			—			.07*		
6. Other patient-care prof.[d]	−.01			—			—			.03		
7. Non-patient-care prof.[d]	—			—			—			−.23***		
Step 2: Illegitimate tasks[a]		.17	.15***		.15	.14***		.03	.02***		.11	.05***
8. Unreasonable tasks	.40***			.38***			−.16***			−.23***		
Unnecessary tasks												
Step 1: Control Variables[a]		.02	.03***		.01	.01*		.00	.00		.06	.06***
1. Gender[b]	−.06			—			—			—		
2. Age[c]	—			—			—			.08**		
3. Managerial position[d]	—			—			—			.12***		
4. Shift work[d]	.07*			.01			−.03			−.01		
5. Physicians[d]	—			—			—			.08*		
6. Other patient-care prof.[d]	−.04			—			—			.05		
7. Non-patient-care prof.[d]	—			—			—			−.21***		
Step 2: Illegitimate tasks[a]		.12	.10***		.15	.15***		.04	.04***		.11	.06***
8. Unnecessary tasks	.32***			.39***			−.20***			−.25***		

Step 1: only the variables with statistically significant correlations were added to the models.

β standardized beta.

***p <.000, ** p <.01, * p <.05.

[a]β-values from the 2nd step of the analysis.

[b]1 = female, 2 = male.

[c]Used as a continuous variable.

[d]0 = no, 1 = yes.

(2019) with engineers. While Pindek et al. found three types of unreasonable tasks (*non-demoting* and *demoting tasks that are another's job* and *poor work by others creating more work for oneself*) and one type of unnecessary tasks (*unnecessary to do at all*), our categorisation was more detailed. Also, the coding of similar themes was somewhat different. Pindek et al. (2019) categorised poor work by others resulting in more work for the employee in its own unreasonable task category, while in our categorisation such tasks were coded under unreasonable tasks outside one's occupational role. They also found a separate category of *unethical or illegal* tasks, which were not classified as either unreasonable or unnecessary, while in our categorisation, tasks considered unethical were, following Semner et al. (2010), included under unreasonable tasks *with difficult or awkward consequences*. The differences can be explained by the different methods of content analysis: Pindek et al. (2019) used a data-driven method as the basis for comparing two major illegitimate task categories (unreasonable tasks and unnecessary tasks) in relation to negative affect, whereas we used a more theory driven approach with inductive elements to elicit as accurately as possible all types of illegitimate tasks that the respondents reported having. Also, it is entirely predictable that the illegitimate task types that are emphasised in employees' reports will vary greatly in two very different work contexts.

However, there are also similarities between the two categorisations. The two unreasonable task categories of tasks that are another person's job (demeaning and not demeaning) in Pindek et al.

(2019) were comparable to the largest category in our study, that is unreasonable tasks outside one's occupational role. Also, their unnecessary tasks category (tasks that did not need to be done at all) corresponded with our category of unnecessary procedures. These similarities between illegitimate task categories show that some similar types of illegitimate tasks can be experienced in two very different fields, engineering and health care.

The expected professional differences emerged between illegitimate task content categories, as nurses reported more unreasonable tasks outside their occupational role than other professionals did, and physicians reported more unnecessary tasks related to dysfunctional technology than all other professionals. Unexpectedly, we found that other patient-care professionals and non-patient-care professionals reported more unnecessary tasks related to bureaucratic demands than nurses.

These results are in line with the previous finding of a high proportion of non-nursing activities in nurses' workload (Institute of Medicine, 2011). Also, the results seem to confirm Duffield et al. (2008), who found that the work of clerical and support staff has been transferred to nurses. In addition, the results confirm previous findings about physicians having a high number of unnecessary tasks (Anskär et al., 2019) and physicians' dissatisfaction with having so many non-care tasks (Kuusio, 2014; Melnick et al., 2020; Pereira et al., 2012; Woolhandler & Himmelstein, 2014), especially in the form of technology-related illegitimate tasks. An organisation-specific explanation for the high number of technology-related unnecessary tasks reported by physicians might be the recently adopted automatic dictation system for physicians, which had been met with a strongly negative reception in the organisation. The opposition to it may partly be a temporary phase of adaptation to something new, which might pass as the system becomes more familiar, but it can also reflect failings in the newly launched system and dissatisfaction at the extra work they cause.

An unexpected finding was that non-patient-care professionals reported a higher number of unnecessary tasks resulting from bureaucratic demands than nurses did. A possible explanation might be that the category of non-patient-care professionals included clerical and administrative staff, whose work might be more closely affected by the bureaucratic requirements and regulations of the organisation than the care work of nurses. For other patient-care professionals (e.g. psychologists, therapists, social care workers), a possible explanation could be that due to changes in the healthcare work environment, their work centers less around direct patient care and more around official requirements (e.g. statistics, patient records, productivity) than the work of nurses.

Our expectations about the detrimental consequences of illegitimate tasks on occupational well-being (emotional exhaustion, cynicism, work engagement and meaningfulness of work) were supported by our results. First, as previous studies have shown that illegitimate tasks increase strain (Björk et al., 2013; Semmer et al., 2015; Thun et al., 2018) and emotional exhaustion (Fila & Eatough, 2018), we expected that someone who reported illegitimate tasks would also report higher levels of emotional exhaustion. Also, because illegitimate tasks impair one's identification with one's work (Semmer et al., 2015), we expected that reporting illegitimate tasks would relate to higher levels of cynicism. Our results showed that reporting unreasonable tasks was associated with both emotional exhaustion and cynicism, but reporting unnecessary tasks was associated only with emotional exhaustion. However, when measured with BITS, both unreasonable and unnecessary tasks were associated with both exhaustion and cynicism.

Second, as illegitimate tasks have been shown to relate to irritability and negative feelings towards work (Semmer et al., 2015), we expected that reporting illegitimate tasks would be associated with lower levels of work engagement. This anticipation was supported only by illegitimate tasks measured with BITS: when freely reported, neither unreasonable nor unnecessary tasks associated with work engagement, but when measured with the BITS, both unreasonable and unnecessary tasks were associated with lower levels of work engagement. The results measured with the BITS were expected, because according to Semmer et al. (2015), illegitimate tasks are mentally draining and undermine one's identification with one's work and may thus lead to disengagement. The result also supports the results of Schmitt and Ohly (2015), who found that illegitimate tasks were negatively related to work engagement.

Finally, because illegitimate tasks are tasks that should not be part of the employee's work, and as they carry demeaning social messages (Semmer et al., 2015), we expected that illegitimate tasks would relate to lower meaningfulness of work. As anticipated, reporting unreasonable tasks was associated with lower meaningfulness of work, but the connection was not found with unnecessary tasks. However, when measured with the BITS, both unreasonable and unnecessary tasks were associated with lower meaningfulness of work.

The negative associations of illegitimate tasks with burnout, work engagement and meaningfulness of work support the view of them as harmful occupational stressors. The associations were especially strong for burnout. The higher levels of emotional exhaustion and cynical work attitudes might be related to the socially demeaning messages of unreasonable tasks, as they feel personally disrespectful and send the message that the organisation does not care about its employees' work or professional expertise. Also, the burden of useless work caused by unnecessary tasks might lead to emotional exhaustion and cynical attitudes, because the work is felt to be pointless despite the time and effort one has to put into it. The associations with work engagement and meaningfulness of work were not as strong, but nonetheless highly significant. The disengaging nature of unreasonable and unnecessary tasks might be the result of the feelings of insufficiency and insignificance that they give rise to in relation to one's core work, making the employee less absorbed, dedicated and vigorous in their work. Also, having to use work time on tasks that fall outside the core of what is otherwise highly meaningful care work, or tasks that interfere with it, may erode the meaningfulness of work. These results strongly indicate that strain increases and positive feelings towards work decrease when healthcare employees have

to do tasks that they do not consider to be part of their professional role or that have no real use. This reflects the importance of employees' being able to concentrate on those core tasks that give them energy, motivation and meaning in their work.

The stronger negative associations measured with the BITS compared with self-reported illegitimate tasks indicates that the BITS may more strongly capture the essence of illegitimate tasks in healthcare work. It can therefore bring out the associations with occupational well-being more clearly. However, the results for illegitimate tasks assessed with free self-reports were partly parallel to those assessed with the BITS, which suggests that the two methods complement each other in capturing the effects of illegitimate tasks.

Theoretically, our results, as seen in higher burnout levels, support the claim of the SOS-theory that illegitimate tasks induce stress (Semmer et al., 2019). In addition, our study reveals that illegitimate tasks are negatively associated with the energy- and motivation-paths of the JD-R model (Bakker & Demerouti, 2007), albeit with a smaller effect, coming behind work engagement and meaningfulness of work. Our results also show that unreasonable tasks are more strongly connected to emotional exhaustion when measured with free self-reports. This finding is in line with the findings of Semmer et al. (2015, 2019) and their theorisation of unreasonable tasks as the more harmful of the two types of tasks. This is because unreasonable tasks are more personally related to one's occupational role and can therefore be experienced as more wounding to one's self-esteem than unnecessary tasks, which are equally unnecessary to all employees doing the same kind of work. This theory was supported by Pindek et al. (2019), who found that unreasonable tasks were the more detrimental of the two. However, as measured with the BITS, the differences between the two types of tasks were smaller. The stronger effect of unreasonable tasks was detectable only in relation to emotional exhaustion. The associations of both unreasonable and unnecessary tasks with cynicism, work engagement and meaningfulness of work were similar, which does not support the earlier theorisation, at least not in health care settings.

5.1 | Strengths and limitations

The strength of our study is that it brings the existing theory of illegitimate tasks closer to practice by describing what kind of tasks healthcare employees see as illegitimate. This adds evidence-based understanding that could lead to better job design and better task distribution in health care. In addition, our categorisation of illegitimate task types in health care can be used as a tool to conceptualise illegitimate tasks and to understand them in more detail. The large sample size makes the results largely generalisable to other public healthcare organisations. The sample also allowed us to compare various professional groups in health care instead of focusing only on one single profession. Finally, the parallel results of our mixed-methods approach on illegitimate tasks supports the validity of the BITS and its suitability for measuring illegitimate tasks in the health care field.

However, our study also has some limitations. First, our study was cross-sectional, which means that our results reflect the illegitimate tasks and their associations only at one point in time. This means that no conclusions can be reached about causal relationships between the variables. Also, our sample consisted only of Finnish public healthcare professionals; the results might not be applicable to other countries or the private sector. Another issue is related to the methodology of our questionnaire: our open-ended question followed immediately after the BITS, which did not include an option to check 'I do not have illegitimate tasks in my work', so we do not know whether respondents left it unanswered because they had no illegitimate tasks or for other reasons, such as lack of time or interest. Because of that, we had to exclude respondents without self-reported tasks who scored high on unreasonable and unnecessary tasks measured with the BITS, in order to increase the validity of our analysis. Also, the response rate was low, which might distort the representativeness of the sample.

To further validate the categories found in our study, the categorisation should be tested in healthcare organisations in other countries. To see whether the experience of illegitimate tasks predicts lower occupational well-being over time, a longitudinal full panel design should be applied in future studies. In addition, comparing illegitimate task content between units or service providers would also provide valuable and more accurate insights into the prevalence of different illegitimate tasks within the healthcare field. These approaches would contribute to our knowledge of what kind of tasks appear illegitimate in different contexts as well as of whether the well-being consequences of illegitimate tasks are also context dependent. This would give us deeper understanding of the factors that cause differences in experiencing illegitimate tasks and the factors that might prevent them or their detrimental effects. Together with our results, these approaches would help to build better working environments, in which employee well-being would be supported rather than undermined.

6 | CONCLUSION

Our study expands existing knowledge about illegitimate tasks by describing what tasks are experienced as illegitimate in a large municipal health care organisation. It supports the theory that illegitimate tasks are an occupational stressor with negative effects especially on health care employees' burnout levels. In addition, our study contributes to this field of research by illustrating that illegitimate tasks can also have negative associations with newer concepts of occupational well-being, work engagement and meaningfulness of work. By showing the broad scale and the strong negative effects of illegitimate tasks, our study has been able to capture the fundamental importance of fair and practical work distribution for occupational well-being in healthcare settings.

The categorisation of illegitimate tasks in healthcare offers valuable insights to health care executives and policymakers who are designing health care services and resources. Our study supports

Anskär et al. (2019), who argued that assigning non-patient-care administrative and service tasks to care administrators and service personnel would be beneficial for employee well-being. Especially the high number of tasks that nurses reported as being outside their occupational range reflects the need to increase the number of support staff in order to prevent burnout in nurses and their loss of a sense of meaning and engagement in their work. Our study also emphasises the importance of well-designed information systems and other technology, as especially physicians reported many technology-related illegitimate tasks that were also found to be a risk factor for their well-being. All the technology that is adopted should be well designed and should support rather than hinder the work of healthcare professionals.

7 | RELEVANCE TO CLINICAL PRACTICE

Illegitimate tasks are associated with burnout and low work engagement and meaningfulness of work among healthcare professionals. This study highlights the importance of adequate staffing, well-functioning technology and practical work design in promoting occupational well-being in healthcare organisations. Given the importance of policies that are cost-effective, valuable healthcare resources should not be wasted on tasks that are illegitimate, especially as they are also detrimental to employees' occupational well-being. To avoid assigning illegitimate tasks, healthcare managers should give careful consideration to the distribution of work tasks among staff.

CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

AUTHOR CONTRIBUTIONS

Study design: KK, TF, MH, UK and SM. Data collection: KK, MH, TF, SM and UK. Manuscript writing: KK. Qualitative content analysis: KK, MH and TF. Statistical analyses: KK. Manuscript preparation and final approval: all authors.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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