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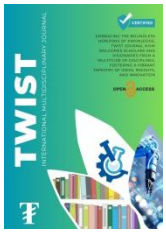

Knowledge Management in High-Risk Hospital Environments:

An Exploratory Case Study of a Moroccan Intensive Care Unit

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Abstract
In intensive care units, knowledge management (KM) is both a technical necessity and an emotional challenge. This case study, conducted in an intensive care unit at a Moroccan hospital, aims to understand how caregivers mobilize, share, and apply their knowledge in an environment marked by urgency, serious illness, and high emotional stress. The main objective is to assess the extent to which KM can contribute to improving hospital performance, while taking into account the daily experiences of professionals confronted with death, the distress of families, and the pressure of critical care. The research is based on a qualitative method combining semi-structured interviews, field observations, and documentary analysis. The data, processed using NVivo 12 software, were analyzed using an inductive and abductive approach. The theoretical framework is based in particular on Bose's (2003) model for KM in healthcare and Donabedian's (1966, 1988) model for hospital performance. The results reveal tensions between the need to structure knowledge and the emotional complexity of end-of-life situations, which hinder the fluidity of exchanges. The KM process is highly dependent on the organizational context, leadership, professional relationships, and technological resources. The study highlights that knowledge management in intensive care is not only a matter of formal systems, but also relies on human, emotional, and collaborative practices that are essential to resilience and performance in healthcare.

Keywords
Knowledge management, Hospital performance, Resuscitation, Emotional burden, Leadership, Collaborative practices

INTRODUCTION

In a constantly evolving hospital environment, knowledge management (KM) has become an essential strategic lever for meeting growing demands for quality, safety, and efficiency in healthcare. The rapid pace of medical progress, the emergence of complex pathologies, and the rise of digital technologies require healthcare professionals to continuously mobilize tacit and explicit knowledge in order to ensure relevant and responsive decision-making. In this context, KM plays a central role: it enables the effective structuring, sharing, and application of clinical and organizational knowledge within healthcare institutions.

This need is all the more crucial in intensive care units, which are considered high-risk hospital environments. These units admit patients in critical condition, requiring careful coordination of human and technological resources, advanced technical expertise, and the ability to adapt emotionally to frequent and morally challenging end-of-life

situations. Caregivers are regularly confronted with ethical dilemmas, the suffering of families, aggressive treatment, or dissatisfaction with sometimes controversial collegial decisions. These extreme conditions underscore the need for a supportive organizational environment conducive to learning, knowledge capitalization, and operational implementation.

However, few studies have examined how knowledge is actually managed in these sensitive environments, or the impact this may have on the performance of hospital services. This research aims to fill this gap by exploring knowledge management practices in a Moroccan intensive care unit, highlighting the organizational conditions that influence them, as well as the perceived effects of these practices on hospital performance. By combining the theoretical contributions of Bose (2003) on knowledge management in healthcare and those of Donabedian (1988) on hospital performance (structure, process, results), this study adopts a qualitative exploratory approach in order to better understand the dynamics of knowledge in a critical care context.

The objective of this research is therefore twofold: on the one hand, to understand how intensive care professionals mobilize and transmit their knowledge in a highly emotional and organizationally constrained context; on the other hand, to analyze how these practices contribute, or not, to the overall performance of the intensive care unit. This approach makes it possible to propose an integrated conceptual model that takes into account the complexity of the interactions between the technical, human, and emotional dimensions of knowledge management in high-risk hospital settings.

LITERATURE REVIEW

The knowledge management (KM) system: components and dynamics

Knowledge management (KM) refers to an integrated system of human, organizational, and technological mechanisms that enable the creation, structuring, sharing, and application of knowledge to improve organizational performance. In hospitals, this approach takes on a strategic dimension, particularly in light of the growing complexity of care, the rapid evolution of medical knowledge, and the quality and safety requirements of the services provided.

Alavi and Leidner (2001) highlighted the central role of technology in knowledge management systems, emphasizing that digital platforms facilitate the storage, retrieval, search, and dissemination of knowledge. According to Newell (2015), these systems take various forms—repositories, databases, or collaborative tools—to ensure that knowledge is always accessible. However, effective management cannot be reduced to its technological supports alone: it also requires active interaction between individuals, processes, and organizational culture (EMRO, 2006).

In line with this thinking, Edwards (2015) proposes an integration model in which individuals, technologies, processes, and organizational structure interact in an interdependent manner. Healthcare professionals play a crucial role as creators, disseminators, and users of knowledge, while technology supports capitalization and sharing mechanisms. Processes represent the key stages in the knowledge life cycle—from acquisition to application—and are influenced by the hospital structure (hierarchy, cross-functionality, specialization).

Complementary approaches make it possible to map knowledge according to different logics: procedural (e.g., GAMETH), conceptual (M3C), social (interpersonal networks), or by skill (expert profiles). Eppler (2001) also proposes several types of mapping—expertise, structure, assets, application, or development—that facilitate the identification and promotion of knowledge in organizations.

Bose's knowledge management model (2003)

In the hospital sector, Bose's model (2003) is a key reference point. It views knowledge management as a systemic and iterative process, structured around four fundamental dimensions: knowledge acquisition, structuring, sharing, and application. This process is influenced by several organizational conditions:

- Leadership, which drives a strategic vision of knowledge, supports learning initiatives, promotes the circulation of knowledge, and develops a culture of continuous improvement.
- Organizational structure, whose flexibility, cross-functionality, and matrix configuration facilitate knowledge flows, unlike rigid structures that hinder their circulation.
- Relational capital, both internal (trust-based relationships, informal exchanges, communities of practice) and external (networks, partnerships, institutional anchoring), which determines the quality of interactions and the mobilization of tacit knowledge.
- Technological infrastructure, including hospital information systems, electronic medical records (EMRs), collaborative platforms, and decision support tools, which supports the knowledge cycle through the availability, traceability, and reliability of information.

This model links knowledge management practices to key dimensions of hospital performance, as defined by Donabedian (1966): structure (resources, equipment), processes (protocols, care coordination), and outcomes (quality, safety, satisfaction).

Other reference models: Boisot (1987) and Nonaka (1995)

Boisot's I-Space model (1987) emphasizes the codification, abstraction, and dissemination of knowledge in relation to the organizational context. It highlights that the effectiveness of knowledge sharing depends on the ability to structure data while taking into account its contextual richness. The social learning cycle (SLC) described by Boisot—codification,

abstraction, diffusion, absorption, impact, and digitization—aligns with healthcare organizations' concerns regarding learning and innovation.

Nonaka and Takeuchi's SECI model (1995) also fits into this dynamic, describing four modes of knowledge conversion: socialization, externalization, combination, and internalization.

Analysis of the Bose model knowledge management process (2003)

This circular and dynamic process explains how tacit and explicit knowledge enrich each other to generate collective organizational knowledge. This model is particularly relevant in hospitals, where clinical knowledge is often rooted in informal practice.

In contrast, the knowledge management process according to the Bose model, shown in Figure 1, comprises four main stages that follow on from one another: creating, organizing, sharing, and using knowledge. Each of these stages plays a critical role in sustaining and enhancing the organization's knowledge, as we will see below.

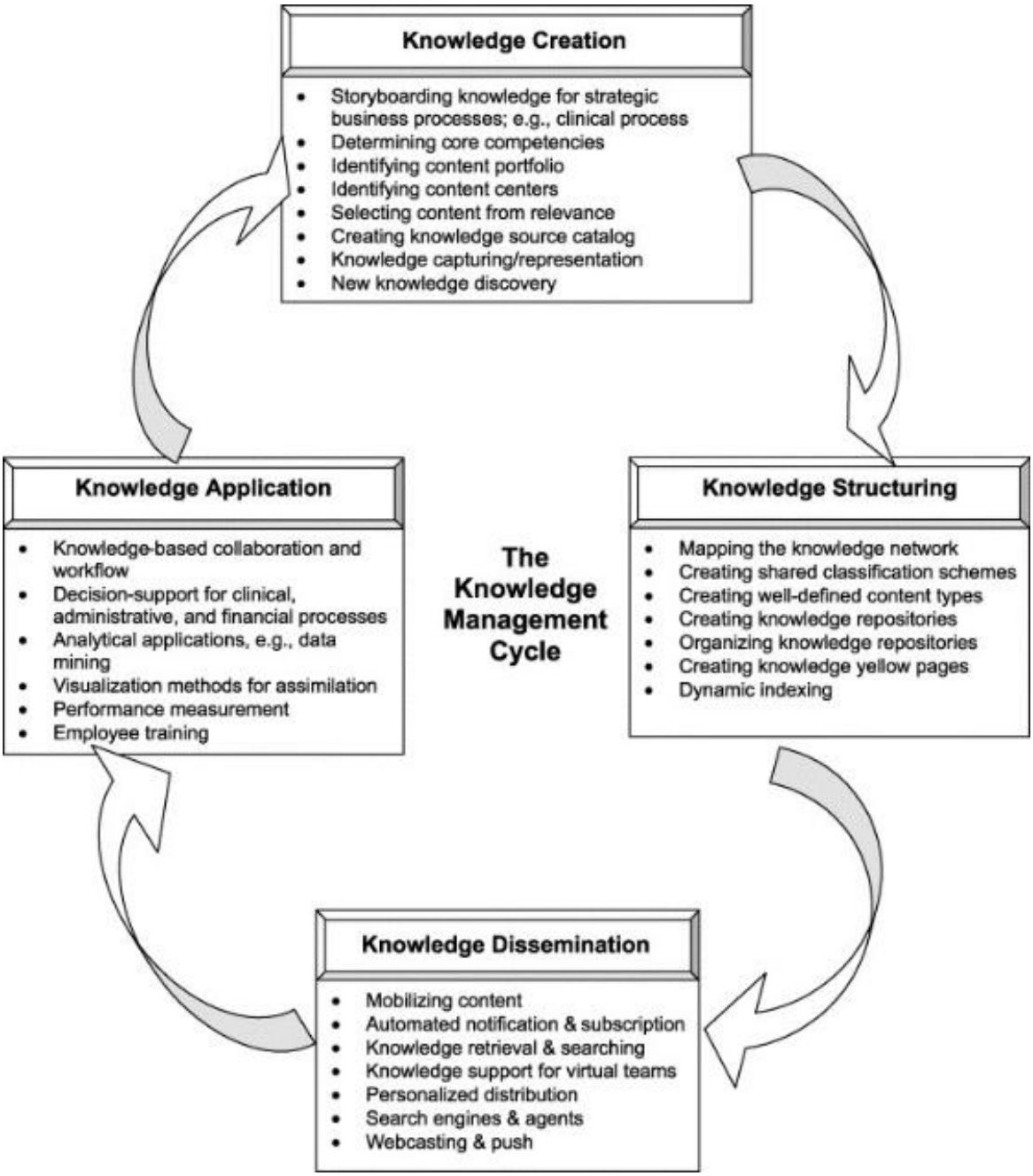

Fig. 1 Knowledge management cycle according to Bose (2003)

The process of creating knowledge relies on both learning and formalizing what we know. This knowledge can come from various sources, such as research and development, the organization's accumulated experience, feedback, or internal innovations. To take full advantage of these resources, reliable methods must be put in place to identify important knowledge, both internally and externally. Once collected, this knowledge must be clearly represented using appropriate tools so that it can be easily processed and used.

The structuring phase aims to organize this knowledge effectively. This involves defining, archiving, classifying, and interconnecting different types of digital resources, such as documents, images, or practical information sheets, by

linking them to specific themes. Mapping knowledge, taking into account its context, importance, and location, helps to create clear categories. Knowledge can then be stored in organized databases, such as expertise directories, skills repositories, or collections of best practices. The key to this is a robust classification system. Each section in an expert directory, for example, becomes an entry in a knowledge taxonomy. This system can be managed manually, automatically, or by combining the two to group content by coherent themes.

The goal is to offer different ways for each user to access knowledge according to their needs and profile. The dissemination or sharing phase, on the other hand, consists of circulating this knowledge throughout the organization and encouraging collaboration among its members. It is based on two complementary ideas: providing access to content when it is needed (pull), or distributing it in a targeted manner (push). The goal is to send relevant and tailored content to each person, taking into account their interests and responsibilities. Sharing best practices is essential, whether through training, intranet platforms, practice groups, internal or external comparisons, publications, or multidisciplinary teamwork. The final step is to use and apply this knowledge to take concrete action. This may mean relying on this knowledge to make decisions, solve problems, optimize human skills by, for example, creating maps to better position profiles, or automating certain repetitive tasks with digital tools. It also includes creating communities of interest, improving customer support, and providing ongoing training to keep everyone up to date and efficient.

Knowledge management as a lever for hospital performance

The global healthcare system faces many challenges in its day-to-day management, such as the emergence of new diseases, the development of innovative treatments, the use of advanced diagnostic technologies, and the rapid increase in medical knowledge. These factors have a significant impact on the quality of care provided to patients. To address these challenges, researchers and healthcare professionals are exploring methods and initiatives to improve the performance of public and private healthcare systems.

Knowledge management appears to be a promising solution to the current crisis in global healthcare systems, improving access, quality, and value of care (Wickramasinghe and Schaffer, 2006). By adopting a structured approach to knowledge management, healthcare institutions can better prepare themselves to meet these challenges. It is crucial to develop improved management techniques and practices through knowledge, while data and information are essential for effective disease management (Wickramasinghe and Geisler, 2010). Implementing a knowledge management strategy in healthcare institutions has many benefits for patients. Indeed, it can positively influence various aspects of healthcare, such as decision-making, patient safety, improving the quality of care, and reducing costs.

According to Abidi (2008), this management aims to provide professionals with relevant knowledge for informed decision-making, leading to better care management. Integrating knowledge into institutional processes, whether tacit or explicit, can help improve the quality and efficiency of health services. According to Handspicker (2018), a knowledge management system based on tangible evidence helps ensure high-quality patient care. Currently, the medical field is booming in terms of knowledge, transforming the healthcare sector into a knowledge-based community. It aims to connect hospitals, clinics, and patients to share this knowledge (Barbosa, 2009). This evolution could lead to a reduction in administrative costs and an improvement in the quality of care (Barbosa, 2009). Researchers have found that decision-making based on knowledge management could help reduce medical errors. Indeed, knowledge management provides support to medical decision-makers, which can reduce errors and their associated costs (Abidi, 2001). To reduce medical errors, rapid and well-organized access to medical knowledge is essential. This knowledge is gathered in an institutional database that compiles experiences, procedures, and the latest advances (Handspicker, 2018; Clover, 2018).

As a result, healthcare professionals can make informed decisions based on their own experiences and those of others in the field (De Brún, 2010). Knowledge management systems enable healthcare professionals to make clinical and medical decisions more efficiently, independently, and in a timely manner (Clover, 2018; Handspicker, 2018). Hospitals are strongly encouraged to adopt knowledge management systems to improve physicians' decision-making in the diagnosis and treatment of patients (Chen et al., 2011). Health knowledge management aims to promote effective practices and minimize the risk of repeated errors by encouraging the sharing of knowledge and experiences among healthcare professionals (De Brún, 2010).

Its goal is to increase the value and effectiveness of healthcare systems by bringing together individuals, technology, and processes to develop, share, apply, and transform knowledge (EMRO, 2006). The WHO emphasizes that knowledge management aims to fill knowledge gaps at the national and international levels (EMRO, 2006).

According to the Association of Public Health Laboratories in the United States (APHL), knowledge management offers many benefits for medical laboratories, including strengthening their reputation, saving time, increasing revenue, and promoting rapid response and early detection of diseases. It also encourages innovation and influences health policy to address new threats in the medical field.

Dr. Al Shorbaji of the WHO emphasizes the importance of knowledge management in strengthening health systems and innovation. It aims to share and utilize the knowledge, technologies, techniques, and tools necessary to improve health systems. Collaboration in knowledge management among health actors promotes innovation, research, and improved quality of care, while reducing costs (De Brún, 2010; El Morr and Subercaze, 2010; Handspicker, 2018).

Knowledge is essential for healthcare institutions, healthcare professionals, and managers on a daily basis. According to El Morr and Subercaze (2010), knowledge management is crucial to ensuring that clinical practices are based on tangible evidence and to promoting organizational learning among managers. Fiol and Lyles (1985) argue that the goal of

knowledge management is to transform a healthcare institution into a learning organization capable of generating new knowledge, developing systems to manage that knowledge, and using it to make organizational decisions (Miner and Mezias, 1996; Driver, 2001; De Brún, 2010; Handspicker, 2018). Knowledge management is also valuable in collaborative healthcare teams, whether multicultural or multinational, to overcome language and cultural barriers and promote communication within these learning organizations (Kisilowska, 2006).

According to De Brún (2010), knowledge management in healthcare institutions has many advantages, such as improving the quality of care, patient safety, and patient satisfaction. It also promotes collaboration between stakeholders, improves outcomes, facilitates team building, and enhances communication with existing IT systems, enabling healthcare professionals to communicate effectively via the internet. Many healthcare institutions, both public and private, have been encouraged to integrate knowledge management models to improve services and patient care, motivated by these multiple benefits.

MATERIALS AND METHODS

Population and research area

This exploratory research was conducted in the intensive care unit of a large Moroccan university hospital, renowned for its intensive critical care activities. The choice of this unit was based on its complex nature, characterized by a high density of clinical information, urgent decisions, and emotionally intense situations. The team studied consisted of four intensive care physicians, 35 nurses, and 21 nursing assistants. These professionals represent a strategic population for understanding the dynamics of knowledge management in high-risk contexts. Data collection took place over a four-month period, between October 2024 and January 2025.

Procedure

Before the fieldwork began, formal approval was obtained from the hospital management and the institutional ethics committee. All participants were informed of the study objectives, confidentiality conditions, and their right to withdraw at any time without justification. Volunteer healthcare workers (doctors, nurses, nursing assistants) were contacted individually and agreed on a time slot to participate in an interview. To ensure freedom of speech, the interviews were conducted in a meeting room outside the department, within the institution's continuing education space.

Collection tool and protocol

The main data collection tool is the semi-structured individual interview, lasting between 60 and 90 minutes. The interview was guided by a thematic grid based on our conceptual framework, structured around the knowledge management process (acquisition, structuring, sharing, application) and its organizational conditions. Healthcare professionals were asked to describe their experiences and perceptions in three main areas:

- Their experience with work organization, including information flows, coordination mechanisms, and access to knowledge in critical situations;
- Their individual and collective management of complex emotional situations, particularly in the face of end-of-life care, decision-making stress, or ethical tensions;
- Their perceptions of the strengths and weaknesses of the current knowledge management system, as well as the improvements they consider necessary to enhance clinical and organizational performance.

All interviews were recorded with the explicit consent of the participants and then transcribed in full to enable in-depth content analysis using a thematic coding method assisted by NVivo software.

Method of analysis

All interviews were recorded with the informed consent of the participants and then transcribed in full for rigorous qualitative analysis. We used a thematic analysis method, as defined in the tradition of qualitative content analysis. This method aims to systematically and objectively highlight the meanings expressed in the participants' discourse through a categorization process based on units of meaning.

The analysis was carried out in several stages. First, each researcher involved in data processing carefully read the transcripts individually to identify emerging themes associated with the different dimensions of the knowledge management process in intensive care (acquisition, structuring, sharing, application), as well as elements relating to organizational conditions and the emotional experiences of caregivers when faced with stressful situations and critical decision-making.

The themes identified were then classified into two categories:

- Main themes: highly developed and recurring in the interviews, revealing dominant representations or those shared by several professionals;
- Secondary themes: mentioned more succinctly or contextually, but offering complementary perspectives on the participants' experiences.

Harmonization meetings were held regularly between analysts to ensure consistency in coding, discuss differences in interpretation, and validate the definition of thematic categories. This collaborative work made it possible to construct a robust coding grid, integrating all the significant units extracted from the corpus.

Finally, partial quantification was integrated into the analysis, indicating for each theme the number of occurrences, i.e., the number of times it was cited by all participants. For this publication, we chose to focus on the most salient themes, those that reflect the most significant dynamics of the knowledge management process in a critical context, as well as their links to organizational issues and perceived hospital performance.

RESULTS

Seventeen healthcare professionals agreed to take part in this exploratory study (13 nurses, 3 orderlies and 1 health executive), including 12 women and 5 men, with an average age of 37.2 years. The majority (11 out of 17) had been working in the department for less than 5 years, while the others had been there longer. They all work in a multi-purpose intensive care unit in a large Moroccan hospital, characterized by intense activity and a high level of technical expertise.
Generally speaking, the interviews revealed a high level of interest among participants in the topics covered, particularly those related to their professional experience, knowledge management (KM) practices, and the impact of the latter on the quality of care.

1. Experience of work organization and knowledge management practices

1.1. An unstable environment and ongoing organizational pressure

All caregivers (17/17) describe a demanding work environment, marked by urgency, cognitive load, time constraints and inter-professional coordination requirements. The mobilization and rapid adaptation of knowledge, whether formal or informal, appear to be a constant challenge. The interviews reveal a tension between the need to apply standardized protocols and the reality in the field, which requires frequent reconfiguration of knowledge. Several professionals mention the difficulty of accessing reliable information in a timely manner:
"Sometimes we waste time looking for information, we ask colleagues, but we don't always have the right reflexes. And yet, in this department, every minute counts."

1.2. The role of tacit experience and informal sharing

The majority of caregivers (15/17) stress the fundamental role of informal learning and peer observation. Knowledge is not only transmitted via manuals or hospital software, but also through accumulated experience and collective adjustments:
"You don't learn how to deal with respiratory distress from the cards. It's by seeing the old-timers do it, by trying, by asking."

2. Emotional feelings about death and the complexity of clinical decisions

2.1. The emotional impact of patient death

The emotional experience associated with frequent deaths, particularly among young patients or in cases of therapeutic limitation, was mentioned by all participants. It is often accompanied by a feeling of helplessness or senselessness:
"When you see a patient you've followed for days leave, you wonder what the point is of everything you've done. Sometimes it just breaks."

2.2. Ethical tensions and feelings of disagreement with decisions

Several caregivers (9/17) report ethical dilemmas linked to situations perceived as therapeutic overkill. The lack of involvement in decision-making reinforces their discomfort:
"We're asked to execute, but when we sense that the person isn't going to make it... we'd like to be heard more."

3. Adjustment strategies and collaborative knowledge management practices

3.1. The importance of peer support

Group dynamics are widely perceived as an essential resource (14/17). Informal exchanges between colleagues play a crucial role in overcoming stress and sharing best practices:
"Talking to each other is like a safety valve. We learn, we put things into perspective, and sometimes, we come up with tricks."

3.2. Lack of formal structuring of knowledge management

Several caregivers (12/17) criticize the absence of a database or centralized clinical knowledge management system. This deficit impacts on continuity of care and collective learning capacity:
"Every time we change teams, we have to start from scratch. What we learned yesterday is not always passed on today."

4. Suggestions for improvement and analysis framework

Participants suggested a number of ways to strengthen knowledge management within the department: reinforce ongoing training (11/17), introduce more regular clinical meetings (13/17), and create supports for capitalizing on experiential knowledge (experience feedback sheets, structured tutoring). Post-emergency psychological support is also deemed essential:
"We should do a debrief after certain cases. It would help to empty the bag, but also to learn."

Analysis framework:

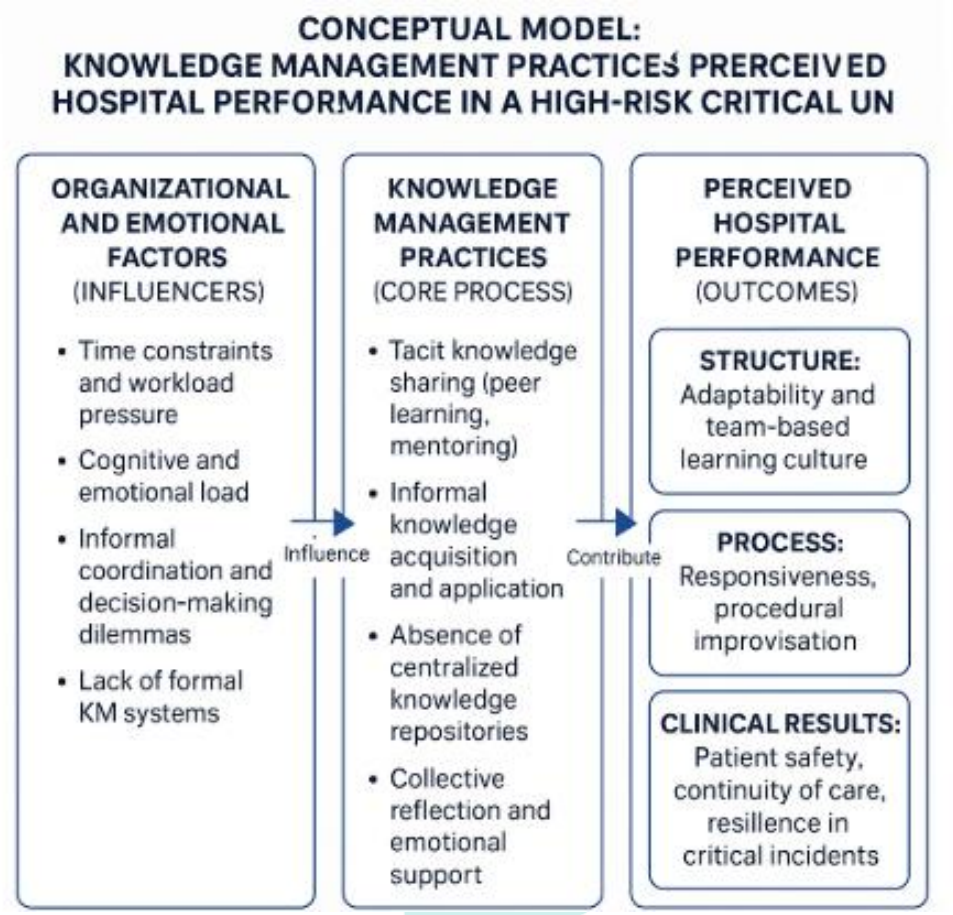

Fig. 2 Conceptual model developing by the author's

DISCUSSION

This exploratory study, conducted among healthcare professionals in a Moroccan intensive care unit, sheds light on how knowledge management (KM) practices manifest, adapt and influence hospital performance in a high-risk context. The results reveal an organizational dynamic marked by a constant tension between clinical demands, emotional constraints and the need for continuous, often informal, learning.

Knowledge management practices dominated by informality and experience

Our results show that knowledge management in this context relies mainly on informal forms: apprenticeship by companionship, oral transmission, peer observation. Knowledge is disseminated by proximity, within a committed collective, but in an unstructured way. This predominance of the implicit - "tacit knowledge" - echoes the contributions of Nonaka and Takeuchi (1995), who stress the crucial role of socialization in intensive learning environments. However, the absence of formalized tools or procedures is a limitation in terms of knowledge capitalization and transfer, particularly when teams rotate or experienced agents leave.

Organizational, human and emotional factors: brakes and levers

Our results identify the factors influencing the implementation of the KM process. Organizational dimensions (workload, access to information, temporality of care) appear to be major obstacles to proactive knowledge management. Similarly, the lack of hierarchical coordination, the absence of time dedicated to collective reflection, and the lack of recognition of nursing knowledge can inhibit sharing dynamics.

On a human and emotional level, affective commitment, confrontation with death, ethical dilemmas and feelings of powerlessness have a strong influence on caregivers' cognitive availability. Yet these same factors can become catalysts for KM when teams organize themselves to exchange, support each other, or learn collectively from critical situations. In this way, psychological adjustment strategies, such as informal debriefings and peer discussion, play an active role in knowledge management, while ensuring a form of professional resilience.

An indirect but real contribution to hospital performance

The data questioned the link between KM practices and perceived hospital performance, according to the structure-process-outcome triad. Although not very formalized, knowledge management contributes to hospital performance on several levels. From a structural point of view, the organization of knowledge (even informal knowledge) enables better adaptation to the unstable context of the intensive care unit. At process level, collectively learned routines improve responsiveness and care safety, despite the absence of documented procedures. Finally, perceived clinical outcomes are

indirectly influenced by caregivers' ability to learn from past experience, collaborate effectively and adjust their practices to critical cases.

However, this contribution remains limited by the absence of a formal KM system. The study thus highlights the urgent need for structured mechanisms to capitalize on, trace and share experiential knowledge. This gap affects not only the transmission of knowledge between generations of caregivers, but also the continuous improvement of care quality.

CONCLUSION AND PRACTICAL IMPLICATIONS

Our qualitative, exploratory study, carried out with caregivers working in a Moroccan hospital intensive care unit, shed light on the concrete manifestations, determinants and perceived effects of knowledge management practices in a high-risk environment. Discourse analysis reveals a professional reality marked by constant organizational pressure, a high emotional load and a strong dependence on the informal circulation of knowledge.

Knowledge management practices, although not very formalized, mainly take the form of tacit learning, collaboration between peers and practical adjustments in the face of clinical emergencies. They appear to be essential mechanisms for collective adaptation in an unstable environment, where standardization coexists with the necessary flexibility of care. However, their effectiveness is limited by the absence of structuring mechanisms for capitalizing on, disseminating and exploiting experiential knowledge.

This research offers a number of ideas for improving hospital performance through better knowledge governance. In particular, it highlights the need to recognize and integrate the emotional and relational dimensions of resuscitation work, which have a direct influence on the circulation of knowledge and the quality of professional practices. It also questions the role of clinical leadership, interdisciplinary coordination and the structuring of sharing processes, in a context where the temporality of action often takes precedence over that of reflection.

Practical implications for hospital governance

The results of this study invite hospital decision-makers to rethink the governance of clinical knowledge along the following lines:

- Institutionalize experience sharing: Set up formal mechanisms for capitalizing on tacit knowledge (feedback sheets, learning circles, tutoring) to secure practices and perpetuate skills within teams.
- Strengthening participative leadership: Encourage more inclusive clinical governance, valuing the voice of caregivers in therapeutic decisions, particularly in end-of-life situations, to reduce the sense of ethical dissonance.
- Development of a knowledge management infrastructure: Create simple, accessible digital tools to store, structure and disseminate knowledge that is useful on a daily basis, while ensuring that it can be traced and updated.
- Taking account of the emotional burden in HR management: Integrating psychological support and debriefing time into institutional routines, to strengthen the individual and collective resilience of care teams.
- Enhancing the value of continuing education and mentoring: Supporting real-life training courses, integrating collaborative learning, clinical mentoring and reflective self-assessment.
- In short, improving knowledge management in high-risk units is not just a matter of technical-administrative logic, but of a global vision of hospital performance, combining organizational efficiency, care safety and professional well-being. These issues deserve to be explored more widely in inter-departmental and inter-institutional comparative research, in conjunction with national policies on quality and safety of care.

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