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Exploring presenteeism among hospital physicians through the perspective of job-crafting

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Abstract

- Purpose

This study seeks a deeper understanding of presenteeism by utilising the perspective of job crafting to explore how a selected group of physicians make sense of their decision to attend work while ill and of their experience of doing so. Job crafting implies that employees not only respond to their job description, but also proactively change tasks, relationships and perceptions in order to experience work in meaningful ways.

- Methodology

A narrative methodological framework involving interviews was adopted to explore the ways in which a selected group of twenty Norwegian hospital physicians engaged in job crafting during presenteeism. The resulting data was analysed using theory-led thematic analysis utilizing the theoretical perspective of job crafting.

- Findings

It was evident that physicians were indecisive and insecure when evaluating their own illness, and that, via task, relational and cognitive crafting, they trivialised, endured and showcased their illness, and engaged in presenteeism in various ways. Furthermore, physicians to some extent found themselves caught in dysfunctional circles by contributing to the creation of a work environment where presenteeism was maintained and seen as expected.

- Future research and implications for management

Future research should address a wider range of contexts, and use longitudinal methods to explore the multifaceted, context-specific and evolving nature of presenteeism and job crafting in more depth. Interventions aimed at countering the negative implications of presenteeism should address the issue from both a social and a systemic point of view.

- Originality/value

The findings extend the current understanding of presenteeism by demonstrating the multifaceted and evolving nature of the ways in which personal illness and presenteeism are perceived and enacted over time.

Keywords: Presenteeism, job-crafting, physicians. Article classification: Research paper

Introduction

The term 'presenteeism' refers to the practice of employees attending work despite experiencing an episode of acute, episodic or chronic illness, with severe or less severe physiological and/or psychological implications (Johns, 2010). There is a wealth of quantitative research on this phenomenon, in which organisational correlates such as organisational policies (Johns, 1997) and job design features (Johansson and Lundberg, 2004) have been identified. There is also evidence that presenteeism causes more aggregated loss of productivity than absenteeism (Collins et al., 2005), which has reinforced the idea that presenteeism is negative for both the employee and the organisation. Hence, there is a gap in the literature when it comes to addressing the multifaceted and dynamic ways in which the phenomenon of presenteeism evolves over time within a specific context (Johns, 2010).

The present study seeks a deeper understanding of presenteeism through an exploration of the storytelling of employees as they make sense of, and enact, work in the event of illness. Sensemaking is an ongoing activity in which individuals retrospectively ascribe meaning to events happening around them, while also facilitating forward action (Weick, 1995). Hence, sensemaking concerns not only discovery and interpretation, but also creation. We utilise the concept of job crafting (Wrzesniewski and Dutton, 2001) to explore the sensemaking involved in presenteeism in a Norwegian hospital context. Job crafting means that employees can proactively change their perceptions of work, relationships at work and work tasks (Wrzesniewski and Dutton, 2001) in ways that are meaningful over time (Berg, Wrzesniewski and Dutton, 2010). Hence, it is assumed that employees not only react or respond to their job description or to the circumstances surrounding their job, but also that they proactively make changes to their job which in turn lay the foundations for future job crafting. This also implies that employees may utilise job crafting not only to make sense of illness, and to enact presenteeism or absenteeism, but also to conceptualise their "ideal" job to include either presenteeism or absenteeism, and restructure their work to fit this ideal.

As new sensemaking is typically triggered by critical incidents, interruption, uncertainty or ambiguity, any of which can prompt a search for meaning (Weick, 1995; Weick, Sutcliffe and Obstfeld, 2005), we assume that an episode of illness leading to presenteeism will trigger job crafting in at least two ways. Firstly, the novelty of an illness episode will trigger sensemaking to allow a decision to be absent or present. Secondly, certain situations and events associated

with presenteeism may trigger sensemaking. For instance, an employee who attends work while sick may experience turning points or breakdowns (e.g. making a mistake as a result of the illness) that call for an explanation or justification of presenteeism.

Many empirical studies suggest that presenteeism is particularly common among hospital physicians and that this behaviour constitutes a normal part of their job (Sendén et al., 2013). The present study will therefore focus specifically on hospital physicians, and we will adopt a narrative methodological framework (Riessmann, 2008) in order to explore job crafting as sensemaking tool in the event of presenteeism. It can be argued that the narrative approach falls within an interpretative framework, rather than the other way round, and that narratives are therefore essentially interpretative (Tsoukas and Hatch, 2001). Hence, the narrative approach of collecting organisational stories (Czarniawska, 1998; Boje, 2001; 1991) was considered particularly helpful as perceptions of illness and the phenomenon of presenteeism are both highly subjective and contextual, and therefore may vary between individuals in various positions and over time. We therefore wanted to allow in our study for the emergence of multiple perspectives and diverse realities, and of past as well as anticipated future events in a hermeneutic parts-to-whole perspective (Barry and Elmes, 1997).

In the following sections, we will provide a literature review where we will firstly explore the concept of job crafting as a tool for sensemaking and storytelling. Secondly, we will provide an overview of the the literature on the phenomenon of presenteeism among hospital physicians in particular. In the methodology section we will elaborate on our methodological framework and our study. Finally, we will present and discuss our findings.

Literature review

Job crafting as sensemaking

In this study, we understand organisations from a sensemaking perspective. Sensemaking has been defined as the social activity in which individuals interpret complex and uncertain cues from the environment, and explain various often novel and unexpected events (Weick 1995; Maitlis, 2005). This implies a social constructionist perspective, where sensemaking is seen as an ongoing activity in which meaning is retrospectively ascribed to events in the present, while simultaneously facilitating forward action. Furthermore, individuals are seen to understand and create their environments concurrently, as interpretation goes hand in hand with action (Weick

et. al., 2005). Following this, we propose that job crafting may be seen as a tool with which employees make sense of, and experience agency in, their work environment and also experience work as meaningful. Job crafting is a context-specific, situated and ongoing activity, and can occur through the adoption of three different but related techniques: task crafting, relational crafting and cognitive crafting (Wrzesniewski and Dutton, 2001). *Task crafting* involves altering the form and number of responsibilities and activities prescribed by a formal job description. This can be done through adding or dropping tasks; altering the nature of tasks; or changing the amount of time, energy and attention that are allocated to various tasks. *Relational crafting* involves exercising discretion over how, when and with whom one interacts while doing the job. Finally, *cognitive crafting* involves changing how tasks and relationships at work are perceived. One way of doing this is through expanding or broadening perceptions of the impact or purpose of the job. Cognitive job crafting can also take place through focusing or narrowing the mental scope of the job's purpose, so that specific tasks and relationships are seen as particularly valuable. Finally, cognitive job crafting may imply linking or making mental connections between specific tasks, relationships, interests or identities that are perceived as being particularly meaningful.

Following the assumption that job crafting implies proactively making changes to work that are meaningful over time (Berg, Wrzesniewski and Dutton, 2010), we argue that employees may also find ways to conceptualise and restructure work in order to include presenteeism. Presenteeism may, for instance, be initially triggered by a wish to avoid putting extra strain on co-workers. On the other hand, it may also imply a greater focus on some tasks than others, with implications for colleagues who have to cover tasks that are undesirable (task crafting). Furthermore, the act of presenteeism may be utilised as a strategy to show co-workers that one can be relied upon, and may hence have positive implications for one's professional identity (relational crafting). Finally, presenteeism may involve the adoption of a mental framework in which work is seen as particularly meaningful and more important than personal health (cognitive crafting).

Hence, the activity of utilising job crafting as a sensemaking tool also has important links to narrative, as human beings inevitably construct stories, imposing a meaningful pattern as the make sense of the world (Laslett, 1999; Syrjälä et al., 2009). This also implies that storytelling is embedded in its context and involves ascribing meaning to situations in both the present and the past, and to events and experiences which are expected to happen in the future. Hence, the

narrator makes sense of the present through recounting and recalling past events and situations, as well as anticipating the future in the light of these events. This also implies that narratives surrounding presenteeism may act as self-fulfilling prophecies, so that presenteeism now may trigger and reinforce presenteeism in the future.

Job crafting was initially considered to be neither good nor bad for the individual or the organisation (Wrzesniewski and Dutton, 2001), although the existing literature appears to focus mainly on the ways in which job crafting may cultivate a positive meaning and identity (Wrzesniewski et al., 2013). We therefore do not know much about the potential negative and dysfunctional dynamics of job crafting. It does appear, however, that although job crafting may have positive consequences for the individuals or groups engaged in it, there may be negative implications such as burn-out for their colleagues who are not engaged in it but who are required to take on more tasks and greater workloads as a result of it (Oldman and Hackman, 2010; Tims et al., 2015). It has also been suggested that job crafting may produce inefficiencies in work processes, due to misalignments between employee behaviour and organisational goals (Oldman and Hackman, 2010). Job crafting has also been associated with increased stress and a sense of regret (Berg, Grant and Johnson, 2010). Finally, it is also worth noting that work that is seen as particularly meaningful, for example as a calling, has been linked to an inherent paradox, in which this sense of purpose, conviction and passion provides employees with a sense of resilience, but also makes them especially vulnerable to challenges that impede their progress (Mitra and Buzzanell, 2017; Bailey and Madden, 2016; Bunderson and Thompson, 2009; Schabram and Maitlis, 2017).

Presenteeism: The case of hospital physicians

Presenteeism has been the object of extensive interest in epidemiology and occupational health, with relatively few contributions within the wider field of work and organisational studies, except for a group of European and UK scholars of management (Johns, 2010). Within the field of work and organisational studies, researchers have mainly been interested in the frequency of the act of presenteeism as a reflection of job insecurity and other occupational characteristics, as well as the effect of presenteeism on productivity (e.g. Worall, Cooper and Campbell, 2000). Within epidemiology and occupational health, major concerns have been medical efficiency and safety as a consequence of presenteeism, as well as costs due to reduced productivity, as employees do not work at full capacity as a result of illness (Collins et al., 2005).

The present study is focused on the area of occupational health, but we still assume that there are also important implications for the wider area of organisational studies and management. We particularly aim to illustrate the multifaceted and social dynamics of presenteeism, in which there is no strict boundary between absence and presence, and where both outcomes are seen as involving a process of sensemaking that may potentially have functional as well as dysfunctional implications for the employee and the organisation. For instance, if work is perceived as being deeply meaningful and joyful, with a work environment characterised by supportive colleagues, absence may not necessarily be seen as the best way to recover from illness.

In the present study we have utilised the dynamic model of presenteeism and absenteeism (Johns, 2010) to understand and explore the phenomenon of presenteeism within the specific context of hospital physicians. Here it is assumed that interruptions, such as health events, will trigger a wide range of evaluations regarding the nature of the illness. The evaluation of illness is therefore seen as subjective, depending on the personal and work-related situation (i.e. the context) of the individual employee, and implies the simultaneous consideration of both presenteeism and absenteeism. Furthermore, this evaluation will not only have implications for the behaviour of the individual employee in the present, but also for the future evaluation of illness and subsequent presenteeism or absenteeism.

Within the context of hospital physicians, presenteeism has typically been found to be associated with organisational and structural pressures, such as difficulties of staff replacement; high workload; pace and pressure; and job insecurity (Hansen and Andersen, 2008; Snir and Harpaz, 2012; Szymczak et al., 2015, Schreuder et al., 2015). In addition, individual and cultural factors have been identified as important. Hospital physicians have, for instance, been found to maintain presenteeism cultures, so that strong loyalty to colleagues and patients implies that they will go to great lengths to fulfil work obligations. Dew, Keefe and Small (2005), for instance, explored the differences between a public hospital and a private hospital and found that the private hospital was characterised by a "sanctuary culture", with a particular prevalence of teamwork-motivated presenteeism. The public hospital, on the other hand, demonstrated more of a "battleground culture", where presenteeism emerged as a consequence of professional identity and institutional loyalty. It also appears that presenteeism can result from the need to uphold a certain professional identity (Van Manen and Barley, 1984), and from the unwillingness of physicians to adopt the role of the patient (McKevitt et al., 1997),

and consequently to call in sick. In relation to this, there are also important links to the literature on impression management, which refers to the behaviours that employees use to shape how they are seen by others, through consciously or habitually trying to create a new desired image or maintaining and protecting an existing image (Bolino et al., 2008). Hence, task and relational job crafting can be seen as ways of engaging in impression management, with the aim of creating the impression of being a dedicated and committed employee, and of achieving goals such as improved social standing, the renewal of employment contracts, and promotion. Furthermore, engaging in impression management does not necessarily entail creating false impressions, as it can also be a means for employees to express themselves in authentic ways. There has not been much research on the implications of deceptive versus authentic impression management, but it appears that authentic impression management can harm the well-being of co-workers (Turnley et al., 2013). Thus, authentic impression management can also have unethical consequences: physicians may be well intentioned, showing themselves to be truly committed employees when they decide to attend work while ill, but this may still have dysfunctional consequences.

Similarly, there is some reason to assume that the pro-social nature of the work of physicians is likely to attract individuals with a calling orientation (Jager, Tutty and Kao, 2017; Yoon, Daley and Curlin, 2017), who see work as particularly meaningful (Horowitz et al., 2003), and are more likely to endure obstacles and "go the extra mile". There is, for instance, evidence that physicians continue to work despite experiencing severe symptoms of burn-out (Thun et al., 2014). There is also some indication that this process can even be initiated before they commence work as professional physicians. Studies have shown, for instance, that medical students display a significant decline in empathy during their third year of medical school, and can develop a cynical attitude to the medical profession over time (Hojat et al., 2009). Some research also indicates that empathy continues to decline during residency training (Bellini and Shea, 2005; Mangione et al., 2002). Hence, there is reason to believe that this decline in empathy and increase in cynical attitudes affect not only the ways in which physicians perceive medical work before they are employed in that role, but also their personal self-image and identity. Furthermore, a general lack of empathy and an increased sense of cynicism can be expected to influence the perception of personal illness, so that, for instance, it is seen as a failure and a sign of weakness. Finally, there is evidence that presenteeism has detrimental consequences not only for the well-being of physicians, but also for work-related outcomes, as it affects recruitment, retention and collaboration between professions (Misra-Herbert and

Stoller, 2004; Heponiemi et al., 2009). Presenteeism also affects the quality and quantity of patient care, for instance through the infection of patients with contagious diseases, medical errors and poor physician-patient communication, with detrimental effects on treatment adherence and patient recovery (Taylor et al., 2007; Virtanen et al., 2009; Rosvoll and Bjertnes, 2001). A large European study of hospital physicians in several countries recently confirmed these findings, but also raised concerns about an apparent inability to change this behaviour (Senden et al., 2013).

Methodology

The study was part of a European intervention research project concerned with the work conditions and health of hospital physicians. The aim was to explore the positive and negative causes and consequences of presenteeism among a group of Norwegian hospital physicians, in order to develop appropriate interventions. We obtained ethics approval from the regional committees for medical and health research ethics (REC) in Noway prior to commencing the study.

Organisations may be viewed as collective storytelling systems in which the narration of stories is an essential aspect of sensemaking (Boje, 1991). The collection of stories therefore represents one way of adopting a narrative approach to understand organisations (Czarniawska, 1998) as narratives not only tell the story of an individual, but also provide information about his or her social environment (Laslett, 1999). Given our theoretical perspective that job crafting is a sensemaking tool, we adopted a method of collecting stories to capture the meaning, construction and actions of hospital physicians who were involved in presenteeism over time. Here we were inspired by the notion of living stories and ante-narratives (Boje, 2014) as we viewed stories as constantly unfolding, rather than having beginnings and ends, a clear plot sequence or coherence. Furthermore, we saw stories as being both retrospective and future-oriented at the time at which they are being told. We were particularly concerned with the subjective and differing interpretations of physicians with different backgrounds, from different specialisms and at different points in their career. Personal stories are particularly suitable tools with which to address the notion of context and the ways in which situations and events unfold over time, as they are embedded in the past, present and future (Barry and Elmes, 1997; O´Connor, 1997). We therefore aimed to capture the process of presenteeism by understanding stories in which meaning is retrospectively ascribed to events in the present, while

simultaneously facilitating future action. Finally, we also wanted to acknowledge the reflexive nature of the research process in which interviewees frame their storytelling in interaction with interviewers, and in which researchers ultimately create their own narratives based on their informants' narratives (Cunliffe, Luhman and Boje, 2004). Hence, we aimed to account for our own backgrounds and perspectives, the potential impact they had on the stories narrated by our informants and the ways in which they were understood by us as researchers.

Interviewees

Twenty Norwegian hospital physicians were interviewed. They were recruited via email and phone through a combination of purposive and snowball sampling (Robinson, 2013). This was because we were aiming for a sample which represented different perspectives on the issue of presenteeism, but also had to be practical in terms of finding physicians who were able to find time in their busy schedules. Throughout data collection we were inspired by the concept of saturation (Bowen, 2008). This meant that we continually brought new interviewees into the study until nothing new would be added and no new insights obtained if we carried out more interviews. We experienced saturation after ten to fifteen interviews, but decided to carry out twenty interviews, to ensure comprehension and completeness.

The sample consisted of physicians from a wide range of specialisms (e.g. internal medicine, surgery and psychiatry), and a wide age group was represented (from 27 to 65 years of age), in order to ensure that the sample included physicians with varying levels of seniority. The sample consisted of eight males and twelve females; half of the sample were undergoing specialist training, while the other half were senior residents.

Interviews

Narrative interviews (Jovchelovitch and Bauer, 2000) were carried out in an attempt to stimulate the interviewees to express their experiences and views on presenteeism by telling the story of their life and career so far. As job crafting was considered to be a sensemaking tool, and that new sensemaking is typically triggered by interruptions and critical incidents (Weick, 1995; Weick, Sutcliffe and Obstfeld, 2005), we adopted the technique of episodic interviewing (Flick, 2000): the interviews were organised and structured around asking physicians to recall and report: (1) situations where they felt ill and had to decide whether to attend work or not; and (2) situations where they had attended work while ill. Here we assumed that: (1) the novelty of the illness episode would trigger job crafting via the sensemaking involved in deciding

whether to be present or not; and (2) that physicians would experience turning points and breakdowns, and hence also job crafting, during presenteeism. We further assumed that recalling and reporting on these events would entail not only a listing of events, but also an evaluation of these events, including how they related to the interviewees' wider experience of everyday work and life, and how the interviewees saw them as being ordered over time (Riessmann, 2008).

An interview guide was prepared before the interviews, but it was designed to be flexible, in order to accommodate emerging topics and modifications. In addition to asking informants to recount episodes of presenteeism, we asked them to provide a description of their educational and family backgrounds; what had led them to a medical career and to their chosen specialism; their current position; and their career to date. They were also asked to describe how they perceived the issue of presenteeism (e.g. "What does it mean to be sick if you are a physician?"). In addition, they were questioned about general perceptions associated with presenteeism in their organisation (e.g. "What are the formal/informal ideals/principles surrounding the issue of sickness presence at your ward?", "What are the consequences of presenteeism?"). Here we were interested in covering both the positive and the negative aspects of presenteeism (e.g. "Can presence while sick potentially have a positive impact on illness?" and "Are there any barriers in the organisation that contribute to presenteeism when you would rather have stayed at home?"), as well as potential measures to alleviate the negative consequences of presenteeism (e.g. "How would you like the issue to be handled in your organisation?").

Interviews were carried out by two project members, a hospital physician and a researcher, in order to acknowledge and utilise the space between the insider (physician) and outsider (researcher) (Dwyer and Buckle, 2009). Here a third space of paradox and ambivalence, conjunction and disconjunction, is assumed. In this space an understanding of the particular context is seen to require an outsider perspective, on the assumption that there is no self-understanding without the understanding of another.

The issue of reflexivity (Cunliffe, Luhman and Boje, 2004) was particularly evident at this point, as we anticipated, from the insider perspective, that informants would want to appear tough and make an impression on the physician interviewer (the insider) through their storytelling (e.g. by exaggerating the severity of presenteeism episodes). We therefore aimed to balance this by having the researcher (the outsider) present during interviews. However, as

the researcher was visibly pregnant when the interviews took place, we were concerned about the ways in which this might have an impact upon the storytelling of the interviewees, in particular that of the obstetricians (e.g. we anticipated that they might hold back certain types of information such as mistakes and critical incidents occurring in the event of presenteeism). However, throughout the interview process both the insider and outsider felt reassured that this was not the case, and we felt that the interviewees were surprisingly open and balanced during the interviews. This impression was also strengthened during one of the interviews, in which an obstetrician described several presenteeism situations when patients were apparently at risk (e.g. *"I'm not sure I'd want to receive surgery from a physician that ill*."). The physician then paused, as if having forgotten that the researcher was pregnant, and said to the researcher: *"You just got really scared, didn't you? To be admitted to the delivery room..?"* testing how what being said was perceived by an outsider.

The interviews took place at the chosen hospital, but outside each interviewee's department. They lasted between 45 and 90 minutes, and were audiotaped and transcribed verbatim by a student assistant.

Data analysis

Following our particular focus on job crafting as a sensemaking tool during presenteeism, we utilised a theory-led form of thematic analysis (Howitt, 2010; Braun and Clarke, 2006) where we utilized job-crafting theory to explore: (1) the decision to attend work or not when ill; and (2) the experience of presenteeism. However, we did not ignore "what gets left out of the themes and taxonomy cages and what goes on between cells" (Boje, 2001, p.125). For instance, the decision to follow this top-down, theory-led approach emerged from the initial inductive data analysis carried out earlier in the project. Here we discovered that, although it was evident that physicians faced immense organisational pressure to go to work, due to issues such as insufficient staffing and working in temporary positions, these issues did not represent the whole picture of presenteeism. We were particularly struck by the fact that physicians were surprisingly insecure and indecisive when it came to evaluating and diagnosing their own illness, and that this represented a stark contrast to the certainty they exhibited in the diagnosis of patients. As a result, this served as the catalyst for a sensemaking process where physicians often ended up disregarding or trivialising the nature and severity of their own symptoms, leading to presenteeism even in cases where they were seriously ill (e.g. in the case of severe infections). Furthermore, following the preliminary analysis, we were under the impression that

physicians engaged in a kind of self-fulfilling prophecy where the phenomenon of presenteeism was taken for granted, and seen as integral to work, and that this in turn led to behaviour that supported and reinforced this assumption over time. We therefore became particularly interested in exploring in depth how physicians engage in this self-fulfilling prophecy over time.

This brought us to the second part of our analysis where we explored cognitive, relational and task crafting as tools for making sense of, and constructing, presenteeism over time. Here, we utilised the five steps of thematic analysis (Howitt, 2010; Braun and Clarke, 2006): data familiarisation; initial coding; generation of themes based on coding; review of themes; and theme definition and labelling. Both authors contributed to the coding process. Firstly, we read through the interview transcripts several times and isolated the passages that related to presenteeism, focusing particularly on the experience of illness, the decision to attend work or not in the event of illness, and the experience of presenteeism. Secondly, we reread the passages and classified those that indicated either task, relational and/or cognitive job crafting into three separate documents. Some sections were placed in more than one category, as the three strategies of job crafting sometimes overlapped. Furthermore, as we had not explicitly asked the informants about task, relational and/or cognitive job crafting, the analysis involved searching for latent content as well as manifest content (Graneheim and Lundman, 2003). Thirdly, we formed a set of codes or categories (the initial coding generation) within each of the three identified categories of job crafting. Finally, we looked for similarities, differences and patterns within the three respective categories of task, relational and cognitive job crafting.

Findings

After analysing the data material, it appeared that the three types of job crafting (task, relational and cognitive) could be related to positive and negative experiences of presenteeism, as well as a sense of being caught in dysfunctional circles, actively contributing to creating a work environment where presenteeism was both maintained and thought to be expected within their work environment. The dynamics of this behaviour and the ways in which physicians engaged in task, relational and cognitive crafting in relation to presenteeism are explored below.

Task crafting

It appeared that the decision whether to attend work in the event of illness was highly dependent on the specific tasks and duties which physicians were expected to perform on the days on which they felt ill, and that most of the time they actively organised their behaviour around those tasks, with the aim of continuing work as if they were well. This meant that, although physicians sometimes slightly altered their responsibilities and activities during presenteeism, it was less about adjusting tasks to their illness (e.g. doing paperwork instead of engaging in patient contact during an infection), and more about finding ways to continue performing their tasks as usual (e.g. engaging in patient contact despite having an infection). Hence, to some extent, presenteeism was seen as an inherent and important part of the job or even as a task in itself. Furthermore, it appeared that physicians made a great effort to find ways of working around their illness, such as wearing protective masks or finding creative ways to carry out their shift despite feeling really ill.

Physician 9: "*Well, I work in the paediatric ward, and you know that your threshold for staying away from work should be extremely low, right. Particularly with infections. It´s really stupid to sit here and say this but you know, I´ve been to work and thought* [...] *and sometimes I´ve said* [...] *'I don´t think I should be close to this patient. I don´t think I should be doing this spinal puncture because I have a cold', and sometimes I´ve worn a gauze mask*."

Physician 11: "*I got my husband to drive me to emergency patient home visits. My reactivity, concentration, that kind of thing, I was kind of scared of myself, it kind of freaked me out, so he drove me so that I could carry out my shift.* [...] *I felt it was irresponsible to drive."*

Physician 20: "*I once had a nurse insert a venous catheter with some anti-nauseants to stop myself vomiting during a nightshift."*

On the one hand, physicians explained that this behaviour was a result of the loyalty which they felt towards their patients, and it was evident that when considering their condition, concern for patients carried more weight than concern for their own health. For instance, when considering their own illness, they would also think about the distance that patients had travelled for a particular procedure, whether they had been on a waiting list before the planned consultation and whether there would be other specialists on the ward who could cover their work. On the other hand, physicians also considered their career path and whether it was important for them to attend a certain procedure or learning situation in order to secure promotion and/or future employment.

Physician 19: "Being at work and not losing out is positive, because in this profession, there's constant development. It´s not the type of job where if you´re away, the work is the same when you get back."

When it came to the experience of actually crafting tasks in the event of presenteeism, it appeared that physicians saw their illness to some extent as having negative implications for their well-being and mental functioning (e.g. feeling exhausted and not being able to focus), something which in turn had implications for the ways in which tasks were carried out (e.g ignoring important symptoms in patients and making the wrong decisions).

Physician 9: *"I was not a good physician at that point. I experienced having a patient who would have been referred for the appropriate treatment more quickly if I had only been more awake*."

Physician 18: *"Well, I´m not sure I would have wanted to receive surgery from someone that ill."*

However, they also experienced that persevering with presenteeism by carrying out work as if they were not ill had a wide range of positive consequences (e.g. it promoted positive self-image and social standing, as we will discuss below in the context of relational and cognitive crafting), something which resulted in physicians arguing that their task crafting was justified in the event of presenteeism (e.g. by claiming that the patient was never really at risk).

On the other hand, physicians also appeared to acknowledge to some extent that by continuing to work while ill (task crafting), they helped to maintain the system of unreasonable demands which surrounded their work. Hence, they saw themselves being caught in a vicious cycle of job demands which was difficult to escape because they themselves actively contributed to it on an everyday basis.

Physician 7: "*We´re not good at delaying work.* [...] *We´re not good at taking the time to do the job properly, so that has consequences."*

Finally, it also appeared that certain responsibilities and activities were not compatible with illness, with the result that some physicians actively and deliberately decided not to attend work while sick. This was typically seen as a coping strategy to avoid long-term burn-out.

Physician 9: "*As a junior resident, shifts were really busy, so you wouldn´t be able to cope with your whole shift, even if you were only slightly sick. Despite having a high threshold for calling in sick, I felt I didn´t have a choice*

[...] *and when I looked at the senior physicians, they looked very tired, and I knew that at least four or five of them had been on long-term sick leave* [...] *so I decided on day one, I´m not having any of those three-month burn-out periods of leave.*"

Relational crafting

The sensemaking process related to the decision whether to attend work was also very much informed by the considerations of colleagues, by their situation and by their potential views on illness and/or absence. For instance, the decision to be absent was informed by a consideration of their colleagues' workload.

Physician 1: "*The most important driving force is the loyalty you feel towards your colleagues. There is this unwritten rule that if you are able to go to work, one way or another, you go, because you know that the workload is really high."*

Physician 6: "*Well, I have gone to work in situations where I couldn't even tie my own shoelaces* [...] *but you have no choice, there's nobody there, everyone is under so much pressure, there are not enough staff, the tempo is so high, in all functions."*

Physician 11: "*It´s not the hospital director I feel sorry for, right, it´s my colleagues."*

Furthermore, the physicians appeared to invest quite a lot of effort in deciding whether an illness was socially "respectable" or "legitimate". "Legitimate" or "respectable" illnesses, where absence was called for, typically included extreme or critical physical conditions such as stroke and cardiac infarction, whereas chronic illness and mental conditions were not considered legitimate reasons to be absent from work. Physicians therefore preferred being "sent home" by colleagues after having gone to work with an illness to calling in sick. In other words, they appeared to rely on the evaluations and judgements of colleagues in order to make sense of their own conditions, and only then to allow themselves to be sick and absent. For the same reason, physicians also preferred returning to work before they were fully recovered, so that colleagues could perceive and assess the reality of their illness, and hence legitimise their absence from work.

Physician 11: "*It's very important to me that people know that my threshold for staying at home is very high. So when I've been absent I try to make sure it still shows that I'm sick when I get back to work."*

In terms of the experience of attending work while ill, it appeared that physicians to some extent interacted with their colleagues and superiors using presenteeism. In other words, presenteeism was a strategy with which the physicians could express themselves and achieve a relational aim. Overall, absenteeism appeared to be frowned upon and seen as a sign of weakness.

Physician 1: *"You´re not supposed to have problems. The threshold for admitting problems is really high."*

Physician 4: "*It´s always noticed if you´re sick a lot. It´s about the impression you give*."

Physician 6: "*You have to show people that you can handle it, that you can be counted on; otherwise your employer won´t take a risk on you; unconsciously it´s at the back of your mind.* [...] *You look up to the others, and I don´t want to be weaker than them."*

Physician 9: *Being sick is admitting weakness* […] *and you don´t want your colleagues to cover the extra workload. If someone is away a lot, it doesn´t take long before people start talking.*

Presenteeism, on the other hand, was associated with immense positive feedback. For instance, it was common on the wards for senior physicians to share stories in which they had worked through a serious medical condition; these stories were then continuously retold in very positive and heroic terms. Hence, presenteeism was associated with positive implications for social standing and professional identity.

Physician 9: *"And then you have these comments being made, that I´m really fed up listening to, like "What? On sick leave while you're pregnant? You know what, when I was pregnant I worked until the last contractions". Or "My waters broke when I was on my shift." And those are the sort of stories that are being told in very positive ways, and that sets a kind of standard in our working environment."*

It was also evident that this reinforced a work environment and culture in which presenteeism was a social expectation, and that the physicians experienced this in both positive and negative ways: positive in the sense that it boosted their social standing, but negative in the sense that it intensified and magnified the expectations and pressures of their work role.

Physician 9: "*We do have a responsibility here: physicians create their own work environments. I mean, it´s about the conditions of employment, your employer and all that, but thinking about the work environment, also about how we refer to colleagues who are off sick."*

Physician 12: *"It´s a self-reinforcing tone in the work environment. It´s a status thing to work until you´re really exhausted. It´s talked about in very admiring ways, sort of a cultural thing, I´m afraid, or rather a negative culture."*

Physician 13: "*I guess we´re a pretty servile group, eager to please in all directions."*

Some physicians opposed these views, however, and reported that they had experienced critical turning points and breakdowns during presenteeism that subsequently led to substantial lifestyle changes (e.g. realising the severity of their illness and experiencing an "aha-moment" because of a patient mistake that led to a change of specialism). However, those physicians still remained ambivalent about these issues and continued to legitimise their illness and absenteeism in different ways (e.g. Physician 11 who had changed specialism and decided to work at a ward with family-friendly work hours, but still made sure that their illness was noticeable when they returned to work after being absent).

Cognitive crafting

The evaluation of illness as a relational undertaking also appeared to permeate their sense of self, their personal experiences of illness and their view of illness. Hence, the evaluation of illness did not only rely on others seeing it as "respectable" or "legitimate". To some extent, illness only became "real" to the physicians when others confirmed its existence.

Physician 14: "*I remember once, when I was feeling really ill, I still went to work, but I had to lie down and rest between each patient. On the bench. I mean, I was really ill. And my secretary was like, "Let´s do some tests. Check your CRP value", and it was above 150, close to 200. So I went home that day. And I´ve often thought about that. I´ve issued medical certificates to lots of patients who were a long way from being that sick, whereas I torment myself in this way. It´s really weird.* […] *It´s a survival instinct that physicians take upon themselves, so it ends up being hard to tell how sick you really are* [...] *so sometimes I have to check with my colleagues: "Can you hear me out, what do you think? Should I start on antibiotics now? I need help, I need someone to hear me out."*

There was also an element of having a certain perspective on illness, and one's illness being perceived in relation to those of other people. For instance, physicians typically considered absence due to their sick children to be more "legitimate" than their own illness. Furthermore, they viewed their own illness in comparison to that of their patients, which was often likely to be more serious than their own, This contributed to a blurring of their perspective on their own illness, and on their perception of its severity.

Physician 15: "*I mean, even if you feel sick, the patients are more sick, and they need your help."*

It was also implied that physicians experienced presenteeism in positive ways: it allowed them to leave their own illness behind and experience work in particularly meaningful and rewarding ways.

Physician 1: *"I did not perceive work as something negative* [during presenteeism] […] *it´s about feeling useful*, […] *focusing on other people´s illnesses, ignoring your own*. […] *Well, I feel it´s good to leave behind the role of a sick person, and to feel that you're giving something back to society. If you stay at home you feel frustrated, and you get way too much time to think, and to notice how you feel*. […] *That´s harder. I feel that going to work doesn't affect my condition in negative ways, and staying at home doesn't improve my condition."*

Physician 12: "*When I´m absent I´m struggling with an intense unease."*

Physician 15 […] *I go to work because I enjoy it.* […] *It´s rewarding.* […] *I mean, life is an uncertain project* […] *I mean the whole thing is a palliative project* [laughing], *so as long as you´re able to work it´s only healthy."*

Physician 18: "*I feel privileged, being allowed to do this kind of work. I feel involved in society, and a sense of obligation when it comes to my work.* […] *I have the competence, and I think we should all do our share. I did not come to this earth to not contribute. I feel joy about it, but also obligation.* […] *I don´t see obligation as something negative.* […] *I mean, the work involves strain, but at the same time it´s meaningful.* […] *I went to work feeling really ill, but then I met this patient who´d been raped several times in Africa, she was a refugee, and, I mean, people deal with war, accidents and all kinds of hardships, and I didn´t realise until later how sick I really was*."

Physician 19: "*It´s like climbing a mountain: it´s hard, but then you make it. You have high expectations for yourself at work.* […] *It´s an obligation*. […] *You take pride in your work.* […] *You have this work ethic ingrained in you*."

On the other hand, the perception that their work required a particular sense of strength, stamina and work ethic, so that it was difficult to admit illness or weakness, was also associated with some negative experiences that were deeply rooted in self-perception and identity.

Physician 12: "*I mean, what does it mean to be sick?* […] *I don´t want to be a person who gives in easily.*[...] *It´s deep-rooted, it´s about standing tall and having a sense of dignity* [...] *but in my experience it can be destructive to have these kinds of expectations for myself, to drag yourself to work when you should have stayed at home. I think it would have been healthier if I could have decided "You know what, I´m feeling really sick and I´ve decided to stay at home" and I'm still a good person.* […] *You know, relying on your achievements to consider yourself a*

worthy person, because it happens actively, this addiction to achievement. […] *I mean, this is all about how we think about this, in our minds*."

However, some of the physicians reported that they actively engaged in mental strategies to change the ways in which tasks and relationships at work were perceived, in order to combat dysfunctional cycles of unreasonable personal expectations and self-contempt.

Physician 14: "*I once read something about burnout among physicians,* [...] *taking care of Number One or something.* […] *I think it's important to find a balance, and some strategies, when it comes to how you respond to certain situations.* […] *For instance, when I wash my hands, I try not to think about where I´m going, what I should have done, or "He´s really sick, he´s not going to make it" and all of these negative thoughts. I try to be present here and now, and it works, I think.*"

Physician 19: "*I choose not to worry about certain things* [*related to work*]. […] *For me work isn't everything, and having kids made me more conscious of that.* […] *I can have a horrible day at work, but then I´m home and that´s where the most important things happen.*"

Discussion

In the present study we aimed to achieve a deeper understanding of presenteeism, by exploring the ways in which hospital physicians make sense of, and act upon, illness and presenteeism. We utilised the concept of job crafting (Wrzesniewski and Dutton, 2001) to explore the sensemaking (Weick, 1995) involved in presenteeism. Job crafting implies agency, so that employees not only respond to their job description, or to the circumstances of their job, but proactively change tasks, relationships and ways of thinking about work. We assumed that hospital physicians may utilise job crafting to make sense of illness, and enact either presenteeism or absenteeism and that they conceptualise and restructure their "ideal" job to include either of those behaviours.

Narrative episodic interviewing (Jovchelovitch and Bauer, 2000; Flick, 2000) was adopted to explore the ways in which hospital physicians evaluated a situation of feeling ill, and consequently decided whether they should be absent, and how they then experienced presenteeism.

It appeared that physicians were extremely indecisive and insecure when it came to diagnosing their own illness, and that this contrasted with the confidence they showed when diagnosing patients. Furthermore, this resulted in physicians trivialising, enduring and showcasing their own illness and engaging in presenteeism. Overall, presenteeism was experienced in positive as well as negative ways. Finally, it appeared that this behaviour also contributed to some extent to a situation in which physicians were caught in a dysfunctional circle, or self-fulfilling prophecy, of actively contributing to maintaining presenteeism as a norm in their work environment.

Job crafting also illuminated the decision-making process involved in evaluating illness, and the experience of enacting presenteeism. It appeared that physicians engaged in task crafting so that they could work around, or even overcome, illness, rather than letting illness define and set boundaries for work. Physicians therefore engaged in a process which allowed their general work situation, tasks and duties to define their illness as a strategy with which they could deal with the insecurity and uncertainty associated with their health situation. They would typically consider the situation of their patients, something that underlines the pro-social nature of their work where patients always come first (Jager, Tutty and Kao, 2017; Yoon, Daley and Curlin, 2017) even when physicians experience exhaustion (Thun et al., 2014).

However, the evaluation of personal illness, and the experience of presenteeism, were also informed by relational crafting, as physicians would carefully consider their colleagues in this process. This happened in three ways. Firstly, they genuinely cared about their colleagues and wanted to avoid absenteeism, to avoid giving their colleagues an excessive workload. Secondly, they were worried about what their colleagues and managers would think if they revealed their illness, and/or engaged in presenteeism. This was in addition to their concerns about the consequences of illness and absenteeism. In general, physicians were worried that this might affect their career trajectories, in particular future promotions and permanent appointments. However, there was also a cultural element to this (Dew, Keefe and Small, 2005), as illness and absenteeism were frowned upon and seen as signs of weakness. In the event of illness and/or absenteeism, it was important that the illness could be defined as “respectable” and “legitimate” in their work environment, something which resonates with the literature on presenteeism cultures. Thirdly, illness and presenteeism appeared to be things which could be “showcased” and utilised to promote a positive sense of self and professional identity. This also implied that presenteeism was also associated with a wide range of positive experiences related to a boost

in social standing, as well as storytelling on their ward, where presenteeism was often presented and socially reconstructed as a heroic act. Hence, physicians appeared to some extent to engage in impression management (Bolino et al., 2008), to build and uphold a certain professional identity (Van Manen and Barley, 1984). Furthermore, it could be argued that the process of engaging in impression management involved an authentic as well as a deceptive element, so that physicians engaged in presenteeism to show colleagues that they cared for them, but also made attempts to exaggerate their illness in front of colleagues (e.g. making sure that the illness was visible when they returned to work, and retelling presenteeism stories from the past). It is also worth noting that physicians were largely aware of this deceptive element (e.g. some were even "fed up" with the stories being told), but still continued to engage in the showcasing of illness and presenteeism, despite experiencing their dysfunctional consequences.

Finally, when considering cognitive crafting, it appeared that physicians did not trust themselves to evaluate their own illness, or that they had somehow lost this ability over time by relying on the confirmation of others, preferably colleagues, in order to allow themselves to be sick. This was mainly due to the subjective nature of illness, which means that it can be difficult to judge whether an illness requires absence from work or not, and to the relative nature of illness, as physicians would consider their illness in comparison to the illness of others, typically patients. There was an element of creating distance from patients and an unwillingness to adopt the patient role (McKevitt et al., 1997). However, the physicians' evaluation of illness and presenteeism also appeared to be rooted in their sense of self and identity, which involved an "*addiction to achievement*" and resentment towards illness, implying that they would actively *"torment"* themselves in order to feel that they were a "*worthy*" and *good person*". There may be several reasons why these perceptions and behaviours emerged, such as the physicians' personality and upbringing. However, it could also have been due to the physicians' education and training, as medical students have been found to display a decline in empathy during medical school and residency training (Hojat et al., 2009; Bellini and Shea, 2005; Mangione et al., 2002). There is therefore some reason to believe that this decline in empathy and increase in cynical attitudes affect not only the ways in which physicians perceive medical work before being employed in that role, but also their personal self-image and identity. Furthermore, a general lack of empathy and an increased sense of cynicism can be expected to influence the perception of one's own illness. This may explain why physicians are particularly hard on themselves, and why they do not want to acknowledge their illness, but instead see it as a failure and a sign of weakness. It may also explain the behaviour and social dynamics of

presenteeism that develop from this perception, with both positive and negative implications for the individual physician and for his/her work environment, so that these perceptions and subsequent presenteeism are reinforced over time. Finally, the decision to work through an illness could also be explained by physicians seeing their work as particularly meaningful (Horrowitz et al., 2003), and even as a calling (Jager, Tutty and Kao, 2017; Yoon, Daley and Curling, 2017), as well as an opportunity to leave their illness behind and improve a health condition, something which contributed to positive experiences of presenteeism.

These findings of the present study develop Johns's (2010) dynamic model of presenteeism, where it is assumed that employees are capable of assessing the severity of their symptoms, as well as weighing up the pros and cons of absenteeism and presenteeism. The present study suggests that the "chain of events" may not necessarily be so straightforward. It also demonstrates that job crafting can have dysfunctional consequences, a finding that is in alignment with previous studies (Berg, Grant and Johnson, 2010; Bunderson and Thompson, 2009). Furthermore, the finding that employees can engage in dysfunctional cycles over time, particularly when experiencing work as being highly meaningful, and as a calling, is in line with existing literature, which has demonstrated that employees who are all initially positively driven by passion and by a dedication to work can follow different paths over time, positive as well as negative, depending on how they cope with challenges in their work environment (Schabram and Maitlis, 2017; Mitra and Buzzanell, 2017; Bailey and Madden, 2016).

Future research and implications for management

We have contributed to the literature by presenting the multifaceted, context-specific and evolving nature of presenteeism in a group of hospital physicians using the perspective of job crafting. However, there are a number of limitations to this research that suggest the possible scope of future research. Firstly, with regard to the phenomenon of presenteeism, and the underlying assumption that employees are capable of evaluating illness, more research is needed to explore the ways in which employees evaluate their symptoms in the onset phase of a health event, and how these evaluations early in an episode of illness can create and reinforce presenteeism over time. Secondly, we only interviewed a selected group of interviewees from this specific work context (hospital physicians). They were recruited through snowball sampling via the author´s network and the recommendations of other participants, so that we may have only recruited interviewees with a particular interest in the topic under investigation. Hence, these findings may not necessarily apply to other contexts, either related (e.g. general

practitioners) or unrelated (e.g. organisations in general). Given that interpretative researchers do not make claims to generalisability, this is not necessarily problematic. However, following the interpretative narrative approach of collecting organisational stories (Tsoukas and Hatch, 2001; Carniawska, 1998), it would still make sense to allow for the emergence of more diverse realities and perspectives (Barry and Elmes, 1997) on the phenomenon of presenteeism. For instance, considering that hospital physicians represent an "extreme" work environment characterised by long shifts and life-and-death situations, it would be particularly interesting to explore the ways in which presenteeism evolves in more "traditional" office environment or in other professions, e.g. in the service industry. The issue of context also applies to us as researchers and the perspectives that we utilised to explore the storytelling involved in presenteeism. This implies that as researchers we ultimately created our own narratives based on the stories being told by informants (Cunliffe, Luhman and Boje, 2004). Hence, researchers who come from other backgrounds and bring other theoretical perspectives may complement our findings and contribute to a deeper understanding of presenteeism. Thirdly, although we used narrative interviews (Jovchelovitch and Bauer, 2000) as our research strategy, in order to capture the evolving and dynamic nature of presenteeism, longitudinal methods may be more suited to documenting the shifting and evolving character of job crafting and presenteeism over time. We therefore suggest that repeated interviews and/or diaries (e.g. Symon, 2006) are utilised in future research, in order to address the evolving nature of these phenomena in more depth.

Given the multifaceted, context-specific and evolving nature of presenteeism (Johns, 2010), interventions aimed at countering the negative implications of presenteeism should avoid the adoption of an individual approach which focuses on the individual employee and his/her personal attitudes and behaviour, but should rather address the issue from a social and systemic point of view, considering, in particular, the implications of presenteeism on productivity and safety (Worall, Cooper and Campbell, 2000; Collins et al., 2005). For instance, the organisation should facilitate a positive working environment, predictable employment and adequate staffing. Furthermore, a formal policy on absence and presenteeism should be in place to minimise the importance of individual evaluations and decision-making with regard to personal health events. Formal and informal modes of leadership are also important ways of avoiding dysfunctional presenteeism. This is particularly the case as presenteeism is closely linked to identity and to professional culture. Hence, employees need positive role models with healthy perspectives and behaviour in relation to illness, absence and presence, in order to outweigh the

influence of potential "self-sacrificing heroes". With regard to physicians in particular, medical schools should address the topic of personal health and illness, and also train future physicians in strategies of self-care to ensure resilience, as part of their curricula.

Conclusion

The present study has explored the phenomenon of presenteeism in new ways by adopting a job-crafting perspective to explore how a selected group of Norwegian hospital physicians made sense of their decision to attend work while ill, and their experiences of doing so. Findings from narrative interviews extend the current understanding of presenteeism by demonstrating the multifaceted and evolving nature of the ways in which personal illness and presenteeism are perceived and enacted among a selected group of hospital physicians. For instance, phsyicians felt very indecisive and insecure when it came to evaluating their illness, and it appeard that they, via the activities of job crafting, trivialized, endured and showcased illness, Furthermore, this led physicians to be caught in dysfunctional circles, through which they contributed to the maintenance of presenteeism as a norm in their work environments. An important implication for management is that negative causes and consequences of presenteeism should not only be recognized and tackled on the individual level, but should be addressed from a social and systemic viewpoint.

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