Physician Parents Attending Work Despite Own Sick Children: A Qualitative Study on Caregiver Presenteeism Among Norwegian Hospital Physicians

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ABSTRACT

BACKGROUND: Studies have shown that physicians manifest a clear duty to work, even in the face of personal risk, and despite their own symptoms of ill health; this is termed presenteeism. We lack knowledge on their willingness to attend work when their children are sick or in times of concern for their unborn; this is termed *caregiver presenteeism*. To gain a comprehensive knowledge on the occurrence of presenteeism among physicians, it is important to include caregiver presenteeism.

OBJECTIVE: The aim of this study is to explore the perception and experience with caregiver presenteeism among hospital physicians who are parents or pregnant and to explore its foundations and its consequences.

METHODS: Secondary thematic analysis of semi-structured interviews of hospital physicians (N = 18).

RESULTS: Positive and negative dimensions associated with (1) situations with severe pregnancy symptoms or responsibility for sick children; (2) the perceived impact on their work commitments, personal health, and adequate care for own children; (3) accompanying moderators in the organisational structure and professional culture; and (4) proposed approaches to resolve caregiver and work responsibilities simultaneously contributing to caregiver presenteeism.

CONCLUSIONS: The study underlines the impact of factors in organisational structure, professional culture, and the personal sphere affecting caregiver presenteeism. It appears that targeting factors contributing to attendance pressure in physicians, including those who are pregnant, is particularly important. This includes changing attitudes towards caregiver responsibilities among physician colleagues, department leaders, and physicians themselves, as well as simple cost-efficient organisational interventions in staffing, routines of absence, and work adjustment.

KEYWORDS: Norway, physicians, hospital, presenteeism, parent, caregiver, qualitative research

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Background

Physicians often manifest a clear duty to work, even in the face of personal risk,[1] and despite their own symptoms of ill health[2-6]; this is termed sickness presenteeism. The persistent high level of presenteeism among physicians[5,7] is fortified by a combination of positive factors, such as job satisfaction, energy, and engagement,[8] as well as negative factors of attendance pressure caused by personal factors, the professional culture, staff shortages, workload, and job insecurity.[2,6] This occurs despite the fact that in Norway and many other countries, paid sick leave is a means to improve employee health and organisational productivity.

Although the extended family is an important source of childcare providers, modern society is transient and many working parents find themselves in unfamiliar municipalities with no relatives around to assist with childcare needs. Accordingly, in Norway, employment is not only stimulated by guaranteed full pay from the first day of illness-related absence for workers, economic compensation for lost work days also acknowledges parental care responsibilities. This includes the statutory right to paid leave to stay at home with sick children, a right to work part-time until the youngest child reaches 12 years of age, as well as subsidised day care for children and other comprehensive parental provisions. These welfare benefits are based on the principle that female participation in the workforce is a precondition in the development of the welfare state and the country's economic performance. To encourage employees, and in particular women, with children to go out to work, Norway and the other Nordic countries have implemented policies that make it easier to combine work and family life.

Accordingly, physicians may have obligations to their own family members,[9] which can act as barriers to both their willingness and ability to work.[10]

Reports worldwide show that a large majority of physicians attend work despite their own symptoms of ill health; therefore,

it is a great concern if this also includes situations when their children are reliant on their physician parents for care when they are sick. We lack knowledge regarding whether this behaviour is prevalent among physician parents, in that they attend work when their responsibilities as caregivers are at a maximum; that is, when their children are ill, when pregnancy symptoms interfere with work productivity or when their unborn is at health risk.

To gain a complete picture of the occurrence and contributing factors of presenteeism among physicians, it is vital to include the impact of family and parental responsibilities in terms of caregiver presenteeism, particularly where unborn and young children are concerned. This is particularly relevant regarding the new generation of physicians, the Millennials and Generation Xers[11] that emphasise flexibility and balance between professional and personal life to meet their responsibilities to their children. A study confirmed that physicians, like other health care workers, felt a duty to work even if there were high risks involved to themselves and their family.[1,12] This increases work-home conflicts, which is one of the key challenges to work-life balance among physicians that differs from workers in general.[13] Unfortunately, work-life conflict is associated with relationship strain and devaluation of the individuals as partners, as well as influencing career decisions, such as intentions to reduce clinical hours or leave the current practice.[14] Accordingly, it is reasonable to assume that physician presenteeism at work when their children are ill can contribute to increased work-life conflicts.

In addition to the new generation of physicians, there is a demographic shift in medicine towards an increased share of women clinicians. This in turn will increase the proportion of pregnant women in this highly demanding profession. Pregnancy is a condition, not an illness that refers to an unhealthy condition/disorder, that requires medical treatment and recovery. However, in the first trimester, almost 70% to 85% of women experience nausea, vomiting, heartburn, back pain, leg cramps, and fatigue.[15] These symptoms can intensify with a lack of rest, together with the high pace of work, increased stress, and nausea may be worsened where smells are prominent.[15,16] Unfortunately, these stressors are characteristic of work conditions in hospital medicine.[17,18] Consequently, work conditions in hospital can promote more severe physical symptoms among pregnant physicians that negatively affect their physical, psychological, and occupational functioning to the same extent as illness and disease.

The impact of being both a hospital physician and a caregiver has not been extensively explored in research on sickness presenteeism among physicians. Although one might be highly dedicated to one's work, being motivated by parental love to put the interests of one's children ahead of all other interests is arguably the defining characteristics of being a parent. In the literature of presenteeism, information is scarce regarding whether physicians' responsibilities towards their young or unborn children – particularly if they are ill – outweigh their responsibilities towards patients. While both parent and non-parent physicians can experience work-leisure conflict, this study examines specifically the interplay between presenteeism while being pregnant or having a sick child, termed *caregiver presenteeism*.

This study aims to gain an in-depth understanding of the phenomenon of caregiver presenteeism among physicians. We wanted to explore its occurrence and relevance and, in addition to identifying contributing factors, its impact and participant's suggestions for interventions to prevent the possible negative impacts of caregiver presenteeism.

Methods

The findings in this article are a secondary analysis from a larger qualitative study that explored factors affecting presenteeism among university hospital physicians.[8] Details on the interview schedule are reported elsewhere.[8] The main study addressed topics related to presenteeim and the conditions that physicians experience when attending work while ill. Addressing these questions, this article explores the components of pregnancy and role as parent in balancing work attendance with caregiver concerns.

Setting

The study took place at a Norwegian University hospital in a large city (population = 180,000) with emergency assignments within a health authority with a population of approximately 715,000 people. About 45% of the physician population at the hospital are female, and 35% are medical residents. A majority of 85% of the physicians are parents, and 45% have children under the age of 6 years.

Hospitals must comply with the Norwegian Working Environment Act (§ 4-6) stating that the employer is obliged to adapt work for employees with reduced work ability. This is relevant to employees with children who are chronically ill, or employees with reduced work function due to severe pregnancy symptoms. In addition, the health trust in this study has incorporated preventive actions for employees in their last trimester, such as exemption from night work and on-call duties, reduced hours of standing, exemption from handling substances that pose a risk to health, and flexible work hours. They can start their maternity leave before term or have extra short breaks.

Participant selection

The participants were invited to join the study by email and phone. To ensure a wide range of contrasting perspectives on the main topic of presenteeism, we included physicians with varying backgrounds in terms of speciality (eg, internal medicine, surgery, and psychiatry) and age (from 27 to 65 years old) to ensure varying seniority. The sample was balanced in terms of gender, participants undergoing specialist training, and senior

consultants. We reached data saturation[19] after 10 interviews, in that no new themes, findings, concepts, or problems emerged. The remaining interviews ensured breadth and depth in the range of opinions and representation on presenteeism; for instance, in relation to gender, speciality, and seniority, as well as contributing to supporting our initial findings.

Data collection

A brief presentation outlining the research was provided to participants. The interviews were conducted as semi-structured and open-ended interviews in a place that was quiet, private, and outside the department where they worked. The interviews were audio-taped, transcribed, and the results were published with the participant's consent.

Permission for this research was granted by authors' Regional Ethical Committee, the hospital's medical association, and the hospital administration. Participation was voluntary and each participant provided their informed consent prior to the interviews. We used pseudonyms and de-identification of data to ensure participant confidentiality. Data were stored as an encrypted file at a separate server that required password and log-on identification.

Data analysis

The recordings were transcribed by student assistants and read by both authors to verify correct transcription. Caregiver presenteeism constituted work attendance in situations of parental responsibility for sick children or concern for the unborn and accompanying pregnancy symptoms. Accordingly, analysis of the transcripts followed the template approach for thematically organising and analysing textual data.[20,21] We identified the data in the interviews that were relevant to one or both of the predefined top-level templates of caregiver presenteeism: (1) pregnancy or (2) parental responsibility. Then, we performed a bottom-up coding of themes, based on examples of topics relevant to one or both of the top-level templates. At the end, we organised the examples into broader secondary codes under each top-level template: (1) the phenomenon that refers to the manifestation and description of caregiver presenteeism being pregnant or caring for a sick child; (2) the impact, which explores how the informants perceived that caregiver presenteeism affected themselves and their interactions; (3) contributing factors of caregiver presenteeism, referring to the interplay among individual, organisational, and cultural factors on the manifestation of caregiver presenteeism; and (4) reporting on proposed actions to reduce the negative impact of caregiver presenteeism. Appendix Table 1 shows the levels and themes in the template.

Initial coding for the top-level templates and examples was carried out by the first author. The construction of the secondary codes and the final template was based on work on the transcripts separately, and agreement between the authors.

Results

The informants comprised 7 males and 11 female physicians, of whom the majority had children (N = 9), 10 had been pregnant, and 1 was pregnant. The 3 informants with no children, of whom 1 female and 2 males, were working with physician parents or physicians who was/had been pregnant. Additionally, 8 were residents and 10 were senior consultants. Because of the small sample size, we omitted details about speciality and department to protect the participant's identity. While data on the interplay of being a parent and calling in sick were provided by parent participants, non-parent participants (N = 4) also shared their insights into this phenomenon. These insights emerged from non-parent participants' experiences of working side by side with physician colleagues who were parents and reflecting on the impact of calling in sick due to children, or female colleagues working with pregnancy symptoms. Most participants (n = 13) had children in day care (age ⩽5, n = 8) or in primary school (age range 6-12 years, n = 8), which qualified the employee to take sick day(s) to care for ill children.

Pregnancy

The phenomenon. Concordant with the occurrence of symptoms in the normal population, when working during their pregnancy most of the female participants had experienced the common symptoms of nausea, vomiting, pelviolysis, sleep disturbances, dizziness, back pain, and fatigue. Disturbingly, many emphasised that the first trimester was challenging in that the inevitably high work pace, night shifts, lack of rest, and heavy workload, in particular, vomiting, intensified these symptoms. This was reported as a period during which they perceived that the organisation had no formal incorporated preventive actions for pregnant employees, beyond taking regular sick leave if their symptoms were affecting their ability to work.

Many explained how they tried to manage their work while struggling with severe pregnancy symptoms. In particular, residents or physicians who were pregnant for the first time went to great lengths to cope with their work (Q1-Q4). In contrast, physicians pregnant for the second time were more likely to prioritise their own and their children's need for care, in their decision to work less or to take sick leave based on experiences from their first pregnancy.

Impact. Although many female physicians emphasised that the symptoms in the first trimester often pass, the interviews revealed the perceived effects of this condition on their work, personal life, and both short-term and long-term effects on their child. First, during this period they explained that these symptoms could have an effect on their work in terms of reduced ability to keep up the work pace, poor concentration and responsiveness, and less endurance (Q5-Q6).

In addition, high stress, lack of sleep, lack of meal breaks and, from time to time, bumps and hits in the stomach from

hospital beds, doors, and exasperated patients raised concerns about the health of their foetus (Q7-Q8).

Many explained that leisure time was mainly spent resting and recovering from the strain of work and pregnancy to be fit for the next work shift, in preference to spending time on other leisure activities (Q9).

Some of the physicians reported long-term personal consequences of this behaviour: although they knew that their behaviour was not necessarily linked to the outcome, female physicians who had experienced miscarriage or had children with chronic disabilities expressed regret for their inability to take care of themselves and consideration of the impact of their work stress on their foetus (Q10-Q11).

Contributing factors. The main factor influencing presenteeism among pregnant physicians was *attendance pressure. Finalising residency* was seen as important for future employment, and financial security when starting a family (Q12-Q13). The significant contribution of attendance pressure was evident in their descriptions of a *professional culture* in which pregnancy and, in particular, pregnancy symptoms, was perceived as reducing the possibility of future *permanent employment*; pregnancy and its symptoms were regarded as a sign of weakness in a culture that emphasised productivity and dedication to the patient and their work (Q14). Most participants, both male and female, reported that the pressure not only to attend, but to fully function at the same level of their healthy colleagues without any allowances for their pregnancy symptoms, was communicated by senior female physicians and some of their leaders (Q15-Q17).

Proposed actions. Presenteeism as a caregiver varied with increased work experience and following permanent positions and advancement to higher positions. Senior consultants, and physicians who had had several pregnancies, expressed more confidence in terms of prioritising their own well-being in their decision to work less or to take sick leave when experiencing severe pregnancy symptoms, based on lessons learned from their first pregnancy, or having gained the security of permanent employment (Q18).

The participants suggested a range of different initiatives that could contribute to a better balance in the first and third trimesters when pregnancy symptoms are more prevalent. They valued the organisation's policy of no night shift duties after the 28th week of pregnancy, as well as performing surgery sitting, taking small breaks, and having flexible work hours for smaller periods, such as coming in later in the morning and leaving work earlier to rest. They emphasised that the advice regarding their options of a leader or a senior colleague was invaluable in this period (Q19).

Parenthood

The phenomenon. The phase with children, in particular when they were ill, was perceived as a stressful period regarding both parenthood and employment. Attending work despite responsibility for a sick child was a situation experienced by all participants, regardless of whether they currently lived with children, had grown-up children, or had no children themselves. Sick children did not only cause parents to be absent from work from time to time, but could start a cycle of nonstop contagion periods between family members causing illness among physician parents. This could cause momentary strain on physician parents, as well as their colleagues without children who often were asked to fill in vacant shifts when these situations occurred. The work-family (WF) conflict increased in situations when children were sick with prevalent caregiver presenteeism.

Although most participants had worked when their children were ill, all participants emphasised that they stayed home more readily with sick children than if they themselves were ill; the latter was perceived as a less legitimate reason to stay home from work. Curiously, having a sick child and simultaneously being ill themselves was perceived by some as beneficial to further their own recovery and allow them to rest (Q20-Q21).

Impact. Their effort to fulfil their work commitments and simultaneously provide adequate care for their children resulted in a variety of more or less successful approaches to resolve this conflict, albeit sometimes at the expense of the child's need for continuous parental care and their own consciences as parents. For instance, though the action was prohibited to prevent contagion of illness among children and staff, most participants said they had sent their ill children to kindergarten as a means to liberate some work time before they were required to pick them up and take them home (Q22-Q23). In addition, many reported that if they had no-one to help and had to go to work, sick children had been left alone at home, part or full time, from an early age (Q23, Q31).

Many reflected on their behaviour as undesirable, in particular for the children in terms of contributing unrealistic expectations of the children's self-worth, their parental capability and obligations; their priorities should have been their responsibilities as parents (Q24-Q25).

Overall, the personal effect of WF conflict caused the physicians to be more irritable at home, and increased their need to recover and rest in their leisure time. As a result, many explained that they had, or were planning to, change their work in terms of changing speciality, reducing their work hours, or changing their (in particular polyclinic) department, or position to avoid working in rotating shifts, to enable a better WF balance for themselves as a parent and for their children (see Q37-Q38).

Contributing factors. It was evident that caregiver presenteeism among hospital physicians was moderated by personal, organisational, and cultural factors. Although most caregiver presenteeism were caused by attendance pressure, many of the participants provided examples of situations where caregiver presenteeism was self-induced and based on their *work engagement, work joy*,

and *ambitions*; for instance, when certain tasks provided new opportunities, learning, and professional development. *Partner's occupation* was important as a source of flexible WF scheduling when children were sick, which contributed to balancing the need to fulfil their work obligations and simultaneously allow proper care for their ill child. Spouses bargained to enable priority to be given to the most significant work tasks; for instance, travelling, level of responsibility at work, mandatory activities, and so on. However, they frequently encountered conflicting responsibilities that caused difficulties in staying home with ill children. In these situations, family, friends, au pair/babysitters, and neighbours were valuable *personal support systems* in providing care for children in their absence. However, many of the participants reported that the period when they had small children often coincided with moving to the city because of work opportunities, leaving their network of personal support behind. The lack of resources in their personal network of support was a source of strain; in particular, when the children were ill.

In terms of *organisational factors*, an important issue was sufficient *staffing* and substitutes to handle the workload at the department. The *type of shift* in outpatient clinics, night, holiday, or weekend shifts affected staffing. Physician parents were reluctant to be away from work in these circumstances because of difficulties of finding substitutes and, most importantly, they did not want to burden colleagues who were also parents (Q26-Q27). This issue was also associated with the *diversity of the workforce*, where age, gender, and seniority were noted as important. Many reported that departments with many employees with childcare responsibilities worked out flexible solutions to arrange for absence when children were ill. This common experience base among colleagues was a positive factor to prevent caregiver presenteeism. In contrast, departments comprising mainly male (senior) physicians often reinforced a culture of attendance pressure where absence indicated a lack of reliability and loyalty to colleagues (Q28-Q29). Unfortunately, sickness absence, even as caregivers, was included in the perceived pool of pros and cons in terms of *future promotion* and permanent position (Q30). Worryingly, some females reported a fear of *discrimination* if they gave priority to a sick child (Q31), which was reflected in statements from male colleagues (Q32). However, most striking was that a group of senior female physicians was reported to be the most explicit in their expressions of the professional attitude of 'putting work before children', prescribing how to behave and prioritise by telling their own experiences and choices and implying the right kind of action (Q15-Q16, Q33).

Culture, lack of staff, and leader philosophy intertwined, and it was difficult to identify the mechanisms of interactions. For instance, lack of a substitute, combined with leadership 'upbringing' within a medical culture, characterised by a high work morale and presenteeism made it difficult for physician leaders, both male and female, to accept absenteeism caused by sick children (Q34). Often in these situations, instead of the leader, colleagues made adjustments and took the responsibility to arrange substitutes and work shift (Q35). Some participants, however, worked or had worked in departments with leaders that acknowledged the need for WF balance and created a flexible culture to allow physicians to attend to urgent personal commitments, including sick children (Q36).

Proposed actions. The participants suggested actions that targeted means within the culture, organisation, and at home that could contribute to simple and cost-effective measures to resolve situations with WF conflicts when children were ill. Undoubtedly, there was both a need to change the culture within certain departments and attitudes among certain leaders to enable them to acknowledge the caregiver responsibilities of physicians as parents and that absenteeism in these situations does not imply fewer qualifications, work effort, motivation, or other core features that constitute a skilled and dedicated employee. In addition, the physicians themselves realised that they had to change their attitudes towards WF balance and prioritising sick children in preference to ill patients and their employer and colleagues. In addition, many respondents recommended changing/reducing work hours when children were young, as they thought this had been successful (Q37-Q38). However, some perceived changing or reducing the hours as adding to the challenges of prioritising sick children, as this was subjected to negative attitudes (Q31, Q39) among physician colleagues.

In addition, the participants suggested simple cost-efficient organisational interventions such as increasing the medical staff with a physician locum who could take over clinical work in cases of high workload or reduced staffing. In addition, instead of automatically registering a whole day's absence when the children were ill, the physicians suggested registering absence by the hour, as many were able to alternate care of the child with their partner. In these situations, the organisational impact of absenteeism, in terms of finding substitutes and altering patient's appointments, was less severe as the physicians often could attend work part time for some days.

Discussion

Physician parents' responsibility for their sick children and unborn presents a wide array of effects on sickness presenteeism that are moderated by personal, cultural, and organisational factors. Many of the symptoms of pregnancy and the WF conflict identified by the participants are probably similar to those experienced by most parents; however, studies are scarce on caregiver presenteeism in physicians. This study contributes to the current literature on this phenomenon, and is necessary, as this behaviour not only affects the physician or the organisation but also the child's health and well-being.

The results show that pregnancy symptoms can impose many demands on female physicians. In particular, high work stress in the first trimester worsened pregnancy symptoms to a

level where the employee could be regarded as ill, and as such sickness present at work. The severity of the symptoms affected their work ability and personal coping, and led to worry about the foetal health and later regrets after miscarriage or having a child with medical problems. On the positive side, studies show that the prenatal period is one of healthy habits and productivity for pregnant physicians equal to their non-pregnant colleagues.[22] However, medical practice is demanding and multiple reports from different parts of the world indicate increase pregnancy complications[23-25] among physicians, due to a variety of potential occupational hazards. Studies suggest that female physicians might be at higher risk of developing pregnancy symptoms and complications due to work stress and psychosocial determinants[15,26-29] because of these occupational hazards.[23,25,30,31] The findings of these studies are, however, contradictory and these relationships have not been verified[32]; nevertheless, they raise concerns about pregnant physicians' work conditions and the health of their foetuses, or strain on the expectant mother, that are verified in this study.

This study has shown that physician presenteeism, despite severe pregnancy symptoms, is mainly derived from pressure not only to attend but also to fully function. Attendance pressure in physicians, including those who are pregnant, is common.[2,3,8,33,34] This study confirms reports that pregnant physicians can experience hostility from their fellow colleagues, especially in a work culture that emphasises efficiency and work commitment.[31,35] This study indicates that pregnancy symptoms can have a negative impact on their physical health and quality of life, as well as family, social, and occupational functioning[31,36] that seems to go unrecognised by their work organisation. According to John's model of presenteeism,[2] the onset phase includes the evaluation of illness and the severity of the health event, which will then dictate how influential the personal or contextual factors will be in the employees decision to be absent or present. However, the study findings suggest that pregnancy symptoms might be disregarded as an illness in the onset phase by the pregnant physician, or by attitudes in the professional culture, though the symptoms have the same impact on work functioning and productivity as other illness. Accordingly, the organisation would benefit by increasing communication to raise awareness about the parallel of pregnancy symptoms and other symptoms of illness and to better follow-up pregnant employees and increase the provision of work adjustments in the first trimester.

With regard to caregiver parental responsibility, all physicians reported situations of presenteeism at work when caring for a sick child, providing a more coherent picture on the occurrence of this behaviour. However, the threshold for staying home with sick children was lower than that for their own illnesses; indeed, some of the physicians indicated they would rather report their absence as being due to a sick child when in fact they themselves were ill, as this is regarded as a more legitimate reason for absence.

In contrast to negative attendance pressure among pregnant physicians, the results were not so unanimous among physician parents. Although many instances of presenteeism was influenced by attendance pressure, occasionally work satisfaction and the desire to be present strongly influenced caregiver presenteeism among physician parents. Concordant with John's model of presenteeism[2] which emphasises the relative influence of positive and negative factors, this study confirms a variety of factors that have shown to promote sickness presenteeism among workers in previous studies and that caregiver presenteeism is not solely a manifestation of a negative phenomenon. For physician parents, caregiver presenteeism could also reflect a positive balance between work and home engagement. In particular, when the physician parent worked in a culture with leaders and colleagues who acknowledged the importance of a WF balance and encouraged a personal support system that enabled shared care and WF flexibility when children was sick. In these situations, the organisations acknowledged and supported the physician's judgement on the need to prioritise personal concerns before work, and work arrangements when the situation warranted work-home flexibility.

Most examples provided by the physicians showed that caregiver presenteeism was caused by attendance pressure derived from a dominant standard/professional culture of dedication and availability, and structural constraints in terms of insufficient staffing and type of shift. Concordant with other studies,[37,38] the divergence between employees' and organisational emphasis on WF balance, and the perceived lack of organisational primacy regarding employees' family responsibilities, combined with high work pressure, influenced work satisfaction and turnover intentions among the physicians. As centrality of work domain among physicians is decreasing,[10,11,39] and the preferences of controllable lifestyle specialities are increasing among male and female graduating medical students,[40,41] the organisation would benefit by encouraging increased work flexibility among physicians, both as a recruitment strategy and to ensure efficient use of a diverse medical workforce.

Limitations and concluding remarks

This study sample is Norwegian. Although pregnancy is the same biological concept for all women, culture has a big say on how the physiological signs and symptoms of pregnancy are interpreted[42] and in turn on the perception of caregiver presenteeism. Pregnancy can be regarded, on one hand, as a medical event where consulting a physician is the given norm. In contrast, other cultures may expect women to go through pregnancy and childbirth without expressing any of the pain or side effects they are feeling. Cultures will also vary in the degree to which restrictions and facilities are put in place to ensure restitution and rest for pregnant women or to protect the unborn and the pregnant. Accordingly, we have included information on the national and organisational framework to emphasise the context of the

current sample. The results reported in this study must be read with cultural differences in mind. In Norway, the welfare system provides compensation for parents with chronically ill children with care demands at home or in an institution, as well as in need of hospital treatment, until the child is 18 years old. However, the informants did not provide examples or experiences of caregiver presenteeism for children between 12 and 18 years of age.

The participants in this study represent a selected sample that might have been more reflective than the average physician and more willing to expose personally demanding situations and/or situations where their personal and children's health and recovery might have been compromised. However, we have no reason to believe that the experiences of our participants differ from those of their colleagues, only their willingness to recount these experiences. The sample included specialists in psychiatry and somatic medicine. The disadvantage of not including a variety of sub-specialists is, of course, that we might have missed out interesting differences between specialities. However, the main aim was to explore the phenomenon of caregiver presenteeism where third-level themes illustrated its variety and complexity. Speciality could be a relevant topic to investigate further in a more quantitatively driven study of caregiver presenteeism that enables hypotheses and theoretical assumptions to be tested and developed to gain a better understanding of the topic.

Although pregnancy is a natural biological condition, the side effects of pregnancy and their severity can overlap with symptoms of illness that require treatment and affect those who are pregnant, their work production, and their productivity. However, how the organisation and the pregnant respond to symptoms of pregnancy can be different from their response to illness, as they have 2 different 'origins'. This could be the reason why we lack systematic research on caregiver presenteeism in studies of sickness presenteeism.

This study has found that caregiver presenteeism occurs as a part of, or in addition to, own sickness presenteeism among physicians. Accordingly, it is important that caregiver presenteeism is included in future empirical research on sickness presenteeism. Only then will we be able to create a comprehensive synthesis of the dynamic relationship among different organisational, personal, and cultural factors that contain both positive and negative correlates and consequences of presenteeism.

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Author Contributions

FG was responsible for the data collection. LTL is the project manager and principal investigator of this study. Both authors analysed, interpreted the data, and contributed in writing drafts of the manuscript. Both authors read and approved the final version of the manuscript.

Availability of Data and Materials

Please contact project manager and corresponding author regarding availability of data and material from the project.

Ethical Approval and Consent to Participate

The hospital administration and Regional committees for Medical and Health Research Ethics approved the study (ref no. 2013/1355). All participants received and signed an informed consent form prior to the interview.

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Appendix

Table 1. Template levels and themes with sample quotes.

PARENTHOOD			
THE PHENOMENON	IMPACT	CONTRIBUTING FACTORS	PROPOSED ACTION
Q1: *I vomited a lot and attended work with a Coke in my pocket. I remember when having critical situations, I managed but then I vomited afterwards (No. 82).* Q2: *… being pregnant is perhaps not a disease, but that is when I felt the sickest (No. 88).* Q3: *Before I became pregnant, I thought that I would be in great shape. I was relying on that. That is what I had experience with, you know. But the second time I was even worse, actually. I was just lying in bed for a long period with as little light and sound disturbance as possible. Not eating. So needless to say, you are not contributing much [at work] (No. 88).* Q4: *I've had pregnant colleagues who obviously have been very dizzy with low blood pressure and shouldn't be at work (No. 91).*	Q5: *During that period when I was really ill I spent more time at work than I really feel I should have. It was my reactivity, inability to concentrate and things like that that made me a little scared of myself. I found it a bit scary. It was very unpleasant (No. 88).* Q6: *I think that if I really believe I would have represented a danger to the patient, then I would not have done it [gone to work pregnant, suffering from extreme nausea and vomiting]. However, I am not sure I myself would have wanted to be treated by such an ill person (No. 96).* Q7: *And I remember an episode where I needed to perform an emergency caesarean. It was so critical with little time. I remember, the [hospital] bed was thrown right into my stomach (No. 82).* Q8: *I've been working 24-hour shifts, having eaten nothing, had three patients at 3, 4 and 5 am, and vomited between every patient. Because I've been pregnant. I've done that several times (No. 96).* Q9: *It was pretty exhausting to be working full time. So, in retrospect, I might well have worked a little less. Because I was so tired when I came home from work and spent the rest of the day recovering (No. 82).* Q10: *I've been thinking that about pregnancy; if one pushes oneself, and then something happens. Then I think it would have been so painful to go around thinking for the rest of my life that … 'Was it because I worked far too much that I had a miscarriage, or was it …' Right? You can have a miscarriage anyway, but what if you didn't push yourself too hard and triggered it (No. 93).* Q11: *During my first pregnancy, and actually also the second: even though I vomited on every shift, I completed all my shifts until week 28. When I have exemption from shift. And I regret that a bit now, because I don't know whether that could be the reason I have a [chronically] sick child (No. 97).*	Q12: *I couldn't have applied for work then, before I had completed my internship and passed, so then I probably would have gone for a longer period without a salary, and obviously, that's got financial implications too (No. 88).* Q13: *I was to try to complete my education. I had to become a specialist (bangs the table). I had to do that. Not wait too long. After all, I was going to stay at home for an entire year during maternity leave, so I should try to accomplish as much as possible before that (No. 82).* Q14: *have experienced myself when getting employed being questioned about my civil status and if I plan getting pregnant and such things. It felt uncomfortable. I have also had colleagues who haven't had their temporary contracts prolonged, because they have been pregnant. So it is definitely a problem. Some departments where they almost exclusively hire young men as residents. Because it's so difficult with 'these women, who become pregnant all the time' (No. 91).* Q15: *Pregnant employees, who get to hear from their senior female colleagues: 'What? Are you on sick leave when pregnant? I myself worked until the contractions started. Worked my shifts till the waters broke'. Such stories being talked about in a very positive way. Like everything was better before. That sets a sort of standard in the work environment (No. 86).* Q16: *The women were the worst. Women at 50-60years. Sure, that's where that comment comes from. They have gone with a walker to work, suffered from pelvis instability, and still attending. They only compare to oneself (No. 88).* Q17: *Our boss has a term, Little Parsley that is being used about those who are perceived a little weak, who is away from work a lot, complains a lot, or a pregnant woman who has pain here and pain there. It's a well-known term. And you do not want to be Little Parsley (No. 97).*	Q18: *If I were pregnant now? Then I simply would have called in sick. I would have said, find a substitute and hire him or her temporarily. There is something about the first time [of pregnancy], isn't it? You are very vulnerable when you are doing your internship (No. 88).* Q19: *I think that if somebody had taken a different approach, talked to me, explained and sketched out the possibilities of finalising my internship. Such as 'If you're short of five shifts, then there's no problem finalising those when you are back from your maternity leave' (No. 88).*

(Continued)

Table 1. (Continued)

PARENTHOOD			
THE PHENOMENON	IMPACT	CONTRIBUTING FACTORS	PROPOSED ACTION
Q20: *At times it has been nice to be home with sick children. Because when I have been tired and half sick myself I have rested on the couch where the children slept. Then it's been nice to be home. But I have reported is as absence due to 'sick child' (No. 82).* Q21: *I do believe that some of those times I've reported absence due to a sick child, I have been home myself, [ill] also, sort of (No. 88).*	Q22: *I have heard it from the kindergarten, yeah. That I sent the kids there when they were sicker, more than other parents. They have called me sometimes, with a sort of annoyed tone and said that you must come and pick them up (No. 88).* Q23: *I've often been annoyed; they call from the kindergarten, saying, 'Oh, your daughter is so tired'. You would think they could let her rest on the couch for a few hours until I come and get her […] I guess the kids have gotten quite used to taking care of themselves. Basically. They've looked after each other a lot, and helped each other. They had to get used to, from an early stage, that they had to be home alone, at least for half of the day if they were otherwise ill, they were from quite early on, alone (No. 89).* Q24: *One reflects quite a lot upon what makes children the way they are. The upside of that is that they perhaps become a bit tougher. The downside is perhaps that some children feel an enormously high expectation pressure if they do not manage being sick on their own […] What I find very interesting about that is this; reflecting upon what it is that makes you sort of a worthy human being. Because I think, some transitions are not always that clear, concerning which signals we give to ourselves as well as to our children (No. 89).* Q25: *Then (sent a sick child to the kindergarten) I thought that this time I might be crossing the line. When I push my children to go to the kindergarten with a fever. One thing is to be hard on oneself, but I am not proud of trying to make the children hard. I don't think that's right. At that time, I felt I was crossing a line (No. 100).*	Q26: *If the absence [because of a sick child] is related to a shift, then it is very unpopular. It is a bit: 'Could you not attend if …' (No. 78).* Q27: *It is always hectic and then you know that they are short on staff. So you know that if I don't come today, the other person for sure has to work overtime. And you know them, and that one of them might want to attend that parental meeting. And you know that if I am absent, your colleague must work overtime and then she'll have to stay until 7 pm. So there I think you have the main reason for having a high threshold for staying home from work (No. 88).* Q28: *Like when I was at department XX, I didn't hear once during two months that any of the physicians was absent due to a sick child. And there were a lot of male doctors there. Male doctors…who I think had wives who did most of the caring for the children (No. 86).* Q29: *These senior consultants who were sort of 5,6,7,8 years ahead of me, they, like, could sit there till 8 pm every evening. But I'm thinking this; then I can't be here. Then my family life goes. And it doesn't work. That's the advantage of younger colleagues, because they don't accept that either. They also want to go home on time, and luckily, the men want that largely (No. 93).* Q30: *When you don't have a permanent position, it's very easy to think that you want to avoid every little thing that can seem negative. That goes for overtime, if you are sick a lot, if you stay away from other things, if you need to ask for help a lot. One wants to be independent, solve the problem, right, show that you are good at this (No. 86).* Q31: *I don't dare stay home from work. It's because I don't feel safe that I'd be attended to by my employer. And I have heard them talk so much shit about other girls being sick, so I assume, that if I'm sick, they will talk the same way about me. I haven't stayed home with him one day since he started school. He has been ill. But mostly he stays at home alone when he's ill. And when the children are ill, and in afternoons and evening, I'd prefer to stay home with them. It hurts me to not be able to stay home. Now I've hardly been home with sick children at all during my career. But it hurts me to leave them. I'd rather have stayed home (No. 36).* Q32: *So if my boss had asked: Would you prefer her with two sick kids or do you want him, who has worked for 10 years and been in good health. Fully motivated and that. I would perhaps have chosen the colleague whom I know is motivated and whom I know could take some work off my shoulders (No. 99).*	Q37: *And that is of immense importance for your family situation. To be able to leave. Not to have to stay when there is overdue work, when something happens, when you stand there with a patient, right. You can't just drop it because, 'Oh, kindergarten is closing'. You have to stay there till somebody else takes over. That is a major difference, and that's the reason why I've chosen the way I have. To get more time at home. To have that opportunity (No. 88).* Q38: *Being ill is one thing. Something else is having small children and being tired and sleeping too little. Considering that I think that perhaps most employees who have small children should be offered the opportunity to work a little less. I think that would be reasonable (No. 82).* Q39: *Some stepped down because they had three small children. A result of that was that they did not get their positions extended, and talk amongst colleagues. One became unpopular, simply. Yes. Bullied. In the canteen when you are talking about someone who's not there (No. 82).*

Table 1. (Continued)

PARENTHOOD			
THE PHENOMENON	IMPACT	CONTRIBUTING FACTORS	PROPOSED ACTION
		Q33: *Yes, throughout the years we have heard stories from colleagues who brought their kids with them on their night shifts and put them to sleep there, when they were called in at night. Or who abandoned sick children and had to ask the neighbour to look after them and such things. Oh, it's a bit heroic, to have such stories to tell then (No. 97).* Q34: *It's kind of uncomfortable to experience oneself, but I see now that I sometimes appear a bit like my superiors when I was 20 years younger, that they become a bit, like, bitchy. A bit like 'Ah, you should have tried, seen what it was like when we were young. We worked much more, and it was much harder, and now you ought to stop complaining'. When we appeared on shift, and placed our children at emergency because they were sick. Because we believe we have worked so hard ourselves, that we deserve to like … Kind of that contempt for weakness. 'You are now 30 years old and at your best age, you really should be able to handle a fair bit'. There's quite a bit of that (No. 89).* Q35: *There was an episode quite recently where there was a woman who had a boy who was to start kindergarten, and that was not ok (for the manager) at all, who talked about it being in the middle of the holidays in addition to them being short on staff. Then the rest of us managed to adapt, 'sure, we'll ask someone from the other department to, we'll improvise and sort it out' (No. 82).* Q36: *At (department X) and (department Y) you could say there are two extremes. It's a complete different environment. At department X perhaps the work pressure is higher, more grave decisions, but they still manage to maintain a much more collegial atmosphere (No. 86).*	