



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

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

Qualitative Research in Organizations and Management

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

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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

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3 with presenteeism may trigger sensemaking. For instance, an employee who attends work while
4 sick may experience turning points or breakdowns (e.g. making a mistake as a result of the
5 illness) that call for an explanation or justification of presenteeism.
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10 Many empirical studies suggest that presenteeism is particularly common among hospital
11 physicians and that this behaviour constitutes a normal part of their job (Sendén et al., 2013).
12 The present study will therefore focus specifically on hospital physicians, and we will adopt a
13 narrative methodological framework (Riessmann, 2008) in order to explore job crafting as
14 sensemaking tool in the event of presenteeism. It can be argued that the narrative approach falls
15 within an interpretative framework, rather than the other way round, and that narratives are
16 therefore essentially interpretative (Tsoukas and Hatch, 2001). Hence, the narrative approach
17 of collecting organisational stories (Czarniawska, 1998; Boje, 2001; 1991) was considered
18 particularly helpful as perceptions of illness and the phenomenon of presenteeism are both
19 highly subjective and contextual, and therefore may vary between individuals in various
20 positions and over time. We therefore wanted to allow in our study for the emergence of
21 multiple perspectives and diverse realities, and of past as well as anticipated future events in a
22 hermeneutic parts-to-whole perspective (Barry and Elmes, 1997).
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34 In the following sections, we will provide a literature review where we will firstly explore the
35 concept of job crafting as a tool for sensemaking and storytelling. Secondly, we will provide an
36 overview of the the literature on the phenomenon of presenteeism among hospital physicians
37 in particular. In the methodology section we will elaborate on our methodological framework
38 and our study. Finally, we will present and discuss our findings.
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45 Literature review

46 *Job crafting as sensemaking*

47 In this study, we understand organisations from a sensemaking perspective. Sensemaking has
48 been defined as the social activity in which individuals interpret complex and uncertain cues
49 from the environment, and explain various often novel and unexpected events (Weick 1995;
50 Maitlis, 2005). This implies a social constructionist perspective, where sensemaking is seen as
51 an ongoing activity in which meaning is retrospectively ascribed to events in the present, while
52 simultaneously facilitating forward action. Furthermore, individuals are seen to understand and
53 create their environments concurrently, as interpretation goes hand in hand with action (Weick
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3 et. al., 2005). Following this, we propose that job crafting may be seen as a tool with which
4 employees make sense of, and experience agency in, their work environment and also
5 experience work as meaningful. Job crafting is a context-specific, situated and ongoing activity,
6 and can occur through the adoption of three different but related techniques: task crafting,
7 relational crafting and cognitive crafting (Wrzesniewski and Dutton, 2001). *Task crafting*
8 involves altering the form and number of responsibilities and activities prescribed by a formal
9 job description. This can be done through adding or dropping tasks; altering the nature of tasks;
10 or changing the amount of time, energy and attention that are allocated to various tasks.
11 *Relational crafting* involves exercising discretion over how, when and with whom one interacts
12 while doing the job. Finally, *cognitive crafting* involves changing how tasks and relationships
13 at work are perceived. One way of doing this is through expanding or broadening perceptions
14 of the impact or purpose of the job. Cognitive job crafting can also take place through focusing
15 or narrowing the mental scope of the job's purpose, so that specific tasks and relationships are
16 seen as particularly valuable. Finally, cognitive job crafting may imply linking or making
17 mental connections between specific tasks, relationships, interests or identities that are
18 perceived as being particularly meaningful.
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32 Following the assumption that job crafting implies proactively making changes to work that are
33 meaningful over time (Berg, Wrzesniewski and Dutton, 2010), we argue that employees may
34 also find ways to conceptualise and restructure work in order to include presenteeism.
35 Presenteeism may, for instance, be initially triggered by a wish to avoid putting extra strain on
36 co-workers. On the other hand, it may also imply a greater focus on some tasks than others,
37 with implications for colleagues who have to cover tasks that are undesirable (task crafting).
38 Furthermore, the act of presenteeism may be utilised as a strategy to show co-workers that one
39 can be relied upon, and may hence have positive implications for one's professional identity
40 (relational crafting). Finally, presenteeism may involve the adoption of a mental framework in
41 which work is seen as particularly meaningful and more important than personal health
42 (cognitive crafting).
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52 Hence, the activity of utilising job crafting as a sensemaking tool also has important links to
53 narrative, as human beings inevitably construct stories, imposing a meaningful pattern as the
54 make sense of the world (Laslett, 1999; Syrjälä et al., 2009). This also implies that storytelling
55 is embedded in its context and involves ascribing meaning to situations in both the present and
56 the past, and to events and experiences which are expected to happen in the future. Hence, the
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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).

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3 The present study is focused on the area of occupational health, but we still assume that there
4 are also important implications for the wider area of organisational studies and management.
5 We particularly aim to illustrate the multifaceted and social dynamics of presenteeism, in which
6 there is no strict boundary between absence and presence, and where both outcomes are seen
7 as involving a process of sensemaking that may potentially have functional as well as
8 dysfunctional implications for the employee and the organisation. For instance, if work is
9 perceived as being deeply meaningful and joyful, with a work environment characterised by
10 supportive colleagues, absence may not necessarily be seen as the best way to recover from
11 illness.
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20 In the present study we have utilised the dynamic model of presenteeism and absenteeism
21 (Johns, 2010) to understand and explore the phenomenon of presenteeism within the specific
22 context of hospital physicians. Here it is assumed that interruptions, such as health events, will
23 trigger a wide range of evaluations regarding the nature of the illness. The evaluation of illness
24 is therefore seen as subjective, depending on the personal and work-related situation (i.e. the
25 context) of the individual employee, and implies the simultaneous consideration of both
26 presenteeism and absenteeism. Furthermore, this evaluation will not only have implications for
27 the behaviour of the individual employee in the present, but also for the future evaluation of
28 illness and subsequent presenteeism or absenteeism.
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37 Within the context of hospital physicians, presenteeism has typically been found to be
38 associated with organisational and structural pressures, such as difficulties of staff replacement;
39 high workload; pace and pressure; and job insecurity (Hansen and Andersen, 2008; Snir and
40 Harpaz, 2012; Szymczak et al., 2015, Schreuder et al., 2015). In addition, individual and
41 cultural factors have been identified as important. Hospital physicians have, for instance, been
42 found to maintain presenteeism cultures, so that strong loyalty to colleagues and patients
43 implies that they will go to great lengths to fulfil work obligations. Dew, Keefe and Small
44 (2005), for instance, explored the differences between a public hospital and a private hospital
45 and found that the private hospital was characterised by a “sanctuary culture”, with a particular
46 prevalence of teamwork-motivated presenteeism. The public hospital, on the other hand,
47 demonstrated more of a “battleground culture”, where presenteeism emerged as a consequence
48 of professional identity and institutional loyalty. It also appears that presenteeism can result
49 from the need to uphold a certain professional identity (Van Manen and Barley, 1984), and
50 from the unwillingness of physicians to adopt the role of the patient (McKevitt et al., 1997),
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3 and consequently to call in sick. In relation to this, there are also important links to the literature
4 on impression management, which refers to the behaviours that employees use to shape how
5 they are seen by others, through consciously or habitually trying to create a new desired image
6 or maintaining and protecting an existing image (Bolino et al., 2008). Hence, task and relational
7 job crafting can be seen as ways of engaging in impression management, with the aim of
8 creating the impression of being a dedicated and committed employee, and of achieving goals
9 such as improved social standing, the renewal of employment contracts, and promotion.
10 Furthermore, engaging in impression management does not necessarily entail creating false
11 impressions, as it can also be a means for employees to express themselves in authentic ways.
12 There has not been much research on the implications of deceptive versus authentic impression
13 management, but it appears that authentic impression management can harm the well-being of
14 co-workers (Turnley et al., 2013). Thus, authentic impression management can also have
15 unethical consequences: physicians may be well intentioned, showing themselves to be truly
16 committed employees when they decide to attend work while ill, but this may still have
17 dysfunctional consequences.
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31 Similarly, there is some reason to assume that the pro-social nature of the work of physicians
32 is likely to attract individuals with a calling orientation (Jager, Tutty and Kao, 2017; Yoon,
33 Daley and Curlin, 2017), who see work as particularly meaningful (Horowitz et al., 2003), and
34 are more likely to endure obstacles and “go the extra mile”. There is, for instance, evidence that
35 physicians continue to work despite experiencing severe symptoms of burn-out (Thun et al.,
36 2014). There is also some indication that this process can even be initiated before they
37 commence work as professional physicians. Studies have shown, for instance, that medical
38 students display a significant decline in empathy during their third year of medical school, and
39 can develop a cynical attitude to the medical profession over time (Hojat et al., 2009). Some
40 research also indicates that empathy continues to decline during residency training (Bellini and
41 Shea, 2005; Mangione et al., 2002). Hence, there is reason to believe that this decline in
42 empathy and increase in cynical attitudes affect not only the ways in which physicians perceive
43 medical work before they are employed in that role, but also their personal self-image and
44 identity. Furthermore, a general lack of empathy and an increased sense of cynicism can be
45 expected to influence the perception of personal illness, so that, for instance, it is seen as a
46 failure and a sign of weakness. Finally, there is evidence that presenteeism has detrimental
47 consequences not only for the well-being of physicians, but also for work-related outcomes, as
48 it affects recruitment, retention and collaboration between professions (Misra-Herbert and
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3 Stoller, 2004; Heponiemi et al., 2009). Presenteeism also affects the quality and quantity of
4 patient care, for instance through the infection of patients with contagious diseases, medical
5 errors and poor physician-patient communication, with detrimental effects on treatment
6 adherence and patient recovery (Taylor et al., 2007; Virtanen et al., 2009; Rosvoll and Bjertnes,
7 2001). A large European study of hospital physicians in several countries recently confirmed
8 these findings, but also raised concerns about an apparent inability to change this behaviour
9 (Senden et al., 2013).

17 Methodology

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

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31 Organisations may be viewed as collective storytelling systems in which the narration of stories
32 is an essential aspect of sensemaking (Boje, 1991). The collection of stories therefore represents
33 one way of adopting a narrative approach to understand organisations (Czarniawska, 1998) as
34 narratives not only tell the story of an individual, but also provide information about his or her
35 social environment (Laslett, 1999). Given our theoretical perspective that job crafting is a
36 sensemaking tool, we adopted a method of collecting stories to capture the meaning,
37 construction and actions of hospital physicians who were involved in presenteeism over time.
38 Here we were inspired by the notion of living stories and ante-narratives (Boje, 2014) as we
39 viewed stories as constantly unfolding, rather than having beginnings and ends, a clear plot
40 sequence or coherence. Furthermore, we saw stories as being both retrospective and future-
41 oriented at the time at which they are being told. We were particularly concerned with the
42 subjective and differing interpretations of physicians with different backgrounds, from different
43 specialisms and at different points in their career. Personal stories are particularly suitable tools
44 with which to address the notion of context and the ways in which situations and events unfold
45 over time, as they are embedded in the past, present and future (Barry and Elmes, 1997;
46 O'Connor, 1997). We therefore aimed to capture the process of presenteeism by understanding
47 stories in which meaning is retrospectively ascribed to events in the present, while
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3 simultaneously facilitating future action. Finally, we also wanted to acknowledge the reflexive
4 nature of the research process in which interviewees frame their storytelling in interaction with
5 interviewers, and in which researchers ultimately create their own narratives based on their
6 informants' narratives (Cunliffe, Luhman and Boje, 2004). Hence, we aimed to account for our
7 own backgrounds and perspectives, the potential impact they had on the stories narrated by our
8 informants and the ways in which they were understood by us as researchers.
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13 14 15 *Interviewees*

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17 Twenty Norwegian hospital physicians were interviewed. They were recruited via email and
18 phone through a combination of purposive and snowball sampling (Robinson, 2013). This was
19 because we were aiming for a sample which represented different perspectives on the issue of
20 presenteeism, but also had to be practical in terms of finding physicians who were able to find
21 time in their busy schedules. Throughout data collection we were inspired by the concept of
22 saturation (Bowen, 2008). This meant that we continually brought new interviewees into the
23 study until nothing new would be added and no new insights obtained if we carried out more
24 interviews. We experienced saturation after ten to fifteen interviews, but decided to carry out
25 twenty interviews, to ensure comprehension and completeness.
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34 The sample consisted of physicians from a wide range of specialisms (e.g. internal medicine,
35 surgery and psychiatry), and a wide age group was represented (from 27 to 65 years of age), in
36 order to ensure that the sample included physicians with varying levels of seniority. The sample
37 consisted of eight males and twelve females; half of the sample were undergoing specialist
38 training, while the other half were senior residents.
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45 *Interviews*

46 Narrative interviews (Jovchelovitch and Bauer, 2000) were carried out in an attempt to
47 stimulate the interviewees to express their experiences and views on presenteeism by telling the
48 story of their life and career so far. As job crafting was considered to be a sensemaking tool,
49 and that new sensemaking is typically triggered by interruptions and critical incidents (Weick,
50 1995; Weick, Sutcliffe and Obstfeld, 2005), we adopted the technique of episodic interviewing
51 (Flick, 2000): the interviews were organised and structured around asking physicians to recall
52 and report: (1) situations where they felt ill and had to decide whether to attend work or not;
53 and (2) situations where they had attended work while ill. Here we assumed that: (1) the novelty
54 of the illness episode would trigger job crafting via the sensemaking involved in deciding
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3 whether to be present or not; and (2) that physicians would experience turning points and
4 breakdowns, and hence also job crafting, during presenteeism. We further assumed that
5 recalling and reporting on these events would entail not only a listing of events, but also an
6 evaluation of these events, including how they related to the interviewees' wider experience of
7 everyday work and life, and how the interviewees saw them as being ordered over time
8 (Riessmann, 2008).
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15 An interview guide was prepared before the interviews, but it was designed to be flexible, in
16 order to accommodate emerging topics and modifications. In addition to asking informants to
17 recount episodes of presenteeism, we asked them to provide a description of their educational
18 and family backgrounds; what had led them to a medical career and to their chosen specialism;
19 their current position; and their career to date. They were also asked to describe how they
20 perceived the issue of presenteeism (e.g. "What does it mean to be sick if you are a physician?").
21 In addition, they were questioned about general perceptions associated with presenteeism in
22 their organisation (e.g. "What are the formal/informal ideals/principles surrounding the issue of
23 sickness presence at your ward?", "What are the consequences of presenteeism?"). Here we
24 were interested in covering both the positive and the negative aspects of presenteeism (e.g. "Can
25 presence while sick potentially have a positive impact on illness?" and "Are there any barriers
26 in the organisation that contribute to presenteeism when you would rather have stayed at
27 home?"), as well as potential measures to alleviate the negative consequences of presenteeism
28 (e.g. "How would you like the issue to be handled in your organisation?").
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41 Interviews were carried out by two project members, a hospital physician and a researcher, in
42 order to acknowledge and utilise the space between the insider (physician) and outsider
43 (researcher) (Dwyer and Buckle, 2009). Here a third space of paradox and ambivalence,
44 conjunction and disjunction, is assumed. In this space an understanding of the particular
45 context is seen to require an outsider perspective, on the assumption that there is no self-
46 understanding without the understanding of another.
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53 The issue of reflexivity (Cunliffe, Luhman and Boje, 2004) was particularly evident at this
54 point, as we anticipated, from the insider perspective, that informants would want to appear
55 tough and make an impression on the physician interviewer (the insider) through their
56 storytelling (e.g. by exaggerating the severity of presenteeism episodes). We therefore aimed
57 to balance this by having the researcher (the outsider) present during interviews. However, as
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3 the researcher was visibly pregnant when the interviews took place, we were concerned about
4 the ways in which this might have an impact upon the storytelling of the interviewees, in
5 particular that of the obstetricians (e.g. we anticipated that they might hold back certain types
6 of information such as mistakes and critical incidents occurring in the event of presenteeism).
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8 However, throughout the interview process both the insider and outsider felt reassured that this
9 was not the case, and we felt that the interviewees were surprisingly open and balanced during
10 the interviews. This impression was also strengthened during one of the interviews, in which
11 an obstetrician described several presenteeism situations when patients were apparently at risk
12 (e.g. *"I'm not sure I'd want to receive surgery from a physician that ill."*). The physician then
13 paused, as if having forgotten that the researcher was pregnant, and said to the researcher: *"You*
14 *just got really scared, didn't you? To be admitted to the delivery room..?"* testing how what
15 being said was perceived by an outsider.
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26 The interviews took place at the chosen hospital, but outside each interviewee's department.
27 They lasted between 45 and 90 minutes, and were audiotaped and transcribed verbatim by a
28 student assistant.
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32 *Data analysis*

33 Following our particular focus on job crafting as a sensemaking tool during presenteeism, we
34 utilised a theory-led form of thematic analysis (Howitt, 2010; Braun and Clarke, 2006) where
35 we utilized job-crafting theory to explore: (1) the decision to attend work or not when ill; and
36 (2) the experience of presenteeism. However, we did not ignore "what gets left out of the themes
37 and taxonomy cages and what goes on between cells" (Boje, 2001, p.125). For instance, the
38 decision to follow this top-down, theory-led approach emerged from the initial inductive data
39 analysis carried out earlier in the project. Here we discovered that, although it was evident that
40 physicians faced immense organisational pressure to go to work, due to issues such as
41 insufficient staffing and working in temporary positions, these issues did not represent the
42 whole picture of presenteeism. We were particularly struck by the fact that physicians were
43 surprisingly insecure and indecisive when it came to evaluating and diagnosing their own
44 illness, and that this represented a stark contrast to the certainty they exhibited in the diagnosis
45 of patients. As a result, this served as the catalyst for a sensemaking process where physicians
46 often ended up disregarding or trivialising the nature and severity of their own symptoms,
47 leading to presenteeism even in cases where they were seriously ill (e.g. in the case of severe
48 infections). Furthermore, following the preliminary analysis, we were under the impression that
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3 physicians engaged in a kind of self-fulfilling prophecy where the phenomenon of presenteeism
4 was taken for granted, and seen as integral to work, and that this in turn led to behaviour that
5 supported and reinforced this assumption over time. We therefore became particularly
6 interested in exploring in depth how physicians engage in this self-fulfilling prophecy over
7 time.
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13 This brought us to the second part of our analysis where we explored cognitive, relational and
14 task crafting as tools for making sense of, and constructing, presenteeism over time. Here, we
15 utilised the five steps of thematic analysis (Howitt, 2010; Braun and Clarke, 2006): data
16 familiarisation; initial coding; generation of themes based on coding; review of themes; and
17 theme definition and labelling. Both authors contributed to the coding process. Firstly, we read
18 through the interview transcripts several times and isolated the passages that related to
19 presenteeism, focusing particularly on the experience of illness, the decision to attend work or
20 not in the event of illness, and the experience of presenteeism. Secondly, we reread the passages
21 and classified those that indicated either task, relational and/or cognitive job crafting into three
22 separate documents. Some sections were placed in more than one category, as the three
23 strategies of job crafting sometimes overlapped. Furthermore, as we had not explicitly asked
24 the informants about task, relational and/or cognitive job crafting, the analysis involved
25 searching for latent content as well as manifest content (Graneheim and Lundman, 2003).
26 Thirdly, we formed a set of codes or categories (the initial coding generation) within each of
27 the three identified categories of job crafting. Finally, we looked for similarities, differences
28 and patterns within the three respective categories of task, relational and cognitive job crafting.
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43 Findings

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

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

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

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33 Physician 11: *“I got my husband to drive me to emergency patient home visits. My reactivity, concentration, that*
34 *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*
35 *shift. [...] I felt it was irresponsible to drive.”*

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

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43 On the one hand, physicians explained that this behaviour was a result of the loyalty which they
44 felt towards their patients, and it was evident that when considering their condition, concern for
45 patients carried more weight than concern for their own health. For instance, when considering
46 their own illness, they would also think about the distance that patients had travelled for a
47 particular procedure, whether they had been on a waiting list before the planned consultation
48 and whether there would be other specialists on the ward who could cover their work. On the
49 other hand, physicians also considered their career path and whether it was important for them
50 to attend a certain procedure or learning situation in order to secure promotion and/or future
51 employment.
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3 Physician 19: *“Being at work and not losing out is positive, because in this profession, there’s constant*
4 *development. It’s not the type of job where if you’re away, the work is the same when you get back.”*
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8 When it came to the experience of actually crafting tasks in the event of presenteeism, it
9 appeared that physicians saw their illness to some extent as having negative implications for
10 their well-being and mental functioning (e.g. feeling exhausted and not being able to focus),
11 something which in turn had implications for the ways in which tasks were carried out (e.g.
12 ignoring important symptoms in patients and making the wrong decisions).
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18 Physician 9: *“I was not a good physician at that point. I experienced having a patient who would have been*
19 *referred for the appropriate treatment more quickly if I had only been more awake.”*
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23 Physician 18: *“Well, I’m not sure I would have wanted to receive surgery from someone that ill.”*
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26 However, they also experienced that persevering with presenteeism by carrying out work as if
27 they were not ill had a wide range of positive consequences (e.g. it promoted positive self-
28 image and social standing, as we will discuss below in the context of relational and cognitive
29 crafting), something which resulted in physicians arguing that their task crafting was justified
30 in the event of presenteeism (e.g. by claiming that the patient was never really at risk).
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36 On the other hand, physicians also appeared to acknowledge to some extent that by continuing
37 to work while ill (task crafting), they helped to maintain the system of unreasonable demands
38 which surrounded their work. Hence, they saw themselves being caught in a vicious cycle of
39 job demands which was difficult to escape because they themselves actively contributed to it
40 on an everyday basis.
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46 Physician 7: *“We’re not good at delaying work. [...] We’re not good at taking the time to do the job properly, so*
47 *that has consequences.”*
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51 Finally, it also appeared that certain responsibilities and activities were not compatible with
52 illness, with the result that some physicians actively and deliberately decided not to attend work
53 while sick. This was typically seen as a coping strategy to avoid long-term burn-out.
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58 Physician 9: *“As a junior resident, shifts were really busy, so you wouldn’t be able to cope with your whole shift,*
59 *even if you were only slightly sick. Despite having a high threshold for calling in sick, I felt I didn’t have a choice*
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3 [...] and when I looked at the senior physicians, they looked very tired, and I knew that at least four or five of them
4 had been on long-term sick leave [...] so I decided on day one, I'm not having any of those three-month burn-out
5 periods of leave.”
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8 9 *Relational crafting*

10 The sensemaking process related to the decision whether to attend work was also very much
11 informed by the considerations of colleagues, by their situation and by their potential views on
12 illness and/or absence. For instance, the decision to be absent was informed by a consideration
13 of their colleagues' workload.
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19 Physician 1: *“The most important driving force is the loyalty you feel towards your colleagues. There is this*
20 *unwritten rule that if you are able to go to work, one way or another, you go, because you know that the workload*
21 *is really high.”*
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25 Physician 6: *“Well, I have gone to work in situations where I couldn't even tie my own shoelaces [...] but you have*
26 *no choice, there's nobody there, everyone is under so much pressure, there are not enough staff, the tempo is so*
27 *high, in all functions.”*
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31 Physician 11: *“It's not the hospital director I feel sorry for, right, it's my colleagues.”*
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34 Furthermore, the physicians appeared to invest quite a lot of effort in deciding whether an illness
35 was socially “respectable” or “legitimate”. “Legitimate” or “respectable” illnesses, where
36 absence was called for, typically included extreme or critical physical conditions such as stroke
37 and cardiac infarction, whereas chronic illness and mental conditions were not considered
38 legitimate reasons to be absent from work. Physicians therefore preferred being “sent home”
39 by colleagues after having gone to work with an illness to calling in sick. In other words, they
40 appeared to rely on the evaluations and judgements of colleagues in order to make sense of their
41 own conditions, and only then to allow themselves to be sick and absent. For the same reason,
42 physicians also preferred returning to work before they were fully recovered, so that colleagues
43 could perceive and assess the reality of their illness, and hence legitimise their absence from
44 work.
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54 Physician 11: *“It's very important to me that people know that my threshold for staying at home is very high. So*
55 *when I've been absent I try to make sure it still shows that I'm sick when I get back to work.”*
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3 In terms of the experience of attending work while ill, it appeared that physicians to some extent
4 interacted with their colleagues and superiors using presenteeism. In other words, presenteeism
5 was a strategy with which the physicians could express themselves and achieve a relational aim.
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7 Overall, absenteeism appeared to be frowned upon and seen as a sign of weakness.
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11 Physician 1: *“You’re not supposed to have problems. The threshold for admitting problems is really high.”*
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14 Physician 4: *“It’s always noticed if you’re sick a lot. It’s about the impression you give.”*
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17 Physician 6: *“You have to show people that you can handle it, that you can be counted on; otherwise your employer
18 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
19 want to be weaker than them.”*
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23 Physician 9: *Being sick is admitting weakness [...] and you don’t want your colleagues to cover the extra workload.
24 If someone is away a lot, it doesn’t take long before people start talking.*
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27 Presenteeism, on the other hand, was associated with immense positive feedback. For instance,
28 it was common on the wards for senior physicians to share stories in which they had worked
29 through a serious medical condition; these stories were then continuously retold in very positive
30 and heroic terms. Hence, presenteeism was associated with positive implications for social
31 standing and professional identity.
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35 Physician 9: *“And then you have these comments being made, that I’m really fed up listening to, like “What? On
36 sick leave while you’re pregnant? You know what, when I was pregnant I worked until the last contractions”. Or
37 “My waters broke when I was on my shift.” And those are the sort of stories that are being told in very positive
38 ways, and that sets a kind of standard in our working environment.”*
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46 It was also evident that this reinforced a work environment and culture in which presenteeism
47 was a social expectation, and that the physicians experienced this in both positive and negative
48 ways: positive in the sense that it boosted their social standing, but negative in the sense that it
49 intensified and magnified the expectations and pressures of their work role.
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53 Physician 9: *“We do have a responsibility here: physicians create their own work environments. I mean, it’s about
54 the conditions of employment, your employer and all that, but thinking about the work environment, also about
55 how we refer to colleagues who are off sick.”*
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3 Physician 12: *"It's a self-reinforcing tone in the work environment. It's a status thing to work until you're really*
4 *exhausted. It's talked about in very admiring ways, sort of a cultural thing, I'm afraid, or rather a negative*
5 *culture."*
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9 Physician 13: *"I guess we're a pretty servile group, eager to please in all directions."*
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12 Some physicians opposed these views, however, and reported that they had experienced critical
13 turning points and breakdowns during presenteeism that subsequently led to substantial lifestyle
14 changes (e.g. realising the severity of their illness and experiencing an "aha-moment" because
15 of a patient mistake that led to a change of specialism). However, those physicians still
16 remained ambivalent about these issues and continued to legitimise their illness and
17 absenteeism in different ways (e.g. Physician 11 who had changed specialism and decided to
18 work at a ward with family-friendly work hours, but still made sure that their illness was
19 noticeable when they returned to work after being absent).
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26 27 *Cognitive crafting*

28 The evaluation of illness as a relational undertaking also appeared to permeate their sense of
29 self, their personal experiences of illness and their view of illness. Hence, the evaluation of
30 illness did not only rely on others seeing it as "respectable" or "legitimate". To some extent,
31 illness only became "real" to the physicians when others confirmed its existence.
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38 Physician 14: *"I remember once, when I was feeling really ill, I still went to work, but I had to lie down and rest*
39 *between each patient. On the bench. I mean, I was really ill. And my secretary was like, "Let's do some tests.*
40 *Check your CRP value", and it was above 150, close to 200. So I went home that day. And I've often thought about*
41 *that. I've issued medical certificates to lots of patients who were a long way from being that sick, whereas I torment*
42 *myself in this way. It's really weird. [...] It's a survival instinct that physicians take upon themselves, so it ends*
43 *up being hard to tell how sick you really are [...] so sometimes I have to check with my colleagues: "Can you hear*
44 *me out, what do you think? Should I start on antibiotics now? I need help, I need someone to hear me out."*
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50 There was also an element of having a certain perspective on illness, and one's illness being
51 perceived in relation to those of other people. For instance, physicians typically considered
52 absence due to their sick children to be more "legitimate" than their own illness. Furthermore,
53 they viewed their own illness in comparison to that of their patients, which was often likely to
54 be more serious than their own. This contributed to a blurring of their perspective on their own
55 illness, and on their perception of its severity.
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3 Physician 15: *"I mean, even if you feel sick, the patients are more sick, and they need your help."*

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

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13 Physician 1: *"I did not perceive work as something negative [during presenteeism] [...] it's about feeling useful,
14 [...] focusing on other people's illnesses, ignoring your own. [...] Well, I feel it's good to leave behind the role of
15 a sick person, and to feel that you're giving something back to society. If you stay at home you feel frustrated, and
16 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
17 affect my condition in negative ways, and staying at home doesn't improve my condition."*

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

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25 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."*

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

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

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

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52 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
53 deep-rooted, it's about standing tall and having a sense of dignity [...] but in my experience it can be destructive
54 to have these kinds of expectations for myself, to drag yourself to work when you should have stayed at home. I
55 think it would have been healthier if I could have decided "You know what, I'm feeling really sick and I've decided
56 to stay at home" and I'm still a good person. [...] You know, relying on your achievements to consider yourself a
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3 *worthy person, because it happens actively, this addiction to achievement. [...] I mean, this is all about how we*
4 *think about this, in our minds.”*
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8 However, some of the physicians reported that they actively engaged in mental strategies to
9 change the ways in which tasks and relationships at work were perceived, in order to combat
10 dysfunctional cycles of unreasonable personal expectations and self-contempt.
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14 Physician 14: *“I once read something about burnout among physicians, [...] taking care of Number One or*
15 *something. [...] I think it’s important to find a balance, and some strategies, when it comes to how you respond to*
16 *certain situations. [...] For instance, when I wash my hands, I try not to think about where I’m going, what I should*
17 *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*
18 *here and now, and it works, I think.”*
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23 Physician 19: *“I choose not to worry about certain things [related to work]. [...] For me work isn’t everything,*
24 *and having kids made me more conscious of that. [...] I can have a horrible day at work, but then I’m home and*
25 *that’s where the most important things happen.”*
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29 Discussion

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34 In the present study we aimed to achieve a deeper understanding of presenteeism, by exploring
35 the ways in which hospital physicians make sense of, and act upon, illness and presenteeism.
36 We utilised the concept of job crafting (Wrzesniewski and Dutton, 2001) to explore the
37 sensemaking (Weick, 1995) involved in presenteeism. Job crafting implies agency, so that
38 employees not only respond to their job description, or to the circumstances of their job, but
39 proactively change tasks, relationships and ways of thinking about work. We assumed that
40 hospital physicians may utilise job crafting to make sense of illness, and enact either
41 presenteeism or absenteeism and that they conceptualise and restructure their “ideal” job to
42 include either of those behaviours.
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51 Narrative episodic interviewing (Jovchelovitch and Bauer, 2000; Flick, 2000) was adopted to
52 explore the ways in which hospital physicians evaluated a situation of feeling ill, and
53 consequently decided whether they should be absent, and how they then experienced
54 presenteeism.
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3 It appeared that physicians were extremely indecisive and insecure when it came to diagnosing
4 their own illness, and that this contrasted with the confidence they showed when diagnosing
5 patients. Furthermore, this resulted in physicians trivialising, enduring and showcasing their
6 own illness and engaging in presenteeism. Overall, presenteeism was experienced in positive
7 as well as negative ways. Finally, it appeared that this behaviour also contributed to some extent
8 to a situation in which physicians were caught in a dysfunctional circle, or self-fulfilling
9 prophecy, of actively contributing to maintaining presenteeism as a norm in their work
10 environment.
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19 Job crafting also illuminated the decision-making process involved in evaluating illness, and
20 the experience of enacting presenteeism. It appeared that physicians engaged in task crafting so
21 that they could work around, or even overcome, illness, rather than letting illness define and set
22 boundaries for work. Physicians therefore engaged in a process which allowed their general
23 work situation, tasks and duties to define their illness as a strategy with which they could deal
24 with the insecurity and uncertainty associated with their health situation. They would typically
25 consider the situation of their patients, something that underlines the pro-social nature of their
26 work where patients always come first (Jager, Tutty and Kao, 2017; Yoon, Daley and Curlin,
27 2017) even when physicians experience exhaustion (Thun et al., 2014).
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36 However, the evaluation of personal illness, and the experience of presenteeism, were also
37 informed by relational crafting, as physicians would carefully consider their colleagues in this
38 process. This happened in three ways. Firstly, they genuinely cared about their colleagues and
39 wanted to avoid absenteeism, to avoid giving their colleagues an excessive workload. Secondly,
40 they were worried about what their colleagues and managers would think if they revealed their
41 illness, and/or engaged in presenteeism. This was in addition to their concerns about the
42 consequences of illness and absenteeism. In general, physicians were worried that this might
43 affect their career trajectories, in particular future promotions and permanent appointments.
44 However, there was also a cultural element to this (Dew, Keefe and Small, 2005), as illness and
45 absenteeism were frowned upon and seen as signs of weakness. In the event of illness and/or
46 absenteeism, it was important that the illness could be defined as “respectable” and “legitimate”
47 in their work environment, something which resonates with the literature on presenteeism
48 cultures. Thirdly, illness and presenteeism appeared to be things which could be “showcased”
49 and utilised to promote a positive sense of self and professional identity. This also implied that
50 presenteeism was also associated with a wide range of positive experiences related to a boost
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3 in social standing, as well as storytelling on their ward, where presenteeism was often presented
4 and socially reconstructed as a heroic act. Hence, physicians appeared to some extent to engage
5 in impression management (Bolino et al., 2008), to build and uphold a certain professional
6 identity (Van Manen and Barley, 1984). Furthermore, it could be argued that the process of
7 engaging in impression management involved an authentic as well as a deceptive element, so
8 that physicians engaged in presenteeism to show colleagues that they cared for them, but also
9 made attempts to exaggerate their illness in front of colleagues (e.g. making sure that the illness
10 was visible when they returned to work, and retelling presenteeism stories from the past). It is
11 also worth noting that physicians were largely aware of this deceptive element (e.g. some were
12 even “fed up” with the stories being told), but still continued to engage in the showcasing of
13 illness and presenteeism, despite experiencing their dysfunctional consequences.
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24 Finally, when considering cognitive crafting, it appeared that physicians did not trust
25 themselves to evaluate their own illness, or that they had somehow lost this ability over time
26 by relying on the confirmation of others, preferably colleagues, in order to allow themselves to
27 be sick. This was mainly due to the subjective nature of illness, which means that it can be
28 difficult to judge whether an illness requires absence from work or not, and to the relative nature
29 of illness, as physicians would consider their illness in comparison to the illness of others,
30 typically patients. There was an element of creating distance from patients and an unwillingness
31 to adopt the patient role (McKevitt et al., 1997). However, the physicians’ evaluation of illness
32 and presenteeism also appeared to be rooted in their sense of self and identity, which involved
33 an “*addiction to achievement*” and resentment towards illness, implying that they would
34 actively “*torment*” themselves in order to feel that they were a “*worthy*” and *good person*”.
35 There may be several reasons why these perceptions and behaviours emerged, such as the
36 physicians’ personality and upbringing. However, it could also have been due to the physicians’
37 education and training, as medical students have been found to display a decline in empathy
38 during medical school and residency training (Hojat et al., 2009; Bellini and Shea, 2005;
39 Mangione et al., 2002). There is therefore some reason to believe that this decline in empathy
40 and increase in cynical attitudes affect not only the ways in which physicians perceive medical
41 work before being employed in that role, but also their personal self-image and identity.
42 Furthermore, a general lack of empathy and an increased sense of cynicism can be expected to
43 influence the perception of one’s own illness. This may explain why physicians are particularly
44 hard on themselves, and why they do not want to acknowledge their illness, but instead see it
45 as a failure and a sign of weakness. It may also explain the behaviour and social dynamics of
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3 presenteeism that develop from this perception, with both positive and negative implications
4 for the individual physician and for his/her work environment, so that these perceptions and
5 subsequent presenteeism are reinforced over time. Finally, the decision to work through an
6 illness could also be explained by physicians seeing their work as particularly meaningful
7 (Horowitz et al., 2003), and even as a calling (Jager, Tutty and Kao, 2017; Yoon, Daley and
8 Curling, 2017), as well as an opportunity to leave their illness behind and improve a health
9 condition, something which contributed to positive experiences of presenteeism.

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17 These findings of the present study develop Johns's (2010) dynamic model of presenteeism,
18 where it is assumed that employees are capable of assessing the severity of their symptoms, as
19 well as weighing up the pros and cons of absenteeism and presenteeism. The present study
20 suggests that the "chain of events" may not necessarily be so straightforward. It also
21 demonstrates that job crafting can have dysfunctional consequences, a finding that is in
22 alignment with previous studies (Berg, Grant and Johnson, 2010; Bunderson and Thompson,
23 2009). Furthermore, the finding that employees can engage in dysfunctional cycles over time,
24 particularly when experiencing work as being highly meaningful, and as a calling, is in line
25 with existing literature, which has demonstrated that employees who are all initially positively
26 driven by passion and by a dedication to work can follow different paths over time, positive as
27 well as negative, depending on how they cope with challenges in their work environment
28 (Schabram and Maitlis, 2017; Mitra and Buzzanell, 2017; Bailey and Madden, 2016).

39 *Future research and implications for management*

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41 We have contributed to the literature by presenting the multifaceted, context-specific and
42 evolving nature of presenteeism in a group of hospital physicians using the perspective of job
43 crafting. However, there are a number of limitations to this research that suggest the possible
44 scope of future research. Firstly, with regard to the phenomenon of presenteeism, and the
45 underlying assumption that employees are capable of evaluating illness, more research is
46 needed to explore the ways in which employees evaluate their symptoms in the onset phase of
47 a health event, and how these evaluations early in an episode of illness can create and reinforce
48 presenteeism over time. Secondly, we only interviewed a selected group of interviewees from
49 this specific work context (hospital physicians). They were recruited through snowball
50 sampling via the author's network and the recommendations of other participants, so that we
51 may have only recruited interviewees with a particular interest in the topic under investigation.
52 Hence, these findings may not necessarily apply to other contexts, either related (e.g. general
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3 practitioners) or unrelated (e.g. organisations in general). Given that interpretative researchers
4 do not make claims to generalisability, this is not necessarily problematic. However, following
5 the interpretative narrative approach of collecting organisational stories (Tsoukas and Hatch,
6 2001; Carniawska, 1998), it would still make sense to allow for the emergence of more diverse
7 realities and perspectives (Barry and Elmes, 1997) on the phenomenon of presenteeism. For
8 instance, considering that hospital physicians represent an “extreme” work environment
9 characterised by long shifts and life-and-death situations, it would be particularly interesting to
10 explore the ways in which presenteeism evolves in more “traditional” office environment or in
11 other professions, e.g. in the service industry. The issue of context also applies to us as
12 researchers and the perspectives that we utilised to explore the storytelling involved in
13 presenteeism. This implies that as researchers we ultimately created our own narratives based
14 on the stories being told by informants (Cunliffe, Luhman and Boje, 2004). Hence, researchers
15 who come from other backgrounds and bring other theoretical perspectives may complement
16 our findings and contribute to a deeper understanding of presenteeism. Thirdly, although we
17 used narrative interviews (Jovchelovitch and Bauer, 2000) as our research strategy, in order to
18 capture the evolving and dynamic nature of presenteeism, longitudinal methods may be more
19 suited to documenting the shifting and evolving character of job crafting and presenteeism over
20 time. We therefore suggest that repeated interviews and/or diaries (e.g. Symon, 2006) are
21 utilised in future research, in order to address the evolving nature of these phenomena in more
22 depth.
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39 Given the multifaceted, context-specific and evolving nature of presenteeism (Johns, 2010),
40 interventions aimed at countering the negative implications of presenteeism should avoid the
41 adoption of an individual approach which focuses on the individual employee and his/her
42 personal attitudes and behaviour, but should rather address the issue from a social and systemic
43 point of view, considering, in particular, the implications of presenteeism on productivity and
44 safety (Worall, Cooper and Campbell, 2000; Collins et al., 2005). For instance, the organisation
45 should facilitate a positive working environment, predictable employment and adequate
46 staffing. Furthermore, a formal policy on absence and presenteeism should be in place to
47 minimise the importance of individual evaluations and decision-making with regard to personal
48 health events. Formal and informal modes of leadership are also important ways of avoiding
49 dysfunctional presenteeism. This is particularly the case as presenteeism is closely linked to
50 identity and to professional culture. Hence, employees need positive role models with healthy
51 perspectives and behaviour in relation to illness, absence and presence, in order to outweigh the
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3 influence of potential “self-sacrificing heroes”. With regard to physicians in particular, medical
4 schools should address the topic of personal health and illness, and also train future physicians
5 in strategies of self-care to ensure resilience, as part of their curricula.
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10 *Conclusion*

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