

Presenteeism in the New Zealand senior medical workforce—a mixed-methods analysis

Charlotte Chambers, Chris Frampton, Murray Barclay

ABSTRACT

AIM: To estimate rates of presenteeism in the New Zealand senior medical workforce and identify reasons why this workforce feels pressured to work through illness.

METHODS: A cross-sectional survey was returned by 1,806/3,740 publically employed senior doctors and dentists (48%). Relationships between rates of presenteeism, sick leave and demographic factors were explored alongside views on cultural and professional norms.

RESULTS: Presenteeism was reported by 88% of respondents. Women and younger doctors had highest rates of presenteeism. Reasons for presenteeism included difficulties accessing short-term sickness cover and concern for the impact of sick leave on patients as well as sociocultural norms.

CONCLUSIONS: Presenteeism is a widespread behavioural norm in this medical workforce. Choosing whether to work through illness reflects the high value placed on duty of care, but also tensions around defining responsible behaviour in this regard.

Presenteeism, or working when too unwell, fatigued or stressed to be at work, can have serious consequences. Presenteeism is likely to influence the safety and well-being of both patients and those who care for them.¹⁻⁴ Doctors who attend work while unwell may risk transmission of illness to their patients and colleagues.^{2,5} Presenteeism has been associated with an increase in the number of errors made while at work.⁶ Presenteeism is also of concern as a form of productivity loss. Hemp⁷ asserts presenteeism can significantly reduce individual productivity by over a third. As a consequence, presenteeism is estimated to represent a far greater cost to employers than sickness absence.⁸

Doctors appear to work through illness at a higher rate than other professional groups and frequently attend work when they would advise their patients to stay away.⁹ Those who continue to work through illness may risk the likelihood of future serious ill health⁴ or burnout.¹⁰ The reasons behind these behaviours are complex.¹¹

Some argue that it reflects a possible indifference of doctors to their own health.^{3,11} Others emphasise the importance of broader workplace pressures,¹² the significance of personal characteristics including commitment to the workplace, and the blurring of boundaries between personal and professional spheres.^{13,14}

This study sought to understand the prevalence of and factors that influence presenteeism within a particular sector of the New Zealand medical workforce. It is based on a cross-sectional survey of members of the Association of Salaried Medical Specialists (ASMS) who work primarily in New Zealand's 20 district health boards (DHBs). At the time of the survey, the ASMS was estimated to represent over 90% of the salaried medical and dental workforce in New Zealand. These medical and dental specialists, along with other non-vocationally registered doctors and dentists, are referred to in this report as senior doctors or collectively as the senior medical workforce.

The research looks at why this group of senior doctors and dentists feel pressured to work when they are unwell. It describes quantitative and qualitative indicators on presenteeism and puts these in the context of workplace pressures, professional norms and thresholds of illness. Finally, the research considers the broader significance of presenteeism for this group, both in terms of possible consequences for patient care and safety, and in terms of what these attitudes say about the pressures on New Zealand's public health system. In so doing, it highlights the barriers that limit the taking of legitimate sick leave and considers the potential risks this behaviour represents to the practitioners and their patients.

Methods

The research was based on a self-completion questionnaire administered online to all ASMS members working at DHBs in September 2015, a total figure of 3,740 potential survey participants. Rates of presenteeism were assessed in different ways and over different time scales. The first questions asked respondents to recall and estimate how many times they had turned up to work unwell and unable to perform to their usual standards over the past two years and how many times they had turned up over the same time period while unwell with an infectious illness. These questions were measured in a 4-point Likert scale from 1=often to 4=never. The survey also required respondents to estimate how frequently their colleagues had turned up to work unwell with an illness using the same 4-point Likert scale. It further requested respondents to recall and specifically quantify how many days they had turned up to work unwell over the past 12 months. Respondents were also asked to recall and quantify the number of sick leave days taken over the same period. Comparisons were then made between the Likert scale answers and the quantified rates of presenteeism and sick leave.

Respondents were asked to rank their top three possible reasons for not taking sick leave from a defined list of seven possible reasons. The survey also collected basic demographic data including age (according to five categories), gender, length of time in

the profession (four categories), primary DHB and number of senior medical officers (SMOs) in the respondent's department. A final free text comments section was provided for respondents to contextualise their answers and provide additional information.

Non-parametric Spearman's rank correlation coefficients, Kruskal–Wallis non-parametric ANOVA and Chi-square tests were used to test associations with quantitative counts of the number of sick days and presenteeism days and the 'at work unwell' and 'at work infectious' Likert responses. Key variables explored for these analyses included age, gender, years worked in New Zealand's public health system, size of department and the primary DHB of the respondent. A two-tailed p-value <0.05 was taken to indicate statistical significance. Statistical analysis was undertaken with SPSS (23.0).

Qualitative data from the free-text section of the survey was coded in NVivo (Pro 11) with additional quantification of the incidence of codes providing for a proportional analysis of the three main coding themes. Many comments alluded to more than one theme simultaneously, which allowed for an exploration of how the issues were related to other concerns. The trends emerging from the quantitative data were explored in conjunction with the qualitative data, which allowed for greater depth and nuance in the interpretation of the findings.

Results

One thousand eight hundred and six (48.2%) respondents completed the survey in its entirety and 660 (17.6%) left comments for qualitative analysis. Not all respondents completed all parts of the survey, but responses relevant to each analysis were included as appropriate. Respondent demographics are summarised in Table 1.

Respondents were 41% female and 59% male. These proportions were broadly representative of the gender spread of the ASMS DHB membership (37% and 63%). The spread of respondents across DHBs was a close match to the ASMS membership profile. Respondents were mainly aged over 40 and most had worked in New Zealand for periods between five and 30 years.

Table 1: Demographic summary of respondents.

Gender	N (%)
Male	1,069 (59.2)
Female	737 (40.8)
Age group	
20–29	3(0.2)
30–39	246 (13.6)
40–49	695 (38.5)
50–59	587 (32.5)
>60	275 (15.2)
Years worked in New Zealand	
Less than 5 years	160 (8.9)
5–14 years	655 (36.3)
15–30 years	790 (43.7)
>30 years	201 (11.1)
DHB	
Auckland	315 (17.4)
Bay of Plenty	61 (3.4)
Canterbury	224 (12.4)
Capital and Coast	130 (7.2)
Counties Manukau	182 (10.1)
Hawke's Bay	52 (2.9)
Hutt Valley	49 (2.7)
Lakes	30 (1.7)
MidCentral	69 (3.8)
Nelson Marlborough	66 (3.7)
Northland	66 (3.7)
South Canterbury	21 (1.2)
Southern	120 (6.6)
Tairāwhiti	25 (1.4)
Taranaki	33 (1.8)
Waikato	145 (8.0)
Wairarapa	21 (1.2)
Waitemata	166 (9.2)
West Coast	14 (0.8)
Whanganui	17 (0.9)
Number of SMOs in department	Median (IQR)
	10 (6–19)

Fifty-seven percent of respondents estimated that they had come into work when they were unwell 'often' and 'sometimes' over the past two years. Only 12% asserted that they 'never' did so over the previous two years (see Figure 1). Thirty-three percent of respondents estimated coming to work with an infectious illness 'sometimes' over the past two years, with 7% estimating that they did so 'often' over the same time period. Seventy-five percent of the senior doctors reported presenting at work at least once with an illness that they knew to be infectious over the preceding two years. Fifty-two percent estimated that their colleagues had done so 'sometimes' over the past two years, with only 6% estimating that they had 'never' done so.

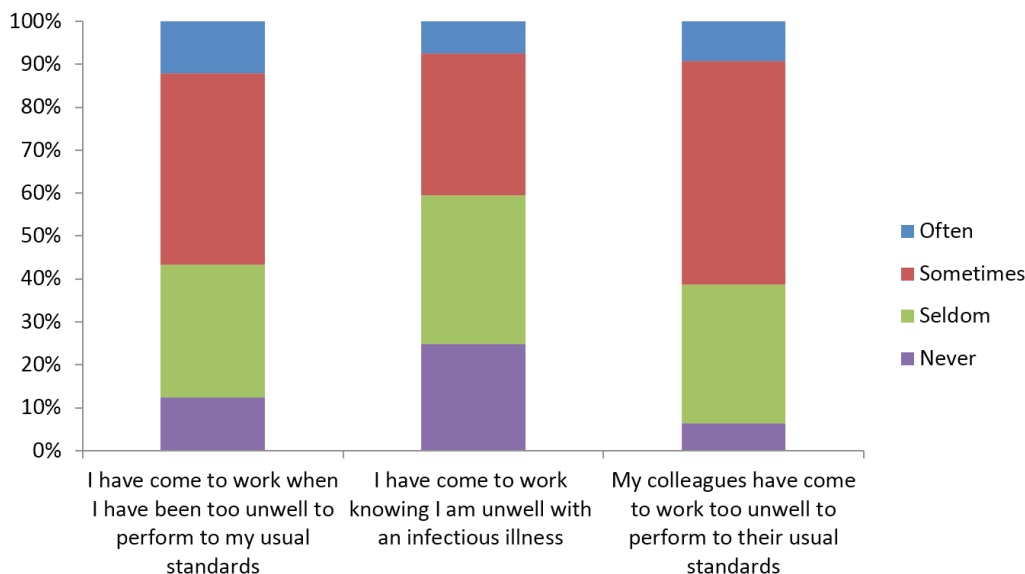
As detailed in Table 2 and Figure 2, respondents estimated coming to work unwell at an average rate of approximately three days per year (median two days per year), with 78% reporting coming into work unwell at least one day in a year. Fifty-four percent reporting taking one or fewer days' sick leave over the same period.

Table 2: Estimation of sick leave days taken and days when sick leave should have been taken over the past 12 months.

	Mean (SD)	Median (IQR)
Number of days present at work when sick leave should have been taken over past year (n=1816)	3.0 (3.5)	2 (1–4)
Number of days sick leave taken over past year (n=1816)	2.8 (7.1)	1 (0–3)

There was a significant positive association between the number of presenteeism days taken and the Likert responses given for being at work unwell ($r_s = 0.473$, $p < 0.001$) and at work infectious ($r_s = 0.313$, $p < 0.001$). There was also a positive association between the number of sick days taken and the number of presenteeism days ($r_s = 0.164$, $p < 0.001$). Female respondents were more likely to assert turning up to work unwell ($p < 0.001$) and infectious ($p = 0.009$) than males. Gender was also significantly associated with both number of sick leave

Figure 1: Likert scale responses to different measures of presenteeism.



days and number of presenteeism days (both $p < 0.001$), with females more likely to take higher numbers of sick days and presenteeism days. Older respondents were less likely to assert presenteeism ($r_s = -0.095$, $p < 0.001$) and turn up to work infectious ($r_s = -0.107$, $p < 0.001$) than their younger

colleagues, and there was a negative association between age and both number of sick leave days taken ($r_s = -0.049$, $p = 0.036$) and number of presenteeism days ($r_s = -0.155$, $p < 0.001$), suggesting the younger the respondent, the higher the number of sick and presenteeism days reported.

Figure 2: Grouped estimates of sick days and presenteeism days taken over the past 12 months.

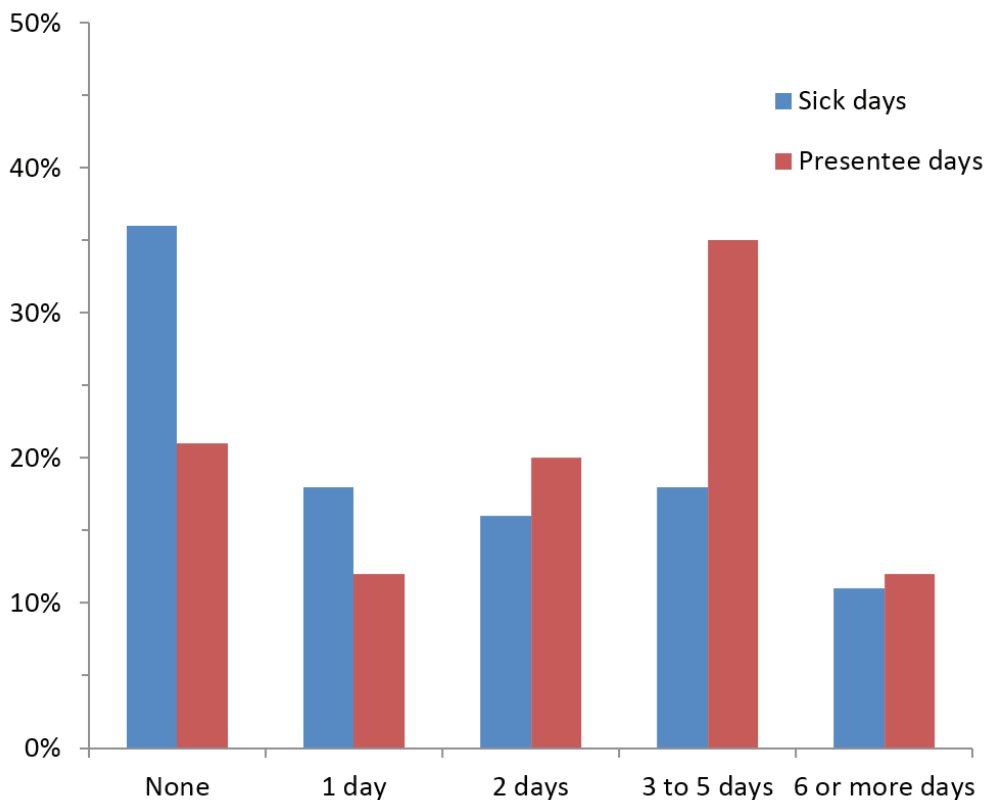


Table 3: Continuous and Likert scale measures of presenteeism and days of sick leave taken grouped by gender, age, years worked and place of work.

Variable:	Continuous and Likert scale measures			
	Number of days present when unwell per year	Number of days sick leave taken over past year	I have come to work when I have been too unwell to perform to my usual standards	I have come to work knowing I am unwell with an infectious illness
Gender	Mean (SD)	Mean (SD)	n 'not never' (%)	n 'not never' (%)
Female	3.2 (3.5)	2.9 (5.1)	676 (91.7)	575 (78.0)
Male	2.9 (3.5)	2.7 (8.2)	910 (85.1)	784 (73.3)
Age group				
20–29	1.7 (2.9)	1.3 (1.5)	3 (100.0)	3 (100.0)
30–39	3.3 (3.2)	2.8 (4.7)	219 (89.0)	199 (80.9)
40–49	3.4 (3.5)	2.4 (4.2)	638 (91.8)	553 (79.6)
50–59	2.8 (3.2)	2.7 (7.7)	506 (86.2)	420 (71.6)
>60	2.5 (4.1)	4.0 (11.7)	220 (80.0)	184 (66.9)
Years worked in NZ				
Less than 5 years	3.1 (3.1)	2.5 (5.1)	695 (88.0)	599 (75.8)
5–14 years	3.2 (3.4)	2.7 (4.5)	588 (89.8)	509 (77.70)
15–30 years	3.1 (3.8)	2.8 (8.2)	138 (86.3)	109 (68.1)
>30 years	2.1 (2.7)	3.4 (10.0)	165 (82.1)	142 (70.6)

Table 4: Ranked reasons for turning up to work when sick leave should have been taken.

Reason	Rank 1 n/1737 (%)	Rank 2 n/1737 (%)	Rank 3 n/1737 (%)
Feeling of duty to patient	606 (35)	452 (26)	270 (16)
Clinics/theatre sessions already booked	474 (27)	374 (22)	232 (13)
Not wanting to burden colleagues	409 (24)	485 (28)	431 (25)
Fear of appearing 'weak' compared to other colleagues	42 (2)	64 (4)	153 (9)
Anticipation of extra workload on return to work	129 (7)	214 (12)	300 (17)
Not knowing the threshold for staying home when unwell	33 (2)	70 (4)	159 (9)
Not feeling unwell enough to stay home	227 (13)	181 (10)	314 (18)

Length of time in the profession had no influence on how likely respondents were to assert coming to work infectious, but the greater the number of years worked in New Zealand meant that the respondents were less likely to assert presenteeism ($r_s = -0.063$, $p=0.007$). There was no statistically significant effect of the host DHB of respondents on either measures of presenteeism or number of sick days taken. These findings are summarised in Table 3.

Additional analysis found no significant correlation between estimates of the number of senior doctors in departments and the likelihood of being 'at work unwell' ($r_s = -0.015$, $p=0.513$). However, there was a positive association between the numbers of senior doctors in a department and the number of sick leave days taken, suggesting the larger the department, the more sick leave days taken ($r_s = -0.077$, $p=0.001$).

Table 4 summarises the top three ranked possible reasons respondents chose as their primary reasons for working through illness with 1 being the most important. Additional correlation tests suggest that respondents who ranked 'duty to patients' ($r_s = -0.052$, $p=0.030$), 'not wanting to burden colleagues' ($r_s = -0.115$, $p<0.001$), 'fear of appearing 'weak' compared to other colleagues' ($r_s = -0.124$, $p<0.001$) and 'anticipation of extra workload on return to work' ($r_s = -0.098$, $p<0.001$) as important variables in deciding whether or not they would take sick leave were less likely to have higher numbers of presenteeism days. Those strongly endorsing 'not feeling unwell enough to stay home' were more likely to have higher numbers of presenteeism days ($r_s = 0.052$, $p<0.001$).

Qualitative results

Responses in the free-text section of the survey ranged in length from one sentence to multiple paragraphs. Analysis of the recurring themes emerging from these comments suggest that presenteeism is inflected by issues concerning structural factors associated with the workplace, including availability of cover, idealised and gendered norms about what it meant to be a medical professional and debates over acceptable thresholds of illness (Table 5). Comments suggested there were important intersections between types of illness and reasons for taking sick leave and highlighted the importance of collegial

recognition and management support as enabling factors for individuals to stay away if they were unwell. Many of the comments referenced more than one theme simultaneously, suggesting the complex and imbricated nature of the problem.

Discussion

The two estimates of presenteeism used in this report are internally consistent with each other. Combined, they suggest presenteeism is a common phenomenon in this senior medical workforce, with more than half reporting coming to work unwell often and sometimes in a 24-month period. These results are in line with findings from other studies into medical professionals in New Zealand^{15,16} and internationally.^{17,18}

In all cases, the score for coming to work unwell or infectious 'sometimes' was consistently higher than 'seldom' or 'never'. The same trend held with respect to perceptions of colleagues coming to work too unwell to perform to their usual standards. This suggests that there is a high self-awareness of presenteeism within this senior medical workforce as well as indicating that respondents are aware of when their colleagues are unwell and how it can affect their performance. The rates estimated for coming to work infectious are of particular concern given the vulnerable patients that some of the senior doctors are likely to be in contact with. The potential for doctors as vectors in the transmission of illnesses is well documented^{2,5} and most of the respondents who left comments readily acknowledged that this was less than ideal behaviour. The high rates of presenting while known to be infectious may reflect an ambiguity as to when symptoms represent a risk to patients, but most likely reflect the considerable pressures that senior doctors face to present at work even when experiencing serious illness; for example, one respondent described being seen in an emergency department while ill with pneumonia then running back to conduct a clinic (comment 175).

The rates of overall presenteeism reported in the senior doctors involved in this study are comparable to those reported in doctors in other studies although this study had more participants than others—1,806 compared with 614¹⁷ and 328.¹⁵ In light of

Table 5: Categories of themes identified in the free-text section of the survey with illustrative quotes.

Macro level themes	n/660 (%)	Sub-themes	Illustrative comments
Workplace factors	441 (66)	Issues of cover, 'no slack in the system'	"There is no provision for SMOs [senior medical officers] to take sick leave as there is nobody to cover the duties. I would feel too guilty as it causes chaos and huge inconvenience to patients who have to be cancelled. So unless I physically can't get out of bed, I would still turn up to work." (Comment 201)
		Difficulties cancelling clinics	"The main reason is that if I don't turn up, there is a clinic full of patients sicker than me who miss out. Given resource constraints, rebooking these patients elsewhere is a NIGHTMARE [emphasis in original]. There is absolutely no cover for unexpected leave." (Comment 497)
		Anticipation of workload on return	"If I do not turn up, there is simply no one to take over my workload—it simply waits until I return, then gets added into whatever has already been booked. It's easier to just keep working." (Comment 420)
		Not wanting to burden colleagues	"The main issue for me is worrying about who is going to be doing my work if I am not there. There is not the resource to cover sick leave without major inconvenience to other colleagues. I once felt obliged to come in to hospital on my day off to do a post-acute ward round for my colleague who had called in sick, because no other cover could be found (and it was my team that was uncovered, although I was off service at the time). Collegiality dictates that we help each other out when things are not going right, and that is fine, but it is often not recognised (apart from the colleague you are covering for) and completely relies on each other's good will. There is little formal provision for cover of sick leave." (Comment 17)
		Institutional processes to enable sick leave	"I think that the main reason people don't stay home when they should is that they fear that their colleagues will resent them the extra workload. By attending, however, they risk getting other people sick and exacerbating the problem. I feel it is important that there is a clear departmental message of 'if you're sick, stay away' so that people don't feel like they must attend no matter what." (Comment 447)
Sociocultural norms	249 (38)	Sick leave as risk to profession	"Patients are a lot less fortunate than me. There is no excuse for having a day of sick leave for feeling unwell." (Comment 95) "Presenteeism is not usually due to illness but laziness!! Some people take excessive sick leave. That's more of a problem." (Comment 213)
		Sick leave as weakness	"There is a culture amongst the older members of the department that one doesn't take sick days unless dying ... Management attitude is a throwback to an earlier time when the Head of Department (now thankfully removed) had a super-hero attitude and expected us all to work even when fatigued and proudly told the story of his wife operating with pneumonia." (Comment 285)
		Doctors don't get sick	"Recently I tried to challenge our culture of working despite being sick, and was told by my colleagues that if the SMOs stayed at home when they were sick there would be no one to look after the patients. Our unit has a strong 'SMO superhero' culture where SMOs are expected to work when sick and not thought to need sleep." (Comment 563) "Doctors don't get sick till they can't walk. This is our culture." (Comment 465)
		Commitments to workplace versus commitments to self and family	"All the same issues of presenteeism and the miserable pressure to attend occur when a child is sick also. Complete lack of support and understanding from colleagues. Often take child into work when unwell too! Or throw them back into school when still unwell to get me back to work. If there was any other way than taking time off, I'd be doing it already. Any time off is implied to be slacking—annual/study leave included. How ridiculous this has all got." (Comment 517)
Acceptable thresholds of illness	199 (30)	Types of illness including psychological illness and the 'visibility' of illness	"Physical illness is barely 'tolerated' amongst the SMOs but psychological stress (when we are 2 FTEs [full-time employees] down for 8 months and now 3 FTEs down for the last month) is even more 'not tolerated'—[The] EAP [Employment Assistance Programme] is doing very well from me though!" (Comment 483)
		Infectious versus non-infectious illnesses	"The main scenario for me and I would consider for most, is upper respiratory tract infections and trying to determine how unwell I am in terms of my own functioning, infectiousness and what clinical burden I am leaving for my colleagues to cover. Usually in this circumstance with mild to moderate symptoms I battle through the week limiting myself to mainly clinical work and then utilising my free time at the weekend for recovery." (Comment 261)
		Thresholds and fatigue	"...the issue of threshold is important; I don't think I know what is reasonable in terms of when to be away, in particular threshold when 'on call'. I've raised with colleagues and others were likewise unsure and our thresholds varied (but typically were high)." (Comment 212)

the wider literature on presenteeism in the medical workforce and the qualitative data collected in this study, it is entirely feasible that the medical professionals involved in these studies have a very high threshold for recognising 'illness' in themselves. Relying solely on the medical professional's own perception of whether or not their state of health would have required sick leave may have resulted in an underestimation of their presenteeism rates. This possibility is further suggested by the very low rates of sickness absence recorded for this cohort in both this and other studies.^{15,16} This study, however, had no way of situating the presenteeism rates estimated with an objective health assessment of the survey respondents. It would be useful to be able to assess whether or not there is a relationship between the presenteeism rates reported and the 'health' of the survey respondents as a whole. As a consequence, it is impossible to assess whether the presenteeism rates reflect underlying rates of chronic illness or other factors.¹⁹

The positive association recorded between the quantitative counts of presenteeism and the days of sick leave taken by the survey respondents was consistent with that in a previous study.¹³ This positive relationship suggests that as the number of sick leave days increase, so too does the number of presenteeism days. The factors contributing to this relationship are likely to be complex, and arguably the study has no way of objectively interrogating the reasons for this association. Nevertheless, with 48% of respondents aged over 50 and 15% aged 60 and over, this may have implications for the underlying health status of respondents. For example, some respondents qualified their amounts of sick leave reported in the survey as required (and planned) for specific surgical operations, or for recuperation from cancer treatment: "I would just like to add that the 10 days sick leave I took [was] because I had undergone an operation and the surgeon told me I had to stay home." (Comment 203). The related high rates of presenteeism could suggest that other than taking large chunks of sick leave for operations or planned procedures, the specialists in this study generally continue to work through illness. It would have been useful to compare the sick leave rates with

the recorded sick leave days held by the respective DHBs to further interrogate this relationship although this was not possible in the current study.

The positive relationship found between size of department and number of sick leave days taken suggests that there may be a relationship between the willingness and ability of individuals to take sick leave and the number of specialists present in a department. In the New Zealand DHB context, locums can be provided in some circumstances if sick leave is planned in advance; for example, for an individual's planned surgery. It is unlikely, however, that formal cover will be provided or is even available for short-term unanticipated sick leave. It is generally expected that other staff will 'cover' the additional workload. It is entirely likely as a consequence, that this cover is more readily available in larger departments. Due to the cross-sectional design of the survey, causality cannot be inferred, but this relationship warrants further investigation.

The close association suggested between presenteeism and sick leave supports other research that finds sickness presenteeism and sickness absence as two sides of the same decision-making process.^{20,21} As other commentators have suggested, low rates of sickness absence is not necessarily an indicator of the absence of sickness.²² Indeed, what emerges from these findings is a clear pattern of coming to work when ill at the expense of taking legitimate sick leave and feeling unable to take legitimate sick leave because of various structural and cultural barriers.

The correlation analysis suggested that women and younger senior doctors were more likely to assert presenteeism and presenteeism with an infectious illness in the survey than their counterparts, as measured by both the quantitative counts and the Likert scale responses. This pattern is consistent with other findings.^{15,18,22} It was suggested by the qualitative comments that female respondents are more likely to experience pressures to reserve their sick leave for when dependents are ill, and this pressure may not apply to their male counterparts.^{23,24} Other research,²⁵ for example, notes that female professionals are still likely to have primary responsibility for

‘caregiving’ in addition to their formal work responsibilities.²⁶ Simpson²⁷ also notes that women with young children are more likely to cite conflicting demands of home and work than their male colleagues and to cite this conflict as a driver for presenteeism.

Other authors⁹ found physicians aged between 30 and 39 were the most likely to work through illness than their older counterparts. They suggest that this was due to the intensive training requirements this cohort were likely to be involved in, but also because of additional vulnerabilities experienced by younger medical professionals who are still trying to establish their positions in the medical workforce.²⁸ Other research supports the idea that presenteeism is common among sectors of the workforce who feel a need to demonstrate a more visible commitment to their workplace as well as those who are trying to ‘impress’ seniors.²⁹ As illustrated in Table 5, presenteeism was described in the qualitative comments with phrases such as ‘superhero’ and the ‘culture’ of medical professionals referenced to justify expectations that doctors ‘soldier on’ through illness. Underlying many of these references to expectations of working through illness were subtle gendered references and comparative descriptions that suggested presenteeism is an important signifier of what it means to be a senior doctor. Sick leave was cast as a negative ‘weakness’ that deviated from the ‘norm’ with some respondents describing it in ways that signalled unprofessional or less-than-collegial behaviour.

Nevertheless, some of the comments in the qualitative section of the survey suggested that senior doctors had ‘wised up’ to the importance of taking sick leave and noted specifically that while they had definitely worked through illness when younger, they no longer felt pressured (or felt better able to resist the pressures) to do so. For example, one respondent noted that “I am less likely to attend work when unwell now than when I was younger. It has taken some time to overcome the fear of being thought ‘weak’ or a shirker to get to this point.” (Comment 209). Many also spoke about needing better guidance and more support from management to help them feel that it was ‘ok’ to ‘stay away’ from work.

The reasons for working through illness cited in this study are broadly consistent with other research that suggests concern for impact on colleagues and notions of duty to patients as important reasons behind presenteeism behaviour.¹⁵ The findings from this research suggest that not feeling unwell enough to take sick leave was less important than the concern for co-workers, feeling of duty to patients and having clinics already booked.¹⁶ The findings from the qualitative data generated by this study reiterate the importance of these variables, but suggest additional factors and more nuanced explanations for the behaviours revealed in this study. Viewed alongside the quantitative patterns, the qualitative data adds considerable depth to understanding the complex issues and decision-making processes that surround presenteeism behaviour.

Summary and conclusions

The results from this survey provide a comprehensive insight into both rates of, and motivations for, presenteeism within this large cohort of senior doctors across New Zealand’s DHBs. The findings from this research suggest that presenteeism behaviour is common, well recognised and an issue of concern. The rates displayed for this target group are consistent with other research into medical professionals both within New Zealand and internationally. The combination of the qualitative and quantitative findings provides a rich and nuanced examination of the complexities that surround presenteeism and suggests that the ‘choices’ available to senior medical doctors about whether or not to attend work when unwell are shaped by multiple considerations.

The findings suggest that participants are keenly aware of the pressures on New Zealand’s public health system and emphasise the limited scope within DHBs for short-term sickness cover. The research suggests that senior doctors are attentive as to how taking sick leave can add to the workloads of their colleagues, and that this can be a barrier to taking legitimate leave. It further suggests that senior doctors are very concerned as to how sickness absence

can impact negatively upon the ability of their patients to access the health care that they require. Conversely, however, the high rates of continuing to work while unwell and while infectious suggest a worrying picture where the potential for further risk of harm to both practitioner and patient alike is considerable.

Importantly, presenteeism is unlikely to decrease if individuals are operating in environments where working through illness is viewed as 'normal' or, at worst, 'necessary' behaviour. Creating an environment that fosters work–life balance, including greater recognition of the challenges faced by working parents who have ongoing responsibilities for dependents, needs more explicit support. Taking sick leave must be reframed by those in positions of leadership as responsible and healthy behaviour. What is clear from the research is that the senior doctors in this study value the support of their colleagues and will work through illness in order to avoid overburdening their peers. Finding a middle ground where it is 'ok' to take leave without being seen to be 'letting the side down' will require better cover arrangements as well as a crucial shift in attitude and culture.

This research also suggests that notions of wellness need to be expanded to encompass the significance of psychological illness as well as fatigue and burnout. Encouraging a culture within the medical workforce that recognises the impact of having workers who are struggling as a consequence of depression, fatigue and emotional exhaustion would be an important step in recognising these factors as legitimate reasons to take time off work while simultaneously encouraging a culture of self-care in this critical workforce.

There are limitations to the current study; in particular, the already noted reliance on self-reported rates of both sickness absence and presenteeism. This reliance on self-reporting may have resulted in some under or over reporting of the data. It would be helpful to include an objective measure of

sickness absence rates as well as including a measure of self-health assessment. Both these additional variables would enable comparison between the rates of presenteeism and some measure of the health of the respondents. For example, there was no way of assessing what types of illness were associated with the rates suggested in this study. Additional variables that could be of relevance to presenteeism behaviour might include number of dependents, ethnicity and working arrangements. While the 48% response rate is reasonable, response bias may be present. It is possible that those who have worked through illness in the past may have been more interested in participating than those who haven't. Further, it must also be asked whether the mode of delivery, in this instance an online survey, may have shaped the responses and the patterns of who responded. A related limitation of the study was the low number of responses in certain categories. For example, there were very few respondents in the 20–29 age group, although this reflects the MCNZ workforce survey,³⁰ which recorded no specialists in this age group, only 28 medical officers. As a cross-sectional design, the associations between various factors do not establish causality but they certainly warrant further examination. Where relevant, this has been noted in the analysis. It is important to consider that unmeasured factors may be at play that could serve to mask or confound the results. Further analysis and more detailed questions are required to investigate these trends further, which was not possible in the current study.

Presenteeism poses clear risks to patients and practitioners alike. Turning up to work while unwell reflects the high value placed on medical professionals' duty of care but also the tensions to do with defining responsible behaviour in this regard. It is clear from this research that the senior medical workforce is under stress. Solutions must prioritise patient health and safety while continuing to find strategies to improve staffing levels and morale.

Competing interests:

Nil.

Author information:

Charlotte Chambers, The Association of Salaried Medical Specialists, Wellington; Chris Frampton, Biostatistician, Faculty of Medicine, University of Otago, Christchurch; Murray Barclay, Clinical Professor, University of Otago, Christchurch.

Corresponding author:

Dr Charlotte Chambers, The Association of Salaried Medical Specialists, PO Box 10763, Wellington 6143.

cc@asms.nz

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