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**Biases in presenteeism decision-making:
Is working whilst unwell the default option?**

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Abstract

Presenteeism, defined as “working in the state of ill-health” (Ruhle et al., 2020; p. 346), is highly prevalent but remains relatively poorly understood. This study offers an in-depth examination of the critical decision-making process that determines when and why individuals engage in presenteeism, underpinned by the presenteeism decision-making process model (PDMP, Whysall, Karanika-Murray & Chen, 2023). Participants completed daily diaries every working day for 2 to 6 weeks, during which 121 experienced ill-health symptoms on a workday, resulting in 476 ill-health incidences captured. Findings revealed that work-related considerations dominate presenteeism decision-making, often requiring a substantial worsening in symptoms to prompt more deliberate consideration of options. Reflection on decisions is rare, and when it does take place, focuses on the impact on work rather than health. Thus, there is an opportunity to encourage individuals to more consciously reflect on the consequences for both work-performance and recovery.

Keywords

Presenteeism, decision-making, health, performance, diary study

Word count (excluding references): 6,565

Introduction

Presenteeism, defined as the “behavior of working in the state of ill-health” (Ruhle et al., 2020; p. 346), is a highly prevalent phenomenon across occupations (Marklund et al., 2021) but is also relatively poorly understood and weakly addressed. The traditional view of presenteeism is that of a substantial but silent negative force. The UK Chartered Institute of Personnel and Development annual survey (CIPD, 2021) identified that 84% of respondents reported presenteeism when they worked in the office or at home during the Covid-19 pandemic, yet only 43% of respondents’ organisations had taken steps to address it. The costs of presenteeism are high for both individuals and organisations, not only presenting a risk to individual health, but also leading reliably to long-term sickness absence (Bergström et al., 2009; Janssens et al., 2013), and being extremely costly to organisations (Homrich et al., 2020).

However, scholars have also identified positive aspects of presenteeism for both health and performance, highlighting its potentially functional and adaptive side (e.g., Karanika-Murray & Biron, 2020; Ruhle et al., 2020). For example, presenteeism has been positively associated with individuals’ increased performance evaluation under high work demands (Wang et al., 2022) and can even be therapeutic for those who work in a supportive social environment with adjusted demands, thereby presenting a potentially positive alternative to long-term sickness absence (Miraglia & Johns, 2016; Karanika-Murray & Biron, 2020; Whysall et al., 2018). Yet, knowledge that can inform practical solutions to address the negative and support the positive aspects of presenteeism is still limited.

To promote functional and minimize dysfunctional presenteeism, it is essential to understand *how* individuals make decisions to continue to work when experiencing ill-health (Whysall et al., 2023). To date, a rich body of research has identified a wide range of factors that can influence presenteeism (see Lohaus & Habermann, 2019 for a review and integration) and a range of consequences of presenteeism behavior (Skagen & Collins, 2016). However, research is yet to unwrap the process and mechanisms via which individuals make decisions to engage in presenteeism behavior. As articulated by Patel et al. (2023), “while an examination of antecedents of presenteeism is valuable, it is of equal importance to understand the dynamics underlying the actual decision process.” (p. 840). Lack of insight regarding the process of attendance decisions severely limits our understanding and therefore our ability to manage attendance behavior and, importantly, the negative side of presenteeism.

The decision-making process is subject to a dynamic interplay of various factors and series of events in one’s job and workplace context, however it is not yet known how different antecedents may interact at the point when the individual is deciding between presence and absence to determine if they will continue to work under ill-health or take absence from work (Gosselin, 2018; Lohaus & Habermann, 2021). Building on attempts to explain the individual decisions that give rise to presenteeism (Lohaus & Habermann, 2021), and explore the process of decision-making behind presenteeism (Whysall et al., 2023), this study offers to deepen our understanding of the decision-making process, *in situ*. The study’s conceptual underpinnings are provided by the presenteeism decision-making process model (PDPM, Whysall et al., 2023), which integrates existing presenteeism research and decision-making theory to outline four stages of the presenteeism decision-making process (see Figure 1). The PDPM addresses both absenteeism and presenteeism decisions, since they are potential outcomes of the same trigger (Halbesleben et al., 2014; Patton & Johns, 2012). The current study utilises an experience sampling approach to examine this decision-making process in real-time when ill-health symptoms are experienced on a working day. Of particular interest in terms of potential biases in this process, is how, after detection of an ill-

health symptom has triggered the initial rapid assessment of their health and work capabilities, the decision-maker identifies the options available to them.

An enhanced ability to understand the presenteeism decision-making process offers substantial potential contributions. First, it can propel research on understanding the individual presentee: how and when they decide to engage in a specific behavior. This is especially important given the broad range of combinations of health issues and work demands that may impact the experience of work and the inappropriateness of one-fits-all solutions in attendance research. Second, it can inform better management of attendance behavior and help to create healthier and more flexible work environments for individuals struggling to balance their health limitations and performance demands (Karanika-Murray & Biron, 2020). Third, it can promote functional presenteeism (Karanika-Murray & Biron, 2020), when working while ill cannot be avoided, thus supporting recovery while maintaining work commitments. Next, we synthesise relevant existing literature to outline the main research questions to be addressed in the study.

Literature Review and Research Questions

The presenteeism literature suggests that the decision-making process of presenteeism is triggered when a health event is experienced on a working day, which activates the individual to conduct a rapid assessment of their ill-health symptoms in terms of severity and impact on work capability (Johns, 2010). It is speculated, but not yet empirically tested, that absenteeism may be the automatic decision when an individual's work capability is directly and severely impaired by their symptoms (Johns, 2010). Thus, it is important to explore in-depth and in a time-sensitive manner, *how* initial symptom severity influences the decision-making process in relation to attendance options.

Research Question 1. How does initial symptom severity influence the decision process and subsequent attendance outcomes?

Following this trigger, identifying available options is an essential step in any decision-making process (Eisenfuhr, 2011), aligning with the pre-decisional phase of the Rubicon model (Heckhausen, & Gollwitzer, 1987) where individuals will consider what options are available to them based on their circumstances. For presenteeism vs. absenteeism, where the focus is on balancing health and performance demands (Karanika-Murray & Biron, 2020), identifying feasible options involves consideration of how the health condition affects work capability, for example, “what options are available to me at my workplace?” and “what tasks am I able to carry out with my symptoms?”. Importantly, ‘options’ here refers not only to a binary choice between absenteeism and presenteeism but also to different variations of presenteeism (Whysall et al., 2023). The option between working and resting is not dichotomous, especially in view of the increase in flexible work and portfolio work that characterizes modern knowledge work. Indeed, there is a range of options between full and partial working (e.g., attending to a limited range of tasks only, working but performing a poor job, or working reduced hours) generated from different work task adjustments to accommodate health limitations or capacities (Karanika-Murray & Biron, 2020). Therefore, the options available describe what the individual believes they can do under compromised health, how they can adjust their tasks or commitments, and what type of attendance behavior may be deemed more appropriate.

Anchored in dual processing theory, a widely accepted explanation of the cognitive processes characterizing decision-making (Kahneman, 2003; Kahneman, 2012; Wason & Evans, 1974), we propose that the identification of available options is likely to be influenced by biases and heuristics such as priming, framing effects, salience and availability biases

(Tversky & Kahneman, 1973, 1982). Decision-making theory suggests that the identified options are not necessarily a perfect reflection of the options available, but a set of perceived available options filtered by a relatively rapid, automatic 'system 1'-driven process heavily influenced by situational cues, biases and heuristics such as priming, framing effects, salience, and availability (Kahneman, 2003; Kahneman, 2012; Tversky & Kahneman, 1973, 1982). For instance, since presenteeism is much more common than absenteeism (e.g. Whysall et al., 2018), availability bias may render presenteeism a more salient option. Furthermore, because of this most decisions are made by people whilst they are still at work, this may prime individuals to attend to work demands, again making presenteeism options more salient. On the other hand, available options may be severely restricted in some cases due to, for example, certain health conditions which may be considered to necessitate sickness absence (Busemeyer & Johnson, 2004). Thus, extent to which decision-makers consider there to be presenteeism and/or absenteeism options available to them, is unknown, and the factors that influence the perceived available options requires investigation.

Research Question 2: What options do employees perceive as available to them when they experience ill-health on a working day?

To select an option, decision-makers evaluate the extent to which the available options will most likely meet their needs, goals, priorities and expectations (Whysall et al., 2023). This aspect of the process revolves around the intrapersonal conflict between the individual's desires (motivation) and what they believe they should do (volition) (Heckhausen, 2007), and is likely to involve comparison of anticipated consequences against the individual's valued outcomes (Vroom, 1964). In the context of attendance behavior, this necessitates a nuanced judgment of likely consequences of presenteeism and absenteeism by weighing up health symptoms (e.g., severity, prognosis, etc.) against work considerations such as job demands (Demerouti et al., 2009), ease of replacement (Aronsson & Gustafsson, 2005; Biron et al., 2006), adjustment latitude (Krohne & Magnussen, 2011), and impact on and/or reactions from colleagues and superiors. Thus, while it may seem reasonable to assume that individuals experiencing ill-health symptoms would want to take sickness absence and rest, this is not always the case. When the goal to preserve work-performance is stronger than the motivation to recuperate, particularly when the consequences of taking sickness absence are perceived as detrimental to work-performance goals either as a result of disapproval from superiors or workload piling up, sickness presenteeism is more likely to be adopted.

However, consistent with dual processing theory, this is unlikely to be entirely deliberate or rational; evaluation of options may be influenced by heuristics, leading to rapid and more automated decisions under some circumstances. Specifically, prospect theory (Kahneman & Tversky, 1979) posits that decision-makers are inherently more strongly influenced by the prospect of avoiding a loss than acquiring an equivalent gain (risk aversion). A similar bias towards over-weighting losses and under-weighting gains is also reflected in the COR theory of organisational stress (Hobfoll, 1989, 2001), in which valued resources commonly include health, well-being, family, self-esteem, and a sense of purpose and meaning (Hobfoll et al., 2018). In terms of presenteeism, all such valued resources may be subject to potential losses or gains as a result of attendance decisions, depending on the circumstances. With a mental health issue, for example, conservation of health resources could lead to a decision to take sickness absence, if work-related factors (e.g., demands or work relationships) are considered to be aggravating or causal factors. However, under other circumstances, conservation of health resources could provide a motive for selecting presenteeism, if the workplace is a positive one which provides social support, structure and a sense of purpose. In addition, people prefer certain outcomes, tending to undervalue

outcomes that are only probable, and therefore will shift to risk-seeking when one of the options is a certain loss (Kahneman & Tversky, 1979). In the case of attendance behavior, since the possibility of health-gains as a result of taking sickness absence is not guaranteed, yet productivity loss is a certain outcome of this option (perhaps in addition to reputational loss and other detrimental outcomes), prospect theory may explain a preference for presenteeism since it reflects a preference for the avoidance of *certain* productivity and potentially reputational losses above *potential* gains in relation to health if one were to take sickness absence.

Research Question 3: To what extent is the evaluation of options influenced by work-related compared to health-related considerations?

The final stage in the PDM process is the Feedback stage, which involves an ongoing assessment of whether the decision was the ‘right’ one, considering its positive and negative consequences on either work or health (Whysall et al., 2023). This may take place during an episode of ill-health, as a reconsideration of whether the chosen behavior was the right one, or after, influencing future decisions via a feedback loop when one reflects on what transpired previously when I was unwell on a working day. In line with the post-decisional phase of the Rubicon model (Heckhausen & Gollwitzer, 1987), it is proposed that individuals will evaluate whether the chosen behavior is helping them to achieve their goals, or, in the case of a previous ill-health episode, reflect on the consequences and the extent to which it helped them achieve their goal, whether that be recovery or maintaining work-performance. Intended and unintended consequences of presenteeism (Lohaus & Habermann, 2019), as well as task feedback, feedback from others, and self-reflection (Tindale, 1989) are expected to feed into this stage. If considered to have had a detrimental impact on valued-goal progress, the desire to fix the discrepancy between motivations and actual outcomes would emerge and is likely to influence both current (if an ongoing health-issue) and future decisions. This imbalance of negative consequences outweighing positive ones creates a learning feedback loop (Montgomery, 1983), as reflected in the PDM.

Feedback on the chosen behavior, health symptoms or work priorities or effectiveness may lead the presentee to reprioritize health or work concerns. For example, a judgement on whether the presenteeism behavior yields positive outcomes (or no change) in both health and performance, is deleterious to one or the other, or proves to be dysfunctional for both, may lead to different types of presenteeism, as described by the health-performance framework (Karanika-Murray & Biron, 2020). Here, the mechanisms are similar for the evaluation of options. For example, the potential loss associated with taking sickness absence may be more concerning and immediate for individuals, due to risk aversion (Kahneman & Tversky, 1979). Similarly, the illusion of control (Langer, 1975) may render work rather than health-related concerns more central in evaluations of whether the decision was the right one.

Research Question 4. What role does reflection play in employee attendance decision-making?

Method

Design

The study adopted an experience sampling or daily diary approach to examine the presenteeism decision-making process. The daily diary approach can reduce recall bias, which is an issue with retrospective research (Conway & Briner, 2012; Myin-Germeys et al., 2018). It allows to capture individuals’ experiences in real-time and in a natural setting

(Delanoeije et al., 2019), which can mitigate post-hoc rationalizations and possible alterations in individuals' perceptions of an event (Nisbett & Wilson, 1977). Furthermore, the online structured self-report diary method as used in this study is well-suited for understanding the presenteeism decision-making process due to its ability to capture the relatively irregular occurrence of ill-health on a working day that necessitates decision-making regarding attendance behavior. Both open-ended and closed questions were used to enable participants to illustrate and describe their thoughts and actions (Parnell et al., 2020). A combination of quantitative and qualitative data enabled us to address both exploratory and confirmatory questions simultaneously (Teddlie & Tashakkori, 2009).

Participants and Procedure

Participants were recruited through a social media platform (i.e., LinkedIn), health-related research charities and organisations (i.e., MQ Mental Health, Lindus Health), and a survey administration service (i.e., Prolific). Recruitment resulted in an initial sample of 379 working adults (100 of whom via Prolific) who were invited to complete the online daily questionnaire every working day for 2 to 6 weeks, depending on their availability and willingness to continue, during June and August 2021. Participants received daily reminders in the afternoons of their working days. The daily questionnaire began with a screening question on whether the respondent was currently experiencing any health-related symptoms. If the participant reported positively, they were invited to answer additional questions relating to their health status, work status for that day (i.e., worked as usual, worked partially, claimed sick leave but still worked on some work-related tasks, or rested without completing any work-related tasks), and questions regarding how they made their decision. On each consecutive day, a check-in then was carried out and the participants were asked if their situation had changed. Participants were asked to 'check in' daily with two questions to (1) confirm that specific day was a working day and (2) report whether they had experienced any ill-health symptoms on that day. If they answered "yes" to both, they proceeded to answer questions on their health symptoms. If they answered "yes" to question (1) but "no" to question (2), they proceeded to answer questions on their daily productivity. The questionnaire ended for that day if participants indicated that that specific day was not a working day. The final sample comprised 121 individuals who provided 1019 observations over 2 to 6 weeks, during which time 476 ill-health incidences were captured. Of these, 78 were female (64.5%) and 40 (33.1%) were male. Their mean age was 37.5 years ($SD=11.7$, range 21–71), mean tenure with the current employer was 6.2 years ($SD=6.3$, range <1–33.5), and the average number of working hours was 38.3 weekly ($SD=11.1$, range 3–70).

Measures

Health issues were assessed by asking participants to indicate the health issues they were experiencing, from a list of 14 most common health issues compiled from the literature (e.g., MedlinePlus, n.d.; Office for National Statistics, 2020; the Council for Work & Health, 2018; Whysall et al., 2018), for example: "Anxiety, depression, stress", "Infectious illnesses (e.g., the flu, gastrointestinal problems, Covid-19)", and "Headache/migraine". An 'other' option was also included for respondents to specify their health symptoms which were then manually categorized.

Presenteeism was measured by assessing work attendance (presenteeism and absenteeism) as a multiple-choice question. Since the choice between presenteeism and absenteeism is not binary, the response options reflected a range of combinations of presenteeism and absenteeism: (1) "I did not take sick leave and I worked (from home, my workplace or elsewhere) even though I am/was feeling unwell", (2) "I did not take sick leave and I had the flexibility to work part of my day or complete part of my tasks only", (3) "I

took sick leave after I worked for part of my day”, (4) “I took sick leave but still did some work-related tasks (e.g. replying to work emails) after I have officially declared myself as on sick leave”, and (5) “I took sick leave and I did not do any work-related tasks (e.g. replying work emails) all day”. If none of these statements were suitable, participants were asked to type in their answers. Options 1, 2 and 4 indicated presenteeism and option 5 indicated absenteeism (coded as 1 and 0 in logistic regression, respectively). Option 3 indicated a combination of both and was thus excluded from logistic regression and the total $n = 456$.

Presenteeism decision-making was measured by asking participants to write their thought processes in four open-ended questions and supporting probing questions for each, based on the four stages in the PDM. For instance, participants were asked to reflect on what triggered them to consider whether they should work or not on that day. Probes included: “What made you start thinking about working or not?” and to identify the options they considered. Probes included: “What were the available options you had? (e.g., taking sick leave; working on urgent tasks only and postpone the rest for later when I feel better; working as usual, etc.)”, “What made you feel that you have those options?”, and “What tasks were you able to carry out with your health issue(s)?”. Evaluation of options was assessed by asking the respondents to explain how they evaluated their options and determined their action. Probes included: “How did you evaluate the available options?”, “What did you consider when making the decision?”, and “At which point did you feel like you had reached the preferred option?”. Finally, the feedback stage was assessed with three “Yes/No” questions, which were “Did you think about the possible outcomes for your options?”, “Did you consider whether you made the right decision?”, and “Did you reconsider your decision?”, before asking participants to provide explain their answers. Probes included: “What were the possible outcomes you estimated?”, “Why did you feel that you made the right decision?”, and “How many times did you change your mind and why?”. Participants were reminded that the probing questions were to be used as assistance only.

Analyses

Thematic analysis was conducted on the qualitative data in NVivo (Version 12, 2018). Braun and Clarke’s (2006) six-phase method was followed, which included familiarization with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the findings. This approach allows for the identification of themes that are cross-referenced to the data and for the use of either deductive or inductive approaches (Hayes, 1997). Descriptive statistics were generated for the quantitative data using SPSS (v.28).

Results

Overview of Health Issues and Decision Outcomes

The 121 diary respondents provided 1109 daily entries of which 476 involved health incidents and therefore required attendance decisions. Of these, 421 decisions (88.4%) were for presenteeism and 35 (7.4%) for absenteeism. The remaining (4.2%) were a mixture of working when sick for part of the day and taking sick leave for the rest of the day. In 3.0% of the presenteeism cases, participants worked despite having declared to have taken sick leave, demonstrating the complexity of attendance behaviors.

The Presenteeism Decision-Making Process

In terms of the influence of initial symptom severity on the decision-making process and subsequent attendance outcomes, participants’ qualitative articulations showed that in some circumstances of high symptom severity participants tended to struggle in, despite feeling

incapable of doing their work. However, this resulted in them either being ‘sent’ home by a manager or deciding to stop/leave work due to an increase in symptom severity, triggering the need for absenteeism instead. As described by these participants:

“I went to work even though I had a temperature, as I felt I wasn’t ill enough to warrant time off... I thought I was well enough. One hour in, I felt so bad I had to ask for a cover teacher because I was not able to interact with the students or manage their behaviour in a way I felt was good enough.” (P116)

“I was sent home early... I was told I need not come in the following day but I felt I could not let my team down...” (P102)

In terms of the options that employees feel are available to them when they experience ill-health on a working day, although participants were aware of a range of alternatives, (e.g. working as usual, working from home, taking sick leave, working on urgent tasks only, having more breaks during work, having a shorter working day, flexible working hours), a clear difference was apparent between what was available and what the individual perceived as feasible. Importantly, perceived feasibility did not tend to be driven by health-needs/the nature of the health condition. The qualitative data demonstrate how perceived available options were heavily biased towards options that met work-related demands in comparison to health-related needs, which appeared to lead to a high threshold for the level of symptom severity at which sickness absence was considered a genuine option. For example:

“I honestly felt like I really didn’t have any options today... postponing a class full of my company’s leadership would have been a very poor career decision, so I decided to go into work today and present to the class.” (P049)

Understandably, a lack of work adaptations to accommodate ill-health appeared to have a severe limiting impact on perceived available options. This resulted in some individuals feeling that they had no other options than to either work as usual or take a leave of absence, despite the inference that if the company would allow it, more nuanced options would be feasible. When respondents perceived that they only had one viable option, the decision-making process of presenteeism was significantly shortened, essentially bypassing the evaluations of options. For example:

“Only option was to take sick leave as was unable to leave the house and employer does not support remote working” (P101)

In contrast, when flexible work adaptations were offered, not only did the likelihood of individuals enacting presenteeism increased, but the behavior was described in more functional terms; the broadening of perceived options made the decision more one including volition (and presenteeism a ‘pull’) rather than a forced choice (a ‘push’). For example:

“I think the fact that I can now work from home actually makes the decision to take sick leave slightly more difficult. I now could work from my couch or even bed rather than face a [two-hour] commute each way. It makes me feel more guilty about taking it, even though I know it is necessary.” (P030)

In terms of research question 3, that evaluation and selection of options would be weighted towards the conservation of work-related rather than health-related resources, thematic analysis supported the dominance of work-related considerations. For instance:

“I think my focus was a lot tighter on reputation as someone who has recently changed jobs, I don't feel as secure to stand out by taking sick leave as I do in an established position” (P017)

Building on this, the analysis pointed towards two different types of decision-making: single-factor and multi-factor. Single-factor decision-making was more rapid, simplistic, and potentially heuristic-based. Participants focused on one single factor, which could be work-related or person-related factors. For example, in addition to the examples presented above, participants described:

“I felt that it was easier to just push through and work rather than take sick leave etc. ... as I have lots of deadlines coming up in next few weeks” (P015)

This decision was made solely based on respondents' evaluation of their workload and upcoming deadlines. Similarly, individuals experiencing financial difficulties were very likely to concentrate mainly on monetary factors for their decision-making. For instance:

“I could take sick leave but that would mean forfeiting an entire day's wages, and that is not a financial decision I can afford to make right now” (P093)

In addition, supervisors' attitudes towards sick leave, as perceived by the participants, also stood out in their single-factor evaluation of perceived available options, often playing a decisive role in the decision between presenteeism and absenteeism. For example:

“I probably could have called my manager at home to tell him I was ill and didn't feel up to working, but he's the kind of person who's nice one minute and nasty the next. He also accused me previously of faking illness even though I had a really bad chest infection and came into work, but other times he's been fine.” (P011)

In contrast, it emerged that individuals with chronic health conditions or persistent ill-health symptoms typically engaged in a more thorough, deliberative, multi-factor evaluation to inform their decision. Even though a combination of work, personal and organisation-related factors were often included in this type of decision-making, work-related factors, again, tended to outweigh other factors. For example:

“I have chronic unpredictable [digestive issues] ... going to work when I am ill is not always advisable... However, I have to balance this with the constant hint that my employer will instigate capability procedures against me for my absence record. If I am off for more than a day... my manager... starts to ask questions. So, options were sick leave or [working] from home [whilst sick] so hiding the sickness as it is not recorded as sick. However, my manager... wants the workforce in the office.” (P018)

Regarding research question 4, the findings revealed that individuals tend not to reconsider their decision unless there is a change in their symptoms. For example:

“I did not reconsider my decision because I didn't feel ill enough. I felt good in comparison to previous times.” (P089)

Furthermore, participants' reflection on whether they had made the right decision tended to be dominated by work-related rather than health-related concerns. For instance:

"I made the right decision to work as I was able to get all work sorted so I have an easy [workday] on Thursday." (P011)

Specifically, coding of qualitative responses revealed that nearly half (169, 49.3%) of these decision reflections pertained exclusively to work-related concerns, 32 (9.3%) focused solely on health-related needs, while 76 (22.2%) indicated a dual consideration of both health and work-related concerns. No reflection took place in 66 incidents (19.2%). Indeed, it was typically only when the health symptoms worsened and/or persisted that individuals tended to reflect on their presenteeism decision and began to shift more towards a focus on their health. For example:

"I woke up [from] another poor night of sleep. The pain is very severe today... I logged in and tried to get on with my day from my bed, but I quickly [realized] that I would not be able to cope with the prolonged periods of concentration... My only other option was to call in sick... I do believe that I am so unwell today because I have 'powered through' work in days previously... at the expense of my own health." (P009)

Discussion

The current study set out to address a critical gap in our understanding of attendance behavior by investigating how individuals decide whether to enact presenteeism or absenteeism when they experience ill-health symptoms on a working day, and specifically, the potential influence of biases in this process. Using the process model of PDM (Whysall et al., 2023) as the conceptual foundation, qualitative and quantitative data were collected using experience sampling.

Critically, despite the increased flexibility offered by post-pandemic hybrid working, the findings reveal that work-related factors appear to dominate presenteeism decision-making, appearing to prime options that facilitate work-related goals, even restricting the range of options that individuals perceive as feasible in the first instance. Beliefs regarding the availability (or not) of flexible working options and other potential work adaptations play a central role in framing what individuals believe their options to be. This highlights the importance of organisations not only doing what they can to allow for work adaptations to accommodate health needs but also making the possibility of flexible work salient to employees, to reduce sickness absence and potentially help to shift dysfunctional presenteeism to functional presenteeism.

The findings also suggest that a worsening in symptoms acts as a prompt to engage in more deliberate consideration, initiating a shift away from the simplistic, heuristic-driven decision-making, in which the 'default option' is presenteeism, towards consideration of sickness absence. This may reflect a status quo bias (Samuelson & Zeckhauser, 1988) or risk aversion (Kahneman & Tversky, 1979). With status quo bias, individuals are more willing to maintain their current or previous decision (Samuelson & Zeckhauser, 1988) and feel worse if their change of action results in bad outcomes (Kahneman & Tversky, 1982). With loss aversion, the avoidance of loss associated with working as planned is considered more attractive, but when the ill-health symptoms deteriorate to a certain level, individuals will become risk-seeking as they are facing a loss-loss situation (Kahneman & Tversky, 1979). In this study, decision-makers gave more consideration to presenteeism options, which reflect

default options, better understood since they offer greater expected utility and less subjective uncertainty to decision-makers who face potential loss (Geng, 2016). However, it could be harmful if the default option is not optimal, but decision-makers may ignore helpful improvements due to status quo bias (Godefroid et al., 2022). Since continuous presenteeism can worsen health and increase productivity loss, effective management interventions are needed to mitigate potential negative impacts. Thus, early, external prompts would be beneficial to initiate a more deliberate consideration of alternative options including modified work or sickness absence, rather than allowing symptoms to worsen before considering alternative options.

In terms of how alternatives are weighed up and what factors are considered in this evaluation, two overarching types of decision-making were identified: single-factor and multi-factor evaluation. Single-factor evaluation describes decision-making that is more simplistic, based on one primary factor, work-related or personal. Similar to System 1 thinking, as described in Prospect theory (Kahneman & Tversky, 1979), it indicates that individuals make this is a rapid decision based by instincts and it is a relatively quick decision and based on heuristics. Multi-factor evaluation is more akin to System 2 thinking in Prospect theory; a more analytical and deliberate process. This was more common among individuals with chronic health conditions or persistent ill-health symptoms, consistent with previous research indicating that people with chronic health conditions normally have a higher optimism bias regarding their health risk (Clarke et al., 2000) and a stronger illusion of control towards their condition (Thompson et al., 1998). These biases could impact the decision-making process of attendance behavior, which could manifest in the evaluation of symptom severity and contextual factors, potentially leading one to rely on heuristics for making these decisions.

Work-related factors seem to play a crucial role throughout, dominating the presenteeism decision-making process. Not only do they seem to restrict the range of perceived available options, but also dominate the evaluation process through an emphasis on potential work-related losses and lack of consideration of potential health gains. For example, high job demands and insecurity may lead one to enact presenteeism irrespective of the severity of their ill-health symptoms. Similarly, when workplace attendance pressure norms are strong, presenteeism may be perceived as the only choice. Such work-related factors, combined with cognitive biases (such as loss aversion, the illusion of control, hyperbolic discounting of the delayed reward of recovery from ill-health, and the status quo bias), can exert a substantial influence on individuals choosing presenteeism over absenteeism.

Regarding the final stage of reflection in presenteeism decision-making, the findings suggest that when asked to evaluate whether they made the right decision to enact presenteeism, individuals' reflection is based mainly on considerations related to the impact on work rather than health. As a goal-orientated behavior aimed at balancing work and health needs (Karanika-Murray & Biron, 2020), this evidence of either no reflection or predominantly one-sided reflection, biased towards consideration of the extent to which the decision and subsequent enacted behavior has met work-related rather than health-related needs, has significant implications for understanding and optimising decision-making in attendance behavior. Thus, there is an opportunity to encourage individuals to more consciously and deliberately evaluate whether the chosen behavior is helping them to achieve their goals, reflecting on the consequences for both recovery and work-performance.

Implications for Practice

This diary study addressed a critical knowledge gap in the field of presenteeism, shining a spotlight on how individuals make attendance decisions when they are unwell, how they deliberate different options, particularly the balance of health and work demands, how

options are evaluated, and how attendance decisions are reflected upon, if so. Ultimately, a more rational decision-making process could support a more purposeful behavior that facilitates optimal adaptation to an experienced imbalance between reduced health capacities and performance demands (Karanika-Murray & Biron, 2020; Whysall et al., 2018).

The findings can inform the development of effective interventions to manage presenteeism and promote its functional form to both support individual health and maintain work performance (Karanika-Murray & Biron, 2020; Whysall et al., 2018). It is important to note that the flexibility afforded by the increased allowance for working from home (Kinman & Grant, 2021) has increased the likelihood of choosing presenteeism over sickness absence. Greater flexibility in work scheduling necessitates greater decision-making autonomy and may facilitate more presenteeism as opposed to absenteeism decisions, especially due to the existing dominance of work-related considerations. Increased autonomy may imply less management influence, and thus attendance decisions could easily fall into a negative cycle of additional health impairment and productivity deterioration. Indeed, increased presenteeism frequency is significantly linked to sickness absenteeism (Bergström et al., 2009). Therefore, there is a need for more structured managerial interventions to prevent prolonged and dysfunctional presenteeism.

Limitations & Implications for Future Research

The findings should be interpreted in light of the study limitations. First, whilst the experience sampling method strengthens context validity through realistic research with rich data on decision-making, it is dependent upon self-report (Csikszentmihalyi & Larson, 2014) which may be subject to its own biases and limitations due to introspective ability. The diary also necessarily restricted the horizon of potential factors that may influence attendance decisions. For example, despite the acknowledgement of contextual variables, structural restrictions such as organisational norms, attendance management systems, organisational culture and climate, or even leadership, were not included in the study. This was due to practical data-collection deliberations (for example, avoidance of priming participants or influencing their decisions with questions on attendance management policies) but also linked to potential disparities between what is espoused within policies and formal processes, and how these are enacted or how they manifest in reality (e.g., trigger points not acted upon, return-to-work interviews not conducted, etc.).

We hope that future research will build on these findings to further elaborate on the presenteeism decision-making process, focusing on sociodemographic variables, types of ill-health, and job/work-related factors, as well as the broader job and organisational context. A number of contextual factors have been linked to the occurrence or frequency of presenteeism (Lohaus & Habermann, 2019; Thun et al., 2013), which can potentially influence the decision-making process. These should be captured systematically in future research. For example, work and job-related constructs (e.g., job type, sector) or attendance management policies (either implemented or enacted) would help us to better explain the patterns in the decision-making process and the process itself.

Conclusion

This study set out to address a critical gap in our understanding of attendance behavior by exploring how individuals decide whether to enact presenteeism when they experience ill-health symptoms on a working day, using the PDPM (Whysall et al., 2023) as the conceptual foundation. The findings of a daily diary study revealed that work-related considerations tend to dominate presenteeism decision-making, priming options that facilitate work-related goals, even restricting the range of options that individuals perceive as feasible in the first instance. Beliefs regarding the availability of flexible working options and other potential work

adaptations play an influential role, highlighting the importance of organisations not only doing what they can to make work adaptations according to health needs but also making the possibility of flexible work salient to employees, to reduce sickness absence and help to shift dysfunctional presenteeism to functional presenteeism. Often, it appears that only a substantial worsening in symptom severity prompts more deliberate consideration of broader options, initiating a shift away from the 'default option' of presenteeism as opposed to absenteeism. In addition, the findings suggest reflection on whether it was the right decision is rare, and when this does take place, it is based mainly on considerations of the impact on work rather than health. Thus, there is an opportunity to encourage individuals to more consciously and deliberately evaluate whether the chosen behaviour is helping them to achieve their goals, reflecting on the consequences for both recovery and work-performance.

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