CHAPTER 4

Findings and Discussion

This chapter consists of research findings followed by the related discussions based on the research objectives of the study. The findings are presented in four parts with tables and descriptions as follows:

Part I: Demographic data of the nurses

Part II: Job stress as perceived by the nurses

Part III: Presenteeism as perceived by the nurses

Part IV: Relationship between each dimension of job stress and presenteeism of the nurses

Findings

Part I: Demographic Data of the Nurses

The demographic data of 282 nurses are presented in Table 4.

Table 4

Frequency and Percentage of the Demographic Data of the Nurses (n = 282)

Demographic data	Frequency (n)	Percentage (%)
Age (Years) (Mean = 37.55, SD = 8.45, Range = 21-59)		
21- 30	66	23.41
31- 40	124	43.98
41- 50	69	24.46
51- 59	23	8.15
Gender		
Female	200	70.92
Male	82	29.08
Marital status		
Married	204	72.35
Single	76	26.95
Divorced	1	0.35
Widowed	1	0.35
Level of nursing education		
Diploma in Nursing + specialty	147	52.12
Diploma + BSc. N (Post RN)	121	42.91
Generic BSc. N (4 years)	11	3.91
Master in Nursing	3	1.06
Years of working experience in nursing (Mean = 13.20, SD = 8.24, Range = 1-40)		
1 - 10 years	149	52.83
11 - 20 years	71	25.18
21 - 30 years	56	19.86
31 - 40 years	6	2.13

Table 4 (continued)

Demographic data	Frequency (n)	Percentage (%)
Monthly basic salary (Rupees: Rs.) (1 US$ = 105.50 Rupees: Rs.)		
20,000 - 35,000 Rupees	45	15.96
35,001 - 50,000 Rupees	149	52.84
50,001 - 65,000 Rupees	73	25.89
65,001 Rupees or above	15	5.31
Sample collected from 3 hospitals		
JPMC	135	47.87
CHK	109	38.65
ASH	38	13.48
Departments		
Medical	80	28.36
Surgical	51	18.08
Uro/Nephro	53	18.80
Gynae/Obs	46	16.31
Opp Theater (OT)	30	10.64
Eye/ENT/Skin	22	7.81

As shown in Table 4, the average age of nurses was 37.55 years old. The majority of nurses were female (70.92%) and the largest age group was between 31- 40 years old (43.98%). The majority of the nurses hold a diploma and specialty (52.12%). The largest group of nurses (52.83%) had between 1 - 10 years of work experience and earned a salary of 35,001 - 50,000 Rupees per month (52.84%). The largest sample from JPMC hospital (47.87%) and working in medical department (28.36%).

Part II: Job Stress as Perceived by the Nurses

The level of each dimension of job stress (work load, uncertainty concerning treatment, patients and their families, death and dying, problems relating to supervisors, problems relating to peers, conflict with physicians, inadequate emotional preparation, and discrimination) as perceived by the nurses is shown in Table 5.

Table 5

Mean, Standard Deviation and Level of Each Dimension of Job Stress as Perceived by the Nurses (n=282)

Job Stress	Minimum	Maximum	Mean	SD	Level
Overall Job Stress	75.00	210	151.82	24.57	Moderate
Work Load	9.00	39.00	24.66	5.35	Moderate
Uncertainty Concerning Treatment	11.00	36.00	23.79	5.39	Moderate
Patients and their Families	9.00	32.00	21.22	4.60	Moderate
Death and Dying	8.00	29.00	19.14	4.76	Moderate
Problems Relating to Supervisors	8.00	29.00	18.54	4.64	Moderate
Problems Relating to Peers	5.00	26.00	15.10	3.87	Moderate
Conflict with Physicians	5.00	22.00	13.02	3.14	Moderate
Discrimination	3.00	15.00	8.63	3.12	Moderate
Inadequate Emotional Preparation	2.00	15.00	7.69	2.60	Moderate

As illustrated in Table 5, the mean score in each dimension of job stress as perceived by the nurses was at a moderate level.

Part III: Presenteeism as Perceived by the Nurses

The level of overall score and the dimension of completing work, avoiding distraction as perceived by the nurses are shown in Table 6.

Table 6

Mean, Standard Deviation and the Level of Overall and Each Dimension of Presenteeism as Perceived by the Nurses (n = 282)

Presenteeism	Mean	SD	Level
Overall Presenteeism	19.15	3.79	High
Completing work	9.71	3.32	High
Avoiding distraction	9.44	3.17	High

As illustrated in Table 6, the overall mean score of presenteeism and the mean score in each dimension of presenteeism as perceived by the nurses was at a high level.

Part IV: Relationship between Overall Job stress and Overall Presenteeism as Perceived by Study Participants

This part illustrated the relationships between overall job stress and overall presenteeism. The results are shown in table 7.

Table 7

Relationship between Overall Level of Job Stress and Overall Presenteeism as Perceived by Study Participants (n=282)

Job Stress	Overall Presenteeism	
	r_s	p
Overall Job Stress	0.08	0.15

As illustrated in Table 7, the results of Spearman's Rank-order coefficient showed that there was no statistical significant relationship between overall level of job stress and overall presenteeism.

Discussion

The discussion of this study is presented in three parts, according to the research objectives.

Part I: Job Stress as Perceived by Nurses

The study found that each dimension of JS including work load; uncertainty concerning treatment; patients and their families; death and dying; problems relating to supervisors; problems relating to peers; conflict with physicians; inadequate emotional preparation; and discrimination were at a moderate level, as perceived by nurses in tertiary care hospitals TCHs, Karachi, the Islamic Republic of Pakistan. (Table 5)

There are many reasons which may contribute to the moderate level of JS as perceived by nurses in TCHs of Pakistan; particularly, the workload caused by shortages of nurses. This finding was consistent with the results of a previous study conducted in a tertiary care hospital in Hong Kong, using a similar instrument by Leung-Chun (2013) which found a moderate level of JS. The existing nurse-patient ratio in the general wards in Pakistan is approximately 1:50. However, the Pakistan Nursing Council has recommended a ratio of 1:10; as per a government reporting in health department, Pakistan lacks 60,000 nurses (Khuwaja, 2013).

In this study, the majority of nurses have perceived that there are too many non-nursing tasks required, such as clerical work (item- 41 with Mean = 3.18, SD = 1.50) (Appendix I). This can be explained by the fact that these are additional nurses' job responsibilities, which can further increase pressure in order to fulfill ward/unit tasks. Nursing job stress is associated with demanding jobs, such as those in healthcare - which subsequently lead to depression, health problems, and decreased job satisfaction (Gelsema et al., 2006). Job-related stress often detracts from the quality of nurses' working lives; often contributes to their experiencing some forms of physical illness; and may increase minor psychiatric morbidity (Golbasi et al., 2008).

The authors reported that death and dying; conflict with physicians; inadequate emotional preparation; problems relating to peers; problems relating to supervisors; work load; uncertainty concerning treatment; patients and their families; and

discrimination were components of JS. They also found that workers could have erratic amounts of all three. However, they did not infer that there was any foundation for adding all the scales to acquire a total score for JS. Thereby, the outcomes of diverse constituents of JS will be discussed.

Work load. Work load as perceived by nurses in this study was the most perceived stressor by the nurses among all nine of the dimensions of JS with moderate level (Mean = 24.66, SD = 5.35) (Table 5). This finding was consistent with the moderate level of the results of previous studies conducted in tertiary care hospitals in Hong Kong and Singapore, using a similar instrument (Leung-Chun, 2013; Wang, Kong & Chair, 2011).

One of the possible reasons for an overall high work load is the performance of non-nursing tasks by nurses. This is probably usually due to lack of allied/ supportive staff, such as nursing orderlies (nurse aids),who are responsible for performing clerical work, such as preparing patients case sheets (files); attaching investigations/ labs; x-rays; attaching extra papers; and the record-keeping of patient files. In public hospitals in Pakistan, there are no electronic records. Therefore, maintaining and record keeping take place manually. This task requires time, as well as workers to perform these tasks. Reducing the shortages of health workers by increasing their rates of employment results in patients' adherence to treatment; reduced readmissions; and better outcomes with enhanced satisfaction scores (Salka, 2016). Consequently, this will help nurses to complete their tasks with full concentration and without impending pressure.

The above study results have also shown some other factors that are likely to produce work load stressors, such as: having to make decisions under pressure (item- 57 with Mean = 2.29, SD = 1.38) (Appendix I); and not enough time to complete all of my nursing tasks (item- 57 with Mean = 2.72, SD = 1.37) (Appendix I). The possible reason could be that nurses are very much engaged and use many of their duty hours in performing other tasks - for example, clerical work - which is against their job description. Therefore, an increase in performing non-nursing tasks thereby consuming too many duty hours - together with the making of decisions under pressure, as under a time shortage - may contribute to the rise in the stress levels of nurses who have little control over their work environment and the heavy workload. Nurses may find it hard to

express their difficulties and to share their feelings in the clinical area setting under such a heavy workload (Wang et al., 2011).

Nurses have also shown a great deal of concern in regard to unpredictable staffing and scheduling (item- 13 with 2.78, SD = 1. 21) (Appendix I). The possible reasons may be that there is a lack of involvement of nurses in duty roster decisions. Healthcare systems have no option except to consider nurses' wishes and preferences in regard to workloads; shift construction; and shift assignment (Bard & Purnomo, 2005). Therefore, nurses' involvement in rostering decisions is essential. This will help to avoid job dissatisfaction, absenteeism, attrition, and poor healthcare service. However, the desires and preferences of nurses may change over time - due to changes in their work environment, as well as acuity and complexity of patients (Mutingi & Mbohwa, 2015). Employees who work irregular shift times - in contrast with those with more standard, regular shift times – experience many consequences, including that of greater work stress (Golden, 2015). In the long term, excess and continuous exposure to stress may lead nurses to leave the profession; consequently, it may contribute to shortage of nursing staff (Kapucu, Akkuş, Akdemir, & Karacan, 2009).

Uncertainty concerning treatment. In this study, uncertainty concerning treatment as perceived by the nurses was at a moderate level (Mean = 23.79, SD = 5.39) (Table 5). This finding was consistent with the results of a previous studies conducted in a tertiary care hospitals in Hong Kong and Singapore using a similar instrument (Leung-Chun, 2013; Wang et al., 2011).

The study findings shown a physician not being present in a medical emergency (item- 24 with Mean = 2.83, SD = 1.26) (Appendix I). One possible reason of a physician not being present in a medical emergency is shortage of medical doctors and increased workload. Empirical literature shows that Pakistani doctors (physicians) and medical students leave their jobs and go abroad for various reasons, including further study. Many of them settle permanently abroad, in order to have a better quality of life; have better career opportunities; avoid the deteriorating law and order situation in Pakistan; and avoid the rising hostilities that have been occurring towards doctors since the last decade. Some other important factors that have led to this trend include: poor service structure and career prospects; lack of funding for research; increased workload;

and stressful working environment. (Afzal, Masroor, & Shafqat, 2012; Imran, Azeem, Haider, Amjad, & Bhatti, 2011; Kamal & Shaikh, 2013; Qureshi & Rathore, 2014). In this critical situation of doctor shortage - combined with a stressful working environment - the workload for doctors on duty apparently increases. This may further lead them to have a lack of interest and poor concentration on job tasks that might result in poor performance, and to incidents such as not being present in medical emergencies to patients in hospitals.

In other stressors in this area, this study has shown that nurses had uncertainty regarding the operation and functioning of specialized equipment (item- 43 with Mean = 2.69, SD = 1.24) (Appendix I) and feeling in adequately trained for what they have to do (item- 29 with Mean = 2.65, SD = 1.37) (Appendix I). The possible explanation for all these issues might be that nurses often lack advanced knowledge in certain areas. This is because most of the nurses are unable to participate in and, thus, do not get the advantages of Continuing Nursing Education [CNE] opportunities. Channa, Aziz, and Latif (2013) found various barriers in regard to keep updated with current knowledge and practice through CNE programs. These have included administrative barriers; personal, financial, family and work-related barriers; and work-related barriers. The American Nurses Association [ANA] (2002) has strongly recommended that nurses should participate in continuing nursing education programs in order to ensure high quality care. In addition to this, data collected from this study clearly depicts that only 1.1% (Table 4) of nurses in Pakistan have advanced degrees (Master of Nursing Science) while the majority (52.1%) (Table 4) have only basic nursing education. The recent literature shows that - due to rapid scientific and technological advances and increased demands - there is a crucial need for more specialized nursing knowledge, skills and practices, in order to provide an efficient and effective quality of care (Bahn, 2006). Factors that have increased stress among nurses since the 1980s include the rising use of sophisticated healthcare technologies; budget cuts; an increased workload; and the constant organizational changes in some healthcare environments (Jennings, 1994, 2007; Schaufeli et al., 1995). In addition, the lack of knowledge of safety measures and poor command of the operation of latest instruments can be possible reasons to produce stress among nurses. Therefore, enhanced continuing education and further training opportunities would ultimately be beneficial for patient outcomes and

safe nursing practice (National Academies Press, 2004), which can ultimately result in reduction in job stress among nurses.

Patients and their families. Patients and their families was perceived by nurses in this study as being at a moderate level (Mean = 21.22, SD = 4. 60) (Table 5). This finding was consistent with the results of a previous studies conducted in a tertiary care hospitals in Hong Kong using a similar instrument (Leung-Chun, 2013).

The findings show that nurses face a great of stress in the area of dealing patients as well their families. Moreover, patients make unreasonable demands (item- 7 with Mean = 2.83, SD = 1.22) (Appendix I). One of the possible reasons could be workplace violence. Workplace violence is a devastating issue in health care settings in Pakistan, and the most significant factor seems to be a lack of respect towards the nursing profession in the Pakistani society. Nurses are still considered inferior and marginalized in both the public and private health sectors (Somani & Khowaja, 2012). Some other factors are also highlighted in relevant literature, such as cultural imperialism (French, Watter, & Matthews, 1994). There are negative images of nurses portrayed by the media in the society of Pakistan - such as being sex symbols and being obedient servants of physicians. Physicians and administrators are considered to be the dominant group in health care settings. Quite often, this dominant group exhibits aggressive and violent behavior towards nurses. This frightens nurses at their work places; creates disrespect and disgrace towards this noble profession; and keeps young females from choosing nursing as a career (Lee & Saeed, 2001). Due to the high occurrence of this problem in Pakistani society, it is very difficult for nurses to work for the benefit of patients, as they feel disrespected and dependent (Somani & Khowaja, 2012). Exposure to violence while carrying out duties adversely affects nurses. Furthermore, it may lead to loss of concentration; inattention to ethical guidelines; commuting mistakes; absence from shifts; repeated absenteeism; reduction in job satisfaction; dislike of job; and refusal to work in stressful wards (Fute, Mengesha, Wakgari, & Tessema, 2015). Workplace violence is also a side effect of the increase in the service expectations of the public. However, when demands for such an increase in expectation cannot be satisfied by the public hospitals, the victims tend to be the frontline nurses (Leung-Chun, 2013). It is confirmed in previous research that among all health care workers - nurses are at

greatest risk for workplace violence, because they work in a central position and interact with patients, families, doctors, and other paramedical staff (Lin & Liu, 2005).

The other possible reason for this issue is harassment on the base of nurses' gender identity. In this study, the majority of nurses (70.9%) (Table 4) were female. The female population tends to be exposed to more workplace violence - as compared to their male counterparts. This has been confirmed in Ethiopia by Fute et al. (2015) who found that a significant association between workplace violence and gender: female nurses had higher odds being exposed to workplace violence than males. Health professionals - including nurses - also face workplace violence and sexual harassment at their workplaces in Pakistan (Somani & Khowaja, 2012). This has also been supported by Chaudhuri (2006) who conducted a study to assess workplace violence and harassment towards nurses in India. The researcher found that - in the healthcare sector - nurses were experiencing terrible harassment, but cases were under-reported due to many reasons. On the other hand, in the previous study in Iran, the results were in contrast to the related negative aspect of workplace violence — abuse. Male nurses were exposed to more abuse than female nurses. Also, the risk of experiencing abuse was higher in nurses with more job experience or who worked more hours (Shoghi et al. 2008). It can be explained by the increasing demand and overall knowledge of patients' rights - and also concerning health issues of patients and their relatives - in the last few decades. The increase in the overall educational level and advancement of Internet technology further increases the workplace stress of current nurses in public hospital. However, though the overall knowledge of the public increases, it does not mean that their behavior becomes polite and reasonable. It becomes even worse if their expectation is not fulfilled in the hospital – regardless of whether no such expectations are reasonable or not.

Death and dying. Death and dying, as perceived by nurses in this study, was at a moderate level (Mean = 19.14, SD = 4.76) (Table 5). The results of this study were consistent with the findings of a previous study conducted by Milutinjnović et al. (2012) in Serbia, which used the same scale.

The possible reason can be the demographic data of nurses. In the current study, the largest groups of nurses' (70.90%) were female and aged between 31 and 40 years

old (44%) and about two-thirds (72.30%) of nurses were married (Table 4). Being young, female and married are very sensitive periods of human life, specifically for females. In this career stage, they perform multiple roles, such as guardian, mother, sister, and wife. Hence, nurses feel stressed to see or listen to someone who is going to die or who is unable get a complete cure. Nurses are perceived to be more stressful, when they were listening or talking to a patient about his/her approaching death (item-17 with Mean = 3.08, SD = 1.37) (Appendix I). The feelings increase for patients who are young or children. The married employees would see the organization as a kind of family provider - as opposed to single employees, who are more self-oriented and, consequently, feel less emotionally attached to their organization (Mosadeghrad, Ferlie, & Rosenberg, 2008). Therefore, married nurses demonstrate more emotional attachment to patients as compared to single or divorced nurses.

Problems relating to supervisors. Problems relating to supervisors, as perceived by nurses in this study are at a moderate level (Mean = 18.54, SD = 4. 64) (Table 5). The current study findings are congruent with other studies findings of nurses' perceived JS in Hong Kong (Leung-Chun, 2013), which used the same scale and had moderate level.

The findings show that in the area of problems relating to supervisors the most frequently occurring stressful events among nurses are lack of support by nursing administrators (item- 40 with Mean = 2.73, SD = 1.32) (Appendix I) and lack of support by other health care administrators (item- 49 with Mean = 2.72, SD = 1.26) (Appendix I). One of the possible reasons for lack of support by nursing administrators to nurses can be the problematic relationships among these professionals. This can probably occur in the presence of junior and inexperienced nurses. This has led to a plethora of problems. The majority of nurses in this study (52.80%) fall in the category of 1- 10 years of work experience (Table 4). Both employers and employees can be emotionally connected to each other (Burke, 2003) - favorable treatment by either party is reciprocated leading to favorable outcomes for both (Settoon, Bennett, & Liden, 1996).

Another reason for nurses who are lacking in support from the senior staff/ administrators might be due to preventing them from making medical errors. Hence, this situation may lead to one of the major stresses for nurses to feel in their workplace.

On the other hand, when employees perceive that the organization - including administrators - are supportive and considerate, and also show concern about their employees' values, a higher degree of commitment among these workers as an outcome is seen in most organizations (Zaki, 2006). With the limited resources, including manpower, the supervisor in public hospitals continues requesting nurses to upgrade their nursing care standard, in order to fulfill the increasing expectation of patients and their relatives (Leung-Chun, 2013).

Problems relating to peers. Problems relating to peers - as perceived by nurses in this study, were found to be at a moderate level (Mean = 15.10, SD = 3.87) (Table 5). The results of this study were inconsistent with the findings of a previous study conducted by Milutinjnović et al. (2012) in Serbia, which used the same scale.

The results of the current Pakistani study show that nurses also lack opportunity to talk openly with other unit personnel about problems in the work setting (item- 4 with Mean = 2.71, SD = 1.21) (Appendix I). One possible reason for this stress factor can be due to the increased workload, which is apparently seen as shortage of health personnel including nurses. Shortage of nurses is a global issue, and Pakistan is no exception (Khowaja, 2009). It can be explained from the fact that the nurse to patient ratio in nurses is very low. Pakistan has 0.56 nursing and midwifery personnel and 0.5 physicians per 1,000 population (Trading Economics, 2015). This issue has worsened because of nurse immigration to other countries (Khuwaja, 2013). Working in situations with few staff - when there is a great influx of patients – makes it likely to develop stress among employees including nurses.

Conflict with physicians. Conflict with physicians - as perceived by nurses in this study - was at a moderate level (Mean = 13.02, SD = 3.14) (Table 5). The results of this study were, once more, found to be consistent with the findings of a previous study done by Milutinjnović et al. (2012) in Serbia, which used the same scale.

In this study, nurses also feel a great deal of stress while working with their co-workers, such a doctors, i.e., in situation such as when they are criticized by physicians (item- 2 with Mean = 2.72, SD = 1.27) (Appendix I). One possible reason for criticism made by physicians towards nurses might be their self- perceived low image, most

probably due to their low level of education - and to be involved in non-nursing tasks. Administrators - including physicians - are considered to be the dominant group in health care settings. Quite often, this dominant group exhibits aggression and violent behavior towards nurses (Somani & Khowaja, 2012). Every day, nurses and their healthcare colleagues are confronted with challenging situations where effective communication is essential, while - at the same time - fraught with difficulty (LaSala & Bjarnason, 2010).

The other reason for doctors' lack of coordination and support for nurses could be the nurses' patterns of education. In this study, the demographic data shows that the majority of nurses had obtained just basic nursing education, such as the three-year diploma plus one year studying a specialty (52.10% (Table 4). Conversely, in this study, nurses who had been enrolled in the current most popular worldwide degree programs - such as the Bachelor of Science in Nursing (Generic) four-year degree program - were only (3.90%) (Table 4). In addition, the selection criteria for admission are very simple for nurses in regard to their diploma courses — ten and/or twelve years of total education; however, there is no entry test examination. On the other hand, the criteria for undergraduate degree students to be admitted for the medical profession is very competitive. It mainly takes place through higher grades, both in matric — ten years of school education; and in intermediate degree college education — two years of general science pre-medical education, which is also a total of twelve years of education. In addition, there is a trend of excellent marks/grades in entry test examination. Whereas, for the Bachelor of Nursing Science Degree program (Generic), the admission criteria are almost the same as for those students who intend to apply for a medical degree program, such as MBBS. Besides the admission criteria, the length of study for medical doctors to complete their undergraduate degree is five years, compared with the four years of nurses. From the said scenario, one can conclude that difference in both admission criteria and the study period for their qualification can be a reason of criticism made by doctors towards nurses which further results in increased stress levels among nurses. In Pakistan, the choice of becoming a medical doctor is much higher, due to various reasons compared to other professions, including nursing (Zakria, 2013).

Still other possible reasons for medical doctors' frequent criticism of nurses could be related to the fact that the nurses are performing additional job tasks other than those described by Pakistan Nursing Council. Most likely, the doctors' perception is that "blue collar" jobs are being done by nurses. The findings of this study show that, in TCHs, general nurses have to be involved in non-nursing responsibilities. Too many non-nursing tasks are required, such as clerical work (item- 41 with Mean = 3.18, SD = 1.50) (Appendix I). In addition, they have to perform other tasks, such as working in Out-Patient Departments - thereby performing the duties of paramedical staff. This phenomenon occurs mainly either because of either the absence or shortage of other support employees. Nurses spend most of their time on maintenance of records through documentation, rather than on patient care. A rather similar trend has also been observed in Bangladesh, where Hadley and Roques (2007) found that only 5.3% of a nurse's time is spent in direct contact with patients in public hospitals. Through such type of work environment, job responsibilities, and performance, a mind-set may have been developed among medical doctors that nurses perform manual work. Therefore, they can be criticized, because doctors themselves have white-collar jobs.

Discrimination. Discrimination, as perceived by the nurses in this study, was at a moderate level (Mean = 8.63, SD = 3.12) (Table 5). The result of this study was consistent with the findings of a previous studies Milutinjnović et al. (2012) in Serbia; Leung-Chun, (2013) in Hong Kong, Mehta and Singh (2014) in Nepal; Damit (2007) in Brunei Darussalam; which used the same scale.

One reason of the lowest score in this component of job stress is that nurses in Pakistan are employed to help solve a staffing shortage. They are seen as being "caring," and one might venture that nurse managers and co-workers welcome them. These are notable, and reassuring results from this sample of nurses from Pakistan. Caring is some sort of a feeling that mainly involves an action (Lachman, 2012). Dr. Jean Watson's caring theory is popular in nursing around the globe. It is mainly comprised of three factors, such as: the carative factors; the transpersonal caring relationship; and the caring occasion/caring moment (Watson, 2001). These dynamics attempt to "honor the human dimensions of nursing's work and the inner life world and subjective experiences of the people we serve" (Watson, 1997).

On the contrary, in spite of the second lowest scores of discrimination among all stressor studied, still, nurses show experience of much stress, due to being sexually harassed (item- 8 with Mean = 2.95, SD = 1.53) (Appendix I). The possible reason for sexual harassment could be nurses' gender identity. In this study, the majority of the nurses (70.9%) (Table 4) were female. The female population is exposed to more workplace violence, as compared to their counterparts. This has been confirmed by Fute, et al. (2015) in Ethiopia who found that a significant association of workplace violence and gender — female nurses had higher odds being exposed to workplace violence than males. Much similar figures have been acknowledged in a previous study in Pakistan by Somani and Khowaja (2012) that workplace violence is a devastating issue in health care settings in Pakistan. Meanwhile, in a previous study in India, Chaudhuri (2006) found that female workers - including nurses - faced enormous workplace violence and harassment. Lack of respect – plus the fact that nurses are considered to be inferior and marginalized in both the public and private health sectors - is the most common trend shown by Pakistani society. An evident study in Iran confirmed that male nurses, too, are exposed to more abuse than their female counterparts (Shoghi et al., 2008) towards the nursing profession in the Pakistani society. Cultural imperialism (French et al., 1994) could be a cause of sexual harassment.

Inadequate emotional preparation. Inadequate emotional preparation, as perceived by nurses in this study, was at a moderate level (Mean = 7.69, SD = 2.60) (Table 5). The result of this study was consistent with the findings of a previous two studies conducted by Kamal et al. (2012) in Saudi Arabia and Mehta & Singh (2014) in Nepal, though in both studies researchers used the same scale.

The most common stressors found among nurses in the area of inadequate emotional preparation was feeling inadequately prepared to help with the emotional needs of a patient (item- 19 with Mean = 2.65, SD = 1.29) (Appendix I). The possible reason can be lack of training either in clinical area or theoretical base in classes. This can be explained in way that in our context much focus is given on accomplishment of tasks through routine procedures - compliance with policies and procedures, and/or risk management - rather preparing nurses to deal with patients' emotions. In addition to

this, the approach we use to prepare staff nurses to be proficient and more skillful in hospital settings is mostly from a skill-competence perspective rather than humanistic view. According to the World Health Organization (WHO, 2006) both medical and nursing practice are becoming more complex, and traditional boundaries between professions are being reduced. The competence in education as well as professional experience needed for student nurses and staff nurses is an important issue in health care - as it is associated to professional standards, patient safety and the quality of nursing care (Kajander-Unkuri, 2015). Even though competence has become a significant concern in recent health care (Numminen, Meretoja, Isoaho, & Leino-Kilpi, (2013); however, emphasis should also be put on preparing nurses in other aspects, including a humanistic perspective.

Part II: Presenteeism as Perceived by Nurses

The study found that the presenteeism as perceived by nurses' in the three TCHs in Pakistan was at high level with the overall score (Mean = 19.15, SD = 3.79 (Table 6). The current study findings are consistent with other studies findings of nurses' perceived presenteeism. A study in China by Yang et al. (2012) found high level of presenteeism; Brborović et al. (2014) in Croatia found high level of presenteeism; Mandiracioglu et al. (2015) in Turkey found high level of presenteeism and in general workers in the USA by Koopman et al. (2002) also found higher levels of presenteeism. Conversely, these findings are inconsistent with a study by Watson et al. (2009) in medical students in the USA which found low level of presenteeism.

As for as higher scores on presenteeism are concerned, it may show active engagement for shorter duration while being ill and performing duty. Conversely, there is much likelihood to have a negative influence among nurses in the long run, in case such trends continue. From an employees' perspective, presenteeism is vital in that it might worsen current medical illnesses; result in loss of the quality of working life; and lead to impressions of ineffectiveness at work due to reduced productivity (Johns, 2010). In addition, presenteeism may have a greater contrary influence on the quality of patient care. There has been little research into how nurses' health and level of productivity would probably relate to their ability to provide care as several health circumstances are identified to affect work productivity (Letvak et al., 2012).

The result shows that most of the nurses were actively engaged in performing their tasks, rather than being concerned with their vital individual health problems. Furthermore, they kept from side to side their involvements for organizational necessities in their workplaces. It is portrayed in this study that despite having their (health problem), nurses were able to finish hard tasks in their work (item- 2 with Mean = 3.56, SD = 1.45 (Appendix J). One possible reason for nurses who remain actively engaged can be social support in Pakistan. In a previous study, Anis-ul-haq and Sohail (1997) while studying stress, social support and burnout among nurses in Pakistan, revealed that different sources of social support were confirmed in the study. Furthermore, social support has a moderating role on reducing stress thereby resulting in increased engagement and performance. According to Schaufeli and Bakker (2004) social support is precursor to the engagement. While studying perceived organizational support and work engagement among nurses in Kunming University Hospital, China, Feng (2012) found that nurses perceived organizational support at the moderate level.

Another possible explanation is that nurses in the TCHs receive several benefits from their hospitals. For example, they have a permanent government job, and they will get a pension after retirement. They will receive three months maternity leave for every childbirth; opportunity for in-service training to achieve higher qualifications; recent up-gradation of nurses from BPS-14 to BPS-16; access to doctors and drugs when needed for their families; provision of stipends for living expenses during studying in a course; and an opportunity to be selected for Haj duty (officially being sent to Mecca, Saudi Arabia, as a part of team providing medical services for Pakistanis during the pilgrimage; in return, the incumbent is remunerated with handsome package). These are some types of incentives which can play a key role in keeping the workers engaged in their workplaces. Presenteeism might include attendance and accompanying productivity decrements in the face of factors along with sickness (Johns, 2010).

The discussions of the two dimension of presenteeism among nurses are as follows:

Completing work. Completing Work as perceived by nurses in this study was at a high level (Mean = 9.71, SD = 3.32) (Table 6). Findings of this study are consistent with the findings of a previous study that was conducted in Portuguese by Martinez and

Ferreira (2012) that shown higher levels for completing work dimension of presenteeism.

The findings of study shown that - despite having their health problem, - nurses were able to finish hard tasks in their work (item- 2 with Mean = 3.56, SD = 1.45) (Appendix J). One possible reason could be that nurses are satisfied in their jobs. This further depicts their commitment to perform their duties in a productive manner, by showing a better performance in spite of barriers and hurdles relating to health. In a recent study that explores the influencing factors in regard to job satisfaction among nurses in public hospitals in Pakistan, Dar, Ahsan-ul-Haq, and Quratulain (2015) found that majority of nurses were in favor of inviting others to join their nursing profession. The reasons for job satisfaction were: enough honor and rewards that they received specially from peers; nursing administration; and physicians. In addition, respondents perceived good working relationships with their supervisors, peers, physicians, and colleagues. According to Watson et al. (2009) various studies have been conducted in the industrial sector - including health - that have explored different possible methods of improving workplace productivity through various factors, including job satisfaction. Many researchers think that presenteeism is one form of productivity at workplaces (Johns, 2010; Koopman et al., 2002; Letvak et al., 2012; Lofland et al., 2004; Turpin et al, 2004). Job satisfaction among any profession helps the individuals to perform better (Dar, et al. 2015); in the nursing profession in particular, job satisfaction has supreme importance, as when employees perform in a better way, which ultimately affects the condition of patients. Hence, the better the job satisfaction at workplace among the employees, regardless of workers' health status, the better the outcome, thereby resulting in increased productivity. At work, nurses were able to focus on achieving their goals, despite their (health problem) (item- 5 with Mean = 3.14, SD = 1.61) (Appendix J). When employees show higher presenteeism at their work stations, this is an indication of better performance in that organization, in comparison to absenteeism (Mandiracioglu et al., 2015; Hafner et al., 2015).

Avoiding distraction. Avoiding distraction, as perceived by nurses in this study was at a high level (Mean = 9.44, SD = 3.17) (Table 6). The result of this study was consistent with the findings of a Portuguese study by Martinez and Ferreira (2012) that shows higher levels for avoiding distraction among nurses.

This study results reveal that nurses felt hopeless about finishing certain tasks - due to their health problem (item- 4 with Mean = 3.49, SD = 1.40) (Appendix J). One possible reason can be the work environment where the nurses are performing their jobs is not satisfactory. Due to such work environment, nurses are feeling that they have psychological illnesses that further distract them from working smoothly. There are various challenges at global level that nurses face while performing their jobs. These including current innovative methods of patient care, along with use of advanced technologies, which are used in diagnosis and treatment; attending to the emotional needs of patients and their families; undertaking managerial responsibilities, such as supervising junior staff (Velhal, Sawant, Mahajan, & Rao, 2013). Pakistan is no exception in this regard. Glass, McKnight, and Valdimarsdottir (1993) explain that the demands of such roles make nurses susceptible to stress and psychological ill health.

This can be further explained in regard to the work environment that, worldwide perceptions and pragmatic studies illustrate the significance of balanced, healthy and supportive nurse practice environments and psychosocial work environments, in order to achieve and endure constant and great performance by nurse employees (Kowalski et al., 2010; Rafferty, Ball, & Aiken, 2001; Schubert, Clarke, Glass, Schaffert-Witvliet, & De Geest, 2009;). Another prominent feature is that - in the area of avoiding the distraction of presenteeism - nurses felt that their (health problem), distracted them from taking pleasure in their work (item- 3 with Mean = 3.01, SD = 1.38) (Appendix J). Researchers consider that such kinds of nurse practice environments are influential in regard to greater productivity, because these environments show upper levels of job satisfaction and engagement; somewhat low levels of stress, burnout and turnover attrition; and promising notches on quality of care and patient safety indicators, such as mortality; co-morbidity; and serious adverse events (Aiken, Clarke, Sloane, Lake, & Cheney, 2008; Friese, Lake, Aiken, Silber, & Sochalski, 2008; Laschinger & Leiter, 2006; Tourangeau, Coghlan, Shamian, & Evans, 2005).

Part III: Relationship between Job Stress and Presenteeism as Perceived by Nurses

The results of Spearman's Rank-order coefficient show that there was no statistical significant relationship between overall job stress and overall presenteeism as perceived by the nurses in TCHs in Pakistan (Table 7). The result of this study were consistent with the findings of a joint study in Australia and the UK by Wan et al. (2014), which found no significant relationship between presenteeism and job stress.

The results of this study indicate that - although the nurses are facing job stress - they are still able to go to work. Job stress was found to be at a moderate level. This means that they can cope with job stress, and there is much likelihood that job stress has no impact on presenteeism (Regardless of whether they get sick or experience stress, they go to work). One possible reason can be the possible rules and regulation for seeking leave. This can be given only in situations when nurses are sick, or have any urgent family emergency, such as attending the funeral of a close relative. Nurses in Pakistan can avail of twenty-five days casual leave (on emergency grounds) per year, which is paid. In addition, they can apply for sick leave, depending upon the severity of illness and the medical doctor's opinion to take rest during such illness. Hence, in many cases, nurses may feel sickness which may hinder their capacity to do their jobs; however, the limited availability of leave options can cause them not to bother even they are sick and have moderate job stress.

The other possible reason could be the organizational culture in the hospitals. Located in South Asia, Pakistan is still strongly perceived as a family-oriented culture. The origins of the current Pakistani culture can be traced back to the Indus Valley Civilization, which places great importance on the extended family (Basham, 1968). This civilization sustains shared values of collectivism and community orientation, as opposed to Western values, which promote active competitiveness and individualism (Ahmed, 2013). Working in such culture, nurses perceive patients' illnesses as their own. The organizational culture in a hospital setting is the product of shared values; attitudes; and patterns of behavior, which health professionals observe during the practice of provision the care (Stock, McFadden & Gowen, 2010). WHO also describes how the organizational culture of a hospital affects health professionals' job satisfaction, role delivery; and quality of patient care (Sorra & Dyer, 2010).

This can be explained by a recent study, showing that nurses are satisfied in their workplaces in Pakistan due to different reasons, including organizational culture (Dar, et al. 2015). In a qualitative study, nurses showed satisfaction, and were committed to serve in the public sector in Pakistan (Ahad, 2013; Dar, Zehra, & Ahmad, 2014). Commitment strengthens employees' positive attitude toward their organizations (Sajjad & Abbasi, 2014) and it has also a substantial impact on the improvement of organizational behavior (Sayyadi, 2009). Cancelliere, Cassidy, Ammendolia, and Côté (2011) in a systematic review found that organizational leadership; health risk screening; individually tailored programs; and a supportive workplace culture had a positive effect on presenteeism. When nurses are satisfied and have better workplace culture, it can improve their output by keeping them actively engaged.