Class Advantage and the Gender Divide: Flexibility on the Job and at Home[1]

Naomi Gerstel and Dan Clawson
University of Massachusetts, Amherst

Using a survey, interviews, and observations, the authors examine inequality in temporal flexibility at home and at work. They focus on four occupations to show that class advantage is deployed in the service of gendered notions of temporal flexibility while class disadvantage makes it difficult to obtain such flexibility. The class advantage of female nurses and male doctors enables them to obtain flexibility in their work hours; they use that flexibility in gendered ways: nurses to prioritize family and physicians to prioritize careers. Female nursing assistants and male emergency medical technicians can obtain little employee-based flexibility and, as a result, have more difficulty meeting conventional gendered expectations. Advantaged occupations "do gender" in conventional ways while disadvantaged occupations "undo gender." These processes operate through organizational rules and cultural schemas that sustain one another but may undermine the gender and class neutrality of family-friendly policies.

Flexibility and the control of time are central and related elements of inequality. In documenting various forms of flexibility and suggesting these are shaped jointly by class and gender, this article argues that both advantaged male and female employees deploy their class privilege in the service of

[1] We gratefully acknowledge research support provided by the National Science Foundation (SES-0549817 and SES-0959712), the Sloan Foundation, the Russell Sage Foundation, the National Association of Emergency Medical Technicians (NAEMT), the Political Economy Research Institute (PERI), and the University of Massachusetts Future of Work Project and Conti Award. We are grateful to Michelle Budig, Mary Ann Clawson, Paul DiMaggio, Nancy Folbre, David Johnson, Milian Kang, Ruth Milkman, Margaret Nelson, Natalia Sarkisian, Viviana Zelizer, and Robert Zussman as well as the audiences

0002-9602/2015/12002-0003$10.00

a kind of flexibility organized around conventional gender expectations. In contrast, without access to the forms of flexibility that promote gendered expectations, class disadvantage pushes both male and female workers to weaken conventional gender expectations concerning families and jobs. Comparing four occupations, we thus show ways that the practice of gender is not fixed but rather varies by class. This interaction, we suggest, is negotiated by employers, employees, and their families in a process that is both shaped by and in turn shapes organizational rules and cultural schemas.

Much of the current discussion of flexibility is driven by what are broadly labeled "work-life issues" and comes from sociologists, psychologists, and economists interested in so-called family-friendly policies (e.g., Christensen and Schneider 2010, 2011). The basic logic is this: in the era when women (at least white, middle-class, married women) stayed home to care for their families and men were the exclusive breadwinners, the assumption was that wives would adapt to their husbands' job demands, and, as Talcott Parsons (1955) conceptualized it, this produced a "fit" between the economy and the family. But as more and more women entered the paid workforce, family members became less available to meet unpredictable demands coming from both job and home. Spouses' joint labor force participation meant temporal demands on families increased, now coming from two jobs rather than one. A growing number of women had jobs that were as demanding and as inflexible as the husbands' jobs of Parsons's era. There was, however, little flexibility or change in the division of domestic labor: even when employed, women continued to do far more of that labor then men. Together this inflexibility of jobs—alongside the inflexibility of families—created what some now call a "mismatch" rather than "fit" between jobs and households.

Such discussions of flexibility often contain at least an implicit assumption that women in particular need flexible workplaces in order to meet the inflexible demands that families place on them. A few scholars have also argued that women disproportionately use such family-friendly policies. Women do so by cutting back on paid work hours and taking leaves to do domestic labor and, in turn, make job sacrifices, while men, less likely to use these policies, do less at home and spend more time on the job (Bergmann 2009; MacDonald 2009). In effect, both men and women enact neotraditional gender expectations. Here, we extend this critique and show the processes whereby family-friendly workplace policies tend to address a particular group of women—primarily those in class-advantaged positions.

and seminars at Columbia University, the Center for Research on Families, the Council on Contemporary Families, Princeton University, Rutgers University, and the Russell Sage Foundation. Direct correspondence to Naomi Gerstel, Department of Sociology/SADRI, University of Massachusetts, Amherst, Massachusetts 01003. E-mail: gerstel@soc.umass.edu

Instead of focusing on official policy, this article examines practice and processes on the ground and asks, What does flexibility at the workplace look like, what processes at home and on the job promote different patterns of flexibility, who can and who does take advantage of these different kinds of flexibility, and what are the consequences of doing so? We argue that answers to these questions require attention to the different types of flexibility of time on the job and at home and that both are unequally distributed by gender and class.

The analysis is based on multilevel and multimethod data we collected on four groups of paid care workers, divided by class and gender. The two class-advantaged groups—nurses and doctors, one almost exclusively women and the other mostly men—obtain a series of choices about work hours, albeit constrained. The two class-disadvantaged groups—female nursing assistants (CNAs, for certified nursing assistants) and male emergency medical technicians (EMTs)—have fewer choices and face greater constraints. A focus on occupations rather than disparate individuals permits us to examine the ways that cultural schemas are not simply individual choices but rather are built into occupational cultures and organizational arrangements; in turn, these cultures and arrangements are shaped by pressure from groups of employees who populate those occupations and organizations.

Examining both relatively advantaged and disadvantaged occupations, this article makes the broad argument that gender and class jointly influence the practice and meaning of flexibility. Gender shapes the demand and desire for particular kinds of flexibility. Class, intersecting with gender, shapes the ability to win and use that flexibility. In advantaged occupations, we show that both women and men obtain flexibility but of very different sorts. Both meet neotraditional gender expectations regarding responsibilities in jobs and families, even if they sometimes have doubts about organizing their lives this way. In contrast, class disadvantage makes it more difficult for working-class men and women to obtain the kind of flexibility necessary to meet neotraditional gender expectations, even if they would like some opportunity to do so. Instead, disadvantaged men and women must violate those expectations, albeit again in very different ways.

Our research covers only four occupations, but we use these to develop a broader theoretical framework. We suggest that class and gender processes are informed by both organizational practices and culturally informed schemas that are intertwined. Integrating the material and symbolic aspects of institutions (both families and work organizations) and borrowing from Sewell (1992, p. 27), we argue that social "structures are composed of mutually sustaining cultural schemas that empower and constrain social action and tend to be reproduced by that action" (see DiMaggio's [1997] discussion of "logics of action" as well as Thornton, Ocasio, and Lounsbury's [2012] "institutional logics"). By examining processes on the ground in both families

and jobs, we highlight the ways both women and men strategically use culture to construct (rather than simply respond to) organizational processes and linked institutional systems. Especially in the sex-segregated occupations we examine, such actions then generate further options to enact cultural schemas organized around gender. While these certainly reproduce inequalities, they also allow women as well as men to obtain a kind of workplace flexibility that eases and reinforces their sense of womanhood and manhood based in large part on responsibilities at work and at home.

This process is further influenced by the privileges associated with class. We suggest that our two advantaged occupations in particular have "access to resources" that "enable them to enact schemas" (Sewell 1992, p. 27) that the two disadvantaged groups cannot so easily obtain. Gender is both resource and constraint. For the advantaged, then, the ability to enact gender conventions is desired but also sometimes disdained; for the disadvantaged, the difficulty enacting conventional cultural schemas is often a burdensome constraint but occasionally a desired release. That is, we use empirical research to develop the theoretical argument that gender is not fixed; it acts both as resource and constraint that shapes institutional practices just as those practices, in turn, help produce and maintain gendered workers. These practices vary by class.

LITERATURE REVIEW

The publication of Juliet Schor's *The Overworked American* (1992) provoked a range of debates over hours of work both at the job and at home. Critiquing this view of the "overworked" American as too broad, researchers argued that well-paid professionals and managers work long hours on the job, often saying they want to work fewer, but low-wage workers work fewer hours, often saying they want to work more (Golden and Figart 2000; Jacobs and Gerson 2004); researchers have also documented significant gender differences in paid job hours, with men more likely to work full time and overtime (Presser 2003; Jacobs and Gerson 2004). The medical literature also contains studies and debates about these issues, but almost exclusively for our two advantaged occupations, nurses and doctors. Examining the temporal patterns of these occupations, Zerubavel (1979; see also 1981) brought into theoretical focus the social conditions, cognitions, and moral premises that promote rigidity, the converse of flexibility, in hospital doctors' and nurses' schedules. Distinguishing these two occupational groups' temporal orders, he emphasized the coordination such schedule rigidity required and the organizational continuity it promoted: "The structural components of the sociotemporal order are collectivities. . . . The persons who are in charge of designing them, that is the regulators of the social temporal order, must deal with such issues as vacation requests, night duty arrangements, or holiday or

weekend coverage on a group basis" (1979, pp. 106–7). It is precisely these collective patterns and issues enacted by medical occupations that we focus on here. We will show that they enact these patterns as collectivities (i.e., as occupations) in the way Zerubavel predicted, although we will expand his frame by addressing flexibility and the ways inequality underpins the attempts or successes of the different groups to enact it.

The focus of most of the empirical literature in medicine on work schedules, however, is not on the flexibility of organizations or occupations or on the lives of the workers themselves. Although some studies examine such issues as whether patients' office visits with physicians are getting shorter as a result of changes in the organization of medicine (Mechanic, McAlpine, and Rosenthal 2001), most of the literature on physician time focuses on recent rules regulating interns' and residents' hours and their responses to it (Lerner 2006; Iglehart 2010; Brooks and Bosk 2012; Szymczak and Bosk 2012). The effects of those rules on patient mortality, and whether work hour limits are in fact followed, has been much debated (Steinbrook 2002; Landrigan et al. 2006; Volpp et al. 2007; Iglehart 2008; West et al. 2009; Antiel et al. 2010). For nurses as well the focus is on long work hours and short staffing. One survey reported that more than a quarter of the sample reported working 12 or more hours per day (Trinkoff et al. 2006); another found that "the risks of making an error were significantly increased when work shifts were longer than twelve hours, when nurses worked overtime, or when they worked more than forty hours per week" (Rogers et al. 2004, p. 202; see also Aiken et al. 2002). Much of the emphasis on hours worked in this literature, however, misses a key aspect of work hours: the flexibility of those hours, or the extent to which those hours and schedules are variable rather than rigid.

Although flexibility is defined in numerous ways (Hill et al. 2008), many survey researchers operationalize it as official policy concerning time on and time off the job, including employees' opportunity to gain leaves and vacations, obtain the right to voluntarily alter their jobs' start and stop times, and compress or extend job time (Greenhouse 2003; Williams 2006; Christensen and Schneider 2010; Feldblum 2010). Most U.S. companies with 50 or more employees provide some vacation, but more than a third of all U.S. working parents lack sick and vacation time (Galinsky et al. 2010; Williams 2010). Applebaum and Golden (2003) examine fluctuations but suggest that employer-generated temporal flexibility has remained confined to 15%–20% of the workforce.

While most work-family scholars now define flexibility as rooted in the needs and demands of employees, some sociologists—typically those who study work and organizations—emphasize employer-driven flexibility, which is tied instead to organizational demands and associated with fewer social protections for workers (Kalleberg 2011); related literature refers to this

as "insecurity" (Webster et al. 2010) or "precarious labor" (Standing 2011). As Williams (2010, p. 3) writes, workplace flexibility "refers to *employers'* ability to achieve a tighter fit between supply of, and demand for, labor through 'just-in-time' scheduling."

THE UNEQUAL ALLOCATION OF FLEXIBILITY: THE IMPORTANCE OF CLASS AND GENDER

Numerous researchers have shown that official policies as well as the practice of workplace flexibility depend on class position. Workplace flexibility policies that support employees' families, Williams (2010) argues, are typically only available to high-income, dual-earner families. Galinsky et al. (2010) find that high-level salaried employees are more likely than lower-level hourly employees to have employee-driven flexibility—that is, flexibility that offers them some control over their schedules. Lyness et al. (2012) report that although affluent workers report an excess of hours, they also have greater flexibility and schedule control. Most quantitative work finds that low wages are linked to lower levels, and less control, of job flexibility (Swanberg et al. 2005; Watson and Swanberg 2010) as well as to fewer vacation and sick days (Swanberg et al. 2005; Hartman and Lovell 2009). A limited amount of ethnographic research that looks at workplace practice supports and extends this assertion. Observing low-wage retail workers on the job, Lambert and her colleagues (Lambert 2008; Lambert, Haley-Lock, and Henly 2011) show that their "flexibility" is employer driven and that for at least some of these workers the practice should be called "instability" rather than flexibility. Kelly and Kalev (2006) suggest that flexible leave policies are used to bolster managers' discretion (who use them as a reward rather than a right) and to improve work conditions for already privileged workers. Such literature provides additional evidence for two very different types of flexibility—one employee driven, the other employer driven; these are associated with class, a distinction we will examine.

Research also suggests that gender shapes the availability of workplace flexibility. Among work and family scholars, flexible work was initially conceptualized as a way to offer greater opportunities to women, especially those in professional and managerial jobs, given their typically greater family responsibilities compared to equivalently placed men. Women still have considerably more responsibility for housework, child care, and elder care than equivalently situated men (Bianchi et al. 2006; Stone 2007; Sarkisian and Gerstel 2012). Townsend (2002) finds that men express their intentions to be more involved at home, but the same men often argue that their inflexible employment prevents an increase in their familial involvement, a formulation we examine in this article. Although women employees are more likely than men to favor flexible workplace policies (Kelly et al. 2011), women

employed full time are less likely than full-time men to obtain flexible schedules that allow them to control their start and stop times, largely because they are concentrated in industries or low-wage jobs that provide little flexibility (Golden 2008).

Studies of flexibility and gender typically focus on the characteristics of individuals. Acker, by contrast, focuses on organizations (1990, p. 142), emphasizing that although "organizational structures and processes are theorized as gender neutral," they are actually gendered male, with this logic contained in written work rules and managerial directives, very much including issues of schedules and hours. "Every time that job evaluation [or, we would argue, a scheduling rule] is used, that structure is created or reinforced" (Acker 1990, p. 148). But the reverse is also true: when such rules are contested, the structure may be weakened or changed. We will argue that cultural schemas and structural realities external to the workplace can lead to the reshaping of organizations, but primarily for the advantaged.

This extends an argument made by Blair-Loy (2003), who analyzed the way female financial executives shifted from a work-devotion schema to a family-devotion schema, but found it difficult to reshape workplaces in ways that support commitment to both families and work. We examine occupations and organizations dominated by women and argue that although Acker's theory holds true for nursing assistants, in many ways the organizational scheduling practices for those in relatively advantaged occupations are not gendered male;[2] rather, both cultural schemas and organizational practices are reshaped to offer an option that provides relatively well-paid employment that also allows devotion to family. More specifically, we provide evidence suggesting that nurses, at least in hospitals, challenge and replace gendered-male rigid schedule practices with flexible organizational practices that are, in many ways, gendered female.

The power of organizational structure and cultural schema is visible not just at the workplace. To be sure, most of the literature on flexibility looks at one institution—the workplace—and then suggests that job flexibility is family-friendly policy that should be developed to better meet employees' needs outside of the workplace. Arguing that "the lack of workplace flexibility is having huge human capital costs," Christensen and Schneider (2010, p. 17) then write: "The solution to the problem lies outside the

[2] We are using the term "gendered female" to refer to the occupations and organizations, like the hospitals and nursing homes that we studied, that are dominated by women in terms of number of staff. The organizations, however, are often still controlled by men (e.g., in the hospitals we studied, the CEOs were male, though many managers and schedulers and even some executives were female). Moreover, in some sense the hospital as a whole is still controlled by doctors, who are likely to be men. Women, however, have relative autonomy; as we will show, within broad limits set by top management, women staff in practice set policy.

family. What needs to change is the culture of the workplace." To understand the "mismatch" between workers and workplaces, however, we suggest a broader frame that assesses the extent to which not only jobs but also families are flexible (see also Hill et al. 2008). Research on a range of processes supports that more expansive frame, as suggested by two examples. First, although there is not full agreement about the direction, shape, or size of the effect, research suggests that increases in the amount and proportion of income that wives contribute to the household are associated with a decline in their share of domestic labor (Deutsch 2007; Gupta 2007; Ferree 2010; Ridgeway 2011). Second, mothers' and fathers' job conditions are related to their share of child care (Craig and Mullan 2011). The first is likely to be an example of how families become more flexible in response to job demands; the second is an example of how family flexibility for some (often men) and inflexibility for others (often women) tends to shape jobs and life-history trajectories. Here, we analyze and connect workplace flexibility to family flexibility—assessing the extent to which unpaid domestic work, like paid labor, is malleable.

Finally, most existing literature looks at gender or class (for an exception, see Kelly et al. 2011). To understand workplace and family flexibility, we argue that research should attend to their joint effect. Looking at two groups of men and two groups of women—each group divided by class—this article examines how the interplay of class and gender produces inequalities in the form and experience of workplace as well as family flexibility.

DATA AND METHODS

We studied four health care occupations for reasons both substantive and methodological. A crucial methodological advantage is that, at least in the northeastern area where we conducted the research, employees in all of these occupations must register with the state, making it possible to draw a random sample. The substantive advantages of studying health care occupations are equally compelling: health care is a strategic research site, a location where temporal issues that are present in many industries appear with particular clarity (Zerubavel 1979). Not only do many parts of the medical system operate around the clock, health care is in some sense the prototypical industry of our time—a part of the growing service sector rather than the diminishing manufacturing sector. Health care accounted for 17.2% of total GDP in 2012 (Centers for Medicare and Medicaid Services 2012) and 24% of government transfers in 2009 (Reis 2012). Medical occupations operate within a similar economic environment, an industry where rapidly increasing costs coexist with strong pressures to hold costs down. Many of the processes we analyze are likely to operate in some fashion in other sectors of the economy where we see many of the same trends. Finally, studying a

limited number of intermeshing occupations and organizations, rather than a sample drawn from all occupations, allows us to analyze the organizational and occupational contexts shaping flexibility.

Because prior research has established gender and class as key determinants of work hours, the four health-care occupations we chose vary by class and gender, creating a classic two-by-two table: physicians (70% male, class advantaged, average income $155,640 for family practitioners to $225,360 for surgeons), registered nurses (94% female, class advantaged, $67,720), EMTs (73% male, class disadvantaged, $33,330), and nursing assistants (89% female, class disadvantaged, $24,240) (U.S. Bureau of Labor Statistics 2010). The minimum training required for each occupation shows the same class variation, with our two advantaged occupations requiring more education than the other two: physicians must attend medical school for at least four years after college and registered nurses must have at least two years of nursing-specific schooling, while nursing assistants and basic-level EMTs require as little as three weeks of instruction (with paramedic EMTs requiring considerably more training). There is also a difference in how work hours are monitored. A survey we conducted shows that the percentage of each occupation paid on an hourly basis—that is, with their hours externally monitored by the organization—is 98.7% of nursing assistants, 80.6% of EMTs, 67.4% of nurses, and only 2.0% of physicians. To the extent that class is a family characteristic, then, spouses and partners matter. The doctors in our study tend to have spouses with at least a college education, though not all of them are employed, and (with one exception) when nursing assistants have partners, they have working-class partners. The biggest range of spousal occupations is among nurses, some of whom are married to doctors, accountants, or engineers, with others married to firefighters, truck drivers, or car salesmen. Note that we use education, income, hourly pay versus salaried, and occupation as readily available indicators of class while recognizing that they do not fully capture the relational character of class. This relational aspect is visible in the relations of authority among our four groups: doctors, nurses, and EMTs are primarily supervised and controlled by other members of the same occupation, but when occupational lines are crossed, it is not only that nurses answer to doctors; nurses also exercise power over EMTs and (especially) nursing assistants. To lessen costs, hospitals and nursing homes have shifted what were nurses' routine tasks, like taking vital signs and drawing blood, to nursing assistants whom nurses then supervise (Applebaum et al. 2003). These four occupations are linked not only in terms of work routines but in terms of authority.

To be sure, the research design entails an asymmetry, but it is important to note that this is rooted in the actual occupational system: the advantaged occupations where women numerically predominate are not as advantaged, whether in terms of income, education, or authority, as those advantaged oc-

cupations where men predominate—an asymmetrical pattern that is more generally true (i.e., women with bachelor's degrees earn less than men with associate's degrees). Although the census reports that physicians are substantially the highest paid occupation overall, among all the occupations whose members are 80% or more women, registered nurses are almost the highest paid.[3] The same asymmetry is found in the two working-class occupations; our working-class men are paid more than our working-class women. Although a high proportion of people still work in gender-segregated occupations or jobs (Hegewisch et al. 2010; Stainback and Tomaskovic-Devey 2012), occupations in which men predominate (doctors and EMTs) have a higher proportion of women than those where women predominate (nurses and nursing assistants) because women have entered male occupations to a greater extent than men have entered women's (England 2010). As theory and much research suggest, occupations dominated by women tend to operate differently from overwhelmingly male occupations and differ as well from those closer to gender balanced (Lorber 2005; Acker 2006; Ridgeway 2012). The fact that the male occupations in our study are not symmetrical in class terms to the female occupations is not a design flaw but a strength, a sample that corresponds to the U.S. distribution where gender affects entry, income, and job conditions.

A common research design would be to use a large-scale survey or design a qualitative study that compared individuals matched on all but one variable (e.g., women and men nurses; Williams 1992). Such an approach makes it easier to control for a range of variables, but it loses the ability to analyze the gendered and classed processes embedded in and shaping an occupation or organization—a central goal of our research. Organizational practices and schemas depend not only on gender but also on class; the rules in an organization numerically dominated by nurses (as most hospital floors are) may differ from those in an organization numerically dominated by nursing assistants (as nursing homes are). Our research design takes into account these processes.[4]

For the last five years, we collected three types of data in two counties in the northeastern United States whose demographics approximate those of the national population. First, we mailed 800 surveys to a random sample

[3] Nurses are second, fractionally below occupational therapists, but there are 2,415,590 nurses compared to only 67,050 occupational therapists.

[4] Organizationally, a majority (62%) of the nation's registered nurses work in hospitals; only about one in 16 (6.3%) work in nursing homes, with a smaller number of nurses working in other settings, including schools, ambulatory-care centers, and households. For the most part, we do not compare nurses in these different settings; yet, given our argument about the importance of organizations, future research could benefit from a comparison of nurses in these different places.

of 200 persons in each occupation, with questions about hours and schedules; the overall response rate was 64.5% percent, with a rate greater than 50% for every occupation.

Second, we observed at eight sites for 615 hours, two for each of four different kinds of organizations: (1) Two hospitals were observed, including an urban teaching hospital employing over 5,000 people and a community hospital employing about 1,000 people, both nonprofit. Within each hospital, we observed both an emergency floor where the workload is relatively unpredictable and a medical surgical floor where the workload is relatively predictable (see Zerubavel [1979] for an argument about the value of comparing these floors for the study of patterns of time). We also observed (2) two nursing homes, including a high-end, stand-alone, nonprofit, 200-bed facility and a less upscale, 120-bed, midrange chain facility; (3) two doctors' offices, including a family practitioner and a specialist surgical practice; and (4) two EMS centers, including a public fire station and a private for-profit company. In the area we studied, about half of the EMT service is provided by firefighters. Field notes for each visit were recorded during and completed following each observation. A coding scheme with a focus on time and organizational attributes was developed and all notes were coded using NVivo8.

Third, we completed 208 intensive face-to-face interviews, three-quarters with direct-care providers (distributed across the four occupations; about one-quarter of them survey respondents) and one-quarter with others who shape hours and schedules in these occupations (including administrators, schedulers, human resources personnel, union representatives, and temp-agency officials). The average age of interview respondents in all the occupations was quite close, with nurses' and CNAs' median age at 38 years, and physicians' and EMTs' median age at 42 years. (For discussion of the importance of age for issues of time, see Schieman et al. [2009].) The demographic characteristics of survey and interview respondents were almost identical. (A fuller description of respondent characteristics appears in the analysis section below.) Interviews averaged well over an hour each. We transcribed all interviews, developed a coding scheme and codebook covering relevant work and family themes, coded all interviews using NVivo8, and held weekly meetings to address questions and inconsistencies in coding.

Note four data limitations. First, given the sample size, we do not look at variations within each occupation, for example, nurses working in hospitals versus nursing homes or doctors who are radiologists versus surgeons (see Goldin and Katz [2011] for discussion of variation in the hours of physicians in different specialties). Second, our ability to analyze the off-gender cases in each occupation is hindered by both data and space limitations. Crossover cases raise interesting issues that other research, which we draw on, has ex-

amined (e.g., Gareis, Barnett, and Brennan 2003). Third, the EMTs in our sample have more income and education than the national average. The EMTs had mean incomes of $45,000 from their main jobs, and $54,000 from all their jobs combined—closer to that of nurses than CNAs (although still lower than that of nurses). Firefighter EMTs are 100% union; private-sector EMTs are mostly nonunion. Therefore, the overall unionization rate for EMTs and nurses is comparable, with few unionized nursing assistants and only one unionized doctor. Thus, we cannot here distinguish the effects of unionization from the effects of other occupational conditions, although we did analyze union contracts ($n = 105$) of EMTs, nursing assistants, and nurses to assess their attention to hours and schedules. In other work, we show that class and gender variation in scheduling rules of the sort we document here are also apparent in comparisons of these contracts. This suggests that variation in unionization reinforces, rather than produces, the type of gender and class differences in scheduling we find here (see Gerstel and Clawson 2001; Crocker and Clawson 2012).

Fourth, much of the discussion of intersectionality invokes race-class-gender. Our work is centrally about gender and class, which we analytically separate to show how they interact. Unfortunately, it is difficult for us to disentangle race from class. Social class is not randomly distributed but is instead still deeply tied to race, a fact that becomes very clear among the workers in our study: only a small proportion of EMTs, physicians, and nurses in our study area are nonwhite (with the highest being 16% of the doctors in our survey, most of them Asian), while close to half (44%) of CNAs in our survey were nonwhite (mostly African American and Hispanic). While these differences are similar to those found in the nation as a whole and in the region we observed, the result is a limited ability to analytically separate race (although we occasionally seek to do so for nursing assistants).

ANALYSIS

In the analysis that follows, we examine each occupation in turn. We begin with an analysis of the flexibility of the two occupations dominated by women—nursing assistants and nurses—and then turn to the two male occupations—EMTs and doctors—although we compare both across class (which this order emphasizes) as well as across gender (which this order deemphasizes). To analyze the multiple meanings and practices of flexibility—whether employee or employer driven, whether rooted in the workplace or family—we focus first on time on the job, looking at hours and schedules worked in each occupation. Second, we examine time off, looking at patterns of leave in each occupation. We then examine the families for each of these four groups and discuss how these help to produce and sustain different patterns of workplace and family flexibility.

Nursing Assistants

While employers expect low-wage nursing assistants to be flexible in response to their schedule demands, these employers allow CNAs little flexibility to meet their other responsibilities, especially for their families. At the same time, these women workers encounter a kind of inflexibility at home. Such practices at home and on the job mean that nursing assistants face difficulty meeting conventional gender expectations; instead, they must violate those expectations.

Nursing Assistants' Jobs

Time on.—With limited exceptions, CNA's basic job schedules must fit into one of three predefined, rigid shifts: 7:00 a.m.–3:00 p.m., 3:00 p.m.–11:00 p.m., or 11:00 p.m.–7:00 a.m. They may request a change, and if another of the alternate shifts opens up, they may be able to move to it. This is a limited choice, however. Explaining why she works the shift she does, one assistant put it simply, "I work when I do because they tell me to. I'd like to work something different; it's not my choice." Another accepted a position from 3:00 to 11:00 p.m., but was told to report at 11:00. Thinking there must have been a mistake, she asked the supervisor. "She goes, 'We overhired for 3:00–11:00, so 11:00–7:00's all we can give you.' I said 'But I was hired for 3:00–11:00.' 'Well, take it or leave it.'"

Many long-time nursing assistants have 40-hour-per-week jobs, and some employers mandate overtime when staffing is short. As one CNA said of such mandatory overtime, "It turns your life upside down." In recent years, however, nursing assistants have increasingly been offered only 24- or 32-hour-per-week positions; if they pick up an additional shift, employers need not offer them any overtime pay.[5] Not surprisingly, the CNAs often want—or need—more hours. In our survey, nursing assistants are the only occupation where the number of people wanting more hours outnumbered the number wanting fewer hours. In interviews they explained why they wanted more hours: "Like if I was to only make 32 hours, I'll be short of money." Nursing assistants do have a choice about whether to pick up additional shifts, but that choice is constrained by economic necessity; many feel compelled to pick up shifts if possible, since a 32-hour-per-week schedule, at $10 an hour,

[5] We expected employers to hire part-time workers to avoid paying health-care benefits. As far as we could tell, this was of minimal importance: our hospitals and nursing homes give health-care benefits to part-time employees (except per diems). The exception was private-sector EMTs: although private-sector EMT companies require a 40-hour week to get benefits, EMTs in any case work that much or more. Perhaps this provision of benefits was because our employers are in health care; other researchers have found reduced work hours tied to reduced fringe benefits, especially in the retail sector (Carre et al. 2010).

leaves them below the poverty line. To get by, they have to show what employers call the "flexibility" to pick up any available shift.

Time off.—Nursing assistants are also the group most likely to encounter policies making it difficult to get time off; even their ability to take a sick day is constrained. At one nursing home where we observed, workers receive six paid sick days per year, but are penalized anytime they use one. This was not an exceptional situation (Lopez 2006). Many of the nursing assistants told us they are afraid to take a sick day off, even though officially they are granted it: "Even if I'm sick I will still go to work [laughs]. . . . Somehow I am going to make it." Another nursing assistant talked about how management told them in meetings that they "were not going to tolerate sickness" and then went on to say:

> R: If you've got diarrhea or vomiting, they still want you to come in. At our meetings, they say a sore throat is not really a sore throat. Lots of times they'll say to come in and do what you can and if you can't stay, we'll let you go home. But lots of times they won't let you go home. The whole idea is to intimidate you so you won't call out.
>
> Q: Have you ever talked to management about that?
>
> R: Others have and lost their jobs.

Another CNA asserts, "Even if you have doctor's notes, emergency room letters, you're terminated. That's it—no ifs, ands, or buts, no explanations."

Administrators agree and legitimate their sick leave policy by claiming, for example, "There are times when people can't survive with this business." And these managers are quite certain they can replace the nursing assistants if they do "not survive": nursing aides' unemployment rate was about 9% over the last 10 years (U.S. Bureau of Labor Statistics 2010),[6] higher than that of any of our other groups. Nursing assistants and their families must adapt to employer demands. Employers, not employees, get "flexibility."

Although the nursing homes where most CNAs work are large enough to be covered by the Family and Medical Leave Act (FMLA), what we find in general is noncompliance with the law (such noncompliance, other research suggests, is quite common; Armenia, Gerstel, and Wing 2014).[7] A

[6] David Johnson, chief, Social, Economic, and Housing Statistics Division, U.S. Census Bureau, personal communication. These figures, like the unemployment figures for the other occupations, should be treated with caution because the BLS sample size for any given occupation is small.

[7] The noncompliance we see here occurs in settings with over 50 workers, where there are low rates of turnover, meaning employers are required by the law to offer workers

number of nursing assistants described situations that should be covered by the FMLA but are not, saying, as one does, "There's no excused absences." As another nursing assistant describes her nursing home's policy, "I think if you bring a doctor's note, you know, they shouldn't be like, 'Ok, if you be absent one more time, you're gonna be fired.'" The rarity of the FMLA's use by the low-wage nursing assistants becomes even clearer when we examine schedules from one of the nursing homes we studied: looking over a six-month period, we find only one CNA who changed her schedule because of the FMLA.

Nor do CNAs have flexibility for vacations, which typically need to be planned long in advance. At a nursing home where we observed, a vacation of two days or more requires a minimum of one month's notice; for summer vacation, requests have to be in by mid-March. The scheduler is clear about this: "Vacations—you can definitely say that those were settled months in advance." A number told us they are allowed to take a vacation, but they skip it so they can get the extra money they need. As one nursing assistant, who was better off than most and lived in a trailer, told us, that when she skips vacation and takes the extra pay, "I save it so I know I have the oil for the coming winter." By paying low wages, employers are assured a workforce that needs time on instead of time off.

Employer policies for nursing assistants did differ between the two nursing homes we observed. One home, where 88% of the aides were people of color, had much more draconian policies about time off and harsher enforcement of them, including a "no exceptions" approach and a management that responded to every difficulty by formulating stricter rules. At the other home, only 25% of the aides were people of color; that home had versions of the same policies, but milder versions enforced with some willingness to adapt to individual requests for time off. Although only suggestive, this indicates that race may intersect with class and gender to shape organizational flexibility.

Nursing Assistants' Families

Not only do CNAs' earnings hover around the poverty line, but their families also contribute to a double-barreled inflexibility. In our survey, fewer than half (48%) are married. Forty-one percent have children younger than 18 still at home; over half of these are single mothers. If they are married, their spouses tend to work for low pay, part time, or intermittently (partners contribute, on average, only 40% of household income). Nursing assistants feel they must put in paid hours at unpredictable times because

(who have worked the requisite 1,250 hours) leaves mandated by the FMLA. They break the law.

they need to be the primary breadwinner for their families. As one single mother nursing assistant explained, "That's the whole reason I'm working, is for the children, and I mean, you have to work to pay bills—that's for your children." Another nursing assistant asserted family as a priority over work, sounding a lot like members of the other groups we studied: "You gotta understand what about the little kids, they're kids, you know? You can't come to work if your kids are sick. . . . I understand work is your responsibility but truthfully, family is your responsibility and it's your first responsibility." But the economic deprivation they suffered and the organizations they worked for made it very difficult to uphold these values.

Although these nursing assistants would like the opportunity to follow some of the traditional expectations associated with gender—those that promote women's ability to take the time to care for their families—their workplaces and class position make that difficult. Instead, they are forced to revise neotraditional gender practices, becoming their family's main, or sole, breadwinner. Asking about the dozens of pictures on the bulletin board next to her desk, the scheduler at one nursing home told us she put them there because CNAs are not allowed to post pictures anywhere near where they work, so "this way they can put up pictures of their family someplace." A nursing assistant listening to the conversation piped up, "She has them up so when you come in and say 'I quit,' she can point to the pictures and say, 'You remember why you are working?'"

These CNAs were also the primary caregivers for their children. The fathers of CNA children were sometimes, but rarely, mentioned as important in providing care while the CNAs were at work. CNAs, instead, tend to rely on others. They rely on their children to act as "mini-moms"—to take care of themselves and their siblings, a survival strategy found often in low-income families (Dodson and Dickert 2004). Although issues of children coping this way caused nervousness in interviews, occasionally a nursing assistant would explain that because she must work a shift, she has to "hope they [her kids] can work the locks to get themselves off" to school. Another explained that she and her husband had been "separated a lot," so often he was not around. To get by, "I have to count on my two children." She worked the night shift because "what better time is there than when they [her children] are sleeping?" She explained why she took this shift by saying, "The kids, they're older, like 9 and 11." Then she concluded, using a sentence we heard often from CNAs: "You do what you gotta do."

Nursing assistants also re-create family in another way: they rely on extended family who make it possible for them to work unpredictable and inflexible hours. Many made comments like "I don't know what I would do without my sister." Referring to a cousin, another said of adding shifts, "We all work together to make it happen." When speaking about her disabled

mother's willingness to keep her kids an extra eight hours so she could unexpectedly add a shift, a CNA insisted, "She is my rock. She is my life." Extended families are often a key strategy for survival among those with little income—one especially vital for getting home late or picking up shifts.

Overall, low-wage nursing assistants do not have the opportunity to obtain the kind of flexibility around which neotraditional gender expectations are framed—those associated with nuclear families, intensive mothering, and lowered job involvement—even if, as Macdonald (2009) and others have argued, these low-wage women are subject to the same cultural models of family, mothering, and jobs as are more advantaged women. To be sure, the nursing assistants occasionally report that escaping such expectations yields some advantage. Sometimes, they told us, they feel drawn to coworkers and residents as a release from demanding families. As one told us, "Back when I was having babies . . . I never took a four-month leave of absence. Because I went nuts at home. I had to have more in my life than that." This comment reminds us that neotraditional cultural models may in some ways be attractive while simultaneously being a burden that the CNAs sometimes seek to avoid and revise. Though she did not discuss class variation, Hochschild (1997) found that much stress and conflict occurs at home while much in the way of support and personal reward may occur at the workplace. As a result, the employees she studied, like the low-wage women workers we examined, may sometimes look to paid work as an escape from family stresses (which may themselves be intensified by difficult conditions at work). At the same time, CNAs often feel harmed by the ways inflexible job demands make it difficult to respond to their families and meet dominant cultural conceptions of women's family responsibilities.

Nurses

In contrast to nursing assistants, nurses are able to deploy their class advantage in the service of conventionally gendered notions of flexibility. In many cases, nurses have the leverage, both market position and cultural support (from managers and the state), to make their families a priority, and they work in organizations that provide family-friendly flexibility in job schedules.

Nurses' Jobs

Time on.—In part because of their favorable market situation (i.e., their unemployment rate is very low, ranging from 1% to 2% over the last 10 years; U.S. Bureau of Labor Statistics 2010), organizations offer nurses basic schedules that encompass a wide range of hours and shifts. Not only do employers

offer different start and stop times, but organizations employing nurses (especially hospitals, which employ 62% of nurses; U.S. Department of Health and Human Services 2010) also offer shifts of varying length—6, 8, 10, or increasingly 12 hours for three days a week; some work only weekdays; others are weekend-only positions. Working on average 36 hours a week, the nurses in our study are rarely required to do mandatory overtime, and nursing is the one of our occupations whose members are the least likely to voluntarily work additional hours.

A number of the schedulers and managers commented on the variety of shifts they offer to satisfy nurses' requests, sometimes emphasizing not only market conditions but also their own support for nurses' family concerns. As one emergency room nurse scheduler remarked, "If I had someone turn up tomorrow and say I want to work 3 to 1:30, four days a week, and I didn't have the position available, I could probably get if for them." A nurse manager on a medical floor quite casually noted that these schedules are often because of children:

R: People will come in, take a full-time job, they have children and they'll go for a part-time job.

Q: And do you have available positions for full time and part time?

R: Oh, we've always got them, yup.

When we asked what determined shifts, another nurse manager of an emergency department explained, "I would say family rises to the top for people who have concerns. It's directly related to child, husband, father, child care. Yeah." We asked, "If a nurse comes to you and says 'I can't do this anymore,' what do you say to them?" And she responded, "Well, let's figure out what you *can* do and we'll look at the master schedule and I'll change the master if I can, to better accommodate them." Still another scheduler in intensive care summed up this managerial view: "So I know that flexibility is key, I think, to keeping your employees happy. . . . You can't be rigid, you just can't." The cultural models emphasizing women's family responsibilities infused the managerial view; these also reinforce the expectations of nurses themselves. One who moved often for her husband's career explains, "One of the great things about nursing . . . you can almost name when and where you work."

Time off.—We see similar flexibility among nurses with regard to time off from the job, especially for sick leave. With relative ease, nurses can and do get time off for sickness, sometimes for themselves, sometimes for family members. Nurses reported that they do not come in if they are sick—they call their scheduler and the full-time (and overburdened) schedulers find someone else to work in their place. In contrast to what the nursing

assistants experienced with the very same symptom, one nurse explained that if she is taking a "mental health" day off, "a good one is I have diarrhea, because they go 'Ohhh! Don't you dare come to this place with diarrhea.'" Sometimes the scheduler finds another regular nurse who volunteers to come in or, if that fails, the scheduler turns to a per diem or an external temporary agency—which serves as an important organizational device to allow nurses flexibility. Temporary agencies sell themselves in their ads as ways to provide "flexibility" to nurses who do not want to work as regular staff nurses. As the director of one temporary agency told us, "The nurses who work for agencies work for agencies because they want that flexibility." Of course, they also allow employers flexibility—the ability to staff leaner knowing that, for a price, a backup is always available. And managers respond, "If somebody came to me tomorrow and said 'my husband's sick and he needs to have an appointment with his doctor tomorrow and I need to go,' we'll fix it or we'll try and fix it."

Nurses also take advantage of official state leave policy for families. While those in the other occupations almost never mention FMLA, nurses mention and use it fairly often. When a child, spouse, or parent requires the kind of care covered by the act, the nurses bring a note from their doctor to obtain official approval for time off from the human relations office, whose personnel know the requirements. Then, nurses call their schedulers, one of whom reported that they would say, "I am not coming in today because I'm taking an FMLA day." As a manager in one hospital said of nurses on her floor, "They can call up today, and say 'I'm not coming in tonight, I'm taking an FMLA day.' And there's not a thing I can say about it, it's already approved, it doesn't matter what the staffing is on the unit, it's 'Okay, thank you for calling.'"

One administrator even turned FMLA into a verb, saying nurses keep "FMLAing us." The managers do not protest what they saw as some of the nurses' all too frequent absences too loudly: they say the law silences them. These are gendered organizations, then, in the sense that for class-advantaged women, the organization is prepared to adapt schedules to what women see as the needs of their families, rather than insist that neutral schedule rules must apply to all.

Nurses' job flexibility is by no means unlimited. Vacations need to be scheduled long in advance and even then are subject to approval. In general, nurses face extra restrictions on vacations during "prime time"—the entire summer and often midyear school vacation weeks as well, that is, the times when children are not in school and are most likely to need care. Working in gender-segregated occupations, nurses face restrictions on vacation times because so many of their coworkers share similar family demands and preferences. Not only do such vacations need to be scheduled months in advance, they may be denied by a supervisor or prohibited by a

sweeping rule. At one hospital there is no flexibility about Christmas and Thanksgiving, no matter how far in advance the request is made: "Why if I get Christmas off do I have to work the day after, so I can never ever go out of town for Christmas? . . . There's no way to go for like three days for Thanksgiving or that kind of thing. You'll never get that kind of time off, for any kind of a big holiday."

Nurses' Families

Nurses insist on job flexibility so they can attend to family concerns, for which they feel primarily responsible. Some basic facts about their families help explain these processes. In contrast to nursing assistants, most nurses are married (71% in our survey) and most are members of dual-earner couples. Most nurses are parents: while only 5% are single mothers, 43% are mothers of children still at home; others have adult children to whom they still provide care, whether babysitting for their grandchildren, helping with housing, or other practical care. Median family income is $90,000, with married nurses contributing on average 56% of family income; their spouses, however, contribute a higher proportion of family income than spouses in any other occupation (national data show that about a third of U.S. wives today contribute more than half of family income; U.S. Bureau of Labor Statistics 2010). Even though women nurses on average earn somewhat more than their partners, nurses tend to do more of the domestic labor and seek flexible family-friendly jobs to do so.

To be sure, we interviewed a nurse who talked about how she could set her work schedule and count on her "flexible" husband to adapt to it. A mother of two daughters ages 8 and 11, she first described the rarity and, as she described it, "the luxury" of a situation in which she and her husband made the choice to give more of the child care to the husband. Asked if this bothered her at all, she responded: "No. Are you kidding? I have never cleaned the bathroom! I wouldn't even be able to tell you what he uses—I have no clue!" But then she went on to describe how she felt it was sometimes hard on her husband, explaining, "Because he's a man and they need to feel like they are superior. . . . He's got to validate himself."

Moreover, while this view of masculinity might be widely shared among nurses, this division is very unusual. Much more commonly nurses adapt their schedules to their husbands' job schedules and do more domestic labor supported by the flexibility they create on their own jobs. Contrary to relative-resource theory, which argues that as women earn more relative to their husbands the division of domestic labor becomes more equal, nurses use their job flexibility to take on more of the domestic labor, even though they often earn more than their husbands. The inequality is apparent in

housework. One nurse whose husband is a self-employed consultant commented dramatically and sarcastically, "My husband's hands would disintegrate if they hit dish water!" This gendered division also exists for the care of sick family members, including elderly parents, but especially for children, who are the main focus of the nurses' discussions of a need for workplace flexibility. As one nurse explained her greater role in the household's division of labor: "I just can't imagine anything. . . . I mean, he's the primary breadwinner. . . . And the whole notion of whose job is more flexible to deal with that, and clearly mine is." Continuing, she explained that she understands this division in terms of what seems, to her, an obvious individual choice rather than part of a broader gendered divide: "Now, it could have been the other way, it just happens to be the way it is in our family. It has always been, that's always been on my shoulders." But there are limits to this individual rather than social explanation; it does not just happen in her family. Both she and her husband, and the organizations they work for, help create this notion of gender.

These, however, are not simply women responding to external constraints or to husbands who earn a living but refuse to do their share in the daily work of the home. Some nurses spoke of liking to cook family meals and garden, or wanting to see their elderly parents. Many told us that they prefer having additional time with their children, that such care provides an appealing contrast to the intensity of their jobs, and that the flexibility of nursing shifts and hours, along with partners earning substantial incomes, allows them to have it. As one explained, "Well, the big thing is that I like to be home with my kids."[8]

Overall, the nurses—women in relatively advantaged positions—insist on and use workplace flexibility to reinforce, even create, a gender divide. Stone (2007) has argued that women who spoke of choosing this pattern can be understood as using a "rhetoric of choice" and "reality of constraint" given alternatives available to them. The stories that the nurses tell us, however, indicate that this rhetoric and reality are mutually constituted: the nurses seek, even push for, organizational patterns to obtain a kind of workplace flexibility that allows them to sustain a relatively inflexible gendered division at home, which in turn leads them to insist on family-friendly flexibility on the job, even if there are some costs to doing so. As such, they are very different from the nursing assistants, who are in a much less advantaged position.

[8] See also Garey (1995, 1999) for a fascinating discussion suggesting that hospital nurses choose the night shift as a way to be publicly visible as intensive mothers as well as available to their children during the day, working during the hours when their children are asleep.

Emergency Medical Technicians

Turning to the two male occupations, we find again that while class advantage tends to be deployed in the interest of gender conventions, class disadvantage may lead workers to violate these gendered expectations. Examining both jobs and families, we see this process operating among the working-class male EMTs.

EMTs' Jobs

Time on.—Like female CNAs, male EMTs' basic schedules are rigid and controlled in large part by others. They (whether firefighters or in the private sector) must work day and night shifts, weekdays and weekends, in a predictable schedule. Among the firefighters, at the beginning of the year each EMT receives copies of the pocket calendar that lists exactly what crews will work which shifts every day for the entire year. These are officially inflexible schedules.

In addition, EMTs are by far the most likely to work second jobs—62% do so, more than twice the rate for any other occupation—and as a result they work on average a total of 55 hours a week. However, it is in scheduling their second jobs and in deciding whether to work overtime that EMTs seek and obtain significant flexibility. Often by working different shifts, their wives shape their own job schedules around the EMTs' basic work schedules; in turn, EMTs choose their overtime and second job hours around the family's needs.

Time off.—It is on the occasions when they take time off that these working-class men most clearly practice flexibility, often in a reversal of gender prescriptions. The EMTs rarely report problems in scheduling vacations at the times they want. When necessary, they swap with coworkers as a way to extend their vacation time. Many EMTs treat their sick leave as a form of entitlement: "There's really no penalization. Unless you're a constant abuser of it, there's really no penalization for it." Most EMTs assume that they will use all their sick days, whether or not they are physically ill. As one asserted, "Most of the time when I'm sick, I want to use those because we just need a mental health day. . . . People think that sick means that you're sick-sick—where a lot of times you just need to get out of there." A number of EMTs told us they took sick days to take care not only of themselves but their children. An EMT with a young child reported that he had just taken three sick days "to stay home when one of the smaller ones was sick."

In part because of EMTs' favorable market position (with unemployment rates at about 3% over the last decade; U.S. Bureau of Labor Statistics 2010), in part because of the stance and power of their unions, and in part because of their cultural capital, the organizations employing EMTs

tend to impose no penalties. One supervisor, discussing a time when an EMT took his wife's Friday evening call and immediately announced he was sick, said, "There's nothing I *can* do. The rules say that if you go home sick that's it—you go home sick." The EMTs have won the right to use their sick leave. It is not inherent in the occupation or institution they work for; it is because they fought and continue to fight for it. In their case, it seems, they have the human and cultural capital (they are heroic figures who risk their lives) that makes employers reluctant to penalize them.

EMTs' Families

The EMTs work long hours and rigid basic schedules, but they also try in some ways to organize their time around caregiving for their families—revising standard notions of masculinity. The basic facts concerning their families help explain these patterns. Most EMTs (60%) are married. But, unlike CNAs and what we will see among male doctors, most EMTs have spouses who are employed (90%), and their wives contribute on average about 29% of the family income (median family income is $70,000). On the one hand, EMTs saw themselves as important breadwinners, saying things like "I don't turn down an overtime shift very often. Because I can't afford it [laughs]. Not because I just looooooove being here so much. The call-back, I try to do them, you know, if I can, but like I said, you know, and it's—I hate it when I have something going on in five hours and I can't take a call-back because of it. Because I'm thinking that's money I could be making, but I'm not." Emphasizing choice instead of constraint, another put it differently but still highlighted his breadwinning role: "I keep her [his employed wife] in a new car. I have a new car. I mean we didn't have to do that. But it's a choice. . . . I could be more careful about money and work less, but I choose to provide that. It's a good life at home you know." Although he emphasized his role as a breadwinner, he quickly added, perhaps emphasizing both equality at home and a certain competition there, "It is not like I'm the money winner, I mean—we both make you know. If I didn't work the hours I work, I wouldn't be matching her. Yeah, so money is really—it's important you know. It rules."

Their employed wives cannot alter the EMTs' basic job schedule, but they can and do influence whether and when their husbands answer call-backs, pick up overtime, or take second jobs. One explained, for example, that "I have a deal with my wife that I will not work Friday night, Saturday, or Sunday unless I can't get any other shifts." He was talking about his second job. The EMTs told us that their wives often insist on their husbands being flexible enough to care for their families, with their wives' influence ranging from subtle signals to outright demands. While eating lunch at work with a number of his fellow EMTs, one EMT responded to the question, "Do

your families ever ask you to not come in for overtime?" by laughing and saying, "No, they tell you: You're not going in." The other EMTs sitting around joined in the laughter and nodded in agreement. Another EMT explained, "There are some guys here who, their wives will tell them, you're not going in; you do not go in; you can only go in if I'm not home, and you better be home before I get home. . . . They won't come in." As Deutsch (1999) found among the working-class men she interviewed, these working-class wives seemed to exert power at home—perhaps in part because their contribution to the family income was significant. The EMTs noted this in explaining their own significant contributions to domestic work. Whether motivation or justification, the result is the same: they implement a kind of family flexibility that involves movement toward an egalitarian division of labor and do not enact conventional gender expectations.

The EMT fathers talk about picking children up from day care or school, taking them to little league games, feeding them dinner, or staying home with them when they get sick. One stated, "My son's out of school at 2:30 in the afternoon. That means that I have to leave here about 2:15 to make sure I'm at the school to pick him up." As another noted, "When my daughters are in school, I come in a lot during the day. Weekends, that's a rarity unless it is late at night or early in the morning. I'll come in from midnight on." Thus, in contrast to what we will see among the doctors, these male EMTs not only go to public events but are likely to participate in the daily "private" care of their kids. Many EMT fathers value time with their children. As one remarked, "I love the fact that I can be home with my kids a lot, because it's long hours at times, but honestly, I get four days off in a row with my kids. How many people get that much?"

Almost half the EMTs work shifts that are different from their wives in order to share parenting. But given the demands of two jobs in these families, EMTs and their wives also often must rely on other people to help care for their children. Like CNAs, they told us they relied on their extended kin to make it possible to care for family and keep their jobs. As one said, "Holidays are a pain in the butt because she [his wife] works them, I work them . . . she's got a job to do and I do and you can't get out of it. . . . So there's conflicts but we roll with it pretty good." Then he went on to explain how they made this possible: "It's only because of our family support system. Without my folks and her folks, forget it—I don't know how we'd do it." Like others in the working class, they rely on kin care because they trust their relatives and such help is less expensive and more flexible than hired help.[9]

Overall, then, we find that these working-class men contravened conventional gender expectations on which the nuclear family depends. To be

[9] See Gerstel (2011) and Sarkisian and Gerstel (2012) for the argument that less advantaged workers are more likely than those more advantaged to rely on extended kin.

sure, they work long hours and in many senses their schedules are rigid like those of CNAs. Because of employer demands, many alternated rigid basic schedules with their wives, which meant that these spouses saw relatively little of each other. That is, many told us, a cost of their schedules. But both the culture and the structure of their family situations led these working-class men to plan their overtime and second jobs so that they could obtain and use a modicum of family-friendly flexibility.

Physicians

What kind of flexibility do male doctors want and use? Like male EMTs, male doctors said they need to be available for long, sometimes unpredictable stretches when their jobs demand it. But unlike EMTs, these advantaged men do not seek the flexibility to cut back on their job hours but rather the kind of flexibility that allows them to work long hours. In doing so, they use their class advantage to construct a conventional gender divide.

Physicians' Jobs

Time on.—What flexibility means to most male doctors is the ability to give their jobs much time and energy. In responding to the survey, male doctors estimated that they worked, on average, 49 hours in a week; that is almost certainly an underestimate because when probed in interviews doctors often talk of doing e-mails or reading journal articles at night; they typically did not count that as work when calculating their hours. Doctors encourage one another to work long hours, celebrating those who do and befuddled by or stigmatizing those who don't. As one physician describes doctors, "The ones who work the most are looked up to. . . . You have to work harder; that gets respect. When you work more . . . that's a big badge." The culture of the workplace and daily interactions there reinforce this pattern and their view of it.

Examining the way they do basic scheduling helps underscore this point. Many physicians meet with one another in scheduling meetings where they discuss who will work when. Before the start of one hospital scheduling meeting in an emergency department, some doctors were talking among themselves; when asked if they were talking about the schedule one replied, "We're always talking about the schedule." Walking into the meeting at 7:30 a.m., the head of the department said, "Oh you are here for the worst scheduling meeting of the year" (because it includes Thanksgiving, Christmas, and New Year's). Throughout the meeting, stress was evident, but what made it evident were pauses and silence. No one raised a voice; no one even sounded particularly angry (and these are people who did sometimes sound angry when they were on the floor talking to nurses or nursing

assistants). No one was explicitly told what to do and no one had—or assumed—the authority to tell others what to do (even though there are differences in rank; one doctor is head of the department, and some are partners while others are not). Instead they used peer pressure. It took little time for the doctors sitting around the table to volunteer for openings. During the meeting, one young doctor kept jumping up from the table to call his wife—to report the pressure on him to come in on one holiday or another. After awhile the other doctors started to look irritated and began to tease him. The director gently reminded this younger doctor that he and his wife wanted a new kitchen and, with a smile, indicated it was the young doctor's obligation to provide the domestic trappings they desired. The young doctor agreed to come in on Christmas day.

Time off.—This commitment to long hours is perhaps most visible with regard to sick leaves. For all other groups, a question about sick days was often answered in relation to sick family members, something that physicians rarely mention. Answering a question about sick leave, physicians almost always focus on themselves. Physicians stand out for their insistence that they simply do not take sick days. The ethic is to work if at all possible, a policy held in place by group pressure rather than any formal rules. One explained, "If you call in sick, there's 10 of us. You better be sick. And nobody calls in sick here." Or as one of the physicians reported, "I had pneumonia . . . and after I got on antibiotics I would see a patient, go into my office, and lie down for awhile, and see another patient and go into the office and lie down for awhile." "I haven't taken a sick day in years" was the typical response to a question about sick days.

Most doctors do take time off for vacations—more time than any of the other occupations we studied. Vacations must be scheduled in concert with colleagues and, for many, planned enough in advance to avoid scheduling patients during that period (or to reschedule those already scheduled), but doctors largely feel they are able to get vacation if and when they want. In a notable case, one doctor—a surgeon in a group practice—was explaining his hectic schedule to us. He contrasted his situation with that of other (subordinate) occupations within his office. Deciding not to come in one week, he said, "I just canceled five days of appointments and went on vacation. *They* can't do that. They can't just decide not to come in. I can." Although sometimes planning such vacations around professional meetings, doctors typically also see these as special time to spend with their families.

Physicians' Families

For these professional men, the flexibility to put in long hours on the job typically depends on having wives who take care of family matters. Most of the physicians are married (77%, according to our survey). Male doctors

are their families' primary breadwinners, which their superior earning capacity allows. They earn, on average, 87% of their family's income. In contrast to EMTs, 40% have stay-at-home wives. Of the remaining who have employed wives, 22% of those wives put in fewer than 30 hours a week and often work in jobs with flexible hours. When neither of those is true, the couple often hires a nanny because physicians' incomes enable those without stay-at-home spouses to purchase a family substitute who provides (but does not get) work flexibility.

This allows doctors to rely on the "flexibility" of their nuclear families to sustain their long and arduous schedules. Physicians can work long (and often unpredictable) hours both because they are the only group able to decide to stay extra hours without the permission of a supervisor and because their families are willing to adapt, say, to eat dinner—or at least sit at the table—at the time dictated by these work hours.

Q: So you do get home for dinner.

R: Yeah, but we eat dinner at 9:00 at night. My kids, you know, they've already eaten, but we'll always, while we're eating, we'll always sit at the table and talk. . . . It's like a great time for us.

This doctor goes on to describe his demanding hours, insisting he never feels undue pressure from his colleagues, as when he agreed to be on call for two weekends in a row: "Where we do tend to feel the pressure a little bit is on the other side—not here, but at home. My son's got a lacrosse game at Williams. She's [my wife] like, '*Why* are you *doing* that?!' I said, 'Well, you know what, that's just the way it worked out.' And I think our families have to be a little flexible in how we do things as well." Another physician explained that his family flexibility came through a decision to home school his children, saying, "If kids are in school then you're kind of tied to their vacation schedule, but if I want to take a vacation in the middle of March, we go in the middle of March."

This does not mean that male doctors are not involved in their home lives: they are "public fathers," while, as we saw, EMTs are both "public" and "private fathers" (for a development of this argument, see Shows and Gerstel [2009]). Physicians emphasize their concerted attempts—even given their long hours or hectic schedules—to attend important athletic events, music performances, and dance recitals. Participation in public activities often requires a significant financial outlay. This pattern is then reinforced by the income associated with their advantaged class position: for these men, to be a good father is to be a good breadwinner.

Overall, then, just as we found among female nurses, flexible work among male doctors—here in the service of long hours on the job—depends on the enactment of neotraditional gender models. This does not mean that male

doctors have no regrets. They sometimes told us they felt sad they could not spend more time at home, especially talking with their kids or putting them to bed. Tears started to roll down the cheeks of one doctor as he spoke about his fears that he was missing his children's development. And the doctors spoke of wives who want them home, not on call, not on e-mail. In some sense, they see themselves as having no other choice—honorable, flourishing, and lucrative careers could be derailed, they thought, by attention to family demands. But the flexibility of medicine is geared to an older notion of masculinity. Although they faced significant constraints, the doctors were in some sense making choices to earn the very high incomes that sustained, indeed depended on, a gender divide. If Stone (2007) could write about the "rhetoric of choice" and "reality of constraint" used by the affluent women she studied, among the professional men we studied, we might write of a "rhetoric of constraint." This divide between rhetoric and reality, however, misses the ways in which cultural models and institutional constraints are mutually constituted and sustaining. What we find is that these male doctors use cultural ideals of work and gender to create organizational patterns that sustain these ideals. They then confront, or are constrained by, these very patterns and ideals.

CONCLUSION

As we have shown, flexibility of time is both variously defined and unequally distributed. It is the joint operation of both jobs and families, as well as the practices and schemas of employers, employees, and their family members, that shape flexibility.

We examined the workplace and family flexibility of only four occupations, all in health care, but our analysis builds the broader argument that gender is not fixed but instead is negotiated (Connell 1995). We show that class advantage is used in the service of "doing gender" (West and Zimmerman 1987), while class disadvantage may lead to a violation of gendered expectations or the "undoing" of gender (Deutsch 2007). Moreover, temporal patterns of the sort we discussed are, as Zerubavel (1979) theorized, collective or supraindividual; this characterizes not only schedule rigidity but also its converse, flexibility. Although Zerubavel emphasizes the importance of egalitarian principles and fairness "as a fundamental rule of scheduling" (p. 117) *within* occupational groups, collective principles of scheduling are also—as we have shown—unequally distributed *across* groups. These unequal processes obtain, we suggest, through organizational rules and cultural schemas that create and sustain one another.

While we have made an empirical case for the mutually sustaining character of cultural models and organizational practices, we do not mean to argue that these are altogether consistent—without ambiguity or disparate

elements. For example, we heard male doctors talk of the value of daily family participation and their recognition that they "should," even want to, do more at home; yet at the same time, they feel the need to stay long hours at work to earn money for their families, which then distances them from their families. Nurses and their managers occasionally express dissatisfaction about their husbands' lack of participation at home at the same time that they insist the care of children suits them because they are women. The EMTs sometimes made fun of one another for doing so much work at home, even while they and their supervisors justified that engagement. The CNAs occasionally spoke of the benefits of escaping their homes to go to their jobs, while at the same time they protested job conditions that did not allow them time to care for their families (see Gerstel and Clawson, in press). But, overall, we saw how members of all four groups invoked frames and practices responsive to some set of conventional gender models, even if class disadvantage led them to violate at least some of these (see DiMaggio [1997] for a useful discussion of these disparate processes).

Although there is variation within each occupation and organization (only some of which we could capture here), there are also marked differences across occupations. The two disadvantaged occupations—male EMTs and female nursing assistants—have little ability to shape their basic work schedules. The basic work schedules of EMTs are rigid and fixed. Yet they have flexibility of still another sort: they have considerable leeway in determining whether to accept overtime and when to put in hours at a second job. Unlike doctors, who provide most of their families' incomes, EMT families rely considerably more on the combined earnings of the wife/mother and the husband/father. Prioritizing the man's career is less common among EMTs and, as we have indicated, other studies suggest that this is true for working-class men more generally (Pyke 1996; Deutsch 1999). Limited income, the family's dependence on a wife's income, and the wife's preferences all encourage male EMTs to do significant domestic work. Many EMTs also actively seek engagement with their children. As one private-sector EMT said, "These are going to be the only children I'm ever going to have. I wanted to be able to raise them myself without palming them off and not seeing them."

Low-wage female nursing assistants face schedules that are as rigid as those of EMTs, but they face a double-barreled inflexibility in their families as well as in their jobs. Stated differently, because their employers can and do insist, these low-wage workers confront another kind of "flexibility"—one from an employer's rather than a worker's perspective. Because many are single parents and because even those who are married rarely can rely on husbands to provide significant income or much child care, juggling work and family becomes a major challenge, usually possible only with the assistance of extended family. Because household income is low—

whether single or married—women nursing assistants often act as their family's primary breadwinner and feel compelled to work additional and unpredictable hours beyond their basic schedules, despite the problems this creates in attending to domestic concerns. Again, class disadvantage coerces these women to violate gender expectations—some of which they want to implement, though they also occasionally sought to escape them. As suggested, we cannot fully disentangle the effects of race from class or gender. But there are at least some indications that race exerts an effect: the more restrictive sick-leave policies at the nursing home where they were primarily women of color compared to the one where they were primarily white may indicate that racial dynamics operate to shape scheduling flexibility. The differences between the treatment of nurses and the treatment of CNAs may be tied to race as well as class.

Furthermore, although there is considerable debate, some argue that black women are more likely than white women to be socialized to "undo gender" (Collins 2010). Using her ethnographic research on advantaged black women, however, Barnes (2008) discusses highly educated, affluent black women who also "do gender" in neotraditional ways. They leave demanding professional careers in favor of marriage (to a high-income husband) and intensive mothering, but this means that they turn away from the cultural models of black womanhood they learned and still encounter in their own extended families and communities. Future research should seek to further distinguish the contributions of race, gender, and class.

By looking across class and gender, we see the multiple meanings of flexibility and the operation of an important distinction between employer-driven and employee-driven flexibility. The "flexibility" for CNAs is driven and controlled by employers who insist on a flexible workforce, which they say is necessary to control costs and respond to changing market conditions (Kalleberg 2003, 2011). This flexibility, unlike the sort that many work-family scholars now advocate, entails an increase in the power of employers and, some argue, an attack on employees (Piore 1986; Ng and Dastmalchian 1998; Standing 2011). What employers call flexibility may be what CNAs call instability and experience as family-work incompatibility.

As we have seen, male doctors look very different: they use their class advantage—their high incomes and ability to control their work—to put even more time into jobs. "Work flexibility" here means an ability to shape schedules to perceived job demands. "Family flexibility" means not facing family pressures to return home at a set time because a spouse takes care of tasks at home, and neither spouse nor children insist on the doctor's return at a fixed time. Socialized as interns and residents to work long hours (Brooks and Bosk 2012) and now egged on by their peers, long workdays become "a big badge" signifying masculine enterprise. As Cassell (1998, p. 103) wrote, the process of socialization into the masculine world of med-

icine involves embracing a "stoic ethos that defies physical weakness." And seasoned physicians insist they have to work long hours to be the primary breadwinner that masculinity requires. Our study includes a small number of women doctors, and we have not discussed them here.[10] But note that they are more likely than male doctors to try to flex their schedules so they can spend more time at home. Our sample of women physicians is much too small to establish the prevalence of this pattern, but it is suggestive: it again indicates the limits of organizational rules when cultural expectations counter them. Future research should explore in more depth how male and female occupants of male-dominated occupations might deploy cultural schemas to create organizational flexibility.

Women nurses have less class advantage than physicians, but they use what they have to insist that their employers provide schedules that will enable them to meet their gendered family expectations. Their pressure has succeeded in significantly changing the options organizations offer. In contrast to the male doctors, who earn significantly more, women nurses were more likely to explain, as one did, that she and her husband were both working, "and [together] we were making over a hundred thousand dollars a year [so] we had plenty of money," or "I only work twice a week and I still make more than some people make working 40 hours a week." Balancing work and family may depend on employee resistance, which can reshape work organizations as well as ideas about how much money families want and need.

Comparing the two relatively advantaged occupations—one dominated by men, the other by women—we see that the practice of workplace and family flexibility reinforces a gendered division of labor. It is important

[10] Of the 11 women doctors we interviewed, we find divisions of the sort Blair-Loy (2003) found among women executives she studied: three of the women physicians work full time and have stay-at-home spouses, four work full time and also have primary responsibility for both child care and housework, and four work part time. This is consistent with national data showing that 40% of women doctors now work part time (Sibert 2011). The women doctors who worked part time explained their decision in terms of gender conventions that they naturalized and simultaneously understood as personal preference (see Clawson and Gerstel 2014). These cases add to our argument that both gender schemas and organizational patterns are negotiated rather than fixed: some women doctors insist on and obtain workplace flexibility through class privilege, but within the context of an occupation (unlike nursing) designed by and for men. Comparing women and men doctors helps us understand what alternative pathways might be available for either group. Moreover, while we focused here on shared or collective patterns in occupations and organizations, research might well focus on variation within occupations and organizations—not only on women as well as men doctors but atypical men doctors who insist on caring for their sick children, nurses who work in schools rather than hospitals or nursing homes, EMTs who resist doing domestic labor, or CNAs who sometimes reject their employers' demands to stay on the job (see Clawson and Gerstel [2014] for a discussion of women doctors and other outliers).

that the kind of workplace flexibility that is the focus in the work-family literature—whether time on or off—has economic costs across advantaged professions. Because forms of flexibility are divided, these costs are divided by gender. Women in advantaged occupations pay an economic "flexibility penalty" for enacting the cultural mandate associated with womanhood (Goldin and Katz 2011). While we have emphasized the ways women are able to use cultural expectations associated with gender to gain workplace concessions around family, we also want to emphasize that women pay a very real material price, and this "preserves positional inequalities between men and women in work organizations" (Ridgeway 2011, p. 30).

Perhaps professional men also pay a flexibility penalty, but one that is social or emotional rather than pecuniary—that is, they may pay a penalty in their relationship with their children and spouses. Gareis et al. (2003) also found that men in their study, many of whom were physicians married to reduced-hour physicians, evidenced considerable distress when they believed that their wives were paying a career price in order to spend time taking care of family. Some of the physicians we studied expressed considerable regret that they were missing time with their children. Neither the cultural schemas nor organizational rules they have helped develop can erase these regrets.

REFERENCES

Acker, Joan. 2006. "Inequality Regimes: Gender, Class, and Race in Organizations." *Gender and Society* 20:441–64.

Aiken, Linda H., Sean P. Clarke, Dougles M. Sloane, Julie Sochalski, and Jeffrey H. Silber. 2002. "Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction." *Journal of the American Medical Association* 288:1987–93.

Antiel, Ryan M., Scott M. Thompson, Darcy A. Reed, Katherin M. James, Jon C. Tilburt, Michael P. Bannon, Philip R. Fischer, and David R. Farley. 2010. "ACGME Duty-Hour Recommendations—a National Survey of Residency Program Directors." *New England Journal of Medicine* 363 (8): e12.

Applebaum, Eileen, Peter Berg, Ann Frost, and Gil Preuss. 2003. "The Effects of Work Restructuring on Low-Wage, Low-Skilled Workers in U.S. Hospitals." Pp. 77–117 in *Low Wage America: How Employers Are Reshaping Opportunity in the Workplace*, edited by Eileen Applebaum, Annette Bernhardt, and Richard Murnane. New York: Russell Sage.

Applebaum, Eileen, and Lonnie Golden. 2003. "The Failure to Reform the Workday." *Challenge* 46:79–92.

Armenia, Amy, Naomi Gerstel, and Coady Wing. 2010. "Estimating and Predicting Compliance with the FMLA: Pressures from Above and Below." Paper presented at the meeting of the American Sociological Association, Atlanta.

———. 2014. "Workplace Compliance with the Law: The Case of the Family and Medical Leave Act." *Work and Occupations* 41:277–304.

Barnes, Riché Jeneen Daniel. 2008. "Black Women Have Always Worked: Is There a Work-Family Conflict among the Black Middle Class?" Pp. 189–209 in *The Changing Landscape of Work and Family in the American Middle Class*, edited by Elizabeth Rudd and Lara Descartes. Lanham, MD: Lexington Books.

Bergmann, Barbara. 2009. "Long Leaves, Child Well-Being, and Gender Equality." Pp. 67–78 in *Gender Inequality*, edited by Janet Gornick and Marcia Meyers. New York: Verso.

Bernhardt, Annette, Ruth Milkman, Nik Theodore, Douglas Heckathorn, Mirabai Auer, James DeFilippis, Ana Luz Gonzalez, Victor Narro, Jason Perelshteyn, Diana Polson, and Michael Spille. 2010. "Broken Laws, Unprotected Workers: Violations of Employment and Labor Laws in American Cities." http://www.unprotectedworkers.org/index.php/broken_laws/index.

Bianchi, Suzanne M., John P. Robinson, and Melissa A. Milkie. 2006. *Changing Rhythms of American Family Life*. New York: Russell Sage.

Blair-Loy, Mary. 2003. *Competing Devotions: Career and Family among Women Executives*. Cambridge, MA: Harvard University Press.

Boulis, Ann K., and Jerry Jacobs. 2008. *The Changing Face of Medicine: Women Doctors and the Evolution of Health Care in America*. Ithaca, NY: Cornell University Press.

Brooks, Joanna Veazey, and Charles Bosk. 2012. "Remaking Surgical Socialization: Work Hour Restrictions, Rites of Passage, and Occupational Identity." *Social Science and Medicine* 75:1625–32.

Carre, Francoise, Chris Tilly, Maarten Van Klaveren, and Dorothea Voss-Dahm. 2010. "Retail Jobs in Comparative Perspective." Pp. 211–68 in *Low Wage Work in the Wealthy World*, edited by Jerome Gautie and John Schmitt. New York: Russell Sage.

Cassell, Joan. 1998. *The Woman in the Surgeon's Body*. Cambridge, MA: Harvard University Press.

Centers for Medicare and Medicaid Services. 2012. "National Health Education 2012 Fact Sheet." www.cms.gov/NationalHealthExpenditureData/2_ NHE_Fact Sheet.

Christensen, Kathleen, and Barbara Schneider. 2010. "Introduction: Evidence of the Worker and Workplace Mismatch." Pp. 1–16 in *Workplace Flexibility: Realigning Twentieth-Century Jobs to a Twenty-First-Century Workforce*, edited by Kathleen Christensen and Barbara Schneider. Ithaca, NY: Cornell University Press.

———, eds. 2011. "Work, Family, and Workplace Flexibility." Special issue, *Annals of the American Academy of Political and Social Science* 638:6–138.

Clawson, Dan, and Naomi Gerstel. 2014. *Unequal Time: Gender, Class and Family in Employment Schedules*. New York: Russell Sage.

Collins, Patricia Hill. 2010. "The Meanings of Motherhood in Black Culture and Black Mother-Daughter Relationships." Pp. 285–95 in *Gender through the Prism of Difference*, edited by Maxine B. Zinn, Pierrette Hondagneu-Sotelo, and Michael Messner. New York: Oxford University Press.

Connell, R. W. 1995. *Masculinities*. Berkeley: University of California Press.

Craig, Lyn, and Killian Mullana. 2011. "How Mothers and Fathers Share Childcare: A-Cross National Time-Use Comparison." *American Sociological Review* 76:834–61.

Crocker, Jillian, and Dan Clawson. 2012. "Buying Time: Gendered Patterns in Union Contracts." *Social Problems* 59:459–80.

Deutsch, Francine. 1999. *Halving It All: How Equally Shared Parenting Works*. Cambridge, MA: Harvard University Press.

———. 2007. "Undoing Gender." *Gender and Society* 21:106–27.

Dimaggio, Paul. 1997. "Culture and Cognition." *Annual Review of Sociology* 23:263–87.

Dodson, Lisa, and J. Dickert. 2004. "Girls' Family Labor in Low-Income Households: A Decade of Qualitative Research." *Journal of Marriage and Family* 66:318–32.

England, Paula. 2010. "The Gender Revolution: Uneven and Stalled." *Gender and Society* 24:149–66.

Feldblum, Chai. 2010. "Workplace Flexibility 2010." www.workplaceflexibility2010.org.

Ferree, Myra Marx. 2010. "Filling the Glass: Gender Perspectives on Family." *Journal of Marriage and Family* 72:420–39.

Galinsky, Ellen, Kelly Sakai, Sheila Eby, James T. Bond, and Tyler Wigton. 2010. "Employer-Provided Workplace Flexibility." Pp. 132–56 in *Workplace Flexibility:*

Realigning 20th-Century Jobs to a 21st-Century Workforce, edited by Kathleen Christensen and Barbara Schneider. Ithaca, NY: Cornell University Press.
Gareis, Karen C., Rosalind C. Barnett, and Robert T. Brennan. 2003. "Individual and Crossover Effects of Work-Schedule Fit: A Within-Couple Analysis." *Journal of Marriage and Family* 6:1041–54.
Garey, Anita. 1995. "Constructing Motherhood on the Night Shift: 'Working Mothers' as 'Stay-at-Home Moms.'" *Qualitative Sociology* 18:415–37.
———. 1999. *Weaving Work and Motherhood*. Philadelphia: Temple University Press.
Gerstel, Naomi. 2011. "Rethinking Families and Community: The Color, Class, and Centrality of Extended Kin Ties." *Sociological Forum* 26:1–20.
Gerstel, Naomi, and Dan Clawson. 2001. "Unions' Responses to Family Concerns." *Social Problems* 48:277–98.
———. In press. "When Work Becomes Family: The Case of Low-Wage Caregivers." *Work and Family in the New Economy*, edited by Erin Kelly and Samantha Ammons. Bingley: Emerald Press.
Gerstel, Naomi, Dan Clawson, and Dana Huyser. 2007. "Explaining Job Hours of Physicians, Nurses, EMTs, and Nursing Assistants: Gender, Class, Jobs, and Family." Pp. 369–403 in *Workplace Temporalities*, edited by B. Rubin. Amsterdam: JAI.
Golden, Lonnie. 2008. "Limited Access: Disparities in Flexible Work Schedules and Work-at-Home." *Journal of Family and Economic Issues* 29:86–109.
Golden, Lonnie, and Deborah Figart. 2000. *Working Time: International Trends, Theory, and Workplace Policy*. New York: Routledge.
Goldin, Claudia, and Lawrence Katz. 2011. "The Cost of Workplace Flexibility for High-Powered Professionals." *Annals of the American Academy of Political and Social Science* 638:45–67.
Greenhouse, Linda. 2003. "The Supreme Court: States' Rights; Justices, 6–3, Rule Workers Can Sue States over Leave." *New York Times*, May 28.
Gupta, Sanjiv. 2007. "Autonomy, Dependence, or Display? The Relationship between Married Women's Earnings and Housework." *Journal of Marriage and the Family* 69:399–417.
Hartman, Heidi, and Vicky Lovell. 2009. "A U.S. Model for Universal Sickness and Family Leave." Pp. 231–54 in *Gender Inequality*, edited by J. Gornick and M. Meyer. New York: Verso.
Hays, Sharon. 1996. *Cultural Contradictions of Motherhood*. New Haven, CT: Yale University Press.
Hegewisch, Ariane, Hannah Liepmann, Jeffrey Hayes, and Heidi Hartmann. 2010. "Separate and Not Equal? Gender Segregation in the Labor Market and the Gender Wage Gap." Briefing paper. Institute for Women's Policy Research, Washington, DC.
Hill, Jeffrey, Joseph Grzywacz, Sarah Allen, Victoria Blanchard, Christina Matz-Costa, Sandee Shulkin, and Marchie Pitt-Catsouphes. 2008. "Defining and Conceptualizing Workplace Flexibility." *Community, Work, and Family* 11:140–63.
Iglehart, John K. 2008. "Revisiting Duty-Hour Limits—IOM Recommendations for Patient Safety and Resident Education." *New England Journal of Medicine* 359:2633–35.
———. 2010. "The ACGME's Final Duty-Hour Standards—Special PGY-1 Limits and Strategic Mapping." *New England Journal of Medicine* 363:1589–91.
Jacobs, Jerry A., and Kathleen Gerson. 2004. *The Time Divide*. Cambridge, MA: Harvard University Press.
Kalleberg, Arne. 2003. "Flexible Firms and Labor Market Segmentation: Effects of Workplace Restructuring on Workers." *Work and Occupations* 30:154–75.
———. 2011. *Good Jobs, Bad Jobs: The Rise of Polarized and Precarious Employment Systems in the United States, 1970s to 2000s*. New York: Russell Sage.
Kelly, Erin, S. Ammons, K. Chermack, and P. Moen. 2011. "Gendered Challenges, Gendered Response: Confronting the Ideal Worker Norm in a White-Collar Organization." *Gender and Society* 24:281–303.

Kelly, Erin, and Alexandra Kalev. 2006. "Managing Flexible Work Arrangements in U.S. Organizations: Formalized Discretion or 'a Right to Ask?'" *Socio-Economic Review* 4:379–416.
Lambert, Susan. 2008. "Women and Work: Difficulties of Opting Out." Paper presented at the Women and Work Conference, University of Massachusetts, Amherst.
Lambert, Susan J., Anna Haley-Lock, and Julie R. Henly. 2011. "Schedule Flexibility in Jobs with Scarce and Fluctuating Hours: Unanticipated Consequences and Promising Directions." Working paper. University of Chicago Work Scheduling Study.
Landrigan, Christopher P., Jeffrey M. Rothschild, John W. Cronin, Rainu Kaushal, Elisabeth Burdick, Joel T. Katz, Craig M. Lilly, Peter H. Stone, Steven W. Lockley, David W. Bates, and Charles A. Czeisler. 2004. "Effect of Reducing Interns' Work Hours on Serious Medical Errors in Intensive Care Units." *New England Journal of Medicine* 351:1838–48.
Lerner, Barron H. 2006. *When Illness Goes Public: Celebrity Patients and How We Look at Medicine*. Baltimore: Johns Hopkins University Press.
Lopez, Steven Henry. 2006. "Culture Change Management in Long-Term Care: A Shop-Floor View." *Politics and Society* 34:55–79.
Lorber, Judith. 2005. *Breaking the Bowls*. New York: W. W. Norton.
Lyness, Karen S., Janet C. Gornick, Pamela Stone, and Angela R. Grotto. 2012. "It's All about Control: Worker Control over Schedule and Hours in Cross-National Context." *American Sociological Review* 77:1023–104.
Macdonald, Cameron. 2009. "What's Culture Got to Do with It? Mother Ideologies as Barriers to Gender Equality." Pp. 411–37 in *Gender Inequality*, edited by Janet Gornick and Marcia Meyers. New York: Verso.
Mechanic, David, Donna D. McAlpine, and Marsha Rosenthal. 2001. "Are Patients' Office Visits with Physicians Getting Shorter?" *New England Journal of Medicine* 344:198–204.
Ng, Ignace, and Ali Dastmalchian. 1998. "Organizational Flexibility in Canada: A Study of Control and Safeguard Rules." *International Journal of Human Resources* 9:445–56.
Parsons, Talcott, and Robert Bales. 1955. *Family, Socialization, and Interaction Process*. New York: Routledge.
Piore, Michael J. 1986. "Perspectives on Labor Market Flexibility." *Industrial Relations* 25:146–66.
Presser, Harriet. 2003. *Working in a 24/7 Economy: Challenges for American Families*. New York: Russell Sage.
Pyke, Karen. 1996. "Class-Based Masculinities: The Interdependence of Gender, Class, and Interpersonal Power." *Gender and Society* 10:527–49.
Reis, Ricardo. 2012. "Evaluating Fiscal Policy in 2007–2009: Looking in the Right Places." Paper presented at the Russell Sage Foundation, March 14.
Ridgeway, Cecilia. 2011. *Framed by Gender*. New York: Oxford University Press.
Robins, Natalie. 1995. *The Girl Who Died Twice: The Libby Zion Case and the Hidden Hazards of Hospitals*. New York: Dell.
Rogers, Ann E., Wei-Ting Hwang, Linda D. Scott, Linda H. Aiken, and David F. Dinges. 2004. "The Working Hours of Hospital Staff Nurses and Patient Safety." *Health Affairs* 23 (4): 202–12.
Sarkisian, Natalia, and Naomi Gerstel. 2012. *Nuclear Family Values, Extended Family Lives: The Power of Race, Class, and Gender*. New York: Routledge.
Schieman, Scott, Melissa Milkie, and Paul Glavin. 2009. "When Work Interferes with Life: Work-Nonwork Interference and the Influence of Work-Related Demands and Resources." *American Sociological Review* 75:966–88.
Schor, Juliet. 1992. *The Overworked American: The Unexpected Decline of Leisure*. New York: Basic.

Sewell, William. 1992. "A Theory of Structure: Duality, Agency, and Transformation." *American Journal of Sociology* 98:1–29.
Shows, Carla, and Naomi Gerstel. 2009. "Fathering, Class, and Gender: A Comparison of Physicians and Emergency Medical Technicians." *Gender and Society* 23:161–87.
Sibert, Karen. 2011. "Don't Quit This Day Job." *New York Times*, June 11.
Staiger, Douglas O., David I. Auerbach, and Peter I. Buerhaus. 2010. "Trends in the Work Hours of Physicians in the United States." *Journal of the American Medical Association* 303 (8): 747–53.
Stainback, Kevin, and Donald Tomaskovic-Devey. 2012. *Documenting Desegregation*. New York: Russell Sage.
Standing, Guy. 2011. *The Precariat: The New Dangerous Class*. New York: Bloomsbury.
Steinbrook, Robert. 2002. "The Debate over Residents' Work Hours." *New England Journal of Medicine* 347:1296–1302.
Stone, Pamela. 2007. *Opting Out*. Berkeley and Los Angeles: University of California Press.
Swanberg, Jennifer, Marcie Pitt-Catsouphes, and Krista Drescher-Burke. 2005. "The Question of Justice: Disparities in Employees' Access to Flexible Schedule Arrangements." *Journal of Family Issues* 2:866–95.
Szymczak, Julia, and Charles Bosk. 2012. "Training for Efficiency: Work, Time, and Systems-Based Practice in Medical Residency." *Journal of Health and Social Behavior* 53:344–58.
Thornton, Patricia H., William Ocasio, and Michael Lounsbury. 2012. *The Institutional Logics Perspective*. New York: Oxford University Press.
Trinkoff, Alison, Jeanne Geiger-Brown, Barbara Brady, Jane Lipscomb, and Carles Muntaner. 2006. "How Long and How Much Are Nurses Now Working?" *American Journal of Nursing* 106:60–71.
U.S. Bureau of Labor Statistics. 2010. "Women in the Labor force: A Databook, 2010 Edition." *Annual Social and Economic Supplements, 1988–2009*, Current Population Survey, U.S. Department of Labor.
U.S. Department of Health and Human Services, Health Resources and Services Administration. 2010. "The Registered Nurse Population: Findings from the 2008 National Sample Survey of Registered Nurses." http://bhpr.hrsa.gov/healthworkforce/rnsurveys/rnsurveyfinal.pdf.
Volpp, Kevin G., Amy K. Rosen, Paul R. Rosenbaum, Patrick S. Romano, Orit Even-Shoshan, Yanli Wang, Lisa Bellini, Tiffany Behringer, and Jeffrey H. Silber. 2007. "Mortality among Hospitalized Medicare Beneficiaries in the First 2 Years Following ACGME Resident Duty-Hour Reform." *Journal of the American Medical Association* 298:975–83.
Watson, Liz, and Jennifer E. Swanberg. 2010. "Flexible Workplace Solutions for Low-Wage Hourly Workers: A Framework for a National Conversation." Report of Workplace Flexibility 2010 and the Institute for Workplace Innovation, Georgetown Law, Washington, DC.
Webster, Edward, Rob Lambert, and Andries Bezuidenhout. 2008. *Grounding Globalization: Labor in the Age of Insecurity*. New York: Wiley-Blackwell.
West, Candice, and Don H. Zimmerman. 1987. "Doing Gender." *Gender and Society* 1:125–51.
West, Colin P., Angelina D. Tan, and Thomas M. Habermann. 2009. "Association of Resident Fatigue and Distress with Perceived Medical Errors." *Journal of the American Medical Association* 302:1294–1300.
Williams, Christine. 1992. "The Glass Escalator: Hidden Advantages for Men in the 'Female' Professions." *Social Problems* 39:253–67.
Williams, Joan. 2006. "One Sick Child Away from Being Fired: When Opting Out Is Not an Option." Report from the Center for Work-Life Law, San Francisco.
———. 2010. "The Odd Disconnect: Our Family-Hostile Public Policy." Pp. 107–219 in *Workplace Flexibility: Realigning Twentieth-Century Jobs to a Twenty-First-Century*

Workforce, edited by Kathleen Christensen and Barbara Schneider. Ithaca, NY: Cornell University Press.
Zerubavel, Eviatar. 1979. *Patterns of Time in Hospital Life: A Sociological Perspective*. Chicago: University of Chicago Press.
———. 1981. *Hidden Rhythms*. Berkeley and Los Angeles: University of California Press.