Redesigning Work for Gender Equity and Work-Personal Life Integration

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Wonderful to be here – and to speak to an audience of work-family researchers – and in conjunction with the one journal that tries to bring all this material together. Some of you, also, belong to the community of action researchers who collaborate with organizations to change the way they work in order to ease the conflicts between employees' occupational work and their family, community, and personal lives, and to create greater gender equity in the workplace.

Many of these efforts have been described in various publications: Sue Lewis and Carey Cooper have such a review, as has Jill Casner-Lotto. A collaborative book that I was involved in, *Beyond Work-Family Balance: Advancing Gender Equity and Workplace Performance,* covers quite a number of examples and describes the method we used. And there are various publications based on projects done by the Center for Gender in Organizations (CGO) at the Simmons School of Management in Boston and by the old Radcliffe Public Policy Institute; and there have been action research projects also by researchers in Australia, Chile, France, Greece, the UK, here in the Netherlands, and one project is just starting in Malta. I was shocked, recently, to realize that it's been almost 20 years since my colleagues and I first got involved with this work.

What I would like to do today is to go over some of this history and then tell you about a project at a women's health center which the MIT Workplace Center[1] undertook over these last few years. The project, directed by Ann Bookman, adds something to these issues that is different from what is usually covered in much of this work.

[1] The MIT Workplace Center was supported by the Alfred P. Sloan Foundation.

The basic problem that all these projects were trying to solve is that work practices established when the workforce was more homogeneous were creating problems for new entrants, particularly women. As more and more women entered the work force during the second half of the 20th century, they hit a number of impediments. At first, they had to fight the barriers to entry – particularly at the professional level. This represents what Susan Sturm calls first order discrimination, i.e. the fight to prevent "overt exclusion, segregation of job opportunity, and conscious stereotyping," (465) which led to sexual harassment and other forms of anti-woman behavior. Though these are still concerns, much of first order discrimination, largely due to legislation, is now more controlled – at least in the developed world. But in its wake has come what Sturm calls second order discrimination, issues that arise after inclusion. These are what she calls "a subtle and complex form of bias" (458) that is based on unrecognized assumptions and habits of mind that disadvantage women without conscious intent.

The work I will be talking about concerns mainly this second order discrimination. It deals with the gendered assumptions – the values, norms, and beliefs – that underlie current work practices, which favor men and their life experiences and thus disadvantage women. It explains why even when progressive companies introduced accommodations for women and began greater efforts to value their contributions, they still did not create gender equity. Even in these progressive companies, women were still not moving to the top. Assuming that women's caretaking roles must be the reason for this "glass ceiling," a number of leading companies developed elaborate family policies and offered numerous flexible work arrangements. But these also did not work well – they were either under-used by the most ambitious women employees, or, if used, were seen as part of a "mommy track" and relegated their users to second-tier status.

It was this dilemma that motivated the Ford Foundation, in a program directed by June Zeitlin and advised by Rhona Rapoport, to sponsor three teams of researchers, each involved with a different company, to work on these issues. This was 1990 and they wanted to get beyond policies and benefits which, though critically important for certain employees, were not getting women up the corporate ladder and not giving either women or men the possibility to better integrate their work and personal lives. They wanted, rather, to see what was preventing these policies from having the desired effect, and what could be done to change these barriers. In particular, they wanted to know if it was the structure of work and the cultural context in which it took place that needed to be changed.

Their thinking is made vivid by a fable.[2] This fable tells the story of a land built for short people. In the workplaces of the land, chairs are low enough for people to have their feet on the ground; shelves are never out of reach; doors and windows are set to accommodate short people. All was well in this land until tall people came to settle and started looking for work. That's when the trouble started. These newcomers found they had trouble getting into the doors of the office buildings in which they wanted to work; they had trouble moving from office to office – all because the doors were built to accommodate short people. What to do? Easy, said the employers. We'll teach tall people how to stoop – and then they'll be able to get through the doors. We'll also allow them flexibility in time in order to accommodate the extra effort they have to expend to navigate the land built for short people. After all, we are tolerant of all peoples and want everyone to be able to contribute to the land.

I've always liked this story – and not only because I am short and can appreciate the amenities of this land. But because it is so obvious, so self-evident that what needs to be done to create equity between short and tall people is to rebuild the doors. And yet, what do our

[2] I am grateful to Deborah Kolb for alerting me to this story.

masculine workplaces offer women in the name of gender equity? Assertiveness and negotiation training – learning how to stoop – and individually-negotiated flexible work arrangements. What the Ford Foundation wanted to do with its three groups of researchers, working in three different corporations, was to see if the doors could be redesigned and rebuilt.

Our team worked with the Xerox Corporation and experimented with different work redesigns in three different units. The problem we agreed to work on was that women at Xerox were not moving up in the company. But, at this early stage of public awareness (early 90's), we were specifically asked not to talk about gender equity, which was seen as too provocative, even in a company that had successfully moved African Americans (mainly men) into top positions. So we entered that first site by defining the goal of our interventions as redesigning work to make it easier for employees to integrate their work with their personal lives. We worked with a committee at Xerox headed by one of their women managers who understood our goal and astutely guided the HR people to think beyond policies and benefits. In a long meeting that followed Xerox's quality process, we came up with the following description of the desired state: "the Xerox culture capitalizes on work/'family' issues as an opportunity to create innovative and productive work practices." This was in contrast to the current state which was described as: "the Xerox culture unnecessarily creates conflict between work and 'family,' which has negative consequences for the business and for the equitable treatment of employees." A pretty good statement of the problem to be fixed. I should add, that the name of that manager is Anne Mulcahy – she is now the CEO of Xerox.

As it turned out, in the early '90s, putting work and family together like this was alien to the company's discourse. The term "work-family" had entered the vocabulary, but it did not mean integrating these two domains. On the contrary, work and family were seen as quite

distinct, with family an individual concern of a few "problematic" employees, which could be dealt with by "work-family" people in the HR department. That's what we were initially associated with, and when we then started asking people about their work in some detail, we got the response "you're the work-family people, why are you asking us about our work?"

But the work was critical, though with a twist. Whereas previous attempts at the redesign of work were concerned only with the effectiveness and efficiency of work, we wanted to add a second goal: the change in work practices we sought were ones that could help employees with their personal lives and family responsibilities, and help women gain equity in the workplace, but not at the expense of the effectiveness of work. It was a *dual* agenda. [Lens Slide] We wanted to look at work through a work-family lens – to see what it was about the arrangements of work that were making people's lives difficult – and a gender lens, to discover whether existing work practices had any unexpected differential impact on men and women. And when we did this – and it was a key finding of that early work – we found that such a perspective on work identifies problematic work practices and assumptions that *also* turn out not to be effective. And the reason for this was that work as well as the workforce was changing. Work was becoming more team oriented and less constricted by place and time. And not only were there more women in the workforce, but more men were seeking better integrated lives. The trouble was that despite the changes in both work and the workforce, basic practices were still anchored to traditional assumptions, especially the assumption of an ideal worker who had no responsibilities or interests outside his occupational career.

Our approach at Xerox was to bring to the surface the assumptions and practices – typically so taken for granted that people were hardly aware of them – that made life so difficult

for people with serious outside responsibilities, particularly women, and to show how they also had become ineffective and detrimental to the goals of the work itself.

One of our interventions was to allow anyone (whether male or female, parent or not) to take any of the flexibilities available *as long as the work got done*. This permission – awarded as a three month experiment – came from a fairly controlling division head in response to our feedback which showed that requests for flexibility were decreasing not because people did not need them but because the response of the supervisors to whom the requests were made created a self-defeating negative feed-back loop. Since supervisors, mimicking the controlling division head, believed they had to be present to make sure their people were working, they either neglected to respond or denied these requests, which, over time, led to fewer and fewer requests, and hence allowed management to conclude that flexibilities were not really needed.

To the credit of the executive, this feedback made him aware that his division may be creating such self-reinforcing negative cycles in other aspects of work as well – hence he proclaimed the experiment. And when the experiment led to a 30% decrease in absenteeism, its future was assured. This one seemingly superficial change actually led to more profound changes in the underlying assumptions about how to accomplish the work of the division. No longer was it possible for employees to negotiate for flexibilities one-on-one with their supervisors – since everyone now wanted some change – and the resulting necessity for collective negotiations at the work unit level led supervisors away from continuous surveillance of their employees. It moved the division head toward a more open and innovative style of managing, and led to viewing flexibility as a collective opportunity for rethinking work effectiveness, rather than as a problem for individual employees and their supervisors.[3] It also

[3] Half of the 14 interventions I looked at which defined the situation in this way, had to do with such scheduling experiments and many showed improvement in both employees' lives and in work effectiveness.

empowered the work groups, which soon led them to make local, collective decisions in other areas besides scheduling. And it significantly eased the lives of employees and reached division goals that had not been previously attained – a clear dual agenda outcome. It is important to note that one of the reasons this intervention was successful was that the decisions about scheduling and time were made collectively – not one-on-one with a supervisor, as had previously been the case.

In the other two work units at Xerox we changed the timing of daily activities and created a cross-functional team across sales and service.

I like to think of the Xerox project as an existence theorem – i.e. it showed that it was possible to redesign work for gender equity and work-personal life integration and at the same time increase the effectiveness of the work itself. It was also a generative project in another way. It produced three PhD dissertations, two of which have been turned into prominent books in this area: Leslie Perlow's *Finding Time* and Joyce Fletcher's *Disappearing Acts*.

A key issue in this way of creating organizational change is to keep both sides of the dual agenda – both work effectiveness and employee lives – together in a complementary, not adversarial way. Our fear had always been that if work becomes more effective, management will co-opt the benefits and not share them with their employees. Indeed, in one of our early sites an engineering manager made this quite explicit. "If I can increase efficiency by 20%," he said, "then I can give them 20% more work to do." In other words, we feared that the personal side of the dual agenda would get lost, and all the emphasis would be put on the work gains to be achieved.

What we had not expected was that the work side might get lost – but in a few cases, it did. In the case of a financial analysis group of a large manufacturer, this is exactly what

happened. The group, in collaboration with us as researchers, worked out an elaborate scheme of keeping track of people's schedules on a white board, which also contained the work flow for which the group was responsible so that individual schedules could mesh with the work of the group. What happened, though, was that the analysts slowly became so invested in their personal schedules that they paid less attention to the work requirements, with the result that a new manager stopped the experiment altogether. A similar result happened in the case of a self-scheduling experiment for nurses on a hospital floor. The work needs in a hospital are clear: there have to be a certain number of nurses on duty for all shifts in a 24 hour day and a 7 day week. So we worked out a monthly sign-up sheet on which nurses could fill in the necessary spaces, and by rotating which group had first shot at the sheets, the system seemed to be fair. When we started this, the nurses were excited: they felt it gave them much more control over their time and, interestingly, they reported that they felt they were now better able to give good patient care – another dual agenda outcome. But over the year of the experiment, they became possessive of their individual needs – to the extent that they sometimes put their names into a shift that already had a full complement of names and left other shifts short. After trying to work with them to change this behavior and listening to many individual complaints, the nurse manager finally stopped the experiment – much to the regret of many of the nurses involved.

In both of these cases scheduling decisions were individually made, though based on consensual agreement; in both cases the personal side of the dual agenda came to be seen as an individual entitlement and employees lost sight of the needs of the work. No surprise, therefore, that the experiments were stopped. The point is that first, there has to be continuous emphasis on both sides of the dual agenda, and second, that scheduling decisions have to be made collectively. Given these conditions, we found that it is possible to provide sufficient flexibility

to give employees more control over their time, and at the same time enhance the effectiveness of the work.[4]

Shortly after the end of the Xerox project, CGO (the Center for Gender in Organizations at Simmons College's School of Management) started a project at the Body Shop. It was also supported by the Ford Foundation and was led by Deborah Kolb and Debra Meyerson. It had a similar dual agenda goal, but here the focus was openly and explicitly on gender. There, it was not time or schedules that came into view, but less obvious aspects of work. For example, one of the reasons, they discovered, that women were not promoted into supervisory positions was because the job description emphasized technical competence whereas the actual work as practiced centered much more on relational skills. This disconnect hurt women employees as well as the effectiveness of the supervisory job.

So, looking at work through an explicit gender lens led to a more nuanced understanding of the work situation, a clearer view of why women were disadvantaged in this otherwise progressive company. But, as it turned out, the CGO group was unable to carry out any intervention. What happened was that gender was hard to keep on people's minds. It was hard because by gender we do not mean a person's sex as an individual characteristic, but rather we regard gender as a systemic and structural principle. Whereas in the self-scheduling examples already mentioned the emphasis on work was lost, in this case work needs began to overshadow the original goal of understanding why women were not flourishing in the company.[5] In other words, when either side of the dual agenda is lost, interventions are not likely to be successful.

[4] Best Buy's ROWE system (results-oriented work environment), which Phyllis Moen has been studying, seems to be another example.

[5] The researchers' analysis of how they "lost gender" fills a fascinating issue of the journal *Organization.* There they concluded that gender was lost because they were not able to provide a convincing narrative that allowed employees to see the connection between gender and work redesign. And, working in a non-profit agricultural

So what can we conclude about these attempts at dual agenda change? A work-family lens on work identifies those aspects that make life difficult for employees, and tends to bring out issues that derive from organizational expectations for an ideal worker who has no other responsibilities except to his occupation. It tends to lead to interventions around scheduling and time. A gender lens identifies seemingly gender-neutral but actually masculinized aspects of work that have a differential impact on men and women. It is more likely to reveal gendered conceptions of competence and commitment, and of ideal work: for example, the emphasis on technical as opposed to relational skills. But it does not lead as easily to actual work practice change.

A different view of dual agenda change arose from a recent project a team from the MIT Workplace Center did at an outpatient women's health center. It pointed to something about work that seemed new and different from what had previously been the case. Here was a workplace, different from the others we had worked with, that was specifically dedicated to the health care of women, and was staffed entirely by female employees. As an outpatient clinic of a larger established hospital complex, the developers of this Center believed in providing women physicians, many of whom had young children, with the flexibilities they needed to maintain their medical careers. [Center Slide] The head of the hospital's women's health division was introduced to the dual agenda approach to change by Ann Bookman, and invited her and the MIT Workplace Center to help with a variety of challenges facing this Center. She, Mona Harrington, and I were the researchers on this project.

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organization, another group from CGO saw the positive effects of such a narrative. The interventions tried while the researchers were on site actually did not succeed. But, based on the researchers' initial gender analysis, the connections that had been established stayed in the discourse of the company and led to dual agenda changes at a later time.

Clearly, the situation was different here from those we usually encountered in our organizational work. Since it was an all female workplace, there was no immediate differential disadvantage to women employees relative to men. And, we found that most physicians – and some nurses – were on flexible part time schedules, and that clinical assistants and support staff were able to leave when a personal situation warranted it: all it took was a request to the practice manager, which was routinely given. In other words, in contrast to other sites where we and others had worked, this was a workplace where the need of women to deal with responsibilities unrelated to their jobs was acknowledged and accommodated.

So what was the dual agenda here? The work goal was obvious and clear: it related to the quality of patient care, which had been getting significant attention from management. On the personal side, flexibilities seemed to be built in and freely available. So perhaps this was an ideal workplace. But what we actually found was surprising: high absenteeism and turnover among administrative staff, and discontent and low morale across occupational groups. The practices that governed the flexibilities employees were given were quite disconnected from the quality of the patient experience. They were not at all integrated – indeed, they almost worked against each other. It was not flexibility per se that was the problem in this workplace, but the way it was allocated and the disconnect between flexibility and work effectiveness goals.

We found that physicians felt they were not well supported and had no voice with top management when decisions about the Center were made. We found that support staff were overwhelmed by demands from patients needing access to multiple specialties and from doctors with different desires on how their patients should be treated. We found that medical assistants were concerned about being asked to shift to areas they didn't feel they knew enough about to be

effective. In other words, we found a workplace where it was difficult for the members to do their jobs in the best possible way.

As we began to talk to people we found out that the Center had recently gone through a reorganization which centralized support staff rather than allocating them to particular clinical areas where they could concentrate on the needs of the doctors and the patients in that area.[6] This decision had been based on emphasis on the patient side of the dual agenda, but its consequences for employees' ability to do their work in ways that were satisfying, were ignored. And as is usual in such cases, the complications created for the employees eventually fed back and undermined the very goals the innovation was meant to achieve.[7]

So it was not the need for flexibility that was the concern here, but rather the impact of the way the work was organized on the staff's ability to contribute to the work of the Center as well as they thought they could, and to feel that their contribution was valued. And, not surprisingly, this lack of satisfaction in their work also detracted from their sense of well-being in general. Hence, in this case, the personal side of the dual agenda had more to do with the work experience of the staff and a work structure that hindered their optimal contribution, rather than the rigidities and lack of flexibilities based on traditional gendered assumptions that we had found in other workplaces. The critical importance of the workforce experience became obvious at this site because, as a women's workplace that provided flexibility, it had seemingly dealt with the problems seen in most of the other sites where dual agenda change had been tried.

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[6] The reason behind this reorganization was in part the belief that centralization of administrative functions would enhance the patient experience; and in part the fact that the Center had added eight medical specialties to its core services without much increase in support staff.

[7] A similar case concerned the loan department of a large bank. Here, too, a reengineering effort prompted by efficiency concerns in the end created problems with the work of the unit, and an intervention geared to reversing some of the changes helped both the work and people's lives.

Nonetheless, we started our work at this site in the usual way. We defined the combination of the patient experience with the workforce experience as our dual agenda, and asked management to create a liaison committee consisting of representatives from all occupational groups and from each of the four clinical areas into which the Center was divided. With the support of this committee, we collected data through individual interviews with all members of staff, from physician to support staff, followed by a month of observation on site.

But complications soon ensued. Our usual approach is to provide feedback to the organization and work collaboratively with all members of a work unit to identify a project for work practice change. This approach depends heavily on getting people together to collectively and collaboratively engage the data and consider leverages for change. Almost by definition, a health care setting does not provide an easy opportunity to get employees together in this way because any time not spent on "patient encounters" cannot be billed and is therefore a drain on the bottom line. We were lucky that we were able to have three such meetings with the members of each of the four clinical areas.

We wanted to deal with each area separately since working with groups of people whose work is interdependent has always proved to be important for dual agenda change. But here we hit another complication resulting from the centralization of support staff in the previous reorganization. So, as a first step and in collaboration with the liaison committee, we divided the support staff somewhat arbitrarily into the four areas (some in more than one) and held our meetings.

The first meeting was geared to feeding back our findings – both what was working and what was not working – as well as some suggestions for improvement that emerged from the individual interviews. Employees really believed in the mission of the Center and were grateful

for the flexibilities they were allowed. But the change to more centralized staff emerged as one of the biggest sources of complaint from all sides. We learned that the plan to centralize had been imposed in a top down manner so lack of employee voice was also identified as part of the problem.

At the second meeting, building on what we had learned, we presented two ways of organizing work – an individual model and a team model. In the individual case, each physician would have her own clinical and administrative support. In the team model, in contrast, a group of MDs would be associated with a group of clinical and support staff. The former is better for specific knowledge, but less good for coverage when staff are absent. The groups agreed that the Center was somewhere in the middle between the two models, but that flexibility arrangements should definitely be team based, and that leadership and decision making for the practice should be more shared.

To deal with these issues, the final meeting was specifically geared to the introduction of the notion of a cross-occupational team – we called them care teams – in each area to further these goals. Previously, problems were typically dealt with by individuals complaining to the practice manager or the medical/administrative leaders, often with few results. And, in the case of individually granted flexibilities, there were detrimental effects for both the patients and the employees. The point of the care teams was to establish an organizational unit at the Center in which staff across occupational levels could jointly discuss and solve problems that arose in their daily interactions with patients and with each other, including as well the issue of staff flexibility. So this final meeting was devoted to teams and how they might best work, and to organizing a structure and a meeting schedule for the care teams.[8]

[8] One of the areas, which consisted of a group of unrelated medical specialties, decided that it did not make sense for them to form such a care team. The other main areas were primary care, gynecology, and dermatology.

Through these three meetings we had already modeled a work environment based on collaborative problem solving. These meetings brought together the staff's local knowledge of how to enhance patient care with the researchers' more general understanding of organizational principles.[9] We hoped that the cross-occupational care teams would serve a similar collaborative purpose within the Center.

Since the change to centralization was such a key issue, we worked with management to undo some of this reorganization. They changed the phone system away from one line to the Center to different lines geared to specific clinical areas and medical specialties. And by the introduction of cross-training it became possible to provide support staff with a primary and secondary clinical area, which made them more secure about the knowledge they needed to be most effective. This greater specialization, or de-centralization, allowed both support staff and physicians to work with each other in a more effective, coordinated, and satisfying way.

This change also rationalized the membership of the care teams in each of the clinical areas, which now consisted of physicians, nurses, medical assistants, and support staff whose primary specialty was in that medical area. It gave meaning to the more arbitrary allocation of centralized staff to the four areas with which we started. These care teams met at regular times and led to a change in approach from individual complaints about problems to the practice manager, to collective airing of issues and team-based collaborative problem solving.

The most successful care team was in the area of gynecology. This team was co-led by a physician and a support person. When we sat in on its meetings it was quite a change to hear the doctors – previously known as complainers – listen to their staff and actually change their

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[9] Joyce Fletcher calls this process "fluid expertise" – where people come together with different knowledge and perspectives and expertise flows back and forth from one person or group to another.

behavior in order to make the coordination of work around patients more effective. It also made every member of the team feel that her contributions were effective and valued – that together they were providing the best care to patients that they could.

And to the extent that team members learn to deal with flexibility requirements within their care teams – something they were just beginning to do when we left – both patient care and employee satisfaction and sense of accomplishment will gain. Previously, when employees were granted flexibilities individually, their absence not only interfered with the flow of patient care and made the staff who remained feel unfairly burdened, but it made the very employees who left feel dissatisfied and guilty about work undone and lack of provision to ensure its satisfactory accomplishment.

As I have indicated, there was no immediate gender equity problem in this Center, since all employees were women. But in the larger context of the hospital there were clear gender issues. In particular, the Center's physicians who worked part-time in the clinic were seen differently from hospital physicians with part-time clinical work because in the Center's case the rest of their time was spent at home with family, whereas the hospital physicians – largely male – spent the rest of their time on lab-based research. This was clearly a gendered assumption that we were not able to deal with, except to clarify the issue for Center management.

Checking in with this site, a good year after finishing our active work there, we discovered that management was continuing to use the care teams in their ongoing efforts to improve the quality of both the patient experience and the workforce experience, that flexibility was beginning to be seen more as a team concept, and that the term "dual agenda" had become part of the Center's discourse.

This female workplace, with care teams that crossed a steep occupational hierarchy, highlights the importance of a work environment where people at all levels come together to engage the problems they face in doing their work, and where they can legitimately challenge ongoing practice. But people's personal lives cannot be lost in the process. What one needs is to deal simultaneously with people's personal needs, the effectiveness of work, and a collaborative and engaging work environment. It really is a triple agenda. [triple agenda slide]

I should say, also, that this is not your standard quality of work life program, whose central thesis is defined in A Dictionary of Sociology (1998) as "work-tasks…redesigned to generate worker satisfaction and harmony in the workplace" (http://www.encyclopedia.com/doc/1O88-QWL.html, Feb 26, 2009). What is missing from this definition is the rest of people's lives. Attention to QWL introduces some concern for employees (even Taylor had that), but still views work as a completely separate domain from family, community, and people's worlds of non-occupational concerns. Indeed, when high commitment work places were found to be motivating and satisfying, it was also true that they often created increased stress in employees' family and personal lives. By bringing all of this together – work effectiveness, a work environment that empowers all to participate optimally, and the ability to integrate their work with their personal lives – the women's health center project added something to dual agenda work.

So what can we conclude from all of this about redesigning work for work-personal life integration and gender equity? The control of time is a clear first concern. Given that most households have all adults in the workforce, people need more time for care – of their children, their elders, their communities, even of themselves. Hence assumptions about an ideal worker that link time at work and continuous availability with productivity need to be questioned and

challenged. But such changes will only help gender equity if they also legitimate the personal responsibilities of all employees and acknowledge that skills learned in the family and the community can enhance people's work effectiveness. There must be integration of the occupational and domestic domains.

Moreover, it is clear that dual agenda change is not something that individuals can do on their own. It clearly depends on the collective action of all the people involved in creating a product or a service, and everyone – across all levels and functions – has to be able to contribute to decisions on how the unit accomplishes its work. And, finally, for both work effectiveness and employee's equitable and satisfying lives, there needs to be a work environment where collaborative problem solving can provide the conditions that allow everyone to contribute up to their potential to the overall goals of the work unit. That is what the health center made so vividly clear.

Before ending, I would like to deal briefly with two caveats. First, we will not achieve gender equity in the workplace if we do not also challenge gender roles in the family. The two must go together; they must reflect each other. For example, when we consider choices that women may have about how to allocate their time between employment and community and family, we ignore not only that economic considerations may be a primary constraint on this so-called choice, but also that this choice for women means that the men in their lives have no choice. And that is not gender equity. What we need is to question gendered practices both in the workplace and in the family. Redesign is needed in both arenas.[10]

A second caveat concerns the more traumatic problem of integration for those whose jobs do not provide enough wages to support a family. No society can long afford to have one third

[10] Jessica DeGroot's work at the Third Path Institute in Philadelphia helps couples dedicated to fully sharing the care of their children redesign their work to make this possible. Though this is still an individual approach to the redesign of work, it begins to address both arenas together.

of its population – as is true in the United States[11] – working legitimate jobs but not having the means to care for themselves and their families. These people must not be lost as we recover from the current economic situation. For the rest, though, is it possible that the economic crisis might actually be an opportunity for creative change? The received wisdom is that in times of economic trouble, companies withdraw benefits, lay people off, and increase the demands on those who stay. But we also hear of alternative responses by some companies to provide more flexibility, sometimes in the form of furloughs and reduced time and pay, and reports by individuals who are discovering the unexpected appeal of more leisure and more time with family. When combined with the possibility that less demanding lives might have economic benefits through decreased health care costs, is it possible that a new way of doing work and caring for our families and communities might emerge? And maybe, along with what we hear about the different motivations of younger generations, perhaps we will come out of this period with work arrangements that better meet the multiple goals of effectiveness, equity, and healthy, satisfying, and caring environments at work, in the family, and in the community.

[11] Data from Canada are not much better.