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# The Design of Work as a Key Driver of Work-Life Flexibility for Professionals

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Ellen Kossek and Brian Distelberg (this volume) provide us with a useful and provocative review of the employer supports which help Americans reduce work-family conflict. They marshal evidence from the best survey data available to suggest that, in short, employers are mostly treading water in this area. Most workers lack access to any formal paid work-family policies, and voluntary adoption by employers is highly uneven across the economy. With regard to an emerging hot topic in work-family research, that of flexibility, Kossek and Distelberg find the data harder to interpret. There is little clarity across employers, across surveys, or across researchers on what this concept means, and it often combines temporal and spatial dimensions (e.g., schedule flexibility versus telecommuting). Nonetheless, with regard to flexibility, as well as other employer supports, a recurrent theme is that even when employers offer relevant policies, workers do not report using them.

Building on earlier work by Kossek (2006), their chapter also offers a useful analytic framework to help us understand why this might be the case, based on a stool with three legs, each representing a feature of the workplace which affects work-life outcomes. The three legs are (1) human resources (HR) policies, (2) organizational culture and informal supports, and (3) the design of work. Kossek and Distelberg argue that all three legs of the stool matter for workers seeking flexibility, but by far, the most practically developed and studied one is the first. This imbalance

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has implications because it suggests that HR policies implemented without cultural and informal supports or consideration of the design of work are likely to be less effective.

This chapter will focus on the third and least developed leg of that stool: the design (and, therefore, also the nature) of work itself. There are good reasons why this leg is shorter than the rest. The design of work is often viewed as a core function of organizations that is central to their effectiveness and survival, making it difficult to critically study or alter for purposes of workers' own flexibility needs. Work also varies greatly across occupations, organizations, work groups, and individuals, making it difficult to conceptualize at any level of generality. Perhaps nowhere are these barriers greater than in professional occupations, in which work is highly complex and variable. Nevertheless, it can be argued that for many professional workers, the nature and design of work is an indispensable lever for flexibility, and one which is, in fact, already being manipulated in powerful and hopeful ways that should not be overlooked by work-family researchers. Using in-depth studies of one particular profession, this chapter will attempt to draw out themes related to work design that may be applied in other occupational contexts as well.

## The Need to Understand the Nature and Design of Work

To begin, consider the case of Susan K.—mother of two preschoolers, only child of ailing parents, and part of a dual-career household. Susan desperately wants the flexibility to adjust her work hours in order to respond to her family demands. What are the chances of Susan finding that flexibility? If Susan has an enlightened employer offering work-life HR benefits such as flextime, her odds should go up. If her supervisor also happens to be enlightened with regard to the value of accommodating subordinates' work-life needs, her odds should rise further.

But how does the story change if we learn that Susan is a physician? Her income will certainly help pay for nannies, babysitters, elder care, housecleaning, and other related services, partly alleviating her inherent need for flexibility. But the limits on her flexibility stemming from the nature of medical work are also formidable. Work schedules are very constrained by the need to treat patients who get sick at unpredictable and inconvenient times. In fact, the traditional medical practice for over

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a century has been organized around this need to respond to untimely patient illnesses (Starr 1982). In this situation, it appears that neither HR policies nor informal supports will do much to help Susan K. find flexibility. It is the nature of work which serves to constrain her flexibility, and therefore, the (re)design of work which holds potential for enabling her flexibility.

From society's point of view, the high price of medical services may be partly justified by the willingness of physicians to make themselves accessible to patients in this manner (Zerubavel 1979). Yet from the physician's point of view, such extreme levels of accessibility were only historically feasible with a family structure that buffered him from any need to be involved in parenting or other significant caregiving or household roles. In short, if the "ideal worker" of yesteryear was a male breadwinner with a stay-at-home wife who could insulate them from family demands (Acker 1990; Bailyn 1993; Williams 2000), the "ideal physician" fit that description to an even greater extent.

The disconnect between that "ideal" image and the current reality of physicians could not be more abrupt. The percentage of women entering the field of medicine has risen from 7 percent in 1970 to 49 percent in 2005 (AAMC 2006). Family structure also shifted over that time, such that dual-career families have become the norm, and in fact, dual-physician families are very common (Sobecks et al. 1999). These changes bring growing interest in schedule flexibility, nontraditional career options, and personal quality of life (Moody 2002).

## Workplaces Where Physicians Actually Have Flexibility

Observing these trends, I set out to find which, if any, workplaces are better for physicians to obtain flexibility. In studying physicians—who lie at an extreme end of the occupational spectrum in terms of constraints on their flexibility—I also hoped to learn something that might be applied to professionals in other occupations with less extreme constraints as well. From June 2001 to May 2005 I gathered data on the work practices and careers of primary care physicians across a range of medical practice organizations in the United States. The research included two original surveys with a combined total of 588 respondents, over 40 interviews combined with field observations in six medical

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practice organizations, and secondary analyses of two national surveys (Briscoe 2006, 2007, 2008).

What I found initially surprised me: physicians have more short-term schedule flexibility when they work in settings that are more bureaucratic—that is, characterized by standardizing rules and procedures. Not only this, but physicians in those more-bureaucratic contexts have greater *career* flexibility as well, reflected in their ability to take part-time stints ranging from months to years in length, during which they spend more time with families or pursue other kinds of work activities outside the clinic. Such part-time arrangements are notoriously difficult for physicians to achieve. More-bureaucratic medical practice organizations also tend to attract physicians whom one would anticipate valuing flexibility. The odds of practicing in a more bureaucratic organization rise for female physicians and for physicians of both sexes who identify themselves as primary caregivers within their families. Bureaucratic intensity also tends to correlate positively with workplace size, although subsequent analyses indicated that the enhanced flexibility derives from bureaucratization rather than size alone.

## How Do Bureaucratized Workplaces Provide More Flexibility?

To understand why bureaucracy enables flexibility for physicians, it helps to start with a simple model of the physician's work. The constraint on physician flexibility stems from two features of that work: (1) patient needs appear unpredictably and urgently and (2) treatment often depends on knowledge and trust forged in an earlier encounter between physician and patient. The confluence of those two conditions implies that when a physician's patients get sick, that physician has few options other than to attend to those patients personally, no matter what else he or she had previously planned to be doing at that time.

The bureaucratization of the medical workplace actually changes that second feature of medical work, reducing the need for treatment to be delivered by the same physician who was present in earlier patient encounters. In the bureaucratic workplace, rules and procedures have the effect of standardizing much about the way physicians approach patient symptoms, the way they record information about patients, and the way they set patients' expectations about the services they will receive. As a

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result, when a given patient becomes ill, the options for competently treating that patient are expanded to include not just the particular physician who treated him or her in the past, but also other physicians and caregivers in the same workplace. In the most bureaucratized settings, those physicians share standardized treatment protocols, use a common electronic medical record system, and have primed their patients to expect a team approach to medical services rather than an entirely personal one.

In short, standardization is increasing the scope for patient hand-offs among physicians, and this appears to be the key for physicians to achieve flexibility. At an abstract level, the link between standardization and hand-offs is something that organizational theorists from Frederick Taylor onward might have predicted. While details, motivations, and consequences of the movement to standardize medical work are certainly complex and contentious, nonetheless it is clear that those medical practice workplaces which are more standardized are also those in which physicians find more flexibility.

It is equally important to appreciate that flexibility for physicians is accompanied by trade-offs. The bureaucratic intensification, which paradoxically enables flexibility, also represents a measurable loss of individual autonomy over work (Briscoe 2006). This is an important change for members of a profession known for individual autonomy (Starr 1982). Anecdotally, the bureaucratic settings also may be associated with lower prestige and income for physicians. Objective effects on the quality of patient care are also of obvious concern and need to be a subject of future research.

## What the Case of Physicians May Tell Us about Other Professionals

If it generalizes, this analysis could offer insights into flexibility for a wider range of professionals. Flexibility in many other professional occupations is also critically limited by the core task of providing client service—clients demand timely attention, and there are nontrivial barriers preventing one professional from handing off client work to another person. When bureaucratic processes such as those outlined above serve to relax that constraint, they should also enable new options for flexibility. Occupations to which this logic might apply include many medical specialties,

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corporate lawyers, laboratory scientists, financial advisors, investment bankers, university professors, accountants, architects, management consultants, and advertising and design professionals. Indeed, work-family scholars are increasingly concluding that there must be distinctive sources of flexibility for such occupations (Epstein et al. 1999; Jacobs and Gerson 1998; Kossek, Lautsch, and Eaton 2005; Lee, MacDermid, and Buck 2000; MacDermid and Tang 2006; Wharton and Blair-Loy 2004).

The model may also generalize further beyond client-based occupations. For example, the project teams which are common in high technology require workers seeking flexibility to orient toward other team members, somewhat like the physician does her patients. That is, the worker has to be responsive to demands that arise from others on the team at unpredictable times and cannot easily hand off those demands to someone else. Similarly, internal-service workers, like computer network administrators, endure constraints in the sense that they must be responsive to unpredictably timed demands that cannot easily be handed off. Here, too, greater bureaucratization may provide increased flexibility.

These professional and technical workers represent a large and growing swath of the overall economy. Depending on the definition used, professional and technical services constitute or directly influence between 15 and 25 percent of the United States gross domestic product (GDP), and however measured, that share has been expanding over time (Barley and Orr 1997; Broschak 2004). Furthermore, bureaucratizing changes are taking place across many professional occupations which parallel the case of medicine. For example, organizations employing lawyers, accountants, engineers, and consultants are adopting standardizing project management and knowledge management systems to coordinate work and transfer insights across projects and clients (Adler 2005; Hansen and Haas 2001; Morris 2001). Such developments could be creating similar conditions for enhancing workplace flexibility.

It is also worth noting how these findings contrast with the view that professional and technical workers can find flexibility by escaping the confines of bureaucratic organizations. Scholars have recently debated the possibility that flexibility might be gained through a career of relative independence from organizations, for example, through independent contracting (Arthur and Rousseau 1996; Evans, Kunda, and Barley 2004). The case of physicians suggests caution: when the constraints on flexibility stem

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from the work itself, the best hope for alleviating such constraints may come from being firmly embedded in an organizational context.

## Implications for Research and Policy

The specific finding that bureaucratized workplaces enable flexibility speaks directly to recent attempts at conceptualizing flexibility. Work-family scholars have recently identified the need to disentangle flexibility over work content, location, and timing (Kossek et al. 2005; MacDermid and Tang 2006). This study's findings indicate that *for some important professional workers, losing control over work content is actually necessary in order to gain control over the timing of work.* Hence, empirically, physicians' job autonomy is negatively related to their schedule and career flexibility. Why? Because the nature of their work is the major constraint on their flexibility, and bureaucratized contexts which reduce their control of work also help minimize that constraint on flexibility. For a broader model of flexibility, this suggests the need to better incorporate the nature of work. One possible way to do that might be to better conceptualize sources of constraint, such as client or project-team interdependencies.

Other interesting questions arise from the convergence of professional bureaucratization and personal flexibility. First, how will future generations of professionals view the trade-off between work autonomy and personal flexibility that is captured in this analysis? Does gaining flexibility mean losing the professional "calling"? This study's research suggests a more nuanced account: career satisfaction was not lower among physicians in the bureaucratized settings. Yet that raises another possibility—namely the emergence of new forms of stratification within the professions based on who is willing to make the trade-off between autonomy and flexibility. This could happen if bureaucratized workplaces are disproportionately chosen by women or by family caregivers of either sex who seek flexibility (Drago 2007; Leicht and Fennell 1997). Hence a second question: Will the many other dimensions that might differ between flexible and inflexible workplaces potentially create new forms of industry and labor market segmentation?

Returning to the three-legged stool, these findings suggest that for key groups of professional workers, focusing on HR practices alone is unlikely to improve flexibility. Neither are improvements in organizational culture

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or informal supports if they are not accompanied by attention to the way work design hampers or enables flexibility. In other words, the third leg of the stool may be the most important one for supporting these workers' access to flexibility.

Because the design of work is a core feature of organizations and occupations, policy efforts to encourage redesign are likely to be fraught with controversy. To date few organizations of any type have agreed to make major changes in the design of core work processes for the purpose of addressing work-family issues, with a few notable exceptions (Moen, Kelly, and Chermack this volume; Perlow 1999; Rapoport et al. 2002). Yet *current changes in the design of work, which are spreading across professional organizations, represent a valuable natural experiment for researchers to study the links between work and workplace variation and flexibility outcomes for professional workers*. Such links may not be immediately recognized by practitioners or scholars who are focused largely on organizational performance outcomes. Research aimed at understanding these linkages will require painstaking field observation (Perlow 1999), a high level of engagement with practitioners (Rapoport et al. 2002), and a deep understanding of occupation and industry.

Many of Kossek and Distelberg's recommendations for advancing research and policy apply equally to the realm of professional work and the focus on work design. For instance, they highlight the importance of tracking organizational outcomes from work-life policies. Though establishing the costs and benefits of changes in work design is a daunting task, it is of great importance here as well. To illustrate, there is a possibility that increasing flexibility for physicians by enabling patient hand-offs will adversely affect patient care. In the professional context more broadly, it will be critical to capture impacts of flexible work design on occupationally specific outcomes, such as the ability to effectively solve client problems and meet project goals.

Two final policy implications arise from the history of how medical organizations began offering this physician flexibility in the first place. The changes in physician work that enable flexibility were forged as a by-product of efforts to reform health care delivery (Briscoe 2006; Laffel and Blumenthal 1989; Starr 1982). The effects on physician flexibility were an unanticipated consequence of those efforts. In fact, such changes might not have emerged at all if they had been framed in terms of work-family needs. That would likely have drawn opposition from traditionally minded physicians who did not want professional commitment (the "calling") to

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be diluted by personal family considerations. But, instead of being cast as a work-family issue, the innovations which enhanced flexibility were rooted in efforts to improve patient care. Perhaps just as important, their use was not limited to physicians who were mothers; others also took advantage of flexibility options to pursue a range of work and nonwork activities that were unrelated to their family needs. As a result, skeptics could not dismiss the flexibility options as the domain of only a narrow group of workers. This account suggests that work-family advocates should attend carefully to those changes in work design which alter or improve flexibility unintentionally. Secondly, whether intended or not, changes which improve flexibility may face less resistance in many professional workplaces when they are framed as broad developments that address a wider range of worker and organizational needs beyond those linked to family.

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