Fathering, Class, and Gender: A Comparison of Physicians and Emergency Medical Technicians
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FATHERING, CLASS, AND GENDER

A Comparison of Physicians and Emergency Medical Technicians

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Using a multimethod approach (including a survey, interviews, and observations), this article examines the link between class and masculinities by comparing the way two groups—professional men (physicians) and working-class men (emergency medical technicians, or EMTs)—practice fatherhood. First, the authors show that these two groups practice different types of masculinity as they engage in different kinds of fatherhood. Physicians emphasize “public fatherhood,” which entails attendance at public events but little involvement in the daily care of their children. In contrast, EMTs are not only involved in their children’s public events but also emphasize “private fatherhood,” which entails involvement in their daily care. Second, the authors suggest that these differing types of involvement can be explained by the contrasting employment conditions of each group as well the gender order of their families, especially the divergent labor market positions of spouses and the division of parenting. The authors conclude by arguing that these working-class fathers are “undoing gender” while professional fathers reproduce the conventional gender order.

Keywords: class; gender; masculinities; work; family; parenting; fathers

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A large and growing literature documents recent changes and growing variation in the relationship of gender, paid work, and parenting. Although most of this research focuses on the range of women’s experiences, some suggests that most men still emphasize employment as central to their practice of fatherhood (Lamb 1995; Orloff and Monson 2002; Townsend 2002), leaving far more of the parenting and daily caregiving to mothers (Casper and Bianchi 2002; Craig 2006). Few studies, however, focus on the varied experiences of men to examine how employment shapes fatherhood (Astone et al. forthcoming), fewer explore how parenting shapes men’s employment (Lundberg and Rose 2000), and almost none compare fathers in different class positions.

This article examines the relationship between class and fatherhood. We compare two groups of fathers, one in a professional occupation and the other in a nonprofessional occupation; we argue that these map broadly onto two class locations—one upper middle class (physicians) and the other working class (emergency medical technicians, or EMTs). We first compare these men’s class-linked practices of fatherhood and, second, argue that their ways of doing fatherhood entail enactments of distinctive masculinities, based in the dynamics of their occupational and familial relations, which have consequences for doing (or undoing) gender.

To address the first issue, we argue that these two groups of men practice different types of fathering—with physicians emphasizing “public fatherhood” and EMTs performing not only public fatherhood but also participating in the daily routines of “private fatherhood.” Second, we suggest these different fathering practices can be explained by the contrasting employment conditions of each group and the gendered character of their families, especially their wives’ involvement in the labor market and parenting.

Three sets of literature frame our analysis. First is the limited literature that directly examines fatherhood, masculinity, and class. The second is a growing literature on paid work hours, schedules, and families. The third set of literature roots fatherhood in gender relations by addressing the connection of fathering to mothering.

FATHERHOOD, MASCULINITY, AND CLASS

Much recent work on the relationship of masculinity to the practice of paid work and domestic life (Coltrane and Adams 2001; Cooper 2000; Townsend 2002) draws on the now classic theoretical formulation of Connell (1992, 1995). Developing the concept of “hegemonic masculinity,” she argues that much older literature used a categorical model of gender
that treated men as an undifferentiated group, but contemporary research documents a considerable range of masculinities. While prior scholarship tended to conflate sex and gender, Connell offers a counterview; she suggests diverse masculinities can be traced to the “social dynamics generated within gender relations” (1992, 735) and through other structures that vary across social locations. In fact, class is a social location Connell emphasizes, although she criticizes work on masculinity for being “class-bound” (1992, 735). Further, Connell and others (e.g., Brines 1994; Griswold 1993; Kimmel 2000, 2006) suggest that men’s involvement in gender relations at home, especially parenting, provide an important locus of institutionalized inequality and significant site for the (re)construction and expression of various masculinities.

Researchers suggest that the way men combine family and paid work now entails two models of masculinity: (1) the still dominant “neotraditional model of masculinity” (Gerson 2007) in which men put their job prospects (or breadwinning) first but rely on their partners for daily care of children; and (2) an alternate, more egalitarian, model of a “newly constituted masculinity” (Cooper 2002), which entails substantial sharing in the daily care of children in addition to market work (see also Dowd 2000; Townsend 2002).

Some research looks at the relationship of social class to the two models of masculinity. Much quantitative research, especially time-use studies, examines the number of hours men spend with their children; summarizing this literature, Pleck and Masciadrelli (2004, 238) conclude there is “no consistent relationship between paternal involvement and socioeconomic variables.” Recent qualitative work on fathering, however, finds some differences by class.

For working-class men, some studies suggest the priority of the breadwinner model, showing that working-class men feel that their masculinity is threatened when they cannot enact the primary breadwinner model of fatherhood (Gerson 1993). Williams (2000), however, indicates that a disjuncture exists between this ideology and the practice of fatherhood, especially for working-class men whose ability to fulfill the primary breadwinner role is waning. Indeed, Pyke (1996) finds that some working-class men emphasize a hypermasculine provider role while sharing in family work. Using longitudinal English data, Sullivan (2006) shows that men assumed more responsibility for family work if they were employed in working-class (manual or clerical) jobs. Deutsch (1999) similarly finds that, among the alternative-shift working-class couples she studied, men did much of the work of parenting even while insisting that their wives were the primary parents.
Research on middle-class fathers finds a contrasting pattern. A number of qualitative studies suggest that such fathers, especially professionals or the “educational elite,” espouse some version of egalitarian parenthood (Cooper 2000; Deutsch 1999; LaRossa 1997; Risman 1998). Yet researchers suggest that middle-class fathers do not enact these ideals (Griswold 1993; LaRossa 1997) due to employment constraints as well as the culture of masculinity in which they believe (Coltrane 2004; Cooper 2000; Pyke 1996). Coltrane (2004) argues that whereas managerial and professional couples were the most likely to share family work in the 1970s and 1980s, by the 1990s and 2000s most sharing occurred in the working-class.

Not only does the level of paternal involvement vary by class, but the type of engagement varies as well. Coltrane and Adams (2001) find that if men participate in “enrichment” or leisure activities with children, they are less likely to do daily chores such as cooking and cleaning. Lareau (2002, 749) ties this variation in type of engagement to class. She shows that middle-class parents were much more likely to participate in organized leisure activities with their children than working-class families, who tend to have “more free time and deeper, richer ties with their extended families.” As this quotation suggests, one important aspect of Lareau’s (2003) work is that she does not simply focus on the nuclear family but widens her lens to include extended kin. Her work suggests that there is class variation in these ties—with working-class parents significantly more likely than those in the middle-class to rely on relatives for help with children (for review, see Gerstel and Sarkisian 2008). These ties shape the demands on both fathers and mothers. Although these studies provide important leads for comparing working-class to middle-class fathers, few have made these explicit comparisons.

WORK HOURS, SCHEDULES, AND FAMILIES

The total hours of household employment have climbed because of women’s increased work hours (Jacobs and Gerson 2004). This is particularly true for parents: Paid working time has increased dramatically for mothers since 1970 (Bluestone and Rose 2000), and the sum of estimated annual hours worked by U.S. mothers and fathers is higher than those of parents in any other country (Bianchi, Robinson, and Milkie 2006). Gender is essential to understanding these hours. On one hand, some research suggests that men do more routine child care when they are employed fewer hours (Coltrane 2000). On the other, while mothers tend to cut back their hours of employment, research suggests that fathers increase their work
hours after the birth of a child (e.g., Jacobs and Gerson 2004; for exception, see Astone et al. forthcoming). Importantly, class influences hours and schedules, with professionals working longer workweeks than other occupational groups (Jacobs and Gerson 2004) and the working-class more likely to alternate shifts (Presser 2003). Although longer workweeks decrease fathers’ participation in family work, alternative schedules increase it (Barnett and Gareis 2002; Deutsch 1999; Presser 2003). This suggests a bifurcation of job hours and schedules by class.

GENDER WITHIN FAMILIES: FATHERING AND MOTHERING

As Connell (1992, 1995) argues, the organization of gender relations is central to the practice of masculinity. When employed, wives challenge the neotraditional model of masculinity, or as Griswold (1993, 220) puts it, “Women’s [paid] work, in short, has destroyed the old assumptions about fatherhood and required new negotiations of gender relations.” Research has shown that fathers are likely to be somewhat more involved in parenting when their wives are employed. Moreover, fathers’ child care and work time correlates with the employment schedules of mothers (Bianchi, Robinson, and Milkie 2006; Brayfield 1995). Coltrane (2000) argues that the employment schedules of wives and husbands are perhaps the most consistent and important predictors of domestic sharing that researchers have documented. Furthermore, researchers find that when wives have higher relative earnings, or when the gap between husbands’ and wives’ earnings is lower, the gendered gap in the division of domestic labor is reduced (Cooke 2007).

Although we might expect the influence of mothers on fathers to vary by class, little literature examines this connection. In one important study of equal parenting, Deutsch (1999) finds that mothers influence fathers’ participation by either fighting for more equal participation (especially in the middle class) or by using alternate schedules (especially in the working class). Other research shows that among the affluent, wives not only develop an ideology of intensive mothering but also sometimes make the decision to withdraw from the labor force to concentrate on mothering; this frees fathers to focus on breadwinning (e.g., see Blair-Loy 2003). For working-class wives, it is much more difficult to “opt out” (Boushey 2005; Kuperberg and Stone 2008). Indeed, as Stone (2007) argues, opting out is often dependent on the earnings of highly paid husbands. Extending these findings, one of the arguments we make in this article is that wives influence fathers’ involvement in parenting but do so in ways that vary dramatically by class.
METHOD

This article uses data collected in the Northeast as part of the Study of Work Hours and Schedules. The four occupations in the larger study—EMTs, physicians, nurse’s assistants, and nurses—were selected to vary by class and gender (for a more detailed discussion of the research methodology of the larger study, see Clawson, Gerstel, and Crocker 2008; Gerstel, Clawson, and Huyser 2007). This article focuses on the two male-dominated occupations in the study—EMTs and physicians—selected due to variation in characteristics that research suggests are tied to class.

Class is a concept that is much contested with little consensus about how to conceptualize or operationalize it (Wright 1997). Acker (2006) defines class in terms of differential access to resources, including wages, intrinsic to employment and organizations; while Hout (2008) suggests that objective criteria of class (which are correlated with subjective class identification) include what people do for a living, their income, and their education. Still others emphasize lifestyle or consumption in their discussions of class (see Lamont 2000; Weinenger 2005). Some minimize the importance of class, arguing against the possibility of aggregating disparate groups, suggesting that the key factor influencing economic differentiation and inequality is organization (Baron 1994) or occupation (Grusky and Sorensen 1998).

Rather than examine a heterogeneous collection of scattered individuals, our study examines people situated in particular occupations. A variety of indicators of class—used in the general theoretical and empirical literature on class cited above—are distinctive among our groups. Physicians and EMTs differ not only by occupation, income, and education but also with regard to their lifestyles as well as workplace constraints. According to the U.S. Department of Labor (2003), EMTs earn an average of $26,930 (a figure including both basic-level EMTs, who earn less, and paramedics, who earn more), while physicians earn $139,640 (a figure for family practitioners, the lowest-paid set of physicians). In our study, both groups earned more than the national average for their occupation: The physicians earned a mean of $206,000 (probably because the sample included both specialists and a smaller number of family practitioners); the EMTs, with a starting wage of only $8.50 per hour, earn a mean of $50,000 (our research included more EMTs who were paramedics than basic level). The minimum training required for each occupation differs dramatically: Although physicians must attend medical school for at least four years after college, EMTs can be certified
with as little as three weeks of instruction. Thirty-nine percent of the
EMTs in our study had a high school diploma or equivalent, and 33 per-
cent had an associate’s degree. The percentage of each occupation paid on
an hourly basis (i.e., with their hours monitored by the organization) is
67.4 percent of EMTs but only 2.0 percent of physicians.

We are using an individual definition of class but should note that many
have made important arguments about the class position of families and
the contribution of wives and husbands to a family’s class position. As we
discuss in more detail below, the employment and earnings of each
group’s wives in our study were tied to the different positions of their
husbands: The doctor’s wives were significantly less likely to be employed
and, if employed, more likely to work part-time. They also contributed a
significantly smaller share of the family’s income than did the EMTs’
wives. These differences contribute to variation in the ways the EMT and
physician men practice fatherhood.

We chose EMTs and doctors because these occupations operate in the
same sector of the economy and we could obtain a random sample of both
occupations from state certification lists. Certification is a required process
generating regularly updated and publicly available lists that made it pos-
sible to generate a true random sample. We chose health care as our
research site because it accounts for more than one-seventh of total GDP
(U.S. Census Bureau 2006) and is part of the growing service sector rather
than the diminishing manufacturing sector. Like an escalating number of
workplaces, many health care organizations operate 24/7 with alternative
schedules. The characteristics of these occupations closely approximate
those of the United States as a whole (Gerstel, Clawson, and Huyser
2007).

For each occupation, we collected three kinds of data: (1) mailed sur-
veys, (2) observations, and (3) intensive interviews. First, surveys on
hours, schedules, family characteristics, and demographics were mailed to
a random sample of 200 physicians and 200 EMTs. The response rate for
the surveys was 57.6 percent for physicians and 64.7 percent for EMTs.
In the survey, 78 percent of the EMTs and 71 percent of the physicians
were men. For this article, we focused on the married fathers with children
younger than 18 years old still living at home, which included 55 physi-
cian and 41 EMT fathers. Moreover, only a small proportion of our survey
respondents were nonwhite: 16 percent of the physicians (most of whom
were Asian) and only 5 percent of the EMTs (primarily African American
and Hispanic). Although we could find no national data on EMTs, the
proportion of white physicians in our sample was only slighter higher than
in the nation (American Medical Association 2008). Consequently, we cannot do a fully intersectional analysis including comparisons with race as well as class and gender.

In addition to demographic items, the survey’s closed-ended items included hours usually worked at main job, number of jobs held, hours worked at all jobs, number of weekends worked in the past 30 days, personal income, and satisfaction with hours and schedules. Family variables included marital status, spousal employment status and number of hours worked, family income, and an item indicating whether the respondent had a family member who would like him or her to reduce hours at work. For a measure of spousal income, we subtracted respondent income from family income; because family income included investments, the spousal income is likely an overestimate (especially for doctors, who are likely to have more investment income than EMTs).

Second, observations were conducted at nine work sites (representing four different types of organizations), including three hospitals (with two floors in two hospitals and the emergency room in the third), two EMT sites, two nursing homes, and two physician’s private practices. These sites differed in terms of the public/private status and size. One hospital was large and located just outside of a major city, while the others were small community-based hospitals. One EMT site was a fire department staffed by 30 firefighters while the other was a private service with approximately 50 employees. The two private physician practices included a specialist’s office and a family practitioner’s office. The frequency of observations ranged from once to thrice a week, covering various day, evening, and night shifts. During each visit, researchers spent anywhere from three to ten hours observing the work site, shadowing individual workers, and talking to individuals and groups at the workplace. Time spent in these sites ranged from six months in two hospitals to two days in the third and two months in each of the EMT sites, doctor’s offices, and nursing home. Field notes for each visit were recorded, transcribed, and coded using Nvivo8.

Third, intensive interviews were conducted with 200 respondents, including the 31 fathers we focus on here (EMTs, n = 13; physicians, n = 18) who were contacted through the survey sample as well as observation sites. This subset was generally representative of the larger survey sample. Interviewers included five women and two men, but we identified no observable differences related to the interviewer’s gender. We offered respondents $35 for their interviews, which were open-ended and lasted one to two hours. Open-ended questions covered work schedules and
hours, preferences for and perceptions of hours and schedules, time off, decisions relating to time and money, and time and relations with spouse and children. Interviews were recorded and transcribed. We developed codes from the literature and interview text and revised after one round of coding was completed. We used multiple rounds of coding using Nvivo8 to ensure consistency.

In the following sections, we first look at the physicians’ fathering and then turn to the EMTs. Comparing them, we distinguish between “public” fathering, which entails primary involvement with children in leisure activities and events outside of the home that are visible to some larger public; and “private” fathering, which entails a primary focus on the quotidian tasks of families, typically less visible to a larger public because much occurs at home.

**PHYSICIANS AND PUBLIC FATHERING: “BEING THERE”**

Physicians tended to highlight participation in or presence at their children’s public events as the way they were involved in their children’s lives. Even with their long hours or hectic schedules, physicians emphasized their concerted attempts to attend those activities. Sometimes this kind of paternal involvement required creativity in scheduling:

I coached [my son’s] soccer, and the way I coached his soccer was I would book two hours in my afternoon and I would not have patients there, and I would go to [town] and coach his practice and do the work, bring him home and then go back to work, and then work ’til 9:00.

As this father’s comment suggests, doctors let their children influence their schedules because they can; when they choose to do so, they exert significant control over their schedules. Physicians engage in other public activities with their children as well. When we were observing in his office, a surgeon showed us—with pride—his phone’s screen with a photo of his daughter dressed for Halloween, saying she was going trick-or-treating with him. But during our interview with this physician, he barely mentioned his daughter, suggesting her daily care was his wife’s domain.

“Being there” for public events was important to these physicians. Yet even when they were able to leave the office to attend their children’s events, work sometimes followed. One physician had a $3,000 car phone installed so that he could return phone calls while watching his children:
Though able to be physically present at the game, his attention was divided between his family and his work. Yet to him, being at the game was what mattered. He is demonstrating, possibly to himself, his child, and the community, that he cares as a father. In some sense, the very difficulty of his being there makes this demonstration all the more dramatic.

Through their participation in these activities, the doctors are publicly “doing fatherhood.” This performance of gender and fatherhood entails signs of “paternal visibility” (Coltrane 1996; West and Zimmerman 1987) to their children and the wider community. Moreover, like the men Townsend (2002) studied, a large part of what it means to them to be a father is to be a provider. Many of these physicians adopted a neotraditional model of masculinity (Gerson 2007)—one suggesting that what it means to be a good father is to be a good breadwinner and provide financially. This is reinforced by the income associated with class position: Participation in public activities often requires a significant financial outlay. How do we explain such public fathering? To answer that question, we first look at the physicians’ jobs and then turn to their family lives.

THE DEMANDS OF PHYSICIANS’ PAID WORK

In the survey, physicians reported working an average of 50 hours per week. However, these hours are underestimates. As became clear in the intensive interviews, many physicians did not include nondirect patient care or off-hours work in response to survey questions asking how many hours they work. They did not report activities such as checking work-related e-mail, participating in hospital committees, staying current in medical literature (often required for recertification), or being on-call; including these activities often led to estimates of 60 or more hours per week.

While much work entailed direct patient care, paperwork—documenting patients’ visits and illnesses, preparing material for insurance companies, making referrals—kept physicians at their desks in the evenings, well after their patients went home. Most said that paperwork could easily take an extra two or three hours per day. We observed a number of them eating
lunch on the run, coming in early and staying until 7:00 or 8:00 p.m., even if they finished patient care by 5:00. Sitting at their desks, they completed necessary documentation for patient records, referrals, and “most of all for insurance companies.” Several said that since their office had “gone electronic,” they would often go to their home computers in the evening to enter patient data they “just had not gotten to during the day.” These were hours when their families were likely available or in need of routine care.

Being available to patients was important to many physicians and often meant being on-call. While physicians could sometimes rotate their on-call status with their colleagues, their turn often interrupted their home lives. One hospital physician described being on-call in this way: “I mean, you can’t do anything; you’re basically . . . it’s like a full day of work.” Or as another doctor put it, “You’re always aware your beeper is there and could go off at any time; you can’t just relax.” Importantly, much of this work occurred before or after shifts or during weekends—that is, at key moments when family members are likely to be home.

To explain their long hours, physicians talked about a number of causes. They emphasized the hours and schedules of medical school and residency that helped socialize them to their current long hours. A number of physicians said they quickly learned the long hours “demanded” of their occupation and internalized these beliefs. Much of this dedication and willingness to work long hours was influenced by the commitment built into the process of becoming a physician (Becker 1960) or what Blair-Loy (2003) terms more broadly a “work-devotion schema.” Many years in school, long hours studying and in residency, and hundreds of thousands of dollars for training push physicians toward intense career commitment. As one physician succinctly said, “There was just no time for anything else.” Another talked at some length about the process and distinguished the experience of physicians who are fathers from those who are mothers:

Physician: Once you get married and once you have kids, things change dramatically and always . . . well, I shouldn’t say always but 80% of the time women doctors want to work less. It’s always the main topic of discussion and a comparison about what kind of schedule do you work. Guys don’t do that. We don’t . . . if anything, there’s this more . . . that if you don’t work at least 50 hours, you’re not working enough . . . with guys I would say.

Q: Because…what’s that about?

Physician: When we train in medicine, it’s like a hazing type of thing. It’s a bad . . . it’s not the best way but you have this that the ones who work the most are looked up to . . . you have to work harder than them . . . that gets
respect. When you work more, you have a big edge in terms of, well, that’s a big badge. Now I wouldn’t say just for men. Man or woman I would say, but man especially.

His comments suggest that doctors learn that respect—especially as men physicians—is related to extremely long hours on the job, which means fewer hours at home. Later in the interview, he commented that he felt sad that he could not spend more time at home having dinner with his family or putting his children to bed. But his version of fatherhood and masculinity, which he learned in part from the “hazing” in medical school and from the hierarchy in medicine, requires long hours on the job rather than a schedule with fewer hours and more direct family involvement.

Physicians also talked about a sense of obligation to be available to their patients. A private practice physician explained, “I mean, if you take care of people it’s really . . . you’re at their mercy and not yours. People don’t choose when they get sick, and you have to take care of them when they’re sick.” Although they sometimes tried, physicians found it difficult to “hand off” patients to others—either because of patient insistence and “loyalty” to them or because of a special skill and relationship with that particular patient. In one private practice we observed, office personnel were instructed to try to convince patients to see a nurse practitioner instead of a physician overwhelmed with patients; the staff often met resistance from those to whom they referred as “loyal” patients. After changing jobs and reorganizing his priorities to give more attention to his family (though not changing his hours greatly), another doctor told us about resistance from a patient. As he put it, the patient eventually “fired” him by letter, complaining that if he had “problems” with his children he should “have better child care.” In this study, obligations to their patients often resulted in physicians spending more time at work than their EMT counterparts.

Money—to pay back medical school debt, to maintain a particular style of life and consumption—also kept them on the job. Earning income was essential to understanding themselves as physicians, men, and fathers. Indeed, public fatherhood required a significant income. One physician said, “If I wanted to see less patients I would see less patients. The problem is your income takes a hit. And there’s so many things taking a hit on your income anyway.” One doctor who worked 60 hours a week reported, “We don’t have an extravagant lifestyle by any means, but I am afraid we have gotten used to a particular way of living. I have to work the hours I do to get what we now think we need.” At a meeting in which emergency room doctors were arranging shifts for November and December, one doctor said he did not want to work on Christmas. The ER director
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 accoutrements they desired. The young doctor agreed to come Christmas day. Overall, then, training, paperwork, obligation to patients, the medical hierarchy, desire for respect as men, and the particular style of life that their breadwinning could provide kept these doctors on the job and away from the daily routines of their families.

**THE DEMANDS OF FAMILY: THE ROLE OF PHYSICIANS’ WIVES**

The ways doctors organized gender relations at home made it possible to work the long hours they did. As the survey showed, physician fathers were likely to have either stay-at-home wives or part-time employed wives (43 percent of physicians had employed wives compared to 86 percent of EMTs; physicians’ employed wives also worked far fewer hours: an average of 13 hours compared to 30 for the employed EMT wives). With an occasional exception, the physicians’ wives’ chose jobs that were less demanding or allowed them to work part-time so they could be available for their families; these choices also allowed their husbands to spend long hours on the job. Some doctors said that they sometimes relied on “nannies” or “au pairs” to help with child care and that this allowed their wives to pursue their own careers. Yet even with such paid child care, many physicians relied primarily on their wives to provide daily and routine parenting. One physician’s wife, a physician herself, worked part-time so their children could have a parent who was “more available.” Though this father perceives himself to be equally involved, he admitted,

> Quite honestly, on a day-to-day basis, kids need mom more than they need dad, and I honestly think that’s true. . . . I don’t know whether . . . it’s not meant to be a sexist statement or anything like that, but we both share in the house . . . I mean I’ll do stuff for the kids just as much as she will, just not as frequently.

This physician’s comment entails seemingly contradictory assertions. He views his participation as “just as much” as his wife but “just not as frequent.” Thus, the unequal practices entailed in public fathering were sometimes invisible to the physicians. Struggling with an involved father ideology in the context of their demanding work, they often feel unable to reduce job demands to participate in routine daily child care. In doing so, they reinforce the gender order rather than contest it.
Physicians often seemed at a loss when asked whether they took off time to care for their sick children. When asked if he ever stayed home with his kids when they were sick, a doctor explained why his wife typically stayed home with them:

You feel that when you have a whole schedule of 24 patients’ schedules and you call in to cancel . . . it’s not like it’s easy to reschedule, and sometimes there’s people in there that you really wanted to see who you were worried about. So it is a pressure, it isn’t an easy thing just to get up in the morning and say “I’m not coming in.”

Clearly this physician felt very pressed by his obligation to care for his patients, an obligation that took precedence over staying home with his children when they were sick. The structure of his job and family life led him to organize his time so that he took care of patients and his wife took care of their kids.

Leaving most of the care of the children to their wives was not an easy bargain for the physicians. While a minority of EMTs (about one-third) had a family member who wanted them to reduce their hours, more than half of the physician fathers reported the same ($\chi^2 = 9.42; p < .05$). Occasionally a doctor would emphasize the loss and pain that this sort of parenting entailed. Tears rolled down the cheek of one doctor as he described his need to be in the hospital while his wife was bathing and putting their children to bed.

Even among the doctors, there was some heterogeneity: A very small minority reported reducing hours or shifts in response to their wives’ pleas. One doctor who divided his time between patients and research told us he shortened his workday at his wife’s insistence: “My wife said I needed to [come home], essentially, and I agreed with her. I didn’t have the insight to see the impact of what not being home was having on people.” The chief physician at a large medical center said that he tried to come home “by 7:00” at the request of his wife. He told us about their conversations, centering on her telling him to restrict work and “to come home at a certain hour.” Gesturing toward the piles of paper on his desk, he remarked that it was often difficult to get home for dinner, especially with the paperwork that piled up by the end of the day. But he tried. Among the male physicians, however, these two were exceptional.

EMTs are very different from physicians. Their fathering routinely emphasized private fathering and more intensive involvement in caregiving. This difference can be explained by the structure of their paid work as well as gendered relations at home.
EMTS AND PRIVATE FATHERING: “STEALING TIME”

While the physician fathers were likely to do what they could to attend public events with their children, EMT fathers were much more likely to participate in the daily care of their kids. The EMTs emphasized private fathering in ways that the physicians did not. They talked about routine involvement in the lives of their children—picking them up from day care or school, feeding them dinner, or staying home with them when they got 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.

Another remarked,

Last year I took three out of my five sick days to stay home when one of the smaller ones was sick. So I’ll use them more for that than for anything else.

One went further and put it succinctly:

I will totally refuse the overtime. Family comes first for me.

To explain their fathering, we turn first to their jobs and then to their homes.

THE DEMANDS OF EMTS’ PAID WORK

In the survey, EMT fathers reported working an average of 45 hours per week, but EMTs worked closer to 60 hours when including the hours devoted to second jobs. More than two-thirds of the EMT fathers reported having a second job; only 9 percent of the doctors did. In their second jobs, however, many EMTs worked per diem, which allowed them to choose if and when to work. Moreover, when the EMTs went home, they left their jobs behind: They did not have paperwork, nor were they on call. Thus, it is not primarily the number of hours that explains the differences in parenting. Although they resembled the physicians in long, often exhausting hours, the boundaries between work and family were much clearer for EMTs.

Even more than the number of hours, the shifts they work are consequential for their family lives. Many of the EMT fathers in our study work...
rotating shifts, nights, weekend, and holidays, and in some sense, they had little control over these schedules. At the beginning of each year, management handed them a booklet with their shifts for the next 12 months. Compared to physicians, EMTs were much more likely to report working two or more weekends in the previous 30 days (almost all of the EMT fathers compared to only half of the physicians). But EMTs were able to leave at the conclusion of their shifts, while physicians stayed after their shifts ended. Moreover, unlike physicians who were often unavailable to their families during key hours of their days, EMTs often worked during the hours that their families were sleeping.

In addition to the structure of shifts, relations with coworkers were important in shaping the way these two groups of men organized fatherhood. In contrast to the physicians, EMTs used swaps to create flexibility in their seemingly inflexible, nonstandard schedules. Often with the support of management, EMTs would switch shifts with another EMT or cover for each other for a few hours. Swaps were a useful means of acquiring “off” time without using their limited vacation or sick days. These exchanges were used in response to family needs; the EMTs in some sense “stole” time to be available for family. One EMT often asked someone to cover for him for a few hours at the end or beginning of his shifts so that he could attend his teenage sons’ sporting events. Swaps were not just used to attend athletic events. Others would swap when they had to take their kids to medical appointments or pick them up from school. Some of the older or childless EMT men covered for those with younger children. As EMTs highlighted, reciprocity—utilized over the short as well as the long term—was key to swapping, even for a few hours. One EMT had often been on the receiving end of swaps; now that his daughter is older, he happily returns the favor, saying his daughter “is just older and it’s nice to have that flexibility to give back to other people that was given to you, to be able to do things like that. I don’t mind doing it.”

While both occupations offer round-the-clock services, the doctors have to be personally available because one doctor is often not a suitable substitute for another (due to specialized skills or a special relationship with a patient). In contrast, EMTs’ skill levels, work requirements, and relationships to patients were more similar to one another; because they were interchangeable, they could practice such “swaps,” collectively making possible more daily sharing of fatherhood.

Income played an important role as well, but one that depended on the father’s orientation to consumption as well as family demands. In contrast to physicians, overtime (with time-and-a-half pay) is financially important
for EMTs. Due to their small staff, overtime was a significant part of the fire department’s ability to function; they relied on a callback system to remain fully staffed at all times. Thus, EMTs were “called back” to the station when the ambulance went out to answer a call. Returning to work could generate a lot of overtime pay for those who answered callbacks, but it was voluntary, and the EMT fathers consciously limited their overtime. The key to this decision was often their sense that they needed to participate in the labor of the home. One EMT made his decision making clear:

I kind of pick and choose [laughs]. Most of the time actually . . . like . . . during their school hours, I come in a lot during the day. Weekends pretty much—this is a rarity for me, coming in on Saturday or Sunday unless it’s later in the night, and early mornings. I’ll come in early mornings, from midnight on.

While physicians considered the time-money trade-off very carefully, and a few said they would give up some time and reduce their incomes, EMTs—who made considerably less money—routinely turned down overtime in exchange for time with their families. This is not to say that the EMT fathers were always happy to give up the overtime. Many refused it because they were solely responsible for their children at the time they received the call to come in for overtime. In these decisions, EMTs discussed both their worries about pay and their guilt in having to “choose” between spending time with their families and going to work. For one EMT father, the guilt he feels results from wanting or needing to go in for financial reasons but also believing his daughters are “only this age once” and “entitled to their father.” When we interviewed another EMT, it was clear that he felt guilty when saying no to the extra hours: “It’s not fair to her [his wife] or the kids [that] it takes my time like that. I have a hard time drawing the line a lot of the times between family and my moral obligation to the job.”

In the interviews, differences between physicians and EMTs in the importance of training also became clear. While the latter were dedicated to patient care, they were not trained in a schema that routinely prioritized work over all other areas of life.

DEMANDS OF FAMILY: THE ROLE OF WIVES AND EXTENDED KIN

Differences in their wives’ employment and responses to their husbands’ employment were critical to understanding the different styles of
fathering. According to the survey data, a large majority (86 percent) of EMT wives were employed, whereas fewer than half of the physicians’ wives had jobs. Moreover, EMT wives contributed much more to the family income: The gap between mothers’ and fathers’ mean income was significantly smaller in the EMT families ($32,000) than in the physicians’ families ($177,000) ($t = 4.69, p < .00). EMTs’ wives who worked for pay, worked substantially more hours than the physicians’ wives. Thus, the wives’ work hours in concert with explicit demands on their husbands’ schedules shaped how much time the men devoted to work and how much they devoted to family.

Like other working-class men, many of the EMT fathers alternated shifts with their wives. But the difference did not simply reside in the structure of jobs. After their children were born, EMTs’ wives often insisted that their husbands alternate shifts as well as reduce their paid work hours so they could contribute to daily family care. Their wives had, and used, their power in the relationships. Wives played a key role in callback responses because of their own work schedules and because they wanted (and often insisted) their husbands to be home. An EMT father of two young girls reported that he loves working on the ambulance and would like to answer more callbacks but has learned to accept his wife’s signals about accepting overtime:

The phone will ring and we have the caller ID, she’ll look at it and she’ll be like, “It’s the Fire Department, what do you want me to do?” So sometimes we just let it ring. And that’s our agreement. I’m able to read her now; I know where she’s “Don’t do this to us.” But there’ll be times where she’s like, “Hey, It’s the Fire Department—do you want me to get it?” She’ll let me know she’s okay with it.

The wives’ influence ranged from subtle signals to outright demands. One EMT kept his pager off and his cell phone on silent at night because his wife told him that callbacks interrupt her sleep and she did not like him going in at night. In another exchange, while eating lunch in the fire station, one EMT responded to the question, “Do your families ever ask you to not come in?” 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.

To be sure, given the demands of two jobs in these families, the EMTs and their wives often had to rely on other people to help take care of their children. Unlike the physicians, however, they often relied on extended family rather than paid child care. One EMT said that he had “definitely
roped in” his mother or brother with last-minute child care dilemmas. When another EMT was unable to pick up his son from school on his two daytime shifts, his mother would be there. They relied on kin care because they trusted their relatives and found such help less expensive and more flexible than hired help.

Importantly, EMT fathers did not manipulate their schedules begrudgingly. Like many of the working-class fathers in Francine Deutsch’s (1999) study, many of the EMTs seemed happy with their schedules because they allowed the EMTs to participate in childcare. While most of the fathers reported being happy with their current schedules (91 percent) on the survey, it was in the interviews that the EMTs discussed their families as a key reason for that happiness. 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?”

These working-class men exhibit a model of masculinity—based both at home and on the job—that provides valued involvement in their children’s daily lives.

**CONCLUSION: PUBLIC AND PRIVATE FATHERS**

Much has been written about the way gender shapes participation in family and work, but much of that literature focuses on women. In contrast, we focus on men and the ways that their class location shapes gender, family, and work. We argue that class shapes the gendered relations and processes rooted in jobs and the domestic division of labor, which in turn shape the ways men behave as fathers. Illustrating that masculinity is neither unitary nor homogeneous, our findings emphasize the “multiple masculinities—some subordinate, some dominant—which are created by differences in . . . class and occupation” (Cooper 2000, 7). Class locations are major contributors to the construction of masculinities because of their role in shaping fatherhood. Class location sometimes sustains but sometimes refashions the gender order (and the social relations constituting it). Our data accords with the few qualitative pieces that suggest that fathers who are least likely to ideologically endorse gender equality (the working-class) are the most likely to engage in equitable actions (e.g., Deutsch 1999; Pyke 1996; Williams 2000).

We selected these two groups of men because of variation in their characteristics tied to class. Putting breadwinning first, the physicians—both by constraint and choice—were much more likely to emphasize their involvement in the special events in their children’s lives over the tasks of
daily care. These upper-middle-class fathers fit the daily demands of fatherhood on the edges of their jobs; they contribute significantly to the material well-being of their families but are otherwise engaged primarily in public activities with their kids. Physicians stay on the job, resist participation in the familial division of labor, and distance themselves from the daily demands of their children. To be sure, this choice comes with a cost that a small number of physicians discussed: missing out on close relationships with their children. No EMTs expressed this sentiment. In contrast, the EMTs weave together work and family (see Garey 1999 for a discussion of the “weaving metaphor” to describe the way women do mothering). These working-class men do not prioritize work over family, nor do they simply balance the two. Instead, they value and are deeply involved with both. In contrast to the physicians, the EMTs emphasized not only the special, public events they attended but also the more routine tasks of daily parenting that sometimes pull them home and sometimes push them into alternate schedules on the job. Consequently, a far greater share of the daily work of parenting falls to the wives of physicians than to the wives of the EMTs. As Connell (1992, 1995) insists, the practices of masculinities are tied to the relational character of the gender order—not only are the relationships between men in each of these occupations important, but their relationships with their wives are essential components of their performance of masculinity. As such, the physicians reinforce the gender order while the EMTs redo it.

By comparing these two groups of men, we can specify the particular class-based strategies and conditions found in both job and families that contribute to variations in masculinity, the gender order, and fatherhood. Numerous aspects of their jobs were important in shaping the way EMTs practiced fatherhood. While physicians spent long hours on one job, EMTs often worked more than one job and used alternative schedules (a difference found by others in comparisons of the working and middle class; for example, see Presser 2003). In addition, as Acker (2006, 449) suggests in her discussion of class, lower-level jobs tend to have less scheduling flexibility than professionals, but she also notes that these differences are “created and renewed through organizational practices . . . and are also reproduced in everyday interactions.” Indeed, in some sense, while the doctors could exert a fair amount of control over their schedules, the EMTs had little control over their rigid schedules, which they received from management a year in advance. But the EMTs could alter these obligations by relying on their relationships with other men at work: These fathers could turn to coworkers for swaps because of the skill similarity
and the tight bonds they formed on the job. This helped them create flexibility in their job schedules. Despite the fact that many workplaces tend to be unresponsive to family demands, and though emergency medical services has typically been seen as a hypermasculine culture (Chetkovich 1997), the EMTs in our study managed to create workplaces responsive to the responsibilities associated with working-class fatherhood.

Not just their jobs were important; their gender relations at home—also similar in a number of ways to other working-class men—mattered as well. They did not only rely on extended kin for help in fathering; EMTs were responsive to their wives’ and their children’s needs when accepting or declining overtime. Some of them turned down promotions or found new jobs in response to their families. They struggled with these decisions and were often strongly influenced by their wives. Their wives’ employment—their hours, shifts, pay—typically shaped the involvement of the EMT fathers as they were more likely to swap alternative schedules with their wives. And as Deutsch (1999) reports as characteristic of other working-class men, their wives’ agency also affected their fatherhood: EMT wives often insisted their husbands be available. Although subject to the power and control of others both on the job and at home, many of these fathers appreciated their jobs and families because they allowed daily involvement with their children. Most EMT fathers not only related the requirements but also the pleasures of private fathering. We did not hear protests from them about threats to their masculinity. Perhaps this is because they work in highly masculine jobs and do not need to use family relations to shore up their identity as men. Whatever the cause, these working-class men are “undoing gender” in their interactions at home. These analyses respond to Deutsch’s (2007, 127) clarion call to examine when and how interactions become less gendered, for, as she writes, “Gendered institutions can be changed, and the social interactions that support them can be undone.”

Physicians, on the other hand, participated less in the daily care of their children. Without much resistance from physicians, their organizations continued to practice as “inequality regimes” (Acker 2006), less responsive to the daily needs of these men’s families. With gendered subjectivities, most physicians were silent in the face of conflicts between work and parenting. Though they had some control over their hours, the physicians talked of time constraints. They could change an appointment (as they sometimes did to attend a child’s game) or trade money for more time with their children (as a few did). But for a variety of reasons ranging from the identities they formed in residency to intense patient demands to consumption patterns, most did not do so. In addition, physicians earn
significantly more money than EMTs; this made it easier to pay for the kind of public activities entailed in “concerted cultivation” that Lareau (2003) finds at the center of parenting in middle-class families. But it was not just the characteristics of jobs and organizations that made such inequalities in parenting possible: The physicians’ wives rarely insisted that they share more fully in the daily hands-on care of their children. Whether because of their own ideological attachment to the importance of their husbands’ career or the pleasure gained in the lifestyle it allowed or for a combination of these and other reasons, the physicians’ wives were much less likely to make demands on their husbands’ time. Moreover, when the wives had jobs, these families paid for child care. Their bargain entails exchange: relatively high income (and perhaps prestige) garnered by the fathers in exchange for the mothers’ (and “her” helpers’) family care. Because of the conditions and relations located both in paid work and families, the physicians can perform public fathering.

Public fathering demands less time than private fathering, but it is more visible. Garey (1999) argues that nurses often choose night shifts so that their mothering, which occurs during the day, is visible to the community. In a similar vein, these doctors choose a kind of fathering that gives them visibility and likely garnishes praise from community members (whose support their medical practices are dependent upon; Fowlkes 1980). There is another implication of this paternal visibility: As Hochschild (1989/2003) argued, when families see other families sharing housework, that may help revise the gendered norms of domestic life. This creates a paradox: At the same time as this type of fathering sustains gender inequality within families, its visibility may contribute to the appearance of norms of gender equality to outsiders who observe them.

We have argued here that for these two groups of men, class shapes fathering. We do not, however, mean to argue that physicians represent all middle-class professionals or that EMTs represent all working-class men. There is too much variation across class to make such an argument. In some sense, the findings we report here are most clearly occupational and organizational differences—important components of class but not the only ones. Given the size and character of our sample, we cannot specify the effects of these particular occupational differences, nor can we generalize to other professional groups (like lawyers or academics) or other working-class groups (like factory workers or janitors). In addition, the limits of our sample restrict our ability to generalize to different types of families that may occur even within each of these two groups.
Instead of claiming generalizability, we hope our findings can and will be used in future research to further specify the relationships of social class to masculinity and parenting. We only have the views of the men about their wives; interviews with the wives themselves would further illuminate the role of class and gender in these families. Does class create the same multiplicity of gender for women as it does for men? What about women in each of our occupations? In the case of women physicians, how do such women respond to the push and pull of families and jobs in traditionally male-dominated professions? Recent research suggests that among physicians, far more women are demanding part-time work. Cull et al. (2002) find that female residents are far more likely than male residents to consider or accept reduced-hours positions. But the consequences associated with such schedules—such as the loss of income; reduction in job benefits; difficulty in loan repayment; and even, as Barnett and Gareis (2002) suggest, lowered marital quality—complicate these choices. Given our focus on work hours and schedules, we did not ask participants directly about threats to masculinity that either form of parenting might entail. Future research should elaborate on this theme to capture these data more directly. Finally, we have examined masculinities and fatherhood rooted in class; due to the limits of our data, we have omitted any discussion of race. Yet our own research (Sarkisian and Gerstel 2004), like that of a growing number of scholars (Anderson and Collins 2007; Browne and Misra 2003), suggests that race, class, and gender will intersect to produce variations in the meaning and experience of fatherhood. Further research should examine these intersections in employment and parenting.

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