CAREER TRANSITIONS IN THE THIRD AGE: A STUDY OF WOMEN PEDIATRICIANS

by

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DEDICATION

This dissertation is dedicated to the memory of my maternal great-grandmother, Mary Eva Hewlett Martin, whose educational journey has been a source of wonder and inspiration to me. At a time when few women were able to pursue higher education, Mary Eva graduated in 1908, at the age of 25, with a Bachelor of Arts in education, Phi Beta Kappa, from The University of Texas at Austin. She married in the same year and moved to New York City where she matriculated to New York University to pursue her master's degree in the College of Pedagogy. Life happened. She got pregnant, left school, and ultimately ended up back in Texas with three children she raised as a single mother after divorcing her husband. In so many ways ahead of her time, Mary Eva returned to New York City to finish her education, graduating in 1927 at the age of 44 with a Master of Arts from New York University's School of Education. Her thesis was titled, "A Study of Vocabulary of High School Pupils." I learned about these details investigating her story as our son attended Columbia Law School, Class of 2017. I had the privilege of knowing Mary Eva who bought me my first pair of ballet slippers when I was 8 years old. She lived to be 103 years old. Sharing Mary Eva's DNA and the experience of being an adult learner evokes a sense of timelessness, where

> Every mother contains her daughter in herself and every daughter her mother, and every woman extends backwards into her mother and forwards into her daughter. This participation and intermingling give rise to that particular uncertainty as regards time; a woman lives earlier as a mother, later as a daughter. The

conscious experience of these ties produces the feeling that her life is spread out over generations. The first step towards the immediate experience and conviction of being outside time brings with it a feeling of immortality. (Jung, 1959, p. 316)

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ABSTRACT

In this qualitative interview study, I explored how eight women pediatricians, ages 61-72, considered and experienced career transitions, including but not limited to retirement transition, and the influence of career transitions on their development. These women are in the third age which has been defined as a period when people are looking for what comes next as they anticipate living longer and consider some form of retirement. I chose to focus on women pediatricians, in part, because of concerns of an aging pediatric workforce which has a high percentage of women. A better understanding of their career transitions can help inform policies on workforce issues, as well as aid third age women pediatricians and other professional women in making transitions where they can continue to use their talents and foster development.

The interview data were analyzed using Nancy Schlossberg's 4 S model of transition (Anderson, et al., 2012) and gendered life course theory (Moen, et al., 2009), with the epistemologies of interpretivism, social constructionism, and existential feminism underpinning my study. Findings indicated that study participants' career transitions emanated from a gendered life course where strategic selections were made in the context of medical culture. They enacted the dominant medical culture, submitting to its terms as required while making significant personal and professional sacrifices in order to participate in their profession. Study participants also subverted the dominant medical culture. They imbued an ethic of care and compassion into their medical practice, with an understanding and appreciation for the relational and bringing feminine

consciousness to their work. In their career transitions, they mourned the loss of relationship and human touch in their medical practice through the drudgery of electronic medical records technology and other system changes they perceived as altering a vocation to merely a career.

Study participants were in strong positions moving in, through, and out of their anticipated transitions, with ample resources in all four components of the 4 S model. Career transitions were based on commitment to spouse and family and a desire to continue meaningful work found in their calling as caregivers. Control of schedule and self-determination about work were key factors in study participants' career transitions. Continuity of identity and role loss influenced transitions where all had pre-bridging strategies that helped mitigate transition effects. All found ways to retain a connection to medicine, even after retiring from clinical practice, although in one case not lasting. Study participants bridging to retirement and those retired were most affected by anxiety about and actual role loss. Some experienced being marginalized due to role loss, which led to sadness. Those still working were focused on transitions to work indefinitely; a means to avert role loss. Their transitions were also aimed at continuing work at a slower pace and demonstrated that, even in high intensity work, there are transition pathway options for full-time employment. The desire for authenticity, introspection, and the inner work of individuation were associated with higher age rather than retirement status.

My study findings support calls for structured, institutionalized policies and processes that facilitate third age pediatricians' career transitions where they can continue

doing meaningful work, compensated or uncompensated, connected to their profession (Hall, 2005, 2013; Silver, et al., 2016). Temporal flexibility and self-determination that support work and family life balance are important elements for these considerations, as is the role of social convoy. There should also be a better road map for the transition to retirement journey including formal acknowledgement and closure in making career transitions to retirement. My findings also support the imperative to do more to integrate feminine consciousness into medical education and medical practice.

I. INTRODUCTION

The baby boomer generation which transformed the US when they came of age in the 1960s is transforming it again. With the first wave of 3.2 million boomers who turned 65 in 2011 (Ortman, Velkoff, & Hogan, 2014), the very meaning of aging is being redefined. In 2014, life expectancy in the US for the total population was 78.8 years—81.2 for women and 76.4 for men with more than a year's gain for each gender between 2004-2014 (U.S. Department of Health and Human Services, 2015). With people living longer and in better health, a new phase of life has been identified, the third age—defined as a middle period between midlife and old age (Freedman, 2011), generated by this longevity revolution, with newfound opportunities for development and creating a "fresh map of life" (Laslett, 1991, p. xiii).

Along with the U.S. population, the nation's supply of physicians is aging. Forty percent of physicians in active practice are over age 55 (Association of American Medical Colleges [AAMC], 2012). There are concerns about physician shortages with the increase in physicians retiring at the same time an estimated 36 million Baby Boomers are entering the Medicare program and an estimated 30 million people, including children, are receiving care under the Affordable Care Act (Conde, 2012; Nusbaum, 2009). Concerns about a diminishing workforce extend to pediatricians with 39.2% of active practice pediatricians aged 55 and older (AAMC, 2014). Reports indicate that the supply of pediatric subspecialists is inadequate to meet the health needs of children (American Academy of Pediatrics [AAP], 2010; Felice, 2011). Furthermore, the mean age of pediatric subspecialists exceeds 50 years (AAP, 2010). Concerns about the competency of aging physicians have prompted proposals to develop guidelines for

assessing aging physicians (AMA, 2015), which if enacted, could further diminish the workforce. Given the potential for unwarranted elimination of higher-aged physicians, others advocate that, rather than isolating aging physicians, acceptable standards should be developed that can be applied to all physicians, regardless of age (Kupfer, 2016).

Women are a force in pediatrics. As a specialty, pediatrics has the third largest number of active physicians (56,262) and highest percentage of females (60.4%) compared to the 32.6% of active physicians overall (AAMC, 2014). This feminization of pediatrics continues, with females comprising 72.7% of the graduate medical education residents and fellows in accredited U.S. pediatric training programs in 2010 (AAMC, 2012). Pediatricians spend seven years in medical training to be eligible for board certification in general pediatrics, with an additional three to five years to pursue subspecialty training. Following their training, pediatricians in general pediatrics may work in private practice or in a federally qualified community health center providing care to indigent children. They may also work in academic medicine, in association with an academic medical center where they provide patient care, teach medical students and physicians-in-training, conduct research, and serve in leadership roles within their profession and communities. Similarly, subspecialty pediatricians, with specialized training in one of 14 disciplines (American Board of Pediatrics [ABP], 2015), may work in a private practice or in academic medicine. During their careers, pediatricians may choose to move from one type of medical practice to another, such as moving from private practice into academic medicine or they may spend their entire careers within one type of medical practice. Throughout their careers, pediatricians must maintain

knowledge and skills through on-going continuing education and high stakes examinations for license renewal.

Having spent their careers caring for our nation's children, women pediatricians of the third age are at a crossroads. A survey of pediatricians, ages 50 and older, found compared with men, women pediatricians were more likely to work part-time, less likely to work past age 65, and more likely to cite poor health and family responsibilities as reasons for retirement (Merline, Cull, Mulvey, & Katcher, 2010). Another study involving interviews of professional women found professionals tend to base their retirement decisions on pension eligibility and health (Price, 2002). A survey of U.S. and Canadian pediatricians over age 65 and department chairs of pediatric academic institutions found that survey respondents were interested in continuing to use their skills, although their skills were often not used due to institutional constraints (Hall, 2005). The author proposed actions to address unused potential, later lamenting the lack of progress and the "unbelievable waste of human capital . . . because of ageism, lack of planning, and inflexibility within systems" (Hall, 2013, p. 108).

Labor force participation rates for older employees have increased in recent years with projections that 38.1% of women age 55 and over will be employed in the U.S. workforce in 2016 (August, 2011). Despite this increased later life employment, there is "remarkably little empirical information about employment experiences in this demographic group" (August, 2011, p. 209). Much of the literature on late career and retirement is still dominated by traditional linear career stage models emphasizing environmental stability with hierarchical assumptions (Arthur & Rousseau, 1996; Sullivan & Crocitto, 2007) and has been based on male-only samples or gender-

comparison research which often assumes women's retirement resembles the male experience (Price, 2002). The emphasis on linear career stage models has its roots in adult developmental psychology, with an orientation toward the individual and much of the original research focused on studies of men (Sullivan & Crocitto, 2007).

Other researchers have noted that career research is still dominated by positivism with scant empirical research applying qualitative methods (Frost, 2012; Sinisalo & Komulainen, 2008). The topic of major work life transitions is under researched (Ebberwein, Krieshok, Ulven, & Prosser, 2004; Sullivan & Baruch, 2009), including research on contemplation of work transitions (Klag, Jansen, & Lee, 2015). Relevant literature about older physicians transitioning to retirement is also limited, with a broad orientation toward policy without a gender focus (Hall, 2013; Moss, et al., 2013; Nusbaum, 2009; Sanders, et al., 2010; Spector, et al., 2014). Career research in the US has been conducted primarily through quantitative survey methods (Kojola & Moen, 2016; Lees, Liss, Cohen, Kvale, & Ostwald, 2001; Merline, et al., 2010; Price, 2000; Stearns, Everard, Gjerde, Stearns, & Shore, 2013) with very little specific to pediatricians (Merline, et al., 2010; Hall, 2005), although there is growing interest in the topic (Dewey, Swiggart, Samenow, & Williams, 2014; Peters, et al., 2013; Silver, Pang, & Williams, 2015).

Research Problem

The overarching research problem is the need to know how third age women pediatricians experience career transitions, including retirement. If the reasons for third age women pediatricians' decisions to remain or leave the workforce are understood better and supports provided, perhaps steps toward addressing physician shortages could

be made. More importantly, I believe, with a deeper understanding of the decisions these women are considering and making about work life plans and the contexts within which choices are made, in their own voices, they can be aided in making transitions in the "fresh map" that lies ahead; transitions to help them flourish in the third age and beyond, finding generative (Erikson & Erikson, 1998) and meaningful ways to continue to use their talents and foster development. Such an understanding also holds the possibility of benefitting not only women pediatricians of the third age but their peers in other medical specialties, younger women pediatricians, other professional women of all ages and, ultimately, our nation which stands to lose a vital resource--highly educated and experienced women physicians who, having contributed greatly to the welfare of society, still have much to offer.

Purpose of the Study

The purpose of this study was to explore how third age women pediatricians consider and experience career transitions, including, but not limited to, retirement transition, and how career transitions influence career and personal development.

Research Questions

For the study, my research questions were:

(1) How do third age women pediatricians experience late career transitions, including retirement?

(2) What are their considerations in making a career transition? What past experiences and future aspirations have informed their thinking?

(3) How do third age women pediatricians describe and view the effects of career transitions on their continued development and life transitions?

Researcher's Perspective

I have worked in academic pediatrics for the past 18 years, in several cases, collaborating with some of the study participants I propose to interview. In fact, most of my 32-year career in public health and academic medicine has involved working directly with physicians and physician organizations in the role of project administrator and educator. As a woman in the third age, I feel a kinship with and empathy for the women I plan to study, in terms of age and gender issues. I admire this cohort of women who attended medical school when women were not particularly welcomed and who have managed to maintain their compassion in what has increasingly become a dehumanized, highly technical profession. As pediatricians, they help keep children well and have saved children's lives. They have also provided palliative care to dying children, consoled their grieving families, and grieved with them. They have advocated passionately for policies and practices that support children and their families, as evidenced in work decrying maltreatment of the recent massive influx of undocumented children fleeing for their lives from their home countries such as Guatemala, El Salvador, and Mexico (Griffin, Son, & Shapleigh, 2014). And they have done this work for years. I am not alone in appreciating what a special group women pediatricians are. Parents surveyed tend to prefer female pediatricians, a preference attributed to the manner in which they interact with families, noted in multiple studies over several decades (Spector, et al., 2014). Studies indicate women pediatricians spend more time with patients; engage in significantly more active partnership behaviors, positive talk, psychosocial counseling, and emotionally focused talk; provide more encouragement, reassurance, and social exchange, and are more likely to gather information directly from children

(Bernzweig, Takayama, Phibbs, Lewis, & Pantell, 1997; Roter & Hall, 2004; Roter, Hall, & Aoki, 2002). I believe my deep understanding of the work of women pediatricians and my relationships, professional and personal, with them will benefit my research, as long as I maintain awareness of my subjectivities.

Definition of Key Terms

Archetype: A concept derived from the repeated observation that motifs pervasive in the myths of world literature appear in the fantasies, dreams, and delusions of individuals (e.g. hero; crone). The archetype itself is an "irrepresentable unconscious, pre-existent form that seems to be part of the inherited psyche and can therefore manifest itself spontaneously anywhere, anytime" (Jung, 1963, p. 380).

Bridge employment: Work that bridges between full-time work and retirement, before fully retiring (Cahill, Giandrea, & Quinn, 2006).

Career: A construct involving an individual's development and learning and work throughout life (Collin, 2007; Collin & Watts, 1996).

Pediatrician: A medical doctor who treats children. Practicing pediatricians have completed a three-year residency, focusing their training in specific knowledge and skills about treating children, from infants to young adults. Until they have passed an initial certification exam given by the American Board of Pediatrics, they cannot call themselves a board-certified pediatrician. After their initial certification, pediatricians are enrolled in the Maintenance of Certification (MOC) program. This is a five-year cycle of learning activities designed to help pediatricians enhance their knowledge in general or subspecialty pediatrics. The

certification program requires that pediatricians actively engage in ways to apply this knowledge by improving their own practice. In addition, every 10 years, pediatricians are required to take another examination to re-test their knowledge and medical judgment. Pediatricians who were board certified in 1988 or before are "grandfathered" and technically exempted from MOC programs (ABP, 2015).

Reflexivity: Researchers' self-conscious awareness of their subjectivities in relation to the research participants and research topic (Roulston, 2010). "Critical reflection on how a researcher, research participants, a setting, and a phenomenon of interest interact and influence each other" (Glesne, 2011, p. 284).

Subjectivities: Assumptions, attitudes, preferences, thoughts, etc., stemming from circumstances of one's personal history and values, to be systematically sought and openly acknowledged (Peshkin, 1988), in order that researchers can "learn about the particular subset of personal qualities that contact with their research phenomenon has released" (p. 17). Subjectivity is an integral part of interpretivist research, from deciding on the research topic to selecting frames of analysis. (Glesne, 2011).

Third Age: Middle period between midlife and old age (Laslett, 1991; Freedman, 2011); the period between ages 50-74 (Jarvis, 2001). Laslett (1991) notes that the third age is a phrase of French origin, associated with the lifelong learning academies called the *Université du Troisiéme Age* which were instituted in France in the 1970s. The phrase "entered Anglo-Saxon vocabulary when the first British Universities of the Third Age was founded at Cambridge in the summer of 1981" (Freedman, 2011, p. 3).

Transition: A change in assumptions about oneself and the world, precipitated by an event or nonevent, which requires a corresponding change in one's behavior and relationships (Schlossberg, 1981). Any event or nonevent that results in changed assumptions, relationships, roles, and routines (Anderson, Goodman, & Schlossberg, 2012).

II. LITERATURE REVIEW

Over the past 40 years, spanning the work lives of third age women, there have been dramatic societal changes. The same women who were redefining societal gender roles in the 1960s and 1970s, completing their education with the intent of combining career and family, are still in the process of self-invention. For many women, this can be a dynamic period with more time, freedom, and flexibility to develop new interests, roles, and identity (Lear, 2013). With few role models for what the future holds, women in this group are making it up as they go along, as they have all their lives (Bolen, 2003; Griggs & Wright, 2001; Moen & Spencer, 2006).

The third age has been defined as a period between ages 50-74 (Jarvis, 2001) and the span between retirement age and the onset of age-imposed limitations (Rubinstein, 2002). Many third age adults are looking for what comes next as they anticipate living longer and carving out a life in retirement that holds unique opportunities for meaning (Schlossberg, 2009). It is an opportunity for personal growth, self-discovery, creativity, and the acquisition of wisdom (Dittmann-Kohli & Jopp, 2007). Others need or want to continue working (Morrow-Howell, 2012) and those with an interest in new careers want options that quickly transition them to new opportunities (American Council on Education, 2007). Moen and Spencer (2006) observed that the traditional occupational blueprint of careers and life course are at odds with the emergence of the third age, yet people in the third age, bring with them existing disparities and outmoded gender and age scripts. Despite a shift in social mores and values, structural changes in organizations are slow (Moen, Kelly, & Magennis, 2009).

In order to understand the context of the careers and career transitions of third age women pediatricians, this literature review is organized into three sections: (a) professional women's careers in the third age with subheadings of milieu of professional women's careers, ageism and women's careers in later life, and the careers of third age women pediatricians; (b) adult development with subheadings of overview of development theories, women's development, the intersection of developmental theories and women's career development; and (c) career transition with subheadings of transition theories and models, retirement transition, and physician retirement transition.

There is no general agreement on a common definition of career (Greenhaus, Callanan, & DiRenzo, 2008). From a social constructionist perspective, career is a construct involving an individual's development and learning and work throughout life (Collin, 2007; Collin & Watts, 1996). Based on an extensive literature review, Sullivan and Baruch (2009) defined career as "an individual's work-related and other relevant experiences, both inside and outside of organizations, that form a unique pattern over the individual's life span" (p. 1543). The authors asserted that this definition recognizes physical movements within and across jobs, occupations, and industries; how individuals perceive career events, alternatives, and outcomes; and the influence of context in terms of environmental factors such as the culture and economy and personal factors such as relationships. Similarly, in this review, career is an overarching construct.

Women's Careers in the Third Age

Milieu of Professional Women's Careers

Although there is a unique pattern to an individual's career, broad career patterns have also been described. In discussing women's careers in the 21st century, O'Neil,

Hopkins, and Bilimoria (2008) outlined the etiology of gender disparities and outmoded scripts in four patterns and associated paradoxes in women's careers. The first pattern is that women's careers are embedded in women's larger-life contexts. The paradox is that careers are still evaluated and rewarded based on the traditional male-oriented model of continuous employment and single-minded focus on work. Women's career histories tend to be relational and non-traditional, characterized by various career interruptions that require attention to non-work needs and consequent fragmentation (Mainiero & Sullivan, 2005). A second pattern is that families and careers are central to women's lives, described in a robust body of literature on work-family conflict, chiefly focused on parenting, and work-life balance. There is evidence that many women at mid-life have ''rebalanced'' their lives to focus more on family, personal interests, and relationships (Gordon, Beatty, & Whelan-Berry, 2002, p. 333). Yet this comes at a cost. Some women of the third age are finding themselves responsible for aging parents, adult children, and grandchildren. They face mounting financial and emotional burdens as they split their time between work and caring for their grandchildren, adult children, and their own parents (Abramson, 2015; Finnegan, 2015; Wolf, 2006). The paradox is that families continue to be liabilities to women's career development in organizations. A third pattern is that women's careers reflect a wide range and variety of trajectories—upwardly mobile, downward, lateral, transitory or static (Huang & Sverke, 2007). Women are more likely to be involved in unpaid voluntary work or informal care, such as care of ill or disabled family. Their attachment to the formal labor market is looser than men's, a pattern that seems to continue beyond retirement (Duberley, Carmichael, & Szmigin, 2014). The paradox is that organizations predominantly organize for and reward

upwardly mobile career paths. The fourth pattern is that human and social capital are critical factors for women's career development. Human capital often depends on social capital of networks. The paradox is that women's actions that strengthen an organization's social infrastructure through collaboration and teamwork do not result in rewards or recognition.

Moen and Spencer (2006) noted that educational, labor market, retirement, and other social policies of the mid-twentieth century standardized an "age-graded, lock-step life course" (p. 138) with consequences for women's well-being in the third age. Various career interruptions in women's relational, non-traditional career paths are associated with a lifetime of cumulative disadvantages (Mainiero & Sullivan, 2005; Moen et al., 2009; O'Neil, et al., 2008). When, for example, women take time out from work to raise children, an immediate consequence is loss of salary, but long-term consequences include reduced access to or lower pay outs from public pensions, private pensions, and savings. Thus, disadvantages accumulate across the life course, generating even greater inequalities in old age. Career advantages and disadvantages are not randomly distributed; they are linked to gender, race, class, and marital status (Elman & O'Rand, 2004; Settersten, 2003).

One of the major changes in understanding of career has been the shift from the traditional, organizationally-based one life, one career model to what has been referred to as the protean career where individuals are their own agents who can no longer rely on the contract of stable employment within organizations (Duberly, et al., 2014; Hall & Mirvis, 1996; Mayrhofer, Meyer, & Steyrer, 2007). A related construct is the boundary-less career, defined as the opportunity beyond the boundary of a single employer. An

individual is independent rather than dependent on a traditional organizational career arrangement (Arthur & Rousseau, 1996; Sullivan & Arthur, 2006). The shift to alternative understandings of career has been driven by a change in the career contract, the tacit understanding between employee and employer, caused by global economics and major job losses in manufacturing and restructuring with permanent cuts and labor needs filled with overtime and contingent staffing (Hall & Mirvis, 1995; Sullivan & Baruch, 2009). The advantages of a self-based career for older workers, including women, are the flexibility and new ways to think about time and work space. Some of the disadvantages are learning to deal with freedom of choice, potential loss of social interaction working as an independent contractor, and loss of health benefits associated with working for an organization (Hall & Mirvis, 1995).

Ageism and Women's Careers in Later Life

The narrative of aging in America relies on the "D words" — difficulty, decline, deterioration, disease, disengagement, dependency (Sadler & Kreft, 2007). Ageism, or the devaluation of aging as a relentless period of decline, is often due to fear of what lies ahead, when, in reality, psychological and spiritual growth, learning, and creativity are independent of age and often continue until very old age (Corbett, 2013). "Much of the accepted account of age and ageing is simply the persistence into our own time of perceptions belonging to the past" (Laslett, 1991, p. 2).

There is a tendency to present information that treats older adults as a single population, although functional limitations and need for support services occur mainly in those over age 80. Thus, aggregating older adults into one group leads to inaccuracies that reinforce stereotypes and perpetuate myths about aging (Morrow-Howell, 2012).

Age biases, such as the common myths that older workers are less productive and more difficult to train than younger workers, is a serious problem and impediment to the development of workers (Casio, 2007; Rothenberg & Gardener, 2011). Studies indicate many employers are influenced by stereotypical views that older workers increase health care costs, resist new assignments, and are not suitable for retraining (Hardy, 2006; Mott, 2006). Older women workers face particular challenges when it comes to training opportunities and advancement in the workplace, with most opportunities targeted to upper-level professional male employees (Mott, 2006). Yet, positive traits have been associated with older workers, including low turnover and absenteeism, strong motivation, good work attitudes and skills, and loyalty to employer (Barth, McNaught, & Rizzi, 1993; Grossman, 2013; Hassell & Perrewe, 1995).

Most people retain mental competence with normal aging and in most jobs, there is not a requirement for maximum mental or physical performance (Sterns & Huyck, 2001). A meta-analysis of 418 empirical studies examined the relationships of age to 39 variables representing the content domain of six stereotypes of older workers as: a) less motivated, (b) generally less willing to participate in training and career development, (c) more resistant and less willing to change, (d) less trusting, (e) less healthy, and (f) more vulnerable to work-family imbalance. Researchers found that the only stereotype consistent with empirical evidence was that older workers are less willing to participate in training and career development activities (Ng & Feldman, 2012).

Neugarten (1976) proposed distinguishing between young-old (65-75), the old-old (75-85), and the oldest of the old (85 and beyond) in researching the elderly. Most of the studies on aging have involved old-old women and men who were institutionalized and

often suffered from depression (Lieblich, 2014), very different from the active, healthy, young-old and those old-old who defy the conventional understanding of *elderly*. Many older adult women view themselves as late-middle-aged, have excellent health and cognitive abilities (Cervone, Artistico, & Berry, 2006; Eisen, 2005; Wolf, 2009) and are still working or actively looking for work (Fideler, 2012). In fact, the fastest-growing cohort by rate of increase in the paid workforce is women ages 65 and older, greater than any other group (U.S. Department of Labor, 2008, 2014). Their presence in the workforce may be due to a variety of reasons, such as financial and familial reasons, the need for health insurance coverage or because they enjoy their work (Fideler, 2012). The civilian, non-institutional population of women in the 55-years-and-older cohort was 6.5 million more than men in 2010 and is expected to be 7.2 million more in 2020 (Toossi, 2012), so, as the population shifts to higher age groups, the population of older women will increase at a considerably higher rate than that of older men. In 2020, the entirety of the huge baby boomer generation will be older than 55 years with its older age cohorts making up a much larger share of both the population and the labor force (Toossi, 2012). The increased interest in workforce age-related issues also reflects concerns about demands of the aging population on welfare systems and the expectation that older people need to remain economically self-sufficient longer (Tomlinson & Colgan, 2014).

Gerotranscendence theory (GT) adopts the premise that change and development occur throughout the life course. The theoretical tenets of GT are that human aging is characterized by shifts of emphasis and redefinitions of the self and social relations throughout the life course (Tornstam, 1999, 2011). This process of shifting and redefining involves the development of a deeper relationship with the self, a discovery of

both good and bad aspects, and a decrease in self-centeredness. Social relations also shift and are characterized by selective investment (Kluge, 2007).

Careers of Third Age Women Pediatricians

The 50-year career trajectory for baby boomer (born 1941-1960) pediatricians has been framed as: ten years of training; ten years of becoming established within the community, a tertiary (specialty) care center, or a university academic center; ten years involved in the profession, the community, and various organizations; ten years of additional responsibilities that come with leadership such as mentoring, advocacy, and professional association work; and ten years of "winding down" or "shifting gears" (Spector, et al., 2014, p. 1119). It is a big assumption that the last 10 years of a pediatrician's career actually involve winding down or shifting gears.

Women pediatricians have trained and practiced within a historically androcentric work environment, whether in academic medicine, private practice, or public health care settings. Their careers, and those of other women physicians, reflect many of the same patterns and disparities experienced by other women working within a hierarchical structure that rewards continuous employment, upward career mobility, and single-minded focus on work. When they were in early and midcareer, they faced a difficult work environment (Frank, McMurray, Linzer, & Elon, 1999) that included sexual and gender-based harassment (Frank, Brogan, & Schiffman, 1998; Nora, 1996), isolation and hostile climate (Fried, et al., 1996), barriers to academic advancement (Kaplan, et al., 1996; Tesch, Wood, Helwig, & Nattinger, 1995), and pay inequities (Kehrer, 1976; McMurray, et al., 2000). They also experienced stress related to work-family conflicts (Gross, 1992; Levinson, Tolle, & Lewis, 1989). Research suggests that these conflicts

may not in and of themselves be a major source of excess burnout among female physicians. Instead, burnout appears to have more to do with implicitly different gender-related work expectations from patients, colleagues, and other sources. Extra stress arises from the greater time and effort being expected of women physicians in communicating with their patients on psychosocial and health maintenance issues (McMurray, et al., 2000). Multiple roles might actually mitigate stress among women physicians (Ducker, 1994; McMurray, et al., 2000).

Although there has been progress, disparities persist. In their study of gender discrimination in academic medical careers, Carr, Szalacha, Barnett, Caswell, and Inui (2003), reported that "the hierarchical structure in academe is perceived to work against women because there are so few women at the top" (p. 1012), with hierarchy as a barrier to advancement for women in academic medicine subsequently reconfirmed in a study of five disparate U.S. medical schools (Conrad, et al., 2010). In 2011, women comprised only 14% of department chairs and 12% of deans of U.S. medical schools, despite holding 54% of instructor and 43% of assistant professor positions (AAMC, 2012). For pediatrics, gender equity in leadership roles over the last decade has improved, although, for example, women pediatricians still hold a minority of the departmental chairs in U.S. medical schools (Stanton, Felice, Marshall, & Sectish, 2011).

Other disparities concerning for women physicians, including pediatricians, have also been documented. Sexual harassment has persisted in medical training despite increased numbers of women in medicine and institutional policies discouraging harassment (Hinze, 2004). Findings from a national study of academic medicine faculty indicated inadequate progress for women in academic medicine associated with gender

climate, lack of parity in rank and leadership, lack of retention in academic medicine, inequity in compensation, and a disproportionate burden of family responsibilities and work-life balance on women's career progression (Carr, Gunn, Kaplan, Raj, & Freund, 2015).

In urging consideration for part-time work as an option, it was noted that many women physicians, like the rest of society, experience the stress of the sandwich generation, with eldercare typically becoming the woman's responsibility (Bowman, Frank, & Allen, 2002; Women Chairs of the Association of Medical School Pediatric Departments, 2007). The pay gap between women and men physicians has not changed since the 1980s (Ash, Carr, Goldstein, & Friedman, 2004; Heyl, 2004; Seabury, Chandra, & Jena, 2013). Some research has demonstrated that the pay gap is actually getting worse. In 2008, male physicians newly trained in New York State made on average $16,819 more than newly trained female physicians, compared to a $3,600 difference in 1999, a significant gender gap, trending toward more divergence over time, which cannot be explained by specialty choice, practice setting, work hours, or other characteristics (Lo Sasso, Richards, Chou, & Gerber, 2011). In a multi-year survey of physicians between 1997-2005, Esteves-Sorenson and Snyder (2012) found male physicians earned more than female physicians by 13% at the start of their careers increasing to a 28% gap eight years later. Furthermore, pediatrics is one of the lowest compensated medical specialties (Felice, 2011). Yet, pediatricians have high job satisfaction rates (Anderson, et al., 2003; Massachusetts Medical Society, 2012). Among older pediatricians, women and men, the most commonly cited reason for remaining active in medicine is career satisfaction (Merline, et al., 2010). Career satisfaction may contribute to the statistic that life

expectancy of all physicians is 73 years compared with 81.2 years for pediatricians (Frank, Biola, & Burnett, 2000; Steele, 2015).

Adult Development

Four Perspectives of Adult Development

Development is generally associated with movement in a positive direction and is understood as more encompassing than maturation (Smith & Taylor, 2010). Within the field of adult development, there are multiple theories with no single theory fully explicating the nature and process of development. Four perspectives of adult development that have been outlined include: biological, psychological, sociocultural, and integrative (Merriam, Caffarella, & Baumgartner, 2007).

Biological perspective. The biological perspective acknowledges that physiological changes are driven by both primary aging and secondary aging associated with the environment, personal health habits, or by an accident or disease process (Clark & Caffarella, 1999; Hansman & Mott, 2010). In terms of primary aging, data suggest a major role of DNA damage in longevity, possibly through cell dysfunction and loss (Freitas & de Magalhães, 2011). Biological aging involves "wear-and-tear as well as the accumulation of errors in genetic replication and repair" (Baltes, Staudinger, & Lindenberger, 1999, p. 475). The importance of age and aging is underscored by the recognition that all common complex diseases increase with age (Brooks-Wilson, 2013). Questions remain about whether aging is the cause or effect of such diseases (Hekimi, 2006; Lapointe & Hekimi, 2010). The study of desirable phenotypes like longevity and healthy aging has been referred to as *positive biology* (Farrelly, 2012). Its premise is that understanding the basis for such desirable traits may allow us to design interventions to

improve human health. Positive biology rejects the fixation on pathology and disease in medical research and its negative biology that "presumes health, survival, and happiness are the default states and aims to explain deviations" (p. 186). Longevity studies focus on lifespan and healthy aging studies focus on healthspan. Lifespan and healthspan are intimately related; individuals who live exceptionally long also tend to be healthy for much of their lives (Brooks-Wilson, 2013). Life expectancy has increased due to overcoming problems related to secondary aging (Bee & Bjorklund, 2004). However, the human life span usually given as 110 to 120 years has not increased (Andersen, Sebastiani, Dworkis, Feldman, & Perls, 2012).

Psychological perspective. Psychological theories of development focus on internal processes and the individual's cognitive, moral, identity and/or spiritual development. Most of the work in adult development has been in the psychological tradition, emphasizing the individual's internal development, with much of the research originating in studies of men and little attention paid to society's influence on an individual's development (Merriam, et al., 2007). These early studies involved male academics using their own life experiences to study primarily male subjects similar in race, class, and sexual orientation to themselves and have been critiqued as being too oriented toward the realities of White, middle-class, Western men (Ross-Gordon, 2003). The models that emerged presented linear, age-related stages stereotypically representative of men's lives at the time and values associated with men's development, such as achievement, competition, separation, and autonomy (Treleaven, 1999).

Erikson's (1950/1963) eight stage model of psychosocial development, considered the most influential theory of adult development proposed (Bee & Bjorklund,

2004), represents such a stage-related view of development. His work, inspired by Sigmund Freud (Kegan, 1982), enlarged the picture of the child's task at each of Freud's stages and added three new stages of development in adult years, young adulthood, adulthood, and old age (Crain, 2000). At each stage, there is a crisis or issue to be addressed. In Erikson's model, the eighth stage, old age, involves a crisis of ego integrity versus despair, where individuals come to terms with their lives. Interestingly, a ninth stage was subsequently added by Erikson's wife, who was his co-researcher (Erikson & Erikson, 1998), in which the task is to develop an attitude of retreat in relation to the world and an increasingly spiritual perspective.

Vaillant (1977) conducted a 35-year longitudinal study of male Harvard graduates and later included women in his studies. Building on and supporting Erikson's work, he considered later-stage adult development, beyond what is considered midlife, as a stage that involves being a "Keeper of Meaning" (Vaillant, 2002, p. 141), with an orientation toward justice, community, and creation of social heirs, rather than biological ones. Vaillant noted that with advancing age, sexual differentiation becomes less distinct, driven by hormonal changes and role changes in women and men. Although he proposed gender differences in development, for example, women are better able to develop creativity in retirement than men, in general, both women and men follow the same developmental stages (Sullivan & Crocitto, 2007). Vaillant posited that personal development comes from using adaptive mature coping mechanisms of altruism, creative sublimation, patience, and humor, and suggested evaluating adult development using career criteria of contentment, compensation, competence, and commitment (Sullivan & Crocitto, 2007).

Levinson and his colleagues studied a sample of 40 blue-collar and white-collar men, ages 35-45, to "construct a theory of adult male development over the age span of about 20-45" (Levinson, Darrow, Klein, Levinson, & McKee, 1976, p. 21). The authors went on to elaborate an adult development theory in terms of an age-graded model of men progressing through an orderly sequence of stable and transitional periods in *The Seasons of a Man's Life* (Levinson, et al., 1978). Middle adulthood, ages 40 to 65, is characterized by a reduction in career investments, changes related to retirement and family roles, and evaluation of one's life. Levinson recognized late adulthood as ages 65-80 and late late adulthood as ages 80+ but did not elaborate. Later, women were added to the model (Levinson & Levinson, 1996) but there was no study of women in late adulthood.

Kohlberg (1976) expanded on Piaget's (1932) studies involving moral judgment in his cognitive-developmental theory of children. He established moral reasoning as the basis of ethical behavior and justice the primary characteristic of moral reasoning. Kohlberg's original research involved 72 boys, ages 10, 13, and 16, from both middle- and lower-class families in Chicago. Kohlberg posited six stages in a cognitive-developmental approach, each a progression from the previous stage, and argued that individuals must progress through one stage before reaching the next. Development is a result of increasing competence and the ability to resolve conflicting claims in moral dilemmas; a product of socialization and individuals' thinking about moral problems (Crain, 2000; Kohlberg, 1976). According to Kegan (1982), "Kohlberg's most exciting claim—and if he is right, his most significant contribution—is that by carefully studying the development of persons' moral meaning-making, one can be led to a solution in the

two-thousand-year-old quandary of the relation between the individual and the group" (p. 67). Gilligan (1977, 1982) critiqued Kohlberg's work as excluding women's voices and a perspective of morality that centers on interpersonal relationships and ethics of compassion and care.

Sociocultural perspective. The sociocultural developmental perspective focuses on the social and cultural aspects of adult lives and factors such as race, gender, class, and sexual orientation (Hansman & Mott, 2010; Imel, 2001) and considers historical context essential. A key example is Neugarten's (1976) life events perspective which views time as a three-dimensional phenomenon in the course of the life cycle, intertwining historical time, chronological age, and social time. The individual passes through a socially regulated life cycle involving a succession of age-statuses, each with designated rights and responsibilities. Neugarten (1972) theorized that individuals evaluate their lives not only in terms of present realities such as income, health, and social interaction, but also against an internalized social clock that reflects the socially-created age norms by which individuals gauge how they are doing and whether or not they are on time in the aging process; a theory that has been critiqued as highly deterministic (Marshall & Mueller, 2003).

In studies of large samples of middle-aged and older women and men, Neugarten and her colleagues at the University of Chicago found that with age, men "become more receptive to their own affiliative, nurturant, and sensual promptings; while women seem to become more responsive toward, and less guilty about, their own aggressive, egocentric impulses" (Neugarten, 1964, p. 199). There was also a change from an outer to inner world orientation among older people (Neugarten, 1979). Neugarten asserted that

while themes of adulthood are often described in sequential order, "it is something of a distortion to describe adulthood as a series of discrete and neatly bounded stages, as if adult life were a staircase" (p. 891) and noted that stocktaking and accepting one's successes and failures preoccupy adults, young and old, with psychological preoccupations recurring in new forms over many years. Neugarten emphasized the individual variability of timing in transitions, an "individual fanning out" as people age (Schlossberg, 1989, p. 3).

Integrative perspective. The integrative perspective recognizes the intersections of biological, psychological, and socio-cultural perspectives and the complex role these dimensions have on development (Roberson, 2005). Key theories in the integrative perspective have been framed in terms of life span psychology and life course sociology (Mayer, 2003; Settersten, 2005) and a bioecological model (Bronfenbrenner, 1995). While there is some overlap, in life span psychology, development is viewed as genetically and organically based change in functional capacity and as behavioral adaptation, whereas life course views development as the result of societal and institutional forces (Mayer, 2003). Others have suggested that life course is "a special case of life span psychology" (Baltes, Lindenberger, & Staudinger, 2006, p. 571) and that the distinction is more a matter of pragmatics and history, to wit:

> Scholars closer to the social sciences, the biographical study of lives, and personality psychology display a preference for using the term life course development (e.g., Bühler, 1933; Caspi, 1987; Elder, 1994; Settersten, 2005). Scholars closer to psychology, with its traditional interest in mechanisms and

> processes as well as the decomposition of mind and behavior into its component elements, seem to prefer life span developmental psychology . . . (p. 571)

Baltes (1987) proposed a metatheoretical view of adult development in lifespan psychology, drawing on the work of Neugarten and others (Merriam, et al., 2007). Lifespan psychology is the study of individual development from conception to old age. A core assumption is that development extends across the entire life course and that from conception onward, lifelong adaptive processes of acquisition, maintenance, transformation, and attrition in psychological structures and functions are involved. Lifespan psychologists view the overall development of mind and behavior as dynamic, multidimensional, multifunctional, and nonlinear (Baltes, Staudinger, & Lindenberger, 1999). Their research and theories focus on three components of individual development: (a) interindividual commonalities (regularities) in development, (b) interindividual differences in development, and (c) intraindividual plasticity (malleability) in development. Development involves both growth (gain) and decline (loss) in capacities and skills. As losses occur, adults may adapt or compensate for deficits by, for example, using strategies to enhance memory or practicing a skill (Baltes, 1987; Smith & Taylor, 2010). Lifespan psychology has been critiqued for its focus on the individual and the need to include the complexities of institutions for a more accurate understanding of context (Mayer, 2003).

The theoretical roots of the life course perspective also include Neugarten's work. The chapter, "Age and the Life Course" (Neugarten & Hagestad, 1976) in the first "*Handbook of Aging and the Social Sciences*" (Binstock & Shanas, 1976), "played an important role in codifying a great deal of aging research in life-course terms" (Marshall

& Mueller, 2003, p. 8), emphasizing timing issues, expectations about life-course transitions, cohort differences in role transitions, and the multiple timetables of different societal institutions (Marshall & Mueller, 2003, p. 8).

Life course signifies a sequence of states and events in life domains from birth to death where individual lives are embedded in social structures (Mayer, 2003). It focuses on continuity and change, social structures, and the relationships as contexts for developmental processes and considers the location of the individual at a particular point in historical time when development begins (Elder, 1974, 1981, 1994; Elder, Johnson, & Crosnoe, 2004). Life course study involves understanding the connections of career and family pathways that are subject to changing conditions and future options, and to transitions such as finishing school or retiring. A core premise is that individual developmental processes are influenced by the social trajectories that people follow and vice versa, "there is a reciprocal influence between social and developmental trajectories" (Elder, 1994, p. 5).

The life course perspective offers a framework for studying the dynamics of these interdependent pathways. Elder (1994) outlined four themes central to the life course paradigm. The first theme involves lives and historical times. Differences in birth year expose individuals to different historical worlds such that individual life courses reflect these different times. A second theme is the timing of lives. Social meanings of age bring a temporal, age-graded perspective to social roles and events. Social timing refers to incidence, duration, sequence of roles, and expectations and beliefs based on age. For example, the impact of involvement in a war is different for people who enter service very young without family compared with those who are older with families. A third

theme is linked lives, considered to be the most central theme since people's lives are embedded in relationships with family and friends across the life span. Linked lives refers to the interaction between the individual's social worlds over the life span, including family, friends, and coworkers. The fourth theme is human agency. Within the constraints of their world, individuals make choices among options that create their life course. Individual differences are important in this research, particularly their interaction with changing environments to produce behavioral outcomes. "Selection processes have become increasingly important in understanding life course development and aging" (p. 6). A critique of the life course perspective is that it needs to acknowledge the role of genetics in development in order to overcome a "simple environment-based conception of social forces" (Mayer, 2003, p. 469).

Bronfenbrenner (1995) drew on the life course perspective, reflecting on his own life course in becoming a developmental researcher and has acknowledged that Elder's work on life course development played a significant role in the formulation of the original ecological model and even greater influence on the model's subsequent evolution (Bronfenbrenner & Morris, 2006, p. 796). The first formal definition of the ecological model of human development stated:

> The ecology of human development involves the scientific study of the progressive mutual accommodation between an active, growing human being and the changing properties of the immediate settings in which the developing person lives, as this process is affected by relations between these settings, and by the larger contexts in which the settings are embedded. (Bronfenbrenner, 1979, p. 21, as cited in Bronfenbrenner, 1995)

In proposing a bioecological model involving process-person-context-time as a system, Bronfenbrenner defined development as "stability and change in the biopsychological characteristics of human beings over the life course and across generations" (Bronfenbrenner & Morris, 2006, p. 796) and outlined five nested layers in the environment that influence development: microsystem (activities, social roles, interpersonal relations immediate to the individual), mesosystem (relationships between two or more microsystems), exosystem (larger society systems), macrosystem (cultural values, law), and chronosystem (time).

Women's Development Theories

Gilligan (1977, 1982) studied moral development of women, critiquing Kohlberg's work (and that of other men who theorized about adult development) which found women deficient in development. She noted that women were missing, not only as theorists of human development, but even as research subjects at the formative stages of psychological theory development. For example, Kohlberg developed his stages exclusively from interviews with boys. His stages reflected an androcentric orientation where advanced moral thought deals with rules, rights, and abstract principles. It ignores the female voice in which morality centers on interpersonal relationships and ethics of compassion and care (Crain, 2000). The paradox Gilligan noted in her ground-breaking book, *In a Different Voice* (1982), was that the very qualities which distinguished women's moral goodness, their relational sensitivity and empathic concern, marked them as deficient in development. She concluded that women's response to moral dilemmas tends to differ from that of men. Women make choices in the context of relationships and based on standards of responsibility and caring versus those of rights and justice.

However, although males tend to consider primarily issues of rights and justice, they do contemplate the implications of relationships on moral decisions. Thus sensitivity to relationships appears to be gender-related, not gender specific. Revisiting her work, Gilligan (2011) asked,

> Why is the ethic of care still embattled? What is the academic debate over care vs. justice about? And what is its association with women and more generally with people's lives? I cannot go further in talking about gender—a word I associated with Latin vocabulary—without speaking about its relation to patriarchy, an order of living based upon gender: where being a man means not being a woman and also being on top. The gender binary and hierarchy are the DNA of patriarchy—the building blocks of a patriarchal order. The word "patriarchy" means a hierarchy or rule of priests in which the *hieros*, the priest, is a pater, a father. In a patriarchal family or religion or culture, power and authority descend from a father or fathers, and human qualities designated masculine are privileged over those gendered feminine. By elevating some men over others (separating the men from the boys) and all men over women, patriarchy is an order of domination. But in separating fathers from mothers and daughters and sons, and bifurcating *human* qualities into masculine and feminine, patriarchy also creates rifts in the psyche, dividing everyone from parts of themselves. (p. 2)

Drawing on Gilligan's (1977) and Perry's work (1970), Belenky, Clinchy, Goldberger, and Tarule (1986) explored the lives of 135 women, ages 16-60 years, beginning in the late 1970s. Ninety of the women were students enrolled in one of six academic institutions and 45 were from family agencies dealing with clients seeking

information or assistance with parenting. Before asking a woman to participate, they told her they were interested in learning from her point of view.

Women's perspectives were grouped into five knowledge perspectives, representing different points in women's cognitive development and dependent on conceptions of self, relationship with others, and understanding of authority, truth and knowledge: *silence*, where women experience themselves as mindless and voiceless and subject to external authority; *received knowledge*, where women see themselves able to receive and reproduce knowledge but not create it; *subjective knowledge*, where truth and knowledge are personal, private, and intuited; *procedural knowledge*, a position where women are invested in learning and apply objective procedures for obtaining and communicating knowledge; and *constructed knowledge*, where women view all knowledge as contextual, experience themselves as knowledge creators, and value subjective and objective strategies for knowing (p. 15). In the course of the research, they found that women went through a maturational process of internal and external knowing that resulted in reclamation of authentic voices. This phenomenon was attributed to intensive self-reflection, frequently at midlife and beyond, when women experienced a heightened sense of who they were and how they wanted to be.

Dr. Jean Baker Miller, a psychiatrist, asked why women were seen as non-achieving, noncompetitive, and dependent (Miller, 1976, 1986). She called for a new psychology of women, recognizing differences in women's development. In Baker Miller's (1991) self-in-relation theory of development, a woman's sense of self emerges from experience with the relational process beginning in infancy. Baker Miller suggested that women actively participate in the development of others and identified women's

sensitivity as a strength (Miller, 1986). In the first comprehensive biographical inquiry of Baker Miller's life, Cohn (1997) identified two intertwined aspects, need for affiliation and need for authentic modes of intellectual, creative self-expression. Cohn (1997) theorized that the origins of Baker Miller's theory can be found in her "profound experiences of marginalization that can be traced from childhood onward" (p. iii), including, at the age of 28 and married, being forced to leave her residency training program because she was pregnant. "Just as Jean gained full admission into and ostensibly equal status in the male world, the rug was pulled out from under her—a clear indicator of her subordinate standing and of the tenuousness of her place in the psychosocial order because she is a woman" (p. 356). She also had issues with the intense scrutiny of character deficiencies inherent in the psychoanalytic thinking dominant at the time of her training. Cohn (1997) posited that Baker Miller's life and theory suggest that the needs for affiliation and authentic self-expression are one integrated phenomenon bound to, and defined by, the relational contexts through which development proceeds.

In her research involving narratives of older adult women learners in transition, Wolf (2009) found that women were establishing a post-Levinson stage of life. She contended "we have few maps of their development after midlife," (p. 56), citing Jung, who forged a conception of the entire life cycle (Levinson, et al., 1978) as one of few offering guidance. Jung (1933) gave particular attention to adult development in the second half of life (Levinson, et al., 1978), with movement toward introspection, a search for meaning, and a deepening spiritual life (Corbett, 2013) and expansion beyond gender constraints towards full humanity and wisdom (Baltes & Carstensen, 2000). It is at

midlife when serious attention to individuation, becoming more the person one is and to incarnate one's potential, begins (Jung, 1960). This process involves close attention to dreams and integration of unconscious material into consciousness.

> Consciously or unconsciously, voluntarily or involuntarily, the inner world will claim us and exact its dues. If we go to that realm consciously, it is by our *inner work*: our prayers, meditations, dream work, ceremonies, and Active Imagination. If we try to ignore the inner world, as most of us do, the unconscious will find its way into our lives through pathology: our psychosomatic symptoms, compulsions, depressions, and neuroses. (Johnson, 1986, pp. 10-11)

The journey toward wholeness that is individuation is an integrative process that involves the recognition, acceptance, balance, and synthesis of various opposite aspects of the self—conscious and unconscious, physical and spiritual, masculine and feminine, individual and collective, etc., (Cohn, 1997). It also means coming to terms with the shadow, the unknown, primitive side of personality. Composed of personal and collective psychic elements, often negative but also including creative impulses, the shadow is denied expression because of incompatibility with the person's chosen conscious attitude (Jung, 1959, 1964).

Jung's contributions to adult development have not been fully comprehended or appreciated in adult development and adult education (Donlevy, 1996, p. 93), although there are exceptions. Levinson, et al., (1976) noted "the extensive work of Jungian depth psychology is almost totally ignored by academic disciplines" (p. 21). In writing about their research on the study of men, ages 35-45, they drew on the Jungian (1963) concepts

of the archetypal puer (eternal youth) and senex (wise old man) which in men "play a significant part in the mid-life individuation process" (Levinson, et al., 1976, p. 25).

Dr. Jean Shinoda Bolen, a psychiatrist, Jungian analyst, and activist has chronicled women's development and individuation, based on her research with individual patients and psychoanalytic study, in a number of books, such as *Goddesses in Every Woman* (1984), *Goddesses in Older Women: Archetypes in Women over Fifty* (2001), and *Crones Don't Whine* (2003). She has written extensively about goddess archetypes in Greek and other mythologies and their potential effects on women's lives. Drawing on Jung's work, Bolen distinguished between universal archetypes and those which function within individuals to form their identities.

> Which goddess or goddesses (several may be present at the same time) become activated in any particular woman at a particular time depends on the combined effect of a variety of interacting elements—the woman's predisposition, family and culture, hormones, other people, unchosen circumstances, chosen activities, and stages of life. (Bolen, 1984, p. 26)

In *Goddesses in Older Women* (2001), Bolen discussed crone images in Greek mythology and practical, intellectual, spiritual, intuitive, and meditative wisdoms personified in Greek goddesses. She also described the goddesses of transformative wrath, mirth and bawdy humor, and compassion which often come into full expression in the third age and which need to be balanced and accompanied by wisdom. Women of the third age can tap into energies of transformative wrath, "enough is enough" (p. 78) to be powerful agents of change. Mirth and bawdy humor come with acceptance of bodies growing older and laughing freely, no longer needing to perform or look good for others.

Interestingly, there is no divinity of compassion in Greek mythology. Bolen (2001) looked to Eastern religion and mythology where the goddess of compassion is prominent, though she identified the Virgin Mary and the Statue of Liberty as unrecognized goddesses with maternal compassion for the poor and powerless.

The crone archetype is viewed as a symbol of women's development, not just in old age but across the life course. Like all other archetypes, the crone is a universal symbol representing specific ways of being and knowing. As such, she is a source of understanding and insight (Ray, 2004; Walker, 1995); a "woman who has wisdom, compassion, humor, courage, and vitality. She has a sense of truly being herself, can express what she knows and feels, and take action when needed" (Bolen, 2003, p. 4). Becoming a crone should be "the crowning inner achievement of the third phase of life" (Bolen, 2003, p. 4). Yet, the crone archetype,

> has been stifled in the psyches of men and women (especially men) living in patriarchal cultures, which render the crone invisible or, if she is present, demonize her. The reasons for this negative attitude are obvious: denial of physical weakness and fear of death . . . both are undeniably part of the human experience. (Ray, 2004, p. 112)

In the US, with its youth-oriented patriarchy, becoming an older woman is to become invisible; a non-entity (Bolen, 2001).

Intersection of Developmental Theories and Women's Career Research

The academic literature has deconstructed and redefined the construct of career itself with feminist scholars questioning the adequacy of career theory and research about women beginning in 1989 (Cohen, 2014). Marshall (1989) and Gallos (1989) critiqued

the androcentrism of career research in hopes of transforming ways of thinking about career, career value, and legitimacy and paved the way to a growing body of gender and career research (Cohen, 2014). In career research, Marshall (1989) proposed unifying the split dichotomies of work and life, male and female principles, attributing value to opposites and diversity, and working from a perspective of communion rather than valuing agency only at the expense of other. However, stage and phase theories of adult development continue to dominate career development studies with emphasis on androcentric linear career stage models (Sullivan & Crocitto, 2007), and older women's experiences of working and retirement have received less attention (Armstrong-Stassen & Cameron, 2005; Griggs & Wright, 2001; Wong & Hardy, 2009).

Drawing on the three non-gendered, integrative developmental theories of life span and life course, and informed by earlier work (Moen, 2001; Moen & Han, 2001), Moen et al., (2009) proposed a gendered life course perspective of adult development that intersects career development. They posited that adulthood is a fundamentally different experience for women and men and that most scholars have concluded that gender differences can only be understood through a consideration of "the combination of biological, sociological, economic, organizational and cultural forces as they intersect throughout the life course" (p. 378). The gendered life course can be viewed as a historically constructed and reconstructed institution with rules and regulations associated with age and gender for different cohorts in light of historical events, technological and economic changes, such as the move to a global economy. The authors acknowledged a limitation in their research in that it did not focus on race/ethnicity and class which also shape the gendered life course.

In outlining their theory, they framed the life course themes of time, context, and linked lives in terms of convoys of relationships (social convoys) and convoys of rules and regulations (institutional convoys) and added the constructs of socialization, allocation, and strategic selection which produce and perpetuate gender differences and disparities. Socialization processes in which each new generation is taught, directly or indirectly by example, what is expected for each gender at different ages and life stages; allocation processes which are the structural arrangements and power differences in groups, organizations, and societies that open or close possibilities to women and men; and strategic selection processes in which women and men choose to enter or exit particular roles and relationships and not others at different points in their lives all contribute to gender inequities.

Time has been a key element in scholars' understanding of the life course (Elder, 1974, 1981, 1994; Elder, Johnson, & Crosnoe, 2004; Neugarten, 1976). Age is an indicator of biological changes in physical and cognitive function that sets limits on social behavior. Age and gender constitute "the backbone of key socialization and allocation regimes in adulthood, creating distinctive sets of challenges and limiting the adaptive strategies (strategic selections) of women and men as they move through adulthood" (Moen et al., 2009, p. 380). Gender and age are not just markers, but are biological, social, and historical forces. Women's biology has great significance in terms of child-bearing and impact of life course. Socially, there are expectations and rules around the time, timing, and duration of roles at different ages (Moen & Chesley, 2008; Settersten & Hagestad, 1996), with gender stratification throughout the adult life course. Age and aging serve to widen gender differences and disparities (Moen & Spencer,

2006). Age is also an indicator of birth-cohort membership with different attitudes and options for women and men. Thus, for example, baby boomer women had access to career options in their cohort not experienced by women of earlier cohorts.

Moen et al., (2009) described adult development as a dynamic ecological process of interaction between individuals and psychosocial environments as these change over time. Individuals make strategic selections in and out of roles and relationships while always constrained by social and cultural environments available to them at different ages. They used the concept of social convoy (Kahn & Antonucci, 1980) in discussing the idea of linked lives, broadening the meaning of social convoy to recognize both the supportive and conflicted relationships with family, friends, neighbors, coworkers, and other networks. They remarked that linked lives differ in nature for women and men with "two prevailing ecologies of adult development: 'his' and 'hers'" (Moen et al., 2009, p. 382). In addition to social convoys, the authors posited that institutional convoys, the organizations and institutions with whom individuals are linked, capture the cultural and organizational expectations that open or close options for women and men at different ages in the adult life course. Social and institutional convoys are the sources of on-going socialization processes, with social understanding outpacing institutional convoys. So, for example, while stereotypes about aging may be changing as baby boomers alter perceptions, institutional policies and practices may persist based on ageist ideas about worker capabilities. "Old strategies die hard" (p. 399), with age- and gender-graded institutional arrangements pulling people back into traditional paths divided by age and gender.

With today's social, economic, and technological changes, there is greater variability within and across gender and age in adult life experiences, creating converging divergences (Moen & Altobelli, 2007; Moen & Spencer, 2006). In terms of convergence, both women and men participate in paid work and unpaid family care. There are also shared insecurities over job and income, regardless of type of job or employer. Divergence is a widening of within-gender disparities as a consequence of traditional gendered expectations associated with paid work, families, and adulthood. Moen et al., (2009) theorized that adult development is both converging (across gender) and diverging (within gender categories). They also asserted that the absence of blueprints for contemporary adulthood, while disconcerting, presents opportunities for "individuals, couples, schools, employers, communities, and governments to reimagine and reinvent alternative scripts of the adult experience. Organizations and nations *can* create a range of options for meaningful, productive, and integrative pathways that move beyond the gendered adult course" (p. 402). Noting the growing recognition of the misfit of work and life course demands, Moen (2011) advocated for policy changes around "the tacit, taken-for-granted beliefs, rules, and regulations about the time and timing of work days," so that paid work time is compatible with caregiving and community engagement and there is alignment of job with the life course and opportunities for "second acts" of employment at every stage (p. 92).

Sullivan and Crocitto (2007) posited that Vaillant's ideas of later-stage adult development are applicable to professionals seeking career change, opting out of corporate life or retiring from work but continuing to contribute their talents through community service. Other research has also recognized the importance of considering the

interdependence between different aspects of people's lives: the historical, cultural, and social context of life experiences in addition to particular attributes, current and past statuses, in order to understand how people manage the transition to retirement (Duberly, et al., 2014; Kim & Moen, 2002; Settersten, 2003) and that it is not only the context of origin but the current personal context that frames the career-relevant opportunity structure for individuals (Mayrhofer, Meyer, & Steyrer, 2007). It has also been postulated that work transitions are shaped by social and institutional policies of the context within which they are made, including philosophical assumptions about the locus of responsibility for transition (Fouad & Bynner, 2008).

Career Transitions

Transition Theories, Models, and Research

Career has served as a resource people use to construct their identities (Collin, 2000) and to attribute coherence, continuity, and social meaning to their lives in complex, highly differentiated societies (Sinisalo & Komulainen, 2008; Young & Collin, 2000). Given that career theory encompasses multiple social science disciplines lacking in agreement, yet is a nexus for transdisciplinary study, (Arthur, Hall, & Lawrence, 1989), research on the subject is vast. I have included a few key theories, models, and research relevant to the focus of my research.

Role theory (George & Maddox, 1977; George, 1993) provides one of the most commonly used explanations of adjustment to retirement (Kim & Moen, 2002). Role theory predicts how older people negotiate age-related changes. Successful management of the shifts in activities due to role change and redefinition of roles determine adjustment to age-related changes. Role theory suggests that certain socially prescribed and

personally relevant roles are critical in self-identity (Carter & Cook, 1995). Some research indicates that people who retire from career jobs, where employment is central to identity, including professional women, are vulnerable to feelings of role loss which can lead to psychological distress (Kim & Moen, 2002; Price, 2002; Silver, Pang, & Williams, 2015).

In continuity theory of aging (Atchley, 1989, 1999), middle-aged and older adults attempt to maintain existing internal and external structures by using strategies tied to past experiences of themselves and their social worlds. Change is linked to the individual's perceived past, producing continuity in inner psychological characteristics, as well as in social behavior and social circumstances. Continuity is an adaptive strategy promoted by individual preference and social approval. Continuity theory, an abstract cognitive construct, "assumes evolution, not homeostasis, and this assumption allows change to be integrated into one's prior history without necessarily causing upheaval or disequilibrium. . . it allows the individual to have goals for developmental direction" (Atchley, 1989, p. 183). Atchley argued that older workers who retire need to maintain daily routines and find it difficult to adjust to no structure at all, particularly after working in emotionally involving or fast-paced occupations. In addition, his theory suggests that individuals who have high career identification are likely to seek continuity through some form of work involvement (Kim & Feldman, 2000).

Career transitions in and out of work can have major mental health repercussions, given the centrality of work to human functioning (Fouad & Bynner, 2008; Gallos, 1989; Levinson, 1978). A number of transition models have been used to facilitate career

transitions and mitigate psychological distress. Among these are four models that are prominent in the literature.

Bridges' (2004) transition model begins with endings, letting go of the old, followed by a neutral zone period which may seem as an empty in-between time, "when under the surface transformation is going on" (p. 80). The third, final phase is new beginnings with new ways of being and doing. Change is situational, transition is psychological. "Without a transition, a change is just a rearrangement of the furniture" (p. xii).

Schlossberg's (1981, 1989) transition model distinguished among four types of transition: (1) anticipated, those that are predicted to occur; (2) unanticipated, those not expected; (3) nonevents, those related to unfulfilled personal aspirations and (4) sleeper, those that go unnoticed and gradually culminate in change where we realize "our roles, relationships, routines, and assumptions have been altered" (Schossberg, 1989, p. 33). Central to the theory are four major variables in how an individual copes with transition: situation, self, supports, and strategies (Anderson, et al., 2012). Situation refers to the person's situation at the time of transition and whether there are other stresses. For example, retiring at a time when your partner becomes critically ill would complicate retirement transition. Self refers to the person's inner strength for coping with the situation. People who are optimistic, resilient, and able to handle ambiguity fare better. "Attitude does not buy groceries, but it can certainly make a difference in the quality of survival" (Schlossberg, 2011, p. 160). Support, such as a support group or understanding colleagues, available during a time of transition is critical to a sense of well-being. Professional associations are an example of support for career transitions. Strategies

refer to coping strategies such as reframing the transition by looking for the opportunities in it.

Sugarman's transition model (1986, 2001), informed by life-span developmental psychology, emphasizes emotional aspects of transition through phases with boundaries which are not always distinct. Transition begins with immobilization or being unable to respond, followed by elation or despair, depending on the event. The "initial post-shock reaction is almost always followed by some form of minimization" (Sugarman, 1986, p. 144) where the person downplays the impact of the event. Minimization is followed by self-doubt which may manifest as anxiety, anger, apathy, or sadness. This phase is followed by letting go of attachments to the past, sometimes very traumatic, but which allows for testing alternatives, followed by search for meaning, and, finally, integration, where the individual is "at home" in the post-transition reality (p. 146).

Ibarra (2005) proposed a career identity transition model with the basic premise that career change entails a corresponding identity change. This identity transition involves a change in an individual's set of possible selves. Possible selves, a construct first introduced by Markus and Nurius (1986), represent individuals' ideas of what they might become, what they hope to become, what they fear becoming, and are influenced by past experiences, sociocultural life context, and current situation. In the first phase of Ibarra's (2005) model, new possible selves are developed and elaborated in three ways: direct action (activities), social interaction (relationships), and sense making (events). The second phase is an in-between, liminal period with separation and disengagement from former identity, but not yet in a fully developed new identity. It is a time of

experimenting with new identities. The third, final phase is defined by a turning point and construction of a transition narrative to explain why the transition occurred.

In their study of Canadian public health physicians, Klag, et al., (2015) characterized the contemplation process of a workplace transition as a thought process embedded within, and impacted by, a broader work and life context. Physicians were recruited at varying stages of development in their thought processes around changing workplaces when they were interviewed. Of 26 physicians in the study, 17 had decided to change work places, two decided to remain, four committed to stay "for the moment" (p. 40) and three were in active contemplation for transition. The researchers used a life history approach (Charmaz, 2006), informed by role exit theory (Ebaugh, 1988), in single interviews with the physicians, lasting an average of 69 minutes. Data analysis was informed by Charmaz's (2006) constructivist grounded theorizing and the concept of spiraling, "where the researcher continually moves both forward and backward to fine-tune the theory at multiple stages, during design, data collection, analysis, and reporting" (Klag, et al., 2015, p. 42). Results of the study indicated evidence as to why single or multiple independent factors, such as pay, may fail to predict or explain individual decisions to remain in or change workplaces. The researchers argued that contemplation of work transition is a complex, evolutionary, and context-dependent enterprise. They noted the prevalence of episodic context-self assessments triggered by either external events, reflecting on several prior events, or a surge of negative affect associated with escalating or ongoing negative situations. External events were distinguishable single events while the other two triggers were cumulative. The researchers noted that the contemplation process involved iterative episodes and identified four characteristic story

lines used to explain manifestation of thought processes: exploring opportunities, solving problems, reconciling incongruence, and escaping situations. Klag, et al., (2015) recommended "story-listening and dialogic conversations to better understand, and potentially affect the evolving socially constructed realities of staff members" (p. 36).

Smith (2009) surveyed 222 adults, ages 50-75, at multiple southeastern U.S. universities, to understand current needs, attitudes, and experiences using career counseling and technology in determining whether to continue work beyond traditional retirement years. For qualitative information, participants were asked to respond to six open-ended questions, two of which related directly back to the research questions. The first of the two questions, "At the current state of your career looking forward, what does 'career development' mean to you?" (p. 127) generated nine themes with the dominant theme being advance, enhance, and improve skills and knowledge. Other themes were career development skills, meaning and life satisfaction, reaching goals, keeping busy, financial needs, slowing down, and looking forward to and planning for retirement. The second question, "What challenges do you currently face (or expect to face) in achieving your future career development goals" generated 12 themes with the dominant themes being the down economy and time issues (too busy to work on career development). Other themes included lack of funds for additional education, professional development, or to retire; age discrimination; lack of career planning knowledge and skills; insufficient skills or educational background to continue working or change careers; health concerns and physical limitation in maintaining or continuing work; lack of positions in the field of interest, glass ceiling; work/family life balance issues; fear of job elimination/uncertain future; and lack of motivation in pursuing career development.

Retirement transition. Retirement is a social construction (Phillipson, 1998), an invention of the late 19th century that did not reach full maturity until after the Second World War when government and corporate pension plans became common, along with well-defined retirement ages (Sargent, Lee, Martin, & Zikic, 2012). In the 1960s and 1970s, retirement at a particular chronological age was the norm. In the 1970s/1980s, early retirement was used to conceal the unemployment of the older workforce. In the 21st century, older employees are being pressured by economic circumstances to remain in the workforce longer (Davies & Jenkins, 2013). Loosened from institutional schedules, retirement as a fixed life course stage has changed with increasing variability in late career employment patterns in terms of timing, permanency, and duration of the retirement life course (Warner, Hayward, & Hardy, 2010). Retirement is increasingly viewed as a transition within midlife, rather than from midlife (Kim & Moen, 2001). Individual differences in attitudes and preferences in work-to-retirement are not met with effective models of retirement by employers (Davies & Jenkins, 2013).

Transition to retirement is no longer a straightforward process but can include transitions not only in the work role, but also in terms of personal, income, family, and other transitions. Feldman (2007) posited that much of the literature on retirement transition has addressed four questions in detail: (1) what factors enter into the decision to retire? (2) when will individuals be most likely to accept organizations' offers of early retirement incentives? (3) when will individuals accept bridge employment? and (4) what factors determine adjustment to retirement? In general, the decision to retire is made in two stages. First, feasibility of retirement from a financial standpoint is assessed, followed by a determination of whether quality of life would be enhanced or worsened

leaving the workforce. Other researchers have noted that decisions about retirement are influenced by a variety of personal and contextual factors beyond financial status such as health problems, reduced job attachment, anxiety about leaving the workplace, perceptions of retirement as uninteresting, relationships and differing expectations (Gee & Baillie, 1999; Vickerstaff, 2006). Four modes of thinking about retirement identified by Hornstein & Wapner (1985) and discussed elsewhere (Davies & Jenkins, 2013; Gee & Baillie, 1999; Jarvis, 2001), include transition to old age and rest, a new beginning, continuation where retirement in itself does not constitute a critical psychological transition, and imposed disruption.

Research on the retirement process in the US indicates a majority of workers shift to bridge employment, work that bridges between full-time work and retirement, before fully retiring and that it is most common in low wage workers, presumably for economic reasons, and high wage workers, presumably for quality of life related to workforce participation (Cahill, Giandrea, & Quinn, 2006), although there is evidence that this is less common among physicians (Farley, Kramer, & Watkins-Castillo, 2008). Using continuity theory to study bridge employment, Kim and Feldman (2000) found that bridge employment was strongly related to both retirement satisfaction and overall life satisfaction. Volunteer work and leisure activity complemented bridge employment in facilitating adjustment to retirement. Age and salary were inversely related to accepting bridge employment.

Johnson (2012) studied the relationship between retirement expectations and attention to daily experiences in a sample of 17 participants selected from a population of U.S. individuals, nine women and eight men, ages 55-68, planning to retire within the

next two years. All participants were in management or professional positions. Finances, health, and time were identified as meta-themes permeating four other major themes of freedom, vitality, people and relationships, and engaging in rewarding activities. Each of these themes involved expectations of positive changes, as well as adjustments and challenges. Subthemes of freedom were freedom from work, flexibility and personal choice, and adjustment to new structure; subthemes of vitality were enjoying life and coping with aging; subthemes for people and relationships were time with family and friends, adjustment to time with spouse, and loss of interactions at work; subthemes for engaging in rewarding activities were time to pursue personal interests and loss of work satisfaction.

Davies and Jenkins (2013) researched individual attitudes and experiences of the work-retirement transition for older academics in the life course in a qualitative study based on interviews with 32 academic staff at ten universities in England. They categorized data into five groups that reflected the different meanings of work-to-retirement. *Clean breakers* viewed retirement as a welcome release from work. *Opportunists* and *continuing scholars* used retirement to renegotiate the employment relationship. *Reluctants* considered retirement as a loss of a valued source of identity. *Avoiders* were undecided about retirement plans.

Duberly, et al., (2014) studied British women's views and experiences of retirement. Many study participants had difficulty deciding whether or not they were retired, either viewing it in terms of a continuity of roles or change to different types of paid work or discontinued employment. Choice was not the only predictor of career trajectories. One of the biggest factors that differentiated experiences of interviewees

was financial security. The researchers noted that any understanding of women's retirement experiences needs to take account of current context and previous employment experiences and suggested "further developing the life course perspective" (p. 86) using qualitative techniques and more in-depth examination of the linkage between women's career histories and their experiences of retirement. Warner, et al., (2010) also suggested future research should apply a gendered life course perspective, noting that despite the fact that older women increasingly have significant work histories, women's work experiences and thus retirement experiences, differ from men's given that they unfold in a gendered context (Moen, 2001; Moen & Han, 2001).

Physician retirement transition. Pediatricians ages 65 and older expect to retire at age 71 (Spector, et al., 2014). Given the time and effort dedicated to training and a high level of career satisfaction, a 35-year career may not be long enough. Furthermore, the prospect of losing the physician identity may lead to psychological distress (Bowman, et al., 2002; Silver, et al., 2015). Although there is not an abundant literature on retirement considerations of the aging physician population (Sanders, et al, 2010; Silver, et al., 2015; Stearns, et al., 2013), there is growing interest in the subject reflected in research conducted primarily with senior faculty in academic medicine in the US and Canada. Research has been driven by societal implications of early physician retirement and physician workforce shortages, coupled with the abolishment of mandatory retirement that prevents younger cohorts of academic physicians from gaining leadership experience, potentially leaving a vacuum when older physicians can no longer work (Hall, 2013; Moss, et. al., 2013; Silver, et al., 2015; Stearns, et al., 2013).

A cross-sectional mail survey of members of the American Academy of Pediatrics (AAP) examined patterns of work and retirement among pediatricians, ages 50 and older (Merline, et al., 2010). Data from 1,114 respondents included in the analysis (73% male, compared with 66% of target population of all AAP members ≥ 50) found that 45% were providing or planning to provide patient care past the age of 65 and engaging in part-time work was increasingly more common with age. Nearly half worked full-time past age 65 and one quarter worked full-time past 70. Women pediatricians were more likely to work part-time than men (32% versus 18% of men), less likely to work past age 65 (26% versus 57% of men), more likely to cite poor health and family responsibilities as reasons for retirement, and less likely to provide or expect to provide patient care past age 65. The authors noted that family responsibilities as a factor in retirement decisions for women pediatricians is consistent with evidence that during middle age and late life, women, including women who practice medicine, often provide care for family members such as aging parents, an ill spouse, or young grandchildren. They concluded making provisions for gradual work hour reduction or other forms of phasing out of the workforce could "benefit the practice of pediatrics by extending the career length of the most experienced pediatricians" (p. 158).

The American Pediatric Society (APS), the oldest pediatric academic organization in North America, decided to survey its senior members about retirement (Hall, 2005). A 10-item structured questionnaire was mailed to 1,444 APS members, ages 65 and older, asking questions about current status, desired information about career/avocation options after retirement, expected needs after retirement, preparations for retirement, and invited other comments. In addition, a 30-item questionnaire was sent to 148 pediatric

department chairs in the US and Canada, to ascertain policies and experience with retiring or retired faculty members. A total of 405 of the 1,197 male APS members responded, 106 of the 247 female APS members responded, and 40% of departmental chairs responded. APS member responses, in order of priority, indicated that as aids in retirement planning, they wanted opportunities in (1) international health and international education, (2) consultant services to use their expertise, and (3) creation of an APS fellowship for >65 year pediatricians aimed at exploring ways to involve senior pediatricians in improving child and adolescent health. Members commented on the need for information for developing later career options, financial planning, and health care arrangements. Many expressed a desire to continue teaching and following their own patients. Pay was not a priority, although payment reflected being valued. There were reports of being treated as unwanted and unvalued. In answer to what pediatricians over 65 want, APS members listed conference attendance, office space, equipment, income, access to patient information, and no call (after-hours) availability. Department chairs responded that senior pediatricians wanted office space, health care, secretarial support, teaching, income, and phone service. The number one problem chairs identified was senior pediatricians' inability to recognize they were having difficulties on the job. The second most common problem was senior pediatricians' ill health and third, their desire for income. Chairs agreed that the ideal age for *complete* retirement and departure from the department was 70 years. The most positive aspects of having senior pediatricians remain on faculty that chairs identified, in descending order, were mentoring, educating, sharing insights, providing clinical services, being loyal, being the "soul of department" (Hall, 2015, p. 917), flexibility, being encouraging, doing committee work, editing,

serving as historians, conducting research, advising on ethics, and fundraising. They also listed 14 other areas in which senior pediatricians could contribute, ranging from manuscript review to mediation. The author discussed the results, noting that while chairs valued contributions of senior faculty, the faculty seemed to believe they were marginalized. Chairs indicated that what senior faculty wanted involved cost, whereas the senior faculty wanted to stay involved and be valued. A number of recommendations were made for developing ways to use the skills and expertise of senior pediatricians and facilitate their transition to retirement and post-retirement careers. While this survey provides data helpful in understanding pediatricians' thoughts about some aspects of retirement, the data reported were not gender-specific, with the exception of the mention of the number of women pediatrician respondents, 7% of APS members, an organization with <5% of academic pediatricians (Hall, 2005).

Another study of retirement expectations among academic physicians was conducted at a large research university in Canada (Silver, et al., 2015). Four focus groups were held simultaneously, involving a purposive sample of eight women and eight men, ages 50 years and older, representing 11 different adult medicine subspecialties within a department of medicine. The groups met an average of 69 minutes. Seven questions were developed to guide the discussion including: (1) what makes people live long and keep well? (2) thinking in general, what kind of mental association do you have with the concept of retirement? (3) again, thinking about the concept of retirement in general, why is it that some academic physicians never retire? (4) what are some strategies for successful late life care transitions relevant to academic physicians? (5) in your opinion, what are some pros and cons of eliminating mandatory retirement? (6) what

sorts of activities and ideas do you have that the department of medicine or the university could create to engage retired academic physicians? and (7) are there any other comments about late life career transitions related to faculty to share? The authors reported using thematic analysis guided by constructivist grounded theory (Strauss & Corbin, 1998; Charmaz, 2000).

The initial question was answered by participants in a round-the-table format which opened the conversation to progress naturally to the second and succeeding questions. In response to the initial question, biological and social factors were identified, with genetics an immediate response in three of the four groups. Physical activity, continued mental engagement, and maintaining psychological well-being were discussed in all four groups. Work was not discussed specifically in any group as an enabling or constraining factor in living long and keeping well. Three major themes were identified as more prevalent in response: identity and social interaction, freedom and flexibility, and retirement as a transition.

In discussing identity and social interaction, the importance of work and institutional position were major sources of identity, personal value, and social connection with love of medicine, teaching, research, and participation in a collaborative mission of healing continually referenced. With decades of training, experience, and a sense of duty, many participants had difficulty contemplating voluntarily leaving the workforce. They shared fears of becoming less competent, innovative, and productive with age. A related fear was obsolescence, apparently connected to personal reputation. "For some, it seemed as though work determined their entire identity" (Silver, et al., 2015, p. 337). A common theme was the relationship between work and identity in the

institutional setting, with some fearing retirement or harboring negative feelings due to concerns about losing key aspects of identity. While some participants looked forward to spending more time with family or beginning second careers in less demanding roles, the primary discussions centered on fears of a life without medicine. All four focus groups emphasized the importance of social aspects of their work and workplaces to their personal lives and sense of well-being.

Retirement for many meant freedom to choose how to spend their time, although some worried about what to do with newfound free time. Ideas about freedom came from a sense of financial security and professional accomplishment but were also connected to flexibility within academic medicine, a career that is "multi-layered" (p. 339) with the ability to change focus of work, for example, discontinuing procedures but still teaching. The manner in which retirement occurs was discussed as personal, context driven, and variable.

In general, focus group participants did not anticipate an abrupt end to work but rather a gradual move to less demanding work. Continued engagement was a key way of discussing retirement transition. Retirement was rarely discussed as a terminal state. Instead, it was viewed in terms of opportunities to continue contributing to medicine. While many expressed a positive attitude about the possibilities retirement could hold, balanced with "a palpable sense of anticipated loss" (p. 340), others had negative connotations about retirement. All four focus groups viewed retirement transition as a strategic process.

This research study is the first I have encountered in the literature involving physicians to use a qualitative research approach that addresses not only pragmatic issues

about retirement transition but also emotional issues. It, too, provides valuable insights about perceptions of retirement among academic physicians. However, the study sample did not include pediatricians and the data were not reported by gender, which is interesting given that three women conducted the research.

Family medicine is a primary care specialty that includes care of children. A 24-item, online survey of 768 U.S. family physicians in academic medicine, ages 50 and older, found significant career concerns and mentoring needs reported as faculty approach retirement (Stearns, et al., 2013). The issues that most frequently concerned respondents were balancing personal and work time (67%), maintaining health (66%), and planning for retirement (60%). Career options most frequently considered by respondents ages 60 and older, a majority of White males, were retiring or scaling back from full-time employment. Survey data indicated that 64% planned to retire, with average age of planned retirement 66.6 years, and 60% had concerns about retirement planning. When asked which areas they would like to remain active in following retirement, most reported teaching (75%) and mentoring (55%). Men, more than women, wanted to continue teaching (78% vs. 70%) and doing research (22% vs.13%). Forty percent of respondents indicated they wanted to continue clinical work after retirement. In terms of mentoring, 51% of respondents reported they were not receiving mentoring of any kind and 47% reported they would like to. Women family physicians (38% of survey participants) were more likely than men to express concerns about finding a mentor (7% vs. 3%). Citing a 2008 Stanford School of Medicine study showing that 47% of faculty ages 50 and older had not engaged in personal financial planning and lacked information on retirement topics, Stearns, et al. (2013), suggested education of senior faculty on

retirement planning and institution-specific policies as one of two foci for medical schools, the other being mentoring. In conclusion, they noted the limited literature on the specific needs, attitudes, and intentions of senior medical education faculty offers future opportunities for research.

Researcher Orientation

Interpretivist

In this study, I used an interpretive lens which "looks for culturally derived and historically situated interpretations of the social life-world" (Crotty, 1998, p. 67). Schleiermacher and Dilthey are two of the major theorists who pioneered an approach in human studies concerned with interpretations people give for personal dilemmas (Palmer, 1969). For Schleiermacher, interpretation involved both the grammatical (language of the text) and psychological (thoughts of the text's author), with empathy in the speaker-listener exchange and in interpretation of text (Crotty, 1998; Palmer, 1969). The principle of interpretation is the hermeneutic circle (Palmer, 1969), deducing how meaning of a whole text informs meaning of segments within the text and, reciprocally, how the meaning of segments make clear the meaning of the whole text (Rudestam & Newton, p. 54). Understanding is circular, partly comparative and partly intuitive (Palmer, 1969). Dilthey, theorizing in modern hermeneutics (with its origins in biblical interpretations), asserted that the physical sciences and human sciences are fundamentally different (Crotty, 1998; Dilthey, 1961; Palmer, 1969). In his culturally-based human science, he recognized "the power of culture to nurture and guide a new and ever-changing species . . . it is culture and the search for meaning that is the shaping hand" (Bruner, 1990, p. 23). Weber, another contributor to interpretivism (Cohler, 1988), posited only a logical

distinction between the search for regularities in the natural sciences and the individual case in human and social sciences. He suggested that in the natural sciences the concern is for causality, as opposed to the human sciences where the concern is understanding, yet still maintained the importance of objective findings (Crotty, 1998). This objectivist stance was critiqued by Habermas (1971) who asserted that the possibility of objectivity is untenable in the study of meaning and experience and emphasized the relevance of hermeneutics for revealing meaning of texts through language use. He explained the distinction as, those using empirical science

> grasp reality with regard to technical control that, under specified conditions, is possible everywhere and at all times, while those in hermeneutic science grasp interpretations of reality with regard to possible intersubjectivity of action-orienting mutual understanding specific to a given hermeneutic starting point. (p. 195)

Ricoeur (1981) moved traditional theological and conservative philosophical understandings of hermeneutics from their orientation toward objectivity to a more general level of human understanding, still noting that because interpretation has a dialogical character, it is not purely subjective (Slattery, Krasny, & O'Malley, 2007). Others have argued that the hermeneutic circle relates to the discovery-oriented analysis of verbal text which characterizes current qualitative research (Rennie, 2012) and "the hermeneutic circle is inevitable in social inquiry; inquiry in human studies is inherently the study of meanings attributed on the basis of shared subjectivity" (Cohler, 1988, p. 556). Interpretivists argue that it is possible to understand the subjective meaning of action in an objective manner, while those in philosophical hermeneutics argue that

understanding requires engagement with one's own biases and that you cannot step outside your own skin (Schwandt, 2003).

Social Constructionist

I also drew on social constructionism which holds that knowledge is a product of social practices and institutions, or of the interactions and negotiations between relevant social groups (Gasper, 1999); a collective generation and transmission of meaning challenging the empiricist account of knowledge (Crotty, 1998; Gergen, 2001). Social constructionism covers a range of views from acknowledging how social factors shape interpretations to how the social world is constructed by social processes and relational practices (Young & Collin, 2004). Key elements are the assumption that human beings explain their experiences by creating a model of the social world and how it functions and that language is the essential process through which humans construct reality. "For the constructionist, all claims to knowledge, truth, objectivity or insight are founded within communities of meaning making—including the claims of constructionists themselves. . . and at the level of metatheory, most constructionist scholarship has been critical" (Gergen, 2001, p. 2), revealing constructs that have served to exploit individuals and groups (Young & Collin, 2004).

The origins of social constructionism can be traced in part to an interpretivist approach to thinking (Andrews, 2012). Berger and Luckmann (1989), considered influential in the development of social constructionism (Burr, 1995), were concerned with the nature and construction of knowledge: how it emerges and how it comes to have the significance for society. They viewed knowledge as created by the interactions of individuals within society (Andrews, 2012) and where socialization occurs through the

medium of language, by interacting with significant others who mediate the objective reality of society and give it meaning which the individual internalizes (Berger & Luckmann, 1989). Four tenets of social constructionism include: (1) a critical stance toward taken-for-granted knowledge, (2) our understandings of the world are historically and culturally situated and relative, (3) knowledge construction is sustained by social processes, and (4) knowledge and social action go together (Burr, 1995; Cohen, Duberly, & Mallon, 2004). In sum, social constructionism asserts that knowledge is historically and culturally specific and language constitutes rather than reflects reality; both a precondition for thought and a form of social action (Young & Collin, 2004). Meaning is not created by individual cognitive processes but within the social exchange of human relationships where knowledge is situated within, and dependent upon, context of historical, cultural, and environmental factors (Rudestam & Newton, 2015).

Existential Feminist

A third lens for my study was an existential feminist perspective, originating with existentialist feminist philosopher Simone de Beauvoir and her book, *Le Deuxième Sexe (The Second Sex)* (1949), which ushered in second wave feminism. She applied Sartre's (1943/1966) distinction between *self* and *other* to the relationship between men and women. Man is self and woman is other, "the incidental, the inessential, as opposed to the essential. He is the Subject, he is the Absolute-she is the Other" (de Beauvoir, 1952, p. xxii). As other, woman is a threat to self. Men feel a need to subordinate women; hence the oppression of women throughout history. "One is not born, but rather becomes a woman" (p. 267) with gender privilege and subordination given at birth. de Beauvoir believed that "joining the workforce, entering the ranks of the intellectuals, and taking

part in the socialist transformation of society are all steps in the right direction" (Crotty, 1998, p. 167) to change the subordinate relationship of women to men. According to de Beauvoir, if women are ever to be liberated from the status of second sex and overcome oppression, they must refuse to be the other, and in this way, "women will liberate not only themselves but also men" (Tong, 2008, p. 244).

For de Beauvoir, the highest human value was freedom—human agency and the freedom to choose one's own direction, freedom from oppression and alienation (Ray, 2004). Suggesting that women were just beginning to know freedom, de Beauvoir (1952) wrote, "What is certain is that hitherto woman's possibilities have been suppressed and lost to humanity, and that it is high time she be permitted to take her chances in her own interest and the interest of all" (p. 715). Her philosophy was to appeal to an *other* imagined to be as free and responsible as she. To do otherwise would be to imagine one's self as superior, transcendent of the other, which makes the other limited and bounded in terms of his/her consciousness (Ray, 2004). de Beauvoir quietly subverted Sartre's notion of freedom, insisting that there might be situations of oppression in which freedom ceases to be a possibility and that freedoms are not autonomous, but interdependent (Kruks, 1987). de Beauvoir (1944/2004) distinguished between transcendent freedom, the existential condition of all human beings, and concrete freedom, the social, political, and economic conditions of daily life. On an existential level, no one is freer than another. On a concrete level, disparities in freedom abound.

One of the most enduring feminist projects is identifying the inequities and the social structures that justify and perpetuate them and to work toward equity at the

concrete level (Ray, 2004). In her review of feminist scholarship over the past several decades, Andersen (2005) wrote,

> Putting feminist analysis into the context of social structures reminds us of the context in which women's (and men's) lives are currently unfolding and that must be the backdrop for understanding gender. In the context of growing inequality and a significant redistribution of wealth, gender is increasingly a matter of economic justice for women, particularly when we analyze the combined effects of gender, race, and class. (p. 452)

On the subject of privilege, de Beauvoir argued that because human beings are always selves "in situation," (Kruks, 2005, p. 186), our actions are both constrained and free, always ambiguous in terms of practical and moral significance. What we do has multiple meanings and consequences, making it essential that we stay cognizant of the fact that our best intentions may not lead to best outcomes. Although she did not directly address White women's privilege in her writings, de Beauvoir's numerous reflections on privileges of class, sex, nationality, and education, and her analyses of situated selves "insightfully navigate between strong notions of the autonomous self and strong forms of social constructionism, which tend to deny any significant degree of individual agency" (p. 186). The relationship between agency and structure remain contemporary themes in feminist studies (Andersen, 2005). de Beauvoir's work has been critiqued for being inaccessible to the majority of the world's women, with abstract thoughts from an educated mind and for negative representation of the female body (Tong, 2008). She carried her philosophy into numerous other published works, including *La Vieillesse/The Coming of Age* (1970/1972) in which she explored the subject of aging in women and

men, as seen from without (biology, ethnological data, historical societies, and present-day societies) and from being-in-the-world (the body's experience with aging; time, activity, and history; old age and everyday life). In it she continued her critique of society's failings, this time in the maltreatment of its elders, noting that "society cares about the individual only in so far as he is profitable" (p. 543), and calling for radical change in the whole system, a machine that turns between youth and old age, "the crusher of men" (p. 543).

My feminist leanings are informed by my own lived experience as an Anglo-American female born in 1959. As the only daughter of five children, and the middle child, I was *othered* from the beginning, in both positive and negative ways. My middle-class parents seemed grateful to have a daughter in the mix, supporting me and nurturing my development, but within their own, and society's, circumscribed understandings of how a daughter should be raised in the dominant White culture to which we belonged. It was a culture in which my mother, who earned her bachelor's degree in fine arts, did not pursue a career but, instead, raised a family, and where my father, who earned his bachelor's degree in civil engineering, was the sole income-earner. Through the years, as they underwent their own development, they remained in what they and others considered a happy marriage. They supported my decision to end my own marriage and, at the age of 27, to take a new surname. In lieu of keeping my married surname or reclaiming my father's surname, I chose the surname Livingston. The choice reflected, in part, my youthful intention to live the questions (Rilke, 1934). In my renaming process, I made a brief study of onomastics, the study of the origin of proper names. I thought about how women were property within the patriarchy, losing a part of their identity by

giving up their names. It was a powerful experience to name myself and one of the more significant feminist statements I have made in my life. In other ways, however, I have lived a conventional life, remarrying and raising a son, always my first priority, while working full-time as an educator in public health and academic medicine, which uphold the pillars of patriarchy and positivism. Yet, I have managed to find myself doing work with others that embraces feminist ideas, particularly the need to work at the concrete level on equity, regardless of gender, race/ethnicity, sexual orientation, ability differences, and other ways humans are othered. In doing so, I have also tried to look beyond the binaries that bifurcate human qualities (Gilligan, 2011) and human beings in order to heal the rifts in the psyche and society that divide us from of ourselves and each other.

Theoretical Model

I used Nancy Schlossberg's (Anderson, et al., 2012) 4 S transition model which has been refined over the course of nearly four decades, integrating her ideas with those of other theorists and researchers. Schlossberg (1981) first proposed an exploratory model for analyzing human adaptation to transition to elaborate a theory of the "extraordinary complex reality that accompanies and defines the capacity of human beings to cope with change in their lives," (p. 3). Schlossberg (1981) drew heavily on elements from the work of adult development theorists and researchers. She used Neugarten's (1979) individual variability and noted that, despite the idea of an emerging age-irrelevant society, people still used age as a defining variable for themselves. Although she did not embrace Levinson's (1978) notion of age-grading, she acknowledged the influence of his work such as life structure, importance of mentor,

dreams, and polarities of young-old and masculine-feminine. Schlossberg (1981) stated that Lowenthal, Thurnher, and Chiriboga's (1975) longitudinal study of men and women, with its focus on adaptation during the life course, was central to her model because of the emphasis on gender differences and influences of individuals' resources and deficits over the life course. She aligned her model most closely with the life-course perspective, noting that "to understand a particular state of life—including middle and old age—it is necessary to place it within the context of preceding and following developmental changes and stabilities and within its historical context" (Abeles & Riley, as cited in Schlossberg, 1981, p. 4). She also drew on her own preliminary research involving interviews with men, employed by the National Aeronautics and Space Administration, who lost their jobs because of a reduction in force. Schlossberg (1981) posited that adaptation to transition was a dynamic process with three sets of factors influencing adaptation: (1) characteristics of the transition including role change, affect, source, timing, duration, and degree of stress; (2) characteristics of the pre-transition and post-transition settings and environments; and (3) characteristics of the individual experiencing the transition.

In the first edition of her book, *Counseling Adults in Transition: Linking Practice with Theory* (1984), Schlossberg reframed her understanding of the model to a response to transition, in lieu of adaptation which does not always occur. She continued to develop the model (Schlossberg, 1989; Schlossberg, Waters, & Goodman, 1995), introducing the idea of three major components of transition: approaching transition (transition identification and transition process), taking stock of coping resources, and taking charge (strengthening resources) and four types of transition: (1) anticipated, those that are

predicted to occur; (2) unanticipated, those not expected; (3) nonevents, those related to unfulfilled personal aspirations and (4) sleeper, those that go unnoticed and gradually culminate in change. Within the taking stock component, there are the four major variables for how an individual copes with transition: situation, self, support, and strategies (4-S). The transition process also locates the person in the transition as moving in, through, or out of the transition. The model identifies the type of transition, degree to which an individual's life is altered (changes in roles, relationships, routines, assumptions), where an individual is in the transition process (contemplating change, initiating change, after change), and resources individuals use to transition.

The fourth edition of *Counseling Adults in Transition* (Anderson, et al., 2012) proposed an integrative approach to the model to include ideas from Bridges' (2004) transition model, Bloch and Richmond's (1998) hope and spirituality, Hudson's (1999) cycle of renewal, and Lorenz's (1993) chaos theory. The first stage of transition can be conceptualized as moving in or moving out (Anderson, et al., 2012). Moving in means new roles, relationships, routines, and assumptions, learning the ropes, socialization, and "hang-over identity" (p. 56). Moving out means separation or endings, role exit, and disengagement from roles, relationships, routines and assumptions. Moving through is the betwixt and between period of liminality, the neutral zone which can be a period of emptiness and confusion, where the individual is "groping for new: roles, relationships, routines, and assumptions" (p. 56) but also a cycle of renewal and of hope and spirituality.

Schlossberg (2011) explained that the first step in dealing with change is knowledge of transition types: anticipated transitions which are major life events such as

starting a first job or changing careers; unanticipated transitions which are disruptive events that occur unexpectedly such as a surprise promotion or factory shut down; nonevent transitions that are expected events that fail to happen, such as not receiving an anticipated job promotion; and sleeper transitions that go unnoticed and but gradually culminate in change. Everyone experiences transitions and different transitions, whether anticipated, unanticipated, nonevents, or sleeper events that alter their lives. "It is not the transition per se that is critical, but how much it alters one's roles, relationships, routines, and assumptions. This explains why even desired transitions are upsetting" (p. 159). The transition process, with changes in roles, relationships, assumptions, and routines, takes time. Three strategies for coping with transition include: changing the situation, as for example, through legal action; reframing the situation such as looking for opportunities that might come as a result of job loss; and taking action to reduce stress such as starting an exercise program (Schlossberg, 2011).

Applications of the model in work life transitions vary according to where people are in their transitions. For example, an employee who has plateaued or reached burn out needs support to continue or be reinvigorated about work. There are also those who need a challenge or may need to leave a job. "Whether leaving is voluntary or involuntary, individuals exiting a job need help figuring out 'what's next' . . ." (Schlossberg, 2011, p. 161). Schlossberg (2009) also applied the concept of mattering, first in higher education research (Schlossberg, 1989) and later to retirement transition (Goodman & Anderson, 2012). Drawing on Rosenberg and McCullough's (1981) work defining mattering as the universal human need to be noticed, appreciated, and depended on, Schlossberg (2009) identified four contexts for retirement transition: work, community, family/friends, and

self, and suggested methods to assess and strategies to help ensure mattering in each context.

Summary

This review of the literature covered three primary topics: milieu of professional women's careers in the third age, adult development, and career transitions. Key themes in the literature reviewed were: (1) progress has been made in women's career self-determination but systemic inequalities persist that perpetuate economic and other disparities for women, including women pediatricians; (2) although baby boomers are altering the interpretation of aging in the US, systems and social perceptions are slow to change, so that ageism and discrimination in the workplace persist; (3) designating human qualities as masculine or feminine, and privileging what is deemed masculine, divides us from ourselves and each other; (4) the understanding of adult development in the third age and beyond suggests that there is movement toward introspection and a search for meaning but more research is needed to understand development in later years; (5) career transition is under researched and there is limited information about the employment experiences of older women, despite the fact that they are the fastest-growing cohort by rate of increase in the paid workforce; (6) recognizing that most career research has been quantitative, based on the androcentric, traditional understanding of lock-step careers, feminist career researchers have proposed other theories, such as gendered life course theory; (7) there is significant potential among third age physicians currently being wasted because of ageism, lack of planning, and systemic inflexibility; (8) physicians have expressed a need for guidance in preparing for retirement transition;

and (9) there are models for career transition that have been used effectively to guide individuals through the transition process.

Based on my interpretations, the literature supported my proposal to study the career transitions of third age women pediatricians using a qualitative approach. It has been suggested that human research decisions and behaviors are guided by both cognitive and emotional wisdom and that learning to be a researcher requires the emotional self to navigate new ideas, skills, choices, behaviors, and criticisms, from self and others (Coryell, Wagner, Clark, & Stuessy 2011). As I embarked on the research journey, I was mindful of the opportunity for growth, drawing on Wisdom and her companions, transformative wrath, bawdy humor, and compassion, in the form of my study participants, dissertation committee, colleagues, friends, and family—all my sources of inspiration.

III. METHODS

Qualitative research is oriented toward understanding the nature and meaning of a phenomenon. In qualitative research, "researchers are interested in understanding how people interpret their experiences, how they construct their worlds, and what meaning they attribute to their experiences" (Merriam, 2009, p. 5). Denzin and Lincoln (2008) asserted that qualitative research is oriented toward capturing the individual's point of view, examining the constraints of the everyday social world, and obtaining rich descriptions. There are many possibilities for framing qualitative research. "The ideal-typical qualitative methods strategy is made up of three parts: (1) qualitative data; (2) a holistic-inductive design of natural inquiry; and (3) content or case analysis" (Patton, 2002, p. 248). In applied fields of practice such as education, administration, health, social work, and counseling, the basic, interpretive study is the most common in qualitative research (Merriam, 2009, p. 22).

Research Design

In this section, I review the research design involving basic qualitative study, the research sample, data collection methods, plans for data analysis and synthesis, ethical considerations, and trustworthiness. Initially, I proposed to use narrative analysis but, based on guidance from my dissertation committee and my own thoughts about the research, I opted for a basic qualitative study. The analysis involved identifying recurring patterns that characterize the data with the primary goal of uncovering and interpreting how people make sense of their lives and their worlds (Merriam, 2009, p. 24). Conducting a basic, interpretive study was a good place to begin my work in qualitative research. As indicated, I used Schlossberg's 4 S transition model (Anderson

et al, 2012) as the framework for analysis of study participants' career transitions. I also applied gendered life course theory (Moen et al., 2009) which provided historical and social contexts for the study participants' careers and career transitions. This theory intersects directly with the 4 S model's use of social convoys (relationships) and institutional convoys (rules, organizational culture), constructs which will be elaborated in the ensuing chapters.

Research Sample

I used criterion and snowball sampling in selecting my study participants. The participants met the following criteria in order to participate: (a) women pediatricians, either general pediatricians or subspecialists, in both academic medicine and private practice, and (b) between the ages of 55 and 74. I identified three study participants who are actively working in clinical practice, with no immediate plans to retire (*working*); two study participants actively engaged in decision-making about retirement, one on the cusp of retirement and the other using bridge employment (no longer doing clinical work but still involved with other aspects of medical practice such as advising or teaching) to phase into retirement from clinical practice (*transitioning*); and three study participants who have retired from clinical practice (*retired*). I knew at least one woman pediatrician who fit the criteria for each of these three categories who was willing to participate in the study. For snowball sampling, I asked study participants in each of the three categories for suggestions of other potential study participants. By studying both general and subspecialty women pediatricians, in academic medicine and private practice, who are racially and ethnically diverse (African-American, Asian/Asian-American, Hispanic and White/European-American), and who represent the three different categories of

retirement transition, I was aiming for maximum variation in the sample to allow for the possibility of a greater range of application of findings (Merriam, 2009).

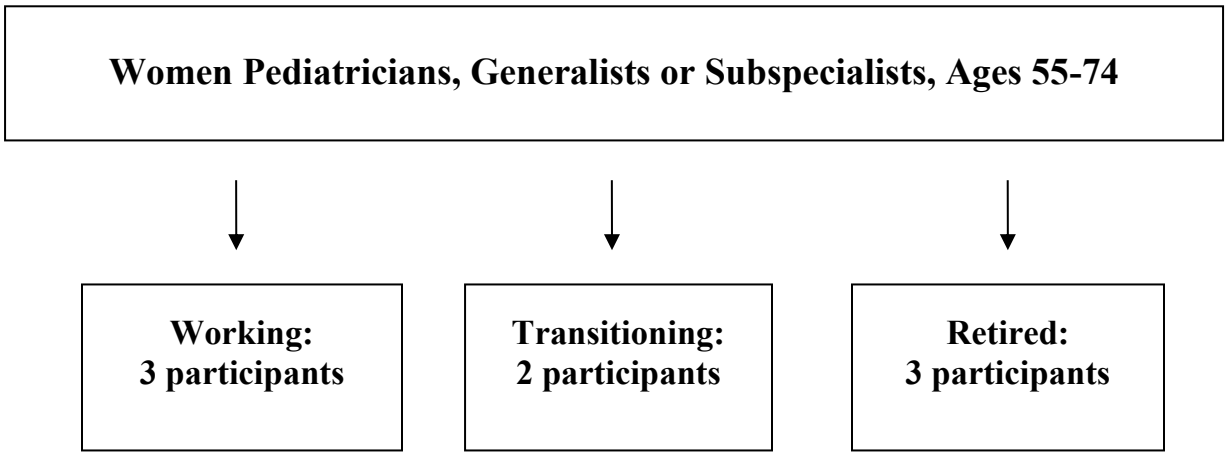

Figure 1. Research Sample Overview.

Data Collection Methods

Although there are many possibilities for framing and focusing qualitative research, there are three primary data collection methods: (a) in-depth, open-ended interviews; (b) direct observations; and (c) documents, with data typically from fieldwork (Patton, 2002). Using interview guides (Appendices A, B, and C), I conducted two, in-depth interviews with each participant, lasting approximately 60-90 minutes each. My interviewing methods were informed by Seidman (2013), Roulston (2010), and Brooks and Edwards (2014). Seidman (2013) asserted that "At the heart of interviewing research is an interest in other individual's stories because they are of worth" (p. 9). The researcher uses primarily open-ended questions, exploring and building on the study participant's responses with the goal to have the participant reconstruct experiences within the topic of study (Seidman, 2013). I followed Roulston's (2010) reflective

interviewing which calls for reflexivity in the researcher's theoretical conception of the research interview and the researcher's subjectivities in relation to the study and study participants. I also attempted to draw on the skills for listening that Brooks and Edwards (2014) outlined for facilitating inquiry, including mindfulness in paying attention, suspending judgment, reflecting, clarifying, summarizing, sharing, and allowing silence which creates space for deeper reflection. The locations of interviews were of the study participants' choosing. Half of the study participants' interviews were conducted in their homes and half in offices. In two instances, I used phone for second interviews; one due to geographical challenges and the other as a convenience to the study participant. I recorded and transcribed each interview verbatim.

I requested a curriculum vitae (CV) from each study participant at the end of the first interview as a tool for gathering detailed information about participants' career history, such as year of completion of residency training and years in medical practice. Six of the study participants provided me a copy of their CVs and the other two provided a verbal accounting of their dates of training and job experiences.

As part of data collection, I also maintained a researcher journal with notes about data not captured by audiotape during interview sessions. The journal also contained reflections, ideas, commentaries, and memos which are part of the data analysis process (Roulston, 2010). The data collection methods protocol is summarized in Table 1.

Table 1.

Data Collection Methods Protocol

Research Methods	Content Focus	Research Questions	Framework Sources
Primary Methods			
1st Interview, 60-90 minutes, audiotaped and transcribed verbatim	Career history and career transition experiences	1,2	Studies of milieu of U.S. working women; careers of third age women pediatricians; career theories; Schlossberg's Transition Model; Seidman; Roulston; Brooks and Edwards-Interviewing; Facilitating Inquiry
2nd Interview, 60-90 minutes, audiotaped and transcribed verbatim	Effects of career transitions on career and personal development	3	Theories of adult development; career development; narrative development
3rd Contact – phone and email contact inviting study participants to review interpretations	Member checking (and additional data collection as needed)	1-3	Lincoln and Guba (1985); Merriam (2009)
Secondary Methods			
Researcher Journal	Notes of data from interviews not collected on audiotape	1-3	Roulston (2010) - interviewing practices

Note: Table adapted from "*Older Baby Boomers Seeking Collegiate Degrees: Developmental Influences on Educational and Vocational Aspirations*" by J. Schaefer (Doctoral dissertation). Retrieved from ProQuest Dissertations & Theses database. (Order No. 3391129), p. 98. Copyright 2009 by Jane L. Schaefer.

Data Analysis and Synthesis

I used a variation of content analysis, an iterative, reflexive data analysis process, alternating between emic readings of emergent data and etic readings involving existing models, explanations, and theories (Tracy, 2013). Acknowledging that analysis begins with thoughts about what to research and continues throughout the research, I used Tracy's (2013) analysis process (Figure 2), informed by other qualitative researchers as referenced.

In considering tools for qualitative analysis, I manually coded the interviews but also used Microsoft (MS) Word to help track study participants' demographic data and sort analytic themes. I organized transcript data according to source, the study participant, so I had data from the source in one file. I created electronic and hard-copy file folders for each intended dissertation chapter (Wolcott, 2009), and files on generic categories, such as the research questions, and created relevant, specific files (Glesne, 2011), such as ageism, as data collection proceeded.

Prior to data collection, I developed a provisional "start list" (Miles, Huberman, & Saldaña, 2014, p. 81) of codes—deductive (etic) coding, using my research questions and theoretical framework. My start list contained codes from Schlossberg (Anderson, et al., 2012) including self, supports, strategies, situation, identity, purpose, and relationship. As I gathered my data, I began data immersion (Tracy, 2013), submerging myself in the breadth of data, reading and re-reading transcripts, listening and thinking about them. I wrote down reflections and hunches in my researcher journal, staying open to meanings.

To manually code, I gathered hard copies of translated transcripts, printed with wide margins and numbered lines. I used differently colored pencils to code using the

start list. Some of the data had multiple colors/codes associated (double or triple-coded). After marking up all the data, I created a locator sheet for each code and then listed the various pages and line numbers within the data associated with the specific code. I began with holistic coding, considered preparation for primary-cycle and secondary-cycle coding, applying a single provisional code (from the start list) to a large unit of data to capture a sense of the overall contents and possible categories that may develop (Miles, Huberman, & Saldaña, 2014). I created a codebook with a list of codes with assigned colors, abbreviations, brief definitions, and a representative sample of each in MS Word.

Next, I used primary-cycle, open coding (Strauss & Corbin, 1990), examining the data and assigning words or phrases that capture their essence; writing codes capitalized in the right margin and using the left margin for *jotting*–an "analytic sticky note" (Miles, Huberman, & Saldaña, 2014, p. 93) for comments. For first-level codes, I focused on the descriptive "who, what, where" (Tracy, 2013, p. 189). I revised and updated the codebook, saving and renaming, to create a chronological map of code emergence (Tracy, 2013). For example, I collapsed identity into the self code and relationships into support code, based on additional reading and thinking about the data.

I used a constant comparative method to compare data that applied to each code, modifying definitions to fit new data or creating a new code. I compared one segment of data with another looking for similarities and differences. Data were grouped, tentatively named, and became a category. The goal was to identify patterns in the data (Merriam, 2009). I added new codes, for example, impact of transition, so that the codebook expanded from seven to 14 codes. As the codes increased, I developed a systematic codebook in MS Word, with data display listing key codes, definitions, and examples. As

I worked on the coding and codebook, I referenced my research questions and research proposal to ensure relevance as other issues emerged. I created a data display in a matrix table form after several cycles of coding to begin organizing central themes and findings from the interview transcripts.

In secondary-cycle coding, I reviewed first-level codes from the primary-cycle and began to organize, synthesize, and categorize them into concepts I interpreted, using theoretical knowledge and creativity. Codes that continued to appear in the data were linked together in a specific way. I was also aware of and created a code for the silences in the data. Second-level codes are analytic and interpretive, serving to explain, theorize, and synthesize data, identifying patterns, rules, and progression (Tracy, 2013). Additional data were not needed to flesh out codes; my experience provided well developed categories in terms of variation with relationships among categories established and validated. I felt that data were sufficient and the emerging analysis addressed my research questions in an interesting and significant way.

After second-cycle coding of the two interviews for a study participant, I created a narrative summary with a synopsis of my initial interpretations for each of 14 coded themes; for example, a synopsis of data and interpretation for the strategies a study participant accessed in making her career transition. I provided copies of the study participant's complete transcripts and the interpretation narrative summary via email, in-person, or regular mail. Each study participant was provided a self-addressed, stamped envelope to return her feedback to me. All of the study participants provided at least cursory feedback on their interpretation summaries. Some also made notes on the interview transcriptions to explain a point or ask me not to use a person's name that was

mentioned. I used this process as a member check and opportunity to communicate with study participants and ask for clarification. After receiving feedback, I cross-referenced the summaries to develop the outline for writing up the findings, while also continuously using individual study participant summaries and the coded transcripts for comparison.

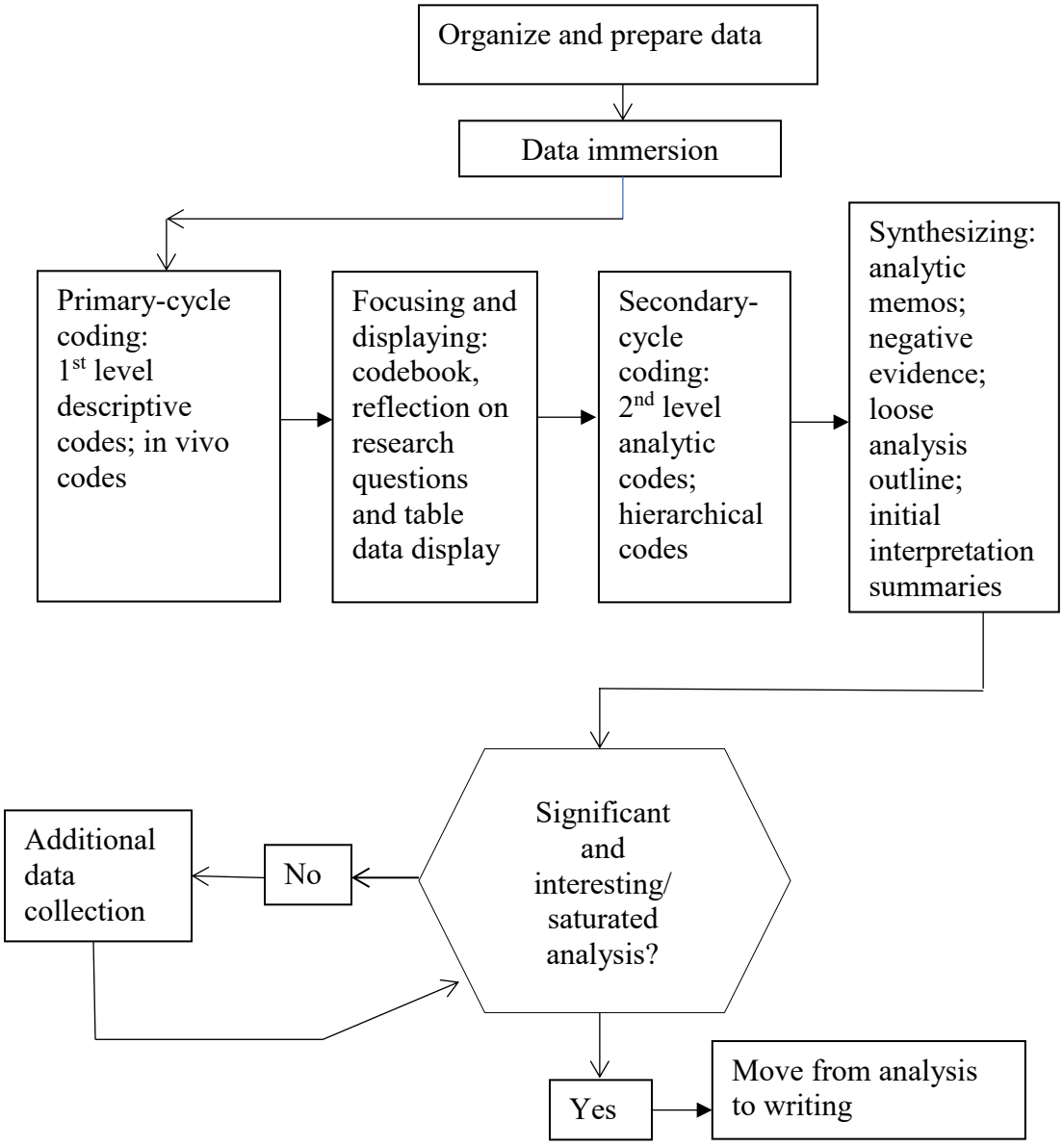

Figure 2. Flowchart of Analysis Process. *Note:* Flowchart adapted from "Qualitative Research Methods: Collecting Evidence, Crafting Analysis, Communicating Impact" by S. J. Tracy, p. 218. Copyright 2013 by Wiley-Blackwell.

Ricoeur (1970) demonstrated two positions in the hermeneutic interpretive stance: hermeneutics of faith, "a care or concern for the object and a wish to describe and not to reduce it" (p. 28) and hermeneutics of suspicion characterized by skepticism and interpretation to decode hidden meanings (Josselson, 2004). In proposing the possibility of combining these interpretive positions, Josselson (2004), described hermeneutics of restoration, much like hermeneutics of faith, where the interpreter's stance is unearthing and highlighting meanings in the participant's story. Interpretation is not limited to directly expressed, explicit meanings but may illuminate implicit meanings. The aim is to "re-present, explore and/or understand the subjective world of the participants and/or the social and historical world they feel themselves to be living in" (p. 5). She also described hermeneutics of demystification (to her, a term without the negative connotations of suspicion), where the researcher is interested in aspects of self-understanding or meaning-making that operate outside of the participant's awareness, citing the metaphor of the fish being unaware that it is swimming in water.

> The goal is not to challenge or disprove the participants' meanings – in fact, we may well believe that the person believes what he or she says – but to turn our attention elsewhere . . . The hermeneutics of demystification recognizes the relativity of all accounts . . . an interpretation toward a more durable truth. (Josselson, 2004, p. 15)

I attempted to re-present the voices of study participants as faithfully as possible, following Josselson's (2004) hermeneutics of restoration, foregrounding tacit knowledge, underlying assumptions, and taken-for-granted milieu. Josselson (2004) posits that it is possible to interpret from both stances as long as the researcher is clear when and how

these shifts occur. Given my position as a novice qualitative researcher, I attempted to examine meanings beyond participants' awareness, in hermeneutics of demystification, when the study participant's stories, their data, or its absence strongly suggested it.

I kept a record of my analytical activities chronologically with dates and discussion of what was accomplished in MS Word in a "Methods Section Draft" (Tracy, 2013, p. 196). This is my audit trail and was a resource for writing up the analysis and for future publications. I composed analytic memos as part of the analysis process focusing on the meaning of codes and connections between them and my decisions about coding. I kept these memos in an MS Word file and in hard copy. I attended to negative evidence incongruent with other data and incorporated it into my analysis. I used the data to report findings and make recommendations. I followed the timeline I devised to facilitate steady progress in the conduct of my research (Appendix D), with the exceptions that, due to a personal illness and a death in the family, I was unable to complete the draft dissertation to circulate to my review committee until early June. However, I remained on schedule to complete the process in August 2017.

Recognizing that "a reflexive research practice does not conclude with the design and conduct of interviews" (Roulston, 2010, p. 127), I attempted to maintain reflexivity during data analysis through use of my researcher journal and analysis of interactions with my study participants, in addition to analysis of interviews. Through these activities, I continued to foreground my subjectivities, aware that I was an instrument in the research process (Rudestam & Newton, 2015). One of my greatest difficulties was hyperawareness of the need to protect confidentiality. There were data that I had to

exclude for this reason and may have contributed to lack of clarity or bias in my interpretation.

Ethical Considerations

I obtained IRB approval for the study from the Texas State University Institutional Review Board, #EXP2015R640057T on October 1, 2015 to ensure my study met IRB ethical standards. When each study participant was invited to consider participating in the study, I provided her with a study information sheet that explained the purpose of the study, the interview process, IRB approval, use of pseudonyms, protection of confidentiality, no direct benefits and no penalty for not participating, as well as IRB contact information for questions or concerns and contact information for accessing study results. I used pseudonyms to protect study participants who were volunteers. Four of the study participants chose their own pseudonyms and four approved of ones that I suggested after discussing the study process with them. I reviewed plans with my dissertation chair at Texas State and other members of my dissertation committee to help anticipate and prevent ethical dilemmas. I also identified mental health resources in the event study participants sought counseling as a result of study participation.

Drawing on Glesne's (2011) discussion of researcher roles and ethical dilemmas, my position was an advocate and a friend. In the role of advocate, I believed that my study participants, women pediatricians of the third age, have a wealth of experience and much to contribute, even as they consider transitioning from medical practice. While I was interested in identifying ways to ensure their talents are valued and they find ways to continue meaningful, productive lives, I had to be careful not to assume that every one of these women wanted to continue *contributing* to society and, instead, truly listen and hear

their stories. As a friend of my study participants, I had to take extra care to protect confidentiality, finding ways to maintain integrity and confidentiality of the interpretations, even though it meant having to omit data and possibly contribute to bias. Intimacy in research is a path to understanding but also requires reflexivity, acknowledgment of power dynamics, awareness of relational ethics and of temporary understandings (Busier, et al., 1997). "Predicated on trust, care, and a sense of collaboration, relational ethics is at the core of research in which friendship relationships are welcomed" (Glesne, 2011, p. 171). In terms of power dynamics, while my position as researcher afforded me power, my subordinate role as an educator working professionally with many of the study participants, who are powerful women, diminished this power differential.

Trustworthiness

Qualitative research has been critiqued through the lens of positivism which holds there is one reality, external to the mind, which can be studied in parts and captured with supreme confidence in a single knowable Truth (Crotty, 1998; Denzin & Lincoln, 2008; Lincoln & Guba, 2013). This epistemology infuses scientific research which puts great emphasis on objectivity and value-neutrality. The gold standard is the randomized controlled trial involving large samples and a search for validity, reliability, and generalizability of results. It is noteworthy that major theories in psychology, medicine, and the natural sciences developed from detailed study of individual cases or instances, e.g. Piaget, and Darwin (Riessman, 2008). It has been argued that the constructs of validity, reliability, and generalizability are inappropriate for qualitative inquiry which

has its own criteria for research soundness: credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985, 2013).

Credibility, which corresponds to positivism's internal validity, refers to establishing confidence in the interpretations and findings of a study. Transferability corresponds to positivism's external validity or generalizability.

Interpretivism does not aim for generalizability but applicability of findings and interpretations. Through thick description (Geertz, 1973), enough description of context is provided so that readers can determine applicability of findings within their own contexts. Dependability corresponds to positivism's reliability and "addresses how the findings and interpretations could be determined to be an outcome of a consistent and dependable process" (Lincoln and Guba, 2013, p. 105). Confirmability corresponds to positivism's objectivity where findings and interpretations result from a dependable process of inquiry and data collection. These alternative constructs give rigor to qualitative research.

Creswell (1998) described eight procedures to strengthen trustworthiness of qualitative research: (a) prolonged engagement and persistent observation; (b) triangulation involving use of multiple data collection methods, investigators, and/or theoretical perspectives; (c) peer review and debriefing; (d) deviant case analysis; (e) clarification of researcher bias through reflection on researcher subjectivity and explanation of how this is used to monitor research; (f) member checking which translates to sharing interview transcripts, analytical thoughts, and/or drafts of the final report with research participants; (g) rich, thick description – writing that allows the

reader to enter the research context; and (h) external audit. Using all of these procedures is not necessary in one study.

I used in-depth interviewing which created the opportunity for prolonged contact with participants, fostering rapport-building and increased possibility for authenticity of responses (Liu, Englar-Carlson, & Minichiello, 2012). I have collegial relationships with many of the study participants which helped foster the trust and openness needed for qualitative research. The description of methodology, interview question guide, codebook, technical notes from the researcher journal, and an audit trail that documents my analytic process make it possible for others to replicate parts of my study process. Through the use of a research journal and in dialogue with my dissertation chair, I worked to maintain reflexivity to ensure awareness of my biases. I provided each study participant with a draft summarizing my interpretations from their interviews as a member check, considered "the most critical technique for establishing credibility" (Lincoln & Guba, 1985, p. 314) of our collaborative narrative creation.

IV. PARTICIPANT PROFILES

In this chapter, I introduce the study participants and present data and my interpretations of study participants' educational journeys toward becoming pediatricians and their practice of pediatrics. The data provide historical context for the career paths of the study participants relevant to my research questions. In this chapter, I apply gendered life course theory (Moen et al., 2009) which frames the life course themes of time, context, and linked lives in terms of social convoys (relationships) and institutional convoys (rules, regulations, culture of organizations).

Introduction to Study Participants

In this section, I provide a synopsis of background and overview of current career transition status of eight study participants: three still working full-time, two in active transition to retirement, and three retired from the clinical practice of medicine. A matrix of study participants' demographics at the time of interviews is provided in Table 2 and elaborated below. Study participants had careers in either academic medicine or private practice. Academic medicine has been defined as being "entrusted by society with the responsibility to undertake several important social missions toward improving the health of the public, including education, patient care, and research" (Schroeder, Zones, & Showstack, 1989, p. 803). In academic medicine, physicians are associated with teaching hospitals, clinics, and medical schools. Academic physicians' responsibilities include teaching the art and science of medicine to medical students, residents, and fellows through direct supervision of patient care, didactic and "bedside" teaching, and medical research. The time spent in these efforts depends on their institution's requirements. Physicians in private practice are focused chiefly on providing patient care.

Table 2.

Participant Profiles

Pseudonym	MD Type	Practice Type/Years	Age at Interview	Race/Ethnicity	Family
Working:					
"Carol"	Subspecialist	Academic – 30 years at same institution	61	Asian	Married to a physician; three grown children
"Camilla"	Subspecialist	Academic – 35 years at same institution	66	African American	Single; widowed; one grown child
"Bunny"	General Pediatrician	Private – 31 years in same practice	61	Hispanic	Married to a dentist; four grown children, grandchildren
Transitioning					
"Birdie"	General Pediatrician	Private – 19 years in same practice; 2 years at other practice; 11 years in public health	68	White	Married to an executive; three grown children; grandchildren
"Grace"	Subspecialist	Academic – 15 years at one institution; 5-10 years at 3 others	72	White	Married to a physician; two grown children; grandchildren
Retired					
"Pepi"	Subspecialist	Academic – 37 years at same institution	72	South Asian	Married to a physician; three grown children, grandchildren
"Maggie"	General Pediatrician	Private – 32 years in same practice; 2 years at another, first job	68	White	Married to a physician; one grown child
"Nancy"	General Pediatrician and Subspecialist	Private – 30 years; 10 years as general and 20 years subspecialist in same practice	63	White	Married to a physician; two grown children

Working, in Career Transition: Carol, Camilla, and Bunny

Carol is a 61-year-old subspecialty pediatrician in academic medicine. She is married to a retired physician and is the mother of three children. Carol self-identifies as Asian, emigrating as a child with her parents and four siblings to a rural community in a southern state where her parents ran a grocery store. Her innate curiosity has propelled her through her life. As a child, she was admonished for asking too many questions. Carol's desire to learn, "It was the quest for knowledge. I want to learn. I want to know what this is about," carried her from 1972-1985 through her undergraduate studies in chemistry and medical school in her home state and her pediatric residency and subspecialty fellowship training in the northeast. Ultimately, Carol settled with her spouse in a large city in the southwest where she has worked in academic medicine at one institution for 30 years, gradually advancing in rank to the level of tenured professor with an endowed chair position. Her current career transition is intentional, an event that was precipitated by the retirement of her predecessor in a role as director of a special clinic. Still on her quest for knowledge, Carol is currently moving through the transition process and projects that will require at least a year to fully transition and become comfortable with her new role.

Camilla is a 66-year-old subspecialty pediatrician in academic medicine. She self-identifies as African American, is widowed, and has one son. Camilla grew up in a southern state in a devoutly Catholic family of four children. Her African American mother was a teacher and her White, European American father was an engineer. Camilla attended Catholic schools and joined a convent where she thought she would spend her life. She felt called to care for others' health needs, rejecting the teaching

career chosen for her and leaving the convent. Camilla's faith in her calling has sustained her throughout her life. "I truly believe in my life that God has always directed my path. It is such a strong feeling." Camilla is extraordinarily resilient and persistent, despite the many barriers imposed by society on African American women. She worked in a lab after completing her undergraduate studies in 1969 before beginning medical school in 1971 in her home state where she was the target of racist acts. She persisted, graduating and going on to do her pediatric residency training in her home state and in a western state. In 1981, she completed her subspecialty fellowship in a large city in the southwest where she has worked in academic medicine for the past 35 years. Camilla is on the cusp of a transition that will position her to be able to move out of her current role doing highly demanding intensive care work to a more sustainable role that balances clinical work with research. Her career transition is intentional as she lays the ground work for creating a research unit in her institution, determined to improve the morbidity and mortality statistics for African American women and their newborns.

Bunny is a 61-year-old general pediatrician of Hispanic ethnicity. She is married to a dentist and has four sons and several grandchildren. She was raised with her four siblings in a small town in the southwestern US. Her father, who was a truck driver, obtained an associate's degree and was later employed in social work. Her mother became an LVN when Bunny was ten years old. When Bunny was a teen, the family relocated to a large southwestern city. Her father was seeking a place with better educational opportunities for the children. Bunny found it a more welcoming community with less racism toward Hispanics. Here, Bunny attended a small private college for her undergraduate studies in science where she excelled. She attended medical school and

completed her pediatric residency in 1985 in the northwest before settling with her spouse in the same southwestern city where she has been a general pediatrician in her own private practice for 31 years. Bunny, an avid runner, explained, "All of my running partners joke about I'm like a little bunny going over the hill. Once I come down, I say, 'Oh, there's one more hill I need to go over before I turn around.'" Bunny's sense that there is always more to seek and a need to keep going informed her recent career transition. She was moving through transition from full-time clinical general pediatrics to doing half-time clinical and half-time administrative work. The transition has been gradual, beginning with what Bunny characterized as her biggest career transition eight years ago when she began taking on practice associates who could help carry more of the clinical workload, giving her space to develop in other ways.

In Active Transition to Retirement: Birdie and Grace

Birdie is a 68-year-old general pediatrician. She is married to a retired higher education executive and has three children and several grandchildren. Birdie did not discuss her race/ethnicity. Birdie and her brother grew up in the southern US. Her father had a highly successful answering service business. Her mother worked in the home. Birdie received her undergraduate degree from a university in the southeast and a master's degree in public health in 1973 from a university in the northeast, working 11 years in public health. She settled with her spouse and children in a large city in the southwest. In 1991, Birdie embarked on her medical career at the age of 39, after holding positions in public health and a short tenure as a stay-at-home mother. "I jokingly tell people I went to medical school because I was depressed." Birdie's sense of humor has imbued her outlook on life and helped her navigate her medical education as an older

adult learner. She also had self-confidence and was pragmatic. When she learned that it would take as long to complete nursing training as medical school, she said, "I'm marching myself over to the medical school. Which is what I did." She received her medical degree and completed her pediatric residency in 1994 in the southwest city where she and her family resided. Birdie worked for two years in a private practice clinic and then became a partner in another general pediatrics private group practice where she worked for 19 years. Her current career transition, moving out of her role as a practicing pediatrician into retirement, was precipitated by the sale of the practice to a large health care system.

Grace is a 72-year-old subspecialty pediatrician. She is married to a retired physician and has two children and several grandchildren. Grace did not discuss her race/ethnicity. Grace and her three sisters grew up in a large northwestern city. Her father began his career working in a foundry but went on to become a quality engineer. Her mother owned a slip cover and drapery business. "Both parents were very much blue collar to start." As a student from 1961-1969, Grace received her undergraduate degree and completed a master's degree in biochemistry with her medical degree at a university in her home town. She did her residency training in northeastern and northwestern cities and her subspecialty fellowship and PhD in a northwestern city between 1969-1975. Grace has worked in academic medicine her entire career, serving as a clinician and in executive leadership roles at four different institutions, with tenures ranging from three to 15 years in length and experiencing multiple career transitions. She holds emerita status at two institutions. Grace's philosophy has been to stay open to opportunities "in the moment," and be helpful and productive, themes woven throughout her discourse.

> I never had a sense that I have to do A, B, or C. I just have to be in a place where I can work and be productive and help somebody else and then I'll be OK. That always worked.

When opportunities seemed to fit her expertise, Grace thought, "I'll give that a try. I might actually be able to do something good." Grace's open approach to career enabled her to adapt to her spouse's career. "I felt I could be flexible and go wherever." Her current career transition to consultancy, moving through transition, is serving as a bridge toward the possibility of full retirement from paid effort. Grace anticipates continuing in a consulting capacity if she can "be of help" for at least one more year but possibly longer.

Retired: Pepi, Maggie, and Nancy

Pepi is a 72-year-old subspecialty pediatrician. She is married to a retired physician and has three children and several grandchildren. Pepi is from a South Asian country, with which she identifies and has a deep connection. Pepi and her three siblings grew up in a small mining town where her father, who had studied mining in the US, worked as an engineer. Her mother worked in the home. She emigrated to the US for residency training following completion of her medical degree in her home country in 1965. Pepi had a fearless drive to achieve, exemplified by an anecdote she shared. Just as she was preparing to come to the US to study, not knowing anyone, a nurse was murdered in the parking lot of the hospital where Pepi would be working. Her parents were worried. "But I knew this was my journey. Just do it." Pepi also had great reverence for education and the life of the mind. She spoke admiringly of her teachers in her home country and in the US. "Those were great teachers in those days" and about her

spouse of 44 years, she said, “I think I fell in love with his intellect. I never met a more intelligent person in my life.” Pepi completed her residency and subspecialty fellowship at one of the largest public hospitals in the US, located in a northwestern city, training from 1967-1972. She settled with her spouse in a large city in the US southwest where she worked in academic medicine at the same institution for 37 years, holding progressively higher academic ranks and ultimately becoming a tenured professor with an endowed chair. Upon retirement, Pepi was named professor emerita. The transition to retirement was gradual, over a period of twelve years, where she reduced her official work time to 80% and then 60%, until retirement, moving out of her role in clinical practice. Pepi still maintains an office at her academic institution and conducts medical research.

Maggie is a 68-year-old general practice pediatrician. She is married to a physician and has one son. Maggie did not discuss her race/ethnicity. She and her sister were raised in the southern US. Maggie explained, “I was this jovial little chubby thing. Very ‘get into trouble,’ do everything that she [sister] hadn't done.” Her mother attended college and became a teacher; a feat Maggie noted was rare for women at the time. Maggie’s father ran a small store and later was in the insurance business before his untimely death at the age of 57. Maggie attended a small, all-women’s liberal arts college in the south, graduating first in her class with a degree in chemistry in 1969. Maggie has approached life with a sense of adventure and joie de vivre. This approach made her open to a career path that to Maggie was something of a “lark.” Things happened without a lot of forethought. In fact, Maggie viewed all of her career transitions as a “lark.” After graduating, she moved to the northeast where she worked in

a medical school lab for two years. She returned to her home state, working two years in another lab at a medical school which she ultimately attended, graduating in 1975. Maggie did her pediatric residency in a southwestern city where she and her best friend worked for two years in a private practice before establishing their own practice in 1980. Maggie worked in her general pediatrics private group practice for 32 years. She transitioned to retirement, moving out of her role as a general pediatrician, when the practice was sold to a large health care system, although a previous career transition set the wheels in motion for her retirement decision.

Nancy is a 63-year-old pediatric subspecialist of Jewish faith who retired from practice five years ago. She is married to a retired physician and has two children. Nancy grew up in a southeastern city, the oldest of four children. Her father was head of maintenance for a private girls' school where they lived and "where my sisters and I all went to school." Her mother was a telephone operator. Nancy, high school valedictorian, attended an all-women's liberal arts college in the northeast. In 1975, she returned to her home state to attend medical school. She completed pediatric residency and subspecialty fellowship training in the northeast, in training from 1979-1983. Nancy then moved with her spouse to a small city in the southwest where she had a private general pediatrics practice for ten years, followed by 20 years practicing her subspecialty. Nancy, who loved the arts, spent her 30-year career in a place that she experienced as lacking amenities and resources. For her, it was "culture shock. Absolute culture shock . . . it was like a desert" and a place that to her was unwelcoming. Nancy, who also had a penchant for mystery, enjoyed solving the puzzles of her pediatric subspecialty patients' complicated medical problems; work that provided great satisfaction and a way to endure

her circumstances. Her transition to retirement was intentional, precipitated by her husband's retirement. In transitioning to retirement, Nancy continued for two years doing medical-legal research for which she was compensated, reviewing malpractice cases and serving as an expert witness as she moved through transition. Nancy is now fully retired from any medical or medically-related activities.

Only three of the study participants had a parent with a college education. All study participants were from two-parent households, most with four or more siblings. Study participants could be classified as growing up in one of four socioeconomic groupings (Gilbert, 2002): two upper middle class; four middle class; one working class; and one working poor. However, all of the study participants enjoyed a very comfortable standard of living at the time of the interview. Their incomes as pediatricians and pediatric subspecialists alone situated them in the upper middle class. Marriage only enhanced their socioeconomic status.

Becoming a Woman Pediatrician

Deciding to Become a Doctor

All of the study participants excelled in academics and had an affinity for science which was recognized and nurtured. Carol reported "I was good in science." Camilla explained, "I knew I loved science," and won a national competition for her science project when she was a junior in high school. Grace, who noted she was a Sputnik-era high school graduate, was influenced by her father to study science. "He pushed all of us. I was the only one to succumb to the pressure." Grace knew she would "do something in science" as a career. Pepi showed great appreciation for science, "I loved science," and, given her aptitude, was steered by her country's educational system to

pursue science. All of the study participants studied science in their undergraduate training. Their abilities and pursuit of education in the sciences laid the foundation to pursue careers in medicine with the value of education their parents instilled in them as children coming to fruition. "My mom always stressed education. She went out, she spent money to buy us an encyclopedia and I read that thing backwards and forwards" [Carol]; "Neither of my parents had a college education but they both worked hard so we would all be able to get an excellent elementary and high school education to be able to go to a good college" [Nancy]; "My mother was a pusher for academics. And she pushed you to get all the education you need" [Camilla]; "My parents and my grandparents were for education [Pepi]." This valuing of education would be essential to their sustained commitment in completing the rigors of 23-26 years of formal education, spanning grade school through pediatric residency and fellowship.

Between 1961-1972, when the study participants were pursuing higher education, perceptions of women's career options were still limited. As Carol explained, "Back then, we only had Marcus Welby [1969-1972 medical drama television program featuring a male family practice physician]." Her older sister and her sister's friends discouraged her. "You don't want to go to medical school. Medical school is too long." Birdie reported that her high school counselor gave her the options of teaching, nursing, or working as an executive secretary. But attitudes were changing. Four of the eight study participants were encouraged by family to pursue a career in medicine and one by a teacher. Two decided on a whim to apply to medical school, and one decided to attend medical school based on her experience working in a lab.

Medical Education

As young women, the study participants were in the vanguard of their generation and had already experienced many firsts; first in their high school and university classes at graduation and first members of their extended families to pursue a medical degree. They had a sense of breaking new ground. As Carol put it, "I know we are just very fortunate to have come along at a good time in life, to be able to be trailblazers." Grace echoed this sentiment.

> In medical school, it was about 10% [women] . . . Those of us who were in medical school at the time who were women felt like we were a unique bunch of people. By and large, it was very bright women. You had to be very competitive to be admitted to medical school at the time.

Grace and her "unique bunch" had a very high standard to meet in order to be admitted to medical school. By doing so, they knew they were exceptional which was empowering.

Gender and racial discrimination. In becoming physicians, the study participants defied the gender stereotypes of their cohorts but not without challenges. Six of the eight study participants described experiences of personal and institutional gender and/or racial discrimination in their medical training or early career. The percentage of women in the medical classes of the study participants ranged from 6-10%, increasing in later years of residency and fellowship training to 25-40%. Minority representation was very low with study participants reporting being the only minority or among a few other people representing minorities in medical school.

In moving to another state for residency training, Carol found that "being the only Asian person, that was kind of gone," but then she experienced being actively

discouraged by a male physician, in an all-male program, from pursuing residency training in the specialty of greatest interest to her at the time. She found her refuge in pediatrics which had more women physicians in practice, although Carol noted they were typically unmarried and childless.

Camilla, the first African American woman to attend her medical school, was greeted in class with a noose hanging over her chair. "I cried silently. I took it down and put it in the trash and started figuring out how I was going to survive." She also experienced sexual harassment by a senior level male professor which threatened to derail her medical education. Later, in her residency training, she was harassed by women for her comments about training to be a pediatrician after she gave an interview for a news story in which she said it was natural for her to be doing pediatrics. "Women gave me a hard time about it. Black women specifically. They were saying, 'Here we are taking care of babies again…Is it natural to take care of somebody else's baby?'" Camilla said she was accused of doing a disservice to women who should be able to pursue any field in medicine. Camilla's career path was littered with land mines; a case of damned if you do and damned if you don't. These experiences and others like them were tempered by Camilla's faith and her appreciation for the people in her life who opened doors for her. "I think these people were so instrumental in my life. I can just see them. Every person along the way that just pushed me further on. Doors closing. Doors opening." Her faith and the support she received from women and men along the way gave her a resiliency that helped ensure not only her survival but her success.

Bunny and her female resident colleagues experienced harassment on the job from a male supervising physician who had difficulty accepting female residents. Bunny also experienced gender discrimination from nurses who were all female.

> I always had a hard time separating in the nursing staff, was it race or being female. I really think it was much more about being female . . . The nurses were a lot friendlier with the males. They were stricter with the female residents. If you made a mistake, of course you are learning, then they would call you on it or tell your attending. A lot of it was behind the scenes. I think as females we always felt like we had to work harder and be much more careful about what we did.

Like Camilla, Bunny was harassed by women. Her interpretation of the experience was complicated by the possibility that her Hispanic ethnicity could also have been a factor. She was only one of a few Hispanic residents in the program. However, one of the nursing supervisors who harassed her was also Hispanic. Bunny reported reconciliation with the nurses as she became a successful pediatrician in the community. "We have a totally different relationship. They were proud of the fact that I finished residency and that I am doing well in medicine." Bunny's experience is a familiar refrain where women who defy the norms are held to a higher standard and endure ordeals at the hands of their sisters. Yet, when they achieve, they become the standard bearers for their sisters.

In 1980, when Maggie and her two women pediatric practice partners applied for a $50,000 loan from a bank to pay for renovations to their new clinic space, they were degraded. Maggie reported, "That was interesting. Three women and the guy called us 'girls.' Wanted our husbands to sign for it." This experience was indicative of the degree of institutionalized gender discrimination in the US. These young professional women,

who had completed medical school, residency training, and had already worked several years in pediatrics, were obviously competent individuals. They went on to acquire the loan and paid it back within the first year, demonstrating they were a good risk and perhaps helping to make it easier for other professional women seeking loans.

As foreign medical graduates, Pepi and her peers were exploited by the US which had a physician shortage and opened up opportunities for work in large, urban public hospitals chiefly serving indigent patients. Foreign medical graduates were willing to work for low pay in difficult conditions. The expectation was that they would return to their home countries and not create competition later for U.S. trained physicians. Pepi also experienced discrimination at home.

> Right at the time my group applied for the foreign medical graduate exam, my country made a rule that physicians cannot leave and they would not give us passports. There was a court case filed by physicians, saying they cannot discriminate . . . the case was won.

Pepi obtained a passport and trained in the US in a specialty not offered in her country. She remained at the public hospital as faculty for five years and went on to lead a successful career, parlaying what began as exploitation into what some would call the American dream.

As a new pediatric subspecialist, Nancy experienced discrimination as a non-Hispanic, U.S. trained White female physician of Jewish faith when she moved into a medical community that was predominantly Hispanic men who had trained outside the US. "When I came in, I was basically seen as a threat . . . None of them really reached out to befriend me . . . I couldn't get referrals." As a consequence, she spent the first

decade of her career doing general pediatrics. It took years for Nancy to develop trust among her colleagues, chiefly by coming to their aid in cases of complex care involving her subspecialty expertise. Nancy's experience of discrimination was complicated, owing to the many ways she was *other* – being female, coming from another part of the US, her Jewish faith, her education, and her perception of the community as a cultural desert.

Grace, who did not discuss her race/ethnicity, asserted that she did not experience gender discrimination in her career. "I have not felt limited by gender. I felt actually advantaged by it. I was the first woman chairman of my department. I think it was a benefit for me to be a woman. They were ready." She considered her life course timing propitious and that her experience of being advantaged may not hold true today. "I think now people are much more willing to say we don't want you because you might have a baby and be gone in nine months or something like that." In her assertion, Grace did not reference the need to be highly competitive to be admitted medical school nor did she factor in her decision not to pursue surgery as a specialty because "back then surgery pretty much meant no family, and I knew I would someday want a family." Her experience of non-discrimination does not account for systemic discrimination such as the expectation that a woman surgeon would not have a family.

The study participants' experiences in their medical training and early career demonstrate the pervasiveness of gender and racial discrimination and the nuances in interpretation. Despite the difficult environment for women and racial minorities in medicine, the study participants endured and prevailed. All of the study participants

reported significant support from key mentors and colleagues, women and men, in helping them achieve educational and career goals.

Institutional and social convoys. As Birdie explained, medical education is "like a conveyor belt. Once you step on that belt and start the process, it's really hard to say, 'hmm, I want to step off.'" Birdie's metaphor of conveyor belt captures the essence of the institutional convoy of medical schools, their accrediting bodies, governance, and other matters. The conveyor belt begins with the white coat ceremony in which incoming medical students adopt the mantle of the profession, symbolized by donning white coats and taking an oath. Medical school culminates with national match day when medical students find out where they will do their residency training. The conveyor belt continues with residency and fellowship training. There are rules, regulations, procedures, and practices, all designed to assure governing bodies and the public of a qualified, competent physician workforce. All of the study participants stepped onto the conveyor belt and stayed on until they were *finished*, sustained and restrained by the institutional convoy that is medical education. Unlike some other professional women, they really could not take a pause to attend to family or personal needs.

Kahn (as cited in Anderson, Goodman, & Schlossberg, 2012, p. 85) introduced the idea of the convoy of social support where individuals move through life surrounded by a personal network of social support. A model of the convoy (Figure 3) puts the individual at the center surrounded by concentric circles (Anderson, et al., 2012). The first circle around the person represents social supports who are stable over time and not role dependent (e.g. close family, close friends, partner); the second circle includes those who are somewhat role-related and likely to change over time (e.g. family, relatives,

friends at work), and the third circle includes those tied directly to role relationships and most vulnerable to role changes (e.g. co-workers, supervisors, neighbors, professionals such as the dentist, doctor, and distant family).

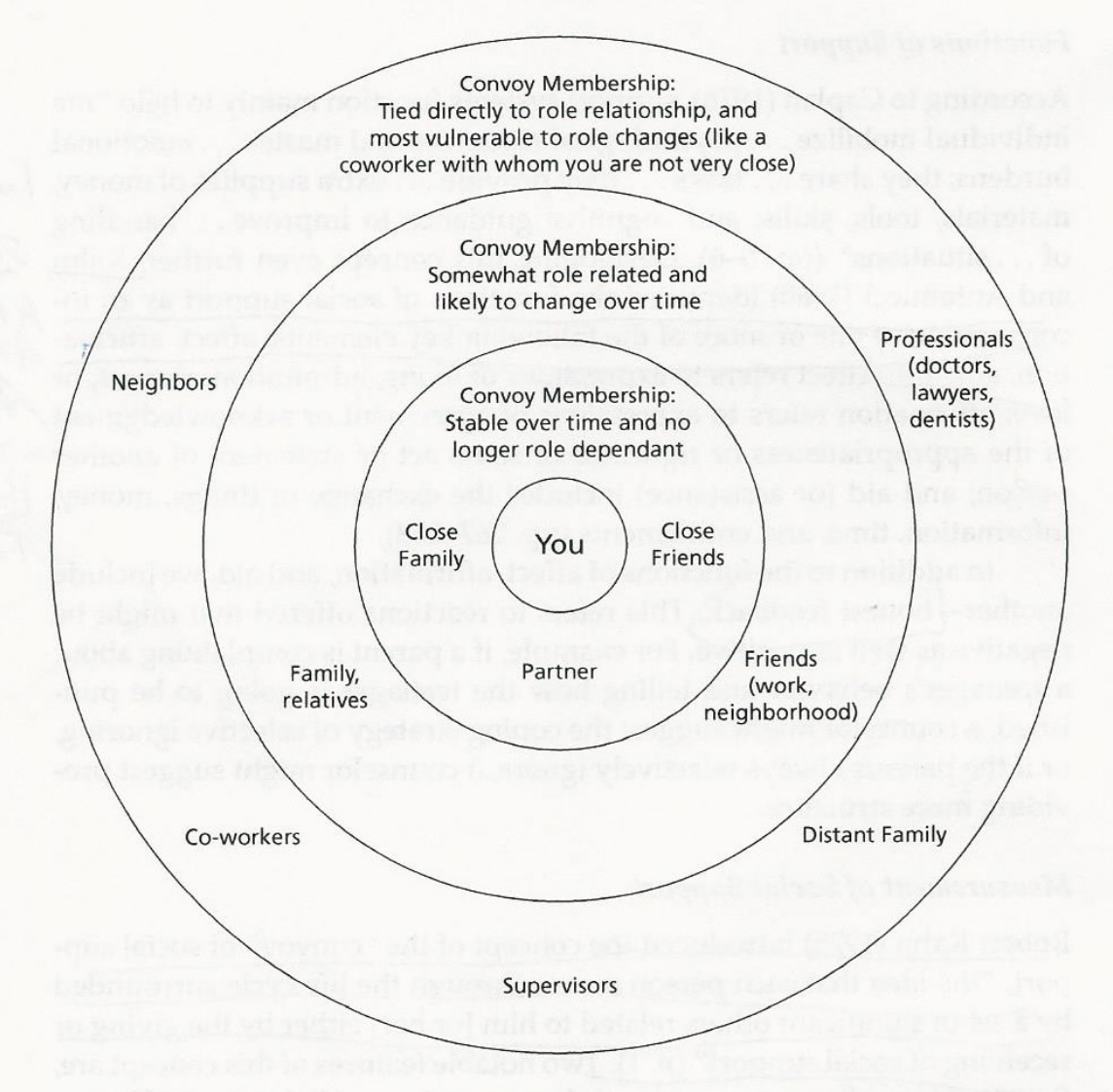

Figure 3. Convoy of Social Support. From "Counseling adults in transition: Linking Schlossberg's theory with practice in a diverse world" (4th ed.) by M. L. Anderson, J. Goodman, and N. K. Schlossberg. Copyright 2012 by Springer Publishing Company, LLC.

The social convoy is at work in undergraduate studies with the decision to pursue a career in medicine. As Carol explained, "there were a lot of other pre-meds and that's how you kind of learn what needed to be done." All of the study participants, with the exception of Camilla who was shunned by her medical school classmates, were embedded in social convoys from which they took many of their cues for navigating medical school and residency training. Deep bonds of collegiality were formed throughout the ordeal of medical training. Maggie reported "we had a lot of people who got married within the class," and was, in fact, among them. Birdie's peers in medical school and residency were a primary source of support in transitioning from being "a normal person to a student 24/7." They are "your social and educational nucleus . . . We would commiserate . . . it was a nice support group." Birdie explained that in residency training, this nucleus is "the only way you survive." She also commented on the practice of sleeping with other residents in the hospital call room when on night duty. In her case, the way the call schedule fell, she was always with the same male resident sleeping in the call room. "A totally different culture. You know, sleeping in the call room with someone. So, I said, you know, David, I sleep more with you, than my husband." All of the study participants were part of this call room culture, although several commented that they were so busy there was no time for sleep. For Bunny, "it was a difficult residency. We started off with about 20-22 people and by our third year, we were down to seven." Bunny bonded with her fellow residents to the degree that years later, when she was looking to hire a pediatrician and had a chance encounter with one of the women with whom she had trained, she offered her a job. "I said I don't need a resume. We had done residency together. She was an excellent resident. I said you have a job tomorrow

if you want. So, she stayed with me for eight years until she retired." The fact that Bunny's former resident colleague accepted the job and worked with her until retirement demonstrates the reciprocity of the bond and underscores the significance of the social convoy.

Being a Woman Pediatrician

A Day in the Life

When deciding on a medical specialty, five of the study participants had entertained ideas of pursuing specialties such as surgery and internal medicine, but ultimately ruled these out after considering the time demands. Most of the study participants were under the assumption that pediatrics would allow them to have a schedule more conducive to having a family and something of a work-life balance. As Bunny said, "I wanted to have a family. I kept thinking, well which field in medicine can I enjoy but at the same time be able to commit time I need to be with my family." While pediatrics may have initially been a concession decision, not considered first, all of the study participants professed a love for their specialty. Camilla described the connections she made with children. "When I did my pediatric rotation, the kids, I just loved them . . . I kept just loving to be around kids . . . I knew pediatrics was where I wanted to be." Maggie explained, "I was doing an elective in pediatric oncology. And I loved it, there was a woman there who was a wonderful mentor and the fellow was wonderful. So, I was like, OK, I can do this."

All of the study participants discovered that pediatrics was a specialty that demanded a great deal more time than anticipated. Unprompted, they shared their "war

stories" of their hectic lives during early and mid-career. Carol, a subspecialty pediatrician in academics said,

> There were days when I would get up real early, take care of the kids, get them to day care, then I would run to the university and do something, then run out to the foundation, then run over to the hospital and see patients. I was all over and it was crazy.

Carol's "crazy" schedule that had her running "all over" set the tone for her career. Even now she is harried with new work responsibilities, still juggling the demands in her life.

Bunny described her life as a woman general pediatrician.

> I remember rounding in the mornings. Four-five different hospitals, starting off at five or five-thirty. I rounded, did all my ICU babies first. Went back and saw my less sick patients and well newborns. Rushed to the office, with an hour's worth of patients waiting for me. Worked through lunch. Did all my paper documentation once I got home because I wanted to see my kids for dinner and homework. After they went to bed, I would stay up doing my documentation. Sometimes I would go back to the hospital.

Bunny's story epitomizes the busy practitioner story. Like her, Nancy had a demanding schedule doing general pediatrics, which came at the expense of time with her children.

> I regret that I didn't take more time . . . My schedule was such that I was gone in the morning very early and didn't get home until about six or seven o'clock at night. By that time, the babies were ready to go to sleep. So it was really difficult.

Nancy's regret was shared by most of the other study participants who had similar anecdotes of not being available in their children's lives, sometimes at significant moments.

Camilla was in the midst of trying to resuscitate a patient and unable to leave to attend an awards ceremony for her teenage son. Telling her story, she said, "it just tears my heart apart" and "that was a hard day. I don't think I ever got it back." Pepi's daughter told her, "Mom, you were not there. You were gone most of the time." Maggie was "just trying to survive being a mother and a pediatrician." Study participants were torn between the work they loved and the people they loved. Grace captured the conundrum for women trying to balance career and family with her comment,

> You feel that you are never doing the parenting quite right because you don't devote enough time to that. And you feel like you are never doing your job quite right because you don't devote enough time to that. You have to acknowledge that whatever your standards are, you are not going to meet them during this period in your life. You just have to get on with it.

Study participants did get on with it and with fierce determination akin to Superwoman, a figure that many seemed to emulate. While raising children in marriages that remain intact, they crafted highly successful careers, continuing to achieve many firsts and other honors; first female president of her local medical society, first female chair of the pediatric department at her medical school, chosen for a prestigious national health policy fellowship, national recognition for contributions to their fields, etc.

Making it Work

These superwomen did not do it alone. As Carol was quick to point out, "the secret to success is to make sure you have good people working with you." Reliable, trusted childcare was key to making it work, enabling study participants to pursue their careers. Although the study participants described their spouses as supportive with childcare at some point early in their careers, all of the study participants received support concomitantly from family members, nannies, other childcare providers, or a mix of providers.

Camilla, Carol, and Bunny had family members who provided support. Camilla's mother took care of her son. After Carol's husband, who was called to the hospital to attend an emergency, left their infant sleeping in the crib alone at home, his mother came to live with them. "He said 'I am so sorry that I did this' and I was just, you did what? The next day he called his mother and said, 'I really need you to think about coming to live with us.'" Carol was fortunate to have her mother-in-law's help, at least a three-generation family tradition of extended family support. Bunny explained, "I usually had a family member be at home with the kids. Or I would have a nanny . . . She was a very sweet lady, the one I finally found, I was happy with . . ." Bunny, too, had the reassurance of dependable caregivers who could help alleviate anxieties.

Birdie, Grace, Pepi, Maggie, and Nancy relied most on non-family for child care. Although Nancy described her husband as predominant in early years of child-rearing, she also had two housekeepers who carried the load.

> When the children were growing up, we had two housekeepers all the time. I had help with housework and cooking and childcare during the day. The

> housekeepers were there when the children came home from school, so I didn't have to leave patients at 3:30 p.m.

These women enabled Nancy to manage as a busy general pediatrician and were a support as she transitioned to doing subspecialty care. In retirement, when her adult children come to visit her, they want to spend time with the women who played a significant role in raising them.

In the on-going struggle of making it work, there were also career concessions for many of the study participants. Pepi shared,

> My mentor wanted me to go back badly. I said in life, there are lots of other important things than just your career. I didn't want to uproot everything and go just because I had better opportunities other places. I decided I would make life here.

Pepi explained that her husband was happy in his work, her children had made friends, and they had a community where they felt like they belonged. The lure of career advancement was not enough to compel her to change.

Maggie gave up her share in the pediatric practice she had helped establish in order to be more available to her family. Her sacrifice came at an emotional cost that surprised her. Still, she said there were no regrets.

Grace made the decision early in her career not to travel so she could be more available to her children. "The tradeoff there is that you don't become the president" [of the national organization of her subspecialty]. She asserted,

> There are things I didn't do professionally. I look at others and admire them for their contributions, but the only way I could have done that would have been to be a different kind of parent. I didn't want that.

From Grace's comments, it seemed as if there were leadership roles to which she might have aspired but chose not to pursue. She also shared,

> Women back then didn't say what they wanted . . . no one expected special treatment for family issues. If you couldn't manage your family, you needed to find another profession . . . It was assumed you would figure it out.

Although she had agency in making career decisions, the constraints of the work environment with little latitude for family shaped Grace's decisions.

All of the study participants adapted themselves to their families' needs yet managed to create very satisfying work lives. Their advice to younger women physicians included statements such as, "make time for family . . . you really need quality time because you can't get that back [Camilla]," "recognize that even though we are in a field where families depend on us 150% of our time and we would be willing to give, we have to think about ourselves and our own families [Bunny}," and "have interests beyond work and for couples, have a shared interest . . . you shouldn't be just dependent on one thing in your life [Pepi]." These statements reflect their feelings about the cost of being Superwoman and the lost time with family while busy taking care of other people's children. There was also some recognition of the need for self-care and development outside of work, an antidote for Superwoman.

All of the study participants came from families who valued education and had a strong work ethic, values they modeled for their own children and grandchildren. Half of

the study participants were grandmothers at the time of the interviews, with two others becoming grandmothers shortly thereafter. The study participants did their medical training between the decades 1965-1985, with seven beginning their medical training in their 20s. Six study participants reported gender and/or racial discrimination in their medical training or early careers, although all reported significant support from male and female colleagues and family at critical junctures. The relationships they formed and the medical education system of which they were a part helped sustain (and restrain) them through their education. All of the study participants moved around the US at various times in their training but followed their spouses as they established their careers. All but one have spent their working lives in an urban setting. They have led highly successful careers, modeling Superwoman to meet the demands of career and family. Yet they have also experienced their share of problems and have made significant sacrifices, personally and professionally. The study participants continue to model Superwoman as they navigate their current career transitions, the subject of the next chapter.

V. CAREER TRANSITIONS IN THE THIRD AGE

In this chapter, I present the data and my interpretations of how the study participants expressed their views of experiences with their late career transitions, relevant to my research questions. I provide the broader context for their career transitions associated with changes in medical practice and the culture of medicine; apply Schlossberg's 4 S model (Anderson, et al., 2012), including developmental perspectives; and examine study participants' thoughts, actions, and personal metaphors related to transition and retirement.

Context for Transitions

Work transitions are shaped by social and institutional policies of the context within which they are made (Fouad & Bynner, 2008). In the broader context of U.S. medicine, there have been large-scale system changes affecting pediatric practice. Changes in medical education have also impacted the culture of medicine. Study participants discussed these developments, providing a backdrop for their transition experiences.

Mourning Changes in Medical Practice

The study participants discussed influences on their career transitions including the changing dynamics of pediatrics, electronic medical records systems, the shift from small group private practice to large health care systems, and burdensome regulatory issues.

Changing dynamics of pediatrics. Many general pediatricians are experiencing a shrinking role in hospital care given the rise of hospital medicine, a relatively new phenomenon. The primary focus of pediatric hospitalists is the medical care of

hospitalized pediatric patients (American Academy of Pediatrics [AAP], 2013). As Bunny, a private practice general pediatrician, explained,

> As time went along in the practice of pediatrics, the kids that were being admitted to the hospital were sicker and sicker. We were helping to prevent hospital admissions so there weren't the simple cases we saw a long time ago. There has been a big change in hospital medicine. I decided that my patients were much better off with a hospitalist.

Bunny still retains her hospital privileges so she can continue to see her newborn patients but her practice has altered to nearly all outpatient care. At the same time, pediatric outpatient care is increasingly being delivered in walk-in clinics at commercial pharmacies by nurse practitioners, under the supervision of a physician. Even Bunny is integrating the use of pediatric nurse practitioners into her practice. Hiring more clinical personnel has enabled Bunny to turn her attention to developing the business, as part of her career transition.

Maggie, retired from private practice, described the progressive disengagement with in-patient pediatrics.

> As we saw more neonatologists, at first, we kept our kids and kept doing and seeing them every day in the nursery, the kids in the NICU. Eventually we gave that up. My practice partner kept saying, 'We are going to lose those skills.' And she was right . . . So, you lost everything . . . it is a slow process of giving it up.

From Maggie's perspective, the move toward highly specialized in-patient pediatric care had a down side. Continuity of care, where the general pediatricians provided history and context for their hospitalized patients, has been lost with the practice changes.

Electronic medical records. Four study participants, one on the cusp of retiring and three retired, described the negative impact of electronic medical records systems (EMR). Birdie, who was transitioning to retirement from private practice, explained that insurance companies were key drivers compelling her practice to transition to electronic insurance claims in 2006. They were given an ultimatum by the companies to implement an electronic system or they would not be reimbursed. Birdie reported that while the system had its "headaches," because they had a private practice, they had the liberty to decide which features to use. Still, the EMR altered the approach to patient care.

> You reduce the time you spend with the patient. You know, there are times I go in there and I am entering all this stuff and I realize as I'm entering, I say wait a minute, I have to stop and look at who I am getting this information from . . .

From Birdie's perspective, entering data information into the EMR and having less patient interaction, "breeds a totally different kind of physician for tomorrow . . ." Birdie explained how one of her partners retired 18 months after implementation of their first EMR because her work was no longer enjoyable. Birdie perceives that changes in medical practice such as EMR have led to an exodus of older physicians.

Maggie felt strongly about the lack of practicality of EMR and real reasons for its use. She shared,

> Give me a paper chart where I can flip and see here are the shots, not do 26 clicks to get to there. Then I also thought, notes, I was checking things, rather than noting. Just check boxes. It might not have been totally normal . . . As long as you are checking a box, there is no gray in that. I think EMR was a tool designed,

> we got it when it was a tool designed for front office and billing, not a tool for patient care. Maybe it is now, I don't know.

Maggie lamented the death of the way she practiced pediatrics when EMR was introduced. Although she and her practice partners remained friends, the loss of collegiality disrupted the dynamics of their interactions. Work became drudgery and they were like drones sitting at their computers, checking boxes for billing.

In Nancy's case, a government mandate to move to EMR within two years was cost prohibitive for her practice. "My practice could not even have afforded to do electronic medical records. I was glad I was out before that had to happen." Although Nancy had other reasons to retire from her subspecialty private practice, the mandate for EMR was influential in her decision-making. Knowing this problem was looming made her decision to retire when her spouse retired that much easier.

Shift to large health care systems. When Birdie's practice partners voted to sell their practice to a large health care system, they lost their autonomy in making practice decisions and were forced to adopt a new EMR.

> It is a big operation, they've got this bevy of attorneys so that every time we turn around to do something, they have to run it by the attorneys . . . I think people retire now out of frustration, as an escape. I don't know anybody in the medical profession in recent years, my contemporaries, who hasn't done that.

Birdie's comment is self-referential. She was extremely frustrated by the changes in her own private practice. There was loss of autonomy with the shift to a large, inflexible health care system and a new, overly prescriptive EMR that consumed much of her time at the expense of patient care and personal time.

Although working in academic pediatrics, Camilla corroborated this perspective on the impact of changes in private practice pediatrics.

> If you are a pediatrician, remember, I told you a lot of them are retiring at 65 because the system is different now . . . There is not the satisfaction they had before. You have to have satisfaction to be able to keep working in pediatrics . . . I find that the people who work [as employees of a health care system] are quitting on time.

Camilla, who works in academic medicine, is under pressures of her own, driven by institutional demands for productivity. She worries about older, senior level physicians like herself. "I think they [hospital administrators] want them out . . . the high salaries and not doing as much patient care which is what they [hospital] need right now . . ." Camilla's current career transition involves positioning herself to contribute and be productive so that she can continue to work full-time.

Regulatory issues. Grace, who is bridging to retirement, discussed her concerns about changes to the practice of medicine overall.

> Medicine today is not about a doctor taking care of a patient to the best of his or her ability. That's not what it is about. It is about filling in the blanks, checking off the boxes so you can get paid . . . As medicine changes, no one is in pure private practice anymore. You can't make it. They are connected to some large entity, at least a purchasing entity and an electronic medical record entity.

Grace is sufficiently concerned about the future of medical practice that she joined the Senior Section of the American Medical Association (AMA) to try to address problems.

By doing so, she has also found a way to participate meaningfully in organized medicine and stay connected to her profession.

Another regulatory issue, perceived as burdensome by study participants, is American Board of Pediatrics' (ABP) mandatory maintenance of certification (MOC). It has replaced periodic recertification through examination for pediatricians to claim board-certification status—a credential indicating competence to their professional colleagues and to the public. In 2010, the American Board of Medical Specialties, which includes ABP, implemented the MOC process which involves not only a secure examination but three other components addressing six competencies in various ways. Competencies are assessed in five-year cycles with a secure examination required every 10 years. The MOC enrollment fee is about $1,500 (ABP, 2016).

All of the study participants were exempted from the mandatory MOC because they were board-certified before 1989 and have permanent certification status granted by ABP (Schuman, 2015). However, two study participants, Camilla and Carol, who were still working in academic pediatric medicine, participated in MOC; chiefly because it was an expectation of their institutions. Bunny, who is also still working in private practice, opted not to pursue MOC, although she is aware that her decision may be a source of future difficulties. "Some of the hospitals are trending to where even though we were grandfathered in, they are probably going to start asking us to get recertified. I think they will make it a condition for continued privileges in the hospital." Bunny does not feel the same pressures in private practice to pursue MOC for herself, although it is an expectation that younger pediatricians in her practice are board-certified. Other study participants commented on the MOC which influenced their career transitions. For

Birdie, MOC was perceived as yet another dictated requirement. “While I enjoy studying medicine and doing the prep for the exam, it was just one more thing.” Maggie, who is retired from private practice, shared Birdie’s sentiments. “They've just got to clean that up to make it useful for people. Right now, it is just busy work. It's money but those little projects that people do . . . it’s busy work.” MOC was a factor in Birdie’s and Maggie’s decision to retire.

Discussion of system changes focused on the private practice sector, although one study participant in academic medicine commented on institutional demands to do more patient care. Study participants who had been in private practice and retired or are on the verge of retiring all shared sentiments of frustration and feelings of loss engendered by system changes. For example, using the EMR system detracted from direct patient care and eroded opportunities for collegial interaction. Study participants in academic medicine worried about the system changes to medicine overall with one volunteering to work with the AMA Senior Section to try to address problems. Only the two study participants still working in academic medicine continued with MOC. The other six study participants were relieved to be exempted from MOC and absolved of what most considered a regulatory overreach. The prospect of these regulatory burdens made retirement transition that much easier.

Mourning Changes in Medical Culture

Study participants discussed their perceptions of the changes in the culture of medicine among physicians-in-training fostered, in part, by work hour limits, an expectation for balance in work and family life, and shifts in medical education.

Residents are prohibited from staying to take care of a patient beyond their 80-hour limit (ACGME, 2016). The impact of this work week limit has been to alter the practice of medicine from staying as long as needed to ensure a patient is cared for appropriately to leaving at an appointed time, regardless of patient status.

In Maggie's experience, the changes in residency training have improved work/family life balance for residents and their families. However, there is a change in the work ethic.

> I think residency taught them, it is five o'clock and I'm going home. Whereas our residency taught you don't go home until the patient is stable. Good and bad. It has certainly helped the resident's life but it carries over to private practice.

In her private practice, the difference in work ethic ultimately impacted the practice which was sold to a hospital system, a move led by the younger partners in the practice. The pediatricians became employees and not responsible for running their own business.

> Maybe it is the age . . . I think for the young people to be able to wash their hands of managing employees, the money, the cleaning people . . . nothing bad about that . . . it's just different.

The decision to sell the practice was what led Maggie to decide it was time to retire. She was disappointed by what she interpreted as a shift in attitude toward patient care.

Carol, who works in academic medicine, described her experiences working with medical students and residents.

> I see these young people and they're so focused on balance of life. I think they forget that you can't always have everything just right going in . . . you have to invest yourself . . . I think they all want something they know they can do . . . it is

that millennial generation kind of thing . . . fear of having to give everything you've got to something because then you may not be able to do something else. From Carol's perspective, the unwillingness of trainees to fully invest themselves in their work is counterproductive to being the kind of physician who can tolerate not having everything already perfect so there is a quest to know more. Carol's quest for knowledge motivated her to make a career transition while also yearning for her younger colleagues to have the same drive.

Grace recalled the change in residents. "Going from 'I want to be the best pediatrician in the world' to 'I need a balanced life and I need time off for my family'. . . It was just a change in what the culture expected." Grace was skeptical that a balanced life and successful career are both achievable. Her bridging strategy was driven, in part, by this belief and her desire to help her physician daughter who was starting a family. Grace quit her full-time job and began bridging toward retirement because, "having lived through that [dual career physician marriage with children] as a couple ourselves, we wanted to be there to support her." Grace felt strongly about helping support her daughter's work and family life, given her own experience. While her daughter is fortunate to have this support, it does not address the structural problems that engender the work/family life balance struggle. Grace's support, which is hidden work, helps conceal larger social issues in work/family life balance of women and men.

Medical education has gradually shifted from expert physicians lecturing medical students and residents on a particular topic and making hospital rounds, doing bedside teaching, to increased use of self-directed learning using technology and team learning. In the fast-paced medical environment, there are fewer opportunities to spend time

developing relationships with learners. Pepi, a retired academic subspecialty pediatrician, spoke of the changes in teaching, the loss of esteem for teachers and fewer opportunities for truly engaging with learners.

> I don't know if we will ever capture that, the old-time teachers. The connection you had with them. The reverence you felt for this person with this much knowledge and that you were trying to learn from that . . . We don't get the opportunity to teach that much. Because when I have a resident rotate through pediatrics, I hardly get to meet them. It's not sufficient to have an impact. The work hour restrictions, your own restrictions on your time, many other things have come into play.

Pepi described the personal impact the lack of time to establish relationships and the consequent change in attitudes had on her transition to retirement.

> You have been a teacher all of your life, you have given so much. Then that last day, there is no acknowledgement. I think it would mean so much if your colleagues decided, hey this is her last lecture. Let's do something for her.

Having been retired for two years, Pepi has had time to process the profound sadness she felt when she gave her last lecture to medical students and residents; a moment when she felt regret for the loss of the relational aspects of teaching acutely. Her feelings about the experience impacted her retirement transition deeply.

The career transitions of five study participants were directly affected by the changes in medical culture associated with work hour requirements of physicians-in-training, work/family life balance expectations, and changes in medical education. The very practices of two study participants were altered by decisions of younger

pediatricians to shift practice management responsibility to large health systems. Study participants perceived that many younger physicians would prefer the security and reasonable work hours as employees of a large health care system, rather than the autonomy, demands, risk, and freedom of private practice. Changes in teaching methods and the fast-paced medical environment have diminished opportunities to develop meaningful faculty-learner relationships. The majority of study participants were unenthusiastic about the changes but viewed them as inevitable, a sign of the times with differences in work ethic and diminution of the human touch in medicine.

Overview of the 4 S Model of Transition

Central to Schlossberg's (1981, 1989) 4 S transition model are four major components in how an individual copes with transition: self, strategies, situation, and support (Anderson, et al., 2012). Self refers to the person's inner strength for coping with the situation. People who are optimistic, resilient, and able to handle ambiguity fare better. "Attitude does not buy groceries, but it can certainly make a difference in the quality of survival" (Schlossberg, 2011, p. 160). Strategies refer to coping strategies such as reframing the transition by looking for the opportunities in it. Situation refers to the person's situation at the time of transition and whether there are other stresses. For example, retiring at a time when one's partner becomes critically ill would complicate transition. Supports, such as a support group or understanding colleagues available during transition, are critical to a sense of well-being.

Coping is a multidimensional process embedded in the complex relationship between individual and environment in response to change (Folkman & Moskowitz, 2004). In the 4 S model, taking stock of coping resources is a central theme (Anderson,

et al., 2012). Individuals are viewed as having resources and deficits in coping with transitions which helps explain why individuals respond differently to the same type of transition or why the same individual may respond differently at different times. Individual potential and deficits are shaped by opportunities and barriers across backgrounds, locations, and birth eras (Anderson, et al., 2012; Fouad & Bynner, 2008; Moen, 2001). Coping, whether problem-focused or emotion-focused, has to do with dealing with problems which belies negative experience in making transitions.

Self

Self refers to socioeconomic status, gender, age, state of health, ethnicity/culture, and psychological resources including ego development, outlook, commitment, values, spirituality, and resilience (Anderson, et al., 2012). In this section, I discuss commitment, values, and identity (ego development) with brief mentions about health and spirituality. Socioeconomic status and ethnicity/culture were discussed in Chapter 4. Outlook is addressed in Strategies and Situation sections.

Commitment

All of the study participants were committed to their families. Seven of the eight continued to be married to the same person they married in college or medical training. Spouse and family issues influenced the current career transitions for all of the study participants with the exception of Camilla. Commitment to family was a compass for the careers of the majority of study participants who chose family over better career opportunities. Study participants reduced their work hours to take care of their children, stayed put when offered career opportunities that would mean relocating their families, but followed along when their spouses had jobs that meant moving. Grace explained, “I

had a couple of really big career transitions. In my case, they were triggered by my husband. In the case of going to [city], he had a great offer. I felt I could be flexible and go wherever." Commitment to family persisted in the study participants' current transitions, driven by the need and/or desire to spend more time with spouse and/or family, regardless of the phase of retirement. Bunny, who is still working, commented, "My adult kids, I find they want to spend a lot of time with me . . . Somebody wants to go to lunch or somebody wants me to visit on the weekend." Study participants were taking care of an ill spouse or parent, providing significant childcare to grandchildren, trying to spend time with their grown children and retired spouses, or taking up the slack in household responsibilities for spouses still working.

Study participants' commitment to family had an important bearing on their career transitions. Their spouses and families needed them. Being needed and having very tangible tasks facilitated coping for the study participants who were bridging to retirement or actually retired. For the study participants still working, spouse and family demands added stress to their careers which prompted their transitions to reduce work hours or work intensity. The one exception was, Camilla, who was widowed and her son grown and living elsewhere. However, she had previously devoted an enormous amount of time caring for her dying mother, staying with her around the clock in the hospital. Her mother died before Camilla embarked on her most recent career transition.

Study participants were also highly committed to their profession. Six of the eight study participants had worked in the same institution or practice setting 30 years or longer. Of the other two, Grace had several major career transitions but had worked in one institution for 15 years, ascending to the highest level of leadership ever held by a

woman at the institution. Birdie, who attended medical school at age 39, committed to work 25 years. "And that was the other thing, when you go to medical school and you take somebody's spot, you think, OK, I really need to do this for a while." She was in retirement transition a few months shy of her goal.

During their careers, most study participants held multiple leadership roles, serving on committees of their local, state, national, and international professional medical organizations. Pepi was president of her local medical society and Birdie served on a mediation committee for her local medical society. Grace served on policy committees of her national subspecialty medical organization. The study participants represented their profession by leading public health initiatives and advising non-profit groups. Service to their profession never waned. Carol and Camilla are still actively involved with state medical association business and non-profit work. Grace recently joined the AMA Senior Section and Pepi still serves on the board of her local medical society. All but two have maintained their medical licenses. Maintaining their commitment to their profession provided continuity to their identities as physicians, thus supporting their transitions.

Values

Natural born caregivers. All of the study participants were dedicated caregivers, concerned with the well-being of others; their patients, colleagues, family, and friends. Many were caring for others long before they took the Hippocratic Oath. In high school, Carol was taking care of other people's children. "Whenever we went to parties, I was always taking care of the little kids and I had two younger brothers . . ." Carol's caregiving as a teen, a natural inclination but also socially prescribed, translated into

caregiving as a pediatric subspecialist. She spent the past 30 years taking care of fragile babies and children with special needs, with no near-term intention of stopping.

Camilla believed very strongly that God directed her to become a pediatric subspecialist, and she practices her faith daily. "When I get up, I ask God to direct my path. I take into consideration everything that is happening to that person today and that I don't make any major mistakes and I don't hurt anyone." Camilla's faith is foundational to her value of caregiving.

Birdie was dismayed when the new health system that took over their private practice closed the offices for two days of orientation. Patients were forced to go elsewhere for care. "They closed the office for two days. We operated our practice on service, you know. You call me, I'll call you back. You didn't leave for the day if you had a phone call." Birdie's caring was grounded in an understanding of professionalism and patient care that she perceived have eroded with the system changes in medical practice.

Grace recalled the effects of patient care. "Some of my patients I still get Christmas cards from. I remember them vividly. I remember how much I loved and appreciated them and how much they gave me as far as warm fuzzies." She continues her caring through use of her subspecialty expertise in consulting, while also providing childcare daily for her infant and toddler grandchildren.

Maggie was heavily invested in work aiding refugee women and children and was surprised by the impact of the work which she found similar to caring for her patients.

> This just shocked me, that when I leave and go away for a week, just like when I left the practice and worried about my patients and worried are my partners

> OK…I found myself that when I am away from the coalition, wondering how are the people with the backpacks doing, how is the house doing? Isn't that strange? Is that commitment?

Maggie could not stop caring about the welfare of others. She spent her career caring about her patients and her partners and so found a way to continue caregiving in her retirement.

Whether working, transitioning, or retired, all of the study participants were actively engaged in taking care of others, whether out of a call to serve, a sense of professionalism imbued by commitment to others, acculturation of women to be caregivers, a natural inclination, familial responsibilities, or a combination of many factors, internal and external. The value of caring remains central to the lives of these third age women. By caring, the study participants imbued their very sense of self in their work. As Camilla stated, "I take into consideration everything that is happening to that person today and that I don't make any major mistakes and I don't hurt anyone." This shared desire to take into consideration everything informed the study participants' transitions.

Love is work in action: Meaningful work. Study participants' orientation to caregiving translated into their passion about their calling. They worked long hours doing demanding jobs, borne of a strong work ethic. Their love for their work helped sustain them throughout their careers. The theme of love for pediatric medicine, which held so much meaning, emerged during the course of their conversations.

Pepi recounted her work with the outpatient clinic in the last years before retirement. "It just engulfed me completely. I just loved it." Pepi had transitioned to a

new role in which she became immersed, still craving the intellectual challenge her work had always provided. As she transitioned into retirement, she still wanted to continue doing what she deemed as helpful, meaningful work. "Writing. Continuing the research work in some fashion. Being helpful if there is some data gathering . . . all the things I was envisioning for myself to keep active and alert in mind." Pepi's imperative was to remain connected to her work, to give meaning to her life and to help maintain her cognitive abilities.

Bunny explained, "I don't want to give it up. I love being at the hospital. I am seeing babies now of kids I took care of 31 years ago. I love the families." Bunny's work affirms her own continuity as she has practiced long enough to be taking care of multiple generations who value her work.

Camilla commented about her work, "I loved every day which is what I still do. Every day, coming in to something I don't know what will happen." Camilla relished the elements of surprise and discovery. Each day was a new day, an outlook emanating from faith in her calling.

Nancy enthusiastically discussed the kind of detective work required of her subspecialty.

"Yes, that's what I really loved about it. Trying to figure out what was going on and be able to really help these kids." Nancy loved a good mystery which she found in her work while also being helpful to children. Her passion for solving problems carried her for 30 years in a lonely solo practice. When she collaborated with her colleagues in other parts of the country solving the mystery of a newly identified pediatric disease, she was most excited about her work.

Maggie called the medical practice she helped start her "baby" and said, "I loved going to work. I loved doing what I was doing." She viewed her practice as a child of her own making. She nurtured this child early in the practice, working very hard to help the child grow. She mourned the separation when she transitioned to part-time. She was able to let go when the practice was no longer the child that she and her partners co-created.

Grace found great meaning and satisfaction in her work as a subspecialty pediatrician and thought leader in her field. "I loved my clinical work. I loved my patients. I think I did a good job. I think I tried very hard. I tried to be responsive and responsible. . ." It was when Grace took a position in academic medical education that she experienced dissatisfaction. She was unable to become a thought leader in a highly regulated medical education environment. She was able to sustain herself in the medical education position when she transitioned to 75% of her time in that role while working 25% on projects associated with her subspecialty expertise; an arrangement where she could be connected with her subspecialty community and do work that held more meaning for her.

The study participants' work was intellectually challenging; affirming; had elements of surprise, discovery, and mystery; fulfilled the need to be helpful and caring; was something of their own making, and was vital; a matter of life and death in some situations. With work so essential and which fulfilled their own need to be caregivers, they did not question their relevance and mattering to the world.

Identity

All of the study participants were strongly identified with their role as pediatricians as evidenced by their stories and continued connections to their profession. Carol, Camilla, Bunny, Maggie, and Pepi have maintained their medical licenses. Birdie, Grace, and Pepi have retired status memberships with their professional medical organizations. Only Nancy has discontinued her connection to her profession, although even in her case, she did maintain a connection briefly.

On the cusp of retirement, Birdie pondered,

> So, making the transition, I think it is a work in progress. You know, what am I going to do? Who am I going to be? . . . I'm thinking when you go to work every day, especially as a professional and a physician, it kind of defines who you are. You know? And so, it is a little bit scary.

For Birdie, there was fear of the unknown in redefining who she is becoming. In discussing retirement, she described the things she was going to do but said nothing about who she was going to be. She said her transition is a work in progress. She is at a crossroads developmentally.

Grace reflected,

> You know, your focus on transition is I think good because people who have been very intensely involved in a profession that they are committed to, like medicine, it's a big part of your personality. It's a big part of your self-image, your identity, your passion.

Grace, too, recognized the significance of having an identity as a physician. The possibility of losing this identity, "a big part of your personality" could have profound

consequences. Grace's awareness of this helps explain her method of bridging to slowly let go of her identity as a pediatrician. In planning to write a memoir, she also found a way to perpetuate her professional identity.

Nancy continued doing medical-legal research after she retired, but let her license lapse. Her desire to extend her involvement with her subspecialty career post-retirement indicated she wanted to maintain a connection.

All three of these study participants shared a common thread in expressing the challenges to their professional identities and took steps in their transitions to maintain a connection to their professions as a way of coping with change in their career transitions.

Carol, who is still working, was having difficulty letting go of prior commitments as she transitioned to her new role but also imbued special significance to the new role.

> I feel bad for the clinic because I had a full load before and I still do . . . I'm trying to let go of other things, I can't drop the other things . . . I have a new swansong . . . it is about leaving a legacy of importance and this need to mentor someone to do it.

Carol was doing work which was very important to her, providing opportunities to influence her field and the rewards that come with leadership. She eased her transition by framing it as doing something even more significant and ensuring it continues beyond her time.

Camilla felt that, given the odds, being an African American woman at a time few women attended medical school, she was not meant to become a physician, yet she became one. She had a sense of being called by God to her work. In her current career transition, she also has a drive to establish a research center to address the long-neglected

problem of high rates of maternal and infant morbidity and mortality in the African American population.

> I know I am supposed to be doing this. That's why it is going to affect how long I stay in it . . . I'm trying to crystallize it so that I can make a difference in these lives. For me, before I retire, I want to do something substantial in that program.

Developmentally, Camilla was at a time in her life that she was ready for authenticity, tired of inaction and prepared to deal with the consequences to her career for taking up the issue in a racist milieu resistant to doing anything "substantial" that could truly have an impact on health outcomes of African American women and their newborns. With God directing her, Camilla felt especially empowered to pursue her plans, although a serious health issue weighed on her mind. "I still have that lurking behind me . . ." Camilla's health concern also influenced her developmentally. The shortened time horizon brought home by her health issue compelled her authenticity and drive for action.

Like Carol and Camilla, Bunny was actively engaged in creating a legacy. She envisioned her sons serving as medical directors and running the business side of the practice, while she continues to consult. "I'd like for my kids to benefit and prosper from the work my husband and I have put into our practices for so many years. . . So, it's a legacy for them." Bunny's identity is embedded in her medical practice which bears the family name.

> My father would tell me, 'I just want to make sure that when you become a doctor, I know it's not something traditional in our culture and not in our generation, but I would love for you to keep your name so you can have

[surname] Clinic.' I told him, that won't be a problem. I think I can arrange that. . . I married someone with the same last name.

With her sons taking on the practice which she has poured herself into her entire career, Bunny is working to ensure her family's well-being and the perpetuation of the family name.

Pepi still does medical research and as professor emerita, maintains an office at the medical school, serves her local medical society, and maintains her international ties in teaching. "For me, it's a very important thing, being connected with academics." Pepi also funded an endowment that carries her name, leaving a living legacy to support on-going work in the field to which she has dedicated her life. Pepi's professional identity is inextricably linked to her sense of self. With the endowment, she has ensured a small measure of immortality.

Several key themes were expressed by the study participants around identity issues. There was awareness that their professional careers have significantly defined who they are and that there were consequences for their transitions to retirement. These consequences caused many to take actions that helped them maintain at least some piece of their professional identities, even in retirement. The majority of study participants were also keen on leaving a legacy, a way to be remembered, thereby retaining their professional identities in perpetuity.

There was extraordinary stability among study participants in terms of family and career, as evidenced by their long-lasting marriages and long-lasting careers within the same practice settings. The study participants demonstrated a solid commitment to their families, with spouse and family issues the primary triggers for career transitions for all

of the study participants with one exception. They were also deeply committed and strongly identified with their profession. All but one of the study participants have continued their connections with medicine. They maintain their medical licenses, serve local, state, national, and international medical organizations, and continue to conduct medical research even after retirement. Five study participants expressed a desire to leave a legacy, whether through their work, including one who had an endowment in her name, or through writing a memoir. The most salient shared values were caregiving and meaningful work. Professional identity was the singular most significant aspect of how study participants defined themselves which is fitting for all of them, given the investment of self in their careers, love for their work, and commitment to their calling. Continuity of identity was a key factor in the transitions of study participants who, consciously or unconsciously, endeavored to maintain their identities during their career transitions.

Strategies

Schlossberg's (Anderson, et al., 2012) 4 S model draws heavily on the work of Pearlin and Schooler (1978) to define strategies as ways of coping that people use to deal with transitions, including work transitions. "By coping, we refer to the things people do to avoid being harmed by life strains" (Pearlin & Schooler, 1978, p.1). Although Schlossberg's model focuses on coping strategies which are focused on problem-solving, the participants in this study also used learning and leveraging power to facilitate their career transitions. While these strategies had elements that could be conceived as coping, they were also developmental, learning for self-improvement, self-discovery, and for its own sake and leveraging power to advance careers.

Coping Strategies

Pearlin and Schooler (1978) distinguished three types of coping strategies: responses that modify the situation (taking action, e.g. asking for help from Human Resources when denied a promotion), responses that control the meaning of the situation (e.g. neutralizing the response by downplaying the value of promotion), and responses that manage the stress created by the situation (e.g. meditating to decrease anxiety about the denial of promotion or venting about it).

Modifying the situation. Six of the study participants responded by modifying their situations, taking action to alter the source of stress and position themselves to attain their career transition goals. There were two other study participants who modified their situations in earlier career transitions but did not indicate coping in their current transitions which they viewed positively.

Carol and Camilla, both still working, sought information from colleagues inside and outside of their institutions. They were hoping to better understand how to segue into roles that would transition them out of highly intensive clinical work, while staying employed full-time. Birdie voted to support her practice partners' decision to sell the private practice to a large health care system, despite reservations, and negotiated concessions during the buyout that would position her to retire on her terms. Pepi took action by doing things to help maintain a role as an academic physician. She acquired professor emerita status, kept her office space, renewed her medical license, and continued working with colleagues on medical research. She also immersed herself in her other passion, teaching dance. "But I don't know, ever since I retired, I've been very busy. Some of this time has been filled up with dance teaching. During that transition

period, it was intense work for me there also." Pepi has had a full life with her medical career and what she viewed as her other job, dance. Her actions to remain connected to medicine and stay busy with dance were about filling what could have been a great void in retirement.

Maggie, who retired from her part-time position at the private practice she helped start, modified the situation by involving herself heavily in volunteer activities.

> The first year, people would call and say, 'Do you want to do blah blah on Wednesday?' Not social things but volunteer things, because you had said no, you couldn't do that, 'I'm working that day.' I did too much.

Maggie volunteered so she could do things she was unable to do when working. She distinguished between social things, interpreted as superfluous, and volunteer things, which were of value to others. Maggie's volunteer effort was about continuing to do work that was meaningful to her and others. Nancy, too, modified her transition into retirement by filling it with social and volunteer activities.

The other two study participants, Grace and Bunny, did not describe coping in their current transitions which were viewed very positively. However, each used coping strategies in their previous career transitions which made their current transitions possible. Grace curtailed her work hours and relocated to take care of grandchildren. Bunny hired associates to reduce her clinical care demands.

The finding that all of the study participants used the coping strategy of modifying their situations through some kind of direct action is consistent with their identities as confident problem-solvers in the vanguard of their generation. They have had long careers as leaders directing patient care and taking action.

Controlling the meaning of the situation. People control the meaning of their situations by cognitively neutralizing what they may experience as threatening; reframing the way they respond, making positive comparisons (e.g. count your blessings) or by re-ordering priorities (Pearlin & Schooler, 1978). For example, if work is problematic, they value family life first. Two study participants, who modified their situations, also controlled the meaning of the situation.

Nancy downplayed the need to continue in her role as a physician when her offer to volunteer as a retired subspecialty pediatrician at a local clinic was declined. "So that was my small little foray into maybe doing some medicine when I moved here. I decided if they don't want me, I'm just going to enjoy retirement. I let my medical license lapse." While rejecting the role for herself, Nancy found other activities that renewed her sense of purpose which helped to revitalize her after she emerged from the end of a career that had, in her words, become "old" and "stale." She joined a newcomer's group and immersed herself in multiple activities associated with women's philanthropic organizations.

Two years into retirement, Pepi found herself caring for and worrying about her husband who was seriously ill. Her coping was to look for the positive. "It is a huge big transition. But such a blessing, my children, my siblings, everybody is on top of things. So much care. So much loving. I shouldn't really complain." Pepi maintained a journal of her experience with her husband's illness. Always the teacher, she planned to share it with others who might learn from her, a direct action. By controlling the meaning, both Nancy and Pepi experienced a way to be in their situations that gave reason for hope and feeling positive. They could not change the situation, but they could change their

perceptions. They combined controlling of meaning with direct action to cope with their experiences.

Managing the stress of the situation. "Stress is ubiquitous, an inevitable feature of normal living . . . what makes the difference in adaptational outcome is coping" (Lazarus, 1980, p. 52). Coping with stress has been conceptualized as the cognitive and behavioral responses that moderate the effects of stress on outcomes (Lazarus & Folkman, 1984). Responses that accommodate stress include emotional discharge, self-assertion, and passive forbearance (Pearlin & Schooler, 1978). Three study participants responded by managing stress, while also modifying their situations in transition.

Carol experienced a steep learning curve in taking on a new role, while also grappling with staff turnover and problems with clinic operations.

> Every time I do something, I am thinking, is this the right thing to do . . . there is this huge learning curve . . . the environment is not right . . . it's like things are not controlled. Today, every room I went in the equipment did not work . . . it is a mess.

Carol vented about what she characterized as "mess." She was unsettled by external problems and feelings of self-doubt. She was also frustrated with younger colleagues who she felt had yet to learn how to be honest with each other and instead came to her to mediate their conflicts. "I've heard both sides, but I don't really want to judge. You guys deal with each other. You are going to be here a long time taking care of things." Developmentally, Carol was determined to be authentic in her work and longed for authenticity in others. Talking about the problems helped her sort out some of the issues.

Birdie also vented as a means of managing the stress she felt about changes to her practice and to medical practice in general.

> I was frustrated about, and I still am, just the change in medicine and all the protocols and legislated types of things. The electronic medical records, very constraining and time consuming. We were bought out . . . They came in with a new electronic medical record. We had been doing electronic medical records for eight years and we were doing OK. As a private practice, it took the fun out of it.

Birdie was disturbed by changes in medical practice over which she had no control. Venting to her spouse, practice partners, and friends was one solution to managing her frustrations.

Pepi managed transition stress through her dance teaching. "That is a great outlet for me. It is like meditation. My mind is focused just on that one activity." She moved her body teaching dance, physically reducing stress, while also focusing her mind in meditation, another method of stress management found to be effective (Barbezat & Bush, 2014). All three of these study participants combined stress management with actions to modify the situation to alleviate anxieties while also altering their situations to reduce further stress.

Learning

All of the study participants incorporated learning as a strategy in their career transitions throughout their life course. They shared an orientation toward lifelong learning that continued into the third age. Their recent career transitions involved learning strategies that were work-related and re-creational, defined here as learning that is enriching outside the realm of work, a term adapted from Kluge (2007).

Work-related learning. Learning was work-related and for self-improvement with particular goals for five study participants: Carol, Camilla, and Bunny who are still working; Grace who is bridging to retirement; and Pepi who is retired. Camilla and Carol, working in academic medicine, also participated in Maintenance of Certification (MOC).

As Camilla explained, "You just need to make sure that you are prepared for whatever thing you want to do, so at the end of that, you have the skills . . . I will always have my credentials." She felt strongly about always being prepared and continuing to better herself out of a sense of need to stay competitive, keeping up her skills to ensure job security and being able to take advantage of job opportunities.

Carol described having a "quest for knowledge" that pushed her out of her comfort zone to venture "into a whole new world of learning." She enjoyed learning new things at work.

> You can't just be satisfied that this is enough. I think that edge is always good. To have a little bit of an edge, a little discomfort that kind of keeps you awake at night . . . so that you are always questioning.

Carol has been curious since childhood. She parlayed this curiosity into a career that has been intellectually satisfying; a life where she is rewarded for asking questions, seeking and creating new knowledge.

Grace, Pepi, and Bunny took part in other formal pediatric CME programs. Grace participated, "because I am interested in it" and "to keep up." Pepi maintained a limited role in research and plans to present lectures, so she needed to stay current. Both Grace and Pepi had identity-related needs to remain engaged in work-related learning. Bunny

found CME to be an opportunity to network with her colleagues but had conditional support for it, disapproving mandatory training like MOC. "We meet at Grand Rounds and different places. Pediatric CME all over the state . . . I think all of us should continue with CME. I think a course being imposed is something different." Bunny also engaged in informal learning during her career transition. She took on a teaching role in her private practice where she was precepting medical students and residents whom she said would "keep me on the clinical side and forefront of new developments in medicine, learning from the younger crowd." Her need to stay current and work with younger people was pragmatic and developmental. By working with trainees, particularly pediatric residents, Bunny was able to identify potential new associates to hire in her practice, while also staying abreast of new medical information. At the same time, serving as a preceptor gave her an opportunity to do something new that promoted her own development.

Grace viewed each of her career transitions as a new learning opportunity, "Here's a whole new set of things to think about, a whole new set of things to do." During her career in academic medicine, she learned how to lead, through formal leadership training and experience, and was prepared when the time came for advancement. In her current transition, Grace's leadership and connections positioned her to continue in a consulting role.

All five of the study participants had internal and external motivations for work-related learning. They were all self-directed learners with a desire for self-improvement. They also had pragmatic reasons for learning, "to keep up" and be competitive so they could continue working in the manner they desired.

Re-creational learning. Re-creational learning was for the sake of learning and the mental challenge, learning a skill that could be applied to help others or for self-discovery. Five study participants, three retired and two in transition, used re-creational learning to transition. Three of the participants were in at least one book club and two took writing courses.

Nancy and Birdie were learning for the sake of learning. They engaged in nonformal courses and participated in book clubs. Nancy learned informally about grantsmanship through work with a philanthropic organization and joined a Mahjong group to learn this game. These activities were perceived as providing "intellectual stimulation." She also attended jazzercise and ballet classes. Interestingly, although Nancy was retired the longest of the study participants, she was also the third youngest. Her desire for intellectual stimulation and physical activity spoke to a need to avoid the stereotypical image of the retiree and the actual consequences of inactivity. She is 63 years young and wants to be able to participate fully in the new life she has created for herself. Birdie planned to learn a new card game and to take a nonformal course in construction to improve her building skills to work with Habitat for Humanity, still wanting to remain helpful and contribute to something bigger.

Maggie was involved in learning chiefly through self-discovery. She spoke of learning about herself through her volunteer work advocating for refugee children and families.

> I am doing all this stuff . . . learning all about the law . . . I'm learning so much and doing such adventuresome stuff . . . I have learned more about myself. When

you are working, you are just a pediatrician . . . When you are retired, maybe it is that I have time to think. I think I am learning more about myself.

Developmentally, it is the second half of life that people move toward introspection and work on individuation, becoming more the person one is and to incarnate one's potential, becoming whole (Jung, 1960). Maggie's comments suggest she is working on individuation.

Grace, who belongs to two book clubs, took a nonformal course on how to write a personal memoir, an exercise in self-discovery. "I think living through the 60s and 70s as a young woman physician in that time period, there is something to say about that. A blue-collar background. A blue-collar city." For Grace, writing a memoir would give her the chance for introspection while also creating an enduring record of her life.

Pepi attended a writing workshop offered by a local non-profit organization. Her goal is to write a family history about the women in her family. "My family, I think from my great grandmother, has very strong unusual kind of women. I thought I would write about their histories." She also became immersed in self-discovery with the sudden onset of her spouse's chronic, debilitating illness. "I'm beginning to write things down in a more readable way as it is happening . . . the impact of it and other things, nobody's prepared for it . . ." Pepi viewed her difficult experience as an opportunity to learn.

Nancy and Birdie have a more extroverted approach to their re-creational learning. They are involved in activities that are socially-oriented. Nancy has been retired five years but is seemingly not as engaged in self-reflection. Possibly because she is younger than the others and/or because she is focused on making up for lost time when she was a busy practitioner living in a community where she did not fit in. Birdie is just

on the cusp of retirement and has not had time for serious self-discovery. Grace, Maggie, and Pepi, who are older and who gradually reduced their work hours and work intensity, are doing more introspective re-creational learning.

Leveraging Power

Healers throughout human history have been accorded power and special status. Because of their status, U.S. physicians may be more aware of power and adept at its uses. In this study, six study participants leveraged power to make their career transitions. In three cases, it was the power of influential people in their institutions or other organizations. In three others, it was the power of colleagues or other personnel.

Three of the study participants leveraged the power of influential people in leadership positions. Camilla held meetings with high level administrators at her institution influential in helping her establish a diversity research center. Grace leveraged her relationships with national leaders in her field, with whom she had prior working experience as a leader, to position herself in her current transition as consultant. "I had several other grants . . . I was very familiar with the people . . . I had always been active in collaborative-type work. So, they knew me . . ." Being "known" in her field and knowing how to exercise influence ensured that Grace could continue to consult, extending her bridging to retirement phase which, for her, helped ease the transition. Pepi drew on the power of the relationships with medical education leaders in her home country to enable her to introduce a curriculum that "caught on like wildfire. I can proudly say I was a part of that, through my mentor . . ." The ability to develop an international reputation in her field, by teaching in her home country, was essential to Pepi's career transitions, ultimately transitioning to professor emerita in retirement.

Three other study participants leveraged the power of their colleagues. Carol called on her colleagues to help her navigate the transition. She needed their expertise to understand the clinical and administrative processes of her new role and to help resolve personnel issues. She knew she would be successful by identifying and leveraging the power of colleagues. Bunny added associates to her private practice who could take on more of the clinical responsibilities. The power of this solution enabled her to take control of hiring and training personnel which had been a source of difficulty for the practice. Birdie leveraged the power of her practice partners' expertise and "laid a foundation" for the possibility of retirement through her contract negotiations. The expertise of her practice partners, particularly those already retired, was invaluable.

The primary coping strategy of study participants was modifying their situations through some kind of direct action—gathering information, pursuing other interests, or negotiating arrangements to meet their needs. Modifying the situation involves taking action, something that is second-nature to these women who have been directing patient care and solving problems their entire careers. They also used learning and leveraging power, strategies that do not conform completely with Pearlin and Schooler's (1978) coping classification scheme. Study participants who were still working participated in work-related learning, as did one transitioning and one retired study participant. Those still working in academic medicine had institutional pressures to participate in the Maintenance of Certification program. The others had practical, social, and/or identity-related reasons for participating in continuing medical education. Five study participants, two in transition and three retired, participated in re-creational learning. Of these, the study participants who were retired and older were more likely to engage in introspection

and self-discovery, associated with the developmental process of individuation. None of the study participants who are still working described re-creational learning. Four of the six study participants who leveraged power were situated in academic medicine where there is an organizational hierarchy and culture, the institutional convoy, which fosters leveraging power and where they have exercised power as leaders in their profession.

Situation

Situations vary for each individual according to a number of factors including trigger (what initiated the transition), timing, control, role change, duration, previous experience with transition, concurrent stress, and assessment (how the individual views the situation). Situations are the context, what is happening at the time of transition and the individual's perceptions of it (Anderson, et al., 2012). In this section, I discuss triggers and the personal contexts in which other factors above are integrated.

Transition Triggers

Transition triggers are life events, anticipated or unanticipated, which stimulate self-reflection and new ways of looking at life (Anderson, et al., 2012). Transitions can be triggered by something that happens to an individual or to someone close to the individual. Three transition triggers were identified in this study: spouse and family issues; work-related issues; and other interests. Six study participants had two triggers while one study participant had one trigger and one had three.

Spouse and family issues. Spouse and/or family issues were triggers for all the study participants with the exception of Camilla. Carol had hopes of having better control of her schedule so she could spend more time with her recently retired spouse and travel to see her children, while still working full-time. "I feel really bad for my husband

because he's retired. He wants to go do stuff, but I've got too many things to do." Carol's conflicted feelings led her to consider and, ultimately, segue into a new position where she had more control of her schedule so she could still work full-time but had a little more time with family.

Bunny's two sons, partners in their start-up medical management service, wanted more of her time in developing their business, piloting strategies with her practice. In addition, she also had to attend to her 82-year-old father who was recently hospitalized. Bunny belongs to the sandwich generation, caught between the demands of her children and parent, while working full-time. She foresees multi-generational caretaking as a serious issue not only for her generation, but the ones to follow. "I think as we continue with longevity, one of the additional stressors is taking care of parents as well as children." For Bunny, these family demands triggered her transition to less clinical responsibility and more time for family and self-care.

Grace and her spouse had been contemplating a move to be nearer their children and grandchildren. With another grandchild on the way, they began preparing to leave their jobs. The discovery of her spouse's medical condition prompted his retirement, reinforcing their decision to relocate near family, and to do so quickly. The sudden matter of a medical problem triggered a rapid transition. "He was operated on in April and we moved in May . . . Looking back now, it was sort of crazy." Grace experienced concurrent stress with this transition, leaving her full-time position while maintaining a part-time directorship, relocating, and dealing with her husband's recovery, all in a very short time frame. Grace's priority was her family and she stuck with the plans. This transition led to her current transition to consultancy.

Birdie was affected by her spouse being retired and the death of her spouse's brother.

> I think the fact that he's retired and his brother died and he started working on me saying, 'You know, come on, retire.' I think when you have a sibling who dies, you start looking at, hmm . . . got to get started on the bucket list.

Although she had already been considering retirement, her brother-in-law's death put Birdie's decision to retire in stark relief, as did the pressure from her husband.

Pepi also transitioned to have time for family. "Giving a lot more time to the grandchildren . . . We want to keep very close to them. My children didn't have that benefit, my parents being in another country." Pepi gradually reduced her work intensity and work load. Her final career transition to retirement gave her control over her time. In her emerita status, she could continue to do research, maintaining her career identity, but had time for family. In early retirement transition, Pepi was so busy she lost track of time. "In this first year, time went too fast. I was mostly clearing the office, clearing the home, taking time off and going and visiting children . . . I don't know where the first year went." Her assessment of early retirement transition was upbeat, a whirlwind of activity. Pepi is now preoccupied with taking care of her seriously ill husband. She worries about him and is currently unable to pursue other plans.

Maggie's transition to retirement from part-time contract work was triggered primarily to have more time with her family. She had already significantly reduced her effort.

> Then my son went into high school. I really cut down. Not so much because he went into high school but because life was just horrible here, nobody was ever at

home together . . . I think by high school, we just got tired of it. So I went even lower time and dropped out of the call schedule.

Maggie's sacrifices earlier in her career to accommodate her family's needs led to a situation where she grieved the loss of her status as a partner in the practice she started. It meant she was no longer included in practice decisions. It took her two years to adjust. "People go through a grieving thing when they give up their practices . . . that was a real shock . . . but seeing my patients, there were very few days that it was not fun." The situation with her final career transition to retirement ten years later was straightforward. With the practice changing ownership, she was emotionally prepared to leave, having already grieved the earlier loss. Her assessment of her transition to retirement was favorable.

Nancy's spouse retired due to issues with his practice. "That was the catalyst for him to retire and certainly when he retired I wasn't going to hang around. That's when I retired as well." Nancy was already emotionally prepared to retire. Her assessment of the situation was quite positive knowing she would move to a city she loved and lead a life doing things she had missed while she was busy being a pediatrician.

Work-related issues. Five study participants' transitions were associated with work demands. Carol and Camilla knew that they needed to move toward a less demanding clinical role. As Carol put it, "Because of aging, you can't do as much . . . the ability to do all these procedures . . . making sure that, you know, the long hours, you have to be alert at three in the morning." Similarly, Camilla was aware that a time would come when the physical and cognitive demands of long hours and fast-paced work were no longer sustainable. "I'm going to have to work a little bit smarter and begin to do

more things in the reading and writing category, as opposed to the intensive care work." With this awareness, they were transitioning into roles where they could continue to maintain full-time positions but with reduced high intensity work demands.

Bunny experienced a high level of stress in the workplace when she was in solo practice. She began adding associates eight years before her current transition which finally brought her to a place where she could focus more on administrative business, freed from some of the demanding clinical work. "Just having the freedom that I didn't have in the past." Bunny felt so good about the changes in her situation that she imagined herself as already being retired, although she technically still had a full-time position.

The primary trigger for Birdie's and Maggie's transitions was when their private group practice was sold to a health care system. The buyout created the conditions that altered feelings about work. Having to master yet another electronic medical record system that was time-consuming and constraining was frustrating. Birdie stated, "I think would I have practiced a little bit longer had it not been this situation, yeah, probably. If it were fun. But it's no longer fun. It took the fun out of practice." After the buyout, she continued working 16 months, considering retirement at some point in the near future. "The transition became easier for me once I made the decision that I was going to quit. Part of that transition, I was getting worn out. I was coming home and having to do the charts . . . I was doing charts until midnight." Birdie was emotionally prepared for the transition to retirement, worn out by the changes imposed. Having already transitioned to part-time contract work, Maggie was able to let go without reservations.

Other interests. Bunny was an avid runner, motivated in part by a desire to maintain her physical health, given a family history of heart disease. She had a running injury from overtraining but healed. "So, I'm back to my running . . . I got my husband to start running . . . our staff are running." Bunny was clearly passionate about her running which takes time, something she made possible through her career transition to doing less clinical work.

> Nancy wanted to pursue other interests. About her subspecialty practice, she said, It was just old. It was getting monotonous, maybe it wasn't fun anymore. I needed a change. I needed to experience something new. I don't think I would have kept on working and working. You know, how many physicians work until they die.

Nancy felt strongly about creating a new life for herself. She feared becoming like some of the physicians she knew who never did anything but work, something she viewed negatively. She wanted to trade "old," "monotonous," and "working until death" for "new," "fun," and "change." Her transition to retirement held great promise where she could start a new life.

Pepi had a keen interest in dancing and teaching dance which influenced her decision to decrease her pediatric work time to 60% at the end of her career. "My dance interest was my other full-time job at home. So, because of all that, I thought part-time work is just fine for me." In retirement transition, she continued to teach dance. She also had a strong urge to pursue writing a history of the women in her family. Pepi had a strong conviction about having multiple interests. "I feel everybody must have an interest outside of work . . . There is so much out there. . . . another interest is always

good." Pepi's situation transitioning to retirement and beyond ensured she had many interests that would keep her feeling vital and connected.

Triggers for study participants still working had to do with positioning themselves to be able to extend the horizon for their work lives, while also enabling them to have more time for family or other interests. Triggers for those bridging and retired were chiefly about more time with spouse/family. An underlying theme for all triggers was the attempt to find a better work and family life balance.

Individual Context of Transition

In addition to triggers, other situational factors associated with individual context involve control, timing, duration, previous experience with transition, role change, concurrent stress and assessment of the situation (Anderson, et al., 2012; Goodman & Anderson, 2012; Schlossberg, 2011). In this section, I review data on control, timing, duration, experience with transition, and concurrent stress.

Control. Each of the study participants' career transitions was anticipated, giving them control over their transitions. However, Maggie, Birdie, and Grace had unanticipated events antecedent to their career transitions not in their control. For Birdie and Maggie, the buyout of their practice irrevocably altered their feelings about their future practice of medicine. Maggie, who had already undergone a career transition to part-time contract employee, was emotionally prepared for career transition to retirement and had no problem making a rapid decision. Birdie took more time in making her decision and was more conflicted about her career transition. Grace's husband's sudden illness put her anticipated career transition plans on the fast track which was a great source of stress. In her current transition, her choices and pace are within her control.

Timing. Study participants used a gradual process to reach their career transitions toward retirement, ranging from approximately one to twelve years, associated with the triggers previously described. None of the study participants made her career transition on the basis of a socially-prescribed idea of age for retirement. Carol, Camilla, and Bunny who are still working full-time intend to work as long as they are able. However, because of the intensity of their subspecialty work, Carol and Camilla are making adaptations to reduce work intensity and hours because of age-related issues. Pepi, who formally retired at age 70, is still actively involved in medical research at age 72, and Grace, also age 72, is bridging to consultancy. Nancy, who retired at age 58 from her clinical practice, was well ahead of typical retirement timing. Birdie, on the cusp of retirement at age 68, reported that she would have continued working had external events in her practice not changed. Maggie, who retired at age 66, was happy in her work but external events in her practice also changed.

Duration. There was much variability in terms of career transition duration. Among those still working, Carol, predicted it would take a year to adapt to her new role; Camilla predicted five years to achieve her transition; and Bunny's career transition had no predicted duration. Grace anticipated another year in bridging mode, although she left open the possibility of continuing as a consultant indefinitely. Birdie predicted it would take a year to adjust to her retirement. Pepi took two years to adjust to her retirement and then was impacted by her husband's sudden grave illness, putting her into a new transition with indeterminate duration. Nancy's career transition to retirement was of short duration, in her mind, practically overnight, although she spent two years in post-retirement transition doing many things to adjust. Maggie's career transition to

retirement was of short duration, although she had spent the last ten years preparing for it. Her post-retirement transition also involved activities to facilitate her transition.

Experience. The study participants had little experience with major career transitions except Grace, who had several career transitions involving physical relocation and change in job to high level administration in academic medical education. All of the study participants had been situated many years within a single organization, even Grace who was with one institution 15 years. However, study participants with limited major career transition experience, underwent transitions such as promotions within their academic departments, from full-time to part-time work, or a change in job status such as moving from partner to contract employee. These smaller career transitions helped prepare them for their current career transitions.

Concurrent stress. Half of the study participants described stressful situations as the context for their transitions. Although four others had experienced stress in earlier transitions, they viewed their current career transitions positively and non-stressful.

Carol felt very unsettled in transition, experiencing a steep learning curve while also grappling with staff turnover and problems with clinic operations. She described her work environment being in "just huge turmoil." A whole new team had to be constituted with redefinition of roles. The workplace was not set up for the kind of patient care she envisioned. There were equipment failures and inadequate staff so that the workplace felt "out of control." She also felt guilty about not spending time with her spouse, adding to her stress.

> Camilla was acutely aware of pressure to perform and stay on top of her game: I think it's a written sort of thing here that as long as you are productive and can do things to contribute to the department, you are OK. . . if you can do the work and you're here, nobody's pushing you out [due to seniority] . . . if you can't work, then you are gone.

Her efforts to develop a diversity center at her institution, where she could transition away from full-time intensive care and do more research and writing, were in keeping with the need to be productive to meet institutional expectations and ensure she could continue to fulfill what she considered was her God-given calling.

Pepi shared contradictory sentiments about her transition to retirement. She reported, "It was the smoothest transition that any faculty person can expect. I was very fortunate to have this step-by-step transition. Most of the time, it is an abrupt transition for people which is very hard to handle." Yet, she also experienced profound sadness at letting go.

> My last day in the clinic, I was seeing the last patient . . . I just blurted out, 'this is my last day of seeing a patient.' Because I think I wanted some acknowledgement of that . . . I closed the door. I sat inside in the examining room. I must have sat in there for ten minutes. I was just pretending to be writing notes in case somebody walked in. But I didn't want to cry . . . Had I walked out, I am sure there would have been tears in my eyes . . . I think it is very hard for people who are working with patients day in and day out to make that transition, make that cut . . . maybe I am just over-sensitive.

Pepi shared her experiences with her local medical society, wanting to help colleagues better prepare for their own retirements. Telling her story was also a way to grieve.

Birdie had mixed feelings about her situation. She was frustrated about the changes in the practice of medicine that triggered her decision to retire. The thought of retiring was also a source of anxiety, although she also imagined it would be great.

> I'm anxious about the financial part of it. You know. You have a certain lifestyle and OK. And the financial advisor says, 'I think you'll be fine' . . . part of me thinks it is going to be great. But you know, I have a lot of trepidation about it. I'm thinking when you go to work every day, especially as a professional and a physician, it kind of defines who you are.

Birdie's feelings reflect the timing of her transition. She was right in the midst of it, still going to work at the time of the interviews. Although she had been preparing for retirement for months, she had not begun to experience it.

Carol, Camilla, and Pepi were all in academic medicine. For Carol and Camilla, the work environments fostered stressful transition contexts but they also had added, self-imposed pressures. Carol worried about her spouse and Camilla worried about living up to her calling. Although retired and still doing some research, Pepi experienced sadness but also joy during her transition to retirement. She was celebrated at an event which provided her recognition and ceremonial closure she had longed for at those moments of giving her last lecture and seeing her last patient. In early retirement, she was happily busy visiting her children and grandchildren. Now, as she cares for her husband who is seriously ill, she feels distraught. Birdie, who was in private practice, was in a situation

where she had prepared to let go but was only just beginning to process its meaning, making it difficult to articulate her thoughts.

Bunny did not have the same stress as when she "was trying to do it all." She crafted a situation where she has the freedom and flexibility to determine her schedule. "I like to be able to say on a day, 'I don't want to work this afternoon. I want to go to the gym . . . I'm acting like a retired person." Bunny's newfound freedom and the pleasure she takes in working with her sons on the business of her practice have made her transition feel like retirement.

After relocating, Grace resigned her part-time role directing a federally-funded project but remained as a consultant. She could focus on taking care of her grandchildren, something she wanted to do for years. She still has a hand in consulting work that keeps her connected to her professional identity. "I am beginning to feel what I think a retired person would feel like, which is free. To feel that I can, now because of babies, most of the time is going to that, but that's a choice." It is noteworthy that Bunny and Grace reported feeling as if they were retired, although Bunny was working full-time in her private practice and Grace was providing childcare, while also continuing to do subspecialty consulting work.

Maggie was happy working in her part-time contract position at the time the practice was transferred to a new health care system. However, she never wanted to practice for anyone else. "When I retired, even though I was really quite happy and not stressed, I knew it [the private practice] was going to change and I didn't want to be a part of that change." She intuited that the changes would not be good ones and felt vindicated by observing the challenges of her practice partners who continued to work. "My gut

feeling from watching them go through what they've gone through . . . I had no qualms about it. I knew there was no way in heck that I was going to do it." Maggie's certainty about her decision to retire made the transition non-stressful for her although she was concerned about her patients and practice partners left behind.

Nancy was also relieved when she retired. She had been "escaping" the community where she had lived and practiced for 30 years.

> We would escape to introduce our children to theater, Broadway . . . that is the way we ended up surviving for 30 years . . . I wanted to do something when I retired that I didn't have time for when I was in a busy practice. Part of that was making lots of new friends.

In transition into retirement, Nancy perceived her transition situation as highly positive, providing an opportunity for making many new friends and having a completely new and different life.

Three transition triggers were identified in this study: spouse and family issues; work-related demands; and other interests. Spouse and family issues were the leading transition triggers, affecting all of the study participants with one exception. Of the seven, four had retired spouses who influenced their career transition situations and three sought more time with their children and grandchildren. For the three study participants still working, work demands were another trigger. They recognized a need to transition to less rigorous physical and cognitive work; a need to stop trying to "do it all," while still wanting to work full-time. Aging was a factor for the two who were doing subspecialty intensive care work in academic medicine. Two study participants, one transitioning and one retired, were impacted by changes to private medical practice they

perceived would have negative consequences. Three other study participants, one bridging and two retired, wanted to pursue other interests.

The contexts for study participants were experienced as stressful by four study participants and non-stressful by four others, much of it associated with timing. Those early in their current transitions experienced their situations as stressful. Those who had been preparing for their transitions gradually did not describe stressful transitions. Having control over the decision to make a transition did not ensure a stress-free transition experience.

Support

Support is defined as intimate relationships, family units, networks of friends, institutions, and communities to which people belong (Anderson, et al., 2012). Functions of support incorporate one or more of the elements of affect (e.g. admiration, respect, love), affirmation (e.g. expressions of agreement), aid (e.g. money, information, time, entitlements) and honest feedback (Kahn & Antonucci, 1980). Schlossberg (Anderson, et al., 2012) also draws on the social convoy model, used by Kahn and Antonucci (1980) to discuss the life course nature of social relationships, with emphasis on emotional closeness (Antonucci, 2001). In this section, I discuss supports and revisit the subject of social convoy discussed in Chapter 4.

Spousal Support

Seven of the study participants have always been married to the same person. Five were in dual career physician marriages. As Grace explained, "I think the marital break ups were less common with dual physician couples . . . it was what you wanted and therefore you would make it work."

Four study participants indicated spouses were their primary support for career transitions. Of these, two were married to physicians, one to a dentist, and one to an executive. Their comments about spousal support were associated primarily with their careers or helping out with their children; enacting affect, affirmation, and aid functions.

Grace stated, "My husband has been hugely supportive and never pushed me one way or the other. It was whatever feels right to you, that is what you should do." In Grace's most recent career transition, her spouse has been there with her, helping to provide childcare support for the grandchildren as she continues doing consulting work.

Birdie did not enjoy being a stay-at-home mom. "My husband said, 'What do you want to do?' I said I want to go to medical school. He said go for it." Going back to school at the age of 39, with children at home, meant a huge commitment from her spouse whom, she noted, supported her throughout her medical training and career. "He was very instrumental and helpful." Her spouse has reassured her in times of doubt as she nears retirement; her decision, although in his retirement he has been encouraging her to retire.

Bunny's spouse was there for her when work demands interfered with parenting. He has remained a key source of support as she transitioned to her new administrative role and reduced work hours. He is also involved with her business affairs and runs half-marathons with her. "We spend a lot of time together . . .The grandkids find it odd when they see us not together." Support from Bunny's spouse for her transition means she is able to continue with her plans developing the practice as a legacy for her family.

When Nancy transitioned to doing only subspecialty pediatrics, she was able to curtail her work, seeing fewer patients and working fewer hours, because of her

husband's support. "I had a very small practice," earning much less that her colleagues in general pediatrics. They eventually co-located offices, where they shared the same space and administration, and he was involved in business affairs. Like Bunny, Nancy was in a partnership with her spouse that involved both private and business affairs and thus, she saw him as her primary support. Having retired himself, Nancy's spouse was in support of her transition to retirement.

Half of the study participants volunteered information indicating that their spouses handled the family finances. They made comments such as, "I didn't worry at all because my husband was the genius in the family. My paycheck went to the bank. That's all I knew . . ." and "My husband took care of all of that. He's very financially savvy." They were in partnerships where this division of labor, apparently based not so much on gender roles but on skills, was a comfortable arrangement. For, Camilla, however, the loss of her second husband, contributed to regrets about finances.

> I think if I had it to do all over again . . . number one, I probably would have thought more about financial planning so I would be, even though I never thought finances was part of my life. I never looked at it as being important. I think if I had a little more financial security, because I didn't know my husband would die . . . He was such a protector. You think it's going to be OK but it didn't work out that way. He was the financial person.

Camilla's expression of financial insecurity aligns with her plan to continue working full-time.

Spousal support played a vital role in all study participants' most recent career transitions with the exception of Camilla. Spouses who were retired influenced study

participants' decisions to retire or modify work demands. Spouses still working supported study participants so they could retire or curtail work.

Social Convoy

The social convoy for medical practice partners involves relationships with a high degree of interaction, flexibility, confidence in capabilities, and trust. Partners cover for each other, meaning if one is scheduled to work at a certain period but needs to be away, she has to call on a partner to step in. They negotiate their holiday and vacation schedules. Most of all, they must have confidence that when they are handing a patient's care over to their partner(s), the patient will continue receiving the kind of care they envision. There must be a sense of trust in the work they share, potentially involving life and death situations, as well as administrative and financial matters. In the hospital, having spent perhaps several nights on service, they see each other disheveled, exhausted, and vulnerable.

The practice partners, whether academic or private, with whom the study participants worked most closely, were cited as primary and secondary sources of support to more study participants than colleagues, family, or friends. These partners were their workplace social convoys, with whom they worked closely over the course of three decades. Figure 4 depicts a modified version of the social convoy model exhibited in Chapter 4 based on the following data.

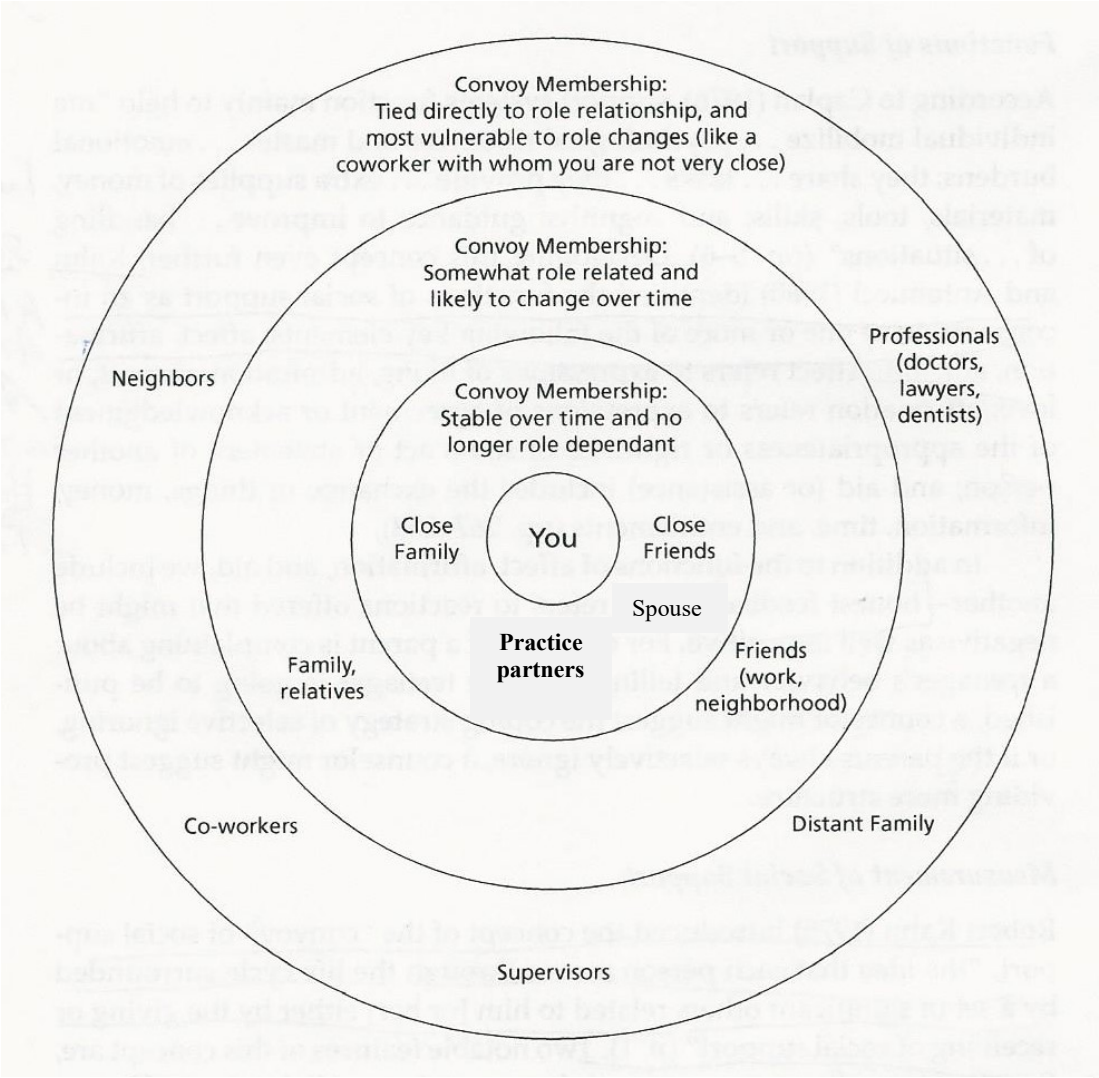

Figure 4. Convoy of Social Support for Women Pediatricians. Adapted from "Counseling adults in transition: Linking Schlossberg's theory with practice in a diverse world" (4th ed.) by M. L. Anderson, J. Goodman, and N. K. Schlossberg. Copyright 2012 by Springer Publishing Company, LLC.

Carol worked in the same place for 30 years, as did her practice partners. Her relationships have been very stable over time. Her practice partners became like family in the inner circle of her social convoy. When considering her transition to the outpatient clinic director role, her practice partner encouraged her to take the position. "She came to me first, kind of like, I really want you to think about this." Carol looks to her practice partners and other peers now to gauge timing of retirement. About the practice partner she was replacing, she said, "I think as long as I'm feeling well and I'm still healthy and I can keep going, I'm going to go. I maybe end up being like her and waiting until I'm seventy-two. She looks great." Carol shares a running joke with a long-time associate from the same state and who has a high-level position at another hospital in the city. She said whenever she sees her friend, they ask about each other's retirement plans. "We've always said what we wanted to do is be able to sit on the porch and drink lemonade and talk about people like they do in the South." In its simplicity, the idea seems both appealing and appalling to them. The chance to relax sounds good but could translate into frittering away time and feeling useless, a future to which neither woman currently aspires.

Birdie's workplace social convoy during her career was her private practice partners. Over the years of practice, Birdie enjoyed the camaraderie and the intellectual stimulation of the exchanges with them. The significance of the workplace social convoy was expressed in Birdie's observation that "you are thrown with people you spend more time with than your own family." She also described the age-related aspect of social convoy in the life course. "The nucleus of the practice, the physicians, we were all the same age, basically, within ten years of each other. Three of us all born the same year

within a month of each other." Birdie and her partners began their careers together and were retiring in close succession, coming off the conveyor belt at last. Birdie plans to continue interacting with her practice partners who have also been lifelong friends, an arrangement that makes her transition to retirement easier.

Maggie's entire career involved working with her original practice partner, although others were subsequently added to the practice. She was very close to her practice partners and her career decisions were made in consultation with them. Maggie felt deep gratitude toward all of her practice partners. "I had wonderful partners who allowed me to do it [work part-time]. If I had been with a bunch of men, do you think they would have allowed it? I really have to thank them." Maggie referred to her original practice partner as her best friend. They worked together for 30 years and, although her friend retired five years before she did, they continued to maintain a very close relationship. Their relationship is a prime example of the kind of bond that many women establish to navigate the workplace and their careers.

When Pepi was transitioning to retirement, she sought advice from her recently retired workplace social convoy. She learned that "a lot of retired faculty do research, they want to continue . . . My plan was never to be done with research . . . being connected with medicine was my plan." She took cues from her workplace social convoy to continue research in retirement.

Family Support

Other family besides a spouse was the primary support for Camilla and secondary support for the career transitions of three others, Bunny, Grace, and Pepi. Camilla always consulted her father, when he was living, and older brother when it came to her career. In

her transition to the diversity center, she still consulted her brother. "I'm still moving forward. I talked to my brother . . . He practiced diversity law. He's pretty bold in things." Although Camilla's spouse had died, it is likely she would have still called on her brother first for support in career decisions, since this was a well-established practice. She had relied on him for advice in deciding which university to attend for medical school and many other major career decisions.

For Grace, Bunny, and Pepi, family was a "rock," "team," and "such a blessing," respectively. From their perspective, their commitment to their families, which meant accommodating spouse and family needs during their careers, was balanced by support they felt in return. There was never any question that they were in it together.

Friends

Friends were secondary and tertiary supports to Nancy and Birdie, respectively. The new friends that Nancy made when she first retired and moved to another city helped her connect with philanthropic work and re-creational activities that kept her "busy" and energized. Birdie relied heavily on her close friend from residency training days. They have remained close friends and medical colleagues, consulting each other about pediatric medical concerns and personal matters. On Birdie's list of things to do in retirement is home remodeling for her friend.

In summary, seven of the study participants have always been married to the same person. Five were in dual career physician marriages. Half of the study participants indicated that their spouses were their primary support for career transitions; providing support in terms of affect, affirmation, and aid. Spouses gave advice about career

decisions, as well as being responsible for family financial matters. Two study participants' private pediatric practices were co-located with their spouses' practices.

The practice partners, whether academic or private, with whom the study participants worked most closely, were cited as primary and secondary sources of support for more study participants than colleagues, family, or friends. They were the workplace social convoys of the study participants for approximately thirty years. Although these working relationships were technically "role-dependent," they were extremely stable over time, involving trust and sharing in decision-making about patient care and other business. These relationships put the practice partners in the circle of support nearest to the study participant, rather than the outer circle that typifies workplace relationships.

Other family was a primary source of support for the one study participant who was widowed and relied on her brother for career transition advice. Family was the secondary source of support for three study participants who viewed their families as an essential part of their career transitions, just after their spouses.

Social support is deemed essential to handling the stress of transition (Anderson, et al, 2012). Study participants relied primarily on their spouses and social convoys of practice partners for the support in making their transitions. These supports included the key elements of affect, affirmation, and aid.

Into the Light: Transition Metaphors

All of the study participants were asked to give a personal metaphor for their late career transitions, including retirement. They had time between first and second interviews to contemplate their metaphors before responding. Several study participants

provided more than one metaphor, and metaphors also arose during the course of the interviews. Common themes of transition metaphors included:

1) Natural world – autumn, swansong, guts of life, light to my path, one more hill to go over; big fish/small pond; letting in fresh air; sunshine, light beyond the door; sunset
2) Quest – for knowledge, adventure, a "lark;" one more hill to go over; seeking what lies ahead
3) Freedom – from responsibility and demands on time
4) Books – book of life with chapters; well-read book completed, starting a new book
5) Portals – opening a window; opening a door
6) Home – leaving home; sliding into home base/going home
7) Sadness about change ripping off Band-Aids® slowly; leaving a world behind; have I left the room I have been in forever? going into the sunset; going away "poof."

There were also distinctions developmentally between the study participants who were still working and those who were bridging to retirement or retired. For the three still working, Carol, Camilla, and Bunny, there was a quality of drive to their metaphors with no indication of plans to stop work. The metaphor that most resonated with Carol's recent career transition experience came up naturally in the conversation where she lamented, "I'm thinking all the time of what I need to do but I just can't get it done . . . I feel like I am tossing a bunch of balls up in the air." When it was suggested to her that "juggler" might be one metaphor, she laughed and said, "Yeah, it kind of is. I am a

juggler. But I don't want to be juggling." Carol also used the metaphor of a quest for knowledge as the driving force in making her career transitions.

Camilla's metaphor was that "God is going to direct my path. He will be the light to my path." It was her metaphor for all of previous transitions and continued with her current transition. Camilla spoke about not knowing what is going to happen and not planning for retirement. She interpreted this as meaning, "I am supposed to keep working. Sliding into fourth base . . . sliding into home base." That is to say, she plans to keep working until she dies and "goes home."

Bunny explained,

> All of my running partners, everyone I have been training with, always joke about I'm like a little bunny going over the hill. Once I come down, I say, 'Oh, there's one more hill I need to go over before we turn around.' I guess that would be my metaphor.

Bunny's metaphor for career transition indicates a sense that there is always more to seek and the need to keep moving.

The metaphors for those in transition to retirement or retired were more emancipatory, philosophical, and reflective. Freedom was Birdie's chosen metaphor for her imminent transition from working as a general pediatrician to being retired. She clearly relished the idea of being free from the constraints of her work. She also described life as a book with chapters. Chapter One is youth, experimenting and coming of age. Chapter Two is the "guts of life" which Birdie perceived as the most fun. Chapter Three is a new chapter she has yet to write. Birdie's Chapter Three represents the third age in which she can exercise her newfound freedom to pursue other interests.

Grace used several metaphors to describe her career transitions. She talked about "ripping off Band-Aids® slowly," as a metaphor for gradually phasing out of paid employment. She described her previous career transitions as,

> Something like setting aside a well-read but difficult book and opening up a new book that is also difficult and challenging but you are glad for the new one.
>
> Here's a whole new set of things to think about, a whole new set of things to do.

Grace noted that in her most recent career transition, she experienced a sense of freedom from responsibility and what it felt like to be retired. She found that her metaphor for this transition differed from earlier career transitions.

> I feel like I am at a door that has been opened but not very much and a little bit of sunshine is shining through the cracks in the door. Now I am opening the door. It is sunny, bright, and pleasant out there. It is time to walk through the door. But it's not like the door hasn't been opened at all. It was opened but I wasn't ready to open it all the way. Now I am actually. When I open the door does that mean that I left the room I have been in forever? Maybe not. Maybe I will walk back if somebody asked me to do something to help them. It doesn't preclude going back into the room if that's helpful to somebody.

Grace's metaphor suggests she is still bridging developmentally, leaving her options open about her career transition. She used this metaphor after having discussed the possibility of consulting indefinitely.

For Pepi, retirement was leaving a world behind.

> I tell you when a transition was very sad and stressful was when I finished high school and I was going away to college. It was like your world, you are leaving

> behind and you are moving on to something else. I think retirement from your profession is sort of like that. You are leaving a world behind and you are going away from it.

Pepi's association of the sad, leaving home for college experience with retirement speaks to the sadness she felt about retiring. She left the metaphorical home of her profession to navigate a new and uncertain time in her life.

Maggie stated, "Lark is a metaphor for all of my transitions." Attending medical school was a lark since she only took the entrance exam on a whim and at the last minute because her roommate was taking it. It was a lark for her when she and her first medical partner "got hooked up" to practice together in her first job as a pediatrician. Even the way she retired was a lark. "Like I said, it was a lark. The hospital coming in, it wasn't a discussion. I knew I wasn't going to do that." Maggie's use of "lark" is in terms of serendipity. It can be a source of or quest for amusement or adventure. Larks happen, they are not planned. There is a quality taking things as they came. Maggie added a metaphor in a letter when she returned her member check comments. "It was fun to reflect on the past as I try to figure out who I am and what paths I would like to wander down at this time." Developmentally, she is in the midst of self-discovery and doing it at a leisurely pace that her retirement allows.

Nancy's metaphors for her transition to retirement were "opening a window and letting in fresh air . . . I let all the stuffy ex-life out and just brought in a whole new life to surround me" and "escape." Nancy also used the metaphor, "big fish in a small pond" to characterize her situation as a pediatrician in a community with few other pediatricians and where she was easily recognized in public places by her patients. In her transition

into retirement, she was greatly relieved to leave the "small pond" and literally begin "a whole new life," echoing a refrain from the third age.

The metaphors chosen by the study participants and those that emerged during the interviews aligned with the emotional states of their current career transitions and provide insight into their transitions from a developmental perspective.

Retirement

Retirement as a fixed life course stage has changed with increasing variability in late career employment (Warner, Hayward, & Hardy, 2010). The change has blurred the meaning of retirement. There are many possible ways to conceive and define it. Four modes of thinking about retirement, identified by Hornstein and Wapner (1985) and discussed elsewhere (Davies & Jenkins, 2013; Gee & Baillie, 1999; Jarvis, 2001), include transition to old age and rest, a new beginning, continuation where retirement in itself does not constitute a critical psychological transition, and imposed disruption.

Definitions of Retirement

The question, "What is your definition of retirement" was posed to each study participant in order to understand their interpretations of its meaning and where they situated themselves on the retirement spectrum. Many of the study participants commented about retirement elsewhere in interviews, further elaborating the responses to the question. Definitions addressed control/self-determination, compensation, self-discovery, cessation, or a blending of ideas. Emotions, both positive and negative, were embedded in definitions.

Control and compensation. Grace had two definitions, stopping paid work or working while being in control over what work she did.

> I would be willing to accept the classic definition of retirement which is stopping paid professional work. I think you can be retired and still be involved in the cognitive and service aspects of your profession but having a job is not being retired. So, you could say, OK, as a consultant, are you retired? Well, I feel psychologically I am retired. It is easy to say 'No, I can't do that' or 'No, I don't want to do that.'

Grace discussed beginning to feel what it means to be retired, while also projecting that she would continue to work as a consultant. By having control over her schedule and choice of work, in her mind, Grace was already retired.

Bunny defined retirement as,

> Having a little more time on a daily basis to make my interests more varied and not 100% directed at just clinical work. . . I like being able to say on a day, 'I don't want to work this afternoon, I want to go to the gym' . . . I am acting like a retired person.

Although she worked full-time, Bunny, too, felt as if she were retired, chiefly because she had control over her schedule.

Pepi defined retirement in terms of control.

> You control your time. Whereas when you are working, whether faculty or private practice, you don't control your time. Your work controls your time . . . But not working at all was not my definition. I wanted more control of my time . . . Retirement is being able with time to put something together and give a nice lecture for students or residents. Retirement is where you can take the time to do some research work.

Pepi's definition included scenarios that to others would mean work. She could not conceive of cessation of activity associated with her professional identity.

Although Maggie was retired from paid work, she felt in many ways as if she was not retired because she did not have control over her schedule. Ultimately, she decided retirement meant time for reflection.

> I mean all the things that flash in my head that people might say, I can say that's not me. You know, freedom to do things. I've got a husband who is not retired. Yes, I do travel and travel without him. No schedule. But I do have a schedule and commitments . . . Maybe my definition of retirement would be that I have learned more about myself. I guess reflection and thinking about, oh, that's you.

Maggie gives a developmental perspective to retirement. Her definition is indicative of her inner work of self-discovery that she combines with outer work of voluntary commitments.

Birdie's definition had two parts, one related to identity and the other the classic definition related to compensation. "It's leaving your life's work and not working for pay. I think most people I know go on to do volunteer work and that kind of thing." She also commented that retirement transition would be easy, yet expressed fears, particularly about impact on her sense of purpose and finances. Birdie's conflicted feelings about retirement were associated, in part, with where she was in the process, just on the cusp of retiring. Her plans were to do volunteer work which would assuage her concerns about having a purpose.

Alternatively, Nancy's definition of retirement did not preclude compensation for work. She continued to do medical-legal case work after retiring; something she enjoyed

and for which she was paid. Her statement, "I don't consider that working. I enjoyed doing that," implied that her work had lost its joy; perhaps a reflection of the last years of work when she began to feel that it had become "stale" and she needed a change.

For each of these study participants, retirement was not the cessation of work. It had much more to do with having control over schedules and, thus, freedom and personal time. The issue of compensation was much less a factor in defining the concept of retirement.

Cessation. Carol defined retirement as cessation of work and viewed it in terms of loss.

> It means to stop working . . . I think you should retire when you are not able to give back any more . . . when you cannot participate and do things the way they should be done, that's when you should quit and that's retirement . . . when you talk about retirement, you talk about giving up everything . . . what do you do with all the skills and abilities you've worked on your whole life?

Carol also discussed the problem of squandering talents by quitting work.

> It's like all the gifts that have been given to you, if you don't use, that bothers me. You know, it's Biblical, that the more talents you have and the more you invest . . . I feel like that's what you should do [use your talents] . . . I don't feel like I can pack up and leave because it is a huge responsibility. It's bigger than me . . . I'm not ready to give up.

Carol's feelings about not quitting, informed by her convictions, are strongly held and keep her committed to her work.

Camilla's view of retirement was literally waiting to die. She perceived that God called her to her life's work and felt especially compelled to continue as long as she lives.

> I see retirement as an end. I see people who retire, going into the sunset. That's how I see it. I don't see myself retiring, but I see retirement as people going away, 'poof'. They don't move anymore. I'm not seeing people in retirement who are really enjoying it . . . So how I see it, is that it's an end. You are slowing down your life. You are not as creative anymore and you are resting, waiting to die . . . So, as I go forward, God's going to direct my path . . . I really have not sat down and planned for retirement. That just simply means to me I am supposed to keep working.

Carol and Camilla have strong negative perceptions about the meaning of retirement and a religiosity to their commitment to work. Quitting would be a waste of God-given talents and a death-like experience for these two study participants whose work, in many ways, is largely how they define themselves.

Study participants expressed a variety of understandings about the meaning retirement. Control/self-determination was an overarching theme in most of the definitions. Half of the study participants, those least comfortable with the idea of retirement, had an undertone of sadness and/or denial in their definitions.

Pre-bridging to Retirement

Bridge employment is work that bridges between full-time work and retirement, before fully retiring (Cahill, Giandrea, & Quinn, 2006). Seven of the study participants made much earlier career transitions as pediatricians, changing how they worked, which prepared them for transition to retirement. I refer to these changes as "pre-bridging."

They were gradual, influenced by external forces or circumstances, and were often unintentional in terms of positioning for retirement. One study participant did not experience the earlier pre-bridging but did essentially bridge to retirement.

Reducing Intensity of Work

Carol and Camilla both reduced intensity of work demands with the awareness that the pace and stressors of their work were not sustainable. Camilla was preparing to increase her research in order to move from "high intensity to still being able to work full-time low intensity." Carol also perceived that the challenges of aging, in terms of loss of physical stamina and mental acuity needed to perform her work, were imminent. She, too, had embarked on a career transition where she was directing a special clinic, working with families on a more routine schedule. This transition is enabling her to continue to work full-time but in ways that she hopes will be less demanding. Both of these women were highly identified with their academic medical careers and found their work profoundly rewarding and meaningful; strong motivations to continue working as long as possible.

Reducing Work Load

Bunny and Maggie gradually reduced their work hours. Bunny hired additional clinical personnel and shifted her effort to "50/50" [clinical and administrative] over a period of eight years. With less clinical work, including call, she was working less time. Maggie gradually reduced her work effort over the course of her career. She went from being a full-time partner in a private practice to part-time partner and then part-time contract employee. Both Bunny and Maggie were private practice general pediatricians whose pre-bridging transitions were driven primarily by a desire to address family needs.

Bunny is still pre-bridging and will continue to do so indefinitely as she moves into a consulting role.

Several study participants reduced work intensity and work load. Grace began to reduce work intensity and hours in her fourth career transition, three years before she began bridging to retirement. While working in medical education, she reduced her hours to 75%, so she could also serve as director of a federally-funded project at 25% of the time. She served in this capacity for two years when she and her spouse left their jobs to be nearer their children and grandchildren. She continued part-time as principal investigator directing a federally-funded project. After resigning this part-time position, she transitioned into consultancy, her bridge to retirement; something she is still doing.

> I see absolutely in this last year, since I am no longer PI [principal investigator] and I don't have those administrative responsibilities anymore, I am beginning to feel what I think a retired person would feel like, which is free . . . I don't know that I was ready to feel that even a year ago . . . I think if I had done this more quickly, that might have felt bad.

Grace's multiple pre-bridging transitions gave her years to gradually let go of her connections to academic medicine and her identity as a pediatric subspecialist, making her feel better about transition to her current bridging stage and the move toward retirement less abrupt.

Pepi transitioned to retirement over a period of more than a decade, reducing work intensity and hours. In discussing her transition to retirement,

> Different things happened. I would say for about 12, 14 years, which kind of guided me to make changes. So, my retirement was not full-time retirement.

> Little pieces of it were happening already. The first thing that happened was I was becoming very active in organized medicine.

The leadership roles she took on in service to her profession required extensive travel. Beginning in her 60s, she reduced her work time to 80% and later to 60%, desisting from high level intensive care work and focusing on leadership roles and the special clinic until official retirement. After a decade running a busy general pediatric practice, Nancy was able to alter her practice to focus only on her medical subspecialty. The transition meant a less demanding schedule and smaller patient load while also doing the kind of medical care for which she had trained and which interested her most.

Nancy felt that in her next career transition which was to retirement, "There wasn't really much of a transition. One day we were living in one community and practicing medicine. Literally, the next day we were living here. . ." Although Nancy perceived there was no transition, she did a number of things, such as attempt to volunteer her services at a pediatric clinic, continue with medical-legal case review, and join a newcomer's group, that were transition strategies in her retirement. Her negation of transition underscores her extremely optimistic outlook on the new life she created after retirement.

All three of these study participants, one in the "transition" group and two retired, were motivated, in part, to have more time with family. Grace and Nancy, when still working, wanted their work to align with their subspecialties for which they had a great passion which was made possible through their pre-bridging strategies. Pepi needed to reduce the mental and physical work demands in her academic medical setting. Their

pre-bridging retirement transitions made the prospect and actuality of retirement much less abrupt.

No Pre-bridging

Birdie went from a full-time career in private practice general pediatrics to retirement, although she had experienced a much earlier career change, transitioning from public health, and then being a full-time mother before becoming a pediatrician. Yet, even in her most recent career change, there was time to consider retirement. Birdie was aware that selling the practice to a large hospital system might lead to changes she disapproved. Her experiences were increasingly negative but she continued to practice another 16 months. One month away from retirement, she viewed herself as being in the midst of transition and projected in three months she would be able to discuss adjustments she made and in one year, long-term adjustment. She believed her retirement would be easy, saying, "I'm going to find a number of things. I don't think I'll have any problem at all." Birdie gave herself more than a year to come to terms with the realities of changes to her practice setting and to take care of practical matters such as consulting her financial advisor about retirement. Although there was no outward pre-bridge to her transition from her medical career, she was doing the psychological and pragmatic work of preparing to let go which led to her forecast that her retirement would be a positive experience.

Study participants made earlier career transitions that served as a pre-bridging to their transition to retirement and for half of the study participants, not intentionally related to transition to retirement. Transitions were made to decrease intensity of work demands, reduce work hours, or both. The underlying reasons for earlier transitions

varied. For the two study participants still working in academic medicine, there was a recognition that the pace and stressors of their work were not sustainable as they aged. Yet they wanted to remain employed as long as possible, a desire related to their identities, meaning they found in their work, and, for one, financial security. Two study participants, both private practice general pediatricians, reduced work hours over many years to have more time with family. Three study participants, one bridging to retirement and two retired, decreased work intensity and hours in recognition of the need to alter work pace and have more family time. The one study participant who did not outwardly demonstrate "pre-bridging" career transitions still gave herself time to prepare for retirement. The gradual process of pre-bridging had a mitigating effect on career transitions, including retirement, for all study participants.

VI. DISCUSSION AND IMPLICATIONS

In this chapter, I discuss the data and analyses presented in Chapters IV and V drawing on the literature and epistemological underpinnings of my research to answer my research questions. I examine the effects of timing and study participants' life course on their education, careers, and transitions as women pediatricians; becoming, being, and beyond. Although the focus of my research is on career transitions in the third age, the use of gendered life course theory (Moen, et al., 2009) necessitates acknowledgment of major social events coincident with the study participants' early careers which shaped their career paths, as well as events contemporaneous with current career transitions. Information provided on the sociocultural milieu of study participants' early careers is cursory with in-depth discussion beyond the scope of this dissertation. For study participants' later careers, I elaborate on the context for transitions, discuss results of the application of the 4 S transition model (Anderson, et al., 2012), the study participants' interpretations of transition through metaphor, and their preparations for a life beyond pediatric practice. I close the chapter with conclusions, implications for practice and policy, and directions for future research.

Context for Transitions

Becoming a Woman Pediatrician

The study participants came of age in the era of Sputnik and began pursuing higher education in the 1960s and 1970s, a period of great social upheaval in the US with the Vietnam War, and civil rights and women's movements. Study participants' lives and career paths were influenced in varying degrees by the maelstrom occurring during this time. However, their timing was propitious in that career opportunities opened up for

them and they were intellectually gifted in ways that made accessing such opportunities possible.

Sputnik-inspired science education movement. The successful 1957 launch of the Russian satellite Sputnik had a powerful impact on the American psyche. Sputnik was considered a direct result of Soviet Russia's supremacy in stressing mathematics and sciences in education (Slobodin, 1977; Steeves, Bernhardt, Burns, & Lombard, 2009). With a perceived loss of technological supremacy and national security fears, the response was to assert that American education must emphasize science and create more scientists and mathematicians (Steeves, et al., 2009). The federal government became directly involved in developing and funding educational reforms to promote a science agenda through the 1957 National Defense Education Act (Steeves, et al., 2009). By the time the study participants were in high school, the milieu strongly favored science which helped to shape the educational experiences of these young women who had an aptitude and affinity for science. Research indicates that learners' positive experiences learning science affects self-concept and self-efficacy positively (Jack, Lin, & Yore, 2014; Tsai, Li, & Cheng, 2017) and are associated with learning achievements (Chang, Singh, & Mo, 2007). All of the study participants pursued undergraduate training in the sciences, strengthening self-concept and self-efficacy which contributed to their ability to compete for acceptance to medical school, residency, and fellowship in pursuit of their medical careers.

Vietnam War. The Vietnam War did not impact the study participants in terms of the possibility of having to serve in combat. The higher-aged study participants were immersed in their medical training during the war, insulated from the turmoil as captured

in Grace's comment, "I missed the Vietnam War. I was in medical school." Yet, some had male siblings who were directly affected. The younger study participants entered medical school when the war was ending or in its aftermath. They, too, were protected from the turmoil, being engulfed by the demands of their training. This is not to suggest that they were not affected by the war and social upheaval which had profound effects on American culture still felt today (Beattie, 1998). "The antiwar movement was not the only social movement during the sixties. The women's movement and civil rights movement were both aspects of the cultural struggle during the Vietnam War years" (p. 22). Some have interpreted the war as "a response to challenges by women and men of color to systems that ensured white male power . . . Vietnam was where America went to reassert and reassure a contested (white) masculinity" (p. 23).

Civil rights movement. Gendered life course theory does not address race or class (Moen, et al., 2009), a limitation acknowledged by its authors. Discussion of racial issues is warranted given data provided by the study participants. The 1960s Civil Rights Movement was a major source of influence on the career lives of all of the study participants. The 1964 Civil Rights expressly banned discrimination based on race, color, religion, sex, or national origin in employment practices and ended unequal application of voter registration requirements and racial segregation in schools, at the workplace, and by public accommodations (Hersch & Shinall, 2015). By law, institutions, such as those for higher education, including medical schools, were required to admit people of color. This monumental change enabled study participants of racial minority status to pursue their dreams of becoming physicians, although it did not mean that the social milieu would be welcoming. Carol, Camilla, Bunny, and Pepi all

experienced discrimination and, in some cases, blatant and terrible acts of racism, during their years of medical training. Some of their experiences demonstrate the complexities of racism and gender discrimination, such as when they were harassed by women of their own racial/ethnic group. Feminist theorizing recognizes that gender, race, class, sexuality, ability, and other categories are intertwined and the difficulties this intersectionality poses for study (Weasel, 2016). White study participants did not share these experiences and, in fact, did not discuss their race during interviews. More than twenty years after Feagin and Vera (1995) penned, "Even today, most white Americans either do not think about their whiteness at all or else think of it as a positive or neutral category," (p. 296), the White study participants, at least in the interviews, were unconscious of their White privilege (McIntosh, 2009; Rains, 1998). Yet, all of the study participants were direct beneficiaries of the civil rights movement with its laws against discrimination and momentum created for social change. The myriad of important events, acts of non-violent protests, civil disobedience, and organizing, laid the groundwork for the women's movement that was fomenting and quickly ensued (Dicker, 2008; Thompson, 2002).

Second wave women's movement. As young women, the study participants pursued their educations and embarked on their medical careers during the second wave of feminism which began in the US in the early 1960s and continued into the early 1980s (Bleakley, 2013; Dicker, 2008). Normative accounts of second wave feminism discuss publication of Betty Friedan's book, *The Feminine Mystique* (1963), establishment of the National Organization of Women, development of consciousness-raising groups, and other actions that signaled women's increasing unwillingness to maintain traditional

gender roles and the desire to alter the conditions of their oppression, such as unequal pay, limitations on economic and reproductive freedom, social acceptance of domestic violence, and other problems (Dicker, 2008; Gilmore, 2008; Thompson, 2002). Excluded from this narrative is the rise of multiracial feminism and the liberation movement led by women of color in the 1970s (Carroll, 2008; Thompson, 2002). While an in-depth analysis of second wave feminism is beyond the scope of my discussion, suffice it to say that all of the study participants benefitted from the changes in cultural norms. They were also trailblazers fostering change as women pursued careers outside the traditional gender role expectations. Although study participants were in medical classes comprised of 10% or fewer women, percentages of women increased a decade later to 25 to 40% in their residency and fellowship training. These numbers were sufficient to make becoming a woman physician more feasible and provided a social convoy (Anderson, et al., 2012; Moen et al., 2009) to help them navigate their medical education. While most of the study participants reported experiences of gender discrimination, they also described significant support from men and women for their professional development, particularly at critical moments in their training.

The study participants' decisions to become pediatricians and pediatric subspecialists were impacted by the presence of more women physicians in pediatrics, as well as the understanding that disciplines such as surgery meant sacrificing their desires to have a family. Although they were helping to break down career barriers for women by becoming pediatricians, their career choices remained circumscribed by socially-imposed limitations. In gendered life course theory, individuals make strategic selections in and out of roles and relationships while always constrained by social and cultural

environments available to them at different ages (Moen, et al., 2009). The study participants' decision to become pediatricians exemplifies strategic selection.

The study participants were aware they were in the vanguard but I do not believe would have claimed the feminist label. They were immersed in academic medicine and, of necessity, conformed to the conventions of their patriarchal institutions. Hartmann (1984) defined patriarchy as a social system where men have dominance over women,

> a set of social relations between men, which have a material base, and which, though hierarchical, establish or create interdependence and solidarity among men that enable them to dominate women. Though patriarchy is hierarchical, and men of different classes, races, or ethnic groups have different places in the patriarchy, they also are united in their shared relationship of dominance over their women: they are dependent on each other to maintain that domination. (p. 199)

Moving beyond the essentialism of male/female biology, Bleakley (2013) defined patriarchy as "a dominant cultural form based on a particular kind of logic that embraces heroism, rationalism, certainty, the intellect, distance, objectification, and explanation before appreciation" (p. 63), which most certainly characterizes the dominant cultural form in Western medicine. As Grace had explained, during her residency training in the early1970s, women did not ask for what they wanted, they were expected to figure things out. In other words, women were to behave like their male counterparts and not look for special treatment, although being a woman, particularly having children, has a different set of demands and expectations than those for men. The study participants did figure things out and, in keeping with de Beauvoir's feminism, joined the men, pursuing extraordinary levels of education, joining the workforce, and taking part in social

transformation (Crotty, 1998; de Beauvoir, 1952, 1989). However, the study participants also became part of academic medicine, the *Doctor's Club*" a patriarchal institution with medical education firmly anchored in positivism and supreme confidence that "scientific knowledge is accurate and certain" (Crotty, 1998, p. 27). Medical education was then, and remains, "habitually formed through the discourse of patriarchy and the masculine protest" (Bleakley, 2012, p. 66) which is defined as "the well-rehearsed argument that doctors see so much suffering that they must protect themselves, through objectification and distancing" (p. 63). The Doctor's Club exemplifies Gramsci's (2000) hegemony, upholding a worldview of the dominant culture, convincing people (students and faculty) that the dominant ideology is in their best interest. As women, belonging to the club meant, while adopting the dominant culture, they would experience inequities: sexual and gender-based harassment (Frank, Brogan, & Schiffman, 1998; Nora, 1996), isolation and hostile climate (Fried, et al., 1996), barriers to academic advancement (Kaplan, et al., 1996; Tesch, Wood, Helwig, & Nattinger, 1995), and pay inequities (Kehrer, 1976; McMurray, et al., 2000).

Study participants' life course timing for a career in medicine was fortuitous in that their own abilities and interests in science coincided with society's desire to promote science. They were also in a position to take advantage of the changes fostered by the civil rights movement and women's movement. As a group, the study participants were part of a quiet revolution, helping to alter the subordinate relationship of women to men by assuming a profession dominated by men and demonstrating that they were capable, albeit on the terms of the dominant medical culture. Their presence has helped alter the culture of medical education, at least in pediatrics.

Being a Woman Pediatrician

Despite incremental gains, gender discrimination experienced by the study participants persists for women in medicine with many of the same issues unresolved such as unequal pay (Jagsi, et al,, 2012; Lo Sasso, et al., 2011; Weaver, 2015) and lack of career advancement (Carr, et al., 2015; Pololi, Civian, Brennan, Dottolo, & Krupat, 2013). Young women medical students are still advised not to pursue high intensity careers such as surgery (Wood, 2015). Yet, there are women in medicine who do not feel they have been discriminated against. Grace's assertion that she never experienced discrimination and felt advantaged as a woman highlights the on-going theme of the relationship between agency and structure as relates to feminism (Andersen, 2005; de Beauvoir, 1952/1989). Her belief in her own control over environment also demonstrates her high degree of self-efficacy (Bandura, 1982; Cervone, et al, 2006).

As career pediatricians, the study participants led busy lives and made sacrifices, personally and professionally, in order to manage their careers and lives. At times, they accommodated their spouses and families by subordinating their own needs. For example, all of the study participants followed their spouses during the course of their medical education and/or settling in a particular geographic region and establishing their careers. This pattern of behavior continues today. Female academic physicians are more likely to leave their jobs for personal reasons (spouse/partner job relocation) compared with male faculty who leave for leadership advancement and higher compensation (Waljee, et al., 2015).

The study participants' careers fit three of the four patterns identified by O'Neil, et al., (2008): women's careers are embedded in their larger-life contexts; families and

careers are central to their lives; and human and social capital (such as in the social convoy) are critical factors for women's career development. The pattern of wide range and variety of career trajectories did not particularly fit this group of women physicians who followed the more prescribed career paths of the institutional convoys in academic medicine and private practice. There was, however, variability in terms of career advancement within their jobs and in full-time or part-time work which was done chiefly to accommodate family.

The study participants made strategic selections (Moen, et al., 2009) to have careers that held great meaning for them, while also having children and maintaining stable marriages, which were of paramount importance to them. All of the study participants came from stable families which they modeled in their own lives. They were in also dual-career marriages that, together, generated very high incomes, helping to assure resources to succeed in career and family life. To be sure, these study participants, half representing racial/ethnic minorities and many from humble upbringings, are now in highly privileged circumstances. This is not to say they did not have difficulties, exemplified by their stories of marginalization, harried work lives and the demands of being Superwoman.

The work-life balance struggle for women in medicine continues, with recognition of the need for women and men raising families to have greater options for part-time work, flexibility with respect to tenure track timing, and access to high quality child care (Chittenden & Ritchie, 2011: Strong, et al., 2013; Women Chairs of the Association of Medical School Pediatric Department Chairs, 2007). At the same time, there is the same dominant culture voice, in one recent example, coming from a woman

leader in academic medicine, advising women pursuing medical careers, that "women should be careful not to fall into the trap of feeling entitled to special considerations or engage in special pleadings" (Wood, 2015, p. 964). Study participants' own advice to younger women physicians centered on having a balanced life with time for family; reflecting regret about lost time with their own children.

Half of the study participants were grandmothers at the time of the interviews, with two others becoming grandmothers shortly thereafter. A key factor for all of their career transitions in the third age was to have more time with family, striving for work-life balance and still behaving as Superwoman. Work/family life balance was the issue most frequently cited in a career survey of family physicians over age 50 (Stearns, et al., 2013). Moen (2011) argued the balance myth focuses on individuals' private problems, not the social structure and called for reframing work-family to consider the social conditions, "the clockworks of work" (p. 82) as producing the fundamental mismatch between demands and resources at work, home, and in community. "The social organization of paid work and unpaid family work remains based on the gendered breadwinner/homemaker model of the life course" (p. 88). Moen (2011) proposed a rethinking of assumptions about time and timing of the work day and work lives and for changes in policies where "paid work time is compatible with caregiving and community engagement" (p. 92).

As third agers and grandmothers, some study participants were transitioning by choice to be caregivers of their grandchildren; a wonderful gift but one which continues the status quo for how work life is structured. Others found themselves providing care for an ill parent or ill spouse. The work/family life misfit conundrum (Moen, 2011), a

theme throughout each study participant's life course, will continue until structural changes are made that support working families' time for caregiving and community engagement. Interestingly, the structural changes in residency training that have created the possibility of a better work/family life balance for younger physicians-in-training were responsible, in part, for career transitions of several study participants. Research on the gender wage gap indicates that structural change supporting temporal flexibility in work life "has taken off in various sectors, such as technology, science, and health, but is less apparent in the corporate, financial, and legal worlds" (Goldin, 2014, p. 1091) and that

> some changes have occurred organically, often due to economies of scale (as in the cases of physicians, pharmacists and veterinarians), some changes have been prompted by employee pressure (as in the case of various physician specialties such as pediatricians), and other changes have occurred because firms want to reduce labor costs. (p. 1117)

It may be that the pressures for temporal flexibility driven by younger pediatricians, and possibly the *enough is enough* of transformative wrath (Bolen, 2001), will benefit pediatricians in the third age who want to continue working, but put in fewer hours on a flexible schedule. Flexibility in work hours is one of the strategies recommended for physician retention in retirement planning (Silver, et al., 2016).

Career Transitions in the Third Age—The Beyond

Context for Transitions

The study participants' career transitions in the third age were impacted by major trends involving changes in medical practice and changes in medical culture. Four issues

emerged associated with changes in medical practice: the changing role of general pediatricians, implementation of electronic medical records (EMR) systems, the shift to large health care systems, and regulatory burdens. Changes in medical culture were associated with professionalism. Each study participant's career transition was impacted by two or more of these changes which contributed to a shared feeling of sadness. I chose headings of mourning to signify this grief while also aware that mourning has been explored in the feminist literature (Lather, 2003; Skrla, 2000). "Mourning work always follows a trauma. Philosophically, the work of mourning is about ontologizing what remains after the rigor of troubling or problematizing a concept" (Lather, 2003, p. 262). I propose that mourning works for these headings, as much for me in discussing study results, troubling the concepts of dominant medical culture, as it does for the study participants' feelings about loss and making sense of it.

Mourning Changes in Medical Practice

The role of general pediatricians in hospital care is shrinking with the shift to pediatric hospitalists, the fastest growing specialty in the US (Landrigan & Srivastava, 2012). Study participants conveyed a sense of loss relinquishing their hospital role and a desire to maintain some degree of connection. It was argued that the understanding of the patient's history and other factors, offered by the general pediatrician, have been lost with potential negative impact on patients. Research on pediatric hospitalist quality of care is equivocal with calls for further study (Mussman & Conway, 2012). There is also increasing reliance on nurse practitioners with nurse practitioner care demonstrated to be cost effective and high quality (Bauer, 2010; Coddington, Sands, Edwards, Kirkpatrick, & Chen, 2011; Stanik-Hutt, et al., 2013).

Implementation of the electronic medical records (EMR) had a negative effect on half of the study participants and played a significant role in their decision-making about career transitions. There was a general feeling that EMR detracted from direct patient care, eroded camaraderie, and killed the joy of their work. The EMR, with its forced choices in drop-down boxes, epitomizes the reductionism of dominant culture and leaves little room for the kind of qualitative interpretation that has long been a part of medical practice. As one study participant decried, "As long as you are checking a box, there is no gray in that," noting that the EMR was a tool for billing, not patient care. The chagrin of study participants was not about the use of technology, although it was a time-consuming burden and costly for implementation in private practice. They were mourning the loss of human interaction and devaluation of the intuitive in medical practice, the relational and receptive qualities associated with feminine consciousness (Bolen, 1984; Jung, 1960, 1963; Kenevan, 1975). In her book, *Woman as Healer*, an exploration of women's healing activities from the prehistoric to the present, Achterberg (1990) discussed the feminine myth of the behaviors, abilities, and belief systems traditionally associated with women, whether originating in biology or culture, which is

> debatable and somewhat irrelevant—it [feminine myth] simply is. In terms of healing, the feminine myth relates to such attributes as intuition, nurturance, and compassion. When expressed in professional practice, it supports the virtues of nature as healing resources and the curative aspects of caring. (p. 3)

Achterberg (1990) goes on to write, "the lack of feminine point of view is the most abject omission in American institutions and at the heart of the problems in American medicine.

The manifestation of feminine values in medicine is critical for the health of the planet" (p. 5).

Although framed in the binary of feminine/masculine, the proposal to integrate the feminine myth/consciousness/point of view aligns with Gilligan's (2011) call to heal the rift that divides humanity. Others have found in academic medicine "that serious problems exist in the relational culture" (Pololi, Conrad, Knight, & Carr, 2009, p. 106). Gilligan's (1977, 1982, 2011) work on the ethic of care speaks to feminine values. Bolen (2001) also speaks to feminine qualities of transformative wrath "enough is enough" (p. 78), mirth, and bawdy humor that may reach full expression in women of the third age. Feminist scholar Patti Lather (2012) critiqued the dominant culture's enamor of quantitative reductionism and scientism and advocated in social science "taking the side of the messy" (Lather, 2009, p. 349). EMR represents reductionism at its height. The study participants, who appreciate that science and technology have advanced medical care, were expressing the need to leave room for the messy in human healing, the need for feminine consciousness.

The shift from private practice to large health care systems, with loss of autonomy in decision-making about practice matters, was also a key factor in decisions to retire and viewed as the reason many general pediatricians are retiring on time, that is by age 65. The anecdotal observation about on time retirement came from a study participant in a large urban setting where most general pediatricians were practicing in large health care systems. This observation differed from the survey by Merline, et al. (2010) which found that nearly half of pediatricians worked full-time past age 65 and one quarter worked full-time past 70. Administrative issues in large group practices and in academic medicine

have been cited as a leading reason for pediatricians to retire (Steele, 2015). "If a pediatrician has no control over administrative issues, the work environment may change to something considered untenable to her or him (Steele, 2015, p. 1310). Research has shown that physicians spending more time on administration have lower career satisfaction and physicians in larger practices, those owned by hospitals, and those with incentives to reduce services spend more time on administration (Woolhandler & Himmelstein, 2014). The loss of autonomy was, in fact, untenable for the study participants who had created and nurtured their private practice for three decades. Having their recommendations about practice matters, based on many years of experience, go ignored was frustrating, especially when the health care system administrators ultimately came to the same decisions.

Regulatory burdens have been similarly cited as motivations to retire (Merline, et al., 2010; Steele, 2015) and were factors in the career transition decisions of the five study participants who were either bridging to retirement or had retired. Expanding on the theme of loss with changes wrought by EMR and shifts to larger health systems, there was an expression of loss in the overall practice of medicine; no longer about a doctor taking care of patients but "about filling in the blanks, checking off the boxes so you can get paid" [Grace]. The six study participants who opted not to pursue the ABP Maintenance of Certification program (MOC), with its many requirements, were relieved to have been "grandfathered." It is unlikely that higher aged pediatricians who are exempt from MOC will experience lack of certification as a barrier to continuing to have some role in their medical practice if they so choose. Recertification was one of the least important factors influencing retirement in the survey of pediatricians by Merline, et al.

(2010). The issue of MOC could become problematic for younger pediatricians as they advance to the third age and want to continue working. Researchers investigating pediatricians over 50 reentering clinical practice and implications for regulatory issues have called for design of a system where "physicians who have left the workforce should be encouraged or required to maintain or expand their medical knowledge so as to better facilitate their return to clinical practice" (Mulvey, Jewett, Merline, & Towey, 2010) that may or may not address this problem.

Mourning Changes in Medical Culture

The career transitions of five study participants were impacted by changes to medical culture. They attributed a shift-work mentality developed during residency training and an expectation of work/family life balance to a change in professionalism among younger pediatricians. A systematic review by Harris, et al., (2015) concluded "there is a paucity of high-level or clear evidence evaluating the effect of the changes to resident work hours" (p. 1600). Other research suggests that the negative impact of work hour restrictions on professionalism is overstated (Szymczak, Brooks, Volpp, & Bosk, 2010). Nevertheless, the fact was that the younger pediatricians' decision to sell the group general pediatrics practice and become employees of a large health system led to two study participants' decision to retire.

Several study participants' comments about work/family life balance implied that since they were able to manage their careers and family lives, younger people should be able to do the same. Their comments reflected the dominant culture perspective that the desire for work/family life balance represents an unwillingness to be totally invested in work, a threat to progress in the quest for new knowledge. Productivity, research in

particular, is the metric for achievement in academic medicine assuring lack of advancement for women pediatricians who spend a greater proportion of time teaching and in direct patient care (Kaplan, et al., 1996; Wietsma, 2014). Married women physicians with children spend 8.5 more hours per week on parenting and household responsibilities than their spouses which correlates to seven fewer hours per week on career work than male physicians with children; this situation is attributed, in part, to the fact that women have less support at home than their counterparts (Jolly, et al., 2014). Given the realities, women physicians are more likely to opt for non-tenure track clinician-educator roles (Wietsma, 2014) with major career consequences in a culture where dedicating more than 30% of the work day to research and less than 5% of time to teaching increases chances for promotion (Beasley, Simon, & Wright, 2006).

Acutely aware of her physician daughter's need for support in her own career, one study participant began her bridge to retirement to be available to her daughter, making up for lost time. In her own struggle with managing career and family, she experienced conflicted feelings over inadequate time for her children. In truth, "many clinicians feel a lack of balance between work and the rest of their lives, which can lead to discontent, guilt, and chronic stress" (Chittenden & Ritchie, 2011, p. 870). From a critical perspective, it can be argued that taking over a daughter's parenting duties is not equivalent to having work/family life balance. Instead it is a shifting of work that supports the status quo of women working as men while the work provided by the grandmothers (and/or grandfathers) remains hidden and unaccounted; much the same as the childcare providers who took care of the children of the study participants.

Work/family life balance continued as a theme for the study participants and in the lives of their children.

A retired study participant, who experienced profound sadness as she transitioned out of her formal teaching role, attributed changes in medical education to the erosion of meaningful faculty-learner relationships and consequent lack of acknowledgment for her transition. Here again is a yearning for the preservation of the relational aspect of feminine consciousness in medicine (Bolen, 1984; Jung, 1960, 1963; Kenevan, 1975). Her recognition of the value of relationship is underscored by research on benefits of relationship-centered education for both medical students and faculty (Haidet & Stein, 2006; Rabow, Newman, & Remen, 2014).

Career transitions were impacted by changes in medical practice and medical culture. Study participants bridging to transition or who had retired expressed loss, frustration, and disappointment about the changes: loss of roles in pediatric practice and loss of relationships in clinical practice and medical education; frustration in giving up practice autonomy and about the regulatory burdens in medical practice; and disappointment about what seemed to be a change in medicine from being a vocation to merely a career. “A vocation is a calling” (Brooks, 2015, p. 24) where not having it would make life unrecognizable. They were mourning the changes they experienced. Medicine, to which they had dedicated their lives, has had its ennobling features of personal sacrifice and doing the utmost for patients tarnished by shiftwork mentality and expectations for career accommodations. Although the three study participants still working were cognizant of medical practice and culture changes, and shared some of the feelings of loss, they are much more present-focused, trying out transitions that would

maintain connection to their work. The distinction suggests that mourning is not only about changes in medical practice and culture, but developmental in terms of letting go of a way of life and a part of their identities.

The 4 S Model of Transition

The four major components of the 4 S model of transition for how an individual copes with transition include: self, strategies, situation, and support (Anderson, et al., 2012). The resources available to the individual in each of the components constitute the difference in ease and success of transitions, whether moving in, moving through, or moving out of the transition. The larger the transition, the more it pervades an individual's life until the transition is integrated and "becomes only one of the dimensions of living" (Anderson, et al., 2012, p. 57).

Self

In the 4 S model, self refers to socioeconomic status (SES), gender, race/ethnicity, age, state of health, and psychological resources including ego development, outlook, commitment, values, spirituality, and resilience. In aggregate, these characteristics inform a person's inner strength and ability to cope with transition. People who are optimistic, resilient, and able to handle ambiguity fare better when making transitions (Anderson, et al., 2012). In this section, I discuss commitment to family and profession, values of caregiving and love for meaningful work, and identity issues; the most salient themes about self, expressed in terms of impact on career transitions. SES, gender, age, health, and race/ethnicity are discussed in other sections.

For those bridging to retirement or who were retired, the commitment to the needs of family were paramount in their career transitions to retirement. Being needed, whether

taking care of an ill spouse, parent, or grandchildren or spending time with adult children and retired spouses, provided a direction and a focus in navigating their career transitions. Schlossberg (2009) discussed the universal need for "people to believe that they count in others' lives and they make a difference to them" (p. 25). Being depended upon is a dimension of mattering (Schlossberg, 2009). All of the study participants were needed by family and knew they mattered. For those still working, needs of family increased stress but were key motivations to make career transitions to accommodate their families.

Commitment to profession was demonstrated in the connections study participants maintained with pediatrics through retaining their medical licenses, continuing medical education, and service to the profession through work in medical organizations. With one exception, all of the study participants had a need to still matter in the context of their profession. Even the retired study participant who was no longer involved with her profession had maintained some connection through medical-legal consulting in the first two years after retirement. However, she had been a solo practitioner in private subspecialty pediatrics with a small caseload. With fewer patients and no social convoy (Anderson, et al., 2012; Moen et al., 2009) there was less to compel her to remain connected.

Whether working, transitioning, or retired, all of the study participants were actively engaged in taking care of others; whether family, friends, patients, or colleagues. This core value of caregiving aligned with their profession, one which they truly loved for its intellectual stimulation and emotional rewards of meaningful work. Being pediatricians fulfilled their need to be caregivers and affirmed they mattered in all dimensions (Rosenberg, 1981; Schlossberg, 2009).

All of the study participants had long careers in pediatrics, with their professions central to their identities. They have a strong sense of self-efficacy (Bandura, 1977, 1982; Cervone, et al, 2006) and self-concept (Fite, Lindeman, Rogers, Voyles, & Durik, 2017; Rogers, 1959; Shavelson & Bolus, 1982) developed early and nurtured throughout their careers. They mattered to their patients (Schlossberg, 2009), were highly accomplished in their fields, and contributed in major ways to society. Some research indicates that people who retire from such careers are vulnerable to feelings of role loss which can lead to psychological distress (Carter & Cook, 1995; Kim & Moen, 2002; Price, 2002; Silver, et al., 2015). The three study participants still working were making transitions that did not affect their identities as pediatricians and did not express feelings of role loss. The study participants who were bridging to retirement did express anxiety about role change, asking rhetorically, "Who am I going to be" and recognizing that the possibility of losing this identity, "a big part of your personality" could have profound consequences. Two of the retired study participants maintained varying degrees of connection to pediatrics, preserving a modicum of their identities as pediatricians, to mitigate role loss. One study participant relinquished all connections with pediatrics two years after retiring and five years out, had no regrets as she created a new third age life. She experienced relief from work that had become "stale" and could now engage more fully in life as a family and community member, the converse of the negative impact of role loss in role theory (George, 1993; Wang, Henken, & Solinge, 2011). Her experience suggests that while role theory (George & Maddox, 1977) may be applicable to retirement transition, other theories, such as continuity theory, are applicable to retirement adjustment.

Continuity theory emphasizes consistency in life patterns and continuity in identity (Atchley, 1989, 1999; Wang, et al., 2011). Individuals who have high career identification are likely to seek continuity through some form of work involvement (Kim & Feldman, 2000). All of the study participants maintained continuity through work involvement, whether associated with pediatrics or other activities. The most salient feature of continuity was the action of a majority of the study participants to preserve a measure of identity through creating a legacy – establishing programs and mentoring people who can carry on their work, funding an endowment, or writing a memoir. These actions were powerful statements about the significance of their professional identities.

A desire for authenticity was expressed directly by study participants who were still working, as well as demonstrated by actions of all study participants in making their career transitions and in telling their stories. Belenky, et al. (1986) attributed authenticity to intensive self-reflection, frequently at midlife and beyond, when women experienced a heightened sense of who they were and how they wanted to be. In Baker Miller's (1991) self-in-relation theory of development among women, there is need for affiliation and need for authentic modes of intellectual, creative self-expression. Bolen (2003) described the crone archetype, a symbol of women's development, not just in old age but across the life course. As such, she is a source of understanding and insight (Ray, 2004; Walker, 1995); and "she has a sense of truly being herself, can express what she knows and feels, and take action when needed" (Bolen, 2003, p. 4). This characterization of women's development fit the study participants who were navigating their career transitions in the third age with authenticity.

The study participants had strong inner resources to draw upon in making their transitions. These resources buffered the emotions of study participants who experienced role loss in making their career transitions. The study participants' orientation toward commitment and service to family and profession provided them with continuity in their transitions, affirming they mattered.

Strategies

Strategies are means of coping that people use to deal with transitions, including work transitions (Anderson, et al., 2012). Three strategies for coping with transition include: modifying the situation, controlling its meaning, and/or managing stress created by the situation (Pearlin & Schooler, 1978). In addition to coping, study participants used two strategies, learning and leveraging power, which are not included in problem-focused coping strategies.

Coping

All of the study participants took direct action to modify their situations in making career transitions, not surprising given their high degree of self-efficacy (Bandura, 1977, 1982; Cervone, et al., 2006). In addition to modifying the situation, two retired study participants controlled the meaning of the situation, reframing their transition experiences to find the positive and drawing on their psychological resources to cope with disappointment and anxiety induced by their transitions. Three study participants, including one who controlled meaning, used stress management. Two vented about their transition and one used dance as a form of meditation. They combined their stress management with actions to modify the situation. Controlling meaning and managing stress were always used in conjunction with modifying the situation.

Learning

All of the study participants' recent career transitions involved learning strategies that were work-related and re-creational (Kluge, 2007). Career transitions were perceived as opportunities for learning; "a whole new set of things to think about, a whole new set of things to do." With learning the milieu of all study participants, using it as a strategy for transition was apropos.

The study participants who are still working did not describe re-creational learning. They were involved with formal learning associated with maintaining professional credentials. However, participating in continuing medical education programs also provided an opportunity for interacting with colleagues, a way to maintain the social convoy connection (Anderson, et al., 2012; Moen, et al., 2009). Informal learning through teaching and mentoring medical students served multiple functions: staying current with medical practice; personal growth, and being in relationship, fulfilling the relational need of feminine consciousness (Bolen, 1984; Jung, 1960, 1963; Kenevan, 1975). Continuing medical education served as a means of self-improvement related to the role of pediatrician and thus, consistent with continuity theory (Atchley, 1989, 1999), study participants still maintained involvement with their work (Kim & Feldman, 2000).

Re-creational learning (Kluge, 2007) involved non-formal programs, volunteer work, and social activities; learning was for the sake of learning, for mental and physical health, helping others, or for self-discovery. While some learning was for the pleasure of intellectual stimulation, it was also associated with concerns about keeping the mind active to prevent cognitive decline and possible dementia. In fact, four of these study

participants and two still working mentioned Alzheimer's disease as a general concern related to aging and/or directly affecting family, reflecting awareness of the disease and the potential for prevention or delay through cognitive stimulation (Borenstein & Mortimer, 2016). Learning involving physical activity was for health benefits and to stave off effects of a sedentary lifestyle on aging. For the study participants, then, aging was not an overarching theme in transition but a co-factor with other themes. Learning new skills as volunteers assisting others facilitated engagement with community, a way to continue meaningful work that is a core value for study participants and a way to matter that contributes to "a higher quality of life for retirees" (Schlossberg, 2009, p. 30).

Study participants engaged in learning for self-discovery were among the higher aged group, reflecting the introspective turn and work on individuation that comes in the second half of life (Jung, 1960); a change from an outer to inner world orientation that occurs among older people (Neugarten, 1979), and developing a deeper relationship with the self, according to gerotranscendence theory (Tornstam, 1999, 2011). In discussing the psychological effects of transition to retirement, Osborne (2012) posited that "an important developmental benefit of the transition is the opportunity to pursue individuation in a less restrictive way" (p. 52).

For all study participants, truly adult learners for the life course, "the whole of life is learning, therefore education can have no endings" (Lindeman, 1926, p. 6). They will continue learning as a key strategy for making transitions of any kind throughout their lives.

Leveraging Power

The study participants were familiar with the uses and abuses of power in medicine: observed, experienced, and exercised over the course of their 30+year careers. Medicine is all about power. Foucault, a doctor's son and one of the most influential thinkers of the past 40 years, drew heavily on medicine in writing about power and critiquing the institutional abuses of power (Jones & Carter, 1994). Foucault's exposition on the history of medicine found that

> Medicine was perhaps the first *positive knowledge* [truth regulated by scientific reason] to take the form of *expertise*, in which the human being was subject of calculated regimes of reform, legitimated by codes of reason . . . Medical sites and personnel were bound up with the mutation of political thought into its modern *governmental* form . . . Medicine was linked to the secularization of *ethical regimes* through which individuals come to describe themselves in the languages of health and illness, to question themselves in terms of norms of normality and pathology, to take themselves and their mortal existence as circumscribing their values. The history of medicine, that is to say, is bound up with the historicity of all the different ways in which we have come to understand what is involved in making us better than we are. (Rose, 1994, p. 36)

There is power in the rigid hierarchies of academic medicine that intimidate those who would attempt to speak truth to power (Dankoski, Bickel, & Gusic, 2014) and create barriers for advancement of women and minorities (Conrad, et al., 2010; Good, 2013). There is power in the medical education hidden curriculum (Hafferty, 1994, 1998) that enculturates hierarchy and abuses of power that lead to student mistreatment (Angoff,

Duncan, Roxas, & Hansen, 2016; Gaufberg, Batalden, Sands, & Bell, 2010; Krugman, Jones, & Lowenstein, 2014). There is power in the work of those who seek to transform what is inequitable, dehumanizing, and destructive in the culture of medicine (Carr, et al., 2015; Dankoski, et al., 2014; Pololi, et al., 2009; Rabow, Lapedis, Feingold, Thomas, & Remen, 2016; Suchman, et al., 2004). There is the power in the social convoys (Anderson, et al., 2012; Moen et al., 2009) that sustain students and practitioners and, ultimately, there is the affirming power in the possibility of healing others.

With power as a mainstay of medicine, it is not surprising that the majority of study participants leveraged power (Bolman & Deal, 2008; Levi, 2011) to help make their career transitions, with four situated in academic medicine. Those who leveraged the power of influential people were themselves leaders in their institutions and their subspecialty disciplines, adept at exercising power and working with the powerful; some with formal leadership training. Those who leveraged power of colleagues drew on their social convoys who could provide expertise for making decisions, as well as support for modifying their work.

> One robust locus of individual power in organizations and communities is the relationships people form and the networks in which they belong. Relationships and networks are powerful forces . . . and have the potential to speed up and block action. (Brooks & Edwards, 2014, p. 129)

All of the study participants leveraged power through relationships.

Study participants relied chiefly on taking direct action to modify their situations as a coping strategy for transition. In addition, they took positive steps that enhanced their transitions through learning, at work or in re-creation, and by leveraging power.

These strategies were not about coping in the negative sense but, instead aligned naturally with study participants' careers as lifelong learners working in settings of power.

Situation

Situation is the context, what is happening at the time of transition and the individual's perceptions of it (Anderson, et al., 2012). The context for each individual varies according to factors including trigger, timing, control, previous experience with transition, role change, duration, concurrent stress, and assessment (Anderson, et al., 2012). Klag, et al., 2015 found that physicians' contemplation of work transition is a context-dependent enterprise, supporting the need to consider individual context of career transitions.

Triggers

Triggers are life events that initiate transition and can be anticipated or unanticipated (Anderson, et al., 2012; Schlossberg 1981, 1989). All of the study participants' career transitions were anticipated. The triggers for transitions were: spouse and family issues, work-related issues, and/or other interests.

Spouse and family issues. Spouse and/or family issues were triggers for all the study participants with one exception. Career transition decisions were based in part on their desire to spend more time with their spouses and family. Transitions involved gaining greater self-determination and control of schedules, providing greater freedom and availability for family. Freedom and time with family have been identified as key themes in retirement expectations of working professionals, including pediatricians (Johnson, 2012; Silver, et al., 2015). A survey of pediatricians found that women pediatricians were more likely to cite family responsibilities and poor health as reasons

for retirement than men pediatricians (Merline, et al., 2010), noting the finding was consistent with evidence that during middle age and late life, women, including women who practice medicine, often provide care for family members such as aging parents, an ill spouse, or young grandchildren. This finding and the phrase family responsibilities connotes obligation and burden. In the case of these seven study participants who made career transitions for spouse and family reasons, it was out of desire, a matter of their own choosing. None of the study participants discussed poor health as reason for their career transitions. The one retired study participant who had to take care of an ill spouse had made the transition to retirement two years earlier before there was a problem. Spousal retirement influenced career transitions of four study participants and was the primary trigger for three study participants' career transitions. Spousal retirement has been noted as influential in retirement decision-making, with evidence that many U.S. couples choose to retire at the same time or within 18 months of each other (Loretto & Vickerstaff, 2012). Married women typically make their retirement decisions relative to their spouse's behavior (Wong & Hardy, 2009). Advocating a life course perspective, Smith and Moen (1998) argued that "the context of the marital relationship (such as gender role ideology and decision history) in which retirement occurs matters for understanding the transition to retirement" (p. 743).

Work-related issues. Five study participants' transitions were associated with work-related issues. For those working in academic high intensity pediatric subspecialties, there was concern about ability to maintain the stamina and skills required as they aged, while also a desire to continue working full-time. Here again is the issue of aging, an influential factor in career transition decisions. Physician competency with

respect to age is an issue under review with recognition of variability among medical specialties (AMA, 2015; Drag, Bieliauskas, Langenecker, & Greenfield, 2010; Kupfer, 2016). For those working in general pediatrics private practice, the shift of ownership to a large health system meant practice changes that were untenable like loss of control over practice decisions and becoming a drone to EMR charting. The consequent work demands and dissatisfaction with practice changes triggered their decision to retire. As discussed previously, in the broader context of systemic changes in medical practice, issues such as loss of autonomy and regulatory burdens contribute to physician dissatisfaction (Steele, 2015; Woolhandler & Himmelstein, 2014). The study participant still working in general pediatrics transitioned to a role with less clinical demand, leaving time for family and other interests.

Other interests. The career transitions of three study participants were influenced by their desire for time to pursue other interests. Two had cultivated passions, running and dance, over the course of many years. They both felt strongly about their need to nurture their passions and were glad their career transitions gave them more time. The other study participant had essentially put other interests on hold until she retired and could relocate to a community where she felt like there were more resources and people with whom she could relate. Merline et al., (2010) found that 35% of women pediatricians listed nonmedical interests as a factor influencing decision to retire, similar to the pattern for my study participants.

Individual Context

In addition to triggers, other situational factors associated with individual context involve control, timing, previous experience with transition, duration, role change,

concurrent stress and assessment of the situation (Anderson, et al., 2012; Goodman & Anderson, 2012; Schlossberg, 2011). I found some of these factors, such as control, overlapped with Schlossberg's self factors (Anderson, et al., 2012) such as self-efficacy.

Control/self-determination. The ability to choose and control the situation contributes to positive feelings about transition (Goodman & Anderson, 2012). Each of the study participants' career transitions was anticipated which gave them greater control. Control and self-determination about work were of paramount importance to all of the study participants. Lost autonomy in clinical practice was an impetus for career transition for some but the desire for control over time, schedules, and lives was unanimous. Control and self-determination translate to freedom and flexibility. The study participants who have worked their entire lives and continue to want to do meaningful work, and others like them, would be well served by institutional policies and practices that create authentic pathways for sustained engagement within their profession. Offering control of schedules and greater self-determination are important elements for these considerations. Recommendations from a systematic review of physician retirement planning include creation of meaningful activity after retirement, advising health care organizations to promote retirement resource toolkits, educational programs, guidance on financial planning, and "creating post-retirement opportunities that maintain institutional ties through teaching, mentoring, and peer support" (Silver, Hamilton, Biswas, & Warrick, 2016, p. 83).

Timing. Study participants had been in a gradual process to reach their career transitions toward retirement, ranging from between approximately one month to 12 years, associated with the triggers previously described. This gradual process helped ease

career transition, although there were strong, often mixed emotions associated with transition. None of the study participants adhered to age-related, socially-prescribed retirement timing, the on-time or off-time of the social clock Neugarten (1976) described. Instead, their career transitions were more in line with Neugarten's (1979) idea of an emerging age-irrelevant society, the effects of longevity on the third age (Freedman, 2011), and broader context of life course events (Moen, et al, 2009). Merline, et al., (2010) surveyed pediatricians over age 50 and found that part-time work was more common with aging. Study participants did not conform to this age-related pattern of work, with two retired study participants curtailing their work effort much earlier in their careers and two study participants over age 65 still working full-time at time of interview. Merline, et al (2010) also reported that 28% of women pediatricians surveyed expected to provide patient care after age 65. In my study, one study participant still working and three of the five bridging to retire or retired continued to provide patient care after age 65. Two other study participants still working anticipate working past age 65. In other words, 75% of my study participants expected to or had provided patient care after age 65. While my study is qualitative with a small sample not intended for statistical analysis, it is interesting to note that my study participants exceeded estimates from a large data sample (Merlin, et al., 2010). Having the qualitative data from study participants was vital to understanding their career transition expectations.

Duration. According to Schlossberg (1981), "ease or difficulty of adaptation to change is expected duration" (p. 9) which has three categories: temporary, permanent, or unknown. Schlossberg (1981) posited that temporary transitions are least difficult emotionally because they are finite whereas the transitions of unknown duration have the

greatest degree of stress and negative affect. The data from study participants who had experienced transitions of temporary duration or had predictions of endpoints seemed to support this claim. However, the one study participant still working and one bridging to retirement who had indeterminate duration in their career transitions seemed very positive about their transition situations; most likely because the open-endedness of the transition was of their own making, within their control (Goodman & Anderson, 2012). The one retired study participant who was undergoing a transition of unknown duration not of her making experienced great emotional difficulty.

Experience with career transitions. Most of the study participants had little experience with major career transitions. They had all been situated for many years within a single organization, with only one having fewer than 16 years in the same location. However, during their careers, they underwent transitions such as promotions within their academic departments, from full-time to part-time, or a change in job status such as moving from partner to contract employee or taking on a new role in medical education administration. These earlier transitions influenced their feelings about their transition toward retirement. Change in job status contributed to feelings of sadness associated with role loss (Carter & Cook, 1995; George, 1993; Kim & Moen, 2002; Price, 2002; Silver, et al., 2015; Wang, et al., 2011). Those who had earlier experiences with role loss were emotionally prepared for later transitions of their choosing while those without role loss experience were more affected by their career transitions to retirement.

Concurrent stress. Concurrent stress influences coping with transition (Goodman & Anderson, 2012; Schlossberg, 2011). The individual contexts for study participants were experienced as stressful by four study participants and non-stressful by

four others, much of it associated with timing. Those early in their current transitions experienced their situations as stressful. Those who had been preparing for their current transitions gradually did not describe stressful transitions.

For those study participants experiencing transition as stressful, two were still working in academic medicine where work environments and self-imposed pressures combined to produce a stressful situation in their early transition period. One retired from academic medicine experienced stress at retirement primarily from role loss (Carter & Cook, 1995; George, 1993; Kim & Moen, 2002; Price, 2002; Silver, et al., 2015; Wang, et al., 2011). Despite the fact that she had been working toward retirement for over a decade and spoke of the ease of transition, she was also deeply saddened at the moment of retirement, realizing her role loss. Two years into retirement adjustment, she is early in current transition which has great stress associated with caretaking of an ill spouse (Schlossberg, 2009). The fourth study participant experienced stress from loss of control in the workplace that led to her chosen, but impending role loss with retirement. Although she anticipated her retirement, a choice she felt positive about for the future, earlier changes to her practice and consequent loss of control led to feelings of frustration and disappointment. Her mixed emotions made it difficult to articulate thoughts about transition.

Study participants who did not experience stressful situations in their current career transitions expressed relief and even elation with changes in their situations. They were further along in their career transitions. One still working and one bridging to retirement were relieved by having greater control of over their schedules to the degree that they described feeling that they were already retired. The two other retired study

participants were both emotionally prepared for their retirements. In retirement, both found other ways of mattering (Goodman & Anderson, 2012; Schlossberg, 2009) with other interests to pursue and were in situations they perceived as positive.

Support

Support encompasses intimate relationships, family units, networks of friends, institutions and communities to which people belong and is critical to a sense of well-being during transitions (Anderson, et al., 2012). In this study, participants cited spousal support, social convoy (practice partners), family, and friends in order of importance to their career transitions.

Spousal Support

Half of the study participants indicated that their spouses were their primary support for career transitions. Patterns of support established early in their relationships, when spouses provided support with parenting and finances, continued into study participants' third age career transitions, informed by gender role ideology and decision history of the life course (Smith & Moen, 1998). Half of study participants reported that their spouses were responsible for family financial matters. Private and business matters were particularly enmeshed for those with practices co-located with their spouses' practices. Division of labor whereby study participants' spouses handled financial matters was viewed as related to aptitude, not an assigned gender role, although some research of dual-earner couples' retirement planning shows men plan more financially, while women tend to plan more in terms of lifestyle (Moen, Huang, Plassmann, & Dentinger, 2006). In terms of financial planning for retirement, Feldman (2007) posited that the first stage of making the decision to retire is assessing feasibility from a financial standpoint. Yet, research indicates that while financial planning is a concern for

pediatricians (Hall, 2005), nearly half of physicians surveyed in one study had not engaged in personal financial planning (Stearns, et al., 2013) and, in general, women think less about retirement and tend to prepare less for it (Jacobs-Lawson, Hershey, & Neukam, 2004; Orel, Ford, & Brock, 2004). Given these data, spousal management of finances for preparing and transitioning to retirement was an important support factor for study participants. Lack of financial planning and absence of spousal support influenced the career transition of one study participant whose spouse had died.

Five of the eight study participants were in dual-career physician marriages and had been married to the same person always. Two of these cited spouse as primary support and three cited spouse as secondary support in their career transition. Mutual support has been identified as a key theme for successful long-term physician domestic partner relationships (Perlman, Ross, & Lypson, 2015; Ryan & Evans, 2015).

Social Convoy

Social convoy (Anderson, et al., 2012; Kahn & Antonucci, 1980) support of practice partners, whether academic or private, with whom the study participants worked most closely, was cited as primary and secondary sources of support for more study participants than other colleagues, family, or friends. They were the workplace social convoys of the study participants for approximately thirty years. As Steele (2015) commented,

> An enjoyable medical practice is very much like a marriage, relying on close personal relationships with people who will be spending the largest portion of time together. You must love and trust everyone you work with or quality of life will suffer. (p. 1310)

Although these working relationships were technically role-dependent (Anderson, et al., 2012), they were extremely stable over time involving trust and sharing in decision-making about patient care and other business. These relationships put the practice partners in the circle of support nearest to the study participant, rather than the outer circle that typifies workplace relationships (Anderson, et al., 2012). A comparison of social convoy models in Figure 3 in Chapter IV and Figure 4 in Chapter V demonstrates the shift in social convoy membership and the importance of practice partners in the social convoys of the study participants.

While study participants did not conform to a socially-prescribed norm for retirement, a social clock (Neugarten, 1976), they did use their social convoys to gauge timing of retirement. They paced themselves according to their peers. If their social convoy members worked beyond age 65, that was their goal. If their social convoy members retired because of events in the broader context life course (Moen, et al., 2009), they followed suit. This pattern of behavior, gauging timing of aspects of the life course, was likely formed beginning with their social convoys in medical training. The social convoy model has been applied in numerous, multidisciplinary research studies on aging (Antonucci, Ajrouch, & Birditt, 2015) with researchers positing that

> as we become increasingly aware of the powerful effects social relations have on the individual, the convoy model of social relations offers potentially useful pathways for understanding and influencing policy to enhance the behavior, health, and well-being of all ages. (p. 90)

The model has also been used in research on retirement (Crowe, 2009; Kahn & Antonucci, 1980; Moen, et al., 2012) and to assess the strengths and challenges of social

relations in the third age (Antonucci, Ajrouch, & Birditt, 2006). Researchers in family medicine have advocated use of the life course paradigm and social convoy in patient care (Daaleman & Elder, 2007). However, I have not identified research specific to the social convoy related to physician retirement.

Family and Friends

Half of study participants cited family as sources of support, primary support for one study participant and secondary support for three others, indicating a lesser role of family in supporting career transitions. Yet, desire to accommodate family needs was a key reason seven study participants made their career transitions; retaining the caregiver role in the third age. Friends were secondary and tertiary supports, playing a lesser role in study participants' career transitions, although one friendship was equivalent to practice partner. Study participants' participation in continuing medical education and membership in professional medical organizations, where they engaged with colleague friends, also served as sources of support. Schlossberg (2011) identified professional organizations as a source of support for career transition to retirement.

Into the Light: Transition Metaphors

On December 8, 2012, I attended the first annual qualitative research conference at Texas State University. The keynote speaker, Dr. Corrine Glesne discussed her book, *Becoming Qualitative Researchers: An Introduction* (2011), and what she framed as the constants in the last 40 years of qualitative research. Number five on her list of top ten things was to ask questions that evoke descriptive answers; listen for metaphors, ask for metaphors. Her advice was the genesis of my interest in asking the study participants for metaphors to describe their career transition experiences.

On the subject of metaphor, Geertz (1973) wrote,

> the literature on metaphor—'the power whereby language, even with a small vocabulary, manages to embrace a multi-million things'—is vast and by now in reasonable agreement. In metaphor one has, of course, a stratification of meaning, in which an incongruity of sense on one level produces and influx of significance on another. (p. 210)

Jungian psychologists find in metaphor a language that mediates the gap between the conscious and unconscious, between "what shows itself in the light and what hides itself in darkness" (Romanyhsyn, 2013, p. 27). Metaphors are expressions of the intuitive, presentational knowing which brings "to conscious awareness the patterns in felt experience," (Kasl & Yorks, 2016, p. 6). They have been used in qualitative research studies in adult education (Nicolaides, 2015) and as tools for presenting qualitative research findings, where "a great deal of meaning can be conveyed in a single phrase of a powerful metaphor" (Patton, 2002, p. 505). In asking for metaphors and listening for metaphors, I found poetic expression of feelings in which much meaning was conveyed in a few words.

Themes of transition metaphors were clustered according to where study participants were in their career transitions. The study participants still working and making career transitions in order to continue working in clinical practice had a quality of drive and action in their metaphors – quest for knowledge; another hill to go over; always seeking what lies ahead; juggling, tossing balls in the air; and working until the end of life, a baseball game where she will slide into home. In this home-going metaphor, working until the end was destined by God. These metaphors, with their energy and

forward movement, are apt images for their career transitions, forging new roles for themselves to "stay in the game."

The study participants who were transitioning to retire or were retired used metaphors with themes suggesting optimism about the future as they were transitioning to retirement: freedom, portals with openings that let in light and fresh air, adventure, and books with chapters yet to be written or read. These metaphors convey a shared feeling of being unburdened and having a new lease on life. However, several study participants also used metaphors that evoked feelings of sadness with emphasis on the thought of leaving: leaving home, leaving a world behind, leaving a room, going into the sunset. There was a retrospective quality to these metaphors. Home, world, room—metaphors for careers as pediatricians, expressions of role loss and identities left behind. Yet, some of these study participants were the ones who have clung the most tenaciously to their physician identities and leaving open the possibility of being connected indefinitely.

Osborne (2012) writes, "the transition to retirement can trigger both a looking back at one's life and a looking forward to its last chapter. The coincidence of retirement with aging is a major catalyst for this pattern" (p. 48). The exception in this group was the study participant who was among the youngest in age but the longest retired. Her metaphors of escape and letting in fresh air spoke volumes about her feelings of having been in a suffocating situation. Of all the study participants, she was least bound to her professional identity and more willing to forego it after embarking on her new life in the third age.

The use of both optimistic and sad metaphors was indicative of the mixed emotions that many study participants had about their career transitions to retirement.

The clearest example of mixed emotions was the book of life metaphor: Chapter One is youth and coming of age; Chapter Two is the "guts of life" perceived as the most fun; Chapter Three has yet to be written; the era of most fun was past but maybe there is still something good to come. Study participants also used metaphors connected to the natural world like autumn, swansong, sunshine, big fish/small pond, light, guts, and hill; emanating from their orientation to the natural, their training in the natural sciences, and as women caregivers in the physical realm. Study participants' transition metaphors brought to light the emotions they were experiencing during transition. The use of metaphors added another element to the study's credibility in that the study participants' metaphors, chosen and occurring during the interviews, aligned with their experiences as they described. Using metaphors in qualitative research provides an opportunity to foreground truths that might not otherwise emerge.

Retirement

Definitions

The question, "What is your definition of retirement" was posed to each study participant in order to understand their interpretations of its meaning and where they situated themselves on the retirement spectrum. Their definitions varied, including themes of control/self-determination, compensation, self-discovery, cessation, or a blending of ideas. The variety of definitions supports the literature that interpretations of retirement are blurred given the increased variability in the retirement life course in the US and lack of consensus on definitions (Shim, 2008; Warner, Hayward, & Hardy, 2010; Wong & Hardy, 2009) with the retirement concept shaped by changing cultural meanings and individual's lived experiences (Coupland, 2009). Study participants' definitions

overlapped some of the concepts about retirement identified through focus groups with academic physicians: identity, social interaction, freedom and flexibility, and retirement as transition (Silver, et al., 2015). Definitions aligned less with others outlined in literature: transition to old age and rest, a new beginning, continuation where retirement in itself does not constitute a critical psychological transition, and imposed disruption (Davies & Jenkins, 2013; Gee & Baillie, 1999; Hornstein and Wapner, 1985; Jarvis, 2001).

Control and compensation. Most of the study participants defined retirement in terms of control; control over schedule and self-determination about work. Being in control contributed to a sense of freedom and provided flexibility in choosing how they spent their time. Thus, there were study participants, still working, bridging, and retired, who were doing work for which they were being compensated, yet they described feeling and behaving as if they were retired. In contrast, two other officially retired study participants considered themselves as working because of their non-clinical volunteer, uncompensated work in pediatrics or in the community. Freedom was a metaphor for several study participants' career transitions, exemplifying the theme of control. This conforms with research by Silver, et al., (2015) which found that for many of their physician research subjects, retirement for many meant freedom to choose how to spend their time. Control over schedule underpinned the primary trigger for study participants' career transitions – the desire to have more time for spouse and family. Compensation was much less a factor in defining the concept of retirement. While acknowledging that not being paid for work is a classic definition of retirement, study participants did not apply it to their personal definitions.

Cessation. Half of the study participants had an undertone of sadness and/or denial in their definitions with subthemes involving cessation, loss, death, and religious calling. For two study participants, the idea of retirement as transition to old age and rest was supplanted by definitions of retirement representing an end, even death. Identity issues were very much bound up in this binary interpretation of retirement, life (continuing to work) and death (retirement). Their definitions suggest extremely negative effects of role loss (George, 1993; Wang, Henken, & Solinge, 2011). Research to date has not produced definitive evidence to support or refute two prevailing beliefs about retirement: retire early and live longer or retirement leads to death (Shim, 2008). In a general review of the literature on retirement as a health/mortality risk factor, Shim (2008) found lack of consensus on the definition or measurement of retirement as a risk factor and a combination of positive, negative, and mixed results for early and on-time retirement. Study participants drew on their observations and experiences of others to form their definition of retirement as a death. Their solution is to continue working indefinitely, which fits with continuity theory (Atchley, 1989, 1999; Wang, et al., 2011).

Pre-bridging Transition Strategies

Bridge employment is work that bridges between full-time work and retirement, before fully retiring (Cahill, Giandrea, & Quinn, 2006). Seven study participants made much earlier career transitions, using a gradual "pre-bridging" process to reach their career transitions toward retirement. For half of the study participants, their pre-bridging was not intentionally related to positioning for retirement but, instead, was associated with taking care of family needs and work/family life balance. Pre-bridging transition strategies included reducing intensity of work, reducing work load, or a combination of these and were indicative of the work experiences unfolding in gendered context (Moen,

2001; Moen & Han, 2001). Continuity of identity, control of schedule for work/family life balance, aging issues in high intensity medicine, and medical practice changes were key factors in pre-bridging career transitions. Study participants in academic medicine doing high intensity work were most affected by continuity of identity and aging, finding ways to begin altering their work demands, while still working full-time. The gradual process of pre-bridging had a mitigating effect on career transitions, including retirement, for all of the study participants.

Kojola and Moen (2016) researched baby boomers' shifting meanings of work and retirement and found that "retirement appears to be a contingent decision, rather than a set plan, developed in response to changing personal, family, health, and work circumstances" (p. 67). There are variable pathways and blurred boundaries of work and retirement, a phasing out to flexible and less demanding work, a desire for meaningful work, whether paid or unpaid, and health and aging concerns affecting decisions (Kojola & Moen, 2016). It has been suggested that academicians, although not specifically physicians, begin considering retirement transition at age 50 and develop plans so they are prepared well in advance for future transitions, including retirement (University of British Columbia Association of Professors Emeriti, 2009).

The pre-bridging strategies to retirement of the participants in my study demonstrate the fluid, mutable quality of career transitions, including retirement. The lack of planning for the particulars among half of the study participants in their pre-bridging had negative consequences such as lack of formal acknowledgement during the "last times" of teaching and patient care and rejection of the offer to do volunteer clinical work post-retirement. Study participants' experiences indicated much of the transition to

retirement process remains ad hoc. Recommendations from a systematic review of physician retirement planning include creation of meaningful activity after retirement, advising health care organizations to promote retirement resource toolkits, educational programs, guidance on financial planning, and "creating post-retirement opportunities that maintain institutional ties through teaching, mentoring, and peer support" (Silver, Hamilton, Biswas, & Warrick, 2016, p. 83).

Conclusion

The career transitions of study participants emanated from a gendered life course where strategic selections were made in the context of medical culture. They enacted the dominant medical culture, submitting to its terms as required while making significant personal and professional sacrifices in order to participate in their profession. Study participants also subverted the dominant medical culture. As natural born caregivers, they imbued an ethic of care and compassion into their medical practice, with an understanding and appreciation for the relational and bringing feminine consciousness to their work. In their career transitions of the third age, they mourned the loss of relationship and human touch in their medical practice through the drudgery of electronic medical records technology and other system changes they perceived as altering a vocation to merely a career.

Study participants were in strong positions moving in, through, and out of their anticipated transitions, with ample resources in all four components of the 4 S model (Anderson, et al, 2012). They navigated their career transitions successfully, although not without challenges. Career transitions were based on commitment to spouse and family and a desire to continue meaningful work found in their calling as caregivers.

Control of schedule and self-determination about work were key factors in study participants' career transitions.

In terms of the self, continuity of identity (Atchley, 1989, 1999) and role loss (George, 1993; George & Maddox, 1977) influenced the transitions of study participants where all had pre-bridging strategies that helped mitigate transition effects. All found ways to retain a connection to medicine, even after retiring from clinical practice, although in one case not lasting. Study participants expressed a desire to leave a legacy which they translated into their career transition work, again a means to assure continuity and mattering (Schlossberg, 2009). The career transitions of study participants bridging to retirement and those retired were most affected by anxiety about and actual role loss. Some study participants experienced being marginalized due to role loss, which led to sadness. Those still working were focused on transitions to work indefinitely; a means to avert role loss. Their transitions were also a means to continue at a slower pace and demonstrate that even in high intensity work, there are transition pathway options for full-time employment. The desire for authenticity (Belenky, 1986; Bolen, 2003; Miller, 1991), developmental turn toward introspection (Neugarten, 1979; Tornstam, 1999, 2011) and the inner work of individuation (Jung, 1960) were associated more with age rather than simply retirement transition status.

All of the study participants took direct action to modify their situations as a coping strategy, with several combining other coping strategies of reframing using a positive outlook and stress management. The majority of study participants employed other non-coping strategies that facilitated their career transitions through work-related and re-creational learning and leveraging power, useful in facilitating and enriching

career transition experiences. Continuing medical education for work-related or re-creational learning also served to maintain social convoy relationships, credentials, and continuity of identity through connection to profession.

Spouses influenced study participants to reduce their work effort and to retire from clinical practice. Support from spouses with finances and assurance of financial security were factors in study participants' career transition decisions, although finances were less an issue in making career transitions than other matters. The study participants were all, save one, in dual-income marriages that situated them in high socioeconomic status, and at least half relied on spousal support for financial management. It may not be enough to rely on spousal support, as was the case for one study participant. The need to offer financial planning for career transitions, including retirement, for physicians has been suggested elsewhere (Hall, 2005, 2013; Heyl, 2004; Silver, 2016).

The importance of workplace social convoy support was unanticipated, although given the deep, lasting working relationships of study participants, it stands to reason. These social convoys were also used to gauge timing of retirement. Study participants paced themselves according to their peers. The social convoy has been applied in numerous, multidisciplinary research studies, including the social convoy in patient care (Daaleman & Elder, 2007). It has not been specifically applied to women physicians transitioning to retirement, a subject worthy of further examination given the importance of social convoy in findings of this study.

The majority of study participants had more than one compelling reason for their career transitions: spouse/family issues, chiefly the desire to have more time with spouse, children, and grandchildren; work-related issues associated with systemic changes in

health care; needing to reduce work demands associated with aging and, to a lesser extent, pursuit of other interests. Career transitions, particularly those involving transition to retirement, did not fit the traditional model of retirement at age 65. Some of the oldest study participants were still working while younger study participants were retired from medicine but working in other domains.

This study demonstrates that study participants in the third age are, indeed, making it up as they go and as they have done throughout their lives. Their definitions of retirement, timing, and career transition to retirement pathways were divergent, although all had pre-bridging strategies of some sort that helped mitigate their career transition experiences. Pre-bridging was most associated with work/family life balance and often unintentional with regards to retirement positioning. Retirement meant freedom and flexibility to choose timing and type of work, not the cessation of work. In the third age, all of the study participants were actively engaged, doing some type of work in pediatrics and/or using their knowledge and skills in the community on projects benefitting women and children.

Implications for Practice/Policy

Findings from this study support calls for structured, institutionalized policies and processes that support third age pediatricians' career transitions where they can continue doing meaningful work, compensated or uncompensated, connected to their profession (Hall, 2005, 2013; Silver, et al., 2016). Temporal flexibility and self-determination that support work/family life balance are important elements for these considerations, as is the role of social convoy. There should also be a better road map for the transition to retirement journey including formal acknowledgement and closure in making career transitions to retirement.

The imperative to do more to integrate feminine consciousness into medical education and medical practice, and in other aspects of dominant culture, remains and could not be more relevant than at the moment. At the time of this writing, there are terrible human rights abuses being enacted, exemplified by a U.S. government proposal under active consideration to separate asylum-seeking refugee children from their mothers (Ainsley, 2017). Third age women pediatricians, with their male pediatrician counterparts, are in a position and are drawing on transformative wrath "enough is enough" (Bolen, 2001, p. 82), working to be change agents against such immoral, unethical practices (Linton, Griffin, & Shapiro, 2017; Miller, 2017). There is meaningful work for all third age pediatricians.

Based on the study and informed by the literature, some recommendations for impacting practice and policy are:

(1) provide self-directed work options with temporal flexibility for physicians transitioning to retirement who want to continue working, with or without financial remuneration;

(2) create post-retirement opportunities that maintain institutional ties through teaching, mentoring, and peer support, monitor activities (Hall, 2013; Silver, et al., 2015);

(3) implement recommendations that organizations formally work with physicians beginning at age 50 to discuss work options available for senior physicians, provide benefits for post-retirement work such as covering travel expenses for scholarly work, and monitor and formally recognize contributions (Hall, 2013);

(4) implement recommendations to promote retirement mentorship programs, resource toolkits, educational programs, and guidance on financial planning (Silver, et al., 2015);

(5) augment retirement transition planning educational programs and materials with guidance on options for career transition to retirement for pediatricians doing high intensity work and strategies for all on formal institutional acknowledgement and closure;

(6) consider using Schlossberg's transition model (Anderson, et al., 2012) and related work on retirement (Schlossberg, 2009) to frame guidance on physician retirement planning;

(7) design an inventory tool for institutional assessment of benefits, services, programs, and policies related to physician retirement transition planning so academic medical centers and health care organizations can identify resources and gaps to improve practices;

(8) encourage medical organizations to develop a set of best practices for career transitions/physician retirement planning and post-retirement career options in academic and other health care settings;

(9) connect AAP women's young physician and senior physician groups to dialogue about work/family life issue and feminine consciousness, share strategies, and craft policies that support balance in life, compassion in medical education and medical care from early career into the third age and beyond; and

(10) support efforts of women and men working to integrate the feminine perspective in medical education and medical practice and be change agents advancing human rights in public policy.

Limitations and Delimitations

As an instrument in the research process, I was aware that I was new to conducting qualitative research which may have affected my inferences from the data. However, my mission was to search for meaning and understanding, not test a hypothesis or predict outcomes. As described in the Methods chapter, I aimed for credibility, transferability, dependability, and confirmability. My adherence to the proposed research design, situated in a theoretical framework that suits the topic, helped meet the criteria for research soundness. I minimized my researcher limitation through adherence to implementation of research design, with expert guidance from my dissertation committee and in collaboration with my study participants. The collegial relationships I have with many of the study participants helped to foster the trust and openness needed for a qualitative interpretive study. My work on child health advocacy and collegial relationships with women pediatricians of the third age biased my thinking about the potential for meaningful work on human rights but also contributed to ideas for future research. In terms of delimitations, this study was confined to interviews with English-speaking women pediatricians, ages 55 and over, who are U.S. citizens and reside in the southwestern US.

Future Research

The study participants, so generous with their time and sharing their experiences, have contributed valuable information to the understanding of how women pediatricians in the third age consider and navigate career transitions. A follow-up study in two to five

years could yield further insights into the impact of their career transitions and inform work on transition planning and post-retirement experience. The study results also suggest several other topics for future research. It would be useful to examine the effects of social convoy on physician retirement transition planning. A better understanding about how practice partners influence decision-making about retirement and their role in their colleagues' retirement transition planning could inform policies and programs. Another area of research is the intersection of work/life balance for younger and older women pediatricians, in terms of both perceptions and policies. Interesting work could come from the proposed dialogical work of younger and higher aged women's medical groups and possibly lead to structural changes that benefit women and men pediatricians across the age spectrum. Finally, I believe there is a need to know more about the status of integration of feminine consciousness in medicine. Have past efforts to address declines in empathy and humanism through medical education had an impact? What work is being done now, and is it sustainable? Are the voices of women and men pediatricians who decry inhumane policies and practices affecting the dominant medical culture and political discourse?

APPENDIX SECTION

APPENDIX A

Interview Guide for Working Study Participants

1) Please tell me your career history, about how and why you became a pediatrician.
2) What was it like going through medical school, residency, and fellowship (if applicable) at the time you attended?
3) Please describe a recent career transition you have experienced.
4) What was going on at work and in your life at the time you realized you were going to make a change?
5) How did you navigate the transition? What was helpful? What was harmful?
6) With whom did you confer about making the transition? What were their responses?
7) How long did the transition take?
8) Please explain if and how you would do things differently in making this career transition if you could have a do-over.
9) How would you advise other women pediatricians about making career transitions?

   For the second interview, I would like you to think about a metaphor that would describe your career transition experience. Can you also provide your CV at our next meeting?

Questions for Second Interview

10) Using a metaphor, how would you describe this career transition? Why did you choose this metaphor?
11) How do you feel after having made the transition?

12) How has this career transition impacted you and others in your life?
13) How does this career transition compare with other career transitions in your life?
14) How long do you think you will continue to work in your current job? Why will you continue to work?
15) What is your definition of retirement?
16) What are your aspirations and plans for the future?
17) Is there anything else you would like to discuss about your transition experience?

APPENDIX B

Interview Guide for Transitioning Study Participants

1) Please tell me your career history, about how and why you became a pediatrician.
2) What was it like going through medical school, residency, and fellowship (if applicable) at the time you attended?
3) Please describe the career transition you are currently making.
4) What was going on at work and in your life at the time you realized you were going to make a change? What were decisions you had to make about transitioning?
5) How have you navigated the transition thus far? What has been helpful? Harmful?
6) With whom did you confer about making the transition? What were their responses?
7) How long have you been in transition?
8) Please explain if and how you would do things differently in making this career transition if you could have a do-over.
9) How would you advise other women pediatricians about making career transitions? For the second interview, I would like you to think about a metaphor that would describe your career transition experience. Can you also provide your CV at our next meeting?

   <u>Questions for Second Interview</u>

10) Using a metaphor, how would you describe this career transition? Why did you choose this metaphor?
11) How are you feeling in this time of transition?
12) How has this transition impacted you and others in your life?
13) How does this career transition compare with other career transitions in your life?
14) What is your definition of retirement?

15) Will you continue to work? What will you be doing?

16) What are your plans and aspirations for the future?

17) Is there anything else you would like to discuss about your career transition experience?

APPENDIX C

Interview Guide for Retired Study Participants

1) Please tell me your career history, about how and why you became a pediatrician.
2) What was it like going through medical school, residency, and fellowship (if applicable) at the time you attended?
3) Please describe your transition to retirement experience.
4) What was going on at work and in your life at the time you realized you were going to retire? What were decisions you had to make about retirement?
5) How did you navigate the retirement process? What was helpful? Harmful?
6) With whom did you confer about retirement? What were their responses?
7) How long have you been retired?
8) Please explain if and how you would do things differently in making the career transition to retirement if you could have a do-over.
9) How would you advise other women pediatricians about transitioning to retirement?

   For the second interview, I would like you to think about a metaphor that would describe your career transition experience. Can you also please provide me your CV?

Questions for Second Interview

10) Using a metaphor, how would you describe the transition to retirement? Why did you choose this metaphor?
11) What is your definition of retirement?
12) How do you feel about being retired?
13) How has retirement impacted you and others in your life?

14) How does the transition into retirement compare with other career transitions in your life?

15) What are you doing now that you are retired?

16) Are you still involved with pediatrics/the medical profession and if so, how?

17) What are your plans and aspirations for the future?

18) Is there anything else you would like to discuss about your retirement transition experience?

APPENDIX D

Research Study Timeline

Sept 2015	October-December 2015	January-March 2016	April-July 2016	August-Sept 2016	October-Dec 2016	January-Feb 2017	March-April 2017	May 2017	June – July 2017	August 2017
Defend proposal	Establish interview schedule for first round interviews in Fall 2015	Establish interview schedule for Spring 2016	Establish interview schedule for Summer 2016	Continue work on data analysis, interpretation	Finalize data analysis, interpret.	Continue dissert. chapter revisions	March: Dissert. to Committee for Review	Corrections back to Dissert. Committee	Defend Dissert. Dissert. to Grad College, Alkek	Grad-uate
Apply for IRB	Conduct first and second rounds of interviews with 2 study participants; transcribe interviews; open code transcripts, draft interpretation	Conduct first and second rounds of interviews with 3 study participants & transcribe; interviews; open code transcripts; draft interpretation	Conduct first and second rounds of interviews with 4 study participants & transcribe interviews; open code; draft interpretation	Begin formal writing of findings	Continue writing up findings		April: Make corrections	Check all forms complete/ included	Paper work Final approval and abstract/ Grad College Dean	
Send proposal to Grad College; Apply for candid.	Conduct 3rd contact member checks on interpretations between first and second interviews and after second interview	Conduct 3rd contact member checks on interpretation between first and second interviews and after second interview	Conduct 3rd contact member checks on interpretation between first and second interviews and after second interview		Begin dissertation chapter revisions		Set date to defend dissertation			

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