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Misunderstood: Stakeholder Perceptions of Respiratory Therapy Professional Identity

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ABSTRACT

No current literature explores how respiratory therapists describe their professional identity. To address this gap, this descriptive phenomenological study used stakeholder theory (Freeman, 1994) as a framework to explore the perspectives of practitioners and educators through the use of semi-structured interviews. Participants were asked to share perspectives about professional identity, minimum degree requirements for entry-into-practice, and the clinical implications for identity and practice. The purpose of this study was to explore how increasing professional education expectations may change the professional identity and clinical practice. This exploratory study found a lack of cohesive identity often ascribed to therapists rather than determined by therapists and problematizes future research about respiratory care identity, teaching, and clinical care. Implications for practice include recommendations for focused reflective practice and increased socialization within the profession.
Keywords: health personnel, professional practice, professional practice gaps, respiratory therapy, social identification, self-concept, social perception, stakeholder participation

Changing the minimum educational requirements for an applied health profession is a complex issue. Consideration must be given to the risks and benefits of the change,

current rules and regulations, institutional implications, new curricular expectations arising from the change, and the current climate of support or opposition. Less frequently considered, however, is the impact such alterations have on the core identity of professionals. As the respiratory care profession prepares to advance educational standards for entry-into-practice, this study seeks to understand how current professionals describe their professional identity.

The professional landscape for degree advancement in respiratory care is quite complicated. The American Association for Respiratory Care (AARC) leads the charge with the Entry to Respiratory Therapy Practice 2030 initiative recommending increasing educational standards from an associate degree to a baccalaureate degree for entry-into-practice American (Association for Respiratory Care, 2019a; American Association for Respiratory Care, 2019b). However, AARC membership accounts for only one-third of employed respiratory therapists in the United States (Bureau of Labor Statistics, 2019, Myers, 2019). According to the Commission on Accreditation for Respiratory Care (CoARC), 84% of respiratory therapy programs confer associate degrees (Commission on Accreditation for Respiratory Care, 2018, p. 17). More than 300 programs receive sponsorship from community or junior colleges, technical or vocational schools, and career or technical colleges (Commission on Accreditation for Respiratory Care, 2018). Currently, only 23 states allow two-year institutions to grant bachelor's degrees, impacting the ability of respiratory care programs to offer a higher level of education (Fulton, 2020). Recent changes to accreditation standards require new programs, including satellites, to award baccalaureate degrees (Commission on Accreditation for Respiratory Care, 2018, 2019). Employers prefer to hire baccalaureate-prepared therapists because they exhibit strong critical thinking skills; however, there is minimal financial incentive for bedside therapists obtaining the higher degree (Becker, 2003; Farach, 2018; Gresham-Anderson et al., 2018; Mishoe, 2003). Identity research also shows increased time connecting with a profession, especially while in school, allows for socialization and strengthening of a professional identity (Cruess et al., 2014, 2015). Many other allied health professions are seeking elevated educational requirements because they believe advanced learning strengthens practitioners through expanded curriculum and increased exposure time to the profession (American Dental Hygienists' Association, 2019; American Occupational Therapy Association, 2014; American Occupational Therapy Association-Accreditation Council for Occupational Therapy Education, 2019; Caffrey et al., 2019; Gigli et al., 2020; Organization for Associate Degree Nursing and American Nurses Association, 2015; Stolberg & Tilliss, 2016)

Declining enrollments raise concerns about meeting future workforce demands. While the Bureau of Labor Statistics (2019) projects a 19% growth in the field of respiratory care by 2029, CoARC (Commission on Accreditation for Respiratory Care, 2018) reports declining program enrollments and the Western Interstate Commission (Bransberger et al., 2020) reports reductions in high school graduating class sizes, further exacerbating the college enrollment crunch. Demand for specialized practitioners continues to grow as baby boomers retire from the field or develop chronic illnesses like chronic obstructive pulmonary disease and become

patients, thus increasing the burden on local healthcare systems (Han et al., 2016; Leider et al., 2018).

Increasing the minimum degree requirements impacts current educational stakeholders such as faculty, students, and practitioners. As healthcare students socialize through clinical practice and educational learning, they integrate various experiences, both personal and professional, to create their identity as practitioners (Cruess et al., 2014, 2015). Through the cycle of socialization (Adams et al., 2016), changes at the educational institution shape students' beliefs about the profession, which are then molded through exposure to clinical professionals. The influences of practitioners eventually return to impact the institution through student clinical experiences. Situational influences impact the perspectives of these primary stakeholder groups, which in turn affect the future of the profession and educational offerings.

Relevant literature (Barnes et al., 2011; Becker, 2003; Berker & Nguyen, 2014; Farach, 2018; Gresham-Anderson et al., 2018; Kacmarek et al., 2012; Mishoe, 2003; Sperle, 2017) focuses on the perspectives of department directors, educators, and practitioners who are AARC members regarding practical differences between associate- and baccalaureate-prepared therapists. There is no literature describing how degree standards impact the professional identity of a respiratory therapist. By understanding the perceptions of key stakeholder groups such as faculty and practitioners, educational institutions can work to create a sustainable system for change inclusive of stakeholder meanings and values (Barnett, 2011). The purpose of this phenomenological qualitative study was to examine stakeholder perspectives of how a degree transition may impact the professional identity of respiratory care professionals. This study was guided by the following research question: How do stakeholders describe their professional identity and those of the profession of respiratory care?

THEORETICAL FRAMEWORK

In this study, we used a theoretical framework to inform the design and methodology of this study as well as to conceptualize who is impacted by respiratory care bachelor's degree transition. R. Edward Freeman (1984) first described stakeholder theory in *Strategic Management: A Stakeholder Approach*. While the term stakeholder was used previously by companies like General Electric Company and Johnson & Johnson (Freeman, 1994), Freeman's research intended to elucidate a management theory integrating business and ethics and focused on social responsibility (Freeman, 1984; Freeman et al., 2012; T. Rowley, 1998). According to Freeman (1984), "The primary function of the corporation is to enhance the economic well-being, or serve as a vehicle for the free choices of the owners of the corporation" (p. 411). Narratives, arguments, business terms, and moral terms originating from an organization's foundational values shape the metaphor that becomes an emblem of the company's purpose (Freeman, 1994).

Stakeholder definitions evolved over time to describe "any group or individual who can affect or is affected by the achievement of an organization's purpose" (Freeman,

1984 p. 53). Wagner Mainardes et al. (2012) further explain the stakeholder-organization relationship as "a network of explicit and implicit relationships spanning both internal and external environments" (p. 1863). These definitions cover a broad scope of persons or groups invested in the success of any given institution. Stakeholder theory shaped this study through the identification of salient stakeholders for respiratory care education.

Wagner Mainardes et al. (2012) recommend using stakeholder theory for a business management approach across three levels: (a) identification of stakeholders; (b) development of processes that recognize their specific interests and needs; and (c) establishing and building relationships with stakeholders and with overall processes. Salient stakeholders of universities include students, governmental agencies, and the academic, or peer, community. Commission on Accreditation for Respiratory Care (2019) defines communities of interest as "both internal (e.g. current students, institutional administration) and external (e.g. prospective students, regulatory bodies, practicing therapists, clients, employers, the community/public) constituencies" (p. 47).

Clarkson (1995) delineates stakeholders into two generic groups based upon their relationships with organizations and their importance to institutional success (Benneworth & Jongbloed, 2010; Wagner Mainardes et al. 2012). Primary stakeholders actively invest in an organization while secondary stakeholders have a vested interest but may be passive recipients of the institution's outputs (Benneworth & Jongbloed, 2010; Clarkson, 1995; Wagner Mainardes et al. 2012). Stakeholder classifications are further stratified based upon dynamic characteristics which can change over time (Clarkson, 1995; Mitchell et al. 1997). Sorting each group through the lenses of power, legitimacy, and urgency identifies which perspectives deserve the highest priority (Mitchell et al. 1997).

We applied stakeholder theory (Freeman, 1984) to determine salient stakeholders for respiratory care education. Study participants, identified as educators and practitioners, represent key stakeholder groups influencing an educational institution's primary output – students. Educators exhibit power, legitimacy, and urgency as primary stakeholders who directly influence professional identity through curriculum delivery. Practitioners exhibit power, legitimacy, and urgency as they work in the field actively employing educational concepts and living out professional identity, which eventually comes back to an educational institution through advisory board recommendations, industry standard changes, or socialization with students. As each stakeholder group impacts professional identity development in a slightly nuanced way, both groups were studied to investigate their perspectives and experiences. Consideration of stakeholder theory (Freeman, 1984) led the researcher to create semi-structured interview questions applicable to all study participants, regardless of stakeholder group, with the intention to triangulate data sources during analysis (Farmer et al., 2006).

In this study, we focused on the identification of the needs and interests of respiratory care education stakeholders. Study participants represent primary stakeholder groups whose interests impact an organization's mission. As respiratory care education looks to increase the minimum requirements for entry into practice, it

is important to understand stakeholder perceptions to establish and build relationships that improve the degree transition process (Wagner Mainardes et al., 2012).

LITERATURE REVIEW

Focused on key elements shaping the academic progression of respiratory care and professional identity development, thematic organization shapes this literature review. Theme One provides an overview of how respiratory therapy developed as a profession over time and discusses past educational trends. Theme Two contextualizes how other professions view degree advancement to understand where respiratory therapy fits within these surrounding fields. Theme Three reviews current literature on stakeholder perspectives about respiratory care education. Lastly, Theme Four discusses professional identity formation and the roles of educators and socialization during this process.

Defining Respiratory Therapy

According to the AARC (American Association for Respiratory Care, 2015b), "respiratory care is the healthcare discipline that specializes in the promotion of optimum cardiopulmonary function and health and wellness. Respiratory therapists actively employ scientific principles to identify, treat, and prevent acute or chronic dysfunction of the cardiopulmonary system" (para. 1). The use of inhaled therapies is documented in India more than 4,000 years ago (Anderson, 2005). Yet, much of the supporting science for the respiratory care profession was not available until the 1700s (AARC's Virtual Museum, n.d.-a). Over time, scientific advances eventually led to the use of therapeutic gases to treat common cardiopulmonary maladies (AARC's Virtual Museum, n.d.-b; Miller & Levere, 2008; Nagendrappa, 2012; Sekhar & Rao, 2014).

Inhalation therapy became an organized profession in 1943 and was later renamed respiratory therapy (AARC Virtual Museum, n.d.-b; American Association for Respiratory Care, n.d.-c). Early practitioners started as on-the-job trainees and practiced under the supervision of nurses and physicians (AARC Virtual Museum, n.d.-a). As the profession advanced, education evolved from on-the-job training to certificates of competency and eventually associate degree education. This resulted in articulations with higher education institutions, most prominently career and technical centers, junior colleges, and community colleges (Commission on Accreditation for Respiratory Care, 2018, 2019). To demonstrate competency, the American Registry of Inhalation Therapists (ARIT) developed written and oral examinations to confer a registry credential (AARC Virtual Museum, n.d.-b). The ARIT is now known as the National Board for Respiratory Care (NBRC) and graduates of an accredited educational program must pass a multiple-choice test and a simulation examination to earn the registry credential (National Board for Respiratory Care, 2020). Currently, only six states require the Registered Respiratory Therapist (RRT) credential for entry-into-practice (American Association for Respiratory Care, n.d.-b). Students earning a low-cut score on the multiple-choice

exam earn the Certified Respiratory Therapist credential and may begin practicing in 42 states (American Association for Respiratory Care, n.d-b; National Board for Respiratory Care, 2020).

 According to the AARC's mission "[t]he AARC is the foremost professional association promoting respiratory therapists" (American Association for Respiratory Care. (n.d.-a). Organizational membership is voluntary and represents approximately 32 percent of employed respiratory therapists nationwide (Myers, 2019). In its role as advocate, the AARC released various guidance documents for reference irrespective of membership status. The scope of practice, the definition of respiratory care, and a professional code of conduct exist to provide direction for members of the field (American Association for Respiratory Care, 2015a, 2015b, AARC's Virtual Museum, n.d.-b). The AARC recently released an issue paper and position statement recommending all respiratory therapy programs award a baccalaureate degree by 2030, as well as encouraging all states to require the RRT credential for new therapists to enter practice (American Association for Respiratory Care, 2019a, b).

Professionalization Trends

The respiratory therapy profession is not alone in seeking advanced educational requirements (American Dental Hygienists' Association, 2019; American Occupational Therapy Association, 2014; Caffery et al., 2019; Organization for Associate Degree Nursing and American Nurses Association, 2015). Dental hygiene seeks to establish baccalaureate education as the new minimum to fill dentist shortage gaps and better train hygienists as patient complexity and diversity increases (Battrell et al.., 2016; L. Rowley & Stein, 2016; Stolberg & Tilliss, 2016). American Occupational Therapy Association (2014) targeted 2025 for a full transition to doctoral education for entry into practice, citing increased requirements for research and scholarship, an increased need for autonomy, and a changing healthcare delivery model that requires more educational content. As of 2018, the American Physical Therapy Association (American Physical Therapy Association, n.d.) set the minimal education requirement as a Doctor of Physical Therapy (DPT) degree. Paramedicine desires to increase their education from certificate to associate degree and nursing seeks to increase their overall number of baccalaureate nurses while ensuring all nurses have access to continuous academic progression (Caffery et al., 2019; Organization for Associate Degree Nursing and American Nurses Association, 2015; The National Academic Press, 2011). Occupational researchers often study stakeholder perceptions regarding the educational changes (Benpow & Kanji, 2019; Druse, 2012; McCombie, 2016a, b; Molitor & Nissen, 2018; L. Rowley & Stein, 2016). Studies showed most professionals disagree with their organization's desire to increase educational requirements (Benpow & Kanji, 2019; Druse, 2012; McCombie, 2016a, b; Molitor & Nissen, 2018).

Stakeholder Perspectives About Education

Current respiratory care literature reveals four distinct themes regarding stakeholder perspectives about associate and baccalaureate-prepared therapists. First, employers prefer to hire therapists matriculating from baccalaureate programs (Barnes et al., 2011; Becker, 2003; Gresham-Anderson et al., 2018; Sperle, 2017). Second, students receiving baccalaureate education for respiratory therapy have better soft skills than their associate degree counterparts (Barnes et al., 2011; Farach, 2018; Gresham-Anderson et al., 2018; Sperle, 2017). Third, there are few immediate or tangible benefits to those who obtain a baccalaureate degree (Becker & Nguyen, 2014; Farach, 2018). Lastly, divergent opinions exist about the necessity of a bachelor's degree for entry-into-practice (Kacmarek et al., 2012; Mishoe, 2003; Smith et al., 2017).

Professional Identity Formation

Professional identity formation is "multiple, dynamic, relational, situated, embedded in relations of power, yet negotiable" (Goldie, 2012, p. 645). More specifically, Cruess et al. (2014) define professional identity as "a representation of self, achieved in stages over time during which the characteristics, values, and norms of the medical profession are internalized, resulting in an individual thinking, acting, and feeling like a physician" (p. 1447). Identity formation research recognizes the implications of myriad factors such as history, lived experiences, other identities, communities of practice, educator roles, and reflection on identity development. These studies, while typically focused on medical school or physician education, reveal insights generalizable to all healthcare professions.

Socialization is the integration of numerous experiences, values, norms, traditions, and identities to create a sense of self (Cruess et al., 2014, 2015). Students entering a health profession learn to separate being, doing, and having through a lifelong process of comparing and contrasting within themselves and amongst others (Colesso et al., 2013). Entering into a system they had no part in creating, healthcare practitioners are shaped by that system and comparing their roles to those of friends, mentors, and colleagues (Adams et al., 2016; Colesso et al., 2013). According to Adams et al. (2016), "The characteristics of this system were built long before we existed, based upon history, habit, tradition, patterns of belief, prejudices, stereotypes, and myths" (p. 17).

Professional identity formation (PIF) research reveals focused educational inquiry is tantamount to positive development (Chen & Hubinette, 2017; Kay et al., 2019; Silveira et al., 2019; Wong & Trollope-Kumar, 2014). Identity development should be an educational objective whereby educators engage students to guide professional growth because classroom learning positively reinforces professional norms and standards and reiterates a distinct collective identity (Cruess et al., 2015; Chen & Hubinette, 2017). Students experience disequilibrium and cognitive dissonance during their educational journey as they learn about the profession and integrate their experiences, influences, and the impacts of societal expectations (Kay et al., 2019; Wong & Trollope-Kumar, 2014). According to Silveira et al. (2019), repetition

without reflection diminishes identity development, disconnection between what is desired and what is observed causes cynicism, and negative role modeling alters the perception of work as a meaningful profession.

Studies regarding stakeholder perceptions of identity formation report different perspectives about the impacts of program duration and time with a profession. In a study by Caplin (2016), nursing students reported increased confidence, empowerment, and changes to professional identity following completion of a bachelor's degree. King et al. (2010) studied physical therapist's perspectives about how increasing educational requirements impact patient care. Study participants believe experience in the field improves the quality of care more than DPT training (King et al., 2010). Intensive care nurses believe educational level is less influential than specialty training to the development of professional identity, self-efficacy, and role clarity (Gigli et al., 2020). Fisher (2014) evaluated professionalism among three levels of nursing education to learn professionalism is not significantly impacted by educational level and depends on the quality of education and well-formed educational standards that account for values and morals.

METHODS

Research Design

This was a phenomenological qualitative study where we used stakeholder theory (Freeman, 1984) to explore the ways educators and practitioners describe their professional identity (Creswell & Poth, 2016). We chose this approach to collect narrative information for evaluation of participants' perspectives, behaviors, emotions, attitudes, or thoughts ascribed to a social problem (Creswell & Poth, 2016). Similar approaches have been used to gain an understanding of professional identity formation (Caplin, 2016; Chen & Hubinette, 2017; Kay et al., 2019; Privitera & Ahlgrim-Delzell, 2019; Silveira et al., 2019). We interpreted findings through a constructivist research paradigm whereby we sought to understand how others make sense of the world (Creswell & Poth, 2016). This study was guided by the following research question: How do stakeholders describe their professional identity and those of the profession of respiratory care?

Positionality

Qualitative research requires the researcher to disclose biases, values, and personal background as they may influence data interpretations throughout the study (Creswell & Poth, 2016). The primary author is a White female educator with ten years of experience working for a consortium program awarding associate degrees for respiratory therapists. The co-author is a mixed-heritage Latino male with significant years as a researcher in higher education. The primary author acknowledges her own experience entering the respiratory care profession after trying a different healthcare program and the impact an associate degree for entry-into-practice had on her ability to begin working. Positionality may limit her perspective and require continual

reflexive practice to understand how personal background shapes the interpretation of the data (Creswell & Poth, 2016).

Participants

Stakeholder theory and CoARC definitions informed contributor classification into two groups: educators and practitioners (Clarkson, 2016; Commission on Accreditation for Respiratory Care, 2018; Freeman, 1984; Mitchell et al., 1997; Wagner Mainardes et al., 2012). We recruited participants through e-mail and social media correspondence to form an intentional purposive sample (*n*=12). Inclusion criteria for faculty members was full-time employment at their institutions in an educational role and at least five years of experience in respiratory care education. Inclusion criteria for practitioners was full-time employment at their institutions as a practicing respiratory therapist and have at least five years of clinical practice experience. Sixteen potential participants responded to the recruitment notices; however, only 12 met the inclusion criteria and completed the necessary steps for participation. All participants were assigned a pseudonym to protect confidentiality (see Table 1). No participants came from the same institution.

Table 1: Participant Demographics

Participant	Total Years of Experience	Gender	Highest Degree Earned	AARC Membership	NBRC Credentials
Practitioner 1	30	Female	Master's	No	RRT
Practitioner 2	42	Female	Master's	Yes	RRT
Practitioner 3	37	Female	Bachelor's	Yes	RRT, ACCS
Practitioner 4	6	Female	Master's	No	RRT, NPS
Practitioner 5	13	Female	Associate	No	CRT
Practitioner 6	48	Male	Associate	No	CRT
Educator 1	20	Male	PhD	Yes	RRT, ACCS
Educator 2	16	Female	Master's	Yes	RRT
Educator 3	20	Male	Doctorate	Yes	RRT, ACCS
Educator 4	15	Male	Master's	Yes	RRT
Educator 5	38	Female	Bachelor's	Yes	RRT, CPFT, NPS
Educator 6	26	Female	Bachelor's	Yes	RRT

Data Collection

We recruited participants through e-mail and social media correspondence. A semi-structured interview guide facilitated the exploration of contributor perspectives during individual interviews each lasting approximately 60 minutes. Study questions focused on stakeholder perspectives of professional identity, beliefs about the minimum degree necessary to obtain licensure, factors impacting professional

identity, and how changing the minimum educational requirements may influence professional identity. We clarified meaning when participants used vague language or shared complex concepts. Interviews occurred virtually and were audio-recorded. We conducted interview until achieving saturation, which indicates there are no new insights or properties in the data. Prior to each interview, we established eligibility via e-mail and social media discussion with prospective participants. Participants received a standard informed consent form which they returned by e-mail or fax. A professional third-party transcribed audio recordings for data analysis.

Data Analysis & Trustworthiness

To understand perceptions of identity and experiences shaping those perceptions, the researcher employed a phenomenological approach. This method "describes the lived experiences of individuals about a phenomenon as described by participants" (Vukojević, 2016 p. 14). Data analysis occurred through a multi-stage approach of reviewing and evaluating interview transcripts and interviewer memos (Creswell & Poth, 2016). We read through the transcripts as data sources several times before initiating the coding process. Three cycles of coding were used to generate final themes. Application of line-by-line initial coding identified elements of meaning for further consideration. We then employed open coding using elemental coding methods including in-vivo, structural, and process coding (Creswell & Poth, 2016). Focused coding was used to group similar open codes into concepts and selective coding collapsed these into themes (Creswell & Poth, 2016). Code charting was used to organize the codes and themes (Creswell & Poth, 2016). We utilized the following trustworthiness strategies (Creswell & Poth, 2016): (a) member checking of interview transcripts by participants; (b) a subject matter expert reviewed and validated the main themes to mitigate researcher bias; (c) triangulation of findings between two stakeholder groups; and (d) the use of thick-description to adequately convey and describe participant perspectives.

FINDINGS

Through our research findings, we present four themes describing the professional identity perceptions of respiratory therapists. First, study participants depict themselves as a motley crew of healthcare providers, with a varied but flexible skillset often shaped by external influences such as mentors and hospital systems. Second, entrance into the field was described as a fortuitous happenstance encounter rather than an intentionally planned academic route. Third, participants described a "dark side of the moon" phenomenon where they are told they are valuable but instead they are misunderstood and feel disrespected. Lastly, clashes with professionals, both in and out of the field, greatly impact how participants perceive themselves.

The Motley Crew

One theme that emerged from the interviews is the idea of respiratory therapists as a motley crew of healthcare providers. Participants appeared to think of themselves collectively as a group of disjointed misfits with a flexible, but varied, skillset. This heterogeneity often stems from the external influences surrounding practitioners, such as respiratory care departments, mentors, and hospital systems. Despite individuality, participants described a tribal existence where the actions of one impact the entire group.

All interviews revealed a diverse and multi-faceted description of how a respiratory therapist operates, with few overlaps of identical descriptive verbiage. Participants described themselves as "MacGyver" with the ability to quickly analyze, problem-solve, and promote solutions to serve both patients and colleagues well. Practitioner 3 described respiratory therapists as, "We all have this high energy level. We are all very demanding. We have high expectations of everyone around us and ourselves." Participants also reported a distinct ability to "get shit done" while "being able to handle every single population in that hospital, every shift." Participants perceive this flexibility to be a core characteristic of a respiratory therapist. However, flexibility and adaptation are circumstantial traits based on clinical experiences and result in a motley skillset.

When describing the characteristics of a respiratory therapist, educators primarily used verbiage portraying higher-order thinking. Educators spoke of a therapist's ability to quickly analyze a situation and apply a depth of knowledge to optimize patient care. This concept is best represented by Educator 3 stating,

> When you walk in a room you're processing all of the non-verbal cues and you're putting that together with the heart rate and blood pressure. It's not a checklist. It's the ability to take a singular set of concepts and apply it to a patient that has a multitude of pathologies and realizing that, while this is how you deal with that type of patient usually, this COPD patient also has a crushing chest injury. So now they have a restrictive and obstructive disease and the therapist can think through those processes.

All participants in the educator group identified critical thinking and analysis as a core trait of a respiratory therapist.

Alternately, practitioners describing professional characteristics focused on the moral sense and heart of a respiratory therapist. Contributors in this group often used situational stories or related the question to specific work areas to contextualize their perspectives. Using words like "flexible", "strong", "passionate", and "empathetic", practitioners depict a group of helpers centered on quality patient care.

Both participant groups expressed how mentorship and organizational cultures shape their professional identity. Participants described being shaped by positive and negative influences external to themselves. For example, Educator 1 shared:

> I 100% think that I am who I am now because of the people that were around me, people that saw something in me that I didn't see. I just mocked them. I mimicked them. I did what they did. I truly honest to God believe the reason I became who

I am in my profession now is because of the people that mentored me, not because I have some special set of skills.

Many of the participants described being shaped positively by mentors. However, members of the practitioner group spoke frequently about the negative aspects of working within a hospital or respiratory care department.

All participants described instances where the way they were treated or how others were treated was the direct result of personal behavior. Educator 2 shared that individual personality has a bearing on perception when discussing "they treated me differently and I think that was because they knew who I was." Practitioner 4 shared:

You can have 20 years of experience and still be a bad therapist. If you have a bad attitude, they really don't care how long you've been a therapist. It still makes you look like a bad part of the team. A bad apple.

All participants agreed the professional identity portrayed within an organization is dependent upon the actions and values of each individual therapist.

Practitioners also noted that despite their individuality and varied abilities and personalities, they are still treated like a tribe or group. Participants appeared irritated when they described being painted with a broad brush by their colleagues. Additionally, practitioners spoke of how the hospital and departmental environment changes individual behavior over time. Practitioner 3 shared,

If you work somewhere where everyone is lackadaisical and don't take their job seriously, you will eventually become like that. You will either leave, or you will become like that. It becomes tribal I think. It's just tribal through and it's very difficult to break that because they teach it to the younger ones and it just perpetuates itself.

This institutionalization, or apathy as a custom that occurs after a long period at an institution, impacts all providers regardless of individual traits.

Respiratory therapists perceive themselves as a motley crew, or a diverse assortment of characters banding together for a similar purpose. Interviews revealed educators and practitioners perceive themselves as individualistic caregivers with variable skillsets shaped by external influences. Participants noted a desire to be a part of the healthcare team but describe difficulties navigating the complexities between group and individual recognition. Individual characteristics and behaviors appear to be more influential for professional identity development than mentorship or training. Professional identity is perpetuated through socialization and institutionalization.

Fortuitous Happenstance

Participants shared professional origin stories often rooted in happenstance. The patterns by which people enter the profession appear to be through a personal connection or an unexpected encounter, as well as an internal recognition that other professions would not be a right fit. A need to get to work is also a recurrent theme throughout the data. Each pathway denotes an unintentional approach to entering the profession.

Educators and practitioners both described how a personal connection made them aware of the respiratory therapy profession. For some, this connection came through a sick relative, such as a sibling or friend. Educator 5 shared

> When I was about 15, my mom ended up getting sick and spending about a month in a hospital. She got very sick and I saw a lot of, back then they were called inhalation therapists, come in and treat her. That was pretty influential in my life where I watched people come in and work on my mom. She ended up spending a month at the hospital and then after that she ended up spending four months at a chest hospital. At that time, I really wasn't sure where you went to school to become an inhalation therapist. I kind of always kept that in the back of my mind.

For other study participants, they learned about the profession because they knew someone in the field. A parent or friend in the field gave the participants insights as they sought to determine a career path. These personal connections directly influenced participant decisions to become a respiratory therapist, either through encouragement to join the profession or through direct observation of the role of a respiratory therapist.

Unexpected encounters are also a hallmark of contributor professional origin stories. Described as "a funny story", "random", a "spur of the moment decision", or an "accident", study participants revealed a lack of intention when seeking the career. This concept was carried throughout the interviews of both participant groups. When describing what drove her to enter the field, Practitioner 1 shared

> An accident. My momma was a respiratory therapist and I told her I would never be one. I went to the technical school to sign up for X-ray because that's what I wanted to do. I was walking down the hall and my momma's teacher saw me. I told her what I was doing and she said 'You don't need to be an X-ray tech. You need to be a respiratory therapist.' When I got to the X-ray department, they acted like they didn't want to talk to me. I wasn't comfortable. In about 15 minutes, I was back in my momma's teacher's office saying 'I give up.' That how I became a respiratory therapist. That was the best spur-of-the-moment decision I ever made.

Both educators and practitioners described a lack of premeditated planning. They also portrayed a fondness for their origin story as a mechanism shaping them rather than depicting how they themselves shaped their professional origin.

Another key finding across both participant groups was how they desired to work in healthcare, often describing a "not nursing" mentality. One participant shared,

> My grandmother was a nurse and I just, I thought that I wanted to be a nurse. I went and shadowed a nurse and it was the most boring thing ever in this whole entire planet. It was not for me.

Educator 1 echoed this sentiment saying, "I enrolled as a nursing student, the first two years where the prerequisite coursework is done. I started that and I just never felt like I was in the right place." Both educators and practitioners shared how they "always wanted healthcare" but were unsure which field to choose. This finding depicts respiratory therapy as an unknown profession and as an alternative medical profession rather than its noteworthy field.

The happenstance described by study participants suggests a lack of intentionality and planning for those entering the respiratory care field. Findings depict respiratory therapy as an alternative to well-known medical professions when those professions do not suit the learner. Knowledge of the field is circumstantial and relies on a chance occurrence exposing people to the skills or nature of the profession. Findings suggest professional recruitment occurs through an unstructured and uncontrollable model of interpersonal connection – fortuitous happenstance.

Dark Side of the Moon

Participants report competing perspectives of the field. Grouped as positive and negative, these lenses reveal known and unknown views of the profession. The *light* side perspectives depict the positive attributes of respiratory care often known or shared with those considering entering the field. The *dark* side perspectives depict the lesser-known considerations of working as a respiratory therapist, such as unequal pay, lack of respect, and a lack of understanding of a respiratory therapist's skillset. Participants discussed the reality of both perspectives impacting professional identity without specifically noting one as more powerful than the other.

While both groups shared positive perspectives of the profession during interviews, educators were significantly more optimistic than practitioners. Study participants described a profession full of caring, hardworking, specially trained patient advocates who can work independently but are a crucial part of the healthcare team. Educators and practitioners depict respiratory therapists as able to problem-solve on the fly, a critical element of quality patient care. Practitioner 1 stated, "We're the ones they call when something goes wrong" and Educator 1 expanded this notion, saying, "We're the people that, if you don't get it right, the outcome is death or brain death." Subjects in both participant groups shared that this expertise and depth of knowledge drew them to the field once they learned about it. These known attributes, often shared during recruitment efforts, paint a positive image of the respiratory care profession.

Simultaneously, interviews revealed a darker, more negative tone about how respiratory care professionals are treated despite their essential role in patient care. All participants expressed being misunderstood, overlooked, undervalued, frustrated, disrespected, perceived as "less than", and tired. Participants described multiple instances where they clarified their skills to other professions because of a lack of understanding about the respiratory therapy scope of practice. Practitioner 1 shared, "I heard one person say, 'I look at an associate degree RT and I think of on-the-job training." Educator 6 echoed this sentiment when stating, "We're still referred to as inhalation people and inhalation therapy hasn't been used since the '50s or '60s." This is also aptly depicted as Educator 4 described an interaction between his students and working emergency medical technicians (EMTs), "One of my students asked if RTs can become a flight therapist. And their response was no, no, no. And I said 'That's not right, we can and we do it all the time in the NICU world'." Participants revealed a sense of frustration at these misconceptions and a desire to rectify the confusion because they cause conflict and impact working relationships.

Participants also identified feeling undervalued for their level of expertise, both professionally and financially. Practitioners focused on the day-to-day wage inequality and communications with other professionals. Participants described the frustration they experience when hospitals quickly provide bonuses or elevated pay to nurses, but respiratory therapists do not receive the same perks despite working right alongside the nurses. Educators spoke of literal devaluation because the Centers for Medicaid and Medicare Services (CMS) do not recognize respiratory therapy as a profession, which "limits what we can bill for." Members of both groups described how the feeling of being undervalued was communicated by other professionals. Educator 6 shared, "We are undervalued for the amount of knowledge we have. We have a wealth of knowledge when we're given the chance to share it. The nurses and physicians don't fully understand what it is we do." Participants consistently reported feeling "less than" as healthcare colleagues override care decisions, fail to recognize the therapist's expertise, and refuse to compensate them in an equal manner.

Educators and practitioners depicted a profession with a bright side and a dark side with "a constant undertone of being disrespected and underappreciated." Participants mentioned how the positive aspects drew them toward the field; however, they spent more time discussing negative aspects than positive. To those inside and outside of the profession, the positive attributes are always illuminated. However, like the dark side of the moon, the negative attributes are also ever-present and only visible to those who know the profession.

The Clash

Participants often described clashing with colleagues as an impactful component of identity perception. Contributors depicted unequal treatment and being "our own worst enemy" as common occurrences influencing self-perception. Participants often expressed frustration when discussing how these inter-personal and intra-professional conflicts communicate the value of the respiratory therapist.

Both participant groups depicted a professional environment invalidating the role of the respiratory therapist through differing standards, unequal treatment, and the resultant conflicts that occur. Educator 6 shared, "Our profession is held to a different standard than nurses, because I know plenty of nurses that acted the same way but they didn't seem to get in trouble...for some reason it's ten times worse for us." When discussing interdisciplinary quality improvement projects, Educator 6 also shared:

> They [PT] were given time to work together on these projects because historically physical therapists only have to see 10 patients a day. I get handed 35 patients in the morning to see. I got a massive amount of people to go take care of. So my director would get very frustrated because OT, PT, and speech would do very well on their performance improvements. RT could never even come close...because of patient load.

Participants described how unfair workload expectations, as well as the discounting of their knowledge by other professionals make them feel "frustrated", "disrespected", and "undervalued". Study participants verbalized this idea of "if I'm

supposed to be part of the team", indicating confusion and frustration with work environments whose words and actions do not match.

Both educators and practitioners described instances where respiratory therapists are their "own worst enemy." Participants depicted this intra-professional clash in a multitude of ways, such as when the poor actions or behaviors of one therapist negatively impact how the whole group is treated, causing turmoil and a constant need to prove their knowledge and skills to other healthcare colleagues. Participants described how respiratory therapists "rip each other apart" and "trash talk" each other openly. Practitioner 1 shared:

> I think respiratory therapists, we're our own worst enemy. We want this, we want this, but we're not willing to do this, this, and this to get it. We want to be treated like diamonds when at this point, we're a lump of coal.

Participants also expressed frustration over the lack of consensus surrounding correct medical treatments "even though we all went to school" and described how therapists undermine each other's treatment choices. Study participants report this intra-professional conflict causes tension, frustration, and an inability to gain respect because "Why would other people give us respect when we don't even give it to ourselves?"

Both participant groups identified unequal treatment and conflicts with other therapists as contributing factors shaping professional identity. Participants feel differing standards and unequal treatment communicate how hospital facilities do not value the therapist's contributions. Therapists also do not value each other as they argue over proper therapies, refuse to take necessary steps to improve their status, and undermine each other's work. The regularity of these conflicts makes practitioners who are defensive, argumentative, and frustrated.

DISCUSSION

Participants addressed the research question through their description and exploration of the intersection of educational changes and current respiratory therapy practices. Practitioners and educators perceived themselves as a group of caregivers with a helping orientation who regularly inhabit multiple, disparate identities often assigned to them by others. Participants described being a critical member of a patient care team that often undervalues their expertise, causing frustration and discord. Despite having an internal recognition of worth and skill, respiratory therapists often feel like second-class citizens when hospitals and colleagues, both in and out of the profession, do not recognize the therapist's value. Awareness of the profession is highly circumstantial and dependent upon personal connections.

Our primary research finding is a lack of cohesive professional identity. Participants of the educator group shared descriptions focused on higher-order thinking, while those in the practitioner group spoke more about the heart and principles of the respiratory therapist. Surprisingly, none of the participants implicated the AARC as a key force shaping professional identity. When faced with documents from the AARC defining respiratory therapy (American Association for Respiratory Care, 2015b) and outlining the code of conduct (American Association for Respiratory

Care, 2015a), less than half of all participants knew of the documents and only one participant in the educator group described actively using the documents. Across both participant groups, the only common language used to describe the respiratory therapist was "critical thinking". This finding complements research that identifies critical thinking as a valued skill in the respiratory therapist (Gresham-Anderson et al. 2018; Mishoe, 2003, 2007; Turkestani, 2022).

Practitioners and educators consistently described how relationships, socialization, and institutionalization impact how they perceive their professional identity. Considered to be primary stakeholders, respiratory care practitioners and educators play a particularly important role in respiratory care education (Adams et al., 2016; Colesso et al., 2013; Commission on Accreditation for Respiratory Care, 2019). As active participants in the systems shaping respiratory care students, educators and practitioners directly influence a student's socialization and identity development journey. During the socialization process, educators and practitioners exercise legitimacy, urgency, and power over students and institutions to categorize what is socially acceptable, how to influence others, and when to act on particular topics (Clarkson, 1995; Mitchell et al., 1997).

Participants in both study groups openly described working among disparate identities, which complements current research depicting socialization as an integral component of identity development (Cruess et al., 2014, 2015; Colesso et al., 2013). In this study, educators acknowledged the negative reality that exists in the professional workplace but primarily focused on the positive attributes of the field. Practitioners tended to focus on the negative attributes. Students are influenced by both perspectives while in school but primarily ascribe to the positive perspectives because they continually return to the educator's influence. Upon entering the workforce, students move away from the educator's influence and the circle of socialization changes. Surrounded by seasoned healthcare providers, the new practitioner's perspectives may change to fit more closely with those in their circle of influence. These findings build on current research depicting identity development as a dynamic process occurring over time and subject to influences shaping the individual (Adams et al., 2016; Colesso et al., 2013, Cruess et al., 2014, 2015; Goldie, 2012;). Additionally, these findings amplify the importance of stakeholders and their perspectives because they are change agents and perpetuators of established norms through the cycle of socialization (Adams et al., 2016).

Limitations

There are limitations associated with this study and the findings. This study did not feature a homogenous sample which consisted primarily of older female educators and practitioners. Their perspective and lived experiences may not reflect those of the entire profession about professional identity and increased educational requirements. The primary author is a respiratory care faculty member and may have *a priori* participant knowledge which may have influenced the responses of the participants. Also, some participants may have selectively disclosed because of fear of stigma. Given these considerations and due to the small size of the research sample (*n*=12)

through the use of a qualitative methodology, findings may not be transferable to across respiratory care practitioners. Future research should address the limitations of this research study and explore professional identity among specific populations' stakeholders (educators or practitioners), particularly among professionals of color, men, women, and students. Additionally, consideration should be given to regional perspectives of professional identity.

Implications for Practice

Because of their power as shaping constructs, socialization and identity formation should become a requisite component of respiratory care education. To mitigate the impacts of identity convergence, a clear, concise professional identity should stem from one place and be perpetuated by all. Reflective practice with targeted educational outcomes assessing professional identity formation over time assists students as they integrate multiple selves.

To break the cycle of socialization and reset current identity perspectives, respiratory therapists must begin questioning the current systems shaping them. Educational institutions should also focus efforts to shape the identities of practitioners working with students to reformulate perspectives of the profession. Increasing exposure time to respiratory care professionals through increased clinical hours or increased classroom time provides more opportunity for identity integration.

Awareness of the profession's existence relies heavily on personal connection and circumstance. This may be a limiting factor for the growth of the profession because the recruitment of practitioners depends on access to a network of professionals. Those people focused on recruiting people to join the profession must expand the size of their network or find a way to improve access to the information provided by the network.

CONCLUSION

This study explored how respiratory care practitioners and educators describe their professional identity. Participants use a multitude of action descriptors to depict a group of individuals with a helping orientation but no clear, cohesive professional identity which supersedes the identities of schools, facilities, or departments. Educational institutions should monitor and evaluate identity formation over time to guide students through the cognitive dissonance they experience during socialization. Formalization of a professional identity may clarify the disparate identities therapists navigate daily. Future research should continue to expand the understanding of the respiratory therapist's professional identity. Moreover, researchers should evaluate more closely the impacts of the cycle of socialization from a student's perspective.

REFERENCES

AARC's Virtual Museum. (n.d.-a). Legends of respiratory care. http://museum.aarc.org/gallery/legends-of-respiratory-care/

AARC's Virtual Museum. (n.d.-b). Milestones of the profession. http://museum.aarc.org/gallery/milestones/

Adams, M., Bell, L. A., Goodman, D., & Joshi, K. Y. (2016). *Teaching for diversity and social justice*. Routledge.

American Association for Respiratory Care. (n.d.-a). About us: Mission and goals. https://www.aarc.org/aarc/mission-statement/

American Association for Respiratory Care. (n.d.-b). States with RRT entry to licensure. http://www.aarc.org/advocacy/state-society-resources/states-rrt-entry-licensure/

American Association for Respiratory Care. (n.d.-c). Timeline and history. http://www.aarc.org/aarc/timeline-history/

American Association for Respiratory Care (2015a). Position statement: AARC statement of ethics and professional conduct. https://www.aarc.org/wp-content/uploads/2017/03/statement-of-ethics.pdf

American Association for Respiratory Care. (2015b). Position statement: Definition of respiratory care. https://www.aarc.org/wp-content/uploads/2017/03/statement-of-definition-of-respiratory-care.pdf

American Association for Respiratory Care. (2019a). Issue paper: Entry to respiratory therapy practice 2030. http://www.aarc.org/wp-content/uploads/2019/09/issue-paper-entry-to-respiratory-therapy-practice-2030.pdf

American Association for Respiratory Care. (2019b). Position statement: Entry requirements to respiratory therapy practice: 2030 and thereafter. http://www.aarc.org/wp-content/uploads/2019/09/statement-entry-requirements-to-respiratory-therapy-practice-2030-and-theraftter.pdf

American Dental Hygienists' Association. (2019). ADHA policy manual. https://www.adha.org/resources-docs/7614_Policy_Manual.pdf

American Occupational Therapy Association, Inc. (2014). AOTA board of directors position statement on entry-level degree for occupational therapist. https://www.aota.org/aboutaota/get-involved/bod/otd-statement.aspx

American Occupational Therapy Association-Accreditation Council for Occupational Therapy Education. (2019). Joint AOTA-ACOTE statement on entry-level education. https://www.aota.org/AboutAOTA/Get-Involved/BOD/News/2019/Joint-AOTA-ACOTE-Statement-Entry-Level-Education-April-2019.aspx

American Physical Therapy Association. (n.d.). Positions, standards, guidelines, policies & procedures. https://www.apta.org/Policies/FullPacket/

Anderson, P. J. (2005). History of aerosol therapy: Liquid nebulization to MDIs to DPIs. *Respiratory Care*, *50*(9), 1139-1150.

Barnes, T. A., Kacmarek, R. M., & Durbin, C. G. (2011). Survey of respiratory therapy education program directors in the United States. *Respiratory Care*, *56*(12), 1906-1915.

Barnett, K. (2011). System members at odds: Managing divergent perspectives in the higher education change process. *Journal of Higher Education Policy and Management*, *33*(2), 131-140.

Battrell, A., Lynch, A., & Steinbach, P. (2016). The American dental hygienists' association leads the profession into 21st century workforce opportunities. *Journal of Evidence Based Dental Practice*, *16*, 4-10.

Bureau of Labor Statistics, U.S. Department of Labor (2019). Occupational employment statistics, Occupational employment and wages, May 2018, Respiratory therapists. https://www.bls.gov/oes/current/oes291126.htm#(1)

Becker, E. A. (2003). Respiratory care managers' preferences regarding baccalaureate and master's degree education for respiratory therapists. *Respiratory care*, *48*(9), 840-858.

Becker, E. A., & Nguyen, X. T. (2014). The current impact of entry-level associate and baccalaureate degree education on the diversity of respiratory therapists. *Respiratory Care*, *59*(12), 1817-1824.

Benbow, P., & Kanji, Z. (2019). Dental hygiene baccalaureate education: A national study of students' perceived value and intentions. *Canadian Journal of Dental Hygiene*, *53*(2), 89.

Benneworth, P., & Jongbloed, B. W. (2010). Who matters to universities? A stakeholder perspective on humanities, arts and social sciences valorization. *Higher Education*, *59*, 567-588.

Bransberger, P., Falkenstern, C., & Lane, P. (2020). *Knocking at the college door: Projections of high school graduates*. Western Interstate Commission for Higher Education.

Caffrey, S. M., Barnes, L. C., & Olvera, D. J. (2019). Joint position statement on degree requirements for paramedics. *Prehospital Emergency Care*, *23*(3), 434-437.

Caplin, M. S. (2016). Professional identity development in nurses returning for a BSN: A naturalistic inquiry [Doctoral dissertation, Kent State University]. OhioLINK Electronic Theses and Dissertations Center. http://rave.ohiolink.edu/etdc/view?acc_num=kent1479746734449734

Chen, L. Y., & Hubinette, M. M. (2017). Exploring the role of classroom-based learning in professional identity formation of family practice residents using the experiences, trajectories, and reifications framework. *Medical Teacher*, *39*(8), 876-882.

Clarkson, M. E. (1995). A stakeholder framework for analyzing and evaluating corporate social performance. *Academy of Management Review*, *20*(1), 92-117.

Commission on Accreditation for Respiratory Care (2018). 2017 report on accreditation in respiratory care education. https://coarc.com/CoARC/media/images/2017-CoARC-Report-on-Accreditation-4-3-18.pdf

Commission on Accreditation for Respiratory Care (2019). Entry into practice standards: Accreditation standards for entry into respiratory care professional practice. https://coarc.com/Accreditation/Entry-into-Practice-Standards.aspx

Colesso, W., Cusinato, M., & L'Abate, L. (2013). Self-identity differentiation: A supermodel expanded into two other models. In E. L. Anderson & S. Thomas

(Eds.), *Socialization theories, processes, and impact* (pp. 79–100). Nova Science Publishers.

Creswell, J. W., & Poth, C. N. (2016). *Qualitative inquiry and research design: Choosing among five approaches*. Sage Publications.

Cruess, R. L., Cruess, S. R., Boudreau, J. D., Snell, L., & Steinert, Y. (2014). Reframing medical education to support professional identity formation. *Academic Medicine*, *89*(11), 1446-1451.

Cruess, R. L., Cruess, S. R., Boudreau, J. D., Snell, L., & Steinert, Y. (2015). A schematic representation of the professional identity formation and socialization of medical students and residents: a guide for medical educators. *Academic Medicine*, *90*(6), 718-725.

Druse, T. L. (2012). *Educator, supervisor, and graduate recommendations of a bachelor degree for physical therapist assistants*. Northcentral University.

Farach, L. (2018). Professional impact of advanced education for practicing respiratory therapists. *Respiratory Care Journal*, *63*(suppl 10).

Farmer, T., Robinson, K., Elliott, S. J., & Eyles, J. (2006). Developing and implementing a triangulation protocol for qualitative health research. *Qualitative Health Research*, *16*(3), 377-394.

Fisher, M. (2014). A comparison of professional value development among pre-licensure nursing students in associate degree, diploma, and Bachelor of Science in Nursing programs. *Nursing Education Perspectives*, *35*(1), 37-42.

Freeman, R. E. (1984). *Strategic management: A stakeholder approach*. Pitman Publishing.

Freeman, R. E. (1994). The politics of stakeholder theory: Some future directions. *Business Ethics Quarterly, 4*(4), 409-421.

Freeman, R. E., Rusconi, G., Signori, S., & Strudler, A. (2012). Stakeholder theory (ies): Ethical ideas and managerial action. *Journal of Business Ethics*, *109*, 1-2.

Fulton, M. (2020). *Community college bachelor's degrees: An update on state activity and policy considerations policy brief*. Education Commission of the States.

Gigli, K. H., Davis, B. S., Ervin, J., & Kahn, J. M. (2020). Factors associated with nurses' knowledge of and perceived value in evidence-based practices. *American Journal of Critical Care*, *29*(1), e1-e8.

Goldie, J. (2012). The formation of professional identity in medical students: Considerations for educators. *Medical Teacher*, *34*(9), e641-e648.

Gresham-Anderson, J. L., Kurszewski, T., Davenport, E., Flagg, S., & Coonce-Smith, M. (2019). Exploring death coping strategies of respiratory therapists who work in neonatal intensive care units: A pilot study. *Respiratory Care Education Annual*, *28*, 36-42.

Han, M. K., Martinez, C. H., Au, D. H., Bourbeau, J., Boyd, C. M., Branson, R., Criner, G. J., Kalhan, R., Kallstrom, T. J., King, A., Krishnan, J. A., Lareau, S. C., Lee, T. A., Lindell, K., Mannino, D. M., Martinez, F. J., Meldrum, C., Press, V. G., Thomashow, B., ... & Dransfield, M. T. (2016). Meeting the challenge of COPD care delivery in the USA: A multiprovider perspective. *The Lancet Respiratory Medicine*, *4*(6), 473-526.

Kacmarek, R. M., Barnes, T. A., & Durbin, C. G. (2012). Survey of directors of respiratory therapy departments regarding the future education and credentialing of respiratory care students and staff. *Respiratory Care*, *57*(5), 710-720.

Kay, D., Berry, A., & Coles, N. A. (2019). What experiences in medical school trigger professional identity development? *Teaching and Learning in Medicine*, *31*(1), 17-25.

King, J., Freburger, J. K., & Slifkin, R. T. (2010). What does the clinical doctorate in physical therapy mean for rural communities? *Physiotherapy Research International*, *15*(1), 24-34.

Leider, J. P., Coronado, F., Beck, A. J., & Harper, E. (2018). Reconciling supply and demand for state and local public health staff in an era of retiring baby boomers. *American Journal of Preventive Medicine*, *54*(3), 334-340.

McCombie, R. P. (2016a). Attitudes of occupational therapists and occupational therapy assistants toward the entry-level bachelor's degree for OTAs. *Open Journal of Occupational Therapy, 4*(1), 1-11.

McCombie, R. P. (2016b). Entry-level doctorate for occupational therapists: An assessment of attitudes of occupational therapists and occupational therapy assistants. *Rehabilitation Research, Policy, and Education*, *30*(4), 389-403.

Miller, D. P., & Levere, T. H. (2008). "Inhale it and see?" The collaboration between Thomas Beddoes and James Watt in pneumatic medicine. *Ambix, 55*(1), 5-28.

Mishoe, S. C. (2003). Critical thinking in respiratory care practice: A qualitative research study. *Respiratory Care*, *48*(5), 500-516.

Mishoe, S. C. (2007). Problem-based learning: Any influence in respiratory care?. *Respiratory Care*, *52*(11), 1457-1459.

Mitchell, R. K., Agle, B. R., & Wood, D. J. (1997). Toward a theory of stakeholder identification and salience: Defining the principle of who and what really counts. *Academy of Management Review*, *22*(4), 853-886.

Molitor, W. M. L., & Nissen, R. (2018). Clinician, educator, and student perceptions of entry-level academic degree requirements in occupational therapy education. *Journal of Occupational Therapy Education*, *2*(1). Article 2.

Myers, T. (2019, Fall). AARC executive office board activities report. *Fall House of Delegates Meeting.* Talk presented at 2019 Fall House of Delegates Meeting, New Orleans, LA.

Nagendrappa, G. (2012). Antoine-Laurent Lavoisier. *Resonance*, *17*(1), 11–22. https://doi.org/10.1007/s12045-012-0002-2

National Board for Respiratory Care. (2020). About us. https://www.nbrc.org/about/

Organization for Associate Degree Nursing and American Nurses Association. (2015). Position statement: Academic progression to meet the needs of the registered nurse, the health care consumer, and the U.S. health care system [PDF File]. https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/id/academic-progression-to-meet-the-needs-of-the-health-care/

Privitera, G. J., & Ahlgrim-Delzell, L. (2019). *Research methods for education*. SAGE.

Rowley, T. (1998), A normative justification for stakeholder theory. *Business & Society*, *37*(1), 105-107.

Rowley, L. J., & Stein, S. M. (2016). A baccalaureate education curriculum to prepare dental hygienists for expanded public health practice. *Journal of Evidence Based Dental Practice*, *16*, 122-128.

Sekhar, K., & Rao, S.S.C. (2014). John Scott Haldane: The father of oxygen therapy. *Indian Journal of Anaesthesia, 58*(3), 350-352.

Silveira, G. L., Campos, L. K., Schweller, M., Turato, E. R., Helmich, E., & de Carvalho-Filho, M. A. (2019). "Speed up"! The influences of the hidden curriculum on the professional identity development of medical students. *Health Professions Education*, *5*(3), 198-209.

Smith, S. G., Endee, L. M., Scott, L. A. B., & Linden, P. L. (2017). The future of respiratory care: results of a New York state survey of respiratory therapists. *Respiratory Care*, *62*(3), 279-287.

Sperle, C. K. (2017). *A comparative analysis of associate and baccalaureate degree respiratory therapy programs preparation of graduates for entry into the profession* (Doctoral dissertation). ProQuest. (10125585)

Stolberg, R. L., & Tilliss, T. (2016). The baccalaureate-educated dental hygienist. *Journal of Evidence Based Dental Practice*, *16*, 136-143.

The National Academic Press. (2011). *The future of nursing: Leading change, advancing health*. Author.

Turkestani, F. A. (2022). *Mind mapping: A learning strategy to promote critical thinking skills for respiratory therapy students* (Doctoral dissertation, Seton Hall University). ProQuest Dissertations & Theses.

Vukojević, B. (2016). Creswell JW: Research design: Qualitative, quantitative, and mixed methods approaches, London: Sage Publications, 2009. *Politeia*, *6*(12), 191-194.

Wagner Mainardes, E., Alves, H., & Raposo, M. (2012). A model for stakeholder classification and stakeholder relationships. *Management Decision*, *50*(10), 1861-1879.

Wong, A., & Trollope-Kumar, K. (2014). Reflections: an inquiry into medical students' professional identity formation. *Medical Education*, *48*(5), 489-501.

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