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Self-employed nurses as change agents in healthcare: Strategies, consequences, and possibilities

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Abstract

Purpose: This article reports on ethnographic research that investigated how self-employed nurses perceive the contemporary healthcare field, what attributes they possess that facilitate their roles as change agents, what strategies they use to influence change, and what consequences they face for their actions, thus contributing to what is known about organizational change in institutionalized settings such as healthcare.

Design: Focused ethnography was used to explore self-employed nurses' work experiences and elucidate the cultural elements of their social contexts, including customs, ideologies, beliefs, and knowledge and the ways that these impact upon the possibilities for change in the system.

Findings: These self-employed nurses reflected on the shortcomings in the healthcare system and took entrepreneurial risks that would allow them to practice nursing according to their professional values. They used a number of strategies to influence change such as capitalizing on opportunities, preparing themselves for innovative work, managing and expanding the scope of nursing practice, and building new ideas on foundational nursing knowledge and experience. They had high job satisfaction and a strong sense of contribution but they faced significant resistance because of their non-traditional approach to nursing practice.

Value: Despite dramatic restructuring in the Canadian healthcare system, the system remains physician-centered and hospital-based. Nursing's professional potential has been largely untapped in any change efforts. Self-employed nurses have positioned themselves to deliver care based on nursing values and to promote alternative conceptions of health and healthcare. This study offers a rare exploration of this unique form of nursing practice and its potential to influence health system reform.

Keywords: Healthcare system, organizational change, institutional theory, institutional entrepreneur, self-employment, private practice, nursing, strategies.

Paper Type: Research paper

In Canada and other western countries, healthcare has changed dramatically over the last two decades. While there appears to have been radical organizational change in the field, shifting from medical dominance toward managerialism (Scott, 2000), healthcare organizations have reorganized for greater efficiency without actually changing how health and healthcare delivery are conceptualized. Nurses working within the healthcare system have experienced considerable work disruption and stress in the name of cost-effectiveness, yet they continue to work in a system that privileges biomedical technology and physician-driven services and that often fails to recognize and value nursing's contribution (Campbell, 2000; Chambliss, 1996). Some nurses have turned to self-employment (independent or private practice) as an alternative to traditional organizational employment in order to enhance their professional potential. This article reports on qualitative research that investigated how self-employed nurses perceive the contemporary healthcare field, what attributes they possess that facilitate their roles as change agents, what strategies they use to influence change, and what consequences they face for their actions, thus contributing to what is known about change in institutionalized settings such as the healthcare system. These nurses have responded uniquely to both physician dominance and managerialism in healthcare and have sought to promote alternative ideas about health and healthcare. They demonstrate how specific actors become aware of the need for change and how they work to achieve it. In analyzing nursing self-employment, neo-institutional theory provides a useful framework for examining long-established and taken-for-granted aspects of social systems and the ways in which change can occur. While institutional theory has typically focused on the structural characteristics of organizational fields and their tendency for isomorphism, there is a growing line of scholarship on agency and change in institutionalized settings. This article contributes to this emerging body of research about change agents and change strategies.

Institutional Theory, Change and the Healthcare System

Institutionalism in Healthcare

Institutions are rules, procedures, norms, and moral templates that structure meaning and guide human action (Hall and Taylor, 1996). They are continually reinforced because stakeholders often cannot even imagine alternatives to the status quo (DiMaggio and Powell, 1991; Meyer and Rowan, 1977). Action is structured according to commonly accepted rules that "constrain the inclination and capacity of actors" and "privilege some groups whose interests are secured by prevailing rewards and sanctions" (DiMaggio and Powell, 1991, p. 11).

Organizations within a field or system, such as healthcare, tend to become similar to each other; they generally incorporate common practices and procedures in order to "increase their legitimacy and their survival prospects" (Meyer and Rowan, 1977, p. 340). Meyer and Rowan (1977, p. 344) note that "many formalized organizational programs are also institutionalized in society" and that "ideologies define the functions appropriate to a business." Healthcare stakeholders expect, as Meyer and Rowan describe, that hospitals will exist and that they will offer certain programs. For Canadians, this means that publically-funded care for episodic medical situations is seen, no less, as part of the national identity (Armstrong and Armstrong, 2003).

Institutionalism and Change

In recent years, the beliefs and values of the welfare state, which have been closely connected to the service ideals of health care professionals, have been scrutinized and replaced by a new organizational order based on market values (Carvalho, 2012). For Canadians, this ideological shift resulted in economic rationalism and chaotic organizational restructuring in healthcare beginning in the 1990s (Laschinger *et al*., 2001; Wynne, 2003). As healthcare

restructuring began, costs were said to be out of control, necessitating sweeping changes in order to preserve the public system. Further, it was suggested that a focus on the social determinants of health would improve the health of Canadians and ensure the viability of the hospital system (Armstrong, 1997; Armstrong and Armstrong, 2003; Church and Barker, 1998). Evidently, however, the main interest has been in reducing spending and balancing budgets (Reay and Hinings, 2005). Thus, healthcare restructuring focused on hospital expenses, resulting in a reduction in hospital services, standardization of care, and increased management surveillance and control. What presently exists is "less of the same or worse" (Armstrong and Armstrong, 2003, p. 87). For nurses, restructuring led to significant job change and heightened work stress (Aiken *et al*., 2001; Daiski, 2004; Laschinger *et al*., 2001; Rankin and Campbell, 2006; Wynne, 2003) but there has been very little uptake of expanded roles for nurses and almost no enhancement in primary and community care (Armstrong, 1997; Armstrong and Armstrong, 2003). Rather than contributing to innovation in healthcare, nurses have had to comply with the efficiency agenda, which has undermined their capacity to provide the patient care they judge appropriate (Rankin and Campbell, 2006). As well, the traditional medical model of care has given physicians the controlling role and much of the professional and operational power in the healthcare system (Hinings et al., 2003). Although medical dominance has been challenged by new business ideologies in healthcare, it has not been eliminated (Reay & Hinings, 2005). Nursing work continues to occur within a system that displays an inflated regard for biomedical technology and high visibility services (Campbell, 2000; Chambliss, 1996). The work of nurses, despite its complexity, is increasingly undervalued, especially when contrasted with the scientific and expert-task curing of physicians, a situation that is worsened by the efficiency-driven policies of contemporary healthcare (Bourgeault and Wrede, 2008).

Although the dominant institutional logics remain, healthcare has been destabilized. While, institutionalized structures are reinforced during stable periods, opportunities arise at "critical junctures" for certain groups to promote institutional change (Kenny, 2007, p. 92). A shift in the sociopolitical and economic context resulted in changes to the Canadian healthcare system, which represented such a critical juncture. Health system restructuring produced "successive jolts due to rapid departures from the way we have come to expect the healthcare industry to conduct its business" and created "environmental instability that challenge[d] the very ingenuity, strengths and expertise that nurses have developed" (Douglass, 1994, p. 4). It also, however, made it possible for nurses to "create and seize the opportunities that an unfrozen system affords" (Douglass, 1994, p. 4).

Organizational actors who can identify organizational failings and propose and justify solutions have been referred to as "institutional entrepreneurs" (DiMaggio, 1988; Greenwood *et al*., 2002). Institutional entrepreneurs are able to mobilize resources to create or transform institutions (Battilana, 2006), using their unique personal characteristics and their capacity to reflect on institutionalized practices and envision alternatives (Beckert, 1999; Hardy and Maguire, 2008). Actors within a field have different points of view, different experiences of struggling to transform the field, and different levels of motivation to promote change (Battilana, 2006). Less dominant actors or marginalized groups at the periphery of a field can be the source of innovation and change because they have different stakes in relation to the status quo (Hardy and Maguire, 2008; Kenny, 2007; Scott, 2008b). They can be more aware of alternatives and more motivated to change than resource-rich central players whose interests are served by dominant institutional logics (Greenwood and Suddaby, 2006; Scott, 2008b). Nurses, for example, although highly involved in the central work of hospital care are ironically peripheral

to it because of the low value placed on their contributions. Some nurses then, perhaps those most aware of their marginalization, will be less interested in perpetuating institutionalized ideas and practices than other actors and may possess unique ideas that can influence change in the healthcare field.

Strategies for Change

Strategies are actions directed toward the transformation of institutions and fields and the rules and standards that control them (Lawrence, 1999 in Levy and Scully, 2007). There is a beginning body of research that explores the strategies used to promote change. Reay and colleagues (2006) identified a set of microprocesses that employed nurses and their managers used to legitimate a new nursing role (nurse practitioner) in their facilities. By cultivating opportunities for change, fitting the new role into prevailing systems, proving the value of the new role, and celebrating a series of "small wins," these actors were able to legitimate the controversial new role. Similarly, Delbridge and Edwards (2008) outlined how strategies for change such as capitalizing on opportunities and attempting to generate consumer demand for innovative practices.

While the term "institutional entrepreneur" has typically referred to organizational actors who promote change, it might be that entrepreneurship as small business is another strategy for building, creating, or changing institutions. Those in small enterprises can remain very connected to an institutionalized field without being organizationally embedded, thus motivating and positioning them for change. For example, Greener's (2009) study of independent childcare providers in England is an example of how entrepreneurial individuals overcame market-based logics to transform their field into a more professional, relational, and collectively-oriented endeavor.

Nicholls, Walton and Price described a private physiotherapy clinic that was established for the purpose of "negotiating new territory at the margins of orthodox practice, inventing new diagnostic and treatment techniques, constructing new clinic environments, and resisting many of the constraints previously thought to be insurmountable by the profession" (2009, p. 341). Similarly, Villanueva-Russell (2008) illustrated how chiropractors used "maverick" entrepreneurial means to respond to their marginalization vis-a-vis orthodox medicine. They did so by emphasizing chiropractic's holistic focus, defending its jurisdictional position, seeking customer validation, privileging experiential knowledge and business acumen, promoting equality between professional and patient, and establishing chiropractic as altruistic, trustworthy, and valuable. Entrepreneurship has also been identified as a way for nurses to use distinct skills and "contribute to making a difference in health outcomes for individuals" (Wilson *et al*., 2003, p. 242).

There is much to discover about the "microprocesses of these acts of subversion" (Delbridge and Edwards, 2008, p. 301) across different sectors, such as within the highly institutionalized healthcare system. This research contributes to understanding about the people that undertake institutional change efforts, the strategies they use, and the consequences of their actions.

Study Methods

In this study, focused ethnography was used to explore self-employed nurses' work experiences. Focused ethnography is a specific form of ethnographic research that deals with a distinct question in a specific context and is useful for conducting social research in fragmented and specialized fields (Knoblauch, 2005; Morse and Richards, 2002; Roper and Shapira, 2000). Participants may not know each other but can still share behaviors, experiences, and a cultural

perspective (Morse and Richards, 2002). Methodologically, this study responds to calls for an increasingly interpretive, critical, and socially-situated approach to research on work and institutional change (Hinings and Tolbert, 2008; Smith, 2001; Wall, 2010).

The setting for this study was a western Canadian province. At the time of the study, there were 241 independent practice nurses registered with the provincial regulatory association (Personal Communication, J.M., regulatory association, November 2, 2007). While this number is growing, it represents a small proportion of the over 29,000 registered nurses (RNs) working in the province, 79.1% of whom work in front-line positions in healthcare organizations with 65.8% of them in hospitals (Canadian Institute for Health Information, 2010). Self-employed nurses were sought for their point of view as possible change agents uniquely positioned within an institutionalized field.

Recruitment was undertaken through the provincial association of registered nurses in private practice (ARNPP). A letter outlining the study and asking for volunteer participants was sent through ARNPP to all association members accessible by e-mail. Nurses were sought who had been self-employed for at least 18 months. Additional participants were recruited using snowball sampling. Study data were collected mainly through interviews with 20 self-employed nurses (19 female, one male). All were mid- to late-career professionals, working in a diverse range of practice types. Each nurse was asked about their reasons for becoming self-employed, the barriers and facilitators they encountered, the nature of their daily work, the knowledge and skills required for their non-traditional practices, reactions and responses from others about their practices, issues pertaining to professional regulation and policy, sources of professional support and networking, their level of autonomy and job satisfaction, and the potential they saw in

nursing self-employment to effect change in the system. The interviews, which were 60 to 90 minutes long, were audiotaped and transcribed.

I took every opportunity to spend time in the field with the nurses, such as viewing their work spaces and attending meetings and social gatherings of their professional association. Opportunities for observation were limited, however, because the participants were geographically dispersed, most worked alone, and some of them had no specific location of work. Further, my ethics approval did not allow my presence in nurse-patient interactions where private health information would be divulged. Roper and Shapiro (2000) point out that there is no general rule about the "right" amount of time to spend in the field. In fact, limited time in the field can be substituted for by a higher intensity and volume of data, such as the type of data that arises from in-depth, semi-structured, tape-recorded interviews (Heyl, 2001; Knoblauch, 2005; Morse & Richards, 2002). Relevant documents such as legislation, regulatory documents, nursing practice standards, professional position papers, newsletters, and nurses' business websites were also reviewed to contextualize the interview data.

The analysis followed an iterative process of coding, categorizing, and abstracting. Coding involves the identification of persistent words, phrases, and/or concepts within the data (Mayan, 2009). I used NVivo 7 qualitative data analysis software to assist with data analysis. Each transcript was read line-by-line and key words and phrases were coded. These codes were then sorted and collated to form categories, in which similar excerpts of data are grouped and labeled (Mayan, 2009). Categories were refined as new data was extracted from each interview. In ethnography, abstraction involves the creation of linkages among categories, the identification of themes and patterns, and the development of explanations about the context of the study (Morse & Richards, 2002). This research revealed rich themes about patterns of behaviour and

activities, ideas, beliefs, knowledge, relationships, and the sociopolitical organization of nursing self-employment, which reveal the very building blocks of culture (Roper & Shapira, 2000).

This study was approved by the university research ethics board. In this article, all names are pseudonyms.

Findings

Despite the diversity of the nurses' practice types and the uniqueness of their experiences and issues, these nurses' impressions were highly cohesive. They raised many of the same issues and described very similar experiences, which provided assurance of the strength and unity of their perspectives. Most of them spoke passionately about their roles and the unique perspective they brought to health care delivery. Hardy and Maguire (2008) note that the accounts of some institutional entrepreneurs are normative and interest based and can take on an evangelical quality. The goal of ethnography is to "attempt to describe the culture of a given group as the individuals in the group see it" (Mayan, 2009, p. 38). As Spradley (1979) said, "I want to know what you know, in the way that you know it, to walk in your shoes, to feel things as you feel them, to explain things as you explain them" (p. 34). Thus, the findings reported herein convey these nurses' perspectives, the passion of their purpose, and the values that are important to them.

Institutionalism in the System

Stemming from massive structural change and the ironic lack of real reform, the nurses in this study perceived overwhelming and disheartening issues in the healthcare system. Overall, they had concerns about institutionalized ideas about economics, efficiency, and reactive illness care, which contributed to a lack of real reform in the system. Sylvia expressed the concern succinctly, saying, "I have a real sense that something is going very wrong in healthcare." She,

like others, had seen how the system had shifted away from a concern for health toward budget consciousness, and eliminated some important patient care services, although, as Doris said, "of course, I knew there was still the need for it." Innovative services that had the potential to produce change were also cut. Lindsay's role in community health education was eliminated because "health promotion and education is easily dropped off the slate" in favor of hospital services. Steve found that managers lacked respect for his role in health promotion as an occupational health nurse. He joked that "you could tell where occupational health fit because we were right next to the morgue in the basement." Mary-Jane saw services for diabetics deteriorate, convinced that the system was dealing poorly with the "fat and lazy diabetic epidemic."

Nurses also observed, in their previous employment, a growing lack of care and compassion within the hospital care system. Carla explained that "the care is falling off the table. That's the spirit of nursing. It's our care. We don't see our care." Lean operations and a continuing focus on medical intervention meant that "only a person's physical needs are attended to, not the whole person," even though patients and families also need "sit-in, hold-your-hand support" (Nancy). Sylvia said, "I don't know what's wrong right now and why it's deteriorating and why nursing is so undervalued." These nurses felt thwarted in their efforts to provide care as they envisioned it because of the low value placed on the interpersonal aspects of their work.

Many of the nurses described their employment situations as dysfunctional, demeaning, abusive, excessively demanding, and/or unchallenging. Denise had felt for a long time that "something seemed to be missing" in her employed nursing roles and that it "was probably the creativity – thinking of something and being able to do it." Carla explained that "everything I believe I am – innovative, professional, problem-solver, empowered – I could not use in the

hospital." Mary-Jane saw that "for nurses in big organizations, it limits your abilities to think outside the box and think for yourself and to do something unique and to make a difference." She believed that "there can be better ways to do things."

Characteristics of Self-Employed Nurses

These nurses perceived that they were "different" in ways that distinguished them for innovative practice. They emphasized their need for change and challenge, their entrepreneurial spirit, and their ability to tolerate risk. Carla was often asked, "You're not a regular nurse, are you?" Sylvia saw entrepreneurial nurses as being uniquely situated to be change agents, observing that "in private practice, we're risk takers. And so it's crossed my mind that maybe that's where the leadership could come from." Carla also perceived a special level of "character development and individuation" and a sense of "awakening" among self-employed nurses, distinct from nurses in general, noting that "you can't have a weak heart and pursue private practice nursing." Denise explained that she "wasn't your 50th percentile nurse." Instead, she was perceived as a "problem nurse," who was always asking, "Why don't we do it this way? Why don't we change this? Let's do something different!" when other nurses just wanted to "leave it the way it is." Allison also felt "like I don't have your typical nurse personality" because she was not afraid of taking a risk.

Several of the nurses enjoyed change and challenge. Kelly said that she has "always embraced change or never been afraid of it and I am very optimistic and positive." Grace said, "I always like to do different things. I always like challenges." Denise pointed out that "there are certain personalities that can have the same body of knowledge but just can't work in the same structures." Others also referred to their "entrepreneurial spirit" as a strong motivator for change in their work. Generally, these nurses believed that they were less connected and less committed

to dominant institutional ideologies in healthcare when they compared themselves to nurses in traditional roles. Consequently, they viewed themselves as risk takers, open to change and positioned to promote innovation in healthcare delivery.

Strategies for Change

These nurses used several strategies to promote healthcare innovation. Notably, they deliberately used entrepreneurship (small business) to effect institutional change. In doing so, they were able to expand the professional jurisdiction of nursing, while calling upon their existing professional knowledge and standards to adapt nursing for a preferred future.

Business Entrepreneurship as Institutional Entrepreneurship

These nurses used entrepreneurial practice to move to a new practice "space" that freed them from what they saw as misdirected and narrowly focused healthcare organizations and allowed them to engage with healthcare practice based on nursing priorities.

Capitalizing on the enterprise culture. In becoming entrepreneurs, these nurses took advantage of the destabilized system and the heightened market focus in Canadian society. Many of them saw self-employment as the only way to structure nursing practice according to their own values, which were so at odds with the system. While the study nurses believed that the healthcare system had become overly business focused, some felt that there was an effective *and* ethical way to capitalize on business perspectives in healthcare delivery. Denise used a polished, success-oriented style in order to inspire confidence and influence change in her workplace wellness consulting practice. Kelly, a home care agency owner, used her business-like manner to establish her credibility and demonstrate her commitment to quality. Wendy felt comfortable in the private sector because she valued prudence and efficiency, although ethical resource allocation was very important to her. Lindsay opened her holistic healing practice to meet

consumer demand for healthcare alternatives. In response to the economic climate in healthcare, these nurses seized an opportunity to secure the independence necessary to advance their nursing values.

Using self-employment to re-establish services. Some of the nurses used entrepreneurship to fill service gaps left by restructuring. Doris started her foot care practice because there was still a need for the service even though it had been "one of the first things that went" during earlier cutbacks. Evelyn was disturbed by a devaluing of the specialized role of wound care nurses; she started her wound care practice because she "had an area of expertise that other people needed and that I wanted to make available to them." Frustrated by the direction that diabetes services were taking, Mary-Jane pursued a diabetic outreach business. Georgette observed that "there is no fat in the system to do anything other than just your everyday operations," which presented an opportunity for her to establish a venture in planning and project management. In their small businesses, these nurses were situated to address service gaps and re-establish lost or disappearing nursing priorities.

Using entrepreneurship to broaden the meaning of healthcare. Self-employment positioned several of these nurses to exercise a vision of healthcare that went beyond hospital-centered care. Lindsay pursued self-employment in alternative therapies because she "knew I wouldn't be able to really bring it out in an employee status in a hospital. There's not an opening for that yet" in the current health system culture. Denise developed a corporate wellness consulting business so she could "find a piece of the puzzle that nursing fits into." Carla used self-employment to go "over on this other side," away from "the chemicals and the procedures" to focus on caring and non-traditional approaches to health. Nancy went "into private nursing practice [in alternative therapies] because of a belief in prevention and holism," which she could not practice while an

employee. Entrepreneurship positioned these nurses to apply their expertise to a broader understanding of health.

Expanding Professional Jurisdiction

Simply by becoming self-employed, these nurses challenged the traditional, institutionalized role of the nurse and used their businesses to broaden their professional potential. Yet, once positioned independently in their small businesses, they also worked to defend and re-negotiate their jurisdiction or scope of practice. Nancy (alternative therapies) described the tendency toward traditionalism in nursing roles, highlighting the significant shift that these self-employed nurses were making regarding their professional scope of practice. She said, "There seems to be a feeling always that you have to keep up your traditional [hospital/clinical] nursing skills." She believed that "nurses need to rethink this" and, indeed, many of these nurses did.

Preparing themselves for a preferred future. These nurses began their ventures by preparing themselves formally and informally for advanced and non-traditional work beyond the scope of their original nursing training. Gabby "looked at my nursing magazines" to help her solidify her ideas and knowledge. Lindsay embarked on "ten years of self-directed study. I just began to pick up books that were related to mind-body connection." Later, both of them pursued formal training in their areas. Sophie, a project manager, took formal courses "so I could learn how to do better [program] evaluation. It's a whole new thing to learn." Others pursued formal training in areas such as sexual health, counseling, wound care, occupational health nursing, personality testing, laser hair removal, and project management. Additional training provided these nurses with skills that are not included in typical nursing education programs and prepared them to expand into non-traditional practice areas.

Re-claiming health services for nursing. As a way of challenging efficiency focused priorities, several nurses sought to re-claim work that was previously considered to belong to RNs but had since been taken on by non-nurses. Nurses in administrative practices saw a difference between what a nurse could offer to healthcare planning and management as compared to a business-trained non-nurse. Sophie, a project manager, explained that, "I'm sure there are people who are not nurses who could do that kind of work as well but I've always worked in the healthcare system so it's helpful to have that." Diana, in a similar practice, said "the fact that I'm a nurse is extra value added." Sophie explained this added value by saying, "I don't think I could do [this] and not be a nurse. You've got to have some understanding of how things work. Otherwise you can't identify the questions and can't determine users or methodology." Georgette, who also did planning and project management, argued that, while non-nurses might be good supports for a project, a nurse can contribute much more richly to a project because "you know where all the typical resources are…The face that meets with the medical team needs to have a medical background." Sylvia was shocked that the public and organized nursing had barely reacted to the declining representation of nurses in system administration and governance. She exclaimed that "if they hired you and me to build a bridge, people would be up in arms. What do they know? It's going to fall down – of course it will and it has."

Nurses in direct patient care practices also undertook reclamation strategies. Gabby explained that one of her clients had recently hired a Licensed Practical Nurse (LPN), a nurse with less training than Gabby but doing similar work. To Gabby, the "healthcare system is such a mess" because of its reliance on lesser trained workers. She believed that an LPN "doesn't know the right thing to do because she hasn't been trained that way." Gabby also noted that "they're doing foot care in all the hairdressing establishments" but explained that she sees people a week

after a pedicure, which costs more than her services, only to have to correct a poor quality job. She wanted to re-claim foot care services for registered nurses, re-establishing an appropriate level of care quality. Doris, another foot care nurse, said that what "concerns me about people who do pedicures is how they're cleaning their instruments, their infection control procedures." As well, she commented on how she was able to assess a client's other medical needs and provide health teaching while doing foot care, leaving a client feeling like they've "had a pedicure although it's from a nursing point of view." By re-claiming services that were once done by RNs, these nurses defended the scope of nursing practice within a system that sought to erode it.

Expanding the territory of nursing. These nurses also influenced change by expanding into jurisdictional territory usually associated with other health professionals or even lay providers. Many of them acknowledged that their roles could be performed by non-nurses but they believed strongly in the value that nursing knowledge brought to their work. For the foot care nurses, expanding nursing's jurisdiction meant not only re-claiming foot care from lower skilled workers but also moving outward into the territory of podiatry. Both of them saw how a nursing viewpoint could improve on the medically-oriented worldview because of the time, attention, accessibility, and quality that nurses offered as opposed to the "podiatrist who had his office in the doctors' office building and he racks them in there one every seven minutes" (Gabby) or "see[s] five or six in the hour I'm talking to [one]" (Doris). Similarly, Allison's area of practice, laser hair removal, was typically associated with estheticians or dermatologists but she was certain that "absolutely this is nursing." She was confident that her business was doing so well because it was based on nursing. She noted that "there's a huge difference between going to an

esthetician for a service and going to a nurse," particularly because of nurses' interpersonal skills.

Carla, a leader among private practice nurses, explained that new provincial health professions legislation provided a framework for thinking about the scope of nursing practice: "So are we supporting health, are we educating, are we coaching, are we counseling, are we restoring, are we health teaching?" Steve, an occupational health nurse, explained that he had moved beyond "those straightforward skill things" that characterize traditional nursing practice because he was "expanding the role of nursing into different areas." Although some "may not see that as something only a registered nurse could do," he offered healthy lifestyle teaching and gave lectures to work groups about occupational hazards. Mary-Jane "saw the element of nursing" in her nurse practitioner practice, even though she was doing work traditionally associated with physicians. Denise used her mental health nursing background to begin working with families in crisis. She overlapped with social work practice in doing so but aimed to promote family well-being beyond the usual motivation of "let's keep the social workers quiet." Paula believed that she offered an "incredible perspective" on "what nursing can do and what nursing is about" as she investigated quality of care complaints, even though her practice blurred the boundaries between her two professional designations in nursing and psychology. Many of the nurses emphasized the potential in an expanded scope of practice for nursing.

Building on the Familiar

Although each of the nurses had moved away from traditional practice, the ability to create a successful nursing business and seek jurisdictional expansion was highly dependent on using transferrable nursing knowledge. As Diana concluded, "some of it comes back to knowing how to do things because I've known them from being a nurse." They also remained connected

to formal professional standards in order to enhance the legitimacy and accountability of their practices.

Applying transferrable nursing knowledge to new work. Even in new areas of independent practice, these nurses relied on foundational nursing knowledge. Diana pointed out that "I think you always have kind of that nursing lens on things." She described the transferability of the nursing process, a ubiquitous, systematized approach to nursing practice, which channels the use of nursing knowledge by "assessing the problem, diagnosing what the problem is, deciding on some actions that you want to take and evaluating it." She has found that it "works in project management." Nancy also explained how she uses the nursing process to perform a holistic assessment and create a care plan using alternative therapies such as Reiki or therapeutic touch. Likewise, Carla has taken the nursing process into her administrative consulting work along with the skills she honed in hospital practice. She sees her practice as "what I do now through my education from before. All those foundational nursing pieces are what provide the continuity in the face of the diversity of what I do."

These nurses also found that communication and relational skills learned through their nursing education and experience supported their innovative work. Denise imported interpersonal skills from her mental health background and "turned that into how to be motivational." Allison found that nurses' caring orientation, communication skills, and comfort with people's bodies enabled her to define laser hair removal as a health service. As Lindsay observed, "nurses already have nurse-client relationships...so they're well on their way with this." In her view, the groundwork necessary for successful innovation is already laid in nurses' work backgrounds. She saw a good fit for nurses and alternative therapies: "They already know that energy works, that touch works." In Sheila's work as an outplacement counselor, she often

spoke to people who were devastated about being laid off. Thinking about these interactions, she asked, "What skills do I draw on? Well, it's the skills that I learned in nursing on how to be compassionate, how to talk to them, how to draw them out and understand where they're coming from." Many of the nurses had additional specialized training for their entrepreneurial practices but they took their prior nursing knowledge with them, using it as a springboard into their non-traditional work.

Attending to professional standards. These nurses saw it as important to base their innovation on solid professional standards, including those related to quality, ethics, and knowledge use. Unique practice types and isolated work necessitated adherence to established standards in order to ensure safe, high quality services. Carla pointed out that, while hospital-based nurses access written policies and standards very infrequently, self-employed nurses "write our own policies and procedures that have to align with the [formal] standards of practice. We just can't fake them and we don't." Noting that "only private practice nurses do this," she "'went through every single [nursing] practice standard and asked myself this question: How does my service meet or not meet or coincide or interact with this particular standard?" Lindsay also believed that she had higher standards than an organizationally employed nurse because "I am the one responsible for them." Evelyn noted that, as one nurse working alone, she might not have a formal policy manual but if "you've practiced in accordance with industry standards and you keep abreast of what's going on in the system in terms of infection control standards, what you should be doing in this kind of a situation vs. this kind of a situation" then she has the necessary guidance. Sylvia was also aware of the need to understand standards of care because "when I'm investigating complaints against nurses, I have to know what the standard is. You have to know what a normal, prudent nurse would do."

Many nurses also mentioned the importance of adhering to ethical principles. Gabby explained that "I'm doing everything the best way that I can according to our code of ethics, according to the nursing practice standards, according to infection prevention and control standards." As a facilities manager, Wendy was attentive to organizational efficiency and effectiveness but also wanted things to make sense from a quality of care perspective. She explained that "ethical things have gone into the practice and that goes back to being trained as a nurse and having some values and ethics."

Part of ensuring competence in their practices included knowing how to find evidence to inform safe practice. Carla knew her own "competencies as a nurse" and "what I need to bring in." She explained that she was "not a know-it-all. I'm going to find sources for them [clients]." Georgette said, 'I don't always know what they're [project teams] talking about but I know where to go to find out…where to go and look up drugs, where to go and look up standards, what medical standards are, what journals are well-recognized in each profession." In short, professional standards of quality, ethics, and competence gave these nurses a foundation upon which to build a safe and credible practice.

In sum, these nurses used a variety of strategies in their efforts to create change in the healthcare system. They took advantage of market changes to establish their nursing practices as business, positioning themselves to redirect and open up the priorities of the system. Once they were independently positioned to influence the system, they developed their knowledge bases so that they would be able to re-claim and expand their profession jurisdiction. Yet, even though they moved into unconventional nursing practice, they built their businesses on a foundation of nursing knowledge and experience and remained connected to formal professional accountability structures to ensure legitimacy.

Consequences

Although there were some positive outcomes to these nurses' change efforts, their actions did result in negative consequences, mainly resistance from others, including the public, other health professionals, and the nursing regulatory association.

Public Understandings

Public responses to nurses in private practice highlighted institutionalized ideas about healthcare and nursing roles. Denise observed that "it's a very funny concept that society has of nursing. It's perhaps not as empowering as I would like." In her experience, the public could not see the connection between nursing and her current work in workplace wellness. Carla was also often asked questions that reflect "the usual perception of nursing," such as, "What hospital do you work at?"

Public perception about these nurses' innovative approaches to practice was, in part, a result of the problematic link between nursing and business, especially for nurses who worked directly with individual clients. Carla thought some people saw private nursing practice as "evil" because of a perception of greediness. Gabby often had to justify her earnings to her clients. For Mary-Jane, a nurse practitioner, the need to charge her clients directly led to questions about her ethics. Yet, a lack of insurance coverage for these nurses' services (which is available for most other health professionals) reflected society's limited conception of the roles and potential contributions of nurses. While they capitalized on the opportunities presented by the contemporary economic climate, they wanted to see nursing brought into the established system of reimbursement, which would make their unique services accessible to the public without financial barriers.

Healthcare Professionals' Responses

Other professionals also responded negatively to entrepreneurial nursing. Paula, who had a counseling practice, was told by one psychologist that "I think you're just taking over." A podiatrist described Gabby's foot care practice as a "pretty nice racket for her." Nancy, in her alternative therapies practice, saw "a fear of spiritual healing being out in the open" and observed that "some physicians are on board but there is still a lot of resistance and they feel threatened." Steve explained that "in acute care, it's very structured, very formal. This is the job of a nurse…When you move away from that and there are other professions involved those boundaries are less clear," although, as Denise said, "we're not here to take your jobs away. We're so complementary to other disciplines."

Regulatory Issues

Regulatory (licensing) issues were perhaps the most significant issues facing these private practice nurses. RNs in Canada are regulated by legislatively empowered provincial colleges. Self-employed nurses in this province must apply for approval of their practices using a lengthy, narrative style form, in addition to the relatively streamlined annual renewal form submitted by all RNs. This approval recognizes their practices as *nursing* practices, allowing them to count their working hours toward the annual renewal of their professional licenses. Almost all of these nurses had difficult experiences with the regulatory association. Denise expressed a common sentiment when she said she has "cried more in my career as a private nurse about [regulatory issues] and being afraid of being kicked out [of nursing]." For most participants, concerns with professional regulation related to delays in obtaining approval, excessive surveillance, and inconsistent decisions about what constitutes nursing practice.

Several nurses described the application process as "grueling" (Paula) and likened it to "writing a thesis because you need an evidence base to support your practice" (Nancy). Several of the nurses waited for many months or more than a year for a decision on their applications. They attributed these delays, in part, to a lack of knowledge on the part of regulatory staff of how to evaluate independent nursing practice and a lack of respect for these nurses' need for formal approval. This prompted a feeling of paranoia and threatened their ongoing qualification to practice. Mary-Jane lost her nurse practitioner license while she waited, while Paula was unable to count hundreds of hours that she worked while her application was being processed.

Many of these nurses felt subject to excessive regulatory surveillance. Kelly (home care agency owner) asked, "Why do I have to justify myself when no other nurse does? I know a lot of nurses and their practice isn't necessarily scrutinized like this is." Often regarded as a privilege of professional self-governance, peer review was seen by several of these nurses as a rigid surveillance tool that did not fit well with their modes of practice. As Evelyn expressed, "there [is] far more rigor in looking at my independent practice than there [is] in my [concurrent] paid employment." For example, the regulatory association expected her to have a formal policy and procedure manual and a risk management program, which Evelyn felt was "too much infrastructure for a one-nurse operation." Even though the nurses respected the regulatory association's responsibility for public safety, they felt unduly policed by their own profession.

They also felt disheartened by the apparently narrow, institutionalized definition of nursing under which the regulatory association functioned. Many nurses had difficulty having their practices recognized. For example, Steve, an occupational health nurse, had been unable to secure approval for his practice. He was told "that occupational health nursing was not in the

scope of practice of a nurse," although occupational health nursing is a recognized specialty of the (non-regulatory) Canadian Nurses' Association. He said:

> I can't call myself a nurse because my association doesn't understand what I do. We're trying to expand our role and educate people about registered nurses and here's a prime opportunity to show what a nurse can do and yet we don't get support from our own organization.

Although they envisioned an alternative approach to healthcare, these nurses encountered many instances of resistance to their innovative efforts because of regulatory conservatism and institutionalized ideas about healthcare delivery.

Possibilities for Change

In spite of the difficulties these nurses had, they spoke passionately about the possibilities flowing from their innovative nursing businesses. Generally, a high demand for their services resulted in personally satisfying opportunities for each of them to bring a caring, holistic, and complementary perspective to healthcare delivery.

Denise was a successful nurse entrepreneur, starting out in family crisis management and moving into corporate wellness. She found that "nursing has made this business for me… because nursing is so respected. It's so well known. It's not threatening. It's always about helping, not taking." Allison, in her laser hair removal clinic, was surprised by "how much I could sell the nursing within the business" because people are looking for care and nurturing that they do not find elsewhere. Almost all of these nurses had busy practices. Gabby is "100 percent busy right now" and Denise has a waiting list for clients, taking about 30% of her referrals. Sylvia said, "There's more work than you could ever possibly do." Whether working in direct

patient care or administrative roles, there was strong uptake of their services among segments of the population.

Job satisfaction for these nurses resulted from the opportunity that self-employment afforded them to create unique and meaningful nursing roles. Paula explained that she "was in a unique position to make a difference," a perspective echoed by Sheila who believed that "the work that I'm doing makes a difference to people in the world." Similarly, Evelyn derived her satisfaction "from seeing the results with the clients. I see how appreciative the clients are that I'm able to improve their quality of life and improve their health status."

In contrast to the institutionalized illness intervention model, Lindsay recognized her clients' own needs for self-healing and described nursing as being "very much about getting people off on their own and being well." Many saw private nursing practice as a key vehicle for health system renewal. Carla foresaw that the self-employed nurse would be "the nurse that can fill a niche where the heavily controlled, institutional [hospital] care can't meet the need for the client." Lindsay stated that "nurses are the key people in the whole realm of bringing allopathic and complementary medicine together." She believed that nurses could "start to think about how we're failing from the traditional point of view [and] how we could add to it." Nancy, also in alternative therapies, saw an "important shift from the traditional perspective" coming, one that utilized holistic healing and viewed patients as partners in their own care. As Paula explained, nurses "have a capacity to see the whole picture and to understand what others are doing in this whole picture." Self-employed nurses in both clinical and administrative roles valued nursing's caring and holistic focus and wanted to infuse healthcare delivery with this perspective.

Others saw private practice nurses as the leaders and innovators of nursing, the "people who take the initiative to pave the way that changes the future" (Mary-Jane) or the ones who

"innovate health" (Carla). Yet, many agreed that independent practice in nursing was "in a little boat on a very, very tumultuous sea. Some days the water's calm and we're very blessed and then other days the storm's there again. And our destination is unknown" (Carla). Mary-Jane realized that "change is hard. To be the first is hard." Despite a strong belief in the possibilities inherent in independent nursing practice, this group's challenge to the status quo resulted in there being many barriers to overcome before their vision could be realized.

Discussion and Conclusions

Self-employment was, for the nurses in this study, an active and innovative response to institutionalism in healthcare. Through this empirical example, it is possible to see how entrepreneurship, as self-employment in a business of one's own making, can itself be a strategy for change within an orthodox field (Greener, 2009; Nicholls *et al*., 2009; Villanueva-Russell, 2008). Self-employment enabled these nurses to distance themselves, materially and ideologically, from the established practices, routines, expectations, and norms that typify institutionalism in the field (Hall and Taylor, 1996). This enabled "boundary bridging," which exposed them to alternative practices and ideas (Hardy and Maguire, 2008). These nurses demonstrated that, by responding strategically to changes in the context of nursing practice, nurses can play an important role in the diffusion of innovative ideas about healthcare (Tamlyn and Reilly, 2003). They also exemplified how the "emergence of new professional identities is an important part of changing healthcare delivery" (Hinings *et al*., 2003, p. S25). They became strong defenders of independent nursing practice because of its potential to extend the range of health services available and lead to new conceptualizations about health. As Fenwick (2002) also found, some enterprises are less about individual success than they are about opening up a

space to resist oppressive structures and discourses and define new goals that contribute to change.

As others have described (Delbridge and Edwards, 2008; DiMaggio, 1988; Reay *et al*., 2006), the nurses in this study used a diverse set of strategies or microprocesses in establishing their roles as change agents. Collectively, they advocated for independent nursing practice by adhering to established professional standards and codes of ethics, while also adapting them and creating new ones for their unique applications (Hwang and Powell, 2005). Each of them took advantage of the opportunities set before them by taking up self-employment. They responded to instability and deteriorating conditions in the illness care system and capitalized on the climate of entrepreneurialism in order to challenge the status quo. While all of them made radical departures from traditional nursing practice arrangements by becoming self-employed, some of them remained connected more closely to prevailing structures than others, in order to secure their situations. For example, several nurses worked in project management, aligning with large healthcare organizations and conforming to the organizational priorities and patterns, while subtly infusing organizational planning with a nursing perspective. Some nurses performed conventional work, such as foot and wound care, providing the direct patient care that is typically associated with nursing. Although some of the nurses worked at the margins of nursing practice, such as laser hair removal, holistic healing, and corporate wellness consulting, they found success because they responded to consumers' health needs, found a niche in the system that complemented other aspects of it, and demonstrated the value of their sometimes controversial roles (Delbridge and Edwards, 2008; DiMaggio, 1988; Reay *et al*., 2006). All of the nurses were able to articulate the value of their roles and the success of their businesses was evidence of the worth and importance of their work.

These nurses appeared to possess unique characteristics that empowered them to be change agents. They felt at odds with the organizational healthcare environment and the traditional perspectives of many of their employed nursing colleagues. Most "nurses have acquiesced to this punishing system" (Sullivan, 2002, p. 183) and have been "sublimely unaware of most of [the] flaws" in the system (Carter, 2007, p. 270), tending instead to appropriate for themselves the discourses and logics of managerialism (Carvalho, 2012). In contrast, these self-employed nurses opted for bolder strategic responses to institutionalism, challenging institutional norms and expectations and those that sought to enforce them (Oliver, 1991). Although individuals, including entrepreneurs, are shaped by contextual forces, there are special types of individuals that make change and entrepreneurship possible (Thornton, 1999). Breaking with custom and convention requires not only new types and applications of knowledge but also a psychological ability to step outside customary ways of thinking and withstand the consequences of ground-breaking action (Biggart and Beamish, 2003 in Delbridge and Edwards, 2008). These nurses demonstrated a strong sense of disconnection from the status quo, a high tolerance for risk, and tenacity and fortitude in the face of significant opposition to their efforts.

Where entrepreneurship challenges convention, entrepreneurs can be labelled as "transgressive" (Fenwick, 2002). Indeed, these nurses' actions were misaligned with institutionalized ideas about healthcare, which prompted opposition from members of the public and many within the healthcare field. These nurses took on roles that were outside the general public's frame of reference and challenged the established moral scripts within healthcare (Hall and Taylor, 1996). Because they were caught between new modes of professional practice and a lack of insurance coverage for nursing services, their motives were seen as suspicious. Professional work is usually associated with a collective orientation, an attitude of service, and a

system of ethics. Conversely, entrepreneurship can be viewed as self-interested, profit-motivated, and opportunistic (Villanueva-Russell, 2008). While it may appear that professionalism and entrepreneurship are ethically incompatible, these nurses provided a fascinating example of balance between nurses as caring professionals and nurses as business owners; they were able to create viable *and* ethical businesses, although they shared the public's concern about the lack of insurance coverage. It may be that professionalism and entrepreneurship offer two approaches to a shared end, equally focused on success, achievement, and innovation (Dingwall, 2008; Villanueva-Russell, 2008). Goodrick and Reay (2011) demonstrate how multiple, apparently competitive logics, such as professionalism and market logics, can co-exist and simultaneously influence professional work. In these nurses' local situations, they have effectively demonstrated this to their existing clients and may be able to demonstrate this more widely as private practice nursing develops.

It may be that "any innovation that challenges the conventional wisdom of a profession's practice will attract criticism" and the greatest critics may come from within the profession itself, where scepticism toward pioneers is high (Nicholls *et al*., 2009, p. 351, 352). This was certainly the experience of these self-employed nurses, who were heavily challenged by their own professional regulatory association. Regulatory elements, in their emphasis on rule-setting, monitoring, and sanctioning, play an important role in sustaining institutionalized norms and behaviors (Scott, 2008a). Professional associations are generally agents of reproduction rather than change, perpetuating convention through their regulatory routines (Greenwood *et al*., 2002). Nursing regulatory associations are keenly aware that professional self-regulation is a privilege rather than a right (Brunke, 2003) and tend to emphasize protection of the public more than self-interest in the advancement of the profession (Risk, 1992). Consequently, they are conservative

in dealing with change and often act to placate and accommodate institutional elements (Oliver, 1991). This is in contrast to the overt and purposeful strategies used by self-employed nurses, through which rules, norms, and values are challenged and re-shaped (Oliver, 1991). Conservative regulatory practices and nursing self-employment are threats to each other. Going forward, these nurses will have to find creative and constructive ways of appealing to their regulatory body.

The process of institutional change is, in reality, messy, non-linear, and iterative (Delbridge and Edwards, 2008), making it difficult to determine what progress has been made toward a desired goal. This is theoretically interesting because research tends to focus on successful institutional entrepreneurship whereas it is equally vital to consider the resistance that change strategies attract and the struggles, losses, and failures that arise (Hardy and Maguire, 2008). Actor-centered accounts of institutional entrepreneurship emphasize the skills that particular change agents employ for strategic problem solving (Hardy and Maguire, 2008). While this study does illustrate the unique attributes and actions of self-employed nurses, it also presents a concurrent process-centric narrative of the difficulties, negotiations, power relations, and limits to change inherent in these nurses efforts (Hardy and Maguire, 2008).

Self-employed nurses have begun to make an impression within the healthcare system and have made an important statement about the potential of professional nursing practice to prompt meaningful healthcare reform (institutional change). It is not necessary to have achieved the widespread transformation of a highly institutionalized field in order to "qualify" as an institutional entrepreneur (Battilana, 2006). It is enough to have taken up the challenge. These nurses have already been able to demonstrate their value in their local circumstances, which is where change within institutionalized settings often arises, eventually moving upward from

lower levels in the hierarchy (Delbridge and Edwards, 2008). Nursing entrepreneurship is growing exponentially on a global scale (International Council of Nurses, 2004). Whether self-employed nurses will see success and change beyond what they have begun will depend on their ability to act collectively, devise new strategies and processes to challenge tradition, secure small and significant wins, and articulate the ways in which self-employed nursing can fit into a comprehensive plan to improve healthcare. This is an intriguing group of entrepreneurs, uniquely positioned to alter institutionalized understandings in healthcare; it will be fascinating to watch their story unfold.

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