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Self-employed registered nurses:

The impact of liminality and gender on professional identities and spaces

A thesis presented in partial fulfilment of

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Abstract

This thesis explores the experiences of self-employed registered nurses in Aotearoa New Zealand working in the practice area of professional advice and policy. Liminality theory and gender theory, with a feminist post-structuralist lens, were used as theoretical approaches. The participants spanned the masculinist areas of business, self-employment and policy, while connected by a strong bond to the normatively feminine nursing profession. Considering these views using a gendered lens and the participants' position as outsiders to both business and nursing proved a powerful way to interpret the data.

The research was conducted using focused ethnography, enabling interviews and observation of the 13 participants' home-based workspaces. Data chapters incorporate the phases of liminality, separation, transition and re-aggregation, all of which provided a strong foundation underpinning the participant journey.

The participant group of mid- to late-career registered nurses had high levels of education, practice experience and skillsets, which could be used across nursing and the whole of health, yet due to their liminal and individualistic positioning the nurses remained invisible, both physically and professionally. Outcomes included insight into why the participants chose self-employment, the gendered assumptions they faced, the difficulties of learning new skills when separated from familiar resources and support systems and the tensions of working from home.

The participants, while each at different stages, followed the phases of liminality in acculturating to self-employment, but remained in a permanent limonoid state for other aspects of their work life. My findings indicate that, anchored by historical discourses, nursing remains a devalued feminised occupation. Captured in gendered subjective positioning, the participants navigate complex and competing discourses in relation to work, home, profession and belonging.

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Abbreviations

ACC	Accident Compensation Corporation
APC	Annual practising certificate
CEO	Chief Executive Officer
DHB	District Health Board
EN	Enrolled nurse
GST	Goods and Services Tax
HPDT	Health Practitioner Disciplinary Tribunal
ICN	International Council of Nurses
IES	International Economic System
IMF	International Monetary Fund
IRD	Inland Revenue Department
MBIE	Ministry of Business, Innovation and Employment
MECA	Multi-employer collective agreement
MoH	Ministry of Health
MPhil	Master of Philosophy
NCNZ	Nursing Council of New Zealand
NP	Nurse practitioner
NZ	New Zealand
NZQA	New Zealand Qualifications Authority
OECD	Organisation for Economic Co-operation and Development
PhD	Doctor of Philosophy
RN	Registered nurse
SME	Small to medium enterprise
SRN	State registered nurse
WHO	World Health Organization

Chapter 1: The focus and content of the research

1.1 Introduction

Self-employed registered nurses (RN) in Aotearoa New Zealand (NZ) working in the non-clinical practice area of professional advice and policy are the focus for this research study. The RN scope enables nurses to work in policy, however these roles are little known, understood and potentially under-utilised. The study is important because self-employment in nursing remains unusual, particularly non-clinical self-employment.

Numerous titles which may be utilised by self-employed RN's are included in this chapter in order to explain the use of specific terminology and position the group being explored. An explanatory section on the registered nursing practice area of professional advice and policy, as defined by the Nursing Council of New Zealand (NCNZ), is provided to contextualise and position the study.

1.2 Research question

What are the experiences of Aotearoa NZ registered nurses working as solo self-employed nurse contractors in non-traditional workspaces?

1.3 Study aims and approach

The aim of the study is to explore the experiences of self-employed RN consultants who work from home in the practice area of professional advice and policy, a practice area which has not previously been examined in Aotearoa NZ nor internationally.

The study identifies the experiences of the participants using the theoretical frameworks of gender theory, with a poststructuralist lens, along with liminality theory which holds that this small group of experienced nurses are marginal not only professionally but also geographically. It explores

the tensions and benefits of working from home coupled with the gendered assumptions and perceptions with which the participants must contend.

The research followed a relativistic ontological approach, reflecting that each participant had a unique interpretation of their experience (Braun & Clarke, 2013). A feminist epistemology (Longino, 2017) and a broadly inductive approach (Braun & Clarke, 2013; Braun & Clarke, 2021; Ormston et al., 2014) are used and reflect my own background as a self-employed nurse.

1.4 Background to the study

The experiences of solo self-employed RN working in non-clinical practice has intrigued and fascinated me since I made my own shift from employee to business owner many years ago. I sometimes experienced a dissonance as my nursing career transitioned into contracting, managing a micro-enterprise and navigating the frankly worrying area of business finance and taxes. I quickly realised that my nursing practice was unusual and marginal, and felt compelled to study this niche workforce, to break new ground and assess possibilities for the future.

My nursing career began after completing a three-year hospital-based training programme in the United Kingdom (UK). I then practised as a state registered nurse (SRN) for three years in the UK, a year in Aotearoa NZ and then a year in Saudi Arabia. I settled in Aotearoa NZ in the early 1990s. I developed an interest in project work during my first designated senior role where, among other things, I created and ran two large Nursing Expos in Tāmaki Makaurau (Auckland) to publicly showcase nursing practice, nursing education and nursing professional bodies. The completion of a Master’s thesis some years later resulted in a deeper understanding of nurses, the nursing workforce and responses to new roles. It also opened doors to new opportunities.

Moving to a national workforce project role cemented my interest in policy work, project management processes, workforce issues, nursing regulation and the ability to utilise my broad nursing knowledge in different and creative ways. I developed extensive networks across the whole of health and was mentored on how to appropriately engage across the traditional hierarchies of health. During this time, I was my introduced to the concept of health professionals working as contractors, which planted the seeds of possibility.

I continue to enjoy shaping and running my solo self-employed business in Tāmaki Makaurau (Auckland) and retain a diverse group of clients, who are a joy to work with. Exploring how other nurses experience their solo self-employment and discovering how these nurses work in Aotearoa NZ is a privilege.

1.5 Definitions

To clarify research and standardise terminology, certain terms and concepts require definition or description since meaning can change dependent on geographical location, local role descriptors and accepted terminology. Definitions of nurses as business owners, entrepreneurs, external/independent nursing consultants, private practice nurses, self-employed, gig workers and knowledge workers are found in this section. To create consistency, role titles are reviewed to explain and contextualise each one according to the literature. The justification for selecting RNs as the sample group is dealt with first, followed by a definition of RNs working in the practice area of professional advice/policy.

1.5.1 Scope in focus

Self-employed RNs in Aotearoa NZ working in the practice area of professional advice and policy are the focus for this study. Inclusion of other groups of regulated health professionals, and nurses in different scopes of practice, were reviewed initially to establish if self-employment was

common practice. The workforces included dentistry, medicine, midwifery, physiotherapy and nursing.

The Ministry of Health (2016) found that approximately 80% of the dentistry workforce is in private practice. Doctors often work in private practice and part-time in District Health Boards (DHBs) (Goodyear-Smith & Ashton, 2019). The Ministry of Health (2016) report that the number of self-employed general practitioners is dropping but there is still a pathway for self-employed practice (Phelan, 2014; Primary Care Working Group on General Practice Sustainability, 2015). Self-employed midwifery is a well-known option in Aotearoa NZ, with some statistics suggesting up to 50% of midwives work in independent practice (Drennan et al., 2007; Healthpoint Limited, 2017; International Council of Nurses, 2004; Ministry of Health, 2016; New Zealand College of Midwives, 2017) while approximately a third of physiotherapists are self-employed (Physiotherapy Board of New Zealand, 2014). Therefore, in Aotearoa NZ most regulated health professional groups have established career pathways and funding options enabling self-employment. But this is not the case for RNs.

In Aotearoa NZ, the Nursing Council of New Zealand (2021) specifies three scopes of nursing: RN, nurse practitioner (NP) and enrolled nurse (EN). The NP workforce is expanding (Nursing Council of New Zealand, 2019) and a small number of NPs have moved into self-employment (Nursing Council of New Zealand, 2015a). However, the NP scope (Nursing Council of New Zealand, 2017) is specifically focused on delivery of advanced clinical practice. Similarly, the EN scope is clinically focused and also requires direction and delegation from an RN or an NP (Nursing Council of New Zealand, 2012b). Therefore, neither NPs or ENs fit the criteria and are excluded from this study.

The RN scope has flexibility, with tailored competencies for both clinical and non-clinical roles despite this, the workforce statistics from the Nursing Council of New Zealand (2018), in the

year of participant interviews (2018), put the number of self-employed RN at only 1.8% of the total nursing population.[1] A review of previous years' nursing workforce statistics (Nursing Council of New Zealand, 2010, 2011, 2013, 2015a, 2018) showed the numbers slowly increasing, with a caveat: this included clinical, research, education, management and professional advice/policy practice areas. This research focuses entirely on the RN scope in the practice area of professional advice and policy.

1.5.2 Practice area: Professional advice and policy

The Organisation for Economic Co-operation and Development (OECD) defines RNs working in management, policy and administration as "professionally active nurses" (Nursing Council of New Zealand, 2007a; OECD, 2017b). Only nurses delivering care directly to patients are described as "practising nurses" (OECD, 2017a). Non-clinical nurses are positioned outside most of the profession and delineated into a separate group.

In Aotearoa NZ, RN working in non-clinical or indirect patient care roles, such as nurse consultants in professional advice and policy, can maintain their annual practising certificates (APC) and are considered practising nurses. The International Council of Nurses (2004) suggests that in many countries this is not the case. As an example, Wall (2015a) describes the anxiety of self-employed nurses in Canada as they endeavoured to have their practise recognised by the provincial nursing regulatory bodies in a process which contains far more complexity than required for their colleagues in direct care clinical roles. Even if clinical, the self-employed nurse may meet barriers or not be recognised as a nurse at all (International Council of Nurses, 2004; Wilson et al., 2012).

In Aotearoa NZ, the nursing regulator defines nurses working in administration, management, policy development and professional advice as not just professionally active but still in

[1] Appendix 1, p.235

nursing practice roles (Nursing Council of New Zealand, 2015a). The broad scope of practice for RNs in Aotearoa NZ recognises the contribution of all registered nursing practice as: *"Using nursing knowledge in a direct relationship with clients or working in nursing management, nursing administration, nursing education, nursing research, nursing professional advice or nursing policy development roles, which impact on public safety"* (Nursing Council of New Zealand, 2007a, p. 34). NCNZ's broad and enabling registered nursing scope is a significant, positive and possibly undervalued feature of nursing in Aotearoa NZ.

To further support the scope of RNs, the NCNZ has specific competencies for RN working in research, education, administration/management and professional advice/policy development (Nursing Council of New Zealand, 2007a). Nurses working in the practice area of professional advice and policy development are "*exempt from those competencies in domain two (management of nursing care) and domain three (interpersonal relationships) that only apply to clinical practice. There are specific competencies in these domains for nurses working in management, education, policy and/or research"* (Nursing Council of New Zealand, 2007a, p. 8). [2]A small number of RNs identify as self-employed and an even fewer are in the practice area of professional advice and policy. [3]NCNZ statistics put the number from 2011-2018 at between 18 and 32. These numbers are unstable and data extrapolated from NCNZ information, which included anonymised identification numbers, suggest RNs dip in and out of self-employment.

The expectation for the study is that the participants, while meeting the criteria for the professional advice and policy competencies could be in a variety of self-employed roles including,

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[2] Review of the NCNZ statistics for the year when participants were sought (2018) shows only the number of female and male RNs identifying as self-employed. Gender identity is not a category available through the regulator. Therefore, only male and female statistics were available and this is reflected in the study.

[3] Appendix 1, p.235

but not limited to: project manager, nurse consultant, policy analyst, quality advisor, career coach, management consultant and nursing/health workforce consultant.

1.6 Terminology

The next section is a review of terminology to ensure transparent consideration for relevant terms applicable to the participant group and to ensure correct and consistent descriptors are used in the study. The areas covered include: entrepreneurship, gig work, knowledge work and self-employment.

1.6.1 Entrepreneur

Early work on data collection showed entrepreneurship has a place in the study. Nursing entrepreneurship is also the topic of numerous opinion articles, editorials and anecdotes which provide practical tips and advice for setting up or marketing a business. These articles are predominantly based on the business and health environment in the US (Danna & Demitrius, 2008; Dayhoff & Moore, 2005; Dirubbo, 2005; Johnson, 2013a, 2013b, 2013c, 2013d; Papp, 2000; Pierre, 2013; Polacek, 2021; Shirey, 2007b; Simpson, 1997; White & Begun, 1998), or less frequently the UK (Boore & Porter, 2011; Cornforth, 2010; Faugier, 2005; Warner, 2011), so do not always readily transfer to the Aotearoa NZ health context. Although many of these articles provide useful insights into the world of the nurse entrepreneur, a standard definition is required for this research.

The International Council of Nurses defines a nursing entrepreneur as: *"An individual who assumes the total responsibility and risk for discovering or creating unique opportunities to use personal talents, skills and energy and who employs a strategic planning process to transfer that opportunity into a marketable service or product"* (International Council of Nurses, 2004, p. 5). This definition is used extensively in the literature and provides a broad-based descriptor, along with an extensive list of potential roles for nurses working outside traditional employment structures. After

reviewing the literature near the end of writing this thesis, few articles dealt with nurse entrepreneurs. This comports with Neergård (2020) systematic review of entrepreneurial nurses which found that most articles are clinically focused with few about non-clinical entrepreneurs.

Entrepreneurship is a normatively masculinist concept (Marlow & Swail, 2014) and as such the literature generally focuses on masculine traits to define success (Ahl & Marlow, 2012; Henry et al., 2016). Research suggests the most common reasons for stimulating entrepreneurial endeavours include: *"1. Achievement, challenge & learning, 2. Independence & autonomy 3. Income security & financial success 4. Recognition & status 5. Family & roles 6. Dissatisfaction 7. Community & social motivations"* Stephan et al. (2015, p. 38). The researchers found reasons 5, 6 and 7 were not often found in research on entrepreneurial motivators and suggest this may be due to them being smaller specific groups, such as female entrepreneurs. Indicating that the primacy of masculinist binary positioning endures in entrepreneurship.

The persistence in referring to men in nursing as "male nurses" indicates a strong feminine binary and the notion that there is something unusual about a male being a nurse (Tollison, 2018). In entrepreneurial terms, the incongruence continues with the reference to both "entrepreneurs" and "female entrepreneurs", further confirming the strong masculinist binary and an emphasis on the female entrepreneur being unusual in an androcentric environment (Hechavarria & Ingram, 2016).

The EntreComp framework (Bacigalupo et al., 2016) presents entrepreneurship in broad terms, accommodating all types of business. *"Entrepreneurship is when you act upon opportunities and ideas and transform them into value for others. The value that is created can be financial, cultural and social"* (Bacigalupo et al., 2016, p. 10). This framework considers that while successful entrepreneurship is usually measured by profits, expansion and an upwards career trajectory (Marlow et al., 2009; Marlow & Swail, 2014), cultural and social entrepreneurship are parallel

concepts. Social entrepreneurship, in which the social, environmental or community needs are met by a business while the focus on making a profit is reduced (Andrews, 2002; Sharp & Monsivais, 2014) is a term often used for nurses in business (Boore & Porter, 2011; Wilson et al., 2012), taking the focus away from the socially unpalatable aspects of paying a fee for a nursing service (Arnaert et al., 2018; Wall, 2013b).

Walker and Brown (2004) described '*lifestyle businesses'* (p. 579) as those in which owners have no interest in expanding a business or making significant profits and instead focus on creating a healthy work-life balance (Ministry of Women's Affairs & Ministry of Economic Development, 2008). Lifestyle businesses are not described in the nursing literature but the concept is often linked to the perception that women in particular are uninterested in growing a business, partly to retain control, but also to focus on a flexible lifestyle. Lewis (2006) contends this is not limited to female business owners since many owners keep businesses small and manageable. In the normatively masculinist entrepreneurial and business literature (Marlow & Swail, 2014), lifestyle businesses are seen as an inferior form of business.

The scholarship about entrepreneurship is relevant to this study, as later chapters address. But entrepreneurship is not a commonly used term in the nursing profession in Aotearoa NZ. Therefore, entrepreneurship will be referred to but not used as a nursing term for this group.

1.6.2 Gig worker

Gig work was a concept borrowed from the music industry. It now represents a new and individualistic model of working (Naghieh, 2020; Petriglieri et al., 2018b). Gig workers are independent contractors working in project management, agency work and freelance work (Randolph, 2019). The nursing sector also has gig work, although in a limited way (Prestia, 2019). For example, some nurses work in co-operative spaces while jointly controlling assets and costs. This

enables shared control of the work, work space and profits (Sarina & Riley, 2018). Technology can enhance and increase working opportunities, particularly work which can be done from home or remotely (de Ruyter et al., 2019; Muntaner, 2018). Because of this flexibility, gig work can enable "*micro-entrepreneurship*" (Sarina & Riley, 2018, p. 29).

Gig work is precarious (Sargeant, 2017) with short-term contracts and flexible part-time work, no sick pay, annual leave pay or retirement scheme contributions (Morgan & Nelligan, 2018) and gig workers who work remotely are at risk of becoming invisible (de Ruyter et al., 2019). Walby (2003) suggests flexible part-time work is a way of contracting women who may want part-time work due to other constraints such as childcare. In large health organisations part-time of flexible work is managed by creating or using nursing bureau or bank staff (Naghieh, 2020), or contracting content experts for short-term work (Randolph, 2019).

Gig work resonates with the roles explored in this study. However, the term creates a negative, reductionist view rather than positive professional framing so will not be used in this study.

1.6.3 Knowledge worker

Knowledge workers were described decades ago by White and Begun (1998) as a development in response to organisations outsourcing certain services, often needing short-term expert input. Hong et al. (2021) use the term "knowledge work" in regard to nurses as experts, but assert that environments and technology still contribute to the view that nurses are physical carers. Nagle (2021) also use the term regarding the role of nurse informaticists, suggesting room for entrepreneurship in which self-employed informatics nurse consultants could advise Information Technology (IT) companies on health systems, or health providers on utilising IT products.

The knowledge worker concept as described by sociologists (Eikhof, 2016) requires more definition to assess its fit for the study. Fenwick (2007, p. 2) succinctly defines four characteristics of a knowledge worker:

> *(1) Their work is typically project-based, defined by individual bounded contracts of varying periods for varying activities; (2) they contract their knowledge services to a variety of employers, including organizations and single clients; (3) they often juggle multiple projects and contracts simultaneously; and (4) they remain self-employed and rarely hire other employees except as limited contracts to assist with particular projects or maintenance services such as their own accounting.*

McKeown (2005, p. 276) posited that knowledge workers are highly educated "*professional elite*" working in non-standard employment with strong career ties looking for life flexibility while contending with financial precarity. Identifying roles under review in this study as knowledge workers offered an interesting insight into how the positioning and marketing of this somewhat niche nursing group could be approached.

1.6.4 Self-employed

Self-employment is a common term in Aotearoa NZ (Campbell, 2013; Ministry of Women's Affairs & Ministry of Economic Development, 2008; Statistics New Zealand, 2015), the United Kingdom (Royal College of Nursing, 2017) and Canada (College of Registered Nurses of Nova Scotia, 2017; Stahlke Wall, 2011b). Self-employment appropriately describes the roles being explored in this study, particularly as it is used by the NCNZ in its nursing workforce statistic reports (Nursing Council of New Zealand, 2010, 2011, 2013, 2015a, 2018, 2019). An exploration of nursing self-employment in Aotearoa NZ is useful to understand the environment, the systems and the structures impacting those being studied. Descriptions provided here are delivered using direct quotes. These are established descriptors and standards used to collect data or define tax status. Beginning with a description of self-employment.

A person with income from self-employment is an individual who (i) operates his or her own economic enterprise or engages independently in a profession or trade, and (ii) receives earnings from his or her enterprise from which tax is deducted.

In theory, self-employed persons are distinguished from paid employees according to the level of responsibility or economic risk and control that an individual assumes in the operation of his or her enterprise. Most or all of the following characteristics are indicative of self-employed persons: they are actively engaged in running their business, control their own work environment and are responsible for getting the work done and making decisions on, when, where and what hours they work, how much they get paid and when to take holidays. A person with a self-employed job invests their own money in their business and provides major assets and equipment for the job (Statistics New Zealand, 2017b, p. 1).

Five terms sitting under the heading of "self-employed" are relevant to nurses in small business:

- Small and medium enterprises (SMEs): Described by the Ministry of Women's Affairs and Ministry of Economic Development (2008) as a business of 19 or fewer people;
- Micro-Business: Described by McGregor and Tweed (2002) as a business of 5 or fewer people;
- Solo self-employed: Described by Hughes (2003) as people working alone;
- Sole trader: Described by the Inland Revenue Department (2017) as:

    [4]*A sole trader is a person trading on their own. They control, manage and own the business. A sole trader usually has no formal or legal processes to set up the business. The owner/manager is personally entitled to all profits but is also personally liable for all business taxes and debts;*

- Limited liability company (LLC): Described by the Inland Revenue Department (2017) as:

    [5]*Companies own the assets and liabilities of the business and are responsible for any debts. Generally, a shareholders' liability for debts is limited to any amounts that remain unpaid on their shares in the company. A company will make losses for tax purposes if its total expenses exceed its income. If a company has losses, it may not have to pay tax and can usually use the loss to reduce its income in the next income year.*

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[4] http://www.ird.govt.nz/how-to/taxrates-codes/

[5] http://www.ird.govt.nz/how-to/taxrates-codes/

The use of an LLC protects an individual's personal assets. Business finance and associated risks are held by the business and any shareholders.

Reviewing these descriptors identified the terms "knowledge worker" and "self-employed" as relevant to this study. The next section contains a review of appropriate role titles.

1.7 Titles

The two key titles are: nurse consultant and private practice nurse. The title of freelance nurse was also considered, but no evidence was found of its use in academic nursing literature. The aim of this section is to identify and position the roles explored within the study.

1.7.1 Nurse consultant

Self-employed RNs providing services to the health sector are often referred to as "nurse consultants". This title is in common usage nationally and internationally, but research suggests it is inconsistently applied (Duffield et al., 2011; Giles et al., 2017). The International Council of Nurses (2004) also use the term "consultant" for nurse entrepreneurs offering management consultancy services. How these roles function in Aotearoa NZ nursing has not yet been fully evaluated.

In a qualitative study comparing the nurse consultant role in the UK to other expert level nursing roles, Mitchell et al. (2010) indicated that nurse consultants had superior skills in many cases due to many years of specialist practice and post graduate education. Wilson et al. (2003) suggest nurses with advanced education, experience and expertise can deliver services to the healthcare system by becoming self-employed. Although the nurse consultant roles described by Mitchell et al. (2010) were all clinically based, there was evidence of entrepreneurial skill, service development and gap analysis, with an ability to be change agents at a local, national and perhaps international level.

Key abilities for nurse consultants included multilevel functioning, flexibility in practice and the skilled use of networks, which the authors described as creating project managers who can undertake business planning and influence strategy.

Drennan et al. (2007) described a group of nurse consultants in roles such as *"management leadership in project planning and implementation"* (p. 463) with considerable experience in education, management or senior clinical roles. The term "nurse consultant" is commonly used in the Aotearoa NZ nursing community and will be used in the current study.

1.7.2 Private practice nurse

Private duty or private practice nursing is a term found in the international literature relating to self-employed nurses. In an Australian Delphi study of nurse entrepreneurs, Wilson et al. (2003) confirmed that "entrepreneur" is an uncommon term in Australian nursing and instead refer to "private practice nurses" (Wilson & Averis, 2002; Wilson et al., 2004).

"Private practice" or "private duty" are unfamiliar terms in Aotearoa NZ. The numbers of clinically-based private practice nurses declined and eventually disappeared after the Social Security Act of 1938 was passed (Wilson, 1998). Following this the vast majority of nurses worked for hospital boards, or in the primary healthcare setting for general practitioners (Gage & Hornblow, 2007). Therefore, although the terms "private practice" and "private duty" appear in the literature, its lack of application to the modern Aotearoa NZ nursing context, and its association with clinical practice, means it does not fit well with the current study.

The review of role titles has enabled considered identification of the appropriate terminology for this study. The title "nurse consultant" will be used throughout the study.

1.8 Overview of study chapters

Chapter 1: Focus and content of the research

The first chapter outlines the research question, research aims and the author's personal background which identified the need for this research. To provide context, this included an overview of the chosen scope of nursing practice and associated nursing regulation. It also included a review of terminology such as self-employment, entrepreneurship, gig work and knowledge work and identified the appropriate descriptors for the roles being explored.

Chapter 2: Exploring and positioning self-employment in nursing

The second chapter contains a review of the principal themes in the literature, resources and research on self-employed RNs. To better identify the extant scholarship, relevant themes from the literature are presented. The review looks at why nurses move into self-employment, education for small business and policy work. It then discusses nurses working in non-traditional environments, including working from home, the problem of isolation and access to support.

Chapter 3: Nursing history: Gender and control

In chapter three, the historical context for the study is presented, to overview development of the nursing profession with a focus on the control and power exerted by patriarchal entities and the history of nurses in self-employment. The exploration begins with women on the margins of society, working as lay healers or "wise women" before moving to the formalisation of nurse training in the UK, a system which underpinned the development of nursing in the Aotearoa NZ healthcare system. The Victorian nursing model will be explored, which saw the emergence of strong nursing leaders who used agentic positioning to make significant changes in health and nursing from within the oppressive patriarchal structures of their time. The experiences of nurses in the historically "private practice" will reveal tensions for self-employed nurses requiring direct pay from patients and families. The chapter concludes with a review of oppressive control points found in nursing such

as the role of religion in nursing orders and the constraints of language, uniforms, behaviour, titles and nursing residences which restrained and homogenised the nursing workforce.

Chapter 4: Theoretical framework and research methodology

The fourth chapter contains an overview of qualitative research, ontology and epistemology. The two theoretical frameworks used in the study, liminality theory and gender theory, are introduced and explained. A feminist framework is presented with a predominantly post structuralist approach. Destabilising the normative positions in healthcare and resultant positioning is important for uncovering how participants frame their roles, businesses, workplaces and income. The research method of focused ethnography links qualitative research, ethnographic methods and feminism.

Chapter 5: Research method

Following on from methodology, chapter five details the key research methods including the details of focused ethnography as applied in this study. An entrepreneurial framework is presented which underpinned question development for the semi-structured interview process. The data analysis section includes a theoretical and contextual framework which brings together liminality, gender and the proximal contextual factors found in the literature review and the historical review of nursing.

Chapter 6: Separation; agency and identity work

Each data chapter is situated within a contemporaneous framework of liminality which has three phases: separation, transition and reaggregation. Chapter six is the first data chapter and is based on the initial separation phase of liminality as the participants moved into a new working space, professionally and geographically. The participants discovered an agentic position and began to reconstruct their identities as self-employed nurses. They also dealt with social constructs which position nursing inside an anachronistic cultural discourse. The participants were de-stabilising the

cultural norms of what a nurse is and does. Their understanding of their position as a practising RN is explored along with their professional identification, or how they chose to describe their practice, while maintaining APCs. Despite proven academic levels and professional expertise, the participants described being positioned as outsiders by their own profession.

Chapter 7: Transition; finance and business

Chapter seven, the second data chapter, focuses on the transition phase of liminality where the participants were least experienced and most challenged. According to liminal theory, this stage is ambiguous and disconcerting as participants moved from traditional, well understood nursing work environments into a less structured, self-directed space. They must cope with uncertainty of contracts and an erratic income. Financial dissonance is experienced with participants regarding their high professional worth, while maintaining low contract rates. Networking is explored as a key component of self-employed success.

Chapter 8: Reaggregation; public and private

Chapter eight, the final data chapter, focuses on the re-aggregation phase of liminality. After the participants moved from the public healthcare space to the private space of a home-office, they developed strategies to manage tensions such as domestic chores and caring roles. The pros and cons of flexibility and freedom are explored against making time for friends and family while trying to inhabit the potentially isolated home-based professional nurse consultant role. Considerations such as the propensity for entrepreneurial risk and reconsidering the concept of success are explored and compared to the transitional masculine indicators of business success, including expansion, profit and increasing capacity.

Chapter 9: Discussion

The final chapter begins with a summarises the findings and discusses their impact. Identity development is examined in relation to how it is impacted and re-shaped by marginal positioning and gender performativity. Consideration is given to the navigation of occupational stigma, cognitive dissonance and the invisibility of nursing. Learned gendered expectations are viewed in relation to household income contribution and the merging of public work with the private gendered space of home, requiring the management of complex and competing roles. The chapter finally considers the future while reinforcing that critically engaging with nursing history is pivotal to avoid its perpetuation.

1.9 Summary

The review presented in this chapter details the aims of the research and clarifies the specific descriptors of RNs which are the focus for the study. The choice of RN scope and practice area of professional advice and policy are explicated. To further situate the study, the terms describing self-employed nurses are explored in the context of healthcare and the social and professional positioning of nursing. The terms “self-employed”, “knowledge worker” and “nurse consultant” are identified as the most appropriate descriptors for the roles under review.

Chapter 2: Exploring and positioning self-employment in nursing

2.1 Introduction

This chapter contains a review of the literature and research relevant to the topic of self-employed RNs. It first considers the complexities of why nurses choose this non-traditional career pathway then reviews the preparation such roles would require. There is a focus on education in business skills and a review of how nurses manage business finance and invoicing. The final section explores the challenges and tensions of a new home-based workspace, the importance of minimising isolation and the outcomes of being self-employed. The first section, after the search strategy, focuses on two significant research studies about self-employed nurses.

2.2 Positioning the literature review

Research and literature on registered nurses in self-employment are scant and almost non-existent on those nurses specifically working in non-clinical practice. No research has been conducted in Aotearoa NZ on this topic.

A qualitative literature review rather than a systematic review was chosen to discuss and contextualise relevant literature (Braun & Clarke, 2012). I was not answering a clinical question, therefore inclusion or exclusion criteria were not specified and precision and replicability were not the focus. A thematic approach was selected, taking the form of a discussion.

I read and utilised many different types of research, reports, tools, editorials and opinion pieces resulting in a meaningful and logical structure for the review, from considering self-employment, to learning how to be self-employed and through to success or failure.

I conducted another search in 2021 to check for more research and the report I found reinforced my chosen literature across this very limited research field.

2.3 Literature search strategy

Literature searches were conducted through a variety of portals: the Massey University library, article databases and websites with relevant statistics or reports. Database searches included Google Scholar, PsycINFO, Business Source Complete, Emerald Insight and CINAHL. Search criteria required varied combinations including: 'nurse business owner', 'nurse entrepreneur', 'nurse small business', 'entrepreneurship AND nursing', 'self-employed nurse', nurse AND freelance', 'self-employed AND nurse consultant', 'nurse AND private practice', 'nurse AND policy', 'nurse AND professional advice', 'entrepreneurial AND nurse', 'business AND nursing', 'small business AND New Zealand', 'female AND business owner', 'female AND self-employed', 'entrepreneur AND theory', 'self-employed AND theory', 'working from home', 'home based business', 'home business AND productivity'.

No limit was set on year or location of publication, though only English language articles were sought. Although the articles and books spanned from 1900-2021, specific research on self-employed RNs was sparse. Searches for statistical information and reports specific to Aotearoa NZ were conducted through relevant websites including: Nursing Council of New Zealand (NCNZ), New Zealand Department of the Prime Minister and Cabinet, Ministry of Health, Ministry of Economic Development, All-Party Parliamentary Group, Ministry of Women's Affairs, International Council of Nurses (ICN), Organisation for Economic Co-operation and Development (OECD), World Health Organization (WHO), Inland Revenue Department (IRD) and Statistics New Zealand.

2.4 Nurses in self-employment

Literature and research on nurses in self-employment are explored in this chapter. Research on nurses in self-employment is scant and almost non-existent on those in non-clinical practice working from home. The first section looks at why nurses consider self-employment.

2.4.1 Main studies and gaps

Only two relevant and extensive studies specific to nurses in self-employment were found. The first and most relevant, was a doctoral thesis by Stahlke Wall (2011b) which looked at the experiences of self-employed nurses in Canada. The second was a doctoral thesis by Wilson (2003) describing nursing entrepreneurship in Australia. No Aotearoa NZ based studies of self-employed nurses were found.

The Canadian qualitative study by Stahlke Wall (2011b), using focused ethnography, explored the overall experiences of self-employed nurses, with no specific exploration into clinical or non-clinical practice areas. The sample of 20 participants were all previously "hospital-based" nurses and after becoming self-employed *"had to navigate a series of in-between spaces, balancing business values with nursing professionalism*" (Stahlke Wall, 2011b, p. 231). Exploration of the marginal spaces in which self-employed nurses find themselves is the nexus of the current study which introduces the duality of this career choice.

Stahlke Wall (2011b) describes the complex reasons nurses choose this career path and the subsequent regulatory complications experienced by some of the participants. Canadian nursing regulation, as described by Stahlke Wall (2017), emphasises the value of the RN scope in Aotearoa NZ (Nursing Council of New Zealand, 2007a) which in comparison, is broad and enables many forms of nursing work.

In describing self-employed nursing work, Stahlke Wall (2011b) introduces the word "precarious" and the concept of "precarity" to describe self-employed RNs struggling with the difficulties and financial impact of an erratic workload. The nurses also found difficulty in being accepted by the public, other healthcare professionals and their own nursing colleagues, limiting their work opportunities. However, this was somewhat offset by an increase in professional and

personal flexibility. [6]The research by Stahlke Wall (2011b) and subsequent linked articles (Wall, 2013a, 2013b, 2014a, 2014b, 2015a, 2015b, 2015c) resonated with my own self-employment experience and was pivotal in developing a direction for this study.

The second piece of research was a doctoral thesis by Wilson (2003) who used a Delphi technique to explore the experiences of 54 nurse entrepreneurs in Australia. The study, which is now 18 years old, was the first to explore entrepreneurial nursing roles including policy/procedure, career advice, self-help and management. A broad range of nursing roles and data specific to the Australian nursing and small business contexts were included. Areas of specific interest included: issues with professional belonging, reimbursement challenges, being isolated in the margins and the participants' financial precarity. The descriptions of private practice and nursing entrepreneurs, funding issues and also the traits of nurses choosing an entrepreneurial path were important in positioning the roles in the current study.

The research studies by Stahlke Wall (2011b) and Wilson (2003) are a useful contribution to the area of nursing self-employment, but a significant gap remains in the Aotearoa NZ research and also on nurses who chose to become non-clinical and work from home.

2.4.2 Beginning to take control

Nurses choose self-employment due to their personal and professional situation and, to some extent, their traits, characteristics and personalities (Wilson, 2011). A common thread in the literature is the concept of "push" and "pull" factors of self-employment (Hughes, 2003; Ministry of Women's Affairs & Ministry of Economic Development, 2008; Sasso et al., 2019; Stahlke Wall, 2011b; Walker & Brown, 2004), or "*opportunity-necessity differentiation*" (Stephan et al., 2015, p. 11). Push

[6] Stahlke Wall and Wall are the same author.

factors are situations that create a desire or need for a person to leave employment (Wall, 2014a). Pull factors refer to the desirable aspects of self-employment such as flexibility and positive work environments (Sasso et al., 2019).

Push factors are described by Wall (2014a) in a study of Canadian nurses who, facing consistent stress, high workloads, healthcare service restructure and job instability, chose self-employment. In another article, Wall (2014b) presents descriptions from nurses who had witnessed low levels of caring and compassion in the healthcare sector and the impact of reduced services on patients which convinced the nurses to move into self-employment.

Sasso et al. (2019) explored the push and pull factors in relation to nursing attrition in a study of over four thousand staff nurses in direct patient care roles in hospitals across Italy. They identified the detrimental impact of suboptimal work environments, stress, dissatisfaction and emotional burn-out as key factors for resigning nurses. The findings could be extrapolated to the Aotearoa NZ healthcare system, Clayton-Hathway et al. (2020) and Vanucci and Weinstein (2017) describe that in general, nurses are considered a high risk group for suffering the effects of pressure and burn-out.

Push factors were also identified by Andrews (2002) in a study of 63 English nurses leaving the National Health Service (NHS) for self-employment. Nurses described many reasons for leaving the healthcare service including burnout, restructure and disillusionment. However, the Andrews (2002) study focused on nurses moving into self-employment to start businesses in a complementary healthcare service not catered for by the NHS. In other words, they found a gap in the market.

A vital component for self-employment is the ability to sense market gaps (Bacigalupo et al., 2016; Elango et al., 2007). Mason et al. (2011) describe a generation of workers in an insecure job market who use their considerable skills, confidence, experience and education to realise their potential and reap the "pull" benefits of self-employment.

Pull factors can be personal, professional or both. The terms flexibility, freedom, creativity, positive work environment, control, family time and lifestyle choice appear often in the literature (Drennan et al., 2007; Hughes, 2003; Ministry of Women's Affairs & Ministry of Economic Development, 2008; Roggenkamp & White, 1998; Shirey, 2007a; Wilson & Averis, 2002). "*Push and pull factors were evident in these nurses' decisions to become self-employed, revealing a complex interweaving of the need to escape, the desire to grow personally and contribute professionally, and the allure of independence"* (Wall, 2015a, p. 231). There is also the sense of providing higher quality work and achieving more satisfying practice (Wall, 2013a). A mixture of reasons draw nurses to self-employment, but preparation for this role in professional advice and policy can be hard to find.

2.4.3 Preparation for project management, professional advice and policy roles

RNs working in the practice area of professional advice and policy are the focus of this study. Project management is included as it is a fundamental component of policy roles as seen in the New Zealand Department of the Prime Minister and Cabinet (2017) policy skills framework. However, nurses are not routinely trained in project management (Stanley et al., 2016). Some nurses may feel they do not require specific training. For example, Wall (2014b) refers to a self-employed nurse project manager from a Canadian study who described the adaptability and transferable skills of nursing to project management as "*assessing the problem, diagnosing what the problem is, deciding on some actions that you want to take and evaluating it*" (p. 520). Stanley et al. (2016) have a different perspective, suggesting project management should be introduced into education programmes for all nurse managers. Although project management courses are available in

Aotearoa NZ (Auckland University of Technology, 2017; ILX Group, 2017; PMI New Zealand, 2017), the courses are not required to meet all the relevant competencies for nurses in the practice area of professional advice and policy (Nursing Council of New Zealand, 2007a).

Promoting nurses into national and international policy development roles is a stated aim in many international reports and presentations (All-Party Parliamentary Group on Global Health, 2016; Daly et al., 2020; Dillard-Wright & Shields-Haas, 2021; International Council of Nurses, 2014; Jackson, 2020; Kunaviktikul, 2014; Polacek, 2021; Short, 2008; Solomon Cohen et al., 1996; Turale, 2015; World Health Organization, 2020). But there are few apparent tangible results. Factors may include perceived unpreparedness for policy spaces, or an aversion to risk taking.

> *Nurses are steeped in risk aversion from their earliest socialisation into the profession; acculturation to silence and conformity in the face of conflict or confrontation continues even today. This is at odds with what policy advocacy requires; advocacy entails taking a stand and putting oneself out there. It is inherently politicised and usually engenders conflict* (Scott & Scott, 2020, p. 3).

Nurses cannot engage at a policy level without appropriate understanding of policy, political cycles and the machinery of government. Without educational preparation nursing will continue to be side-lined (Manning & Krieble, 2020). Preparation for healthcare policy involves learning a new set of skills, a new lexicon and having dedicated resource to be in the right place at the right time.

The All-Party Parliamentary Group on Global Health (2016) specifies that nurse leaders should be encouraged to promote engagement and leadership in policy development on a global scale. The Triple Impact report begins with a recommendation to *"Raise the profile of nursing and make it central to health policy"* (All-Party Parliamentary Group on Global Health, 2016, p. 5). Four years later, the international Covid-19 response has seen nursing leaders challenge the invisibility of the profession in the policy space (Daly et al., 2020; Jackson, 2020).

Carryer (2020b) in an Aotearoa NZ-based editorial suggests that too often, when governance or policy roles are open to a nursing nomination, nurses opt for a clinical expert rather than a non-clinical nurse leader. Nurses are rendered impotent in national policy without relevant policy experience and education. Mason et al. (2016, p. 17) state that: *"Subject matter expertise without knowledge of policy and its processes is a doomed strategy."* Scott and Scott (2020) also identified the need among nursing leaders for a broader understanding of the healthcare sector, wider networks and a better grasp of the language of policy, more so than expert clinical knowledge.

An introduction to policy education in undergraduate nursing programmes is proposed by Whitehead (2003) who suggests early identification of students with political interests could re-energise the policy aspect of nursing. He asserts that nursing consistently fails to influence and lead in healthcare policy processes. Decisions are repeatedly made that exclude nursing and the nurses who take-on policy roles later in their careers often lack the energy to challenge. This argument has some merit because nursing in the UK (Clayton-Hathway et al., 2020) and Aotearoa NZ, still lack respect in the policy space (Clendon, 2019; Manning & Krieble, 2020). Despite this, there is already considerable pressure on undergraduate programmes to teach the complexities of nursing and engage in a new graduate entry to practice year (Nursing Council of New Zealand, 2015b) without introducing policy education (Whitehead, 2003).

Late career nurses possess extensive knowledge of the healthcare sector, long experience in practice leadership and are in a prime position to fill policy roles. A qualitative study on nursing policy and political leadership in Aotearoa NZ by Donovan et al. (2012) recommended training in leadership and internships to steer nurses towards healthcare policy work. The caveat was that there are not many positions for interns in the current governmental structure.

The New Zealand Department of the Prime Minister and Cabinet (2017) created a policy skills framework for application across all policy roles which includes the areas of knowledge, applied skills and behaviour. The framework added detailed and pragmatic descriptors to support competence in each area and has the potential, with minimal adaptation, to be a valuable resource for nurses transitioning into self-employed professional advice and policy roles.

New initiatives targeting nurse leaders are also emerging in Aotearoa NZ. Manning (2019), reports on a pilot workshop where the College of Nurses Aotearoa (NZ), Treasury, the World Health Organization and the New Zealand Institute of Economic Research (NZIER) unpacked the fundamentals of health policy and provided a glimpse into the machinery of government. This work fits well with the World Health Organization (2020) State of the World's Nursing 2020 report which recommended the building of knowledge and nursing leaders fronting dialogue on national and international health policy to strengthen the nursing workforce and evidence-based decision-making.

2.4.4 Preparatory education for self-employment

Formal education that introduces nurses to business is described by Boore and Porter (2011) who created a business entrepreneurship course for undergraduate nursing students. Multiple authors (Berragan, 1998; Canadian Nurses Association, 1996; Drennan et al., 2007; Shirey, 2007b; Wilson & Averis, 2002; Wilson et al., 2003; Wilson et al., 2004) refer to the need of nurses in self-employed business for significant experience and qualifications prior to providing an independent service, so the idea of promoting entrepreneurship during a nursing undergraduate programme may be premature. Despite this, the lack of business education is a recurring theme in the literature on self-employment in nursing.

Experienced nurses are qualified to provide nursing services in their practice area, but are underprepared for setting up and running a business (Andrews, 2002; Cadmus et al., 2017; Salminen et al., 2014; Sankelo & Åkerblad, 2009; Sharp & Monsivais, 2014; Shirey, 2007a; Wilson et al., 2012). To fill this gap the Royal College of Nursing (2007) provided UK nurses with guidance about self-employment covering financial advice, calculating fees and insurance options. Unusually, the document includes a section on working from home and using new technologies to support "off-site" working. This simple and useful toolkit helps RNs test the waters of self-employment.

A lack of business skills was found by Redmond and Walker (2008) to be a common problem among many trades and professions. Their research explored the acquisition of skills to run a small business in community-based training courses for small businesses owners in Australia. They conclude that rather than embarking on expensive and time-consuming academic courses, the necessary education needed for business owners is available in their own communities. Aotearoa NZ is generally considered an easy place to set up a business (Campbell, 2013), with numerous accessible resources from the New Zealand Government (2017), Ministry of Business Innovation and Employment (2017) and Business Mentors NZ (2017). However, setting up a business is an area of weakness for nurses (Sharp & Monsivais, 2014) and it is as yet, unclear how self-employed RNs in Aotearoa NZ learn how to run their businesses.

2.4.5 Value and finances

The literature on self-employed nurses indicates that placing a monetary value on their work, invoicing and understanding the value of their services are the biggest hurdles to successfully running a business (Iyer, 2015). The ICN makes addresses these issues in its information about nursing entrepreneurship. This quote foregrounds the subsequent articles on nurses understanding their financial value:

The calculation of fees need not be interpreted as a profit seeking measure. It is important to recognise and reward nursing services at their just value. If nurses are not able to determine true cost and monetary value of their service, how can they expect others to do so? (International Council of Nurses, 2004, p. 23).

Nursing is still viewed as caring work, normatively feminine and paid at a lower rate (Arnaert et al., 2018; Campbell, 2000; Clayton-Hathway et al., 2020; Marlow, 2002). Clayton-Hathway et al. (2020, p. 42) in the Royal College of Nursing report on gender in nursing introduce the concept of the "*ingrained devaluation*" of nursing due to the social constructs and contexts related to women and caring roles. As a normatively masculine endeavour, dealing with finance and charging for work, especially work deemed normatively feminine and low value, may seem unpalatable or a challenge to the feminine "*tyranny of niceness"* (Lewis, 2020, p. 309). However, if those in feminised professions remain uninformed about finance and the costs of business, they will continue to be marginalised.

Barriers faced by rural NPs when setting up a business were studied by Sharp and Monsivais (2014) using focused ethnography. A sample of 24 US-based NPs identified a lack of specific skills in finance, coding and budgeting. Skills acquisition for nurses in business is also addressed by Cadmus et al. (2017) who in an US study of 372 advanced practice nurses found nurses were least competent in financial and business planning areas. US research, literature and advice frequently refer to the complicated insurance and billing practices within the US healthcare and insurance systems as obstacles to overcome(Dillard-Wright & Shields-Haas, 2021). This does not translate readily to Aotearoa NZ, but there is merit in self-employed nurses understanding how healthcare is funded.

Nurses working in clinical practice facing difficulties accessing a payment for service are identified by Wilson et al. (2003) in an Australian Delphi study of self-employed nurses. While general practitioners, physiotherapists and midwives all have funding mechanisms in place, there

was no clear funding mechanism for RNs as they have not traditionally been self-employed. This is also the case in Aotearoa NZ. If a nurse is self-employed, particularly in a non-clinical role, costs must be either passed on to clients, or the RN reduces charges and thereby lowers their income.

The public view of nursing service as a benevolent venture (Elango et al., 2007; Girvan et al., 2016; Wall, 2013b) means allocating a monetary value to nursing work can be perceived as unpalatable. Wilson et al. (2004) suggest the public does value nursing service, but not enough to pay practitioners reasonable fees for service. In a study of UK nurses who left the National Health Service for small business, Andrews (2002) found that the increased flexibility and freedom of self-employment, was offset by a sense of frustration and stress from reduced incomes. Cubbon et al. (2020) identified that moving from a stable, secure and supportive environment to the high-risk of self-employment can lead to personal and financial distress.

Self-employed nurses offering services the public healthcare system no longer funds (Andrews, 2002; Wall, 2014b) must provide value and quality and make a reasonable, sustainable income. Wall (2015a) identified two issues which could prevent this: 1) nurses undervalue themselves and 2) nursing is undervalued by healthcare employers and the public. These issues exist due to the lack of clear definition and delineation of nursing work, but also the ingrained social positioning (Clayton-Hathway et al., 2020) and historical legacy which makes the direct payment of nurses distasteful (Wall, 2013b).

In an US article about nurses setting fee structures, Iyer (2015) proposes a balance between affordability of service and the perception of quality. A tension exists between expectations exceeding ability if charges are too high and the difficulty of rectifying fees if set too low. To counter this, Iyer (2015) suggested the reasonable solution of “fee integrity” and the consistent charging of

an hourly rate which involved calculating fees based on the running costs of the business. However, there may be some unknowns about cost in the early days of a business.

It is clear from the scant research on self-employed RNs that financial management can be problematic, with some specific issues regarding charging a fee for service. Numerous factors affect this situation ranging from the nurses themselves, employer and public perceptions of nurses and nursing work, to the types of groups and organisations with which nurses' sign contracts and the type of work. No research shows if fee-setting is a common issue for self-employed nurses in Aotearoa NZ, but from personal experience and past discussions with other self-employed nursing colleagues, it is an area of interest and relevance to this study.

2.4.6 New work places

Advances in technology are pertinent to this study with the concomitant diversity of workplace choice enabled by digital technology (Cassioli et al., 2020; Eikhof, 2016; Royal College of Nursing, 2007). Mason et al. (2011) explore an increase in home-based self-employment in the UK and report that many businesses in rural areas of the country are now supported by improved technologies. This not only increases choice in where nurses work (Myrie & Daly, 2009; Walker & Brown, 2004), but also simplifies the setting up of a business, especially for knowledge workers using their considerable qualifications, skills and networking as external contractors. In a study of Canadian self-employed nurses, Wall (2014a) interviewed one nurse who described being able to work anywhere with a Wi-Fi connection.

Where a nurse locates their business is affected by the type of services they offer. For example, a project management consultant can work from anywhere, but for a nurse providing a clinical service a rental property may be more appropriate than working from home (International Council of Nurses, 2004). Wherever a nurse locates a business, there is an opportunity to create a

new space reflecting their practice and values where they feel in tune with their environment. Wall (2014a) describes a nurse's workplace as a way of *"creating a new space for nursing and to show the value of nursing"* (p. 189). The creation of a positive work environment (Hughes, 2003) that reflects the business owner and service being provided (Myrie & Daly, 2009) is important. Such aesthetics are often in stark contrast to the work environments traditionally experienced by nurses.

Traditional work spaces and ways of working were significantly impacted by Covid-19. There has been an exponential increase in the use of online consultations in clinical work (Dean, 2020; Greenhalgh et al., 2020). More managers (Redmond & McGuinness, 2020) are working from home, which is a new experience for most people (Dubey & Tripathi, 2020). The limited articles which are available at the time of writing, though not focused specifically on the healthcare sector, suggest this way of working has been broadly welcomed, though not without some discomfort from the disruption to home life (Bick et al., 2020; Dubey & Tripathi, 2020).

Combe (2020), in an article about school nurses in the US, includes a section on the disruption and opportunities of suddenly working from home during the pandemic. She acknowledges family tensions, chores and caring for family members while managing a physical space never meant for paid work. Research into the impact for nursing of increased home-based working during Covid-19 is not yet found. It could be anticipated that, if nothing else, there will be better understanding that working from home can be productive and appropriate for some, but that remaining connected to networks for professional support is good for an individual's mental wellbeing (Reuschke & Felstead, 2020).

2.4.7 Finding support

Working from home as a solo self-employed business owner can create professional and/or geographic isolation and even loneliness (Baines, 2002; Cubbon et al., 2020; Drennan et al., 2007;

Elango et al., 2007; International Council of Nurses, 2004; Mason et al., 2011; McGregor & Tweed, 2002; Ministry of Business Innovation & Employment, 2020; Sankelo & Åkerblad, 2009; Wall, 2014a; Wilson et al., 2012). A participant in a study of self-employed businesses run from home by Baines (2002) even described this loneliness as *"intense"* at times (p. 96).

The access to mentors or supervision was recommended by Thorns (2013) who in a phenomenological study with five participants, found nurses who moved from the NHS to private aesthetic nursing practices experienced isolation. A Ministry of Women's Affairs and Ministry of Economic Development (2008) report on women in small business in Aotearoa NZ suggests small businesses are successful when linked with professional networks, business networks and support structures to avoid professional isolation. As an example, Business Mentors NZ (2017) supports owners of highly successful local businesses to become mentors for new business owners or who need support or advice.

Networking and sharing experiences were found to be vitally important by McGregor and Tweed (2002) in an Aotearoa NZ study into women's small business ownership. This is also supported in relevant grey literature (Ministry of Business Innovation & Employment, 2020). Networking was particularly important during a business start-up phase but does need to be ongoing or could result in increasing isolation and possible psychological issues (Cubbon et al., 2020). In Aotearoa NZ, professional isolation can be problematic for maintaining competence and nurses are encouraged to maintain professional networks for the purpose of education, reflection and evaluation (Nursing Council of New Zealand, 2012a).

Collegial and cooperative networking behaviour is described by McGregor and Tweed (2002). They suggest women in business have a particular tendency to come together to share stories, experiences and support each other, often informally. This behaviour appears to echo

relational theory, described by Buttner (2001) in a US qualitative study of 129 women in small business as *"one's sense of self and worth is grounded in the ability to make and maintain connections with others*" (p. 256). The use of connections and care for others in similar positions is also seen in Jurik (1998) who described the experiences of home-based self-employed business owners. She also suggests this co-operation is more common for women than men. According to McGregor and Tweed (2002), self-employed women with substantial networks are also more likely to access a business mentor. In a review of home-based small businesses in the UK, Mason et al. (2011) identified that home-based workers need access to cafés, not only as a meeting space, but also as a way to maintain networks and collegial relationships.

Vanucci and Weinstein (2017) in an exploratory study of the self-care and wellbeing practices of 44 nurse entrepreneurs in the United States Social found professional relationships are vital for sharing information and accessing support. They noted the importance of professional nursing organisations in keeping up to date and maintaining connections with other nurses.

In a scoping review of general business entrepreneurship, Cubbon et al. (2020) found that distress can be exacerbated by isolation and financial stress. Isolation can be significantly alleviated by accessing networking and mentorship (Ministry of Business Innovation & Employment, 2020). Nurses in self-employment have moved away from their familiar resources and accessible colleagues and, possibly for the first time, must consciously maintain networks to maintain their client base and find contract work. This is in addition to the requirements of any healthcare profession to remain professionally connected and current.

2.4.8 Freedom and flexibility

Although there is limited literature specifically on self-employed nursing, one common observation is how much nurses enjoy the freedom and flexibility of self-employment (Andrews,

2002; Shirey, 2007a; Wall, 2015a; Wilson & Averis, 2002; Wilson et al., 2003). Wall (2013b) found nurses to be positive about their self-employed status and the belief they were making a contribution by offering a professional, quality service. They found a way to reach the full breadth of scope of their specialty (Wall, 2014a, 2014b), promoting nursing outside of traditional work environments. And although they were proud of their businesses, they all still identified as nurses.

Walker and Brown (2004) explored the perception of job satisfaction and success in 290 small businesses in Australia. They contend that in contrast to the traditional ideas of measuring success in financial terms such as profits, turnover, staff, productivity and expansion, smaller businesses are happy to remain small and have often made a considered decision not to expand. The attractions of work-life balance, freedom, flexibility, positive work environments and being your own boss were found to be more compelling. Cubbon et al. (2020) reinforced this finding in an exploration of depression in entrepreneurs. They found that entrepreneurs place a higher value on autonomy and self-determination than on a regular income under the control of an employer.

The Ministry of Women's Affairs and Ministry of Economic Development (2008) identified self-employment as a stronger motivator than money. Buttner (2001), who explored the entrepreneurial styles of 129 female owners of small businesses in the US, reported that self-fulfilment as the most important measure of success for participants and rated highly the relational aspects of their work: *“the evidence also suggests that working from a relational stance enhanced the entrepreneurs sense of accomplishment and self-worth"* (p. 264). This finding is echoed in a study of 84 nurse entrepreneurs in Finland by Sankelo and Åkerblad (2009). Participants appreciated the autonomy of self-employment, saying it challenged them and offered a sense of self-worth.

Nurses who move into solo self-employed business ownership are taking a risk. They must navigate not only the erratic nature of contract work, but also negative perceptions, new business

skill acquisition, the difficulties of working alone and an unpredictable income. Despite these difficulties, the small amount of research into self-employed nurses suggests the choice is worth it.

2.5 Summary

The review of the literature covered a broad span of years. To secure relevant research and articles on self-employment and nursing, older articles were considered, whereas for more well-researched topics they may not have been appropriate. The scant research reinforces the need for original research.

Individual reasons for self-employment are as varied as the nurses themselves. However, the literature suggested common “push-pull” triggers for those considering self-employment which can offer benefits not accessible to those in employed positions. Self-employment was found to result in new and more challenging roles for the nurse, beyond their existing skill set.

The literature indicated that nurses are, in general, under-prepared for business. However, non-nursing research suggested this is not limited to nurses and a nursing specific solution may not be needed. Along with business skills acquisition comes confidence with charging a reasonable rate for services. This may create more tension for nurses due to the way nursing work is viewed, not only by clients but by the nurses themselves.

Solo self-employment can be a lonely endeavour. The need for support, networks, mentors and professional engagement appeared across the literature about self-employment. Working from home creates its own tensions, challenges and benefits which, due to the Covid-19 pandemic and the increase of remote working, has been revisited as the landscape on this topic has changed since this study began. The tensions related to working from home require developing different dynamics with family and friends and pressure to create the physical space for success in self-employment.

There is currently no research exploring RNs self-employed in the practice area of professional advice and policy. Research is available on various aspects of the subject, but none that comprehensively explores the specific topic of this study or that relates to Aotearoa NZ. This study will contribute to filling this gap by exploring the experiences of this largely invisible group.

To effectively position and understand how and where nurses are contextually located in societal discourse, it is important to understand the history of nursing, including key moments, players, structures, gender impact and professional traditions which have shaped the profession and public image of nursing. Understanding nursing history can offer insights into the tensions and perceptions with which the nurses in this study contend as they move outside the socially understood role of a nurse.

The next chapter explores the long history of nursing, specifically in relation to the social and gender positioning of nurses and, where possible, in self-employment.

Chapter 3: Nursing history: Gender and control

3.1 Introduction

The focus in this chapter is the development of nursing throughout the ages, with a lens on the control and power exerted over nurses by patriarchal entities. The tenacious grasp of religion on nursing orders and the pervasive control reflected in the rhetoric, traditions, uniforms, medals, language, behaviour and titles which still pervade nursing, is explored. The journey from hired, untrained carers to the development of nurse training in the UK is presented since the nursing structures in Aotearoa NZ today can be traced back to the British Nightingale model, which was exported to Aotearoa NZ in the mid to late 1800s.

The institutions of healthcare are examined, including the early nursing residences and the resultant control exerted on nursing students and qualified nurses. The experiences of private practice nurses in the late 1800s and early 1900s reveals the tensions around self-employed nurses requiring direct pay from patients or their families. The development of nursing in Aotearoa NZ in the 1900s to the present is addressed. Key nursing leaders who have used agentic positioning to make significant changes in healthcare and nursing from within an oppressive patriarchal structure are discussed in the final section. The first section presents women as healers, marginalised, non-conforming and working outside the institutional and religious norms of their time.

3.2 Wise women and religion

History is important (Anderson et al., 2020; Finkelman, 2017; Foucault, 1980) and an understanding of the past can help make sense of today's challenges and power dynamics (Roberts, 2000; Smith, 2020). Exploring nursing history shines a light on the development of the profession, embedded beliefs, stories, rhetoric and traditions (Anderson et al., 2020; Beard, 2018). History can

also create more understanding about how women and nurses were perceived across a web of complex structures and times (Dawson, 2021).

Nurses and nursing have existed since ancient times (Cooper, 2007; Narayanasamy, 1999; Nutting & Dock, 1907), but the story of nursing becomes more distinct in the Western world in the 4th Century when women were seen as the providers of care for the sick, infirm and elderly. Tooley (2012) identified two distinct groups of such women. Firstly, the independent, non-conformist women on the margins of society who were often known as cunning-women, lay healers or even witches (Ehrenreich & English, 2010). Secondly, the nursing sisters within religious orders who were pious, selfless and invisible. The dichotomy of witches and religious sisters positions the individual, marginalised witches as evil heretics (Briggs, 2002) doing the work of the devil (1 King James, 2012) and the homogenised, obedient religious orders as controllable and oppressed. This religious connection continued for hundreds of years and the title "nursing sister" is today still retained in many countries (Attenborough et al., 2019).

The deep religious roots within nursing are demonstrated in the work of Abbess Hildegard (1097-1180) in Germany who was highly respected across Europe and eventually canonised (Bragg, 2014; Ramos-e-Silva, 1999). Hildegard was one of many Abbesses who turned their educated attention to improving care by the training of nurses. Religious orders viewed nursing care of the sick delivered in convents and monasteries as a duty, a charitable action, or pious exercise with no monetary gain. This sense of vocation, women's work and duty prevails through the centuries for those undertaking nursing duties in control of language, titles (Attenborough et al., 2019), dress and behaviour.

In London, St Bartholomew's hospital in 1102 and later St. Thomas' hospital in 1213 were run by religious brethren and sisters (Tooley, 2012). The Dissolution of the Monasteries in 1525-1540

meant religious institutions swept away accessible healthcare (Lipscomb, 2021a). St Bartholomew's and St. Thomas' were the first hospitals to re-open their doors in 1553 (Clark, 2013) and previous titles reappeared, such as matrons and nursing sisters, along with terminology and forms of control. *"Stringent rules were laid down for the conduct of the matron, sisters, and nurses and one of the ancient regulations mentions chastisement with a birch rod as a form of correction."* (Tooley, 2012, p. 18). This is a strong example of the power of words and titles in nursing history and the control of nurses. Nursing history until recently was predominantly written by men. When nursing is mentioned, it is aligned with domestic, unskilled work (Purvis, 1995; Stevenson, 1994). Historical commentators on the nursing profession often take a reductionist position, minimising the work and skill of nurses while poorly describing this large and predominantly female workforce.

In the 15th Century, evidence suggests that nursing (and midwifery) outside of religious orders remained the province of women variously called peasant healers, lay-healers, wise-women or cunning women (Ehrenreich & English, 2010; Horsley, 1979; Tooley, 2012). Women at this time could make herbal remedies for minor ailments, assist in delivering babies, care for the infirm (Ehrenreich & English, 2010) and were a significant source of help and support to their communities (Clark, 2013). Peasant-healers were paid in some form, so they did have a part in the wider economy and were in effect self-employed. Although, in this deeply religious era, the Church had a different view and declared the healers to be dangerous (Briggs, 2002; Ramos-e-Silva, 1999).

Peasant healers in the 1500s were still viewed as dangerous and at risk of being accused of witchcraft (Darbyshire, 2006; Kane & Thomas, 2000). These people may have constituted half the victims of the witchcraft trials across Europe. Horsley (1979) surmised that peasant healers often lived alone, away from male control and the social and religious norms of the day. The patriarchs of the nobility and the Church developed a form of social control in which the establishment and communities victimised dependent neighbours and those on the outskirts of society. According to

Horsley (1979) this facilitated a process of marginalisation which pushed problematic behaviour or unwanted burdens out of a community. The Church justified its persecution of lay healers as an "*attack on magic, not medicine. The devil was believed to have the real power on earth, and the use of that power by peasant women – whether for good or evil – was frightening to the Church and State"* (Ehrenreich & English, 2010, p. 46). This belief led to tragedies such as the 1612 Pendle witch trials in the north of England (Holding, 2019).

The Pendle witch trials (Holding, 2019) were an example of lay healers, herbalists, or just non-conforming marginalised people being accused and executed for witchcraft (Eriera, 2011). Men also fell victim to such accusations in Britain and Europe. Dr Ólína Þorvarðardóttir (Lipscomb, 2021c) describes the witch trials in 17th century Iceland where 91% of executed witches were men. The predominantly male population of Iceland at that time had a large number of itinerant workers and healers, who were roaming around a country strictly controlled by the Lutheran church and unwittingly creating hysteria, resulting in accusations of witchcraft. The persecution of marginal, non-conforming, itinerant populations, two centuries later than the rest of Europe, was also seen in Estonia and it is suggested by Þorvarðardóttir (Lipscomb, 2021c) that both Iceland and Estonia were countries liminal to the rest of Europe.

Briggs (2002) described witchcraft as a charge which could be easily manipulated to reflect all sorts of perceived rebellious behaviour. *"At the imaginary level witches were the ultimate heretics and the most extreme social rebels, engaged in a conspiracy whose aim was the utter subversion of religious and social order"* (Briggs, 2002, p. 351). The State, the Church and the overwhelming patriarchal structure of the times, while not always driven by gender bias (Briggs, 2002; Lipscomb, 2021c), were certainly driven by the need to retain power, control and social structure.

Exclusion and persecution of those who do not conform to social expectations has resonance with Foucault (1988, 2003) who described undesirables or those who do not follow the norms of society being re-located by structures or patriarchal institutions of power, education and control, including by the Church, the State and medicine. Foucault (2008) described this as Sovereign power, where control is found in removal of those perceived the troublesome or burdensome. If patriarchy invents and creates superstition and a view of women as undesirable, dangerous and doing the work of the devil (Beard, 2018; Piper, 2018), then women become marginalised, removed from acceptable society and in effect silenced, rendering them invisible.

Marginalisation and silence could also be perpetuated by women in religious orders, such as the Sisters of Charity, founded in Paris in the 17th century by St Vincent de Paul. The Sisters showed their commitment to caring for the sick by selling their personal belongings and bringing the poor and infirm into their homes. "*A devotee who desired to emulate the saints and martyrs, chose nursing of the sick and poor as the most humiliating and disagreeable thing she could do and hoped thereby to perfect her salvation*" (Tooley, 2012, p. 15). The organisation saw nursing as a religious vocation which women undertook as a form of penance and to be seen as pious and doing their religious duty. At the other end of societal spectrum, duty and piety were not the primary drivers for women in poverty, who nursed only to earn enough money for food and were paid less than domestic servants (Clark, 2013).

Religion, charity and selflessness underpinned early nursing in England. In the mid-1800s, Elizabeth Fry, a wealthy philanthropist, prison reformer, Quaker and distant relative of Florence Nightingale, created the “Nursing Sisters”. The rules and regulations of the Nursing Sisters were drawn up in accordance with Fry's idea that care of the sick was the religious duty of intelligent women (Tooley, 2012), rather than paid skilled work (Baptiste et al., 2021). Reimbursement of

nurses at this time was certainly a consideration, but Fry's Nursing Sisters believed nurses should not worry their minds about money or profit as this was beneath them and beyond them.

> *The sisters...are not permitted to receive any private remuneration, and it is requested that in no case they be informed of the amount paid for their services, as it is desired that their minds should be kept perfectly free from secular matters, to attend to their own sufficiently responsible duties* (Tooley, 2012, p. 35).

The lack of financial control decreased the power of nurses. The suggestion that their minds should not be troubled with money (Tooley, 2012) indicates nurses were paid less than was being charged for their services and were controlled by their employer.

Women working as "hireling nurses" in the 1800s delivered care and were famously culturally embedded by Charles Dickens in the characters of Sairey Gamp and Betsy Prig (Sweet, 2007; Tooley, 2012). The term "hireling" generally indicates a person undertaking menial, low value work which was how caring was viewed (Helmstadter & Godden, 2016). Abel-Smith (1960) firmly situates nursing at this time in the same position as laundry women and domestic servants, "*nursing amounted to little more than a specialized form of charring*" (Abel-Smith, 1960, p. 4). Florence Nightingale wrote that nursing was only undertaken by those who are *"too old, too weak, too drunken, too dirty, too stolid, or too bad to do anything else"* (Abel-Smith, 1960, p. 5). Unsurprisingly, the institution had a significant problem finding "appropriate" or "good" women to work in the hospitals, due at least in part to the poor reputation of nursing (Helmstadter & Godden, 2016).

In 1860, Florence Nightingale launched the first hospital-based nurse training system in the UK (Tooley, 2012) to contend with a system in which upper-class women took a philanthropic role in healthcare and nurses were drawn from the lower classes (Heggie, 2015). Despite these changes, the view of nursing as low status persisted. *"People still shook their heads over the idea of making*

nursing a calling for women of gentle birth, and of the exclusion from it of the uneducated, unskilled and unfit woman" (Tooley, 2012, p. 93). Once a nurse's probationary year was complete, they were paid a salary of about £40 per annum (approximately £5,108 in 2021 terms) and given free board and lodging. However, their lives were controlled beyond their work, the monitoring and control of their off-duty activities, clothes, religious services and gatherings began with the introduction of nursing residences.

The nurse training schools, which were run by Matrons, also included domestic chores. Even into the early 1900's, cooking and cleaning were still taught in nursing schools and cleaning the hospital was a nursing duty (Helmstadter & Godden, 2016), forever entangling nursing with domesticity and chores. More focus was put on developing a good character and a pleasing personality than education (Abel-Smith, 1960). Women of a lower or "domestic" class found nurse training presented an opportunity to move into a respected career (Papps, 1998; Reverby, 1987b) that gave them somewhere safe and warm to live, an education and an income. At the same time in Aotearoa NZ, women were also seeking an escape from poverty and to avoid *"domestic service and prostitution by working in factories or training as teachers and nurses in the 1880s and 1890s"* (Stevenson, 1994, p. 3). The same situation was being seen across the British Empire, women had agency, they saw nursing as a way out of poverty and they took it.

Florence Nightingale and nursing entrepreneur Mary Seacole (Attenborough et al., 2019; Clendon, 2014) were both associated with caring for wounded soldiers during the Crimean war (1853-1856) where sentimental language began to emerge about nurses. Soldiers described angelic nurses laying their calming hands on the foreheads of the injured and dying (Tooley, 2012), and at times of despair nurses were seen as a warm light and a comforting memory of home. This sentimental language persists today and still inflates the angelic, chaste and pure image of the

nurse/woman (Fealy, 2004). Nursing had come a long way from the drunken, hireling and charring of the early 1800s.

Expectations of nurses at the time, as observed by Tooley (2012) in 1906, seem to the modern eye as beyond reason and nothing to do with nursing.

> *People are so astonished if she is not an absolute paragon of perfection. The general cry of patients and their friends is for a nurse with a sweet sympathetic face, a melodious voice, noiseless manner and pacific demeanour. She must be a beautiful reader, and able to play and sing if desired. She must be willing to take advice from older people, not intrude her own opinions, be conciliatory to the servants, do without off-time and sleep if circumstances require it. Also, she must show a marked aversion to male society. Of course, she is expected to nurse her patient well, but take the advice of the family as to what he should eat. If her religious and political opinions coincide with those of her employers for the time being, it is greatly in her favour* (Tooley, 2012, p. 262).

In this view, a good nurse is a paragon of religious quality (Bradshaw, 2013) while being compliant, silent, oppressed and without complaint or reasonable remuneration.

Private practice nursing was a common choice in the late 1800s and early 1900s. Tooley (2012) suggested options existed for nurses working in this way. Nurses could join a nursing cooperative where fees came directly from earnings, take salaried work or become an independent nurse with private clients. This form of independent nursing was often facilitated though personal recommendation of doctors in the area which meant doctors decided what made a ‘good’ nurse.

In the early 1900s, a nurse could earn between two to five pounds per week (£255 to £638 in 2021 terms) a reasonable amount for the time (Tooley, 2012). Nursing at this point had moved from a low value, untrained menial role to one through which a reasonable living could be earned by unmarried women. The nursing ideal was for women to accept an unmarried station in life, staying

within the limits of that station and knowing their place as a tiny cog in the vast machinery of Victorian society.

3.3 Development of the nursing profession in Aotearoa NZ

In Aotearoa NZ, the earliest documented nursing care is from 1814 by European settlers (Burgess, 1984). Until the late 1800s, women had the role of caregivers and healers playing an important role in pioneer communities (McKillop et al., 2012; Rodgers, 1985; Sargison, 2001). Women were under pressure to be good women, doing good work (Papps, 1998), embracing the 19th Century Victorian values of piety, modesty and obedience (Fortune & Prebble, 2012). Women were positioned in society to use their "natural abilities" in mothering and domestic skills (Reverby, 1987a) to support and care for the wider community.

The title of "nurse" was used by anyone freely giving assistance or help (Rodgers, 1985). Sargison (2001) suggests nursing volunteers were often older women who already had families where they gained experience in caring. "*With no formal apprenticeship, women needed to claim some years of familial service to the sick to be accepted as a nurse, while exposure to naked bodies, especially men, was deemed neither shocking nor arousing to older, motherly women"* (Sargison, 2001, pp. 33-34). She described how women, with experience of delivering babies and of nursing the sick, could earn an income from providing basic nursing care, even taking the sick into their own homes. Sargison (2001) identified many unmarried or widowed nurses at this time who advertised their services to support themselves, an early model of home-based self-employed nurses.

Hospital patients were overseen by matrons and masters (Burgess, 1984) while nursing work was delivered by untrained carers. Though the conditions in these hospitals was sometimes poor quality, Burgess (1984) maintained that the perception of nursing in Aotearoa NZ never sank lower than it was in the mid-1800s in England. Conversely, Hester Maclean, the director in the Division of

Nursing in the New Zealand Department of Health from 1906-1923, contended that *"The evil of women of low repute adopting a nursing uniform and posing as nurses in private families with disastrous results is keenly felt*" (Maclean, 1932, p. 24). These strong and condemning words were a political move, supporting her predecessor Grace Neill's introduction of nursing regulation for Aotearoa NZ (Maclean, 1932), a world first.

This notable vision and achievement was tinged with Maclean's belief that nurses should have a domestic cleaning role along with her arguments against nurses having a regular 8-hour shift so they could fit their working hours around patient needs (Sargison, 1996). Maclean demonstrated farsighted leadership, but then continued to situate nurses as subservient, not unexpected for a First World War army nurse. However, Maclean did want nursing to be described as a profession and her creation of the first Aotearoa NZ journal for nurses reflects this (Lambie, 1947).

Nightingale-era nurses emigrated to Aotearoa NZ as early as 1860 (Burgess, 1984). These nurses were *"part of 'the colonial enterprise' and were often perceived as their country's envoys, representing 'civilised' Christian values"* (Bradshaw, 2013, p. 85). Sargison (2001) explained that soon they were perceived as a significant threat to medical institutions, which in turn closed ranks (professional closure) and the hierarchical, patriarchal system was reinforced. *"In the early 1900s, hospital authorities, all male, selected probationers and promoted nurses on the basis of family connections rather than to ensure high standards of nursing care"* (Sargison, 2001, p. 13). Nurse training commenced in Aotearoa NZ in 1883 (Maclean, 1932), but unlike the confident nurses who arrived from the UK, Aotearoa NZ nurse probationers were not expected to undertake hospital management, training or administration (Wilson, 1998). Wilson (1998, p. 15) described this as "*occupational imperialism*" since Aotearoa NZ nurse training was almost an extension of the domestic service model. It was not until the mid-1960s that domestic chores such as, washing up, cleaning beds and kitchen preparation were taken over by domestic staff (Brown et al., 1994).

Lack of progress in Aotearoa NZ nursing was not all about medical oversight or the Nightingale ethos (Stevenson, 1994). Rodgers (1985), Kinross (1984) and Stevenson (1994) identified that two consecutive Nursing Directors in the then-Division of Nursing in the New Zealand Department of Health, Hester McLean in 1920 and then Jessie Bicknell in 1923, resisted medical practitioners in the Department of Health who advised creating university courses for nursing. The plan was for a 5-year Diploma in Nursing (Lambie, 1947). Two nurses who had excelled in overseas secondments were to return to Aotearoa NZ and deliver the programme. Unfortunately, Otago University withdrew from the plan citing their inability to pay the nurses and the government chose not to do so as it would set a precedent. As a result, nursing in Aotearoa NZ preserved a model of hospital training, feminine obedience and subservience (Rodgers, 1985).

In the early 1900s, nurses were needed in Aotearoa NZ's predominantly rural settings. Wood (2008) explained how "back blocks nursing" helped boost the recruitment of medical doctors to rural areas. Two systems were created for tackling this through nursing, one for Pākehā (European) settlers and one for Māori. European settlers were expected to pay half the salary of the Pākehā nurses, the other half was funded by the government. This created two reporting lines, as well as input from medical colleagues who were not always supportive (Wood, 2008). Though this scheme was led by a number of stakeholders, it allowed nurses the independence to run their practice almost like a business by charging fees, managing inadequate resources and working alone, away from the domineering hospital hierarchy (Wood, 2008). Maclean (1932) stated, regarding the working conditions and challenges, that the nurses were courageous women. The nurses also needed to be decisive, creative and resilient since they dealt with community groups, hospital administrators and medical colleagues. Tensions arose from medical colleagues who perceived nurses taking away potential revenue, or overstepping the mark in their practice. Wood (2008)

identifies these nurses as needing to be politically astute to manage the dual reporting lines while, like self-employed nurses today, enjoying a degree of freedom in their practice.

After the Second World War, healthcare became a major employment area for Aotearoa NZ (Gage & Hornblow, 2007). Young British women were recruited and offered training to become a RN in the Aotearoa NZ mental health system. The Director General of mental health, Dr Theodore Gray, had specific criteria for recruits. They must be of the right class, ethnicity, educated, unmarried and hard-working. In other words "*Suitable Girls*" (Fortune & Prebble, 2012, p. 157). The focus was on recruiting hardy, working-class women with the caveat they did not look or sound working-class, preferring they be perceived as of good middle-class stock who would work hard and not complain. The concept of "docile bodies" is appropriated by Fortune and Prebble (2012) to describe a compliant workforce, able to be directed. Foucault (1980, p. 136) suggested a body is docile that may be *"subjected, used, transformed and improved."* The recruitment drive was largely unsuccessful in retaining most of the recruits within the mental health system.

New medical disciplines also demanded a more skilled and prepared nursing workforce. A system of hospital-based training was embedded, reinforcing the dominant hierarchies (Walby, 1989; Wuest, 1994). In 1971, the Carpenter report (Carpenter, 1971) recommended a new system of nursing pre-registration education, which involved tertiary education providers taking over preparation of nurses from the traditional hospital-based schools of nursing. Despite not gathering full national support, the transfer of nursing to education had begun (Gage & Hornblow, 2007). In 1973, post-registration education courses started at Massey University, closely followed by other Aotearoa NZ universities. Nursing research and scholarship has since spread across the profession, including an increase in focus on previously unwritten and unexplored nursing history.

Radical political health reforms in the 1990s significantly impacted nursing, leaving it devoid of senior experience and struggling with workforce issues. Nursing and nurse management between 1993 and 1997 became victims of cost containment and the move to Crown Health Enterprises (CHE) was led by business managers with no experience in healthcare, who shifted healthcare to a commercial model (Somjen, 2000). The office of the Chief Nurse at the Ministry of Health was removed and nursing leadership in hospitals and across the regions was disestablished. Healthcare quality suffered as a result of these reforms (McCloskey & Diers, 2005) and a layer of nurse leaders, mentors and experts was lost.

The business reforms of the 1990s were an example of nurses being perceived as a generic, expendable, deployable workforce commodity. Nursing expertise and specialism was underestimated and their contribution across the whole of health unknown and invisible to business managers. The outcomes of the reforms led to a period in the early 2000s of workforce planning and productive conversations about advanced practice roles and subsequent Masters-level education for RNs (Gage & Hornblow, 2007). The Health Practitioners Competence Assurance Act (2003) enabled the NCNZ to amend the registered nurse scope of practice (Nursing Council of New Zealand, 2007a, 2012b, 2017) to create specific competencies for RNs practising in the non-clinical practice areas of education, research, management and professional advice/policy.

Healthcare across Aotearoa NZ now focuses on collaborative practice between all healthcare professionals, though there are still professional tensions in leadership.

3.3.1 Māori mahi tapuhi (nurses)

In Aotearoa NZ, practitioners of rongoā Māori (traditional Māori healing) were known as tohunga (Martinez, 2018). Tohunga (expert healers) were central to health practice, tradition, healing injury and managing illness in Māori communities. Colonisation devastated Māori

communities (McKillop et al., 2012; Wilson, 1998) by introducing new infectious diseases and limiting rongoā using the Tohunga Suppression Act passed in 1907 (Jones, 2007).

New hospitals and nurse training programmes throughout the British Empire were created for white European settlers (Baptiste et al., 2021). In Aotearoa NZ, this Eurocentric model meant funding and management of healthcare separated European from Māori, who became even more marginalised. There is a complex history to be explored in the development of Māori tapuhi (nurses) and the continuing struggle against inequitable healthcare structures (Came et al., 2018; McKillop et al., 2012). The suppression of lay healers in past centuries is an important part of Aotearoa NZ nursing history, but this subject is outside the scope of the current study.

3.4 Strong women and strong nurses navigating patriarchy

Nursing leaders have taken agentic positions within their culture to promote nursing and patient safety throughout time and it is easy to view these actions in hindsight with a modern perspective. Choices made by nurse leaders are worth considering as examples of the controls and constraints under which nurses of the time were practising.

One example of a politically astute nurse is Grace Neill (Wood & Papps, 2001) who proved herself able to navigate and negotiate her way through paternalistic dominance. Neill made a lasting impact on Aotearoa NZ nursing by creating the nursing register after the world's first Registration Act for Nurses was passed in 1901 (Lambie, 1947; Maclean, 1932). Another example is Sybilla Maude, who created a public healthcare service in Christchurch, finding public support for improvement in the care of patients with tuberculosis and improving first aid in factories (Burgess, 1984).

We proffer these examples not to denigrate nursing but rather to suggest a complexity in nursing that is reduced to a sanitary and straightforward hagiography. Nursing and those nurses who have constructed the discipline are complex. Products of their time, yes, but also sometimes problematic (Dillard-Wright & Shields-Haas, 2021, p. 202).

Elizabeth Fry did not support nurses dealing with money, believing their only duty was care provision. Florence Nightingale required nurses to obey their 'Master', the physician (Sargison, 2001), perpetuating an oppressive patriarchal system. These nurses all made significant impacts from within patriarchal systems. Roberts (2000) proposed that nurse leaders gained their own rewards for continuing the existing system, even if it did not further the nursing profession.

Nurses oppressing nurses is explicated by Reverby (1987a) who describes this self-induced oppression using the experiences of nurses in 1888 who needed to earn a living wage and were ostracised and condemned by nursing leaders. "*Their letters were often edited out of nursing journals, and their voices silenced in public meetings as they were denounced as being commercial or lacking in proper womanly devotion*" (Reverby, 1987a, p. 9). The nurses were merely trying to earn a living wage, but were marginalised and criticised by other nurses (Kaiser, 2017; Mikaelian & Stanley, 2016). The public viewed nurses as charitable sisters of care and at the time the nursing sector considered self-employed nurses as troublesome outliers.

Nurses have been identified as selfless for centuries and found it difficult to argue their financial worth. Helmstadter and Godden (2016) described how a hospital matron was expected to, and did, forgo her gratuity where other "hospital officers", did not.

She described how she had been elected matron in 1794 at a salary of £20 a year plus a 3-guinea gratuity. She was never paid the gratuity, but when she discovered that other hospital officers were receiving theirs, she applied for the arrears. She was then convinced to forgo it

because the hospital was five quarters behind in paying its bills (Helmstadter & Godden, 2016, p. 12).

This is an example of history repeating itself and of the self-induced oppression of nurses, internalised and carried within the profession for years. Roberts (2000) described this as passive acceptance in which women are unaware of the discrimination and oppression affecting them.

In forgoing an appropriate financial reimbursement, nursing leaders have unknowingly done an enduring dis-service to the profession by continuing to hide the true cost of nursing care. Nurses following in their footsteps have for years struggled to earn an appropriate pay. Fealy (2004) describes how the social perception of nurses and nursing work has impacted their financial, social and professional position. He described a state where nursing is not seen as a profession and there is a belief that a woman's satisfaction is entirely met by her ability to provide good nursing care and that is payment enough.

3.4.1 Uniforms, hats and medals

The legacy of angelic, religious headwear and the white robes of religion (Brown et al., 1994) with their associated purity have persisted. Nurses are publicly perceived as *"mostly female, Caucasian and dressed impeccably in white uniforms, stockings, laced leather shoes and, most importantly, a white cap*" (Evans, 2002, p. 61). An apron was also added in the early days, linking the profession to domestic service. Fundamentally, the uniform speaks more for the nurse than their work or their own voices (McAllister & Brien, 2020).

A photographic display of nursing uniforms used at Auckland Hospital from 1890-1990 is presented by Brown et al. (1994) and though they have evolved since then, the white theme remains. Uniforms suggest more than profession. They can imply a gender, a class and a social

position (Burr, 2015). For example, along with the white caps and dresses are the militaristic epaulettes indicating hierarchy and rank, an important part of nursing since nurse training began.

Nursing uniforms in Aotearoa NZ and globally carry echoes of the religious past (Dock & Stewart, 1920). The angelic white dresses, the crossed red capes and the hats which retain links to the Sisters of Charity. In today's world nurses often wear scrubs which preserve homogeneity, uniformity and anonymity. One consistent item, throughout the evolution of the uniform, is the Aotearoa NZ nursing medal, which is still issued to nurses by the NCNZ on receiving registration (Spence, 2001).

The Aotearoa NZ nursing medal connects much of the history and imagery associated with nursing. Developed in 1901, the medal's five-point star has been interpreted in a number of ways. Spence (2001) presents a number of descriptions proposed over the years, including links to the Aotearoa NZ flag and the Christian cross. The colours also carried meaning: white for purity, red for blood, blue for honesty and gold as "*symbolic of charity, mercy and kindness in the relief of suffering*" (Spence, 2001, p. 30). Religious and militaristic images have followed nurses down the years, and while some of the older meanings of the medal may be outdated and anachronistic, nurses remain proud of the medal, and it is a tangible sign of being an RN in Aotearoa NZ.

3.4.2 Training programmes

The modern formal period of nurse training began in the mid-1800s to relieve the burden on medical staff within workhouses and improve nursing care. The scheme was broadly successful but where it was unsuccessful, a lack of honesty and sobriety were reported to be the primary problems (Abel-Smith, 1960). The formal preparation and training of student nurses began in 1860 at the Florence Nightingale Training School (Abel-Smith, 1960) which perpetuated the overarching control of nursing preparation by the medical profession (Tooley, 2012). According to Abel-Smith (1960), the

students were then called “probationers” or “lady-pupil” nurses. Training for probationers was free as they were from the middle- or lower-classes, basically women who would normally earn a living in some way. “Lady-pupil nurses” were from upper-class families and paid for their training.

The educated upper-class was at first considered a threat to medical practitioners, according to Abel-Smith (1960, p. 27), the doctors *“feared that these educated women would undermine their authority, however much the nurses protested they were there to carry out the doctors’ instructions.”* Tooley (2012) described probationer training from 1895 as lessons provided by medical practitioners and senior nurses, including physiology and cooking. At the end of the first year, a viva voce and practical examination was delivered for each probationer by a medical practitioner.

The pull factors for women becoming nurse probationers are described by Abel-Smith (1960) as: romantic ideal, religious devotion, agentic positioning, income and emancipation. In their hospital training, probationers had to cope with demanding matrons who, along with male medical practitioners and hospital administrators, controlled nursing and ran the hospitals. At this time, across the Commonwealth and in the US the focus was on duty and creating obedient and compliant nurses. *“Thus, nursing did not need a code of ethics, physician John Shaw Billings told nursing leaders at the turn of the century, because a good nurse should merely be told to be a good woman”* (Reverby, 1987b, p. 202).

The first training school in Aotearoa NZ began in 1883 at Wellington Hospital *“under the matronship of ex-Crimean War nurse, Mrs F.M. Moore. The new regime, with nursing tasks being carried out by probationers (pupil nurses) ‘from a higher order of society’, was hailed as very successful by the Inspector of Hospitals, Dr G.W. Grabham”* (Sargison, 2001, p. 50). The concepts of a regime and completion of tasks, infers the continued militarism of the war nurse with restrictive rules and regulations of the zealous matrons of English training hospitals (Abel-Smith, 1960).

The Florence Nightingale training model was introduced to Auckland in 1889 (Sargison, 2001) following the arrival in 1883 of Matron Annie Crisp (Brown et al., 1994). Medical oversight remained central to nurse training in Aotearoa NZ from the late 1800s until end of the hospital training system in the early 1970s (Brown et al., 1994; Spence, 2001), controlling what nurses were allowed to learn and how they practised.

Senior nurses or matrons were complicit in homogenising the nursing workforce, ensuring rules were followed. Obedience and duty were vital, and identities were hidden behind uniform dress and behaviours, positioning nurses as invisible and task driven. Nurses in the 20th Century were identified as State Registered Nurses (SRN) from 1919 (Ford, 2017). Nursing was firmly an occupation, not a profession and tightly regulated by the state (Healy et al., 2018). The state used training programmes and titles to regulate and create structural norms and hierarchies within nursing (Papps, 1998).

In 1971, the oversight of nursing education standards became a function of the newly created Nursing Council of New Zealand (Wood & Papps, 2001). Though the Council was to support the transition to polytechnic and university programmes, the final hospital-trained nurses did not graduate until 1990 (Wood & Papps, 2001).

3.4.3 The nurses' residence

The nurses' residence evolved to accommodate and contain nursing students and RNs. In a review of the development and management of nurses residences in Canada, Zerr (2006) outlines the areas of control and opportunity found in this aspect of nursing history. Developing in the early 1900s, nurses' residences were managed by a superintendent who could oversee day-to-day running of the residence and control social activity. The residence was a place to protect nurses from men

and save nurses from themselves. There is no literature of the time on the concept of gender identities or the possibility of men in nursing (Eliason, 2017; Fowler, 2017). A nurses' residence was created and controlled in a binary, gendered model.

Heteronormativity is a cultural mechanism by which oppressive discourses normalise power structures. If a nurse married, she would have to leave nursing (Fowler, 2017) as a married woman became the property of the husband (Waring, 2018). Nurses in leadership roles did not usually marry. Whether this was by design or preference is unclear. Oppression, supervision and control were enforced in the nurses' residences by a series of strict rules and regulations which persisted for decades across nurses' residences in Canada, the UK and Aotearoa NZ.

Nursing accommodation by 1910 in Auckland was purpose-built with considerable improvements in living conditions for the nursing staff. The Auckland nurses' residence was opened by Lord Islington who spoke of his great concern for nurses, pointing out that:

"Great progress had been made in hospital administration and in treatment for patients but that nurses' welfare had been overlooked. Surgeons and physicians depended on the work of nurses. 'Few professions required finer qualities than that of the hospital nurse.' They had earned comfort and repose in their off-duty time, and were deserving of this comfort when they were devoting 'their lives to ministering to the sick and injured at Auckland'" (Brown et al., 1994, p. 35).

The use of the words "nurses' welfare", "finer qualities", "earned", "repose", "deserving", "devoting" and "ministering" are all powerful words when used in this way. Even looked at as an act of beneficence, the paternalism here is significant.

Patriarchy, oppression and control followed nurses into the residence. Foucault (2012, p. 172) stated that architecture is created for more social purposes than to be just seen:

> *"…but to permit an internal, articulated and detailed control – to render invisible those who are inside it; in more general terms, an architecture that would operate to transform individuals: to act on those it shelters, to provide a hold on their conduct, to carry the effects of power right to them, to make it possible to know them, to alter them. Stones can make people docile and knowable."*

In nursing residences, the control over the activities of nurses both on and off duty create a homogenised workforce, a docile body which can be manipulated to behave as required and undertake their duties bound by strong rules and restrictions.

The restrictions placed on nurses at this time are presented by Brown et al. (1994) who supply an example from 1902. Nurses were forbidden to leave the hospital after eight o'clock at night (Rule 136) unless the Lady Superintendent issued them a pass. On hearing this was being challenged by the nurses, the chairman of the Auckland Hospital Board *"marched into the private dining room of the Nurses' Home during the dinner hour and said to the nurses 'You must accept rule 136 or a considerably more stringent one*'" (Brown et al., 1994, p. 30). This bullying was an example of paternalism and oppression invading every aspect of nurses' lives, whether on or off duty.

It would be many years later at the time of the Social Security Act 1938 before the number of nurses' residences was reduced. The Hospital Boards then created a system in which SRN could receive an allowance to "live-out", a freedom nurses reportedly enjoyed. It then became unusual for SRNs to live inside residences (Lambie, 1947). Once they became state registered, they were free of the control and oversight found in the nursing residences.

In an alternate view of nurses residences, Zerr (2006) described the lifelong friendships based on the camaraderie at the residences. The safety, convenience and the often-impressive architectural buildings for nurses was an important step and a tangible value-add for the progress of women. However, there is still an overarching theme of control in the training of these women, not only in nursing care practices, but to believe, dress and act in the same safe way, to become "docile bodies" (Foucault, 2012). This "safety" was for the patriarchs, so nursing did not get above itself. If a nurse should attempt to rise above the crowd, she risked being ousted from the in-group (Tajfel, 2010) formed in the formative training years and in the nurses residence, a group with deep roots and shared experiences.

3.5 Summary

Nursing history in relation to the continuous shaping, control and oppression of nurses was outlined in this chapter. It was posited that an understanding of the current situation requires knowing the past's entrenched views, language, behaviours, traditions and control points which have evolved over the years. The position of "cunning women" and "religious sisters" was presented to show the dichotomy experienced by women in early nursing. This dichotomy lasted for centuries as women were marginalised in communities or hidden in religious orders as the dominant power structures increased control. Oppressive titles, language and behaviours from these early times persist today.

The development of nursing in the British system under the eye of Elizabeth Fry and Florence Nightingale was presented. Emphasis was placed on the situation of nurses prior to the interventions of Nightingale and the resultant change in the position of nurses. The rhetoric about nursing at this time changed from dire to sentimental, marking a point in history where obedience and gendered subservience were deeply entrenched. As British 'Nightingale' nurses moved to Aotearoa NZ, the colonisers took control of nurse training in Eurocentric hospitals while rural

populations were supported by unprepared nurses, or women who nursed from their homes to supplement income.

The role of nurse leaders was described, along with their agentic positioning and political abilities within a patriarchal system as they worked within the culture and entrenched gendered inequalities of the time. Three specific areas of control and oppression were discussed: uniforms, education and the nurses' residences which, throughout the 20th Century, helped fix the societal image and gender of a nurse.

Culturally embedded anachronistic images are jarring when seen through the lens of contemporary nursing and directly impact the epistemology and theoretical frameworks of this study, as described in the next chapter. Gender theory is explored along with an overview of feminism, with a focus on post-structuralism to shape the explanation of nursing as a highly gendered profession. Liminality theory is introduced as a concept specific to the explored roles.

Chapter 4: Theoretical framework and research methodology

4.1 Introduction

The theoretical frameworks underpinning this study are introduced in this chapter. Liminality theory is outlined from its early development to the evolution of a model relevant to modern workplaces. The concept of gender theory, specifically post structuralist feminism, is explored in relation to nursing. Destabilising the normative gendered positions within healthcare, and the resultant positioning in the liminal spaces, were important in uncovering how the participants frame their self-employed roles.

The research method used in this study is focused ethnography. Its development and evolution are presented, along with the strong link between qualitative research, ethnographic methods, feminism and liminality. The first section of this chapter attends to liminality theory.

4.2 Liminality theory

Liminality or liminal describes a time of ambiguity and transition, hence the term "betwixt and between" is often found in literature in reference to liminality (Garcia-Lorenzo et al., 2018; Garcia-Lorenzo et al., 2020; Mahdi et al., 1987; Turner, 1987). A theory of liminality was first developed and published in 1909 by van Gennep (2019), initially focusing on "rites of passage" or the series of transitions a person goes through with life changes. The original work on liminality was based on the ethnographic method and divided into three sections: *"rites of separation, transition rites and rites of incorporation"* (van Gennep, 2019, p. 11). The theory was further developed in the 1950s and 1960s by Turner et al. (1996) who described cultural initiations, tribal traditions and stages of gender development with a Eurocentric patriarchal dominance in observing and judging non-European cultures.

Turner's view has resonance with structuralism in that society has a more or less fixed view of positions and structures. *"If our basic model of society is that of a "structure of positions" we must regard the period of margin or "liminality" as an interstructural situation*" (Turner, 1987, p. 4). He also referred to profession, office and rank as social constants. *"By "state" I mean "a relatively fixed or stable condition" and would include in its meaning such social constancies as legal status, profession, office or calling, rank or degree"* (Turner, 1987, p. 4). According to Turner, there are fixed and constant contexts. For example, if a nurse moved away from the culturally understood stable condition of role and environment, they would de-stabilise the state and become interstructural or liminal. He explained the term "state" in this context: *"State, in short, is a more inclusive concept than status or office and refers to any type of stable or recurrent condition that is culturally recognized"* Turner (1987, p. 4). This concept of cultural recognition is key. The culture of the privileged is uppermost in this view. Though the original use of liminal theory provides a useful framework, the outdated examples and descriptions were too limiting for the current research.

Liminality in contemporary society and as a career or work life model, is a relatively new development. A contemporaneous model was sought for practical application in this study, beginning with the work of Czarniawska and Mazza (2003) who introduce the employment aspect of liminal theory. This perspective is much closer to the current research. However, while the phases in liminality and transition in this model are a fluid time, moving backwards and forwards between the phases, they both suggest an ending to the liminal phase. van Gennep (2019) and Turner (1987) also viewed the liminality as temporary and a route back to culturally known and accepted stability or states.

A contemporaneous and contextually appropriate approach to liminality theory is required for this study, such as creative liminality as described in Table 1 (p. 72) by Garcia-Lorenzo et al. (2018, p. 384).

Creative practices at liminal stages	In relation to self *(reconstructing self-identity)*	In relation to institutional contexts *(finding institutional 'pores' to develop entrepreneuring ideas)*	In relation to social and cultural contexts *(decentring wealth as part of entrepreneuring)*	In relation to business contexts *(generating enough material outcomes)*
Separation	Questioning previous self-identities *(e.g., renouncing expertise as 'scientist' to set up as a 'merchant')*	Renouncing hope to find institutional help *(e.g., exploring other collective forms of support)*	Breaking with previous social structures *(e.g., using critical events such as redundancy, divorce, or death to separate from known social structures)*	Redefining work skills and networks
Liminality	Self-reflection disengaging from relationships that constrain self- development	Undeclared payments to avoid taxes, registration of business on-and -off	Setting up tax-free charities and foundations, involving family and neighbours in developing the business	Relying on family for housing and business premises, earning enough to cover business unit rent, utilities pay-as-you-go
Reaggregation	No need to justify oneself, seeking out business opportunities, willing to take risks	Using tax breaks and welfare benefits to sustain or expand the business	Volunteering to make a name in the community, pro-bono work	Relocating to different geographical locations (e.g., urban vs rural)

[7]*Table 1. Creative liminality*

The creative liminality model introduces the concept of continuous liminality in work-role transitions and can be applied to this study as it was based on new entrepreneurs. This study will use the liminal stages as identified by Garcia-Lorenzo et al. (2018) with adaptations to ensure connection with liminal theory and the needs of this study:

- Separation: This represents a time of leaving known employers and employment models and detaching from familiar structures, practices, resources and networks;
- Liminal/transitional: The liminal or transitional phase represents a time where the participants are most obviously learning to straddle the allocated binaries of nursing and business. This ambiguous time is often the most challenging stage, requiring the learning of new skills, creation of new networks and developing new identities which may be unclear and complex.

[7] Appendix 5, p.246

- Reaggregation: This represents a coming together, the finding of a place and an identity, the realising of potential and understanding of the new identities and complex ways of belonging.

Garcia-Lorenzo et al. (2018) refer to continuous liminality, or a continued limonoid state, suggesting it is not always possible to move through liminality. In some cases, people can continue indefinitely in this state and remain highly effective, comfortable and creative, while for others it is disturbing, unstable and risky.

The concept of enduring liminality and its resulting creativity is supported by Willis and Xiao (2014) and Ibarra and Obodaru (2016) who identified that contract and knowledge work both create liminal identities that can remain in a liminoid state long-term. A review of the literature on liminal theory showed that the Garcia-Lorenzo et al. (2018) model fits the roles in this study well, since contract roles move around organisations remaining external to the workforce and working in a separate space.

4.3 Gender theory

Nursing is an inherently gendered profession (Eliason, 2017), in practise and in workforce statistics. Women represent the majority of the workforce in Aotearoa NZ and globally (Mitchell, 2017; Nursing Council of New Zealand, 2018). Gender theory is an appropriate and fitting lens though which to approach this study of RNs working in non-traditional ways in non-traditional settings (de Bruin & Dupuis, 2004; McKeown, 2005), including the normatively masculine domain of entrepreneurship (Bruni et al., 2004; Moreira et al., 2019; Yousafzai et al., 2018).

Inherent social constructs support the premise that masculinities are privileged and femininities disprivileged in terms of socially accorded value (Bhakuni & Abimbola, 2021). Walby (1989) describes masculinity as outward facing, functioning in the world beyond the home to

support, provide and protect the family, while femininity is framed as caring, mothering and nursing in a private world. Nursing, as a predominantly feminine endeavour, is captured in received view as best suited for women, not just in educational terms, but biologically which deeply impacts the societal positioning of nursing (Busch, 2018). Vuolanto and Laiho (2017) asserted that gender research offers a way of revealing and understanding how dominant cultural and societal constructs create privilege and disprivilege. The Ministry for Women (2020) described predominantly gendered professions, such as nursing, using the sociological term "occupational segregation".

This study captures the views of nurses, their experiences and perceptions on becoming solo self-employed nurse consultants. I was interested in how the nurse participants described the phases of transition into a different form of nursing work, the words they used and the areas they found easy or difficult to navigate which revealed their barriers and opportunities. Gender theory is an appropriate lens with which to view the predominantly female and occupationally-stereotyped nursing profession (Busch, 2018).

4.3.1 Why feminist theory?

The choice to use feminist theory for this study needs explanation, justification and definition. Feminism is a philosophical stance and can be difficult to define in a simple way, so it is often explained as four "waves". The first wave began in the late 1800s and continued into the early 20th Century. Its focus was on increasing opportunities for women and was a direct challenge to domesticity (Rampton, 2015). The work of philosopher De Beauvoir (2015) in 1949 raised questions for women about their bodies, positing that societally held customs and beliefs about the inferiority of a woman's body are just that – customs, beliefs and judgments. These are based on what men think a woman should be. Her book *The Second Sex* was the foreground for the second wave of feminism, which began in the 1960s and carried on until the 1990s (Rampton, 2015). This wave

focused on reproduction and equal rights. It was at this time that the concept of the patriarchy was first overtly challenged as the feminist movement critically considered the oppression of women.

The third wave of feminism started in the 1990s by challenging the idea of feminine essentialism in which the presentation of feminists as Eurocentric white women in the middle or upper classes of society ignored, for example, lesbians and transgender (Fotaki & Harding, 2017). The fourth wave emerged in the 2000s and is considered by some to be still evolving (Rampton, 2015). It encourages gender disruption and intersectionality (Fotaki & Harding, 2017) in which the interconnection of people's lives including, but not limited to age, ethnicity, disability and social position can overlap and create discrimination, privilege, disadvantage, workplace inequality and control (Acker, 2006).

Xenofeminism (Cuboniks, 2018; Hester, 2018) is a term that challenges the existence of binaries, identifies the problem of interconnected systems and aims to address gender justice and emancipation. Feminism continues to develop through many theoretical periods arriving at the more diverse and nuanced understandings of post-structuralist feminism. While these ideas are still being contested, at the centre lies the issue of gender, the binaries and gendered performativity.

The evolution of feminism is messy, with overlaps and co-existing beliefs. As such, the four-waves theory is problematic (Olufemi, 2020) since it does not account for the differences in women and that feminism is not so clearly delineated. While not always called feminism, the ideas have existed for much longer than usually considered (Lipscomb, 2021b). For example, in 1405 Christine de Pizan wrote about her despair at being surrounded by texts written by men describing women as inferior and vile (Dawson, 2021). The long existence of patriarchy means cultures are steeped in gendered discourse and positioning. History is often the voice of privilege and patriarchy (Lipscomb, 2021b) and where there is privilege there is disprivilege.

History also reveals control points. It surfaces the traditions and beliefs absorbed by nursing along with gendered positioning and behaviours. In the past, nurses in positions of leadership were described as complicit in maintaining patriarchal hierarchies in healthcare. The historical section of this study shows the concept of gender binaries was central to the role, residence, uniform and work of nurses. Feminism has been viewed by nursing with suspicion and discomfort (Sullivan, 2002; Wall, 2007), despite the ideas being evident in nursing since the late 1800s (Dock & Stewart, 1920).

Feminist theory is political and disruptive (Butler, 2004; Cuboniks, 2018; Dawson, 2021; Olufemi, 2020) and people can be uncomfortable talking about changing and disrupting what they believe they understand. But "feminist theory *"can help us understand how dominant cultural practices are an inherent part of existing power relations that a given society supports through deploying a variety of discursive and effective means"* (Fotaki & Harding, 2017, p. 2). Nursing is a gendered role and societally constructed gender norms control how nurses exist, work and navigate the world (Barker & Iantaffi, 2019). While not a road map to a solution, feminism provides a view of what has come to be understood as nursing and helps problematise the gender constructs which constrain and anchor nursing. In clear terms, feminist theory explores the impact and existence of sexism and the resulting oppression (Dawson, 2021).

This study, in looking at the highly gendered profession of nursing (Eliason, 2017; Hallam, 2000) and the masculinist worlds of policy (Scott & Scott, 2020), entrepreneurship and small business (Ahl, 2006; Marlow et al., 2009; Marlow & McAdam, 2013; Marlow & Swail, 2014), will explore the experiences of nurses transitioning within these culturally embedded views. Post-structuralist feminism describes the destabilising effect of moving away from socially constructed norms of nursing and business. To introduce the theory of post-structural feminism, the next section describes its change from structuralism.

4.3.2 Structuralist beginnings

The evolution of post-structuralism first required the development of structuralism. The beginnings of structuralism arrived with the work of Swiss linguist de Saussure (1959) whose work was posthumously published in 1916 (Sanders, 2004) as *Course in General Linguistics* (de Saussure, 1959). Structuralism could be described as a system of meaning production which makes language predictable, understandable and stable. Language is made up of words or units. However, units of language, or words, are arbitrary. Arbitrariness can be reduced with systems or sets (Lévi-Strauss, 1973). This system or "union of meaning" (de Saussure, 1959) makes the word more stable, or predictable.

Structuralism treats human culture like a language (Brabazon, 2018), structured, meaningful (Lévi-Strauss, 1973) and predictable. For example, when using the word "nurse", there is a fixed, concrete idea of a nurse linked to a hospital, linked to female, linked to femininity, linked to domesticity and linked to caring. This use of structured language fixes the idea of who a nurse is, what a nurse does and where a nurse works. In this context, society accepted nurses, but as descried by Andrews (2015) "*arguably women's position in the nation is almost inevitably as subaltern; it is always conditional."* Conditional inclusion is based on knowing one's place, not getting above one's station in life (Baptiste et al., 2021) and not creating any disruption or destabilising accepted norms. Stability and structure are challenged in post-structuralist feminism and deconstruction.

4.3.3 Post-structural feminism

In post-structuralism, language is inherently unstable (Weedon, 1997). In society, knowledge, power and language are used to position women at the margins (Beard, 2018). Post-structural feminism, rather than describing men and women, focuses on the social construction of multiple femininities and masculinities (Ahl, 2006).

> *"The plurality of language and the impossibility of fixing meaning once and for all as basic principles of post-structuralism. This does not mean that meaning disappears altogether but that any interpretation is at best temporary, specific to the discourse within which it is produced and open to challenge"* (Weedon, 1997, p. 82).

Dawson (2021) argues that feminism must constantly adjust and adapt to embrace those at the gender margins while Cuboniks (2018, p. 15) states that: *"Nothing should be accepted as fixed, permanent, or 'given' – neither material conditions nor social forms".* Feminism rejects inflexible forms and constructs of a gender binary and refutes essentialist ideas of what a woman is and does. Dawson (2021, p. xl) relates to gender as a *"spectrum rather than a binary",* a view which challenges feminism to attend to and include those who are liminal to cultural norms and who challenge socially constructed essentialist ideas of what is feminine.

Social constructs pivot on the nexus between power and certain epistemologies. The knowledge most likely to be accorded power in Western countries is found in the masculinist disciplines of science, finance, politics and law (Healy et al., 2018; Kane & Thomas, 2000; Yam, 2004). The value of these certain ways of knowing is maintained by hegemonic structures (Aranda, 2017) and institutions, by degrees, grants, fellowships, systems and accreditation. Nursing has adapted to this reality by absorbing technical specialities and the biomedical science model (Eliason, 2017). To counter this growth in nursing expertise and specialisation, the reductionist terms "mini-doctors" (Coombes, 2008; Kendall-Raynor, 2016; Ousey & Johnson, 2007; Stenner et al., 2010) and "sub (or semi) professional" (Healy et al., 2018) emerged to describe nurse prescribers, clinical nurse specialists, nurse consultants and nurse practitioners. *"So we lower our voices. Women whisper. Women apologize. Women shut up. Women trivialise what we know. Women shrink. Women pull back"* (Dawson, 2021, p. xxi). Even with an ostensibly valued scientific and expert knowledge base,

nursing is still silent, invisible and found wanting as political planners and funders decide which disciplines are of value and worthy of attention and investment.

Power, as hegemonically maintained by the masculinist disciplines, manage, use and shape docile bodies. There is an argument that nurses promote this hierarchy by their tacit actions in practise, in micro-behaviours and their acceptance and normalisation of roles (Burford et al., 2013), confirming that power not only arises from dominant disciplines, it also comes from within outwardly oppressed groups. *"Micropolitics of power which operate to sustain the dominant view of nurses. However, nurses implicate themselves in the creation of their subjectivity and are themselves agents in creating their own identities"* (Papps, 1998, p. i). In effect, nurses have and continue to engage in a myriad of micro-behaviours which cement their powerlessness.

Concepts of post-structuralism are used in this study to focus on expanding the understanding of nursing beyond the existing social constructs of uniforms, hospitals and other anachronisms about what a nurse is and does. Post-structuralism facilitates the ability to *"play with the possibility of subjectivities that are both and neither – to understand power as discursively constructed and spatially and materially located*" (Davies & Gannon, 2005, p. 2) as the liminal spaces in which the participants work, professionally and physically, are explored.

4.3.4 Deconstruction

Deconstruction as part of the post-structuralist movement was developed by French philosopher Jacques Derrida (2016) in response to the concept of assumptions (Williams, 2005) and binary oppositions, where one of the terms is always dominant or privileged (Sutton, 2018). Derrida described this not as a peaceable co-existence but as unstable identities and violent hierarchies (Newman, 2001). In deconstruction, the binaries are inverted (Derrida & Stocker, 2007), so the suppressed binary is uppermost. This creates disruption and shows power as contingent and

unstable. Deconstruction then goes further, as simply inverting the binaries retains the binaries (Newman, 2001).

Deconstruction subverts binary opposition and creates general displacement of this system where the concept of meaning or identity is never fixed, or is deferred (Derrida & Stocker, 2007), to create room for difference, ambiguity and liminality. *"In deconstruction, language is an infinite process of difference and concerned as it must be with power, looks to the historically and socially specific discursive production of conflicting and competing meanings*" (Weedon, 1997, p. 82). The description of deconstruction is important as it raises the concept of liminal spaces to work within "grey" areas and to destabilise and defer meaning. The ability to see the possibilities, to value and reflect on the "other" outside of binary constructs, is an important step for nursing.

4.3.5 The language-power nexus

Words and voices matter (Beard, 2018; Slaughter, 2016). Words can position nurses as lower value, remove authority, move nurses into a domestic sphere, trivialise the work of nurses and position nurses under hegemonic power brokers. Words are powerful tools of historical oppression (Pijl-Zieber, 2013) used by men, women and nurses to shape and describe the world.

Linguistic determinism suggests how way the world is viewed is shaped by language and words (Neuliep, 2017), but it is constraining. The language used in nursing or to describe the profession defines and sustains how nurses and nursing are perceived (Stewart, 1994). Nursing has been positioned outside empiricism and science by assumptions that caring work has no empirical or scientific foundation (Wall, 2007). There is little consideration in day-to-day work on gendered language and the positioning of nursing as an oppressed workforce. However, connection with gender theory and the concept of language and discourse as powerful tools of social order has merit, in considering how nursing identity is expressed.

Nursing as a profession is often omitted from healthcare history (Kane & Thomas, 2000; Stevenson, 1994). Foucault (1980) refers to subjugated knowledges, in which history is hidden or even disguised by a dominating system or institution. Nursing and nurses are rendered invisible (Buresh & Gordon, 2013; Mitchell, 2017) and called a "semi" or "sub-profession" (Healy et al., 2018; Lokatt, 2014) by consistent gendered oppression and the political positioning of nurses as subservient (Pijl-Zieber, 2013). The public perception of nurses lies anywhere between a ministering angel and a bullying matron (Darbyshire, 2006). The historical positioning of nurses was achieved by the use of the dominant narrative of hegemonic and empirical hierarchies (Wall, 2007).

Words and titles powerfully demonstrate how nurses were historically and politically positioned as docile (Papps, 1998) and invisible (Buresh & Gordon, 2013) in a specific space in healthcare. Words can still cause people to overlook the qualifications, skills and expertise in contemporary nursing (Stokes-Parish et al., 2020). Cabrera (2011) warned against confusing words and language. Language can create difficulties (Aston, 2016) or alternatively it can create an opportunity to reflect and analyse, to destabilise and disrupt. *"Language is not merely a means of representing reality, but also operates as a system of signification that intervenes actively in the production of meanings attributed to the real world and through which practice is organised and its meaning established"* (Cabrera, 2011, p. 32). This position is supported by Slaughter (2016) who posits that a change in language can raise the profile of the invisible, the silent and the oppressed.

The words and phrases found during this study relating to nurses in both historical and current literature are listed in table 2 (p.82). These words are laden with tradition, meaning, cultural positioning and gender.

Admirable	Grace	Paragon/paragon of perfection
Angel/angelic	Handmaiden	Persevere
Assistant	Harridan	Pious/piety
Bossy	Hero/heroine/heroic	Policy victims
Calling	Hooker	Politically apathetic
Charitable	Kind	Pretty
Chaste	Lady-in-waiting	Pure
Cheery optimism	Lady pupil	Sacrifice/self -sacrifice
Conciliatory	Matron/matronly	Selfless
Docile	Ministering	Serve/service
Domestic	Modesty	Stoic/strong
Devotion	Mothering/motherly	Subordination/subordinate
Duty	Naughty	Sub/semi-profession
Endurance	Nice	Sympathetic
Feminine/feminine ideal	Noble	Trustworthy
Forbearance	Nurturing	Virtuous
Genteel/gentle/gentlewoman	Obedient/obey	Vocation
Good	Pacific demeanour	Warrior

Table 2: Descriptors of nurses and nursing work

Slaughter (2016) asserts that how words are used is important. It is within the grasp of all to recognise agency, change the message and redress the rhetoric and narrative. Language expresses the views of the people using it and the people who write it. Foucault (1980) observed that the professions have their own languages, which he saw as mechanisms of knowledge and power. The dominant language is sustained and normalised (Davies & Gannon, 2005) when there are force relations (Henderson, 1994) and people do not consider or recognise the forces of dominance and oppression. If nursing history is not written by nurses but by social commentators, medical hierarchies and the politically dominant, then the language used is theirs, it becomes the norm, the accepted convention (Bleiker & Chou, 2010), the dominant knowledge.

The dominant language at the higher levels of healthcare is that of politics, funding and public health, not nursing. Bleiker and Chou (2010) referred to Foucault and the control of language

or discourse, elevating one group into dominance and pushing others to the margins. To raise the position of nursing in the hierarchies would require a different approach to language and somehow find equality with the dominant group. However, nurse leaders have used the language of the dominant group and worked within patriarchal systems to achieve their goals for centuries (Bennett, 2006), resulting in ongoing suppression rather than valuing of nurses and the language of nursing.

4.3.6 Patriarchy

The concept of patriarchy currently has a new lease of life (Dawson, 2021; Faludi, 2017; Higgins, 2018). It became a contested term as feminist theory followed post-structuralism and a more nuanced understanding of the mechanisms of oppression and agency. Baxter (2016, p. 43) said a radical *"post-structuralist perspective on subjectivity is its refusal to accept the modernist view that all women are necessarily victims of patriarchy*". Some feminists now suggest that if there was no patriarchy, the world would not require feminism. One cannot exist without the other (Dawson, 2021). Other feminists suggest patriarchy is too broad a term and too blunt an instrument to define the subtleties of oppression (Higgins, 2018).

Walby (1989), in a definitive but historical publication on patriarchy, defined and delineated places, strategies and forms of patriarchy, arguing it is still present in the international and amorphous institutions which wield masculine power, such as: education, law, religion, health, politics and the media. Writing after the #metoo movement, [8]Dawson (2021, p. xxx) provides a contemporary and definitive statement on the existence of patriarchy: "*With a renewed structural understanding, feminism now is both keenly focused on differential oppression, as well as comfortable again with the juggernaut concept of patriarchy".* Definitions and descriptions of patriarchy suggest it is agile, resilient and tenacious (Myrttinen, 2019).

[8] XXX is the page number

In healthcare, the highly paternalistic activities of medicine helped shape the subjectivity of nursing and the public. "*This finding reflects the reality that patriarchy is not a homogenous system of oppression, but rather a malleable one that differentially shapes the structures of different occupations and sectors*" (Agarwala & Chun, 2019, p. 12). This can be seen in examples of unconsciously accepted oppression in healthcare (Fletcher, 2006). For example, when doctors delegate time consuming, repetitive procedures to nurses (Clayton-Hathway et al., 2020), they position the act as a show of trust, when in reality it is a task they no longer wish to perform (Coombes, 2008). Another example is using reductionist language about nurses with advanced practice who may be perceived as professionally threatening, to position them as less important and of a lower professional standing (Coombes, 2008; Kendall-Raynor, 2016; Ousey & Johnson, 2007; Stenner et al., 2010).

The concept of patriarchy within this study is still valid and appropriate in the review of the participants' experiences, not only in healthcare, but also in the highly gendered space of self-employment and entrepreneurship.

4.4. Combining theoretical approaches

Feminist and liminal theories are combined in this study to provide a comprehensive approach for considering this non-traditional group of nurses. The management and challenges of marginal spaces, professionally and physically, as well as straddling the feministic and masculinist spaces of nursing and policy respectively, creates a complex picture and requires multiple frameworks. These approaches are supported using an ethnographic method which provides an appropriate way of examining the subject.

4.5 Ethnography

Ethnography is a method of exploring a culture or a group using interviews and observation. Roper and Shapira (2000, p. 1) position ethnography as a method of "*learning about people by learning from them*". As a naturalistic form of enquiry, ethnography examines human behaviour, beliefs, values, activities and communication. Ethnography emerged from anthropology in the late 1890s (Holloway & Galvin, 2017; Roper & Shapira, 2000) and for decades afterwards, classical ethnography involved spending time observing and taking notes on the everyday lives of cultures different to that of the researcher (Polit & Beck, 2012). Ethnographers would immerse themselves, often for long periods, in a culture or society, capturing all aspects of the subjects. This is data collection as a participant observer (Boyle, 1991; Knoblauch, 2005; Roper & Shapira, 2000) in which the researcher, by being present, observing and asking questions, is directly involved in the phenomenon or culture being studied.

Data capture in ethnographic methods requires a researcher to have practised skills in observation and interviewing, and will generally create three different perspectives (Polit & Beck, 2012). The perspectives include: the emic or insider view (how those being studied see their world), the etic or outsider view (whereby researchers interpret what they have seen) and the reflexive aspect (in which a researcher will capture their own responses, enabling a deeper understanding of the situation and possible biases) (Roper & Shapira, 2000). Polit and Beck (2012) also introduce the concept of tacit knowledge as information which the group being studied may not talk about nor even be consciously aware.

Nurses are often well prepared for ethnographic methods with well-honed skills in observation, the ability to build relationships (Leavy & Harris, 2019) and training in enquiry, assessment, reviewing and making decisions using a variety of information sources. The observation, participation and questioning aspects make ethnographic methods a familiar process when applied

to nursing research (Higginbottom et al., 2013; Leininger, 1985). Ethno-methodologies derive from ethnography to suit a specific type of research or enquiry. Focused ethnography is one such method and is the chosen method for this study.

4.5.1 Focused ethnography

Focused ethnography addresses the two principal aims of this study: to observe work settings and to describe experiences using the words of those being studied. It is an inductive approach (Roper & Shapira, 2000), sometimes described as micro-ethnography or mini-ethnography (Holloway & Galvin, 2017; Holloway & Wheeler, 2010; Morse, 1991; Polit & Beck, 2012; Roper & Shapira, 2000; Streubert & Rinaldi Carpenter, 2011). Focused ethnography is an innovative research method with the capacity to focus on elements of the researcher's own culture or society (Knoblauch, 2005). In this study, the participant group is my own society (Aotearoa NZ nursing) since I have personal experience in the role being studied (self-employed nurse contractor). This kind of researcher experience is described as "insider research" (Wall, 2015b) or the emic perspective (Holloway & Galvin, 2017; Polit & Beck, 2012). Insider research can be culturally specific and provides a level of pre-understanding for a deeper probing of the topic (Berger, 2015; Brannick & Coghlan, 2007; Holloway & Galvin, 2017).

Focused ethnography is an excellent method for solo researchers (Cruz & Higginbottom, 2013; Higginbottom, 2011; Mueke, 1994; Roper & Shapira, 2000; Wall, 2015b), enabling a focus on: a specific community group, a specific skill-set or knowledge base and a limited number of participants, along with increased flexibility on requirements for participant observation. This form of micro-ethnographic research is appropriate to detail cultural shifts or changes within a group (Holloway & Wheeler, 2010), and therefore appropriate for this study.

4.6 Summary

The theoretical framework of the study was described in this chapter, exploring both gender theory and liminality as philosophical stances through which data is viewed. Gender theory led to an overview of post-structuralist feminism and deconstruction, with the concept of unstable identities and deferred meaning in relation to the understanding of what a nurse is and does.

The words of oppression and the impact of linguistic determinism was explicated using examples from historical and contemporary nursing literature describing nurses and the deprivileging of femininities as a form of social control. Patriarchy was described, positioning this polarising term in the context of private and public patriarchy in self-employed and nursing spaces.

Liminality theory was introduced as a theoretical lens for the study. Contemporary developments in liminality theory support its use in the work-role transition and broaden the concept of liminality as potentially a long-term or even permanent state. Liminality has resonance with the chosen methodology for the study of focused ethnography, the development of which has been outlined. The next chapter will focus on the research method where the research is explicated to confirm the study is underpinned by robust processes.

Chapter 5: Research method

5.1 Introduction

The research method is presented in this chapter, building on the methodology of focused ethnography introduced in the previous chapter. The initial approach included mind mapping and adopting an entrepreneurial framework. This developed into a base on which a set of questions was created to guide the participant interviews. It describes the testing phase and use of reflexivity to fine-tune the questions and prepare for participant interviews. The research process is outlined, including ethics approval, sample size, criteria, sampling processes, role of the researcher as an insider, coding and data analysis.

5.2 A qualitative approach

The intent of this study is to explore the experiences of a specific group of nurses who have chosen a less well-known career direction. The nurses are a distinct sub-group within the nursing profession with a particular set of experiences and skills which are unusual in wider nursing profession. The study aims to describe experiences which indicates a qualitative approach, best suited for person-centred description (Holloway & Galvin, 2017) and most appropriate for the research question.

The research question was: ***What are the experiences of Aotearoa NZ registered nurses working as solo self-employed nurse contractors in non-traditional workplaces?*** The study explores their unique experiences and how and where they manage their day-to-day work. These aims lend themselves to a method by which experiences can be relayed using the words of the participants, enabling insights which enhance understanding (Smythe & Giddings, 2007) of their work and environments. The most appropriate way to explore and describe not only experiences but also work spaces was using an ethnographic methodology, in this case focused ethnography.

The ontological approach has a relativistic lens in which each participant has a different interpretation and knowledge, as do I, the researcher (Braun & Clarke, 2013). Epistemologically, the study has a feminist (Longino, 2017) and an inductive approach, also acknowledging the impact on the direction and research questions from my own experience (Ormston et al., 2014) as a nurse and a self-employed knowledge worker.

5.2.1 The application of focused ethnography in this study

Focused ethnography is a relatively new and flexible ethnomethodology which enables research into previously unexplored contemporary cultural/ social contexts and phenomena (Wall, 2015b). This section will outline the focused ethnographic method and its application in this study utilising categories adapted from Higginbottom et al. (2013), Cruz and Higginbottom (2013) and Wall (2015b).

- **Commonly used in nursing**: The application of focused ethnography enables a methodologically flexible approach and is identified as appropriate for nursing research (Cruz & Higginbottom, 2013; Higginbottom, 2011; Stahlke Wall, 2011b; Wall, 2015b) and is described by Holloway and Galvin (2017) as ethno-nursing.

- **Solo researcher**: As a micro or mini ethnographic method focused ethnography suits solo-researchers. Rather than the traditional immersion in different cultures for long periods of time, focused ethnography enables episodic participant contact and a truncated ethnography achievable by a solo researcher (Knoblauch, 2005).
    - **Emic research;** Focused ethnography facilitates the exploration of specific questions using an the emic perspective (Holloway & Galvin, 2017; Rashid et al., 2019) or "insider research" (Brannick & Coghlan, 2007; Dwyer & Buckle, 2009), as applied in this study. There is a view, particularly in focused ethnography, that having this prior understanding

improves access to the groups being studied and also enables a deeper probing of the subject (Brannick & Coghlan, 2007). Dwyer and Buckle (2009, p. 55) support an "*insider epistemology*" suggesting this creates a sense of belonging (Berger, 2015), shared language (Holloway & Galvin, 2017; Smythe & Giddings, 2007) and experiences within the group (Leavy & Harris, 2019) and an even greater acceptance or membership of the group being studied. For example, the insider stance enabled a stronger sense of connection and ability to talk freely (Leavy & Harris, 2019) knowing there was understanding and it was a relief to talk to someone who understood, as friends, family and colleagues often did not.

- **Observation:** Participant observation is an inherent component of traditional ethnographies (Roper & Shapira, 2000; Simonds et al., 2012) but in focused ethnography there is a flexibility (Cruz & Higginbottom, 2013; Wall, 2015b). Short or episodic visits may be utilised (Knoblauch, 2005) and observation achieved online and in some cases eliminated altogether (Higginbottom et al., 2013; Wall, 2015b).
    - ***The participant observation*** component in this study took the form of:
        - A review of the online presence of each of the participants.
        - Observation of the participant's working space.

In line with the findings of the literature review and mapping exercises, this "invisible" workforce is situated away from the traditional settings of clinical care, or administration. Wall (2015b) noted in her study of self-employed nurses in Canada that these nurses were creating spaces which reflected their own practise values and professional identities. In this study a brief tour of the participants' workspaces reviews the importance of having a positive work environment while highlighting the various barriers (Myrie & Daly, 2009) and rules to help manage the experience of working and living in the same space. DePoy and Gitlin (2016, p. 256) described

this as *"non-participatory observation"* in which the observer does not take an active role but can review contexts and settings which are part of the focus for the study.

- **Context specific/ limited number of participants:** Focused on a discrete community or social phenomena. Described by Knoblauch (2005) as social research in alternative dispersed and specialised fields, which may result in low participant numbers.
    - ***Specialised:*** Participants with particular experience or knowledge of a topic or field of work (Cruz & Higginbottom, 2013; Higginbottom et al., 2013; Wall, 2015b)
    - ***Alternative:*** Participants who may not know or be aware of each other but have attributes, behaviours, practice patterns (Higginbottom et al., 2013) or skills in common which meet the focus of the study (Wall, 2015b).
    - ***Dispersed:*** Creates opportunity to study those individuals who may be isolated geographically and/or professionally but have commonalities (Simonds et al., 2012). To interview and observe individuals in isolated practice who would otherwise not be studied is a particular strength of this method (Wall, 2015b).

- **Precedent:** The use of focused ethnography for researching self-employed nurses was established by Stahlke Wall (2011b); Stahlke Wall (2017); Wall (2015b) with participants who were geographically and professionally dispersed, alternative and specialised.

5.2.2 Reciprocity

The practice of reciprocity in research was first described by Wax (1952) as a field technique for anthropologists. Reciprocity is a valuable tool for the feminist ethnographer enabling researchers with an established understanding of the context, to not just be accepted, but to reciprocate as appropriate with advice and support for the participants (Leavy & Harris, 2019). I am situated as an insider within this area of nursing, running my own business as a nurse consultant for many years.

As I interviewed the participants, I found shared experiences and language which the participants found unusual and valuable. To at last be able to talk about what they do and have someone understand their practice context (Leavy & Harris, 2019; Wax, 1952) was, in some cases, a relief. In the interview and subsequent conversations were moments of reciprocity, where my experience in the practice field was relevant to support a learning process for the participant, or to have a conversation where mutual support and understanding was refreshing and invigorating for this potentially isolated group.

The concept of reciprocity involves freely giving something both parties need (Wax, 1952). The participants had taken time out of their busy lives to participate in the interview. I believed it should be a positive experience for them. Reciprocity is something familiar to nurses who have a shared set of experiences and what some describe as a "sisterhood" (Fowler, 2017). In this case, the nurse participants had a distinct set of experiences, unknown by many, but familiar to me as the researcher. Reciprocity in this study was observed in the respect, shared understanding, shared language, experience and practical tips present during the interviews which enabled a safe, empowering, non-oppressive (Carryer, 1997) and positive dialogue, a strong feature of this feminist ethnographic study.

5.2.3 Reflexivity

Reflexivity is an important part of qualitative research (Braun & Clarke, 2013; Holloway & Galvin, 2017), feminist research (Dowling, 2006; Stewart, 1994) and also of ethnographic methodologies (Berger, 2015; Dowling, 2006; Koch & Harrington, 1998; Rashid et al., 2019). Higginbottom et al. (2013)described reflexivity as a process commonly seen in focused ethnography by which a researcher maintains an awareness of themselves, their point of view and their understanding of a context or set of experiences. *"It is about bringing awareness to how our*

perception, thinking, and perspective is dynamically shaped by our culture, age, gender, social status, personal history, languages, values, and experiences" (Rashid et al., 2019, p. 3). Addressing my own epistemological reflexivity, assumptions, beliefs and worldview and how these might affect the research and engagement with the participants (Dowling, 2006) was the beginning of a significant shift in my worldview.

5.2.4 Credibility, transferability and trustworthiness

Credibility, transferability and trustworthiness (Holloway & Galvin, 2017) were established in multiple ways.

- **Credibility:** The [9]theoretical and contextual framework (Fig.2, p.106) was sent to each of the participants. The six who responded showed strong resonance with the model. Though they did not understand all the component theories, such as liminality theory, they could engage with the concepts used in the model. The theoretical framework was also reviewed by the thesis supervisors as it evolved.

- **Transferability:** A practice interview was conducted with a non-nursing friend, also a female solo-self-employed professional, to test the study questions. The interviewee engaged with all the questions and was able to reinforce the usefulness and transferability of the study. I have also discussed the major concepts of this study with a wide variety of nurses and people from other professional groups for whom the study has resonated. However, Braun and Clarke (2013) posit that ultimately the reader decides whether transferability is achieved.

[9] Appendix 7, p.249

- **Trustworthiness:** Consideration was given to the issue of trust and the honesty of participants in answering the interview questions. The participants stated they enjoyed the interviews and were comfortable in answering the questions and all participants reviewed their interview transcripts prior to their use in this research. The transcripts were also discussed with the supervisors.
    - **Reflexivity:** An important aspect of focused ethnography, particularly for a researcher with an emic perspective. *"Reflexivity will allow the researcher to establish validity of the phenomena being studied and that it is not just an expression of his or her ideology"* (Cruz & Higginbottom, 2013, p. 42).
    - **Reflexive interview:** I underwent a reflexive interview conducted by an experienced senior nurse interviewer, to reveal my pre-existing biases or assumptions.

5.2.5 Ethics

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 17/59. Ethical considerations were presented using the ethics questions framework from Holloway and Galvin (2017, pp. 66-69), apart from te Tiriti o Waitangi section, included because this study was undertaken in Aotearoa NZ.

- **Informed consent**:[10] The research advertisement was launched in relevant nursing networks and through individuals.[11] The participants were given an information sheet and then consented at the time of interview [12]using a written consent form.

[10] Appendix 2, p.242
[11] Appendix 3, p.243
[12] Appendix 4, p.245

- **Privacy/confidentiality**: The participants were asked to select a pseudonym for the research. Care was also taken not to identify the participant from nuances of speech or reference. Any specific person or organisation named in the data was redacted during the transcription approval process to maintain privacy. Each interview was conducted in a private location of the participant's choice, usually their home-office, but others were conducted online. The transcribers also signed confidentiality forms. Each participant could review and make changes to the transcripts before signing a transcript release form. The requirements of the Massey University specifications for research were all adhered to.

- **Nonmaleficence/beneficence**: The interviews did not contain any sensitive, distressing or disturbing questions. The interviews were scheduled to last between 60 to 90 minutes.

- **Fairness/justice**: The only potential conflict of interest would have been information for the researcher on possible sources of future employment inadvertently received from the participant. Because of this, no details on the participants contract holders were discussed, only the general method of finding contract work.

- **Data protection**: Electronic data was stored on a password-protected hard drive accessible only by the researcher. Paper transcripts and consent forms are stored when not in use in a locked fireproof filing cabinet in the researcher's office. All data will be kept for five years.

- **Te Tiriti o Waitangi/The Treaty of Waitangi**: The project was discussed with the Director of Nursing, Te Ōhanga Mataora Paetahi and Te Whare Wānanga o Awanuiārangi who agreed to support the researcher and to be available to advise participants if issues arose pertaining to culture.

5.2.6 Participant selection

Self-employed RN participants inclusion criteria:

- Aotearoa NZ RN
- Current APC
- Practice area: Professional advice/policy
- Non-clinical practice
- Owner/operator of limited liability company or sole trader
- Providing contracted services to the Aotearoa NZ healthcare sector as a RN e.g., project manager, quality auditor, external management consultant, policy analyst
- [13] Solo self-employed (no employees or partnerships)
- Full-time or part-time
- [14] No other employment
- [15] Within 10 years of start-up (2007-2017)
- Willing to allow observation of office/work space

5.2.7 Sampling

Volunteers were sought using purposive and snowball sampling (Minichiello et al., 2004; Polit & Beck, 2012) across relevant national nursing networks. Purposive and snowball sampling are commonly used methods for a focused ethnographic approach, whereby the participants have a particular knowledge, experience or skill set which is of interest to the research (Higginbottom et al., 2013). When a potential participant made contact, an initial email was sent to introduce the

[13] Nurses employing others bring issues regarding PAYE, Human Resources and performance management. The study focuses on solo-self-employed nurses to explore, in part, the experience of moving from a "traditional model of a health team" to a solo role.
[14] It was important for the study that the participants relied on the income from their self-employment.
[15] This enabled a review of participants who could clearly remember their business set-up and had done so across a period when healthcare providers, healthcare funding mechanisms and nursing structures where reasonably consistent.

researcher and deliver the information sheets for consideration. Interview arrangements were made to suit both parties.

There were 13 participants in the study which, according to Holloway and Galvin (2017), is a reasonable size for a qualitative study focusing on a small specialist subset, this is also complimented by the use of focused ethnography (Higginbottom et al., 2013). The total number of nurses identifying in this practice area as self-employed in 2018, the interview year, was 24. Some of those did not meet the inclusion criteria e.g., some had secondary employment.

5.2.9 The participants

This section introduces the 13 participants. Qualitative data presentation can result in the fragmentation of participant views, mixing them into themes and snippets of information (Carryer, 1997; Holloway & Galvin, 2017) to create a broader picture. So, a brief introduction offers presents each person more fully while maintaining their anonymity. Note: this group forms a tiny proportion of the nursing workforce and, as a result, were reasonably easy to identify. Therefore, the introductions are general and do not specify location, identifiable characteristics or specific types of work. Pseudonyms were selected by the participants.

- **Billie:** Self-employed in her limited liability company for 8 years. Billie had significant experience working at a senior level in both regional and national roles. She describes an often-erratic workload, sometimes busy, sometimes quiet, although the quiet times leave room for her PhD study. She enjoyed the freedom of self-employment and the working environment. She lived in a stable environment with a supportive family.

- **Jacqui:** Self-employed as a sole trader for approximately 6 months. Jacqui had long experience in a senior position working at a national level and had a PhD. She described having enough work

but was concerned about a lack of long-term contracts. She enjoyed some aspects of self-employment but was highly career focussed and preferred a full-time employment. She had a stable and supportive family environment.

- **Jayci:** Self-employed in her limited liability company for 18 months, Jayci had previously been self-employed in Australia before returning to Aotearoa NZ. She worked for organisations in a quality-based role. Jayci had plenty of work and enjoyed the freedom of self-employment. She was considering retirement. Jayci had a supportive family and stable situation.

- **Jeanette**: Self-employed as a sole trader for 14 months, Jeanette was previously employed in a senior regional role. Jeanette had contracts but was concerned about long-term work and income. She enjoyed the flexibility and freedom of self-employment after frequent restructuring in her previous organisation. Jeanette had a supportive environment and family.

- **Jessie:** Self-employed in her limited liability company for 6 years, Jessie previously held local, regional and national roles, with a relatively high profile. Jessie had numerous contracts and described often working over 40 hours a week. She was confident with the self-employed model and enjoyed the freedom and the flexibility. Jessie had no plans to return to an employed role and lived in a stable environment with a supportive family.

- **Jill:** Prior to working in her limited liability company for 4 years and 6 months, Jill held senior regional roles with a national profile. Jill described working on local, regional and national projects, and had no plans to return to an employed role. She enjoyed the diversity of her work and was supported by a stable family and environment.

- **Lou:** A self-employed sole trader for 4 years 6 months. Lou previously held a senior position in a large regional organisation. In her capacity as a contractor, she had one main contract and some fragmented work. She enjoyed the freedom and flexibility in her life. Lou had considered retirement as her next step. She had a stable family and environment.

- **Margaret:** A sole trader for 6 months, Margaret had worked in a senior role at a local/regional level and had a PhD. Margaret had struggled to find contracts and had no significant contract income. She was disappointed more work had not been forthcoming, despite her skills and experience. Margaret was reviewing her options for more contract work was considering a move back into an employed role. Margaret had a supportive family and environment.

- **Mary:** A sole trader for 3 months, Mary previously worked at a senior regional level. She had one contract at the time of interview and was uncertain about the environment of contracting in relation to work and payment levels. She left open the option of returning to a full-time employed role should the right position become available. Mary had a supportive family and ability to work from home.

- **Nancy:** Working in her limited liability company for 2 years, Nancy had previously held a senior local level role. She had a variety of contracts and was positive about the freedom and flexibility of self-employment. She was open to a part-time employed role, mixing it with self-employment and/or study. Nancy had a supportive family and environment.

- **Sally:** In her limited liability company for 3 years, Sally had previously worked at a senior local level. Sally was very busy with contracts and found the flexibility and freedom a positive aspect of self-employment. Sally had no plans to return to an employed role but would not rule it out should the right position appear. She had a stable home life, family and environment.

- **Susan:** Self-employed in her limited liability company for 5 years and 3 months, Susan had previously worked at senior national and international levels and had already been self-employment some years prior. Susan described her work life as extremely busy. She was confident with self-employment and was able to move in and out of contracting. Susan had a stable home life and work environment.

- **Tash:** Self-employed in her limited liability company for approximately 2 years and 5 months, Tash had work experience locally, regionally and nationally and had a PhD. She had a busy work-life. Tash enjoyed the freedom of self-employment and had no plans to return to an employed role. Tash had a supportive family and stable environment.

To further position the group in preparation for the presentation of data, further non-specific data is helpful. At the time of the interview 7 different titles were used by the participant group: nurse consultant (x4), independent consultant (x2), health consultant (x3), director (x1), health policy and management consultant (x1), registered nurse (x1) and consultant (x1). As a result, only five of the 13 were actively using their "nurse" title.

The age range of the participants included one participant under 45 years old, others in their 50s and a couple aged over 60 who were considering retirement. Hodges (2012) contended for self-employment that age matters since in the "knowledge economy" experience, education levels and expert skillsets are highly valued. The participants had high educational levels. Nine had completed a Master's degree, three had achieved PhDs and one was a PhD candidate. The remaining four participants had postgraduate education. All participants had held senior positions in nursing and/or healthcare either regionally, nationally or internationally.

5.2.10 Development of interview questions

Developing a research process required identifying relevant topics to the question. This was achieved using mind mapping techniques (Eppler, 2006) of colours, shapes, associations, links and my own experiences as a self-employed nurse. Mind mapping enables a creative "freeing-up" of the thought process and, as described by Eppler (2006, p. 202), can *"enhance motivation, attention, understanding and recall."* [16] The results of the mind map were then transferred to a MS Word document to build a more logical flow. This provided a broad overview of study which fit into four key areas:

- Nursing context
- Aotearoa NZ small business context
- Characteristics/traits/skillset of self-employed RN
- Running a business

This exercise proved vital in guiding a comprehensive literature search. The literature on nursing self-employment and entrepreneurship matched the key areas, validating the process.

Interview questions were developed using key areas from the mind mapping exercise and the Entrepreneurship Competence Framework (EntreComp), developed by Bacigalupo et al. (2016) on behalf of the European Commission. The framework has three sections with 15 segments and matched the topics created in the initial mind mapping exercise. This provided a clear framework covering all aspects of setting up a business. [17]The EntreComp model (Fig 2. p.100) is supported by useful descriptors for each segment. The competence levels were not used to develop questions for the participants in this study as competence is not being assessed. But the segments provided a guide to the question order and structure (Bacigalupo et al., 2016, p. 11).

[16] Appendix 2, p.240
[17] Appendix 5, p.246

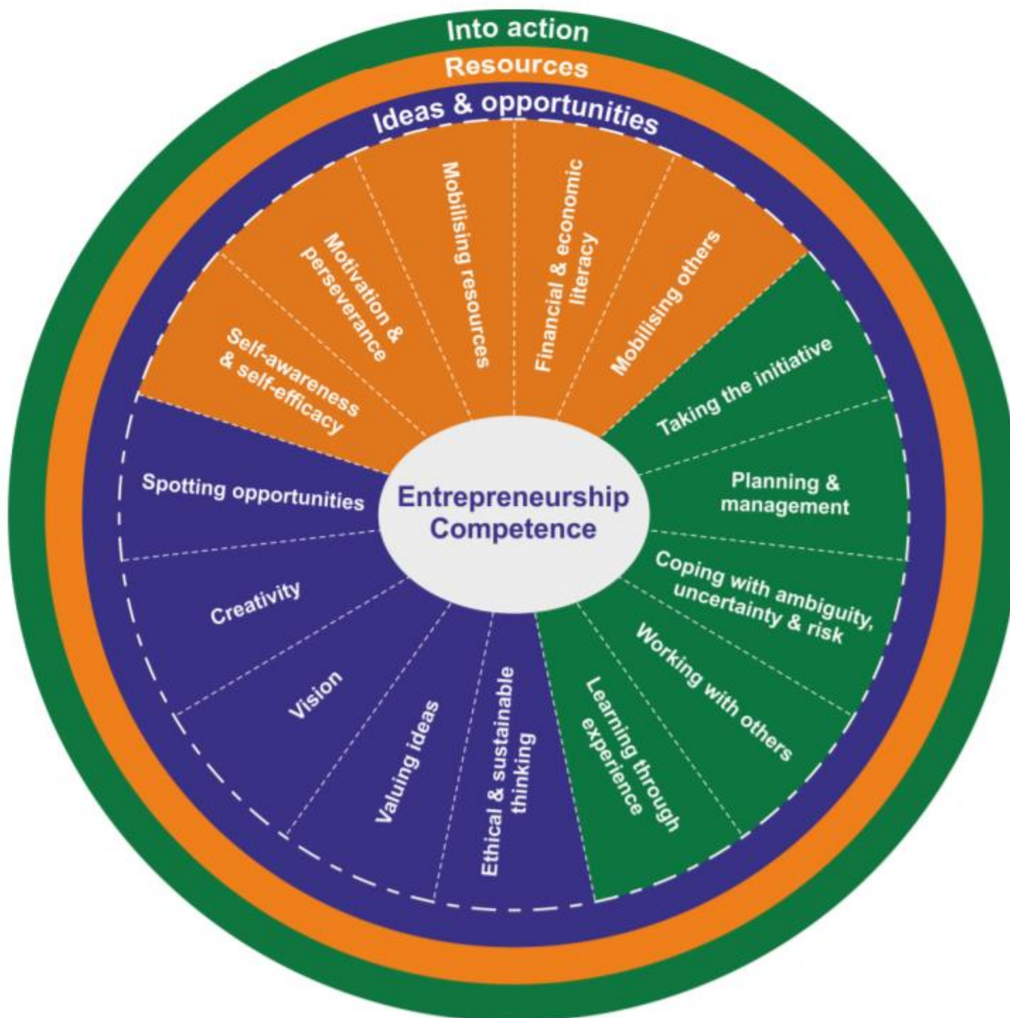


Figure 1: EntreComp conceptual model

Early feedback and reflection suggested basing questions on the EntreComp framework (Bacigalupo et al., 2016) could be too rigid, too focused on entrepreneurship and would not allow the interview to flow. Munhall (2012) showed that different reflexive approaches may be required to maintain rigour and study integrity. In this case, I re-examined my use of this model, how it was applied in the interviews and if it had too rigidly driven the direction of the participant questioning.

Testing enabled fine-tuning, verification of the questions and a check on interview flow. I also undertook a reflexive interview with an experienced academic interviewer using the developed question schema to take notes and observations. This reflexive process enabled a review of the

framework in relation to my own experience (Court & Court, 1998; Polit & Beck, 2012), to be aware of my own voice in the study (Munhall, 2012), to enable fluidity with the questions and to surface some of my own thoughts and ideas about my own experience as a self-employed nurse.

5.2.11 Semi structured interviewing

This study used semi structured interviewing, (Drever, 2003; Holloway & Galvin, 2017) which is commonly used in focused ethnography (Higginbottom et al., 2013). This method uses questions as a guide to pick up on any areas not covered by the participants in the general flow of conversation. DePoy and Gitlin (2016) support the use of semi structured interviewing in inductive research as it enhances a study's purpose and focus. There was no hierarchy to the questions (Bacigalupo et al., 2016) and the order depended on the flow of each interview. The interviews had a logical but flexible base providing a level of consistency while prompt and probe questions encouraged expansion on answers of particular interest or that were pertinent to the research.

Data were collected by video and audio recording of the interviews, appropriate for focused ethnography (Higginbottom et al., 2013). Video recordings captured participants' facial expressions and body language and enabled the researcher to focus on listening and conducting the interview (Braun & Clarke, 2013; DePoy & Gitlin, 2016). Video also let the researcher observe how a participant engaged with their work environment.

The participants were based all over Aotearoa NZ. Video interviews were initially planned for those participants, who were geographically distant, as an alternate method of conducting an interview (Higginbottom et al., 2013; Wall, 2015b), considering such technology is commonly used by nurses to conduct their business. Early in the study, two online interviews were undertaken to both ask the questions and to observe the office environment. In both instances, video interviewing resulted in a poor-quality audio recording and a stilted interview, with screens freezing due to

unreliable broadband connections. This is in stark contrast to the high-quality discussion achieved with face-to-face interviews. To ensure a higher quality interview experience, all remaining interviews were conducted face-to-face.

5.2.12 Selective coding and data analysis

Manual data analysis was chosen for this study, a common methodology for qualitative studies and an appropriate fit for focused ethnography. Combining coding guidance from Holloway and Galvin (2017) and selective coding and thematic analysis (TA) from (Braun & Clarke, 2013) (Braun & Clarke, 2012; Braun & Clarke, 2021).

Raw data was first transcribed into MS Word documents with identical formatting. These were then read alongside the audio to ensure accuracy. Once the transcripts were appropriately prepared, they were all reviewed again alongside the audio/visual recordings (Holloway & Galvin, 2017; Holloway & Wheeler, 2010). Coding was undertaken by categorising associated instances (Braun & Clarke, 2013; Holloway & Galvin, 2017) initially using colours to highlight the relevant sections and to facilitate data reduction. The aim of this "pre-analytic" (Braun & Clarke, 2013) process is simply to form data into useable sections or categories. However, for an emic researcher *"It also requires pre-existing theoretical and analytical knowledge that gives you the ability to identify analytic concepts that you're looking for, and where that instant starts and finishes"* (Braun & Clarke, 2013, p. 206). Sections related to nursing and business were followed by 10 upper-level general categories and 56 lower-level, specific data categories.

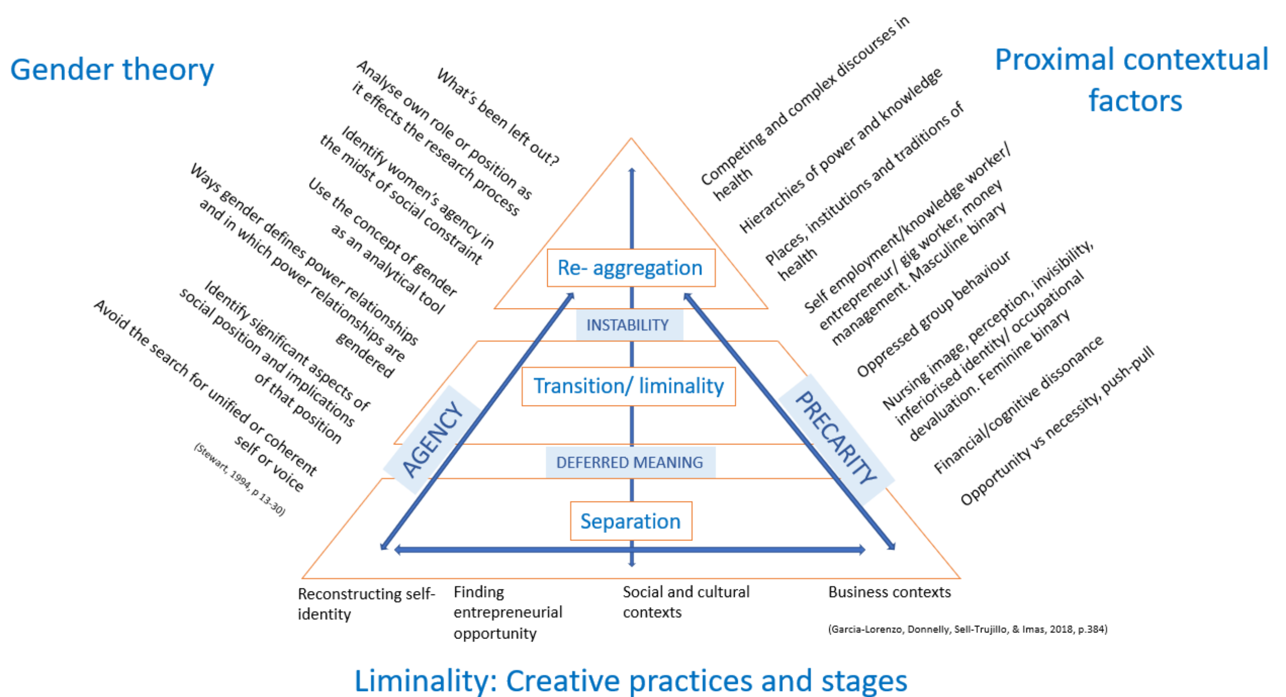
The initial approach was *" Inductive TA: Aims to generate an analysis from the bottom (the data) up; analysis is not shaped by existing theory (but analysis is always shaped to some extent by the researcher's standpoint, disciplinary knowledge and epistemology*)" (Braun & Clarke, 2013, p. 175). However, as the study evolved and the theoretical framework became clearer the approach of

"Theoretical TA: Analysis is guided by an existing theory and theoretical concepts (as well as by the researcher's standpoint, disciplinary knowledge and epistemology)" (Braun & Clarke, 2013, p. 175) also resonated, particularly as the theoretical and contextual framework (Fig 2, p.106) developed. Recently, Braun and Clarke (2021) have described the problems encountered by being too prescriptive when using a TA method, as TA approaches share characteristics and a highly flexible approach, as demonstrated in this study.

The results of data merging, reduction, revisions and being prepared to let things go (Braun & Clarke, 2013) are found in the examples of theme and category development (App 6, p.247). Once themes became apparent the theoretical and contextual framework (Fig 2, p.106) was used to consider the data in more depth using liminality, gender and proximal contextual factors. Ultimately the sections clearly fit within the three main phases of liminality as described by Garcia-Lorenzo et al. (2018).

5.2.13 A theoretical and contextual framework

Interpretation of the data required the development of an approach which could encompass a large array of theoretical and contextual considerations, tensions, beliefs, traditions, views and experiences, reflecting the use of thematic analysis (Braun & Clarke, 2013). **A framework was developed throughout the study as new ideas and findings required different shapes and levels of relevance**. A diagram (Fig 2, p.106) was developed and used throughout to ensure the theoretical frameworks of liminality and gender, and the proximal contextual factors from the literature review, were considered for each statement, category and theme. It captures the complexity of the environment in which the participants were positioned: geographically, professionally, experientially, socially, creatively, contextually and liminally.



[18]*Figure 2: Theoretical and contextual framework*

- **Liminality: creative practices and stages,** as described by Garcia-Lorenzo et al. (2018), forms the base of the triangle as a strong underpinning theory with the potential to move along the continuum. The centre of the triangle contains the stages or phases through which the participants will transition. The phases of liminality are fluid and, in some cases, participants may remain in the liminoid state (Garcia-Lorenzo et al., 2018). The phases are also present in the 3 sections of the triangle: separation, transition and re-aggregation. A full description of liminality theory is found in chapter 4.

- **Agency, instability and precarity** are present throughout the phases of the participant's experience.
    - Agency is possible when people can review their subjectivity and raise their consciousness to view and pursue a different way of being (Burr, 2015). In healthcare,

[18] Appendix 7, p.249: Larger image

dominant discourses centre on powerful masculine structures and hierarchies which are resistant to change. *“Whereas power is always subject to reversal, states of domination are static, ossified relations of power”* (McLaren, 2002, p. 39).

- Instability reflects the potential for a destabilising effect when people experience liminality, which can be a creative time of renewal with extraordinary accomplishments (Mälksoo, 2015). Instability is also a feature of post-structural feminism, in which meanings can be deferred and destabilised.

- Precarity emerges in self-employment (Agarwala & Chun, 2019; Petriglieri et al., 2018b; Wall, 2015a) and entrepreneurship when workloads and income are erratic and unpredictable. This phenomenon happens to knowledge workers (McKeown, 2005) as a financial precarity and professional liminality (Eikhof, 2016; Garcia-Lorenzo et al., 2018).

- **Gender theory** is represented on the left side of the triangle using the work of Stewart (1994). This enables data to be approached from a feminist perspective to ensure key considerations are repeatedly applied to data. Post-structural feminism is a philosophical stance, not a method (Longino, 2017), and as such the process of analysing data can be unclear. I needed to attend to my own views and biases when dealing with data to ensure the reflexive research component was maintained (Mauthner & Doucet, 2003). This was achieved with a strategy developed by Professor Abigail Stewart, Distinguished Professor of Psychology and Women’s Studies at the University of Michigan, who saw value in taking a considered process to approaching data from a feminist perspective. It offered thoroughness when considering data themes and categories. Stewart’s seven-step approach below is presented as it applies to this study.

- *"Look for what's been left out"* (Stewart, 1994, pp. 13-18): Over the centuries, nursing has been largely left out of history, theory and research (Kane & Thomas, 2000). The broad understanding of a nurse and nursing relates understandably to general clinical nursing (Prebble & Bryder, 2008) and mostly to the hospital environment. In this section, *"the strategy of resisting the 'canon' or currently accepted definition"* (Stewart, 1994, p. 13) is suggested. This study's participant group was not a part of the canon or the currently accepted definition of a nurse or nursing, but did have impact and influence, and for that reason was worthy of study.

- *"Analyse your own role or position as it affects your understanding and the research process"* (Stewart, 1994, pp. 18-21): Reflexivity was a key component of this study and sat well within not only the feminist lens but also within the research method of focused ethnography (Berger, 2015; Dowling, 2006; Koch & Harrington, 1998).

- *"Identify women's agency in the midst of social constraint"* (Stewart, 1994, pp. 21-23): Paternalism, hegemonic institutions and structures have oppressed nurses for centuries, but oppression does not define nurses. Nurses have agency. Nurses in Aotearoa NZ are now a degree-prepared profession, with a growing number undertaking Master's and doctorate-level education. Nursing is ready to *"negotiate, contest or overturn dominant subject positions"* (Baxter, 2016, p. 43).

- *"Use the concept of 'gender' as an analytic tool"* (Stewart, 1994, pp. 23-25): Nursing has always been highly gendered (Eliason, 2017; Wall, 2007). The entrepreneurial domain is also highly gendered (Ahl, 2006). The participants were business owners but also nurses, placing them into a feminine binary aligned with emotion and caring roles, despite high-level academic qualifications. Each aspect of this study explores a gendered component.

- *"Explore the precise ways in which gender defines power relationships and in which power relationships are gendered"* (Stewart, 1994, pp. 25-27): In healthcare, the masculinist domains of medicine and money management are more powerful and socially valued, certainly from the policy and political perspectives. How the participants encountered and managed power relationships and engaged with their less powerful nursing backgrounds, was explored.

- *"Identify other significant aspects of an individual's social position and explore the implications of that position."* (Stewart, 1994, pp. 27-29): The impact of privilege, financial security, family support and education were all explored, along with assumptions that someone working from home would perform household chores. These multiple social relations and gendered dimensions (Wall, 2007) uncovered inherent complexity and instability.

- *"Avoid the search for a unified or coherent self or voice."* (Stewart, 1994, pp. 29-30): The study does not look for homogeneity, but instead explored difference. Everyone has a unique experience of the world. In the past, nurses were presented as an oppressed, homogenous group dressing, behaving and believing in the same way. The concept of "woman" is different for everyone. Likewise, the concept of "nurse" is unstable and meaning is deferred. In this study, the word "nurse" was used since the participants all had valid APCs, but they were not the same as other nurses nor as each other.

- **Proximal contextual factors** are represented on the right side of the triangle. These were developed not only from the literature search and gender concepts, but from the historical perspectives on the development and control of nursing over time. Theories such as vertical

discounting (Anderson et al., 2020) and oppressed group behaviour (Dubrosky, 2013; Young, 2011) are also present. The concept of push/pull developed by Stephan et al. (2015, p. 11) as "*opportunity-necessity differentiation"* described how and why the participants chose self-employment.

- **Financial dissonance** identifies a complex internal and external discourse. Financial literacy combines financial knowledge, behaviours and attitudes about finance. Financial self-efficacy relates to financial confidence or savvy whereby any financial matters are proactively managed rather than avoided. Nitani et al. (2019), OECD (2016) and Farrell et al. (2016) all discuss the concepts of financial knowledge (included under financial literacy) as the understanding the practical "how-to" of financial behaviour and practice.

The theoretical and contextual framework (Fig 2, p.106) supported research integrity, as considering the complexities at each stage of data revision not only mitigated emic researcher bias, it also substantially challenged my understanding, views and position as a self-employed RN.

5.3 Summary

In this chapter the qualitative research processes were described in detail, particularly in relation to focused ethnography. Ethics approval, participant recruitment and inclusion criteria were all presented, as well as the data analysis method of theoretical thematic analysis. A general introduction of the participants was offered to help contextualise the situation of each participant prior to commencing the data chapters where their words were used to frame the developed themes.

This completes the presentation of the research process and brings together the theoretical frameworks, ethnographic methodology and the framework used to analyse the data. The next

chapter is the first of three chapters of findings and attends to the reasons the participants chose to become self-employed in the first place.

Chapter 6: Separation; agency and identity work

6.1 Introduction

The participants' experience of moving to a new and unusual area of practice is explored in this first data chapter. The separation phase of liminality in this study represents the participants experience of leaving their familiar employment models and detaching from the resources, colleagues and support structures.

The six subsections of this chapter are; (1) **Tipping points** describing the participants experiences of separation from familiar spaces and people. The participants described their views on the (2) **Value of post-graduate education** for their nursing identity and their self-employment. Exploring the relevance and (3) **Value placed on the RN scope and APC** surfaces dissonance and tension related to how the core business of nursing is perceived.

Non-clinical nursing practice is considered in relation to the public understanding of a nurse in the (4) **Enduring image of a nurse.** Nursing colleagues' response to the participants is then explored in (5) **Outsiders.** Finally, in (6) **Professional identities** perspectives of their professional position as practising RNs are explored and how they chose to describe their practise.

The first section of this chapter focuses on the tipping points which pushed or pulled the participants into their self-employment journey.

6.2 Tipping points

The participants had left hierarchical healthcare organisations often as a result of reaching a tipping point in their roles either professionally, personally or both (Garcia-Lorenzo et al., 2018). They described finding it unappealing to be in a career position with significant experience and skills, facing further years of long hours, organisational pressure, commuting and personal sacrifice.

Billie wanted an alternative lifestyle and a more flexibility outside organisational pressures.

> **Billie:** *I got to 2011 and they were restructuring again. My job was secure but I thought, no, I can't be doing this again. And because of the grounding I'd had in project work and the training I'd had doing Prince2 and various other things, I felt I could consider setting up on my own because I wanted a change in lifestyle. I wanted a reduction in pressure and my husband was very keen for me not to work full-time, and not to get burned out. Because I had gone through burnout previously.*

Billie's aims matched the findings of Hodges (2012) who described the mixture of issues women face, often at the pinnacle of their careers, to care for family, deal with career barriers and a juggle the lack of flexibility with burnout in high pressure roles. Billie expanded on her situation:

> **Billie:** *I think with what happened with the burnout in 2007, where I really did fall to pieces, and the [illness] in 2010, it was a tipping point for sure. I had to do something to make my life more doable.*

Billie described reaching a tipping point in her professional and personal life. She recognised her options included a non-standard way of working as a nurse. This was an example of agentic positioning where, while describing burn-out and a reluctance to again be subjected to re-structuring, she also recognised options beyond the familiar search for a new job.

Healthcare organisations can bring pressures on senior nurses in the form of frequent re-structures, leaving the affected employees feeling disempowered and at the whim of organisational leadership. Jeanette had already coped with four restructures.

> **Jeanette:** *I think I had been working towards that for maybe a couple of years having been through significant restructures, having been in my role for 15 years as a [senior nurse] as*

> *well. I still loved that job but finally the fourth disestablishment it was well now is the time for me to be really thinking about what else I want to do with my life.*

Nursing and nurse management roles are often targeted for cost cutting since they are large workforce and often considered a homogenous and deployable commodity. At such times, senior nurses may start looking for other options. Jeanette exemplified that moment.

> **Jeanette:** *So, toe in the water stuff, I guess and to be honest, last year I just needed a break. I was really tired. I knew I was, but I didn't actually realise just how tired I was. Not tired of the job, just tired I think from huge hours and working often seven days a week as well too, travelling. And so, it was, right, okay, let's do something different and let's look at this.*

Jeanette described the emotional and physical toll of coping with restructures, working long hours and relying on the organisation for job security.

Loss of trust in an employer can create dissatisfaction and a feeling of powerlessness which could also result in nurses leaving organisations, as described by Sally and Jacqui.

> **Sally:** *I ran into a kind of roadblock at the [organisation] I had worked at for years and lost faith in the leadership, in terms of following due process, and that led to me feeling unable to do my job.*

> **Jacqui:** *Well, I'm not self-employed by choice. It was what I call a 'values driven' career change.*

Wall (2015a) and Hughes (2003) describe such experiences as "push/pull" factors. Several participants chose to be self-employed due to push factors such as unsatisfying or negative work experiences. Sally and Jacqui exemplified push factors, where continuation with an organisation was felt to be untenable.

Most of the participants made a definite choice to move into self-employment for "pull" factors such as lifestyle, improved health, increased family time, greater control and more freedom and flexibility. The pull phenomenon was described by Jessie.

> **Jessie:** *Freedom, I would say, would be the biggest – the sense of freedom. And the autonomy. I'd always had a hankering to one day be self-employed. So, it's the realisation of a dream and the dream was a mixed portfolio, and I've certainly got that.*

Jess highlighted that freedom and the ability to make a difference beyond the constraints of a role description and job expectations were important factors. She had eliminated workplace power relations, which increased her flexibility and removed the dominant structures of healthcare organisations.

Margaret viewed the prospect of self-employment to facilitate a change in lifestyle, to be more flexible and self-directed.

> **Margaret**: *I thought if I could do something that was more self-directed in the time you worked, you know ideally, I'd like to work four months, have a month off work, work four months, have a month of work-that would be my dream. So, some sort of self-employment seemed to be the only way to do that.*

Margaret sought a lifestyle shift with the capacity to privilege the personal. A self-employed lifestyle can be about building a business to meet a creative need, to be more self-directed and reduce workload to care for family and home. The participants needed a career that let them be available for and immersed in family commitments. Data showed that families were one of the main drivers for change, as in this example from Jill.

> **Jill:** *I was offered a role for 12 months that was a full-time role working for one of the national mental health workforce centres managing a large project and they were prepared*

> *to support me to work from [region] and work a day or two a month in [city] or [city] and travel a bit about the country. That worked well with family life and it worked well for me in terms of the intellectual stimulation involved.*

Jill found work which she soon realised was a good fit for family life. Nancy also chose self-employment as the best way to prioritise family and study.

> **Nancy:** *Chose to become self-employed because I was embarking on my thesis and I wanted to study full-time, and I didn't want to be in employment where in actual fact employment always has to be the priority in your life; so, I wanted the study to be the central foci and then I worked around what fitted study and also being a mum. And, then I could do at any time of the day or night, any day of the week. And, so the contracting work that I chose fitted around that.*

Nancy and Jill both found ways to meet their needs, but through different routes and for slightly different reasons. Participants, while seeking a lifestyle shift or more freedom, were taking a step with no established career path.

Nancy explained that stepping into self-employment was an unknown career pathway without obvious role models.

> **Nancy:** *I kind of saw glimpses of nurses doing the odd kind of contract work, but I didn't know anyone that was full-time. It wasn't obvious and it wasn't a pathway that was ever encouraged.*

Nancy's experience illustrated self-employment was almost a hidden option and not encouraged as few nurses were aware of this choice. Mary also found most nurses were unaware of self-employment as an option.

> **Mary:** *Other than normal career pathways in nursing, of 'What do you want to be? Do you want to be an educator? Do you want to go into a management role? Or, do you want to be*

> *a nurse practitioner, is the new flavour now? Or, a clinical nurse specialist?' Other than that, it's actually really hard for newer nurses and younger nursing leads, I think, that haven't been around for as long as everybody else in the sector that has got this breadth of knowledge and has seen it all evolve; it's actually really hard to navigate. It's not as easy; you don't get taught about it.*

Mary and Nancy both pointed out that information on this form of work was scarce. A career path would be difficult to position, as there was no consensus among the participant group on how they had reached their current situation. Despite this, several the participants took a purposeful step into self-employment.

Margaret had purposefully become self-employed to find an option which could give her the freedom to work flexibly without sacrificing the professional fulfilment she sought. She did not have a contract prior to leaving her employed role.

> **Margaret:** *I want to make a difference at a national level, that's like in my mind is what I want to do, so therefore I don't want to take… I mean there's been lots of jobs which people have rung me about and I don't want that. If I'd wanted a job, I'd have stayed where I was.*

Margaret was unclear about how becoming a contractor would result in her creating change, particularly at a national level, and may not have realised that contract work is usually working behind the scenes for groups and organisations which then lead the change. Contract workers in professional advice and policy often take a back-seat and remain unrecognised. Jill, having worked on contracts for a while, understood she could make change from behind the scenes and viewed making a difference as important.

> **Jill:** *I'm very lucky in that the organisations that I work for do recognise the contribution that I make and I'm not really that bothered whether they publicly do that or not because I do much prefer to be behind the scenes and just driving change and driving things in ways that*

are hopefully sensible. I'm very lucky that the contracts that I do have enable me to do work that I feel very strongly about.

Jill repeatedly stated how "lucky" she was to work for the organisations to which she was contracted. A search of the thirteen participant transcripts found the word "lucky" appeared twenty-five times. Seven from Jill. Use of the word could be self-effacing language or, in Jill's case, it could be simply that she was good at her job and sought for her expertise in an area she felt professionally engaged and satisfied.

Jayci and Susan were the only two participants who had prior experience of being self-employed and understood what they wanted to achieve in their latest self-employment endeavour.

> **Jayci:** *It was more a case of do this because this is the next logical step. Not because I will race out and do this because I'm all fired up about it. It just seemed to be a logical way to go.*

Jayci had no apprehension about becoming self-employed again. It made sense to continue with this model of working. Susan had a similarly pragmatic view about the value of having a contract before moving back into self-employment and she had the confidence to negotiate.

> **Susan:** *I'd sort of been thinking about the options and I said, "Okay, I'll leave the [organisation]and you can contract me to do it." So, he [the contract manager] said, "Oh great scheme." So, I went back to the [organisation]and I always advise people this, he faxed through a contract fairly soon. We had a wee negotiation. I'd been thinking about it a bit over the weekend. Okay, if they don't let me then I think I'm ready to leave the [organisation]. So, I had the contract in my pocket and I handed in my resignation. I always advise people to have their first contract in their pocket before they resign from their job.*

Susan and Jayci were positioned differently to all the other participants, as they had already proven success in prior self-employment. Susan demonstrated such confidence in contracting that she could

advise others in how to approach contracting. Jayci and Susan had already experienced a shift in power relations and gained a sense of freedom.

Pivotal events, or tipping points, were experienced by all participants in some form. The outcome of the shift into self-employment, whether pushed or pulled, partly depended on the skillset, experience and education level of each participant. The educational preparation of the participants is explored in the next section in relation to content expertise, which underpins their new endeavour as self-employed knowledge workers.

6.3 The value of post-graduate education

Tertiary education institutions in Aotearoa NZ are modelled on the British structure of higher education. Historical evidence shows that professionally dominant groups can legitimise their expertise, importance and position using their education and training to exert control. The participants in this group have skilfully navigated the masculinist institutions of healthcare and, in many cases, also attained the highest levels of university education.

Billie used postgraduate study to manoeuvre into an agentic social and professional situation.

> **Billie:** *I had a regional portfolio as a [senior nurse] and I thought I knew my stuff, and then I went to [national organisation] and realised I really didn't know much at all. It was a shift up from operational thinking…, to a more strategic view and understanding how health works more… I think to have that nursing background and to have the MPhil under my belt was something that gave me some credibility as a project manager for nursing workforce, because I was known in the nursing world, I was known as a project manager but I was also known as having some academic credibility that I had done my own MPhil.*

Billie believed undertaking postgraduate study and completing a Master's thesis was pivotal for success in self-employment, giving her legitimacy with her targeted client group – nurse leaders. Jeanette captured the often-tense situation in relation to RNs and postgraduate education.

> **Jeanette:** *I definitely think that a degree of post-graduate education is really important...I'm just wondering if that also goes to our sense that nurses need to do more to get to the same place as another professional for instance. I've often thought about that over the years is terms of we have always felt like we've got to prove ourselves that we're capable of doing something and certainly being able to say you've done your masters or you've done post-graduate diploma I think adds to that.*

Jeanette pointed out the phenomena of nurses claiming academic legitimacy by becoming increasingly highly qualified and endeavouring to showcase intelligence and capability at the highest levels.

Jill mentioned an initial reluctance in undertaking postgraduate education, but was able to reflect on the value of completing her Master's degree.

> **Jill:** *I did my Master's. I had to do it because it was a requirement of a role that I was in and I don't think to be honest I would have done it otherwise. So, I started doing it because I had to but by the end of it, I was a complete convert and I had a lot more confidence in my ability to write reports and to present information*

Postgraduate education gave Jill more than content expertise: it built her confidence, credibility and professional language skills, all important abilities for finding contract work.

The participant group needed a different skillset to facilitate a move across healthcare, write reports, manage projects and contribute to policy. Susan identified that for a policy role she took a strategic view of the education which would open up opportunities.

Susan: *I was doing papers for the Master of Public Policy, which I knew I needed to actually move into understanding policy. I went in as a nurse advisor and within a year I needed a bit more economics and I needed other things to put in my policy analysis.*
My Master of Public Policy gave me the language of economics and management which I think is effective when working in these settings.

Susan had focused on postgraduate study specific to her policy practise and was the only study participant to do so. Policy education, combined with her experience as a CEO, instilled a level of confidence and opened doors to work in gendered policy spaces.

Nurses who can successfully navigate higher education may realise extra benefits from gaining a qualification. Billie described one such benefit from completing postgraduate study, related to self-direction and an ability to write.

Billie: *So, "how do you get where you got?" and she was quite a bit younger than me, this person that asked me lately, and I said "well, number one was post-graduate education", "oh." I said, "I had to have my Masters." The first place I learnt to write at home and to be at home and to work, was doing my Master's thesis. That was a precursor to everything.*

Billie reflected on the value of working and writing from home which, for nurses in the practice area of professional advice and policy, is a fundamental skillset and a pragmatic application of postgraduate education beyond subject expertise.

Susan: *In our business you have to be able to write. That's what we're selling actually as well as the thinking.*

Susan supported Billie's statement in relation to contract work and report writing. In an environment where nurses are rarely seen and are competing for contracts, potential clients need an indication of a contractor's abilities.

Three of the participants had doctorates and different views about degree’s impact for them personally and in terms of work opportunities. Tash wanted greater confidence and agentic positioning after completing her PhD which she hoped would be viewed as professionally valuable to the groups with whom she worked.

> **Tash:** *Yes, definitely confidence and belief in myself. My supervisor said she noticed that doors opened to her more and that's something I've noticed too. It seems that people may take you more seriously with the title doctor.*

Tash stated the reason she was taken more seriously with a PhD was because the title made a gendered statement, suggesting that the feminised profession of nursing is viewed as less credible unless nurses have the highest level of academic achievement. Such self-interrogation of academic worthiness possibly stems from affiliation to a stigmatised profession which suffers from a public (and sometimes internal) perception that nursing does not require academic ability.

However, Jacqui found that people were challenged by her academic achievements.

> **Jacqui:** *I think it's quite possible that people are intimidated by my qualifications, and yet I’m adding to them now, but expanding my repertoire so, they’re in two different disciplines.*

Jacqui saw value in expanding her knowledge despite people being daunted by her qualifications. This experience speaks to PhD’s retaining high social value but being remaining relatively unusual in nursing. This statement needed more clarification.

> **Researcher:** *How, as a nurse and a woman, would you explain that people are intimidated by your qualifications*?
> **Jacqui:** *If I were a man, I wouldn’t have made that statement.*
> **Researcher:** *Can you expand on that*?

> **Jacqui:** *Outside of nursing a PhD in nursing is thought of as unusual. It's an impediment to you getting work as you are more qualified than they need or want. It [nursing] is seen as a really narrow field. Whereas it is really broad*.

Jacqui described a highly gendered situation in which nursing as a feminised occupation and doctorate-level education do not fit comfortably together. She viewed nursing as being socially and professionally positioned in a constrained space which also reflects the invisibility of nursing work and how nurses are perceived. Rather than encouraging contract offers, Jacqui indicated that her education level hampered her search for work and that a nurse with a PhD may be considered too highly qualified.

Margaret believed attaining a PhD should be both socially and professionally impressive and add to the value of a contractor, even if all it shows is the trait of tenacity.

> **Margaret:** *I guess I thought, 'Well I've done this bloody thing [PhD], I spent so much money on it and so much time,' that you know my whole life more or less for five years, it's got to be some fucking use, hasn't it, I mean really. And I thought, how do I use this? It's got to be impressive; it's got to impress people, it's got to. I mean it would do; it would impress me if I saw it. I guess it gave me the confidence, yes, I suppose it did, yes. Because it says something about you, it says that if nothing else you've got the tenacity and bloody mindedness to continue on.*

Margaret saw tenacity and focus as important traits which indicate an ability to complete complex work to a high standard. With the PhD, Margaret proved herself academically capable. Yet, for self-employment this capability may not be the only requirement. Margaret revealed that she had struggled to get contracts despite her qualifications, indicating there are other skills beyond academic success which must be in alignment for this way of working to be successful.

Accomplishing high-level qualifications certainly enhanced the participants' skillsets beyond subject expertise. But they were also examples of gendered subject positioning and continued social constraints. The next section explores how, alongside their education, the participants' status as practising nurses was viewed by other nurses, healthcare professional colleagues and the public.

6.4 Value of the RN scope and APC

Nurses in self-employment must not only address their capability for the work and their business responsibilities, they must also consider their professional registration. Healthcare work, even if not the delivery of clinical care, may still require nursing knowledge and therefore an APC. The Nursing Council of New Zealand (2007b), in defining the nursing scopes of practise, expanded the RN scope to include non-clinical nurses working in education, research, management and policy. This section explores the participants' understanding of the regulatory requirements and the value of maintaining an APC.

Tash indicated her awareness of the RN scope and the tailored competencies for nurses in policy.

> **Tash:** *I think we are lucky to be able to say, whether it's policy straight through to kind of working on the shift in a unit, that if it informs nursing and it's leading nursing, and it's developing practice, then you're still kind of fit to be a nurse.*

Tash described her fitness to practise despite being non-clinical. She valued her nursing knowledge and understood its impact on her role as a nurse consultant in professional advice and policy. The participants all noted that their nursing knowledge was not ignored once they stepped away from clinical practice. They carried their knowledge into their self-employed endeavours.

Lou identified the nursing skills of communication, active listening, planning and assessment as useful for her role as a project manager.

> **Lou:** *Definitely communication. Definitely assessing people's responses to things. Being able to firstly make an assessment, I think, and then monitor what you're going to say, how you're going to say it and when you're going to say it, accordingly - in the same way that you would with a patient or a client. Planning, I'm quite a good planner. And I can probably communicate my plan to my client pretty articulately, I think.*

Lou described applying the competencies of nursing as assessment, planning, communication and evaluation, beyond a clinical setting, to sustain the client relationship, manage teams and navigate projects.

Susan also saw the value of her underpinning nursing knowledge and experience in her relationship with clients.

> **Susan:** *That's one of nursing's key functions is being the glue for the health service that connects, being the connector between the patient and their particular situation and the services and the policy and everything else. That's how I see nursing. It's sort of central. It's right there in the middle. So, if I didn't have the nursing, I wouldn't be the same. And I think that actually some clients mightn't realise it but that's what they're buying.*

Susan identified that not only could she trade on her nursing skills and knowledge; she also carried a skillset and knowledge base which her non-nursing colleagues lacked and undervalued until it impacted their work.

> **Susan:** *These guidelines I'm developing at the moment, I'm talking about [clinical practice] and what hospitals need to have to stop [manage risk]. That's nursing. The people I'm working with say, "Wow! Oh yes, how do you know all that?" because they're scientists and they're not nurses.*

Susan has a canon of nursing knowledge which non-nursing colleagues find valuable. She could also claim the expert content knowledge vital for working in self-employment.

> **Susan:** *They're buying that absolutely in-depth knowledge and experience of the health service from 360 degree from the client perspective, the clinical perspective, the management perspective, the policy perspective.*

Susan can trade not only the in-depth knowledge of the healthcare system, but also her nursing, policy, regulatory and clinical experience, a knowledge which generalist policy makers value.

Tash identified the same opportunities as Susan but noted that non-healthcare-based professionals had an advantage of asking the naïve question since they were not immersed in the hierarchies, traditions and institutions of healthcare.

> **Tash:** *I love being with those people because they'e not DHB-minded. They're going, "Tash, why do people think this way?" and I've had to explain. "Really? I would never …why do doctors…how do they get away with that…really?" These people have worked in completely different industries and they're great. They just ask the right questions at the right time.*

Both Tash and Susan found working with people from outside healthcare was a refreshing change as their own knowledge about healthcare was viewed as valuable, including their knowledge about how the healthcare system worked and how the professions intersect. They became healthcare sector interpreters and navigators, showing a different way to positively increase the visibility of nursing. The positive feeling in being valued and accepted for their expert knowledge by non-healthcare professionals also inferred that, within the hierarchies of healthcare, their nursing knowledge was not valued to the same extent.

Most nurses remain in clinical practice throughout their career and may be unaware of the specific practise competencies for nurses in non-clinical roles. Jeanette related a situation where she was treated as if she was defensive about still being a practising nurse.

Jeanette: *I'm helping out tomorrow with the [nursing] strike and so I asked the question: what am I being referred to? Am I a clinical volunteer? And the person said, "Oh, you're an ex-nurse." And I said, "Excuse me." Then she realised as soon as she said it. It was somebody that I knew really well and she goes, "Oh, I'm really sorry, I said that to you many years ago and you were really adamant that you were still a registered nurse."*

The idea that Jeanette was insisting that she was still a nurse suggests the interlocutor did not agree, moving Jeanette into a disenfranchised liminal space. This showed a lack of understanding that a person can still be a practising nurse even if they move away from the clinical space.

Jayci found her nursing knowledge enabled her to help clients beyond her contract work, as she could identify issues of clinical risk and advise accordingly.

Jayci: *I mentioned it to one of the other clients. I said something like "look, you know that medication policy is really bad news? Do you want me to look and actually write it for you?" And he said, "so and so looked at that and she was happy with it." And I said, "well, I'm not." She had no medical or nursing background and I said, "as it stands, it is quite dangerous."*

Rather than losing touch, she took her nursing knowledge into every aspect of her work. Despite this example of ongoing application of nursing knowledge, Jayci related her yearly struggle at the time of her APC renewal.

Jayci: *I have definite reservations about whether I am justified in doing it [maintaining a practising certificate] but because I'm using nursing knowledge, I've always thought I perhaps should.*

I read it every year, I read the damn stuff. So, now I think do I? Or don't I? I always struggle with it.

Jayci was unsure if she should maintain an APC in her non-clinical role. On further questioning, it became clear she was unaware of the tailored RN competencies for nurses in professional advice and policy.

Jayci: *I think you need to have someone who can tell you, yes, you are still a nurse. You are supposed to be registered. Because I tell you, that has worried me so much. Should I? Shouldn't I? Should I? Shouldn't I?*

Jayci appeared to be contributing to her liminal positioning and disenfranchisement by questioning her entitlement to an APC and the title of RN, [19]conflating registration as a nurse with the requirement of maintaining an APC.

Susan identified that some of her non-clinical nursing colleagues had decided to surrender their APCs.

Susan: *I know quite a few nurses who haven't actually maintained their practising certificates. They don't see themselves as nurses and don't think it important. So, they've considered that they've left nursing. Nursing is a part of me. I don't consider that I've left nursing. I'm always going to be a nurse. I can't shut that off.*

Susan recognised that she carried her nursing with her into self-employment where she used her knowledge and skills. That her colleagues no longer see themselves as nurses strikes at the core of

[19] While a few sections of the 'Act' (Health Practitioner Competence Assurance Act, 2003) allow for nurses to be suspended, the reason must reach a threshold of risk to the public. For example; someone who is unwell but continues practising or a person whose incompetence is so great they must be stopped from practising. In both cases, a person can be reinstated after remedial action. Nurses can be suspended from practice under a disciplinary process when there is risk to the public, such as criminal behaviour or medical negligence. Nurses can apply to return to the register and the Health Practitioner Disciplinary Tribunal (HPDT) can dictate that conditions must be met (P. Doole, personal communication, August 25, 2021).

nurse's misunderstanding of their own scope of practise in Aotearoa NZ. When moving away from a traditional clinical setting, many nurses undervalue their nursing knowledge and are unconsciously complicit in perpetuating constrained boundaries of what it means to be a nurse.

Jeanette also witnessed a lack of awareness from nursing colleagues regarding the breadth of the registered nursing scope.

> **Jeanette:** *I think even general public understanding, other workforce's understanding of what the scope of nursing is, is limited. It's such a shame really because I think that perhaps nurses themselves are not fully aware of and therefore limit their own ability to do more things.*

The participants lacked a unified understanding of the broad RN nursing scope, as explicated by Jeanette. Each had a different perspective ranging from misinformed and unsure to the comprehensive understanding described by Nancy.

> **Nancy:** *I'm very clear about what I'm doing and how it's impacting health outcomes, and it's not at the frontline in the traditional kind of practice nursing or hospital, or anything like that. But it's still having an impact on health outcomes and the environment. And, I probably have more clarity now that I'm self-employed, than what I would have as an employee. I absolutely know how it ties into my APC.*

Nancy used her self-employed status to broaden her understanding of the regulatory space since she could advise individuals and organisations. Knowing the professional tensions in legislation and regulation was also beneficial.

Under Section 41 of the Health Practitioners Competence Assurance Act (2003), a random audit of continuing competence can be requested by the Nursing Council of New Zealand (2020). In

Aotearoa NZ, creation and curation of the audit documents for NCNZ recertification audit is often referred to as a “portfolio” (Manning, 2017).

> **Mary:** *That is the other worry: portfolios. Like, if you get audited by Council, has been another one of my, you know. I think it's another thing that feels more difficult than if you were in an organisation with other nurses, because it would be easy to get somebody to do your senior assessment, versus when you’re working by yourself.*

Mary showed anxiety about delivering a portfolio since she believed she had no simple way to complete the peer and senior nurse assessment component due to the isolation of self-employment.

This group of senior nurses had a spectrum of understanding about APC and nursing regulation. If the non-clinical competencies were under-utilised or even unknown, then nursing may be losing senior nurses to non-clinical roles. The concept of non-clinical nurses with active APCs can create a cognitive dissonance for their clinical colleagues, other healthcare practitioners, healthcare organisations and the public. The participants’ need to maintain an APC is contestable and each had their own reason for doing so.

The enduring social construct of a nurse is clinical care provider which prompts an exploration into how these non-clinical participants are perceived.

6.5 The enduring image of a nurse

In Aotearoa NZ, the nostalgic socially constructed image of nurses as a hospital-based workforce is fixed in the minds of the public and constrains the development of the profession (Carryer, 2020a, 2020b). Mary and Nancy share their experiences.

Mary: *I think society – it's not just certain people or organisations – they don't understand if you're a registered nurse. They automatically think of nurses in a hospital, or nurses in primary care kind of thing.*

The clinical nurse in a hospital setting remains a powerful image (Urban, 2014) .

Nancy: *But, when I say I'm a nurse, then there is an absolute expectation that I'm beside the bed giving out medication. So, I don't think society has evolved in that space either.*

Nancy experienced a dissonance about her new role. The reality of the contemporary nursing profession has not penetrated the public understanding of what a nurse is and does, including healthcare leadership.

Jacqui had moved her practice to work more broadly across health and identified another phenomenon which could explain why nurse consultants in health policy are few and far between.

Jacqui: *I have been surprised that people don't necessarily think that the transition from nursing to health is a logical thing; like, so they don't appear to connect nursing with health, and I'm pretty intrigued by that.*

Nurses do not just deliver healthcare but are also found in leadership, funding and management across all parts of the Aotearoa NZ health and disability sector. However, as Jacqui stated, nurses do not come to mind when people consider a broader knowledge of health. Nursing is seen as the utility toolbelt of healthcare, a labour workforce to be controlled and budgeted for. The persistent cultural construct is that nurses deliver healthcare and do not lead strategy or give systems advice.

Neither is the breadth and depth of nursing expertise recognised within the profession itself. It is unsurprising that the public, other healthcare professionals and potential clients are unaware that nursing is a skilled and academically prepared profession. Billie identified this hidden resource.

> **Billie:** *We're really poor at explaining what nurses are and do. I think the public perception and the nursing perception of a nurse is not keeping up with reality of what a nurse is and I know there's not many people who work the way I do. But there are a lot of nurses out there who are not front-line nurses who are functioning in such an important way for nursing and for patients and for the wellbeing of the whole thing that are really invisible and not recognised. So, I think that we could get a lot more-savvy about how we promote nursing.*

Billie noted that the breadth of the nursing scope is unknown and non-clinical nursing work can be invisible. The participants are trying to reconstruct an identity as a self-employed, non-clinical nurse in a professionally invisible space.

The fixed construct of nursing and nurses means those who strive for success in non-clinical spaces, such as policy, can be met with discordant reactions. Tash found people were surprised by a nurse working internationally.

> **Tash:** *People ask, "What do you do?" and I say, "I'm an independent nurse consultant." They go, "Oh, what does that mean? What kind of work?" And, I say, "I do contracts, so I can work in a DHB or do some teaching, I do bits of research here and there." And, then when I mention [International] University, it's like, "Ooh, you at [International] University." It's a weird thing.*
> **Researcher:** *Is that people just not understanding what RNs do or is it a gendered response?*
> ***Tash:*** *Yes, it's like "get you...!" Then I interpret it as maybe I'm showing off or who would have thought like an RN doing this. They are probably conveying surprise and 'good on you' spirit. Who knows? As I usually play it down unless they go on to show real interest in what activities I'm involved in.*
> *Yep, and not just about my gendered working-class roots too. Colleagues don't see you as a real nurse anymore.*

Tash described internalised norms and an experience of understanding oneself as inferior. The participants confounded the narrow social view of what a nurse is "allowed" to be and "allowed" to

do. The response to a nurse (or a woman) working at an international university can be interpreted as both gendered and a sense that nurses are out of place in traditional masculinist academic hierarchies.

The fixed construct of nursing was a point of tension for the participants as they reinvented their professional identities, creating a dissonance for people who do not understand nurses as self-employed, non-clinical contractors. This sense of dissonance is more troubling when nursing colleagues viewed the participants as professional outsiders.

6.6 Outsider

Moving away from traditional and familiar spaces of healthcare and nursing work resulted in the participants becoming part of the "out-group" as described by Tajfel (2010) in social identity theory. Outsider status reduced their access to resources and limited their ability to succeed as knowledge workers since they were seen as breaking social norms. This was exhibited as vertical discounting described by Anderson et al. (2020) in which nurses were dismissive of those in supervisory or senior roles.

In Aotearoa NZ where reserve and humility are a part of societal expectations, tall poppy syndrome is common and consists of series of negative gendered behaviours aimed to undermine and control those who self-promote or claim leadership (Holmes et al., 2017).

> **Jeanette:** *I'm not sure whether also there is some level of thinking - and this is just conjecture on my part - but some level of thinking around once you've left a senior role you will lose grasp of the environment and the situation very quickly or whether it's part of the tall poppy syndrome as well too.*

Jeanette experienced an undermining of her knowledge even though it was still relevant. Such a disdain towards those moving away from the in-group norms and environments of traditional practice suggests an oppressed group behaviour and structural oppression, as identified by Young (2011). A sense of disenfranchisement is also found in social identity theory as out-group and ostracising behaviours. Jeanette talked about moving away from the bedside where “real nursing” happens (Drevdahl & Canales, 2020).

> **Jeanette:** *You move away from the bedside into other roles, into a senior nursing role, whatever it might be, whether it’s probably more of an educator, sometimes as a charge nurse or similar, that you’re also seen as slightly separate to the body of nursing that are at the bedside or with the patient. And so, I guess the further away you get actually the more almost ostracised.*

Jeanette described feeling “ostracised” (Jeanette) and, in effect, liminal as she was positioned at the edges of her own nursing culture. Discourse internal to the nursing profession still promotes clinical practice as the only real nursing, embodying oppressed group behaviour (Drevdahl & Canales, 2020). The move away from direct care to knowledge work had positioned the participants in a liminal space, outside of their own profession.

Jeanette used the phrase “body of nursing” (Jeanette) to describe the majority, clinic or nurses – those in clinical practice. Nursing is culturally known for the physical activity of caring for the physical body of a patient. The study participants transitioned from caring to caring about. They had moved away from working with their minds and bodies to care for the minds and bodies of patients, to working entirely with their mind. This is reflected in the concept described by Eikhof (2016) of knowledge workers who can make a contribution, often based from home, using their intellect to complete and deliver work which the participants had found was positioned separately.

Mary was new to contracting and felt invisible and like an "outsider" (Mary) to influential nursing leadership groups.

> **Mary:** *If you feel like you're an outsider to your own profession then… you know, nursing can have a lot of influence. People that are in positions of influence, leadership and management can have a lot of influence and sometimes it's unintended. Consequences I guess, but they have choices and I think also can make, particularly newer people coming into different pathways – feel accepted or not.*

Mary experienced marginalisation, feeling she was not accepted by her nursing leadership colleagues, which suggested that as she was no longer an organisational nurse leader and no longer met the criteria of the nurse leadership group. Her statement above needed some clarification.

> **Researcher:** *You were alluding to being excluded or finding it hard to break into existing leadership groups.*
> **Mary:** *Yes, the nursing profession and those in influential nursing positions/groups can both support or marginalise and make it difficult for one to be able to contribute, be successful. Particularly for individuals who may not be so well known, but may actually have a lot to offer etc., but may not get a look in as the "cliques" exist, and others will be offered opportunity instead.*

Mary described being unable to get a foothold in established nursing leadership groups. However, it could be argued that unless she volunteered or positioned herself advantageously, she would remain unseen. Leadership groups may not convey overt resistance to new people, but nurses in many settings do engage in negative behaviours which subtly convey their dismissal of those they consider group outsiders (Anderson et al., 2020).

Nursing leadership groups may also practice preferential selection of contractors who either have group membership or who are already known and trusted. Limiting behaviours, which may not

be conscious or understood by the group members, could create a sense of liminal positioning and even disenfranchisement for those on the receiving end. Mary was asked to explain further.

> **Researcher:** *What would have made you accepted? Was there something you needed to do or have to be in the group?*
> **Mary:** *I think it's just collaboration. Being invited to participate or have a voice, or being "used" for your strengths, etc. (better yet paid, but even without that initially - it's the participation that can then lead on to things). Particularly if you put yourself out there - having that acknowledged helps you learn, develop, grow.*

Mary suggested that having a chance to take part could be her opportunity to prove herself as capable. Finding that initial break, as an untried contractor, could be problematic, creating feelings of disenfranchisement and lost confidence.

Lou explained that the nurses she worked with were unsure of her as a contractor. Her status as a contractor seemed to confound her role as a nurse.

> **Lou:** *By the nurses, who are throughout the country, who I'm only on the end of the phone to, or the ones I might see - not really a nurse, not really a nurse. Yes, because I'm not doing the client assessments. I think. I mean, they know I'm a nurse, and I have to speak to them about clinical things a lot of the time. But I am seen as the contractor, and they're not quite sure about that.*

Lou's situation confused her nursing colleagues who may never have considered that nurses could be self-employed contractors. Most nurses remain in clinical practice (Nursing Council of New Zealand, 2019) and may never engage with a self-employed, non-clinical nurse.

Jeanette described another challenge to her self-employed, non-clinical status, simply because she was no longer employed by a healthcare provider.

> **Jeanette:** *One of the things that has been challenging I suppose for me is, and actually just happened just recently, "Have you got a job yet?" A couple of people, not a lot of people, but, "When are you going to get a job again?" or, "Have you got a job yet?" those types of questions which I found really challenging to begin with. Obviously, I would just respond and say, "Well, I am working. I might be at home but I'm actually doing some work at home."*

The dismissal of self-employed contract work or knowledge work as real work is professionally short-sighted and constraining for the profession. Mary experienced a blunt challenge to her nursing status.

> **Mary:** *I've had someone say, "Are you really nursing?" Then other people have said, "So, you're admin?" Which is interesting.*

By explaining she was no longer working in clinical practice, Mary was positioned into an administration role, reflecting a narrow view of nursing since the only alternative to clinical practice was perceived to be administration. This is an example of the persistent notion that nursing knowledge is only relevant to bedside care delivery and not policy or healthcare strategy.

The expectation that RNs can only work in a traditional employment model in a traditional clinical space remain powerful. Jeanette found if a nurse is not in a traditional workplace people assume they will be out of date.

> **Jeanette:** *It almost goes back to not being a real nurse. So, you're no longer an employee of a health organisation and so therefore how could you possibly know?*

Despite this constrained perception of nurses and nursing work, the participants noted that self-employment allows for a broader reach and an ability to work in a much wider variety of settings as they are no longer bound by job descriptions and organisational expectations.

Nancy found the release from a job description liberating, but maybe something which is not understood until experienced. She also realised that she could be outspoken since she was no longer limited by communication policies. Nurse leaders' voices are often silenced by these restrictions.

> **Nancy:** *You can be more outspoken in that kind of self-employment space, because you're not as confined to one way of thinking; you can kind of look across. Whereas, if I was employed, I would only be focusing in – and historically I've only focused on a piece of the health system – whereas being self-employed you can kind of move in and out and across the eco-system. So, I think it's quite liberating in that way. You get to see a lot more. You get to hear a lot more.*

Far from losing touch and not being a "real nurse", self-employment in the contract space can give nurses a broader understanding of healthcare. This was reflected in the ability of the participants to professionally diversify within their businesses and expand their previous roles. Jeanette expanded her professional horizons in a way she could not have achieved in her previous employed role.

> **Jeanette:** *I'm doing things that I wouldn't have done before. So, I'm not just focusing on nursing for instance. The conversations with people are about the health system as a whole or the health workforce as a whole as opposed to nursing only. So, I think that it gives you the freedom to actually be looking a little bit wider than simply our own profession as well too.*

Jeanette, while still working on nursing contracts, no longer limited herself to nursing. She could work more broadly across health into other professions and the wider sector. Expanding horizons fits into the separation phase of liminality and professional re-identification, as well as freeing-up the participants up to work in different ways, practice areas and spaces.

The participants experienced being marginal to their own professional group, positioning them in a separated, liminal space. It was interesting to note the reactions of the participants who were accused of no longer being a real nurse. While they were liminally situated and working in non-

clinical spaces, they wanted to maintain a connection, a belonging and a bond to nursing. To respond to this tension and mixed view of their role as self-employed, non-clinical nurses, the participants described how they approached their new professional identities.

6.7 Professional identities

The participants were asked about their professional identities, starting with a review of their chosen self-employed titles. Challenges can emerge when socially constructed identities depart from accepted convention and "stations in life", an old fashioned term but purposefully selected to infer a static, continued situation (MacGregor & Davidson, 2012), as opposed to the unstable, fluid status of the participant group.

Highly complex and competing discourses surround, infiltrate and emanate from the nursing profession, at times promulgating the social stereotype of what a nurse is and does, and where they practice. Mary articulated her views on negative stereotyping.

> **Mary:** ***Health Consultant/Advisor.*** *I did have someone say to me, "Do you even want to put that you're a nurse?" Which was interesting. Like, it is quite interesting as to how we are perceived. To be frank, I think people think you're obviously less intelligent because you're a registered nurse. If I was a doctor as a consultant, I actually think you would be accepted differently and perceived differently.*

Mary received an unequivocal message that suggested she divest herself of her allegiance to nursing, identifying as a nurse would potentially hamper her goals or status. In this way, nursing can be described as a stigmatised group associated with the disprivileged side of the binary divide.

Doctors are viewed as high status due to perceived higher value of scientific knowledge base (Wall, 2013b). Nurses are expected to deliver care, which is synonymous with nurturing, (Wall, 2013b)

domesticity, duty, obligation and dirty work. Jayci saw this as a negative affiliation and distanced herself from her nursing identity.

> **Jayci:** ***Health Consultant.*** *I don't include nurse as part of my title for the same reason. People want to plunk you into a hospital and although nurses know the huge scope of their work fields, the general population doesn't. So, although it is intrinsic to me, and has certainly been of interest to the operatives in some of the roles I have had and of use in all of them I tend not to highlight it in the initial negotiations.*

Jayci viewed her nursing identity as a liability when dealing with contracts, fostering ideas of nurses working in hospitals and negatively impacting contract rates. She did, however, still value her nursing knowledge and experience and, rather than divesting of the association, could put it aside when necessary.

Jessie noted that the concept of non-clinical nurses and self-employment did not stimulate the same level of interest found in the clinical aspect of nursing.

> **Jessie:** ***Director****. So, mostly I say to people, "I run my own company," then they'll say, "what sorts of things do you do?" I usually only tell them a couple of them because then their eyes start to glaze over!*

Jessie provided an example of cognitive dissonance among people. A lack of interest may, as described by Harmon-Jones and Mills (2019), develop as avoidance since it can be difficult for people to change their view of what a nurse is and does. This may result in the participants' instigating avoidance strategies to reduce their sense of dissonance.

Sally related an experience in which identifying as a nurse elicited from the interlocutor a list of ailments to be advised upon. This indicates how nurses are publicly perceived: with absolute trust and a belief that any clinical condition or story can be safely shared, or even fixed, by any nurse.

> **Sally: *Independent consultant/Director.*** *If people ask me what I do, I say "I'm an independent consultant." On forms I'll usually put "director" because I'm the director of my company – woohoo! And, the nursing thing usually just provokes stories of healthcare issues and woes. Most people who know me know what I did, and that sort of history. Quite often I just say to people "I'm an independent consultant."*

People do trust nurses (Dillard-Wright & Shields-Haas, 2021), and from personal experience I know that even in a public space, seem able to divulge highly personal health information on the smallest indication they have found a nurse. Sally chose to avoid the title of nurse to avoid incurring stories of "healthcare issues and woes" (Sally). Instead, Sally chose the titles Director or independent consultant. The two titles remove any professional indicators, and any stigma which a professional affiliation may cause. While it is easy to understand and respect their study participants' reasons for distancing themselves from nursing, it further supports a narrow view of nursing rather than actively challenging public perception.

Billie embraced her nursing identity since contracting within nursing, her nursing knowledge and networks were pivotal to finding contracts.

> **Billie: *Nurse Consultant/Health workforce consultant***. *I see myself predominately as a nurse. As a business owner, I wouldn't say that's an equal thing – probably 2/3 nurse and 1/3 business owner. My business is important, and I have to tend to it regularly to keep it safe and keep it as it needs to be, but that just ticks along in the background, but I like to say I'm self-employed. I like that. I'm a self- employed nurse. That's so cool, because it's unusual.*

Billie saw value in the difference of her role and traded on the nurse component of her identity. Using the nursing title was contingent on who the participants were dealing with and the source of their contract work.

Susan mentioned it could be problematic to even use the word nursing when working at executive levels of healthcare, policy and government.

> **Susan:** ***Principal/ Health policy and management consultant:*** *I've never hidden the fact I'm a nurse except when I was working in government, I guess.*
> **Researcher:** *Can you expand on that?*
> **Susan:** ***Principal/ Health policy and management consultant***: *It was not so much hidden as just not declared…I did not announce that I was a nurse, rather, I used my nursing knowledge and understanding in my policy advice but presented as [policy leader] in the MoH, not as a nurse.*

Susan, in choosing to not declare her nursing background within government, exhibited the value of the flexibility of such a background by still using her nursing knowledge but deferring the meaning and definition of nurse.

> **Susan:** ***Principal/ Health policy and management consultant:*** *If I had declared that I was a nurse or used nursing language, my views would have been largely discounted as professional self-interest.*

Susan in this situation (based on her long association with government entities) believed that identifying as a nurse could be disadvantageous or viewed as nursing parochialism. Her background was set aside in an example of pragmatic use of professional identity, further obscuring the translation of nursing knowledge and skill into the broader policy area. Setting aside a nursing identity in this way perpetuates the problem of invisibility, professionally and as a career direction.

Social positioning and using network contacts was deployed by several participants to establish a new career direction. Mary introduced the role of business consultant which has traditionally been associated with masculinist professions.

> **Mary: *Health Consultant/Advisor.*** *It's not seen as a career kind of thing. Like, if you're a marketing consultant, or you're a business consultant, it's been around for a very, very long time. A lot of people do it. Whereas this is quite different. It's not seen as a career pathway, I think, by many people.*

Mary pointed out the rarity of a self-employed, non-clinical career direction and as a result, nurses were not sought as consultants as they were an unknown resource in consulting work. Nurses do not have a clear career pathway to enter the normatively masculine world of a self-employed entrepreneur and can experience a complex set of dissonant and dismissive responses as evidenced by the participants in this section.

The participants had experienced a de-stabilised, liminal identity, after moving away from healthcare delivery or management, finding themselves as outsiders to their own profession. Several participants were questioning and moving away from their nursing identity, finding it unhelpful or even stigmatising. Fluidity in their professional identities enabled participants to blend into groups as their work required. Some of the participants chose a loose affiliation with nursing, able to switch their identity as a nurse on or off, contingent on their work requirements.

6.8 Summary

This chapter focused on the participants' move into a liminal separation phase, leaving known employers and employment models and detach from familiar structures, practices, resources and networks. They refocused and reconstructed their identities as RNs, becoming professional individuals, external from organisations and institutions of healthcare delivery and education. In developing a self-employed identity, they had navigated the public expectations of what a nurse is and does.

The participants experienced a combination of pull/push factors. Organisational restructure, health issues, family needs or unsatisfying work environments were common push factors. The pull factors were lifestyle, health benefits, work space, freedom, flexibility and, again, family commitments.

All participants valued postgraduate education since most had Master's level qualifications and some had PhDs. As consultants in professional advice and policy, the lack of broader policy-based formal education was notable. The concept of credibility was important as the group must prove to potential clients that they could produce quality work. Doctorate-level education was perceived as opening professional doors, however in practice, this was not always the case. The group agreed that postgraduate education created more than content knowledge by building confidence, writing skills and strategic language.

Nursing language, knowledge, relational skills and group membership were viewed as beneficial in navigating this new environment. All the participants had current APCs, but there was a mixed understanding of nursing regulation, scope and competencies. The group faced some tension in relation to their practice by noting the assumption from others that as they were no longer clinical, they were no longer practising.

The participants found people experienced cognitive dissonance in response to the concept of non-clinical nurses. The view of nursing as clinically-based work endures for the public and the profession. Other nurses exhibited negative behaviour towards those perceived as outside of accepted group norms. The response to their status as a non-clinical nurse was vital to the participants as they considered their new professional identification. The title of nurse was often viewed as unhelpful in securing contracts, as some of the participants sensed negative stereotyping made them appear less intelligent and lowered their financial worth to clients.

The participants have exposed the gendered positioning of the nursing profession and the difficulties inherent in being affiliated with a stigmatised professional group. They developed new professional identities, such as nurse consultant or business owner, which were unstable and contingent on their role for any given context.

The next chapter explores the transition phase of liminality where the participants learned how to run a business and navigate their new financial responsibilities.

Chapter 7: Transition; finance and business

7.1 Introduction

The participant's experiences in the liminal /transitional phase of liminality theory are described in this chapter. According to liminal theory, the transition phase can be ambiguous and disconcerting as new skills must be learned and challenges met. But it can also be a highly creative time with many possibilities.

The participants had separated from traditional, well understood nursing work environments into less structured, self-directed spaces. They had navigated the constraints and nostalgic views of nursing as they adjusted to their new enterprises. Their next challenge was learning how to run a business, a steep learning curve since most participants had been employees for their entire careers. To address their experiences this chapter is split into 5 subsections which are; (1) **Precarity** which explores both contract work and financial income. None of the participants had previously needed to consider (2) **Marketing** their work. Adapting to (3) **Financial literacy: Tax and finance** and (4) **Financial self-efficacy: Financial security and value-add** were areas which created significant anxiety for many participants**.** In the final section (5) **Networking and social capital** are addressed in relation to accessing contracts.

The first area explored is precarity and the management of erratic workloads and at times, minimal or no income.

7.2 Precarity

Relying on contract work, finding clients and learning to manage the feast or famine of contracting meant the participants dealt with the precarity of work and income, as described in relation to nursing by Stahlke Wall (2011a). For the participants in this study, precarity was

something few had experienced since most had been salaried employees their entire working lives. In their new reality, the phenomenon of work precarity was an inevitable precursor to precarity of income and, from there, concerns regarding business viability.

The participants offered a variety of responses to managing this new way of working. Billie identified precarity in both contracting and finance.

> **Billie:** *You've got to be comfortable to take risks I think and to work in areas of grey and also to work in areas of precariousness, because I can go, I can either have too many contracts and I don't know which way's up or I can just not have any work and that's contractually precarious and it's financially precarious and you've got to be comfortable to be able to cope with that. And that part of being self-employed I'm reasonability comfortable with. Knowing that I am also very fortunate to have an incredibly supportive structure around me. I have a very supportive, unquestionably supportive family and friends that are just, yes whatever, we support you, so I am very lucky like that.*

Billie had a degree of confidence in managing the risk associated with an erratic workload, but this still created an unstable and unpredictable existence, mitigated by a supportive family and social structure.

Billie's social situation meant she could withstand a degree of risk. She described a skillset which included availability and the flexibility to manage multiple contacts or no contracts.

> **Billie:** *I mean I've known that I've got 2 or 3 projects coming up now for months but I don't know when and things can be glacial in the way they come through or I can get rung tomorrow and have a contract. So, like a couple of months ago I had no work. I had a little piece of work that takes me a couple of hours a week and that's all I had so I was doing a lot of studying and then within a week I had like 5 different projects that people wanted me to do that I had no idea were coming. Not biggies, but something, so it's like that, it can either*

be, I know stuff's coming and it'll get here when it gets here or bang somebody's rung you up, you've got work. That's why you need to be flexible.

Billie recognised the need to be responsive and adaptable. Immediate availability can make contractors attractive to organisations. However, the precarity of work suddenly appearing or never eventuating can complicate time management and financial planning. Contractors must have a degree of comfort with flexing their work pattens up and down.

Flexibility can create unexpected problems as well. For example, Tash described the result of being unable to turn down work and needing a settling-in period to develop confidence that work would keep coming.

> **Tash:** *I got exhausted in the first year. Gotta have the contract, gotta have the contract, doing, doing, doing. I kept thinking, "I didn't think it would be like this." I felt like I might as well be back at the university. And, I went through a period of thinking, "Surely it's not going to be like this forever." But it took me about a year and a half before I felt I got a balance.*

The problem with declining work is losing clients. Most participants had a small client base at the start of self-employment while they were initially unknown and professionally invisible, so losing a client could be damaging to the business. Jill described working long hours because she enjoyed the work, but she also did not want to turn work down.

> **Jill:** *I think that is one of the tensions about being a one-person [company] is that you don't want to turn work down when it's offered to you, particularly if it's something super interesting and cool, but you are only one person and you can't work 24 hours a day. I find that's my biggest challenge is that when I say to my family, "I'm going to cut down my working hours next year." They just laugh at me because they know it's not going to happen.*

Erratic and unstable work can result in uncertain prospects and insecurity for these small businesses and leave the participants, like Tash and Jill, feeling unable to turn work down.

Susan was one of only two participants with a steady, high-level income enabling her to choose her work.

> **Susan:** *Well, I've earned more. I've done better financially being self-employed than being employed in the health sector but I didn't do it for money. I think at that particular stage it was because I really wanted to set up the [project] and carry on with implementing the policy I'd been working on. So, a lot of it is because the contract or the job that I'm doing actually appeals. You can pick and choose what you do, so the more boring ones, I don't bother doing now.*

Susan had been self-employed before and combined with her experience working as a CEO, she appeared to have the insight and confidence to be selective in her latest self-employment endeavours.

Margaret struggled to establish a client base. She described getting some short contracts but despite initial interest, no significant work or income was forthcoming.

> **Margaret**: *I've created this space to be a self-employed person but really, I've just got some of the rats and mice things which...It's like, you know, I could get a phone call now and someone could say, "Hey, do you want to come and do...?" So, I don't even think I think of myself as self-employed...So, it's like I'm almost, I'm ready, I'm here I'm ready, and just come and give me some work."*
>
> *So perhaps I'm not right for this gig but I don't know yet. I don't know because I haven't had the opportunity, or I haven't done the right things or ever, it's not come together yet.*

Margaret was prepared, capable and enthusiastic to set up her self-employed business, but things were not coming together. It appeared that having a high level of education, ability and the will to be available for consulting work were not enough. Margaret's subjective discourse became negative

and a lack of contracts and therefore income, made her question whether self-employment was right for her.

Unstable income can be problematic and create anxiety. Though unable to invoice for periods of time, Billie recognised she was in the privileged position of being able to lean on a supportive partner in times of low income.

> **Billie:** *I never feel, well no, sometimes I just get a bit wobbly sometimes if things are getting a bit tight financially. I'll say things like "I'm not contributing enough" and [partner] will say "…don't be ridiculous, we can manage, things will pick up." He's very confident and comfortable with all the way things are. Again, I'm very, lucky and not everybody has that I know.*

Participants were moving from reliable incomes to uncertain incomes, the effects of which played out differently across the group. But the stability of a life partner's income could provide security during periods of economic uncertainty.

The participants were adding layers of complexity to their living environment, relationships and financial security. Tash's experience of moving from employee to self-employed resulted in a feeling of financial uncertainty and loss.

> **Tash:** *I went from literally being a wage slave for like 40-odd years, and the first few weeks…the structure had gone completely. I think I got quite low and quite tearful and emotional. I realised it was just there was a loss of something; I lost something. I think it was the uncertainty.*

The term "wage slave" (Tash) is a sardonic reference to a person's dependency on a salary. Tash described what appeared to be a manifestation of grief about losing what was once an intrinsic part

of her life. She lost her long-term colleagues and a sense of work structure, including financial security in her transition to self-employment. She vividly described her nightmares.

> **Tash:** *But the nightmares were really interesting. Well, they weren't nightmares but there was just this image I had of getting into business, having this big mortgage and being homeless. You know the images of refugees that are fleeing, and they've got their old people in wheelbarrows and I had visions me and [partner] destitute with [mother-in-law] in a wheelbarrow; like nowhere to go and homeless. I laugh about it now. I kept talking to [partner] about it. She said it was just my anxiety that's all it was.*

At this point, Tash was not certain how her self-employment would develop, if she could sustain a much-needed income and how that would inevitably affect her partner and family.

Jessie found that after earning a substantial income as a CEO she did have some financial concerns which manifested as worry and panic, especially over the long summer break.

> **Jessie:** *There were certainly times in that first year where I'd wake up at 2 o'clock in the morning and think, 'Oh, my god, what have I done?' Interestingly, two years ago over the Xmas period, … over that time I suddenly thought, 'Oh, gosh, I haven't got much work lined up for the coming year.'*

Jessie quickly realised that the long summer break over Christmas and the New Year in Aotearoa NZ could result in financial uncertainty. Billie also identified the same quiet time for contractors in Aotearoa NZ.

> **Billie:** *I've had months where I've not invoiced anything, generally January, February, the long summertime holiday is generally very quiet.*

Periods of zero income, as described by Billie, would ideally be carefully considered and planned. This gap in income would be unsustainable for the majority of nurses, and reinforces the social positioning of the participants.

Tash took sensible advice from an accountant in planning out a 10-month year, which prepared her for a slow time over the Christmas summer period.

> **Tash:** *She said to me, "You're really working ten months out of a 12-month cycle when you're self-employed." And, that was great, because then she said, "Plan for not much happening over the Christmas and New Year, you might have two months when nothing happens."*

Tash had some warning and preparatory information from her accountant. Generally, the participants had been paid fortnightly salary across their careers, so planning for two months or more without any income at all was a significant challenge. Jeanette added:

> **Jeanette:** *I mean, probably the financial part was the scariest I think, not seeing that regular wage coming in as well too. There's a honeymoon period of course and then all of a sudden, it's like your bank balance is coming down and nothing's coming in. I think that that definitely was quite scary.*

Jeanette noted the change from a senior nurse salary to income from self-employment can be a shock. Additionally, the participants had to start thinking about paying tax. When invoices are first paid in a business start-up it can appear that earnings are substantial. Once GST payments, provisional tax and income tax are due, the reality hits. Sally put aside as much money as possible for tax purposes but remained unclear how much would need to be paid.

> **Sally:** *So, there's concern that I've got children, I've got a mortgage; there's concern about financial security when you've gone from a salaried regular known income to an unknown income. I still don't know what's going to happen, because this will be the first year that what's it called – that tax that you have to prepay... Yes, provisional tax. So, I've yet to find*

out what my provisional tax will be as a result of last year. So, therefore I've just put a whole lot of money over there, so that whatever it is, I should have it covered. But it's not knowing and not finding things useful.

Sorting out provisional tax can be a challenge, especially in the second year of the business as both income tax from year one and provisional tax for year two tax must be paid.

The necessary ability to plan and mitigate financial precarity took time and a degree of experience. Those new to contracting such as Mary, found it overwhelming at times.

Mary: *I don't like it – uncertainty. And, it's not so much uncertainty… well, no it is, but I think because it's new, but it's also not well established in the [nursing] profession, again is that I think that makes it even more scary.*

Mary felt ill-prepared for this aspect of business and noted that nursing does not prepare nurses for this model of work, but this is not limited to nursing. A wide variety of tradespeople, professionals and businesses struggle with finance and tax responsibilities (Redmond & Walker, 2008).

Precarious self-employment income had a negative psychological impact for most of the participants. To improve and increase their workloads, the participants may have benefitted from marketing strategies. The tensions related to self-promotion are explored in the next section.

7.3 Marketing for the first time

Marketing is just one of the new roles to consider for solo self-employed people. This section reviews the participants' marketing strategies and shows how their difficulties in this area speak, to some extent, to their background in nursing.

The participants are predominantly nascent business owners and have never had to market their services. Margaret had a straightforward response to questions about marketing.

> **Margaret:** *I've just really knocked out a CV and said, "Here I am." I haven't really.*

Sending out a curriculum vitae (CV) is only useful when applying for a job or a specific contract and was unlikely to work as a marketing strategy for Margaret. Delivering a CV to people on the off-chance they will think about offering work in the future is similar to cold-calling and not always viewed positively.

Apart from a couple of exceptions, none of the participants were actively marketing and when the subject was broached the participants became uncomfortable. Billie described her discomfort.

> **Billie:** *Marketing, not very good at it, because again it's about touting for work and it's all wrapped up in that package of how much you are going to pay me. It falls into that really uncomfortable pile for me, is the marketing and the money side of things, is the pile that I don't do very well.*

Billie used the word "touting" which has negative connotations similar to cold-calling, hawking or peddling, indicating she found marketing uncomfortable and unpalatable. Disciplinary and gendered norms in nursing were part of how the participants viewed themselves every day, unconsciously reinforcing that nurses do not promote their work and contribution, as in this example from Jayci.

> **Jayci:** *I didn't actually ever advertise; I was just handed round from people to people - like chocolates basically.*

Jayci did not market her work and identified feeling like an item, an object or commodity. Commodification resonates with the historical positioning of nurses as a homogenous, deployable workforce.

Tash was aware of the discursive positioning of women and nurses and somewhat subconsciously added depth and breadth to her brand as a self-employed nurse.

> **Tash:** *Sometimes I'll put the "we" to make it look like it's not just me. I mean, it even goes back to why did I put "Associates" what was that about? But, at the time I just thought it through; I didn't want to say Tash [surname] Consulting. I don't know why I didn't want to say that. I just wanted to give the impression that I've got a group of people with a shared interest.*

Tash's branding was designed to suggest that her business was not a solo endeavour. A gendered lens could suggest Tash was subconsciously asserting the worthiness of her endeavour to those who may not consider it valuable. This strategy could work for those who value the masculinist indicators of business success, such as expansion and growth. However, Tash had simply used a smart branding tactic.

Several of the participants chose an identifiable brand for their business as a low-cost way of advertising. Sally made initial progress into online marketing, but then did not follow up with any strategies to encourage potential clients to search for her website.

> **Sally:** *I did build a website and print a business card, but I haven't done any marketing or publicity at all.*

She bought minimal advertising and a website is only useful if it attracts web-traffic. Jessie was the only participant who mentioned reviewing the number of "hits" (visitors) on her website.

> **Jessie:** *I've got the website and I do get hits on that; LinkedIn, every week there's searches on that, which you can go in and it shows you who's been looking.*

Jessie used a website, analytics tools and LinkedIn as her main marketing strategies, but she was an outlier in the group. Even when participants had websites, they gave no further indication of web-based strategies.

LinkedIn was the only social network used by all participants. Soft marketing, such as business cards, were also common. Low profile marketing was more acceptable to the group than cold calling or hard-sell marketing. Susan explained how her work is normally found.

> **Susan:** *I basically just get people coming to me and the odd proposal if I hear about it and I go for it I do that. But I haven't really got much into the cold calling. You don't need to. Actually, if you've got networks, meeting for coffee and lunch reminds them that you're around and that's enough.*

Susan argued a position whereby cold calling and active searching for work was not required, though it should be stated Susan was an experienced and confident contractor.

The participants operated in a niche market and creating a reputation for high quality work seemed to be the way they found more contracts. Their target clients were not necessarily going to respond to media-based advertising. Healthcare is a diverse market and it would be difficult to position an effective marketing campaign. Creating a reputation by word of mouth seemed to be the primary strategy but this could be problematic for those in a liminal state, removed from the resources of employment and network access.

Although marketing was a seemingly obvious way to procure more contracts, most of the participants rejected it, citing issues about how or where to market but also in the very act of

marketing nursing work. The participants were navigating through powerful gendered and in-group behaviours which viewed marketing nursing work as unpalatable. The lack of marketing extended the invisibility of nursing diversification.

Moving into self-employment inevitably required adopting many new roles to run a business, such as marketing, invoicing and paying taxes. The next section begins with financial literacy.

7.4 Financial literacy

7.4.1 A whole new world of worry, tax and finance

Financial management for self-employment, especially dealing with tax, was difficult for 11 of the 13 participants to cope with. This subgroup had no idea about the intricacies of invoicing, IRD rules or fees. Sperber and Linder (2018) and Nitani et al. (2019) identify that females are more self-critical about their financial abilities than men. This lack of ability in finance may result in accounting tasks being side-lined in favour of a focus on the core contract work. Billie described learning the tax side of her business as stressful and difficult.

> **Billie:** *But where I saw a novice to expert curve was in running the business, was the finances, was the GST. GST was massive for me it was like "oh my god, I don't know what I'm doing." That was stressful, I really struggled with that. But if I can learn to do my GST by myself and keep the whole thing ticking over year-on, then I can pretty much do anything. So that's my thing is if I can do my GST I can do anything. Yes, that was really hard.*

Billie had never dealt with business finances before becoming self-employed and initially found it stressful. Learning how to complete her own GST returns boosted her confidence since there is a satisfaction in being able to attend, not only to the work itself, but also to the business finance and IRD requirements.

Dealing with the IRD was the area participants found the most worrying. The IRD is the government department for collecting income tax, and it could be described as a normatively masculine institution. Lou ascribed the IRD and the banks masculinist identities.

> **Lou:** *I mean, those phone calls with ACC [Accident Compensation Corporation] going to the bank man, getting him to help me set up my accounts, so that - I was always terrified that I wouldn't have enough money to pay the tax man. Anyway, lovely bank man helped me with all that, and the ACC people.*

Lou's fear of not having enough money to pay taxes was a common experience in the participant group. Tash also worried about "getting it wrong" which was a powerful and common feeling among the participants to such a degree that it caused notable anxiety.

> **Tash:** *Actually, with the [organisation] I get less invoices, but for that first year and a half there was invoices here and there and everywhere. I just couldn't do it. I was okay doing the invoices GST, but when it came to trying to subtract and add it frightened me literally. I was having nightmares about it. They were going to come and arrest me. Always the catastrophic thought.*

Managing the GST requirements with the potential to make an error caused Tash such worry that she became psychologically distressed. Fear of the unknown and viewing the IRD as a punitive organisation were common experiences among the participant group.

The participants relied heavily on informal help from friends and family, described by Sperber and Linder (2018) as informal relations, to manage the initial lessons about finance rather than approaching the IRD. Jill described her experience.

> **Jill:** *It was interesting because my sister had a very small business that she's grown into a very large business and she was quite strong with me about understanding all of that, that it was actually really important that I understood all of that.*

Jill's experience of a less formal approach to learning the financial ropes of self-employment is great for small enterprises. Lou provides an example of using a book-keeper who was also a personal friend.

> **Lou:** *Well certainly my weakness was around the book keeping. I had a friend come, who was a book keeper, or she did accounts for numbers of small businesses around here. And she said, "Now, Lou, you've got to do your mileage, you've got to keep all your bank records, you've got to keep..." I think at the start I used to have one of those little books, I used to write paper invoices. And she showed me how I had to keep spreadsheets. And I remember thinking, "Oh, this is going to take just as long as it does to do the work." And it did for a while. In fact, it did for quite a long while.*

Rather than using informal networks, Billie also developed a trusting relationship with a supportive local accountant who took on the role of financing teacher.

> **Billie:** *So, I met a lady down the road who is a chartered accountant. She's become a very good friend and she, instead of coming in and doing my accounts she sat down and she said I'm going to teach you how to do your own GST. Which she promptly did, she taught me how to invoice and she taught me how to do my GST. I do all my own GST she just does my annual round up and my income tax once a year…I think that was very kind of her to do that*

Billie found a more personal approach where in which her accountant took an enabling mentorship role. Accountants are pivotal in the self-employment space as they advise not only on financial requirements, but also more generally on business management. Tash was guided at different times by her accountant in regard to GST issues.

> **Tash:** *...the accountant keeps reminding me, "Tash Associates is the company, you're the woman Tash." You know there's two different things going on here, because I paid my tax wrongly; paid it to the wrong account. I paid it to the business account instead of the Tash account. So, simple things like that, that she keeps me on my toes. Like, why I have got this*

letter from tax man? “Oh, because you’ve done it this way.” Oh, right, okay, and it's just the apprenticeship really.

The participants accessed accountants to help set up of their business finances and for ongoing business support and mentorship. Newer financial management software programs let small business owners to manage their finances relatively easily, but the personal approach is better for advice and support about income tax, provisional tax and GST.

The participants quickly learned the financial aspects of their work but were conservative with their money, as in this example from Nancy.

Nancy: *And, putting the money aside, a third of my contract. The other thing that I’m blimmen’ so scared to death of is, not putting away enough PAYE. The tax and the GST…Provisional tax, so I’m always like, take a third and leave it there, and don’t touch it kind of thing.*

Nancy described putting aside tax money to ensure she could afford any income tax, provisional tax or GST for which she may be liable. Jayci also followed this practice of saving for tax.

Jayci: *I learnt that no matter what happens you do not interfere with what you’ve got put aside for tax and put it in a separate account and earn interest on it and sit there and watch it for six months.*

Jayci’s conservative practices created a cushion for the times when taxes were due, a strategy seen across the participant group and described by Jessie as a “buffer”.

Jessie: *So, I've made sure that I've built up a good reserve in my company so that I never have any trouble with the tax department and have a buffer if I became unwell. And I've got that reserve really protected. And kept contributing to my super[annuation] and my KiwiSaver [pension] and all those sorts of things in readiness for 65. But all of them would be*

> *a protection if something untoward happened. So, I do think you have to be really, really, disciplined about how do you make sure that you never, ever get into financial strife.* ***The last thing you ever want is any trouble with the tax department****.* (Emphasis in audio)

Jessie summed up the feelings of the majority of participants, that the IRD was initially viewed with trepidation and as a punitive organisation. The group were cautious with their incomes and made plans to save and manage their money. Despite this, the majority had little confidence in their financial abilities.

The participant group learned to deal with the IRD with the support of accountants, friends and family. They were conservative and careful, seeking guidance when required. The next section explores the more difficult area of charging for their services, negotiating contract rates and navigating through loss-leaders, which are used to sell services, in this case the contractor at a loss to attract customers, in some situations the term 'bait' may be used (Dong et al., 2021) and "mates-rates" which are lowered rates for personal friends or colleagues as a favour (Beachcroft, 2017).

7.5.2 Navigating new waters

The historically gendered notion of women depending on men for financial support, manifests when financial matters are considered a normatively masculine space, unsuitable for women. This myth perhaps perpetuates female avoidance of such skills and reinforces the public perception that women have essentialist deficits in business-related skills. Certainly, neither nursing education nor employment structures challenge these notions.

Billie experienced discomfort in confronting the difference between contracting rates and the employed nursing hourly rate.

> **Billie:** *I can do the finances in the background but it's that 'up front, "this is how much I cost" I've never had to do that before I've always been an employee, nurses are employees generally. So how do you say "this is what you're going to need to pay me"? It's hard I think, and that might be a gendered thing.*

Billie never had to ask for an hourly rate while employed and found it difficult while self-employed. Contractors have overhead costs, resources and utilities to cover, along with hidden costs. The increased charge per hour to deal with this, plus no sick pay or annual leave, can create a dissonance for those unused to dealing with contractors. Jill had similar challenges and identified self-employed nursing as problematic.

> **Jill:** *You do get, I find as a consultant a bit of an attitude about that. Some of it is a reaction against an entrepreneurial side of things and some of it is just a lack of understanding that if you charge $100 an hour, plus GST actually, in your pocket, you're probably getting about $45. People don't understand the compliance costs, the ACC, and the PAYE, and the office expenses and all those other things. So, some of its lack of understanding but some of it is nurses in particular get a bit kind of agitated about it. I don't know what it is but I notice it a lot.*

Jill found a lack of understanding from nurses when it came to invoicing for work. Billie and Jill were both working with nursing groups and found the contradictions and tensions towards their invoicing rates frustrating. Nurse leaders may not be seeing average or benchmarked contract rates across healthcare, but there is also a devaluing process by which nurses perpetuate their own professional constraints.

Jessie and Susan were the only two participants who described a relaxed attitude about contract fees. Both had worked as CEOs of large healthcare-related organisations and had experience with negotiating contractor fees.

Jessie: *When I had my change of career, I set what I think was quite a realistic annual income – given the sort of salary I've been on as a CE of a [health provider] – so I think I was very realistic about I'm not going to remotely earn that sort of money any more but I will need to earn this amount, because I'm the breadwinner in our household.*

As the main income earner, Jessie used her experience to ensure she could earn enough to be comfortable. Susan was at the forefront of financial management, reporting and budgeting for years prior to her shift in career and understood what contractors charge.

Susan: *If I'm on an hourly rate, usually I'd prefer fixed price. I estimate how long it's going to take me and I give a fixed price. It's much more comfortable for everybody. But clients nowadays expect you to delineate what your daily rate and what your hourly rate is when you do the proposal so it's all up front.*

Susan and Jessie were confident with the language of finance and power. Their experience and words were noticeably different from the rest of the group, including those with the highest level of academic qualification.

Jacqui was a nurse leader with a PhD, no contracting or business experience and an acute discomfort about setting contract fees. But she did believe she gave value for money.

Jacqui: *Really uncomfortable I have to say. You just need to bite the bullet and do it. In the end, because I'm pretty committed to producing quality output, they get plenty of… the hourly rate drops – you know.*
But it is hard. What makes it hard? I think it's because really, you're saying, "I am worth this, I am worth this amount."

Jacqui identified valuing oneself as pivotal for declaring an hourly rate or a contract fee. The International Council of Nurses (2004) contended that if self-employed nurses cannot determine their value, others are unlikely to positively do so. Conversely, if self-employed nurses did charge

reasonable rates, they would risk losing contracts and possibly clients. It is a fine line. Lou had a similar experience.

> **Lou***: It does feel strange invoicing people. Because what you're saying in some ways is, "I'm really rating my ability here. I've got something that you don't have, and I'm charging you for it. So, I'm feeling fairly confident that I'm giving you something that's going to help you." So, you have to be in that space, you do have to rate yourself.*

Lou found that charging a reasonable fee meant developing the confidence to put a high value on her work. Ingrained inferiority and homogeneity would make it difficult for nurses to position themselves as different and able to offer and charge for advanced, high-quality work in an unusual practice area.

Billie described how the submission of an invoice caused her anxiety and embarrassment even after doing the required work.

> **Billie:** *I think they get a good service and I really struggle to…, I almost feel embarrassed to submit an invoice. Especially if it's a big one and I have actually rung up and apologised and said, "Look I'm sending this in, it's a whopper." But that's what we did this month and they are like, "no, no, no it's fine" and I'm like oooohhh hit send. But that's what it is. So, I'm not very good at that side of it.*

Billie underestimated her own financial value and despite an agreed contract rate, felt uncomfortable charging for work done. This has a gendered component and suggests an inferiorised identity, so more detail was sought from Billie.

> **Billie:** *I get a bit cross with myself, because I think it's under-valuing what I offer and I think they are getting a really good service for not enough and I think people, certainly nurses are really naïve about actually what is a reasonable hourly rate. And I think I am extremely cheap, and they still balk at, they are like, "oh my god that's a lot of money" well actually no*

it's not. Not when you add it up for the project that I'm doing, it's not a lot of money. And if you were employing somebody you would be paying a lot more than that. But they don't get it. Because it's broken down into hourly rate, they don't really get it.

Billie felt her clients did not understand her fee structure but she probably did not recognise her own position in this performance. Participant subjectivity can contribute to low contract rates. Billie knew her costs and the quality of her work, but her subjective discourse situated her as a performer in her own oppression.

Employed, salaried nurses perceive the self-employed hourly rates as being high. When compared to salaried rates, they are. But this is an over-simplification and when the addition of resources, experience and leave allowances are all considered, the comparison is entirely different. Jeanette identified a lack of understanding about what a contract fee includes.

> **Jeanette***: To be honest, I don't think they do understand that, they just see the dollar and think that that's very high and don't actually realise well no it's not. I mean, I was probably quite lucky that I'd had a little bit of experience of working with some nurses working in an independent capacity, so I had a bit of an idea of what they had charged previously when we were using them.*

Jeanette had worked with contractors and understood the contract environment. Self-employment and entrepreneurship are traditionally focused on making money, which may account for the common but erroneous belief that contractors are high earners. Mary had also experienced pushback from other nurses on the amount she charged per hour.

> **Mary:** *Yes, there's definitely not an understanding at all. No. And, part of the reason where I just lost some work, was around the other nurse that had rung me, then went, "Pardon, how much are you charging?" And, that's a real detriment, yes, I think to our profession. It continually just supresses the whole workforce.*

In oppressed group behaviour, members who perform differently can be subject to exclusion and criticism, both overt and covert, from members of their own group, indicative of oppressed group behaviour as described by Young (2011).

The topic of payment for service has been unpalatable in nursing for years. Tash noted the lack of communication within the small pool of nurses because without advice from experienced peers, new contractors have little to no insight about current contractor rates.

> **Tash:** *So, three years in, what's everybody else charging and where am I in terms of parity with other women? But I think there is something about, "you're a nurse, so why would we pay you anymore?"; but that's never been tested and nobody has ever said that. It is purely, I think, around them not really understanding what I'm bringing.*

Lack of communication about contract rates could indicate that each contractor perceives a limited pool of available work and so contract rates and information are carefully concealed. Tash's report that being a nurse can affect a person's contract rate was echoed by Nancy.

> **Nancy:** *But, absolutely there's no appreciation, that actually what my hourly rate is only a third, because I pay my own GST and I pay my own tax. If I'm sick I don't get paid. If my child's sick I don't get… you know, none of that. So, I absolutely agree; there's no appreciation of that. And, I didn't appreciate it too, because I would kind of pitch myself quite low and I'd feel really shy and embarrassed about saying, "Actually my hourly rate is $[---]," and so I would shudder and I would see their expression too around that, until I started working with colleagues that charged double – not nurses of course – and had no qualms about saying, "Actually my hourly rate is $[---] and you're co-contracting with me, so what I get paid you get paid and this is how it works." I just would be kind of horrified. But I guess, it's about how we value ourselves, and that we're not encouraged to actually promote ourselves in that space. But I tell you, once you've become self-employed then you have a different appreciation – entirely different.*

Nancy observed that non-nursing contractors charge higher rates, but this realisation did not make it easier to increase her own rates. In charging lower rates, self-employed nurses devalue their own professional background, especially when working for colleagues or friends.

Working for friends at a lower rate than normal or mates' rates (Beachcroft, 2017) is something most of the participants had either offered or were asked to provide. Billie had not only delivered work at mates' rates but admitted to struggling with invoicing even at a reduced rate for friends and colleagues.

> **Billie:** *I have in the past done a lot of "mate's-rates" stuff and once you do mates rates it's really hard to retrieve it and they think that that's quite a big hourly rate, well actually it's not because I only ever charge for the hours I work. If I work 1 hour for you, in a day, I only charge you for an hour, I don't charge you for an 8-hour day. So, I'm very careful about what I charge and I think I've come in under budget so often that people trust me. I am very careful; I mark down every hour that I work so that I don't over charge anybody. But I do, I undercharge and I'm really bad with that.*

Billie admitted to undercharging for her high standard work. There is a gendered aspect to this practise through the low value often attributed to women's work. Nursing work has interpellated into subjective discourse. Jacqui related a story of a colleague who worked for mates' rates.

> **Jacqui:** *Well, I think you do one contract with them on mate's rates and then it just gets worse. I've got a friend who's been contracting for a long time ... and I've seen her get into quite a bit of grief over that; kind of like, well "no wonder they want you, you do fantastic work and you're so cheap." so of course they'll ring back because you're so cheap.*

Working for free or at lower rates can help to market a profile however, as Jacqui and Billie both noted, working for less is difficult to adjust once the precedent is set.

The participant group had no access to sick leave or annual leave unless it was factored into their contract rates. Contract rates must accommodate for future down times, periods of illness, inability to work and the time spent seeking work. Despite these precarities, the participant group still found value in working for lower rates or, in some cases, pro bono.

> **Nancy:** *I've done some free work for my iwi and not charged anything. One provider I did some work for and I set up a project. Then I gave it to them and the agreement was that I would go on a health quality safety improvement course ...Well, it kind of fell over and I couldn't complete that course, but I still offered the provider to work with them until it built momentum.*

Nancy described her involvement in supporting a local community and working to deliver a product despite not being offered the contract. Good will, trust and reputation are vital in building a profile.

The financial concept of loss-leaders (Dong et al., 2021) within the participant group was for completed work, meetings voluntarily attended or a product delivered but free of charge or at a discounted rate. This strategy was used to develop a working relationship, new contacts and potentially a future contract. Margaret used this method to test the possibility of securing university contracts.

> **Margaret:** *It was a sort of fixed term contract or whatever and that was you can't say, "I want this now," because [The provider] said, "Well this is how much you're going to get; this is how much we pay people and there's nothing you can do." And again, that was a bit of a loss leader because I thought, 'I'll see if I like it,' because it could be that working at [University] might be something I want to do, and it's not encouraged me there, it's not filled me with enthusiasm for their systems.*

Margaret described using a loss-leader approach to not only find work, but to assess if it was an area she wanted to pursue. However, she found herself working a small amount for a very low hourly rate and in no position to negotiate.

Jill noted another situation where loss leaders were commonly found. A self-employed nurse attending meetings for no remuneration, whereas for other nurses and attendees the day was a paid workday.

> **Jill:** *I'm here today for the college work that I'm doing but I'm not being paid for the day I'm here today, I'm volunteering that, but the other nurses in the room are being supported to attend by their DHBs.*

Data showed Jill's experience was common. If a nurse is self-employed, meeting organisers may not consider reimbursement for their time and won't allocate part of their budget for it. Jill positioned the meeting work as a loss-leader, lowering her value and rates to access networks for potential future work. Building a reputation and a profile was an upfront cost to the participants.

This section explored the problematic and gendered space of charging for service and hourly rates, an area in which the majority of the participants felt the most uncomfortable. They had to adjust their expectations of their earnings and consider using loss leaders. This sort of risk can be mitigated when there is financial security underpinning the business. The next section considers the financial security of the participants.

7.6 Financial self-efficacy

7.6.1 Financial security and value add

The participants' level of risk aversion depended on their financial security. Data show all the group were reasonably financially secure. Either they were earning enough through contracting

to be their family's primary income earner, were equal earners or added to another full-time earner's household income. For example, Margaret was financially secure.

> **Margaret:** *Financially we're fine, I don't need to work, and I find that worse because it's like, "Oh, you don't need to work; you could actually just give up." And then I'm just, like. "Aah, I need to work, for me, and for my brain, for my sense of self; probably more for that."*

Margaret was in a fortunate position where her only pressure to work came from what she put on herself. She approached self-employment from a position of social and financial privilege, which mitigated the issues of income precarity. Jessie noted the difficulty of self-employment without a financial backstop.

> **Jessie:** *I'm not quite sure how people do self-employed as a sole operator if you've got the pressure of a mortgage. I think that raises the stakes quite considerably. And I worked really, really hard to be in a position where I didn't have a mortgage and I had savings in the bank. But for me I knew I needed to be mortgage free and have a buffer. That's all part of that intentional decision making.*
> *I can't even envisage what it must be like to be worried about losing your home. I couldn't handle that.*

Jessie identified the need for a supporting income and financial security before becoming self-employed. A sole income earner or someone with a large mortgage could find self-employment too risky.

Margaret also experienced a lowered income and could see how this might limit the pool of nurses able to pursue self-employment.

> **Margaret:** *It's not a skill, but I think you need some financial grit behind you because to go from a modest income to nothing, 90 percent of nurses just couldn't even contemplate that.*

They couldn't even do it. They'd probably try and do it while they're doing another job or something; they just couldn't even think of it.

Margaret indicated that a significant financial buffer was needed to cushion a drop in income when moving to self-employment. Margaret saw that taking the risk of self-employment required a confidence only bought by financial security.

Nancy further exemplified the issue of low contract rates, whereby she had moved from a higher senior nurse salary to a significantly lower self-employed income.

Nancy: *I haven't really [been] in a position where it's been my only source of income. I mean, obviously you go from earning a six-figure salary to like a $20,000 salary, or whatever it was. It was a marked drop. I was prepared for that drop. I have a belief that actually I am self-employable and I do have a skill set that's needed in the sector, so I can kind of do that.*

Nancy was not her household's only income earner but even so, she experienced a substantially lower income, as did most. Data showed that the majority of participants had a drop in income, reinforcing the need for existing resources and support.

The participants were all female with life partners, most of whom were either fully employed or self-employed and could support the participants when contracting income fell or was non-existent. The two with retired life partners were also the most financially successful contractors. Financial security also factored into decisions about investing in resources previously taken for granted.

Sally: *I felt really anxious going out on my own, and going from health where you have to validate and evidence base everything, I felt really exposed and anxious and not confident in that way at all. And, vulnerable because you haven't got the resources suddenly anymore to do a literature search in the way that you did before.*

Self-employment can create significant anxiety from losing all the resource and back-up available as an employee (Statistics New Zealand, 2017a). Participants had to balance the resources they needed to provide a service with what people were prepared to pay for those services. The participants did not need a great deal of upfront capital, but some resources were required, such as paying for their own professional development, communications, office infrastructure and transport costs.

Although an expert practitioner, Tash's accountant said she was significantly underestimating her value.

> **Tash:** *I broke even in that first year. I probably after tax probably got the same that I would have got if I stayed at the university. Again, last year. But [my accountant] keeps saying to me: "You need to be at the $150,000 to $250,000 women like you." Women like me? Yes, well help me get there, what do I have to do? There's a lot more I could earn; there's a lot of higher expectations by my accountant on my ability.*

Tash said "*Women like me?*" as if her own value of her abilities was inferiorised, despite obvious proven achievements. She explained further.

> **Tash:** *It's that kind of, the imposter syndrome and I think women talk about that. Or you know the fraudulence or being a charlatan in some way. But, for me, it was more about being good enough, or other people are better than me, and other people have more success than I do.*

Imposter syndrome (the feeling of not being worthy of the level of achievement or seniority) is fairly common among women in leadership positions (Ladge & Eddleston, 2016) including those in self-employment. Positions of power are generated and maintained through cultural norms and are reflected in repressive subjective discourses which challenge contradictory logical evidence as presented by Tash.

The participants were unable to assimilate their achievements and downplayed their financial worth. They were captured by subjective discourses about their value, knowledge and skill. They needed an external agent, such as an accountant, to assist them in seeing what could be achieved. In this example, Tash was imbued with confidence by her accountant.

> **Tash:** *But I think the one thing I got from her was the ability to think that it was okay for me to do this; sort of break down some of those, kind of working class, what I call the "North of England." You know, you get married, you have kids and that's it and that's how you live your life.*

In Tash's gendered subjectivity, self-employment was not a consideration. Tash was raised with a certain understanding of what a woman is and does. Predominant discourses of appropriately-gendered behaviours formed Tash's subjectivity about self-employment.

Data suggest most of the participants were undercharging when compared to contractors from comparable professional groups. The impact of gendered subjectivity and occupational devaluation was evident as participants navigated the challenges of invoicing and understanding their own performance in their oppression as they stepped into the normatively masculine space of financial management for business. In the next section, the participants were asked about the value they placed on networking as a process for increasing work.

7.7 Networking and social capital

In the separation phase of liminality, Garcia-Lorenzo et al. (2018) identified the participants as outsiders with limited or no access to resources and familiar institutions to support their progress. The development and maintenance of networks was pivotal for this study's participants.

Once the social capital of networks exists, the participants could launch their businesses. This strategy was exemplified by Jessie who showed great insight into the value of networking, not just to access contracts, but also as a mentorship option.

> **Jessie:** *I work really hard at sort of connectedness and one of the things I do spend money on is dinners and lunches, and because I don't pay for an office, any week I will have lunch meetings with people, and I actually mentor quite a few people and most of those people aren't earning much money so I'll usually pay for their lunch and put it on the business.*

Jessie found investing in networks and mentorship a far productive use of her time and money. She was not using the time simply to find work, but to support and encourage others in healthcare. This form of contribution and philanthropy can be rewarding for both parties.

Jill described the maintenance of networks and groups she had developed prior to becoming self-employed.

> **Jill:** *Probably what helped was that when I first started, I already had strong national networks and when I was a nurse in [city] I'd been on a couple of national boards and knew people across the country in different roles. I had a lot of those links before I started which really helped.*

Networking at a national level kept Jill in the forefront of potential clients' minds as an expert and contractor. Susan had no issue in using her networks to source work and supported the continued use of networks as a strategy. Susan had experience as a contractor with a high workload, suggesting this method is successful.

> **Susan:** *I always advise people setting up that you need good networks to start off with, and at the beginning you need to actually spread your cards around and suss out and work with your networks and try and get a contract.*

Susan displayed comfortability with both networking and the socially acceptable masculine norms of business.

Social identity theory, described by Tajfel (2010), suggests that in-group membership increases acceptance and credibility resulting in improved ability to converse and understand an interlocuter's context. Billie viewed in-group membership as a social position and key to securing work.

> **Billie:** *To work within the nursing community, you have to have the right language. I've seen people who are not nurses try and work in nursing. It's hard enough trying to come into health. I think health is a very hard area to get into if you're not familiar with it and to get into nursing as well is another language again, and I don't have any problem with that because I know the language. I've been immersed in nursing my whole adult life. I think it's about speaking the right language and being able to "getting-it" when people say things. I know the organisations. I know the landscape of nursing.*

Billie believed network navigation within the profession was vital. The participants all came from nursing leadership positions which gave them access to various nursing groups and practice areas using the relational skills of nursing, enabling, acceptance and creating work opportunities.

The participant's expertise was specific and unusual in nursing which meant that without a substantial client network, the participants remained unknown, unproven and potentially no longer part of the accepted nursing in-groups. Mary experienced "out-group" behaviour from some nursing networks, creating barriers and feelings of exclusion.

> **Mary:** *I mean, you can try certain networks that are well established, and others you can try; but I'm not going to continue to try if you're hitting a brick wall. But I think definitely it seems it's who you know, not what you know kind of thing. And, it's scary to put yourself out there and then you get rejected.*

Rejection, as experienced by Mary, can result from an in-group phenomenon, requiring a set of behaviours which enable group regulation.

Nursing may appear, in the eyes of the public, to be a homogenous group, but there are multifarious groups and specialties. Despite this, most nurses understand the cultural norms and group language, so their behaviour is acceptable and seen as normal. The participant group had to bring their past cultural experience to bear while developing a new professional network and building their social capital.

7.8 Summary

This chapter found the participants in transition, the most challenging liminal phase, in which they felt the least skilled and the most challenged. They needed to learn new skills, create new networks and develop new identities which may be unclear and complex. The evidence of gendered subjective discourses and the tenacious positioning of nurses as an occupationally devalued femininised profession resonated across the data.

The concept of precarity was explored as the previously salaried participants experienced an erratic workload and subsequently erratic income for the first time. The group had a high level of comfort with taking a calculated risk since they were all financially stable prior to becoming self-employed, giving them the ability to ride out weeks or months of low income.

Networking and social capital were explored in relation to accessing work and maintaining a presence and profile among the target client group. The participants viewed this as a vital area to support their businesses. All participants performed low-level, soft marketing with some spending

an initial small investment but with no plans to spend more. The most effective ways of finding contracts were word of mouth, networks and maintaining a strong professional reputation.

Finance was their most significant area of concern. Most were undercharging for their services despite offering quality work. It appeared the legacy of nursing in the roles of charity and duty still had an impact, both externally and internally, on the nursing profession. Tax and other financial requirements created the highest levels of anxiety and most sought advice from family, friends and accountants. This support group became pivotal and often helped not only with financial aspects, but also took on a broader role as business advisors.

In the next chapter the participants move out of the public structures and institutions of healthcare and into the private, domestic sphere of home-based self-employment.

Chapter 8: Re-aggregation; public and private

8.1 Introduction

The participants were all at different stages in their self-employment experience, but this chapter focuses on areas of business which would be more often found in the re-aggregation or incorporation phase of liminality, such as the propensity for entrepreneurial risk and beginning to see possibilities for the future.

This chapter is split into six subsections beginning with (1) **Combining public work and private** spaces; the group had left the control and oversight of health institutions and moved into home-based spaces. Strategies to manage the tensions of working from home are explored, including managing domestic chores and caring roles. (2) **The duality of freedom and flexibility**; the pros and cons of flexibility and freedom are considered against making time for (3) **Family and friends** who also need to learn new boundaries as part of the home becomes a work-space**.**

(4) **Entrepreneurship and risk** are explored as self-employment confidence builds. Moving professional work into the home has the potential to create family tension while conversely the participants could also be dealing with (5) **Isolation.** The final section considers (6) **What does success (or failure) look like?**

The first section in this chapter explores the participant experience of moving their non-clinical nursing work into private spaces of home.

8.2 Combining public work and private spaces

Creating a space for a new business is a way of positioning the work. The relocating of one's business is identified by Garcia-Lorenzo et al. (2018) to be within the re-aggregation phase of

liminality. How the participants approached this depended on the available physical space in their home, family life, business needs and what they felt was required to run a small business. Four of the participants had created an office space, either inside the home as an extension or outside the home. Two were using a home-office space, two were using converted spare rooms and five were working in communal family spaces such as the lounge or dining room. Whatever the working environment, it was starkly different to traditional healthcare spaces and created specific challenges.

Working from home requires one of the key traits of a successful self-employed nurse consultant: self-discipline. Jill suggested that while working from home is seen as the ideal, it does not suit everyone.

> **Jill:** *I think that from the outside looking in, it can look like a really good option. People go: "oh, you're working from home." Yes, well, there's many great things about it but I think knowing whether you can be self-motivated, knowing whether you can be disciplined enough to do all the compliance paperwork and all that sort of behind-the-scenes stuff that nobody pays you for. That's quite a skillset really.*

Jill observed that working from home may seem like an attractive option but it had its challenges and required both self-discipline and a place to work.

The participants all had some form of dedicated workspace. Jacqui's office space was a calm environment, disconnected from the noise and a place to retreat.

> **Jacqui:** *I prefer to work here. If I'm doing any serious thought-work, then I do that here.*

Jacqui's idea of a thinking space resonated with Lou, who also identified the space she occupied as a specific thinking space, separated by physical boundaries, to create a peaceful working environment.

> **Lou:** *The first thing for me is coming upstairs. I come up these stairs and it removes me from the rest of the house. The only other place up here is our bedroom, which is a place of calm. So, I come up here, and this is at the very apex of our house, and I feel like this is my secluded space of quiet. A place to think and a place to concentrate on whatever it is I'm doing with work, or just my administration of my home. I feel like it's a really nice space.*

Lou had also found a place to think and optimise her work time. Both Lou and Jill used their home's office space. Wagner and Wodak (2006) suggest women in self-presentation have the skills to create spaces which match their goals of a healthy and positive workspace and an ability to pursue a healthy lifestyle. Lou reflected this ideal.

> **Lou:** *I feel good in here. I feel like me. I need to feel like me, doing a job. If I go into an office space that's very dry, and everybody's very serious, and I think the decor is so boring and mean-looking, I don't feel very inspired. I feel like me in here, and I can put that flavour into my work, I think.*

Making spaces to support creative activities, thinking and individuality, as well as foster a positive working environment are important components of working from home. Not all the participants relayed a such a positive experience. Sally described how carving out a space to work in an already busy family space can smother the ability to think and create.

> **Sally:** *The office is in our living room, so I would call that stifling the need for creativity and space. Eventually, I'd like to have a sleep-out or something outside that is the office, rather than the office being in the living space. But it is what it is. We have two desks in our living space, and we manage and it's fine.*

Space is not always available to set up home offices and some of the participants had to make the best of what they had. Sally talked about managing, but her situation was not ideal.

One of the participants, despite establishing a dedicated workspace, fell victim to the precarity of contract work. Margaret set out with a goal to create a self-employed working life to give her flexibility and freedom while enhancing her professional potential. She created a workspace at home to accommodate and reflect this endeavour.

> **Margaret:** *It is a symbol of failure as I set it up with a sense of optimism that someone would want to utilise the skills and experience, I have. When I do have work, I do it at the kitchen table and prefer that.*

To create an ideal and hopeful office space in a home that cannot not be used is a risk.

> **Margaret:** *…it's a room I avoid as it symbolizes what I see as failure.*

Margaret's workspace was a daily visual reminder that plans did not come to fruition and as a result any work which was forthcoming was relegated to the kitchen table. A symbolic positioning of a work life which did not eventuate.

Ability to manage a small business in the home space was described as both positive and negative by the participants, as some had to overcome challenges to ensure their productivity while working in shared family spaces. Billie used a temporal boundary in which the flexibility of working from home had to be followed in a disciplined way.

> **Billie:** *It's lovely being able to work from home but you've got to be very disciplined at cutting yourself off from work otherwise it's always there.*

Billie had found that taking a break from work is important but if work is in the home, separation can be challenging. Susan also used time to accommodate time zones in her international work, an uncommon difficulty for nurses.

> **Susan:** *When I was working internationally, I had to set boundaries and my boundary was actually 12 to 5 and I said, 'Right, I won't do any teleconferences between 12 and 5,' but in fact I have sometimes got up in the middle of the night.*

Susan managed to move around her self-created boundaries when necessary. Because she was self-employed, Susan could manage the ramifications of waking in the middle of the night by using her time flexibly in the following days.

Without a physical space for her business, Jeanette worked in the family living space, so during work-time she was at constant risk of being disturbed. Without a physical space for her business there was a strong risk of conflict and disruption.

> **Jeanette:** *Whenever we need the table for meals, when there is four or more of us, I have to tidy up my space and move my things elsewhere until after the meal is completed.*

Jeanette was not only unable to create physical boundaries, but there were also no spatial boundaries, such as a desk, or allocated space in the family room to work. Jeanette's work was physically and psychologically pushed to one side to make room for family activity.

> **Jeanette:** *Given I work in an open plan living area there are no physical barriers. However, I will go to another room to make and receive phone calls if anyone else is at home. If I have a planned call or teleconference in my diary, I will let my family know so that they realise I need quietness during that period.*

Jeanette experienced a tension between home as a workspace and a family space in which daily activities and chores were still done. Since the Covid-19 pandemic and the lockdowns, many more people now work from home and may well experience the same tensions (Toniolo-Barrios & Pitt, 2021).

Nancy experienced a similar issue, however there was a space for work within the family area, which could be allocated predominantly, but not completely, for work.

> **Nancy:** *It's comfortable, it's home. I kind of go in and out of it, but it's not just my space where I do the big thinking. It's a practical space. Functional space to work in, yes. Predominantly I sit in it. It's not a dumping ground, but it's kind of the space where we put all our books. The ironing board is sometimes in there, and things like that. So, it hasn't been kind of a closed off space where I just work.*

And:

> **Nancy:** *It's always been work hours are 8.30am till 3.00pm for me. The house is cleared out and nobody comes around. So, those are kind of my office working hours. If I need to work on the weekend, or at night, then I try and do it around when everyone has cleared out, or they clear out. But the ring-fenced time has always been when [daughter] is at school, [husband] is at work, and then 8.30 till 3.00 that's a protected time. Which is why when I talked about, it's got to be efficient, because I know I've only got that amount of time when there's nobody around, and nobody comes.*

In creating a time-based boundary, Nancy both reaped the benefits of quiet, thinking time and was also limited by those time constraints. Again, family time was privileged. As knowledge workers, the participants navigated the complexities of multiple belonging, as well as learning how to be self-employed by bringing public work into a private place. They were professionally positioned in an in-between or liminal space, physically, relationally and discursively.

The pressure of having a workspace and work tools close by can be challenging and require disciplined management. The next section explores the freedom and flexibility of self-employment in the context of living and working in the same space.

8.3 The duality of freedom and flexibility

The participants had been self-employed for varying amounts of time, from a few months to nearly ten years. This section explores how they experienced their self-employment in relation to freedom and flexibility. There can be a duality in flexibility as women work part time to fit in with family and other commitments and benefit from the flexibility of choosing how and when they work.

Jessie used the word freedom which encapsulated the feelings of several participants.

> **Jessie:** *Freedom is a word that I definitely use. I'm busy but I still have an incredible sense of freedom.*

Jessie noted that freedom was a strongly positive outcome of her self-employment. Freedom, flexibility, autonomy and self-direction are all factors which cannot be realised to the same extent in employed roles. Billie said that self-determination, self-realisation and self-direction were important when building her bespoke office away from the house.

> **Billie:** *I got a bit over it and I had wanted a [built office] for quite a long time, so I got to the point where I said, "You know, this is going to have to happen" so we sorted this out. So, working from here is like a breath of fresh air. It's wonderful, I love it here. Because working as self-employed from home, I can get up whenever I want unless I've got a meeting. I pottle down when I'm ready and I work till I finish, which can be until 7 or 8 o'clock at night if I want to. Oh, just the freedom to do that is astonishing, I love it.*

Billie experienced great pleasure in being self-employed away from healthcare institutions. She expressed a sense of freedom in relation to the time to work, for sleep and relaxation along with the self-directed ability to work at the most productive parts of her day. These freedoms are rarely found in employed nursing roles.

Nancy identified that not only could she work when she preferred, she could select what she worked on. Freedom and creativity were imbued when not tied to key performance indicators within a job description.

> **Nancy:** *I like that I can pick and choose what I work on too. I don't have to be doing things that I don't like, or I'm not good at doing. I just put my energy into things that I know I'm relatively okay at, or good at.*

Ownership of the work enabled creativity among the participants who enjoyed working in new innovative ways as part of their self-employed roles. Billie described how creativity was a critical skill for her role as a self-employed project manager.

> **Billie:** *When I went into it, I thought it'd be "do this project please, and this is what it's going to look like," but that's not what happens. What happens is, "we kind of want to do something like this, can you draw up a project plan?" and you're like, "what? All the content?" So, you have to create something from nothing because people have an idea about what they want. But rarely have I had a clear brief about my project, very rarely.*

Billie described situations in which she was given a blank project canvas, requiring expert content knowledge and creativity. Gherardi (2015) and Garcia-Lorenzo et al. (2018) suggested that creativity is often found in nascent business owners and there can be benefits from a continued limonoid state. Whilst continued liminality may be a positive benefit for the participants, it is also something for which they need a high level of tolerance.

Liminality, self-reflection, innovation and exploration are all part of finding entrepreneurial opportunity. Jacqui saw this creative opportunity as a refreshing change from the employed role.

> **Jacqui:** Q*uite frankly, I haven't felt this intellectually challenged in a very long time …Intellectually challenged, as in "Thank goodness something intelligent has come my way."*

> *I'll finally get to properly engage yes, instead of just working and slogging. I'm actually back to creating something unique and valuable really.*

Jacqui viewed her work as creative and stimulating after been anchored to an employed role with expectations. In self-employment, she rediscovered creativity, producing and delivering tangible products.

It is unusual for nurses to deliver an actual product and this ability feeds into a new way of viewing success. Billie found this to be a satisfying aspect of self-employment.

> **Billie:** *To be given that type of freedom to create something, and being supported to do it, is hugely professionally satisfying. To be trusted to that degree is very satisfying.*

Billie not only enjoyed the freedom to develop and create, she found the inherent trust highly rewarding.

The participants were already identified as self-starters and able to be self-directed, so the addition of flexibility at first appeared to have no negative aspects. However, as with numerous other experiences, there was a duality in which their part-time work must fit in around family and domestic chores. Nancy described her experiences with flexible work.

> **Nancy:** *I think it's been really important having that flexibility, and that I can work on Saturday or Sunday, that I can work at night and can get up at four o'clock in the morning and work on it. I can work outside the traditional nine to five hours. So, it's probably one of the benefits of being self-employed, is having the flexibility to do that in and around your family.*

Nancy described a situation where her flexibility involved catching up on work at all times of the day and night to accommodate space for her family.

> **Jayci:** *Sometimes you feel it's out of control and you think, "oh God, I've got all this stuff to do, this one wants this and this one wants that." But it all comes right in the end but yes. It is about knowing that if something happened to anyone the family, I could just set aside what I'm doing and help them.*

Nancy and Jayci positioned their work as secondary to family, behaviour that is culturally normal and most mothers and grandmothers would feel the same way. While there is no suggestion this is wrong, it is gendered. It could be that the implications of gendered performance are unseen by the participants, not understood or considered unimportant.

> **Jill:** *Being around for my family, knowing that I can take a couple of hours off during the day and watch my daughter play sport or take her to an appointment or those types of things. I can have flexible working hours. If I wake up in the middle of the night and can't sleep, I can go to work and somebody will pay me for it. That's pretty good. I've had some health challenges. I've got pretty serious arthritis, so I can get up in the morning and light the fire and tap away on the computer in my pyjamas and most of the time I don't get caught.*

Jill made way for family during her workday, but she also found self-employment beneficial for her personal health concerns. This level of flexibility for coping with health issues was a distinct pull factor for the participants. In these examples, the duality of flexibility is established.

Jessie described how she experienced freedom and flexibility when she first became self-employed.

> **Jessie:** *I still, even after five and a half years, have a real awareness of the sense of freedom. I can remember the first day in my new life and I just walked all around the town. I was going to sort out my telephone, my mobile and sort of set it up, but I just walked outside and the sun was shining. It was the middle of winter but it was a beautiful frosty day, and I thought, "oh, my goodness – the freedom."*

Jessie described a powerful and positive memory. Freedom and flexibility can be viewed as the principal positives of self-employment but there is tension in ensuring time and space to enjoy those benefits, not just to pick up other work.

Procrastination can easily accompany flexibility. However, the participants were aware of the need to be responsive to clients and to be self-disciplined. Billie described her approach.

> **Billie:** *I can do what I like, and I don't have to answer to anybody apart from my contract holders. I have always been the sort of person that if something needs to be done I do it before it needs doing. I try and be slightly ahead of the game so if something is coming up, whether it's a meeting or deadlines or whatever, I like to have things done before the due date. That frees me up because I know that I am generally, not always, but generally very prepared so if I need to take time or I don't feel like doing something, then I can take time and I can go and do whatever needs doing and take time off if I want it.*

Billie thrived with flexibility and was self-determined enough to plan and prepare to such an extent that she could access time off when needed. Jacqui used the concept of work-time much more flexibly.

> **Jacqui:** *If I felt like I hadn't got the work done that I wanted to get done, I'd just do it at night. So, very fluid. My work and personal life has always been quite fluid anyway, and this is just an extension of that.*

The ability to work fluidly does require the space to do so, for those who worked at home in a shared space such as a living room, the option to work at night may not be possible. Jacqui had both the space and experience to manage work and time in a way she viewed as flexible and positive.

Flexible time can cause tension with the convenience of technology, which has significantly impacted how people live and work. The participants all expressed comfort with technology.

However, the proximity of smartphones and tablets has made work highly transportable which can be both an asset and a hindrance. Another duality. Susan identified her method of keeping up with work commitments while on holiday.

> **Susan:** *I've never had a holiday without a laptop since 1994. I answer emails every night. My husband objects to that. I went tramping. We did a walk in Switzerland in the mountains, an eight-day walk, and I had my laptop in my backpack, and we'd get to our accommodation at night and I was sitting down [with it].*

Clients value availability and the flexibility of contractors to work at any time. Tash realised her work time was creeping onto home life and so created time boundaries in relation to work phones and emails.

> **Tash:** *I am more careful now about what I do out of hours when I switch things off and don't look.*

Technology can be an entrepreneurship enabler, but it can blur the lines between home and work. Clients can also take advantage of a contractor's responsiveness by not remunerating the contractor for being available outside of normal business hours and weekends or, as in Susan's example, while on holiday.

Lou described prioritising work, while managing the competing demands of work and family time after normal office hours.

> **Lou:** *If I think there's been an incident at work, there's a complaint or somebody needs attention urgently, I will do it at any time. Because that's my job. If it's somebody just wanting a bit of information, and they email me, as they do, at 10 o'clock at night, I might see it and think, "oh, that's nothing important, I'll flag it and leave it." So, I don't tend to do that. But there have been a number of occasions where we've had some things happen and I've been on the phone at all times.*

Although flexibility can be considered a bonus to this way of working, there is a duality to consider. With flexibility comes the pressure to use the downtime productively, foregoing planned annual leave and picking up tasks at night. A positive is working in a way that fits around the family, but the family also must be carefully managed to ensure the paid work gets done. Flexibility, like many concepts in this study, is gendered with both public and private benefits and costs.

This section focused on how the participants managed freedom, flexibility and creativity. The participants had moved away from professional and institutional domination and had increased the opportunity for professional and personal freedoms. They were in a state of re-aggregation with new understandings and a new subjectivity about their professional existence and work life. At the same time, they exist in a liminoid state by maintaining their position on the edges, embracing creativity and self-direction. The next section explores another challenge to self-employment freedom: coping with friends and family who see the participants as at home and, therefore, available.

8.4 Family and friends

Moving the public work of nursing into the private space of the home can create unexpected tensions and expectations which have deep historical roots. Nursing history illustrates that nursing has always been socially constructed as linked to domesticity, women's work and unpaid or low paid labour. The tension of managing a move into a home-office and balancing it with the expectations of family, friends and colleagues, is explored in this section.

Interruption during work hours was a common issue described by the participants, in different ways and depending on their situation. Susan presented a strategy of instilling into her family an understanding and respect for her work, and thereby manage interruption.

> **Susan:** *I think you have to be firm, and you have to train your family.*

Clear rules for family and friends can minimise interruption. Susan had a strong work routine which supported her work needs.

> **Susan:** *What I found after he [husband] retired, the last few years, that he still sometimes comes in and wants to sit and chat about what he's doing, and I have to be tolerant. So, it's become a different sort of an issue in the last year or so. He knows I'm not cooking meals or doing the washing, that I'm in the office from 9am till 6pm and I come out for lunch and say, "Do you want a coffee?" and I'll make a coffee if I make a coffee. But I take it back into the office. I'm very structured.*

Susan made it clear she did not do chores during work time, a discipline which others did not find easy to follow.

Billie also described interruption but inferred some complicity in perpetuating the issue. She had accepted the role of homeworker by fitting her home life around her work life, however she also wanted to be seen by friends and family as a professional working full-time.

> **Billie:** *I think it's me projecting and sometimes it's not me projecting. I think it's just me picking up that you're available to do the chores, you're available to pick up things from the shops, you're available to go out for lunch, you're available to do whatever you want to do, and on the whole, I am. But sometimes I get fed up with it because it's not my job to do the washing up, it's not my job to do this that and the other. There are now four adults living in this house. The kids are older, and I know they go to work, **but so do I**!* (Emphasis in audio)

Billie is an example of how participants often complete household chores when work time allows, such as folding washing while talking on the phone. This duality of roles and spaces can become

overwhelming. This can result in a more part-time role, pushing the business into an increasingly marginal, liminal space.

Billie described how the gendered issue of domestic chores can create complex issues, induced by unspoken expectation, or an issue perpetuated by the participants themselves. The obligation to complete household work is still the province of women, and while men do housework, prevalent discourse still positions it as women's work. Jeanette described her approach to the issue of chores.

> **Jeanette:** *The chores thing I struggle with, to be fair. I'm not a particularly good person in the morning workwise. Always been the same. While I could get up and go to work, shift work at 7am and things like that, yes, I did that and that was absolutely fine. But I'm not a person that very often gets up and sits down at my computer straight away. I tend to tidy the kitchen and the room, maybe put a load of washing on and then I'll sit down and start working. To be fair, it really depends on how tight my timeframes are as well too. But I know I'm much better working from about morning tea onwards.*

Jeanette developed time and routine barriers to cope with her need to manage her workspace. This may be more important for those working in a shared family space, rather than those with a dedicated workspace. She also identified her ability to work when she is most productive, rather than conventional office hours, a freedom unusual in employed nursing roles.

Jill identified the social expectations of women working from home, although she did not feel compelled to fit the social convention.

> **Jill:** *I do prioritise work. I'm not particularly house proud. I have people quite commonly say to me, "Oh, how do you work from home if there's dishes to do or washing or windows to clean? Nah, I'd rather work." So, I don't get annoyed by those little things around the house.*

Jill challenged the gendered assumption that as a woman working from home chores will be high on the to-do list, again confirming a lack of consensus in the participant group. Stead (2017) introduced the concept of multiple ways of belonging whereby, as professional women working from home, the participants are always a mixture of nurse, business owner, partner, mother, daughter and friend. Jessie described being seen as the family nurse.

> **Jessie:** *My family still see me first and foremost as the nurse in the family. If somebody's ill or somebody needs support, or particularly if somebody's dying and that whole end of life, I'm always the one in the family that's called. It's primarily being a nurse ...so they always get me to be the one that walks them through – people more and more want to bring the person home or the body home.*

Jessie had not worked clinically for many years before her self-employment, but her family still saw her as the nurse. Jayci related her family obligations as a grandmother.

> **Jayci:** *The only thing I do struggle with a little bit, I love them dearly, but my children have got children who seem to be very needy at times, hence yesterday I went down to babysit for the whole day.*

As a nurse and as a woman, Jayci was called on to put work aside for family needs, therefore positioning her paid work as less important. The duality of personal and private spheres is a point of tension for a home-based knowledge worker. This was a highly gendered situation in which Jayci had professional responsibilities, but the socially understood role of carer usually found in the home prevailed. As a nurse, a woman and person working from home, the default, socially understood position, was that of carer.

Jayci was managing the tensions of being a grandmother and self-employed nurse, but Tash noted the potential for her self-employed worktime to be whittled away by caring for an older family member.

> **Tash:** *Since we moved in here with [my mother-in-law], she's very independent but she has mental health issues. So, there have been times when I've said to [partner] that I've noticed I'm creeping around literally creeping around, so she doesn't know I'm up here. Because I feel like sometimes… and it's more about me because she's always said, "I don't want to interrupt your work because you've got people coming…" But there's a sense of she needs help sometimes, or she needs attention.*

Tash was available to leave her work quickly to assist or support her mother-in-law. Meanwhile, both Tash and her mother-in-law were (quite literally) treading carefully around their own home to ensure they did not disturb each other. Such a tension would not occur if Tash did not work at home. Behaviours had to be established to create space, sound and time barriers to protect both parties.

Moving from long-term employment into self-employment at home was a risk for the participants who faced numerous challenges and tensions along the way. These tensions were often unexpected, sometimes self-induced and frequently due to dominant gendered social conventions. The next section explores how they saw themselves as risk takers or entrepreneurs.

8.5 Entrepreneurship and risk

In its development stages, the concept of nursing entrepreneurship was anticipated as the main focus of the study. But it became less so as data showed the increasing importance of gender and liminality. The relative rarity of entrepreneurship in nursing is explored in this section.

The participants were asked if they thought of themselves as entrepreneurs. This was greeted with surprise as most had never considered it. However, the participants each showed strengths in innovation, risk taking and being opportunists, as with Susan's response.

> **Susan:** *I'm just opportunistic and it's always worked. I've got to where I've got to right through my life and my career opportunistically.*

To work in a non-clinical, self-employed role, the participants had to be able to see opportunity in the road less travelled, to be chameleons and to cope with an unstable professional identity.

Each participant had an entirely different account about how they arrived in this space, there was no consensus story. Their only commonality was increased agentic positioning, by having a postgraduate education, financial security and a depth and breadth of nursing knowledge and experience. But they still had to summon the courage to seize opportunities, as in this example from Jeanette.

> **Jeanette:** *I think I've always been a bit of a risk taker. In my career as a nurse, this is maybe slightly different, but I've always stuck my head above the parapet and get bashed down too, there's no doubt about that. But I've done that and encouraged other people to do that as well too or to try and do that.*

Jeanette was an example of someone steeped in nursing who was also able to take risks, to fall back on her knowledge and networks to lead her into this new space. Likewise, Jayci and Tash talk about "grey" areas (Jayci; Tash) and feeling comfortable in a liminal space.

> **Jayci:** *I am sort of a little bit of a risk taker or I would never have got into this. Certainly, comfortable in the areas of grey.*
> **Tash:** *I do work well in the grey. I like the grey. I like that kind of liminality around moving into new.*

Tash had no issue at all working in the in-between, taking opportunities as they arose and trying new things. This can be a highly privileged position, but the participants knew the risks and that inhabiting entrepreneurial liminal spaces does not suit everyone.

Tash engaged with the idea of being an entrepreneur. Simultaneously, by working in this non-traditional way in a non-traditional space, the participants were challenging how nurses work and changing nursing's professional boundaries by increasing its reach.

> **Tash:** *I can make decisions about what I do, and I do it. That, for me, is why I am successful in what I do, because now I'm planning three years ahead. Anything I do now is not just to keep me afloat, it's the entrepreneurial.*

Tash and the other participants were not starting a business solely as a new endeavour, but as a new endeavour in a profession with long history in which the concept of non-clinical self-employment is barely known. They were de-stabilising the social construct of what a nurse is, does and where it is done. The entrepreneurial label fits to a point, but a more apt name would be nurse pioneers.

This section explored the concept of risk among the participant group. Another risk which may arise for self-employed nurses is isolation, whether professional, geographic or both, as explored in the next section.

8.6 Isolation

Isolation can be a benefit or a problem for those working from home, another duality. The work of the participants, as presented earlier, relies heavily on professional networks. The participants, while individualistic, now in a liminal space after working in large health teams throughout their careers, had to contend with both geographic and professional isolation.

Sally described missing the chance for spontaneous meetings and conversations along with the often-valuable sharing of ideas and networks at her previous employed role.

> **Sally:** *I miss the corridor conversations and I miss the kind of dynamic and the collective intelligence of those organisations in healthcare, and that energy. But it is what it is.*

Sally pointed out that for nurses there are usually lots of people in the workplace, all of whom add to the richness of a day at work. In their self-employed roles, there were fewer people and no opportunity for “corridor conversations” (Sally). Jacqui not only missed the face-to-face social aspect of a workplace but was coping with feeling less important.

> **Jacqui:** *What I like the most now is I don’t have so much email. Yes, I mean I’m really busy, but I’m not having to deal with dozens, dozens and dozens of emails a day. I do appreciate that. That actually took me a little while. It took me a long time to stop checking my phone constantly. And, for a while it was really a bit of a… “Oh, none. Oh, none.”*

Jacqui came to terms with her changing status, but it was an unexpected situation. The participant group may not have considered this before becoming self-employed, but as lead nurses in their previous employed roles, they had full email inboxes. In self-employment, an inbox is only busy if there is work. This could introduce a stark realisation of changing identity, of lessening importance, of increasing invisibility and possibly grieving for a professional standing.

Susan was self-contained and comfortable working in this way for long periods. Despite this, she had thought about her isolation could advise others accordingly.

> **Susan:** *There is isolation. That can be an issue. And that affects some people more than other people. But that’s something I’ve always advised people that are going out in business to think about. In fact, I’m really self-contained. I’m really missing my isolation at the moment being in a big, open plan office with a whole lot of other people. I just want to get on with my report.*

Susan was an example of a knowledge worker who had remained connected to relevant networks while retaining a professional distance and physical space. Similarly, Billie noted that working from home and self-employment did not equal isolation.

> **Billie:** *I'm physically alone, not professionally alone. I'm very professionally connected, and I think that's the only way I can successfully do what I do.*

The increasing use of web-based meetings, especially during the Covid-19 lockdowns in Aotearoa NZ, made more people familiar and comfortable with online working and connecting with teams across health. But there may yet be emerging consequences of such increased isolation.

Nancy realised she could not function in the self-employed nursing model without connections and the ability to keep up a profile and a network.

> **Nancy:** *I think you probably have to make a conscious effort to be in that space. That's probably why I stay on some of the boards that I'm on at the moment, just to make sure that I'm in that space hearing the discussions, or part of the discussions. Yes, I absolutely agree. There would be a risk of kind of getting isolated and becoming a professional recluse. But part of it too, is you have to kind of be connected to the sector, because that's kind of you're doing the work for the sector.*

Professional engagement is vital, and a successful knowledge worker must be well-informed and connected. Nancy noted this could be achieved by being on governance boards, using potential loss-leaders, financially speaking. Professional connections are the real key. Jill used this model as well and noted the dissonance she felt at times as she moved from one space to another.

> **Jill:** *Sometimes I find that a really stark contrast. I'll go from me and the cat one day to the Ministry of Health and 30 people in the room the next and people looking at me and I think, oh, they want me to say something. And I make jokes about being a hermit. But I guess the*

other way that I manage it is through my own clinical supervision, having professional supervision with a colleague who also works in isolation from the rest of the health sector.

Jill identified the need for professional supervision and mentorship in self-employment for a variety of reasons, including isolation. This is vital to sustaining a healthy work life and a successful professional practice. The next section explores the participants' views on success or failure.

8.7 What does success (or failure) look like?

Data suggest that a primary indicator of perceived success was ongoing work and being sought out to do work.

Jeanette described regular and stimulating work while maintaining the freedom and flexibility of self-employment.

Jeanette: *Success for me would be having a number of contracts or contracts that are available on an ongoing basis. I don't mean the same one necessarily, but ones that you know you can work on. So, I guess what I'm saying there is that regular work or regular contracting work with a regular income, whatever that might look like, and still maintaining the freedom to actually work in the way that I'm currently working as well. But also building a reputation as well or having people trust you to the point that if like yourself when you've been previously used that they'll pick up the phone and say, "Look, we've got some more work, are you interested?"*

These factors were not only indicators of success for Jeanette, but data suggest they are key indicators for sustaining any self-employed business. Billie stated this even more clearly.

Billie: *The biggest success for me is maintaining my networks and the fact that I get offered work without ever approaching anybody. The fact that people say, "I thought about this and you're the only person I thought could do it." That is incredibly rewarding, to be thought of in that way.*

Billie took great satisfaction in being recognised as capable and sought out for knowledge work. Tash had professional networks, consistent work and was also sought out for contract work.

> **Tash:** *Success for me means that people are seeking me out. That's what I've noticed, I position myself really well in terms of relationships that I develop.*

Jeanette, Billie and Tash, in terms of liminality, were re-aggregating and it is likely they were becoming comfortable with a perpetual liminoid state.

The traditional indicators for entrepreneurial success for entrepreneurs include expansion, more staff, more work and profit. However, as solo self-employed knowledge workers, the normal measurements of entrepreneurial success do not fit. The profit aspect of the work came much further down the list, as clarified by Billie.

> **Billie:** *Success for my business is not financial success. I like enough to be able to contribute and to support the business. I am proud of my business, even though it's just me and it's only little. I'm quite proud of sustaining it for this long. So, I guess, sustaining the business, having something tangible like the [built office] and the car that are visible representations of my business and that I have something I've created of my own.*

Billie wanted to sustain her business, to contribute to family income and to create tangible representations of the business she created, a concept which surfaced for other participants. The most significant improvements were in quality of life, flexibility and freedom. Some participants, however, had not yet reached this stage.

Margaret had been self-employed for only 6 months at the time of interview and despite having recently completed her PhD was struggling to find contract work.

> **Margaret:** *I feel like a failure – and I don't even take it personally. I just feel it's not working for me at the moment.*

Margaret took a full-time employed role not too long after the interview. Self-employment does not suit everyone, and the participants had varying levels of what they considered success. Helping people was considered a key success factor for some of the participants. As nurses, they still appeared to be drawn towards helping and supporting people.

> **Jill***: Yes, definitely I think that what drives me is more the social end of things certainly than the financial. I think if I was in it for the money, I'd be doing something else. I think at this stage in my career that's sort of where my passion lies.*

The connection with nursing, the helping role, was important to Jill and other participants. Despite being non-clinical, the participants could still advise, support and guide, all key parts of their feminised nursing skillset. Lou described feeling immense pleasure in helping and making a difference.

> **Lou:** T*he people I work with now can get really stuck with things. I'll say, "well, have you thought about this?" or, "In my experience, this could work quite well," and the joy is immense. Because they might have had to go round the block a few times to get there. So that's a great feeling, and that's helping. I'm still in a helping role.*

Lou summed up a frequent theme of still being in a helping role and the satisfaction found in supporting others.

Shared findings on success included: good outcomes for clients, happy clients, creativity and freedom. Measured in masculinist entrepreneurial terms, or traditional performance measurements, this would be a failing model. But supporting clients and making a contribution proved a greater

reward for the participants. The ability to work on such terms is only possible with a degree of privilege and social capital.

8.8 Summary

This chapter focused on the participants in the incorporation phase of liminality after moving from a public environment to the private space of a home office with all the connotations of domesticity. The privilege of a separate workspace was experienced by some participants, creating room to think and enjoy a positive work environment. For others, a shared family space created issues about priorities and disruptions. The tension of establishing a dedicated home workspace and then being unable to find work was presented. This example showed that every aspect of self-employment was different for each participant.

Freedom and flexibility were the most obvious positives of self-employment, but a duality created tension. Flexibility was most impacted by the pressure from feeling required to be available for friends and family and working outside normal office hours to catch up on paid work. The participants were known to be at home and therefore considered available for chores, phone calls and coffee breaks. They found ways to create barriers and manage interruptions, even if their friends and family still did not really understand what they were doing.

The propensity for risk was explored in the context of the participants' views of their entrepreneurial status. Established as proven risk takers, the participants broadly accepted their entrepreneurial strengths and agreed they were comfortable with taking risks, innovating and trading on their creativity. They all identified isolation as a problem and described to mitigate this risk. Sourcing support in the form of supervision and networking were key strategies, but not just from within nursing, as some took advantage of contacts in other businesses, especially accountants.

Success and failure data showed the participants had similar views and principles about success in self-employment. Success was found in contributing, work flexibility, sustaining the business, happy clients and helping others. Financial success was mentioned only in terms of earning enough to pay the bills. Failure was experienced as a lack of contracts despite numerous skills, expertise and experience.

Chapter 9: Discussion

9.1 General summary of data findings

The aim of this research was to explore the experiences of a niche group of highly skilled solo self-employed RNs working in the practice area of professional advice and policy work. They forged a different career path to the mainstream nursing trajectories. I drew from theories of gender and liminality to unpack how participants shifted from the conventional to the fringes of nursing practice. These theories have enabled me to highlight the freedoms gained; the identity shifts traversed; and the tensions that continue to be navigated as part of this work life.

The participant group represented a niche workforce. Participants were all held senior regional and national roles and all had many years of nursing experience and expertise. The majority had also achieved high level academic qualifications. All had embarked on their self-employed endeavours for different reasons and the “push and pull” phenomenon was evident. The participants as nurses had inhabited the feminine binary but realised their agentic positioning and started to learn how to inhabit the more traditionally masculinist space of self-employment.

Identity transitions were experienced by the participants. Despite decades of expertise, they questioned if they were entitled, or if it was even expedient, to claim a nursing identity. The participant group had various levels of understanding of the RN scope and APC requirements for nurses in non-clinical work. This surfaced challenges for them when asked if they were “real” nurses with “real” jobs and created feelings of being outsiders to their own profession. A narrow view of what counts as a nurse is present within the profession as noted in comments made to participants by other nurses. A conflation of historical views, media presentation and damaging rhetoric has reduced the perceived value of nursing knowledge. Distancing themselves from their nursing

identity enabled the participants to navigate gendered terrain, using generic titles such as "director" or "independent consultant".

These expert nurses were naïve novices in the unfamiliar terrain of business. They experienced financial precarity in their new roles often for the first time, although all were relatively financially secure and able to mitigate financial risk to some extent. In perpetuation of gendered performativity, financial security was often secured since they could fall back on a life partner's earning capacity. Most participants struggled to position their financial worth in regard to high level quality work while also undercharging and losing income on loss-leaders, creating financial dissonance. The stigma of nursing resulted in lower financial value and positioning within an increasingly liminal space. The liminal existence ensured the continuing hidden nature of their work.

A key tension across the dataset was the participants' distaste and discomfort with self-promotion. Mainstream nursing practice typically shapes a nursing ethos not orientated to commercial value. Most participants considered that networking was the real key to finding work in the Aotearoa NZ health space. The majority of the group experienced a substantial lowering of income and dealing with the IRD (Inland Revenue Department) filled them with anxiety. The majority were fiscally conservative and saved specifically to pay tax. Financial advice was largely sought from family and friends, while others found female accountants who reflected their ethics.

Participants described complex dynamics at play; greater freedom and re-creating identity were countered with the endeavour to be a businessperson within a domestic space. A move from the gendered masculinist space of health into the gendered feminised domestic home environment led to creation bespoke offices or finding space to work on the dining room table. Home environments were largely described as a positive place where thinking work was possible or, conversely, could stifle creativity. The positioning of work into a domestic space required

management of family, friends and domestic chores. Despite these tensions, there was also the benefit working at optimal times and privileging the personal. Isolation could be a risk of self-employment, but this was mitigated with extensive networks and contact with professional groups. Membership of relevant groups was contingent on being accepted into the group, reinforcing the power of in-group behaviours at all levels of nursing.

Participants weighed up what counted as success in their chosen position. Success was not guaranteed or universal and some participants revisited their options for permanent employment. Freedom and flexibility were viewed as the most significant benefits of self-employment, but being able to work anywhere was balanced against working long hours, on weekends and during holidays. The most successful in the self-employed space understood what self-employment could bring and often started with experience in project work and having been sought out to undertake a contract. Success was not described in terms of profit or expansion, but instead as continual and interesting work, making a contribution and satisfied clients. This could be seen as a perpetuation of old notions that nursing is a vocation and that remuneration is less important than making a difference in peoples' lives.

Evidence is marshalled in this discussion chapter and theoretical frameworks are applied to further explore the impact of data findings on self-employed nurses and their contribution in the normatively masculinist spaces of health and policy.

9.2 Separation and identity work

The fundamental aim of this study is to illuminate the experiences of nurses who overlap traditional binary positioning. It highlights that women's workplace liberation remains complex, six decades after the phrase "women's lib" was coined. Participants had separated from the feminised nursing workforce, moving into the masculinist world of business and entrepreneurship while

working from the domesticated and feminised environment of the home, compounding their liminal positioning. Their situation required navigating power and gender dynamics from every angle: family and friends, the public, potential clients, other healthcare professionals and nursing colleagues.

Data shows that the participants both created and experienced dissonance and disruption. They also navigated the complexities of oppression, stigma and professional constraint in their new unfixed, fluid self-employed identities, all while retaining their APCs and absorbing new knowledge relevant to the new skillset they required to run their businesses.

9.2.1 Creating dissonance, being invisible and coping with stigma

Nursing has for centuries maintained a low profile. The modest approach is characteristic of nursing, which has a long history of being an oppressed (Dubrosky, 2013) feminised, silent and hidden workforce (Buresh & Gordon, 2013). Images of nurses as subservient, dutiful and obedient hospital workers endure within societal norms (Cleary et al., 2018; Fealy, 2004; McAllister & Brien, 2020) and can result in people, including health professionals, experiencing cognitive dissonance when their fixed gendered notion of a nurse is challenged.

Non-clinical, self-employed nurses provide a substantive challenge to contemporary understanding of a nurse. But that challenge may be a source of psychological discomfort for those thus positioned and can lead a to purposeful avoidance of any information which is likely to create dissonance (Harmon-Jones & Mills, 2019). As shown by the research participants, avoidance can extend to changing or considering changing a role title and setting aside a stigmatised nursing identity.

The perception of nurses as having limited skills and needing to be directed contributes to the creation of a stigmatised profession. Goffman (1990) presented the concept of stigma in relation

to social identity and personal attributes, but also in structural positioning, such as occupations. The idea of stigmatised occupational identity in nursing is noted by Simpson et al. (2012) who suggest that both the public and healthcare professionals still identify nursing as women's work.

Inferior positioning and assumptions about gendered capabilities complicate the transition into self-employment. As women and as nurses, they would be "*doubly-oppressed*" (Roberts et al., 2009, p. 289). Association with a stigmatised profession is a distinct disadvantage to those moving into self-employed professional advice and policy roles in which clients look for knowledge workers with skillsets not normally associated with the nursing profession.

Knowledge work is an individual endeavour based in intellect, innovation and relational skills (Buttner, 2001; Eikhof, 2016). It could be assumed that intellectual non-clinical work would have fewer issues with gendered performativity, but the findings of this study show that knowledge work for nurses remains a highly gendered space.

The history of nursing confirms a connection with dirty work and the hidden care of the sick (Abel-Smith, 1960). But as stated by Young (2011, p. 222), *"this normative hierarchy of occupational intelligence contains a white male bias. The work of abstract rationality is coded as appropriate for white men, while the work that involves caring for the body or emotions is coded for women."* This draws attention to a powerful binary, so that when people move into non-clinical knowledge work, they are assumed to leave the body behind to engage instead with their minds.

Outdated views which assume clinical work does not require intellectual expertise continue to position nursing firmly on the disprivileged side of the binary. This view is inaccurate, anachronistic and exploitative by preventing nurses from realising their power and ability to impact

positively across the whole of health (Dillard-Wright & Shields-Haas, 2021) in both clinical and non-clinical roles.

This study demonstrates continual attempts by the participants to bridge the binaries and, in some cases, set aside the stigmatised identity of nurse to increase access to income and contract work from a health sector that drives workforce gender inequality.

9.2.2 Identity work in a liminal space

Nursing continues to be a troubled professional identity and doing nursing differently requires identity work. Nursing identity work is particularly complex because the societal understanding of a nurse is fixed and therefore rendered predictable. Most common visual representations of nurses position them in a hospital working alongside and even ***for*** doctors (Gill & Baker, 2021), undertaking the duties of caring, organising and comforting. Nursing identity within the profession is also complex, based on shared understandings, experiences, language and discursively constructed subjectivities. When nurses move outside known hierarchies, they (as well as colleagues and community members) question the authenticity of the claim of being a nurse.

These participants' accounts draw attention to public and private identity work for those who spent their formative adult years in a feminised profession. Nursing is still seen as normatively feminine, as the work of women, inferior in status (Thompson & Watson, 2021) and of less financial value (Clayton-Hathway et al., 2020). Internalised beliefs about "*inferiorised identity"* (Simpson et al., 2012, p. 175) make it difficult to challenge traditional power brokers. Post-structural feminism illuminates the contingent and unstable meaning of "nurse", exposing how in-between the binary poles of masculine and feminine, of "doctor" and "nurse", there is an interesting and ambiguous liminal space where meaning is un-fixed. As such, feminised nursing can create new identities and explore different ways of working and places to work.

When examining nursing promotional material, the anticipated spaces and places nurses occupy are immediately apparent (Urban, 2014). Of note, the roles of my participants do not appear in such representations of what counts as a nurse. Separation from the institutions and places of healthcare found the study participants reconstructing their identities (Evans, 2017) to meet their need to find clients and signal the type and level of work they could deliver. In liminality theory, the separation phase occurs when previous roles and identities are questioned and past expertise such as clinical work is relinquished (Garcia-Lorenzo et al., 2018).

For these participants, going forward involved setting aside the outmoded definitions of what counts as a nurse. Relinquishing infers completely letting go, whereas setting aside suggests it could be picked up again in a new context. In regard to identity, setting aside fits more appropriately the actions of the participants in this study. In the separation phase identities become fluid and unstable (Garcia-Lorenzo et al., 2018), providing an opportunity to re-imagine a nursing identity or set aside nursing to embrace the identity of a contractor and knowledge worker. Positioning the professional self above the profession may support more contract work at higher rates. While this is not wrong in any way, it does support the assumptions about the devaluation of nursing work (Thompson & Watson, 2021).

Nursing work has routines, common behaviours, structures, traditions, beliefs and understandings which suggest that nursing is a stable, fixed profession existing within a certain station in life, reliable and a social constant (Turner et al., 1987). Anything which shifts outside of this stable position occupies a liminal space, uncertain and marginal to the majority. Setting aside nursing identities allows the development of new identities as knowledge workers and contractors (Garcia-Lorenzo et al., 2018) with the capacity, capability and fluidity needed to adapt to new and

rapidly changing environments and ways of working. Nursing has evolved into a broad spectrum of skillsets, unknown to the public and even sometimes to the profession.

This research invites nurses to consider whether their practice is constrained by a limited view of what counts as nursing. If a nursing identity is still viewed as a type of subordinate straightjacket (Bennett et al., 2020), then those with considerable nursing experience may divest themselves of this identity. Setting aside a nursing identity can remove or at least reduce dissonant reactions to a nurse working in a different space in an unexpected way.

Nurses around the world unconsciously hold a fixed idea of what counts as a nurse and are complicit in the oppressive gendered norms. *"We cling to a fixed idea of who we are, and it cripples us because nothing and no-one is fixed"* (Fletcher, 2006, p. 54). Any structured idea of a nurse is constraining. Several participants assumed alternative identities and role titles to more clearly identify the skills and expertise they offered. This act further reduced opportunities to expand the conventional notions of nursing (Thompson & Watson, 2021).

The participants become outsiders to some degree in a profession where they were once mainstream "movers and shakers". This shift enabled them to critique not only what they valued about their profession, but also to analyse aspects within nursing holding the profession back. Oppressed group behaviour is frequently found in nursing (Roberts et al., 2009). Marginalisation and exclusion are key components (Dubrosky, 2013; Young, 2011) used by nurses when unable to confront those in positions of power and so the focus shifts to criticising or dismissing the expertise, knowledge and capability of nursing colleagues. A concept frequently considered within nursing is that nurses inhibit the development of their own profession (Anderson et al., 2020; Fealy, 2004; Fletcher, 2006). A trust in the hierarchies, passive acceptance or a belief in the status quo and social

constants (Dillard-Wright & Shields-Haas, 2021; Roberts, 2000) can reinforce powerful and often negative behaviours found in the nursing profession.

These participants experienced an irony not evident in many professions. The more skilful and adaptable they became, the more they were alienated from the "worker bee" mentality that continues to pervade some areas of nursing (Carryer, 2020a). Power is held within nursing to facilitate group inclusion or exclusion, and the power brought to bear here is exclusionary (Ahl & Marlow, 2012). Anderson et al. (2020) found that nurses in advanced practice roles can experience vertical discounting where other nurses dismiss their expertise. Discounting behaviour is strongly suggestive of out-group behaviour found in social identity theory (Tajfel, 2010). Embedded within nursing is a belonging, shared experience, shared language and history (Zerr, 2006) which can strongly bond those who have membership of the profession. Moving outside of group norms is fraught with disapproval from the "sisterhood" (Fowler, 2017) and can generate power behaviours (Lynch, 2014) from the in-group (Tajfel, 2010) to ostracise non-conformists.

The participants were, to some degree, victims of their own success in identity terms. "Tall poppy syndrome" (Donovan et al., 2012) is a damaging phenomenon found in Aotearoa NZ which controls those who strive for success or difference. "*The 'tall poppy syndrome' (TPS) is one example of a societal constraint whose function in Australasia is to enforce society-wide ideologies such as egalitarianism and the gender order. The TPS acts as an enforcement mechanism which keeps self-promoting discourse in check*" (Holmes et al., 2017, p. 1). The TPS is a subtle mechanism that can discourage those seen to step outside the accepted norms of an occupational or membership group. As such, TPS acts as a reinforcing mechanism or a discouragement to group members who seek difference. Power operates at a micro-behaviour level to control behaviours and maintain the acceptable, gendered, social norms (Lynch, 2014), or in liminality, the stable state or condition (Turner, 1987).

This research provided an opportunity to question if those embracing this role are aligned with broad feminist aspirations. As an insider to this role, it is a question I ask myself. Behaviours within nursing which constrain the profession and maintain the historical gendered hierarchical order may to some extent be understood when considering the discomfort which nursing seems to feel about feminism (Sullivan, 2002; Wall, 2007). Feminists can be perceived as a radical disruptive few who wish to subvert the natural order. *"Traditions do not, however, always make for progress, a blind loyalty to outworn traditions often blocking necessary reforms"* (Dock & Stewart, 1920, p. 353). In an ordered and understood environment where people (including patients) understand their role, disruption of the expected hierarchical order and norms would create discomfort and concern. Nurses who are speaking a new professional language, who are distanced from what the majority understand as nursing's core business are recipients of this constraining behaviour. Such nurses are considered to have lost touch with the "shop-floor" or "coal-face" and are pushed to the edge of their own nursing culture (Roberts et al., 2009) entering the liminal space of "not a proper nurse" (Jackson, 2020).

The participants painted a compelling picture of shifting from an esteemed professional insider to an outsider with a curious and ambiguous identity. Falling between working as a "real nurse" and working in strategic health policy, Croft et al. (2015) noted that people in liminal spaces drop into conceptual gaps and do not fit in policy or nursing. In this interpretation, employed nurses working in government and regulation could fall into a liminal gap and be viewed as out of touch with current practice. Whatever is considered current practice is, of course, highly contestable and rarely clarified.

Study data confounded such an argument by uncovering descriptions of the participants' professional flourishing, adding to nursing knowledge and enhancing their roles and experience for a

broader and more strategic understanding of the whole of health. This matches the new creative experiences and identities described by Garcia-Lorenzo et al. (2018) in the separation phase of liminality and also offers possibilities for redefining notions of nursing.

"Shaking up" the world's largest health profession is not for the faint hearted. Post-structuralist thinking demonstrates that meaning is unfixed, contingent and unstable (Brabazon, 2018). Meaning is created and re-shaped through the nexus of knowledge, language and power. Despite the popular belief that nursing is a homogenised group, even in shared workspaces all nursing roles differ, there is no homogeneity, no unified version of a nurse. Despite this, internal professional constraint remains. Oppressed group behaviour is as strong as ever and unfortunately could arguably be interpreted as the only control and power the nursing profession can completely own and wield, unless they are self-employed.

My study arose directly from my own experience in segueing from nursing to an identity which was both nursing contractor and business owner. Women who have skills and knowledge to offer and for whom further years of long hours, organisational pressure, commuting and personal sacrifice are unappealing can find self-employment a viable option (Hodges, 2012) . Donner and Wheeler (2010, p. 12) described this as the "*consolidation phase*" of a nursing career. This was reflected in the confidence of the participants to professionally diversify within their businesses and their freedom to try things which were an expansion of previous roles.

Positioned liminally as outside of nursing facilitated a release from the anchor of nursing constraints, freeing the participants to optimise their agentic positioning. Petriglieri et al. (2018a, p. 110) claim that "*unshackled from managers and corporate norms, people can choose assignments that make the most of their talents and reflect their true interests.*" For the participants, everything was open to question – how they worked, how they identified, who they worked with and what they

worked on – this freedom is described as *"unlimited potentiality"* by Garcia-Lorenzo et al. (2018, p. 376). Nursing roles become un-fixed and contextual, situated in the liminal space between binaries. Finding themselves betwixt and between, neither one thing nor another, is an opportunity to be different. To be a nurse and a business owner, to be a contractor and a knowledge worker, to be complex and unique.

9.2.3 Retaining links: APC and scope

I propose that nursing would benefit from the radical identity disruption that has given visibility to the enfranchisement of gender politics and sexual identity fluidity (Cuboniks, 2018; Hester, 2018; Stafford, 2020). Nursing identity in Aotearoa NZ and around the world is linked to status as holders of a professional registration and remains fixed in the public consciousness. The nursing profession has a long history of hierarchy, medals (Spence, 2001) and uniform-based indicators of rank (Brown et al., 1994). Uniforms and medals no longer feature in the day to day of many nurses, particularly those who are no longer clinical. But registration remains and an annual APC is required for professionally active nurses (Nursing Council of New Zealand, 2007a).

Aotearoa NZ is potentially an advantageous place for nurses to experiment with self-employment in professional advice and policy areas. Self-employed RNs are not always recognised as actively practising nurses by national or provincial regulators in other countries (International Council of Nurses, 2004; OECD, 2017b; Wall, 2015a), especially if non-clinical. However, the Aotearoa NZ RN scope is flexible, enabling and in some ways, unique in the world.

The Nursing Council of New Zealand (2007a) competencies for RNs in professional advice and policy legitimise the continued practice of making it possible for non-clinical RNs to maintain an APC when they still have much to offer the profession. The competencies for nurses in policy (Nursing Council of New Zealand, 2007a) are an under-utilised guide to the skills required to become

competent in policy and professional advice roles. However, they are not widely known or understood even by those in relevant roles.

My analysis showed that the participants occupied an ambiguous space in the regulatory setting. The Nursing Council of New Zealand (2007a) performs random annual audits of competence in the form of four pieces of documentation (Nursing Council of New Zealand, 2020). Audits are perceived by many RN as a difficult challenge (Heath, 2019; Manning, 2017) and when they are no longer working clinically many choose to relinquish their APC rather than risk having to undertake a practice audit. Choosing not to maintain an APC can provide distance from a stigmatised profession and the professional identity of a nurse (Carryer, 2020b). Alternatively, RNs moving into a non-clinical self-employed role may simply feel they no longer require an APC. It could then be argued they are unconsciously complicit in maintaining the limited boundaries of what constitutes the discipline of nursing.

At the beginning of this study, I held a position that nurses in these roles can and should identify as nurses. However, the research has moved my thinking into a liminal space where I have considered what it means to do nursing from the margins. The utility of maintaining an APC is arguable, especially when work is non-clinical and removed from health provider or education spaces. One key signifier of a "real" nurse is the annual practising certification process which shapes identity claims.

The contestability of the APC emphasises the liminal positioning of the participants and even within the profession reinforces the enduring image of nurses as belonging in clinical practice. However, maintaining an APC could be a pragmatic decision to secure a fall-back position or to facilitate contracts within nursing and to be seen as professionally active, auditable and competent.

9.2.4 Knowledge and education

Initially, I assumed that the higher a nurse's level of education, the easier it would be to find work. But on reflection, this may have been reflective of my personal beliefs on academic worthiness whilst affiliated to a stigmatised profession. As an example, cognitive dissonance occurs when hearing nurses have doctorates. My personal experience has included comments such as, *"So, would you be a Dr nurse? Is that a thing?"* A nurse with qualifications, an educated woman, is a challenging incongruity (Martin, 2019). More than half of the participants who held PhDs were unsuccessful in finding contract work with not too subtle indications that they were considered overqualified for nursing work, which created feelings of disenfranchisement and a loss of self-belief.

There was clear evidence of imposter phenomenon among the participants. Imposter syndrome is commonly found among women in leadership positions, including those who are in self-employment (Ladge & Eddleston, 2016). Women will often downplay their abilities as they are unable to comfortably assimilate obvious successes and achievements. Imposter syndrome shows lack of self-belief and that one has stepped outside invisible or imagined boundaries and barriers. I would contend that in nursing these are at least, to some extent, the result of facing gendered boundaries (Lee et al., 2021). This study shows that the attaining higher education may not ameliorate imposter syndrome to the extent that might be expected.

Higher degrees may also be considered irrelevant because nursing knowledge has historically been viewed as a "lesser" knowledge (Clayton-Hathway et al., 2020) compared to the hegemonic professions of medicine, law (Broadbent et al., 2017) and academia. Reed (2016, p. 241) stated that *"nursing, as a distinct profession and discipline, holds epistemic authority in professional practice. Epistemic authority is defined in terms of owning a unique and reliable, truthful, recognized, and authorized body of scientific and practice knowledge in nursing practice."* However accurate this

may be, nurses continuing to make statements about epistemic authority suggests that despite positive progress in regard to nursing research (Kokol et al., 2019), there has been minimal progress in levelling out the balance of power. Nursing remains powerless and invisible (Cleary et al., 2018) and the dominant patriarchal structures are sustained.

Nursing is by far the largest of all the health professions globally in terms of workers (World Health Organization, 2020). But the dominant language of health is not nursing, which is seen as task-based and non-intellectual. Foucault (1980) described the professions as having their own languages, which he saw as mechanisms of knowledge. "*We describe two forms of epistemic wrongs, credibility deficit and interpretive marginalisation, which stem from structural exclusion of marginalised producers and recipients of knowledge*" (Bhakuni & Abimbola, 2021, p. 1465). This study found evidence for a belief that nurses deliver care and do not get involved in strategising or making decisions in health. The dominant language is the privileged norm (Davies & Gannon, 2005) and in health this is medicine. Society views medicine as the centre, if not the natural leader, of all healthcare and in a position of such authority they can speak for all of health (Disch, 2020).

9.3 Transitioning and negotiating learned gendered expectations

Nursing continually strives to develop, to be heard and to be taken seriously. Yet it is consistently and historically resistant to accept that gender issues still exist and to recognise the power of feminism as a unifying analytic and strategic approach (Lewis, 2006). Wall (2007) identified the value of nurses understanding post-structural feminism as a mechanism to challenge assumptions about binary positioning and shared subordination based on gender. The majority of nurses are oblivious to the nature of patriarchy in health (Rickards, 2019; Smith, 2020) and how masculinities are privileged over femininities.

This study used gender theory for analysis to illuminate areas of nursing and the behaviour of a highly educated group with social capital and agentic positioning. It showed the profession is still deeply affected by entrenched ideologies and forces which compel normative behaviours and gender positioning, particularly in the area of business finance, tax responsibilities and managing the precarities of income contribution.

9.3.1 Managing precarity and tensions about income contribution

Giving up a fortnightly salary can be stressful and for nurses without financial security, solo self-employment would be an untenable financial risk. McKeown (2005) showed that the primary self-employment drivers for women with life partners is the search for a new lifestyle and time for family. However, the move to a flexible self-employment model can bring unexpected financial tensions. Kautonen et al. (2017) suggested a level of financial security is required as the income drop from employment to self-employment can be dramatic (Taylor, 2015a). For many people, a life partner's income would create a degree of financial stability and security which (Kumar et al., 2018) can mitigate the risks of financial precarity. However, this carries a risk of gendered anxiety which can play out in relationships as tensions about financial contribution. All the participants in the study were in significant relationships, or life partnerships.

A phenomenon found in the transition or liminal period is the incorporation of family into the self-employed endeavour (Garcia-Lorenzo et al., 2018). But data suggests this goes further. Rather than the banks and IRD, the self-employed relied heavily on "*informal relations*" which simply means accessing accounting help from friends and family (Sperber & Linder, 2018, p. 2).

In this study, supportive local female accountants were also sought and often took on the role of teachers and mentors (Blackburn et al., 2018) who could understand the nuanced structure

and aims of the self-employed endeavour. Participants then avoided the risk of being judged against heteronormative business success criteria (Ahl & Marlow, 2012).

9.3.2 Social positioning

As nurses, the participants were highly socialised as women aligned with caring work and as such often subconsciously battled against their own embedded discourses (Smith, 2020). As Walby (1989, p. 95) stated: *"we cannot understand the oppression of women without a theory of the unconscious, since such a concept is necessary to theorize deeply entrenched patriarchal ideology in people's psyches. Patriarchal practices are continued because of the way our minds are ordered from generation to generation."* So, it is possible to reflect on the behaviour of the participants and their potential clients as being unknowingly captured in subjective gender positioning.

The idea of female essentialism and the assumed societal and professional positioning ascribed to nurses arises from the historical and persistent assumption of homogeneity and a prescribed socio-economic status. The implications of social positioning and financial stability saw the study participants using lowered contract rates partly to sustain client engagement, but also due to the entrenched gendered positioning of a stigmatised workforce and their own financial security.

Knowledge workers tend to be contracted for the length of a project or on a limited time frame (Eikhof, 2016), which increases precarity and lacks security. Kautonen et al. (2017) found that people shifting to self-employment later in their careers had the benefit of having already reached a place of financial security and were able to cope to some extent, with quite significant drops in income.

The privilege of financial security can result in setting the financial bar low and not striving to be financially valued, but settling for a modest income. Such behaviour echoes philanthropic upper-

class women from nursing history who saw care of the sick as their duty (Tooley, 2012). Working at lower contract rates for the nursing community or the wider health sector reinforced a liminal positioning (Garcia-Lorenzo et al., 2018). This is both positive in a philanthropic sense, but also a negative as charging less than the value of their experience and academic worth has impact on the perceived low value of nursing work.

9.4 Merging the public into the private

Working from home is a highly gendered and complex situation (Eikhof, 2016; Taylor, 2015b). The nurse consultant participants were also life partners and homeowners at least partly if not fully, responsible for the household activities. Working in a domestic space magnified the gendered assumptions about daily chores and family. This study found the participants were captured in gendered positioning as they adopted both a liminal and flexible approach to the gendered demands of the family, home and work.

9.4.1 Making space

Nursing has been tied to hospitals and clinical treatment spaces for centuries. Foucault (2012) in the mid to late 20th century, viewed hospitals as a part of the healthcare process and a performer in therapy, not just a building. Hospitals are dominant structures with stark clinical settings and spaces designated to deliver healthcare (Halberg et al., 2021). The historical and cultural associations tying nurses to hospitals, make the meaning of nurse more predictable and stable, linking back to outdated (Wall, 2014a) structuralist beliefs of systems of meaning (de Saussure, 1959; Lévi-Strauss, 1973). The strength of cultural discourse is so profound that when people experience cognitive dissonance when faced with non-clinical nurses who work from home, away from their culturally accepted working spaces.

Working in private spaces, not designated for healthcare removes management and oversight and offers a freedom to create new spaces (Wall, 2014a). However, being in a domestic space is not without tensions and is as different for each person as are their individual homes (Toniolo-Barrios & Pitt, 2021). The idea of working from home, while seemingly enviable, depends largely on each person's available space, resources and role in the household. Evidence from the dataset suggests fitting work around other activities such as domestic chores and caring commitments can dominate the work day.

Flexible working is a popular model for female workforces (Agarwala & Chun, 2019) but can result in anachronistic and gendered discourses about women working for "pin-money" (Traflet, 2008). Compounding these discourses, the work of caring for family is still predominantly viewed as the work of women (Eikhof, 2016; Simpson et al., 2012; Waring, 2018). The participant group offered examples where the needs of family were identified as primary drivers for change. Morgan and Nelligan (2018) suggested that flexibility can be managed to a worker's advantage by organising work time and workload in whichever way suits them best.

The blurring of boundaries between work and home life (Jurik, 1998; Mason et al., 2011; Toniolo-Barrios & Pitt, 2021; Walker & Brown, 2004; Wall, 2015a) required the creation of space, routines, times and rules (Myrie & Daly, 2009). Basile and Beaureguard (2016) suggested that those working in a home which lacks a separate workspace struggle the most. According to Gherardi (2015), working from home inevitably privileges family and renders paid work less important, but data suggest a more complex and nuanced situation.

The gender performativity in the domestic space was challenged as rules were set and barriers created to ensure paid work was completed. Built offices where space and money allowed, showed a commitment to the paid work, as did the creation of spaces within living rooms or on

dining room tables. Despite limitations, work space was retrieved to ensure paid work could be done.

The ability to work from anywhere, also known as mobile, agile or remote working (Samushonga, 2020), was a model used by all the participant group. At the start of this study, it was considered unusual for nurses to work from home and participants gave examples of it causing cognitive dissonance. Since then, the Covid-19 lockdown response in Aotearoa NZ has led to a significant increase in remote work and online meetings (Dean, 2020; Hackston, 2020; Sherrod & Holland, 2021), significantly reducing professional isolation (Samushonga, 2020).

Isolation is a common issue in self-employment (Ministry of Business Innovation & Employment, 2020) and if not recognised can be problematic for those separated from familiar institutions and networks who are physically and professionally liminal. A move from the hub of activity to self-employment can elicit different responses, from suddenly feeling professionally unimportant, to revelling in the self-containment of a liminal space (Cubbon et al., 2020).

9.4.2 The gendered complexities of home

Nursing is often described as a vocation or a calling (Fowler & Gallagher, 2019) rather than a profession or career, harking back to class divisions, gender, religion and domestic chores (Cleary et al., 2018). Cleaning, cooking and washing-up were all a part of nursing work for centuries (Brown et al., 1994). Nursing resonates with stories of women in domestic service with uniforms, invisibility, dirty-work, class and gender positioning (MacGregor & Davidson, 2012). The domestic service mentality of nursing work may seem antiquated and removed from the work of nurses in professional advice and policy. However, working from home can trigger unconscious gendered beliefs and behaviours regarding household chores and caring for family.

Women face more complexity when navigating different and competing roles (Sperber & Linder, 2018) where identities are unfixed and contingent on their role. In this study, participants were nurses, project workers, contractors and business owners while at the same time life partners, mothers, sisters, friends and daughters, all while working from the feminised domestic space of the home. Wagner and Wodak (2006, p. 390) suggested that women often self-present with the skills to create spaces which match their goals of a healthy and positive workspace and show an ability to pursue a healthy lifestyle. But working from home is fraught with unintended gender issues.

The gendered issue of doing domestic chores during the day (Myrie & Daly, 2009) reveals deceptively complex ways of belonging (Stead, 2017). Establishing themselves as highly professional, while contending with pressures to be many other roles to many other people, could result in hours of the day spent on family and friends, then working evenings and nights to catch up on paid work. This is a point of tension for a home-based knowledge worker and a duality of their personal and private spheres (Tomlinson & Colgan, 2014). Explanation of professional identities can help general understanding and legitimise working from home as real work.

Moving nursing work into the private sphere of a home can result in both freedom and difficulties. The opportunity to do creative thinking work is finely balanced with a process of managing home life and creating a self-employed identity. Women working from home re-aggregate into a successful and productive home based knowledge worker by navigating complex and gendered assumptions about how they function in the domestic space and learn to weave their many subtle ways of belonging (Stead, 2017; Tietze & Musson, 2010).

9.5 The future

My study has shown that in the 2020s, nurses remain constrained and are still seen as deliverers of care not health leaders or strategists (Cleary et al., 2018). I no longer believe nursing is

actively left out of decision-making spaces, I think nursing is simply not considered (Carryer, 2021). While changes are needed in how decision-makers regard the value of nursing expertise, nursing must first understand how the profession is viewed in the spaces from which it claims to be excluded. Perceived as parochial, self-serving and profession focused (Disch, 2020), the nursing professional identity is *"relational and legitimacy has to be actively constructed and reproduced in relation to others*" (Currie et al., 2010, p. 944). Changes in the nursing profession are required to prepare the way for future nurse leaders to claim primacy in the decision-making spaces of healthcare policy and advice.

9.5.1 Embracing complexity and disruption

It is no longer realistic to portray nurses as a homogeneous, hospital-based and uniformed professional group. Rather, they are as complex and diverse as the rest of society. As the largest health workforce in the country, nurses are positioned across multiple settings with many roles and responsibilities. In post-structuralism, nothing is fixed, meanings are deferred and social norms can be interrogated towards disruption (Brabazon, 2018). This complexity, fluidity and instability represents nursing today, far removed from nostalgic media stereotypes.

Solo self-employment embodies the complexity, adaptability and fluidity of nursing. Carrying their nursing knowledge with them, the participants could assess situations and adapt their approach to achieve optimal outcomes as they re-aggregated their identities while remaining in a permanent liminoid state. There is work to be done to support a new future in which moving from clinical practice to contributing knowledge and expertise to the wider sector is less challenging to a nursing identity.

9.5.2 An invisible contribution

Formal nursing was established when a woman's place was fixed and constrained (Tooley, 2012). Voting rights, money, work and education levels were all controlled by men. However, some nurse leaders did seize opportunities which contributed to the development of women and nurses before the concept of feminism existed (Dock & Stewart, 1920). The historic and nostalgic ideas of what counts as a nurse endure today, so the idea of a self-employed, intellectually competent nurse is disruptive to the normative social structure which believes that a nurse, is a nurse, is a nurse, with no concept of specialities and non-clinical expertise (Cleary et al., 2018).

Global media focus between 2020-21 has been on exhausted intensive care (Hackett, 2021) and emergency department nurses, or what the media position as "front-line nurses" (New Zealand Nurses Organisation, 2020) thus perpetuating the notion of nurses as predominantly hospital-based. In reality nurse leaders across Aotearoa NZ were seconded into multiple aspects of Covid-19 planning, [20]mobilising many workforces and linking with public healthcare services to manage a hugely complex situation. But this work was largely done behind the scenes, silent and hidden. In the week I concluded this thesis, two panels were convened from Auckland – the area of major Covid-19 outbreaks – to provide advice and guidance for other regions. A sole nurse is present amongst about twenty panellists thus rendering invisible the massive contribution of nurses well away from any bedside practice.

Covid-19 has created, over the last 2 years, some degree of challenge for anachronistic beliefs (Gagnon & Perron, 2020), but also revealed a dichotomy in nursing. *"Nursing is caught in the*

[20] Since the beginning of the pandemic response in 2020, nursing leaders in Aotearoa NZ were seconded to a variety of roles often outside their existing skill set. These secondments occurred with little support notice or the development of a new subset of the healthcare system for the Covid-19 response. Initially, the secondments were under emergency response incident management frameworks used to manage natural disasters (e.g., the Christchurch earthquakes), tragedies (e.g., Whakari White Island) or regional epidemics (e.g., measles). The healthcare system is creating longer-term structures such as Managed Isolation and Quarantine Facilities, as well as testing and vaccination centres. These new healthcare service delivery models show the responsiveness of nursing leaders to adapt quickly, often with a range of partners and across regions, to deliver a safe and effective new way of providing healthcare. Relationships with Māori and Pacific healthcare providers, primary healthcare and pharmacies were also built on to meet governments goals of universal vaccination (K. Sangster, Personal communication, 23 September 2021).

balance between being elevated as vital key workers, yet politicians expect servitude, compliance (and even silence), rather than open criticism of their failings" (Bennett et al., 2020, p. 3). It could be argued that nurses in Aotearoa NZ have not been required to be as deployable since the time of the Spanish flu (Wood, 2020), but nursing remains invisible and unconsidered (Carryer, 2021).

Nurse leaders are usually bound by organisational policies to remain silent (Carryer, 2020b). However, it could be argued they are overly constrained by such policies. Certainly, they are unable to publicly criticise their employers. But nothing is stopping them expressing professional opinions about healthcare matters. Self-employed nurses, not bound by organisational policies, could have a voice, yet they too are invisible.

9.5.3 The key to the future is in the past

Multiple philosophers and academics claim that to understand today, we need to understand our past (Anderson et al., 2020; Beard, 2018; Dawson, 2021; Finkelman, 2017; Foucault, 1980; Roberts, 2000). This study shows that nurses across the entire profession are captured in gendered subjective positioning in a working-class career (McAllister & Brien, 2020). Nurses with the highest level of academic achievement still struggled with ingrained gendered roles in both professional spaces and when working from home.

The position of all nurses on the disprivileged side of the gender binaries strongly confirms the views of Wall (2007) who argued that feminism remains a contentious subject for nursing, possibly stemming from disinformation, misunderstanding or avoidance. In reality, *"All that feminism is, is the objection to patriarchy"* (Lipscomb, 2021b). Misinformation and derision are familiar challenges faced by feminists and it is important to correct these erroneous views (Olufemi, 2020), particularly in nursing. Post-structuralist analysis is a tool to understand gendered positioning in healthcare which, once seen, cannot be unseen, but can be destabilised.

An opportunity exists to re-imagine nursing. To take away the blinkers and alert the profession to the mix of roles and careers already present within this huge workforce, including those small in number and liminally positioned. Once nursing's societal and gendered positioning is better understood, including its complicity in upholding such positions (Fletcher, 2006), identities can be questioned. *"If we wish to realize our emancipatory potential as nurses, critically examining our role in upholding oppressive structures is a critical step towards a more robust future of nursing"* (Dillard-Wright & Shields-Haas, 2021, p. 195). Historical, gendered control points can then be challenged to create a nursing workforce which can adapt and excel in future healthcare workspaces, whether they are in a hospital or a home.

9.5.4 Backwards in coming forwards

Nurses are a profession based predominantly in clinical care (Nursing Council of New Zealand, 2019); we need nurses to provide; excellent care and to be the glue that holds healthcare together. The nursing profession must also be heard. The Aotearoa NZ healthcare sector might work very differently if nursing was included and acknowledged, respected, sought for opinion and expertise in decision-making. It would recognise that nurses see the whole of healthcare and can position and frame their knowledge in different ways and in different spaces.

The acquisition of professional advice and policy skills is an important step for the nursing profession (Rains & Barton-Kriese, 2001). Currently, few nurses participate in policy development both nationally and internationally (Carryer, 2020b; Clendon, 2019; Donovan et al., 2012; Kunaviktikul, 2014; Lewinski & Simmons, 2018; World Health Organization, 2020). Nursing's absence from the policy arena (Carryer, 2020a) raises questions about access to policy education. Although it is available in Aotearoa NZ, policy education is not a priority or a career path for the nursing profession. Nor do any of the existing education funding streams directly support such a choice.

Project and policy work employ many hidden skillsets needed not only for project work, but to engage with networks, to collaborate and position and to understand the environment. In the meantime, nurses remain universally underrepresented globally in policy, politics and government (Carryer, 2002; Daly et al., 2020; Dillard-Wright & Shields-Haas, 2021). But this study shows nurses may be present but not professionally visible. Visibility in this sphere would do a great deal towards expanding the perceptions of nursing beyond the bedside and towards becoming significant sources of knowledge and wisdom in the design and delivery of health services.

9.6 Recommendations

Based on my research findings, I recommend that nursing leaders across Aotearoa NZ consider the following:

- **Feminist analysis**: The study surfaced the difficult relationship nursing has with feminism, and demonstrated how gender can be a valuable lens through which to view nursing research. While there may never be a widespread acceptance or understanding of the concept across the profession, socialisation of feminist theory to key nursing leadership groups is a way to challenge entrenched gendered thinking language and behaviours in the profession. Feminist solidarity might support a reduction in oppressed group behaviours by mitigating "tall poppy syndrome" and "othering" of nurses who move outside traditional patterns of employment.
    - *Once understood, feminist theory offers a way to understand our past in order not to perpetuate it*.
- **A new nursing specialty:** The study demonstrated that nurses working in the policy space are vital for expanding wider health sector consciousness of what nursing can contribute. RNs working in these spaces develop distinct skillsets. Specialty practice is a familiar concept to nursing in Aotearoa NZ and professional delineation could legitimise professional advice and policy practice utilising established nursing language and concepts.

- *Consider policy as a nursing specialty.*

- **Targeted education:** A clear result of the study was the part non-nursing education could play in helping the participant group. The Aotearoa NZ nursing profession has successfully focused on clinical post-graduate nursing education. It is time to turn the profession's attention to skills and education which normally sit outside the profession but could enhance opportunities for self-employed nursing and nursing engagement in policy spaces. These include business finance and skills, health economics, public policy, machinery of government, project management and critical thinking. Policy socialisation opportunities, such as internship scholarships for RNs in health policy spaces, would invigorate nursing leadership and introduce policymakers to the value of nursing knowledge and experience.
    - *Explore targeted education from outside of the nursing profession on in policy, finance, and business.*
- **RN scope and APC**: The study showed that Aotearoa NZ nursing fosters a strong and unique foundation in terms of the RN scope and APC. The ability for non-clinical RNs to maintain an APC stretches beyond self-employed nurses in professional advice and policy to RNs working in regulatory, governmental and industrial spaces. The Nursing Council competencies for RNs in policy not only help to regulate, but could also be re-considered a useful guide to the skills needed for working in professional advice and policy, however data suggests they are not widely understood or known about.
    - *Professional organisations to promote the professional advice and policy RN competencies to support RN considering this career option.*

Actioning these recommendations could develop create a much-needed nursing career pathway to policy work, self-employment and working in new spaces.

9.7 Significance of the findings and suggestions for future research

This original research explores a small group of self-employed RNs in Aotearoa NZ. Self-employment in nursing remains an underexplored area of the nursing canon and research specific to the Aotearoa NZ context is absent. No research is available nationally or internationally focusing specifically on RNs working the non-clinical practice area of professional advice and policy.

This research offers new knowledge across a range of subjects in Aotearoa NZ nursing which could contribute to the increasing diversity of the nursing profession and reveal hidden but valuable nursing skills and connect policy and public health in a powerful way. A next step for consideration would be research to explore how nursing is viewed by policy analysts, economists and politicians. This would help understand how nursing must adapt to be heard and sought out as experts in the healthcare of Aotearoa NZ.

9.8 Study limitations

This original research illuminated a poorly-understood and unexplored area of nursing practice and the barriers or opportunities of that practice. However, there were limitations to the study.

1. **Regulation:** This study was undertaken specifically on RNs working in Aotearoa NZ. Nursing regulatory requirements are different depending on the country of registration. Nurses in Aotearoa NZ have an advantage as the scope of the RNs is broad and enabling and the ability to work in a non-clinical way as a RN with an APC is achievable. In other countries (International Council of Nurses, 2004; Wall, 2015a), nursing regulators apply tighter scope boundaries.
2. **Ethnicity:** The engagement of Māori nursing and the struggle against the inequitable structures of hauora (health) is a complex and important part of Aotearoa NZ's nursing history. Ethnicity data was not collected and was outside the scope of the current study.
3. **Time periods:** The sections in relation to precarious income relate in part to the Aotearoa NZ summertime, which includes Christmas and New Year and the long school summer break. The

study participants often identified financially lean months during this time. The Northern hemisphere may not relate to this phenomenon. Future research could explore income regularity for self-employed nurses relating to seasonal work patterns.

4. **Sex /Gender identity:** Reviewing the NCNZ statistics for 2018, the year when participants were sought, showed only the number of female and male RNs identifying as self-employed. Gender identity information was not available and this is reflected in the study. The statistics showed zero self-employed male [21]RNs in professional advice and policy.
5. **Sample size:** The sample group consisted of 13 participants. The NCNZ statistics from the year when participants were sought (2018) shows only [22]twenty-four nurses identified with this category and of those some did not meet the study criteria. The study included at least 54.1% of the total potential participants. Larger countries with more nurses could have larger sample sizes. Alternatively, exploring a wider range of self-employed nurses, including those in education, research and management, may elicit a wider range of views. While this study presents the experiences of self-employed nurses in Aotearoa NZ, it is necessarily focused on a small group.

9.9 Final Summary

This thesis shed more light on the challenges faced by RNs entering solo self-employment and working from home. The research explored a group of nurses in Aotearoa NZ who did not fit the outdated ideas of what counts as a nurse or of nursing work. The participants represented a niche group of experienced and high calibre professionals within the nursing workforce able to work across the health sector and in spaces, such as policy, where nurses are rarely found.

[21] Appendix 1, p.235
[22] Appendix 1, p.235

Nursing in Aotearoa NZ is a diverse and complex profession with its own language, hierarchy and traditions. Anchored by historical discourses and behaviours, nursing is positioned as a devalued feminised occupation. Nursing must develop an active and critical relationship with the history of the profession. Although silent obedience was once seen as an asset in nursing, it is now untenable. In the 21st century, nursing has valuable, specialised expertise and knowledge which would be beneficial for policy analysts, health strategists and economists.

Liminality theory underpinned the study and liminal positioning was found to increase creativity, innovation and diversification of work. Gender theory with a post-structural feminist lens found gendered positioning still dominates the profession and the epistemic authority of nursing appears to have made minimal progress outside of the nursing profession. In a group which had destabilised nursing work, and what counts as a nurse, there was potential to move nursing into a different social and cultural space. But, as with many nurses, the participants were largely unaware of their discursive subjectivities and the gender positioning within which they worked, resulting in continually inferiorised identities.

The gendered lens is strong in relation to the financial and business aspects of the study. The participants existed in both the feminised nursing space and the masculinist space of self-employment and entrepreneurship which compounded their liminal positioning. Additionally, working from home created a link with gendered domesticity and required the management of new financial precarity and family tensions.

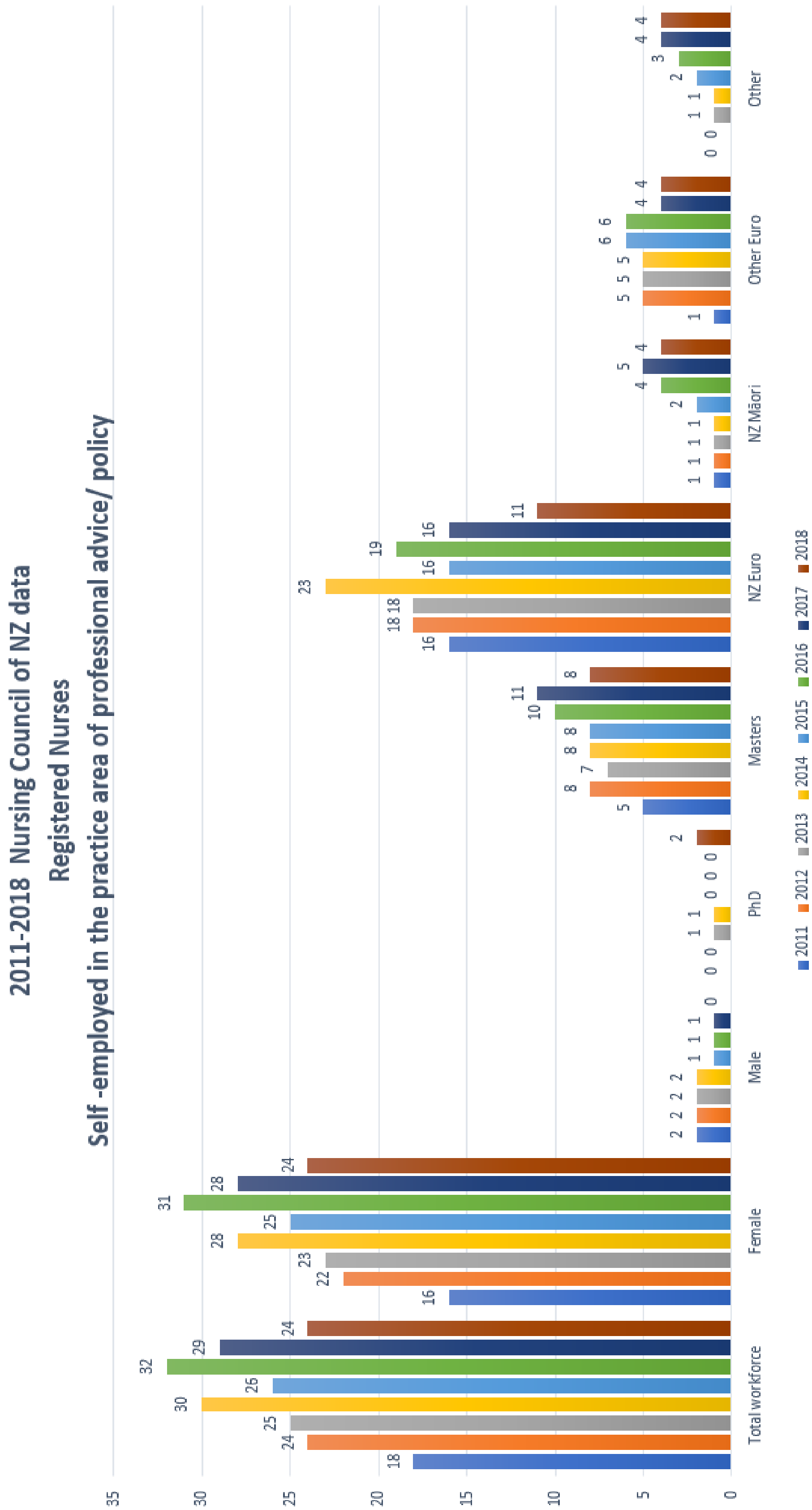
Positioned liminally and on the margins of their own profession, the participants were captured in gendered performativity regarding the financial expectations of contractors versus the lowered value of feminised nursing work. This resulted in significant undercharging for high quality work and gendered barriers for rectifying the situation. Despite this, the newly realised freedom

from organisational expectations, and the flexibility of work and lifestyle, meant the participants embraced their new self-directed endeavours.

Gender inequality remains across health workforces in Aotearoa NZ and unless recognised and addressed, the mechanisms of discrimination and patriarchy will continue to flourish. Nurses could take a lead and be the first professional group to awaken to the privilege and disprivilege found across health, starting with supporting and trusting colleagues who are liminally positioned in different practice areas, working in non-traditional ways and in non-traditional settings.

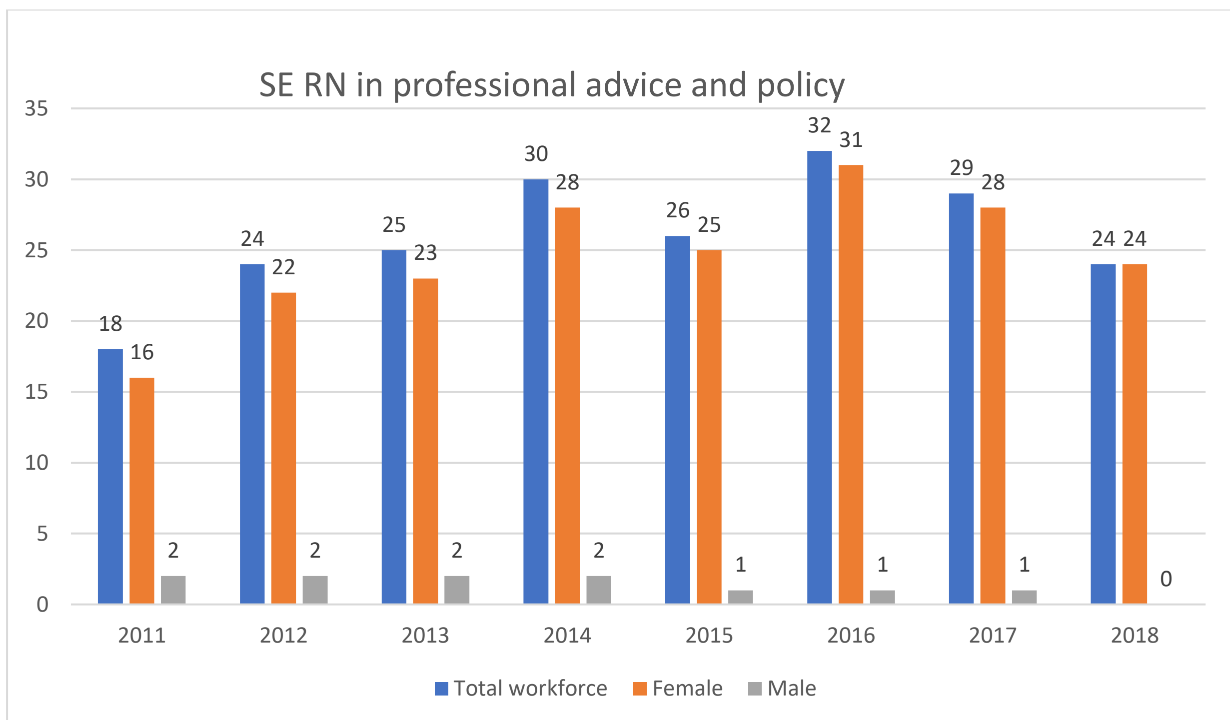
Appendices

1. Graphs



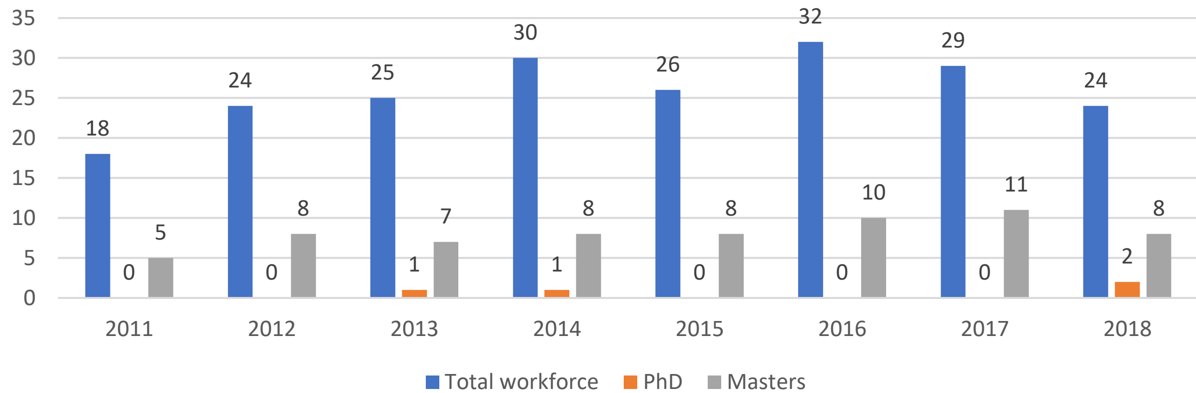
	2011	2012	2013	2014	2015	2016	2017	2018
Total workforce	18	24	25	30	26	32	29	24
Female	16	22	23	28	25	31	28	24
Male	2	2	2	2	1	1	1	0
PhD	0	0	1	1	0	0	0	2
Master's	5	8	7	8	8	10	11	8
NZ Euro	16	18	18	23	16	19	16	11
NZ Māori	1	1	1	1	2	4	5	4
Other Euro	1	5	5	5	6	6	4	4
Other	0	0	1	1	2	3	4	4

Table 4: NCNZ statistics: Self-employed in the practice area of professional advice/policy



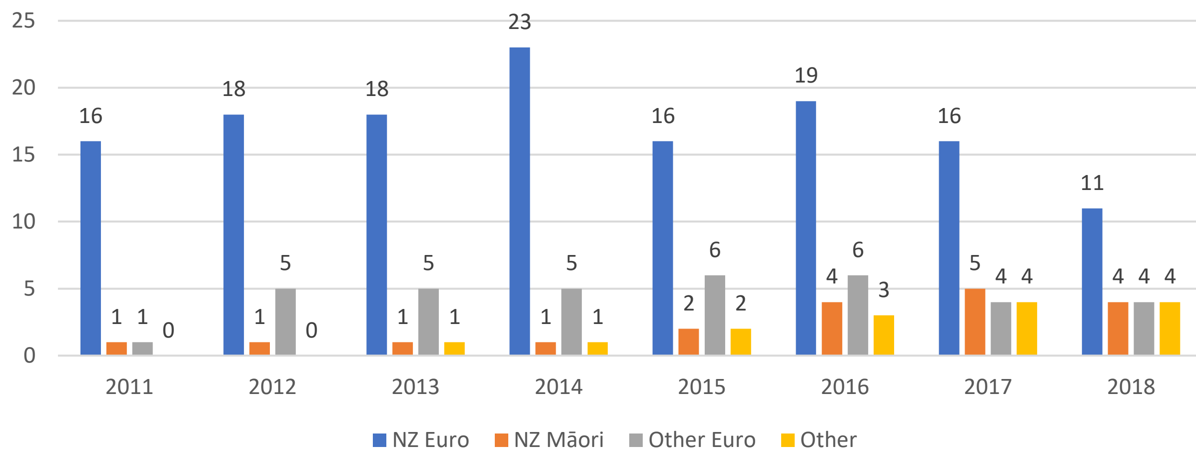
	2011	2012	2013	2014	2015	2016	2017	2018
Total workforce	18	24	25	30	26	32	29	24
Female	16	22	23	28	25	31	28	24
Male	2	2	2	2	1	1	1	0

Table 5: NCNZ statistics: SE RNs in professional advice and policy



	2011	2012	2013	2014	2015	2016	2017	2018
Total workforce	18	24	25	30	26	32	29	24
PhD	0	0	1	1	0	0	0	2
Masters	5	8	7	8	8	10	11	8

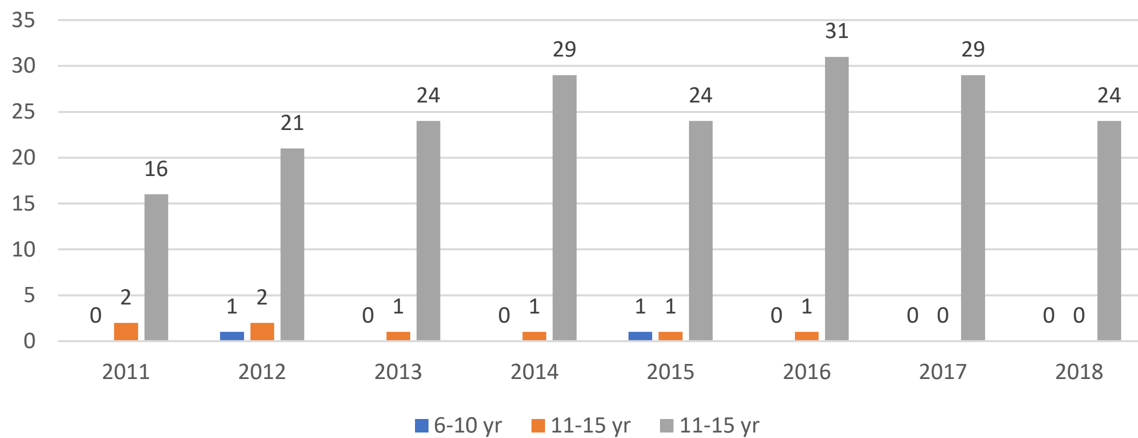
Table 6: NCNZ statistics: SE RNs in professional advice and policy: PG Qualifications



	2011	2012	2013	2014	2015	2016	2017	2018
NZ Euro	16	18	18	23	16	19	16	11
NZ Māori	1	1	1	1	2	4	5	4
Other Euro	1	5	5	5	6	6	4	4
Other	0	0	1	1	2	3	4	4

Table 7: NCNZ statistics: SE RNs in professional advice and policy: Ethnicity

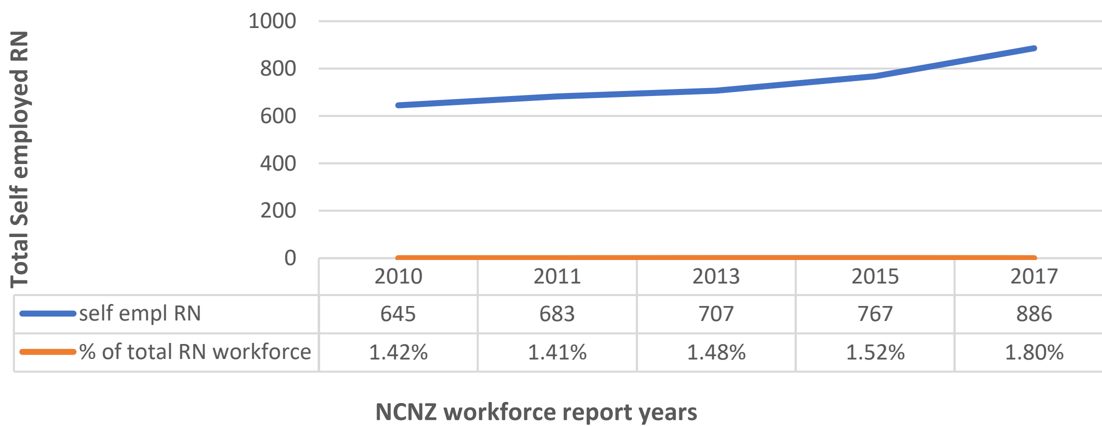
SE RN in professional advice and policy: years post registration experience



	2011	2012	2013	2014	2015	2016	2017	2018
6-10 yr	0	1	0	0	1	0	0	0
11-15 yr	2	2	1	1	1	1	0	0
11-15 yr	16	21	24	29	24	31	29	24

Table 8: NCNZ statistics: SE RNs in professional advice and policy: post-registration experience

Number of self-employed RN 2010-2019



NCNZ workforce report years

Table 9: NCNZ statistics: Percentage of self-employed RNs 2010-2017

	2013	2014	2015	2016	2017	2018	2019
Master's	1815	1889	1944	2014	2159	2321	2465
PhD	110	108	118	121	122	119	118
Grand Total	**1925**	**1997**	**2062**	**2135**	**2281**	**2440**	**2583**
Scope	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
Registered Nurse	47018	48406	49769	51021	52400	53507	55176
Enrolled Nurse	2965	2871	2815	2737	2648	2549	2487
Nurse Practitioner	91	129	145	164	242	300	373
Grand Total	**50074**	**51406**	**52729**	**53922**	**55290**	**56356**	**58036**
% Master's	3.62%	3.67%	3.68%	3.74%	40.07%	4.12%	4.24%
% PhD	0.22%	0.21%	0.22%	0.22%	0.22%	0.21%	0.20%

Table 3: NCNZ statistics: Percentage of nurses with Master's and PhD 2013-2019

2. Initial mind-mapping categories

Nursing context

- *Global trends for nursing entrepreneurship and self-employment*
- *NZ nursing workforce:*
  - Historical trends in employment vs self-employment
- *What a nurse is and does…*
  - Prevailing understanding of "nurse" and nursing roles
  - Nurses in self-employment compared to other NZ healthcare professionals
- *The current context of NZ nursing*
  - Role of the NCNZ as regulator
    - Scopes and competencies
- *Supporting workforce diversification*
  - RN workforce statistics and trends
    - RN self-employed
    - Area of practice
    - Gender
    - Ethnicity
    - Age range
    - Qualifications
    - Part time/full time
    - Regions
    - Experience
- *Define*
  - RN professional advice and policy
- *Considering a skill set/framework*

Aotearoa NZ small business context

- *The climate for small business in NZ*
- *Gender statistics in NZ small business*
- *Impact of increasing and available technology in small business set up*
- *Define*
  - Business owner vs entrepreneur vs self-employed
  - Sole trader vs self-employed
  - Solo employed role vs employer of staff
- *Drivers for self-employment in nursing*
  - Push or pull: Loss of job, restructure, economic, job/contract opportunity, lifestyle
    - Confidence level: Past experience. Previous roles lending themselves to self-employment e.g. project manager

Characteristics/traits/skillset of self-employed RN

- *Leadership*
  - Resilience, confidence, networking
- *Entrepreneurship*

- risk taking, innovation, self-motivation

- *Experience*
  - transferable skills, support system, depth of knowledge in the discipline, profession

Running a business

- *Barriers and stress*
  - New business skills
    - Set-up, finding a niche/market
    - What to charge: Defining professional self-worth
    - Estimates/quotes/business planning
    - Tax, IRD, accounting
    - Marketing, technology
  - Where and when to work
    - Home/near home/rented offices
    - Blurring home/work -life
    - Solo worker isolation, loneliness, professional, collegial, geographical.
    - Learning to take time off
  - Additional roles
    - Manager/director/marketing/accounting
    - Total responsibility
    - Increased precariousness – financial, contractual
- *Opportunities, benefits, rewards*
  - Lifestyle: work/life balance, working from or nearer to home
  - Setting own hours and priorities
- *Resources and support*
  - Where to get support, supervision/mentorship
  - Maintaining broader networks
- *Defining success vs failure*
  - Relational/affiliative
  - Financial
  - Ethical
  - Performance/output
  - Work life balance/lifestyle
  - Maintaining control

2. Participant advertisement

You are invited to participate in a research project to explore:

The experiences of self-employed registered nurses working in professional advice and policy

My name is Liz Manning and I am a doctoral student at Massey University. I am exploring the experiences of registered nurses who work in the nursing practice area of professional advice and policy as self-employed business owners providing contracted services to the health sector. This qualitative research is intended to gain insight into how registered nurses' approach and manage self-employment and what environments they create in which to work.

I invite you to participate if:

- You are providing contracted services to the NZ health sector as a registered nurse e.g. project manager, external management consultant, policy analyst
- Hold a current APC
- Your practice is non-clinical and in the practice area of professional advice/ policy
- You are the owner/ operator of limited liability company or a sole trader
- You are solo self-employed (no employees), working full time or part time in your business
- You have no other employment
- You are within 10 years of business start-up: 2007-2017
- Are willing to allow observation of your office/ work space

If you choose to participate:

I will require between **60-90 minutes** of your time to interview you in your office/ work space.

If you are in the Auckland region, you can be interviewed face to face in your office/ work space, or if elsewhere in New Zealand (or you prefer it), the interview can be over a video link.

The interview will be at a time and date agreeable to you.

The interview will be audio and video recorded, then anonymised and transcribed.

Thank you for your consideration

If you would like more information about this study please contact:

Researcher: Liz Manning ______Or **Supervisor**: Professor Jenny Carryer

3. Participant information sheet

A New Zealand study of self-employed registered nurses: Exploring the peaks and troughs of self-determination.
INFORMATION SHEET
Self-employed RN Participants

Invitation

My name is Liz Manning and I am a doctoral student at Massey University and a self-employed registered nurse running my own consulting company, Kynance Consulting Ltd. I would like to invite you to become a research participant in this study as you have identified as a self-employed registered nurse working in the non-clinical practice area of professional advice / policy.

Project Description

This is a qualitative study to find out more about the experiences of registered nurses who work in the area of professional advice and policy as self-employed business owners providing contracted services to the health sector. There is no research in New Zealand currently on this small but growing group of nurses, who work outside of the traditional health settings in non-clinical roles.

Your involvement

- I plan to interview you about your experiences and that might take 60-90 minutes.
- I will audio record and video record our interview.
- I can come to visit you if you live in the Auckland region, or if elsewhere in New Zealand, or you prefer it, we'll use video calling so I can see you and your office set-up.

Use of data

- The interviews will be transcribed using the audio files. I'll email the transcript to you so you can edit any parts you want changed.
- I'll keep all the video and audio recordings and the transcripts and observational notes safe in a password protected computer file and stored for a period of 5 years, when it will be deleted.
- The only people with access to the information you provide, will be me and my supervisors, as listed below.
- Findings from the data will be used to complete my thesis and may include quotes and statements you have made.

- The thesis will be made available through Massey University library, article publication and presentation to appropriate nursing groups.

Confidentiality

- To ensure confidentiality, I will ask you to choose a pseudonym for the purposes of presenting the data. Only I will know your actual identity.
- If you name specific institutions, people or places in the course of the interview, the names will not be used in the presentation of data.
- Your consent form will remain secure in a locked filing cabinet, to which I will hold the key.

Statement of rights

- You are under no obligation to accept this invitation. If you decide to participate, you have the right to:
    - Decline to answer any particular question
    - Withdraw from the study up until you return the transcript to me.
    - Ask any questions about the study at any time during participation
    - Provide information on the understanding that your name will not be used unless you give permission to the researcher
    - Be given access to a summary of the project findings when it is concluded
    - Have the right to ask for the audio or video recordings to be turned off at any time during the interview

Thank you for taking the time to read this information. If you have any queries regarding your rights as a participant of this study, you may wish to contact your professional organisation.

Please feel free to contact me or one of the research supervisors if you would like more information.

Elizabeth (Liz) Manning	***Professor Jenny Carryer***	***Dr Shane Scahill***
Researcher	***Supervisor***	***Co-Supervisor***
Director/ owner/ nurse consultant	*School of Nursing*	*Senior lecturer*
Kynance Consulting Ltd	*College of Health*	*School of Management*
09 411 5320	*Massey University*	*Massey University*
Liz.Manning.1@uni.massey.ac.nz	*027 4491302*	*021 02771583*
	J.B.Carryer@massey.ac.nz	S.Scahill@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 17/59. If you have any concerns about the conduct of this research, please contact Dr Ralph Bathurst, Acting Chair, Massey University Human Ethics Committee: Northern, email humanethicsnorth@massey.ac.nz

4. Participant consent form

A New Zealand study of self-employed registered nurses: Exploring the peaks and troughs of self-determination.

PARTICIPANT CONSENT FORM - INDIVIDUAL

I have read the Information Sheet and have had the details of the study explained to me.

My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being sound recorded.

I agree/do not agree to the interview being image recorded.

I agree/ do not agree to my office space being observed.

I wish/do not wish to have a transcript of my recordings returned to me.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: .... **Date:** ....

Full Name - printed ....

5. Copyright permissions log

Page number	Details of in-copyright material	Date permission requested	Permission granted	Conditions/ notes from authors
70	Garcia-Lorenzo, L., Donnelly, P., Sell-Trujillo, L., & Imas, J. M. (2018). Liminal entrepreneuring: The creative practices of nascent necessity entrepreneurs. *Organization Studies*, *39*(2-3), 373-395. https://doi.org/10.1177/0170840617727778	2/6/21 By email	2/6/21 From primary author Dr Lucia Garcia-Lorenzo	none
99	Bacigalupo, M., Kampylis, P., Punie, Y., & Van der Brande, G. (2016). *EntreComp: The entrepreneurship competence framework*. Publication Office of the European Union. https://ec.europa.eu/jrc/en/publication/eur-scientific-and-technical-research-reports/entrecomp-entrepreneurship-competence-framework	2/6/21 By email	2/6/21 From primary author Dr Margherita Bacigalupo	All work done by the European Commission free for reuse under CC4.0 or an equivalent licence, so you actually do not need permission.

6. Theme and category development

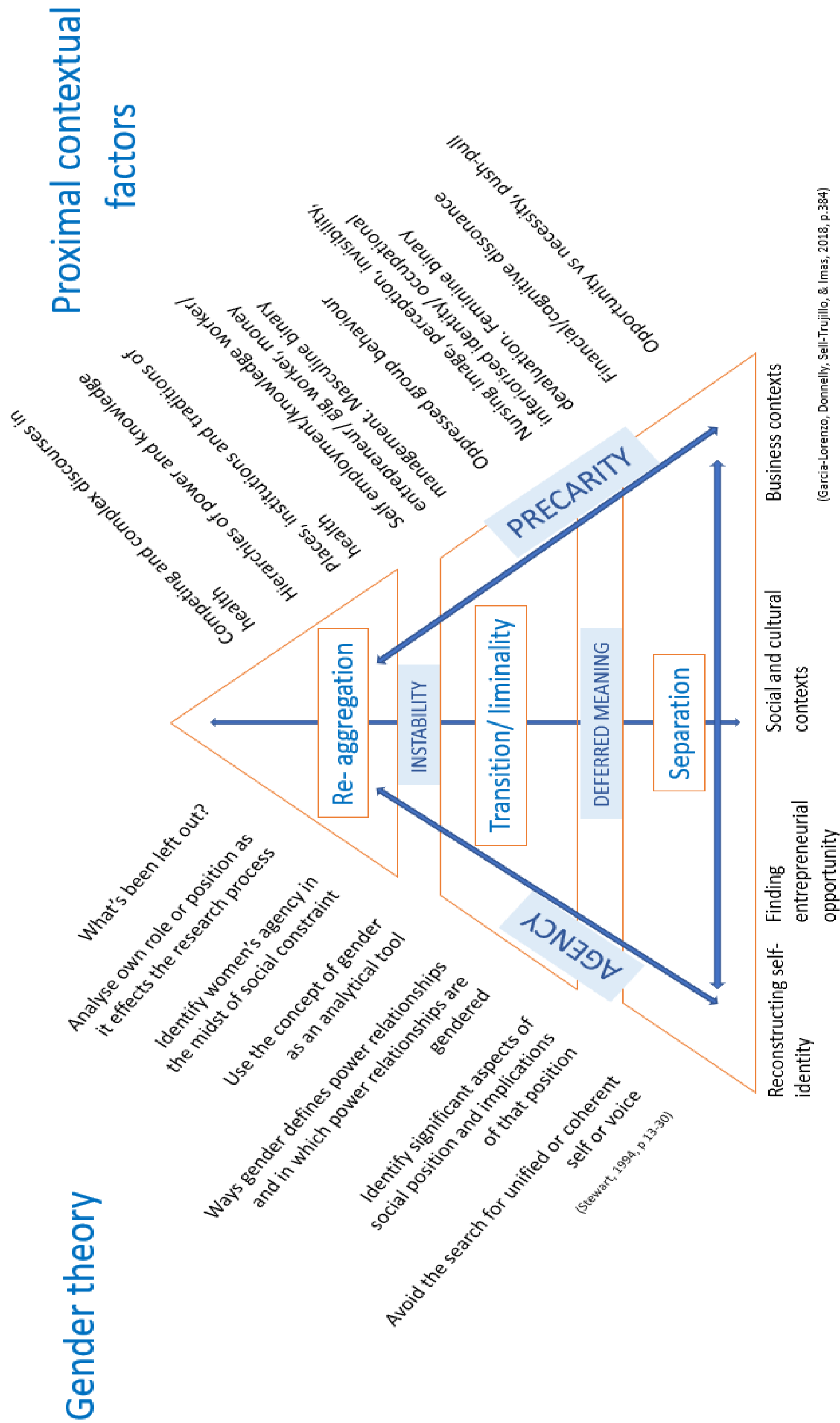
Instances	Theme	Category	Subcategory
How it feels to be self-employed			
How it feels to work from home			
No control in external organisations	The business	Setting up	Reason for self employment
Control of home office environment			Business set up
Shared space issues/ barriers at home office			Business plan/ vision
Reason for self- employment			Sole trader or Ltd co
Self-directed			Insurance
Flexibility/ work life control			Contract set up
Marketing			Technology and resources
Less important			Marketing
Professional agility/ diversification		The money	Precarious income
Precarious work			Free time/ loss leaders/ mates
Precarious income			GST/ Business finANCE
Networks			Quoting and hourly rates
Financial security			Financial security
Quoting and hourly rates			Value of work/ value for money
Value of work/value for money		Working from home	How it feels to work from home
Real cost of nursing			Control of home environment/ positive workspa
Free time/ loss leaders/mate's rates			shared space issues
Expectations of being available			Expectations of being availbale
Not real work			Flex/ work-life balance
Not a proper nurse			Self-care
Qualifications to be self-employed/ confidence/competence			No control in external organisations
Creativity			Building confidence to work across orgs
Professional presence		How things have worked out	How does it feel to be self employed
Social context of nursing			Entrepreneur
Technology and resources for self-employment			Self-directed
GST/ business finance			Creativity
Business expansion			Quality of the work
Isolation			Success
Mentoring /coaching			Failure
Success			Precarious work
Failure			Professional agility/ diversification
Quality of the work			Business expansion
Ability to work in other organisations- building experience			Employee again
No orientation/ socialisation	The nursing	Nursing skills and education	Skills needed
Self-care			Qualifications for self-employment
Contribution			Nursing knowledge
Employee again			Not a career option
APC/scope		Being a self employed nurse	Social context of nursing
Entrepreneur			Outsider
Nursing knowledge			Isolation
Business set -up			Not a proper nurse
Sole trader or Ltd liability company			Networks
Business plan/ vision			Mentoring/ coaching
Insurance			Reception/ perception
Collegiality of nursing			Professional presence
Contract set-up			APC /scope
How received and perceived			Advice for others
Outsider			
Skills needed			
Advice for others			
Not a known career option			

Table 4 Early categorised instances

Beginning to take control	Reason for self-employment	Seperation; agency and change	6.2 Tipping points
	Business set up		6.3 Value of post graduate education
	Business plan/ vision		6.4 Value of RN scope and APC
	Sole trader or Ltd liability		6.5 Enduring image of a nurse
	Insurance		6.6 Outsider
	Contract set up		6.7 Professional identities
	Technology and resources		
Learning to charge for high value work	Precarious income	Transition; finance and business	7.2 Precarity
	Free time/ loss leaders/ mates rates		7.3 Marketing
	GST/ business finance		7.4 Financial literacy
	Quoting and hourly rates		7.4.1 Tax and finance
	Financial security		7.5 Financial self efficacy
	Value of work/ value for money		7.5.1 Financial security and value add
			7.6 Networking and social capital
Mixing public work and private space:	How it feels to work for home		
ce	Control of home/ shared space	Re-aggregation; Public and private	8.2 Combining public work and private spaces
	Expectations of being availbale		8.3 The duality of freedom and flexibility
	Flexibility / work-life balance		8.4 Family and friends
	Self-care		8.5 Entrepreneurship and risk
Precarity, creativity, control	How does it feel to be self-employed		8.6 Isolation
	Entrepreneur		8.7 What does success (or failure) look like?
	Self-directed		
	Creativity		
	Quality of work		
	Success/ failure		
	Precarious work		
	Skills needed		
	Professional agility/diversification		
	Business expansion		
	Employee again		
Reframing an identity	APC /scope		
	Qualification for self-employment		
	Nursing knowledge		
	Reception/ perception		
	Outsider		
	Isolation		
	Networks		
	Mentoring/ coaching		

Table 5 Theme and category development; early and late

7. Theoretical and contextual framework



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