Communities of Practice for Unwitting Entrepreneurship[1]

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Abstract

Dans cet essai, j'étudie les actions entrepreneuriales des praticiens de santé indépendants qui appartiennent à un CdP. Je réponds à la question "Comment des actions entrepreneuriales peuvent-elles émerger involontairement de praticiens qui font partie de communautés de pratique" en étudiant leur pratique quotidienne à travers deux semaines d'immersion totale et deux ans de réflexion sur mon expérience et mes interactions avec les participants à l'étude. Les résultats dévoilent une pratique de "prendre ce qui vient" comme une pratique récurrente dans leurs interactions sociales. Cette pratique initie un "processus d'entreprenariat" avec de multiples possibilités ouvertes d'entreprenariat émergent. L'appartenance à un CdP permet aux praticiens indépendants de maintenir leur esprit d'entreprise sur la bonne voie car le CdP joue un rôle de régulation. La contribution est triple : tout d'abord, je présente le concept d'"entrepreneurs involontaires" et j'invite les spécialistes de l'entrepreneuriat à repousser les limites de l'investigation en reconnaissant l'"entrepreneuriat involontaire". Deuxièmement, je dévoile l'ouverture des entrepreneurs en tant que pratique en expliquant leur pratique consistant à "prendre tout ce qui vient". Troisièmement, je suggère d'approfondir l'étude du potentiel des CdP en tant que lieux qui renforcent et promeuvent l'esprit d'entreprise involontaire parmi les praticiens indépendants.

[1] Issu de ma thèse de doctorat

1. Introduction

In the French healthcare ecosystem, General Practitioners (GPs) work on their own as self-employed and the majority work in single-handed practices. To counteract this isolation, the French Society of General Practice has created and registered a knowledge-sharing tool known as "Peer Group" in 1994. This group aims to promote continuous learning and evaluation between GPs in a limited geographic zone. Six to ten GPs constitute the peer group on a voluntary basis and meet monthly in order to share their day-to-day practice of family medicine sharing information and experience. This GP peer-group constitutes a Community of Practice (CoP) following the definition of Wenger et al., (2002) "Group of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis" (Wenger, McDermott and Snyder 2002: 4). This concept introduced first by Lave & Wenger (1991) in their work on situated learning met a considerable success among researchers and practitioners. Wenger developed the concept through other works (Wenger, 1998, 2004, 2010; Wenger et al., 2002) that made of him the 'father' of the concept (Bolisani & Scarso, 2014). Interestingly, the main lines of the seminal work on CoP guided the conversation over three decades. Although Wenger is not known to be a 'Knowledge Management' scholar (Bolisani & Scarso, 2014), his work around 'situated learning', 'social learning' and 'tacit knowledge' influenced electively 'Knowledge Management' Scholarship according to different literature reviews of the concept (Aljuwaiber, 2016; Bolisani & Scarso, 2014; Cox, 2005; Murillo, 2011). This made a shift of the concept's influence away from other dimensions hidden between the lines such as entrepreneurship and its emergence out of CoP.

In the Entrepreneurship literature, emergence is central in the organizing process (Gartner, 1993). Scholars went to define entrepreneurship as 'organizational emergence' (Gartner, 2014) with the ontology of becoming (Chia, 1995, 2002; Tsoukas & Chia, 2002). Entrepreneurship emergence relies then on a process of entrepreneuring (Johannisson, 2018a; Rindova, Barry, & Ketchen, 2009; Steyaert, 2007). For which 'creativity' (Burger-Helmchen, 2012; Gilad, 1984; Lerch, Thi Thanh Thai, Puhakka, & Burger-Helmchen, 2015; Tsai, 2014) through a 'generosity' of actions (Hjorth & Holt, 2016) gives birth to 'novelty' & 'newness' (Hjorth, Holt, & Steyaert,

2015; Rindova et al., 2009; Roberts, 2006) getting back to the seminal work of Schumpeter (1991) defining entrepreneurship as "getting something new done".

Research on entrepreneurship emergence (Gartner & Brush, 2007; Lichtenstein, 2011) is then crucial to advance our understanding of entrepreneurship. Nevertheless, in investigating entrepreneurship, scholars tend to identify an entrepreneur or a context of emerging entrepreneurship (Anderson & Gaddefors, 2017) so that we know less how entrepreneurship may emerge alternately. Only a few studies focused on accidental entrepreneurs (Aldrich & Kenworthy, 1998; Görling & Rehn, 2008; Shah & Tripsas, 2007) in which unintentional engagement in entrepreneurship occurs such as students (Aldrich & Kenworthy, 1998) or users (Shah & Tripsas, 2007) becoming entrepreneurs. While scholars admit that there is no entrepreneurship without surprise (Ramoglou, 2013; Sarasvathy, 2004; Van de Ven & Engleman, 2004), it is difficult for researchers to anticipate the emergence in everyday life or in non-identified contexts. Consequently, we know less how entrepreneurship may emerge in other contexts and by other people from a problem-solving perspective without even being conscious about it; in one word: unwittingly.

In this paper, I shed the light on entrepreneurial actions emerging from self-employed GPs working in four distinct but neighbor villages who are linked by a CoP. I investigate their day-to-day social practice that contributes to engaging in entrepreneurship unwittingly. Focusing on their social micro-practices, I try to answer the question of "How entrepreneurial actions may emerge unwittingly from practitioners who are part of communities of practice?"

Results put forward a 'taking whatever comes' practice that initiates a process of information processing and bricolaging with open possibilities to entrepreneurship emergence. I call this process 'process to entrepreneuring'. Results attribute to CoP a regulatory role that permits going further up to entrepreneurship accomplishment.

The contribution is three-fold: first, I introduce the concept of unwitting entrepreneurs in an attempt to push boundaries of entrepreneurship investigation. Second, I unveil their social micro-practice that may explain the expansion of their resources at hand and their engagement in entrepreneurship. Third, I shed light on how CoP may contribute to the emergence of unwitting entrepreneurship among self-employed practitioners through ideation, resource pooling, and continuous evaluation.

To contribute to our understanding about unwittingly emerging entrepreneurship, in communities of practice, as practice, and to answer the research question, this essay takes the following structure: first, I try to bring some insights from entrepreneurship literature in regards to entrepreneurship emergence and others from communities of practice literature in regards to CoP research orientation. Next, I narrate in form of stories the research settings, methods, and design. Then, I share the study results and interpretations and move forward to discuss them in light of previous literature. Finally, I conclude with emerging insights from this study.

2. Entrepreneurship Emergence and Communities of Practice: Literature Review

2.1. Entrepreneurship Emergence

Entrepreneurship literature does not provide a single definition of entrepreneurship (Anderson & Starnawska, 2008; Gartner, 1985; Johannisson, 2018b; Low, 2001; Shane & Venkataraman, 2000). The multiplicity of approaches resulted in a multiplicity of views and definitions. In this range of definitions, some keywords seem to get some consensus being essential to entrepreneurship that are 'novelty' (Hjorth et al., 2015; Rindova et al., 2009; Roberts, 2006) and 'creativity' (Burger-Helmchen, 2012; Gilad, 1984; Lerch et al., 2015; Tsai, 2014). Though creativity is different from novelty, both are about emergence. This makes sense of why Lichtenstein (2011) considers entrepreneurship as emergence and Gartner (2014) defines entrepreneurship as organizational emergence. Studying the emergence of the emergence or, in other words, entrepreneurship emergence is then essential for entrepreneurship scholarship.

Research on entrepreneurship emergence (Gartner & Brush, 2007; Lichtenstein, 2011) focused on entrepreneurial organizing and organizational creation (Brush, Manolova, & Edelman, 2008; Gartner, 1985, 1993; Lichtenstein, Carter, Dooley, & Gartner, 2007; McKelvey, 2004) opportunity recognition and creation (Heinonen, Hytti, & Stenholm, 2011; Mainela, Puhakka, & Servais, 2014; Puhakka, 2007), entrepreneurial networks (Birley, 1985; Hansen, 1995), institutional entrepreneurship (Katz, 1991) and effectuation (Johannisson, 2018a; Koivumaa & Puhakka, 2013; Sarasvathy, 2001, 2009). Entrepreneurship research focused as well on entrepreneurship promotion in incubators (Aernoudt, 2004; Allen & Rahman, 1985; Bøllingtoft & Ulhøi, 2005) and entrepreneurial education (Koivumaa & Puhakka, 2013; Kuratko, 2005; Peterman & Kennedy, 2003).

However, the scope of research on entrepreneurship and entrepreneurship emergence does not cover every day and every context entrepreneurship due to the difficulty for researchers to predict and anticipate entrepreneurship where it is less expected.

2.2. Communities of Practice

A community of practice defines itself by both terms 'community' as a group of people having regular interactions and 'practice' as the main concern and the subject of these interactions (Goglio-Primard, Guittard, & Burger-Helmchen, 2017; Probst & Borzillo, 2008; Wenger et al., 2002) so that they improve that practice and develop expertise around it. Three main characteristics constitute CoP and they are then the joint enterprise as agreed among members, mutual engagement and a cumulative shared repertoire of resources (Wenger, 1998).

CoP are everywhere (Wenger, 1998) and they have existed since ever without being called such as (Wenger & Snyder, 2000). Historical CoP were composed of people working on their own while today's CoP are intra- or inter-organizational as Wenger & Synders (2000: 140) state: "Today's communities of practice are different in one important respect: instead of being composed primarily of people working on their own, they often exist within large organizations". These lines directed three decades of research to focus on intra- or inter-organizational CoP with considering the supportive role of from top management (Probst & Borzillo, 2008) which undermines the 'spontaneous' character of CoP that was essential in early works (Lave & Wenger, 1991; Wenger & Snyder, 2000) (Wenger and Snyder, 2000). Little attention is directed then on CoP of independent or self-employed workers.

Moreover, Wenger and Synders (2000) mentioned the capacity of CoP to bring entrepreneurial insights and develop new lines of business. Nevertheless, the focus of early works by Wenger and others (Lave & Wenger, 1991; Wenger, 1998, 2004, 2010; Wenger et al., 2002) was on learning and related concepts and areas such as situated learning, social learning, knowledge management, and knowledge sharing. Areas most investigated by CoP literature (Aljuwaiber, 2016; Bolisani & Scarso, 2014; Cox, 2005; Murillo, 2011). Little research has focused on the entrepreneurial emergence out of CoP.

2.3. Emerging Entrepreneurship in Communities of Practice, as an Outcome of Social Practice

While research on CoP has mainly focused on knowledge management (Aljuwaiber, 2016; Bolisani & Scarso, 2014; Cox, 2005; Murillo, 2011) with less attention to entrepreneurship emergence, the literature on entrepreneurship has focused on predefined entrepreneurs and contexts favorable for Entrepreneurship (Anderson & Gaddefors, 2017). Therefore, we still need to look at entrepreneurship in its context where it is less expected in order to enhance our understanding of entrepreneurial diversity and entrepreneurial emergence. One of the contexts might be that of CoP as emerged from the field of this study in which I try to understand how entrepreneurial actions may emerge unwittingly among practitioners of CoP.

3. Self-employed General Practitioners as Communities of Practice

In this essay, I focus on the social practice of a group of self-employed GPs, who meet regularly for over fifteen years in a "peer group" composed of nine GPs in the southwest of France. They meet the first Tuesday of each month 9 times per year (except summer and December). They meet after work in the evening at 08:00 pm at the practice of any of them for three hours. Alternatively, one of them becomes the host and prepare food to share with others. Another one would be the secretary taking time and moderating time. They organize their discussions into three parts. The first part lasts 90 minutes. It is about sharing practices with real-case studies. The cases are real patient cases that they met during the month and that they find intriguing. Here, the contribution depends on their month-to-month medical practice so that they do not attribute in advance the role of case provider, as it is the case for the host and the secretary. GP who is willing to share a case should prepare it as an anonymized detailed case study with patient characteristics, medical history, and the symptoms. Peers then, one after another, share how they would diagnose the case and deal with it in matter of treatment and follow up. Last, the case provider,explains how he diagnosed and treated.

While they improvise during this first part, the second part of their meeting is previously planned. In this part, they discuss, for 60 minutes, subjects on which they have agreed to the previous meeting. Subjects are variable but must be connected to their practice of family medicine. They may include new regulations, new medicines on the market, new practices in primary healthcare or simply a review of protocols related to specific diseases.

The last part of 30 minutes is for concluding remarks and subjects' proposals, debating priorities and making decision about subjects of interest for second part of next meeting. Their planned three hours last yet longer and they rarely leave by midnight.

The objective of their Peer group meeting is continuous learning and development. It was created thanks to a freshly graduated GP who joined a joint-practice in a rural area in 2002. In prevention from isolation and routine, he has initiated the group. He contacted all GPs in the surrounding villages and composed the group. Between arrivals and departures, the composition has partially changed. Five of the peers have continued to be part of the group since 2005 and the other four joined progressively with the last arrival in 2012.

3.1. Their Story: Organizational Emergence between Learning from Each Other and Entrepreneuring Together

The nine GPs of the peer group are self-employed. Except for one who is working in a single-handed practice, they work all in four multi-disciplinary joint-practices (MJP). Each of them has participated in the creation of these practices introduced by the French law in 2009 and known as Multi-professional Health Homes (MHH). Earlier, the law prohibited GPs from sharing facilities with other primary care practitioners considering such sharing should influence patients' choice. In other words, patients who get out of GP appointment with the need for physical therapy should have the freedom of choice; which physical therapist they want consult. Sharing facilities with a physical therapist was considered as influencing the choice of the patient. In response to new healthcare challenges, the law legalized and incentivized MJP. As the law introduces MHH, the concept was abstract and everything was in need of creative imagination.

The eight peers who are working today in MJPs have participated in the creation of their MHH with other self-employed practitioners from their villages. Six of them passed from either single-handed practices or mono-disciplinary joint-practices of five GPs to MJP of 14 to 24 primary care practitioners from different disciplines. The other two were already sharing facilities with two nurses and a speech therapist. As that was not legal, they had a visit from work inspection requiring them to split the waiting room to which they responded by splitting by a set of plant pots.

During many peer meetings, they discussed the law in the second part as the main subject affecting their practice. Simultaneously, in the four villages, they engaged in creating four MJP. The creation lasted from two to six years in which they initiated, with other self-employed

practitioners, their MJP, designed, funded and implemented. The type of investment, number of practitioners and their specialties vary among the four MJPs. However, it is easy to observe the influence of one MJP on another with the peer group to be the main connection.

After the establishment and stabilization of their MJPs, they engaged in the conception and implementation of a Patient Therapeutic Education (PTE) project on the level of four villages. The beneficiaries of the project are patients with complex cases especially with chronic and multiple pathologies from the whole territory of four villages. Such education operates in the hospital setting which is ill-adapted to their patients. In response to territorial needs, 15 participants (GPs, nurses, physical therapists, a podiatrist, and a nutritionist) had collaborated and developed it. Three other private, single-handed practitioners joined the PTE project.

The peer group was not only the connection between practitioners of the four MJPs; it was also the place of need assessment ten years earlier and the place of revival of the PTE project. Through case-discussions that peers agreed on the need for such a project for their patients. However, the available resources and skills were inadequate to set up such a project as they were working either single-handedly or in small joint practices. It is ten years later that the peers brought back the discussion on the table in response to recurrent cases. Four of them volunteered to coordinate and to spread the word to their co-workers in the four MJP. As they successfully convinced their respective MJP co-workers, they built and implemented the PTE project.

To sum up, in four distinct villages in the southwest of France, 14 to 24 self-employed primary care practitioners engaged in the creation of four MJPs and one another project by practitioners, and for patients, from the four villages. The peer group offered a place of experience sharing in regards to the creation of MJPs and the conception place for the PTE project.

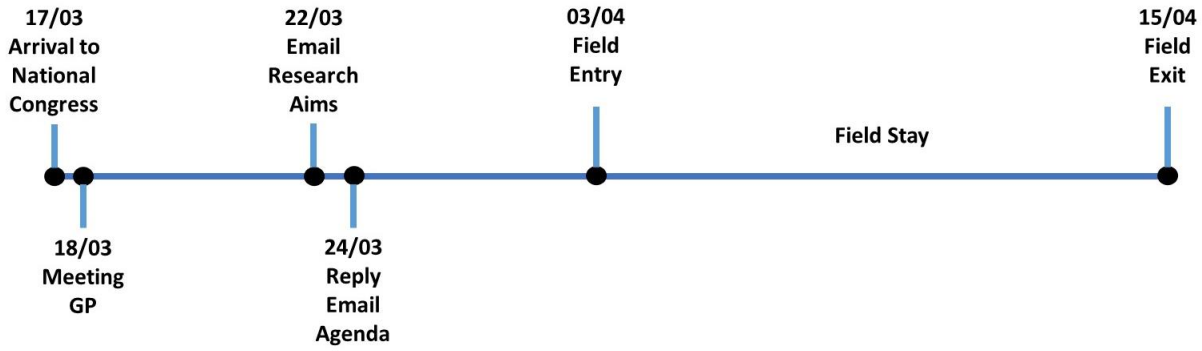
3.2. Our Story: Field Access and Researcher-Practitioners Interactions

After documentary research of public documents and recurrent discussions with a coordinator of a regional federation of MHH, I decided to target MHH to be my research lab as an emerging organizational form. In spring 2017, I participated in the national days of the national federation of MHH where I went to meet and to discuss with people working in MHHs. I was seeking for interviews and hoping for planning some appointments. Through coffee-break discussions, I met a GP to whom I expressed as I did to others my willingness to conduct interviews and my readiness to go to visit MHHs. Unexpectedly, and fortunately, she was welcoming and took

out her agenda so that we can plan immediately a week-visit to her MHH. Located in a rural area, she asked about my plans for accommodation and I was simply willing to figure out something in the area. Unexpectedly, she suggested hosting me for the week and I agreed immediately. We planned the week and then she asked if I am intending to visit other MHHs. To my positive reply, she talked about other three MHHs in neighbor villages with which they do some work and to which she can introduce me. To my positive reply, she volunteered to talk to them so that I can visit them another week before or after our planned week. While she was leaving and over two-meter distance, she cried: *"Do not worry about the accommodation, we will figure it out*".

One week later, I sent her an email to explain my research interest, the day after she replied and put in cc people from the other three MHHs. In her reply, she provided planning for my stay in the four MHHs trying to give me access to meetings that are held in the four MHHs. Fifteen days later, I conducted field-visit for two full weeks in the four MHHs and slept over in the different villages at their places as shown in Figure 12.

Figure 1. Timeline of Field Access



I have been, then, in the four MHHs for one hundred and forty-two hours of formal presence in which I conducted interviews with 42 healthcare practitioners and 3 administrative assistants. I had also ninety hours of non-participant observation in which I attended a peer group meeting, three MHHs meetings, two general assemblies, and one PTE project coordination meeting. I had twelve hours of participant observation in the Kick-off day of the PTE project as a new emerging project among the four MHHs. Besides documentation collection and taking pictures, I had seven informal dinners and eight informal breakfasts with my research informants allowing an almost in vivo field study.

Being two full weeks in the field, sleeping over, having informal dinners and breakfasts, sharing their cars, and other moments shared in their private sphere catalyzed immersion and enactment of their realities. At the middle of my stay and after my participation in the kick-off day of their collective project, one of them reacted:

"*You become so dangerous. You know a lot about us*!" (GP, MHH I).

Another told me as he was giving me a ride

"*I must have you as a friend so you can connect me to everybody here*" (GP, MHH II).

Besides taking field notes, each night I wrote down some notes and reflections before sleeping deeply after information-intensive long days. I was overwhelmed with the richness of my stay full of interactions and reflections as can illustrate the verbatim of GP from MHH IV

"*You know more about some people here in our MHH than I do though we have been working side by side for years. You had time to observe, learn, interact and reflect while we are in action all the time*."

Once back home, I stayed by my own three full days without any social interaction.

Three months later, I met some of them in a professional regional event. One year later, I conducted three follow-up phone interviews.

3.3. My Story: From Researcher to Research Subject

Transcribing, listening to interviews, reflecting on and telling the story and the stories to academic and non-academic people helped me to make sense of my data. Though I aimed first to explore MHHs day-to-day practice, data was loudly speaking in favor of "Entrepreneurship" with the emergent project as well as with the creation of the four MHHs. During six months, I was reluctant to go further, as they do not present it as entrepreneurship. I presented my field stay, observations, and reflections to researchers in health management, strategy, and entrepreneurship. Though I did not share my thoughts about entrepreneurship, these researchers advised me to explore entrepreneurship research and the field enactment in entrepreneurship-as-practice where experience-based knowledge fits best. Another important reaction that I received repeatedly was about my experience of field access, the informal time spent with the study participants and how I was so close to them.

These reflections lead me to consider my experience in the field; including how I felt when I was in the field particularly through my participant observation. We experimented new tools they

had created. My participation released an adrenaline rush that brought back memories of my early twenties when I was involved in creating something new, experimenting and implementing. During my pharmaceutical studies, I participated in the creation of pharmaceutical students association at school and a youth initiative that we called "let's start together" out of the school. Both aimed at truly joining youth together to create cultural events and free-time activities. Right after my graduation, I received training of trainers and created with four other participants a training program that we offered free of charge to youth associations. We were aiming at enriching ourselves by practicing what we learned and meeting people. One year later, with other volunteers, I participated in the initiation of a new multi-dimensional project and in securing finance. By then, I designed the health promotion part, hired a collaborator, created tools and implemented the project.

From immersion, self-reflection in regards to field stay and self-reflections in what this field mirrored in me, I opted to undertake an ethnographic approach reflecting on my study participants' day-to-day practice and an auto-ethnographic approach to discuss and reflect on my own experience.

4. Taking Whatever Comes

As I was looking, at 'what was surprising' in my experience and the interactions I had with my study participants and trying to make sense of that, it appeared that they were "taking whatever comes" from our interactions. However, I was not in an expert position and that seemed weird to me so I continued to dig more identifying other anecdotes out of their practice, the "taking whatever comes" hidden motto become more obvious

The 'taking whatever comes' was a common pattern of these unwitting entrepreneurs' everyday interactions: To illustrate this hidden motto, I was welcomed and "taken" in their world, up to the point to be hosted in their homes. This micro-practice was common in their everyday social practice, in which they took whatever came, processed information, and bricolaged when needed to solve an emerging problem.

4.1. The 'Taking Whatever Comes' in their Daily Life

As I attended the General Assembly for MHH IV, which, was held in the evening, we had an elaborated homemade dinner. A person who is a patient of MHH IV prepared this food. They

explained that this person wanted to offer them something many years earlier so that she proposed to cook something for them. Since then, she cooks for their meetings and they pay her for the food.

Not only food gather people, but the place also does. Although the embeddedness of socio-materiality in each of the four MHHs, the Corridor is special in MHH II. When I did my interviews in MHH II, they were telling me, one after another, they meet in the corridor between different appointments. They just go through the corridor and chat a little bit with the one whose door is open. In the evening, they had their general assembly where they had to discuss an extension project. While discussing all possible ideas, a GP, said:

"*The corridor, we need to keep the corridor*".

Others confirmed and they agreed they have to keep the corridor and thanked me for letting them realize its importance. One year later, I had another GP by phone to follow up on the project. Then, he told me

"*We are going forward in our common project at MHH II, we started the extension project with new sharing holders among the co-workers… and guess what? We managed to keep the corridor*".

In MHH III, the corridor was hosting a photography exposition. This has started when a patient passionate about photography suggested to MHH III to expose her pictures in their common areas. Practitioners from MHH III accepted and she comes regularly to hang up her pictures around a specific theme. She changes them each three to four months. In MHH IV, practitioners appreciated the idea so that they suggested hosting her expositions when taken off from MHH III.

This 'taking whatever comes' went further to create a job. A young receptionist is working for MHH IV. They created the position for her after doing an internship. Her father who is a patient of one of the GPs of MHH IV discussed with his GP during a medical appointment that his daughter is looking for an internship. The GP invited him to let her contact him. She did her internship and then they created her position as part-time first and become then a full-time position.

Their 'taking whatever comes' created a registered association as well. A non-profit association holds the PTE project. A GP and other co-workers from MHH IV created it twelve years ago. A student in psychology was willing to do an internship to write a dissertation about healthcare in rural areas. She went to see them investigate the possibility. They welcomed her but then realized that they cannot have her as intern for legal issues. They are self-employed healthcare professionals and there was not a psychologist among them. They decided to create a non-profit

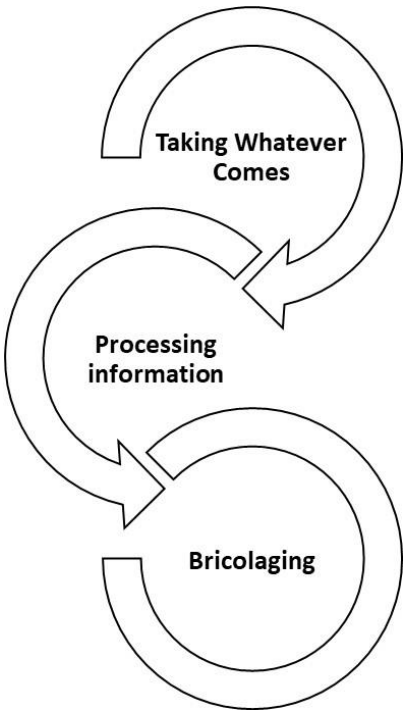
association so that they can host her. Once done, they simply kept the association so they can develop new projects here or there.

4.2. Process to Entrepreneuring

The ‘taking whatever comes’ was a recurrent micro-practice in their day-to-day life which lead to others. Whatever they took was then followed by processing information, identifying necessary actions and consequently bricolaging. In each situation, they were creatively dealing with the coming in. This creativity brought novelty sometimes and lead to collective entrepreneurship as they did in creating their MHHs and in the montage of the PTE project.

The ‘taking whatever comes” followed by information processing and bricolaging when necessary resulted in a ‘process to entrepreneuring’ as illustrated in Figure 13.

Figure 2. Process to Entrepreneuring



4.3 Peer Group and its Regulatory Role

The ‘taking whatever comes’ opens possibilities of diverse experiences to the concerned people with unexpected outcomes. This practice makes them continuously in action through processing and bricolaging. Belonging to the peer group as a community with a predefined purpose helps them in achieving entrepreneurship. The peer group, though its main purpose is sharing around their medical practice, it has a canalizing role due to its regularity promoting entrepreneurship accomplishment. Its role was obvious in the PTE project as it is the place in which the need was assessed. Its regularity over years made it the place of revival of the idea when resources become reachable. The monthly meeting of the peers allowed them to share the evolution of their respective projects of creation of each of their MHHs. Their achievement of MHH creation and their sharing around their collaborative practices with their co-workers in their MHHs created a large image of available and reachable resources. This vision allowed them to bring the idea of constructing a PTE project together back to their discussions and to aim to its development and implementation.

5. Discussion

I was reluctant to identify healthcare practitioners as entrepreneurs. Although they were engaging in creative organizing so that novelty and creativity were obvious in their organizational emergence, the main reason is that they do not realize that as entrepreneurship nor themselves as entrepreneurs. Nevertheless, according to Hjorth and others (2002): “entrepreneurial capabilities are inherent in all human beings. 'Entrepreneuring' is then a continuously ongoing process manifesting itself at certain times and in certain places” (Johannisson, 2003: 4). Consequently, entrepreneurship manifested through entrepreneuring exists everywhere and may emerge by anybody. Researchers need to capture this entrepreneurship undertaken by not non-entrepreneurs but rather by unwitting entrepreneurs.

5.1. Unwitting Entrepreneurship

Entrepreneurship research is a multi-paradigm field of research in which scholars traditionally focused on traits, personalities, and motivations based on psychology and economic theories (van Burg & Romme, 2014). Other researchers invited to consider the context (Aldrich & Kenworthy, 1998; Cope, Jack, & Rose, 2007; Hjorth & Johannisson, 2008; Hjorth, Jones, &

Gartner, 2008; Jack & Anderson, 2002; Welter, 2011; Welter, Baker, & Wirsching, 2019; Zahra, Wright, & Abdelgawad, 2014). Considering the context and progressively practices, some entrepreneurship scholars joined the practice turn. They developed entrepreneurship as a practice (Anderson & Ronteau, 2017; Champenois, Lefebvre, & Ronteau, 2019; Gartner, Stam, Thompson, & Verduyn, 2016; Hjorth et al., 2015; Johannisson, 2011, 2014, 2018b; Steyaert, 2007; Thompson, 2018a, 2018b; Welter, Baker, Audretsch, & Gartner, 2017) based on practice theories. While some scholars developed the myth of a hero, others invited to embrace entrepreneurial diversity and everyday entrepreneurship (Aldrich & Ruef, 2018; Welter et al., 2017). This debate enriched the field and introduced a variety of entrepreneurs through social entrepreneurship, liminal entrepreneurship, micro-entrepreneurship, gender entrepreneurship, rural entrepreneurship, etc.

Such multiplicity in paradigms (Fayolle, Landstrom, Gartner, & Berglund, 2016) and the lack of consensus on the entrepreneurship definition (Gartner, 1988; Johannisson, 2018b) drove Watson to suggest focusing rather on entrepreneurial action (2013). In his paper "Entrepreneurship in action: bringing together the individual, organizational and institutional dimensions of entrepreneurial action", he refers to a marketing manager acting entrepreneurially to show us how studying entrepreneurial actions would broaden the scholarship of entrepreneurship. Nevertheless, he does not consider that marketing manager as entrepreneur given that he does not identify himself such that in his personal autobiography considering his entrepreneurial action an extension of his own main practice as a manager seeking to preserve employment of his employees.

In contrast to Watson, though I agree with his call to investigate entrepreneurial actions, I disagree that we should not call the people undertaking this entrepreneurship as entrepreneurs. Instead, I suggest calling them "unwitting entrepreneurs". I build my rationale in this regard on two arguments from entrepreneurship scholarship. First, Schumpeter's pioneering work in which he writes, "No one is an entrepreneur forever but only while doing a particular type of activity" (cited in Rindova et al., 2009: 478). Second, Fletcher (2006) put forward in her reflections on entrepreneurial processes how we might not label some behaviors and activities as entrepreneurial. She adds: "It is fair to claim […] there is a whole range of activities and practices going on in a variety of social, economic, political and family spheres that are (or might be) labelled with the term entrepreneurship" (Fletcher, 2006: 423). Consequently, I suggest considering entrepreneurs whose entrepreneurship is an extension of their main activity as "unwitting entrepreneurs". I define

unwitting entrepreneurs as "people undertaking entrepreneurial actions in a perspective of problem solving as extension of their own 'main' activity".

5.2. Unwitting Entrepreneurship-as-Practice

During my field immersion, I become part of the unwitting entrepreneurs' social world (Johannisson, 2018b). By focusing on unique situations of their life (Johannisson, 2014), I was able to "identify the every-day and socially situated nature of [their] entrepreneurship" (Gartner et al., 2016: 814). In particular, investigating their social interactions (Puhakka & Stewart, 2015) led to consider more deeply their improvisation and bricolage (Baker & Nelson, 2005; Imas, Wilson, & Weston, 2012; Johannisson, 2011; Watson, 2013).

In their investigation of how entrepreneurs create something from nothing, Baker and Nelson (2005) put forward skills of bricolage. They define bricolage out of their emerging data and the base of previous studies of different disciplines as "making do by applying combinations of the resources at hand to new problems and opportunities" (Baker & Nelson, 2005: 333). 'Resources at hand' can range from material such as "wood and lorry gears" (Garud & Karnøe, 2003) to "social network contacts" (Baker, Miner, & Eesley, 2003). To be good at doing bricolage, it is important to see value where others do not. Therefore, before being '*bricoleur'*, an entrepreneur is '*collectionneur'* collecting things all over the way though not having a vision of what to do with them. While social interactions (Puhakka & Stewart, 2015) are already discussed as essential in entrepreneurship, unwitting entrepreneurs are '*collectioneur'* in these terms as manifested by their 'taking whatever comes'. This practice, which is synonym to openness, expands their social 'resources at hand' allowing then-new possible combinations to new problems and opportunities. Relying on these social resources obtained through their 'Taking whatever comes' practice, they frame information positively as argued by Palich & Bagby (1995) which explains their exploitation of opportunities regardless discovered or created through their 'process to entrepreneuring'.

5.3. Communities of Practice of Self-employed Practitioners: Beyond Knowledge Sharing

First introduced by Lave & Wenger (1991), CoP gained popularity among researchers and practitioners. Scholars focused mainly on CoP in intra-organizational and inter-organizational levels. The concept was widely accepted, mobilized and developed in the knowledge management

stream for the last three decades (Aljuwaiber, 2016; Bolisani & Scarso, 2014; Cox, 2005; Murillo, 2011).

Wenger and Synders (2000) suggested that CoP may contribute to the development of new lines of business. This study shows that CoP (i.e. peer group) contributes to entrepreneurship. The regular meeting of self-employed practitioners allows them to learn about each other, build trust and share other interests and practices in side discussions. This regularity and continuity have an important regulatory role. Exchanging around their entrepreneurial projects in their side discussions of CoP helps them to keep on track. Moreover, CoP was the place of need assessment through discussions on their main practice that gave the idea of a territorial project. Belonging to CoP, pools resources for self-employed practitioners as they bring in their networks of practice (i.e. MHH) (Goglio-Primard et al., 2017). This growth of resources at hand (Baker & Nelson, 2005) opens possibilities to collective entrepreneurship as was the case with the development of the collective project.

6. Conclusion

This study investigates entrepreneurial actions emerging from self-employed healthcare practitioners who belong to a CoP. Studying their day-to-day practice, I answer the question of "How entrepreneurial actions may emerge unwittingly from practitioners who are part of communities of practice?" Results unveil a 'taking whatever comes' practice as a recurrent practice in their social interactions. This practice initiates a 'process to entrepreneuring' with multiple open possibilities of emerging entrepreneurship. A CoP seems to play a regulatory role allowing them to keep on track their entrepreneurship. The study's contribution is three-fold: first, the study calls for pushing the boundaries of entrepreneurship investigation through the recognition and introduction of 'unwitting entrepreneurs' and 'unwitting entrepreneurship'. Second, the study unveils entrepreneurs' openness as practice by elucidating their practice of 'taking whatever comes'. Third, the study presents a CoP as a place that empowers and promotes the unwitting entrepreneurship among self-employed practitioners.

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