The role and development of consultancy in nursing practice

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Abstract
The term consultancy is used in many contexts. It has been applied to advanced nursing practice roles such as clinical nurse specialist, advanced nurse practitioner, nurse practitioner and other occupations. This causes confusion in the healthcare setting as the word is often used interchangeably between roles and has traditionally been used in a medical context. In addition, the development of nurse consultant posts has further compounded the uncertainty around consultancy. However, regardless of the role holder, consultancy in nursing is normally used in the context of a person in possession of expertise. This article describes consultancy in nursing; identifying its development, approaches, application and possibilities for the future.

Key words: Consultancy, Advanced practice, Advanced nurse practitioner, Clinical nurse specialist, Process consultancy

Introduction
Consultancy as a term is often seen as complex, abstract and ill-defined in the literature. However, while many interpretations exist, there has been little change in individual authors’ definitions (see Table 1) since its original interpretation by Caplan (1970). Therefore, regardless of the variety of definitions, consultancy appears to be based on a joint problem-solving approach in which the consultant serves as a catalyst for change. Using this premise, it could be said that all nurses are involved in consultancy. However, the consultancy process is more complex than this idea suggests and publications regarding consultancy in nursing are scant. This article aims to describe consultancy as it relates to nursing through identifying its development, application and possibilities for future nursing practice. Within this article, the term consultant refers to the nurse engaged in consultancy and the consultee refers to the person(s) in receipt of the nurse’s consultancy work.

Table 1: Traditional views of consultancy

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Interpretation of consultancy</th>
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<tbody>
<tr>
<td>Caplan (1970)</td>
<td>A process in which the help of a specialist is sought to identify ways of handling work problems involving either the management of clients or the planning and implementation of programmes</td>
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<tr>
<td>Lippitt and Lippitt (1977)</td>
<td>An interactional process, where the consultee requests assistance to solve a problem; with the ultimate goal of learning, change and growth</td>
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<tr>
<td>Kohnke (1978)</td>
<td>A process where an expert with specialist knowledge/skill who can prescribe solutions, bring about a change, provide information to enable the consultee to make decisions based upon alternatives</td>
</tr>
<tr>
<td>Bell and Nadler</td>
<td>An act of helping, a two-way process of seeking, giving and</td>
</tr>
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Consultancy in nursing

While the term consultancy is relatively common and is seen as a means of developing and enhancing advanced practice in a number of occupations, within health care, consultancy has normally been interpreted in a medical context as relating to the expert physician or surgeon. More recently, the term consultancy has been used within the nursing profession in relation to those who undertake a range of activities offering their expertise in nursing. The role of consultancy in nursing was first promoted in American literature in the 1970s when referring to advanced practice and clinical nurse specialists (CNS’). (Blake, 1977; Kohnke, 1978; Lareau, 1980). In the UK, nurse consultancy was introduced in the early nursing development units from the 1980s (Pearson, 1983; Wright et al, 1991; Wright, 1992; Marr 1993; Wright, 1994a; 1994b). The role of nurse consultant in the UK was one of an internal consultant and this contrasted with the increasing numbers of independent consultants working in the USA (Braddock and Sawyer, 1985) and Australia (Keane, 1989). However, this contrast in the nurse consultant role was reflective of its stage of development and the duration that the posts existed in the UK, America and Australia. Generally, consultancy only truly began to develop as an explicit area of nursing practice when Fenton (1985) identified the consulting role of the nurse as an addition to the roles proposed by Benner (1984).

As with many contemporary issues in nursing, language evolves to describe current developments and innovations. Internationally, several advanced nursing roles have developed and evolved such as CNS (Dunn, 1997; McCreadie, 2001), nurse practitioner (NP) (O’Baugh et al, 2007; Duffield et al, 2009) and advanced nurse practitioner (ANP) (Gerrish et al, 2007). The various advanced roles (NC, CNS, ANP, NP) are often referred to under the umbrella term of advanced practice and the notion of consultancy as a sub-role of these advanced roles has long been acknowledged and supported (Fitzgerald et al, 2003; Fulton et al, 2010). However, in the UK, the Department of Health (DH) (1999) set out to establish the post of nurse consultant (NC) with the same status as medical consultants as a result of the developing progression of CNS’ and ANPs (Wilson-Barnett et al, 2000). In Ireland, the term consultancy is encapsulated as one of the core concepts required within the role of the CNS (clinical focus, patient/client advocacy, education/training, audit/research, consultancy) and ANP (teaching, consultancy, practice development).

There are many nurses who successfully incorporate consultancy into their nursing practice, such as ANPs and CNS’ who are educated to Master’s level and beyond (Barron 1989; Beitz 2010). However, many factors remain that have impeded the development of consultancy in nursing. These relate mainly to the perceived inferiority of nursing in comparison to medicine (Chinn and Wheeler, 1985; Fulton et al, 2010) and the development of nursing knowledge within a framework created by women’s position in a patriarchal society and a gender-defined occupation that is given little value by society.
Consultancy in practice

Caplan (1970) was the first to identify types of consultancy (Table 2):

**Table 2: Caplan (1970) four types of consultation**

<table>
<thead>
<tr>
<th>Client-centered case consultation (expert opinion model – Case direct)</th>
<th>Programme-centered administrative consultation (expert model – Administrative direct)</th>
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</thead>
</table>
| • Focus is on advice and involves the consultant making direct recommendations to the consultee on how best to help an individual client.  
• Consultee should consider how they | • Focus is on the organisation and to advise how best to help the organization.  
• A consultant may be invited to help with a problem concerning some area of service provision or to help |
can best use client-centered case consultation.  
- Consultant functions as a specialist who assesses the client, makes a diagnosis, and makes recommendations as to how the consultee might modify his or her dealings with client.  
- It is direct and usually short-term.

with planning and implementation of organisational policy.  
- Involves assessing the problem and making direct recommendations,  
- The purpose is the improved understanding and operation.  
- It is direct and usually short-term.

<table>
<thead>
<tr>
<th>Consultee-centered case consultation (supervisory coaching model – Case indirect)</th>
<th>Consultee-centered administrative consultation (process/organisational development model – Administrative indirect)</th>
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</table>
| - Focus on providing help to the consultee to pinpoint difficulties and build new skills.  
- Would not meet the client directly, instead work with the provider.  
- Consultee would seek consultation after a determination of lack of knowledge, lack of skill, lack of confidence, and/or lack of objectivity within the client–clinician relationship.  
- Primary goal is to remediate the shortcomings in the consultee’s professional functioning that are responsible for difficulties, with client improvement a secondary goal. | - Focus on improving professional functioning of members of an organization.  
- Conducted over on a long-term basis.  
- The consultant helps to improve their capacity to handle problems on their own in the future.  
- Collects information about the organisation, its goals, programmes, policies, administrative structure and functioning; to assess the problems that impede operations and assist consultees to improve their tools for overcoming their work difficulties. |

- Client-centred case  
- Programme-centred administrative  
- Consultee-centred case  
- Consultee-centred administrative.

While client-centred consultancy can be undertaken while working in a direct care role with the consultee (patient/client and their family or colleagues), the three other forms of consultancy are fulfilled by responding to a request from the organisation or colleagues and all types require the consultant to effectively engage in the consultancy process and use the necessary skills within their role. Each model has its niche and the model of consultancy employed is dependent upon the focus and desired outcome of the consultancy relationship.

**Gallessich’s model of consultancy**
Gallessich (1982), illustrating the process and practice of consultancy, outlined three stages of development practiced to a greater or lesser degree by all engaged in consultancy. The first stage is a preliminary one in which consultancy is practised as a peripheral activity and an extension to one’s professional responsibilities. The second stage features a greater level of commitment to consultancy, although consultancy remains subordinate to the primary occupation. Within the third stage, consultancy is equal to or greater than the primary occupation. Nurses operating at third stage attempt to promote nursing and the development of nursing practice, generally operating as external/independent consultants. Thereby, autonomy is a key characteristic and advantage (Beare, 1988; Warr, 2006).

However, this raises questions about whether autonomy comes from the process of consultancy or whether it results from the nature of external/independent consultancy in that one becomes self-employed. This notion of autonomy was analysed by Braddock and Sawyer (1985) and Crowley (1989), who suggest that external/independent consultants may discover that rather than gaining autonomy, they face a greater number of constraining forces in the external environment that will impose control over their work and thus stifle their autonomy. Today, the notion of autonomy in consultancy is underpinned by the nurses’ preparation and education before taking on the role (Woodward et al, 2005; 2006), effective interpersonal skills (Abbott 2007; McSherry et al, 2007) and a transformational leadership approach (McIntosh and Tolson, 2009; Young et al, 2010).

Based on Gallessich’s (1982) three stages of consultancy, it is evident there is a difference between each stage relating to the degree in which the consultant becomes involved, their commitment to the consultant role and the degree to which this role is differentiated from their other roles. Within stage one, the consultant may only act as a consultant on certain occasions. This probably describes many nurses and expert/advanced nurses and consultancy has little impact on the time they spend in practice. Within stage two, however, the consultant is drawn into more frequent consultation activities. While these consultants are committed to consultancy, this may cause role tensions as they have less time to spend on other activities. These consultants need to be creative and assertive in order to incorporate this role into their practice, but also need to allow time for their main field of practice (direct care). This stage describes mostly expert/advanced nurses and may take varying degrees of their time. In stage three, the consultant is committed to the activities, principles and values of consultancy and it occupies a significant amount of time (Gallessich, 1982).

However, the professional must be aware of the fact that the key characteristics of consultancy are that the relationship between the consultant and consultee is:

- Temporary and voluntary
- A cooperative venture
- A process
- Educational in nature.
In addition, it has a ‘take it or leave it’ quality; the consultant is an expert in relation to the consultee, and the consultee initiates the relationship (Blake, 1977; Barton and Mashlan, 2011). It is an indirect service, and this ‘take it or leave it’ aspect of consultancy may be difficult as the professional responsibility for the patient/client remains with the consultee who can accept or reject the consultant’s recommendations (Barron, 1989; Charters et al, 2005). However, nurses must be prepared to step out of the consultant role and assume responsibility if patient/client care is being seriously compromised (Barron, 1989; Humphreys et al, 2007). In order to partially overcome this problem, Kohnke (1978) proposed that the consultant should prioritise his or her recommendations and highlight the consequences of each, as opposed to just offering a set of recommendations and leaving the consultee to choose. Based on Gallessich’s (1982) three stages, a consultant operates from one of two perspectives (internal or external consultant). Internal consultants fulfil a number of roles, including practitioner, innovator, change agent and consultant (Wright, 1992) and align with stages one and two. External consultants, however, tend to practise independently, seeing their role as entrepreneurial, autonomous and often driven by the ethos of business (Keane, 1989).

Schein’s models of consultancy
Building on this work, Schein (1988) developed a number of different approaches or models of consultancy (see Table 3), which aligned well to healthcare practitioners’ knowledge and current practice approaches.

Table 3: Schein (1988) approaches to consultancy

<table>
<thead>
<tr>
<th>Model</th>
<th>Description</th>
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<tbody>
<tr>
<td>Purchase of expertise model</td>
<td>The purchase of expertise model is characterised by the purchase of expert information or service from a consultant by a manager or group who has defined a need, and decided that the organisation is unable to fulfil that need (Schein, 1988).</td>
</tr>
<tr>
<td>Doctor-patient model</td>
<td>The doctor-patient model is characterised by a consultant being brought into an organisation to diagnose a problem and to prescribe treatment for that problem (Schein, 1988). The necessity for trust is essential and a focus on the role of the consultant to serve the client with no thought of self-interest (Schein, 1988).</td>
</tr>
<tr>
<td>Process consultation model</td>
<td>The process consultation model is characterised by a set of activities on the part of the consultant that help the client to perceive, understand and act upon the process events that occur in the client’s environment in order to improve the situation as defined by the client (Schein, 1988).</td>
</tr>
</tbody>
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Purchase of expertise
The purchase of expertise model refers to the purchase of expert information and advice where the client hires the consultant to bring a separate and autonomous perspective on the issues that exist (Schein, 1999). The consultant’s role is to bring, alongside with its experience, a particular expertise or skill that is currently lacking in the organisation.
Although there has been evidence that consultants see their role more as that of a coach than an expert (Lashkarbolouki et al., 2011). In Schein’s expert model, the consultant advises clients what has to be done to solve their problems.

**Doctor-patient**

The doctor-patient models refer to the purchase of diagnostic and prescriptive services and was adapted from the relationship existing between a doctor and his patient. In this model, the role of the consultant is to prescribe a solution aiming to alleviate the pain experienced by the consultee. The process consultation models refer to collaborative client-consultant relationships in which consultants function as facilitators and help the consultee learn to improve their internal problem solving processes. Therefore, it involves more than making a diagnosis or solving a problem by way of expertise.

**Process consultation**

Process consultation involves a series of different activities aiming to help the consultee to perceive and to understand their problems in order to solve them by themselves. Process consultation is pragmatically defined by Schein (1999: 3) as ‘what goes on between a helper and the person or group being helped’. Regardless of the model employed, these models must be used with careful consideration and clear assessment of the aim of the consultation and outcomes required (Schein, 1988). Depending on the organizational scenario, one or more of these models may be applied to different changes in the organisational setting (Schein, 1988; 1992; 1999).

Process consultation takes the Chinese proverb past the point of simply teaching a man to fish; the consultant facilitates a process of discovery through which the man can build his own fishing pole or choose a net, while understanding the patterns of fish and using the correct types of bait. While the other types of consulting may produce similar results in the short-term, the process consultation model provides the consultee with the tools to continue assessing their needs and produce different outcomes each time the problem occurs. In the process consultation model, the consultant acts as a facilitator by providing the consultee with methodological tools for assessing or defining the problem and locating the best potential solutions (Canback, 1998; David, 2012). The consultant works with the organisation to find internal methods for resolving the issues and for implementing change, using existing resources within the organisation.

While the fish proverb provides an interesting point of comparison between the three models, the process consultation model has more often been compared to psychoanalysis. While the consultant brings their own expertise to methods for directing potential organizational behaviours, the process is based primarily in the ability of the organisation to sort through their needs, discover their own resources and the best methods for change, and implement changes using their own internal resources. The consultant simply acts as a catalyst providing the necessary methods for making change. The tools, resources, and expenditure of human capabilities occurs within the organisation, while the consultant directs and redirects the activities taking place to help the organisation achieve the best outcomes based on their needs. This process is seen by Gallessich (1982) as a means to resolve the difficulties within previous models.
Most consultation takes place using either Schein’s first or second model (purchase of expertise or doctor-patient). The basic argument behind this is that consultants provide services that cannot be defined within an organisation, including, but not limited to:

- Competence not available internally
- Varied experiences
- Time to study the problem
- Professional focus
- Independent of organisational pressures
- Ability to create action based on what is uncovered.

(Bower, 1982; Appelbaum and Steed, 2005)

**Value of nurse consultancy and outcomes**

With the development of consultancy models over time and the advent of advanced/expert roles in nursing such as NP, NC, CNS and ANP, nurses have a greater understanding of consultancy and all nurses have an opportunity to engage with it when you consider the bases of consultancy as a two-way process of seeking, giving and receiving help. (Bell and Nadler, 1979). In addition, as advanced/expert nurses have gone through the ‘bedded-down’ period where they have transitioned into their roles, they should fulfil their role components, one of which is consultancy. Given that these nurses consult regarding direct patient/client care and these consultations are part of their role, the outcomes of these consultations need to be highlighted to show their effectiveness. This can be done through practice-based publications by individuals or by using the support of an academic or mentor to assist in the process. This is essential to highlight the value of nurse consultancy, offer support to other junior nurses who may have a consultancy role and promote the profession of nursing in healthcare delivery. In addition, nurses are continually faced with a complex and ever-changing healthcare environment when reform and new policies influence our practice. Through nurse consultancy and publishing the outcomes, nurses have a greater opportunity to actively influence healthcare provision and this need to be considered and supported. The development of the nurse consultant role, the inclusion of consultancy within advanced/expert practice roles and the establishment of clinical commissioning groups in the UK demonstrates the commitment by health services to advancing the nursing profession (Doody et al, 2012). The evolving shortages of nurses, ageing of the population, profound increases in chronic illnesses and the increased use of support personnel, for example, are contributing to opportunities where nurses can share their expertise in brief, informal encounters or through more formal contractual relationships. In some instances, this consultation allows organisations to move services out of acute care, thereby reducing expenses but preserving the level of services. Nurse consultancy can help hospitals ‘take care of patients’ while they ‘take care of business’ (Cesta and Cunningham, 2008). Combining standards of care and benchmarking are powerful processes by which nurse consultancy can determine if the patient/client is receiving the best and most cost-effective care (Bedell et al, 2003; Jones, 2005; LaSala et al, 2007; McSherry et al, 2007). Although consultancy is often presented as a ‘new’ opportunity or role option, consultancy is not a new venture for nurses. Nightingale consulted with the
British Army medical establishment to drastically decrease mortality and morbidity in the Crimean War (Norwood, 1998).

**Conclusion**

Having discussed the development of consultancy in nursing, along with the variety of roles that encompass consultancy and future opportunities for this comparatively new dimension in nursing, it can be seen as an exciting and inspiring step in nursing. Despite the obvious differences between internal and external consultancy, the goal remains the same in that both approaches have the potential to impact upon nursing practice and benefit practitioners and recipients of care. Consultancy has become an important function of many advanced practice posts and it is in these situations that the post-holder may be acting in both an internal and external capacity, consultancy being one of a number of roles demonstrated within that particular post. It is this notion that must be emphasized in order to develop our understanding of consultancy and the realisation that both roles are not mutually exclusive. It is the independent consultant who demonstrates a purely external role following the more traditional pathways of self-employment and entrepreneurialism. Nurses and nursing would benefit from exposure to nurses who can demonstrate expertise and excellence in their fields, and who are able to facilitate creative and innovative practice that ensures patient/client-centred care. Nursing needs to decide its own destiny based on patient/client need and high quality nursing; however, true autonomy in a nursing setting is unrealistic because a holistic, multidisciplinary team approach is considered best practice (Pearson, 2003). Therefore, the main role of consultancy should be to ensure high standards of care for the patient/client and his or her family. The nurse can work with partial autonomy, acquiring new skills and advising clinical teams and colleagues on patient/client management and service delivery. Stanley and Eberhardie (2005) suggest a shared responsibility is in the best interest of the patient/client and the nurse consultancy is in a position to promote this.

As advanced practice is grounded in patient/client-centred practice (Manley, 1996), to focus on the advancement of nursing, ANPs/CNS’/NPs will frequently be required to act as consultant, both informally and formally. Overall, those engaging in consultancy act as educators, have clinical credibility, act as role models and have extensive expertise and knowledge. However, they need to assume a leadership role within the profession and make the invisible visible, actively engaging in research and practice publications to highlight their work and its effect.

**References**


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