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Allied Health Professionals as Consultants: An Exploratory Study in an Australian Context

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ABSTRACT

Allied health professionals (AHPs) acting as consultants to other professionals and workers is an important emerging issue. It has received little research attention, despite this role being central to many AHP job descriptions, particularly senior positions. This exploratory qualitative study, conducted with AHPs and other key informants, examined consultancy in metropolitan, rural and remote settings in Australia. Thirty-nine professionals were interviewed in individual and focus group settings, using semi-structured questions. Analysis of data revealed roles, definitions and processes of consultancy, the influence of the context in which it occurs, and the multi-layered outcomes of consultancy. This led to the drafting of a framework noting roles and relationships of the key actors – consultant, consultee, and client. Further research is required to establish the generalisability of the framework.

INTRODUCTION

Allied health professionals (AHPs) are a heterogenous group of healthcare providers. In Australia, AHPs make up approximately 18% of the health workforce delivering over 112 million consultations per year to the Australian population and include medical imaging workers, pharmacists, physiotherapists, psychologists, social workers, dieticians, orthoptists, occupational therapists, podiatrists, speech pathologists, and audiologists.¹ Role descriptions for AHPs increasingly include the requirement to “provide clinical consultation” or “act as consultant” in an area of expertise. Paradoxically, this issue has attracted little published research or discourse to underpin AHP practice.

Consultants are defined by the Oxford Dictionary as “persons providing professional advice etc., especially for a fee” and consulting is the “giving of professional advice to others working in the same field or subject.”² In the business sector, the relationships and interactions between consultants and consultees have been analysed, and attributes and techniques for

successful consultancy are well documented.³ These include ensuring sound formulation and process, educational dimensions, as well as people and leadership skills.⁴

As part of the "Agenda for Change" in the UK National Health Service (NHS), the most senior AHPs are now referred to as Consultants in their particular allied health discipline.⁵ These people are typically lead clinicians, providing advice regarding diagnosis, prognosis, and treatment as well as carrying out specialist programs of care. According to the NHS Job Evaluation Handbook, the purpose of the naming convention was to consolidate and validate career progression, reflecting the significance of the Consultant role.⁶ The stated aims of formally recognising the AHP consultant within the NHS include the strengthening of clinical leadership, provision of career opportunity, and retention of clinical expertise. It has been anticipated that the rise of AHP consultants will drive creativity and innovation.⁷

Stevenson examined nursing and AHP consultants' interpretations of their own roles.⁸ Participants characterised the consultant role by the extra responsibilities of education, leadership, and research, and emphasised being a catalyst for clinical and organisational change. High level political and negotiation skills, emotional intelligence, and lateral thinking were also seen as requisites for such roles. Similarly, others have suggested that allied health and nursing consultants have highly complex roles, integrating clinical expertise, leadership, and education.⁹ However, despite the recent emergence of consultancy within AHP services, evidence of effectiveness is currently lacking.¹⁰

Currently, there is no formal process, criteria or registration for AHPs as consultants in Australia. While information emerging from consulting AHPs in the UK is helpful, the degree to which it translates internationally is unknown.¹¹ For instance, in Australia, where the formal title is not widely used, clarification on a number of issues will be highly relevant to the establishment of the role. Key questions include: a) How is consultancy practised? and b) How effective is AHP consultancy as a knowledge translation medium? To explore these questions within contemporary Australian practice, an exploratory study was conducted to examine how Australian AHPs characterise consultancy and perceive it to be carried out.

METHODS

A qualitative methodology was chosen, guided by a social constructionist framework in which the focus was on the collective generation of meaning, emphasising the way culture shapes perceptions.¹² Focus groups were chosen as the primary method of data collection to gather the group constructs of AHP consultancy. Participants were recruited through snowballing based on reputation of being able to contribute to the discourse on AHP consultancy. AHPs were deliberately recruited from two significantly different geographic profiles - Queensland and remote Central Australia (Northern Territory). Queensland is characterised by AHPs who work across large metropolitan centres and provincial cities as well as rural settings, while Central Australia is predominantly characterised by AHPs who work in remote locations, operating from a central provincial town base. Invitations to participate were issued through personal contact. Those working in rehabilitation and/or aged care settings were the initial target; however, as recruitment progressed, participants identified other potential key informants from outside the original scope, consistent with a snowball sampling technique. Participants were invited based on their understanding of, and willingness to provide information and opinions about consultancy as a model of service provision for AHPs. Participants outside the allied health professions but with professional links (specifically, nursing and special education consultants) were also invited to contribute for the purposes of contrast and comparison. All participants provided written consent for their participation.

Table 1 shows participant numbers by location, professional discipline, and employing organisation for the six focus groups (FG1-FG6) and four key informant interviews (IV1-IV4). The four interviews were conducted as an adjunct to the focus groups, as these key informants were keen to contribute to the research but were unable to attend a focus group session. Three focus groups were conducted in Brisbane, Queensland, and three in Alice Springs, Northern Territory. All focus groups included a mix of professional disciplines. Four of the focus groups were conducted at specific facilities and comprised participants exclusively from that facility. The other two focus groups were a mix of individually invited participants from various health care organisations. These two groups were conducted at the workplace of the principal investigator.

Table 1. Profile of Participants (By Location, Profession Discipline, and Employing Organisation)

Location	Professional Disciplines	No. of Participants	Employing Organisations	No. of Participants
Queensland	Physiotherapist	8	Government - health	17
	Occupational Therapist	4	Government - education	1
	Speech Pathologist	2	Government - aged & disability	0
	Social Worker	3	Non-Government Organisation	3
	Clinical Nurse Consultant	3	University	0
	Dietician	1		
	Advisory Teachers	0		
	Total	21	Total	21
Northern Territory	Physiotherapist	3	Government - health	7
	Occupational Therapist	8	Government - education	3
	Speech Pathologist	2	Government - aged & disability	7
	Social Worker	1	Non-Government Organisation	0
	Clinical Nurse Consultant	1	University	1
	Dietician	0		
	Advisory Teachers	3		
	Total	18	Total	18

A semi-structured interview protocol was used to guide focus groups and interviews. This protocol is included in Appendix A. The protocol was developed on the basis of the literature and the research questions for the study. During the focus groups and interviews, participants were asked to recall some situations in which they fulfilled the role of consultant and some situations where they were the consultee. Based on their reflections, participants were asked to describe their role (as consultant or consultee), the techniques they employed, personal expectations and obligations, and indicators of success or failure. Focus groups were facilitated by two moderators, and interviews were conducted by one member of the research team. The moderators of the focus groups involved various combinations of the investigators. All investigators, whilst having allied health backgrounds, hold non-clinical research positions and do not provide clinical consultancy. Some of the participants were known professionally by the moderators. This was inevitable given the relatively inter-connected nature of the allied health professional community. The duration of focus groups and interviews ranged from 1.5 to 2.5 hours. Focus groups and interviews were digitally recorded and transcribed verbatim. Data collection was ceased when preliminary analysis of transcripts identified repetition of information, suggesting data saturation.

Spoken word and discussion data, collected in the focus groups, were also triangulated with supplementary written data in which each focus group participant was asked to record on a piece of paper the two ideal attributes that they would use to describe each of the following: a) consultant, b) consultee, and c) consultancy process. This data collection was undertaken at the completion of each focus group.

The study protocol was approved by the Princess Alexandra Hospital Human Research Ethics Committee and Flinders University Social and Behavioural Research Ethics Committee.

Analysis

Transcribed data from focus groups and interviews were analysed together. Data portions were initially read and summarised independently by the investigators using both open and inductive thematic coding.¹³ These coding summaries were discussed by the research team, key themes were identified, and jointly agreed descriptions for themes were established. Three research assistants then coded the entire data set against the key themes using NVivo 8.0 to manage the process. To ensure breadth of analysis, each investigator summarised one (or more) of the key theme data sets and provided these summaries to the research group for collective discussion.

Following the development of themes, separate content analysis was undertaken on the supplementary written data collected on ideal attributes. These data were also thematically analysed and compared with the focus groups themes. This method allowed triangulation of the data to enhance rigour. The supplementary analysis confirmed the themes developed from the primary data source.

RESULTS AND DISCUSSION

Defining Consultancy

In contrast with the clear dimensions described in management consulting, AHPs describing consultancy seemed most certain about what consultancy is NOT.¹⁴ For some, it clearly differed from an advisory role. Consultancy was portrayed as a “broader and more active, two way [process]” (FG2).

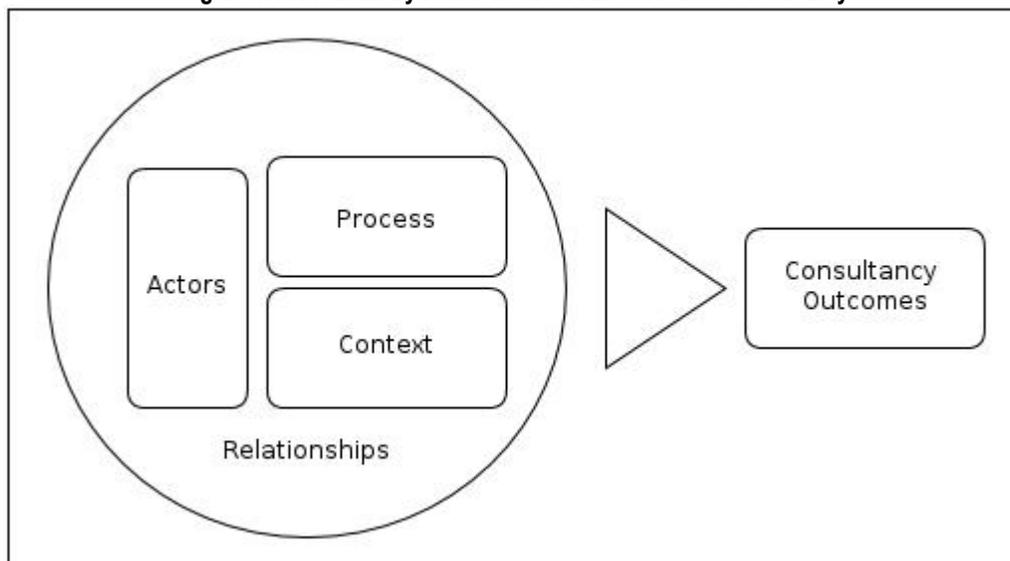
Similarly, expert and consultant were not seen as synonymous. As one participant described, “an expert is someone who owns the knowledge; a consultant is somebody who gets the knowledge out there” (FG1). Another stated: “the consultant may be an expert but an expert doesn’t necessarily mean that they’re going to be a consultant” (FG1). Indeed, literature emerging from the United Kingdom regarding the roles of nurse/therapist consultants supports the notion that a specialist differs from a consultant.⁷ Block suggested that consultants broadly adopt one of three roles: the expert, the pair of hands, or the collaborator.¹⁵ The current findings suggest that, within allied health, consultants are perceived more consistently as collaborators.

Several participants expressed trepidation about the use of the term “consultant” in a job title whilst clarifying that professionals may still be capable of providing “consultancy” without the title: “Sometimes ... having consultant in your title means ... that you are supposed to know just about everything, and that’s impossible” (FG2). Nurse consultants in the UK have expressed concern that the title of “consultant” came with an expectation of knowing everything.¹⁶ The present study indicated that the nomenclature for leading allied health clinicians remains an area of ongoing debate: “We’re still argy bargy (arguing) about that ourselves in our own clinical association” (FG2).

One participant defined consultancy as providing “support around professional knowledge” (FG2). “It’s something that people have been providing for years ... and now the last several years we’ve called it consultancy” (FG2). What emerges is that the term “consultant” in allied health may mean different things to different healthcare professionals, disciplines, and even individuals.¹⁷ Interestingly, consistent with the notion of consultants as collaborators, consultancy could occur both within and between different allied health disciplines, often dependent on the context within which the consultant/consultee worked. “...whoever the recipient is, you have to be able to respond so they are able to take on board information...”(FG6)

In addition to defining consultancy within allied health, the data reflected four key themes, namely the actors, process, context and outcomes. These themes represent a basic framework for describing allied health consultancy as shown in Figure 1. Each theme is discussed below.

Figure 1. A Preliminary Framework for Allied Health Consultancy



The Actors

Fundamental to participants' understanding of consultancy were the roles and relationships that play out between the actors - consultant, consultee, and client. Findings showed that the consultant role ranged from formal and distinct to informal and undefined. Paradoxically, participants felt formal identification as a consultant didn't necessarily mean that consultees would turn to that person for a consultancy service: "There are people I'm sure out there who certainly work as consultants to colleagues and other people because they do have that area of specialist knowledge that other people recognise" (FG2). Similarly, one participant reflected that "clinical nurse consultants" were not always perceived as the most valuable source of information.

Our study indicated that recognition and respect can effectively create consultants. As one participant stated: "They know me now and then they sort of say 'oh I know her, she knows this' or 'she might know' or 'she knows how to get the answers', so it's by reputation" (FG2). Another suggested, "...you get known that you can actually do stuff..." (FG2). "The fact that these other service providers and people within the community are seeking our professional opinion for the treatment and management of our clients" (FG4) was considered sufficient to identify a consultant. This finding is consistent with allied health consultancy literature that suggests recognition, respect and authority contribute to being a successful consultant.¹⁶

Many instances in the data suggested participants viewed the allied health consultancy relationship as a collegial and supportive one in which consultant and consultee "shared responsibility" (FG1). There was no suggestion of hierarchical structures but, rather, the emphasis was on mechanisms of support. For example:

And you have to be supportive in that role. If someone comes up to you for advice and you give that to them and you support them through that process, then they are going to come back to you again. If you don't support them through that process, then it's not really consultancy is it? It's just education, and they're not going to really approach you again (FG2).

Regarding consultant duties, the data strongly suggested that consultants do not want to be bogged down in the day to day implementation of advice: "It's not really the consultant's responsibility to document and follow through on all of that stuff" (FG1). "I'm very clear that the treating therapist remains the boss" (FG2). "Consultants may make recommendations, but they don't usually in most circumstances have the authority to implement the changes...one entity removed" (FG6). "We don't offer, we can't actually offer continuous ongoing therapy because we are not there" (FG4).

Complicating this clarity of role however, most consultants also continued as treating therapists and therefore struggled with maintaining boundaries in the consultant role: "I think sometimes also, because we're acting as consultants but we're also a treating therapist, the two roles can be at odds with each other from time to time" (FG4). The emotional turmoil and blurring of role boundaries that this creates has been similarly experienced by allied health and nursing consultants in the UK where this can be made worse by the expectations of other stakeholders.¹⁷ In the current study, some participants perceived a potential need to cross that boundary if client outcomes were threatened: "If something happens that we're not satisfied with, because it's not going to be the right outcome for the client, then we would do more" (FG6).

The identified actors in allied health consultancy, namely the consultant, consultee, and client, were also importantly identified as part of a larger network of AHPs and community agencies: "In order to work well within a community, you need to establish really good social networking within the community, they need to trust you" (FG4). "We network; our strength is in our networks, so we actually have to know just about every agency in town" (FG5). This finding is supported by the literature emerging from allied health consultancy in the United Kingdom where the success of these roles is linked with the development of effective working relationships within teams and networks.⁷

Process

In the business sector, the way in which consultancy is initiated or commenced is considered integral to its success.¹⁸ In the current study, AHP participants suggested that the consultancy process was variously initiated by a formal or informal invitation to consult, ranging from written requests for consultation to corridor conversations in passing. Likewise, agreements were also often unclear: "I think it is a gut feeling when you need a formalised agreement as opposed to being quite happy to just run with it and go with the flow" (FG1). "Once it's invited, it's a lot more formal -- if somebody comes to you and says can you explain to me about trache [ostomy] management or something, that's when you tend to sit down and possibly make it more structured" (FG3). Most AHPs considered the informal invitation the more commonplace approach: "I would generally go to people that I already know, often within my own team, and it's more of an 'I've got this problem, this is the situation, what do you reckon?'" (FG1). In contrast, education professionals described a formal procedure and perceived this formal approach was advantageous as it could help avoid "passing the buck" (FG5). Requiring people to put something in writing would provide a reminder for the

consultant to act upon a request. Similarly, booked appointments were seen as ideal for a productive consultancy process: "I try and avoid that casual thing because I haven't found that I get good positive outcomes out of that" (FG5). This approach, supporting more formal invitations, is consistent with the contractual nature of consultancy relationships within the management and business sector.¹⁸ Formal mechanisms for initiating and establishing consultancy may warrant further attention in AHP settings.

Finding an appropriate consultant was sometimes identified as a challenge: "It depends who does the asking, and being able to identify who's the best person to ask for that information, you know, word of mouth or this person has previously given me information so try that person"(FG1). Relationships were considered integral to establishing and maintaining consultant/consultee links: "I guess we would have key people that we built up a relationship with to go back and get that advice" (FG1). Participants saw consultants as having an obligation to advertise their services and scope, a finding supported in the literature.¹⁷

Information exchange was described as a vital part of the process. Most importantly, the exchange must be timely, "knowing that you can get a response in a reasonable timeframe" (IV2). Participants were very definite that the consultee should be proactive in establishing the foundation for information exchange: "But you also need to find out what they [the consultant] want as well, not just write them a letter and say please consult, you know, respect the fact that they need information as well" (FG1). For the consultant, learning about the consultee and encouraging them to play an active role in the process was considered important.¹⁸ "Respect" (FG1,3,6; IV3,4) was a term frequently used in participants' descriptions of the process of consultancy: "two way respect", "professional respect", "respectful relationship" (FG1), as well as cultural respect.

The collaborative and egalitarian nature of the consultancy process in AHP settings is evident in the literature.¹⁷ This is supported in the data: "There's sort of that process of collaborative consultation that they use... but there's certainly no managerial whatever, the relationship is there..." (FG2). The collaborative approach was seen as beneficial in facilitating learning and change.^{17,19} One highly experienced consultant explained it this way:

It actually becomes a bit of a partnership type situation and yes, there's the consultancy thing, but I try and get rid of that as quickly as possible, the perception of I know everything. And I mean, I'll come down on people that say 'oh get [consultant's name] to help you with the tricky patients because he can sort it out for you'. No, I can't, I can maybe help you work through what we need to do to actually help work it out. And I mean that takes a bit longer. It might take a few hours or a few sessions but then longer term they're the ones that then do the training stuff with other staff coming through, and that's how we get the change happening (FG2).

In some instances participants discussed processes that appeared to fall outside the scope of consultancy. Seeking confirmation from one's peers was referred to by one participant as "peer consultancy" (FG2). Seeking action on behalf of clients was discussed at length by two participants but was eventually more accurately termed advocacy. "When you can see that something is just not happening because there are not the resources there, it means you have to work at another level which is not consultancy, it is advocacy I guess" (IV4). Similarly, a number of participants talked about striving for best outcomes for clients by involving other professionals in a highly organised way. This might be better classified as case management.

Context

Effective consultancy depends on an understanding of the context within which the consultancy occurs, including consultee background, client setting, the location/proximity of the consultant/consultee, and the nature of the broader healthcare systems. In the specific case of AHP consultancy, these data confirm the literature that describes consultancy as inherently an inter-professional activity which therefore must be understood within an inter-professional context.²⁰

The background of the consultee invariably influences the consultancy. When consulting with non-professional or entry level professionals, the consultancy might be specifically directive: "It's only when you start talking about the diagnosis and the clinical picture that you start asking them questions, and they go 'oh I didn't think about that, I haven't looked at that yet'" (FG1), or broadly directive, requiring an element of "knowing what they don't know" (FG1). Similarly, consulting across disciplines highlighted the importance of the background of the consultee and the importance of a shared language.¹⁶ As one participant stated: "Delivering your consultancy in a way so that you were communicating with the person in a way that you both understand, as opposed to using your professional jargon...things that maybe someone from a different discipline might understand as well" (FG1). In the business sector, failure to consider background, culture, and character of the consultee(s) is seen as a cause of unsuccessful consultancy.²¹ Likewise, AHP and nursing consultants have highlighted the importance of being able to work across both professional and agency boundaries and understand the contexts within which consultancy is occurring.^{16,17}

Client settings are important, particularly when consultation relates to culturally diverse client populations: "Everybody talks about best practice. But trying to incorporate best practice into finding a culturally safe way of delivering that is sometimes very difficult" (IV1). In these instances, many participants found that evidence-based practice was not necessarily the most appropriate knowledge to impart without consideration of the client's context: "How do we put best practice into our environment ... that's tricky too...our clientele sometimes don't care about certain things which revolve around best practice" (IV1).

Participants highlighted the contextual challenges in regional or rural locations. The consultancy has to be realistic within the context: "When I was working as a sole therapist, the advice that you'd give to somebody in another rural area would be different to what perhaps you would give in a major metropolitan area" (FG1). Participants identified that consultees in regional or rural locations often had limited support and capacity to implement suggestions: "They don't have access to resources or time or those sorts of professionals. It's a waste of everybody's time so you need appreciation of what is possible" (FG1). Furthermore, such consultees often had to fulfill roles that were much broader than traditional disciplinary roles: "I think, working rurally ...you're consulting to people who are working in the trans-disciplinary capacity so, say, someone who is working in an indigenous community or somebody who's a nurse who's doing quite a lot of different things, and you're the occupational therapist in the main hospital" (FG1). Indeed, understanding the consultee within their workplace context is a key factor in consultancy.¹⁸ "It's getting people to understand the parts of the contexts that are significant to what I can do" (IV4).

Outcomes

In consultancy, outcomes occur at multiple levels, including within and between the actors.¹⁷ "I think that there is probably too much emphasis on the end outcome, whereas our role as a consultant is probably more the process to get that knowledge and skills and confidence that you're trying to provide" (FG2). Clearly, process outcomes between actors are highly valued as are the relationships that emerge, and these are an outcome of consultancy.¹⁸ "Approachability and that rapport and you know the right environment and an effective avenue of delivering that information...I'd see them as reasonably successful with successful outcomes" (FG3).

Echoing the literature, our findings indicate that at a macro level, systemic change management outcomes were seen as an intrinsic part of consultancy:²⁰ "So it's all the change management and actually having to try to sell the idea and the idea is from the evidence base" (FG2). "I want the change management; I want the investment because it is bloody hard work at times" (FG2).

Within the UK, a highlighted outcome for consultant positions is recognition within the health professions.^{7,20} Similarly, the current findings suggest that outcomes for the consultant included recognition and acknowledgement as a consultant: "I think the important thing is...recognition and acknowledgement of this role" (FG2). This recognition and acknowledgement often relied on feedback. "You don't get feedback very much in this job so if someone gives you feedback and actually says 'thank you', you will probably think you have done an alright job" (IV2). Feedback also helped to contribute to continuous quality improvement. "It's like the cycle -- the plan, do, check, act; it's a circle all the time- you're going back and revisiting" (FG1). This continuous quality improvement and learning will be essential for expanding and improving consultancy within the allied health professions.¹⁷

For consultees, reported outcomes also included improved job satisfaction: "I think consultancy also adds a lot to generic practitioners in job satisfaction and in interest and in what you learn" (FG1). The resolution of information needs and the use of advice in both specific and generalised ways (as defined by context and actors) were seen as key for the consultee: "So then that becomes about allowing them to generalise what they've learnt in that consultancy to other situations as well" (FG2). Obolensky suggested that "implementation is key; without implementation, the most elegant consulting solution is of little value" (p. 155).²¹ Confidence building, skill development for the consultee, and learning and information exchange were also seen by participants as desired outcomes of consultancy: "If I can get someone to give it a go -- that person who is really reluctant to do something different because of confidence or knowledge or whatever the issue was -- and then you can go down and you actually see them doing something different" (FG2). As stated by Rassam, "a good consultant empowers their clients [consultees] by helping them to gain new insights into themselves and their organisation.²² Enabling a client to contribute to their own solutions is part of this process." (p. 147)²²

An important outcome of the relationship between the consultant and the consultee was the attainment of an agreed goal: "That's what the aim of it is -- achieving the goal that was set out" (FG3), and the knowledge translation that occurs: "So, in that instance, their relationship with you and their communication is much more important than their knowledge per se. You've got to have that before you get any kind of knowledge transfer" (FG2). There is significant support within consultancy literature for establishing good communication and relationships between parties for effective knowledge translation.¹⁸ Similarly, the achievement of agreed goals is important. Within management consultancy, this deliverable is often formalised within a contract at the

commencement of the consultancy.²³ However, the current findings suggest that in AHP practice, the identification of goals and the evaluation of whether they have been achieved as an outcome is much less formalised.

Fundamentally, however, AHP consultancy is about facilitating outcomes for clients, and successful consultancy benefits not only professionals, but also clients or patients.²⁴ The current study found that for clients, outcomes of effective consultancy included resolution of existing clinical problems, skill changes, change in their environment, the prevention of future clinical problems, and greater satisfaction: "The consultee is employed with the client to start with -- that's why they've asked you to get involved, so I guess that there is an assumption that they're doing this, I guess, in order to have that outcome for the client in the end." (FG1) However, while actual outcomes were seen as desirable, participants often spoke in terms of intended outcomes. Indeed, for the consultant, the actual outcomes for the client may never be known to them. What remained important is that the consultancy interaction between the consultant and consultee remained focused on achieving the desired outcomes for clients.

Finally, participants noted that successful knowledge translation was characterised by a demonstrated understanding of and appropriate application of that knowledge in relevant settings. This was acknowledged from both the consultant and consultee perspectives:

I think if they don't need me anymore, that's really good in some ways, and that's great when what you've suggested has really worked, and I'll follow up a bit later when I need your help again, but they take over and I think that's really good and they understand more (IV3).

Hopefully you can come away knowing more about whatever it was than what you did to begin with. And you have an understanding of that as well, so you don't actually have to go back again and ask the question 20 times (FG4).

IMPLICATIONS

The current study represents one of the first attempts to explore consultancy within allied health practice in Australia. The study provides preliminary information about how consultancy is defined in this context, how it is practiced and how knowledge translation is achieved. The study offers a framework for allied health consultancy that may provide a platform upon which future research can build. The findings suggest that relationships are key to allied health consultancy, both within and across disciplines. Further, since allied health consultancy has not been formalised within the Australian setting, but is being practiced in an ad hoc manner, there is a need to align policy, practice, training, and research. Similarly, there is a need to examine how documentation of the processes and outcomes of consultancy are best approached to address medico-legal implications.

In drawing implications from these findings, it is apparent that policy and training initiatives are required at discipline and workforce levels to further define and delineate the role that allied health professionals have as both consultants and individuals who may seek consultancy. Key topics should include a) defining consultancy in allied health, b) understanding contextual barriers and facilitators, c) understanding goal setting in consultancy, d) establishing processes and outcomes for consultancy, and e) developing consultancy relationships and roles. It is evident, however, that these policy and training initiatives would need to be informed by a stronger evidence base. Further research is required to more clearly articulate how consultancy can be enhanced in practice, and how it will be taught.

A deeper understanding of allied health consultancy will also contribute to the development of health workforce reform policy. Consultants doubtless have a significant role to play in the ideal skill mix of the AHP workforce of the future. Therefore explicating the mechanisms they employ and assessing their capacity to translate knowledge is essential.

LIMITATIONS

As an exploratory study, there are considerable limitations to this study that warrant consideration. This study was conducted with the participation of Australian AHPs from a number of professional disciplines. The data were considered collectively and not from discipline specific perspectives. While it is recognised that each of the AHP disciplines have their own historical and cultural context within Australian practice, AHPs are typically collectively employed as health practitioners and workforce development occurs within this framework. It was therefore considered appropriate, at least during this early exploratory phase, to study AHPs as a group, hence potentially missing discipline specific dimensions. Discipline-specific dimensions of consultancy may be a focus for future research.

A second limitation arises because the full range of disciplines potentially engaged in allied health practice in Australia were not represented in the sample. As such, the study does not represent the entire spectrum of consultancy experiences in allied health. Future research should attempt to seek inclusion and representation across all allied health professions.

The social constructionist perspective which was adopted at the outset of this study asserts that knowledge is local and context driven.²⁵ In their descriptions of AHP consultancy, participants revealed personal understandings of consultancy which were strongly influenced by the culture of time and place. Another way to investigate AHP consultancy in future may be through a more dispassionate approach, observing and recording day to day practice to augment the data derived from participant's perceptions.

CONCLUSION

The framework for consultancy identified within this exploratory study suggests that consultancy has subtle complexities when considered within allied health. AHP consultancy comprises complex processes, multiple actors, varied outcomes and is highly contextual in nature. Relationships are important determinants of outcomes within allied health consultancy.

This study has outlined a framework for ongoing exploration of allied health consultancy. Further research, with larger samples and using quantitative methods, will expand and confirm this framework within specific disciplines and in a variety of health and rehabilitation contexts. Further research will help to clarify, define and promote acceptance of allied health consultancy in an Australian context. The authors have initiated a larger study to achieve this aim.

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DECLARATION OF INTEREST

There are no conflicts of interest to declare.

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