

EDITORIAL

Global perspectives on under-funding for Clinical Research Training Fellowships in Nursing

We are delighted to showcase this series of papers on clinical academic careers in nursing throughout this special issue of the Journal of Clinical Nursing. The issue casts the spotlight on career pathways for clinical research training, with a focus on pre-doctoral to professional career stages. A common theme throughout the issue is how fragmented the clinical research training pathway is, with it being at a point of crisis. Our nursing profession comprises the single largest healthcare workforce globally; however, our research training pathways are severely under-developed and under-supported in comparison to our colleagues in allied health and medicine. Research training and support requires radical advocacy and reform at local, national and international levels.

When nurses make a career decision to pursue either a research or clinical career pathway, there is an inherent expectation that both pathways will provide foundational systems, structures and processes to promote success. However, this expectation is not always realised due to a lack of training, mentorship, grant support, protected research time and organisational commitment. In Australia, the research pathway decision is often timed post-registration when nurses face a choice between undertaking a transition to practise (new graduate) programme or an honours degree. Bachelor honours are a common research training pathway into doctoral studies (Halcomb et al., 2018). However, we are witnessing a worrying downward trend in enrolments into these degree programmes, impacting on subsequent enrolment into doctoral training programmes. The approaches used to teach research in pre-registration nursing programmes may be contributing to this downward trend, compounding the general disinterest or lack of engagement in clinical research (Ferguson et al., 2017). Public commentary during the COVID-19 pandemic has called to question nurses understanding of statistics, research design and critical appraisal of research (example quote in relation to research appraisal).

Why are so many healthcare workers refusing vaccination?

@wesyang Twitter Jan 2nd 2021.

I believe they're mostly (perhaps all?) nurses. No disrespect to nurses, but research design & statistics aren't covered in a nursing degree – so there's no reference point from which to judge study quality

@clairlemon Twitter Jan 2nd 2021 (The Australian Journalist/ Contributor).

Whilst factually incorrect, this quote invokes deep concerns around the public's perceptions of the nursing profession and its academic credibility. Improving the teaching quality of research in pre-registration programmes is imperative, and novel approaches to learning about research are critical (Ferguson et al., 2017).

A research versus clinical career choice need not be dichotomous. Robust evidence demonstrates that where research is embedded within teaching and clinical practice, patient outcomes are enhanced and clinical academic precinct health settings are increasingly popular for this reason. Yet, an unhelpful contemporary discourse remains that nurses 'can't do it all'. The quote below exemplifies this, fuelling the argument that it is not possible to successfully combine teaching, research and clinical practice.

I think you need to let go of something. You cannot be a clinician, a researcher and educator. Otherwise you will burn out.

Tweet from @NurseEducToday 11 November 2018. (Top-ranked Nursing Education Journal).

Engaging clinical nurses in research is frequently challenging (Siedlecki & Albert, 2017). Nursing differs from other healthcare professions, with intensive and constant engagement and care provision for patients and their families. Nurses, unlike our medical and allied health colleagues, are frequently working in systems where research time is not funded; therefore, it is challenging to organise research time around clinical responsibilities. To draw parallels, our medical colleagues have research identified as part of 'normal duties' in their job descriptions and have entitlements included in structural workforce policy recognising research as part of their work. This may include the allocation of research time in enterprise, public health awards to undertake research (Halcomb et al., 2018) and research infrastructure (such as grant office and research administrative support).

Nursing research barriers and challenges are well described in this special issue, along with enabling factors such as protected time, financial support, structural career supports and formal traineeship pathways. Research does not happen without money. Research is costly; and it takes skills and expertise in design, methodologies,

data maintenance and analysis to deliver quality research outcomes and impact. It is a high-risk activity that needs financial investment in people. It is critical to support, mentor and grow the next generation of nurse researchers. Growing this talent takes time, energy and a financial investment. A doctoral degree is important to establish foundational knowledge and skills in research and often needs to be followed by a fellowship; however, these educational and skill attainment processes requires a significant time commitment and financial support.

Protected time is fundamental to delivering clinical nursing research. Some common approaches are internship models as described by Olive et al in this special issue (Olive et al., 2020). These include protected time ranging from 0.2–0.4 full-time equivalents, secondment opportunities and joint appointments between research and clinical teams. Postdoctoral research training opportunities range in time from a few months to a few years. Other clinical academic workforce models are showcased including The St Bartholomew's Hospital model, that increased critical infrastructure such as academic appointments and integrated supervision (Sanders et al., 2020).

Funding is likely the biggest critical infrastructure factor to enable and support protected time. We were alarmed by this quote from Olive et al that quantifies the proportion of trainee funding from the National Institute for Health Research in the United Kingdom.

Collectively, nurses, midwives and allied health professionals make up more than two-thirds of the healthcare workforce, yet they constitute 1%, <1% and 4% of trainees in the National Institute of Health Research training infrastructure, respectively. Olive et al. 2021.

This lack of uptake may be a reflection of a variety of factors inhibiting UK-based nurses from successfully being awarded research training opportunities. These include a lack of research mentorship and training, limited role modelling and representation on research panels and committees, lack of confidence, lack of time to undertake research and a lack of support from managers and a lack of partnership between universities and NHS organisations. However, this stark inequity between research training uptake in nurses, midwives and allied healthcare professionals compared to medical professionals is not unique to the United Kingdom, with similar findings in the United States and Australia. We undertook an analysis of Australian National Health and Medical Research Council (NHMRC) research training schemes. Funding outcomes were accessed in excel format via the NHMRC public website (NHMRC), and outcomes of the 2020 Investigator Grant scheme and Postgraduate Scholarship scheme were coded by profession. Registered health professions were sourced from the publicly available AHPRA Register of Practitioners (AHPRA) in January 2021 and coded by profession. From the 2020 round, there were a total of 238 investigator grants awarded. Of these, 7 were awarded to nursing (3%), 17 to allied health (7%) and 1 to midwifery (0.4%). Of the 64

postgraduate scholarships, one was awarded to nursing (1.6%) and two to allied health (3.2%). When these two main pre-doctoral and postdoctoral research training schemes were combined, nursing was awarded 1.9% of the overall total grant funding value for the year. It is concerning that nursing, midwifery and allied health when combined, received 9% of funding, particularly given that these three professional groups comprise 80% of the registered health practitioner workforce in Australia (AIHW).

1 | HOW CAN WE FIX THIS PROBLEM?

Workforce solutions to this clinical academic impasse can include interventions such as.

1. inclusion of research in 'normal duties' within job descriptors for all levels (not just senior levels) of nursing;
2. increasing nursing doctoral scholarships, where limited opportunities exist;
3. investment in protected time or clinician 'buy out' to engage in research activities;
4. investment in more joint and honorary clinical academic nursing appointments, including postdoctoral and professorial levels; and
5. development of collaborative clinical academic strategies for nurses across university and healthcare organisations.

Clinical academic appointments can offer research mentorship and shared resources between partner sites. Historically, the academic site may have nurse researchers who enjoy mentoring clinical nursing teams in research or have a desire to conduct clinical research that requires clinical collaboration. Clinical sites would encourage collaborations to demonstrate community support or, importantly, to encourage clinical nurses to become research-active, as a way to promote evidence-based practices. However, when academic and clinical sites with and without clinical academic collaborations were studied for research-based outcomes, authors of a paper in this special issue (Albert et al., 2020) were surprised to learn that very few sites had a clinical academic collaboration. Further, sites with and without collaborations had similar outcomes. The authors hypothesised that clinical academic partnerships may have emerged based on a desire to collaborate with colleagues, rather than because there was a need to enhance site-based research (Albert et al., 2020). Of note, most clinical sites that participated were large urban centres that may have been better able to support nurse-led research services. Ultimately, the benefits of clinical academic research collaborations have not been fully actualised or articulated (Albert et al., 2020).

The impact of nursing research is well described in the literature and nurses have a long-standing track record in delivering high-quality clinical research that adds value and improves patient care and outcomes (Ferguson et al., 2020). Yet, in the current economic climate, it is critical to demonstrate the value proposition of nursing research, the impact and the return on investment following

successful projects (Kiely & Wysocki, 2020). As a profession, we must strive to develop a new generation of research leaders and raise the profile of nursing research through successful competitive funding, conduct of high-quality research and improved clear communication of research impact. This is particularly important in the COVID-19 era when the long-term sequelae of the disease will provide a prime opportunity for nurses to demonstrate their expertise in supporting patient care outcomes, as well as the wider health, social, economic and psychological challenges and issues that lie in its wake.

2 | CONCLUSION

We hope this special issue will be used widely to inform clinical academic workforce planning and strategy, models, pathways and policies. Radical funding and workforce policy reform is needed from both universities and health services to invest in, and support, the next generation of nurse researchers.

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CONFLICTS OF INTEREST

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