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EDITORIAL

The invisible ceiling: barriers to clinically focused research for university-based nurse academies

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The shift of undergraduate nursing education into university settings has fundamentally altered the profession's academic landscape. This transition created a cohort of nurse academics who, despite extensive clinical backgrounds, often lack active practice connections. Because university career progression prioritises research output and demonstrable impact, this disconnect is critical. While national initiatives like clinical-academic roles and NHS-embedded hubs aim to bridge this gap, they remain inaccessible to most university-based nurse academics (Trusson et al., 2019). These academics face multifaceted barriers when attempting to penetrate clinical teams. Challenges intensify when research targets traditionally medical domains—such as clinical decision-making or acute care protocols. These hurdles lead to institutional epistemic injustice, where nursing perspectives are systematically devalued (Bueter & Jukola, 2025). This paper examines these disciplinary barriers and their implications for healthcare knowledge development.

The Interprofessional Context of Modern Healthcare

Modern healthcare relies on multiprofessional teams where patient outcomes depend on effective team functioning (Sarfati et al., 2022). Investigating the human factors shaping these practices requires researchers who can bridge disciplinary divides. However, professional hierarchies and territorial boundaries create significant obstacles for those crossing traditional lines (Essex et al., 2023). Despite decades of interprofessional education, these barriers remain embedded in organisational cultures (Bueter & Jukola, 2025). Nurse academics must navigate these hierarchies while establishing research credibility—a dual challenge that places them at a disadvantage compared to medical researchers.

Case Study: Early Warning Systems (EWS)

EWS systems aggregate vital signs to track patient deterioration, mandating physician review when thresholds are exceeded (Smith et al., 2014). Despite their safety benefits, research reveals widespread non-compliance; adherence to escalation protocols can be as low as 26.1% for high-risk values (van Galen et al., 2024). Common failures include scoring inaccuracies and omitted measurements (Petersen et al., 2018). The predominant research response has focused on technical fixes—refining algorithms or automating alerts—reflecting the orientation of the field's dominant researchers (Watkinson et al., 2024). However, qualitative investigation suggests non-compliance stems from human factors rather than technical flaws (Greaves, 2017). Mandatory reviews often conflict with physicians' urgent workloads (Flenady et al., 2020). Consequently, staff negotiate informal workarounds to manage conflicting demands. Because such research challenges technical investments, it often struggles to gain traction.

Barriers to Initiating Clinical Research

University-based nurse academics face immediate obstacles when seeking clinical access. Research governance and ethics committees often scrutinise academics lacking active clinical ties. Proposals are evaluated on investigator credibility and institutional risk; however, nurse academics frequently face questions that medical researchers do not (Bueter & Jukola, 2025). Concerns regarding negative publicity—especially for research into protocol compliance—can lead to rejection. To succeed, nurse academics often must often secure a medical consultant or a clinically based nurse academic as the Principal Investigator (PI). This arrangement subordinates the originating academic to a co-investigator role, altering power dynamics and compromising their intellectual leadership. These barriers reinforce a credibility deflation that suggests nursing perspectives are insufficient for investigating clinical questions (Bueter & Jukola, 2025).

Challenges in Data Collection

Even with access, nurse academics face resistance during data collection. Medical staff may question the legitimacy of nurse-led research in "medical

territory" (Saragih et al., 2024). This manifests as recruitment reluctance or "testing" the researcher's clinical knowledge during interviews to evaluate their ability to grasp clinical complexity (Vamadevan et al., 2025). Navigating these dynamics requires significant emotional labour (Bueter & Jukola, 2025). Researchers must build rapport and demonstrate competence without becoming defensive. This invisible labour consumes time and energy, potentially impacting data quality. These challenges mirror Stein's (1967) "doctor-nurse game", where nurses influenced decisions through deferential subterfuge. Despite changes in education, professional autonomy, and formal IPE initiatives, nurse researchers encounter modern iterations of these dynamics where academic credentials are undervalued due to professional background.

Dissemination Barriers

Nurse academics struggle to reach medical audiences (Sánchez-Gómez et al., 2023). Medical journals may favour specific methodologies, causing qualitative research to face rejection regardless of quality (Bueter & Jukola, 2025). Findings that challenge technical solutions by highlighting team dynamics are often met with scepticism. Scepticism among physicians regarding qualitative research often persists because they evaluate it using quantitative benchmarks like generalisability and replicability (Bueter & Jukola, 2025). This can lead to a systemic 'credibility deflation' where nursing-led qualitative findings are viewed as less rigorous than medical quantitative studies (Bueter & Jukola, 2025) as are qualitative methodologies. These barriers ensure that vital insights into team function fail to reach the audiences who could most benefit (Cashin et al., 2022). Clinicians continue implementing technical solutions to problems requiring organisational change, while policymakers lack evidence regarding the human factors of protocol compliance.

Systemic Implications for Knowledge Development

The cumulative effect is to discourage nurse academics from pursuing clinically focused research. Early-career researchers may choose "safer" topics within nursing's traditional domain, creating significant knowledge gaps in patient safety and shared decision-making. Podgorica et al. (2026) found that weak interdisciplinary cooperation is a persistent feature of European nursing research, suggesting these hierarchies are deeply embedded. Similarly, Vamadevan et al. (2025) identified systemic challenges in the UK regarding professional identity and leadership representation. Furthermore, research translation is hampered by organisational obstacles, including insufficient time and lack of institutional power to improve care (Berthelsen & Hølge-Hazelton, 2017).

Conclusion

The obstacles facing university-based nurse academics reflect fundamental flaws in how healthcare knowledge is produced and validated. By marginalising nursing perspectives and limiting methodological diversity, these barriers create critical gaps in our understanding of healthcare delivery. Addressing this requires a shift toward research cultures that genuinely value interprofessional perspectives and methodological pluralism. Contemporary healthcare challenges cannot be solved through single-discipline lenses. To improve patient outcomes, we must transform the research cultures that maintain professional hierarchies, ensuring that all valuable perspectives contribute to the evidence base.

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