

"There is a lack of translat nursing scientific knowled

"There will inevitably have to be a redistribution of activities between the healthcare professions to ensure healthcare provision." In the cover interview with "Monitor Versorgungsforschung", Prof. Dr Gabriele Meyer, Professor of Health and Nursing Sciences at Martin Luther University Halle-Wittenberg and former member of the German Council of Economic Experts for the Assessment of Developments in the Healthcare System, speaks out in favour of adequate funding for nursing science, but above all for a better skills and degree mix, better communication between the professions and, "to a relevant extent", clinical-academic nursing roles.

Cover interview: Prof Dr Gabriele Meyer, Professor of Health and Nursing Sciences at Martin Luther University Halle-Wittenberg

>> Professor Meyer, at the last German Congress for Health Services Research, you used the term "evidence-free zone" and linked it to practice in long-term care in Germany. As of December 2022, there are now over 200 care-related degree programmes in Germany - 68 of which are Master's programmes; a few more will probably have been added in the meantime. Is the "evidence-free zone" now over, and not just in long-term care?

My statement at the DKVF did not actually refer only to long-term care, but to nursing practice in general or to all nursing activities and their inadequate foundation in corresponding scientific findings. In the case of long-term care, the fact that there are not only major gaps in the evidence but also considerable implementation problems is particularly aggravating. The transfer of the little knowledge available into practical care does not work because we have far too few people who are trained to act as translators of nursing science findings. Conversely, there is a lack of people and structures to help bring questions from practice to the scientific community.

If we have no or far too few university-trained nurses in clinical care, who is supposed to transfer the knowledge into practice?

That is one of the biggest challenges. The lack of extended nursing roles in long-term care makes things even more difficult. There is also a lack of evidence-based guidelines for outpatient and inpatient long-term care that would be comparable to the AWMF S3 level and that are regularly updated. Carers in this country therefore have to work with expert standards that do not reach this level - despite methodological quality gains in recent years - and are less suitable for practical use and are therefore criticised by nursing science.

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What is the problem?

Whether guidelines or expert standards: The content must be translated into the respective outpatient or inpatient setting by someone who can deal with scientific methods and knowledge bases. We lack the necessary number of these well-trained people in this country. It is particularly regrettable that there is no established co-operation between nursing science and nursing practice in Germany - much less so in long-term care than in acute care. In the latter, at least some places now have staff units for nursing research and nursing science activities that are being developed in clinical practice, albeit not to a satisfactory extent. Overall, there is a large gap between the ivory tower of nursing science and nursing practice.

Some very practice-orientated nursing projects have emerged recently.

I don't want to deny that, but there are far too few for the importance of nursing and the universal need for nursing. For example, our team in Halle is working with colleagues from the University of Cologne on a project funded by the BMG called "Living Lab Dementia". Here, we are trying to establish close collaboration between care practitioners and care scientists for the long-term care of people with dementia. The contact persons from science and practice, the so-called linking pins, worked together on questions from practice using scientific methods in order to then be able to bring the results back into practice. This approach was successfully initiated by colleagues at Maastricht University 25 years ago. In Bremen, a nursing science project funded by the Federal Ministry of Education and Research is also attempting to bridge the gap between theory and practice. The project is called "T!CALL". The subject of the project "Transfer cluster of academic teaching care facilities in long-term care" is technical, digital, structural and process-controlling innovations in the field of care.

So not quite such an evidence-free zone after all.

Perhaps not free, but poor in evidence. This begins with the self-evident aspects of nursing activities and actions, such as basic care techniques: positioning, washing, dressing, mobilising, offering food. If we take a closer look at these topics, we will very quickly realise that their implementation in practice is often based on traditional doctrines and expert opinions, rather than on evidence, because they are simply very poorly researched.

What use is it if evidence might be available, but there is a lack of transfer into practice?

Exactly. Then we will continue to have a broken pipeline. And this is mainly because we lack translators in this country to translate scientific knowledge into practice.

Are there too few degree programmes in nursing?

There are currently 66 locations and 174 professorships in nursing science. However, only 15 of these are university locations that do not have to cope with extensive teaching obligations like the universities of applied sciences and therefore have the freedom and infrastructure to carry out larger studies. I'm not saying that colleagues at universities can't do research, there are also very good scientists there. But when 18 hours of teaching have to be provided and mountains of performance records have to be assessed, there is hardly any freedom to pursue appropriate and longer-term scientific projects.

Is there a sufficient volume for nursing research?

No. At the moment, I have the impression that there is no way at all to generate sufficient research funding if you don't want to research a digital or robotic solution. Here I would like to make an urgent appeal to all research funders that not all topics are digital, robotic or a case for AI. Caring is human business, according to a recent editorial in the British Medical Journal. We have many purely analogue topics that require analogue solutions and are so fundamental that they cannot be neglected simply because they do not have a digital component. Of course it makes sense, for example, to promote an app that records movement patterns in order to prevent falls, but we must not neglect the human "to care" that must be at the centre of all care: caring for someone, creating a caring relationship and feeling responsible. Despite all the robotics, this task is and remains predominantly analogue.

After all, there have been two major lines of care research funding in the past.

That's right. That was through the BMBF more than 20 years ago with the nursing research alliances and then in 2019 with the call for proposals to strengthen nursing research. But can these funding programmes be described as "large"? Hardly, considering the volume of the Innovation Fund or the NUM network, for example. For the 2021 to 2024 funding period, this involved a maximum of 5.6 million euros for eight projects. That is a comparatively small budget for the size and importance of this professional group.

In order to be able to work on topics for nursing practice in a promising and fundamental way, there must also be longer-term and more extensive research funding in order not to remain small-scale or incoherent, but to be able to penetrate the problem in question with descriptive and explorative methods, develop a theory, model the intervention components to solve the problem and test them for feasibility, investigate the effects in controlled studies, understand the processes of embedding the intervention and finally research the longer-term implementation.

Unfortunately, such large research cycles are not planned or - if they are - only come about by chance.

Unfortunately, some promising approaches are often not pursued because research funders now change their thematic focus in their short-term, often seemingly arbitrary calls for proposals. Due to a lack of adequate funding of its own, nursing science finds itself in competition with other disciplines for the few sources of funding available. However, if a discipline is really to be given the opportunity to establish itself and build up sustainable structures, it not only needs more targeted and solid research funding, but also a sufficient infrastructure, such as programmes for doctoral and post-doctoral students and university professorships and institutes for nursing science.

"Politicians must decide on structure-building measures for nursing science, as was the case with the public health initiative in the 1990s."

How could nursing science be given a boost?

By politicians adopting appropriate structure-building measures, as was the case with the Public Health Initiative in the 1990s. This is the only way to create a real foundation. Not so long ago, a great deal of money was also invested in geriatrics, general medicine and palliative medicine in order to develop these professions, including their own research culture. The most recent example is the establishment of a network structure for research practices to strengthen general practice, which was financed by the BMBF. We need something like this not only for nursing science, but also for midwifery science. As midwifery training is now exclusively university-based, we have a huge need for young scientists.

What are your main demands on politicians?

A central demand is for adequate research funding and not just a few million euros every 20 years, as has been the case so far. At the same time, the DFG must be prepared to fund appropriate nursing research priorities. The DFG and/or BMBF must also create incentives at university locations to open doctoral programmes.

Which studies in nursing science would you describe as milestones?

That is of course completely subjective. I find some studies on the care of people with dementia very interesting and also challenging. I am thinking, among other things, of our efforts to reduce measures that restrict freedom or antipsychotics in long-term care. With the latter topic, it is particularly important to analyse barriers in order to find out why it is not possible in Germany to successfully implement programmes to reduce antipsychotics that have proven to be effective in other countries. Such studies are always interdisciplinary projects in which it must be possible to bring together several disciplines with equally diverse resear

Where can nursing science develop further?

More investment in and focus on methodology. As a university lecturer, I am naturally interested in the further development of our methods and have followed with great interest in recent years how the research culture on complex interventions has differentiated. Nursing science is a discipline that has responded actively to the UK Medical Research Council's framework model for the development and evaluation of complex interventions. This can make it possible to develop and implement promising interventions, even against the background of limited resources in nursing practice. There are some interesting recent studies on this that were recently presented at our Winter Summit of the European Academy of Nursing Science. For example, there were approaches that aimed to find out how patients in the home care setting can be trained to carry out certain care measures themselves, such as putting on compression stockings, following good instruction and a check-up by nursing professionals. Incidentally, this not only has an economic component, but also an ecological one if it reduces the number of patient visits and automatically also the number of small cars travelling through towns and communities. Of course, this always has a "flavour" because a home visit always has several functions - including social contact.

Shouldn't we be more honest and say that care cannot treat all social emergencies?

Of course. Care is not there to take over all social interactions, it cannot compensate for loneliness and can only provide rudimentary life support. In the coming years, we will have to economise on our limited resources even more than we do now. This is why such projects are sensible and important.

Are we succeeding in this to a sufficient extent?

So some extent, yes, but not enough. To change this, we need major lines of research with which many more such topics can be systematically developed. One such topic, for example, is the promotion of activity and participation of people in care homes, for which we have already received funding from the BMBF in various phases in

order to describe prevalence and incidence, develop an outcome instrument and arrive at an implementation strategy by developing an intervention and testing its feasibility in an experimental phase.

If you look at the current level of academisation of nurses in Germany, as the Bertelsmann Foundation did in its 2021 study "Potentials of Nursing 4.0", you can see that there is a huge backlog. According to the study, around 77 per cent of employees in geriatric care - as of 2017 - had vocational training and only just under 6 per cent had academic training (including master craftsman and technical college qualifications). And according to this study, only 0.45 per cent of employees in outpatient and inpatient care facilities had a degree in nursing science from a (technical) university in 2017.



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What has happened in the meantime? Where do we currently stand in terms of the level of academisation?

Clinical practice in Germany is characterised by a lack of prospects for university-educated nurses. A 2018 survey of university hospitals found that the proportion of nurses with a bachelor's degree in clinical care is around 2 per cent. The bachelor's degree programme as a - now standard - option in nursing training has hardly been taken up to date; less than two percent of trainees in a given year study nursing. Even if the Nursing Studies Strengthening Act holds out the prospect of improvement, this status is a far cry from the recommendation of the German Council of Science and Humanities to employ at least 20 per cent of university-trained nurses in clinical care. Clinically oriented Master's degree programmes are largely lacking. Master's graduates play almost no role in nursing practice. The few graduates mostly occupy positions outside of nursing practice. One approach to integrating nurses with academic nursing qualifications into practice is the so-called "career model", which is also increasingly being promoted for nurses at university hospitals. Here, areas of employment and remuneration models are formulated that allow permeability from a bachelor's degree to a doctorate/habilitation. However, the conditions are often unclear, there are hardly any role models and there is often a lack of suitable applicants. Internationally, the roles of university-qualified nurses at all qualification levels have long been established and contribute significantly to the volume of research through practice-based projects and the circulation of knowledge.

Research, teaching and patient care are quite normal for doctors in university hospitals, so why not for nurses?

This is an absolutely justified question. Instead of laboriously trying to find out the most pressing issues in nursing practice in an ivory tower, there should be a relevant number of clinical-academic nursing roles, one part of which is dedicated to nursing practice and the other to scientific work. In contrast to other countries, there are practically no such roles in Germany, neither in university hospitals nor in other places of nursing.

What does nursing science do in the non-university clinical setting?

We sit in an ivory tower and struggle to identify the really relevant topics. We are either dependent on the topics that practitioners bring to us or those that we can find in the literature. The latter is common practice, but I don't think it's expedient from this perspective.

What about academicised nursing from Germany?

In this country, the majority of training still takes place at technical colleges. This is likely to change a little now with the Nursing Academisation Strengthening Act and the new Nursing Professions Act. Then a nursing degree programme at a university or college will also be the norm here. In other European countries, a Bachelor's degree has been the entry criterion for professional nursing for many years. In other words, we have a lot of catching up to do.

We now have - let's say - one to two per cent academised nursing staff. What would be the goal?

The goal is not bindingly defined. In all discussions to date, reference has always been made to the German Council of Science and Humanities, which initially called for at least 10 per cent of nursing staff in nursing practice to be university-trained. Since this was not nearly achieved, the Science Council is now calling for the magic figure of 20 per cent. This is nothing more than an expert opinion and it is completely unclear why doubling the required quota should lead to a change. It will be many years, if not decades, before we reach this proportion in Germany. In the meantime, colleagues with Bachelor's degrees are coming to us from European and non-European countries whose qualifications have not yet led to corresponding recognition and positions.

We need a better skill and grade mix. Also, and above all, a better understanding of who should take on which tasks and which areas of responsibility. However, this requires cross-professional behaviour based on a common legal foundation. A general Healthcare Professions Act would be the basis - above all to remove regulatory hurdles, create a basis for the distribution of tasks for nurses with and without extended competences and regulate cooperation with other healthcare professions, including liability law.

The 20 per cent level of academisation that is often talked about: Is the figure more thumb times pi or is there a bigger consideration behind it?

We know from international studies that patient-relevant outcomes improve when the percentage of bachelor-qualified nurses increases. Whether this finding is transferable to the German situation must be questioned; however, there is also no reason to claim that this finding does not apply to Germany. Questions such as this and whether 10 or 20 or 30 per cent etc. need to be investigated in studies with robust designs.

On the occasion of the 2nd expert exchange on the key points of his "major care competence law", which is to be presented before the summer break, Federal Health Minister Prof. Dr Karl Lauterbach spoke of the fact that - quote - "in Germany, care can do much more than it is allowed to" (3). He went on to say that although there are far fewer academically trained carers in Germany than in the Scandinavian or Anglo-Saxon countries, for example, "our carers are at least as well trained and have the same level of experience". Is he right?

Higher education training is met with resentment in nursing practice and also among doctors. There are fears that university-trained carers will be lacking in day-to-day work.

In fact, nursing degree programmes in recent decades have predominantly trained nurses for desk jobs. In other words, for jobs in management or quality assurance, teaching positions, positions in science and self-governing organisations in the healthcare system. However, this is exactly what we want to change with the primary qualifying Bachelor's degree programmes, whose graduates have all doors open to them: practical nursing with extended expertise, specialisation in a nursing specialism, further studies, a clinical-academic career, a career exclusively in higher education, etc. These prospects will certainly make the profession more attractive and hopefully lead to more demand.

What could the new internal differentiation in nursing practice look like?

First and foremost, positions and fields of activity must be made available for Master's and Bachelor's graduates with extended competences. The care of chronic wounds, intensive support for people with heart failure and other chronic illnesses, to name just a few examples, can be taken over or managed by nursing experts. However, it is also clear that even nurses who have completed three years of specialised training will have to hand over some of the activities they have previously carried out to nursing assistants. One thing is certain: there will be enough work for everyone, which is ensured by the dual demographics alone, with more and more elderly and multi-morbid patients on the one hand and fewer and fewer carers on the other.

And yet the medical profession fears that some of its activities could be taken away.

Of course, taking away is not the right term. There will inevitably have to be a redistribution of activities between the healthcare professions to ensure the provision of healthcare. Hopefully, good quality, efficient and, above all, safe solutions for patients will be found in the future. The double demographic gives us the task, but also changing life and work patterns. Some want to work less, others want to work more simply or flexibly and others want more responsibility and competences. We will have to integrate all of these models and lifestyles into the care sector in order to make it fit for the future.

The "Great Care Expertise Act" is intended to provide those in need of care with better care that meets their needs. In addition, specific forms of living are to be promoted that represent an alternative to both assisted living and traditional care homes, and a communal form of living with care until the end of life is also to be made possible. Here, too, the question arises: it may sound good and be understandable from a gut feeling, but what evidence is there?

Strengthening the resilience of long-term care involves the further development of housing and care concepts. The SARS-CoV-2 pandemic has made us painfully aware of the disadvantages of mass accommodation in long-term care. Other countries such as the Netherlands in particular are providing the impetus to develop and research alternatives. One example is green care farms. Or people in need of care in a host family. It is a social necessity to overcome the dichotomy of outpatient versus inpatient long-term care. We need to create more diversity in living arrangements. Examples include shared flats and residential groups that are flanked by semi-professional support and voluntary work in order to keep them affordable and use professional staff resources sparingly. Of course, these are complex interventions that are not easy to research, and the methods of clinical epidemiology often reach the limits of feasibility here. Nevertheless, here too it is important to prove the benefits and the absence of undesirable effects as well as possible.

Another issue: although nursing is by far the largest professional group in Germany, it is not represented in the self-governing bodies - above all in the G-BA. This is mainly due to the fact that there is no national nursing chamber. Why is the nursing profession finding this so difficult?

The main reason is that the nursing profession itself is not a closed professional conglomerate. The generalist training programme is still very young. Until now, we have had largely separate geriatric nursing, nursing and paediatric nursing - and all with a different understanding of the profession. This makes it difficult to fight together for a chamber that is then supposed to speak as a whole for a profession that is separated into small groups. In addition, nursing is a profession in which around 80 per cent of employees are women, many of whom work part-time. In addition, most carers are not very active in professional politics. It is therefore understandable that there is no great pressure to establish a centralised professional self-administration and finance it through membership fees. Furthermore, nursing in this country is not characterised by a struggle to improve its professional status like other professions, but rather goes back to a historical understanding of humble devotion. These and other aspects are the reason why professional political standing is not seen as an absolute must.

Is it not also due to a lack of understanding of what role nursing should play in the healthcare system in the future?

With around 1.76 million employees, nursing is already the largest professional group in the healthcare sector, which makes it all the more absurd that it plays a marginal role in decision-making on the organisation of the healthcare system. Ensuring care is also a guarantee for social peace and a civilised society. In future, nursing care must not only be an executive, but also play a part in shaping the healthcare system. This is also the wish of the WHO and the International Council of Nursing. This unfamiliar role must be communicated to society, but also to nursing. In its reports from 2023 and 2024, the German Advisory Council on Health and Care makes it clear that the perspective of carers should be included in all issues relating to the nursing profession and represented in self-governing bodies. According to this, the nursing profession must be fundamentally involved in the organisation of the healthcare system and have a relevant say in planning and management processes, legislation and decisions, e.g. regarding remuneration or staffing levels. Limiting co-determination to individual bodies in the healthcare system such as the G-BA or gematik is not enough.

"It is a social necessity to overcome the dichotomy of outpatient versus inpatient long-term care."

What tasks must or should a care self-administration take on?

It starts with the registration of carers. So far, it is not known how many carers there are in Germany and with what qualifications. Only registration and the resulting information on the status and availability of carers make it possible to estimate in which qualification areas there is a need for training. At the same time, it is also possible to determine whether training needs can be met on the basis of the existing pool of trainers. Further education and training programmes need to be based on the needs of the nursing care system and the content needs to be derived from nursing science. The next topic would be the introduction of compulsory further training for nursing and the recognition of further training. There is a need for a harmonised training and further education structure in nursing. <<

Thank you very much for the interview <<

The interview was conducted by MVF publisher Prof Dr Reinhold Roski and MVF editor-in-chief Peter Stegmaier.

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