

Allied health professionals and nurses as paramedical research coordinators in French healthcare institutions: a national cross-sectional survey of workforce characteristics, roles and scientific activity (PRC-FR 1)

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Research Article

Keywords: allied health professionals, clinical research nurse, research capacity building, paramedical research coordinator, nursing research, allied health professional research

Posted Date: October 12th, 2026

DOI: <https://doi.org/10.21203/rs.3.rs-10828192/v1>

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Additional Declarations: No competing interests reported.

Abstract

Background

Allied health professionals and nurses (AHP&N) increasingly contribute to clinical research, yet the way this activity is organised within healthcare institutions varies between countries and remains poorly documented. Since 2018, France has introduced a new profession, the Paramedical Research Coordinator (PRC), dedicated to supporting and enhancing AHP&N research. No national description of this workforce had been published. We aimed to map French PRC, describe their missions, compare their professional and academic profiles and scientific activity.

Methods

We conducted a national, observational, cross-sectional survey reported according to the STROBE recommendations. A self-administered online questionnaire collected data at the institutional and individual level. It was distributed between July 2024 and April 2025 through the national research network of university hospitals (CHU), general hospitals (CH), comprehensive cancer centres (CLCC) and non-profit private institutions (ESPIC). Analyses were descriptive, with Fisher's exact and Kruskal-Wallis tests for subgroup comparisons.

Results

Across 122 responding institutions, 101 coordinators were identified; 67.2% of institutions employed at least one, but the funded time was limited (median 20.0%, IQR 0.0–57.5, of a full-time equivalent) and concentrated in university hospitals. Missions were predominantly strategic—supporting project design (84.1%), building a research culture (79.3%) and training staff—rather than operational trial-delivery tasks. Academic attainment was high and rising: 80% met the expected qualification level (master's degree) and 45.3% were PhD holders or PhD students. A clear gradient emerged, from the highly structured university hospitals to the emerging, less-resourced general hospitals.

Conclusions

The paramedical research coordinator role has spread throughout France and has been institutionalised as a defined occupation with a recommended doctoral pathway. This is in contrast to other countries that approach this role through temporary, ad hoc frameworks and time-limited pilots.

Background

Evidence-based healthcare practices are improved by scientific production, which leads to better patient care, greater efficiency in the organisation and economic benefits [1–3]. The number of authors and

publications in life sciences has tripled over the past 30 years [4]. This increase is also pronounced in the health allied and nurse sciences. However, a considerable degree of variation in production levels is evident among nations [5]. There are numerous challenges: lack of dedicated time, clinical priorities, inadequate managerial support, insufficient training, language and cultural barriers, and unclear academic career paths [6–11]. Although this is an ethical, collective, and personal responsibility, there is a trend of underpublication in international journals among French-speaking healthcare professionals: only 0.7% of international nursing publications come from French researchers [12]. In the domain of rehabilitation sciences, there is a heterogeneity of publishing activities [13].

Allied health professionals and nurses have historically received less funding for research compared to medical and scientific colleagues [14, 15]. In France, since 2009 the Ministry of Health has initiated a national research grant programme focused on clinical studies, with the aim of guiding nursing and allied healthcare practices [16].

Certain research support roles are specific to allied healthcare and nursing research, and have fundamentally focused on its technical and operational aspects. Among these roles, the clinical research nurse and the clinical research coordinator have become essential to the safe and compliant delivery of studies, undertaking participant recruitment, informed consent, data and case-report-form management, monitoring and adverse-event reporting, and the day-to-day care of research participants [17–20]. International descriptions of this workforce have multiplied over the past decade, from national surveys in Italy [17] and role-delineation studies in the United States [19] to scoping reviews and cross-country comparisons spanning the United Kingdom, the United States and China [20–22]. Competencies and tasks vary between and within countries, job titles are inconsistent, professional recognition is incomplete, and contractual precariousness is common [17, 23, 24].

However, four levels of research capacity-building have been described [25], among which interventions at the organisational level remain rare and sporadic. Some recent work reports an extension of the clinical research nurse role beyond conventional drug trials into social care and community settings [26, 27].

Running in parallel to this operational literature is a distinct body of work concerned not with the delivery of individual trials but with building the capacity of the allied health and nursing workforce to engage in research at all. Allied health professionals and nurses (AHP&N) are encouraged to become researchers by moving from consumers to leaders [28, 29]. Research engagement by professionals correlates with better healthcare outcomes, higher staff retention, and increased job satisfaction [30]. Yet the evidence base shows that this capacity is typically developed through ad hoc instruments rather than through any single occupation. Rapid and systematic reviews have catalogued numerous frameworks for embedding a research culture [28, 29]. Research facilitators, joint clinical-academic positions, and pilot embedded researcher models, such as the nurse, midwife, and allied health professional embedded researcher (NMAHP-ER) model, which was tested in two English hospital trusts and a university, are all options [31–33]. Surveys of research capacity and culture in the United Kingdom, China and elsewhere consistently

describe heterogeneous and often fragile capability, with lack of protected time, funding and mentorship as the dominant barriers, and with clinical-academic career pathways that remain difficult to sustain [6–9, 34–38]. Across these initiatives, the functions of facilitating, mentoring, training and embedding research are widely recognised as important, but they are almost never consolidated into a single, nationally defined profession.

France occupies a distinctive position in this landscape. Since 2018, the national repertoire of health and social-care occupations has included a defined profession, the paramedical research coordinator in nursing, rehabilitation and medico-technical care (PRC), whose mission is explicitly strategic: to design, steer and lead actions that develop and promote AHP&N research, to build a research culture through critical-appraisal workshops and scientific events, to train AHP&N teams, to forge partnerships with training schools and universities, to structure research activity across regional hospital groupings (groupements hospitaliers de territoire, GHT), and to create networks of expertise [39]. The expected entry level is a master's degree, with progression towards doctoral training explicitly recommended. This profession is part of a broader effort to recognise and fund AHP&N research in France, despite a lack of documentation in this area [10, 11, 16]. The responsibilities assigned to the CPR align closely with the capacity-building functions that the global body of knowledge provides through frameworks and pilot studies [28, 29, 32]. In France, there is no legal requirement for all institutions to have this type of role.

The Commission Nationale des Coordonnateurs Paramédicaux de la Recherche (CNCPR) was established in 2015 to unite and promote the research and innovation of paramedical coordinators in national French hospitals. No national survey or cartography of this profession had been done, and its role beyond university hospitals was unknown.

We conducted a nationwide survey with the main objective of mapping paramedical research coordinators in all categories of French healthcare institutions and secondly, comparing them between university hospitals, general hospitals, comprehensive cancer centers and non-profit private institutions; describing their roles, professional and academic profiles, and scientific activities at both institutional and individual levels.

Methods

Design

This was a national, observational, descriptive online cross-sectional survey. Reporting follows the STROBE recommendations for cross-sectional studies [40] (Additional file 1).

Participants and setting

The survey targeted national French healthcare institutions liable to employ a PRC, including university hospitals (centres hospitaliers universitaires, CHU - including the multi-site entities of the Assistance

Publique–Hôpitaux de Paris), general hospitals (centres hospitaliers, CH), comprehensive cancer centres (centres de lutte contre le cancer, CLCC), non-profit private institutions (établissements de santé privés d'intérêt collectif, ESPIC), and military hospitals (hôpitaux d'instruction des armées, HIA). No formal sample-size calculation was performed; the survey aimed at exhaustive coverage of eligible institutions in each sector.

Instruments

A consensus-based approach with a group of four CNCPR members was carried out to confirm each item based primarily on the defined profession of PRC as described in the national repertoire of health and social-care occupations [39]. Content evaluation of the questionnaire involved many iterations, until consensus was achieved on the wording and format of each item. Pilot testing was carried out before the beginning of the survey with two external testers who were not involved in the project's development. This questionnaire was developed specifically for this study and has not been previously published; an English-language version of its structure is provided as Additional file 2.

Data were collected through a self-administered online questionnaire built and hosted on a secure REDCap® (REDCap project, Nashville, United States) platform (redcap.chu-poitiers.fr). The questionnaire operated at two levels: the institution (one questionnaire per hospital grouping) and the individual coordinator, with a dedicated record completed for each coordinator identified within an institution.

The institution-level part recorded awareness of the CNCPR, the type of institution, the existence of a dedicated institutional structure for AHP&N research, whether AHP&N research was inscribed in the institution's strategic plan, the number of PRC, the hierarchical reporting line of the post, the total funded time allocated to coordination (as a percentage of full-time equivalent, % FTE), and the missions performed by the coordinator, selected from a predefined list of thirteen items. These items summarise the national job description [39]. The individual-level part, repeated for each coordinator includes sex, age, professional qualifications, highest university degree, master's speciality, complementary activities, and indicators of scientific activity such as indexed and non-indexed publications, previous and current experience as a principal investigator, and affiliation to a research laboratory.

Data collection

Data proceeded in two sequential phases through the professional research networks that structure each category of institution. In the first phase, university hospitals were surveyed between 3 July and 7 October 2024 through the directors of AHP&N acting as CNCPR referents, with an initial mailing followed by two reminders relayed through the CNCPR network. In the second phase, from 4 April 2025, the remaining institutions were surveyed through their respective networks: comprehensive cancer centres through their dedicated AHP&N research network, general hospitals through the RICH network supplemented by individual invitations, and non-profit private institutions through the research network

of their federation (FEHAP). Military hospitals were contacted at the outset of the study, but did not respond as their organisational structures did not include paramedical research coordinators. A reminder was issued within each distribution network.

Data analysis

The main analyses were descriptive. Categorical variables are summarised as counts and proportions and continuous variables as means with standard deviations (SD). Where a continuous variable's distribution was markedly non-normal, results are instead reported as median with interquartile range (IQR). Subgroup comparisons were conducted between university hospitals, general hospitals, comprehensive cancer centres, and non-profit private institutions. Unsolicited organisations, such as psychiatric hospitals and private, for-profit institutions, responded to the questionnaire via a snowball sampling method. The data was examined in the aggregate to ensure representativeness. Despite their low frequency, they were not considered in the institute's comparative study.

An exploratory univariate analysis was conducted to examine differences between groups. For binary variables, Fisher's exact test was used, while a Kruskal-Wallis test was employed for continuous variables. The institution served as the unit of analysis ($n = 117$ institutions categorised into one of four main institutional types). Denominators differed by level of analysis: institution-level proportions were computed on the 122 responding institutions for overall figures and on the 117 institutions of the four main types for between-type comparisons (the 4 psychiatric hospitals and 1 for-profit private institution being counted in overall totals only), whereas individual-level indicators were computed on the 101 identified coordinators, with per-variable denominators reflecting missing data (Fig. 1; seen reported in each table). Statistical significance was established at $p\text{-value} \leq 0.05$, without any imputation of missing data. Analyses were therefore performed on available cases, with the denominator reported for each variable; missing data were limited at the coordinator level (median 3% per variable; below 6% for every indicator except age, 15%, and clinical profession, 11%) and absent at the institution level. In this descriptive study, no data were adjusted [41]. All statistical analyses were performed using R v4.5.3 (R Core Team, 2026) within the RStudio environment v2026.01.2 (Posit Team, 2026).

Ethical considerations

This survey collected professional information from healthcare institutions and from consenting coordinators, without any patient data. Full details of ethical approval and participant consent are provided under Declarations, below.

Results

Sample characteristics

Of 213 invited institutions, 122 responded (57.3% response rate). Responding institutions included 37 university hospitals (CHU), 34 general hospitals (CH), 17 comprehensive cancer centres (CLCC) and 29

non-profit private institutions (ESPIC) – the four main types compared in subgroup analyses (n = 117) – together with 4 psychiatric hospitals and 1 for-profit private institution counted in overall totals only (n = 122; Fig. 1). Participation by healthcare institutions is exhaustive for CHU and CLCC, and cover the majority of general hospitals (CH) and private non-profit hospitals (ESPIC).

Awareness of a structuring network such as the CNCPR stood at 64.8% of the 122 responding institutions overall but varied markedly by type, from 24.1% of non-profit private institutions to 97.3% of university hospitals (Fig. 2). A dedicated institutional structure for AHP&N research was reported by 73.0% of institutions overall, with a clear gradient from non-profit private institutions (41.4%) and general hospitals (67.6%) through cancer centres (82.4%) to university hospitals (94.6%).

Paramedical research coordinator's workforce

One hundred and one paramedical research coordinators were identified in 122 institutions. Eighty-two institutions (67.2%) employed at least one coordinator, with a mean of 0.8 coordinators per institution (SD 0.7). The total funded time devoted to coordination had a median of 20.0% (IQR 0.0–57.5) of a full-time equivalent, and 73 institutions (59.8%) allocated any funded time to the role. These workforce indicators differed substantially between institution types: university hospitals had 1.1 mean PRC per institution (SD 0.8), 83.8% employed at least one coordinator, and the median funded time reached 50.0% (IQR 10.0–90.0), whereas general hospitals' mean PRC was 0.7 (SD 0.6), 64.7% employed at least one, and funded time had a median of only 0.5% (IQR 0.0–37.5) (Fig. 2).

Paramedical research coordinator's missions

Among 82 institutions with an identified coordinator, the missions most frequently performed were strategic and developmental rather than operational. Overall, the most common missions were supporting AHP&N teams in designing and conducting research projects (84.1%), collaborating with institutional research-support structures (81.7%), developing a research culture through critical-appraisal workshops and scientific events (79.3%), contributing to internal and external communication on AHP&N research (79.3%), identifying and networking professional expertise (72.0%) and disseminating research results through publication (72.0%); academic partnerships (62.2%), staff training (61.0%) and the coordinator's own research and teaching (58.5%) were also frequent, whereas innovation-related missions communication on innovation (42.7%) and collaboration with innovation support structures (34.1%) were less common. The Fig. 3 illustrates the job description of a paramedical research coordinator across these 77 institutions.

Paramedical research coordinator's profiles

Among the 101 PCRs, 74.3% are female, with an average age of 47.6 years, and there is no noticeable variation in age distribution across institutional types. PRC were mostly nurses, although the disciplinary mix differed between settings (Fig. 4). On the one hand, in the analysis by type of establishment, we have 85 PCR records; nursing science family represented 82.9% and 86.4% in university and general hospitals; on the other hand, 30.8% and 46.7% respectively in ESPIC and CLCC. The proportion of non-AHP&N

professionals ranged from 2.9% to 6.7%, except in ESPIC where it increased to 38.5%. Almost one PRC in two (42.6%) was a health manager, particularly in university hospitals (56.4%).

Academic attainment was high and differed by setting. Out of 95 PCR's that responded, 80.0% met the qualification level expected by the national job description (master's degree), and 45.3% were PhD holders or PhD students. University hospital coordinators were the most qualified (92.1% at the expected level and 63.2% engaged in doctoral program or more), whereas general hospitals and cancer centres reported lower figures (61.9% and 66.7% at the expected level, and 33.3% were PhD holders or PhD students in each) (Fig. 5).

PRC reported substantial scientific activity. Overall, 64.3% (63/98) had produced non-indexed publications and 58.3% (56/96) indexed publications, 51.5% (51/99) had previous experience as a principal investigator, and 48.0% (48/100) were currently principal investigator of an ongoing project, with no significant difference between institution types. However, 55.3% (21/38) were affiliated to a research laboratory in university hospitals, versus 25% (15/56) for other institution types (Table 1).

Table 1
Academic profile and scientific activity of AHP&N research coordinators (n = 101)

Characteristic	Overall (%)	Missing (n)	CHU (%)	CH (%)	CLCC (%)	ESPIC (%)	p-value
Expected academic level (> = Master's degree), % (n)	80.0 (76/95)	6	92.1 (35/38)	61.9 (13/21)	66.7 (10/15)	86.7 (13/15)	0.017
Doctoral engagement (ongoing or completed), % (n)	45.3 (43/95)	6	63.2 (24/38)	33.3 (7/21)	33.3 (5/15)	40.0 (6/15)	0.076
Indexed publication(s), % (n)	58.3 (56/96)	5	68.6 (24/35)	45.8 (11/24)	58.8 (10/17)	64.3 (9/14)	0.370
Non-indexed publication(s), % (n)	64.3 (63/98)	3	78.4 (29/37)	50.0 (12/24)	52.9 (9/17)	71.4 (10/14)	0.083
Prior experience as principal investigator, % (n)	51.5 (51/99)	2	59.5 (22/37)	41.7 (10/24)	35.3 (6/17)	66.7 (10/15)	0.166
Currently active as principal investigator, % (n)	48.0 (48/100)	1	52.6 (20/38)	37.5 (9/24)	41.2 (7/17)	60.0 (9/15)	0.475
Affiliated with a research laboratory, % (n)	35.0 (35/100)	1	55.3 (21/38)	29.2 (7/24)	17.6 (3/17)	26.7 (4/15)	0.027
<i>AHP&N: Allied Health Professionals & Nurses. PI: Principal Investigator.</i>							
<i>Overall n = 101 coordinators; "Missing (n)" = number with no response to this item (Overall denominator = 101 - Missing).</i>							
<i>p-values: Fisher's exact test comparing the 4 institution types (CHU, CH, CLCC, ESPIC; denominator n = 95); computed on each variable's own available cases (see the denominator reported in the Overall column for each row).</i>							

Discussion

This national survey provides the first nearly comprehensive cartography of paramedical research coordinators (PRC) representing the majority across predominant categories of French healthcare institution. One hundred and one coordinators were identified, present in two-thirds of responding institutions (n = 122), confirming that the profession now extends well beyond its historical university-hospital base. Three findings emerge consistently: funded time is heavily concentrated in university hospitals, while implementation is substantially uneven; the missions performed are overwhelmingly

strategic and developmental rather than operational; and the workforce is highly qualified, with a substantial proportion PhD holders or PhD students.

The most striking feature of this cartography is the gradient of maturity that separates the four institutional profiles. University hospitals have a fully-fledged research mission and represent the reference model: coordinators are employed more frequently, allocated with a median funded time two orders of magnitude higher than in general hospitals (50.0% vs 0.5% FTE). They are more academically advanced and more productively embedded in research structures than their counterparts in general hospitals. At the other end of the spectrum, general hospitals constitute the sector in which the role is most fragile. Here, the gap between policy intent and institutional reality is widest. This may indicate a more recent structural change or a structural deficit. Comprehensive cancer centres and non-profit private institutions occupy distinctive intermediate positions. Cancer-centre coordinators present the most professionally diverse profile of any, and show an orientation towards communication and dissemination. The apparent paradox is that cancer centre coordinators have the lowest laboratory affiliation despite high publication activity, and suggests that AHP&N research's motivations and ideas come from the ground clinical practice rather than from laboratory expertise. Non-profit private institutions show the lowest coordinator implementation rate overall, yet the minority of institutions that have implemented the role have done so through a distinctive governance structure: coordinators in this sector report to a research and innovation directorate far more often than to a director of nursing, which is the norm in all other sectors. This suggests that these institutions embed the role within a broader research-governance framework, reflected in the high proportion of non-AHP&N coordinator profiles.

This implementation gradient resonates with international surveys of research capacity and culture, which consistently report substantial heterogeneity across institutional types: university-affiliated and larger organisations tend to be more research-active, better resourced and more supportive of staff research engagement, while smaller and non-university settings struggle with protected time, mentorship and infrastructure [6, 7, 9]. The regional hospital grouping (GHT) framework, which links general hospitals into territorial networks, represents a natural lever for mutualising scarce coordination resources across the health territory and for extending the experience of university hospitals to emerging settings. The regional hospital grouping framework already provides an organisational structure through which general hospitals can pool resources; formalising coordination as a shared territorial function within the GHT model would align structural policy with the coordinator's explicit mandate to structure research across hospital groupings.

Beyond the quantitative gradient, the qualitative character of the PRC role is its most defining feature in international perspective. The missions prioritised by coordinators — developing a research culture, training staff, forging academic partnerships, building networks of expertise — are largely absent from the task profiles of clinical research nurses and coordinators described in the Italian, British and American literature, where the dominant activities are participant recruitment, informed consent, data management, adverse-event reporting, and the operational delivery of individual trials [17, 20, 24]. This inversion is not incidental: it reflects a deliberate institutional design, a nationally defined occupation

whose mission is to build research capacity at the level of the workforce and the institution, not to deliver any particular study. This places the French PRC in direct functional alignment with the research-capacity-building literature, which has catalogued numerous frameworks for embedding a research culture in allied health and nursing practice. One review alone identified sixteen distinct frameworks across four countries, none of which constitutes a formally defined profession [28]. Where comparable health systems pursue these capacity-building functions through dedicated facilitator posts, joint clinical-academic appointments, or time-limited embedded-researcher pilots such as the NMAHP-ER model [32]; France has consolidated them into a single occupation inscribed in the national health profession repertoire. The institutional gradient described above modulates how fully this strategic mandate is expressed: in university hospitals, the role is being consolidated comprehensively; in general hospitals, it is still being constructed.

The academic profile of coordinators reflects and reinforces this trend. Across all types of institutions, four out of five coordinators hold a master's degree or higher, the level expected nationally. In most international programs, this qualification remains a goal rather than a requirement. University-hospital coordinators were the most academically advanced, with doctoral engagement nearly twice as frequent as in general hospitals or cancer centres. The academic ambition embedded in the national job description is progressively taking hold and forms part of the ongoing trend towards the academisation of the AHP&N professions currently underway in France. Naturally, scientific productivity followed the same gradient. Laboratory affiliation was approximately three times more frequent in university hospitals than in cancer centres, mirroring the difference in doctoral engagement. The high publication rate and reported principal investigator experience suggest that dedicated research positions and mentoring accelerate the research activity and output of AHP&N [30, 35, 42]. The observation that nurse managers are proportionally more prevalent among coordinators in university hospitals suggests that the role draws on a management culture as well as a scientific one, and that career trajectories towards coordination may differ between professional streams [36, 37].

This survey has several strengths. It is the first to cover predominant proportion categories of French healthcare institution, achieving exhaustive coverage of university hospitals and comprehensive cancer centres and substantial representation of general hospitals and non-profit private institutions. The dual-level design, collecting data at both the institution and the individual coordinator, enables a richer characterisation of the role than would be possible from institutional records alone. Nevertheless, several limitations should be noted. Institutional and individual data were self-reported, introducing the possibility of reporting bias, particularly for variables such as missions and scientific activity. Confounding factors may be present due to the lack of adjustment. In a descriptive study, causality cannot be inferred. The network-based recruitment strategy, while effective in achieving complete response within each sector's network, may have favoured institutions already engaged in AHP&N research, suggesting that implementation may be even more uneven in the national population than these data indicate. The pragmatic questionnaire allows adaptation to the changing nature of this recent structuring but has not been validated against internationally recognized research capacity

measurement instruments. Finally, the number of non-profit private institutions with identified coordinators was small, and comparisons within this group should be interpreted with caution.

Future surveys should extend psychiatric hospitals and private for-profit institutions and should incorporate validated research-capacity-and-culture instruments to enable meaningful international comparison. Longitudinal and mixed-methods studies are needed to evaluate how far the PRC role translates into sustained changes in institutional research culture, AHP&N scientific production and to monitor the ongoing development and implementation of this recently established profession. The French model, a nationally defined profession with a recommended doctoral trajectory, offers a comparator for international research examining how different health systems build research capacity in their non-medical workforce.

Conclusions

This first national cartography identified 101 paramedical research coordinators across two thirds of responding French healthcare institutions and characterised a recent profession whose missions are strategic and developmental rather than operational. Through this role, France has institutionalised nationally the research-capacity-building function that comparable health systems pursue through ad hoc frameworks, dedicated posts and time-limited pilots. The workforce is highly and increasingly qualified but unevenly resourced, with a clear gradient from university hospitals through comprehensive cancer centres to general hospitals, and a distinctive profile in the non-profit private sector. An assessment of the impact of these PRCs on scientific production is necessary. These data can be used to inform national policies on structuring allied health and nursing research and for comparing international models of research capacity-building in non-medical workforces.

Abbreviations

AHP&N

Allied Health Professional and nurses

CESRDS

Comité Éthique et Scientifique des Recherches sur Données de Santé

CH

General hospital (centre hospitalier)

CHU

University hospital (centre hospitalier universitaire)

CLCC

Comprehensive cancer centre (centre de lutte contre le cancer)

CNCPR

National Commission of Paramedical Research Coordinators

ESPIC

Non-profit private health institution (établissement de santé privé d'intérêt collectif)

FTE

Full-time equivalent

GHT

Territorial Hospital Group

HIA

Military hospital (hôpital d'instruction des armées)

IQR

Interquartile range

NMAHP-ER

Nurse, Midwife and Allied Health Professional Embedded Researcher

PhD

Doctor of Philosophy

PRC

Paramedical research coordinator

SD

Standard deviation

STROBE

Strengthening the Reporting of Observational Studies in Epidemiology

Declarations

Ethics approval and consent to participate

This survey collected professional information from healthcare institutions and from consenting coordinators; no patient data were collected. The clinical trial number is not applicable. All procedures were conducted in accordance with the Declaration of Helsinki. The study was approved by the local ethics and research committee, the Comité Éthique et Scientifique des Recherches sur Données de Santé (CESRDS) of the Centre Hospitalier Universitaire de Poitiers (approval no. 2026-07-08, 25 August 2026). Informed consent to participate was obtained from all participants; completion and submission of the online questionnaire was considered to constitute consent to participate.

Consent for publication

Not applicable.

Availability of data and materials

The aggregated institution-level dataset and the R analysis code supporting the findings of this study are openly available in Zenodo at <https://doi.org/10.5281/zenodo.21268326>. Individual-level data are not publicly available, owing to the risk of re-identifying participating institutions or coordinators given the small size of some subgroups, but are available from the corresponding author on reasonable request, subject to institutional agreement.

Additional file 1: STROBE checklist for cross-sectional studies.

Additional file 2: Survey questionnaire (institution-level and individual-level instruments).

Competing interests

The authors declare no competing interests.

Funding

This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

Authors' contributions

Conceptualization, Methodology : GD, VB, BC

Formal analysis, Investigation, Data curation, Writing – original draft, Project administration : GD.

Writing – review & editing : GD, PHH, HD, VB, BC.

Supervision : BC.

All authors read and approved the final manuscript.

Acknowledgements

The authors thank Laurence Laignel (CHU Angers) and Thierry Brugeat (CHU Reims) for their support of the project and their role in disseminating the survey. Thanks to Véronique CABARET for her insightful perspective and her help in this project.

Authors' information

All the authors are members of the French CNCPR (Comission nationale des coordonateurs paramédicaux de la recherche)

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Figures

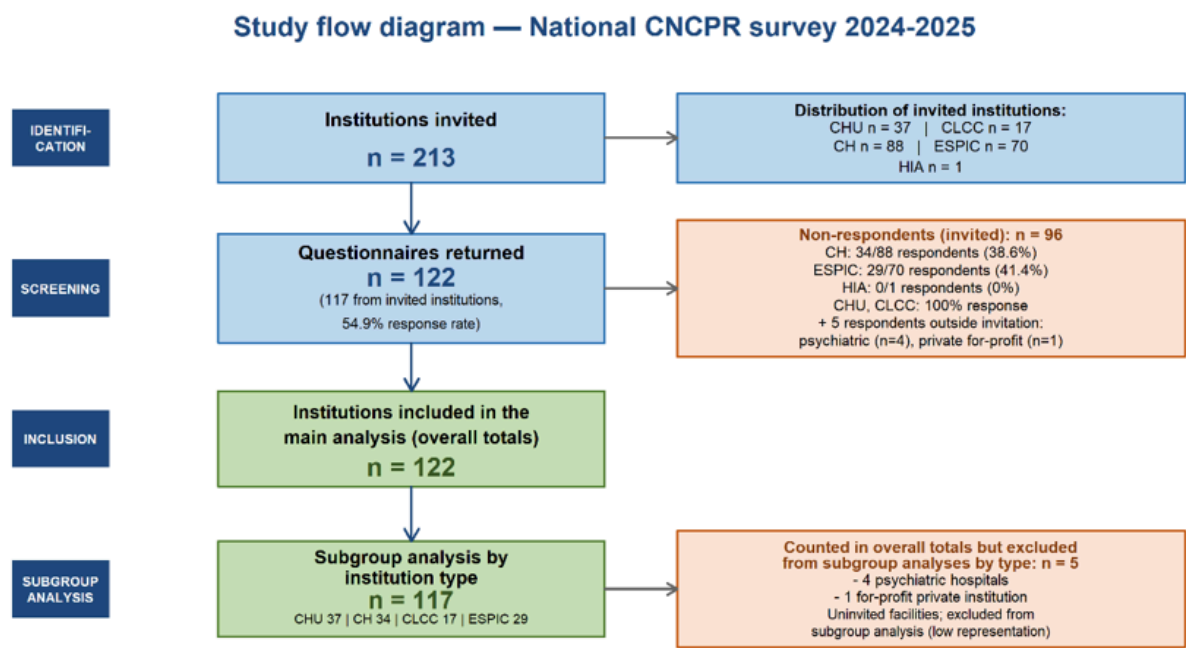


Figure 1

Study flow diagram of institution invitation, response and inclusion in the overall and subgroup analyses.

Gradient of key indicators by institution type

	CHU (n=37)	CH (n=34)	CLCC (n=17)	ESPIC (n=29)	Total (n=117)	p-value *
Awareness of the CNCPR	97% (36/37)	56% (19/34)	76% (13/17)	24% (7/29)	64% (75/117)	<0.001
Dedicated institutional research structure	95% (35/37)	68% (23/34)	82% (14/17)	41% (12/29)	72% (84/117)	<0.001
AHP&N research in the institutional strategic plan	100% (37/37)	88% (30/34)	94% (16/17)	76% (22/29)	90% (105/117)	0.007
Institutions that identified ≥1 AHP&N research coordinator	84% (31/37)	65% (22/34)	82% (14/17)	34% (10/29)	66% (77/117)	<0.001
Institutions allocating funded time	78% (29/37)	50% (17/34)	65% (11/17)	38% (11/29)	58% (68/117)	0.006
Mean number of AHP&N research coordinators per institution	1.1	0.7	1.0	0.5	0.8	0.003
Median funded time allocated per institution (full-time equivalent)	50.0%	0.5%	10.0%	0.0%	10.0%	0.003

Colour scale normalised within each row across the four institution types (darker = higher);
the Total column is shown for reference and excluded from the colour scale.

* Fisher's exact test for proportions, Kruskal-Wallis test for medians (n = 117: CHU, CH, CLCC, ESPIC).

Figure 2

Institutional characteristics and PRC workforce indicators by institution type.

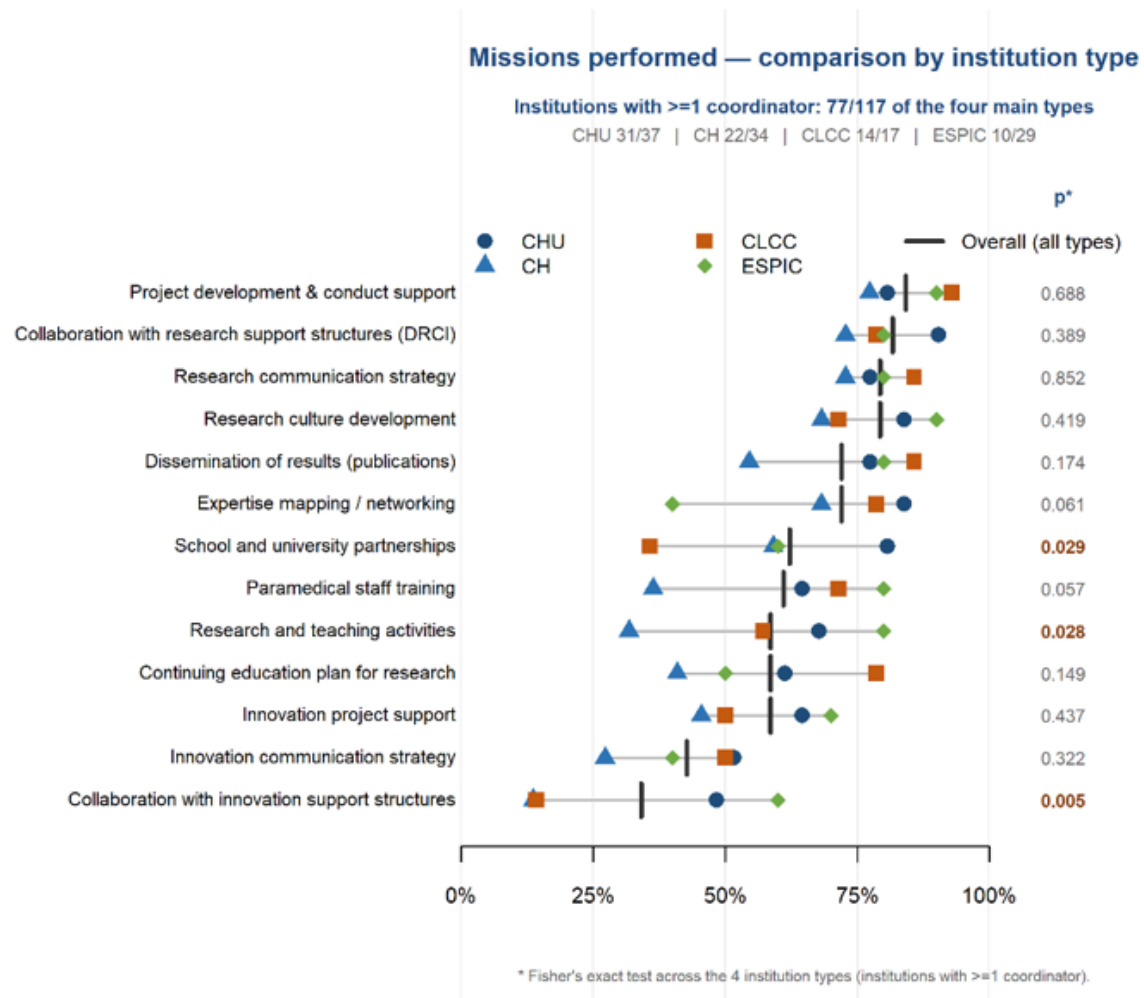


Figure 3

Paramedical research coordinator mission's description per institution type.

Professional profile of AHP&N research coordinators

n = 101 coordinators (90 with recorded profession) — each square = 1%

- Registered Nurse (IDE) — 58.9% (n=53) ■ Occupational Therapist — 3.3% (n=3)
- Nurse Anaesthetist (IADE) — 8.9% (n=8) ■ Speech & Language Therapist — 1.1% (n=1)
- Paediatric Nurse (IPDE) — 2.2% (n=2) ■ Radiographer (MERM) — 4.4% (n=4)
- Adv. Practice Nurse (IPA) — 1.1% (n=1) ■ Non-AHP&N — 8.9% (n=8)
- Physiotherapist (MK) — 11.1% (n=10)

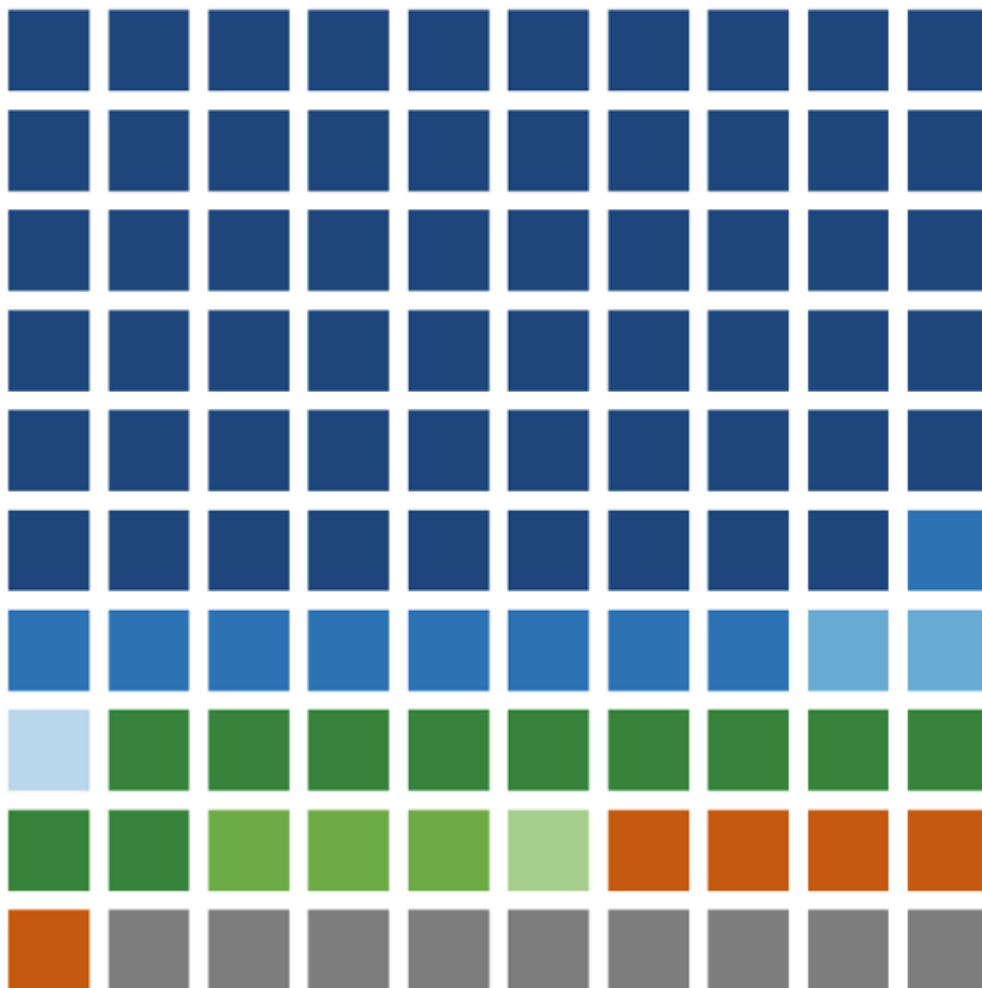


Figure 4

Initial professional profile of paramedical research coordinator.

Education level of AHP&N coordinators by institution type (n=89)

<- below expected level | expected level (>= Master's degree) and above ->

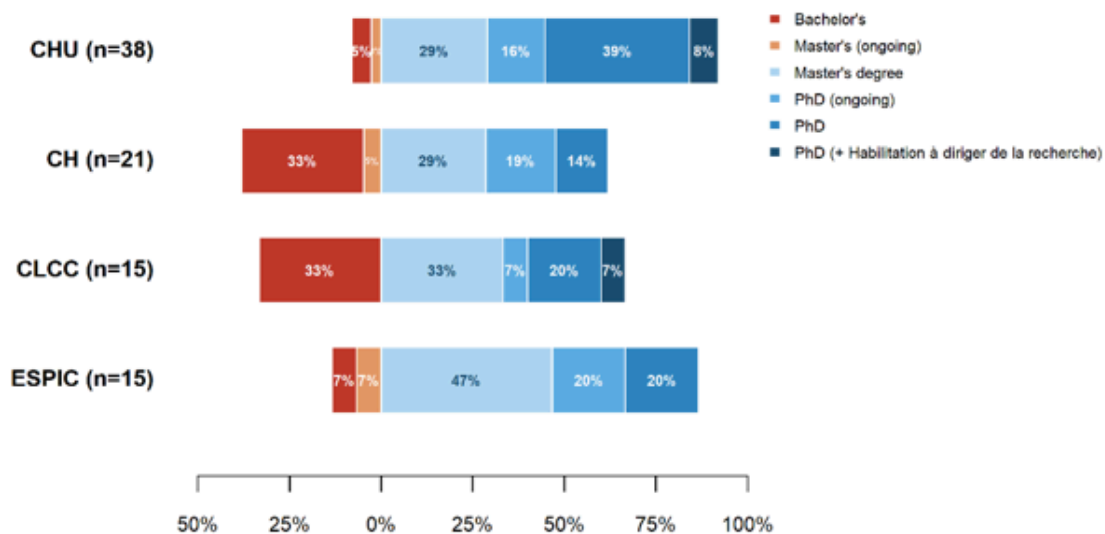


Figure 5

Educational levels of paramedical research coordinators by institution type.

Supplementary Files

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