A renewed urgency has emerged in the qualitative health research community concerning the utility of qualitative research. This urgency is the result of several converging trends in health care research, including the elevation of practical over basic knowledge, proliferation of qualitative health research studies, and the rise of evidence-based practice as a paradigm and methodology for health care. Diverse conceptualizations of use and users exist, and these have different implications for understanding, demonstrating, and enhancing the utility of qualitative research findings. Issues affecting the utilization of these findings include the varied ways in which they are conceived, presented, synthesized, signified, and translated, and the complex repertoire of skills required to activate the knowledge transformation cycle in qualitative health research fully.

**Keywords:** knowledge transformation; knowledge dissemination; qualitative research; research utilization

A renewed urgency has emerged in the qualitative health research community concerning the utility of qualitative research. Now that so many qualitative studies have been conducted in the health care arena, researchers, front-line practitioners, policy makers, and other stakeholders in the health care community are increasingly exhorted to use the findings of these studies to improve the public health and to reduce disparities in health care delivery. Qualitative health researchers are pressed to produce findings that are immediately or potentially relevant for practice and to present findings in ways that enable their use by others. Front-line practitioners are, in turn, pressed to translate these findings for practice, put them to use, and evaluate how useful they actually are in effecting desired change.

The current interest in the utility of qualitative research findings raises important questions that go to the heart of the qualitative research enterprise, including (a) What does use mean in the context of qualitative research? (b) Who are the users of qualitative research findings, and what are their obligations? (c) For what can and should qualitative research findings be used? (d) Is the evidence-based practice imperative to exploit research findings compatible with the non-exploitative
imperatives of qualitative research? and (e) Of what use—and to whom—is all the talk about use in qualitative research? I consider these questions in this article.

SITUATING THE UTILITY DISCOURSE

Questions about the utility of qualitative research were raised soon after qualitative health research emerged in the 1980s as a distinctive domain and mode of inquiry. These questions turned on the premise that qualitative research was largely useless because it was not objective and could not yield generalizable findings (Sandelowski, 1997). Although these charges, unfortunately, continue to be made by critics with an impoverished view of objectivity, generalization, and qualitative research, the current urgency about the utility of qualitative research findings is the result of several converging trends in health care research that have served both to extend and to offset this critique. These trends include the elevation of practical over basic knowledge as the highest form of knowledge and the raison d’être of inquiry, the proliferation of qualitative health research studies, and the rise of evidence-based practice as a paradigm and methodology for health care. These events have, in turn, contributed to the growing interest in incorporating qualitative health research findings into evidence-based practice and in instilling an evidence-based practice mindset into researchers conducting qualitative health research.

The New Primacy of the Practical

A resurgence of interest in the “actionability” of research findings (Greene, 1994, p. 10) has led to a new “primacy of the practical” (Heron, 1996). Largely inspired by criticism of Western science (Harman, 1996) and by activism to resolve persistent social problems and health disparities engendered by differences in gender, race/ethnicity, and class (Greene, 1994), the emphasis on actionability has moved practical knowledge from its lowly position in, to the top of the hierarchy of knowledge. Once viewed as contaminated by discussions of use and usefulness, practical knowledge is now increasingly privileged over pure knowledge by virtue of its focus on use (Dickoff & James, 1992). Even scholars in such traditionally nonpractice disciplines as anthropology are increasingly depicting these disciplines as “interventions” in scientific, technological, and medical practices (Downey & Dumit, 1997). Practical interpretations of methods, such as applied ethnography, have emerged in response to the new call to be useful (Chambers, 2000): to produce knowledge that discernibly matters to someone for something.

Moreover, as fully embodied in participatory action research, knowing can be consummated only in use (Heron, 1996). Indeed, practice disciplines, such as nursing, which are concerned with the doable and makeable (Johnson, 1991), are not mere applications of knowledge borrowed from disciplines trading in basic or pure knowledge but, rather, sites where the utility of any knowledge can be put to the ultimate test. And this testing function of the practice disciplines requires, in turn, knowledge of how to put knowledge to the test, that is, in the language of research utilization, how to transform it for use, implement it, and evaluate its implementation against specified outcomes. Knowledge in the practice disciplines entails not just knowing that but also knowing how, when, why, whether, and for whom. As
Kim (1994) proposed for nursing, practice requires theories of intervention, approach, deliberation, and enactment.

Practice entails not just theories of the etiology, course, diagnosis, and treatment of health problems but also theories of diagnosis and treatment themselves and of how to put this knowledge to use. In the practice disciplines, the pragmatic and ethical validity (Kvale, 1995; Maxwell, 1992) of knowledge in particular situations is at least as relevant as, if not more relevant than, the internal and external validity of the research procedures generating that knowledge and its putative generalizability across situations. Research findings are expected to be accessible, relevant, significant, and credible, and to hold the prospect of change to those who have a stake in them (Chambers, 2000). Practitioners and patients are interested in the questions (a) Does it work? and (b) If it works, should it be used?

The Proliferation of Qualitative Health Research

Coinciding with the new primacy of the practical is the rising popularity of qualitative health research, which encompasses a diverse collection of approaches to inquiry intended to generate knowledge actually grounded in human experience. Thousands of reports of qualitative health studies are now available concerning a range of topics of importance to researchers and practitioners in nursing, medicine, public health, and other consumers of health research. These topics include (a) the personal and cultural constructions of disease, prevention, treatment, and risk; (b) living with and managing the physical, psychological, and social effects of an array of diseases and their treatments; (c) decision making around and experiences with beginning- and end-of-life, and assistive and life-extending, technological interventions; and (d) contextual (e.g., historical, cultural, discursive) factors favoring and militating against access to quality care, the promotion of good health, the prevention of disease, and the reduction in health disparities. These reports appear not only in exclusively qualitative research publication venues but also in venues that once rejected qualitative studies as unscientific.

Supporting the exponential growth of reports of qualitative studies is the dramatic increase in qualitative methods literature, institutes, conferences, academic courses and curricula, and businesses specifically devoted to the dissemination and sale of qualitative research methods, findings, and expertise. Qualitative research is now a growth industry and a research methods utilization success story, the very success of which has engendered a renewed imperative to make better use of all of the research findings produced from qualitative research.

The Rise of Evidence-Based Practice

Also driving the new utility discourse around qualitative research is the emergence of another “growth industry” in health care (Estabrooks, 1999b, p. 274): evidence-based practice. A result of the convergence of several sociohistorical trends in Western countries—including the rise of the consumer and risk societies, a renewed turn to managerialism and standardization in health care, a continued drive to maintain professional jurisdictions, and the explosion of health-related information (Timmermans & Berg, 2003; Traynor, 2002; Trinder & Reynolds, 2000)—evidence-based practice has become one of the newest mantras in health care. The urgency of
the turn to evidence-based practice is evident in the burgeoning literature on the subject; the rise in several Western countries of centers and institutes of evidence-based practice; the establishment of new journals and special features in existing journals devoted to evidence-based practice; local, regional, national, and international conferences on evidence-based practice; and the increasing availability of databases housing evidence syntheses and evidence-based guidelines for practice. The Cochrane Collaboration and Library, arguably the central icon of the evidence-based practice movement, is now a global enterprise said to rival in importance the Human Genome Project (Naylor, 1995).

Although variously conceived across the disciplines, evidence-based practice generally connotes the thoughtful, explicit, conscientious, and judicious use of the best evidence available to develop the best practices for individual patients (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996; Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000; Zarkovich & Upshur, 2002). Intended to bridge the wide gap that still exists between research and practice, evidence-based practice is ideally depicted as a dynamic methodology that includes the cyclical (a) systematic retrieval of all evidence available concerning the treatment of a clearly specified clinical problem; (b) ranking of evidence in an evidence hierarchy; (c) evaluation of evidence using quality criteria; (d) synthesis of evidence using clearly specified research techniques; (e) translation of evidence syntheses into practice guidelines; (f) implementation of these guidelines in practice settings; (g) evaluation of this implementation against clearly specified outcomes; and (h) the subsequent refinement of practice guidelines derived from this evaluation (Stevens, 2002). Champions of evidence-based practice contend that its adoption in health care will result in more informed use of evidence, more effective treatments, more efficient use of scarce resources, transparency and accountability in clinical decision making, and the empowerment of both practitioners and patients (Trinder, 2000).

But critics (i.e., both critical inquirers and frank opponents) of evidence-based practice view it as itself problematic and even as a potentially retrograde step (Clarke, 1999) in the advancement of the public health and for the establishment of professional identity and autonomy (Gupta, 2003; Timmermans & Berg, 2003; Trinder & Reynolds, 2000; Walker, 2003). Focusing on the casuistry in clinical medicine and nursing, whereby idiographic knowledge (or knowledge of the particular) prevails over nomothetic knowledge (or knowledge of the general) (Hunter, 1989), and on the importance of the practical knowledge embedded in clinical expertise (Benner, 1984), critics have decried the scientific aesthetic of averages and dispassionate objectivity promoted by evidence-based practice (Colyer & Kamath, 1999; White, 1997). For these critics, evidence-based practice appears to devalue the personal knowledge (Benner, 1984) and knowledge of persons (Liaschenko & Fisher, 1999) critical to excellent patient care that is drawn from and produced in irreplaceable interactions between practitioners and their patients. Although proponents of evidence-based practice note the importance of including patients’ preferences and values in treatment decisions, critics argue that these have yet to be discernibly included in the evidence-based practice process.

Advocates of qualitative research are especially incensed by the use of hierarchies of evidence that assume the randomized clinical trial as the gold standard in inquiry, which thereby devalues or frankly excludes qualitative research (Evans, 2003; Mitchell, 1999). Instead of ensuring best practices that truly reflect the judicious consideration of all of the evidence available, the evidence-based practice
paradigm—as actually put into practice—reinforces well-worn prejudices against certain forms and sources of evidence (McKenna, Cutcliffe, & McKenna, 1999). Moreover, as critics of evidence-based practice contend, prevailing evidence hierarchies tend to reify the very idea of evidence as their proponents fail to acknowledge that what is deemed to be evidence is, in the end, always theoretically informed, historically situated, socially constructed, and even politically motivated (Eisner, 1991; Fawcett, Watson, Neuman, Walker, & Fitzpatrick, 2001; Forbes et al., 1999; Hampton, 2002; Madjar & Walton, 2001; Upshur, 2001a, 2001b).

**Qualitative Health Research and Evidence-Based Practice**

The sheer proliferation of qualitative health research has made qualitative findings difficult to dismiss and has generated urgent calls to incorporate them into the evidence-based practice process. Scholars across the health-related disciplines have increasingly recognized the error in excluding qualitative research from systematic reviews of research and in adhering to biased evidence hierarchies and quality criteria that automatically exclude qualitative studies from any consideration at all, let alone consideration as best evidence (Barbour, 2000; Dixon-Woods, Fitzpatrick, & Roberts, 2001; Giacomini, 2001; Green & Britten, 1998; Greenhalgh, 2002; Popay & Williams, 1998).

One manifestation of this new demand to incorporate qualitative research into the evidence-based practice process is the recent upsurge of interest in conducting systematic reviews and integrations of qualitative studies. This new turn to what is variously referred to as qualitative metasynthesis, qualitative meta-analysis, qualitative meta-data analysis, and meta-ethnography is evident in the burgeoning methodological literature on the subject (e.g., Campbell et al., 2003; Finfgeld, 2003; Jensen & Allen, 1996; Noblit & Hare, 1988; Paterson, Thorne, Canam, & Jillings, 2001; Sandelowski & Barroso, 2003a, 2003b, 2003c), in the growing number of reports of studies designated as qualitative metasyntheses or the like (e.g., Barroso & Powell-Cope, 2000; Kearney, 2001a; Thorne & Paterson, 1998), and in the formation of the Cochrane Qualitative Methods Group (http://mysite.freeserve.com/Cochrane_Qual_Method/index.htm). Although they differ in their views of what qualitative metasynthesis is as method and how metasynthesis studies should be conducted, scholars engaged in qualitative metasynthesis agree that it represents an advancement in making qualitative research findings more useful and in moving them to the center of the evidence-based practice process.

The flip side to the call to incorporate qualitative research into evidence-based practice is to instill an evidence-based practice mindset into qualitative research. And it is this very appeal that is the most immediate precursor to the current utility discourse around qualitative research and, therefore, to this article. Having briefly reviewed the complex origins of the new discourse on use in qualitative research, I turn now to the varied uses of *use* at its center.

**USING USE**

Whether something is deemed to be usable or useful depends on what *usable* and *useful* are deemed to be. As Baker, Norton, Young, and Ward (1998) proposed, use-
fulness is conceived and valued differently across research traditions. For example, in what is generally referred to as “quantitative research,” usefulness derives from the generalizability of findings from study samples to populations not studied but deemed to be like those samples. In grounded theory inquiry, usefulness derives from the transferability of theories to situations beyond the ones from which they were generated. Indeed, the key objective of grounded theory is the development of successively more abstract and formal theories that are both empirically faithful to the cases from which they were developed and enduring beyond the single case. These formal theories have the complexity to encompass increasingly more diverse domains of research and practice (Kearney, 1998). In contrast to the formal generalization that is foundational to utility in quantitative inquiry, analytic generalization and theoretical transferability are the bases for utility in grounded theory research.

In contrast to both of these traditions is Heideggerian hermeneutics research, in which understanding is conceived to be fundamentally about applicability. Whereas use is integral to understanding in Heideggerian hermeneutics, it is a necessary prelude to understanding in participatory action research in which knowledge is produced only in use. The sine qua non of participatory action research is action as the key criteria by which studies in this tradition are evaluated are the extent to which an identified problem was resolved and, when conducted in a more critical vein, the extent to which oppressive structures were undermined and liberatory/emancipatory goals were achieved.

RESEARCH UTILIZATION

Estabrooks’s (1999a, 2001) classification of research utilization as instrumental, conceptual, and symbolic is a useful frame of reference to examine the various meanings of use and their implications for understanding, demonstrating, and enhancing utility in qualitative research. Instrumental utilization is the concrete application to practice of research findings that have been translated into material forms, such as clinical guidelines, care standards, appraisal tools, pathways, intervention protocols, or algorithms. These forms are then put into practice and evaluated with specific groups of patients in specific practice settings to achieve specific outcomes. In instrumental utilization, the utilization of findings is discernible to others and to the users themselves. By virtue of its emphasis on the visible, tangible, material, and measurable, instrumental utilization is the ultimate goal of empirical/analytical research (which may include qualitative and quantitative inquiry) and of the evidence-based practice paradigm that favors this form of research.

Symbolic utilization is less visible and concrete, as it entails no change per se but, rather, the use of research findings as a persuasive or political tool to legitimate a position or practice. Although its actionability resides largely in talk, symbolic utilization may be a precursor to instrumental utilization as a change in practice may ultimately result from this form of use. Conceptual utilization is the least tangible—and therefore the most dubious example of research utilization—as it entails no observable action at all but, rather, a change in the way users think about problems, persons, or events. Giacomini and Cook (2000) described qualitative research findings as useful in the ways either a window reveals or a mirror reflects. For individuals with no personal experience of a target event, qualitative research findings offer
a window through which to view aspects of life that would have remained unknown. For individuals with personal experience of a target event, qualitative research findings offer a mirror that allows them to look back on and reframe their experience. Whether revealing or reflecting, in conceptual utilization, the action happens in the user who is newly informed or enlightened, but this change in the user may not be obvious to anyone nor have any obvious impact on anyone or anything else. Indeed, the users who experienced this change may be unable to articulate the change experience even to themselves. Yet, like symbolic utilization, conceptual utilization may be a precursor to instrumental utilization as users develop the capacity to articulate the change experience and to translate it into more observable or material form.

Qualitative research findings lend themselves most obviously to symbolic and conceptual utilization but less obviously to instrumental utilization. Because the thrust of evidence-based practice is interventionist—that is, oriented toward observable action—qualitative research appears to be less useful by virtue of appearing less instrumentally useful. Instrumental utility is face utility. For many people, what has no face utility has no utility at all. Moreover, because the material forms into which research findings are translated are composed largely of standards of practice for problems primarily in the physical, physiological, or technical—that is, more visible and tangible—domains of practice, the qualitative research imperative to eschew standards, combined with its focus on problems in the less visible and tangible psychological, social, and cultural domains, seem to operate against instrumental utility. Accordingly, if the three-category classification of research utilization is used as the framework to appraise and address the utility problem in qualitative research, the resolution to the problem lies in showing or enhancing the instrumental utility of qualitative research findings, and in making more apparent the value of symbolic and conceptual utilization by itself or as a precursor to instrumental utilization.

**Demonstrating and promoting instrumental utility.** Inspired by the evidence-based practice movement and its emphasis on instrumental utility, champions of qualitative research have increasingly turned their attention toward showing how qualitative research findings can be of material and measurable use in practice. For example, Morse, Hutchinson, and Penrod (1998) described a process for transforming theory generated in qualitative research into clinical assessment guides. Morse, Penrod, and Hupcey (2000) described a process for evaluating interventions derived from primary qualitative studies. Kearney (2001b) described three instrumental uses of qualitative research findings, including the development of tools or guidelines for clinical assessment, anticipatory guidance, and active coaching. In their review of the discussion and implications sections of a sample of qualitative health research reports, Cohen, Kahn, and Steeves (2002) found that researchers often promoted instrumental changes in communication among patients, families, and clinicians. Included in the category of communication were recommendations for active listening, appraisal, teaching, and the provision of social support.

In all of these instances, the “difference model” of the role of qualitative research findings in health research is invoked by which qualitative findings are valued for their contribution independent of quantitative methods (Popay & Williams, 1998, p. 34). In these instances, the instrumental utility of qualitative research and ways to enhance it are featured. Qualitative research findings are shown to
have face utility; they are shown to contribute materially to the development of appraisal tools and communication protocols that have greater psychometric and cultural specificity and sensitivity. Moreover, in these instances, qualitative research findings do not necessarily have to be subjected to quantitative testing before they can be put to use in practice. They can be moved directly to practice and evaluated in the field by qualitative, quantitative, or mixed methods research.

Promoting the value of symbolic and conceptual utilization. Although not necessarily presented in research utilization terms, conceptual and symbolic utilization appear as the most important objectives of qualitative research both in reports of qualitative research and in literature promoting the utilization of qualitative research findings. These objectives are most apparent in the recurring depiction of understanding as the prime imperative of qualitative research and in the regular allusions to the persuasive power of narratives, or stories. In the qualitative research literature, understanding is not merely a prelude to or basis for action (understanding → action) but, rather, is itself action, or a consequence of action (understanding = action, or action ⇒ understanding). Whenever users see something for the first time or see it differently, they change the world. If their prior understandings were damaging or sickening to themselves or others, they “heal [their] worldview” (Reason, 1996, p. 25). As worlds are created with words, and words are the primary currency of qualitative research, to reword something is to remake the world. Indeed, a primary agenda in critical inquiry with marginalized individuals and groups is to empower them to rename the world.

Accordingly, even in qualitative studies that are not hermeneutic or participatory action research, understanding is the primary intervention on which all other interventions are inescapably based. Moreover, the narratives (or stories) that are prized in qualitative research, and which typically make up the largest portion of data in qualitative studies, are themselves actionable research texts because they function as agents of understanding. Indeed, what is important about stories is their “usefulness” (Ellis & Bochner, 2000, p. 754) in evoking, persuading, and provoking; in promoting empathetic, feeling, or visceral understandings of the people and events in stories; and in moving listeners or readers to act. Stories are considered to be symbolically useful by nature, because they invite listeners/readers to use them to tell new stories. Narrative utility is defined as the readability, writability, and evocativeness of, and also the meaningfulness and transformative possibilities in, stories. Because human beings characteristically use stories (i.e., read, write, tell, and listen to them), stories must be useful.

In contrast to the difference model of the role of qualitative findings in health research emphasizing their independent contributions is the “enhancement model” (Popay & Williams, 1998, p. 34) focus on the utility of qualitative research findings to enlarge and even to “salvage” quantitative research findings (Weinholtz, Kacer, & Rocklin, 1995). Here, the utility of qualitative research findings resides in their capacity to clarify, explain, verify, or show the instrumental utility (i.e., clinical significance) of quantitative research findings (Barbour, 2000; Cohen & Saunders, 1996; Sandelowski, 1996, 1997). Statistically significant findings are not necessarily clinical useful, and qualitative findings are said to show the tears that statistical accounts wipe off (Selikoff, 1991). Because qualitative research findings address realms of experience that quantitative findings cannot reach (Pope & Mays, 1995; Power, 1998), they may complicate or even refute quantitative research findings.
Scholars have demonstrated the enhancement functions of qualitative research findings to develop, refine, and validate instruments and interventions (e.g., Barroso & Sandelowski, 2001; Cox, 2003; Gamel, Grypdonck, Hengeveld, & Davis, 2001; Mallinson, 2002; Miller, Druss, & Rohrbaugh, 2003; Popay, Bennett, et al., 2003).

In summary, the utility of qualitative research findings resides in their capacity—by themselves or in conjunction with quantitative research—both to direct the development of culturally-sensitive theories, culturally-appropriate research tools, patient-centered, targeted, or tailored interventions that are effective, feasible, and acceptable to users; and to redirect or reframe future research and research utilization efforts (Cohen, Kahn, & Steeves, 2002; Sandelowski, 1996). Qualitative research findings close the gap not only between understanding and action but also between efficacy (or what works in research) and effectiveness (or what works in practice) (Greenhalgh, 2002).

MAKING QUALITATIVE RESEARCH FINDINGS USABLE AND USEFUL

Qualitative research findings have been shown to be necessary to the advancement of health research. But we qualitative health researchers can do more to demonstrate how research findings not only can change but also have changed practice. To demonstrate the utility of qualitative research findings, we must first meet several challenges.

Clarifying Conceptions of Findings

A key factor affecting the demonstration of the utility of qualitative research findings is the way they are conceived. The empirical/analytical view of qualitative findings is that they are the results of inquiry supported by and, therefore, distinguishable from data (Sandelowski & Barroso, 2002a, 2003a). Data here constitute the evidence for (or ground for belief in the credibility of) research findings. Researcher findings are data based, or composed of what researchers conclude, infer, or interpret from the data they have collected in a study. Qualitative research findings are the grounded theories, ethnographies, phenomenologies, and other integrated descriptions or explanations produced from the analysis of data obtained from interviews, observations, documents, and artifacts. The validity of data-based studies is said to depend primarily on the ability of researchers to show that their findings are empirically grounded in the data they collected in those studies. Data-based findings ought, therefore, to be readily identifiable and separable from (a) the data themselves, or the quotations, excerpts from field notes, stories, case histories, and the like that researchers used as evidence for their findings about a target phenomenon; (b) data and findings not about that phenomenon; (c) imported data or findings, or data or findings from other studies to which researchers referred to situate their own findings; (d) analytic procedures, or the coding schemes and data displays researchers used to transform their data into findings; and (e) researchers’ discussions of the meaning, implications, or signifi-


cance of their findings to research, education, practice, or policy making. The data-based view of findings is highly compatible with evidence-based practice because of its emphasis on data as evidence to support conclusions. Moreover, findings that are distinguishable from data and other elements of inquiry are themselves ready for use in evidence syntheses as these are conceived in evidence-based practice.

Less compatible with evidence-based practice than the data-based view of qualitative findings is the data-as-constructed view, whereby both data and findings are conceived of as indistinguishable from each other, from the participants with whom these data and findings were produced, and from the researchers who decided that some, but not other, things were data. Indeed, the word *finding*, implying that entities are out there waiting to be found, is itself at odds with the idea that everything about the research process is socially constructed. *Data* are not plural, or countable as this or that number of instances, but, rather, singular, or an uncountable “body of experience” (Holliday, 2002, p. 69). Following the data-as-constructed line of argument, making something into data is the first stage in the process of data transformation (Wolcott, 1994). In contrast to the *data collection* in the data-based line of argument, where data are commodities to be obtained from people from whom, and via procedures from which, these data are distinguishable, the *data generation* in the data-as-constructed line of argument has no independent existence. Data generation is inseparable from the (a) researchers who decide what will become data for their projects; (b) specific and irreplicable encounters between researchers and the people and events that are the subjects and objects of study that together produced those data; and (c) researchers’ interpretations of these subjects and objects of study and, in a reflexive move, of themselves and the research process itself. Neither findings nor any other element of the research process or report can be readily separated from each other, nor should such a separation be attempted.

Following the data-as-constructed line of argument, it is as impossible—and even as nonsensical—to extract findings from a poetic, dramatic, or storied presentation of qualitative research as it is to extract them from a poem, play, or novel. Conceiving qualitative findings as evidence is as nonsensical as conceiving a poem as evidence. Indeed, because data can be construed as findings, merely retelling a person’s story or providing excerpts from interview data can be construed as the end product of qualitative inquiry. As stories are considered to be actionable by themselves, researchers following the data-as-constructed logic to its extreme believe they have fulfilled their obligations to produce something useful merely by retelling stories.

In summary, the empirical/analytical orientation to qualitative findings is in line with evidence-based practice as it is typically conceived, but by virtue of its view of findings as extractable, it may undermine the qualitative research imperative to attend to particulars as wholes, that is, to take in a research report as a whole and not to anatomize it. Conversely, although in line with the holistic imperative in qualitative research, the data-as-constructed orientation is less compatible with evidence-based practice by virtue of its view of findings as inextricable from data. In its extreme form, it threatens the very acceptance of qualitative research as research. A story by itself, with no interpretation, may not be considered a research finding. Research reports composed only of uninterpreted stories or excerpts of stories contain no findings that can be extracted for use in evidence syntheses.
Using Representational Styles Enabling Use

The way qualitative findings are conceived directly influences how they are presented in reports of qualitative studies and, therefore, their usability. Most qualitative health research is reported in the experimental/APA style (Bazerman, 1988; Sandelowski & Barroso, 2002b). The experimental/APA style is a standardized format for presenting research mandating that the results of a study be provided in a results section clearly separate from and immediately following a methods section and immediately preceding a discussion section. This style reflects and reinforces the data-based view of findings as objectively produced and as distinguishable from and supported by data. The experimental/APA style of reporting qualitative research is the most amenable to the instrumental utilization of qualitative findings as the style itself demands that findings not only be clearly stated in a result section but also be shown, in a separate discussion section, to be immediately or potentially significant to specified persons for specified purposes.

A departure from the experimental/APA style of reporting is the amended-experimental style (Sandelowski & Barroso, 2002b), in which findings are presented along with references to literature that serve to situate those findings, or in which data are presented in the results section and findings, or researchers’ interpretations of those data, are presented in the discussion section. Because they are embedded in other elements of the research report, the findings in these studies may be more difficult to identify and may, therefore, be less usable in the empirical/analytical sense. Writers have to take more care, by their use of voice, tense, and other elements of style, to ensure that readers can differentiate the researcher’s line of argument from the various kinds of evidence used in support of it (Holliday, 2002).

Non-Experimental Experiments in Style. Wholly outside the empirical/analytical realm of representation are the growing efforts to present, and even perform, qualitative research in forms such as the novel, poem, play, dance, and performance theater (Richardson, 2000). Such artistic experiments in representation are partly responses to the “crisis of representation” (Denzin & Lincoln, 2000, p. 16), whereby scientific modes of reporting research are seen to misrepresent human experience, to further “otherize” Others (Holliday, 2002, p. 15), and to reproduce social inequalities. Literary and artistic modes of representing people and their lives are considered to be more amenable to the varied goals of qualitative researchers, including giving voice to the voiceless, revealing the actor’s point of view, revealing the researcher’s point of view, privileging alternative ways of knowing, and empowering and mobilizing marginalized persons and social groups. A key scholar in qualitative education research and a painter, Eisner (1996) proposed that the novel be accepted as a dissertation in the field of education.

But such modes of research reporting are the least amenable to showing the face utility of qualitative findings, as neither findings nor utility are requirements of literary and artistic presentations. Moreover, rather than resolving the crisis of representation, such experimental forms may intensify it (Schwalbe, 1995). Experimental forms of presenting findings do not resolve but, rather, generate new problems in representing people and events; nor do they dependably evoke the feelings or provoke the actions desired. Although well intended, researchers trained in the practice disciplines are typically unschooled in the art and craft of poetry, fiction writing, photography, drawing, choreography, and performance theater. In their eagerness
to be literary and artful, and understandably attracted to the beauty and novelty of literary and art forms, qualitative health researchers too often lack the skills required to produce them and knowledge of the place of these forms in the realm of representation and utilization (Eisner, 1991, 1997). Such researchers doom their work to be not only useless but also artless.

Furthermore, the current zeal to do “transgressive writing” (Schwalbe, 1995, p. 394) enables researchers to avoid the responsibilities of inquiry. Unlike poets, painters, and novelists, scholars in the practice disciplines are supposed to offer an interpretation of the data they collect or the stories they generate (Eisner, 1997). Addressing phenomenological inquiry, van Manen (1990) observed that “phenomenology aims at making explicit and seeking universal meaning where poetry and literature remain implicit and particular” (p. 19, emphasis in original). Qualitative inquirers may use poetry and literature as data in their studies or use poetic and literary devices to analyze and interpret data and to write up the results. But qualitative inquiry begins where poetry ends, that is, with an explicit interpretation that is available for critique and that can be compared with other interpretations. As Greene (1992) noted, “Unlike the artist . . . applied social inquirer(s are) responsible for how (their) stories are read, understood, and acted upon” (p. 42). Eisner (1991) observed,

The use of particulars to provide guidelines for the future is a central function of both folktales and proverbs. In the case of the folktale, the story is to be appreciated not only for its interesting narrative or its humorous qualities, but also because there is an important lesson to be learned from it. The point of learning a lesson is that it is intended to influence our understanding and behavior; it has some instrumental utility. (p. 104, emphasis added)

But unlike folklorists, qualitative health researchers are obliged to make the utility of stories explicit.

Yet, recently, analysis and interpretation have, unfortunately, too often come to be seen as instances of the domination of the powerful over the weak. For researchers to put forward their interpretation of others is now too often conceived of as the unethical subversion of the liberatory goal of voicing the voiceless. Lauing works that privilege stories over analysis and arguing that the “narrative text refuses the impulse to abstract and explain,” Ellis and Bochner (2000) implied that analysis and interpretation are antithetical both to the true mission of qualitative inquiry and to use. As they observed,

Evocative stories activate subjectivity and compel emotional response. They long to be used rather than analyzed; to be told and retold rather than theorized and settled; to offer lessons for further conversation rather than undebate conclusions; and to substitute the companionship of intimate detail for the loneliness of abstracted facts. (p. 744)

But theories are by their revisionist nature never settled and always debatable; abstracted facts can be companionably intimate; intimacy can too easily become voyeurism, sensationalism, and exhibitionism; and compelling emotions can be coercive.

In the name of the reflexivity that characterizes many of these experiments in representation, researchers may now not only avoid the responsibility of
interpretation, but also completely abandon others as the subjects of inquiry. The most dramatic examples of reflexivity gone wild can be found in the growing collection of works designated as auto-ethnography, autobiographical inquiry, experiential analysis, and the like (Ellis & Bochner, 2000), which focus on researchers themselves and their own engagement in the research process, not on any participants or events per se. Whereas the researchers advocating auto–modes of inquiry were initially attracted to them, in part, to protest the privileging of researchers’ over participants’ voices in reports of research, these modes of inquiry too often wholly and perversely replace participants with researchers as the subjects of inquiry. Hoping to reinstate the I-researcher in the conventionally author-evacuated research report, auto-research reports can be excessively author saturated (Geertz, 1988). Conceived as action research for the researcher and participant observation of the observer (Ellis & Bochner, 2000; Tedlock, 1991), auto–modes of inquiry too often cast researchers not only as the primary targets but also as the primary users of qualitative research. In extreme examples, others are said ultimately to benefit when inquiry promotes researchers’ understanding of themselves.

Traditional empirical/analytical inquiry allows researchers to get away with categorizing, slicing, and dicing (Ellis & Bochner, 2000, p. 737) human experiences into findings that no longer resemble these experiences; making insupportable claims to objectivity and generalizability; and escaping accountability as the creators of research findings. But auto–modes of inquiry allow researchers to escape the disciplined, skilled, and risky work of interpretation; study no one but themselves; legitimate virtually anything in the name of reflexivity and representation; and draw solace from the belief that inquiry that is therapeutic for researchers must be therapeutic for participants.

Yet, an alternative to these extremities in representation exists that allows qualitative health researchers to develop new ways of representation while remaining accountable to both research participants and the purpose of inquiry in the practice disciplines. Tierney (1995) warned that qualitative researchers must avoid a “methodological version of psychoanalysis” (p. 383) of themselves. We qualitative health researchers cannot lose sight of our goals to contribute to change. We cannot address the crisis of representation by “retreat[ing] to the easy assumption that we can understand no one but ourselves” (p. 383). As Tierney observed,

As we experiment by developing a play, a prose poem, or a short story, we consistently should question the purpose for which we are writing. . . . The point surely is not to avoid experimentation (with alternative forms of representation), but to be certain that our experiments are efforts at creating change rather than merely an exercise in intellectual narcissism. (p. 383)

Just as the abstraction of facts does not have to be a lonely, heartless, or surgical enterprise, so, as Lawless (1992) observed, voicing the voiceless does not have to mean that researchers lose their own voice or abdicate their responsibility to interpret. Continuing with Lawless’s line of argument, experimental modes of representation do not require that researchers relinquish the role of scholar as interpreter, thinker, and observer. Scholars may offer interpretations without privileging them; along with research participants, they may have their say, but no one gets the last word. Entry into the hermeneutic circle that qualitative researchers prize requires interpretations that can be subjected to others’ interpretations.
In short, the reflexivity at the heart of most experiments in representation in qualitative inquiry does not mean placing researchers at the center of inquiry but, rather, acknowledging their role and “vulnerability” (Behar, 1996) in inquiry. Acknowledging the challenges of representing other people does not mean failing to represent them at all. Although the auto-researcher’s goals to reinstate the researcher into research and to “revel” in the “messiness” (Ellingson, 1998, p. 511) of research are laudable, they do not legitimate leaving research audiences with a mess. Experimental modes of inquiry require inquirers skilled in these modes and able to show how these modes advance knowledge for the public good.

Addressing the Complexity of Qualitative Metasyntheses

Although the increasing efforts to integrate qualitative health research findings are laudable, qualitative metasynthesis itself presents dilemmas that researchers have yet fully to recognize, address, and resolve. The most notable among these challenges are (a) distinguishing qualitative studies from other species of research, (b) distinguishing qualitative metasynthesis from other species of synthesis or narrative reviews of the literature, (c) locating relevant qualitative studies for inclusion in bibliographic samples, (d) understanding research reports written in diverse discipline-specific styles, (e) locating the findings in these reports, (f) classifying these findings, (g) determining which findings are about the same target phenomenon or event, (h) determining which findings merit inclusion, (i) deciding which methods and techniques to use to combine different kinds of findings, (j) determining what form the product of analysis should take, and (k) determining how best to present this product to showcase its relevance for a target audience.

The increasing publication of reports of studies designated as qualitative metasynthesis that are little more than conventional literature reviews is generating new concerns that qualitative metasynthesis is becoming the latest methodological fad to attract would-be researchers eager for an easy entree into research and qualitative research, in particular. The methodological naiveté of many of these studies has generated a new threat to the utility of qualitative findings.

If the synthesis of qualitative findings remains a challenge, the combination of qualitative and quantitative syntheses remains uncharted terrain. Virtually no effort has been directed toward integrating syntheses of qualitative findings with syntheses of quantitative findings and then translating this knowledge for practice. Although advancements in the use of mixed methods in primary research have the potential to offer solutions for accomplishing such meta–combinations of findings, they have yet to be examined for their actual utility in producing evidence syntheses that truly take account of all of the evidence available in a target domain of health research.

Assuming and Sharing Responsibility for Signifying and Translating Findings

In addition to clarifying our conception of qualitative findings and becoming more adept and responsible in representing and synthesizing them, we qualitative health researchers must assume and share responsibility for signifying and translating them. Health researchers are typically expected to attach significance to their find-
ings or show their immediate or potential utility for future research, practice, policy, and education. Qualitative health research findings are typically signified by appeals to analytical or idiographic generalizability and transferability, or to transformative understanding: one that changes researchers, participants, and/or the way participants, problems, and events are viewed. Although we qualitative health researchers have assumed some responsibility in attaching significance to our findings, we have also tended to shift more of this responsibility to readers of our research reports. As we have typically argued, qualitative researchers are obliged only to provide enough detail about our findings to enable readers to determine their generalizability. Smaling (2003) referred to this transfer of obligation as “receptive generalization,” a form of “communicative generalization” (pp. 17-18). Here, the burden of signification rests primarily with audiences.

The presumption that qualitative health research audiences should carry the primary responsibility for signifying qualitative research findings calls into question how users, and the relationship between user groups, are generally conceived of in the research utilization literature. In this literature, producers of knowledge—or researchers—are typically distinguished from users of knowledge, for example, other researchers, members of the health professions, health care organizations, government regulators, policy makers and analysts, health economists and epidemiologists, health insurers, lawyers, medical industries, patient groups, and the general public (Ray & Mayan, 2001). The most common manifestations of this binary distinction in the health-related disciplines are the line typically drawn between researchers and clinicians and the literature on why clinicians “fail” to use research findings. Here, producers and users are depicted in a one-way, hierarchical, and even adversarial relationship.

Yet, the line typically drawn between users and producers of research findings is an artificial one, because producers of findings are also users of them, and users, by virtue of their use alone, re-produce and re-create those findings. Following a reader-response line of argument concerning the relationship among diverse readers (i.e., users) and texts (i.e., research findings in reports), readers of research findings transform them by the very act of reading, reading into, and even rewriting findings (Sandelowski & Barroso, 2002b). Following a symbolic interactionist line (Blumer, 1969), qualitative research findings do not exist as objects independent of users but, rather, become what they are in use; they become meaningful in a unique user context.

Dissemination is inherently social, even when, as is typically the case, writers and readers of research reports never actually meet each other over the research report. Researchers use the findings of other researchers (often in ways not intended or even anticipated by them) to produce their own findings, which are then used to generate other studies, the findings of which will be disseminated for use by others. Research findings are used whenever anyone disseminates, translates, implements, and evaluates them. All of these producers/users generate and use findings for some purpose, such as the promotion of quality care, enhancement of professional effectiveness, ensuring of fiscal accountability, reduction of risk and liability, and the satisfaction of personal needs (Ray & Mayan, 2001), which may include a patient’s need for symptom relief and a researcher’s need for academic promotion and tenure.

Research utilization thus involves a host of producers/users of research findings with a host of agendas for use. But research utilization itself requires a
repertoire of skills, all of which are not likely to be possessed by any one user group. Among the complex skills required to use qualitative health research are understanding and evaluating qualitative research reports written in different styles and with different disciplinary commitments, synthesizing the findings of qualitative research, translating the findings from primary qualitative or qualitative meta-synthesis studies for use in practice, and implementing and evaluating these translations in practice. Although researchers are recurrently exhorted to develop the clinical acumen to move research findings into practice, and clinicians are exhorted to develop the research acumen to appraise and use research, these goals are rarely achieved. The research-practice gap recurrently referred to in the research utilization literature derives, in part, from the failure to achieve these unrealistic goals. Unrealistic is the expectation that clinicians will have the knowledge of grounded theory, ethnography, qualitative metasynthesis, and the like required fully to understand and appraise these works. Conducting qualitative metasynthesis projects, like quantitative meta-analysis projects, requires the knowledge and skill of experts—not novices—in research. Equally unrealistic is the expectation that researchers will have the knowledge of patients, clinical problems, and practice settings required to accommodate qualitative research findings.

Because different user groups come to the research utilization enterprise with different expertise, they must work together to make the dissemination and translations processes more participatory: to enhance the “participative value” (Smaling, 2003, p. 22) of findings. Any one user group will always have to depend on the skills of one or more other user groups to realize the full utility potential of qualitative findings and to instill in each other confidence in the expertise they uniquely bring to the research utilization enterprise. To activate all phases of the knowledge transformation cycle fully, clinicians must be able to trust the primary research findings and evidence syntheses produced by researchers, not produce these findings and syntheses themselves. Researchers must be able to trust the transformations of findings produced by clinicians and their ability ethically to accommodate research findings to the constraints of practice settings, not merely use clinicians to gain access to clinical sites for research.

Most urgently, diverse user groups must work separately and together to enhance the knowledge transformation process itself in the qualitative health research context so that its findings can become transformative for practice. Working to improve the “utilization value” (Smaling, 2003, pp. 20-21) of reports, researchers can do more to write up findings in ways that will more directly appeal to different user groups, including the patient groups who might benefit from them. Instead of relying on readers to signify findings for practice, qualitative researchers can assume more responsibility for showing their potential actionability. No matter how poetic or reflexive our efforts are, we qualitative researchers can be more accountable for coming to some clearly defined point by the last page of our reports. We would thereby show our understanding that in qualitative health research, poetry and reflexivity are means to an end, not ends in themselves. Instead of writing formulaic and clichéd discussion and implications sections, we can write informative significance and translation sections in which we point the way to one or more material forms in which our findings might be used and the one or more health objectives they might satisfy.
CONCLUSION

The utility discourse can be put to good use to advance the qualitative health research enterprise without compromising it. Discussions of utility move qualitative health research further into the mainstream of health care research, but they do not have to undermine qualitative research as itself a protest to mainstream research.

Qualitative health research is the best thing to be happening to evidence-based practice. Qualitative health research complicates and thereby unfreezes the idea of evidence, foregrounds the politics in definitions of evidence, and precludes a priori prejudices against certain kinds of evidence. Qualitative health research is the best chance for evidence-based practice to realize its ideal of using the best evidence to create the best practices for individuals. With its emphasis on the contingencies, subjectivities, discursiveness, and politics of evidence, qualitative research can make evidence-based practice a truly mindful (as opposed to mindless or rote) methodology for improving the public health. Incorporating the methods and findings of qualitative research will help reverse the current trend toward making evidence-based practice a technologized professional discourse (Holliday, 2002) and disciplinary technology (Walker, 2003) that serve only to reinforce invidious distinctions and to reproduce the very problems it was intended to solve. Qualitative health research offers the best chance for incorporating the critical consciousness (Berkwits, 1998) required to offset the tendency to dogmatism in efforts to promote evidence-based practice (Traynor, 1999). Qualitative health research offers the best chance of producing truly transformative knowledge and fully activating the knowledge transformation cycle foundational to the evidence-based practice paradigm.

Evidence-based practice, in turn, directs qualitative health researchers to address the utility question as seriously as they continue to address the validity question and even to see validity as residing in utility. Qualitative researchers can use evidence-based practice, not as a prescriptive rhetoric or disciplinary technology but, rather, as a useful guide to action. We qualitative researchers cannot evade the utility question by dismissing it as irrelevant and antithetical to qualitative research. Prideful assertions that qualitative health research is not about solving problems or “doing” anything at all, or that it is useful merely by virtue of being, will only revive the charge that it is irrelevant. Indeed, such prideful assertions constitute a misuse of qualitative research. Qualitative research is misused when it is used to escape the disciplined and risky work of inquiry and interpretation. Qualitative research is misused when it is used largely as therapy for researchers. Qualitative research is misused when it is used to proclaim that discussions of utility in qualitative health research are useless.

The turn to evidence-based practice moves us as qualitative health researchers to take more stock of our stories: to showcase what and how they reveal, clarify, distill, elaborate, extend, complicate, confirm, refute, explain, reframe, personify, individualize, specify, sensitize, persuade, evoke, and provoke. As researchers in practice disciplines, we have a special obligation to conduct transformative inquiry by activating this taxonomy of use, that is, to show the beneficial outcomes for the public health of these revelations, clarifications, distillations, elaborations, extensions, and the like. Emphasizing the artfulness of qualitative research does not preclude
the incorporation of qualitative research findings as evidence in evidence-based practice, nor the requirement that artful scholarship be transformative and meet canons of criticism and utility.

I conclude with a call to use in the health practice disciplines adapted from one of the most compelling calls for action in the 20th century: Ask not what qualitative research can do for you, ask what qualitative research can do “with” (van Manen, 1990, p. 45) you and what you can do better with qualitative research. Answer not that qualitative health research is only about asking the right questions, counter that qualitative health research is about answering them too.

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