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Reconceptualising ‘Impact’ through Anthropology’s Ethnographic Practices

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Abstract

Academic funding bodies are increasingly measuring research impact using accountability and reward assessments. Scholars have argued that frameworks attempting to measure the use-value of knowledge production could end up influencing the selection of research topics, limiting research agendas, and privileging linear over complex research designs. Our article responds to these concerns by calling upon insights from anthropology to reconceptualise impact. We argue that, to conduct socially beneficial studies, impact needs to be turned from a product to an inclusive process of engagement. Anthropology’s epistemologically and methodologically rich tradition of ethnography offers a particularly apposite set of tools to achieve this goal. We present three concrete examples of how we have used ethnography to impact the work we carry out, particularly in shaping multidisciplinary team-based research approaches.

Keywords: impact, ethnography, health care, process, participatory research, reflexivity, anthropology, REF2014

Introduction

Academic research is increasingly required to demonstrate that it can address the problems of the ‘real world’. Linking research with societal need has become particularly embedded in the United Kingdom and other places where governments fund much of this research as well as the supporting institutional infrastructure. Particularly in the recent climate of fiscal austerity, questions about the use-value of research have propelled the development of policies of accountability and reward that explicitly build and enforce research ‘impact’ (Bannister and Hardill 2013). In the UK, this has translated into the development of an ‘impact’ component of the Research Excellence Framework (REF), a ‘non-negotiable criterion’ (Watermeyer 2012: 127) to measure and subsequently allocate university research funding. The significance of this has not been lost on scholars who note that it ‘represents the greatest change thus far in the way that university research is assessed and funded’ (Ward et al. 2010: 529). Indeed, the ‘new game in town’ (Wolff 2013) is projected to grow in its significance, given that impact comprised 20% of the REF framework in 2014, with a greater proportion projected for the next assessment in 2020 (Gibney 2013).

There are a range of views – from ‘whole-hearted enthusiasm’ to ‘equally deeply-held opposition’ (Greenhalgh 2014) – about the REF’s emphasis on impact. Critics across academic disciplines are concerned about the difficulties of measuring the use-value of knowledge production, the privilege placed on economic over other kinds of value within the REF framework, the lack of skills possessed by researchers to enable knowledge translation, and the influence of such an impact regime on researcher behaviours and, in turn, the quality of the research itself (Smith and Meer 2012; Ward et al. 2010). Indeed, some are worried that impact-

driven research will result in forsaking longer, more complex endeavours that carry greater risk (Rafols and Wilsdon 2013).

In response to these debates, and along with the general consensus that impact assessments are here to stay, there is an increasing interest in formulating guidance to help researchers maximise impact. There are plenty of models, but, to our knowledge, none of them calls upon the insights from anthropology to truly engage with the ways in which researchers can shape research to make an impact. Anthropology contributes well-honed, highly conscious reflexive methods that pay attention to the process of ‘doing’ research. Our argument is that, to conduct socially beneficial research, we need to draw upon anthropology to conceptualise impact as a process, rather than a product, of engagement. This is a particular kind of process, requiring multiple kinds of practices, over iterative research stages. It relies upon relationship-building with everyone engaged in research enterprises, including those who design studies, embark upon collecting and analysing data, and populate the research field.

Anthropology’s epistemologically and methodologically rich ethnographic tradition offers a particularly apposite set of process-specific tools. Ethnography, as Harry Wolcott says, ‘presents the opportunity and the challenge to pursue an inquiry in a manner especially attentive to broad social contexts’ (2008:101). Jason Combs has highlighted this idiosyncratic quality of ethnography in which ‘the researcher literally becomes both a part of the field that he or she is studying, and the medium through which that studying occurs’ (2012: 247). This pursuit is a mode of learning by becoming deeply enmeshed with those who are involved in the research enterprise, and in the various institutions in which research is conducted. We believe that the use of ethnography enables researchers to envisage and carry out more impactful research.

In the sections that follow, we briefly review the REF framework, along with other models, to explore circulating conceptualisations of impact. We then turn to anthropology to query what the discipline offers conceptually and methodologically, given its historical debates and emerging principles of engagement. We elaborate upon the use of field-based ethnographic techniques, and present three concrete examples from our research in health care to show how we have used ethnography to foster a style of engagement that interlinks the process of doing research with the generation and influence of its findings. Our claim to prioritise process over product is ultimately in line with those who see in this moment an opportunity to ‘empower researchers to be active and engaged citizens’ (Clappison 2013). We hope that our article offers some ideas on how this can be both conceptualised and practically enacted in a more meaningful way.

The article is written from the perspective of two medical anthropologists actively engaged in healthcare research in the US and the UK. We are currently affiliated with a UK-based, academic department conducting policy-relevant, outcomes-oriented health research. One author (CVP) has been appointed as an embedded qualitative researcher with dual affiliation (to an academic institution and a health organisation) to develop research that suits the needs and interests of National Health Service (NHS) trusts. The other author (ABL) is involved in the qualitative component of several mixed-methods program evaluations in the UK, and in the US conducts ethnographic research pertaining to HIV/AIDS and chronic healthcare delivery in collaboration with a health-related government agency.

The REF and Impact-Driven Research

The REF has defined how academic research is evaluated through its system of expert review, in which it both drafts the criteria for assessment, and then assesses higher education institutions' (HEIs) submissions. The REF2014 guidelines specify three areas for evaluation: 1) outputs, defined as the 'quality of submitted research outputs based on publication standards' (65%); 2) impact as 'the reach and significance of impacts on the economy, society and/or culture' (20%), and 3) environment as the 'vitality and sustainability of the wider discipline or research base' (15%) (REF 2014: 6).

With respect to impact, HEIs submit case studies to the evaluating panels with the purpose of presenting their 'strongest examples of impact that are underpinned by excellent research, and to show how the research enabled impact' (REF 2014: 28). These two requirements highly circumscribe how HEIs should both self-assess and, as a result, conduct themselves to produce 'impact' performance evidence. The first requirement means that in order to produce valid examples, the HEI needs to present outputs (up to the REF's 'excellence in research' standard) as the main justification of their impact work. Arguably, this criterion serves to strengthen research 'outputs', rather than build up additional working areas or projects less able to dovetail with the outputs metric.

The second defining parameter of impact is found in the use of the phrase, 'research enabled impact'. This is consistent with several descriptions in the impact case study template and guidance section (Annex G) such as: 'in turn led to', 'arose from', 'contributing to,' and 'how [the research] came to influence users or beneficiaries, or how it came to be exploited, taken up, or applied' (53). Their meaning suggests that HEIs are being asked to submit case

studies in which they can demonstrate the catalysing effect of research on some later activity. Such guidance is consistent with other government directives (see BIS 2014) in which impact is considered as the change taking place as a result of research-related activities.

There are other, more nuanced models that have arisen as scholars see the potential in this moment to promote use-value research. For example, scholars working within the growing field of Knowledge Translation (KT)¹ are developing guidance for researchers to recognise and respond to the ‘inherently social process’ of impact-oriented research (Ward et al. 2010: 532). TK proponents argue that, to truly enable change, there are dynamic, and multi-directional ‘interactions between the producers and users of research’, which are in themselves ‘contingent and complex’ (Ward et al. 2010: 532). While they focus on enabling end-result changes borne of research, included in such undertakings is the long-term engagement with a variety of stakeholders groups (from lay advocates to policy makers) to formulate research problems, participate in research design and conduct, and interpret research findings.

This model suggests that producing research that has an impact requires participation. Its advocates also suggest that such initiatives should be tailored around each project to avoid making impact-driven research ‘cookie-cutter’ in its implementation (Ward et al. 2010). The attention placed on the relationships that develop within and between each stage of research is a significant conceptual move because it considers that the social process of doing research is an important criterion in shaping research impact. However, while KT’s emphasis on process is welcome, it does not go far enough in imagining the challenges entailed in these arrangements. Furthermore, it does not offer particular techniques for researchers to meaningfully negotiate relations and build awareness of the various contextual influences that are paramount to the

research trajectory. The turn to anthropology – its epistemological legacies and methodological offerings – is one way to work through these difficulties, and to which we now turn.

Anthropology's Productive Challenges and Alternatives

Anthropology has long contended with the tensions entailed in pursuing research on and with the public, given that its object of study centres on individuals and their social relations with and in the world. Anthropology does not hold sole claim to such an orientation, but it offers insights through its longstanding pre-occupation and discomfort with being a science of social change. To start with, the epistemological roots of anthropology are relativistic, privileging description over intervention. To this, the postmodern turn strongly influenced the discipline's theoretical orientation towards complexity and partiality, thereby complicating any quest to delineate neat and, therefore, actionable findings. As Marcia Inhorn and Emily Wentzell write, 'the complex "truths" our research produces are often out of harmony with the official, usually simplistic truths formulated by those with influence in areas of anthropological interest, including health, the environment, welfare, and education' (2012: 16). Further, by the mid-20th century, scholarship examining how power manifests led anthropologists to become increasingly critical, and less willing to align with political projects advocating for change. Dubious historical engagements by anthropologists becoming handmaidens of powerful, state-driven projects, such as during the Vietnam War, also made those in the discipline wary of too quickly assuming a role within use-value driven projects (Low and Merry 2010; McCourt 2012).

As a result, some anthropologists have chosen to retreat from the conversation, or lob critiques in adversarial terms. Other, more application-driven anthropologists, have taken a different approach: they use the ideas and methods of anthropology to contribute to more

thoughtful, well-crafted impact-oriented research. We align ourselves with this second project to recuperate troubling questions as strengths anthropology offers through its ‘burden-filled legacies’ (Field and Fox 2006).

One place to begin is Setha Low and Sally Merry’s work on an ‘engaged anthropology’. According to them, ‘engagement’ encompasses a broad set of activities occurring around and through anthropologically-oriented endeavours such as: sharing and support, teaching and public education, social critique, collaboration, advocacy, and activism. We find Low and Merry useful in situating our approach for three reasons. First, given that the activities listed are indeed broad, an anthropological orientation to engagement draws upon a diverse set of practices. Second, these activities are in fact social, directing researchers to fine-tune their ability to be enmeshed and involved with a wide range of individuals. Third, and perhaps most importantly, Low and Merry’s terms of engagement are, as Paul Mullins says, ‘an example of the growth of a self-critical, engaged anthropology that has pushed beyond simply advocating for collaboration, and is now reflectively probing the social and political dimensions of engagement’ (Mullins 2011: 236). The terms of engagement are built out of an attention to issues of power and ethics within knowledge production and application-driven projects. Taken together, conceptualising research that has a commitment to impact along these lines entails diverse practices, lively interaction amongst all of those engaged in research, and a commitment to thinking about and intervening into the research process.

Practicing Ethnography to ‘Impact’ Health Care² Research

For anthropology, engagement principles are not lofty platitudes but anchor a mode of socially engaged research that aspires to study the world while considering the implications of doing so. Ethnography, what might be considered anthropology’s signature, offers techniques to

investigate social issues while including the research endeavour in the frame of study. Indeed, an ethnographic approach is one that allows researchers to understand the range of contextual factors and processes influencing a research setting, track how they meaningfully shape the collection and analysis of data, and adapt what is learned to various sites in which impact is desired.

Specific ethnographic techniques are precisely in the service of research organised using the engagement principles that we have outlined: participant observation, in which the researcher is immersed in a research setting by building relations with everyone involved, including research team members; reflexivity, which encompasses a self-consciousness about the process of producing knowledge; and iteration, to continually consider the ethical dimensions of research, particularly the unintended consequences of producing new knowledge. Impact may always refer to a desire to grasp and transform the world in some way, but an ethnographic approach cultivates a mode of doing research that enlarges the space of reflection about what it takes for academic researchers to make meaningful and, possibly, more ethical contributions.

For health care research, ethnography is already considered well-suited to untangle complex issues that require nuanced and flexible approaches to unpredictable variables (Dixon-Woods 2003; Weinstein and Ventres 2000). It is viewed as helpful in understanding the institutional contexts in which medicine and other forms of care are practiced (Townsend et al. 2003), generating comparisons between what people say and do (Savage 2000), and shedding light on the ways in which behaviours surrounding health and medical care are influenced by individual beliefs and practices (Savage 2000; Searight and Campbell 1992). In clinical settings, ethnography has become a popular method to, for example, collect and report on: performance measures in intensive care units, communication in operating theatres, causes of intravenous

medication errors, perception of risk in wards, user involvement practices, and the role of context in quality improvement (Braaf et al. 2013; Dixon-Woods et al. 2009; Dixon-Woods et al. 2012; Fudge et al. 2008; Leslie et al. 2014; Riley et al. 2006). Indeed, to many health services researchers and clinical staff, ethnography is the main contribution anthropology makes to the improvement of health care. Other disciplines such as nursing, psychology, occupational therapy, psychiatry, and medicine have adapted ethnographic methods and approaches to the needs and realities of clinical settings (e.g., Braaf et al. 2013; Cameron 1990; Maggs-Rapport 2000; Searight and Campbell 1992; Townsend et al. 2003; Ventres and Frankel 1996; Winkelman and Halifax 2007).

Even though we acknowledge this recognition of anthropology's utility for applied work, the current application of ethnography in health care does not match its potential. Indeed, it can offer a more meaningful exploration of the kinds of challenges that accompany research pursuits. In the next section, we illustrate how a different kind of ethnographic approach, one in the spirit of Low and Merry, ultimately produced in our work more meaningful 'impact' using engaged, research processes. The work we describe was carried out in clinical settings and the examples are drawn from daily interactions in multidisciplinary research teams. Low and Merry's typology of engagement does not include a discussion of modes of engagement with fellow researchers but, from our position in applied health research, interdisciplinary team-based research is the norm and as such constitutes part of the 'field of learning.' An ethnographic engagement offers to such teams an invitation to articulate the positions members occupy as relevant to the research endeavour. This might include what each member brings by way of scientific and social assumptions and disciplinary inclinations, and what each person seeks to accomplish, how and why.

1) Being the participant observer

In the health care literature, ethnography is often presented as a form of data collection involving discrete observations (defined as participant, direct, unstructured), interviews, or the analysis of artefacts in confined spaces (Dixon-Woods 2003; Leslie et al. 2014; Weinstein and Ventres 2000; Savage 2000). The researcher working ethnographically in a hospital ward or operating theatre is typically constrained to the clinical setting rather than, for instance, including in her research the more informal conversations that take place with staff or patients, or with fellow researchers, within or outside of professional hours. This focus on formal methods is a limited application of ethnography since, as Darrouzet et al. argue, ethnography is a ‘mode of relating to others...through which positional knowledge of a certain ethnographic kind gets formed’ (2009: 64). This definition conceptualises as meaningful all of the interactions around research as moments of critical learning. Becoming embedded in a research setting in this social, analytical fashion helps positions us to better explain what is learned through research, and how such learning can be mobilised towards social change. Our first example further illustrates this point.

ABL conducted 15 months of ethnographic research in publically funded HIV clinics in the United States to examine HIV positive patients’ ideas and experiences of ‘quality of care’. She was hired by an agency of the state’s Department of Health to generate this understanding of patients’ values as part of a larger effort to develop a strong, patient-centred care framework. This objective was articulated at the outset by the agency’s medical director who hired her under the premise that: ‘it is the patient who ultimately matters the most’.

In setting up the research project, ABL worked closely with this medical director, a physician with a specialty in infectious disease. He championed using an ethnographic approach feeling that its philosophies and methods could possibly challenge the clinically-driven

framework that drove their quality of care management programme. ABL also worked with the agency's consumer affairs manager, who had for many years served as the state's advocate for patient involvement in healthcare. He took part in setting up the research, participant recruitment, and some of the clinic-based data collection. Three clinical leads from the HIV clinics where the research took place (a doctor, nurse practitioner, and an administrative director) supported the research by: allowing it to take place, submitting the required ethics applications to the clinics' research management bodies, assisting in the formulation of a tenable research design; gaining staff acceptance; and periodically attending meetings to discuss the research process and emergent findings. In the day to day research, ABL worked with a range of clinical staff, study participants, as well as other patients who were not formal participants but who populated the clinical settings. Because the agency served as the operational base for research management, ABL also engaged on a daily basis with agency staff, as well as attended meetings and made presentations to various agency working groups.

There were numerous instances in which research expectations circumscribed a flexible, ethnographic project. Starting with its early development, under the auspices of a government agency, the research needed to conform with some normative principles of scientific research by using a semi-deductive research framework from the health services management literature to design its central objectives and topic guides. Assumptions surrounding generalisability led to a participant sampling procedure that all involved felt comfortable using. It also became clear in discussions that it was essential that the findings offer something useful in the development of a patient-centred framework. The need for such an assurance was generally informally conveyed. In regular check-in meetings with the medical director ABL initially shared the importance participants placed on stories of transformation. While he found these narratives interesting, he

also critically probed, ‘But what are we going to do with that? The clinic’s quality program can’t be improved with that’. Later in the project, ABL shared some thoughts about the way that quality of care ideas seemed to be fluid for participants, but because most of the ideas reflected how positive they felt about their care, the clinic leads focused mainly on the fact that they now had evidence that validated their high standard of care. Through the ethnographic technique of participant observation used throughout the process, ABL was able to reflect on these reactions as features of the determination of relevant knowledge production, and thus how findings would need to be carefully embedded into that field if they were going to have an impact.

Throughout the course of research, ABL needed to respond to arising frictions, and in particular, concerns about the substantive contribution of her work. This occasionally threatened its sustainability, and required a large amount of negotiation and patience. However, such interactions built trust between ABL and her research colleagues. After the analysis was completed, ABL and the consumer affairs manager drafted an initiative built out of the study findings. Together, they satisfied the agency’s required fit with its quality management program and the clinical leads’ use-value requirements. This was possible because ABL understood over time how to frame some modest intervention-driven moves honouring the richness of patient experiences in a contextually sensitive way. In this example, both ABL (as researcher) and her colleagues changed, expanding the capacity to work together to make meaningful, anthropologically informed improvements in healthcare.

2) Reflexivity in practice

Reflexivity is often presented as an important component of ethnographic research in the health care literature. Although definitions vary, reflexivity is commonly equated with reflection and

critical thinking (Pope 2005) where the ethnographer recognizes the influence of her own biases (in the form of assumptions and preconceptions) throughout the research process (Reeves et al. 2008). Some authors have argued that reflexivity can be taught to clinical teams and can lead to a form of ‘self-reflexive learning’ in which staff think critically about their daily practice and seek ways to improve it (Dixon-Woods and Bosk 2010; Pope 2005).

While useful, this notion of reflexivity can be expanded to engage with the distinction between reflection and reflexivity made by Chiseri-Strater where, ‘to be reflective does not demand an “other”, while to be reflexive demands both an other and some self-conscious awareness of the process of self-scrutiny’ (1996:130). In other words, the most common applications of reflexivity in the health care research literature resonate with definitions of reflection, which entail looking back or thinking critically about one’s work and engagement. Although these are components of the reflexive method, the relational aspect, the interaction of the researcher with the ‘other’, and the processes of ‘othering’ are absent. The researcher’s own position can only be understood in the context of the relations created throughout the ethnographic process.

Our second example helps clarify this point. In a project meeting in which CVP was involved, an issue emerged when a fellow researcher in a study also provided care to the patients who were considered potential study participants. When working in health care organisations, we are often a part of teams composed of researchers who are also clinical staff and provide services to patients throughout the research process. In fact, many times research and clinical work are carried out simultaneously, an arrangement seldom highlighted or problematised during team meetings.

While the researcher tried to create distance between her dual roles when informing potential study participants about her study, essential elements had not been considered pertaining to the way she might be perceived by the patients she recruited. This was exemplified by the fact that she continued to wear her nurse's uniform when she was acting as a researcher. This raised issues around coercion: patients refusing to take part in the study might think they could be denied care. Though the uniform might not have made a difference for patients (they already knew the researcher as a nurse in the unit), the issue still needed to be considered as the researcher entered a terrain in which she was intimately familiar, but wanted to understand it in new ways.

After several discussions with CVP on the implications of the uniform while carrying out research, the nurse decided it would be better if she conducted the study in her regular clothes. The conscious decision not to wear the uniform helped the nurse see her working environment in a different light and pointed to issues around the provision of care that she might have taken for granted. The discussion around the uniform also 'made her think' about other ways in which she might have confounded both roles. Most importantly, it made her realise the importance of describing these situations in the process of writing about her research.

In this example, the ethnographic mode of engagement raised to view the position of authority that may be held by a researcher, potentially influencing study outcomes. Raising the impact of positionality works hand-in-hand with the increasingly common team-based and multi-disciplinary approach to studying complex social problems from multiple angles (Marcus 1995). The anthropological role of drawing out critical reflection can transform the process of knowledge creation into a self-reflexive and iterative exercise for all members of a research team. In this way, an anthropologically oriented team member is always a partial evaluator for

the study team, helping to make sense of the choices its members make to ‘define, create, and validate research’ (Ward 2010: 171). In the example we presented in this section, the contributions CVP made to her team added an important dimension pertaining to examining and even challenging the status quo, perspectives not normally included in current study designs that fail to recognise the effects that norms have on the process and outcomes of research.

3) Surfacing the consequences of research

In the previous section we identified the anthropologist in multidisciplinary teams as occupying the role of partial evaluator. This role emerges from our preoccupation with the consequences of our research on the people with whom we work and study. These attributes often turn us into the team member who exerts caution regarding, for instance, interventions that might not produce the same types of outcomes for all those involved, or processes for implementing programmes that might not be designed to foster the engagement and participation of stakeholders. We are many times the ones who try and halt projects that appear to have unintended consequences. Our third example describes a situation where one of the authors felt compelled to play this role.

CVP worked as part of a multidisciplinary research team that actively collaborated with clinical teams to develop joint research projects. The team had spent time on several hospital wards, interviewing and observing staff to identify improvements in their working conditions. During this period and due to their knowledge of the internal working mechanisms of the hospital and the relationships they had created with clinical staff, the team was approached by a group of hospital managers tasked with the responsibility of improving the quality of care in a select number of wards that had been identified as ‘problematic’.

The hospital managers wanted the research team to help them develop and evaluate a series of audits aimed at improving care delivery. The team agreed to sit down with the managers to discuss the topic further. When looking at the data the managers wanted to collect, it was evident that the purpose of the audits was to track individual staff members' use of time, errors, and deviations from 'standard' practice. In other words, the audits were to serve as a performance management tool that would have direct consequences on the working experience of clinical staff. The audits were also framed under a punitive system where staff would be reprimanded if they did not adhere to the 'standards'.

The research team met on several occasions to discuss this potential project. Initially, the team's involvement in the project was cast in a positive light, pointing to the opportunity that had been granted to take forward research that could make a 'real' impact on the hospital's internal audit system. CVP, however, consistently pointed to the other type of impact the research could produce: the negative consequences on staff members' working experiences. She drew from examples and contextual information obtained after a long period of engagement with her research participants and her knowledge of internal political processes taking place in the hospital to highlight to the other members of the team the unintended, or undisclosed consequences of the audit system. For example, it became clear that clinical staff would be penalised for actions that did not always depend on their individual decisions, but were influenced by faulty management processes established at higher levels of the organisation.

After a series of team meetings (and CVP recurrently voicing her discomfort), the research team met with the group of managers to express their concerns about the repercussions of the new audits, and their inability to take part in the project. Instead, the team continued to work with clinical teams and management staff and tried to salvage working relationships that

had been damaged by their unwillingness to participate in the audit project. In the end, the hospital implemented a modified version of the audit system and is working towards conducting an internal evaluation of its effectiveness next year. The evaluation will take into consideration the experiences of staff with the new system.

The drive towards translating research findings into changes in practice can sometimes obfuscate, without clearly discerning the unintended consequences of research. In this cautionary tale, the desire to prove that research can have a direct impact almost outweighed critical considerations of involvement. Yet, an anthropological intervention exposed the negative consequences of a particular research agenda. Critical, ethical and engaged reflection on the process of knowledge production acted as a reminder of our responsibility to those we study, and with whom we collaborate.

Conclusion

This special issue has urged us to think about impact from an anthropological standpoint, by taking its mandate seriously and at the same time going beyond the limited vision imposed by REF. We believe our discipline can make an important contribution to a reconceptualisation of impact by using ethnographic practice to shift the focus from product to process. As we have shown, process- and impact-driven research requires an active practice of engagement as well as methods to attend and respond to challenges and negotiations. Ethnographic techniques provide us with especially good tools to engage in such nuanced and continually unfolding and generative opportunities.

We do not presume that impact measurements will be upended, but we hope that while counting, sorting and filling in boxes, anthropologists can further an animated discourse on the

assessment of the impact of research, and shed light on the wide range of ways in which research can be turned into a more integrative, reflexive, and critical endeavour. We are also not suggesting that everyone becomes anthropologists, but that our examples are accessible to multidisciplinary and multi-stakeholder teams who may elect to take up an anthropological sensibility in their projects. We also invite anthropologists to not shy away from a mantle of engagement. In these ways, we believe that the values now inscribed in such impact-driven work like the REF can better achieve their potential.

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¹ The term 'knowledge translation' has been defined in different ways, but it generally refers to the translation of research into practice (Woolf 2008).

² Even though we talk about health care in this section, we mainly refer to the provision of health services in clinical settings.