

ARTICLE

CARING INSIGHT, OR CARING, IN SIGHT?

BY A. KUCKERT-WÖSTHEINRICH, P. ESTERHUIZEN, J. MAZ, J. GILMARTIN, H. CHIN

Abstract: This paper collates five studies presented as a symposium at the Anthropological Association of Ireland Annual Conference “Caring Cultures/Cultures of Caring” in March 2016.

The concepts of care and caring from a nursing perspective contextualises the paper against a backdrop of recent, high-profile national reports such as Willis (2012), Francis (2013), Berwick (2013), Keogh (2013) and Bubb (2014) – all of which emphasised the need for care to be patient-centred, compassionate and well informed. The aim of this contribution, therefore, is to critically examine the manner in which the concept of caring is presented in the nursing literature through philosophical and empirical approaches and discuss it in terms of clinical, organisational, and educational perspectives. The paper concludes with a critical reflection of the sustainability of a caring culture.

Correspondence: *a.kuckert@ak-neuss.de*

Introduction

Caring theory proposes a description of what occurs between nurse and patient within a caring relationship. Roach (1984) described the caring behaviours of nurses the six C’s of caring, which are competence, confidence, compassion, courage, conscience and commitment to which, in 2014, the duty of candour was introduced (NMC, 2014). Nursing

is constructed when social meanings, goals, tasks, responsibilities and duties have been identified and clarified. Caring finds expression in various healthcare measures and should be based on the expressive (human kindness) and instrumental (goal-orientated) interventions of nursing care activities. The strength of caring in nursing lies in its moral foundation (or the "ought" of nursing) which Chambliss (1996) describes as the nurse's "commitment to the welfare...of the 'whole' person" (p. 3).

Whilst the idea of “commitment to the whole person” as suggested by Chambliss (1996) is important, it should be recognised that health professionals are formed by the society in

which they live and are influenced by dominant societal values. To illustrate a societal shift of current attitudes, the example of obesity and weight loss is raised. While, at one point in time it was an exception, one should be mindful that Bariatric surgery currently appears to be growing in the UK, and is also increasingly prominent in anti-obesity policy. According to the NHS health and social care information centre, it is estimated that approximately 80% of all bariatric surgery patients are women (Ellis et al. 2006). Quality of life (QoL) after bariatric surgery is frequently assessed in terms of improvements in the patient's overall physical health (King et al. 2016) and the empirical and statistically supported evidence shows improvements in comorbidities after bariatric surgery (Costa et al. 2014).

Although several professionals believe that aesthetics should not drive the decision to undergo bariatric surgery (Throsby 2012, NICE 2014), it is frequently a point of contention in discussions of patients' motives to seek bariatric surgery (Munoz et al. 2007). The subjectivity of what represents an aesthetically pleasing body image will, unsurprisingly, vary and what is considered to be purely aesthetic in one moment (and by one health professional) may be medicalized in other contexts. Aesthetics, however, can be used as a measure of improvement of QoL. Some patients report feeling immensely happy, after reaching their ideal weight post-surgery being able to shop for clothing at a regular high street store or go to a public place without feeling embarrassed (Gilmartin et al. 2014). Other studies by Kitzinger et al. (2012) and Aldagal et al. (2012) showed that patients following massive weight loss reported problems with appearance, physical activity and finding clothes that fit appropriately and a desire for plastic surgery. On the basis of results outlined above body image concerns appear to impact on QoL amongst some massive weight loss patients.

Contemporary plastic surgery techniques allow correction of body contouring deformities following massive weight loss. According to The American Society of Plastic Surgeons more than 45,000 body contouring procedures

after massive weight loss were performed in 2012. While women who undergo plastic surgery may pursue bodily changes that do not conform to patriarchal and radically defined norms of feminine beauty, nevertheless, the degree of control they have in defining the nature of bodily modifications they desire is limited. Ultimately, they are in the hands of surgeons whose training has been based on Western ideals of beauty. Gilman (1999: 134) discerns: 'When we turn to the physician, we demonstrate our autonomy and abdicate it simultaneously'. Although Davies (1995) postulates a guarded support for the practice of plastic surgery as a way for individual women alleviate the suffering endured from their experience of alienation from their bodies, she stops short of advocating its redeployment as a political weapon to challenge dominant ideals of feminine beauty (Balsamo 1996).

Although the NHS has historically limited access to plastic surgery based on medical 'need', most aesthetic procedures performed in the UK are funded privately. Despite this change, however, a language of 'need' permeates the accounts of the physical and emotional pain associated with the pre-surgical body. The study undertaken by Gilmartin et al (2016, 2014) was based on data drawn from in-depth interviews with 18 British women who had undergone body contouring surgery following massive weight loss. Here, examples data from the study illustrate the difficulties and challenges they encountered.

The first of these challenges was a shifting body image: Prudence, a 58-year-old retired medical administrator, stated that before contouring surgery she was 'flappy' and in a 'mess', 'hated her body'. Similarly, Arran felt 'deformed', 'depressed' had 'severe body hatred' and struggled with daily life. The women's accounts share several important elements. They medicalize the pre-surgical body not only in terms of suffering that it seemed to cause, but also that it disrupted function and well-being, a source of disadvantage.

Several of the participants characterized the consumption of plastic surgery as essential to

fix their pre-surgical appearance ‘flaws’ and limiting function. Nevertheless, this fixing process appeared to be transitory because early accounts of scarring were expressed in highly negative terms. For instance, Nicole, aged 29 years, recounted ‘I’m like Frankenstein. I’ve got a long scar that goes all the way down my abdominal area. Once, um, I was having a bra fitting and the lingerie assistant saw it and said ‘Oh my God! Have you been burnt.’ I didn’t want to be spoken to like that’. Similarly, Prudence remarked: ‘The scarring is immense. I look like a rag doll underneath my clothes. I do not like people looking at my body’.

As, these excerpts show, early scarring was troublesome, being perceived as a salient feature that impacted on body esteem and well-being. In contrast, late scarring accounts were more enthusiastic, pointing to increased body esteem and dramatic shifts in appearance. The decline in salience was mostly attributed to the time (1-5 years) following surgery, suggesting that many had become accustomed to their new body image. For example, several respondents describe their scars as ‘fading’ and ‘shrinking’ with others saying ‘looking normal’ and expressing feelings of self-worth. Jewel, aged 37, disclosed: ‘feeling excellent about her new body, appearance and body confidence’. The majority were trying to recover lost time, invest in wearing new clothes and celebrate their new sense of self. Most saw themselves as being on a dynamic trajectory, being accepted and integrated into society rather than marginalised.

The participants in this study reported considerable distress in relation to body image, following massive weight loss and, for the first year after plastic surgery, experienced feelings of shame, disgust and ugliness. Their accounts imply that long and intense scars contributed towards their distress. In some cases, the negative effect of others reaction to their appearance implied a criticism. The psychological perspective presented by Lazar et al. (2009) also points out that, after a long duration of suffering because of the obesity, the emerging body image can become a source of deep shame and humiliation.

It is apparent that individuals undergoing bariatric treatment can become traumatised by the experience calling for a sensitive caring environment. Kirkpatrick et al (2009) suggest that health professionals should create a healing environment where ARTS modalities (A = aesthetic, R = recreational movement, T = therapeutic, and S = spiritual) are incorporated with best practice guidelines and toolkits. In their study, Gilmartin et al (2016, 2014) go further to suggest that in an attempt to empower clients to achieve their individual outcomes in terms of body image enhancement, it may be useful for caring professionals to facilitate body image acceptance programmes (Iannantuono & Tylka 2012; Wood-Barcalow et al. 2010), and/or offer involvement in support groups. The support groups might enable participants to ‘notice blocks’ and ‘let go of self-criticism’ before engaging with body image acceptance programmes. In addition, the employment of mindfulness cognitive behavioural therapy strategies (Gilbert 2010) might also be useful to facilitate positive effect ‘positive adjusters’. Gilmartin et al (2016, 2014) leaves the reader with an uncomfortable suggestion: ‘If we can abandon the prevailing culture that sets high values on slimness, youth and beauty, while rejecting ugliness as a disgrace, we could celebrate afresh and navigate a journey of caring optimism with compassion and goodwill’.

One could question how to reflect on the previous section, as in the Maz, (2016) meta-analysis undertaken to map, interpret, and critique a wider range of empirical evidence on professional nurse caring, four main philosophical caring positions were identifiable in the caring literature: (i) Positivist, which assumes an external and knowable reality that can be objectively measured, an impartial researcher, and the possibility of producing generalizable statements about the behaviour of the natural and social world; (ii) Interpretivist, which assumes a socially constructed reality that is never objectively or unproblematically knowable and a researcher whose identity and values are inevitably implicated in the research process, (iii) Critical, which assumes that the social order is inherently unstable. In particular,

it involves the domination of some groups by others, such as women by men, workers by capitalists, or patients by health professionals and (iv) Recursive (or integrative), which assumes that subject and object, micro and macro, social structure and human agency, are reciprocally related and that the purpose of research is to explore the flux between these various dualities over time.

There would appear to be a tension in the literature between a cognitive view of the human subject (the nurse is seen as an information processor or decision maker) and a relational view (the nurse is defined primarily by his or her position within a social system). The tension here might be expressed as “clinical work as decision-making” versus “clinical work as situated practice,” and between “knowledge as transferable facts” versus “knowledge as information-in-context.” Positivist traditions tend to view clinical work as largely reducible to a series of decisions. The alternative view is that clinical work is less about decision making than about addressing the ongoing, local question, what to do next? Since professional caring is personalized, filled with exceptions, and context bound, the nature of caring sets natural limits to the possibilities of being able to truly measure it.

The former perspective potentially explains sub-optimal care as a “knowledge gap,” “skills gap,” and “motivation gap” (thus as attributes of the individual nurse) for which much of the solution is the provision of information, training, and incentives. The cognitive view assumes, broadly, that the caring outputs of a group of nurses will be the sum of their individual inputs. The relational view sees the Nurse as inextricably linked to (indeed, as embodying and reproducing) wider social structures, institutions, or relationships (and perhaps as “shaping” Caring) and thus regards the collective as more than the sum of its parts.

While different language is used in the different traditions identified above (“situated, caring” “embedded caring,” “accommodated caring,” “networked caring”), these terms share many meanings, and all place greater emphasis on system-level approaches than on interventions

aimed at the individual. One key difference between two traditions that otherwise have much in common—caring -in-practice (meta-narrative 1: Professional Caring conversations) and the practice of caring (meta-narrative 2: The Principle of collaboration)—is the treatment of the human being. Caring-in-practice draws on structuration theory and sees human identity and agency as central to the analysis. The Practice of Caring in contrast, considers caring to be a *product* of the nursing team rather than something intrinsic to the individual nurse, so such things as knowledgeability and motivation are only weakly and indirectly theorized. One could expect the reader to feel manoeuvred into a position of dualism by attempting to coherently link the personalisation of care for the post bariatric surgical individual to the philosophical debate on the meaning of caring. This begs the question as to whether caring can be part of an academic debate or whether it is a fundamental element of “being human”.

Again in their systematic review Maz (2016) states that, at the synthesis stage, literature was primarily based on the following aspects: (i) social significance (Bassett, 2002; Leininger, 1991; Finfgeld-Connett, 2008), (ii) clarified goals and tasks (Coulson et al, 2008; Sochalski, 2004 and (iii) clarified responsibilities and duties (Zhang, et al, 2001; McCance et al, 1997). Further, nurses have characteristics and criteria that differentiate them from other professions (Watson, 1979; Benner et al, 1987; Cheung, 1998; Gaut, 1993; McCance et al, 1997; Morris & Fault, 2012). Personal factors (Swanson, 1991; Benner, 1984; Yam & Rossiter, 2000; Lewis, 2003) were also evident in that nurses often cite their motivation for entering the profession as ‘a calling’ or to fulfil a desire to care for others. A robust knowledge base (practical experience and know-how plus scientific knowledge/evidence base for practice) (Swanson, 1991; Paley, 2001; Asperso-Varano, 2007) is also apparent which duly supports the professionalism requiring the nurse to develop his/her own professional identity to become a member of the profession. This appears to be a process based on the individual’s subjective view of the profession

and professional ethics which provide moral guidance. Succinctly put, a common knowledge base and common values (Sumner (2006); Morris & Fault, 2012; Gooding et al, 1993; Gustafson, 2005) fuel the evolving nature of Total care and continuity of care (Briloski & Wendler (2005); Huynh et al, 2008; Izumi et al, 2012). Crossing professional borders. Dalpezzo (2009); Izumi et al, 2012 Henderson, 2001; Sochalski, 2004) was also identified as a way by which caring can be maximised with a strong professional identity and appreciation of contribution promoting co-operation with the patient/individual/family/significant other. Likewise, knowledge of other professions and esteem for the contribution of others is also identified.

In keeping with the personal interpretation of caring as suggested by Maz (2016) and others, a multidisciplinary, collaborative, organisational approach to caring as suggested above is reflected in an institution such as the St. Augustinus Memory Centre situated in Neuss, Germany. It highlights how individual and professional perspectives translates to understanding different points of view in the context of supporting people diagnosed with dementia. Kuckert-Wöstheinrich (2016) indicates that the St. Augustinus Memory Centre was built to incorporate a nursing home, a day care unit, an out-patient's clinic for psychogeriatric patients, an education and a research department with the fundamental goal being to assure or improve the service user's quality of life and is seen as being one of the most important factors of the caring process.

According to O'Rourke et al (2015) four factors related to quality of life can be distilled. These factors are: relationships (together vs alone), agency in life today: (purposeful vs aimless), wellness perspective: (well vs ill), and sense of place: (located vs unsettled). Using interventions related to one of these four factors result in either happiness as an outcome for good quality of life or sadness for a poor quality of life. The guiding principle of the St. Augustinus Memory-Centre is the multidisciplinary approach in providing service-users, diagnosed with dementia, with

an appropriate, safe and comfortable environment, dignity and respect and acknowledging the individual as an equal member of a single society in order to stabilize or improve their quality of life. This overriding principle is communicated and embodied by, and through, the management.

Representatives from different disciplines including the architect, family members and people diagnosed with dementia were called upon to describe their vision of care and support for this client group and be in partnership from the inception of the concept, through the design of the building to the inauguration of the Memory Centre. In the following excerpts, a service user, followed the family and professionals articulate their ambitions associated with care for this, society's, vulnerable group.

The person diagnosed with dementia: "It also happens that I do not remember. I think: What has happened now? In the supermarket, it has happened more than once that I was standing at the cashier, and took things away from other people. People behind me shouted: "Hey! He wants to steal! That's not done!" When this happens several times, it is absorbed into your self-image. ... I would like to be free, but basically the fear increases. The fear, that I may lose control again. And so I am glad that my wife does everything. I think sometimes that I cannot go shopping anymore. There were times that I felt that something has been stolen from me while shopping. But it is only a feeling I had... I had not been robbed, but had mislaid something in the checkout area."

The family member about supporting their loved one: "...to arrange daily routines or to remember something is very difficult for him. I always notice that when we go out or when we have visitors. The same evening or the next day he thinks about everything and then asks, "When was that, where have we been?" "Yesterday we were ..." He does not answer, he looks at me, waiting until it comes to his mind, tries to reassemble the threads. That's very sad. If we have nothing planned, he reads the newspaper all day. Some articles more than once, each time anew. To start a conversation,

I ask, "What's interesting in the newspaper today?" "Here! Read it yourself!" Then I read line by line loudly and try to involve him in a conversation. He prefers to sit for hours with the newspaper...then he is at peace. But in the end he cannot remember a lot."

The senior nurse about her way of caring: "Someone, who wants to work with our residents in our nursing home, has to bring along a lot of empathy. One must work from the heart. If it is not from the heart, then it does not matter if I'm a nursing assistant, technician, nursing manager, housekeeper, facility manager or cleaning lady. I do not think that I can do my work well, because it does not correspond to the high standards, I set for myself. For example, if I were a housekeeper and I don't care whether the tablecloth or the entrance area is clean, then I am not working from my heart. I put my heart into my work and I think that I have many staff, who also put their hearts into their work. It is not always easy to continually do this work. It is quite normal that one has moments that are easier or harder. But, because it is so important to me and I have high standards toward myself, I pull myself together time and again, and I demand the same from my colleagues."

The medical doctor from her, supportive, vision: "The overriding principle in the treatment is not to harm the patient, but to promote health and improve quality of life. Here, doctors, psychologists and therapists depend on continually updating their knowledge and not only take mental illness into account, but also any somatic illnesses that may be present. Each patient has an individually tailored treatment plan, which allows a reasonable daily structure."

The architect about his vision of care: "The implementation process was, and still is, influenced by the aim to collaborate very closely with users in order to set objectives and planning principles for the centre's design. Workshops, excursions and regular service-user meetings have underpinned the whole process led by the guiding principle that dementia is not "a disease", but consists of various symptoms. These symptoms must be

taken into account in the care and support, but also in the architecture. For example, different living environments for group homes were created to serve the personal design preference of the residents such as tasteful, modern or country style. This offers the possibility of orientation for the service-user. Furthermore, entrances to private apartments were deliberately designed differently, so that a unique address is created within the group home and the recognition value is increased."

Everyone – doctor, architect, nurse, care assistant, family member, neighbour or facility service staff – is supported in operationalizing this idea in terms of their own discipline. In this process communication strategies play an invaluable role. The added value of the multidisciplinary approach is celebrated and communicated; people are treated in an equal, respectful way paying attention to and using their specific knowledge and competencies. Appreciating specific diversity amongst the employees is the spine of success for the institution. The aim of this approach is to align human resource processes and human resource policies of organizations such that, on one hand, the workforce reflects the demographic diversity of the environment and, on the other hand, all employees are valued and motivated to maximise and fulfil their potential for the benefit of the organization and therefore for the quality of life of the people diagnosed with dementia.

As reflected in the opinions of the stakeholders above, this approach seems to sit more comfortably within a non-positivist tradition that views Caring as either a social construction (something whose meaning and purpose are a matter of interpretation) and is, specifically, situated within constantly changing contexts rather than fitting into a positivist tradition of an essentialist, functionalist, and determinist view of Caring (which has inherent properties that will become manifest in certain tasks and, if implemented properly, will more or less predictably improve the process and outcome of the nursing clinical encounter).

As seen from the preceding discussion, caring in nursing is multifaceted and complex from

both personal and organisational perspectives. Paley (2001:188) complains that scholars are "describers on the same treadmill" because they do not define caring in any practical or applicable way. Esterhuizen (2016) suggests that this raises challenges for nursing as a profession in terms of how new generations of nurses are educated to meet the expectation to provide compassionate care (Department of Health, 2012) in an environment with fewer resources (Royal College of Nursing, 2012). An environment where the provision of compassionate care risks being reduced to a checklist (Department of Health, 2012; McElroy & Esterhuizen, 2016) and where quality is assessed in terms of quantifiable audit ratings (White et al, 2014), how does professional education support nursing students develop professional identity that builds on their personal vision and their deep motivation to enter the profession in order to care (Swanson, 1993; Burtson and Stichler, 2010) and where they are supported by positive role models, but are also confronted with power imbalances and bullying (Freshwater, 2000; Farrell, 2001; Burnes & Pope, 2007). Nursing education has attempted to address this question and various authors (Melia, 1987; Spouse, 2000, 2001, 2003; Esterhuizen 2010) identify the impact that professional socialisation has on students. In a longitudinal study, Esterhuizen (2009, 2010) discusses the merits of confluent education (Castillo, 1978; DeMeulle & D'Emidio-Caston, 1996) in an attempt to blend physico-psycho-socio-spiritual aspects of an individual student into a single, Gestalt, learning process which cannot be separated from the social context in which learning takes place. Central in this approach to education is the empowerment of the individual to manage their learning process in order to cope with and address challenges they encounter en route to registration.

Reflecting on the preceding discussion in this paper in which the authors suggest that sustainable caring has both personal and organisational components, Chin (2016) reports on Smith's (2015) study exploring 'curiosity' among nurses take the implications of this idea further. Smith (2015) refers to

Silvia & Kashdan (2009) who state that 'curiosity' is a critical motive which stimulates action to explore, integrate and build knowledge. Given the fact that nursing's professional epistemic discourse invites nurses to engage in reflexive knowledge activities to provide and improve patient care, curiosity would seem to be a vital mechanism for nurses to embrace and engage in. Smith (2015) suggests a nursing narrative on curiosity which is socially constructed, with curiosity acting as a liberator and antecedent to reflexive knowledge correspondence and construction. Primarily, the study found that nurses viewed their engagement in curiosity as a key asset for melding the various sources of knowledge required for the provision of person-centred care. Curiosity is, however, also lived within the tension afforded by organisational compliance discourse, which demands engagement with prescriptive, formulaic forms of knowledge and a felt dismissal of the need for professional nursing knowledge and curiously crafted practice. The perceived dominance of prescription and compliance leads nurses into moments of incongruence to perceived epistemic truths and highlights an immersion in multiple realities. Smith (2015) suggests that in these moments of incongruence, curiosity can become inhibited, resulting in expressed uncertainties regarding nurses' professional identity, knowledge and future purpose. To ameliorate uncertainty, acts of containment mediate the existential and cognitive impact on inhibited curiosity. Personal independent action is taken externally to the professional role, which acts as practices of self-formation and readiness to resist. Acts of resistance to dominant organisational compliance discourse are evident, as nurses engage in curiosity on a moral but covert basis, in an attempt to preserve epistemic truths, subvert and circumvent compliance and prescription and thus exercise professional freedom. Concerns are raised as to 'knowledge lost', which may be generated from covert curiosity practices. Nurses lament a lack of discourse on curiously led practice, resulting in perceptions that curiosity is significantly compromised as a critical motive to engage

with professional knowledge correspondence, practice improvement or innovation initiatives.

In these reflections on the symposium ‘Caring insight, or Caring, in sight?’, the authors have presented their thoughts on caring within the nursing context, highlighting the need for conscious and caring practitioners in the clinical setting, from organisational and educational perspectives. In keeping with the theme of ‘curiosity’, it was not the intention of the authors – either during the symposium, or in this publication – to provide answers, but to pique the listener’s and reader’s curiosity to reflect on their own perceptions of caring in the Twenty-first Century. The sustainability and fitness for practice of ‘care’ and ‘caring’ concepts that have been handed down through generations of health care providers in general and nurses (in this case) in particular and what the ambitions are, could and should be as we move towards the Twenty-second Century.

References

- Aldagal SM, Samargandi OA, El-deek BS. et al. 2012. Prevalence and Desire for Body Contouring in Postbariatric Patients in Saudi Arabia. *N Am J Medical Science* 4 (2): 94-98.
- Aspesoa-Varano, E. 2007. Educated caring: The emergence of professional identity among nurses. *Qualitative Sociology*. 30, 249-274.
- Bassett, C. 2002. Nurses’ perceptions of care and caring. *International Journal of Nursing Practice*, 8, 1, 8-15.
- Balsamo A. 1996. *Technologies of the Gendered Body: Reading Cyborg Women*. Durham NC and London: Duke University Press.
- Benner, P. 1984. *From novice to expert: Excellence and power in clinical nursing practice*. Menlo Park, CA: Addison-Wesley.
- Benner, P. & Tanner, C., 1987. Clinical judgement: how expert nurses use intuition. *American Journal of Nursing* January, 23–31.
- Berwick, D. 2013. *Berwick Review into Patient Safety*.
<https://www.gov.uk/government/.../berwic>
- [k-review-into-patient-safety](#) (Accessed 17th December 2015)
- Briloski, G.A. & Wendler, M.C. 2005. An evolutionary concept analysis of caring. *Journal of Advanced Nursing*. 50(6): 641-50.
- Bubb, B. 2014. Winterbourne View- Time for Change: Transforming the commissioning of services for people with learning disabilities and/or autism.
<https://www.england.nhs.uk/2014/11/26/learning-disabilities-action/> (Accessed 17th December 2015)
- Burnes, B. and Pope, R. 2007. Negative behaviours in the workplace: A study of two Primary Care Trusts in the NHS. *International Journal of Public Sector Management*. 20(4): 285 – 303.
- Burtson, P.L; Stichler, J.F. 2010. Nursing work environment and nurse caring: relationship among motivational factors. *Journal of Advanced Nursing*. 66(8): 1819–1831.
- Castillo, G. A. 1978. *Left-Handed Teaching: Lessons in Affective Education*. (2nd ed.) Toronto: Holt, Rinehart & Winston.
- Chambliss DF. 1996. *Beyond Caring. Hospitals, Nurses and the Social Organization of Ethics*. Chicago, Ill: The University of Chicago Press.
- Cheung, J. 1998. Caring as the ontological and epistemological foundations of nursing: A view of caring from the perspectives of Australian nurses. *International Journal of Nursing Practice*, 4, 225-3.
- Chin, H. 2016. Paper title: Curiosity, Knowledge and Liberty: A narrative study exploring nurse engagement in curiosity. Presented as a paper during the symposium ‘Caring insight, or Caring, in sight?’ at the Anthropological Association of Ireland Annual Conference “Caring Cultures/Cultures of Caring” in March 2016.
- Costa RC, Yamaguchi N, Santo MA, Riccioppo D, Pinto Jr PE. 2014. Outcomes on quality of life, weight loss, and comorbidities after Roux-en-Y gastric bypass. *Arq Gastroenterol*. 51(3): 165-70.
- Coulson, L; Mok, M; Krause, K.L; Andresen, M. 2008. *The pursuit of excellence in nursing*

- care: What does it mean??
DOI:101046/j/1365-2648.1996.25921.x
- Dalpezzo, NK. 2009. Nursing care: A concept analysis. *Nursing Forum*, 44, 256-64.
- Davis K 1995. *Reshaping the Female Body. The Dilemma of Cosmetic Surgery*. New York and London: Routledge.
- DeMeulle, L., & D'Emidio-Caston, M. 1996. Confluent education: A coherent vision of teacher education. In J. H. Brown (Ed.), *Advances in confluent education*, Vol 1: Integrating consciousness for human change (pp. 43-62). Greenwich, CT: JAI Press.
- Department of Health. 2012. *Compassion in Practice*. <https://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf> (Accessed 14th August, 2016)
- Department of Health. 2012. *Ward rounds in medicine: Principles for best practice*. A joint publication of the Royal College of Physicians and Royal College of Nursing. <https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2012/october/pub-004342.pdf> (Accessed 14th August, 2016).
- Ellis JE, Macknight M, Wilinon JR. 2006. Obesity Surgery in England: an examination of health episode statistics 1996-2005, *Obesity Surgery*, 17, 3, 400-5.
- Esterhuizen, P. 2009. Annemieke's "Blue sky story: the one that got away". *International Journal for Human Caring*. 13 (2): 14-20.
- Esterhuizen, P. 2010. *The journey from neophyte to registered nurse: a Dutch experience of professional socialization*. VDM Verlag Dr. Muller: Saarbrücken.
- Esterhuizen, P. 2016. Paper title: Holistic nurse education as a route to achieving holistic care? Presented as a paper during the symposium 'Caring insight, or Caring, in sight?' at the Anthropological Association of Ireland Annual Conference "Caring Cultures/Cultures of Caring" in March 2016.
- Lazar, C.C.; Clerc, I.; Deneuve, S.; Auquit-Auckbur, I.; Milliez, P.Y. 2009. Abdominoplasty after major weight loss: improvement of quality of life and psychological status. *Obesity Surgery*. 19, 1170-1175.
- Finfgeld-Connett, D. 2008. Meta-synthesis of caring in nursing. *Journal of Clinical Nursing*, 17, 196-204.
- Francis Report of the Mid Staffordshire NHS Foundation Trust Public (Francis Report) 2013. Inquiry <https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry> (Accessed 17th December 2015).
- Freshwater, D. 2000. Crosscurrents: Against cultural narration in nursing. *Journal of Advanced Nursing*. 32 (2): 481-484.
- Farrell, G.A. 2001. From tall poppies to squashed seeds: Why don't nurses pull together more? *Journal of Advanced Nursing*. 35 (1): 26-33.
- Gaut, DA. 1993, *Caring: A vision of wholeness for nursing*. *Journal of Holistic Nursing*, 11, 164-71.
- Gilbert, P. 2010 *The compassionate mind*; Constable and Robinson, London.
- Gilman S. 1999. *Making the Body Beautiful*. Princeton, NJ: Princeton University Press.
- Gilmartin J, Long AF, Soldin M. 2014. Changing body image and well-being: following the experience of massive weight loss and body contouring surgery. *Healthcare* 2, 150-165.
- Gilmartin, J. 2016. Paper title: The patient's experience of changing body image and well-being following massive weight loss and subsequent body contouring surgery. Presented as a paper during the symposium 'Caring insight, or Caring, in sight?' at the Anthropological Association of Ireland Annual Conference "Caring Cultures/Cultures of Caring" in March 2016.
- Gooding, B.A, M. Sloan & L. Gagnon, 1993. Important nurse caring behaviours: Perceptions of oncology patients and nurses. *Canadian Journal of Nursing Research*, 25, 65-76.
- Gustafson, D.L., 2005. Transcultural nursing theory from a critical perspective. *Advanced in Nursing Science*, 28, 2-16.
- Henderson, A. 2001, *Emotional labour and nursing: An under-appreciated aspect of caring work*. *Nursing Inquiry*, 8, 130-8.

- Huynh, T.; Alderson, M.; Thompson, M. 2008. Emotional labour underlying caring: An evolutionary concept analysis. *Journal of Advanced Nursing*, 64: 195-208.
- Iannantuono, A.C.; Tylka, T.L. 2012. Interpersonal and intrapersonal links to body appreciation in college women: An exploratory model. *Body Image*, 9, 227-235.
- Izumi, S; Konishi, E; Yahito, M. 2012. Japanese patients' descriptions of "The Good Nurse" personal involvement and professionalism. *Advances in Nursing Science*, 29, 2, 14-26.
- Keogh, B. 2013. Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report.
- King WC, Chen JY, Bell S et al. 2016. Change in pain and physical function following bariatric surgery for severe obesity. *JAMA* 315 (13) 1362.
- Kirkpatrick, M.K.; Esterhuizen, P.; Drake, D. 2009. An Optimal Caring/Healing Environment for Obese Clients. *Bariatric Nursing and Surgical Patient Care* 4(2): 123-132.
- Kitzinger H.B, Abayev S, Pittermann A. et al. 2012. After massive weight loss: patients' expectations of body contouring surgery. *Obesity Surgery* 22 (4): 544-8.
- Kuckert-Wöstheinrich, A, 2016. Paper title: Changing perspectives – an institutional challenge in delivering qualitative good care for people with dementia. Presented as a paper during the symposium 'Caring insight, or Caring, in sight?' at the Anthropological Association of Ireland Annual Conference "Caring Cultures/Cultures of Caring" in March 2016.
- Leininger, M. M. (1991). *Culture care Diversity and Universality: A Theory of Nursing*. New York: National League of Nursing Press.
- Lewis, SM. 2003. Caring as being in nursing: Unique or ubiquitous. *Nursing Science Quarterly*, 16. 37-43.
- McCance, T.V; H.P. McKenna & JKP. Boore. 1997. Caring: Dealing with a difficult concept. *International Journal of Nursing Studies*, 34: 241-8.
- Maz, J. 2016. Paper title: What is the meaning of caring for professional nurse practitioners? Presented as a paper during the symposium 'Caring insight, or Caring, in sight?' at the Anthropological Association of Ireland Annual Conference "Caring Cultures/Cultures of Caring" in March 2016.
- McElroy, C.; Esterhuizen, P. 2016. Compassionate communication in acute healthcare; establishing the face and content validity of a questionnaire. *Journal of Research in Nursing* (in press).
- Melia, K. 1987. *Learning and working: The occupational socialisation of nurses*, Tavistock, London.
- Morris, A & Fault, D. 2012. Perspective transformation: Enhancing the development of professionalism in RN-to-BSN students. *Journal of Nursing Education*, 46, 10, 445-451.
- Munoz DJ, Lal M, Chen EY et al. 2007. Why patients seek bariatric surgery: a qualitative & quantitative analysis of patient motivation. *Obesity Surgery*. 17(11) 1487-91.
- National Institute for Health and Clinical Excellence (2014) *Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children*. NICE Guidelines, London. <http://www.nice.org.uk.Guidance> (accessed June 2016).
- Nursing and Midwifery Council, General Chiropractic Council, General Dental Council, General Medical Council, General Optical Council, General Osteopathic Council, General Pharmaceutical Council, Pharmaceutical Society of Northern Ireland (2014) *The professional duty of candour* available at: <https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/openness-and-honesty-professional-duty-of-candour.pdf> (accessed 16 June 2015).
- O'Rourke HM, Duggleby W, Fraser KD, Jerke L. 2015. Factors that affect quality of life from the perspective of people with

- dementia: a metasynthesis. *Journal of the American Geriatrics Society*. 63(1):24-38.
- Paley J. 2001. An archaeology of caring knowledge. *Journal of Advanced Nursing*; 36: 188-198.
- Roach MS. 1984. *Caring: The human mode of being*. Toronto, ON: University of Toronto Press.
- Royal College of Nursing. 2012. *Overstretched. Under-resourced. The UK nursing labour market review 2012*. London: Royal College of Nursing.
- Silvia P.J., Kashdan T.B. (2009) Interesting things and curious people: Exploration and engagement as transient states and enduring strengths. *Social and Personality Psychology Compass*. 3(5): 785-797.
- Smith, H.E. 2015. *Curiosity, Knowledge and Liberty. A Narrative Study Exploring the Lived Reality of Registered Nurse Engagement with Curiosity, in the National Health Service in England*. University of Leeds: PhD Thesis.
- Sochalski, J. 2004. Is more better? The relationship between nurse staffing and the quality of nursing care in hospitals. 42, 2, 1167-73.
- Spouse, J. 2000. An impossible dream? Images of nursing held by pre-registration students and their effect on sustaining motivation to become nurses. *Journal of Advanced Nursing*. 32 (3): 730-739.
- Spouse, J. 2001. Workplace learning: Pre-registration nursing students' perspectives. *Nurse Education in Practice*. 1: 149-156.
- Spouse, J. 2003. *Professional Learning in Nursing*. Oxford: Blackwell Publishing.
- Sumner, L. 2006. Pediatric care: The hospice perspective. In B.R. Ferrell, & N. Coyle (Eds.), *The textbook of palliative nursing* (2nd ed., pp. 909-924). New York: Oxford University Press.
- Swanson, K.M. 1991. Empirical development of a middle range theory of caring. *Nursing Research*, 40(3):161-6.
- Swanson, K.M. 1993. Nursing as Informed Caring for the Well-Being of Others. *IMAGE: Journal of Nursing Scholarship*. 25(4): 352-357.
- Thorsby K. 2012. Obesity surgery and management of excess: exploring the body multiple. *Sociology of Health & Illness*. 34 (1) 1-15.
- Willis, P. 2012 *Quality with compassion: the future of nursing education*. Report of the Willis Commission on Nursing Education, 2012. www.williscommission.org.uk/__data/.../The_Willis_Report_2012
- Watson, J. 1979. *Nursing: The Philosophy and Science of Caring*. Boston: Little Brown
- White, M.; Wells, J.S.G.; Butterworth, T. 2014. The transition of a large-scale quality improvement initiative: a bibliometric analysis of the Productive Ward: Releasing Time to Care Programme. *Journal of Clinical Nursing*. 23(17-18): 2414-2423.
- Wood-Barcalow, N. L.; Tylka, T. L.; Augustus-Horvath, C. L. 2010 "But I like my body": Positive body image characteristics and a holistic model for young-adult women. *Body Image*. 7, 106-116.
- Zhang, Z, W. Luk. 2001. Nursing competencies: personal characteristics contributing to effective nursing performance. *Journal of Advanced Nursing*, 33, 4, 467-74.
- Yam, B.M. & Rossiter, J.C. 2000. Caring in nursing: perceptions of Hong Kong nurses. *Journal of Clinical Nursing*. 9(2): 293-302.