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Reflections of the collaborative care planning as a person-centred practice

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Abstract

The ageing population is increasing worldwide with an increase in chronic disorders. At the same time, person-centred care has become a policy within both health and social care. To facilitate coordination and collaboration and integrate the older adult's perspective in the decision-making process the collaborative care planning process with the development of a written care plan can be used. In this study, the result of an interpreted analysis of four empirical studies of the collaborative care planning as a person-centred practice will be discussed and reflected on. A framework based on the French philosopher Paul Ricoeur's little ethics was used in the synthesis of the studies. The findings revealed two common threads: personhood and power asymmetry. Both challenges in achieving a person-centred collaborative care planning. Ricoeur's dialogical thinking and description of a person served as an underpinning in discussing and reflecting upon the findings of the interpreted synthesis. Collaborative care planning is a complex process. However, Ricoeur's philosophy contributed to a greater understanding of the collaborative care planning as a person-centred practice and accentuated that ethics, human values, and the older adults and care partners perspectives need to be given the same importance and considerations as the medical and social sciences perspectives for the collaborative care planning process to truly become person-centred.

KEYWORDS

collaborative care planning, ethics, health and social care, person-centred practice, Ricoeur

1 | INTRODUCTION

The demographic and epidemiological transitions with increased survival of older adults have resulted in ageing populations worldwide and an increase in chronic disorders (Prince et al., 2015). Older adults want to be acknowledged and respected as a person (Westgard et al., 2019), regarded as an equal, involved in decision-making and making contributions (Gregory et al., 2018) and having consistency and flexibility of the care and services (Kwan et al., 2019). However, older adults often feel powerless in relation with the health and social care professionals and system. Research has shown that they experience lack of recognition of their personhood and unique needs (Tiilikainen et al., 2019) and feel unseen and unheard as a partner (Gregory et al., 2018) and unable to partake in decision-making and care planning (Kwan et al., 2019).

To involve patients in decision-making has been a guiding principle for many decades. Paternalistic approaches have been gradually losing

ground, and in health and social care policies, strategies and practices principles of person-centredness have become the norm (Edvardsson et al., 2020; McCormack & Dewing, 2019). To facilitate coordination and collaboration and integrate the older adult's perspective in the decision-making process the collaborative care planning process with the development of a written care plan can be used. Research has shown that the plan increase person-centredness, reduce unnecessary care utilisation (Burt et al., 2012; Newbould et al., 2012) and guarantee transition between care levels (Britten et al., 2016). In Sweden, collaborative care planning, between health and social care, normally takes place when a person is discharged from the hospital or when a person, living in their own home, has the need for efforts from both health and social care. To achieve deeper knowledge and understanding of collaborative care planning as a person-centred practice an interpreted synthesis of four empirical studies and their results was conducted (Table 1). The studies described different aspects of the collaborative care planning taking place between health and social care for older adults 65 years and above (Jobe et al., 2018, 2020, 2021, in press).

2 | INTERPRETED SYNTHESIS

Inspired by Wallstrom and Ekman's (2018) article the interpreted synthesis used the French philosopher Paul Ricoeur's (1913–2005) 'little ethics' and the ethical intention of '*aiming for a good life with and for others in just institutions*' for the analysis. Ricoeur (1994) discusses

TABLE 1 Summary of the empirical studies

Study I	**Aim:** To describe the care planning conference from the participants and the researchers' perspectives focusing on exploring aspects of person-centred interactions. **Method:** Qualitative case study. Observation of one care planning conference and interviews with participants before and after. **Findings:** The purpose of the collaborative care planning conference was not clear, and the different parts in the planning process were not achieved. The analysis of aspects of person-centred interactions resulted in three themes: 'expectations meet reality, that is, the expectations of the participants ahead of the conference differed, they were not able to connect during the conference, and the outcome was not apparent. 'Navigate without a map' concerned the professionals' lack of knowledge. Despite an established organisation for collaborative care planning, they struggled with the implementation. 'Lose the forest for the trees' revealed that the professionals performed a task; however, the reason for their undertaking, the older adult, was absent. Jobe, I., Lindberg, B., Nordmark, S., Engstrom, A. (2018). The care planning conference: Exploring aspects of person-centred interactions. *Nursing Open*, 5, 120–130. DOI: 10.1002/nop2.118
Study II	**Aim:** To explore how person-centred practice framework can be applied to professionals participating in collaborative planning. **Method:** Qualitative content analysis. 11 health and social care professionals were interviewed. **Findings:** The findings revealed that the professionals did not use the guidelines for collaborative care planning in the same way. The professionals from health and social care defined person-centred practice differently, and power asymmetries between organisations and professionals became evident. The professionals struggled to implement a Constructivist person-centred collaborative care planning process; it was a complex process and system factors at both micros- and macro-level needed to be considered. Jobe, I., Lindberg, B., Engstrom. A. (2020). Health and social care professionals' experiences of collaborative planning -Applying the person-centred practice framework. *Nursing Open*, 7, 2019–2028. DOI: 10.1002/nop2.597
Study III	**Aim:** To explore the collaborative care planning process and attributes that contribute to making the process work for all participants. **Method:** Grounded Theory. Observations of collaborative care planning conferences and interviews with older adults, care partners, health and social care professionals, and managers. **Findings:** A conceptual model was developed that explained the attributes identified and how the overarching process "holding the chain together" was connected with the two sub-processes: the missing link and connecting the links. The participants' different perspectives were brought together, and the complexity of the process was confirmed. The process and participants were affected if attributes were missing or did not function optimally. We concluded that a mutual ethic could contribute to making the process work for all the participants. Jobe, I., Engström, Å., Lindberg, B. (2021) The collaborative planning process: holding the chain together. A grounded theory study. *Cogent Medicine*, 8:1, 1896426. DOI: 10.1080/2331205X.2021.1896426
Study IV	**Aim:** To explore the content of documented collaborative care plans and describe whether they demonstrated a person-centred approach to practice. **Method:** Content analysis. 60 collaborative care plans. **Findings:** The quality of the documentation was poor and content lacking. There seemed to be a confusion about what and how to document the different parts (i.e. main goal, objectives, and interventions). The analysis of person-centredness revealed that two thirds of the collaborative care plans had no component related to person-centredness documented. Jobe, I., Engström, Å., Lindberg, B. (in press) Collaborative care plans: having a person-centred approach or not?

his ethics from a hermeneutics of the self and the three levels: self, interpersonal and societal. Aiming for a good life is the act itself, what a good life is for the person. With and for others shows the dialectic with the self but also the care of others and the partnership in care. Just institutions are about the third person in the concept of personhood and the sense of justice, all people have equal value, and we need institutions to live a good and flourishing life. The definition created was: 'Older adults and their care partners expressing their narrative and the health and social care professionals listening (a good life for the older adult), reaching a common agreement (with and for others) of the care and services provided within a continuous partnership within the health and social care (just institutions) that cares for all older adults, care partners and professionals equally' (Inspired by Wallstrom and Ekman [2018]). The results of the studies were problematized against the definition in a dynamic process looking for similarities and discrepancies. Extracted sentences and keywords were grouped and re-contextualized, and in the process, a new understanding emerged. The synthesis revealed two common threads: personhood and power asymmetry.

The first common thread, personhood, revealed that for the older adults participating in the studies it was essential to be seen as a person and to be respected and listened to. The older adults all had care partners (family or friends) acting as a lifeline, providing care and services for them and communicating with authorities and health and social care professionals, and thereby being an indispensable part of their lives. Both the older adults and their care partners wanted the professionals to acknowledge and see them as unique persons in their own context. They felt that the health and social care professionals lacked knowledge of them as persons and their needs, resources, and situation. The care partners also acknowledged that it was sometimes difficult to separate their own needs from the needs of the older adult. The health and social care professionals had no common approach to person-centred practices, did not define and carry out collaborative care planning with the same values and beliefs. The person-centred practices were not visible in everyday practice. The lack of person-centredness was also reflected in the way they documented the collaborative care plans. The collaborative care plans contained only vague traces of the older adults and their values and beliefs, even less amount of evidence of professionals' knowledge of the older adults or professionals' ability to recognize the uniqueness of the person.

The second common thread, power asymmetry, revealed that the older adults lacked knowledge of what the collaborative care planning comprised, its purpose, and what was expected from them as participants. The health and social care professionals were responsible for inviting older adults as equal partners in the collaborative care planning process and linking the different parts of the planning process together. However, their individual views and definition of person-centred practice decided the level of the partnership. The collaborative care planning process highlighted power dimensions and an asymmetric relationship between the older adults, their care partners and the professionals. The older adults and their care partners felt sidelined, and it was difficult for them to influence the care and services provided and to participate in the decision-making process. The older adults were dependent on their care partners, and sometimes they did not want the same things. During the collaborative care planning conference, the professionals outnumbered the older adult with a care partner. Observing conferences, it was difficult to know if or when decisions were made and only 4 of 60 collaborative care plans contained evidence of shared decision-making. There were also power differences between professionals and between health and social care professionals and their organisations. The collaboration and teamwork between professionals and between professionals from the different organisations did not function in an optimal way. The professionals felt they lacked a good method for conducting collaborative care planning together with the older adult, and none of the documented collaborative care plans had a holistic perspective.

3 | PHILOSOPHICAL UNDERPINNINGS

The findings of the interpreted synthesis revealed challenges in achieving a person-centred collaborative care planning. They also highlighted the need for a different focus in health and social care on the interpersonal and institutional levels. Even if person-centredness is endorsed within health and social care, there is still a lack of guidance on how to successfully implement it (Santana et al., 2018). One can also argue that it is difficult to practice person-centredness with little knowledge and understanding of the philosophical ideas underlying the concept.

In this study, I will anchor my discussion of the challenges with practising a person-centred collaborative care planning using the work of the French philosopher Ricoeur (1994). His philosophy was a continuous discussion where he, through mutual exchange, confronted, merged and balanced different interpretations and French and German philosophy and analytical philosophy. His dialogical thinking and description of a person will serve as an underpinning in the reflection.

4 | PERSONHOOD

Ricoeur (1994) uses hermeneutic of the self to explain who the person is. He is doing this through reflective intermediation of the self, a dialectic relation between idem and ipse, a dialectic between selfhood and sameness. Our identity as selfhood (ipse), who I am, defines our identity as sameness (idem), what I am, when I meet and integrate with other people. '*The selfhood of oneself implies otherness to such an intimate degree that one cannot be thought of without the other*' (Ricoeur, 1994, p. 3). According to Kristensson Uggla, (2014, 2019), to be able to travel from what (idem) the person is to who (ipse) the person is, the health and social care professionals need to introduce a narrative culture of knowledge.

A narrative culture of knowledge requires changes in the health and social care organisations and of the health and social care

professionals' attitudes (Naldemirci et al., 2020). The health and social care professionals need to listen to the narration. Active listening is a fundamental and complex phenomenon in the encounter with other human beings and an integral part of ethic communication and an ethical, caring relation. Listening brings an understanding of belonging to a larger common story and a common world with a common meaning (Koskinen & Lindstrom, 2015).

All the professionals said they conducted the collaborative care planning as a person-centred practice. However, the older adults expressed feelings of being invisible and they wanted to be acknowledged as unique persons in their own context. There can be several reasons why older adults felt invisible and not acknowledged. Suppose the health and social care professionals view the older adult as an object. In that case, the professionals created a distance between them and the older adult and in doing so failed to recognize the other (Foth et al., 2017). By viewing the older adult as an object, they also denied their own humanity and functioned only as hands in a system constructed to take care of and fix biological machines (Mitchell, 2019).

Ricoeur (1994) view a person and the person's value from a relationship perspective, that is, we develop in relationship with others, and we become acknowledged through others. The older adults in the studies all depended on assistance and support from care partners. During the collaborative care planning process, the care partners often acted as proxies on the older adult's behalf and contributed to narrating the life story of the older adult. This is common during care interactions in health and social care (Rejno et al., 2020). People reveal themselves as humans through narration, and it is also how their identity as persons appear. Alternatively, in the words of Ricoeur, *'the narrative constructs the identity of the character, what can be called his or her narrative identity, in constructing that of the story told. It is the identity of the story that makes the identity of the character'* (Ricoeur, 1994, p. 148).

The care partners revealed a close relationship with the older adults and expressed it as being part of each other and creating a narrative and life together. The uniqueness of the person is always shaped and expressed through a web of relations, including the one between health and social care professionals and the older adult (Naldemirci et al., 2018). The older adult and their care partner narratives and the health and social care professionals' narratives become jointly constructed during the collaborative care planning and bind them together as all life stories are intertwined (Kristensson Uggla, 2019).

According to Ricoeur (1994, p. 158), *'the idea of gathering together one's life in the form of a narrative is destined to serve as a basis for the aim of a good life'*. The collaborative care planning is taking place to support the older adult to achieve their aim in life. The care and services provided by the health and social care professionals should allow the older adult to maintain existing abilities and/or acquire new ones. We all need to feel that we belong to a context where we can use our capabilities to flourish and have health. Our abilities depend on the context we are part of; therefore, it is important to see the older adult in his or her own context to understand his or her abilities.

Ricoeur (1994) developed an understanding of personhood through interpretations and discussions of the human as being capable of acting. He views the person as capable with different abilities, and each ability penetrates the other ability as a series of broken rings. Our vulnerability is part of our ability. Therefore, the human person is acting and suffering at the same time, our vulnerability constitutes us as human beings, and according to Ricoeur (1994), we are wounded beings with a wounded existence.

Illness can alter capabilities, both physical and cognitive (Sofronas et al., 2018), and threaten the continuity of selfhood and make retaining that continuity difficult (Kingma & McCabe, 2012). During the collaborative care planning process, the older adults are confronted with their own vulnerability. The health and social care professionals have a crucial role to play in contributing to the older adults' insight into their own abilities and strengthening their self-esteem and self-understanding, as well as identifying, guiding, supporting, and strengthening the abilities and resources that exist and offer different opportunities and solutions to the person. The professionals can help older adults to view themselves from the outside and thereby support the process of rediscovering themselves and their abilities. By fitting in the illness or injury in their own context and understanding it in their world, older adults can overcome their illness/injury (Svenaeus, 2011). However, it is important to acknowledge that the meaning of illness/injury depends on who the person is and the contexts in which he or she is involved and the older adults will also need different quantities of resources to come to the same level of ability and to achieve a good life.

5 | AN ETHICAL APPROACH TO COLLABORATIVE CARE PLANNING

According to Ricoeur (1994, p. 194) living well is not limited to interpersonal relations but extends to the life of institutions. Health and social care organisations are political and institutional practices. Political and economic control of health and social care and services contribute to deciding which of the older adult's needs and abilities are strengthened or satisfied. However, the health and social care professionals have to use their mandate and competencies in working together to comprehend the unique needs of the older adult, assist him or her to rehabilitate abilities or develop and learn new ones, and thereby achieve the aim of a good life. The resources spent are useless unless they can be converted into opportunities that support the achievement of the desired aim in life of the person (Pirhonen, 2014).

The values that permeate different organisations manifests itself in the professionals' approach. Professionals' actions are visible in practice but also as aspects (ethics) that can only be partly verbalized (Friesacher, 2017). The collaborative care planning conference is an opportunity where the participants can acknowledge and support each other, or a situation where they can objectify and omit each other. Whether the older adult becomes an object or subject, invisible or acknowledged, during the collaborative care planning process is

mainly determined by the professionals' attitudes and ability to reflect on what it is like for the older adult to be in that situation and how they can acknowledge and strengthen the person. To achieve a person-centred collaborative care planning process, the participants need to articulate an overarching ethics, a philosophy behind their own person-centred practice, including their own view of personhood. Thereafter, they need to together discuss, reflect, and agree upon what a person-centred collaborative care planning process means and entails in their context and how they should carry it out together. Ethics need to become more visible, and the understanding that ethical thinking and conduct must permeate everything.

6 | POWER ASYMMETRY

According to Ricoeur (1994, p. 220), *'it is difficult to imagine situations of interaction in which one individual does not exert power over another by the very fact of acting'*. Health and social care are characterized by asymmetrical relationships with the inequity of powers (Remmers, 2017) and this was evident during the studied collaborative care planning processes as well.

The older adults and their care partners lacked knowledge about the collaborative care planning process and what was expected of them, and this influenced their ability to participate in the process. The older adults and their care partners also thought it was difficult to participate in the decision-making process during the collaborative care planning conference and to influence the care and services provided. Through an authentic dialogue between the older adult, his or her care partner and the health and social care professionals, even if their relationship is unequal, they can be able to understand themselves (Mitchell, 2019), set goals, and plan the care and services together. However, the health and social care professionals need to be aware that older adults and their care partners can make choices other than those suggested by the professionals (Mitchell, 2019). When this happens, they have to be prepared to change perspective, use practical wisdom, take responsibility, and set aside their own treatment goals in favour of a less satisfactory outcome that better meets the needs of the older adult at the time. According to Ricoeur (1994, p. 289), '*the path of eventual consensus can emerge only from mutual recognition on the level of acceptability, that is, by admitting a possible truth, admitting proposals of meaning that are at first foreign to us*'.

By accepting to participate in the collaborative care planning process, the older adults stepped into the unknown, reinforcing their vulnerability. The goal for the health and social care professionals should be to reduce the asymmetry and strive for reciprocity and an enabling environment. The focus should be on building and strengthening the older adult. The professionals need to put more emphasis on creating an enabling environment for the unique older adult participating in collaborative care planning. The health and social care professionals and the older adults share the experience of being human and therefore, can develop the ability to empathize with each other's vulnerability. If the professionals can perceive the vulnerability of the older adults, they can use the vulnerability and disadvantages to create a bond (Strebler & Valentin, 2014) and by recognising the asymmetry in the relation, the professionals can use it to benefit and empower the older adult (Scott et al., 2009). The health and social care professionals and the older adult form a dialectic unity and are dependent on each other. Neither role makes sense without the other (Mitchell, 2019). Or in the words of Ricoeur (1994, p. 191), '*in true sympathy the self, whose power of acting is at the start greater than that of its other, finds itself affected by all that the suffering other offers to it in return. For from the suffering other, there comes a giving that is no longer drawn from the power of acting and existing but precisely from weakness itself. This is perhaps the supreme test of solicitude, when unequal power finds compensation in authentic reciprocity in exchange*'.

If the health and social care professionals want to understand and accept the perspectives of other professionals, they first must create a distance to their own perspective (Greb, 2017). Interactions with colleagues and professionals from other disciplines are only likely to thrive when the partnership is based on mutual respect and self-determination are created so that reciprocal, complementary, and symmetrical relationships can be formed. In a reciprocal relationship, all parties grow. For this to happen, an environment has to be created in which all the participants are meaningfully involved and which reflect the existence of multiple opinions and perspectives, and the participants use the same language and concepts (Nolan et al., 2004). According to Ricoeur (1994, p. 176), '*practices are cooperative activities whose constitutive rules are established socially*'.

During the collaborative care planning process, the participants need to develop mutual understanding and trust for each other (Naldemirci et al., 2018). The older adults are dependent on the professionals' willingness to acknowledge them and involve them as partners in the process. If they do not feel part of the collaborative care planning process, their suffering will increase. Ricoeur (1994, p. 190) defines suffering as '*not solely by physical pain, nor even by mental pain, but by the reduction, even the destruction, of capacity for acting, of-being able-to-act, experienced as a violation of self-integrity*'.

The partnership between the participants during the collaborative care planning process can only be established as an asymmetrical relationship, as their partnership assume an asymmetrical mutuality. For the partnership to work, the health and social care professionals need to restrict their freedom, relinquish power and control, and practice reciprocity and equity. The aim is to search for equality amid inequality (Van Stichel, 2014). There must be reciprocity, a recognition of the other and an understanding of the other as a unique person, but also that the health and social care professionals dare to show themselves to the older adult, and make the professional relationship become a personal relationship (Schuster, 2006). By practising reciprocity, the participants perceive the relationship from both sides and accept the other as they are. A right for reciprocal recognition of personality and personhood should be a guiding target for all caring interactions. In relationships that sustain personhood, the participants collaborate and reinforce each

other (Lislerud Smebye & Kirkevold, 2013). Without ethics and reciprocity, the collaborative care planning process risks to become a demonstration of power and reinforcing the asymmetry.

7 | INTERACTION OF DIFFERENT PERSPECTIVES DURING THE COLLABORATIVE CARE PLANNING PROCESS

Ricoeur's (1994) hermeneutic philosophy is a "dialectic of interpretations" where different perspectives, understood as interpretations, in a conflicting way, are discussed with each other. Always critical, but never without listening to the arguments of the other and always to develop a better understanding. Always with a critique that also includes a self-critical readiness to break up, but never prestigious and rigid, and always defending the human.

Using Ricoeur's (1994) critical dialectic of interpretations would allow the collaborative care planning conference to be a forum where the participants together, can consider and discuss their different perspectives concerning the aims of the older adult, professionals, and the health and social care organisations and the local context. When we meet, we tend to focus on sameness. However, real openness is about being open for the unexpected. The health and social care professionals must learn to welcome both sameness and otherness and not feel threatened by other perspectives and views. Collaborative care planning is an opportunity to explore their own professional limits and to question the collectives' perceptions of the professional role. Acknowledging the older adult requires the professionals to see both that which unites and that which separates them. By practising reciprocal respect, they can agree that they do not agree. The participants need to bring together the different dimensions and perspectives by improving the dialogue, and discussing and reflecting together. All perspectives are necessary, and a constant movement and dialogue will be enriching on all sides (Van Nistelrooij et al., 2014). Practising dialectic, thinking about and viewing the same thing from different perspectives, should be natural. It is possible to interpret things differently however the older adult should have interpretive precedence when it comes to his or her own life.

If the professionals view each person, participating in the conference, as having exclusive knowledge, the partnership developing will then be about respect for each other's knowledge. The older adult contributes his or her unique knowledge and experiences. The care partners have their knowledge and experiences of the older adult's situation. Finally, the health and social care professionals have their scientific and professional knowledge. There is a need for a variety of perspectives to be able to create a complete picture of the older adult's situation and cocreate a new understanding. Mutual respect lays the foundation for collaboration and in holding the fragmented self of the older adult together (Lislerud Smebye & Kirkevold, 2013). The perspectives should be viewed as complementary and not replace or supersede each other (Karazivan et al., 2015). The professionals must be able to weave together the perspectives of the explanation (medical and social science) with the perspectives of understanding (the older adult's experiences of his or her own lived body and the experiences of his or her care partners) and at the same time practice both human closeness and scientific distance (Kristensson Uggla, 2019). According to Ricoeur (1994), a critical and conflicting perspective will create a constructive distance that will facilitate to become clearer to oneself and others and understand the other and understand himself or herself differently. By challenging the collaborative care planning with a constructive conflict perspective and affirming reciprocity the outcome, the collaborative care plan will improve and facilitate the participants' continuous partnership.

8 | IMPLICATIONS

The reflection of the challenges identified during the collaborative care planning highlighted the need to think differently and change focus. We must focus more on human values and the dialogue between the older adults, their care partners, and the health and social care professionals, but also between the professionals and between the health and social care organisations. To be able to truly acknowledge the older adult and his or her life, including abilities, resources, health, social and cultural context, new patterns of relationship between older adults, care partners and professionals but also between professionals and between the health and social care organisations are required. More focus and emphasis on relationships and human values in practice are needed. Health and social care professionals and their organisations need to better understand how they best can co-construct the older adult's identity and plan the care and services together with the older adult in need of care and support and the professionals providing the care and support without undermining the older adult's self-identity and capacity for self-determination.

Transformation of practice is not easy and requires insights and actions on all levels of the organisations. It is not just about how the organisations can improve the conditions for the professionals but also how the professionals can improve the organisations (Rushton & Edvardsson, 2018). What does the person, as a professional, aim for with his or her own interaction with the older adults, care partners, colleagues, other professionals and managers? If all people are woven together, the individual professional needs to reflect on the personal energy, attitude and behaviour he or she brings to the relationship.

Health and social care organisations are relational practices and organisations. During the collaborative care planning the older adults, their care partners and the health and social care professionals become interwoven. How the collaborative care planning and the encounter with health and social care professionals are understood and interpreted will remain in the memory of the older adults. Personhood can be sustained or undermined in relationships with others (Lislerud Smebye & Kirkevold, 2013). The professionals have a responsibility towards the older adult as the outcome of the collaborative care planning process, the collaborative care plan, will influence the life of the older adult.

All levels, the older adult and their care partner, the professionals and the organisations, need to be permeated of ethics and human values, and these must be visible in every action and practice. By using reciprocity and balancing the different dimensions and perspectives, the collaborative care plan, their relationships and the organisations will improve.

9 | CONCLUSIONS

The ethical intention of 'aiming for a good life with and for others in just institutions' (Ricoeur, 1994) can be interpreted and symbolize what the collaborative care planning is about and how it can be achieved as a person centred practice. A person-centred way of working requires hard work and conviction, as it in many ways provokes the existing working methods, organisations, and hierarchies. It moves the focus from illness and diagnosis to health and ability and requires a different or new approach. However, it is important that the patriarchal system will not be replaced with a new model of uniform practices. Person-centred practices are not routines, or a one size fits all answer (Naldemirci et al., 2018). Every person is unique, and therefore, each collaborative care plan will be unique. Health and social care professionals cannot rely on standardized tools. Rather, they need to use their professional and practical knowledge, wisdom, and flexibility at all times, and invite and assist the older adults and their care partners in being part of the collaborative care planning process as partners. They need to practice scientific distance without losing the perspectives of the older adults, their care partners, and their humanity as persons (Kristensson Uggla, 2019). Ethics, human values and the older adults and care partners perspectives need to be given the same importance and considerations as the medical and social sciences perspectives for the collaborative care planning process to truly become person-centred.

DATA AVAILABILITY STATEMENT

The data is not available online.

CONFLICT OF INTEREST

The author declares no conflict of interest.

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