

## ORIGINAL ARTICLE

# Practising the ethics of person-centred care balancing ethical conviction and moral obligations

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## Abstract

Person-centred care is founded on ethics as a basis for organizing care. In spite of healthcare systems claiming that they have implemented person-centred care, patients report less satisfaction with care. These contrasting results require clarification of how to practice person-centred ethics using Paul Ricoeur's 'Little ethics', summarized as: 'aiming for the good life, with and for others in just institutions'. In this ethic Kantian morality is at once subordinate and complementary to Aristotelian ethics because the ethical goal needs to be critically assessed and passed through the examination of the norm in each care situation. This paper presents examples that describes a person-centred care practice that balance a critical review of care activities based on a conviction of aiming for patients' wellbeing. In contrast to patients' experiences of person-centred care in real life, research projects have shown that if the clinical performers comprehend and apply the practice of person-centred ethics, patients report positive outcomes. The implementation of person-centred care therefore demands that stakeholders and managers enables and requires that healthcare staff study ethics in the same way as studying for example pharmacology is required when handling patients' medicines.

## KEYWORDS

ethics, patient-centred care, person-centred care, person-centered care, Ricoeur

## 1 | INTRODUCTION

In the clinical setting, the patient is understood chiefly from a medical and natural science model. With that point of departure, parts of the complex biology of human beings can be explained. Even if this medical knowledge is essential, healthcare professionals obviously need to know more about how to perform care where health processes are strengthened in a relationship in which patients are accepted as persons with their own will and experiences and in which responsibilities and capabilities are recognized. The concept of person is crucial in legal matters and used to give somebody

responsibility vis-a-vis a situation which concerns him or her. Person-centred care therefore more clearly than the concept of patient-centred care emphasizes the need for a shift away from a model in which the patient is the passive target of medical intervention to another model where a more contractual arrangement is made involving the patient as an active partner in his or her care and the decision-making process. Person-centred care is about building this relationship, which requires ethics as a springboard. The meaning of person-centred care may seem obvious. Still, as noted by Öhlen et al. (2017), the literature portrays a somewhat ambiguous view of person-centred care, particularly how to practice it in a clinical

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context. Based on Ricoeur's (1992, p. 240–296) writing on 'The self and practical wisdom in concrete situations—convictions', the Swedish philosopher, Bengt Kristensson Ugglå, suggests that there is no shorter path to the good life than moral judgement and practical wisdom in concrete situations (Kristensson Ugglå, 2016; Ricoeur, 1992). Health care is indeed about activities and practices involving moral judgement and health professionals often experience great uncertainty in these situations. In other words, conviction and critically reflected upon convictions are necessary elements in health care

## 2 | DISAPPOINTING REPORT

Can a person-centred care practice that balance a critical review of care activities based on a conviction of aiming for patients' health and wellbeing be described? This question seems to be particularly important at present, since person-centred care has, since long, been endorsed by patient organizations and professional bodies as one of a set of core competencies needed to effectively meet the complex challenges facing today's healthcare systems (Swedish Nurse Association, 2019; European Patient Forum 2019). Also stakeholders such as, for example, World Health Organization (WHO) and the Health Foundation (WHO, 2015; The Health Foundation, 2016), have spurred calls for implementing person-centred care in healthcare practice. In addition, health systems in Europe are currently evolving towards more person-centred care, as indicated by a recently published international standard for minimal patient involvement in person-centred care (CEN/TC450, 2020). During the past few years, most regions in Sweden have been in the process of implementing person-centred care (Swedish Association of Local Authorities and Regions, 2018), Personcentrerad vård i Sverige [Person-centred care in Sweden], (2018) which has been expected to maximize the quality of care from the patients' perspective. However, this year the Swedish agency for health and care services reported disappointing results. Their analysis showed that Swedish citizens in several aspects were less content with their care compared to patients from 10 other countries (such as the United States, France, Norway) (Swedish Agency for Health and Care Services, 2021). This agency's mission is to strengthen the position of patients and users through analysing health care and social care services from the perspective of patients and citizens. A concrete example from the report of a typically person-centred care action is that only 20% of the Swedes with chronic illness had received a plan for self-care. Applying person-centred care is easier said than done, and efforts have been hampered by several factors, including health professionals' conservative and skeptical attitudes and time constraints (Moore et al., 2016; Naldemirci et al., 2017).

Considering the difficulties health professionals face to actually practice person-centred care, the ethics probably needs to be comprehended as critically reflected convictions on how to select care actions tailored to each patient's wellbeing and reviewed by rules and obligations in the daily care. The aim of this paper is therefore to

discuss how Ricoeur's 'Little ethics' can be connected to practices in healthcare.

## 3 | THE 'LITTLE ETHICS'

The French philosopher Paul Ricoeur presented his thoughts on ethics as an integral part of a wider investigation about identity instead of a 'large' presentation of ethics, and therefore called it the 'little ethics'. This ethics of Paul Ricoeur (1992, p. 172), summarized as 'aiming for the good life, with and for others in just institutions', combines the autonomy of the self with solicitude for other people and justice for each individual. According to Ricoeur, Kantian morality is at once subordinate and complementary to Aristotelian ethics because the ethical goal needs to be critically assessed and passed through the examination of the norm. Obligations, norms and sanctions are not as basic as the human desire to live the good life together with others in just institutions. This attitude to life and to our fellow human beings is obvious to us all, but in the care situation, this is put on its end because relations between the patient and professionals are extremely asymmetrical. Patients, as described by Kristensson Ugglå (2020), have a threefold subordination: the institutional (being at the bottom of the hierarchy), the existential (feeling vulnerable and insecure because of illness) and the cognitive subordination (the professional have expert knowledge about the disease and its treatment) towards the health care (Kristensson Ugglå, 2020).

To engage clinicians and patients (and relatives of patients) to feel at home and comfortable with the language we adapted Ricoeur's 'Little ethics' to a healthcare context; *Aiming for health and wellbeing with and for patients, relatives and staff in just institutions*. This paper discusses ways to understand, explain and practice this short summary of the ethics in concrete care, starting with the first part of the ethics—*aiming for the good life*, continuing with the second part *with and for others* and concluding with the third and last part, *in just institutions*.

### 3.1 | Aiming for the good life (health and wellbeing)

Ricoeur reasons that the ethics as a vision or goal has primacy over morality but is reviewed through the moral norm and assessed in each situation. Accordingly, obligations cannot be relied on to resolve our moral confusion, which is what often happens in care situations when the professional walk the safe way by referring to rules or generic care programs. In contrast, Ricoeur (1992) suggests that the path to a good life involves ethical considerations and practical wisdom in concrete situations. The many moral perplexities that are constantly faced in health care are reviewed in terms of the ethical aim—health and wellbeing to the patient, in each care situation. In order for the professional to understand and assess how to achieve health and wellbeing to each specific patient, an alliance—a

partnership—between the patient and the caregiver needs to be initiated.

## 4 | INITIATING THE PARTNERSHIP

In research, we have, in a rather concrete way, adapted the ethic situationally to the care process (e.g. Britten et al., 2020, Ekman et al., 2011, 2012). In each situation professionals ask whether the choice of actions conforms to the aim, namely providing the patient with the best possible life quality. However, the care process is not only about how we relate to our profession's ultimate goal. Nurses do not ask whether they should support, care and comfort their patients, just as a teacher would not doubt the aim to teach and provide a good learning experience for students. Nevertheless, the question is how to do the right things (the good actions) in our obligation to provide care of good quality based on strengthening the individual patient's autonomy and integrity. Ricoeur (1992, p. 176–177) discusses the concept of *internal goods* whose rules are established socially and related to the ethical aim of living well. My interpretation of internal goods is linked to the notion of human vulnerability (being human, by implication, implies a degree of fragility). The internal goods will not help base the action on the normative conception of morality mechanically. Therefore, the internal goods can be described as an implicit awareness of how to do the good things for other people, and thereby serve as a guide to practically achieve the main goal, that is, providing the good life to the patient. In nursing care this can be practiced by for example breaking the care setting's generic rulings to be able to relieve the patient's suffering. Simple things such as serving coffee to patients off schedule or helping a patient to get in contact with someone that the patient has difficulties in reaching are such examples. The internal goods also provide moments of reflection related to the concept of self-esteem. Self-esteem is linked to the pursuit of the ethical aim (i.e., health and wellbeing for the patient) because it is an agreement on what to achieve, a common understanding between the professional and patient. Ricoeur talks about solicitude, which can be seen as an umbrella term of consideration and care and explains how it unfolds the relational dimension of self-esteem. Because they are intrinsically linked, you cannot experience self-esteem without the desire to have solicitude and care for others.

### 4.1 | Aiming for the good life (health and wellbeing) with and for patients, relatives and staff in just institutions

This second part of the 'Little ethics' concerns collaboration and building a partnership between the patient and the professional.

Ricoeur (1992) claims that to act is always to act with others. Therefore, the starting point for person-centred care is the dialogue between patient and professional, which lays the ground for a

partnership—a mutual and respectful relationship between the patient and the professional (Ekman et al., 2011).

## 5 | WORKING THE PARTNERSHIP

Given the asymmetrical relationship between patients and professionals, procuring a mutual and respectful partnership (rather than a show of dominance) is challenging. Marja Schuster has studied the asymmetry and reciprocity in the meeting between the professional and patient. From her work, she suggests that for the asymmetry to be reduced, it is necessary to emphasize reciprocity by acknowledging both the sameness (sharing the basic human conditions) and the otherness of the patient (Schuster, 2006). Thereby, reciprocity opens the door to a critical dimension in nursing and the professional role. This role often fits the medical culture of being a physician assistant or overemphasizing the patient's lifeworld perspective without including medical evidence. Optimum patient–nurse relationship and person-centredness need to consider patients' emotional and personal responses that highlight the process rather than the outcome of interactions (Wolf et al., 2017).

The partnership builds on the patients' narratives about their illness and its profound impact on life. In contrast to the medical anamnesis reflecting the process of diagnosing and treating the disease, the patients' narrative captures their suffering in daily life. Patient narratives are not merely one long story told by a patient on one occasion; instead, they are often a series of conversations between a patient and a health professional (perhaps with other professionals or family members present) (Coulter et al., 2015). This interactive process of listening and narrating between the professional and the patient can be compared to how researchers interpret texts from interviews on which the whole and the parts are to be understood and explained in relation to each other and where the choices of interpretation are also validated together. Because all human beings are vulnerable, professionals recognize and understand the suffering that patients experience, which motivates their natural disposition to achieve a positive outcome for the patient. In this context human vulnerability refers to being sensible and deeply affected by the patient's suffering. This ability can sometimes be painful for the professional because the suffering of patients can be overwhelming, especially under stressful conditions, and where the time allocated for patient care is limited. The patient may then be reduced to representing only objective disease data (disease-oriented care), rather than an open system that enables the patient to be a person with an illness, able to tell their story and collaborate with professionals on plans for care, treatment and rehabilitation (person-centred care).

## 6 | THE PATIENT ROLE

Being a person implies having distinct roles during certain periods of life, such as patient, teacher or mother. Even if you have a chronic disease, you are only a patient when you visit a health facility or are

hospitalized. The rest of the time (and even when in the patient role), you are primarily a person. Being a beggar is also a role, and a beggar is a person. However, it is not evident that these people are treated with dignity and respect in these diverse roles. If a nurse receives information (age, diagnosis, test results) about a patient, such information is only objective. The patient's narratives can then bridge the gap between the objective perspective and the patient as a unique individual. Therefore, a person and a lifeworld become achievable to help understand and explain the patient's unique situation and illness. The story/conversation can sometimes be without words. Professionals and patients can learn to know each other more authentically by meeting and communicating through other forms (e.g., body language such as smiles, glances, actions). Similarly, a relationship can be initiated with an unknown person who is often sitting outside the local shop. You start to worry about this person who, silently, asks for your help. The apparent suffering of the beggar affects your vulnerability, which can cause overwhelming concern and frustration.

## 7 | VULNERABILITY-REDUCING AGENDA

Dahl Rendtorff noted in his discussion on ethical principles in bioethics that vulnerability in modern medicine was largely misunderstood. This misunderstanding was guided by a vulnerability that reduces the goal of eliminating all forms of exposure (such as suffering and disability) to create perfect human beings (Dahl Rendtorff, 2002). As a human asset in care, the right balance must be struck between this logic of the struggle for immortality and vulnerability. Medicine has its basis in physiology and personalized medicine of the body, which is sometimes mixed with person-centred care. These therapies are based on the genetic content or other molecular or cellular mechanisms of each patient. Such an objectified and biological view of human beings dominates health systems. This view of human beings makes the necessary understanding of both professionals and patients as vulnerable and sensitive to the suffering of others trivial. When the starting point is ethics and each person is understood as unique, care actions can never be the same for each patient, even if diagnosis and treatment are included as determining factors. Instead, daily person-centred care practices must dialectically see the patient as both object body and lived body. In this way care practices are guided by person-centred ethics and human protection. Consequently, awareness of human vulnerability should be made more evident as an essential attribute of care.

## 8 | HUMAN CAPABILITIES

Another vital aspect that health professionals need to be mindful of is the concept of human capabilities. The roots of the capabilities approach can be traced to Aristotelian ideas about human flourishing, but it has been developed in more recent times to work on human development and social justice by several authors, including Amartya

Sen, Martha Nussbaum, Vikki Entwistle and Paul Ricoeur (Entwistle & Watt, 2013; Nussbaum, 2011; Ricoeur, 1992; Sen, 2009). The capabilities approach incorporates a relational rather than an individualistic ontology of persons and their capabilities. This approach involves recognizing that people's capabilities are, at least in part, shaped and constituted by their environmental and social circumstances, both past and present (Entwistle & Watt, 2013).

Entwistle focuses on capabilities eminently associated with the concepts of persons and being treated as persons, including the ability to reason, feel and respond to emotions. Moreover, persons intend and initiate actions, have self-awareness and self-directing abilities (Entwistle & Watt, 2013). Human capabilities can be strengthened or neglected by interaction with other human beings. This ability to empower or make powerless is particularly evident in situations characterized by asymmetric relationships, as is often the case in health care (Kristensson Uggla, 2020). Findings from an interview study on patients and professionals' experiences of person-centred care underline that staff members must be aware of the relationship with the patient and how it is manifested, thereby incorporating proximity and receptiveness of professionals and building a close connection and confidence to patients (Wolf et al., 2017). In this context an important dimension is that patients' suffering is sometimes reduced to physical or mental pain alone. However, Ricoeur (1992, p. 190) suggests that the most challenging suffering occurs when human capabilities are not recognized. Individuals are reduced to only part of their potential, overlooking their capabilities and aspirations. To illustrate, patients know that they are human beings (and not just a collection of medical conditions) and want to be recognized, treated and cared for accordingly. To be recognized and cared for with respect and dignity is sometimes not the case in certain patient groups (e.g., patients diagnosed with dementia). Also, in intensive care units much focus is on biological parameters and sometimes less on how the patient experiences the situation. Because so much emphasis is on the object body in health care, vulnerability opens up the sensitivity of professionals not only to the suffering of patients but also to their capabilities. The role of health professionals is to recognize their mediating role between patients' internal and external capacities and their realization.

### 8.1 | Aiming for health and wellbeing with and for patients, relatives and staff in just institutions.

The third part of the 'Little ethics', care in just institutions, concerns the anonymous other.

## 9 | WHAT IS AN INSTITUTION?

The good life, health and wellbeing, is not limited to interpersonal relations but extends to institutions. What fundamentally constitutes the institution is the bond of common practices and not that of restrictive rules. Therefore it cannot simply be defined as an

organization within the healthcare sector, but instead be seen as an extension of human relationships to all those outside of the face-to-face encounter of an I and you and remain third parties, the anonymous other. Solicitude is not something added externally to self-esteem but unfolds the dialogical and relational dimension, similarly, justice is not recognized as something added because it is to life in institutions what solicitude is to interpersonal relations (Kristensson Ugglå, 2013). Institutional justice must be grounded in a teleological ethical framework, the principles of justice may complement this teleological basis, but the sense of justice is still to be recognized as more fundamental than the principles.

## 10 | A JUST INSTITUTION—AN EXAMPLE

Let us take an example from a primary care centre where nurses answer the telephone when patients call to book an appointment. The centre is a busy workplace with many phone calls from patients and other people, so the call must be made reasonably quickly. For a variety of reasons (e.g., cognitive disabilities, age, infirmities, language barriers), some patients may have difficulty explaining the problem to a practitioner. In these cases the nurse senses the patient's needs and suffering after just a minute of listening, which requires a flexible organization that allows a nurse to be occupied with a patient while the other nurses take calls. Preparing this situation means responding to the anonymous other and an example of person-centred care. Practising ethics, as in person-centred care, creates conditions for which the organization, law and norms may not match the effort to achieve a good life for the patient. Moreover, it causes dilemmas that must be managed based on an awareness of coping with conflicts of interpretations and critically reflected convictions (Kristensson Ugglå, 2013). The solicitude practised in this situation towards the anonymous patient and recognizing the vulnerability of others opens up the self-esteem of patients and professionals.

## 11 | SOCIAL JUSTICE

The organization of care must seek to ensure fair and appropriate care that allows all patients to express their needs and capabilities. The philosopher Martha Nussbaum and the philosopher and economist Amartya Sen developed the 'Human development approach' or 'Capability approach' which is a theory on basic social justice, which urges societies to offer their citizens opportunities to use their capacities as human beings (Nussbaum, 2011). In this theory Nussbaum exemplifies the interrelationship between institutions and each citizen, stating that a government that only make legislations but does not actively enforce laws against, for example, domestic violence, such a government is accountable for the suffering women and children may endure (Nussbaum, 2011). Expressions of fundamental rights are just words until actions support them. The same holds for health care, where documents on 'value bases' often are formulated, but they are invisible for many patients in a real-world care setting.

The Swedish healthcare act is another example of a governmental document where the content do not harmonies with consequences, there are, for example, no penalty if healthcare institutions do not follow the law ensuring person-centred and fair care in their daily practices and routines. The meaning of a just and fair institution is that each patient, relative or health professional *senses* justice on a fundamental level when in contact with health care or any other institution in a democratic society. To ensure the patient a sense of being fairly treated and cared for is challenging for the professional because the perception of being unfairly treated is difficult to express through words and actions. For example, patients with difficulties explaining what they need over the phone or face-to-face must feel that they will receive good care.

## 12 | THE INSTITUTION OFFERS A SENSE OF PARTNERSHIP

Relatives of chronically ill people often act as informal carers, and their support is characterized by mutual respect and shared responsibility. In contrast, they are rarely involved as partners and co-creators of care in contact with healthcare professionals. An interview study showed that, despite the formal (and sometimes impersonal) nature of healthcare institutions, a few informal carers could connect with a healthcare professional with whom they could share their frustrations and concerns (Blanck et al., 2021). This connection was necessary to ensure that their ill relatives could live daily life as well as possible, an outcome that should concern a just institution. The informants valued these meetings between informal carers and health professionals, sensing that they were included as equal partners in the care process. The challenge to the healthcare system is to make this always happen in practice for all patients and relatives.

## 13 | PERSON-CENTRED CARE REFLECTED IN RESEARCH

To assess and implement person-centred care an interdisciplinary group of clinical and nonclinical academics in Sweden created a research centre in 2010 funded by the Swedish government to study person-centred care: the University of Gothenburg Centre for Person-Centred Care (GPCC) (Ekman, 2018). The GPCC steering committee formulated a 'position paper' with three simple care practices: to initiate, integrate and safeguard person-centred care in daily clinical practice (Ekman et al., 2011).

The first care practice initiates the partnership by eliciting the patient narrative, defined as the patients' perception of their illness and its impact on their lives. The second care practice serves to implement the partnership using a commonly agreed upon health plan so that professionals, patients and their relatives work jointly to achieve common goals. Both resources and capabilities within the patients and their context are identified during this process, including

their needs. The third care practice safeguards the partnership by documenting the health plan often in the patient record, available to professionals and patients. These three practices represent clinical tasks to be embarked upon by the professional and everyday goals of the patients/relatives. Since 2010, this model of person-centred care rooted in ethics has been applied and tested in more than 20 controlled studies (Britten et al., 2020). In each study the intervention was guided by the person-centred three care practices and the researchers regularly discussed the ethics and how to apply it with the clinicians that performed the respective intervention (Gyllensten et al., 2020). These studies provide evidence of an ethically based but practical framework for person-centred care in various clinical areas. Britten et al. (2020) conclude that while the framework will require adaptation to different contexts, clinical specialties, patient populations and organizational structures, fidelity is underpinned by the ethical approach rather than standardized guidelines.

Process-oriented assessments using qualitative methods have described the experiences of applied person-centred care as outlined in the GPCC position paper (Ekman et al., 2011). One example is an interview study in which patients had received remote person-centred care through phone calls and a digital tool. The patients reported that person-centred care was experienced as a sense of being more of an insider in the healthcare system, which can be interpreted as a partnership with health professionals (Barenfeld et al., 2020). If health professionals recognize and cultivate patients' capabilities to experience inclusion in the team, they must be awarded the status of people who matter. The process of creating a partnership between patients and professionals will involve interacting with patients who signal that they are valued and knowledgeable. One of the subthemes in the Barenfeld study—'Gaining support—not help'—highlighted this point, where patients experienced that their skills were reinforced (Barenfeld et al., 2020). This requirement is associated with the notion of respect that is featured in frameworks of person-centred care (Dewing & McCormack, 2017; McCormack & McCance, 2006).

## 14 | CONCLUSIVE REMARKS

The question why several controlled studies evaluating person-centred care have shown significant effects from patients' perspectives, while patients in real-life settings report that they have not been cared for in a person-centred way, is difficult to respond to. The reason for this difference might be related to how the ethics of person-centred care have been practised. This paper attempted to illustrate how to practise an ethic that balances a critical review of care actions and care activities based on a conviction of aiming for the patients' wellbeing. One might speculate that in the Swedish regions, where person-centred care claims to have been implemented, convictions to the ethical aim have not been reflected on in each care situation. Instead, tasks such as writing care plans were emphasized. This mechanical use of the practice of person-centred care means that the Aristotelian ethics have not had primacy over Kantian morality, but instead been subordinate and complementary.

Explorative research on how partnership in person-centred care is developed points towards the importance of human connectedness and the feeling of being listened to and acknowledged as a person for patients, while routines and formal aspects of care risk coming into the foreground for the practitioners. It is tragic to realize that in this kind of care, avoiding moments of ethical reflection in specific care actions, professionals miss the opportunity to develop their self-esteem and their ability to perform care of an excellent standard. Suppose the demand from stakeholders and managers for a change to more person-centred care is seriously meant. In that case the implementation process requires ongoing and systematic work in recognizing and acknowledging the importance of genuine knowledge and practice in the ethics of person-centred care. The implication is that stakeholders and managers enable and require health professionals to study ethics in the same way as they would study other topics to be able provide the best care to patients.

## CONFLICT OF INTERESTS

The author declares that there is no conflict of interest.

## DATA AVAILABILITY

Study data are maintained in deidentified secure database.

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