

MODULE TITLE: PRINCIPLES OF HEALTH AND SOCIAL
CARE PRACTICE

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ESSAY A2: *Ethics of Care as a Foundation for Person-Centred
Care in Health and Social Care*

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INTRODUCTION

One of the most important organising principles of health and social care policies in the UK today is person-centred care (PCC) that propagates the significance of people as active receivers of demonstrated care as opposed to passive receivers (NHS England, 2019; Department of Health and Social Care, 2021). Nonetheless, PCC implementation is less aligned with its policy salience because of a variety of structural factors that include workforce shortages, pressures in resources and bureaucracy that mediate task-based care over relationship care (Care Quality Commission, 2023; Glasby and Dickinson, 2021).

Ethics of care can be used to critically engage and respond to these tensions. Care ethics with its focus on the concept of relationality, interdependence and responsiveness is being used to put to task the prevailing models of care that focus on individualists and efficiency (Held, 2006; Tronto, 2013). This essay will contend that care ethics provides adequate support to person-centred care, but when it comes to practice, the systemic and organisational aspects of health and social care inhibit its implementation.

The essay initially discusses the birth and rise of care ethics, their main criticisms and reactions. It then critically reviews how it is applicable in the policy and practice of UK health and social care, especially in adult social care. Lastly, it gives recommendations to enhance the application of person-centred care and recognizes the drawbacks of such strategies.

THE EMERGENCE AND DEVELOPMENT OF THE ETHICS OF CARE

Care ethics emerged against the backdrop of traditional moral theories that emphasised autonomy, impartiality and principles. Gilligan (1982) claimed that traditional moral theory's focus was on developing knowledge of the self as an autonomous person and more recently care-based theory has led care ethics to become a broader theory of power, inequality and democracy (in the collective sense) (Tronto, 1993). We are social, vulnerable and dependent (Held 2006; Kittay, 2019). This has implications for health and social care as service users may require care that is not necessarily individualistic like when they are sick, incapacitated, old, traumatised and marginalised. As such, care ethics is congruent with person-centred care because it would never be appropriate to follow rules without understanding the person, and their experiences. Tronto's model is relevant to health and social care as she understands care as a number of activities that include attentiveness, responsibility, competence, responsiveness and solidarity (Tronto, 2013). These relate well to person-centred practice. Attentiveness - workers pay attention; responsibility - they take responsibility; competence - care is safe; responsiveness - account is taken of the service user; and solidarity - the system focuses on care as a social good. Contemporary studies take this argument to systems and reform. For instance, integrated care research argues person-centred care needs compassionate inter-organisational rather than person-to-person care. For instance, online, integrated care systems in England are supposed to represent the National Health Service, local government, voluntary sector and communities to plan services to meet local needs. This is because this is a care ethics intuition as people have relational and social needs, which are often complex.

CRITIQUES OF THE ETHICS OF CARE

According to Beauchamp and Childress (2019), principles of autonomy, beneficence, non-maleficence and justice might be obligatory in health care. Therefore, care ethics seems to be undecided regarding ethical judgement regarding risk and safety, or distribution of limited resources, or interests. This criticism is possible, though, and is perhaps excessively strong, since care ethics does not deny principles but rather underlines that ethical decision making should also take into consideration relational and contextual elements (Held, 2006).

Care ethics does not negate principles, only that they are insufficient. To illustrate, person-centred care employs both relationships and principles. So, upholding autonomy in adult social care isn't just about asking the person what they want, but the person's capacity, their verbal and non-verbal communication capacity, family dynamics, culture, risks and supports. So, care ethics is added to principles. Second, it's argued care ethics supports gendered care. This is because referring to care as romantic can justify the oppression of the low-paid or unpaid work of women, family carers and low-paid care workers (England, 2005; Kittay, 2019). This is a major concern in the area of adult social care, where care work is devalued and important.

This criticism is particularly relevant in the case of social care to adults where the care work is nonetheless being undermined even against the backdrop of ascription of opposing social values to this occupation. Structural pressures that hamper the provision of relational care still exist, including workforce shortages and funding limitations (Care Quality Commission, 2023). This creates a very important problem where the care ethics can be rhetorically developed and does not take a material stand on the issues that should be taken to achieve the care ethics. Thereby, the obligation to support care workers to deliver compassionate care, person-centred care, without adequate support, is likely going to continue creating disparities within the field (England, 2005; Kittay, 2019).

APPLICATION TO HEALTH AND SOCIAL CARE POLICY AND PRACTICE

In the UK there are numerous health care policies and social care policies that could be examined as care ethics. Care Act 2014 is proactive, person and preventative friendly (to social care users) and the Health and Care Act 2022 formed statutory integrated care systems in England. These policies are as well relevant as they seek to change the current system of service provision which is fragmented as a lot of emphasis on service and organisational boundaries to the integrated system which emphasises on the life of people in the community, healthcare and social care.

The existing approach to personalised care, which National health service (NHS England) invests in, is also moral to the code of ethics of care, since it dwells on the concept of shared decision-making, personal care and support plans, social prescribing, assisted self-management and personal health budgets. The policies may be applied in person-centred care because it presupposes the significance of communicating with the receiver of the services because the professionals should assume the role of communication and not act. This is in correlation with McCormack and McCance (2017) person-centred practice in respect of the professional competence, practice environment, person-centred processes and person-centred outcomes.

This is a theory that can help in providing an adult with multimorbidity social care. It is worth noting that care ethics is important as the older service users may need assistance with personal care, mobility, medication, social, accommodation, family and end of life. The biomedical model cannot be applied as it would only concentrate on illness. However, care ethics would emphasise the values of the individual and relations and how to promote autonomy and dignity.

There are several advantages of care ethics. It is argued because it enhances dignity since it places greater importance on relational interaction and emphasis on personal needs (Tronto, 2013). To what extent this can be realised in practice is an issue of debate. Structural constraints (workforce shortages and time pressures) do not always allow the practitioners to develop meaningful relationships with service users (Glasby and Dickinson, 2021; Care Quality Commission, 2023). This brings a lot of concern regarding the issues of care ethic scalability in large systems with resource constraints.

Additionally, compared to the care ethics, which promote cooperation and collaboration, the integrated care systems often fail to establish a real degree of coordination because of the disintegration of organisations, power dynamics, and the absence of information exchange (Thomson et al., 2024). The policy ideal of integrated, person-centred care thus may not find its way into the experiences of service users.

The 2022 Health and Care Act offers integrated care systems with an organisational structure, but this is not necessarily reflected in relational practice. There may be integrated care systems that are not actually delivered in practice when there is a lack of integration of assessments and care plans and communications between professionals. The findings of the fast review research also indicate that workforce and information control, organisational and power imbalance stimulates integrated care.

Nordin et al. (2023) determined that the outcome of co-production in health and social care differs, but a difference exists in defining the outcomes. Conquer et al. (2024) that it can be also applied to co-production prove that it will help to introduce a change in integrated care, but it must not be tokenistic co-production. This is vital to ethics of care perspective: co-production ought not only seek professional judgement input of service users. This brings out another major conflict between policy design and practice in which the integration of structure may not translate to relational care or the person-centred care.

However, there are online health strains. The care, monitoring and co-ordination could be helped by use of technology but could be antithetical to the people centred care, which is relational with issues of digital divide and care delivery that substitutes the human contact. Ramvi et al (2023) led a research into the use of technologies in care and found that technologies have the ability to disrupt cultures of care. This would result in the care ethic approach not only enabling consideration of technologies in terms of their effectiveness, but also encompassing the aspect of respect, responsiveness and inclusion.

RECOMMENDATIONS FOR POLICY AND PRACTICE

First, relational care needs to be made a quality standard, rather than a goal. Commissioners and regulators need to determine if care is continuous, involves shared decision-making, person-centred care planning and includes carers in care. This would address the moral aspect of person-centred care.

Second, we need workforce policy to support care ethics in terms of staffing, pay, supervision and training. The CQC flag workforce as a priority issue in social care for adults, including workforce capacity in home care. It is almost impossible to implement person-centred care without staff being able to listen, reflect and connect with individuals. This should include communication skills, responding to trauma, cultural responsiveness, shared decision-making and ethics. However, this needs to be supported by staffing and organisation.

Finally, integrated care systems should enhance partnerships by setting up care plans, joint accountability and opportunities for service user involvement. Statutory integrated care model is an excellent model and there should be local solutions whereby voluntary organisations, unpaid and family carers and service users are empowered. This will help in evolution of partnership working that is not managerialist to collaboration.

Fourth, information technology should be assessed from an ethics of care perspective. Services need to ensure that digital technologies improve responsiveness, accessibility and continuity, or create isolation and dehumanisation. Digital technologies should facilitate, not replace, relationships.

Finally, value should be created with (rather than from) service users. This includes involving service users, being vigilant to power dynamics and consulting with them as experts. The difficulty is co-production is about people and can be time consuming, expensive and requires expertise; if not, co-production can be empty.

Nonetheless, there are constraints associated with these suggestions. Investments in the workforce consume a lot of money and this may not be practical in the present budget limits. Similarly, the co-production plans, although attractive, are time consuming, and even tokenistic without the support of the actual power-sharing policies (Nordin et al., 2023; Conquer et al., 2024). Thus these proposals are in line with the principles of care ethics, but they cannot be implemented without continued structural and cultural change in health and social care systems.

CONCLUSION

Care ethics provides a strong conceptual framework of person-centred care to pay attention to relationality and responsiveness as well as to dignity and interdependence as the issues of health and social care. But care ethics is also prone to challenges. It can be vague, gender-biased and difficult to put into practice in complex organisations. Care ethics relies on policy and organisations providing an environment for relational care.

In summary, the ethics of care is an economical and desirable principle in meaning person-centred care especially in the emphasis of relationality, interdependence and responsiveness. Its application in UK health and social care systems is however still limited due to structural, organisational and resource-based limitations. Despite the increasing vulnerability of policy frames to the care ethics, a very wide gap between the policy rhetoric and the reality itself exists. This gap has to be bridged by more than mere conceptual commitment but by investing and working on workforce capacity, partnership working and organisational change. Lastly, care ethics is not merely a useful theoretical contribution but can transform the systems of care, provided the circumstances of relational practice are supported by aspects of significance.

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