




# From person-centered to person-based care: Implications for organizational ethics and innovation

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**Author:** Carlos Gomes , Escola Superior de Saúde Norte da Cruz Vermelha Portuguesa, Portugal, [carlos.gomes@essnortecvp.pt](mailto:carlos.gomes@essnortecvp.pt).

## Abstract

The literature tells us that the concept of person-centered care is based particularly on humanistic psychology and participatory clinical practice, valuing autonomy, empathy, and individual experience. Person-based care seeks the ontological and moral roots of the very act of caring, insofar as the person is the foundation, meaning, and ultimate goal of all ethical and professional action. Historically, the concept of person-centered care emerged with Carl Rogers (1961) and was further developed in nursing by McCormack and McCance (2006, 2017). This model promotes the humanization of practice, recognizing the individual as an active participant in their own health process. However, despite its clinical value, this model can be limited to a methodological or relational approach, without questioning the nature of the human being who is being cared for. Person-based care, on the other hand, introduces an ethical and anthropological depth. It is not merely about placing the person at the center, but about recognizing that care finds its ethical, spiritual, and ontological foundation in the person. In this article, we seek to engage with several authors who address and develop the concepts of person-centered care and person-based care. This paper also explores the implications of person-based care for organizational contexts, particularly in healthcare management, innovation processes, and entrepreneurial ecosystems. By reframing care as an ethical and ontological foundation rather than a procedural model, the study contributes to discussions on value creation, leadership, and responsible innovation in contemporary organizations.

**Keywords:** Autonomy; Ethics; Humanistic Psychology; Person-Based Care; Person-Centered Care.

This paper adopts a conceptual and hermeneutic approach, drawing on key philosophical and bioethical authors to critically analyse the evolution from person-centered to person-based care. In this sense, the present work does not aim to introduce conceptual novelty for its own sake, but rather to deepen and reinterpret existing frameworks through a philosophically grounded perspective. This position resonates with calls in organization theory to avoid “theoretical neophilia” and instead engage in reflective and historically informed theory development (Hassard, Cox, & Rowlinson, 2013).

## 1. Origin of Person-Centered Care to Person-Based Care

### 1.1. Person-Centered Care

#### 1.1.1. Humanist Origins — Carl Rogers

Carl Rogers (1902–1987), American psychologist, founder of the person-centered approach, was the first to use this expression initially in the field of psychotherapy, arguing that the therapist should focus on the person of the client, and not on the problem. The key ideas of his thought state: a) the person has within himself the potential to grow and to realize himself; b) the professional must adopt an empathetic, authentic and non-judgmental attitude; c) The therapeutic relationship is the space of healing.

From Rogers onwards, the expression “person-centered” was adapted to health and nursing, becoming a paradigm of humanized care.

### 1.1.2. Tom Kitwood (1937–1998)

Tom Kitwood is a British sociologist and psychologist and applied the concept to the care of people with dementia, introducing the term person-centered care in geriatrics. It argues that the essential thing is to preserve the identity and dignity of the person with dementia, recognizing him as a subject and not as a “patient”.

### 1.1.3. Person-Centered Care in Nursing — Kitwood, McCormack and McCance

As nurses and researchers, Kitwood, McCormack and McCance, structured the theoretical model of person-centered care in nursing and proposed the *Person-Centered Practice Framework*, one of the most influential models at the international level. Person-centered care emerges as an evolution of the biomedical model, which focuses predominantly on disease and symptoms, and to counter the disease-centered tendency, the authors propose an approach that integrates the biological, psychological, social and spiritual dimensions of the individual. The elements of the model include: a) practice based on values of respect, empathy and partnership; b) authentic and reflective professional; c) Organizational context that supports humanization; c) the care resulting from a mutually significant relationship.

This is the most widely used framework in nursing and care management at an international level.

## 1.2. Person-Based Care

### 1.2.1. Paul Ricoeur— Ethics of Relationship and Responsibility: Phenomenological Basis of Person-Based Care.

Paul Ricoeur defines ethics as the “desire for a good life, with and for others, in just institutions.” Ethical care is born from interpersonal relationships, reciprocal responsibility and the recognition of otherness. This vision is at the basis of person-based care as a moral subject. In his work *“Soi-même comme un autre”* (1990), Ricoeur proposes an ethics centered on the idea that personal identity is built in the relationship with the other, through a continuous process of recognition and responsibility.

“To be a person is to be able to say 'I' in front of a 'you.'” — Paul Ricoeur, 1990

In the context of care, this means that care is a relational and ethical act, in which the caregiver recognizes the other as a dignified, free and vulnerable being, and not only as an object of care. The author develops the ethics of solicitude (*sollicitude*), understood as a moral response to the vulnerability of the other. Solicitude is more than compassion: it is an active recognition, which implies accepting, understanding and acting in favour of the other, respecting their dignity and autonomy.

“Solicitude is the reciprocity of esteem for oneself and esteem for the other.” — Ricoeur, 1990

In this way, person-based care has its phenomenological foundation here: it is born from the encounter between two subjectivities, where the professional and the person cared for coexist in a relationship of ethical reciprocity.

Vulnerability, for Ricoeur, is a constitutive trait of the human condition. It is precisely in vulnerability that care becomes ethical, because the presence of the vulnerable other awakens in me the responsibility to respond. It is an “ethical call” similar to what Emmanuel Levinas describes as the “face of the other”, an interpellation that invites me to care.

“The other is the one who obliges me, even before I choose him.” Ricoeur, 1995.

In this sense, responsibility is born of recognition: caring is an act of response to the presence of the other who suffers. Thus, recognition is essential for authentic care to take place, which requires recognizing the other as equal in dignity, but different in individuality. However, “recognizing” is not only identifying, but respecting and valuing the person in their history, body and life project. Care, therefore, is an act of ethical reciprocity, where those who care and those who are cared for mutually transform each other.

“It is through the mediation of the other that I become myself.” — Ricoeur, 1990



Ricoeur provides the philosophical basis for understanding person-based care as a relational and ethical experience, not just a technical one.

In clinical practice (nursing and medical) and bioethics, Ricoeur inspires a vision of care that values the interpersonal relationship as a space of meaning, rejects technical or utilitarian reductionism and affirms that the act of caring is always ethical, as it is addressed to a concrete person, bearer of dignity and history, because in the person to be cared for co-responsibility is recognized: Caring and being cared for belong to the same humanity.

### 1.2.2. Viktor Frankl — Existential Foundation of Care

Viktor Frankl starts from the perspective of logotherapy and the spiritual dimension of the person. Care must be based on the meaning of life and on the interior freedom of the person. Health is more than the absence of disease; it is fullness of meaning. The caregiver helps the other to find meaning again, even in pain. For this author, the person cared for is not only a sick body, but a spiritual and free being, who retains an inner capacity to signify what he lives, even in pain, illness or dependence.

For Frankl, the human encounter is the place where meaning manifests itself. The professional who provides care must welcome the person as a subject, recognizing their suffering, values and history. Care becomes, then, an act of presence and compassion, where the caregiver helps the other to find meaning again, even in the face of vulnerability. Caring is “helping the other to discover meaning, even in suffering”.

## 2. Ethical and Philosophical Framework — Personalism and Bioethics in Portugal

Portuguese bioethics (born in the 1980s and 1990s) is marked by a fruitful dialogue between science, medicine and philosophy. From the creation of the Center for Bioethics Studies and, later, by the Institute of Bioethics — UCP, an ethical and humanistic model was consolidated, guided by four fundamental axes:

- Dignity of the human person as an absolute principle.
- Recognition of vulnerability as a requirement for care and solidarity.
- Ethical relationship between professional and sick people, based on trust and prudence.
- Social and ecological responsibility of human action.

Bioethical thought in Portugal developed from a solid personalist tradition, inspired by European philosophical and anthropological currents that affirm the dignity of the human person as the foundation of all ethical action. This view is part of a broader movement of humanistic bioethics, which is opposed to utilitarian, technocratic or merely procedural views of health care.

Portuguese personalism, consolidated by figures such as Daniel Serrão, Walter Osswald and João Lobo Antunes — among other authors, such as Neves Patrão M — and later deepened by Carlos Costa Gomes, today constitutes a structuring ethical reference for reflection on the foundation of care, founded on life and human dignity.

### 2.1. Personalism as the Foundation of the Ethics of Care

Personalism is based on the idea that the person is the supreme value of moral reality. Unlike ethics centered only on action, consequences, or norms, personalism places the person at the center of morality, recognizing it as an end in itself, endowed with freedom, rationality, relationality, and transcendence. Maria do Céu Patrão Neves<sup>1</sup> integrates the idea of person-centered care into a personalistic bioethics, in which human dignity is the

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<sup>1</sup> Emmanuel Mounier and Jacques Maritain — who saw the person as a being of relationship, whose dignity is concretized in the encounter with the other; Karol Wojtyła — who developed Christian personalism by integrating Kant and the phenomenological tradition: the person is free, rational, relational and open to transcendence (God, the Good, the Other). Daniel Serrão and Carlos Costa Gomes, in Portugal, follow this line when they say that the person is the foundation of ethics because he is a free, conscious, relational and transcendent being.



supreme criterion of ethical action. It emphasizes that the person is not only the center of care, but its value and moral purpose.

For Serrão, there is only a disease if there is a person. Therefore, the person is prior to the disease, therefore, by *autonomia*, the intrinsic dignity of the person confers on him the substantial and never circumstantial right and duty.” (Costa Gomes, 2013, p. 82–83). Here is a clear formulation by Serrão about the dignity of the human person as an ethical foundation, regardless of the health condition.

Personalism and Portuguese bioethics offer a profoundly integrative view of the action of caring. It recognizes the inviolable value of the human person and articulates ethics, technique and spirituality, promoting a humanized and prudent clinical practice that underpins the model of person-based care, which assumes the person as the origin, measure and end of the entire act of care, since “caring is more than treating; it is to recognize in the other his dignity and mystery.”

This thought has philosophical roots in Emmanuel Mounier, Jacques Maritain and Karol Wojtyła and finds in Bioethics in Portugal an original expression applied to biomedical practice. In the context of health care, personalism is not limited to respecting rights, it proposes an ethic of recognition and responsibility because caring is responding to the absolute value of the person. More recently, Carlos Costa Gomes deepens and systematizes this tradition through the Ethics of Complementarity, which articulates the dimensions of personalism, bioethical principlism and moral virtues. The ethics of care requires complementarity between principles, people and virtues: a dialogue between rationality and affectivity.”

From this perspective, personalism offers the ontological and axiological foundation — the person as an absolute value; principlism provides normative rationality — autonomy, beneficence, non-maleficence and justice — vulnerability and integrity; The virtues give the practical and prudential dimension — compassion, prudence, empathy and responsibility. Thus, and in this way, care ceases to be a mere technical or procedural act and becomes an integral ethical act, rooted in the dignity and uniqueness of the person.

The act of caring is an intrinsically human act. The foundation of this service is rigorously ethical and takes place within the ethical universe of the person. To serve the other, the vulnerable, is to satisfy their need for fulfillment as a person.” (Costa Gomes, 2020). The author emphasizes that care must be founded “on the ethical universe of the person”, recognizing vulnerability and dignity as foundations for the action of caring.

## **2.2. Daniel Serrão: The Person is the Foundation and Not Just the Center**

For Daniel Serrão, the person is the foundation of ethics and bioethics, not just the center of action. He rejects a utilitarian or technocratic view of medicine and proposes a model that recognizes the human being as an “absolute value” — never a means, always an end in itself. For Daniel Serrão, “the human person is always an end and never a means to any end, no matter how noble it may be.”

### **2.1.2. Difference Between “Person-Centered” and “Person-Based”**

Daniel Serrão does not use the expression “person-centered care” (of more Anglo-Saxon origin, linked to nursing and humanistic psychology), but his thought offers an implicit critique of this formulation. In this sense, Serrão states: “if centered care places the person at the center, grounded care starts from the person as the root and ethical end of all care. The implicit critique of the “Person-Centered” does not reject care in this perspective but warns against its ethical superficiality if it does not integrate a complete anthropology. In the light of Serrão's thought, the “centered” model can privilege individual autonomy, forgetting the relational, spiritual and transcendent dimension of the person, it can transform the ethics of care into an ethics of choice, instead of an ethics of being, which can lead to the lure of becoming instrumental or pragmatic, if it is not founded on the ontological dignity of the person.

We can say that Daniel Serrão transcends the person-centered care model. His thought invites an ethical and ontological evolution of the concept: From person-centered care (empathy and autonomy) to person-based care (dignity and transcendence).



### **2.3. Walter Osswald and the Centrality of the Person in Bioethics**

Walter Osswald (1928–2021), a physician and bioethicist, developed a deeply personalistic view of the ethics of care. His thinking recognizes the importance of “person-centered care” but refuses to reduce it only to a clinical or communicational methodology. For Osswald, the centrality of the person must be ethical, ontological and spiritual in nature and not just practical. What is at stake is not only to treat the sick with humanity, but to recognize in him the inalienable dignity of a person.”

#### **2.3.1. Person-Centered Care Is the Starting Point, the Foundation Is Arrival**

Osswald sees the person-centered model of care (inspired by Carl Rogers, McCormack, and others) as an important advance over the traditional biomedical model, because it values the autonomy and participation of the person, prioritizes dialogue and empathetic listening, and calls for a more humanized clinical practice.

However, for Walter Osswald, it is not enough if it is not based on a solid anthropological basis. That is, without understanding what the person is, person-centered care runs the risk of becoming an “ethical slogan” without moral depth. Because this author, “to humanize is not just to be kind; it is to recognize the other as a person endowed with absolute value.”

Walter Osswald does not reject the concept but proposes an ethical reformulation. Care must be person-centered, because it is person-based. In other words, “centering” on the individual is important, but it is not enough to recognize preferences, it is necessary to recognize the dignity and moral dimension of the person. The centered model can be too subjective or autonomist, reducing care to individual choice. The model founded on the person, on the other hand, has a solid anthropological basis, integrating body, soul, spirit and community.

Walter Osswald integrates person-centered care within a broader personalistic vision. True “centered” care is ethical only when it is also “person-based,” that is, when it recognizes human dignity, vulnerability and transcendence.

“Technique must be subordinated to ethics, and ethics to respect the person.”

### **2.4. João Lobo Antunes Calls for a Philosophy of Care that Is Close to “Person-based Care”**

João Lobo Antunes (1944–2016) is an unavoidable reference in ethical and humanist reflection on care, and his vision offers a profoundly complementary reading to that of Walter Osswald and Daniel Serrão but does not formulate a “formal ethical model”. Lobo Antunes develops a “philosophy of care” that is close to “person-based care”, going beyond simple “person-centered care”. As a neurosurgeon and essayist, João Lobo Antunes united science and ethics, technique and humanity, in a discourse where the act of caring is a profoundly human encounter. For this author, “medicine is an encounter between two weaknesses: that of the patient and that of the doctor.” It is in this encounter that he recognizes that the person of the patient is not only the carrier of a disease, but a being with history, values, affections and mystery. The totality that technique, by itself, does not reach.

#### **2.4.1. Person-Centered Care, but with Ethical Density**

Lobo Antunes accepts the ideal of person-centered care, especially as a humanisation of medicine and respect for the uniqueness of the sick person. But his approach is not merely communicational, it is ontological and ethical. “The patient is not a clinical case, it is a world that is entrusted to us.” Person-centered care is not limited to “putting the sick person at the center”, it implies recognising their absolute value and our moral responsibility towards the sick person. True care is the relationship between people, not the provision of services. Thus, person-centered care, in Lobo Antunes, gains moral and spiritual depth because it is based, precisely, on the ethical density in the relational universe of the encounter between two people.

## **3. The “Fallacy” of Person-Centered Care: Bioethical Analysis**

In recent decades, the expression “person-centered care” has become a recurring motto in health policies, in the training of professionals and in discourses on the humanization of care. However, Ana Sofia Carvalho warns of



the risk of this concept becoming an ethical and anthropological fallacy, when it is used in a superficial or instrumental way, without true foundation in human dignity.

The term “person-centered” can, paradoxically, reinforce an individualistic and isolated view of the subject, if it is misinterpreted. By focusing excessively on “individual autonomy” it can devalue relationships of interdependence, ignore the family, social and cultural context and distance care from its community and solidarity dimension.

In this sense, we consider that the designation of the term “person-centered care” can become a rhetorically humanistic, but ethically empty discourse. According to the author, the concept is fallacious for three main reasons:

- **Instrumentalization of the person:** The discourse places the person as the “center” of a technical model, but not as a subject of relationship. The language of “centering” is still a language of power, because it keeps the professional in the role of the one who decides “around” the other.
- **Anthropological reduction:** The term “person” is used vaguely, without reference to its ontological and ethical dimension. It thus becomes synonymous with “user” or “customer”, losing its absolute value.
- **Ethical contradiction:** By affirming that care is “centered” on someone, there is a risk of reducing care to a method of managing the patient's experience, rather than an interpersonal encounter.

“Person-centered care can fall into a fallacy when the person is only the pretext of a technical model of humanization.”

Reading Daniel Serrão's thought, care should not only be person-centered but person-based. “Centering” refers to a position of focus; The “foundation” refers to an ethical root. Thus, in the logic of Person-Centered Care, the person is the object of care. The focus changes, but the technical logic remains. There is a risk of practicing a technical-formal autonomy or of functional paternalism. In the logic of Person-based care, care is born from the inherent and intrinsic dignity of the person, based on the recognition of a dialogical autonomy and a relationship with responsibility. Therefore, from this perspective, the center is a door, but it is the foundation that matters. Only when care is person-based does it become truly ethical.” Health care is not born from centered models, but from well-founded ethical relationships, where the professional and the person being cared for share responsibilities and meanings.

Ethical care is, therefore, an act of alterity: it is not centered, it is found; it is not measured, it is recognized; it is not managed, it is shared. It invites us to rethink the ethics of care from a personalistic and relational anthropology.

“Person-centered care,” if not critically reviewed, can be a well-intentioned fallacy, a discourse that promises humanization but maintains the logic of objectification. True ethical care is that which recognizes the person as the foundation and end, and not as the center or means, it is an act of recognition, not of centralization. It is an act of ethics and truth.”

The concept of person-centered care is valuable and desirable, but it has serious barriers at the conceptual, normative, and practical levels. There is a risk of confusing discourse with reality — saying “the person at the center” is not enough, it is necessary that practices, structures and policies effectively allow it. Without this, there is a risk that “person-centered” will be just a formulation with no real impact.

#### **4. Ethics of Vulnerability and Responsibility**

In UNESCO's Universal Declaration on Bioethics and Human Rights, approved in October 2005, one of the ethical principles proposed is that of respect for human vulnerability.

Vulnerability and vulnerable are terms that come from the Latin *vulnus*, meaning that entity is subject to injury. Kempe Rendtorff offers us a clear and succinct notion of the principle of vulnerability: “The principle of



vulnerability prescribes, at the foundation of ethics, the respect, care and protection of the others and of the living in general, on the basis of the universal observation of the fragility, finitude and mortality of beings.”

For Maria do Céu Patrão Neves, the word vulnerability can be defined as the susceptibility to being hurt. Thus, all human beings are liable to injury just because they are alive.” For the author, vulnerability as an intrinsic condition of the person reinforces the ethical dimension of care. “Vulnerability, in the adjectivating function with which it is used, is first presented as a fact, on a descriptive level. However, it cannot be considered axiologically neutral, but, rather, it also denotes the expression of values, in the openness to a prescriptive plane.” The vulnerability of the person is therefore presented as an ethical foundation, a requirement of responsibility, respect and care.

João Lobo Antunes approaches the ethics of vulnerability and responsibility, inspired by authors such as Emmanuel Lévinas. It emphasizes that the vulnerability of the other is an ethical call to response and what gives rise to true care. “The vulnerability of the other is a call to our humanity.” Thus, for the author, care is no longer only person-centered (as a technical principle) and is based on the ethical relationship with the person, marked by compassion, prudence and presence. He does not implicitly criticize the “centered” model, he does not reject the term, but he makes a criticism very similar to that of Osswald and Serrão: “Technique can cure, but only presence truly heals.”

João Lobo Antunes goes beyond the technicist vision of the “person-centered”, proposing a model of person-based care and the ethical relationship. From person-centered care — the person as the center of clinical decisions — it prefers the concept of person-based care — the person as the origin and meaning of care, in their vulnerability and mystery — to the extent that care is the most human gesture we can offer: it is not just science, it is encounter.”

## **5. Implications for Organizations and Entrepreneurship**

The transition from person-centered to person-based care has important implications beyond clinical settings, particularly in organizational and entrepreneurial contexts. Contemporary organizations, especially in healthcare, social innovation, and service-based sectors, increasingly recognize that value creation is not only technical or economic, but also relational and ethical.

From an entrepreneurial perspective, person-based care contributes to a deeper understanding of user needs, not merely as preferences, but as expressions of dignity, vulnerability, and meaning. This perspective can inform the design of products, services, and business models that are more responsive, inclusive, and ethically grounded.

In terms of organizational ethics, person-based care challenges purely instrumental approaches to management by emphasizing responsibility, recognition, and relationality. This perspective resonates with stakeholder theory (Freeman, Harrison, & Zyglidopoulos, 2018), which frames organizations as systems of relationships where value is created with and for multiple stakeholders. It also aligns with emerging discussions on responsible innovation, human-centered leadership, and sustainable value creation.

Furthermore, in innovation processes, particularly in health and social sectors, adopting a person-based perspective may enhance user engagement, trust, and long-term impact, contributing to more resilient and socially embedded entrepreneurial ecosystems.

The person-based perspective is closely aligned with the principles of responsible research and innovation (von Schomberg, 2013), emphasizing ethical acceptability, sustainability, and societal desirability.

## **6. Concluding Summary**

Person-based care is an ethical and philosophical evolution of person-centered care. It recognizes the person as the foundation, criterion and purpose of all health action — not only as the center of decision, but as a source



of dignity, relationship and transcendence. It is a paradigm that unites science, ethics and spirituality in the same gesture of caring.

“Person-Centered Care” is based on a relational and practical ethic that has its origins in Carl Rogers (humanistic psychology) and McCormack & McCance (nursing), whose scope is understood to be clinical, relational and organizational issues. The ethical contributions are positive in that they valued respect for the autonomy of the person and the promotion of empathy, active listening and respect for uniqueness. It privileges the humanized relationship instead of a dehumanized relationship with a technician vision, reinforces the ethics of the relationship and the professional dialogue between person and patient.

In terms of ethical limitation, it can be reduced to a communicational or technical model, focused on preferences, and not on values. It runs the risk of moral individualism — caring “as the other wants”, without evaluating whether this is ethically good and beneficent. It focuses more on the shared decision than on the moral foundation of the decision.

“Person-centered” care is ethical based on an ethic of being (ontology) and decision (moral). It is a more deontological and less fundamental humanist paradigm in the wake of ethical depth.

“Person-based care” is based on a personalistic and prudential ethic<sup>2</sup>, looking at the person not only as the center of care, but as its moral foundation and purpose. Ethical action is born from the intrinsic and inherent dignity of the human person, and not only from his or her choices. It values prudence, the relationship of otherness and transcendence (spiritual dimension). It integrates reason, emotion, and moral virtue with the ethics of practical wisdom (phronesis). He cares not only with technique and empathy, but with ethical wisdom. It recognizes that the person is an absolute value, even when he or she cannot decide (child, elderly, critically ill person), because it is in the person that the origin of the foundation that unites science with ethics and competence with conscience lies.

The concept of “person-based” care does not replace “centered” care, it perfects it. It is the highest ethical form of care, because it recognizes the ontological value of the person as the principle and end of action.

From the perspective of Paul Ricoeur (and also of Viktor Frankl and Walter Osswald, Daniel Serrão...), the person is not only the center of the action of caring, but the foundation of the very meaning of care. This means that caring is not only doing good to the person, but acting for him and with him, recognizing his intrinsic value, as a value that does not depend on health, utility or autonomy, but on his condition as a human being.

Thus, person-based care rises as the highest ethical form of care, as it transcends mere functional centrality and reaches the ontological and transcendental dimension of human dignity. At this level, caring becomes an act of respect, love and responsibility, in which the other is always considered as an end in itself, never as a means — according to the Kantian principle of morality and Ricoeur's ethics of solicitude.

In conclusion, person-based care represents the ethical maturity of care: it unites technique with compassion, science with conscience and transforms the encounter between professional and person into a relationship of mutual recognition and existential meaning. It is the point at which care ceases to be just a professional practice and becomes an expression of humanity itself.

**Table 1:** Comparative Scheme.

Person-Centered Care	Person-Based Care
Relational and participatory approach	Ethical and ontological approach
Valuing the person’s autonomy and lived experience	Recognition of human dignity
Improved communication and person satisfaction	Respect and responsibility in action

<sup>2</sup> Origin: Personalism (Mounier), Ethics of Complementarity (Carlos Costa Gomes), Personalist Bioethics (Patrão Neves).



The concept — ethical-ontological approach designates a way of understanding and acting that is based on the dignity of the human being as a being, and not only on the circumstances or consequences of actions. “Ethical” refers to moral action, to decisions guided by the good, justice, respect and responsibility. “Ontological” comes from “ontology”, the branch of philosophy that studies being in itself; it concerns what constitutes the essence of the person — his dignity, freedom, rationality, relationality and transcendence.

Thus, the ethical-ontological approach considers that the action of care should be guided not only by moral values, but also by the recognition of the intrinsic value of the person's being. That is, caring is a duty that is born from what the person is, and not from what he has, does or feels.

Ethical: asks “how should I act well towards the other?”

Ontological: it asks “who is the other who asks me for care?”

“To care ethically is to act according to the good; to care ontologically is to act from the being.”

The concept — participatory relational approach is a way of understanding and practicing care that values the active participation of the person in decisions, actions and in the evaluation of their own health and well-being process. Instead of seeing the person as a passive recipient of care, this approach recognizes them as a partner, co-responsible and agent in the care process. The person is listened to, respected in their preferences, values and experiences, and actively participates in the planning, execution and evaluation of care.

In person-centered care, the participatory approach is essential — care is built with the person, not for the person. In person-based care, this participation acquires an ethical-ontological sense — participation is seen as an expression of the freedom and dignity of the person, not only as a method of involvement.

In this way, person-based care not only enriches bioethical reflection, but also offers a valuable framework for rethinking organizational practices, innovation strategies, and entrepreneurial approaches grounded in human dignity and ethical responsibility.

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