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FINDING AND FOSTERING COMMUNITY IN THE PRACTICE OF WHOLE PERSON CARE

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Practicing whole person care often begins quietly. It begins not with a protocol or framework, but with an internal orientation: a commitment to attend to the full humanity of those we care for, and to our own. For clinicians, educators, and healthcare leaders alike, this commitment shapes how we listen, how we tolerate uncertainty, and how we remain present in moments that resist easy solutions.

Across my professional life, I have carried this commitment through multiple roles and environments: as a clinician working directly with patients and families; as an educator supporting learners navigating their professional identities; and as a healthcare leader responsible for shaping systems that influence how care is delivered. In each setting, whole person care has felt both deeply meaningful and, at times, unexpectedly solitary.

Healthcare environments, whether clinical units, academic institutions, or administrative offices, are increasingly shaped by time pressures, documentation requirements, fiscal constraints, and performance metrics. Within these systems, relational work can become invisible. The acts of listening deeply, acknowledging suffering, and holding complexity rarely appear in productivity reports or strategic dashboards. As a result, those who hold whole person care as central to their practice may find themselves quietly questioning whether their values are fully supported.

It took me time to recognize that this sense of isolation was not a personal shortcoming. It was a signal. I was trying to sustain work that is inherently relational without adequate relational support. What I needed, though I did not yet have language for it, was community.

Whole Person Care as an Individual Commitment

Early in my career, I understood whole person care primarily as an individual responsibility. I focused on cultivating reflective practice, emotional awareness, and clinical competence. I worked to become more attentive to patients' narratives, more comfortable with ambiguity, and more transparent about the emotional dimensions of care.

In clinical encounters, this meant pausing when conversations became difficult rather than redirecting them. In teaching environments, it meant inviting learners to reflect on how clinical experiences affected them personally, not only technically. In leadership settings, it meant advocating for policies that recognized staff wellbeing as integral to quality care.

This individual commitment served me well in many respects. It allowed me to build meaningful relationships and to experience moments of authentic connection, even within constrained systems. Yet over time, the limits of this framing became clear. Without spaces to share experiences, voice doubts, and reflect collectively, the emotional weight of the work accumulated. I began to wonder whether practicing in this way was sustainable, or even welcome, in environments that seemed to reward speed and certainty over reflection and presence. I rarely voiced these concerns aloud. I assumed others were managing better. In hindsight, this silence reinforced the very isolation I was experiencing.

Discovering Community in Practice

The most meaningful experiences of community in my professional life did not arise from formal initiatives, though structured programs can play an important role. They emerged instead in ordinary moments across diverse environments.

In a hospital corridor after a difficult clinical outcome, a colleague once paused long enough to ask how the day had affected me, not just operationally, but personally. In a faculty office, a learner shared uncertainty about their capacity to remain compassionate in the face of repeated suffering. In a leadership meeting, a senior administrator quietly acknowledged the moral strain experienced by frontline staff.

Amongst these, one conversation stands out. After a particularly challenging period, I found myself speaking with a colleague whose role differed significantly from my own. What began as a logistical discussion shifted into a shared reflection on grief, responsibility, and the tension between institutional

expectations and personal values. There was no attempt to fix the situation. There was only recognition. That recognition itself was restorative.

Conversely, I have worked in environments where whole person care was prominently featured in mission statements and strategic plans, yet where little space existed to speak openly about moral distress, vulnerability, or emotional impact. In those settings, the language of whole person care was present, but the relational infrastructure was absent. I often felt more alone there than in places where whole person care was never explicitly named.

These experiences clarified something essential: community cannot be assumed based on shared terminology. It must be enacted through listening, reciprocity, and sustained attention to one another's lived realities.

Conditions That Nurture Community

Across clinical, academic, and administrative contexts, I have observed several conditions that consistently nurture community in whole person care.

Psychological safety is foundational. Community flourishes when individuals can speak openly, not only about successes, but about uncertainty, emotional responses, and mistakes, without fear of judgment or reprisal. In leadership roles, I have learned that psychological safety is modeled before it is mandated. It grows through consistency, transparency, and a willingness to acknowledge one's own limits.

Shared reflection is equally vital. Whole person care invites us to examine who we are in relation to our work. When reflection occurs collectively, whether in debriefs, peer conversations, or interdisciplinary rounds, it normalizes emotional experience and reduces isolation. Naming moral distress together transforms it from a private burden into a shared human response.

Mutual respect across roles and disciplines further strengthens community. In healthcare settings shaped by hierarchy, relational wisdom can be overshadowed by positional authority. I have come to value spaces where lived experience, of nurses, physicians, allied health professionals, administrators, and learners alike, is treated as legitimate knowledge. When expertise is broadened in this way, community becomes a space of learning rather than comparison.

Forces That Undermine Community

Just as community can be nurtured, it can also be quietly eroded.

Time pressure remains one of the most pervasive challenges. Across the environments I navigate, clinical care, academic teaching, and organizational leadership, schedules are dense and margins thin. When relational work is framed as secondary to productivity, opportunities for connection diminish.

Hierarchical cultures can also impede authenticity. In settings where authority is equated with certainty, admitting uncertainty or emotional impact may feel risky. Individuals retreat into professional personas that prioritize self-protection over openness.

Perhaps most insidious is the normalization of emotional detachment. When caring deeply is framed as a liability, practitioners may distance themselves from patients and from one another. In such contexts, whole person care becomes an internal, private practice rather than a shared endeavor.

Making Space for Community

One of the enduring tensions in my practice has been how to create space for community within already full roles. Over time, I have come to understand that community does not always require extensive time; it requires intentional presence.

Some of the most meaningful connections I have experienced occurred in brief exchanges: a few minutes of undivided attention, a shared silence after difficult news, a thoughtful follow-up message. Their significance lay not in duration, but in quality.

As a leader, making space for community has also required difficult choices. For many years, I equated commitment with availability. I accepted responsibilities aligned with institutional priorities, often at the expense of reflective space. Gradually, I realized that protecting relational capacity sometimes meant declining opportunities, not out of disengagement, but out of stewardship for the aspects of work that sustain both staff and patients.

In practical terms, fostering community has involved facilitating peer check-ins, encouraging reflective dialogue in team meetings, celebrating collective achievements, and creating forums where interdisciplinary perspectives are genuinely welcomed. These actions may appear modest, yet over time they reshape culture.

An Evolving Understanding of Community

My understanding of community has shifted significantly. Early in my career, I associated it with belonging to a defined group: a department, a discipline, an institution. While such affiliations matter, they are not sufficient.

I now understand community as relational rather than structural. It is grounded in shared values rather than shared titles. It may include colleagues, learners, patients, mentors, and brief encounters that leave lasting impressions. It may be transient or enduring. What defines it is not permanence, but presence.

Community does not eliminate systemic constraints or prevent moral distress. It does not remove the complexities inherent in healthcare. What it offers instead is companionship; a reminder that the weight of caring work is carried collectively, not individually.

Community as Renewal and Responsibility

In a healthcare landscape marked by increasing complexity and strain, fostering community is not optional: it is essential to sustaining whole person care.

As a healthcare leader, I have come to see community-building not as an aspirational ideal, but as a professional responsibility. Creating environments where staff feel seen, heard, and connected strengthens resilience, engagement, and ultimately the quality of care provided to patients. When relational infrastructure is intentionally cultivated, whole person care becomes embedded in culture rather than dependent on individual endurance.

Community asks only that we show up: imperfectly, honestly, and with willingness to listen. In doing so, whole person care becomes a shared practice capable of sustaining us over time.

For those of us committed to this work, fostering community is both a responsibility and a gift. It allows us to practice with integrity and compassion. Most importantly, it reminds us that while the work may at times feel solitary, it was never meant to be carried alone. ■

Biographical Note

Sarvesh Mohan is a healthcare leader with experience across health system leadership, clinical operations, and education in diverse care settings. His work focuses on advancing quality improvement, patient safety, healthcare innovation, and workforce wellbeing. He is pursuing a Master of Business Administration, is a Certified Health Executive, and has completed executive education from Harvard University in healthcare leadership and coaching. He also holds a postgraduate qualification in Healthcare Administration and Service Management and a Bachelor of Dental Surgery, and is committed to whole person care, reflective practice, and interprofessional collaboration.