Feature
Cultures Of Healing
By Whitney Easton
Low trust and dissatisfaction plague the health-care industry. To improve the patient experience and boost health-equity outcomes, health-care organizations and providers should adopt a more holistic approach to health-care delivery.

**cultures of healing**

**HEALTH CARE GLOBALLY IS FAILING TO SECURE PATIENT TRUST AND SATISFACTION.** Of 27 countries surveyed in the 2022 Edelman Trust Barometer, trust in health care averaged 66 percent. In the United States, where most Americans believe the health-care system is in crisis, Deloitte reports that patient dissatisfaction is at an all-time high, and that significant disparities in trust are correlated with race and ethnicity.

While the conditions are ripe for a systemic change, health equity cannot be realized using old methods and tools. Instead, I propose “cultures of healing,” a human-centered, holistic, and culturally informed vision for health-care delivery that addresses decaying trust and satisfaction to improve health equity.

A cultures of healing approach demands that the health-care industry embrace a more nuanced view of culture. Currently, the industry’s discourse on culture focuses mainly on discussions about cultural competence—largely perceived as a thorny barrier that providers must navigate through trainings. In this context,
organizations have a limited understanding of culture because they fail to account for their role as active creators of the culture that affects everyone the system touches, from care seekers to their families, providers to staff.

But what if culture were something that could be innovated, just like technology? For anthropologists, culture is dynamic and porous, rather than fixed and static. Medical anthropologists have defined culture as “patterned ways in which individual lives unfold in multilayered, dynamic group contexts,” which suggests that, like culture itself, groups and identities are not monolithic but heterogenous and overlapping.

An anthropological view of culture also reveals how meaning is created in health-care encounters and how it informs healing. Medical anthropologists have shown how the tools healers use serve both practical and symbolic functions in the healing process. For example, the symbol of the doctor’s white coat represents medical expertise to elicit feelings of trust from care seekers. Such symbols create and legitimize a patient’s faith in their doctor, which positively shapes the entire course of their diagnosis, treatment, and healing.

Given that culture is socially constructed and is fundamentally dynamic, how can health-care systems create cultures of healing that deliver better patient experiences and outcomes? In this article, I present four levers of change to harness the power of culture to create a more positive and effective patient experience: center caregiving to humanize health care; amplify care-seeker agency to increase patient responsibility and build trust; and integrate local context and lived experience into care to reach marginalized populations. Combined, these levers can reform the health-care industry.

Center Caregiving

CARE IS THE HUMAN GLUE THAT HOLDS TOGETHER FAMILIES, COMMUNITIES, AND SOCIETIES,” ARTHUR KLEINMAN ASSERTS IN HIS 2020 BOOK, THE SOUL OF CARE. “CARE OFFERS AN ALTERNATIVE STORY OF HOW WE LIVE AND WHO WE ARE. BUT IT IS BEING SILENCED AND DIMINISHED IN VALUE, IN THE UNITED STATES AND AROUND THE WORLD, SACRIFICED ON THE ALTAR OF ECONOMY AND EFFICIENCY.”

Kleinman’s observations reveal the critical tensions between patient care and profit that define the health-care industry today. His critique is based on his experience of his wife’s end-of-life medical treatment for early-onset Alzheimer’s disease, in which he was forced to fill the gaps in care left by the health-care system. When organizations sideline caregiving, they dampen not only the patient experience but also the practitioner’s job satisfaction. Utilizing Kleinman’s observations and the work of other scholars and practitioners, I offer four recommendations for how organizations can better support caregiving.

Physicians experience decreasing control over their time, and specifically their time with patients, in profit-driven health-care organizations. On average, outpatient doctor’s visits in the United States are 13 to 16 minutes, which is often the maximum appointment time that insurance companies will reimburse to institutions. By comparison, family physicians spend an average of just over 16 minutes working in an electronic health record (EHR) for each nonsurgical-adult-patient visit. The accumulation of such bureaucratic tasks comprises the largest portion of their workday and contributes to physician burnout.

Health-care institutions must allocate more resources to enable practitioners to spend adequate time with patients. Research has shown that longer visits are associated with more attention to psychosocial problems, lower prescribing rates, better-quality prescribing, lower referral rates, lower return consultation rates, and higher patient-satisfaction indicators. These positive effects suggest that patients might also feel more trust and connection with their providers, and, according to research compiled by clinical psychologist Shamini Jain, patients who feel supported by their practitioner are proven to have a more successful healing process.

Even in clinical settings where time constraints remain intractable, Kleinman and Jain indicate that providers can build meaningful moments with their patients through eye contact, reassuring body language, supportive touch, careful listening, clear and comprehensible explanation of diagnosis and treatment, and encouraging words.

Health care must be a relationship, not a transaction. Additional factors can make patient touchpoints with health-care systems feel transactional, rather than relational, for patients, including poorly designed digital platforms and patient experiences that feel clinical—as in cold, rather than caring. Technologies used for diagnosis and treatment consume an increasing amount of clinicians’ time, replacing or severely eroding direct patient interaction. Caregiving is also overlooked in the design of clinical tools and technologies like the EHR. Until recently, in fact, most versions of the EHR did not include a space for provider notes or day-to-day observations of patients’ emotional well-being as crucial information for treatment.

However, technology does not need to be at odds with caregiving, relationship building, and patient experience. My design studio, Artefact, recently created a vision for Traverse, a digital companion that uses AI and natural-language processing to deliver personalized, culturally responsive care without compromising the patient experience. Traverse is built to promote cultural humility—clinicians’ ability to use skills of critical self-reflection and empathy to listen, learn, and adapt to the full range of patients’ cultural values, health-related practices, and multilayered identities in clinical encounters. The platform gives clinicians the tools to enact a culturally humble approach, including real-time access to information about patients’ backgrounds, which patients control through an AI-based digital-identity wallet. Traverse delivers relevant resources to providers in real time, supplies tailored and culturally responsive follow-ups with patients, and continually builds provider capacity that boosts learning and self-reflection.
Prioritizing care means respecting the care seeker’s dignity, agency, and autonomy. Care-seeker choice gives patients some control over their health-care journey, and it can improve patient access and satisfaction, particularly for marginalized people.
patient and provider—and the benefits cascading from it, including improved outcomes—is strengthened when any potential source of bias, discrimination, or discomfort is avoided by giving patients the power to choose a culturally congruent provider. Second, it triggers a better response from the patient. Humans respond to illness or injury and embark upon healing in three ways: autonomous responses (systems invoked by the body to regain health or equilibrium), specific responses (effects of medical treatment), and meaning responses (effects of the interpersonal interaction within the context of healing).

Meaning responses are often underestimated but demonstrate the role of culture in healing. For example, a patient enters a clinical encounter with certain preconceptions about the ability and suitability of their provider. Pioneering research by anthropologist Daniel Moerman argues that these beliefs shape treatment outcomes. For instance, Moerman found that clinicians’ conviction about their ability and the efficacy of treatment affects the patient’s response to the treatment: “In so far as these convictions are somehow conveyed to patients and, in the process, convince them of their doctor’s power, then they are likely (within the bound of our physical mortality) to be effective,” he observed in his 2002 book, *Meaning, Medicine, and the “Placebo Effect.”*

What if meaning responses also work in reverse, and the patient’s expectations shape their treatment and healing? A whole web of meaning responses originating from the patient’s initial expectations of their provider—including their choice of a provider—might cue meaning responses that inform treatment outcomes. This possibility should further encourage the health-care industry to support care-seeker choice.

Another important dimension of choice is care-delivery location, options for which were expanded as virtual-care services broadened during the COVID-19 pandemic. Flexibility of care delivery—in clinic, virtually, or at home—can extend the range of provider choice to the care seeker. For example, virtual visits enable care seekers to meet with a culturally congruent provider. They help patients to surmount barriers like distance and the cost of logistics like transportation, missed work time, and childcare. Of 525 people of color sampled by Deloitte in the United States in 2021, more than half of Hispanics and nearly half of Blacks and Asians were willing to use virtual visits in order to meet with a culturally congruent provider.

Organizational leaders and designers of health-care systems should incorporate the following practices to increase care-seeker agency and overcome any barriers to care seekers’ making choices about provider and location:

**Avoid top-down, cultural, or linguistic “patient matching.”** Organizations may assume that taking the initiative to match patients with providers based on race or other identities is acting responsibly and in the service of diversity and inclusion. However, such assumptions often rely on stereotypes, and they fundamentally eliminate patient agency. Research on patient matching in mental- and behavioral-health contexts does not support formulaically matching patients with providers based on perceived cultural congruence. And anthropological research indicates that some care seekers may fear being negatively judged by a provider from the same cultural background. For example, patients may worry that they will be negatively judged if a clinician with a shared cultural background treats them for a condition or is delivering care that is stigmatized or sanctioned in their culture.

**Confront how inequities show up in the culture of medicine across different practice environments.** While care seekers may enjoy the ability to select culturally congruent providers, their quality of care might still suffer because of existing structural forms of discrimination negatively affecting their providers. Compared with their white counterparts in the United States, physicians of color have been more likely to be in solo practice, have been less likely to obtain referrals to specialists, and have experienced more trouble getting their patients admitted to hospitals. They also experience racism in peer review, hospital promotion, Medicaid and Medicare reimbursements, malpractice suits, private-insurance oversight, and the awarding of managed-care contracts. These racist conditions often put patients in a dilemma of having to choose between culturally appropriate care and high-quality care. Organizations should carefully collect data and track emerging patterns on practitioner job satisfaction and experience and then take steps to support clinicians who experience these constraints.

**Address access barriers to provider choice.** Services and apps that enable provider choice may be inaccessible to care seekers for many reasons—from lack of internet access to language or literacy barriers and different abilities. Transportation and mobility barriers related to social determinants of health also limit patient choice. Institutions should study how health-care choices are constrained by these factors to solve for access equity, including virtual access points in communities and transportation assistance to support care-seeker choice.

**Improve Care-Seeker and Provider Relationships**

In biomedical settings, the focus of care is largely on the diagnosis of disease, rather than on attending to a person’s experience of illness. But healing is a biopsychosocial— not just biological—process in which the situated experience of illness and social supports greatly shape healing outcomes. This means that the quality of the relationship between the care seeker and the provider affects the former’s healing journey.

People craft their own “illness narratives” about their ailment, including expectations about the cause, diagnosis, and treatment course. Kleinman and Moerman have argued that providers must elicit illness narratives from their patients to avoid cultural miscommunications and support healing through shared understanding. Clinical communication, care management, patient adherence, and satisfaction improve when the illness narratives of patients, their families, and practitioners are mutually understood. Improved patient outcomes are tied to the ways in which
clinicians discuss treatment plans with care seekers. For instance, clinicians who encourage patients to ask questions and share decision-making with them reduce patients’ anxiety.

Illness narratives can be incorporated into clinical care in ways that support a more positive patient experience and better outcomes. One inspiring approach is narrative-based medicine (NBM). According to medical educator George Zaharias, NBM “shifts the doctor’s focus from the need to problem solve to the need to understand,” resulting in a stronger patient-doctor relationship and improved health outcomes. Since patients seek not only relief of their physiological symptoms through biomedicine but also, Zaharias explains, “personally and socially meaningful explanations and psychosocial treatments for illness,” NBM can more powerfully bring these qualitative dimensions into clinical care. Studies demonstrate that NBM has increased patient well-being, reduced cancer pain, alleviated rheumatoid arthritis, improved lung function in asthma, and bolstered immune response after hepatitis B immunization.

Several tools and frameworks aim to help clinicians communicate better with patients and ensure narrative alignment. Kleinman’s Eight Questions framework helps clinicians elicit illness narratives and open up discussion about what patients believe about their affliction. Similarly, the American Psychiatric Association’s Cultural Formulation Interview, which is included in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) to help psychiatrists understand the cultural and social contexts of their patients, can be adapted to other domains of medicine to enhance clinical understanding through the care seeker’s point of view. Both tools provide actionable scripts for clinicians to bring elements of NBM into their practice, especially through asking about and listening for the care seeker’s own understanding of what is troubling them. Medical databases like EthnoMed and CultureVision house information about the health beliefs and practices of different cultural groups, help to contextualize culturally specific beliefs about health and illness that might surface in discussions of

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illness narratives, and offer suggestions for culturally appropriate care. In addition, OurNotes is a platform that allows providers to record voice memos that are accessible to care seekers.

To improve relationships between care seekers and providers, organizations should offer a supportive environment and resources for clinicians. As growing infrastructure and governance for health equity develop, health systems are beginning to understand that commitments to health equity require longer visits or more support in certain patient contexts. Organizations should explore tools like those mentioned above might support clinicians in spending more quality time with their patients. Additional support in the form of training in narrative-based medicine or illness-narrative elicitation can educate those clinicians who did not encounter these frameworks in medical school.

While illness narratives can reduce misunderstandings between patients and providers, disparities in medical treatment are not simply a matter of differences in beliefs. Organizations should track how health disparities manifest in their institutions and address them through investing in understanding the barriers that patients face in receiving quality care. Being committed to developing mutually beneficial and nonpaternalistic clinical partnerships with diverse communities requires critical self-reflection on how power dynamics show up at each step of a care seeker’s health journey. Asking questions such as “What power differences might be present in this interaction?” and “How might we work to move the needle on unequal power relationships in this solution?” can help teams center health equity by pushing them to understand and design for how power operates—and could operate more equitably in their institution.

**Integrate Structural Competency into Care**

Although health professionals are rarely trained to address social determinants of disease, there is growing awareness among them that social determinants and structural factors inform health and health-care access. Structural competency, or practitioners’ ability to understand and respond to health disparities, is becoming increasingly important in the practice of medicine.

Fully addressing the health-care industry’s crises of trust, dissatisfaction, and health-outcome disparity requires looking beyond individual interactions to institutional and societal structures. Discrimination, from racism to classism to poverty, is a significant factor shaping health disparities and outcomes. Estimates by Deloitte report that social determinants of health factors—such as income, location of residence, and quality of social support—account for 80 percent of health outcomes.

Community-based health-care models demonstrate what structural competency looks like in clinical care. Community-based health care encompasses services delivered by a broad range of care workers who build partnerships within communities to provide people-centered health care and build health-system resilience. Community health workers (CHWs) are trusted members or respected guests of the community who are uniquely positioned to develop an understanding of the local contexts of care, the social forces that shape them, and social disparities, since they spend extended time in the communities they serve. Community health-care models also help address scenarios in which clinics’ and providers’ physical locations limit patient access to care.

Two pioneering examples illustrate the potential of using structural competency to reduce health disparities. The NGO Partners in Health (PIH) has pioneered a community-health model that has radically strengthened equity of outcomes in some of the most structurally constrained and resource-poor settings in the world. PIH has worked with more than 13,000 CHWs in 10 countries. In the late 1980s in Haiti, PIH predicted that patients with tuberculosis were not recovering because of structural barriers to care caused by extreme poverty. They also compared outcomes associated with free medical care alone with their model of free care accompanied by a range of socioeconomic supports. They saw astounding results: While only 56 percent of patients were cured and 10 percent died in the free-care group, 100 percent were cured in the group with full support. Supplementing high-quality care with social supports has become PIH’s signature approach to community health care.

A similar model that proves how integrated care and effective use of CHWs can make a significant impact on health disparities has been pioneered by Commonwealth Care Alliance (CCA), a nonprofit, community-based, payer-provider health plan. CCA’s member base would be classified by the health-care industry as difficult to serve: They tend to be dually eligible for Medicare and Medicaid, culturally diverse and low income, and they experience complex medical, social, and behavioral health needs, including trauma and disability.

CCA’s guiding belief is that investing in the medical care and social supports that promote holistic well-being and a high standard of care for people with complex needs will ultimately
decrease the necessity of costly emergency medical care. While most health systems focus on treating patients once they are already sick, CCA tackles the more encompassing interventions that can prevent illness, help manage chronic conditions, and bypass emergency care. CCA’s care model consists of enhanced primary care, including coordinated multidisciplinary teams; individualized care plans; integrated behavioral health care; and a 24/7 care team in the home, hospital, or clinic. In 2021, almost 60 percent of CCA members received assistance with at least one social support, ranging from transportation to housing to health outreach for nontraditional care services like peer support, acupuncture, and massage therapy.

CCA has been recognized nationally for its quality of care and notable outcomes. A recent study found that CCA members receiving home-delivered meals tailored to their medical needs for at least six months saw substantial reductions in emergency-department visits and use of other big-ticket health services like inpatient admissions. The study points to the promise of meal delivery to improve health and reduce medical costs. CCA’s Senior Care enrollees experience 66 percent fewer nursing-home placements and 48 percent fewer hospital days than comparable dual-eligible patients, along with decreased overall acute-care expenses.

PIH and CCA are two trailblazing examples of how health-care organizations that meet care seekers in their local contexts not only deliver a high quality of care to disadvantaged populations but also work toward advancing health equity. To incorporate structural competency into clinical care, organizations can implement the Structural Vulnerability Assessment Tool, an assessment questionnaire that helps clinicians identify patients who are likely to benefit from multidisciplinary health and social services. In addition, health-care leaders should adopt these four practices to embed structural competency within their organizations:

**Communicate aspirational beliefs and values.** Organizational leaders and designers of health-care systems should prioritize crafting aspirational organizational values, leveraging best practices from community-health models, maximizing impact through partnerships, and investing in staff experience.

PIH cofounder Paul Farmer maintained that all humans have the right to receive quality health care with dignity and respect. Similarly, in CCA’s 2021 annual report, President and CEO Christopher D. Palmieri affirmed, “We believe in our community-based, uncommon approach to care.” To promote a cohesive and consistent approach to care, the values that leadership expresses should be incorporated into staff education, training, and practice. For example, CCA provides robust onboarding and routine training in motivational interviewing, trauma-informed care, and cultural sensitivity.

**Leverage best practices from community health models.** CHWs must be professionalized members of care teams. Organizations should integrate CHWs into their structures and give them long-term support and financial and time budgets that specifically allow for community work, not just medical work.

**Think creatively about values-based partnerships.** Strong partnerships have allowed PIH and CCA to maximize their impact. PIH’s guiding values include capacity building and true participatory partnership with local stakeholders, which ultimately equip locals with the resources and knowledge to maintain health in their communities, rather than depending on external NGOs to fill gaps. CCA’s partnerships have enabled it to scale to serve four states, fill gaps in state health-care markets, and bolster its integrated-care model. Additionally, a 2022 study by researchers at Mass General Brigham (MGB) demonstrates how major academic medical centers can partner effectively with nonprofit community-based primary-care organizations like CCA. Through targeted, intensive-care management provided by CCA, MGB was able to reduce total medical expenses in a high-cost, high-risk Medicaid population.

**Invest in staff experience and satisfaction.** Incorporating structural competency into clinical care can either add to staff burnout or alleviate it. For many health-care providers, there is a professional imperative to provide holistic care and work to reduce health disparities wherever possible. Health-care providers could likely find more meaning and satisfaction in their work if they were given more opportunities to alleviate their patients’ structural vulnerabilities. According to the medical information website Medscape, contributing to a better world is the second-most rewarding part of the job for family physicians in the United States, behind building relationships and feeling gratitude from patients.

**Better Health for All**

Health-care organizations that adopt a broader understanding of culture can significantly improve health-care systems for all. Cultures of healing is an ideal vision that places care-giving at the heart of health care. Care seekers feel empowered in selecting whom they see and how, care seekers and providers alike feel understood and respected in their clinical interactions, and health outcomes are attuned to patients’ lived experience. Ultimately, each of the four levers of change work toward achieving health equity. Addressing the social determinants of health, as PIH and CCA have done, would not only contribute to cultures of healing for individuals but also nurture societal healing from the painful injustice of structural discrimination.

The levers of change and recommendations serve as launchpads for organizations to start and/or deepen conversations about how they can take advantage of the already existing cultural dimensions of both care seekers’ lives and health-care systems. The producers of health care are also the producers of the cultures of health. Culture can be changed to create better health for all.

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**Notes**