Structural Competency: Confronting Inequity in Health

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Structural Competency Session

Learning Objectives

1. Identify how social structures influence patient health
2. Identify how social structures influence the practice of healthcare
3. Articulate strategies to respond to the influences of structures in the clinic
4. Articulate strategies to respond to the influences of structures beyond the clinic
5. Describe structural humility as an approach to apply in and beyond the clinic

Why are people poor?

"No one has a right to work with poor people unless they have a real analysis of why people are poor."

Barbara Major, Director, St. Thomas Health Clinic

SCWG Structural Competency Working Group

Why are people sick?

"No one has a right to work with sick people unless they have a real analysis of why people are sick."

Shirley Strong, Director of Diversity, Samuel Merritt University

SCWG
Structural Competency Working Group

Overview Presentation:

1. Introduction to Structural Competency
2. Current Work
3. Key terms
4. Two “Cases”
5. Historical and Contemporary Examples
6. Follow Up

Structural Competency

"A shift in medical education … toward attention to forces that influence health outcomes at levels above individual interactions."

–Metzl and Hansen 2014

- The capacity for health professionals to recognize and respond to health and illness as the downstream effects of broad social, political, and economic structures.
- The ethical attention to and response to the social, political and economic structures that influence health and health care.

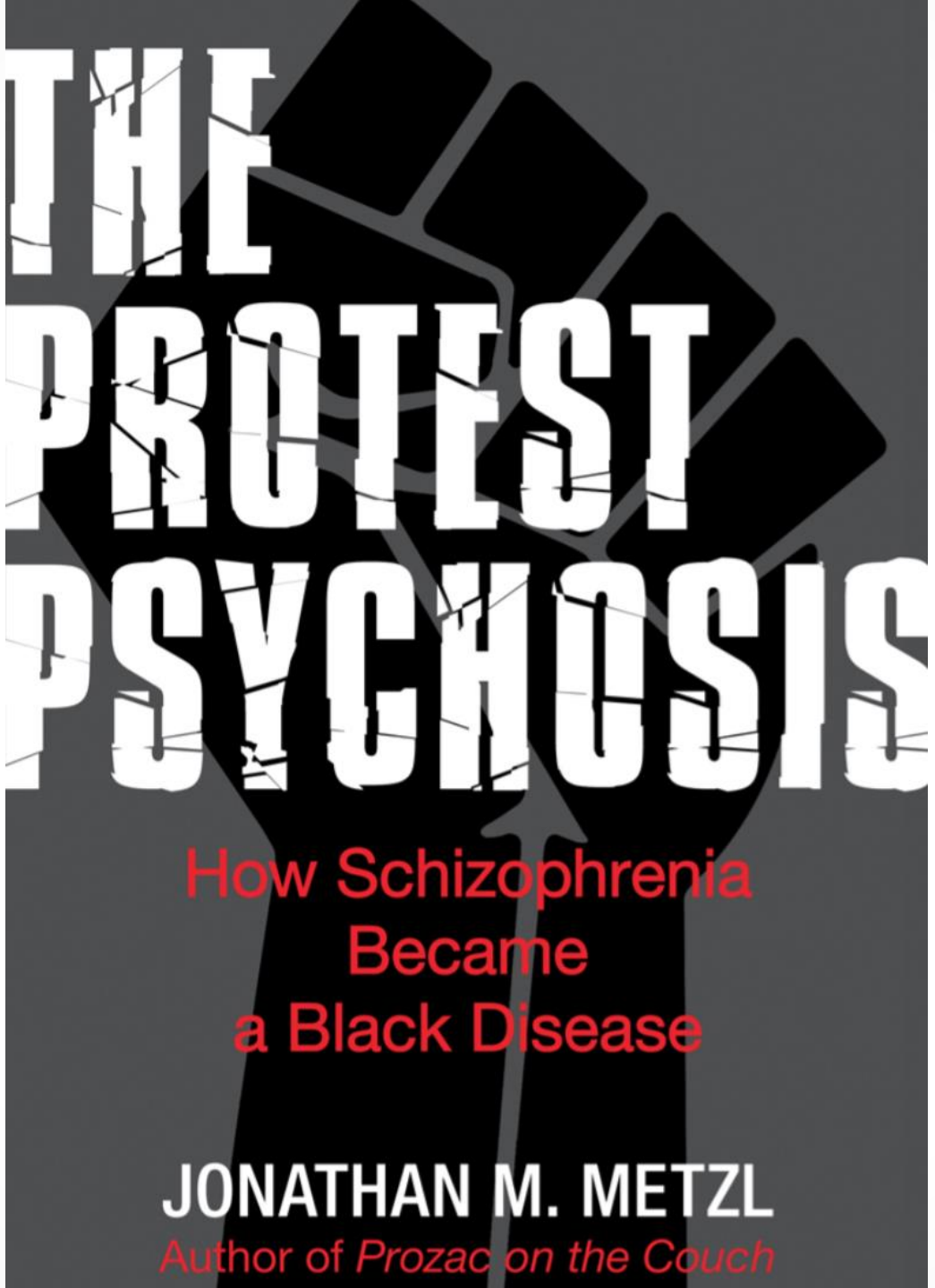
THE
PROTEST
PSYCHOSIS
How Schizophrenia
Became
a Black Disease
JONATHAN M. METZL
Author of *Prozac on the Couch*

Figure 2. 1974 Haldol advertisement, *Archives of General Psychiatry* [41]. Metzl and Roberts, American Medical Association Journal of Ethics September 2014, Volume 16, Number 9: 674-690.

Social Science & Medicine

Volume 103, February 2014, Pages 126–133

Structural Stigma and Population Health

Structural competency: Theorizing a new medical engagement with stigma and inequality

Jonathan M. Metzl[a], , , , Helena Hansen[b, c]

[a] Center for Medicine, Health, and Society, Vanderbilt University, Nashville, TN, United States

[b] New York University, New York, NY, United States

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"We argue that, if stigmas are not primarily produced in individual encounters but are enacted there due to structural causes, it then follows that **clinical training must shift its gaze from an exclusive focus on the individual encounter to include the organization of institutions and policies, as well as of neighborhoods and cities**, if clinicians are to impact stigma-related health inequalities."

Virtual Mentor

American Medical Association Journal of Ethics
September 2014, Volume 16, Number 9: 674-690.

FROM *VIRTUAL MENTOR* SPECIAL CONTRIBUTORS

Structural Competency Meets Structural Racism: Race, Politics, and the Structure of Medical Knowledge

Jonathan M. Metzl, MD, PhD, and Dorothy E. Roberts, JD

Virtual Mentor
American Medical Association Journal of Ethics
September 2014, Volume 16, Number 9: 674-690.

FROM *VIRTUAL MENTOR* SPECIAL CONTRIBUTORS
Structural Competency Meets Structural Racism: Race, Politics, and the Structure of Medical Knowledge
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In medical education "hypothesizing mechanisms that include the micro-processes of interactions between patients and professionals and the macro-processes of population-level inequalities is a missing step in our reasoning at present… **[A]s long as we see the solution to racism lying only in educating the individual, we fail to address the complexity of racism** and risk alienating patients and physicians alike." (Bradby 2010)

Structural Competency Working Group

- Est in East Bay in 2014; focused on integrating structural competency into the training and practice of healthcare providers
- Comprised of health professionals, anthropologists, sociologists, community health activists, patients, administrators, and graduate and professional students in several disciplines
- Over 100 structural competency trainings since 2015, for all kinds of health professionals & across all stages of training/practice
- This is an abbreviation of the usual 3-4 hour training

Research shows:

- SC effectively **shifts perceptions of disease etiology**
  - Before SC Training: *genetics, behavior, culture*
  - Post-SC Training: *poverty, racism, harmful policies, unequal resources*
- Trainees indicate **increased empathy and solidarity with patients**

Current Work

- Has been adapted by increasing health institutions
  - Family Medicine, Pediatrics, Internal Medicine Residency, Psychiatry, OB/GYN Programs
  - Global Health Fellowships
  - Nursing Schools
  - Medical Schools
  - Physical Therapy Schools
  - Interprofessional Teams
  - Schools of Public Health
  - Departments of Public Health
  - State of New Mexico
  - California Nurses Association
- USA, Europe, Latin America, Southeast Asia, Middle East, Africa
- Despite positive feedback, it is still a work in progress

Key Terms: Social Structures

- The policies, economic systems, and other institutions (judicial system, schools, etc.) that have produced and maintain contemporary social inequities and health disparities, often along the lines of social categories such as race, class, gender, and sexuality.

Structural Competency

Develop trainees' capacity in:

1. Recognizing the influences of structures on patient health
2. Recognizing the influences of structures on the clinical encounter
3. Responding to the influences of structures in the clinic
4. Responding to the influences of structures beyond the clinic
5. Structural humility

Structural Humility

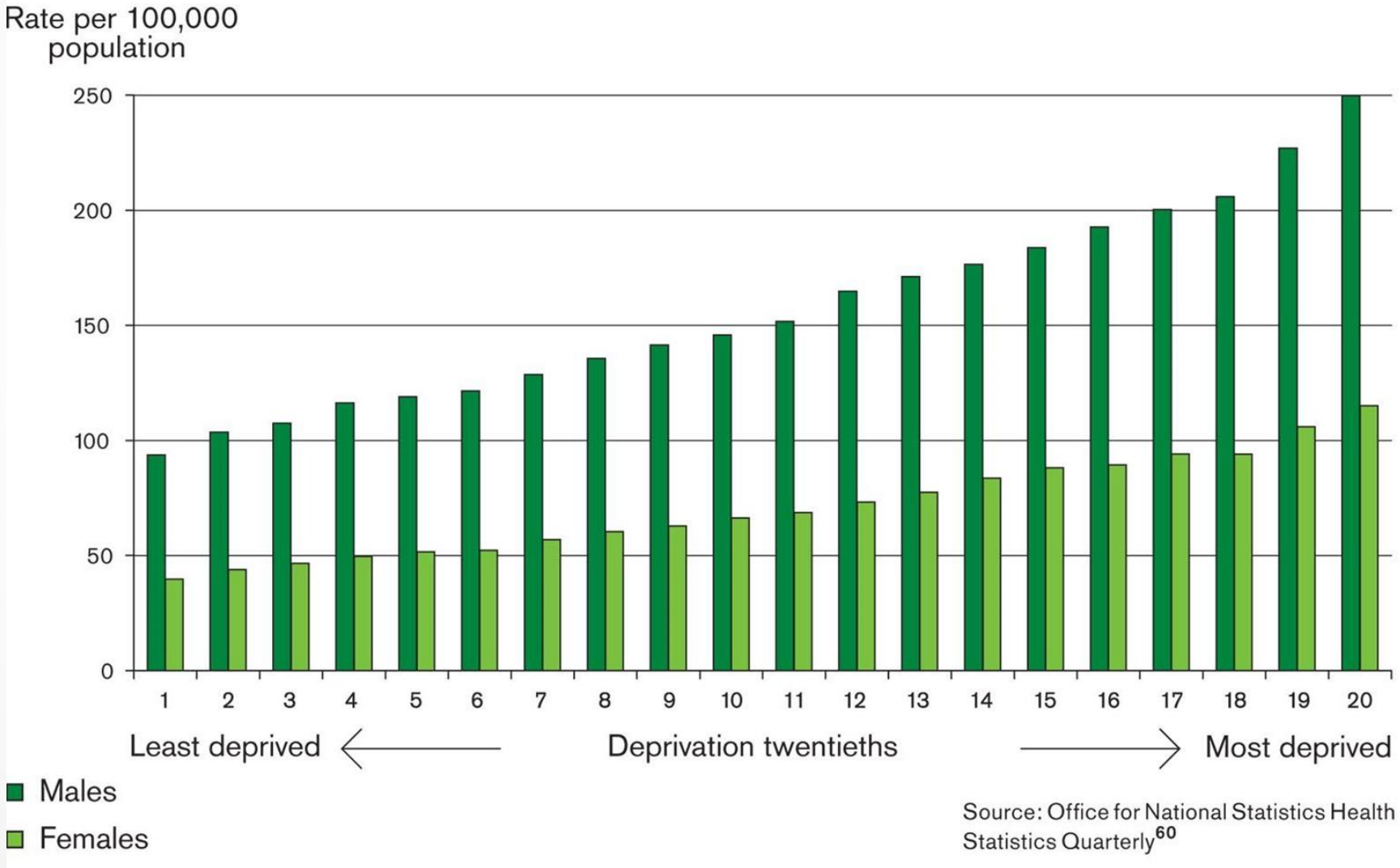
Structural humility cautions providers against making assumptions about the role of structures in patients' lives, instead encouraging the ethical stance of ***collaboration with patients and communities*** in developing understanding of and responses to structural vulnerability.

—Helena Hansen, 2015

Traditional Social Determinants of Health

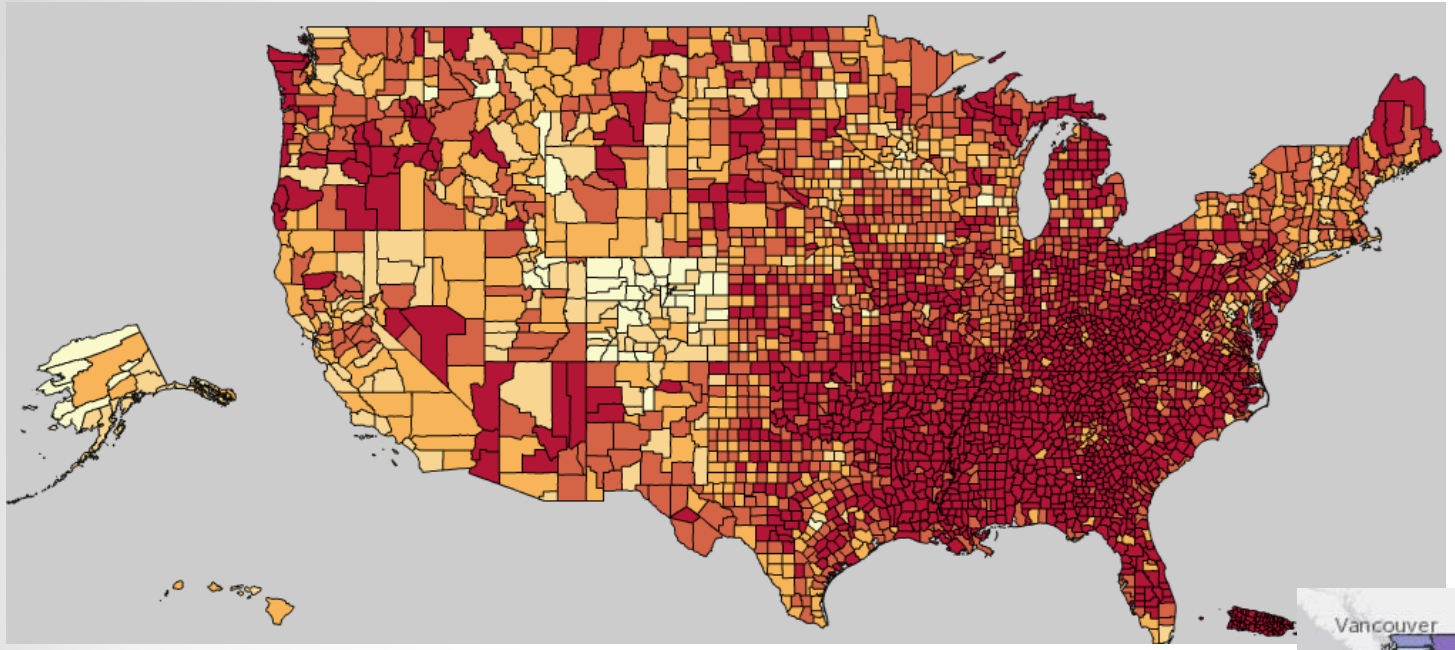
Figure 2.10 Age standardised (a) circulatory disease and (b) cancer death rates at ages under 75, by local ward deprivation level, 1999 and 2001–2003

(a) Circulatory disease

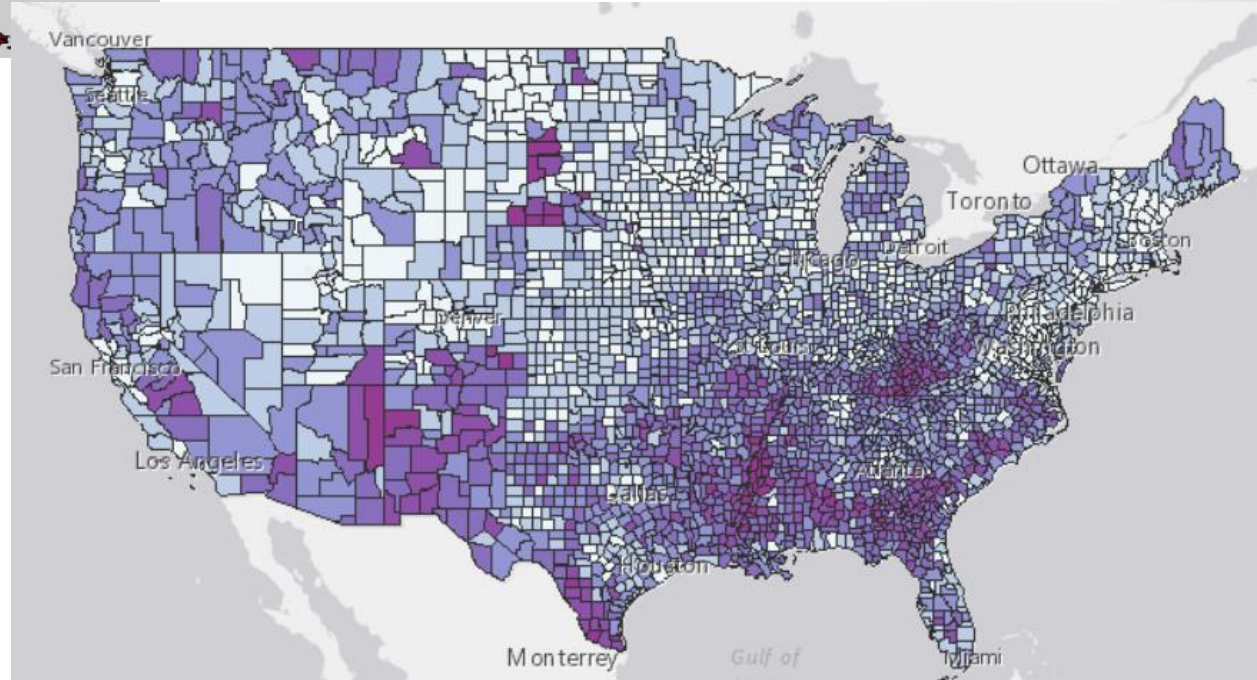


Source: Office for National Statistics Health Statistics Quarterly[60]

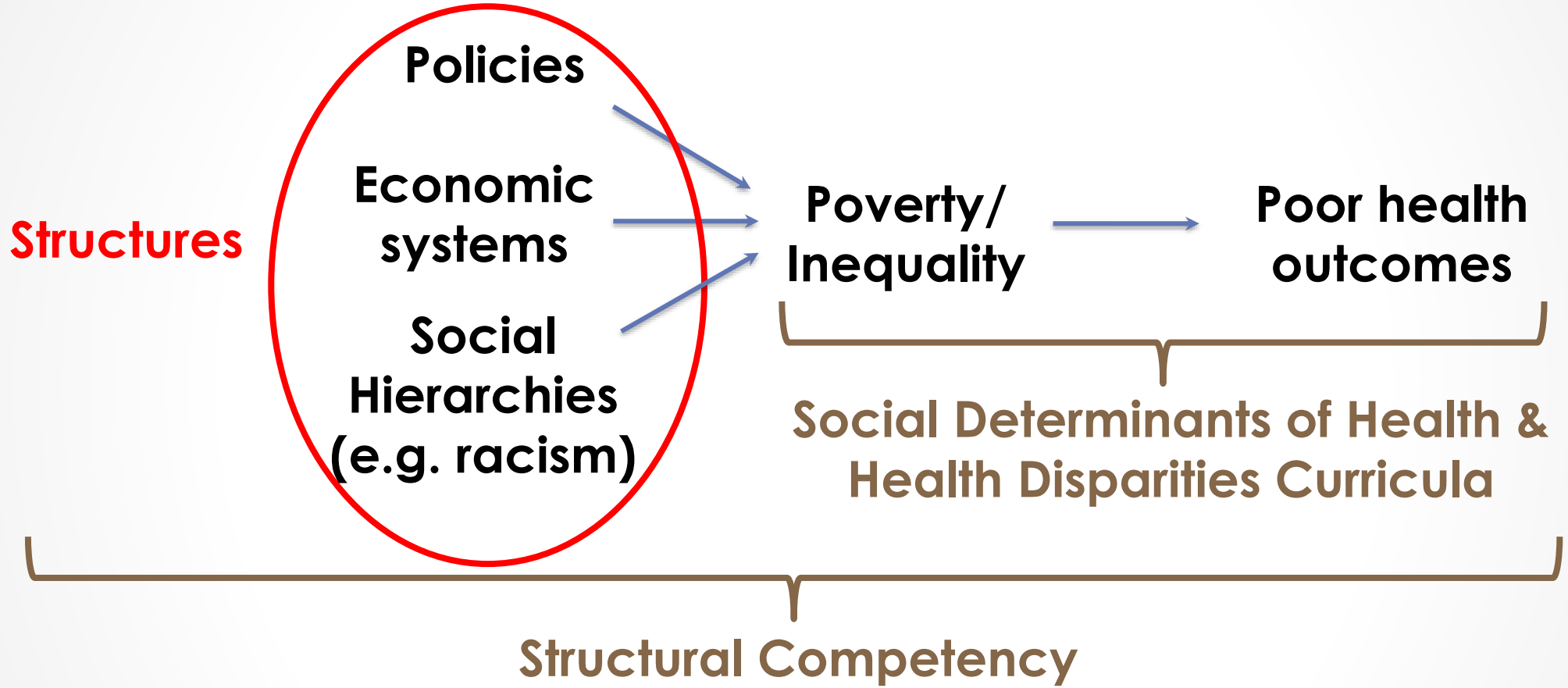
County-Level Diabetes Prevalence, 2013
(source: CDC)



County-Level Poverty Rates, 2016
(source: US Census)



SCWG
Structural Competency Working Group



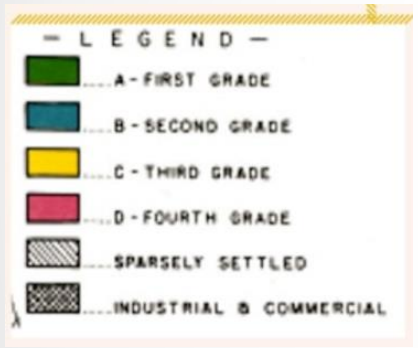
"Structural determinants of the social determinants of health"
"*Social determin<u>ation</u>* of health"

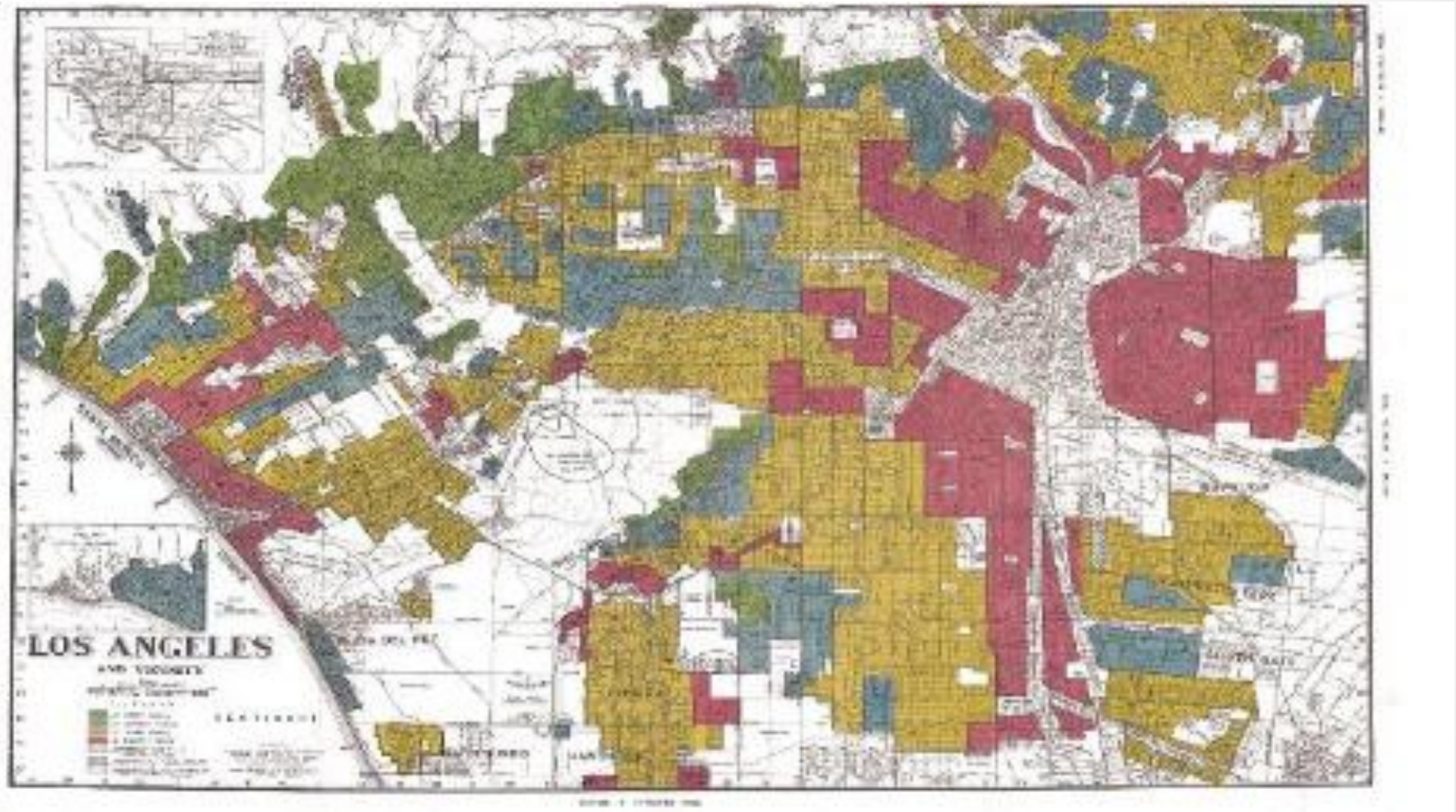
Structural Violence

- "Structural violence is one way of describing social arrangements that put individuals and populations in harm's way... The arrangements are structural because they are **embedded in the political and economic organization** of our social world; they are violent because they cause injury to people."

– Farmer et al. 2006

Structural Racism: E.G. Housing and Lending (Redlining)





Mapping Inequality *Redlining in New Deal America*

Structural Vulnerability

- The risk that an individual experiences as a result of structural violence – including their location in multiple socioeconomic hierarchies. Structural vulnerability is not caused by, nor can it be repaired solely by, individual agency or behaviors.

- How do structures affect patient health?

Case

HPI (History of Present Illness): Patient is a 37-year-old Spanish-speaking male found down w/ LOC, visible head trauma

PMH (Past Medical History): Frequent flyer well known to the Emergency department for EtOH-related trauma, withdrawal associated w/ seizures

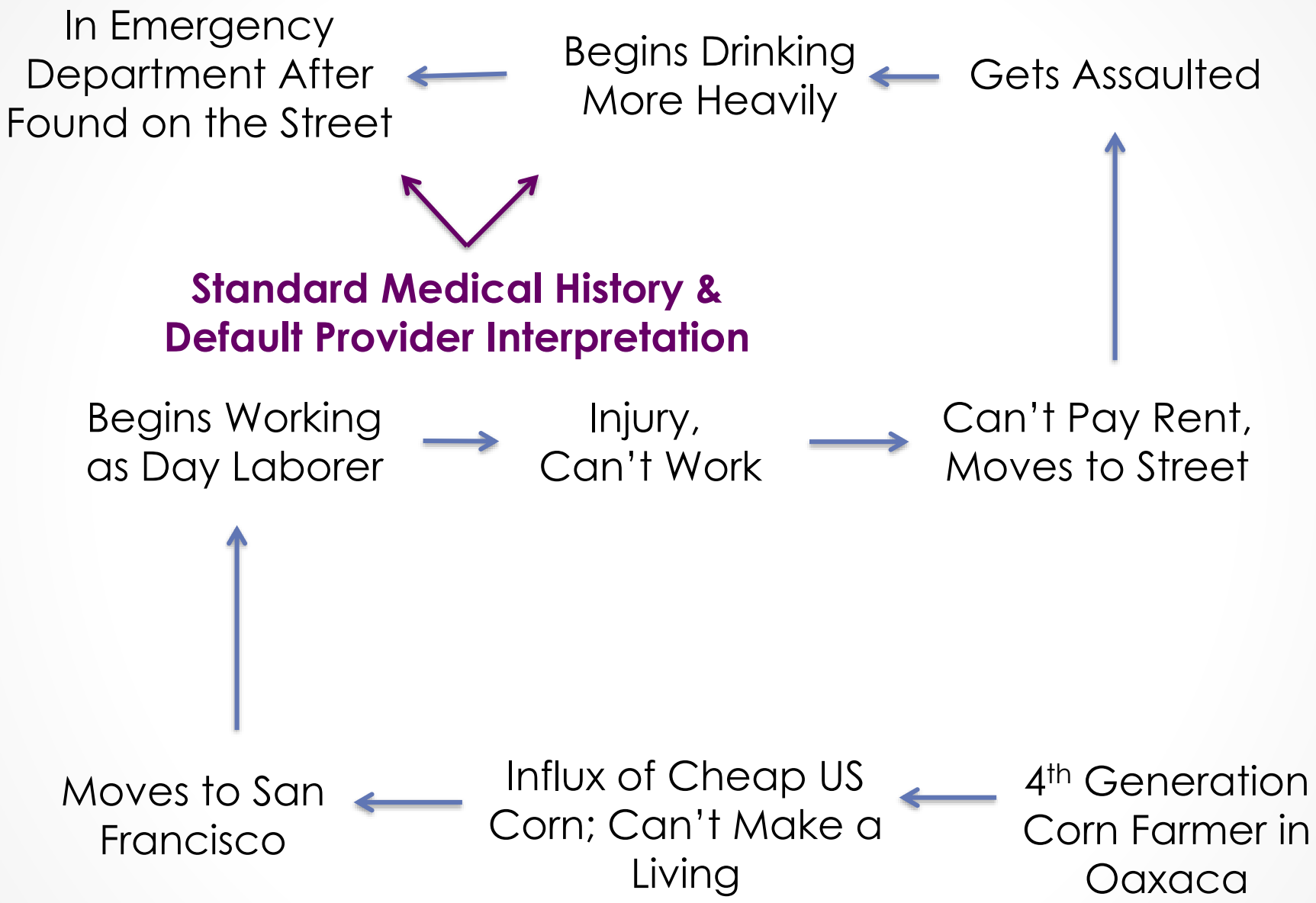
PSH (Past Surgical History): R orbital fracture 2/2 assault w/o operative intervention

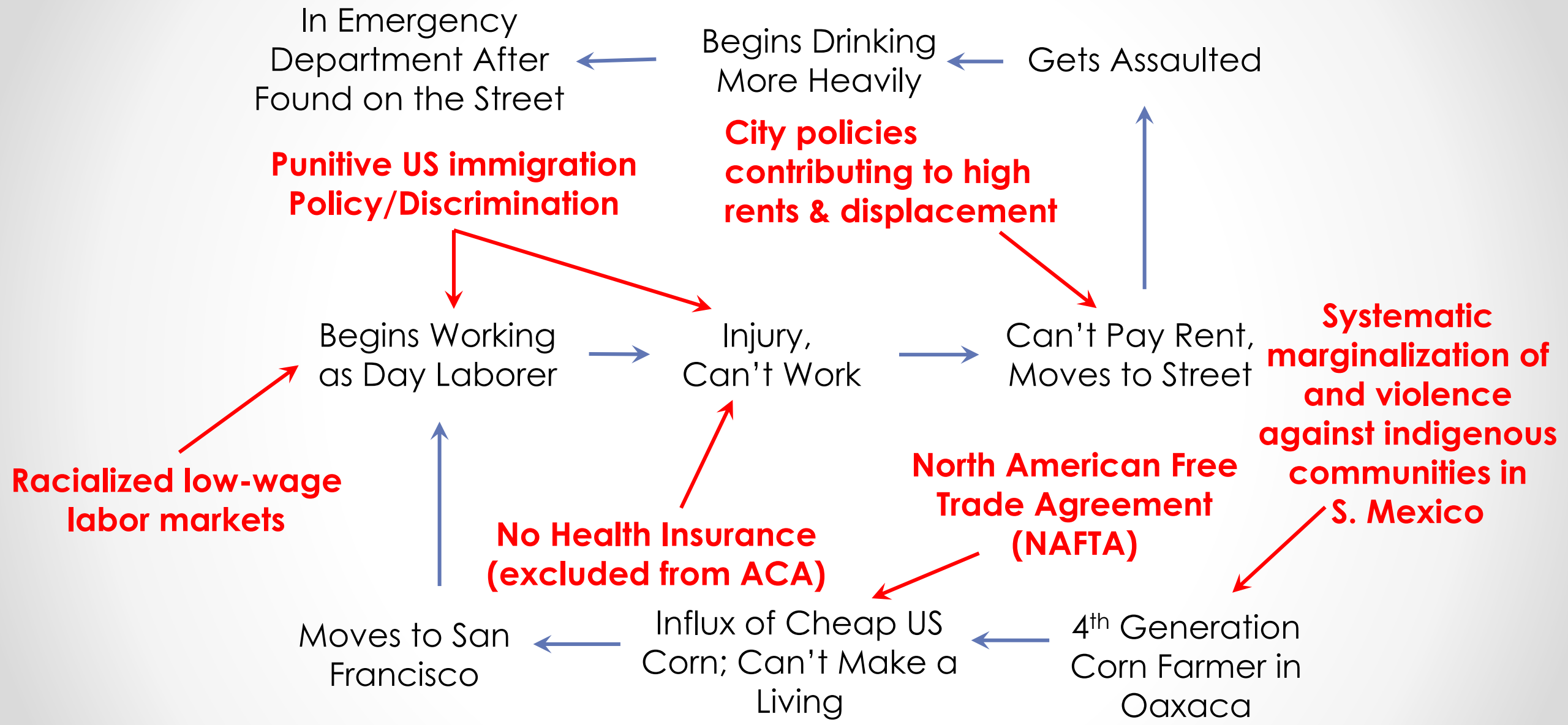
SH (Social History): Heavy EtOH use, other habits unknown. Apparently homeless.

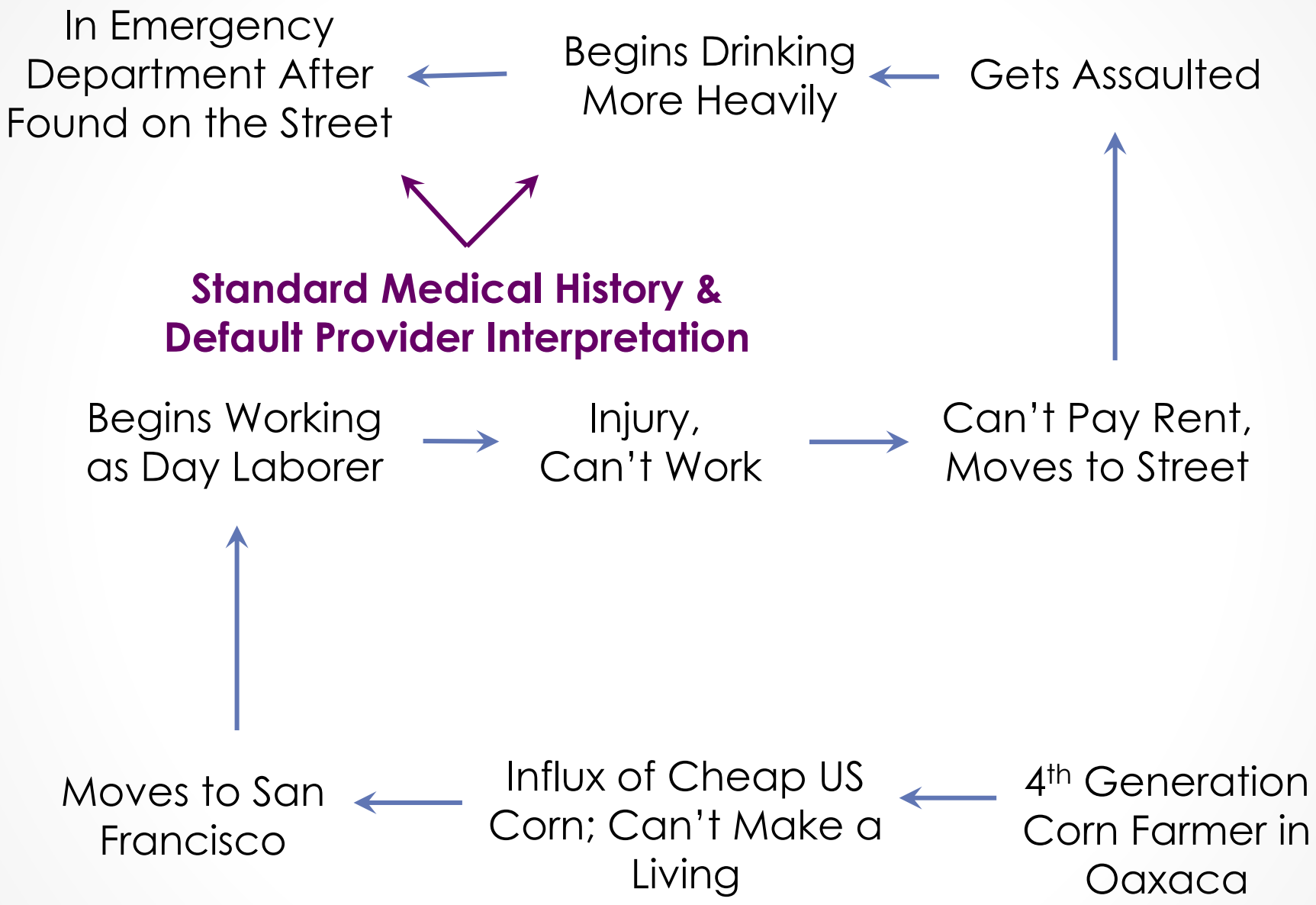
Meds: currently noncompliant w/ all meds, D/C'ed after last hospitalization on folate, thiamine, multivitamin, & seizure prophylaxis

Neuro/Mental Status: pt. muttering in incoherent Spanish, inconsistently able to answer "yes/no" & follow simple commands

Why do you think this person is sick?


In Emergency Department After Found on the Street
Begins Drinking More Heavily
Gets Assaulted
Standard Medical History & Default Provider Interpretation
Begins Working as Day Laborer
Injury, Can't Work
Can't Pay Rent, Moves to Street
Moves to San Francisco
Influx of Cheap US Corn; Can't Make a Living
4th Generation Corn Farmer in Oaxaca


In Emergency Department After Found on the Street
Begins Drinking More Heavily
Gets Assaulted
Punitive US immigration Policy/Discrimination
City policies contributing to high rents & displacement
Begins Working as Day Laborer
Injury, Can't Work
Can't Pay Rent, Moves to Street
Systematic marginalization of and violence against indigenous communities in S. Mexico
Racialized low-wage labor markets
North American Free Trade Agreement (NAFTA)
No Health Insurance (excluded from ACA)
Moves to San Francisco
Influx of Cheap US Corn; Can't Make a Living
4th Generation Corn Farmer in Oaxaca

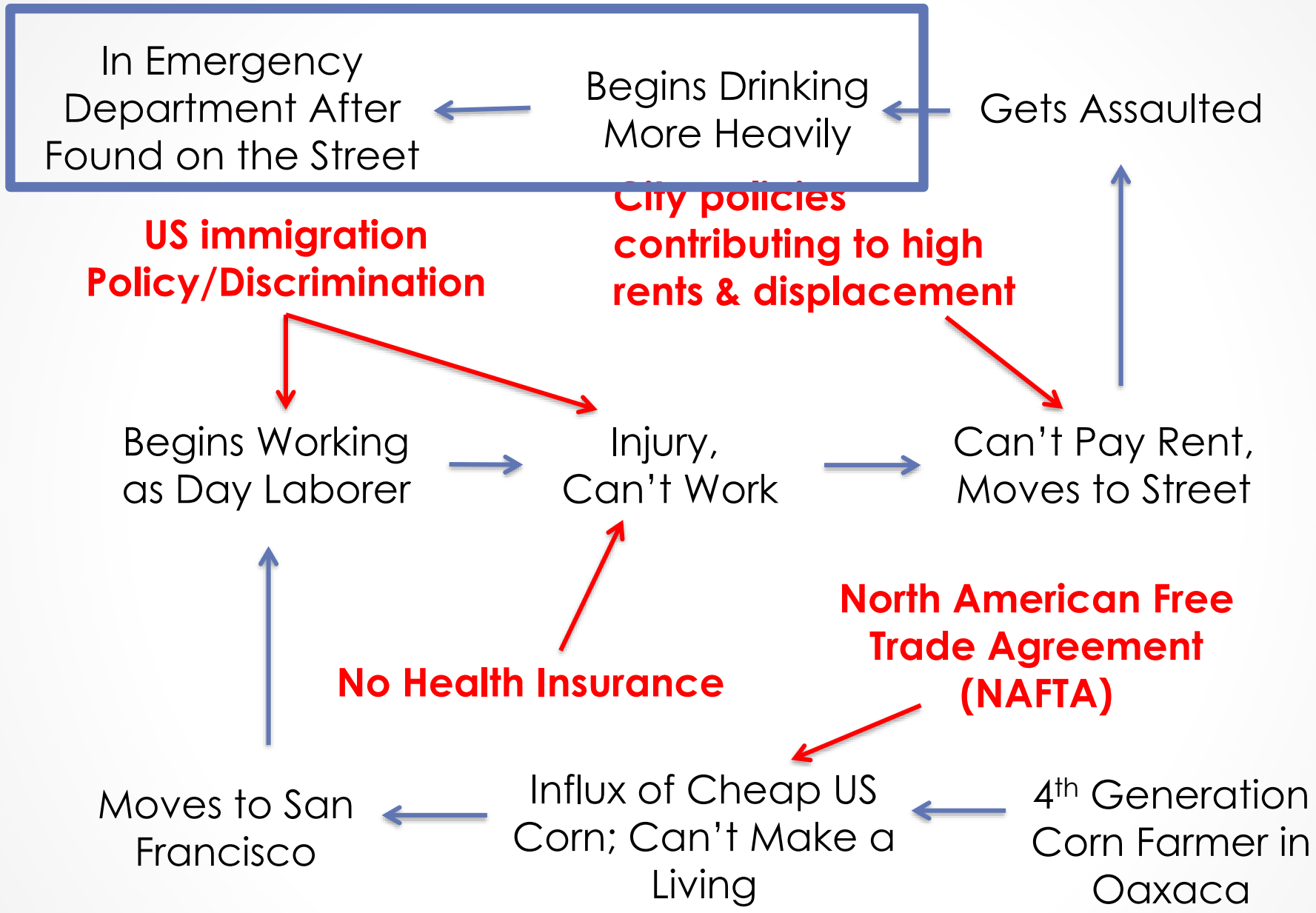

In Emergency Department After Found on the Street
Begins Drinking More Heavily
Gets Assaulted
Standard Medical History & Default Provider Interpretation
Begins Working as Day Laborer
Injury, Can't Work
Can't Pay Rent, Moves to Street
Moves to San Francisco
Influx of Cheap US Corn; Can't Make a Living
4th Generation Corn Farmer in Oaxaca

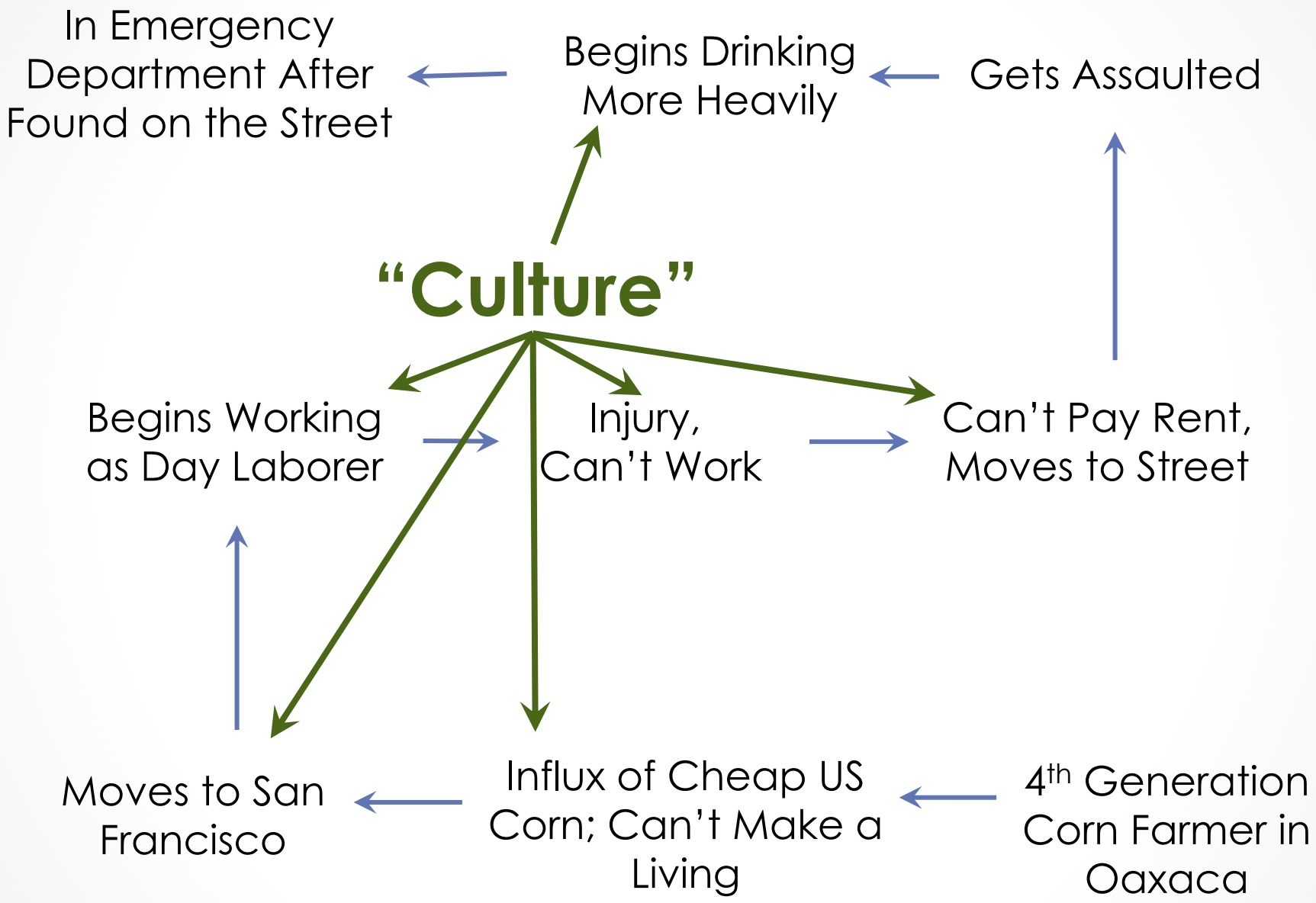
Naturalizing Inequality

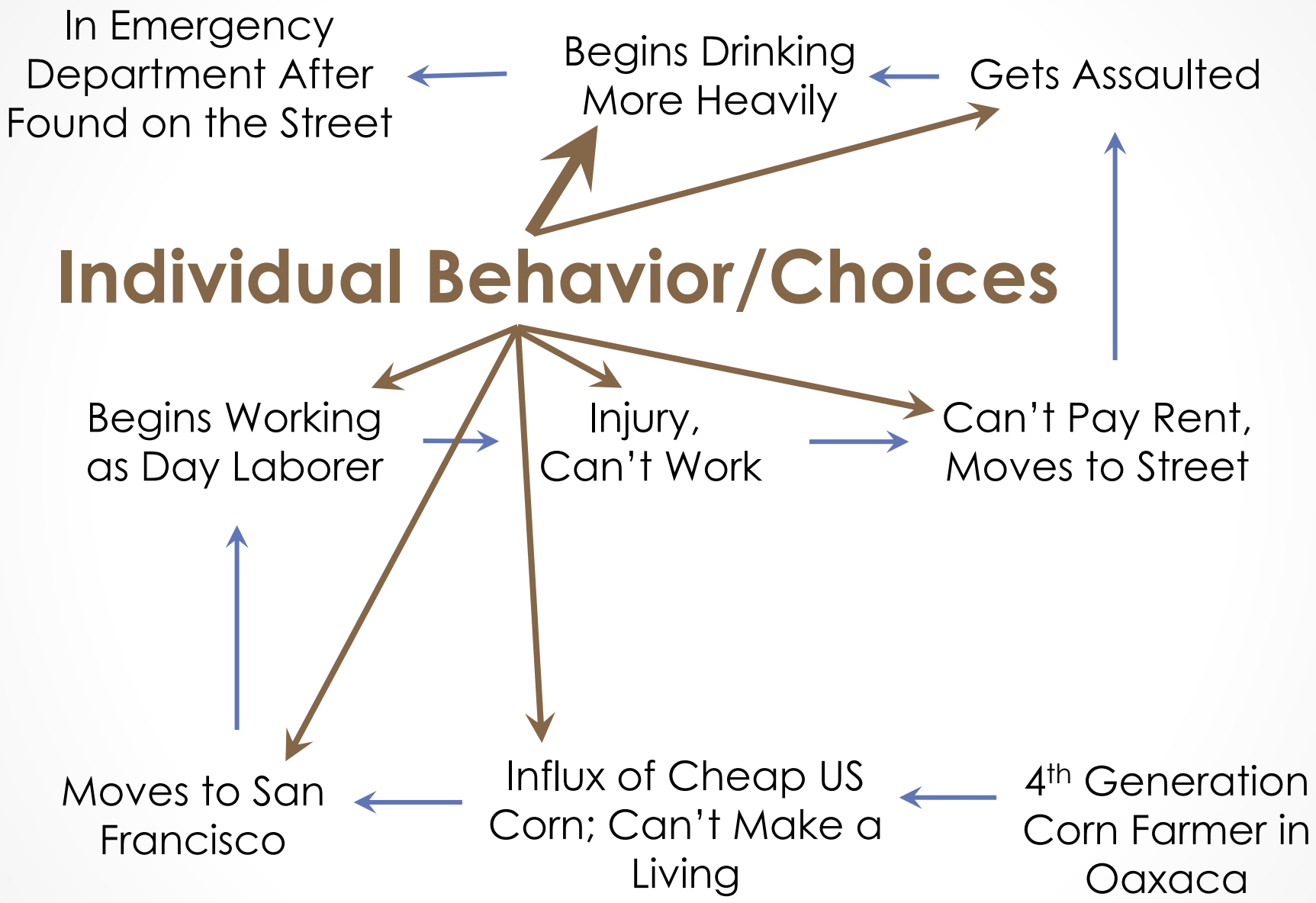
- The sometimes subtle, sometimes explicit, ways that structural violence is overlooked and normalized
  - Often through stereotypes about **cultural difference**, **behavioral shortcomings**, or **racial categories** -> "*Implicit Frameworks*"
  - Over-reliance on *implicit frameworks* can distract from the structural causes of harm
  - "Noncompliant"; "Lost to follow-up"; "Frequent flyer"; "Risk factors" as decontextualized characteristics

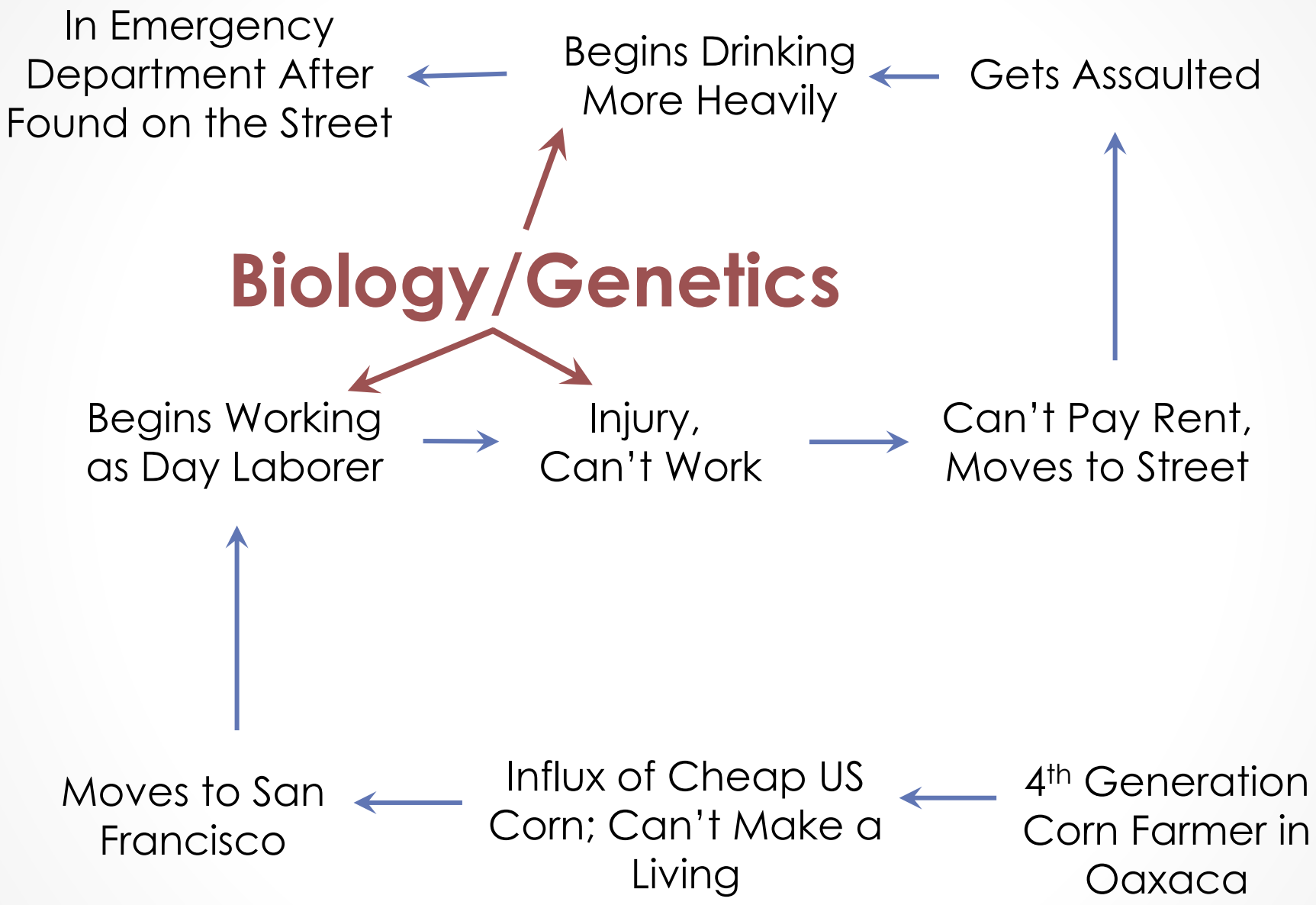
- **There is no neutral position –**

- **If we are not thinking structurally, we are thinking through another *implicit framework***


In Emergency Department After Found on the Street
Begins Drinking More Heavily
Gets Assaulted
US immigration Policy/Discrimination
City policies contributing to high rents & displacement
Begins Working as Day Laborer
Injury, Can't Work
Can't Pay Rent, Moves to Street
No Health Insurance
North American Free Trade Agreement (NAFTA)
Moves to San Francisco
Influx of Cheap US Corn; Can't Make a Living
4th Generation Corn Farmer in Oaxaca


In Emergency Department After Found on the Street
Begins Drinking More Heavily
Gets Assaulted
"Culture"
Begins Working as Day Laborer
Injury, Can't Work
Can't Pay Rent, Moves to Street
Moves to San Francisco
Influx of Cheap US Corn; Can't Make a Living
4th Generation Corn Farmer in Oaxaca


In Emergency Department After Found on the Street
Begins Drinking More Heavily
Gets Assaulted
Individual Behavior/Choices
Begins Working as Day Laborer
Injury, Can't Work
Can't Pay Rent, Moves to Street
Moves to San Francisco
Influx of Cheap US Corn; Can't Make a Living
4th Generation Corn Farmer in Oaxaca


In Emergency Department After Found on the Street
Begins Drinking More Heavily
Gets Assaulted
Biology/Genetics
Begins Working as Day Laborer
Injury, Can't Work
Can't Pay Rent, Moves to Street
Moves to San Francisco
Influx of Cheap US Corn; Can't Make a Living
4th Generation Corn Farmer in Oaxaca

Case Two

Assuming positive intent and giving the physician the benefit of the doubt:

What are the factors that contributed to the physician seeing the patient in this way?

Stressed:
8 more patients to see in under 2 hours (like every day)

Frustrated: seeing this patient doesn't feel like a good use of time

Writes note with terms like "frequent flyer" (and perhaps provides suboptimal care)

Burning out:
Weary of seeing patients' health follow similar decline

Profit-based healthcare system

"Jeff"

Decided to go to med school to work with underserved (after trip to Global South)

Race/class/gender inequities: who goes to medical school

Empathy decline: "Hidden curriculum" of MS3/4 years and residency

Few & poorly integrated resources to address issues like homelessness and addiction

Recently had dinner with med school classmate who is now ENT doc… who will soon pay off med school debt and work 4 days/week

Limited opportunities to discuss structural context in pre-clinical years

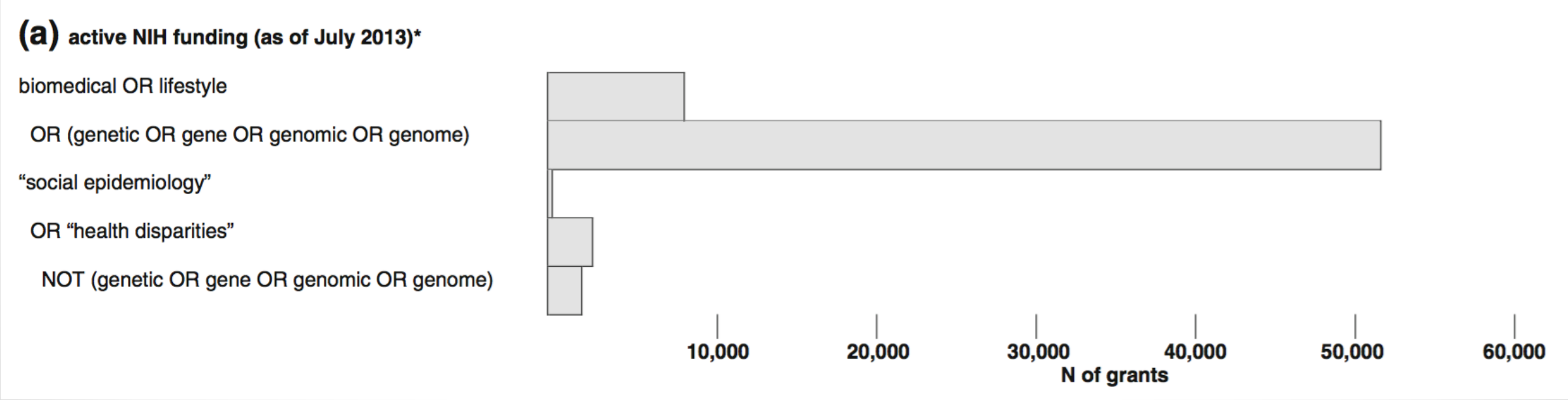
US education funding

No structural analysis in training

Fee for service reimbursement

Structural Competency & Research

- How do structures affect the kind of knowledge we produce?



Krieger, N. (2014). Got Theory? On the 21st c. CE Rise of Explicit Use of Epidemiologic Theories of Disease Distribution: A Review and Ecosocial Analysis. *Current Epidemiology Reports*, *1*(1), 45-56.

Frameworks in Immigrant Health Research

- **1) Behavioral**
- **2) Cultural**
- 3) Structural

Immigration as a Social Determinant of Health

Heide Castañeda,[1,*] Seth M. Holmes,[2,3,*] Daniel S. Madrigal,[2] Maria-Elena DeTrinidad Young,[4] Naomi Beyeler,[5] and James Quesada[6]

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*These authors contributed equally to this work.

Keywords

immigration, immigrant health, migrant health, social determinants of health

Abstract

Although immigration and immigrant populations have become increasingly important foci in public health research and practice, a social determinants of health approach has seldom been applied in this area. Global patterns of morbidity and mortality follow inequities rooted in societal, political, and economic conditions produced and reproduced by social structures, policies, and institutions. The lack of dialogue between these two profoundly related phenomena—social determinants of health and immigration—has resulted in missed opportunities for public health research, practice, and policy work. In this article, we discuss primary frameworks used in recent public health literature on the health of immigrant populations, note gaps in this literature, and argue for a broader examination of immigration as both socially determined and a social determinant of health. We discuss priorities for future research and policy to understand more fully and respond appropriately to the health of the populations affected by this global phenomenon.

Possibilities for Change

- How can we intervene on the structures affecting health and health care?

Levels of Intervention: Examples

1. Intrapersonal
2. Interpersonal
3. Clinic
4. Community
5. Research
6. Policy

Elevated Blood Lead Levels in Children Associated With the Flint Drinking Water Crisis: A Spatial Analysis of Risk and Public Health Response

Mona Hanna-Attisha, MD, MPH, Jenny LaChance, MS, Richard Casey Sadler, PhD, and Allison Champney Schnepp, MD

Objectives. We analyzed differences in pediatric elevated blood lead level incidence before and after Flint, Michigan, introduced a more corrosive water source into an aging water system without adequate corrosion control.

Methods. We reviewed blood lead levels for children younger than 5 years before (2013) and after (2015) water source change in Greater Flint, Michigan. We assessed the percentage of elevated blood lead levels in both time periods, and identified geographical locations through spatial analysis.

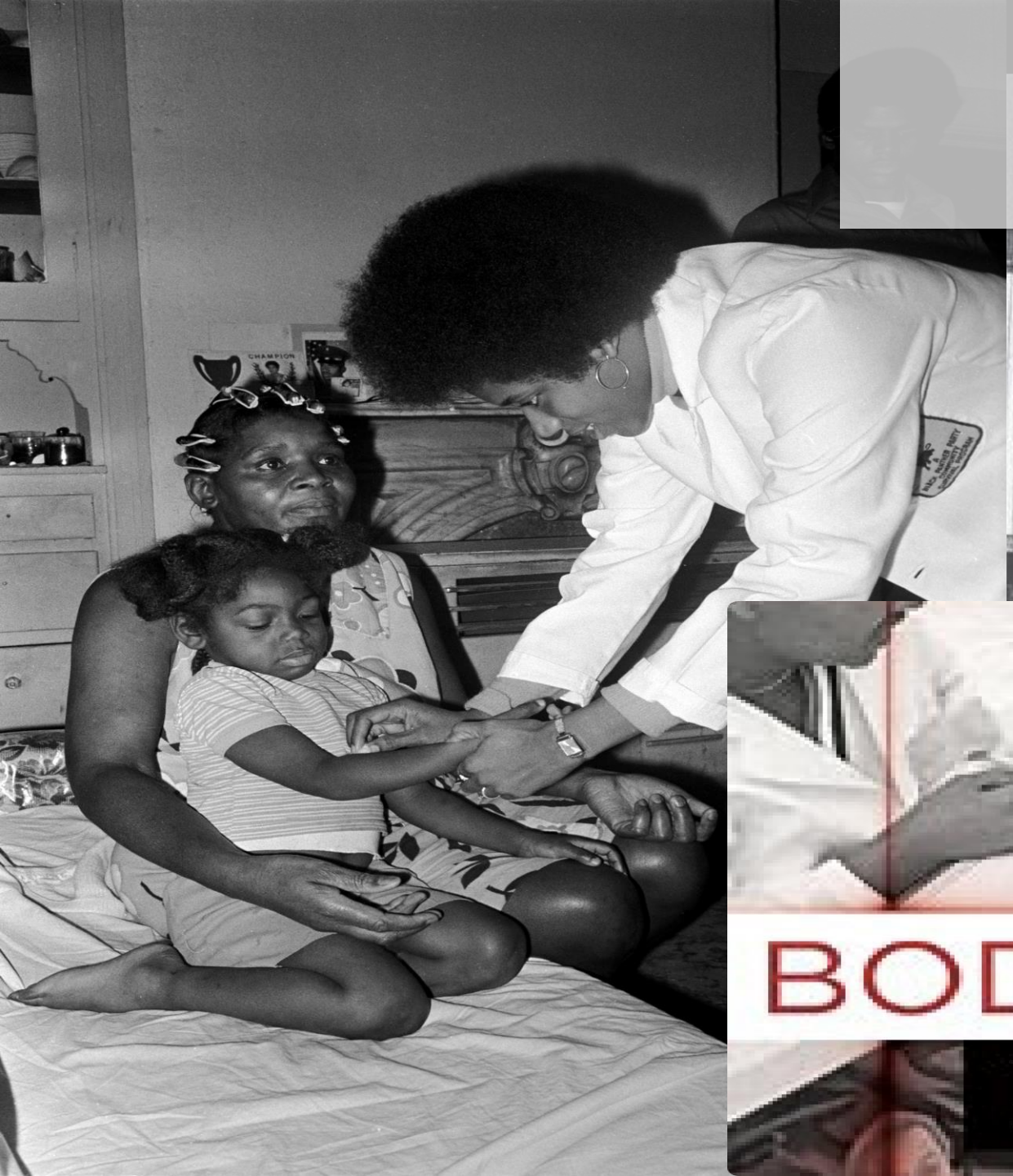
percentage of lead pipes and lead plumbing, with estimates of lead service lines ranging from 10% to 80%.[7] Researchers from Virginia Tech University reported increases in water lead levels (WLLs),[5] but changes in blood lead levels (BLLs) were unknown.

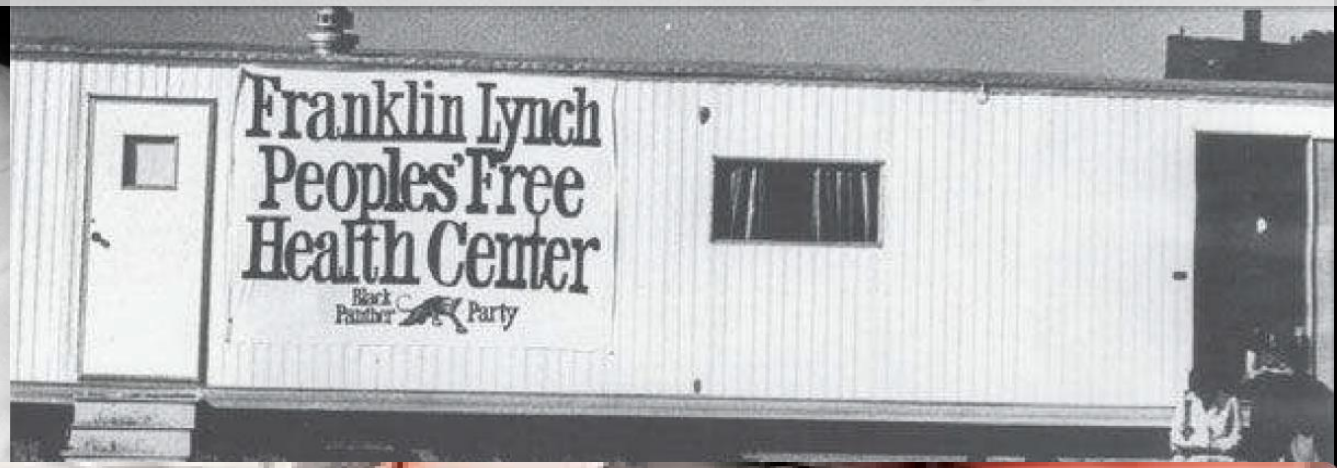
Lead is a potent neurotoxin, and child-

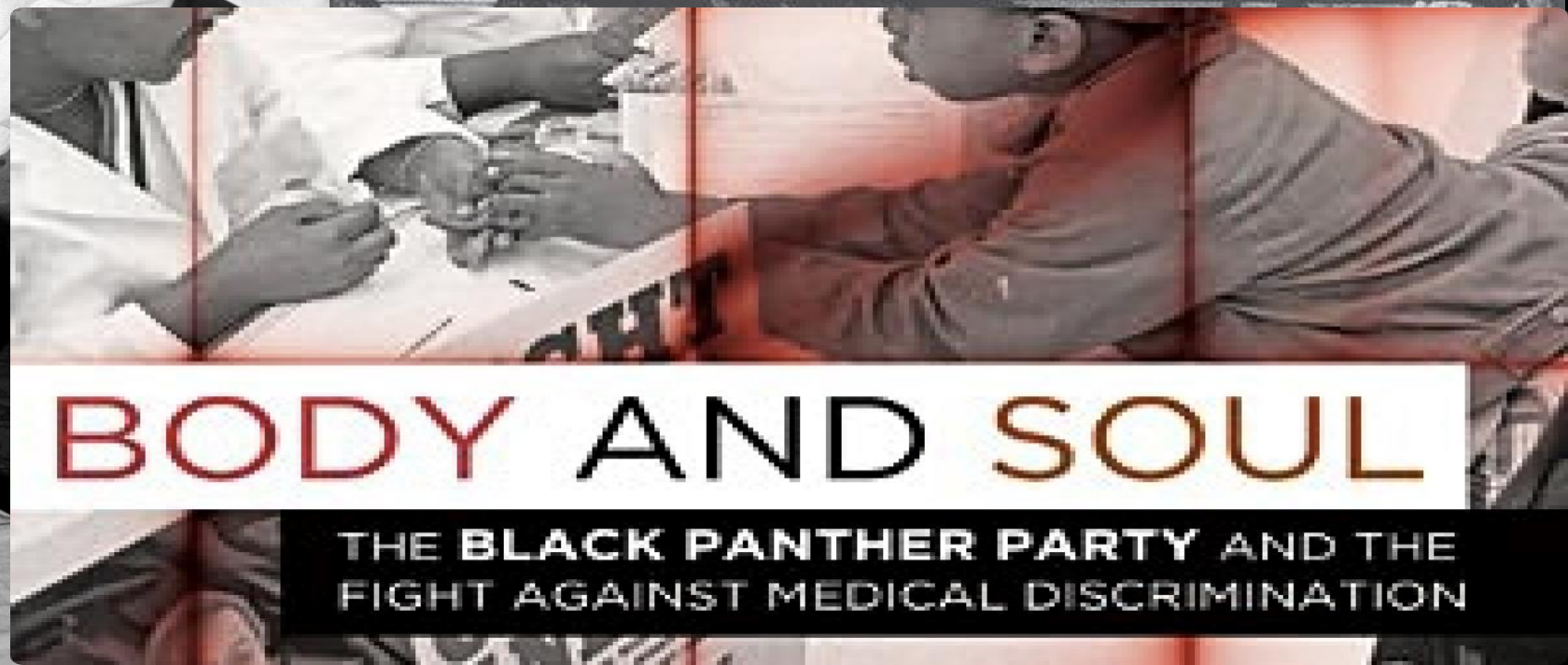
Clinic to Community to Research to Policy

Flint Water Crisis

The People's Free Health Clinics of the Black Panther Party







SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

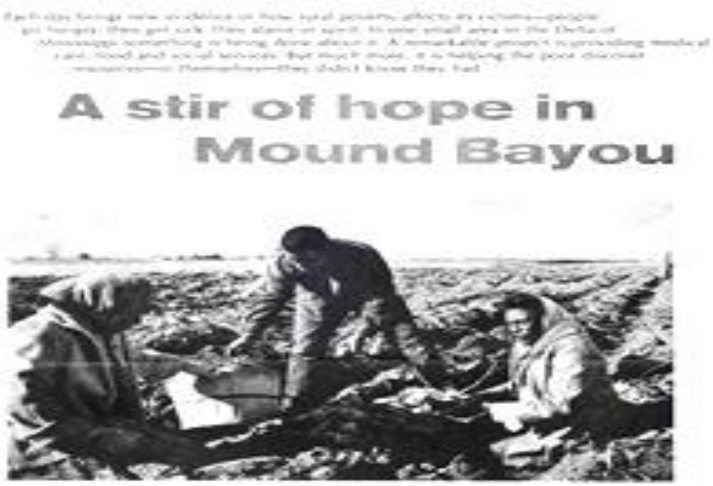
The Integrated Soft Tissue Infection Service Clinic

"They prioritized pain management and recruited experienced clinicians committed to what they called 'compassionate' healthcare for injection drug-users."

– Messac et al.

Photo by Jeffrey Schonberg

The Federally-funded Community Health Center Movement



ACT UP

DYING FOR HOMES

HOW MAYOR NUTTER IS WASTING CITY MONEY AND FAILING PEOPLE WITH AIDS

A report on the Philadelphia AIDS Housing Crisis

ACT UP

"City policy was changed in accordance with ACT UP's housing first, harm reduction demands"

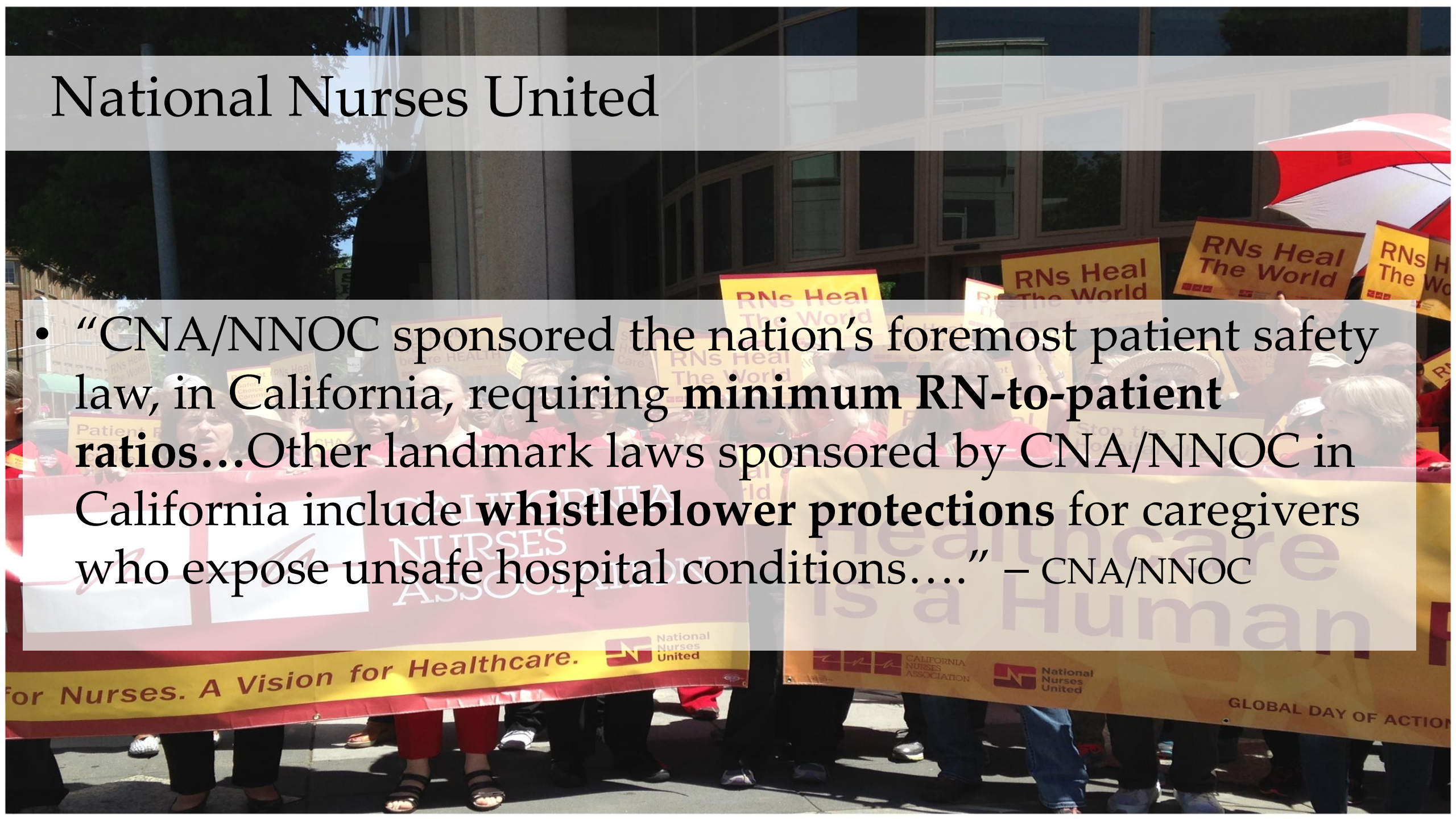
– Messac et al.

- Tomorrow, April 12th
- Public Hearing on Texas House Bill 7 and House Bill 20

- HB 20:
- Establish a "Border Protection Unit" that seems to deputize citizens to engage in immigration enforcement operations.
- Codify a state version of public health Title 42, stopping asylum seekers.

- HB 7:
- Allow border counties to create a separate "Border Protection Court" to handle border related issues.
- Provide funding to community institutions to create and maintain border facilities to engage in or assist with border security.
- Establish a "Border Property Compensation Fund" to pay property owners for damages caused by someone crossing the border.
- Create a grant program for higher education institutions to promote and recruit for careers in immigration and law enforcement.

National Nurses United



- "CNA/NNOC sponsored the nation's foremost patient safety law, in California, requiring **minimum RN-to-patient ratios**…Other landmark laws sponsored by CNA/NNOC in California include **whistleblower protections** for caregivers who expose unsafe hospital conditions…." – CNA/NNOC

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

AUGUST 15, 2019

CASE STUDIES IN SOCIAL MEDICINE

Reproductive (In)justice — Two Patients with Avoidable Poor Reproductive Outcomes

Kelly R. Knight, Ph.D., Laura G. Duncan, B.A., Marek Szilvasi, Ph.D., Ashish Premkumar, M.D., Margareta Matache, Ph.D., and Andrea Jackson, M.D.

Case A: California, 2017

In 2017, in a California hospital, Ms. W. turned her face away as the attending physician, a white woman, entered the room followed by two residents, a white man and an Asian American woman. The physician picked up her chart and read, "39-year-old African American woman. Opioid user. Possibly homeless. Preterm birth at approximately 24 weeks of pregnancy, most likely due to cervical insufficiency, resulting in neonatal demise." The attending approached Ms. W.'s bed, saying quietly, "We realize you probably don't have a place to go, or any family. We understand that you have experienced a loss. This might not be the first time? We would like you to stay the night

PERSPECTIVE
FEB 21, 2019

Structural Iatrogenesis

S. Stonington and D. Coffa
N Engl J Med 2019; 380:701-704

When he gets tangled in new restrictive policies on opioid prescribing, a factory worker with severe rheumatoid arthritis, whose pain must be managed for him to perform his job, ends up buying oxycodone from a friend.

PERSPECTIVE
JAN 17, 2019

The Structural Violence of Hyperincarceration

G. Karandinos and P. Bourgois
N Engl J Med 2019; 380:205-209

After an uninsured Puerto Rican man with back pain, other chronic conditions, and a history of incarceration admits to a doctor at a free clinic that he's bought oxycodone illegally, he refrains from filling his

PERSPECTIVE
NOV 21, 2019

Biological Citizenship

I. Kalofonos
N Engl J Med 2019; 381:1985-1989

A man with multiple mental health conditions stops attending the clinic where he received wrap-around services. Denied Supplemental Security Income because his psychiatrist had documented his improvement, he had ceased taking his medications and ended up hospitalized.

PERSPECTIVE
JUL 18, 2019

The Right and Left Hands of the State

A. Berlin and Others
N Engl J Med 2019; 381:197-201

A woman escapes a violent homeland and a rapist-captor in the country where she seeks refuge, only to have an ED nurse turn her over to the police as an undocumented immigrant. How can clinicians negotiate between governmental expectations and their duty to patients?

PERSPECTIVE
MAY 16, 2019

The Power and Limits of Classification

D. Stroumsa and Others
N Engl J Med 2019; 380:1885-1888

A 32-year-old transgender man, presenting with severe lower abdominal pain and hypertension, is classified as a man who hasn't taken his blood-pressure medications. When examined several hours later, he's found to be pregnant, but no fetal heartbeat can be detected.

PERSPECTIVE
APR 18, 2019

Structural Racism

K. Pallok, F. De Maio, and D.A. Ansell
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A woman on Chicago's primarily black South Side is seen for a breast lump at a community hospital that lacks the resources for high-quality cancer care. A navigator from the Metropolitan Chicago Breast Cancer Task Force reroutes her to a qualified medical center.

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https://www.nejm.org/case-studies-in-social-medicine

If medicine is to fulfill her great task, then she must enter the political and social life. Do we not always find the diseases of the populace traceable to defects in society?

—Rudolph Virchow, 1848

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