Structural Competency Training:
How Structural Inequality is Making Us Sick

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Critical Social Medicine Working Group
Relevant Financial Disclosure

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“Disease… is not just the straightforward result of a pathogen or physiologic disturbance but a result of a variety of social structural conditions, such as malnutrition, social stratification, economic insecurity, alienation in the workplace, occupational risks, industrial and motor vehicle pollution, inferior housing and sanitation, and the stress that are part and parcel of the culture of consumption--all of which are ultimately rooted in the capitalist world system.”

Baer 2004. Toward an Integrative Medicine
Structures and Patient Health
Figure 2.9 Disability-free life expectancy at birth, persons: regional averages at each neighbourhood income level, England, 1999–2003

Age

Most deprived ← Neighbourhood Income Deprivation (Population Percentiles) → Least deprived

- Yorkshire/Humber average
- South West average
- East of England average
- East Midlands average
- South East average
- North West average
- North East average
- London average

Source: Office for National Statistics59
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

Rate per 100,000 population

Source: Office for National Statistics Health Statistics Quarterly
Figure 2.15 Obesity prevalence at ages 16 and over by social class, (a) males and (b) females, 1997–2007

(a) Males

Percentage obese
(BMI > 30)


Source: National Obesity Observatory, based on the Health Survey for England.

Legend:
- I - Professional
- II - Managerial, technical
- III M - Skilled manual
- III N - Skilled non-manual
- IV - Semi-skilled manual
- V - Unskilled manual
Figure 2.15 Obesity prevalence at ages 16 and over by social class, (a) males and (b) females, 1997–2007

(b) Females

Percentage obese
(BMI > 30)

Year

Source: National Obesity Observatory, based on the Health Survey for England

Legend:
- I - Professional
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- V - Unskilled manual
Figure 2.14 Alcohol-attributable hospital admissions by small area deprivation quintile in England, 2006–2007

Age standardised persons per 100,000

Note: IMD = Index of Multiple Deprivation for Lower Level Super Output Areas
Source: NHS Information Centre Hospital Episode Statistics
Map 1: Mortality Rate by Census Tract, Alameda County

Life Expectancy
- 72.7
- 78.6
- 82.7

Mortality Rate
- >950.0
- 704.4-950.0
- ≤704.3
- No data

Life expectancy is years at birth.
Alameda County overall life expectancy = 79.9 years.
Rate is age-adjusted all-cause mortality per 100,000.
Alameda County overall rate = 704.3/100,000

Source: Alameda County vital statistics files, 2001-2005.
Short Distances to Large Gaps in Health

Life expectancy at birth (years)
- Shorter
- Longer

1 mile

Red Line
Green Line
Orange Line

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Center on Society and Health
Robert Wood Johnson Foundation
Increasing Inequality in Where Americans Live

The percentage of middle-income neighborhoods has been shrinking, while the percentage of both very high-income and very low-income neighborhoods has increased.

Prepared for the Robert Wood Johnson Foundation by the Center on Social Disparities in Health at the University of California, San Francisco.

*Very low-income neighborhoods have median family incomes less than 50 percent of the metropolitan area median. Other income ranges include: low income (50 percent to 80 percent); middle income (80 percent to 120 percent); high income (120 percent to 150 percent); and very high income (>150 percent).*

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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
Born in rural Mexico in a town which came under cartel control

Husband and oldest son moved to US

Fled to US with her youngest child, abused in transit

Taking care of grandchildren, at mercy of children's schedules

2016 Presidential election

Abdominal Pain Worsens

Lapses in medical coverage

Presents to clinic for follow-up visit

Standard Medical History & Default Provider Interpretation
Social Structures:

• The policies, economic systems, and other institutions (judicial system, schools, etc.) that have produced and maintain modern social inequities as well as health disparities, often along the lines of social categories such as race, class, gender, and sexuality.
Taking care of grandchildren, multiple stressors for her adult children.
Fled to US with her youngest child, abused in transit.

Husband and oldest son moved to US.

Presents to clinic for follow-up visit.

Abdominal Pain Worsens.

Lapses in medical coverage.

Husband deported to Mexico 6 months ago.

2016 Presidential election.

Born in rural Mexico in a town which came under cartel control.

American Insurance System

Electoral System

American domestic drug policy

Immigration Policy
Structural Violence

Structural Vulnerability
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 Violence

• “Racism is both overt and covert...We call these individual racism and institutional racism...The second type is less overt, far more subtle, less identifiable in terms of specific individuals committing the acts. But it is no less destructive of human life. The second type originates in the operation of established and respected forces in the society, and thus receives far less public condemnation”

• Institutional racism leaves individuals and communities “destroyed and maimed physically, emotionally and intellectually because of conditions of poverty and discrimination in the black community, that is a function of institutional racism...”

- Stokely Carmichael, Black Power: The Politics of Liberation
Presents to clinic for follow-up visit

Abdominal Pain Worsens

Lapses in medical coverage

Electoral System
Taking care of grandchildren, multiple stressors for her adult children

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Lapses in medical coverage
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.
Structural Vulnerability

• Framework for working and engaging with patients
• Consider domains in which an individual is structurally vulnerable
  o Analogous to other health risk factors
• Uses can be both:
  o Preventative medicine
  o Efficient, tailored and holistic treatment and healing
Other examples

- **War on Drugs**
  - Increased incarceration
    - Reduced economic prospects, family instability, poor health outcomes

- **LGBTQ discrimination**
  - Lack of non-discrimination laws in many states
  - Reduced access to affirming healthcare

- **Water Crisis in Flint, MI**
  - Contaminated water
  - What communities “count”?
Writing Exercise

Write about example(s) of structural violence leading to poor health for patients you have worked with (or other people you have known).
Naturalizing Inequality
Determinations

Nature  Society
ETHNIC ISSUES. Minority ethnic groups are increasing as a proportion of the total U.S. population, with Hispanics being the fastest growing group. Considerable evidence exists for differences in CVD epidemiology between whites and African Americans and Native Americans. African Americans have higher blood pressures and worse hypertensive outcomes than whites, and some Native American groups have a sharp excess of diabetes. Data also suggest excess obesity and diabetes in Hispanics and a high risk of insulin resistance and CHD among immigrants from the Indian Subcontinent.
Writing Exercise

Think of an example from your life or education of a naturalizing inequality; that is, a phenomenon with social dimensions which is presented as though it were exclusively natural.
Cultural Competency

• Motivation: Providers and patients can misunderstand one another if they have different understandings of illness and health

• Cultural competency ideally helps providers to recognize that their own views are also culturally determined

• In many cases cultural competency was taken up as a “list of traits” for providers to learn
Cultural Humility

• “A commitment and active engagement in a lifelong process that individuals enter into on an ongoing basis with patients, communities, colleagues, and with themselves”

—Tervalon and Murray-Garcia, 1998

• Emphasizes ongoing humility, self-reflection, self-critique, and lifelong learning
Health Disparities

• More widespread discussion in medicine following publication of 2002 IOM report *Unequal Treatment*

• Addressed in medical education through cultural competency curricula
Cultural Competency

“In attempting to address racial and ethnic disparities in care through cultural competence training, educators too often conflate these distinct concepts. This leads to an inappropriate collapsing of many of the forces affecting racial and ethnic minority populations—such as poverty, violence, and racism—into the less threatening concept of culture.”

—Gregg and Saha, 2006
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.
Structural Competency

Develop trainees’ capacity in the following five areas:

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

—Based on talk by Helena Hansen, April 2015
Structural Competency: FAQ

1. Why the word competency?
2. How is this different from the social determinants of health?
3. Doesn’t everyone already know this stuff?
4. Why should providers learn this?
“Competency”

- Recognizable as parallel to cultural competency
- Competency-based framing of medical education
- Using “structural humility” to mean something specific
- “Structural attentiveness” or “awareness”
- Focus on the content
Social Determinants of Health

- Yes! SC descended from SDOH
- “Social” can come to mean anything outside the clinic
- As can “upstream”
- “Structural” points to origins of inequality that produces poor health
Social Determinants of Health

Structures
- Policies
- Economic systems
- Racism (etc.)

Poverty/Inequality

Poor health outcomes

“Structural determinants of the social determinants of health”
Why should clinicians care?

• What is cost of not addressing these issues?

• Can change how we think about/approach patients and our roles

• No neutral position

• “People who demand neutrality in any situation are usually not neutral but in favor of the status quo.”

—Max Eastman
Discussion
Structures and The Clinical Encounter
American domestic drug policy
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Assuming positive intent and giving the provider the benefit of the doubt:

What are the factors that contributed to the provider writing their note in this way?
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.

Wrote note with terms like “frequent flyer” (and perhaps provides suboptimal care).

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.

Burning out: Weary of seeing patients’ health follow similar decline.

Empathy decline: “Hidden curriculum” of MS3/4 years and residency.

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

Frustrated: Seeing this patient doesn’t feel like a good use of time.

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

Limited opportunities to discuss structural context in pre-clinical years.

Empathy decline: “Hidden curriculum” of MS3/4 years and residency.

No structural analysis in training.

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Profit-based healthcare system.

US education funding.

Fee for service reimbursement.

Race/class/gender privilege: who gets to go to professional school.

“Jeff”

Recent trip to the Global South.

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Medicine as Structure & Culture: Evidence, Integration, and (In)Equality
“...biomedicine and conventional science are not value-free endeavors but rather are culturally-constructed and deeply embedded in larger political-economic structures ...”
Western Medical Hegemony

• Historical power struggles to establish & maintain orthodoxy
• Perpetuated in part by silencing this history
• Positivism as an ideology that excludes the possibility of other ways of knowing
• Maintenance of power structures that exclude certain individuals, syndromes, methods of investigation, and healing modalities
• Not to mention a for-profit healthcare model...

“Without heresy, or ideas of heresy, orthodoxy could not establish or perpetuate itself.”

The Rise of Evidence-Based Medicine

“A new paradigm for medical practice is emerging. Evidence-based medicine de-emphasizes intuition, unsystematic clinical experience, and pathophysiologic rationale as sufficient grounds for clinical decision making and stresses the examination of evidence from clinical research.”

- randomized clinical trials
- meta-analysis of multiple trials
- ease of accessing this data via electronic media
- clinician training in evaluating scientific evidence, and utilizing clinical data in clinical context

Guyatt G et al . Evidence-Based Medicine: A New Approach to Teaching the Practice of Medicine. JAMA. 1992
Efficacy of a Tyrosine Kinase Inhibitor in Idiopathic Pulmonary Fibrosis


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Efficacy of a Tyrosine Kinase Inhibitor in Idiopathic Pulmonary Fibrosis

analysis. The manuscript was drafted by medical writers from Fleishman-Hillard, with funding from Boehringer Ingelheim and in line with guidance from the first author, and was amended substantially, critically reviewed, and edited by all authors. The trial was carried out in com-
Biomedical research as structural violence
Share of US Biomedical Research Funding, 2012*

- National Institutes of Health (NIH), 27%
- Biopharmaceutical Industry, 49%
- Medical Device Industry, 10%
- Other Federal Government Entities, 6%
- State and Local Government Entities, 5%
- Foundations, Charities, Other Private Sector, 4%

Assaultive and belligerent?

Cooperation often begins with HALDOL (haloperidol)

a first choice for starting therapy

Acts promptly to control aggressive, assaultive behavior

Several studies have reported the special effectiveness of HALDOL (haloperidol) in controlling aggressive and dangerously assaultive behavior. Even the number of violent assaults committed by a group of criminal psychotics resistant to maximal doses of phenothiazines was reduced substantially during treatment with HALDOL. Symptom control can be achieved rapidly, frequently within a few hours when the intramuscular form is used for initial control of acutely ill psychotic states.

Usually leaves patients relatively alert and responsive

Although some instances of dose-related drowsiness have been observed, marked sedation with HALDOL (haloperidol) is rare. In a report on a study with criminal psychotics the investigators stated, "The patients remained alert and more amenable to psychotherapeutic intervention." Another investigator reports that HALDOL "normalized" behavior and produces a sensitivity to the environment that allows more effective use of the social milieu and the therapeutic community.

Reduces risk of serious adverse reactions

HALDOL (haloperidol), a butyrophenone, avoids or minimizes many of the problems associated with the phenothiazines. Hypotension is rare and severe orthostatic hypotension has not been reported. There is also less likelihood of adverse reactions such as liver damage, cellular changes, serious hematologic reactions and skin rashes. The most frequent side effects of HALDOL (haloperidol)—extrapyramidal symptoms—are usually dose-related and readily controlled.

A crisis in EBM?

- Research agenda is dominated by vested interests
- Unmanageable amount of evidence & clinical guidelines
- “Statistically significant” benefits may not manifest in reality
- Guideline-based care may not always be patient-centered
- Such guidelines fail to account for complex health realities

AND…

- Fail to account for any structural or individual factors
- Exclude complementary & alternative modalities

Other ways of knowing... and healing

- Traditional/empirical knowledge
- Qualitative, ethnographic research
- Participatory Action Research
- Health coaches & peer outreach
- Incorporating traditional healers into community health centers
- Re-learning self care techniques
From CAM to Integrative Medicine

• If alternative therapies do not address structural influences on health...
• If alternative therapies are available only to those who can pay...
  → they perpetuate the same systems of health inequity

• If conventional health care practitioners & systems see alternatives as merely “complements” to Medicine...
• If conventional providers only accept “evidence-based” alternatives to the exclusion of other forms of knowledge ....
  → integration is cooptation
Summary

• Western and “evidence-based” medicine are not neutral forms of knowledge or practice

• Complementary, integrative & alternative medical practice also needs to address structural factors in order to create a more just and holistic healthcare system
Levels of Intervention

• Intrapersonal
• Interpersonal
• Clinic
• Community
• Research
• Policy
To consider…

1. Which levels of action are present in each of these initiatives?

2. Do they affect the structural determinants of health themselves, do they ameliorate the effects, or both?

3. Can you share about any other initiatives that you’ve been involved in or heard that impact structural violence in inequality?
The People’s Free Health Clinics of the Black Panther Party
Acupuncture for Pain and Reduction of Opioid Use

New Law, Opiate Bill, S.243, in Vermont

Pilot project to offer acupuncture for Medicaid patients with dx of chronic pain
Marijuana Laws Differ State by State

[Map showing the different marijuana laws by state, with varying shades indicating medicinal and recreational laws, limited medicinal marijuana laws, comprehensive medical marijuana laws, and no marijuana access.]
Does pot legalization improve safety & equality?

- States with medical cannabis laws had a ~25% lower mean annual opioid overdose mortality rate compared with states without medical cannabis laws (Bachuber et al 2014)

- In states with medical marijuana laws, physicians prescribed significantly fewer drugs for conditions treated with cannabis, with estimated yearly cost savings of $100 to $165 million (Bradford & Bradford 2016)

- Despite a 50% reduction in cannabis-related arrests in states with legalizations, racial disparities remain

http://www.drugpolicy.org/sites/default/files/Marijuana_Legalization_Status_Report_101316.pdf
Building Beloved Community In Our Life and Work
Working Definition of Beloved Community

- An inclusive, interconnected consciousness
- based on love, justice, compassion, responsibility, shared power, and
- a deep respect for all people, places, and things
- that radically transforms individuals and restructures institutions.
“When one cannot find the Beloved Community we need to take steps to create it and if there is no evidence of its existence then the rule to live by is to:
—Act so as to hasten its coming”.

Josiah Royce (1855-1916),
Boston University School of Theology
Movement Building (Community Organizing) using the Beloved Community Ideal

- A movement begins when the oppressed stop seeing themselves as victims
- Movement builders recognize the humanity in others, including their opponents
- Movement builders create programs that transform and empower
- Movement builders believe in two-sided transformation, self and institutions
- Movement builders accept contradictions--great hopes but also great disappointments