STRUCTURAL COMPETENCY HANDOUTS

CONTENTS

An evaluation of this training is available: Neff J, K Knight, Satterwhite S, Matthews J, Nelson N, Holmes S M. "Teaching Structure: A Qualitative Evaluation of a Structural Competency Curricular Innovation." *Journal of General Internal Medicine. In Press*

Case Exercise

Please read the following note describing an admission to the inpatient medicine service. When you have finished, discuss with your colleagues, imagining that you're the attending hearing this case. What questions do you have that might help you better understand the situation? What social, political, and economic structures might be contributing to this patient's problems?

Presenting Complaint: Acute loss of consciousness

History of Present Illness: Patient is a 37 year-old Mexican male found down with acute loss of consciousness. Was minimally responsive in ambulance, no response to naloxone, smell of alcohol on breath noted by first responders, pt. found on park bench w/empty cans of malt liquor. In Emergency Department patient received fluids, initially somnolent but now tremulous and anxious despite IV lorazepam. Medicine consulted for admission for inpatient detox given risk of withdrawal.

Past Medical History: Frequent flyer well known to Emergency Department for alcohol-related trauma, assaults, withdrawal with associated seizures, and clearance for jail. Previous diagnosis of hypertension, treated for seizure disorder with anticonvulsants but lost to follow up.

Past Surgical History: Right orbital fracture secondary to assault w/o operative intervention, open reduction and internal fixation (ORIF) Right wrist secondary to alcohol-related fall, ORIF Left tibia/fibula for alcohol-related auto vs. pedestrian motor-vehicle accident.

Meds: currently noncompliant with all meds. Discharged after last hospitalization on folate, thiamine, multivitamin, and phenytoin 100mg orally 3x a day for seizure prophylaxis.

All: No Known Drug Allergies
Family History: Not obtainable.
Social History: Heavy alcohol use, other habits unknown. Apparently homeless.
Review of Systems: Not obtainable.
Physical Exam:
Blood Pressure 165/89, Pulse 135, Respiration Rate 22, Temperature 37, 100% on Room Air
General: malnourished, Hispanic male, disheveled, appears older than stated age.
Head, Eyes, Ears, Nose, Throat: Decent dentition.
Respiratory: Reduced breath sounds right base.
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops.
Abdomen: 3cm tender hepatomegaly.
Ext: no edema, surgical scars noted
Neurologic/Muscular Skeletal: patient muttering incoherently in Spanish. Alert and oriented to person and place, directable, able to answer "yes/no" consistently and follow simple commands. Denies pain. Tremulous, neuro nonfocal.

Case Exercise

Labs: Alcohol level on presentation 0.35, CBC shows Hb 11.2 with MCV 105, AST 100 ALT 75, otherwise chemistry normal. EKG shows sinus tach.

Assessment: 37 year old male noncompliant with meds with persistent Alcohol abuse and history of seizures presents with high alcohol level, now with signs of alcohol withdrawal.

1) Altered mental status: Likely alcohol withdrawal, given history priors admissions for similar. Do not suspect CNS or metabolic pathology. CIWA protocol instituted, patient admitted to floor with sitter. Fall precautions.
2) Hepatomegaly and elevated LFTs: likely alcohol hepatitis. Discriminant function does not indicate likely benefit from steroids, treat supportively.
3) Reduced breath sound right base: concerning for aspiration PNA given acute loss of consciousness – CXR PA and lateral.
4) Seizure disorder: unclear if primary or related to recurrent alcohol withdrawal; continue phenytoin in house.
5) Malnourishment: folate, thiamine, MVI
6) Homelessness: Medical Social Worker consulted for shelter/board and care given recurrent Emergency Department presentations.
7) Code: Full
8) Disposition: floor

What Social, Political, and Economic Structures Might Be Contributing to This Patient's Problems?

Structural Vulnerability Tool

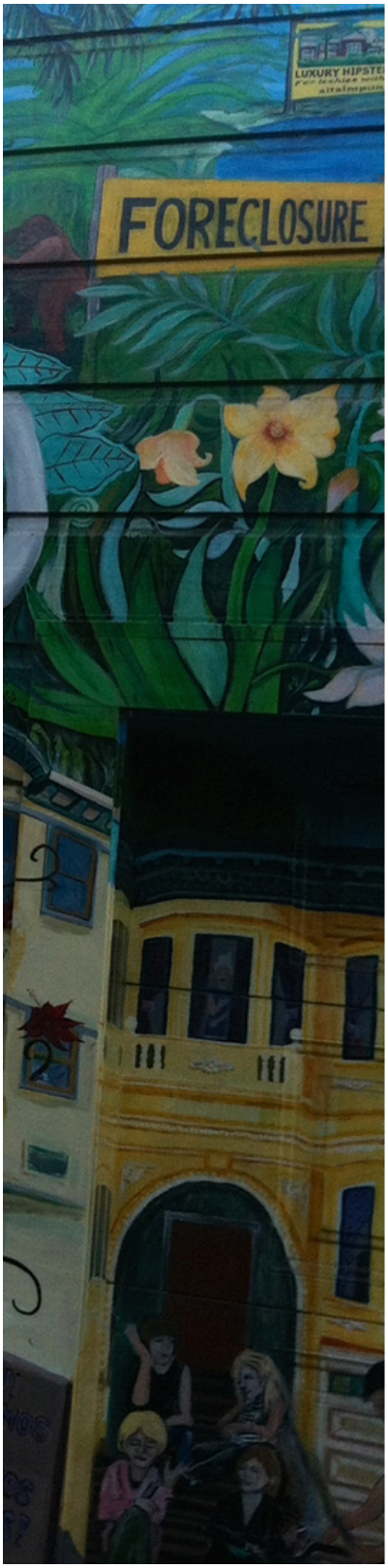
*Please adapt this tool to your own context.

*From Bourgois P, Holmes SM, Sue K, Quesada J. 2016. Structural Vulnerability: Operationalizing the Concept to Address Health Disparities in Clinical Care. *Academic Medicine*.

Structural Vulnerability Domains and Potential Sample Questions	
Financial Status	How do you make money? Do you have any difficulties doing this work? Do you have enough money to live comfortably—pay rent, get food, pay utilities and phone, basic living supplies? Do you run out of money at the end of the month? Do you receive any forms of government assistance? Are there other ways you make extra money or do you depend on anyone else for their income? Have you ever been unable to pay for medical care or medicines at the pharmacy? Do you have access to preventive and primary care?
Residence	Where do you sleep? How long have you lived there? Is that a stable or reliable place for you to live? Do you feel the place that you live is safe and clean?
Risk Environments	Are you exposed to any toxins? Are you exposed to any violence? Are you exposed regularly to drug use?
Food Access	Do you have adequate nutrition and access to healthy food? What does your regular diet consist of? What are your favorite foods? Do you have cooking facilities?
Social Network	Which people make up your social network, family and friends? Is this network healthy or unhealthy for you? Do you have people who function as a social support system for you when needed? Do you have enemies seeking to hurt you?
Legal Status	Do you have any legal trouble? Do you fear any repercussions related to your legal status? Are you eligible for public services? Have you been arrested and/or incarcerated?
Education	Are you able to read? In what language(s)? What level of education have you reached? What are your favorite books to read/movies/television/other entertainment?
Discrimination	Have you experienced discrimination based on your skin color, your accent or where you are from? Have you experienced discrimination based on your gender or sexual orientation? Have you experienced discrimination for any other reason? Do you have friends or in-laws from different ethnic groups?
Presumed Worthiness	The clinician could ask themselves if this person is likely to be considered by others as someone not to be trusted because of aspects of their appearance, ethnicity, accent, addiction status, personality, or other traits. The clinician could ask themselves if other people are likely to assume that the patient deserves their plight in life or their sickness due to any of their traits. The clinician could ask themselves if other people are likely to assume that the patient does not deserve top quality health care due to any of their traits.

KEY CONCEPTS:

"Language is never neutral." — Paulo Freire.



Social Structure: 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.

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

Naturalizing Inequality: When social inequalities are preserved through the perception that the status quo is appropriate, deserved, and natural. Those at the top are seen as deserving their position at the top, and, especially, those at the bottom are seen to be at the bottom due to their own faults. Such perception is shaped by what we will call "implicit frameworks."

Implicit Frameworks: Taken-for-granted lenses through which health professionals most commonly understand health and wellness, including individualizing behavioral frameworks and conflating cultural frameworks. Implicit as in "implicit bias."

Individualization: The common perception in healthcare that the most important causes of a patient's sickness lie in their individually chosen actions and habits and/or their individual biology (genetics, etc.). This leads to treatment plans focused primarily on education and incentive for individual level behavior change.

Cultural Frameworks: "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. It also leads to the misdirected application of cultural competence education as a solution to health care disparities for minority populations who are as familiar with mainstream American health care practices and institutions as the majority population, but who lack the resources and political clout to improve their health and health care." —Gregg and Saha

Structural Competency is the capacity for health professionals to recognize and respond to health and illness as the downstream effects of broad social, political, and economic structures.

"A shift in medical education … toward attention to forces that influence health outcomes at levels above individual interactions." —Metzl and Hansen 2014

Components of Structural Competency:

1. Recognizing influences of structures on patient health
2. Recognizing influences of structures on the clinical encounter, including implicit frameworks common in healthcare
3. Responding to structures in the clinic
4. Responding to structures beyond the clinic
5. Structural humility

Structural Humility:

The orientation emphasizing collaboration with patients and populations in developing responses to structural vulnerability, rather than assuming that health professionals alone have all the answers. This includes awareness of interpersonal privilege and power hierarchies in healthcare.

Levels of Intervention Exercise

Listed below are potential structural challenges and interventions ranging from the micro to macro-level. You may note that many items could potentially fall under multiple headings. While presented in a static format, some of what makes these challenges so difficult to change or pinpoint, is the shared responsibility among many agents.

Level	Challenges	Strategies
Intrapersonal	- "Implicit Bias" - Discrimination: Racism, sexism, heteronormativity, ageism - Moral judgments of patient behavior - Negative/blaming language - Concern for medical education debt and choice of career path - Ignorance of structural problems and solutions/services	- Education - Find ways to hold one-self accountable - Use neutral language - Ask more questions of your patients. - Talk less, listen more. - Cultivate structural humility
Interpersonal	- Language Barriers (including complex medical jargon/terminology) - Power imbalance between patient and provider - Training and/or clinical team hierarchies - The "Hidden" Curriculum - Time constraints - Student needs (learning, performance) balanced with patient needs - Exploitation of patients (both historical and immediate) - Preference for biomedical interpretation over patient interpretation	- Use existing support services (interpreters, etc) and use real language - Recognize the hierarchies, practice humility, resist where you can, use your status for good where appropriate/possible (med students). - Understand that medical professionals have a culture as well. - Structural vulnerability checklist (as a tool to avoid assumptions, address patient needs)
Clinic	- Poor interpretation services - Inaccessible for families (hours of operation, location, etc) - Disorganized, chaotic care (different providers) - Unadapted to patient/community needs - Providers feeling overstretched, time pressures - Underfunding	- Restructure clinic within constraints to best meet patient needs, advocate to change the restraints - Community engagement –ask what they need - Case management - Integration of behavioral services with mental health services

Levels of Intervention Exercise

Listed below are potential structural challenges and interventions ranging from the micro to macro-level. You may note that many items could potentially fall under multiple headings. While presented in a static format, some of what makes these challenges so difficult to change or pinpoint, is the shared responsibility among many agents.

Community	- Lack of community representation - Exploitation of communities - Community policing practices leading to violence and trauma, including especially racialized police violence - Poor access to clean water - Poor access to affordable gas and electricity and - Poor access to healthy food - High levels of toxicity, environmental racism and classism	- Create opportunities for community voices/leadership - Work to educate police about the health costs of policing/incarceration - Partner with CBOs working on structural issue outside of clinical settings - Affordable and safe ride share opportunities for lower income communities - Community food gardens - Community organizing for safe water, lower neighborhood toxicity - Home/phone visits - Group visits - Use your white coat/title as symbolic capital
Research	- Emphasis on quantitative research that takes for granted social categories - Demand for particular kinds of evidence - Lack of funding for social science research relative to basic science - Publishing bias-research preferentially published from elite universities	- Engage patients in defining important research questions and aims - Situate research in a structural context - Use the accepted forms of evidence to point to structural causes for health disparities - Research the historical effects of policies - Advocate for better funding for qualitative research
Policy	- Immigration and housing policies - SSI benefits that require mental health diagnosis - Prison industrial complex and criminalization of drug use - Medicare value measurements that contribute to pressures - Access to/Cost of pharmaceuticals - Lack of diversity/inclusion in health professional education instructors - Lack of formal curriculum on structural determinants of health in health profession schools - Political redlining	- Refuse to report undocumented migrants - Contact media, seek out radio speaking opportunities - Write media article, editorials, and position statements demonstrating the relationship between policies and poor health - Challenge claims (e.g. based on genetics) that naturalize inequality - Research the historical effects of policies - Make pharmaceutical access inequity transparent through blog posts, social media, and formal media (e.g. Shkreli) - Activism - Be a medic or wear your white coat (with permission from organizers) at rallies, marches, etc. - #whitecoats4blacklives and other student movements to change admissions policies, national policies about policing and incarceration - Medical education reform

Recommended Reading

This training barely scratches the surface. Here is a list of readings that will allow you to go deeper...

Introductory:

- Beth Rogers. "With Understanding Comes Empowerment: How 'structural competency' can change the paradigm for practitioners working with patients of low socioeconomic status." The New Physician, March-April 2014. Available online.
- Holmes, Seth M. 2013. *Fresh Fruit, Broken Bodies: Migrant Farmworkers in the United States.* University of California Press.
- Metzl, Jonathan M. 2010. *The Protest Psychosis: How Schizophrenia Became a Black Disease.* Beacon Press.
- Metzl, Jonathan and Dorothy Roberts. 2014. "Structural Competency Meets Structural Racism: Race, Politics, and the Structure of Medical Knowledge." *The Virtual Mentor.* P. 674-684.
- Bourgois P, Holmes SM, Sue K, Quesda J. 2016. Structural Vulnerability: Operationalizing the Concept to Address Health Disparities in Clinical Care. *Academic Medicine*.

Interventions:

- Geiger H. J. 1984. "Community health centers: health care as an instrument of social change." In *Reforming Medicine: Lessons of the Last Quarter Century* (Edited by Sidel V. W. and Side1 R.), pp. 11-32.
- Messac, et al. 2013. "The good-enough science-and-politics of anthropological collaboration with evidence-based clinical research: Four ethnographic case studies." *Social Science & Medicine.* P. 176-185.
- Scheper-Hughes, Nancy. 1993. "Toward a Liberation Medicine: A Pedagogy for Patients (and Practitioners)." From *Death Without Weeping*. P. 213-215.
- Metzl, JM and Hansen, HH. 2014. "Structural competency: Theorizing a new medical engagement with stigma and inequality." *Social Science and Medicine*.
- Ansell, David. 2012. *County: Life, Death, and Politics at Chicago's Public Hospital.*
- Mullan, Fitzhugh. 2006 *White Coat, Clenched Fist: The Political Education of an American Physician.*
- Cohen, Lawrence. 2001. "The Other Kidney." *Body & Society.*

Theoretical Genealogy I: Marx and Engels on Capital and Inequality

- Marx, Karl. "The secret of primitive accumulation." Ch. 26 of *Capital.* p. 873-876
- Engels, Friedrich. "The Results." Ch. 5 of *The Condition of the Working Class in England.* Read p. 106-124, and skim 124 - 143.
- Pine, Adrienne. 2011. "From Healing to Witchcraft: On Ritual Speech and Roboticization in the Hospital." Cult Med Psychiatry. p. 262-281.
- Navarro, Vicente. 1988. "Professional Dominance or Proletarianization?: Neither." *The Milbank Quarterly*, Vol. 66, Supplement 2: The Changing Character of the Medical Profession. pp. 57-73.
- Taussig, Michael. 1980. "Reification of the Patient." Soc. Sci. Med. p. 3-13.
- Baer, Hans, Merrell Singer, and Ida Susser. 2004. *Medical Anthropology and the World System.*
- Minkler, Meredith et al. "The Political Economy of Health: A Useful Theoretical Tool for Health Education Practice." *Int'l Quarterly of Community Health Education,* 1995.

Theoretical Genealogy II: Bourdieuian and Gramscian Takes on Legitimizing Hierarchy and Inequality

- Hall, Stuart. 1986. "Gramsci's Relevance for the Study of Race and Ethnicity." *Journal of Communication Inquiry*, p. 5-27.
- Wacquant, Loic J. 2006. "Pierre Bourdieu." In R. Stones ed. Key Contemporary Thinkers. New York: Macmillan. (~12 pages)
- Bourdieu, Pierre. 2003. "Gender and Symbolic Violence." In Scheper-Hughes, Nancy and P Bourgois, eds. *Violence in War and Peace: An Anthology*. 2003. p. 272-274.
- Rivkin-Fish, Michele. 2011. "Learning the Moral Economy of Commodified Health Care: 'Community Education,'

Recommended Reading

This training barely scratches the surface. Here is a list of readings that will allow you to go deeper...

Failed Consumers, and the Shaping of Ethical Clinician-Citizens." Cult Med Psychiatry. P. 183-205.

- Gramsci, Antonio. *Prison Notebooks*.
- Bourgois, Philippe and Jeffrey Schonberg. *Righteous Dopefiend.*
- Nader, Laura. 1997. "Controlling Processes: Tracing the Dynamic Components of Power." *Current Anthropology.*
- Bourdieu, Pierre. *Pascalian Meditations.*
- Wacquant, Loic. *Urban Outcasts.*

Precursors to Structural Competency: Social Medicine, Social Analysis of Colonial Medicine, and Structural Violence

- Porter, Dorothy. 2006. "How Did Social Medicine Evolve, and Where Is It Heading?" *PLOS: Medicine*. P. 1667-1671.
- Virchow, Rudolph "Report on the Typhus Epidemic in Upper Silesia." *American Journal of Public Health*, December 2006. (Original 1848.) P. 2102-2105.
- Breilh, Jaime. 2008. "Latin American critical ('Social') epidemiology: new settings for an old dream." *International Journal of Epi*. P. 745-749.
- Fanon, Franz. 1965. "Medicine and Colonialism" Ch. 4 of *A Dying Colonialism. P*. 121-145.
- Farmer, Paul. 2006. "Structural Violence and Clinical Medicine." *PLOS: Medicine*. P. 1686-1690.
- Wacquant, Loïc. 2004. Critique of structural violence. *Current Anthropology*. Sidney W. Mintz Lecture. P. 322.
- McKenna, Brian and Hans Baer. 2012. "Dying for Capitalism: 'Good Growth' at the World Bank?" *Counterpunch*.
- Bourgois, Philippe. 2001. "The Power of Violence in War and Peace: Post-Cold War Lessons from El Salvador." *Ethnography*. P. 5-30.
- Farmer, Paul. 2004. "An anthropology of structural violence" + critiques. Current Anthropology. Sidney W. Mintz Lecture for 2001.
- Quesada et al. 2011. "Structural Vulnerability and Health: Latino Migrant Laborers in the United States." Medical Anthropology.
- Waitzkin, Howard. 2011. *Medicine and Public Health at the End of Empire*. Paradigm Publishers.
- Phelan, Link, and Tehranifar. "Social Conditions as Fundamental Causes of Health Inequalities : Theory, Evidence, and Policy Implications." *Journal of Health and Social Behavior*, Oct 2010.
- Holmes, Stonington, Green. 2014. "Locating global health in social medicine." *Global Public Health.*
- Stonington, Holmes. 2006. "Social medicine in the Twenty-First Century" *Public Library of Science Medicine.*
- Howard Waitzkin. "Social medicine in Latin America: productivity and dangers facing the major national groups." Lancet, 2001.
- Pine, Adrienne. 2010. *Working Hard, Drinking Hard*. University of California Press
- Briggs, Charles and Clara Mantini-Briggs. 2009. "The "Barrio Adentro" Experiment in Confronting Health Disparities: Cuban Doctors, Low-Income Communities, and Innovative Collaborations in Venezuela." *American Journal of Public Health*.
- Briggs, Charles and Clara Mantini-Briggs. 2009. "Confronting Health Disparities: Latin American Social Medicine in Venezuela." *Am J Public Health.*

Theoretical Genealogy III: Foucault on the Clinical Gaze

- Foucault, Michel. 1973. Excerpts from *The Birth of the Clinic* ("Preface" p. ix-xix, "Open Up a Few Corpses" p. 124-148)
- Holmes, Seth and Maya Ponte. 2011. "En-case-ing the Patient: Disciplining Uncertainty in Medical Student Patient Presentations." *Cult Med Psychiatry*. P. 163-180.
- Rhodes, Lorna. 2004. "Starkness was everywhere." Chapter 1 from *Emptying Beds.* P. 11-33.
- Rosenberg, Charles. "The Tyranny of Diagnosis: Specific Entities and Individual Experience." Milbank Q. Jun

Recommended Reading

This training barely scratches the surface. Here is a list of readings that will allow you to go deeper...

2002; 80(2): 237–260.
- Rhodes, Lorna. *Emptying Beds.*

Theoretical Genealogy IV: Foucault on Biopolitics
- *Foucault, Michel. Part V of *A History of Sexuality*: "Right to Death and Power Over Life." P. 258-272.
- Knight, Kelly Ray. 2015. Chapter 7:"Victim/perpetrators" from *addicted. pregnant. poor.* P. 188-213. Duke University Press.
- Bourgois, Philippe and Jeffrey Schonberg. 2009. Ch. 7 "Male Love" of *Righteous Dopefiend*. P. 209-240.
- Foucault, Michel. *Birth of Biopolitics* "14 March, 1979" and "21 March, 1979."
- Bourgois, Philippe. 2000. "Disciplining Addictions: The Bio-Politics Of Methadone And Heroin In The United States." *Culture, Medicine and Psychiatry*.

Cultural Competence and its Discontents: Origins and critiques
- Kleinman et al. 1978. "Culture, Illness, and Care." *Annals of Internal Medicine*. P. 61-68
- Tervalon, Melanie and Jann Murray-García. "Cultural Humility Versus Cultural Competence." *Journal of Healthcare for the Poor and Underserved*. P. 117-123.
- Fadiman, Anne. 1997. Ch. 5 of *The Spirit Catches You and You Fall Down*. p. 38-59.
- Taylor, Janelle. 2003. "The Story Catches You and You Fall Down: Tragedy, Ethnography, and 'Cultural Competence'." *Med Anthro Quarterly*. P. 159-180.
- Gregg, Jessica and Somnath Saha. 2006. "Losing Culture on the Way to Competence: The Use and Misuse of Culture in Medical Education." *Academic Medicine*. P. 542-546.
- Jenks, Angela. 2011. "From 'Lists of Traits' to 'Open-Mindedness': Emerging Issues in Cultural Competence Education." *Culture, Medicine, and Psychiatry*. P. 209-231.
- Fadiman, Anne. 1997. Ch. 17 of *The Spirit Catches You and You Fall Down*. P. 258-277.
- Kleinman and Benson. 2006. "Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix It." *PLOS Medicine*.
- Pon, Gordon. 2009. "Cultural Competency as New Racism: An Ontology of Forgetting." *Journal of Progressive Human Services*.
- Santiago-Irizarry, Vilma. 1996. "Culture as Cure." *Cultural Anthropology*. (16 pages)

Teaching structural competence
- Willen, Sarah. 2013. "Confronting a 'Big Huge Gaping Wound': Emotion and Anxiety in a Cultural Sensitivity Course for Psychiatry Residents." *Cult Med Psychiatry.* P. 253-276.
- Wear and Aultman. 2005. "The Limits of Narrative: Medical Student Resistance to Confronting Inequality and Oppression in Literature and Beyond." *Medical Education*. P. 1056-1064.
- Boler, Megan. 2004. "Teaching for Hope: The Ethics of Shattering World Views." In *Teaching, Learning, and* Loving. P. 114-129.
- "A New Direction for Cultural Competency Education at Penn: Report of the Doctor-Patient Student Committee" (Incorporates structural competence into UPenn SOM curriculum). Sections to be determined.
- Freire, Paolo. 1970. *Pedagogy of the Oppressed*.

Structural Violence Exercise

Write about examples of structural violence leading to poor health for patients you have worked with (or other people you have known). You can list examples from different cases in which structural violence has been a factor, or you may focus on one case in detail, pulling out themes of structural violence as you go.

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