STRUCTURAL COMPETENCY SMALL GROUP PARTICIPANT WORKBOOK

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About the Content

Some of these materials have been created by the UCSF Center for Health Equity in Surgery and Anesthesia as Creative Commons, and many have been borrowed or adapted from the Structural Competency Working Group, www.structuralcompetency.org; you can contact the Group at structuralcompentency@gmail.com.

How to Use this Resource

Trainee participants should be provided a copy of this prior to the discussion session. To download or print this and related materials, please use the QR code to the right. If you are an instructor and want to edit these slides, please open in your browser and go to the 'File' menu at the top right, then 'Make a copy' and work from the copy on your own google drive.

Quick Review: Terms & Key Concepts

Adapted from: Bourgois P, Holmes SM, Sue K, Quesada J. "Structural Vulnerability: Operationalizing the Concept to Address Health Disparities in Clinical Care." Academic Medicine, 2017; and the Structural Competency Working Group Toolkit

> *Medical education has of late developed a potential over-competency syndrome, claiming expertise over a range of highly complex topics that have eluded humanities and social science scholars for years."* -Metzl & Hansen, Soc Sci Med, 2014

Social Structure: The way society is organized, i.e. policies, economic systems, and other institutions (policing and judicial systems, schools, etc.) that have produced and maintain social inequities and health disparities, often along the lines of social categories such as race, class, gender, and sexuality (i.e. "Social determinants of health").

Social Determinants of Health: The social structural forces that impact health.

Structural Violence*: "Structural violence*, a term coined by Johan Galtung and by liberation theologians during the 1960s, describes social structures—economic, political, legal, religious, and cultural—that stop individuals, groups, and societies from reaching their full potential [Gatlung, *J Peace Res*, 1969]. In its general usage, the word *violence* often conveys a physical image; however, according to Galtung, it is the "avoidable impairment of fundamental human needs or…the impairment of human life, which lowers the actual degree to which someone is able to meet their needs below that which would otherwise be possible" [Gatlung, 1993]. Structural violence is often embedded in longstanding "ubiquitous social structures, normalized by stable institutions and regular experience" [Gilligan, Violence: reflections on a national pandemic, 1996]. Because they seem so ordinary in our ways of understanding the world, they appear almost invisible. Disparate access to resources, political power, education, health care, and legal standing are just a few examples. The idea of *structural violence* is linked very closely to *social injustice* and the social machinery of oppression [Farmer, An anthropology of structural violence, 2004]." - Farmer, PLoS Med, 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.

Structural Racism: (aka "Institutional Racism"): "When white terrorists bomb a black church and kill five black children, that is an act of individual racism, widely deplored by most segments of the society. But when in that same city – Birmingham, Alabama – five hundred black babies die each year because of the lack of power, food, shelter and medical facilities, and thousands

more are 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. When a black family moves into a home in a white neighborhood and is stoned, burned or routed out, they are victims of an overt act of individual racism which most people will condemn. But it is institutional racism that keeps black people locked in dilapidated slum tenements, subject to the daily prey of exploitative slumlords, merchants, loan sharks and discriminatory real estate agents. The society either pretends it does not know of this latter situation, or is in fact incapable of doing anything meaningful about it." -Kwame Ture (Stokely Carmichael) and Charles V. Hamilton *Black Power: The Politics of Liberation*, 1967

Naturalizing Inequality*:* When social inequalities and structural violence are unacknowledged or preserved/justified by ways of thinking that focus on individual behaviors, "cultural" characteristics, or biologized racial categories. This helps preserve social inequities by giving the impression that the current, inequitable status quo is "natural," in the sense of not being primarily social or structural in origin. In other words, those at the top have earned/deserve to be there and those at the bottom are their as a result of their own faults. Such perception is shaped by what we will call "**implicit frameworks**."

Implicit Frameworks: The common, taken-for-granted (implicit) ways of understanding health and wellness — among health professionals and in society more broadly. Examples include interpreting health disparities in terms of individual behavior, "culture," and biology/genetics, without also adequately considering underlying social and structural factors. Discussing implicit frameworks does not suggest that individual behaviors, culture, and genetics do not matter for health. Instead, this highlights ways we and others might inadvertently fail to recognize, acknowledge, and address the structural factors that are primary drivers of health disparities (see "naturalizing inequality" above).

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, Acad med, 2006*

Structural Competency "seeks to promote skills, not so much for replacing awareness of "culture" in medical settings, but for recognizing how "culture" and "structure" are mutually co-implicated in producing stigma and inequality. We find common ground in the belief that conceptualizing and intervening into abstract social formations is a skill that requires study and practice over time. And, that the competency that results from such efforts helps clinicians develop, not the hubris of mastery, but the humility to recognize the complexity of the structural constraints that patients and doctors operate within. In this exercise, you will examine several clinical scenarios." Tervalon, J Health Care Poor Underserved, 1998

"

A shift in medical education… toward attention to forces that influence health outcomes at levels above individual interactions." Metzl & Hansen, Soc Sci Med, 2014

Structural Competency Components

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

Cultural Humility

An orientation emphasizing collaboration with patients and communities in developing responses to structural vulnerability, rather than assuming that health professionals know best. This includes (but is not limited to) awareness of interpersonal privilege and power hierarchies in healthcare.

Structural Vulnerability Checklist

Bourgois P, Holmes SM, Sue K, Quesada J. "Structural Vulnerability: Operationalizing the Concept to Address Health Disparities in Clinical Care." Academic Medicine, 2017.

Domain	Screening questions and assessment probes[b]
Financial security	**Do you have enough money to live comfortably—pay rent, get food, pay utilities, telephone?** • How do you make money? Do you have a hard time doing this work? • Do you run out of money at the end of the month/week? • Do you receive any forms of government assistance? • Are there other ways you make money? • Do you depend on anyone else for income? • Have you ever been unable to pay for medical care or for medicines at the pharmacy?
Residence	**Do you have a safe, stable place to sleep and store your possessions?** • How long have you lived/stayed there? • Is the place where you live/stay clean/private/quiet/protected by a lease?
Risk environments	**Do the places where you spend your time each day feel safe and healthy?** • Are you worried about being injured while working/trying to earn money? • Are you exposed to any toxins or chemicals in your day-to-day environment? • Are you exposed to violence? Are you exposed regularly to drug use and criminal activity? • Are you scared to walk around your neighborhood at night/day? • Have you been attacked/mugged/beaten/chased?
Food access	**Do you have adequate nutrition and access to healthy food?** • What do you eat on most days? • What did you eat yesterday? • What are your favorite foods? • Do you have cooking facilities?
Social network	**Do you have friends, family, or other people who help you when you need it?** • Who are the members of your social network, family and friends? Do you feel this network is helpful or unhelpful to you? In what ways? • Is anyone trying to hurt you? • Do you have a primary care provider/other health professionals?
Legal status	**Do you have any legal problems?** • Are you scared of getting in trouble because of your legal status? • Are you scared the police might find you? • Are you eligible for public services? Do you need help accessing these services? • Have you ever been arrested and/or incarcerated?
Education	**Can you read?** • In what language(s)? What level of education have you reached? • Do you understand the documents and papers you must read and submit to obtain the services and resources you need?
Discrimination	*[Ask the patient]* **Have you experienced 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? *[Ask yourself silently]* **May some service providers (including me) find it difficult to work with this patient?** • Could the interactional style of this patient alienate some service providers, eliciting potential stigma, stereotypical biases, or negative moral judgments? • Could aspects of this patient's appearance, ethnicity, accent, etiquette, addiction status, personality, or behaviors cause some service providers to think this patient does not deserve/want or care about receiving top quality care? • Is this patient likely to elicit distrust because of his/her behavior or appearance? • May some service providers assume this patient deserves his/her plight in life because of his/her lifestyle or aspects of appearance?

Levels of Intervention for Structural Challenges

What challenges and strategies can you think of specific to your work?

Level	Challenges	Strategies
Individual	• *"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 oneself accountable • Use neutral language • Ask more questions of your patients. • Talk less, listen more. • Cultivate structural humility
Intrapersonal	• 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 service (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
Clinical/ Institutional	• Poor interpretation services Inaccessible for families (hours of operation, location, etc.) • Disorganized, chaotic care (different providers) • Not adapted 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*
Community	• *Lack of community representation* • *Exploitation of communities* • *Community policing practices leading to violence and trauma* • *Poor access to clean water* • *Poor access to affordable gas and electricity* • *Poor access to healthy food* • *High levels of toxicity, environmental racism/classism*	• *Create opportunities for community voices/leadership* • *Worktoeducatepoliceaboutthehealth costs of policing/incarceration* • *Partner with CBOs working on structural issue outside of clinical settings* • *Affordable and safe rideshare opportunities for lower income communities* • *Community food gardens* • *Community organizing for safewater,*

		• *lower neighborhood toxicity* • *Home/phone visits* • *Group visits* • *Use your white coat/title as symbolic capital*
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*	• *Refusetoreportundocumented migrants* • *Contact media, seek out radio speaking opportunities* • *Write media articles,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-Beamedicorwearyourwhite coat (with permission from organizers) at rallies, marches, etc.* • *#whitecoats4blacklivesandother student movements to change admissions policies, national policies about policing and incarceration* • *Medical education reform*
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*

Case 1

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.

Presenting Complaint: Acute loss of consciousness

History of Present Illness: Patient is a 37-year-old Spanish-speaking 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 a park bench w/empty cans of malt liquor. In the Emergency Department the 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 & Surgical 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. 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. 1 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, nonfocal.

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 admission 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 LOC – 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: (Hospital) floor

Discussion Questions

1. What questions do you have that might help you better understand the situation?
2. What social, political, and economic structures might be contributing to this patient's problems?

Case 2

Please read the following note describing an admission to the inpatient ward service. When you have finished, discuss with your colleagues, imagining that you're the attending hearing this case.

Brief vignette: A 79-year-old Navajo man is brought to the emergency room by ambulance from an Indian Health Service (IHS) Clinic from a reservation approximately 2 hours away accompanied by his daughter because of complaints of RLQ abdominal pain fatigue, headache, muscles aches, and nausea over the past several days. He speaks some English, but Navajo is his primary language. You have some difficulty understanding his responses and you are not certain that the patient understands your questions.

Question 1: Has anyone taken care of an Indigenous American patient? What comes to mind when you are seeing an Indigenous American patient? What Biases might a provider have towards an Indigenous American patient?

1. If a health care provider is aware of a stereotype this stereotype can become activated in his or her mind upon encountering a member of the patient group in question. This will not likely lead to increased attention towards aspects of the patient's behavior that reflect negatively.
2. For example, according to a study that surveyed health care personnel in the Southwest United States, medical providers thought the stereotypical indigenous patient is someone who is non-compliant, participates in risky behavior and does not comprehend complex care plans or follow up.
3. **Key Teaching Points:**
   - "Indigenous American" encompasses a huge swath of cultures and belief systems (574 federally recognized tribes in the land area called the United States) and they cannot be generalized into one belief system. For some Indigenous American cultures, illnesses are not defined as diseases, diagnoses, or moral maladies, nor are they viewed as physical or character flaws. Instead, they are seen as symptoms of imbalance in the individual's relationship with the world. Hence, if a patient is being "non-compliant", make sure this "non-compliance" is not due a lack of acknowledgement and inclusion of, healing and treatment approaches that are inclusive of all aspects of life—spiritual, emotional, physical, social, behavioral, and cognitive on the part of the provider.
   - Providers may have implicit and explicit biases that can impact patients, but we should attempt to transition from behavioral to structural causes - health related behaviors are often blamed on something intrinsic to the patient, when structural factors (i.e. limited access to services, transportation, necessities of basic living, english as a second language etc) often play a much larger role.
4. **Value of Cultural Awareness:** Remind providers to reflect on their own cultural awareness. If providers are aware of their own cultural backgrounds, they will be more likely to acknowledge and explore how culture affects their interactions, particularly their relationships with clients of all backgrounds. Without cultural awareness, providers may discount the influence of their own cultural contexts— including beliefs, values, and attitudes—on their initial and diagnostic impressions of clients and selection of healing interventions.

Question 2: What perceptions might an Indigenous American have toward a health care provider?

1. In several studies, indigenous Americans exhibited higher levels of mistrust compared to other populations toward health care workers.
2. Amongst multiple racial groups in a community based survey, mistrust was highest and satisfaction lowest among Indigenous Americans
   ○ This persisted despite income or health plan type.
3. **POINT:** This mistrust and low confidence in health care providers are among the barriers to receiving general medical care.
4. **POINT:** Indigenous American trust and perceptions of quality of care are significant potential impediments to eliminating health disparities in this resource-denied population.
5. **POINT:** Much of this trust stems from historical trauma and poor access to care from a severely underfunded Indian Health Service (IHS).
   ○ Trust is the cornerstone in the provision of high quality care, especially when healthy individuals are being asked to undergo screening or sick patients to adhere to complex treatment recommendations.
   ○ This mistrust is one of many contributing factors to late diagnoses- Indigenous Americans presenting more often than non-indigenous populations with advanced breast colorectal, prostate cervical and lung cancer (50% presenting with stage III or IV disease compared to 36% or non-indigenous patients).
   ○ With increased trust, patients may be more likely to participate in screening, which is available for all of these diseases.

Question 3. What power imbalances do you see inherent to your patient/physician relationships (and other relationships?) What can you do to mitigate their impact during a patient encounter?
1. **POINT:** "American history" taught in most schools presents a much more majority friendly view of the settler colonialism and genocide that occurred such that many providers may not even be aware of or knowledgeable about why indigenous Americans would have historical trauma
2. Many Indigenous Americans believe that historical trauma, including the loss of culture, lies at the heart of substance use and mental and other illness within their communities.
3. Some indigenous Americans may be distrustful of western medicine and the healthcare system, both internal and external to the Indian Health Service, due to a long history of misuse by researchers and transient healthcare workers with little understanding of their culture. Also, the lack of knowledge of the health belief/customs by providers including traditional medicine and the importance of medicine men may enhance mistrust.
4. Many Indigenous people feel stereotyped, ignored, and disrespected by non-Indigenous providers.
5. **POINT**: Up to 50% of indigenous Americans in some studies think of the cultural trauma on a daily basis.

6. Many programs and providers serving Indigenous people are often not culturally relevant or sensitive to the significant trauma within Indigenous communities. There are several significant periods in US History that exemplify the cultural trauma inflicted by the United States upon indigenous Americans (Reading for brief history of US History and Indigenous Communities - link coming soon):

1. Annihilation → Pre-1880s
Navajo Long Walk, Trail of tears
"The only good Indian is a dead indian" - General Phillip Sheridan, 1869

2. Forced assimilation → 1890-1950s
Boarding schools
"Kill the indian, save the man."- Captain Richard H. Pratt

3. Termination/Relocation → 1950-1970s
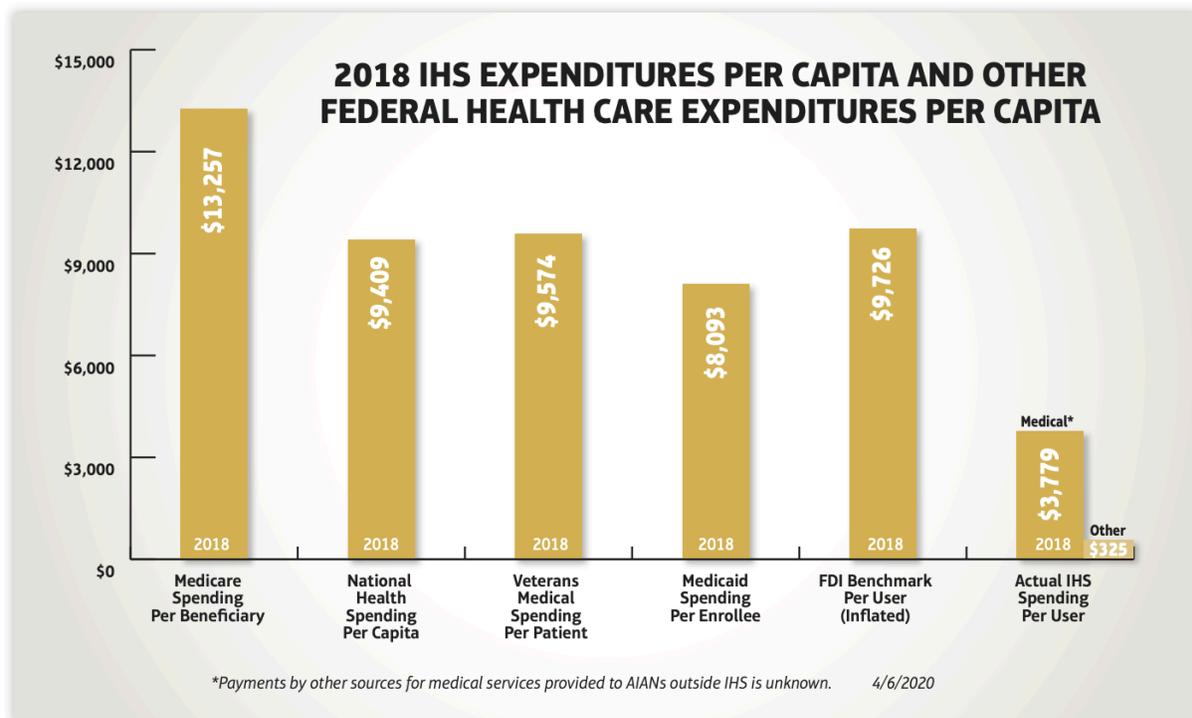Indian Relocation Act of 1956 → Move from rural to urban areas,
House Concurrent Resolution 108 → payouts to eliminate Native tribes

4. Self-Determination - 1970s - Present
American Indian Movement

Question 4: Do Indigenous Americans receive free health care? What impact does the health care system have on Indigenous American health?
1. **POINT:** Underfunding. The federal government promised to take care of Indigenous Americans' health when it signed the treaties in which tribes gave up almost all of their land. Congress has long failed to allocate enough money to meet this promise.

2018 IHS EXPENDITURES PER CAPITA AND OTHER FEDERAL HEALTH CARE EXPENDITURES PER CAPITA

Medicare Spending Per Beneficiary	National Health Spending Per Capita	Veterans Medical Spending Per Patient	Medicaid Spending Per Enrollee	FDI Benchmark Per User (Inflated)	Actual IHS Spending Per User
$13,257	$9,409	$9,574	$8,093	$9,726	Medical* $3,779 / Other $325

*Payments by other sources for medical services provided to AIANs outside IHS is unknown.   4/6/2020

Patient Centered Care: Knowing the history of Indigenous peoples is critical in implementing best practices. Here are a few best practices to keep in mind when working with Indigenous people:

1. **Recognize**: Given the significant trauma, PTSD should be high on your differential diagnosis, which is often missed or misdiagnosed as depression or borderline personality.
2. **Acknowledge** the "intergenerational trauma" including the loss of sacred lands, forced assimilation, and family ruptures. Emphasize and validate the strength of the survivors.
3. **Accommodate:** Intake forms may also need to be translated to the language of the indigenous people in the area. Be mindful that there has been mistrust of clinics run by the federal government, which have a history of ulterior motives.
4. The Evaluation should be thorough to **avoid stereotypes and misdiagnosis**.
5. Allow **the patient to tell their story**, and encourage them to share their cultural identity.
6. The physician and primary care provider (including indigenous provider) should work closely together.
7. The discharge process should be thoughtful with ongoing accessibility for care made explicit.