Structural Competency: Framing a New Conversation on Institutional Inequalities and Sickness

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By

The conference on structural competency organized and hosted by Jonathan Metzl and Helena Hansen, and held at the NYU's Department of Social and Cultural Analysis on March 23rd 2012, proved to be enormously successful. The conference was an experiment on the part of Hansen and Metzl to generate a new conversation among doctors, clinicians, urban planners, social theorists and activists regarding the larger structural issues at the heart of our health care problems today. While closely related to the long-established concept of cultural competency, structural competency arose out of a need to go beyond the cultural specificities of patient care to confront the larger social inequalities of place, race, and economy. It was delivered to an over-capacity audience by a very eclectic group of speakers, representing the disciplines of sociology, medicine, psychiatry, anthropology, social policy, social work and the humanities. Throughout the daylong event the wide range of talks and panel discussions converged to suggest both what it means to be structurally competent today as well as possible directions which this conversation might take.

Metzl and Hansen give opening remarks

Hansen's and Metzl's opening remarks set the tone for the day. The organizers cited the fact that the biomedical model has become increasingly dominant in academia and practice, making it all the more difficult to discuss and study the social and economic mechanisms that

contribute to health disparity. Hansen argued that making progress on these issues first requires looking at the language of medicine and determining how to link social structures linguistically and conceptually to the determination of health. One way is by framing knowledge about social determinants of health as a competency. Competency refers to the practical expertise that medical practitioners need in order to provide patient care in light of "the broad based stratifications that delimit the choices of individuals and the possibilities for the doctor patient relationship". Metzl explained how the larger aim of "structural competency" was to "form coalitions that work against the learned helplessness that medicine often assumes about structural matters," and by so doing to address "forces are often assumed invisible or immutable or beyond the reach of medical intervention or repair."


Bruce Link addresses the conference

Bruce Link, whose work with Jo Phelan on stigma has shaped much of the conversation on structure over the years, started the day off the day by describing the context in which structural power is manifest. He began by evoking two interrelated ideas of the French sociologist Pierre Bourdieu, symbolic power and *meconnaissance* (misrecognition). Symbolic power is the capacity to impose a "legitimate vision" of the world, allowing powerful social actors to achieve their goals under the radar. Second, *meconnaissance*is the denial that people are pursing interests that benefit them, another means by which power structures are rendered invisible, thus keeping motivation to resist or oppose them untapped. These related concepts formed the background to Link's argument about the invisible yet concrete mechanisms of power structures. Simply stated, our means of improving or changing any condition (through a new medicine, methodology, etc.) is always wrapped up in social and economic realities that determine access. Link cited differences in interstate delivery systems for new drugs and patient care as examples of fixed determinants of access. As for mechanisms underlying inequalities in access, Link described research demonstrating how stigma contributes to depriving those victimized from access to proper care. His opening remarks led the way for the first panel's presentations.

The members of the first panel were Philippe Bourgois, Dalton Conley, Alondra Nelson and Michael Ralph. Philippe Bourgois, professor of anthropology and community medicine got things started by discussing the concept of structural vulnerability and its political implications. The idea is that "vulnerability is produced in an individual by his/her location in a hierarchical social order and its diverse networks of power relationships and power effects." Bourgois emphasized the importance of this concept as a critique of the dominant model of agency in US health care, with its assumption of a freely-willing and rationally-choosing subject. His talk was highlighted by examples of embodied structural inequalities displayed in a number of graphic images of the effects of the drug trade in impoverished ethnic neighborhoods.

NYU sociologist Dalton Conley, who spoke next, defined structure as an invisible causal relationship among social and/or non-social factors. He pointed out that in this definition the idea of the non-social as well as the emphasis on causality were both very important. For example, non-social factors, like potassium levels in the soil, can lead to vastly different levels of human development. The bulk of his talk focused on the structures influencing infant and perinatal health. Conley cleverly put the direction of cause into question, asking if it is socioeconomics that cause perinatal health problems or if perinatal health problems can be the cause of lifelong socioeconomic disparity. Using his own empirical research as support Conley found complicated outcomes in twin studies. Comparing twins who were raised together, yet had different birth weights, he found a correlation between the lower birth weight participants and their performance in school and later vocations, which had a large effect on their socioeconomic status. Moreover, he found that once he added in the SES level of the family, there was a protective factor for low birth weight twins who came from more affluent households. The conclusion to be drawn is not that poverty affects health or vice-versa but that there are implications of recognizing the role of structure on multiple causal levels.

Following Conley was sociologist Alondra Nelson, who brought a historical angle to her talk on structural competency. Citing the work of W.E.B Du Bois, Nelson emphasized that structural components of racism are not only to be found in institutions but in norms, schemas and ideas that influence forms of inequality. She also gave the example of doctors who were affiliated with the 'Occupy" movement and had voiced their dissatisfaction with the state of the health care system bolstered by their platform of health, not wealth. Towards the end of her talk Nelson acknowledged the critique of cultural competency argued by Arthur Kleinman, namely that instating protocols would prove too reductive for the complex concept of culture. Kleinman once told the story of an impoverished Mexican father who failed to take his sick son to the doctor. Kleinman's reservation was that a clinician trained in cultural competency

might pay too close attention to the racialized reasons why a man failed to find his child medical care when the real trouble was heavy labor demands laid upon the family, that is, a structural issue.

Michael Ralph's talk dealt with the very topical issue of health insurance. Introducing the concept under the guise of the 'structures of liability' he focused on the relationships of between insurance and health, wellness, governance and cost. Ralph brought up the disquieting example of corporate-owned life insurance, where corporations and even states have the ability to take out policies on their employees while not offering the same benefits to the employees and their families. Thus corporations make money off the life of the work force while the families are often left with little or nothing in return. He drew a powerful parallel between this form of insurance, in which the employee is a security rather than an individual, and slave insurance which was considered a form of property insurance rather than life insurance. Finally, he turned to the problem of disaster insurance, which even when owned by the victim are not guarantees for the reimbursement or protection from the disaster itself. In the case of hurricane Katrina, many insurers were able to get away without reimbursing hurricane-insured victims by claiming that flooding, rather than the hurricane, was directly responsible for property damage. There is clearly a larger structural component at work in the profit-focused aspects of the insurance industry.

After lunch Mindy Fullilove opened the afternoon ahead of the second panel with a talk on urban restoration as competent medicine. She spoke about the intricate ways in which a developing city can work to segregate and displace entire populations through restructuring the urban landscapes. Segmenting and segregating populations and spaces leave not only food deserts but also economic and social deserts. This can in turn have a tremendously negative effect on health care delivery. In the case of Pittsburgh, new highways and large parking lots work to fracture certain ethnic and class-based communities. The danger is that such segregation cuts the lines of communication between city populations. For Fullilove the problem had to be dealt with from a homogeneous vision of the city rather than focusing on disparate neighborhoods of poverty. Out of this she proposed initiatives of restoration based on connectivity, not only of the literal space, and shared urban areas, but also connectivity of meaning and history of the city. In order to overcome the violent attributes of structure, its takes an entire city, organized and working together as a whole.

The first afternoon panel entitled "Structural Interventions" started off with John Jay professor Ernie Drucker's talk about mass incarceration as a structural phenomenon. Drucker immediately drew the correlation between incarceration and disease epidemics like drug addiction and

AIDS, arguing that the three must be thought about together. He used geographical data to demonstrate that the system of mass incarceration in New York occurred specifically in low income neighborhoods where particular ethnicities were highly represented. These fracturing points of the community are where widespread incarceration rates impede the ability of families and communities to access health and economic resources. Mass incarceration produces a cyclical health and humanitarian disparity that is often invisible to health care research and breaks up family units, making it impossible for the community to heal and move forward economically.

Of all the speakers on this panel, Kim Hopper provided what was perhaps the clearest definition of structural competency. He emphasized "refocusing upstream…by committing to take stock of present day social arrangements and inquiring into how they shape the field of 'possibles' in peoples' lives and how they bend, complicate or distort the exercise of choice itself." Hopper's wording eloquently summarizes the daunting task of confronting structure and its surface invisibility against the social and economic interworking of the community.

Fellow panel member and disabilities studies professor Kathryn Church's talk "Making Madness Matter" offered examples of practical interventions for those with mental health histories in community life. Perhaps the most detrimental structural device for those recovering from mental illness is stigma. As Church points out, the intervening power of the mad movement lies in its ability to reappropriate terms like "mad", nutter", "psycho" in order to rebuke the social shame and discrimination that psychiatric survivor often deal with for a life time. Church's argument focused on re-education of a society pervaded with ignorance about the meaning of psychiatric illnesses. Both Church and Hopper illustrated new ways to inspire awareness and intervention of structure by foregrounding the university courses they created respectively. For Church and Hopper the first place for powerful and creative modes of intervention is in the academic setting.

From there Pyser Edelsack took the idea of intervention further into the realm of education and the medical school as the ground zero for structural competency. He began with the important point that attrition rates for equivalent students from lower economic backgrounds were much greater than those of their wealthier counterparts. Along these lines he offered the provocative notion that it may be possible to see a positive structural advantage for students who, being from a wealthier household, could contribute all their time to internships, academics and medicine without the problem of having to work at the same time. Next he brought up the glaring problem of profit making in medical school culture. Today's schools teach specialization to garner the highest salaries while primary

care and social medicine pay the price. He cited the program at the Sophie Davis School of Biomedical Education as an alternative initiative to expand the pool of underrepresented minorities who, commit to perform primary care work in underserved areas of New York for two years in exchange for tuition reduction.

The final panelist, Irène Mathieu, a medical student at Vanderbilt, spoke about her experience with three academic organizations that found ways to account for structural competency in practice. Mathieu gave testimony of her work in the Dominican Republic with SOMOS (Student Organization for Medical Outreach and Sustainability) a service learning project which subverts the problems of "duffle bag medicine" by assigning students to a multi-year commitment in healthcare outreach and research. This multidimensional program had a seminar component where the students learned about the history of DR and its relation to the US. Mathieu also participated in Vanderbilt's inter-professional learning program, with the opportunity to work with other healthcare disciplines such as social work and nursing. The plurality of approaches to healthcare in marginalized areas of the community took better account of all aspects of the patient's situation. Finally, Health Justice Council, co-founded by Mathieu, is an organization that provides activities to medical student to think critically about how to insert structural competency into the clinical setting.

The final panel of the day was a round table discussion on how best to move from concept to praxis. The panel included Marc Gourevitch, Bradley Lewis, Gary Belkin, and Neely Myers. The conversation was complex and eventually involved the entire audience. Issues ranging from lobbying, policy change, and community commitments were voiced. Jonathan Metzl acknowledged that a focus on structure should not override other important indicators like race and gender in the guise of social and economic reform. The discussion also shifted to how the concept would resist being co-opted by the academic and institutional machine and avoid the problematics of the cultural competency model. Finally Marc Gourevitch posed the tough question of whether delivery is really the central issue as opposed to regulation, tax reform, lobbying and institutional changes that may be the top catalysts for structural change.

The conference closed with a screening of the film *All of Us* by physician/anthropologist Merhet Mandefro. The film followed the lives of underprivileged African American women living with AIDS. The film powerfully demonstrated the multiple and complex factors of social status, class, race and gender that are implicitly linked to the deadly disease. After the screening Mandefro fielded questions and spoke about her experience as a young physician working in a setting where the direct practice of medicine was only a fraction of a larger scale battle against disease tied to the inequalities of social structure.

What started out as a heterogeneous group of ideas progressed toward a coherent and unified thesis by the end of the day. The conference opened the possibility for the beginning of a new movement in healthcare. Metzl and Hansen revealed plans for a follow-up series of conferences and workshops in Spring, 2013. This initial conference got the ball rolling. The next step towards assessing the power structures that determine healthcare practice and delivery will reside in how these ideas are put into action.

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For more information on this conference and upcoming events please visit structuralcompetency.org