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CASE STUDY

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 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 park bench w/empty cans of malt liquor. In 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 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.


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.

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 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: (Hospital) floor

What social, political, and economic structures might be contributing to this patient’s problems?
KEY CONCEPTS

“Language is never neutral.” — Paulo Freire.

Social Structure: The policies, economic systems, and other institutions (policing & judicial systems, schools, etc.) that have produced and maintain social inequities and health disparities, often along the lines of social categories (race, class, gender, etc.).

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.”

- Paul 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.

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


**Naturalizing Inequality**: When inequality and structural violence are justified by—or go unacknowledged due to—ways of thinking that focus on individual behaviors, “cultural” characteristics, or biologized racial categories (see “implicit frameworks” below). 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.

**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).
# STRUCTURAL VULNERABILITY CHECKLIST


## Chart 1

**Structural Vulnerability Assessment Tool**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Screening questions and assessment probes</th>
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</table>
| **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** | 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/chaired? |
| **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 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? |
STRUCTURAL VIOLENCE EXERCISE

Please reflect on an example of structural violence you have witnessed, as a provider/trainee or otherwise. Before you start writing, be sure to reflect: what were the structures involved, and how were they violent (i.e. what bodily and/or emotional harm did they cause
NATURALIZING INEQUALITY EXERCISE

Underline the parts of the passages below where you see inequality/injustice being naturalized through “Implicit Frameworks.” Implicit Frameworks discussed include focusing on any of the following instead of the influence of structures: “culture,” individual level behaviors/choices, and/or biology/genetics.


#1: When asked why very few Triqui people were harvesting apples, the field job known to pay the most, the Tanaka Farm’s apple crop supervisor explained in detail that “they are too short to reach the apples, and, besides, they don’t like ladders anyway.” He continued that Triqui people are perfect for picking berries because they are “lower to the ground.” When asked why Triqui people have only berry-picking jobs, a mestiza Mexican social worker in Washington state explained that “a los Oaxaquenos les gusta trabajar agachado [Oaxacans like to work bent over],” whereas, she told me, “Mexicanos [mestizo Mexicans] get too many pains if they work in the fields.” In these examples and the many other responses they represent, perceived bodily difference along ethnic lines serves to justify or naturalize inequalities, making them appear purely or primarily natural and not also social in origin. Thus, each kind of ethnic body is understood to deserve its relative social position.

#2: The urgent-care doctor he first saw explained that Abelino should not work, but should rest and let his knee recover. The occupational health doctor he saw the following week said Abelino could work but without bending, walking, or prolonged standing…. After a few weeks, the occupational health doctor passed Abelino to a reluctant physiatrist who told Abelino that he must work hard picking strawberries in order to make his knee better. She told Abelino that he had been picking incorrectly and hurt his knee because he “didn’t know how to bend over correctly.” Once Abelino had recovered, this doctor explained to the researcher that Abelino no longer felt pain, not because he got better, but because the picking season was over and he could no longer apply for worker’s compensation…. Knee and back pain continue to be the most common health complaints among pickers on the Tanaka Farm.
YOUR ARROW DIAGRAM EXERCISE

1) In the space below, write out your personal trajectory. What has your trajectory been up until now, as a provider/trainee and otherwise? You may want to include why you chose to go into healthcare. If you are early in your career, you could consider the possible trajectories you could have moving forward.

2) Next, in a different color, if available, identify the structures that have influenced (or might influence) your trajectory. What structures have given you advantages? What harmful/unjust structures have you encountered? Have any structures put you at risk for feeling burned out?

3) For Module 3: what strategies could modify your trajectory moving forward?
COMPONENTS OF STRUCTURAL COMPETENCY

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

Levels of Intervention

1. Individual
2. Interpersonal
3. Clinic/Institutional
4. Community
5. Policy
6. Research

Structural 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.
## LEVELS OF INTERVENTION

Listed below are potential structural challenges and interventions at each of the levels. Note that many items could potentially fall under multiple headings.

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<tr>
<th>Level</th>
<th>Challenges</th>
<th>Strategies</th>
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<tbody>
<tr>
<td>Individual</td>
<td>• “Implicit Bias”</td>
<td>• Education</td>
</tr>
<tr>
<td></td>
<td>• Discrimination: Racism, sexism, heteronormativity, ageism</td>
<td>• Find way to one-self accountable</td>
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<td></td>
<td>• Moral judgments of patient behavior</td>
<td>• Use neutral language</td>
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<td></td>
<td>• Negative/blaming language</td>
<td>• Ask more questions of your patients</td>
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<tr>
<td></td>
<td>• Concern for medical education debt and choice of career path</td>
<td>• Talk less, listen more</td>
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<td></td>
<td>• Ignorance of structural problems and solutions/services</td>
<td>• Cultivate structural humility</td>
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<tr>
<td>Interpersonal</td>
<td>• Language Barriers (including complex medical jargon/terminology)</td>
<td>• Use existing support service (interpreters, etc.) and use real language</td>
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<td></td>
<td>• Power imbalance between patient and provider</td>
<td>• Recognize the hierarchies, practice humility, resist where you can, use your status for good where appropriate/possible (med students).</td>
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<td></td>
<td>• Training and/or clinical team hierarchies</td>
<td>• Understand that medical professionals have a culture as well.</td>
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<td></td>
<td>• The “Hidden” Curriculum</td>
<td>• Structural vulnerability checklist (as a tool to avoid assumptions, address patient needs</td>
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<td></td>
<td>• Time constraints</td>
<td></td>
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<td></td>
<td>• Student needs (learning, performance) balanced with patient needs</td>
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<tr>
<td></td>
<td>• Exploitation of patients (both historical and immediate)</td>
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<td></td>
<td>• Preference for biomedical interpretation over patient interpretation</td>
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<tr>
<td>Clinic/Institutional</td>
<td>• Poor interpretation services</td>
<td>• Restructure clinic within constraints to best meet patient needs, advocate to change the restraints</td>
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<td></td>
<td>• Inaccessible for families (hours of operation, location, etc.)</td>
<td>• Community engagement -ask what they need</td>
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<td></td>
<td>• Disorganized, chaotic care (different providers)</td>
<td>• Case management</td>
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<tr>
<td></td>
<td>• Not adapted to patient/community needs</td>
<td>• Integration of behavioral services with mental health services</td>
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<td></td>
<td>• Providers feeling overstretched, time pressures</td>
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<tr>
<td></td>
<td>• Underfunding</td>
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# Levels of Intervention

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<tr>
<th>Level</th>
<th>Challenges</th>
<th>Strategies</th>
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<tbody>
<tr>
<td>Community</td>
<td>• Lack of community representation</td>
<td>• Create opportunities for community voices/leadership</td>
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<td></td>
<td>• Exploitation of communities</td>
<td>• Work to educate police about the health costs of policing/incarceration</td>
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<td></td>
<td>• Community policing practices leading to violence and trauma</td>
<td>• Partner with CBOs working on structural issue outside of clinical settings</td>
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<td></td>
<td>• Poor access to clean water</td>
<td>• Affordable and safe ride share opportunities for lower income communities</td>
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<td></td>
<td>• Poor access to affordable gas and electricity</td>
<td>• Community food gardens</td>
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<tr>
<td></td>
<td>• Poor access to healthy food</td>
<td>• Community organizing for safe water, lower neighborhood toxicity</td>
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<td></td>
<td>• High levels of toxicity, environmental racism/classism</td>
<td>• Home/phone visits</td>
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<td>• Group visits</td>
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<td></td>
<td></td>
<td>Use your white coat/title as symbolic capital</td>
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<tr>
<td>Policy</td>
<td>• Immigration and housing policies</td>
<td>• Refuse to report undocumented migrants</td>
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<td></td>
<td>• SSI benefits that require mental health diagnosis</td>
<td>• Contact media, seek out radio speaking opportunities</td>
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<td>• Prison industrial complex and criminalization of drug use</td>
<td>• Write media articles, editorials, and position statements demonstrating the relationship between policies and poor health</td>
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<td>• Medicare value measurements that contribute to pressures</td>
<td>• Challenge claims (e.g. based on genetics) that naturalize inequality</td>
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<td>• Access to/Cost of pharmaceuticals</td>
<td>• Research the historical effects of policies</td>
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<td>• Lack of diversity/inclusion in health professional education instructors</td>
<td>• Make pharmaceutical access inequity transparent through blog posts, social media, and formal media (e.g. Shkreli)</td>
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<td>• Lack of formal curriculum on structural determinants of health in health profession schools</td>
<td>• Activism - Be a medic or wear your white coat (with permission from organizers) at rallies, marches, etc.</td>
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<td>• #whitecoats4blacklives and other student movements to change admissions policies, national policies about policing and incarceration</td>
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<tr>
<td></td>
<td></td>
<td>• Medical education reform</td>
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</table>
## LEVELS OF INTERVENTION

<table>
<thead>
<tr>
<th>Level</th>
<th>Challenges</th>
<th>Strategies</th>
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<tbody>
<tr>
<td>Research</td>
<td>• Emphasis on quantitative research that takes for granted social categories&lt;br&gt;• Demand for particular kinds of evidence&lt;br&gt;• Lack of funding for social science research relative to basic science&lt;br&gt;• Publishing bias-research preferentially published from elite universities</td>
<td>• Engage patients in defining important research questions and aims&lt;br&gt;• Situate research in a structural context&lt;br&gt;• Use the accepted forms of evidence to point to structural causes for health disparities&lt;br&gt;• Research the historical effects of policies&lt;br&gt;Advocate for better funding for qualitative research</td>
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RECOMMENDED READING

This training barely scratches the surface. Here is a list of reading to go a little deeper.

Defining, Teaching, & Operationalizing Structural Competency


The Need for Structural Competency in Healthcare Education


Limitations of Behavioral, “Cultural,” & Biological Framing of Health Disparities


Structural Violence & Structural Racism
• Coates TN. (June 2014). The Case for Reparations. The Atlantic.

Foundational Social Theory & Structural Analyses of Healthcare

Writings on Teaching & Framing


Social Medicine: Examples of Healthcare-Based Responses to Harmful Social Structures


