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Structural Competency in the U.S. Healthcare Crisis: Putting Social and Policy Interventions Into Clinical Practice

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The U.S. healthcare system is in crisis. The United States spends more on healthcare per capita than any country in the world (Kane 2012) but ranks below most other industrialized countries in measures of health outcomes, with marked inequalities in health and healthcare by socioeconomic status, ethnicity, and race (Institute of Medicine and National Research Council 2013). McCord and Freeman's seminal 1990 contention that black men in Harlem are less likely to reach the age of 65 than men in Bangladesh (McCord and Freeman 1990, 176) captures a reality that remains true in the present day. Meanwhile, U.S. whites with less than a high school education now demonstrate a three to five year decline in life expectancy, the first decline in many generations (Case and Deaton 2015; Olshansky et al. 2012). These discrepancies suggest the need for large-scale intervention—yet the United States lags behind other industrialized nations in treating the pathologies of social systems that are major drivers of health outcomes (Foege 2010; Woolf and Braveman 2011).

Although a number of national initiatives address the U.S. healthcare crisis, they focus primarily on individual patients and providers, rather than on the social and institutional structures determining population-level outcomes. For instance, the U.S. Patient Protection and Affordable Care Act (ACA) primarily seeks to contain growth in healthcare spending and secondarily improves health outcomes through expanded coverage. While the ACA emphasizes reducing the number of uninsured citizens, it remains unclear how the healthcare system will otherwise intervene in social and institutional determinants of health (Hardcastle et al. 2011). Meanwhile, a majority of surveyed U.S. physicians express frustration that they do not have the tools to address the social causes of disease (Harris Interactive 2011). Coincidentally, increasing numbers of U.S. physicians link structural factors such as restrictive insurance policies, lack of time with patients, and unsatisfying relationships with communities (Pathman et al. 2002; Spickard, Gabbe, and Christensen 2002) with feelings of

professional burnout (Krupka 2012; Dyrbye and Tait 2011) and plans to leave clinical practice (Doulgeris 2012; Maki 2012; Landon et al. 2006).

The symposium in this issue of the *Journal of Bioethical Inquiry*, framed around the rubric of “structural competency” (Metzl and Hansen 2014), convenes leading scholars and opinion-makers from global health and the social sciences of health to address the crisis of U.S. healthcare in social and structural terms. Key to our intervention is critical engagement with the ways that current medical paradigms often place responsibility for health-related choices and behaviour on individuals. Increasingly, we hear that low-income African Americans are unable to follow doctors’ nutritional advice, not because they harbour cultural mistrust of the medical establishment but because they live in food deserts with no access to grocery stores (Metzl and Roberts 2014). Or, that Central American immigrants who are at risk for Type 2 diabetes refuse to exercise, not because of cultural preferences but because their neighbourhoods have no gyms or sidewalks or parks. These and other examples suggest that we need a paradigm shift in medical practice: to attend to institutional pathologies that lead to clinical pathologies.

The diverse and divergent authors in this issue commonly hold that the key to treating social and institutional morbidities lies, to a large extent, in international examples of structural health promotion that the U.S. medical education system cannot afford to ignore. So too, it lies in the insights and nascent interventions of social science scholars. For the lessons of these global health and social science approaches to have an impact, however, they must be framed as clinical interventions. That is because in the United States, the financial, social, and symbolic capital in the health field is disproportionately held by physicians and other clinical practitioners, rather than by those trained in public health.

Indeed, global demonstrations of collaborations among medical practitioners, policymakers, and community members to treat social and structural determinants of health can inform the U.S. healthcare crisis. They range from the implementation of universal HIV prevention and treatment programs in Brazil, which reduced HIV mortality by 50 per cent and hospitalizations by 70 to 80 per cent over a seven-year period (Berkman et al. 2005), to community- and family-based psychosocial rehabilitation programs that significantly improved symptoms and functioning among people with schizophrenia in rural India (Chatterjee et al. 2003), to the assignment of a family doctor to every 1,000 Cubans, who receive annual home visits, nearly universal vaccinations, prenatal care, blood pressure checks and who enjoy a higher life expectancy and lower infant mortality rate than the United States (Campion and Morrissey 2013; Keck and Reed 2012). The key to adapting these approaches from global health to the structurally imbedded U.S. health crisis will be their adoption by medical practitioners, who have the symbolic, social, and knowledge-based capital to implement them.

Structural competency directs clinical training and healthcare systems to intervene at the level of social structures, institutions, and policies that must be altered to improve population health and promote health equity. Building upon a growing number of publications and interventions (Metzl 2010; Tsevat et al. 2015), structural competency is now a movement of U.S. clinical professionals, social medicine researchers, and health activists (see

structuralcompetency.org), a movement that through national conferences and webinars has examined how a structural competency approach can put the best of social medicine scholarship into clinical practice.

We have identified a need, however, to move from theory to an appraisal of core interventions that operationalize the goals of structural competency. Drawing on global and U.S.-based examples of structural interventions in illness, health, and health equity, written by clinical practitioners, social scientists, and policy makers, the essays in this special issue address one or more of the following questions:

1. How can clinical eyes be trained to see social structures?
2. What competencies and interdisciplinary sensibilities are required in order to act on those structures?
3. Which imaginative structural approaches to promoting health equity might U.S. health practitioners adapt from global health and might all health practitioners adapt from fields outside of medicine?
4. Which alliances with parties outside of medicine (e.g., urban planning, schools, corrections) and outside of the United States are needed in order to impart structural change?

In answering these questions, this symposium also addresses a core problem of “cultural competency” training, one of the only ways that U.S. clinical education examines health inequalities in terms of race/ethnicity and socioeconomic status. “Culture” in this setting often refers to patients’ beliefs, doctor–patient communication, and culture as a static, causal variable in individual outcomes, rather than on the social and structural causes of population differences in health (Kleinman and Benson 2006; Carpenter-Song, Nordquest Shwallie, and Longhofer 2007). However, the shift proposed here, from a focus solely on individuals to one that also encompasses institutions and populations, will require translation to bridge the gap between the literature documenting social determinants of health and the strategies that medical practitioners and clinical institutions might use to alter those determinants. It also will require translation of international models of structural health intervention into the U.S. context. Given the relative paucity of expertise on structural and social determinants of health in U.S. medical schools and healthcare organizations, developing structural strategies will require intellectual resources from healthcare systems outside of the United States and from fields outside of clinical medicine, including the social sciences and population health.

The contributors to this symposium illuminate multiple levels on which clinicians can take structural action: (1) in their interactions with patients in clinics, as they incorporate into their practice insights from the medical humanities and social sciences as well as emerging bio-social life science paradigms; (2) as collaborators with community organizations and non-health sector agencies, including urban planning, to create health-promoting neighbourhoods and social environments; and (3) as advocates for health-promoting public policies at local, national, and international levels, drawing on their influence as “health experts” to make the health impact of policies visible and actionable.

The first two papers in this issue re-orient the conceptual underpinnings of clinical practice from individuals to social structures. Adam Reich, Helena Hansen, and Bruce Link (2016) open the discussion with a contribution of medical sociology to structural competency—the idea of “fundamental interventions” to address the fundamental causes (Link and Phelan 1995) of health disparities in the form of social inequalities. Their paper bridges the established population health literature to clinical practice and ends with examples from medical training and practice that target social determinants of health. Sociologist and geneticist Dalton Conley and leading epigenetics researcher Dolores Malaspina (2016) follow with a conceptual contribution from epigenetics to “personalized medicine,” based on the mutual constitution of biology and environment as mechanisms underlying ethnic-, racial-, and class-based inequalities in health. They explain the ways that social–environmental exposures drive genetic expression and have heritable effects, arguing that personalized medicine, if it is to incorporate newer life science paradigms of heritability, will have to address the social environments of patients, not only individual genetic traits.

The second set of papers argues for a retooling of clinical institutions as structures in themselves, structures that can exacerbate social inequalities or, alternately, can lead the way to social change. Pioneering medical educator Nancy Angoff and co-authors Laura Duncan, Nichole Roxas, and Helena Hansen (2016) describe the development and impact of “Power Day,” a series of curricular innovations that call attention to race-, class-, and gender-inflected abuses of power within medical training and that reward responsible uses of power by medical faculty and residents. Renowned social psychiatrist Mindy Fullilove and award-winning urban planner Michel Cantal-Dupart (2016) describe their work to redesign cities for social integration and enhanced public space as health interventions. Their approach, transported to the United States from a model developed in France, is one in which hospitals and clinics can become part of the solution to persistent race and class segregation in U.S. cities, segregation that drives health inequalities in a country where public health researchers often point out that postal code is more predictive of health status than genetic code.

The last two papers illustrate how clinicians can change non-healthcare institutions and policies to promote health. Political scientist Danielle Celermajer and psychologist Jack Saul (2016) document their intervention to address collective trauma and moral injury among members of Nepalese police forces that have tortured inmates. They illustrate that political violence must be addressed systemically, because individual perpetrators are institutionally compelled to participate. Given the pervasive mental health impact of political violence and trauma on perpetrators as well as recipients, reversing professional incentives and institutional pressures in order to discourage violence is a form of structural competency. Finally, an international group of leaders in the global movement for harm reduction in drug policy (Drucker, Anderson, Haemmig, Heimer, Small, Walley, Wood, and van Beek 2016) conclude this symposium with their account of the role of physicians and other clinicians in creating harm-reduction models, as well as in documenting their effectiveness and advocating for national and international policies to decriminalize narcotic addiction and institute public health interventions in their stead. Their examples provide a guiding light to other practitioners whose clinical and scientific expertise, as well as moral authority as health professionals, is needed in order to promote public health approaches to stigmatized and criminalized health conditions.

Together, these contributors paint a portrait of resurgent social medicine that is informed by global examples but will take shape locally in diverse forms, tailored to the multiple ways that social structures shape health outcomes. This re-articulation of social medicine—structural competency—relies on the inventiveness, adaptability, and commitment of a new cohort of clinicians, clinicians who actively redefine health and medicine, conscious of their own role in building the new structures that are needed to reduce inequalities in health.

References

- Angoff N, Duncan L, Roxas N, Hansen H. Power day: Addressing the use and abuse of power in medical training. *Journal of Bioethical Inquiry*. 2016; 13(2) doi:XXXXXXX.
- Berkman A, Garcia J, Munoz-Laboy M, Paiva V, Parker R. A critical analysis of the Brazilian response to HIV/AIDS: Lessons learned for controlling and mitigating the epidemic in developing countries. *American Journal of Public Health*. 2005; 95(7):1162–1172. [PubMed: 15933232]
- Campion EW, Morrissey S. A different model—medical care in Cuba. *The New England Journal of Medicine*. 2013; 368(4):297–299. [PubMed: 23343058]
- Carpenter-Song EA, Nordquest Shwallie M, Longhofer J. Cultural competence reexamined: Critique and directions for the future. *Psychiatric Services*. 2007; 58(10):1362–1365. [PubMed: 17914018]
- Case A, Deaton A. Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century. *Proceedings of the National Academy of Sciences*. 2015; 112(49):15078–15083.
- Celermajer DD, Saul J. Preventing torture in Nepal: A public health and human rights intervention. *Journal of Bioethical Inquiry*. 2016; 13(2) doi:XXXXXXX.
- Chatterjee S, Patel V, Chatterjee A, Weiss HA. Evaluation of a community-based rehabilitation model for chronic schizophrenia in rural India. *British Journal of Psychiatry*. 2003; 182(1):57–62. [PubMed: 12509319]
- Conley D, Malaspina D. Socio-genomics and structural competency. *Journal of Bioethical Inquiry*. 2016; 13(2) doi:XXXXXXX.
- Doulgeris, J. New survey validates that US physicians are ailing.. *Physicians Practice*. Sep 27. 2012 <http://www.physicianspractice.com/new-survey-validates-us-physicians-are-ailing>
- Drucker E, Anderson K, Haemmig R, et al. Treating addictions: Harm reduction in clinical care and prevention. *Journal of Bioethical Inquiry*. 2016; 13(2) doi:XXXXXXX.
- Dyrbye LN, Tait SD. Physician burnout: A potential threat to successful health care reform. *The Journal of the American Medical Association*. 2011; 305(19):2009–2010. [PubMed: 21586718]
- Foege W. Social determinants of health and health-care solutions. *Public Health Reports*. 2010; 125(Suppl 4):8–10. [PubMed: 20626188]
- Fullilove MT, Cantal-Dupart M. Medicine for the city: Perspective and solidarity as tools for making urban health. *Journal of Bioethical Inquiry*. 2016; 13(2) doi:XXXXXXX.
- Hardcastle LE, Record KL, Jacobson PD, Gostin LO. Improving the population's health: The Affordable Care Act and the importance of integration. *The Journal of Law, Medicine & Ethics*. 2011; 39(3):317–327.
- Harris Interactive. [August 17, 2012] 2011 Physicians' daily life report. 2011. http://www.rwjf.org/vulnerablepopulations/product.jsp?id=73646&cid=XEM_2809280.
- Institute of Medicine and National Research Council. U.S. health in international perspective: Shorter lives, poorer health. The National Academies Press; Washington, DC: 2013.
- Kane, J. Health costs: How the U.S. compares with other countries.. *PBS Newshour*. Oct 22. 2012 <http://www.pbs.org/newshour/rundown/2012/10/health-costs-how-the-us-compares-with-other-countries.html>
- Keck W, Reed G. The curious case of Cuba. *American Journal of Public Health*. 2012; 102(8):e13–e22. [PubMed: 22698011]
- Kleinman A, Benson P. Anthropology in the clinic: The problem of cultural competency and how to fix it. *PLoS Medicine*. 2006; 3(10):e294. doi:10.1371/journal.pmed.0030294. [PubMed: 17076546]

- Krupka, C. Nearly half of physicians struggle with burnout.. AMA News. Sep 3. 2012 <http://www.amednews.com/article/20120903/profession/309039952/2/>
- Landon BE, Reschovsky JD, Pham HH, Blumenthal D. Leaving medicine: The consequences of physician dissatisfaction. *Medical Care*. 2006; 44(3):234–242. [PubMed: 16501394]
- Link BG, Phelan J. Social conditions as fundamental causes of disease. *Journal of Health and Social Behavior*. 1995; 35(Extra Issue):80–94. [PubMed: 7560851]
- Maki, A. Survey: 34 pct. of physicians to leave medical practice.. Memphis Daily News. Aug 8. 2012 <https://www.memphisdailynews.com/news/2012/aug/8/survey-34-pct-of-physicians-to-leave-practice/>
- McCord C, Freeman HP. Excess mortality in Harlem. *The New England Journal of Medicine*. 1990; 322(3):173–177. [PubMed: 2294438]
- Metzl JM. *The protest psychosis*. Boston: Beacon Press. 2010
- Metzl JM, Hansen H. Structural competency: Theorizing a new medical engagement with stigma and inequality. *Social Science & Medicine*. 2014; 103:126–133. <http://www.sciencedirect.com/science/article/pii/S0277953613003778>. [PubMed: 24507917]
- Metzl J, Roberts D. Structural competency meets structural racism: Race, politics, and the structure of medical knowledge. *AMA Journal of Ethics*. 2014; 16(9):674–690. <http://journalofethics.ama-assn.org/2014/09/spec1-1409.html>.
- Olshansky SJ, Antonucci T, Berkman L, et al. Differences in life expectancy due to race and educational differences are widening, and many may not catch up. *Health Affairs*. 2012; 32(3): 1803–1818. [PubMed: 22869659]
- Pathman DE, Konrad TR, Williams ES, Scheckler WE, Linzer M, Douglas J. Physician job satisfaction, job dissatisfaction, and physician turnover. *Journal of Family Practice*. 2002; 51(7): 593. [PubMed: 12160487]
- Reich AD, Hansen HB, Link BG. Fundamental interventions: How clinicians can address the fundamental causes of disease. *Journal of Bioethical Inquiry*. 2016; 13(2) doi:XXXXXXX.
- Spickard A, Gabbe SG, Christensen JF. Mid-career burnout in generalist and specialist physicians. *The Journal of the American Medical Association*. 2002; 288(12):1447–1450. [PubMed: 12243624]
- Tsevat RK, Sinha AA, Gutierrez KJ, DasGupta S. Bringing home the health humanities: Narrative humility, structural competency, and engaged pedagogy. *Academic Medicine*. 2015; 90(11):1462–1465. [PubMed: 25945967]
- Woolf SH, Braveman P. Where health disparities begin: The role of social and economic determinants—and why current policies may make matters worse. *Health Affairs*. 2011; 30(10):1852–1859. [PubMed: 21976326]