



Structural competency: Theorizing a new medical engagement with stigma and inequality[☆]

Jonathan M. Metzl^{a,*}, Helena Hansen^{b,c}

^aCenter for Medicine, Health, and Society, Vanderbilt University, Nashville, TN, United States

^bNew York University, New York, NY, United States

^cNathan Kline Institute for Psychiatric Research, Orangeburg, NY, United States

ARTICLE INFO

Article history:

Available online 04 July 2013

Keywords:

Stigma
Cultural competency
Medical education
Social determinates of health

ABSTRACT

This paper describes a shift in medical education away from pedagogic approaches to stigma and inequalities that emphasize cross-cultural understandings of individual patients, toward attention to forces that influence health outcomes at levels above individual interactions. It reviews existing structural approaches to stigma and health inequalities developed outside of medicine, and proposes changes to U.S. medical education that will infuse clinical training with a structural focus. The approach, termed “structural competency,” consists of training in five core competencies: 1) recognizing the structures that shape clinical interactions; 2) developing an extra-clinical language of structure; 3) rearticulating “cultural” formulations in structural terms; 4) observing and imagining structural interventions; and 5) developing structural humility. Examples are provided of structural health scholarship that should be adopted into medical didactic curricula, and of structural interventions that can provide participant-observation opportunities for clinical trainees. The paper ultimately argues that increasing recognition of the ways in which social and economic forces produce symptoms or methylate genes then needs to be better coupled with medical models for structural change.

© 2013 The Authors. Published by Elsevier Ltd. All rights reserved.

Introduction

A patient walks into a doctor's office speaking a language that the doctor struggles to understand. The patient points to his chest while making pain gestures. Or mimics actions that suggest a seizure. Or fights to breathe. But the doctor is in her first week of residency, having just moved from rural Indiana to the Bronx, New York. And the patient grew up in low income housing and is on methadone maintenance. Or lives in a Hmong neighborhood where English is the third tongue. Or is an HIV-positive gay man who spends his life surrounded by a tight-knit community of orthodox Jews.

For much of the past two decades, “cultural competency” has been the rubric most often deployed in U.S. medical education for addressing the tensions of such moments of clinical encounter. Competency, in this formulation, implies the trained ability to identify cross-cultural expressions of illness and health, and to thus counteract the marginalization of patients by race, ethnicity, social class, religion, sexual orientation, or other markers of difference.

[☆] This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

* Corresponding author.

E-mail address: jonathan.metzl@vanderbilt.edu (J.M. Metzl).

URL: <http://www.vanderbilt.edu/mhs>

Clinical professionals learn approaches to communication, diagnosis and treatment that take into account culturally specific sources of stigma, such as the stigma of mental health diagnoses among Asian immigrants, or the stigma of HIV and homosexuality in certain religious communities. Doctors train by analyzing vignettes that depict instances where “cultural” variables impact symptom presentations or attitudes about care. “Mrs. Jones is an African American woman in her mid-60s who comes late to her office visit and refuses to take her blood pressure medication as prescribed.” Or, “You see a Mexican migrant who just received health counseling for Type II diabetes eating fried tortillas in the waiting room.” Meanwhile, nurses develop “linguistic competencies” that teach them culturally sensitive, non-judgmental ways to build rapport with such patients. And pharmacists train in “communication skills” aimed to help build relationships when working in “multicultural settings” (American Association of Colleges of Pharmacy, 2006; Perez, 2008).

These are not insignificant developments. Cultural competency emerged during an era when U.S. medicine failed to acknowledge the importance of diversity issues (National Juneteenth Medical Commission). In the twenty years hence, it helped promote consideration of the impact of stigma and bias into treatment decisions. Yet the politics of the present moment challenge cultural competency's basic premise: that having a culturally sensitive clinician reduces patients' overall experience of stigma or improves

health outcomes. Increasingly, we hear that low-income African Americans are unable to comply with doctors' orders to take their medications with food, not because they harbor cultural mistrust of the medical establishment, but because they live in food deserts with no access to grocery stores. Or, that Central American immigrants who are at risk for Type-II Diabetes refuse to exercise, not because they are uneducated about the benefits of weight reduction, but because their neighborhoods have no gyms or sidewalks or parks. Or, that small numbers of opulent white Americans pay for their healthcare out of pocket, not because they do not qualify for coverage, but because the tax breaks and advantages they receive allow them to pay cash for office visits with elite practitioners who do not accept insurance. Or even that doctors overlook "cultural" variables, not because they are insensitive, but because they work in clinics with inadequate resources, and dwindling community support. These and other encounters suggest how the clinical presentations of persons at both ends of the economic spectrum are shaped by "cultural" variables, and also by the economic and political conditions that produce and racialize inequalities in health in the first place. And, that stigma and cultural conflict in health-care settings needs to be understood as the sequellae of a host of financial, legal, governmental, and ultimately ethical decisions with which medicine must engage politically if it wishes to help its patients clinically.

This paper tracks an evolving discourse that redefines cultural competency in structural terms. We theorize a five-step conceptual model meant to promote awareness of forces that influence health outcomes at levels above individual interactions. We argue that, if stigmas are not primarily produced in individual encounters but are enacted there due to structural causes, it then follows that clinical training must shift its gaze from an exclusive focus on the individual encounter to include the organization of institutions and policies, as well as of neighborhoods and cities, if clinicians are to impact stigma-related health inequalities.

As this special issue attests, public health, social science, and critical race studies scholars have, over the last decade, begun to locate stigma, not just in the attitudes of individual persons, but in the actions of institutions, markets, and health care delivery systems (Bonilla-Silva, 2003; Hatzenbuehler & Link, 2014). This literature importantly reveals how stigma in clinical encounters needs to be addressed in the institutions and social conditions that produce the markers of exclusion that we call stigma, as well as in on-the-ground encounters. Similar sensibilities now suffuse a number of interventions that address the material realities of illness and health. These interventions have, to this point, been disparate and disciplinary, and thus largely developed outside of clinical practice. For instance, global-health students at Harvard learn to think about "sickness," diagnosis, and treatment in relation to food and medication distribution networks (Farmer, Nizeye, Stulac, & Keshavjee, 2006). Masters students at the Michigan College of Architecture and Urban Design form the first cohort of a new program in Design/Health, train to build city environments that promote health (Taubman College). And sociologists learn to observe the interplay of social structures and "neighborhood effects" (Sampson, 2012). These and other initiatives suggest possibilities for a major shift in the objects of clinical intervention assumed by cultural competency training, and in the broader outcomes sought by considering the impact of "culture" on clinical interactions.

We cull generalizable principles from a number of medical and extra-medical literatures to propose a new paradigm for medical education, *structural competency* (Metz 2010; structuralcompetency.com). Central to our intervention is the belief that, just as stigma in clinical encounters must be addressed structurally, so too must inequalities in health be conceptualized in relation to the institutions and social conditions that determine

health related resources. We contend that medical education needs to more systematically train health-care professionals to think about how such variables as race, class, gender, and ethnicity are shaped both by the interactions of two persons in a room, and by the larger structural contexts in which their interactions take place. And, that as such, clinicians require skills that help them treat persons that come to clinics as patients, and at the same time recognize how social and economic determinants, biases, inequities, and blind spots shape health and illness long before doctors or patients enter examination rooms.

In 1968, the civil-rights activist Stokely Carmichael famously assailed forms of racial bias embedded, not in actions or beliefs of individuals, but in the functions of social structures and institutions. "I don't deal with the individual," he said. "I think it's a cop out when people talk about the individual." Instead, speaking to a group of mental-health practitioners, Carmichael protested the silent racism of "established and respected forces in the society" that functioned above the level of individual perceptions or intentions, and that worked to maintain the status quo through such structures as zoning laws, economics, schools, and courts. Institutionalized racism, he argued, "is less overt, far more subtle, less identifiable in terms of specific individuals committing the acts, but is no less destructive of human life" (Carmichael, 2003: 151).

Attention to structure as an organizing principle in medical education seems particularly important at the present moment because the forces Carmichael described have become ever-more destructive to human life. Evidence also suggests that inattention to these forces has caused a crisis of confidence for which American medical education is ill-prepared.

On the one hand, US physicians have never known more about the ways in which the pathologies of social systems impact the material realities of their patient's lives. Epigenetics research demonstrates, at the level of gene methylation, how high-stress, resource-poor environments can produce risk factors for disease that last for generations (Johnstone & Baylin, 2010). Meanwhile, neuroscientists show neuronal linkages between social exclusion, poverty, hampered brain development, and mental disorders (Buwalda et al. 2005; Evans, 2009). And economists prove that low income persons can reduce their rates of obesity, diabetes, and major depression by moving to safer, more affluent neighborhoods (Judwig, 2011). These are but a few examples of the types of research that doctors can now access—at a level of microscopic and macroscopic precision unimaginable in Carmichael's time—to understand how diseased or impoverished economic infrastructures can lead to diseased or impoverished, or imbalanced bodies or minds. And, how locating race-based symptoms on the bodies of marginalized or mainstream persons risks turning a blind eye to the racialized, stratified economies in which marginalized and mainstreamed bodies live, work, and attempt to survive.

On the other hand, many of these physicians work in a country that has never invested less in infrastructure, or done less to correct fatal and fatalizing inequities—even in the aftermath of the Affordable Care Act. Bridges, roads, clinics, and public transportation and food distribution programs decay in many US urban settings, along with the social programs that sustained them (Davey, 2011). Some locales prosper, while many others face a state that urban planners define as "infrastructure failure." As U.S. Housing and Urban Development Secretary Shaun Donovan recently put it, "you can predict the life expectancy of a child by the zip code in which they grow up" (Bostic & Lavizzo-Mourey, 2011).

This divergence, between knowing a lot about the health effects of wealth imbalances and doing little to address them, puts US medicine in a particular bind. Its practitioners ostensibly want to help the persons who come before them in times of need. Yet when "social" issues are at play, these practitioners often know not what

Download English Version:

<https://daneshyari.com/en/article/7335933>

Download Persian Version:

<https://daneshyari.com/article/7335933>

[Daneshyari.com](https://daneshyari.com)