Structural Competency and Pain Management

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CSAM Pain Day
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Biography

• Joined UCSF in 1995: Center for AIDS Prevention Studies & SFGH Positive Health Program (Medicine)

• Currently faculty in Dept. Anthropology, History, and Social Medicine and Global Health Sciences

• NIH-funded research on the social factors that produce poor health outcomes for urban safety net patients

• Research Faculty in Dept. of Psychiatry: NIDA T32: “Drug Abuse Treatment/Services Research Training Program.” (post-doc) and faculty mentor for the Cultural Psychiatry Area of Distinction (residency)

• Medical Education: curriculum development as faculty representative on the UCSF Bridges, Differences Matter Goal 3, and Structural Competency Working Group (Rad Med); national structural competency efforts

• 20+ years of community-based women’s health promotion: Women’s Needle Exchange, Ladies Night, Women’s Community Clinic Outreach Program
Overview

- Social Determinants of Health

- Social and Structural etiology of chronic non-cancer pain (CNCP)

- Structural Competency framework
  - case review
  - key concepts
  - levels of intervention
Three principles of action

(1) Improve the conditions of daily life

(2) Tackle the inequitable distribution of power, money, and resources

(3) Measure the problem, evaluate action, expand the knowledge base, develop a workforce trained in SDOH

US-Heath and Human Services, Office of Disease Prevention and Health Promotion 2020 Topics and Objectives: Social Determinants of Health
NIDA-funded studies

Pain Management in the Clinic and Community (PMCC)
RO1 DA034625, Knight, PI; 2013-2017

Examining the Consequences of Reductions in Opioid Prescribing for CNCP on Patients, Clinical Care, and Community Health (ECROP)
R01 DA043631, Knight, PI; 2017-2022
PMCC publications


CNCP Clinical, Community and Policy-level solutions

Level of *intrapersonal* and *interpersonal*: implicit and explicit bias

**Clinic** level: policies and practices of the clinic as a whole

**Community** level?

**Research** level?

**Policy** level?
“Poverty is Painful”

I think **poverty is painful**. I think a lot of people that come here [to this clinic], they have pain, they have a lot of stress, they’re really poor, I think our patients are more poor. [Patients present as] “I have shoulder pain,” or back pain or body pain, and, like a lot of the people don’t work, right, they can’t, they either can’t find a job or they just don’t work and so in order, I think, to keep getting their benefits and stuff like that they have to have some problem, and I think a lot of it’s pain. And I think it’s painful, I think **it’s painful to be poor** and not have a job, have to deal with your family, and then even if you have maybe some underlying, like osteoarthritis or something, back pain. I think maybe just all the stress, it just seems so much more augmented.

I would define [chronic non-cancer pain in this community] as a **physical pain, which is often compounded by social and psychologic comorbidities**. So if you took a patient with exactly the same arthritis and moved them to an intact family with plenty of financial resources and gainful employment and flourishing community maybe it wouldn’t be nearly as debilitating.
Why so much CNCP?

Int: Why do you think chronic non-cancer pain is the number one diagnosis at this clinic?

I think partly the population that we work with. I think it’s a lot of people who have abused their bodies over time, they’re low income, so whether it’s through work, whether it’s through not having insurance, working and they got injured, so we get a lot of people that come through with pain. And then I also think just being, I think that in the economic situations that the people are thrust into in our community, I think it makes them difficult to get out of the cycle that they’re in. You know, there’s a lot of depression that go hand in hand with this. [W]e know if people don’t have something that they’re actively working towards they have a higher likelihood of being depressed. I think in our community that’s very likely that people can become depressed, and I think that increases the likelihood that they’re going to have pain. So I think it’s a cycle that goes on.
Structural exacerbation

Patient’s physical pain being exacerbated, made worse by their mental health or just their circumstances. [W]e try to get a patient’s comorbid depression and treat that as a way of addressing their pain. But just because our patients just have just such amazingly rough lives, aside from clinical depression, that has to change their pain threshold. And so sometimes, I think to some degree like that’s how they’re manifesting, they’re manifesting the stress of living, day to day, on the streets [of their neighborhood] as, “My back pain is worse than it would be if I was in a middle-class circumstance,” so.
Behavioral and structural factors are intertwined

Q: What were the other red flags for her [beyond the UTOX]?

Some of it is behavior around it [asking for opioids], like really, really, really wanting it. Maybe some early refills, running out early, [but] not a lot. Those are, those are harder to define and I don’t, I mean, they’re the intangibles that when we talk about parity across the board and treating everybody equally they’re, they’re a little harder, but there’s just sort of an “on the edge” quality, and really poverty, you know. I know they’re living “on the edge”, financially, and it wouldn’t surprise me if they needed income out of Vicodin, you know.
Why crack use for pain?

I don’t think [crack is] a good analgesic. I mean I can’t think of why it would be a good analgesic. It’s a great local anesthetic but that’s not how they’re [patients are] using it. And I think that probably it’s very euphoric and so I think a lot of people who have chronic non-cancer pain, like there’s always a very strong, there’s always some kind of psychosocial background that makes their pain different from everybody else’s pain and that makes their pain unique and the history of their pain and its manifestations unique. And I think that part of the reason that there’s such a high prevalence of crack use among the underserved because there’s a very large shared psychosocial structural background of sort of generalized unhappiness and depression, and cocaine makes you feel a lot better, particularly when that’s the sort of background grind of your daily life. And so with her I think the cocaine probably doesn’t specifically affect the nociceptors in her back responsible for her back pain, but it probably helps a lot of other stuff that determines her pain.
Three principles of action for CNCP

(1) Improve the conditions of daily life

(2) Tackle the inequitable distribution of power, money, and resources

(3) Measure the problem, evaluate action, expand the knowledge base, develop a workforce trained in SDOH

Cultural and Structural Competency Frameworks:

- To help clinicians recognize the ways cultural and structural factors can impact health and healthcare.
- Suggest ways to ameliorate the negative impacts of the social determinants of health and bolster mechanisms that improve health and reduce health inequities.
Cultural Competency: Critiques

- Devolve into trait-based employment of culture which could perpetuate stereotyping
- Collapse the forces affecting racial/ethnic minority populations – poverty, violence, racism - into less threatening concept of “culture”
- Perpetuate the false notion that only patients, and often only immigrant, non-English speaking and/or patients of color, have “culture”
- Often assumed a white western physician or healthcare worker
- Forward cultural competence education as the main “solution” to healthcare disparities
A shift in medical education ... toward attention to forces that influence health outcomes at levels above individual interactions.” —Metzl and Hansen 2014

Structural competency reorients clinical and public health practice and training toward community, institutional and policy level intervention.

In order to increase the capacity for health professionals to recognize and respond to health and illness as the downstream effects of broad social, political, and economic structures.
Structural Competency

Develop trainees’ capacity in the following five areas:

1. Recognizing the influences of structures on patient health
2. Recognizing the influences of structures on the clinical encounter
3. Responding to the influences of structures in the clinic
4. Responding to the influences of structures beyond the clinic
5. Structural humility
Social Structures

The policies, economic systems, and other institutions (judicial system, schools, etc.) that are organized to produce and maintain social equity or inequity, often along the lines of social categories such as race, class, gender, ability and sexuality.
Structural Determinants of SDOH

Structures

- Policies
- Economic systems
- Racism (etc.)

\[ \overset{\text{Poor health outcomes}}{\longleftrightarrow} \overset{\text{Poverty/Inequality}}{\longleftrightarrow} \overset{\text{Policies}}{\longleftrightarrow} \overset{\text{Economic systems}}{\longleftrightarrow} \overset{\text{Racism (etc.)}}{\longleftrightarrow} \]

“Structural determinants of the social determinants of health”
THE PROTEST PSYCHOSIS

How Schizophrenia Became a Black Disease

JONATHAN M. METZL
Author of Prozac on the Couch
Assaultive and belligerent?

Cooperation often begins with Haldol
(haloperidol)

a first choice for starting therapy

Acts promptly to control aggressive, assaultive behavior

Several studies have reported the rapid effectiveness of HALDOL (haloperidol) in controlling dangerous and dangerously assaultive behavior. "Even the number of violence awards submitted by a group of criminal psychiatrists--"resistant to maximal doses of phenothiazines"--was reduced substantially during treatment with Haldol. "Symptoms can be achieved rapidly; frequently within a few hours when the intramuscular form is used for initial control of acutely disturbed psychotic states."

Usually leaves patients relatively alert and responsive

Although some instances of movementlessness have been observed, marked sedation with HALDOL (haloperidol) is rare. In a report on a study with criminal psychotics the investigator states, "The patients remained alert and more amenable to psychiatric therapeutic intervention." Another investigator reports that HALDOL "normalized" behavior and produces a sensitivity to the environment that allows for more effective use of the social milieu and the therapeutic community.

Reduces risk of serious adverse reactions

HALDOL (haloperidol), a butyrophenone, avoids or minimizes most of the problems associated with the phenothiazines. Hypotension is rare and severe orthostatic hypotension has not been reported. There is also less likelihood of adverse reactions such as liver damage, cerebellar changes, serious hyponatremic reactions and skin rashes. The most frequent side effects of HALDOL (haloperidol)--extrapyramidal symptoms—are usually dose-related and readily controlled.


No information relating to Indications, Contraindications, Warnings, Precautions and Adverse Reactions, please turn page.

Haldol Laboratories, Inc. 1976.

Figure 2. 1974 Haldol advertisement, Archives of General Psychiatry [41]. American Medical Association Journal of Ethics September 2014, Volume 16, Number 9: 674-690.
Structural competency: Theorizing a new medical engagement with stigma and inequality

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Buprenorphine and methadone treatment for opioid dependence by income, ethnicity and race of neighborhoods in New York City

Helena Hansen, Carole Siegel, Joseph Wanderling, and Danae DiRocco

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White opioids: Pharmaceutical race and the war on drugs that wasn’t

Julie Netherland and Helena Hansen
Virtual Mentor
American Medical Association Journal of Ethics
September 2014, Volume 16, Number 9: 674-690.

FROM VIRTUAL MENTOR SPECIAL CONTRIBUTORS
Structural Competency Meets Structural Racism: Race, Politics, and the
Structure of Medical Knowledge
Jonathan M. Metzl, MD, PhD, and Dorothy E. Roberts, JD

Dorothy Roberts:
The problem with race-based medicine
TEDMED 2015 - 14:36 - Filmed Nov 2015

10 subtitle languages
View interactive transcript
A New Way to Fight Health Disparities?

To fight health inequality, researchers say we need to look at health--things like poverty, housing, employment and stress.

Miriam Zoila Pérez | JUL 15, 2014 7:00AM EDT

Academic Medicine: Post Author Corrections: July 12, 2016
doi: 10.1097/ACM.0000000000001264
Perspective PDF Only

Structural Vulnerability: Operationalizing the Concept to Address Health Disparities in Clinical Care.

Perspective

Structural Racism and Supporting Black Lives — The Role of Health Professionals

Racism impacts the healthcare system.
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.”

– Farmer et al. 2006
The risk that an individual experiences as a result of structural violence – including their location in multiple socioeconomic hierarchies. Structural vulnerability is not caused by, nor can it be repaired solely by, individual agency or behaviors.
Case

Patient is a 37 year-old Mexican male found down with ALOC. PMH: Frequent flyer well known to the ED for EtOH-related trauma, withdrawal associated with seizures. PSH: R orbital fracture 2/2 assault w/o operative intervention. SH: Heavy EtOH use, other habits unknown. Apparently homeless. Meds: currently noncompliant with all meds, D/C’ed after last hospitalization on folate, thiamine, multivitamin, and seizure prophylaxis. Neuro/MS: pt. muttering incoherently in Spanish, directable, able to answer “yes/no” consistently and follow simple commands.
Begins Drinking More Heavily

Can’t Pay Rent, Moves to Street

Injury, Can’t Work

Can’t Pay Rent, Moves to Street

In Emergency Department After Found on the Street

Begins Working as Day Laborer

Moves to San Francisco

Influx of Cheap US Corn; Can’t Make a Living

4th Generation Corn Farmer in Oaxaca

Standard Medical History & Default Provider Interpretation

Gets Assaulted
In Emergency Department After Found on the Street

Punitive US immigration Policy/Discrimination

Begins Working as Day Laborer

Injurious, Can’t Work

No Health Insurance (excluded from ACA)

Can’t Pay Rent, Moves to Street

Influx of Cheap US Corn; Can’t Make a Living

4th Generation Corn Farmer in Oaxaca

North American Free Trade Agreement (NAFTA)

Systematic marginalization of and violence against indigenous communities in S. Mexico

Racialized low-wage labor markets

Move to San Francisco
The sometimes subtle, sometimes explicit, ways in which structural violence is erased and elided by claims of cultural difference, genetic variance, behavioral shortcomings, or racial categories.

Labeling language: “Went AWOL” “Noncompliant” “Lost to follow-up” “Frequent flyer”

The “Culture of Poverty” (usually applied to poor communities of color): predetermined poor health and premature mortality

“Risk factors” as decontextualized, objective, apolitical realities. Risk is viewed as what people or communities have, not as what societies and social policies produce
Think of a clinical situation that you have encountered in which structural violence was playing a role in chronic non-cancer pain management.

What were the structural factors?
How did you recognize the role of structural violence?
[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.

–Metzl and Hansen 2014
Levels of Intervention

1. Intrapersonal
2. Interpersonal
3. Clinic
4. Community
5. Research
6. Policy
The work of structural competency

- Identifying **key social determinants of health** that should be the focus of clinical intervention
- Training medical practitioners to **implement structural interventions**
- Clinical partnerships with **community organizations** and health relevant sectors/agencies to design interventions.
- Enhancing the role of medical practitioners in **crafting public policy**

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https://structuralcompetency.org/