Structural Competency and Pain Management

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UCSF

CSAM Pain Day
September 20, 2017

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

Marmot, M. et al. (2008). Closing the gap in a generation: health equity through social action on the social determinants of health. *Lancet, 372*, 1661-1669.

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

- Ceasar R, Chang J, Zamora K, Hurshak, E. Kushel, M. Miaskowski, C, Knight, KR. Primary Care Providers' Experiences with Urine Toxicology Tests to Manage Prescription Opioid Misuse and Substance Use Among Chronic Non-Cancer Pain Patients in Safety Net Healthcare Settings. *Substance Abuse.* 2016. Jan-Mar; 37(1):154-60.

- Chang J, Kushel M, Miaskowski C, Ceasar R, Zamora K, Hurstak E, Knight, KR. Provider Experiences With the Identification, Management, and Treatment of Co-occurring Chronic Non-cancer Pain and Substance Use in the Safety Net. *Substance Use and Misuse,* 2017; 52(2):251-255.

- Hurstak E, Kushel M, Chang J, Miaskowski C, Ceasar R, Zamora K, Knight, KR. The risks of opioid treatment: perspectives of primary care practitioners and patients from safety-net clinics. *Substance Abuse.*

- Knight KR, Kushel M, Chang J, Zamora K, Ceasar R, Hurshak E, Miaskowski C, Opioid pharmacovigilance: a clinical-social history of the changes in opioid prescribing for patients with co-occurring chronic non-cancer pain and substance use. 2017. *Social Science and Medicine.*

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

Marmot, M. et al. (2008). Closing the gap in a generation: health equity through social action on the social determinants of health. *Lancet, 372*, 1661-1669.

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

Structural Competency

"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

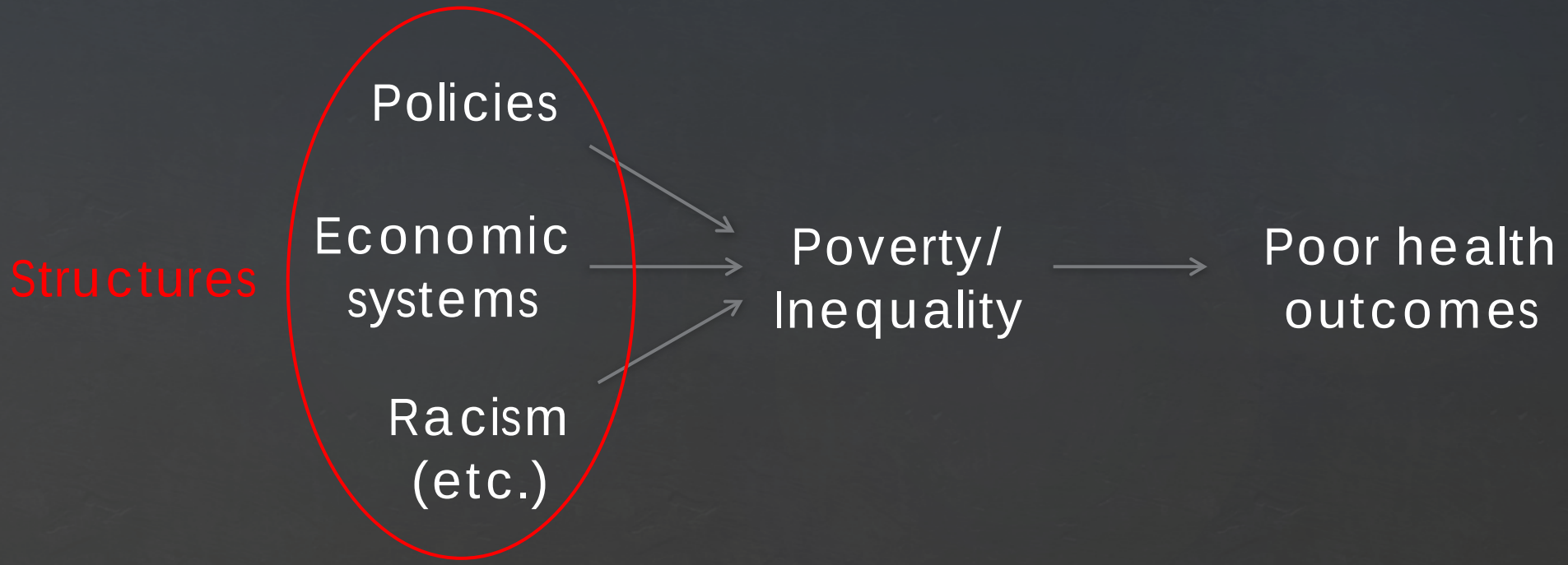
Develop trainees' capacity in the following five areas:

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



"Structural determinants of the social determinants of health"

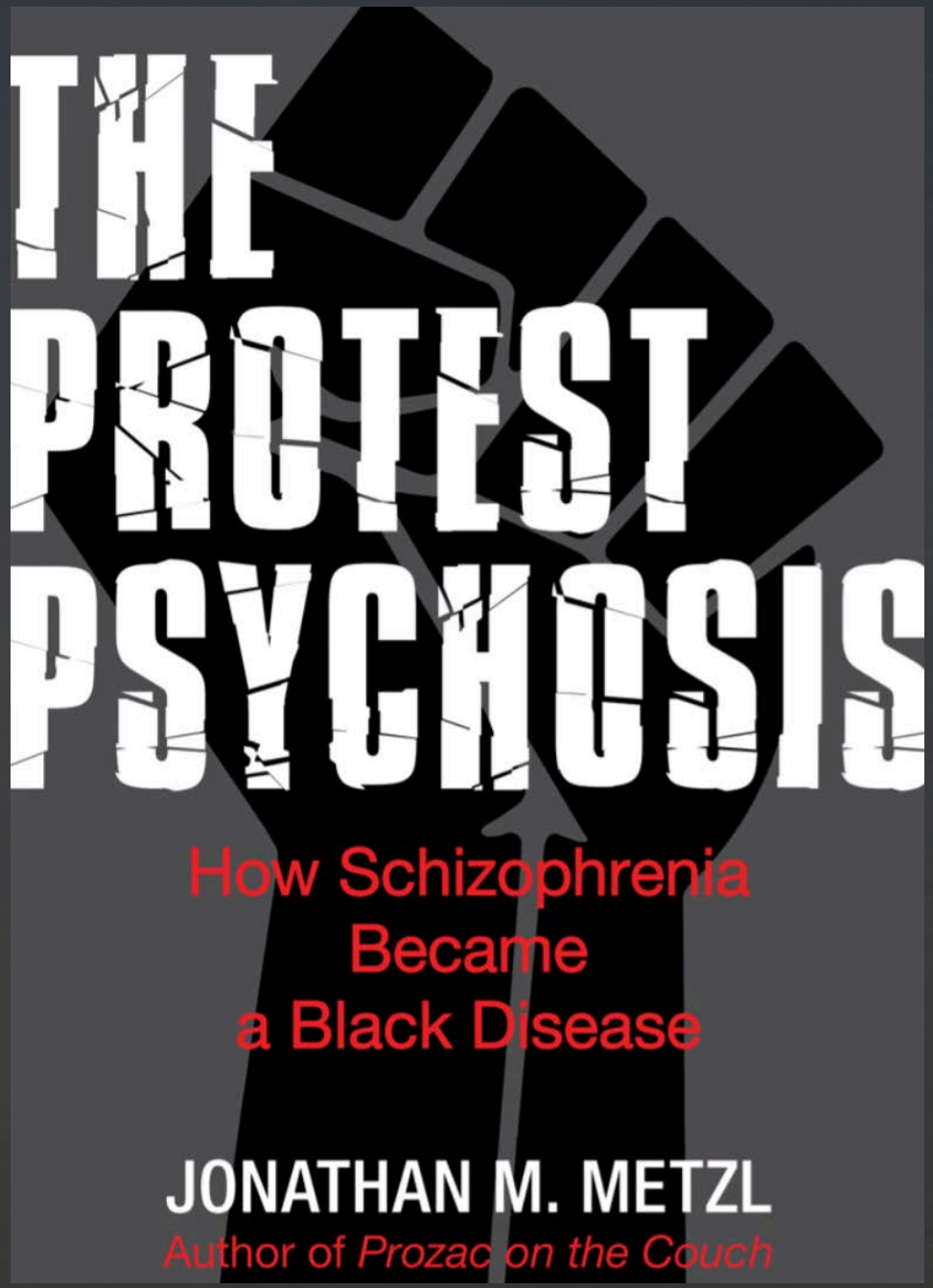

THE PROTEST PSYCHOSIS
How Schizophrenia Became a Black Disease
JONATHAN M. METZL
Author of Prozac on the Couch

Figure 2. 1974 Haldol advertisement, *Archives of General Psychiatry* [41].

American Medical Association Journal of Ethics
September 2014, Volume 16, Number 9: 674-690.

Social Science & Medicine
Volume 103, February 2014, Pages 126–133
Structural Stigma and Population Health

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

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[b] New York University, New York, NY, United States
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Is the Prescription Opioid Epidemic a White Problem?

Helena Hansen MD, PhD, and Julie Netherland PhD

HHS Public Access
Author manuscript
Drug Alcohol Depend. Author manuscript; available in PMC 2017 August 02.

Published in final edited form as:
Drug Alcohol Depend. 2016 July 01; 164: 14–21. doi:10.1016/j.drugalcdep.2016.03.028.

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

Helena Hansen[a,b,*], Carole Siegel[c], Joseph Wanderling[d], and Danae DiRocco[e]

HHS Public Access
Author manuscript
Biosocieties. Author manuscript; available in PMC 2017 July 07.

Published in final edited form as:
Biosocieties. 2017 June ; 12(2): 217–238. doi:10.1057/biosoc.2015.46.

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

Julie Netherland[a] and Helena Hansen[b,c,*]

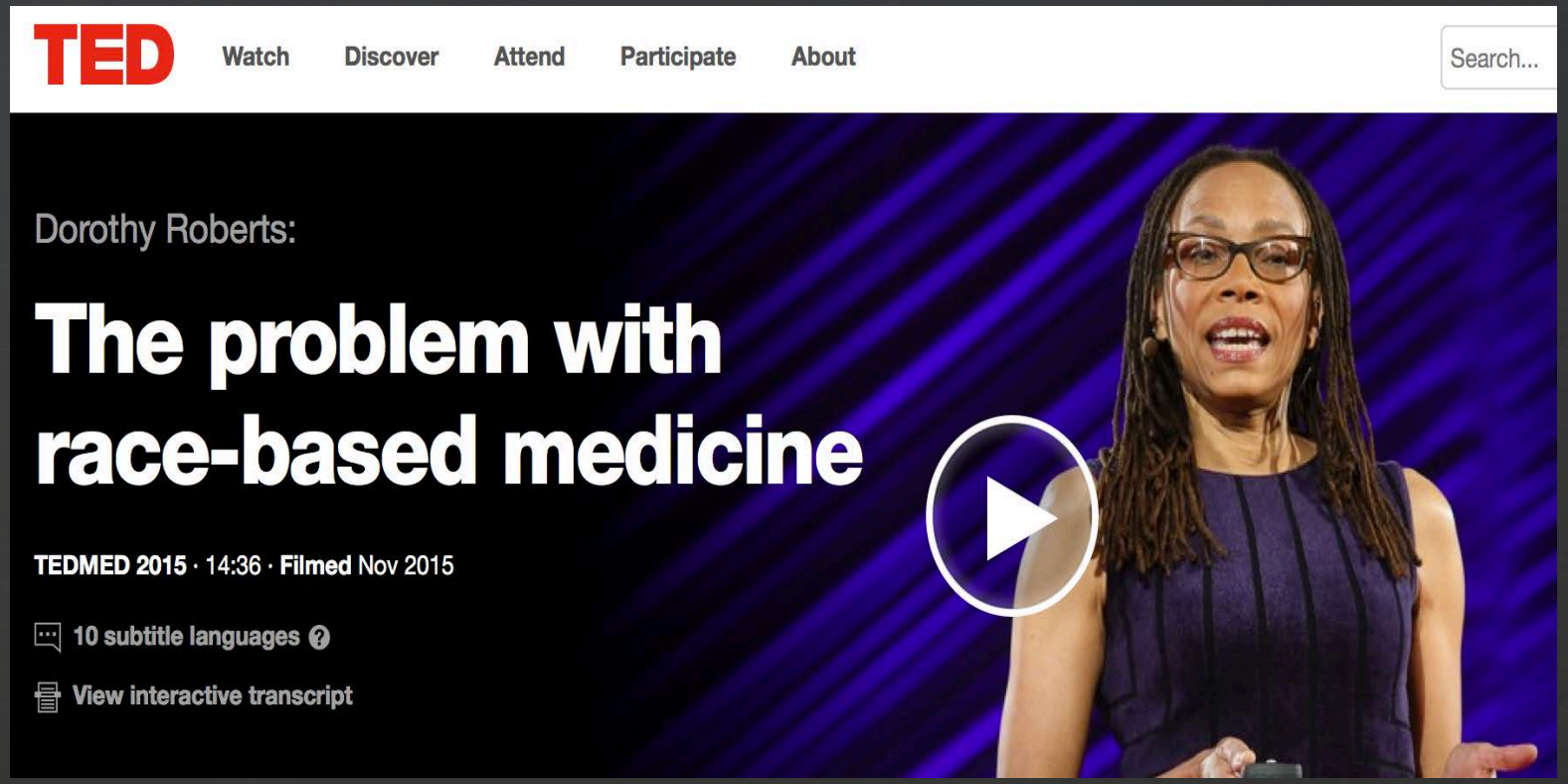
Virtual Mentor

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



Teaching Structure: A Qualitative Evaluation of a Structural Competency Training for Resident Physicians

Joshua Neff, MS[1], Kelly R. Knight, PhD[2], Shannon Satterwhite, BA[3,4], Nick Nelson, MBBS[5,6], Jenifer Matthews, MD[7], and Seth M. Holmes, MD, PhD[1,2,3,4,5,8,9]

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Academic Medicine:
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Perspective: PDF Only

Remembering Freddie Gray: Medical Education for Social Justice.

Wear, Delese PhD; Zarconi, Joseph MD; Aultman, Julie M. PhD; Chyatte, Michelle R. DrPH, MPH; Kumagai, Arno K. MD

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Dealing with Racist Patients

Kimani Paul-Emile, J.D., Ph.D., Alexander K. Smith, M.D., M.P.H., Bernard Lo, M.D., and Alicia Fernández, M.D.
N Engl J Med 2016; 374:708-711 | February 25, 2016 | DOI: 10.1056/NEJMp1514939

Comments open through March 2, 2016

A New Way to Fight Health Disparities?

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

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

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Academic Medicine:
Post Author Corrections: July 12, 2016
doi: 10.1097/ACM.0000000000001294
Perspective: PDF Only

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

Bourgois, Philippe PhD; Holmes, Seth M. MD, PhD; Sue, Kim MD, PhD; Quesada, James PhD

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Perspective

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

Rachel R. Hardeman, Ph.D., M.P.H., Eduardo M. Medina, M.D., M.P.H., and Katy B. Kozhimannil, Ph.D., M.P.A.
October 12, 2016 | DOI: 10.1056/NEJMp1609535

Comments open through October 19, 2016

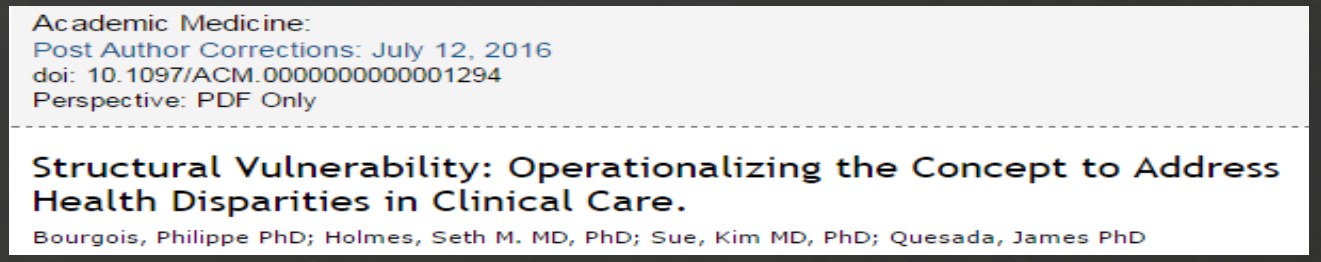
Key Term: Structural Violence

"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."

– Farmer et al. 2006

Key Term: Structural Vulnerability

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.

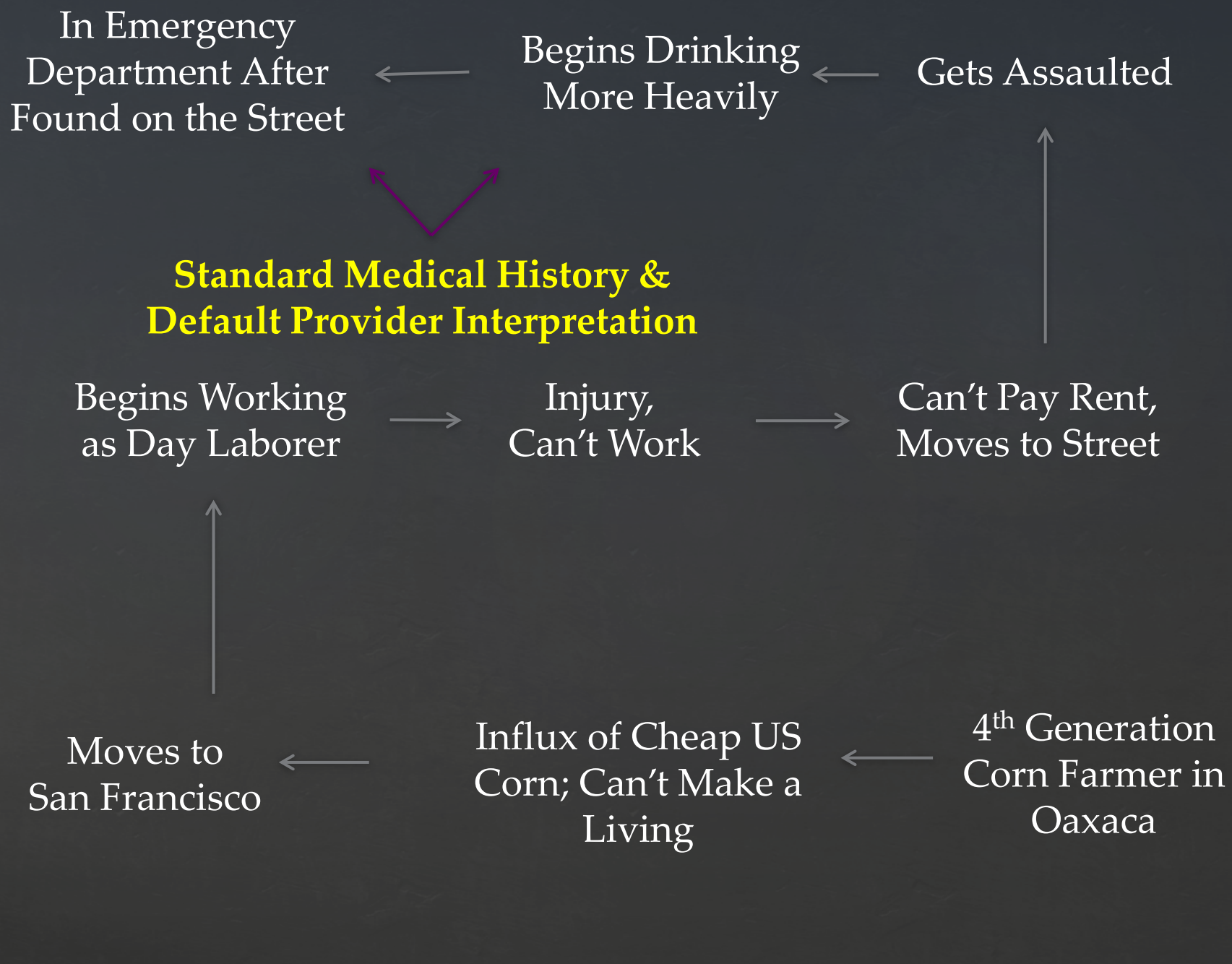
PMH: Frequent flyer well known to the ED for EtOH-related trauma, withdrawal associated with seizures

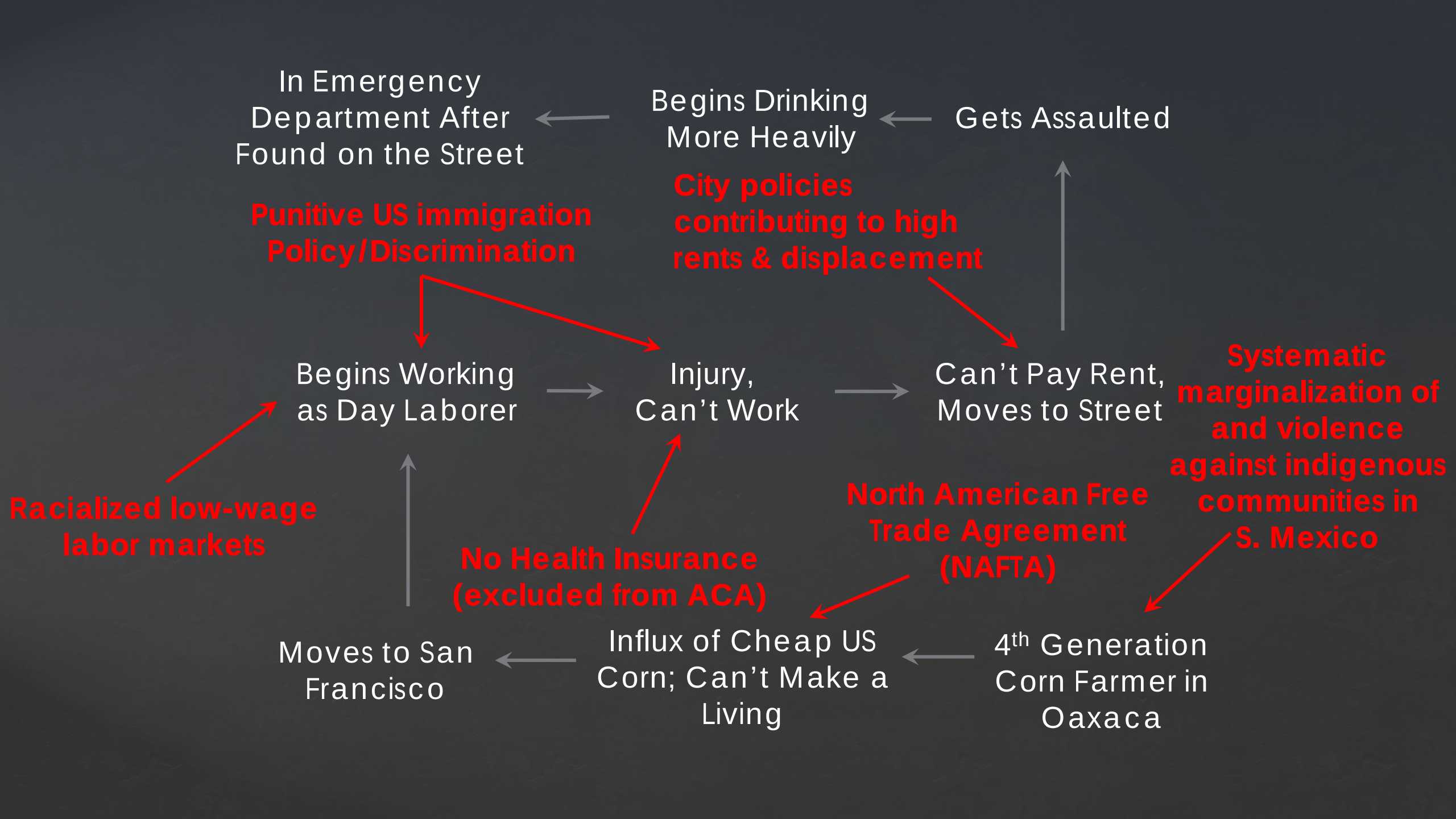
PSH: R orbital fracture 2/2 assault w/o operative intervention

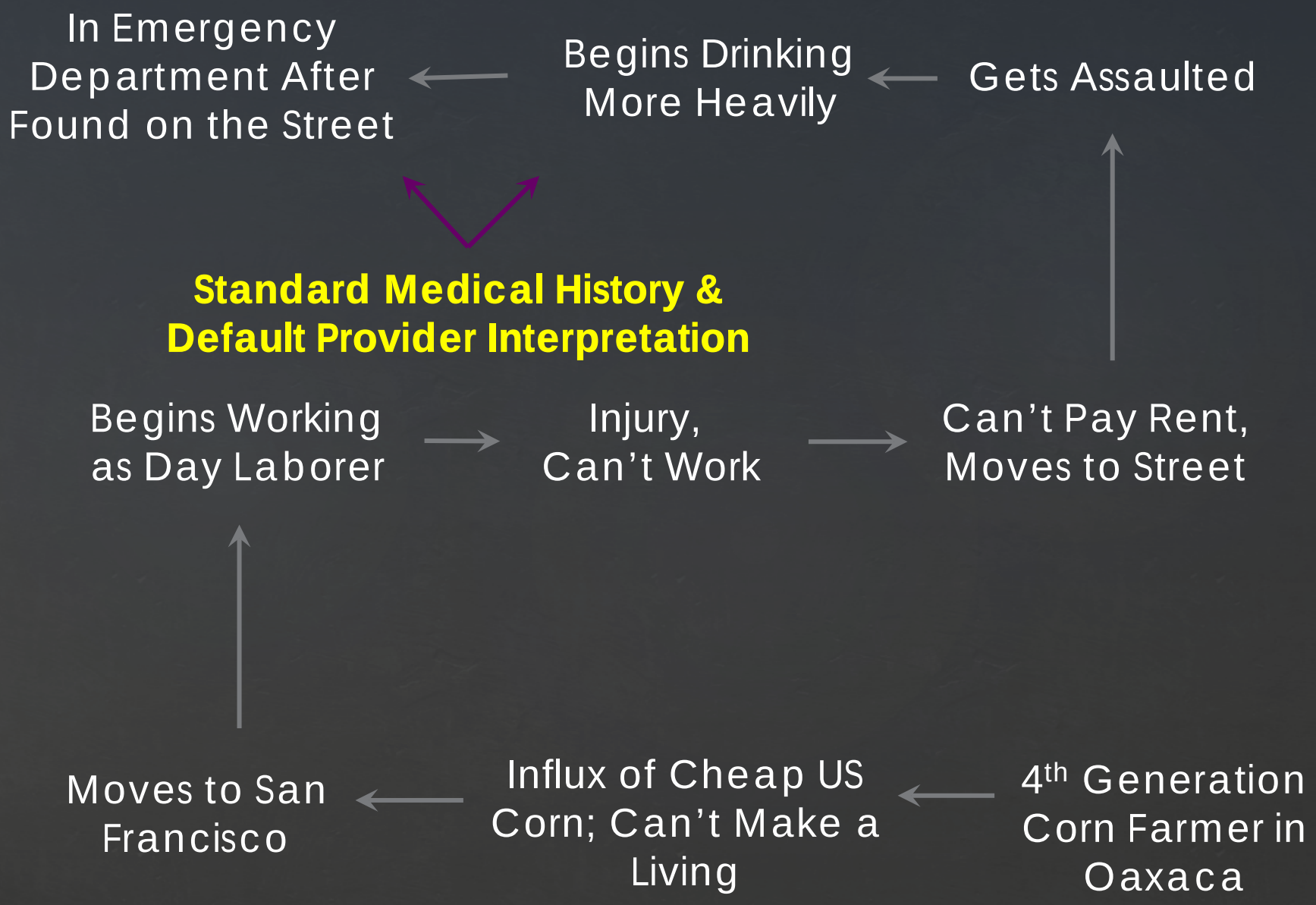
SH: Heavy EtOH use, other habits unknown. Apparently homeless

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


In Emergency Department After Found on the Street
Begins Drinking More Heavily
Gets Assaulted
Standard Medical History & Default Provider Interpretation
Begins Working as Day Laborer
Injury, Can't Work
Can't Pay Rent, Moves to Street
Moves to San Francisco
Influx of Cheap US Corn; Can't Make a Living
4th Generation Corn Farmer in Oaxaca


In Emergency Department After Found on the Street
Begins Drinking More Heavily
Gets Assaulted
Punitive US immigration Policy/Discrimination
City policies contributing to high rents & displacement
Begins Working as Day Laborer
Injury, Can't Work
Can't Pay Rent, Moves to Street
Systematic marginalization of and violence against indigenous communities in S. Mexico
Racialized low-wage labor markets
North American Free Trade Agreement (NAFTA)
No Health Insurance (excluded from ACA)
Moves to San Francisco
Influx of Cheap US Corn; Can't Make a Living
4th Generation Corn Farmer in Oaxaca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In Emergency Department After Found on the Street
Standard Medical History & Default Provider Interpretation

Key Term: Naturalizing Inequality

- 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

Example: structure in the clinic

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?

Key Term: Structural Humility

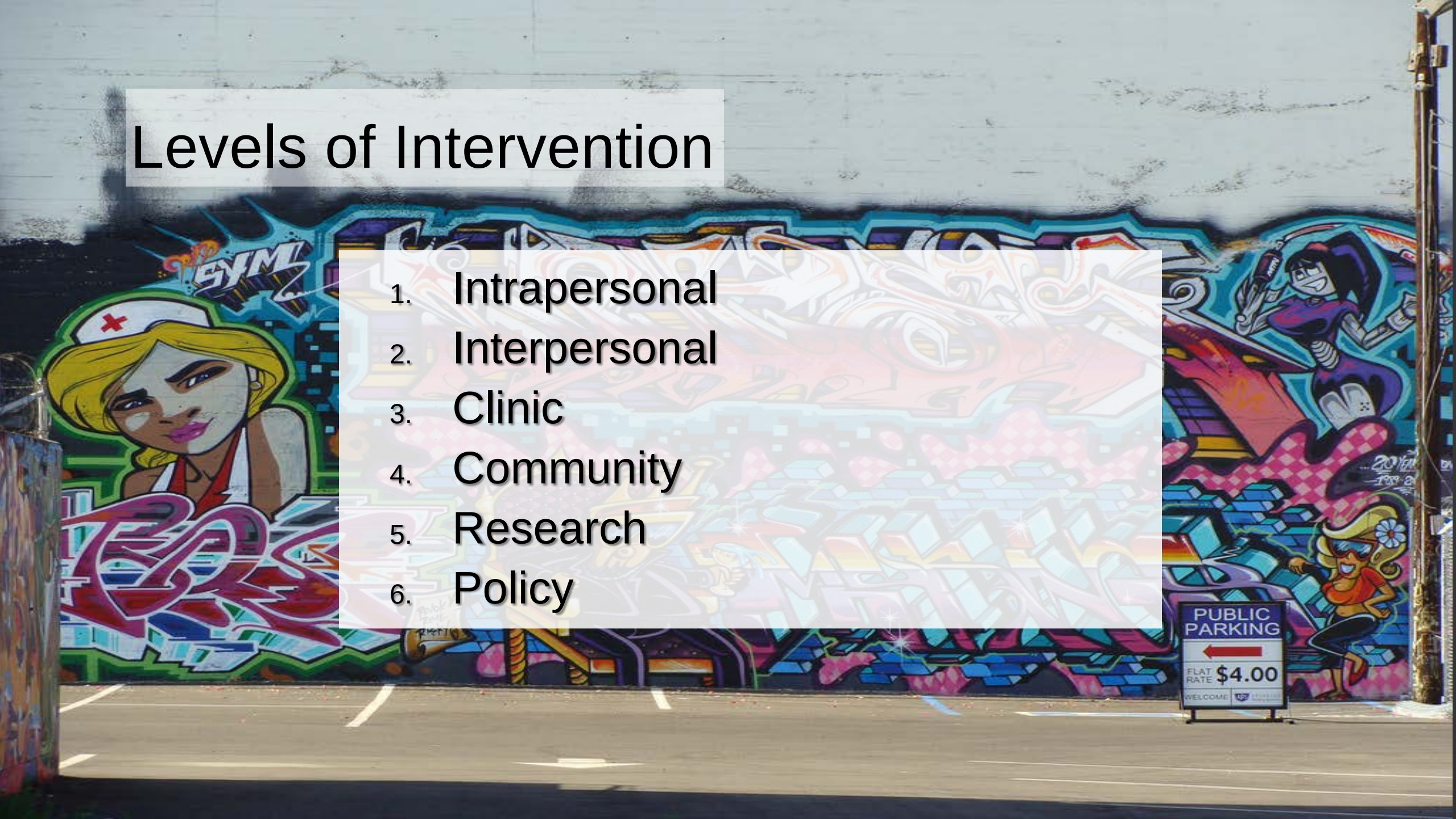
[Structural] competency seeks to promote skills, not so much for replacing awareness of "culture" in medical settings, but for recognizing how "culture" and "structure" are mutually co-implicated in producing stigma and inequality.

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

Helena Hansen. Structural Competency: New Medicine for the Inequalities that are Making us Sick. UCSF Psychiatry Grand Rounds. October, 2015.
Metzl JM, Hansen H. Structural competency: theorizing a new medical engagement with stigma and inequality. *Social Science & Medicine.* 2014;103:126-133

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