Structural Competency in Mental Health and Medicine

A Case-Based Approach to Treating the Social Determinants of Health

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The Structural Competency Working Group: Lessons from Iterative, Interdisciplinary Development of a Structural Competency Training Module

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No one has a right to work with poor people unless they have a real analysis of why people are poor.
(Barbara Major, The People's Institute for Survival and Beyond, New Orleans [1])

Building Social Analysis into Curricula for Health Professionals

Structural competency incorporates frameworks from the social sciences into clinical training. This is done in hopes of preparing clinicians to recognize and respond to the connections between social, political, and economic structures and their

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downstream effects on health and healthcare. To paraphrase the words of Barbara Major above, these frameworks can help providers develop a real analysis of the *social structures* (see definition) that make certain people poor – and thereby also more vulnerable to preventable disease, injury, and death. Similarly, social science frameworks can enable providers to recognize the structural influences on the organization and practice of healthcare. In other words, social science frameworks can help healthcare providers attend and respond to the influence of structures both within and beyond formal clinical roles.

Definition: Social Structures
The policies, economic systems, and other institutions (judicial system, schools, etc.) that have produced and maintain modern social inequities as well as health disparities, often along the lines of social categories such as race, class, gender, and sexuality

There remains much to learn, however, about how to introduce social science analysis into the training of healthcare professionals. Active questions include:

- *Who should be trained in the social analysis underpinning structural competency?* Which professionals and at which stage of their training or careers? Who tends to be most or least receptive?
- *How should such social analysis be taught?* By whom and through which pedagogic techniques? How much curricular time is necessary to make a meaningful and lasting contribution to participants' thinking and practice?
- *What content should be included?* Of the wide array of social science literature and other relevant content available, what should be emphasized within structural competency?

Since 2014, the Structural Competency Working Group (SCWG) – an interdisciplinary group of healthcare providers, scholars, students, and community health advocates based in the San Francisco Bay Area – has been exploring the above questions by designing, implementing, and evaluating classroom-based structural competency training modules for healthcare professionals. At the time of writing this, training had been implemented over 35 times – in a range of formats and for providers in a range of health-related disciplines (Table 1).

This chapter describes the SCWG, which includes many of the authors of this chapter, and our process through the development, refinement, adaptation, and dissemination of our structural competency training. We also share lessons learned thus far from our efforts to operationalize structural competency training for healthcare professionals. These include the value of practicing "impractical" thinking; the importance of iterative, interdisciplinary collaboration; the necessity to make

Table 1 SCWG structural competency training sites[a]

SCWG structural competency training sites
Alameda Health System (Highland Hospital) Internal Medicine Residency (3x)
Contra Costa Family Medicine Residency
HEART-IM Clerkship – University of New Mexico School of Medicine (2x)
MiMentor (pre-health undergraduates)
Oregon Health Sciences University (4x)
Prep Medico (pre-health undergraduates)
Samuel Merritt University School of Nursing (2x)
Santa Rosa Family Medicine Residency
Society for Teachers of Family Medicine
UC Berkeley School of Public Health (2x)
UC Berkeley-UCSF Joint Medical Program (4x)
UCSF Benioff Children's Hospital Oakland – pediatric residents
UCSF Benioff Children's Hospital Oakland – social work trainees (3x)
UCSF Department of Physical Therapy and Rehabilitation Science
UCSF Global Health Master's Program
UCSF HEAL Initiative Global Health Fellowship (4x)
UCSF Internal Medicine Residency Primary Care Program at San Francisco General Hospital (SFPC)
UCSF School of Medicine – 1st year students (3x)
UCSF School of Nursing – Masters Entry Program in Nursing (nurse practitioner) students

[a]As of writing in summer 2018

content "sticky" and balance pedagogic approaches; the benefits of feedback-driven pedagogic development; and strategies for adapting and disseminating structural competency for diverse audiences.

Theoretical Framework: Practicing "Impractical" Thinking

The SCWG grew out of an initiative called Envisioning Radical Experiments in Clinical Medicine, or "Rad Med." Rad Med originally consisted of two working groups: one focused on medical education and the other focused on the intersection of mental health, policing, and incarceration. Rad Med's medical education group, which evolved into the Structural Competency Working Group, aimed to introduce social science-informed critical perspectives into medical education and clinical practice. Meeting for two hours every other week, we started by reading and discussing relevant articles and book chapters – e.g., Geiger [2], Holmes and Ponte [3], Metzl and Hansen [4], Pine [5], and Rivkin-Fish [6]. Through these readings and discussions, we settled on structural competency as a useful guiding framework for our efforts.

Over our first semester, MD/anthropology PhD student Sam Dubal introduced a number of imaginative proposals designed to push clinical practice to confront

unjust social, political, and economic structures. For instance, he created sample "radical" medical histories incorporating structural and symbolic factors that lead to sickness, as well as corresponding structural "prescriptions" that could be offered by clinicians in a structurally responsive medicine. Such creative exercises helped us establish, as a core orientation for our group and our training efforts, a commitment to giving ourselves and others permission to think, as physician-anthropologist Seth Holmes put it, "impractically" as well as "practically" when considering interventions in medical training and practice. Our goal in highlighting that which at first appears impractical was to avoid constraining our imaginations with received notions of what is possible – which we felt could lead us to set our sights too low and stifle "out-of-the-box" thinking. We hoped to shake some of our inurement to the status quo by keeping in view our most ambitious hopes for medical practice and training – and for society at large.

As the semester continued, we decided to focus on developing our first structural competency training. Seth Holmes and MD/MS student Josh Neff began discussions with a family medicine residency program about conducting this session with their residents. Ultimately, we arranged to run a three hour training for their cohort of interns, at the end of their first year of residency, in June 2015. We decided also to prepare a similar training for the program's core faculty, informed by literature suggesting that faculty who receive ongoing education in parallel to their trainees can better reinforce (rather than contradict) trainees' learning [7–10].

The Path: Iterative, Interdisciplinary Collaboration

With our pilot training approaching in early summer, our group worked steadily through winter and spring 2015 to develop a classroom-based structural competency training module that would be relevant, compelling, and impactful for family medicine residents and faculty.

During our twice-monthly meetings, we brainstormed what to include in the training. Informed by these discussions, in the weeks between meetings, Josh Neff – whose medical anthropology master's project focused on the development, implementation, and evaluation of this training – worked to generate training materials. At the following meeting, Josh would present to the group what he had developed; based on this, the group offered feedback and brainstormed next steps, which would once again guide Josh's efforts until the next meeting. Group members' diverse experience was essential to this process. Having clinicians, social science scholars, administrators, activists, students, and patients collaborating together – in real-time, in person – yielded ideas and approaches for training that we otherwise could never have developed. This interdisciplinary group composition, enabled in part by members' involvement in various academic settings, was cultivated by proactively striving to broaden the variety of backgrounds and perspectives of those involved in the group.

Week by week, piece by piece, the training took shape. We decided to organize the training into three main sections:

1. How structures affect patient health
2. How structures affect the practice of healthcare
3. Strategies for responding to structures in and beyond the clinic

In all three sections, we planned to emphasize the importance of *structural humility* (see definition). The content of the training and key aspects of our process are described in the following section.

Definition: Structural Humility
Coined by Metzl and Hansen [4], structural humility highlights the importance of respecting and deferring to the knowledge of patients and communities, rather than only or primarily considering the knowledge of the health "expert." It also encourages clinicians to follow the lead of patients and communities in developing appropriate, sustainable interventions to address harmful social structures.

Developing the Training: Making Content "Sticky" and Balancing Pedagogic Approaches

As we developed the various components of the training, we were guided by a few core intentions. First, we did not only want to interest or persuade participants – we wanted the core themes of our training to stay with them long afterward. As some of us came to say, we wanted to make sure that the training was "sticky." We pushed ourselves to think creatively about how we could present the material to facilitate this. In support of this effort, we also wanted to make sure the various components of training were clear and cohesive, with key themes reiterated throughout the session. And we knew it would be important to strike a balance between reflection, discussion, and didactics. Too much time spent on didactics and learners would not have a chance to process and integrate the material, and their attention would wane. Conversely, a brief session with no didactics at all would be unlikely to offer novel frameworks and perspectives.

Early in our process of creating the training, we wrestled with how we could succinctly and memorably illustrate the concept of social structures (definition above) and the impact of structures on patient health. These conversations prompted Josh Neff to develop a diagram – revealed incrementally in an animated slide – that illustrates how one patient's life course and health are influenced by large-scale social, political, and economic structures (Fig. 1). These simple animated diagrams, which

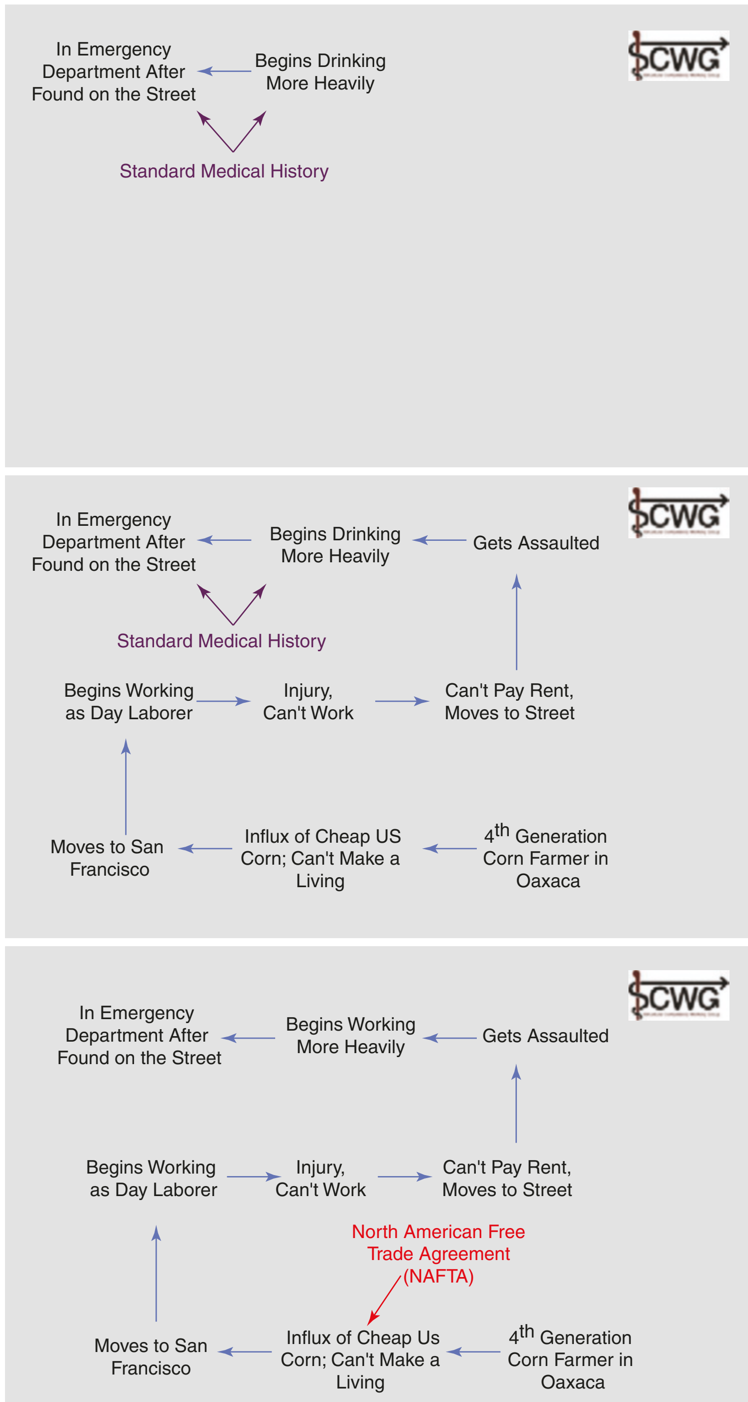

Fig. 1 Patient arrow diagram

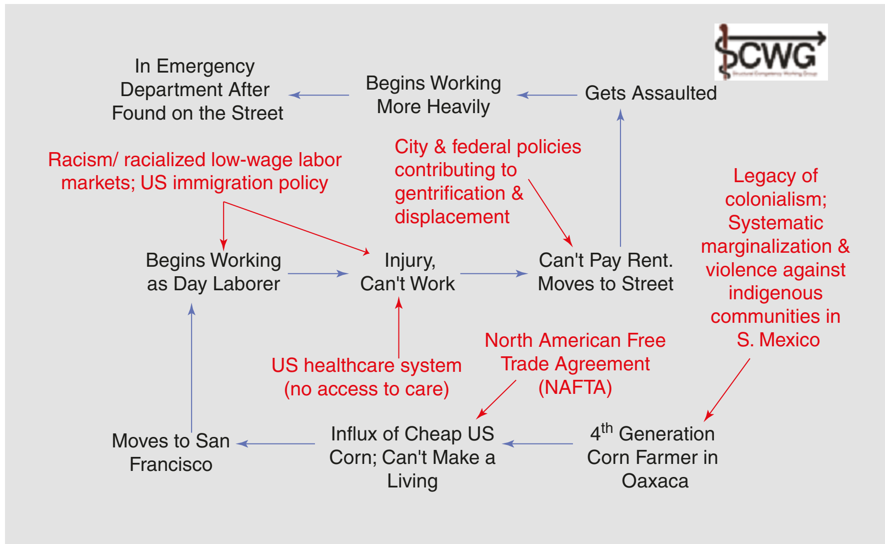

Fig. 1 (continued)

we came to call "arrow diagrams," have since become a core pedagogic tool of our trainings.

This original arrow diagram – based on a case from the ethnographic work of James Quesada [11] – sketches the trajectory of an indigenous Mexican corn farmer who is unable to make a living due to an influx of cheap American corn. He immigrates to California looking for work, where he finds intermittent employment as a day laborer. However, he gets injured on the job. This injury prevents him from working, which means he can no longer pay rent. He starts sleeping on the street and while doing so is assaulted several times. This ongoing trauma triggers increased alcohol consumption, which eventually leads to his arrival in the emergency room.

The slides start with the pieces of this man's history most often discussed in clinical settings – that he needed medical care after losing consciousness secondary to heavy alcohol use. Facilitators then walk through the above-described life course step-by-step, starting with his background as a corn farmer. After tracing his story, structures that likely influenced his trajectory are shown in red.

Based on this slide, internal medicine physician Nick Nelson wrote up a sample chart note for such a patient for participants to read and discuss prior to our sharing this slide and the patient's trajectory (see Appendix A). Our hope in this activity was to interest and prime participants to engage with the arrow diagram. We intended the arrow diagram, in turn, to help us introduce and define the key concepts of *structural violence* and *structural vulnerability* (see definitions) [12–15]. In order to balance didactic and interactive portions and to give residents a chance to apply these concepts, we decided to then ask them to share examples of structural violence and structural vulnerability they had witnessed, in the clinic or otherwise.

Definition: 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 [12].

Definition: 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.

In addition to discussing the ways in which structures affect health, we felt it essential to highlight how structural influences are often overlooked. Specifically, we wanted to offer participants language for discussing ideology, internalized and often implicit, that can habituate us to look for individual and "cultural" level explanations for poor health outcomes – often overlooking the structural determinants of harm in the process. We decided to introduce this concept in terms of "naturalizing inequality" (see definition) [13, 16–18]. Again we planned time for residents to reflect on and share how they had observed inequality being naturalized in their clinical and personal experience.

Definition: Naturalizing Inequality

When inequality and structural violence are justified by, or go unacknowledged due to, nonstructural explanations for structurally mediated harms/inequities. These nonstructural explanations – which often emphasize individual behaviors, "cultural" characteristics, or biologized racial categories – help preserve social inequities by giving the impression that the status quo is "natural," in the sense of not being primarily social or structural in origin.

Table 2 Structural competency training learning objectives

Learning objectives
1. Identify the influences of structures on patient health
2. Identify the influences of structures on the practice of healthcare
3. Generate strategies to respond to the influences of structures in the clinic
4. Generate strategies to respond to structural influences beyond the clinic
5. Describe structural humility as an approach to apply in and beyond the clinic

We set aside the last portion of section 1 to define structural competency, including a discussion of our learning objectives for the session as a whole (Table 2). We also here planned to discuss briefly the relationships between structural competency and the frameworks of cultural competency and the social determinants of health (SDOH). Our key point with respect to cultural competency was that cultural frameworks – while potentially helpful in training providers to provide care cross-culturally – are not well suited to analyzing health disparities that have primarily structural rather than cultural origins [4, 19, 20]. As for SDOH compared to structural competency, we first of all noted that SDOH is a broad umbrella that sometimes includes a structural analysis – including in the work of those who framed the term [21–23]. We observed, however, that curricula framed in terms of the SDOH sometimes fail to mention the various structural factors that create and maintain inequities – even as they describe the epidemiology connecting social inequity and health outcomes (Fig. 2). As a result, these curricula can inadvertently naturalize inequalities, and they generally do not discuss strategies for intervening on the structural drivers of inequalities [24–26]. To highlight this distinction, we started introducing a phrase Josh Neff had said at a meeting: “the structural determinants of the social determinants of health.”

In the second section of the training, we sought to cultivate awareness of the structures that affect the practice of healthcare. We decided to minimize didactics in this section, instead giving participants an opportunity to reflect upon the social, political, and economic structures that they had experienced as enabling or impeding their delivery of care. We also invited the participants to apply the concepts of structural violence and naturalizing inequality to their and their colleagues’ practice and trajectories – with particular attention to realities such as the stress and burnout experienced by providers due to their participation in structures of violence.

The third and final section focused on strategies for responding to structures in and beyond the clinic. Guided by our commitment to practice “impractical” thinking, we asked participants to imagine, share, and discuss both “practical” and “impractical” strategies for addressing harmful structural influences on health and healthcare. Again we felt that participants would be best served by a reflection and

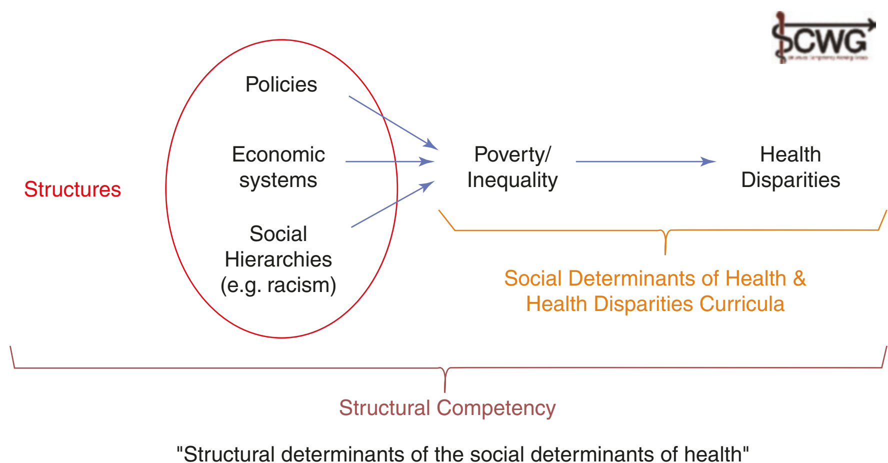

Fig. 2 Structural competency and SDOH curricula

discussion-driven approach, as this would allow them to brainstorm strategies relevant to their particular practice settings and circumstances.

Inspired in part by our literature review of related trainings, we recognized that if discussions about structural and other societal issues focus too heavily on describing problems and too little on ways to address them, participants would be more likely to feel discouraged and disempowered [27–29]. With this in mind, we decided to close the training on a hopeful note, emphasizing the possibility of structural change through collective work – including the California Nursing Association's successful campaign to cap nursing ratios in California, which has been shown to benefit patients as well as nurses [30, 31].

With the resident training thus laid out, our last step was to prepare a shorter version of the training for faculty, who had only two hours available. We wanted to make sure that the faculty were familiar with the range of material we covered with residents, so we shortened the training's interactive portions.

Implementation and Evaluation: Identifying Strengths and Weaknesses

The resident and faculty training were implemented in June 2015. We felt these went smoothly, and residents and faculty appeared to be engaged throughout their respective sessions. In post-training written-response surveys, both residents and faculty provided predominantly positive feedback – some emphatically so – along with a number of critiques and helpful suggestions for how the training could be improved. For a sample of residents' responses, see our article in the Journal of General Internal Medicine in 2017 [32].

Following these sessions, Josh Neff analyzed participant surveys and conducted a focus group with residents one month post-training, to learn more about their perspectives after they had returned to clinic and to find out how "sticky" the training had in fact been. Our expectation in anticipation of this focus group was that the residents would still generally feel positively about the session. However, we also expected that, with the passage of a month's time and the many demands of residency, our session would have faded from the forefront of their minds.

To our surprise, we found that, to the contrary, the training was still very much on residents' minds. The residents in attendance – all those not on call or on vacation – highlighted that they were "thinking about it constantly." Some said this awareness was influencing how they related to patients – as one resident put it, "It has been very effective in helping to build a partnership with patients." They also commented that having a "shared vocabulary" with one another made it "a lot easier to talk about" structural influences on health.

Many residents, however, also reported that their heightened awareness of the structural influences on health was leading to a sense of distress. They said that the extent and seeming immutability of this influence was discouraging when they encountered structures harming their patients' lives. This sentiment was particularly acute, they reported, because they already felt overwhelmed by how little time they had with patients and how much medicine they still needed to learn. Despite this experience, they advocated unanimously for the expansion of structural competency

training. Again, see Neff et al. for resident quotes and further discussion of the evaluation of our pilot effort [32].

Three specific suggestions for future structural competency education efforts emerged from this conversation. First, the residents recommended providing more examples of how healthcare providers have responded to structural issues. They appreciated space and time to brainstorm responses, but they wanted to hear more about past and current efforts to address harmful structures and work toward positive social change. Second, they recommended including structural competency during earlier stages of training, before trainees are expected to efficiently manage the many demands of providing patient care. As one resident put it, "It would be good to develop tools before… you need them in 10 minutes." Third, they recommended expanding structural competency training into a more in-depth, longitudinal curriculum.

From Key Learnings to Revisions: Feedback-Driven Pedagogic Development

Based on evaluations and our observations from our pilot effort, in the fall of 2015, we worked to improve the training. First and foremost, we wanted to address the extent of the distress described by residents. We felt that incorporating more examples of providers' responses to harmful structures, as suggested by the residents, would be necessary toward this end. We thought, however, that this might not be sufficient – that it would be important also to normalize a range of possible responses, recognizing that many feel some level of distress when reflecting on injustice – and that this is a potentially appropriate response. Additionally, we suspected that some of the discomfort experienced by residents was related to the fact that people who choose to go into clinical healthcare frequently have action and outcome-oriented dispositions (several authors included). There is a tendency for providers to want, and perhaps to some extent expect, to be able to fix problems. This orientation can make it uncomfortable to discuss challenges – such as trying to change unjust social structures – that cannot be addressed primarily through individual effort or on a predictable timeframe.

We also felt it important to develop further the second section of the training, which addresses the structural influences on the practice of healthcare. First, we noticed that this section was not much emphasized by participants in our evaluations, which led us to believe there was room to make this section "stickier." Second, we thought it important to enhance this section to the extent that residents' distress was connected to structural factors influencing their delivery of care – for instance, the fact that they felt they already had too much to do in too little time. Though we did not believe that a greater focus on the structural influences on healthcare practice would alleviate distress in and of itself, we felt it important for them to keep in view the structural determinants of these experiences of distress and overwhelm.

In response to the residents' experience and suggestions, we created several new components of section 3. First, led by pediatrician Jen Matthews, anthropologist Kelly Knight, MD/anthropology PhD students Shannon Satterwhite and Laura G. Duncan, and Josh Neff, we developed the "levels of intervention" activity, to help trainees recognize the different levels of potential engagement (Table 3). In this activity, participants are divided into groups, and each group is asked to brainstorm

possible responses to structural violence at a particular level. Groups then share what they considered, and we lead a discussion of the interconnections of the levels as well as the possibility of engaging in different levels over time. Prior evaluations had suggested that some participants had concluded that structural competency implies they should become directly involved in policy-level work; we hoped that this exercise would help address participant distress by making clear our view that there are various scales at which providers can beneficially act based on their recognition of the harms caused by large-scale structures.

Also in response to trainee distress in the first iterations, we prepared a range of examples of provider responses to structural issues at various levels, both historical and contemporary. The examples ranged from historical examples such as the Black Panther Party's People's Free Health Clinics and the Delta Health Center in Mississippi – and the legacies of each – to more recent examples including ACT-UP's housing activism for AIDS patients and the California Nurses Association's influence on state healthcare policy [2, 30, 33, 34].

We closed section 3 of the training with Shirley Strong, Chief Diversity Officer at Samuel Merritt University, presenting her definition of the "Beloved Community" (see definition). In our group meetings, Shirley had discussed the concept of Beloved Community, as articulated by Martin Luther King, Jr., as a guiding principle in her career as an advocate and activist. She noted that people trying to address harmful social structures too frequently offer critique without articulating a positive vision. Beloved Community is Shirley's guiding principle for developing such a vision.

Shirley Strong's Definition of Beloved Community
An inclusive, interconnected consciousness – based on love, justice, compassion, responsibility, shared power, and a deep respect for all people, places, and things – that radically transforms individuals and restructures institutions

We made just one major change to section 2: adding the "provider arrow diagram" (Fig. 3). This diagram returns to the case presented at the start of section 1, focusing this time on the structural influences behind the provider's trajectory over time. It follows the provider as they slide from idealism toward cynicism over their

Table 3 Levels of intervention

Levels of intervention		Example(s)
1.	Individual	Develop awareness of and work to counter one's own implicit racism/bias
2.	Interpersonal	Apply structural thinking to approach patients without blame or judgment
3.	Clinic/ institutional	Diversify staff and provide structural competency training to all staff
4.	Community	Collaborate with community members/organizations to do community organizing around affordable housing for vulnerable patients
5.	Policy	Participate in collective efforts to establish universal healthcare, reform immigration laws/practices that harm one's patients, etc.
6.	Research	Conduct research that considers the influence of structures (not only behavior/ culture/ genetics) on health and healthcare

early career. Following the model of the previous arrow diagram, the structural factors influencing the provider's trajectory are then illustrated in red. Our hope was that this parallel arrow diagram – this time illustrating the structural influences on providers (including even relatively privileged providers) – would help make this section of the training "stickier" than it seemed to be in our pilot effort.

Based on our observations and evaluations of our subsequent iterations of the training, the above additions appeared to have the intended effects. Shirley's

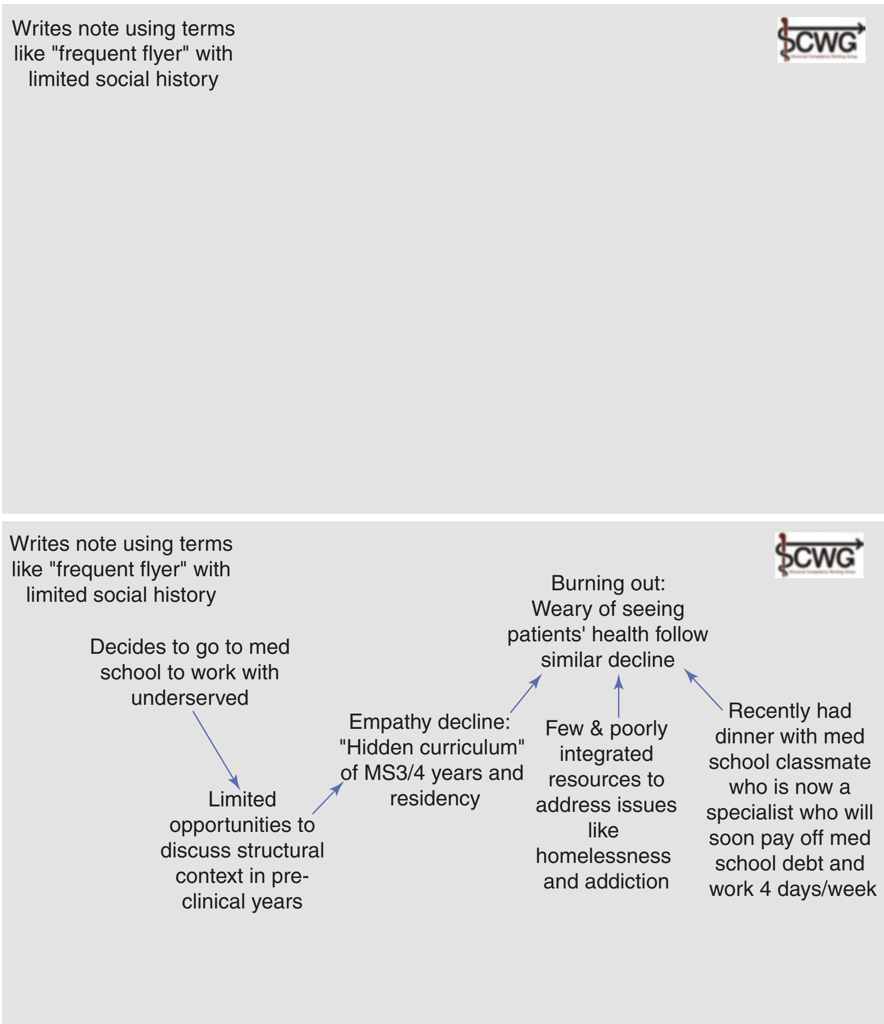

Fig. 3 Provider arrow diagram

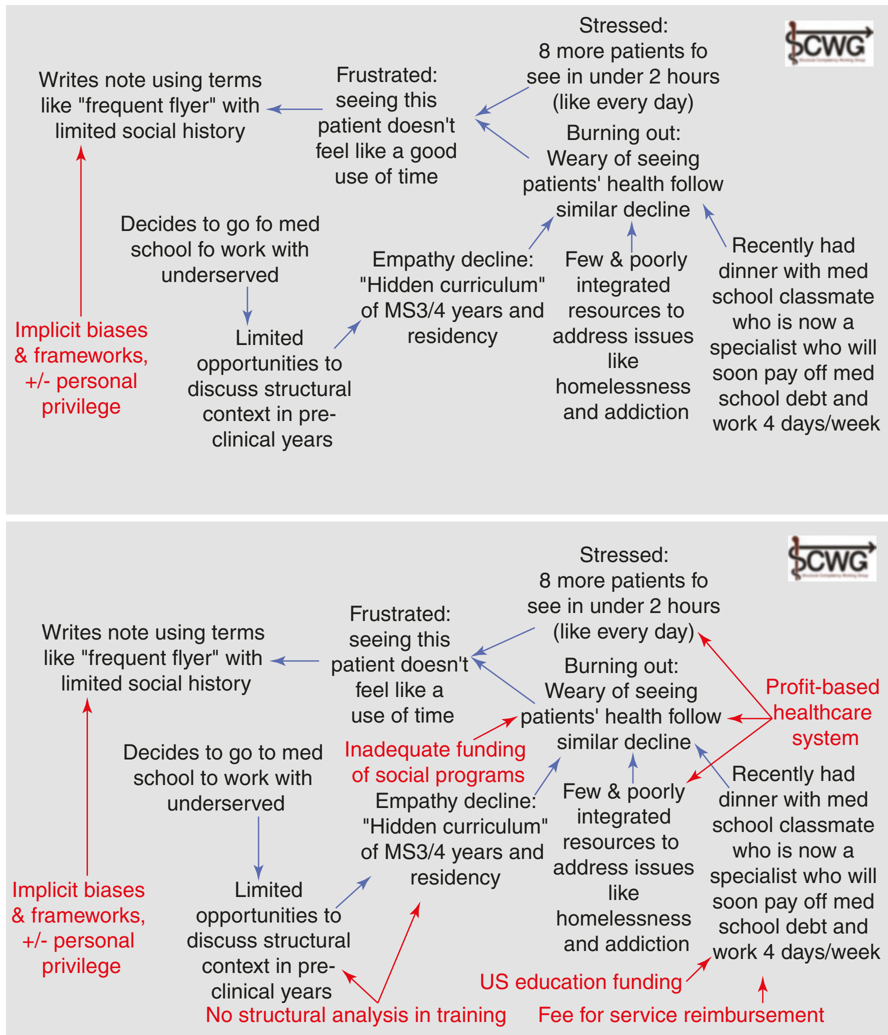

Fig. 3 (continued)

Beloved Community section and the examples of responses to structural issues were particularly popular. A number of participants commented that the "Levels of Intervention" helped them understand how they could implement structural competency into their work in the short term. And the addition of the provider arrow diagram appeared to make section two of the training "stickier" as hoped, as numerous participants commented on this diagram in post-training surveys.

Adaptation and Dissemination: Structural Competency for Diverse Audiences

In our second year, our group's experimentation and adaptation of the training for a variety of formats proliferated. See Table 1 above for a full list of training sites as of summer 2018.

In the fall of 2016 through the summer of 2017, the group focused on disseminating our training for others to utilize, adapt, and modify for their own settings. To accomplish this, we divided ourselves into subgroups. One subgroup focused on developing a training manual to provide context and training suggestions for educators and trainees who might view the training videos and introduce elements of the training to their institutions or other settings. Another subgroup explored in parallel the possibility of developing a "train the trainers" session, while a third developed a website for our group that could host the training videos, manual, and other resources.

This effort to disseminate the material raised various challenges. Aware of cultural competency's development in unintended directions – from its origins as a call for providers to recognize their cultural biases to its adoption as othering "lists of traits" to be memorized about various groups [20, 35, 36] – we wrestled with the potential for our materials and structural competency generally to be misunderstood, watered-down, and deployed in ways we would not support. With this in mind, we ultimately decided to abandon the "train the trainer" session development, concluding that we did not have capacity to do this in adequate depth – and that offering such a session could be perceived as our group endorsing the training abilities of those who participated. Instead, we are now planning to hold large, open-enrollment trainings once or twice yearly that interested parties can attend – and then bring what they desire to their own contexts. Meanwhile, we have made our 2016 training videos, trainer's manual, slide deck, and training handouts available to all on our website, www.structcomp.org. We are currently preparing our updated 2018 materials for dissemination.

With the wider distribution of our training, we expect our materials and message will be transformed – possibly for better as well as for worse. However, structural competency as a framework is rapidly gaining traction. Our hope is that the dissemination of materials such as these can contribute to structural competency maintaining a critical and meaningfully structural approach as it travels and grows.

Nuts and Bolts: Lessons About Group Structure

Before we close, in this section, we will share a few reflections about lessons we have learned over time about how to organize our group. For the first several years of its existence, the SCWG had minimal formal group structure. Initially, this informal approach worked well, as we were a small, committed group. We developed strong working relationships and came to know one another reasonably well. At any

given time, one to three student members coordinated the group – planning and facilitating meetings, sending out emails, etc.

Gradually, however, the group's training became more widely known, and more people grew interested in joining us. At any given meeting, several new people would show up, many of whom would not sustain participation. It became ambiguous who was and was not in the group at any given time. As this happened, it became more challenging to conduct meetings and move projects forward. The informal approach that had worked for us initially seemed increasingly unsustainable.

To address these shortcomings, Shirley Strong and Josh Neff began developing a structure for the group, based on the organizational structure Josh had witnessed as a volunteer at the Berkeley Free Clinic. They created an application for new members, to complete after participating in at least one training. They requested a commitment of at least 1 year's involvement, with 6 hours total per month. They established a clear division of labor, with designated roles for various members (for instance, a website manager, a communications person, etc.). Finally, they created a process by which new members could become SCWG training facilitators. This process includes reading, writing about, and (at meetings) discussing a progression of articles and chapters and then helping lead portions of several trainings under the guidance of our group's established trainers.

Thus far, this new structure has restored a sense of momentum and accomplishment that the group had lost after its first few semesters. With this in place, the SCWG has recently been working in project-focused subgroups to better tailor the training to specific audiences, for instance, creating cases and other materials specific to reproductive health, mental health, and pre-health (undergraduate or high school) audiences. We have a highly motivated cohort of soon-to-be designated trainers who will be able to carry the group forward. Crucially, this new cohort represents a broad cross-section of professions and positionalities who are already bringing their various backgrounds and experiences to the training's ongoing development.

Conclusion: Core Lessons and Remaining Questions

At the start of this chapter, we framed several open questions about structural competency: to whom and how should structural competency be taught ("who" and "how") and which content should be highlighted ("what")? We will close by summarizing key insights into these questions that we gained from developing, implementing, evaluating, refining, and disseminating our structural competency training.

Who Our experience suggests that structural competency is potentially applicable to many disciplines. Providers across a variety of health fields – from nursing, medicine, and physical therapy to social work and even public health – responded favorably to our training, frequently expressing desire to incorporate structural

competency into their practice. Furthermore, in a moment in which healthcare is striving to provide increasingly team-based and interprofessional care, it stands to reason that whole teams should be trained in structural competency. We have had positive experiences implementing trainings for both single-profession and interprofessional groups.

The reach of structural competency need not be limited to health practitioners; certainly cultural competency has been taken up well beyond its healthcare origins. We would propose that any field with professionally mediated contact with structurally vulnerable communities could benefit from structural competency training – for instance, teachers, attorneys, city planners, and environmental advocates, among many others.

Profession is just one axis to consider when contemplating the receptivity of various audiences to structural competency. Another variable is the political leanings of a given audience. The majority of our trainings have taken place in the relatively politically progressive Bay Area, so we are not able to speak to the ways that such content would be received in settings with different political climates.

It is notable, however, that our training was felt to be valuable in programs with reputations for being politically progressive. One might expect that structural competency training would be deemed redundant or unneeded in such settings, to the extent that progressive politics tend to highlight structural injustices. To the contrary, one month after participation in our training, SRFMR residents reported that they were "thinking about it constantly," that it was helping them "to build a partnership with patients," and that it made it "easier to talk about" structural issues with peers and faculty. Faculty comments post-training suggest that our training was of value even for long-time practitioners and clinical educators. As one faculty member put it, "I have a language and framework to use in something I have been teaching to residents for years without the language." We have received similarly positive responses at other sites at which we have conducted trainings.

We also have had experience running structural competency sessions with healthcare trainees at various stages of training. There have been minor modifications to our approach with participants at different stages – namely, creating more time for participants with significant clinical experience to share and process what they have encountered – but for the most part, we have delivered the same training. Based on our experience facilitating these sessions, the reactions have been more or less similar across stages of training, with the exception that pre-clinical trainees tend to request more explanation of how the content at hand is relevant to their field when compared to participants with greater clinical experience.

How We found that thinking about what would be "sticky" for clinicians was helpful in developing and refining the pedagogy of our training. By pushing ourselves to think in these terms, we designed sessions distinct from the usual presentation of social science content. While it is challenging to present such material in a fashion that most will find engaging, it is even more challenging to present in a

way that the content will be remembered by participants more than a day or a week afterward. To achieve this, we employed visuals (including our "arrow diagrams"), case-based pedagogy, and a minimum of technical social-scientific jargon, as well as providing repeated opportunities for reflection and interaction. This combination of techniques appears to have been effective, as a month afterward participants reported thinking about the content we introduced "constantly." In addition, the brevity of these trainings – generally three hours – pushed us to be clear and focus on the most essential, potentially "sticky" points that we wanted to impart to participants.

We continue to strive to balance the didactic sections of our training with the interactive and reflective elements. We are often asked to condense the training into one or two hour sessions to fit into available time slots, which restricts the time available for interaction and reflection. Post-training, we often get feedback that participants would like more time for the training, and particularly for the interactive portions. We continue to believe, however, that the didactic portions of the training are indispensable, given limited time and that we are attempting to promote a common vocabulary among participants.

As far as the "how" of our group organization, we have had to adjust our approach as our work and our group have developed. While we initially had success with an informal group process, over time we have found it beneficial to develop a clear group structure. Among the most important aspects of this structure were requesting a specific commitment from new group members, establishing a clearer division of labor, and developing a process by which new group members could become SCWG "trainers." We think and hope that this structure will help the group to be sustainable and maintain diversity over time.

What In our experience, *structural violence* has been a powerful and "sticky" concept. Perhaps this is inherently so for healthcare professionals, to the extent this lens helps us as providers to better understand the health and experiences of patients with whom we work on a day-to-day basis. Though initially less "sticky" than structural violence, with revisions, *naturalizing inequality* has also become a concept that trainees report influencing their thinking. Several participants noted that they found our discussion of the relationships among structural competency, cultural competency, and the social determinants of health crucial as well, noting that these distinctions clarified what it means to develop a structural analysis of health and healthcare.

Time and again in the evaluations, participants' expressed a strong desire to intervene to change harmful social structures. In some cases, this desire to intervene has been paired with distress about uncertainty as to how to do so. To address this, we have included more historical and contemporary examples of how clinicians and others have responded to structural issues; subsequent participants have expressed appreciation for this portion. We also began emphasizing the various possible "levels of intervention," which participants have reported has helped them feel able to begin taking action based on a structural perspective.

These modifications are not adequate to resolve all participants' distress at social and health inequities. In fact, as noted earlier, we feel that some distress is an appropriate response when confronting the extent of the suffering that results from unjust social structures. Furthermore, we suspect that a degree of distress may motivate health professionals to partake in efforts to address harmful structures. However, we know how overwhelming healthcare training and practice can be, and we do not wish to contribute to this burden. To help prevent participants from feeling overwhelmed, we now close our trainings by discussing and attempting to normalize a range of possible reactions, from distress and overwhelm to inspiration and motivation. We also attempt to speak to the fact that – while many healthcare practitioners, whether due to training or disposition, wish to take individual action and see discrete outcomes – structural issues require collective responses. Such collective action often involves following the leadership of others, and change develops over unpredictable timeframes. Ideally, we hope to promote a sense of working to address structural issues over "the long haul" – which means making peace with being structurally humble and not necessarily getting immediate results, as well as trying to avoid overextending oneself and thereby increasing the likelihood of burning out.

In the United States and around the world, social, political, and economic structures are hugely determinant of the distribution of illness and health. Structural competency is a promising framework to help clinicians recognize, analyze, ameliorate, and hopefully alter these harmful inequities. To bring this framework to health professionals, the Structural Competency Working Group has developed, operationalized, evaluated, and revised a three hour structural competency training. Encouraging "impractical" innovative thinking, striving to make content "sticky," and responding to findings from evaluation, the SCWG developed a brief training that we have found to be surprisingly impactful. Our efforts to implement and evaluate this training for a variety of healthcare professions suggest that it can be similarly relevant across a range of fields.

We hope our case will inspire others to implement similar trainings in other geographical locations and for professionals in other fields – within and beyond healthcare. One of the benefits of structural competency training that emerged in our evaluations was the development of shared language and frameworks among colleagues. We think that structural competency has potential to foster a similar phenomenon at a larger scale, promoting a shared structural language and orientation within entire disciplines and, ultimately, across various sectors of society. And we believe that providing this foundation is a key step toward developing a movement in which we can work together to realize a more equal, healthy, and just future.

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