Don't "Just Call the Social Worker": Training in Structural Competency to Enhance Collaboration between Healthcare Social Work and Medicine

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In this short paper, we argue that providing in-depth structural competency training to both social workers and physicians has the potential to promote a deeper collaboration between these two fields—to the benefit of patients as well as providers. We describe structural competency's evolution as a pedagogical and practical framework in medicine and social work, then discuss three overlapping ways in which structural competency can enhance collaboration between physician and social work practitioners and educators. First, training in structural competency can fill gaps in both medical and social work education and training—namely a lack of curricula that consistently attend to the sociopolitical forces that influence health and healthcare—thereby offering these fields shared vocabulary and concepts that can improve inter-professional understanding. Second, structural competency frameworks can denaturalize the hierarchies between these professions, a necessary step for working together in genuine collaboration. Third, by

preparing medical providers and social workers to imagine and work toward changing the sociopolitical forces that harm their patients and constrain the practice of healthcare, structural competency training provides a basis for these two professions to join together and work alongside patients, communities, and other providers to demand and help build social structures that promote health and well-being.

Keywords: structural competency, medicine, social work, health

Healthcare social workers are an essential part of effective healthcare delivery. From hospital floors and emergency departments to primary care clinics, physicians turn to social workers when the social influences on patients' lives (e.g., housing, immigration status, unemployment) arise in the course of medical care. In turn, social workers understand healthcare to be a necessary and impactful site of social work intervention (Social Work Policy Institute, 2011, 2012). Various observers have suggested that successful collaboration between social workers and physicians can improve a range of clinical outcomes, including reducing incidence of health complications, length of hospital stay, hospital readmission rates, functional decline, and mortality rates (Marmo & Berkman, 2018; McPherson, Headrick, & Moss, 2001; Naylor, Aiken, Kurtzman, Olds, & Hirschman, 2011; Zwarenstein, Rice, Gotlib-Conn, Kenaszchuk, & Reeves, 2013). It may also improve overall job satisfaction for physicians and social workers, as well as nurses and other health professionals (Marmo & Berkman, 2018).

The interactions between healthcare social work and medicine, however, often fall short of true collaboration (Goldman et al., 2016; Mizrahi & Abramson, 2000; J. Park, Hawkins, Hamlin, Hawkins, & Bamdas, 2014). Previously documented challenges to collaboration include lack of physician understanding of social work scope of practice; social workers' experience of physicians lacking respect for them and their profession; status differences reflected in disparate compensation and working conditions; and the physical and professional isolation of social workers from other healthcare professionals (Abramson & Mizrahi, 1996; Ambrose-Miller & Ashcroft, 2016; Garth et al., 2018; Goldman et al., 2016; Mizrahi & Abramson, 2000; Nugus,

Greenfield, Travaglia, Westbrook, & Braithwaite, 2010). And yet, as healthcare systems increasingly strive to address social determinants of health (Centers for Disease Control and Prevention, 2017) and the need for interprofessional clinical care models increases (Ambrose-Miller & Ashcroft, 2016; Hoff, Weller, & DePuccio, 2012; Meyers et al., 2010; McCleary, Porterfield, Stanhope, & Wiford, n.d; Nyweide et al., 2015), physicians and social workers must collaborate more often and more deeply. In this short paper, we argue that providing in-depth structural competency training to physicians and social workers has the potential to address such difficulties by promoting more meaningful collaboration between these two fields—to the benefit of patients as well as both types of providers.

Structural competency is an emerging paradigm in healthcare and healthcare education that centers the influence of social, political, and economic structures on the degree and distribution of health disparities. Initially proposed by physician-scholars, structural competency articulates the need for healthcare providers to recognize and respond to the structural factors—from labor markets and zoning laws to criminal justice policies and trade agreements—that impact health outcomes and the practice of healthcare (Metzl & Hansen, 2014). Though originally framed as a paradigm for medical education, structural competency is equally relevant to other health-related professions. Accordingly, a range of such disciplines (e.g., community psychology, public health, bioethics) have commented on structural competency's capacity to address gaps in healthcare knowledge and improve research, training, and practice in their own fields (Ali & Sichel, 2014; Metzl & Petty, 2017; Tsevat, Sinha, Gutierrez, & DasGupta, 2015).

As a practice and pedagogy, structural competency has clear relevance for social work. Its core component of recognizing the upstream factors that impact individual and community well-being while working collectively to address them resonates with social work's principles of empowerment, social justice, and advancing human dignity (National Association of Social Work, 2017). Furthermore, medical care requiring a structurally-competent approach will often involve patients eligible for social work services. Prior to this special issue, however, the implications of structural competency for the training and practice of social work have not been adequately considered in

the literature, nor has the existing literature examined the ways that structural competency can influence the intersection of and interactions between medicine and social work specifically.

In this article, we specifically attempt to address the latter gap by discussing three overlapping ways in which structural competency can enhance collaboration between physician and social work practitioners and educators. First, by filling gaps in both medical and social work education and training—namely a lack of common curricula consistently attending to the sociopolitical forces that influence health outcomes—structural competency offers these fields a shared vocabulary and concepts that can improve inter-professional understanding among social workers and physicians. Second, structural competency may help these providers to denaturalize the hierarchies between their professions, a necessary step for working together in genuine collaboration. Third and finally, in preparing physicians and social workers to imagine and work toward changing the sociopolitical forces that harm their patients and constrain the practice of healthcare, structural competency training provides a basis for these two professions to join together and work alongside patients, communities, and other providers to demand and help build social structures that promote health and well-being.

Medicine and social work are just two of many professions within healthcare. While other inter-professional dynamics (including those involving nurses, physician assistants, patient care technicians, pharmacists, and physical and occupational therapists, among others) may be similarly influenced by the incorporation of structural competency into training and practice, it is beyond the scope of this article—and beyond our collective experience as an author team—to consider these. We hope that practitioners from other professions will expand this discussion to include their work and interprofessional experience.

Background: Structural Competency in Medicine and Social Work

Currently, neither medicine nor social work consistently applies frameworks that adequately account for or attend to the myriad structural forces that influence their professional practice

and exacerbate persistent health disparities. Physician-scholar Paul Farmer and colleagues observe that medicine continually struggles to develop "biosocially" informed answers to the persistently disproportionate burden of illness and disease in certain groups, instead focusing primarily or exclusively on biological approaches (Farmer, Nizeye, Stulac, & Keshavjee, 2006). Contrary to the vision for medicine articulated by medical luminaries from Rudolf Virchow and Salvador Allende to Melanie Tervalon and Atul Gawande, this orientation conceives of physicians' role as narrowly attending to patients' physiology and pathophysiology. Structural competency represents a substantive departure from standard medical education in that it situates health problems not only in the bodies of patients, but in the society that gives rise to ill health in the first place.

Structural competency is gaining traction in medical education at sites around the country, for trainees of various stages (Hansen et al., 2013; Metzl & Petty, 2017; Neff et al., 2017; Neff et al. 2019; Paul, Curran, & Tobin Tyler, 2017; Tsevat et al., 2015). Various observers have commented on the potential benefit of incorporating such perspectives into medical practice, ranging from improved relationship-building with patients to helping physicians to engage in addressing structural issues (Messac, Ciccarone, Draine, & Bourgois, 2013; Neff et al., 2017). Medical students and physicians note they feel ill-equipped to understand and address such issues (Harris Interactive, 2011); structural competency proposes to fill this gap in physician education and workforce development.

However, not all physicians share the perspective that structural competency is relevant for their practice. In his experience regularly conducting structural competency trainings for medical audiences (Neff et al., 2019; Structural Competency Working Group, 2018) and in his clinical training, author Neff has observed that some physicians and physicians-in-training believe it is beyond the scope of their role to consider the structural factors affecting patients' lives. In some instances, participants have suggested that the appropriate response is rather to "just call the social worker"—suggesting a belief that it is principally the social workers' role to consider structural factors influencing patient health, and an assumption that it is within the training and scope of practice of social work practitioners to attend to such matters. In these instances, a social work referral is

misunderstood as a structural intervention and physicians miss an opportunity for meaningfully engaging with their social work colleagues around the structural issues facing patients.

Given social work's role in helping patients navigate social systems as well the profession's association with vulnerable populations, it is not surprising that some physicians conclude that healthcare social workers are universally trained to approach social issues surrounding health in a fundamentally structural way. (Similarly, some may also view public health as a discipline that is inherently structural in its framing/orientation. However, Harvey and McGladrey [2018] argue that this is far from the case.) Contrary to this view, however, various observers of social work practice and education have argued that curricula which prepare social workers to think and intervene structurally are the exception rather than the rule (Fisher & Corciullo, 2011; Reisch, 2016; Reisch & Andrews, 2002). Some highly influential approaches within social work are parallel to and in fact overlap significantly with the perspectives highlighted within structural competency, including but not limited to feminist, anti-oppressive, and ecological frameworks. In this sense, structural competency's potentially novel contribution is not analytic or theoretical. Rather, it is in its effort to establish understanding and applying such frameworks as an essential, core competency for all healthcare practitioners and trainees—healthcare social workers included.

Indeed, the inclusion of the above frameworks and structural perspectives generally in social work training is far from ubiquitous. Nor, for that matter, is there agreement that such content should be emphasized; the debate around how social work should relate to structures affecting patients' and providers' lives is unresolved within the profession.

Yoosun Park and colleagues have observed that since its inception (Park & Kemp, 2006), social work has struggled internally as to whether its leading frameworks sufficiently account for structural forces such as poverty, inequality, racism, nativism, or classism (Park, 2008a, 2008b; Park, Bhuyan, Richards, & Rundle, 2011; Park, Crath, & Jeffery, 2018; Park & Kemp, 2006). Through extensive reviews of social work practice both past and present, these scholars argue that "structures are relegated to the margins" of social work education and practice "in favor of individualized analysis and intervention" (Park et al., 2018,

p. 15). As a result, social workers can ultimately promote their clients' "capacity to accommodate—not actively change—their social/political environments, including their interactions with social work and social workers" (Park et al., 2018, p. 15).

Others have argued similarly that social work training and practice lack a consistent, interprofessional tradition of accounting for the influence of structures on patients and providers (Murdach, 2010; Pine, 2016). In other words, while social work research, education, and practice consistently relate to structurally-shaped realities such as poverty and inequity, the structural analysis and subsequent intervention vis-à-vis these forces is not ubiquitous. The field sometimes misses or even reinscribes problematic trends that individualize social problems and demand that an individual, family, or group be responsible for changing their own circumstances, as authors Downey and Dubé have observed in their training and practice. In sum, contrary to an assumption sometimes made outside as well as within social work, although they attend to social factors as a matter of course, social workers today are often not prepared to engage structurally.

As above, this is not to overlook or diminish the many inspiring historical and contemporary examples of social work practice and curricula that do seek to address harmful societal structures. For instance, in the 1930s and 1940s, social work's Rank-and-File movement collectively organized for labor rights of social workers at a national scale as well as organized against the ongoing lynching of Black people in the United States and widespread racial discrimination at welfare agencies (Abramovitz, 1998; Reisch & Andrews, 2002). In the 1960s and 1970s, as Joyce M. Bell observes, Black social workers drew on the lessons of the Black Panther Party to challenge the White supremacist agenda of social and medical research and to organize a Black Social Workers caucus within the National Association of Social Workers to address the White-dominant nature of their professional organization (Bell, 2014). More recent efforts include Smith College's School of Social Work implementation of a school-wide anti-racism commitment (Smith College School for Social Work, n.d.), Columbia University School of Social Work's "Foundations of Social Work Practice: Decolonizing Social work" curricula (Columbia University School of Social Work, 2017), and the policy & services section of the integrated behavioral health (IBH) curricula that exists

across more than 30 schools of social work (Council on Social Work Education, as cited in Horevitz & Manoleas, 2013). These and other examples point the way toward and have helped lay a foundation for a structurally-oriented social work, including medical social work.

Structural competency presents an opportunity for social work and other health professions to build on these efforts by developing the analytic and practical skills necessary to help address structural issues. Furthermore, as we argue in the remainder of this paper, offering structural competency training across professions has the added benefit of promoting interprofessional collaboration.

Shared Understanding: Promoting Collaboration via Building Structural Vocabulary and Concepts

Previous research suggests that one barrier to physician-social worker collaboration is a lack of common language around what is happening to patients and why (Min, Spear-Ellinwood, Berman, Nisson, & Rhodes, 2016; Reilly, Patten, & Moffett, 1977; Sheppard, 1985). Physicians and social workers from the same care team may utilize different terms and explanations to describe the same patient context, characteristics, or needs. They may in turn come to different and sometimes divergent conclusions about patient need, which can interfere with a team approach to care and create or exacerbate inter-professional tensions (Reilly et al., 1977). For example, an ethnographic study of physicians and other allied health professionals (including social workers) on an internal medicine hospital ward found that difficulties in communication "may arise from lack of a common cross-team understanding of the care priorities for a specific patient at a specific time" and that "(t)his… may cause patient, family, professional and team confusion and dissatisfaction, with delays and readmission rather than directly attributable specific adverse events" (Zwarenstein et al., 2013, p. 2).

Training physicians and social workers in structural competency can promote collaboration between medicine and social work by creating a common framework for analyzing and discussing the structural issues that impact health and healthcare. As discussed in Neff et al.'s evaluation of a structural competency curriculum for medical residents, structural competency

training may lower the barriers to discussions among providers about the structural influences on health and healthcare—perhaps in part due to the shared vocabulary and conceptual frameworks offered by such training (Neff et al., 2017). It may also reduce stigmatizing language that blames individual patients for outcomes shaped by structural factors beyond their control (Neff et al., 2017). We expect the same effect would be observed across professional lines—including but not limited to social work and medicine. Interprofessional training may further improve the benefits of structural competency training (McPherson et al., 2001); however, we expect interprofessional collaboration will improve through structural competency training so long as the training offered is similar across professional lines. For a description of structural competency training offered in a range of professional contexts, see Neff et al., 2019.

In sum, giving social workers and physicians a common vocabulary of structure has the potential to improve understanding, communication, and ultimately collaboration between these professions. Further study is needed to explore this possibility.

Denaturalizing Hierarchies: Promoting Collaboration via Understanding Structurally-Shaped Work Hierarchies

One of the stated goals of structural competency is to help providers understand, analyze, and improve the practice of healthcare (Metzl & Hansen, 2014; Neff et al., 2017). Structural competency may help accomplish this by giving providers a fresh perspective on the hierarchies entrenched within healthcare itself.

Physicians and healthcare social workers are differentially positioned within their workplaces and within society. Traditionally, if implicitly, physicians hold a higher social status. This hierarchy often goes unquestioned in medicine and social work alike. Whitehead (2007) provides a contemporary example of interdisciplinary education on diverse healthcare teams in which communication regarding patients takes place around the doctor's schedule, reinforcing the doctor's "centrality." Other professional asymmetries that go unquestioned include

physicians' higher salaries, greater professional autonomy, and greater decision-making authority vis-à-vis their social work counterparts (Ambrose-Miller & Ashcroft, 2016).

These under-acknowledged hierarchies between physicians and social workers impede meaningful interprofessional collaboration by hampering effective communication, increasing interpersonal tension, and increasing stress or burnout (Abramson & Mizrahi, 1996; Goldman et al., 2016; Mizrahi & Abramson, 2000). As one social worker in a 2015 focus group on collaborative care models shared:

> I'd love to see our body talk more with the medical body. As social workers we need to have this conversation (about role clarification) so often. Medical doctors don't need to do that so I think we need to show how we, as social workers, need to communicate this. If we did this in the education then things would change drastically. (Ambrose-Miller & Ashcroft, 2016, p. 105)

Given the rapid expansion of the social determinants of health framework and IBH in primary care settings (Horevitz & Manoleas, 2013), increased attention to workforce preparedness for collaboration is necessary. Without a shared understanding of entrenched professional hierarchies, true collaboration between social work and medicine may prove difficult or impossible.

As articulated by Pierre Bourdieu in his discussion of "symbolic violence," hierarchies and other forms of inequality become "naturalized" when they are made to appear inevitable or deserved (Bourdieu, 2001; Bourdieu & Wacquant, 1992). Structural competency, through introducing and discussing the concept of "naturalizing inequality" (Neff et al., 2019), can help healthcare providers develop a critical understanding of the professional hierarchies in which they are embedded. Understanding how hierarchy is naturalized may also help social workers and physicians alike to imagine new forms of interprofessional collaboration, which could in turn help improve interactions between the professions.

To be sure, such understanding is not sufficient to eliminate the harmful effects of workplace hierarchy, but it may be a necessary component. Teaching physicians and social workers about the structural forces—both historical and contemporary—

that shape these workplace inequalities creates a basis for these professions to begin conversing and working together to address these inequalities. Moreover, without this shared language, providers may reflexively focus on interpersonal factors (thinking of an individual or group as mean-spirited, lazy, difficult, incompetent, etc.), rather than recognizing and working together to address root causes. Again, research is needed to investigate if and to what extent structural competency improves interprofessional collaboration by denaturalizing common and taken-for-granted hierarchies.

Common Cause: Social Workers and Physicians Working Together for Social Change

Finally, structural competency training can promote collaboration among social workers and physicians as well as other healthcare professionals by orienting providers toward working collectively for structural change. In the absence of a structural approach, when confronted with structural inequity, healthcare providers in the U.S. today may think primarily of what they can accomplish as individuals or at other relatively individual scales. While recognition of structural-level issues can inform action at any scale (Neff et al., 2019), addressing structural issues at their roots requires collective-level action. Structural frameworks can help providers to expand their horizons accordingly.

Increasingly, healthcare scholars use the language of political solidarity and political will as important frames for addressing health inequities, outlining the integral role these approaches can play in transforming healthcare systems (Braveman, Egerter, & Williams, 2011; Braveman, Egerter, Woolf, & Marks, 2011; Gould, 2018; Pine, 2016). The California Nurses Association (CNA) offers a powerful example of this potential. Among other accomplishments, through more than a decade of sustained effort—including grassroots political organizing, direct action, and building relationships of political solidarity with allied organizations and communities—CNA was able to establish California legislation capping patient-to-nurse ratios in various clinical settings (e.g., 5:1 in medical-surgical units and 2:1 in intensive care units). These ratios improve not only nurses' working conditions, job satisfaction, and risk for burnout—they

also are good for patient care (Aiken et al., 2010). For example, a study from the University of Pennsylvania School of Nursing found that implementing California's nursing ratios would result in 14% and 11% fewer deaths in surgical units in New Jersey and Pennsylvania, respectively (Aiken et al., 2010). This is just one example of people wielding collective power to influence structural change.

Unfortunately, there are countless examples of healthcare providers continuing to individually go above and beyond to fill in the gaps caused by systemic issues—leaving the larger issues in place and increasing their own risk of burnout. Primary care physicians, for example, regularly work extra hours to provide essential care for their patients and complete charting requirements while being compensated a fraction of what their specialist colleagues earn. Thus far, there is no broad, collective movement among primary care providers to address these issues at their roots. Social workers, meanwhile, typically make far less than primary care doctors, for work that has potential to address health issues further "upstream" and is no less taxing. And yet social workers also lack a cohesive, grassroots movement that can address structural inequities through and within their profession (Reisch & Andrews, 2002). We suspect that the structural awareness developed through training in structural competency may be necessary, if certainly not sufficient, for social workers, physicians, and various other professionals to begin organizing collectively for structural-level change.

This holds true for organizing across as well as within professions. The ongoing hierarchy and accompanying pay differential among these professions notwithstanding, the fact remains that healthcare providers more and more face similar challenges and constraints in a system that prioritizes profit and a myopically-defined "efficiency" over long-term patient and provider well-being. The manifestations of this include the increasing bureaucratic demands placed on providers in order to meet arbitrary insurance billing requirements; the continual pressure to see patients in less time than allows for quality care; the defunding of social programs that leaves healthcare settings as the front-line social safety net (accessed by people with illnesses that could have been prevented through services such as affordable housing, job training, etc.); and the need across healthcare professions for most providers to take on exorbitant

educational debt (Morra, Regehr, & Ginsburg, 2008). All of this hinders job satisfaction and contributes to high rates of burnout, stress, and fatigue across the healthcare professions (Gabassi, Cervai, Rozbowsky, Semeraro, & Gregori, 2002).

The ideological landscape in the United States in recent decades is such that many healthcare workers do not consistently recognize the influence of social structures that afflict their patients and hamper their workplace efficacy and satisfaction. Nor do providers consistently recognize the potential for structural change to be leveraged through sustained collective action (Wear & Kuczewski, 2008). We believe that structural competency holds potential to help providers develop that awareness —awareness that may be necessary, if not sufficient, for healthcare professionals to organize for structural change within as well as across professions.

We do not know exactly what forms interprofessional organizing inclusive of physicians, social workers, and other providers might take. Nevertheless, we are hopeful that interprofessional collaboration among healthcare providers to address structural issues can be fostered in part through a shared understanding of the structurally-mediated harms to patients and to providers. Such a movement would have tremendous power. Physicians and social workers alike wield a great deal of symbolic capital and are well positioned to recognize and challenge the impacts of various structural issues on health and healthcare. Here as well, further study can shed light on the merit or lack thereof of these hypotheses.

Conclusion

Physicians and social workers struggle to effectively collaborate across disciplines at a time when increasingly complex health systems and persistent health disparities demand the opposite. We have discussed three reasons that rigorously training physicians and social workers alike in structural competency may improve collaboration and address longstanding challenges within and between these professions. First, co-education in structural competency gives physicians and social workers a shared framework to recognize and discuss the structural factors impacting the health of their patients. Second, structural competency can improve collaboration by offering a lens to

denaturalize the hierarchy that has long-defined the relation-
ship between physicians and social workers. Finally, structural
competency can promote social worker and physician collabo-
ration by enhancing both professions' awareness of their poten-
tial to contribute to a wider movement for structural change.

Structural competency highlights realities, from police bru-
tality to wealth inequality to labor exploitation, that may at first
seem daunting and insurmountable to healthcare providers. It
also, however, emphasizes that healthcare providers can and
should play a role in addressing such injustices. In a moment
when other social services are minimal and shrinking, health-
care providers are uniquely positioned to recognize the harms
—to body, psyche, and spirit—of unjust social structures. More-
over, healthcare providers have both social standing and wide-
spread trust among the public, positioning them to be effective
advocates for change.

Our hope is that structural competency training for both
social workers and physicians will give both of these profes-
sions the analytic and practical skills to move beyond a shallow
collaboration in which physicians "just call the social worker"
when they observe structural factors impeding patient health
outcomes—and toward collaboration built on a shared under-
standing of structure, equitable work partnerships, and com-
mon cause in working for social change.

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