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Flexner Report 3.0—Structurally competent healthcare

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FROM THE EDITOR:

Flexner Report 3.0—Structurally competent healthcare

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In October 2023, the Liaison Committee for Medical Education published Requirement 7.6, Structural Competence, Cultural Competence, and Health Inequities. That requirement states:

> "The faculty of a medical school must ensure that the medical curriculum provides opportunities for medical students to learn to recognize and appropriately address biases in themselves, in others, and in the health care delivery process. The medical curriculum includes content regarding the following: The basic principles of culturally and structurally competent healthcare."[1]

What is Structurally Competent Healthcare?

The Flexner Report

The Flexner report was published in 1910.[2] This report established the basic sciences as part of a quality medical education. As documented by Paul Starr, medical students performed scientific investigations while also caring for patients in the community.[3] Because the fund of knowledge at the time was circumscribed and relatively small, the basic sciences were well integrated with clinical practice. As the fund of knowledge in the basic sciences expanded there grew an increasing distance between these two components of medical education. Eventually they became sequential. Translational Medicine, a concept from the National Institute of Health, was designed to re-integrate the basic and clinical sciences of medical practice.

Clinical disciplines have foundational pre-clinical basic sciences. Surgery requires the basic science of anatomy; infectious disease medicine requires the basic science of microbiology; endocrinology requires the basic science of the physiology of hormonal pathways; and etc.

Flexner Report 2.0

The Flexner Report 2.0 was published in 2010.[4] This report called for the integration of social sciences into medical education as there was an increasing awareness of the impact of social determinants of health (SDH). Medical students can recite the social determinants of health and they understand SDH as precursors of biologic disease. They demonstrate passion for greater equity in society. But there is not yet a part of the medical curriculum that teaches medical students to treat health outcomes by addressing SDH.

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Flexner Report 3.0

It is time for a third iteration of the Flexner report. Social scientists fundamentally perceive the question of health inequity differently from medical scientists: How are culturally mediated power structures created and maintained, resulting in the observed social determinants of health?

Doctors need to make a cognitive shift to understand the social determinants of health not as risk factors for poor biological outcomes but as outcomes in and of themselves. Doctors then need to be able to recognize the upstream or antecedent cultural and social processes if we wish to improve health disparities.

The paradigm shift I propose is to formalize the addition of "Medical Social Sciences" as a basic science in our Schools of Medicine and "Clinical Decision Science" as the corollary clinical practice discipline: a "Flexner Report 3.0."[5]

Structurally Competent Healthcare

The standard medical education curriculum trains doctors to diagnose and treat diseases of the human body. There is little understanding of the diseases of the body politic. It is the cultural body and the body politic that gives rise to the social determinants of health.[6-8]

We propose a curriculum to diagnose and treat diseases of the body politic. Diagnosing diseases of the body politic is the definition for structural analysis. By adding these new diagnostic skills, clinicians will be able to practice structurally competent healthcare.

Structural analysis is a form of diagnosis—the diagnosis of embedded power structures. These power structures can result in unequal treatment, with corresponding unequal health outcomes. The ability to diagnose power structures requires skills derived from theory and methods of the social sciences. (The Flexner report 2.0 mentioned this in a glancing manner, but there existed no infrastructure to formally Incorporate social sciences into medical education.)

To provide structurally competent healthcare, we must know something about social structures. Social structures have benefits for society, but they can also cause structural violence. Structural violence is when social structures or institutions harm people by effecting inequitable treatment.[9]

Being able to place oneself in a social power structure allows for individual perspectives that recognize privilege (being situated higher on the social power hierarchy). This will address the other major component of LCME Requirement 7.6, understanding bias in the individual practitioner. This is a far less threatening path towards understanding health inequalities than being scolded in a DEI seminar.

The conceptual power of social diagnosis allows doctors to conceptualize treatment options specific to the pathology. Social prescriptions are a natural part of clinical practice; this is usually learned through an apprenticeship model but is not taught as one of the basic sciences in medical school.

Clinical Decision Science

Clinical Decision Science requires a knowledge base from the social sciences.

From the inception of this journal, we have always recognized that clinical research is done on a population of patients and that to apply clinical research to individual patient care requires a social context. Our next transition is toward understanding the structures of that social context. That is how we conceptualize clinical decisions (Clinical Decision Science). Applying clinical research together with basic medical social sciences is a good description of clinical medical practice. We will continue to develop these themes as editorial priorities in future issues of *Clinical Research in Practice—The Journal of Team Hippocrates*.

In this issue, we publish our second Translational Social Science article. Translational Social Science is merely incorporating the theories of social sciences into medical settings. We believe that to be effective, education needs to be grounded in experience. The

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experience of caring for patients provides material for our Clinical Decision Reports. Although this is not a new concept, we are trying to develop more rigor and systematic incorporation of the medical social sciences in our publications.

Blending the current medical curriculum with the skills needed to understand the health of a human organism in its social environment should result in structurally competent healthcare and health equity.

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