

# The TOLERance Model for Promoting Structural Competency in Nursing

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## ABSTRACT

**Background:** Structural competency is the trained ability to recognize how social, political, economic, and legal structures shape diseases and symptoms. Although structural competency has become an increasingly accepted framework for training and teaching, it usually has not addressed nursing students and has not included marginalized patients as trainers. **Method:** This article analyzes a structural competency training model for nursing students that includes five components: Theory, Observations, Learning from patients, Engagement, and Research (the TOLERance model). **Results:** The TOLERance model increases the understanding of the interrelation between the individual clinical level and the sociopolitical structural level. It encourages nursing students to actively engage in social, political, and policy issues that affect their patients' health and to advocate for policy change. **Conclusion:** The moral and professional commitment of nurses to their patients demands that they do not ignore the structural forces that are detrimental to their patients' health. The TOLERance model provides nursing students with skills and competencies that help them to fulfill this commitment. [*J Nurs Educ.* 2020;59(8):425-432.]

In the past few years, there has been growing recognition of the need to promote “structural competency” among health care professionals and students (Metzl & Hansen, 2014). Structural competency is the trained ability to discern and acknowledge how sociopolitical structures, such as public policies, economic systems, and health care delivery systems, have produced and maintained social inequities and health disparities. Structural competency calls on health care professionals to recognize how these structures shape diseases and symptoms. It also encourages them to be aware of how these inequalities are manifested in provider–patient interactions, as well as in the community and policy levels, and to take action on these three levels (Metzl & Hansen, 2014; Neff et al., 2017).

Structural competency has become an increasingly known and accepted framework for training and teaching, especially in the United States. However, there are two main gaps in the existing literature on structural competency programs that this article aims to address. First, most of the programs and trainings have been designed and designated mainly for physicians and resident physicians (Hansen et al., 2018; Neff et al., 2017, 2019), medical students (Rabinowitz et al., 2017) and prehealth students (Metzl et al., 2018; Petty et al., 2017), rather than for nurses and nursing students, even though nurses' position allows them to recognize the bodily harm caused by structural forces (Pine, 2013). This article discusses a unique structural competency training program for undergraduate and graduate nursing students in Israel that specifically addresses nurses' professional practices and concerns.

In addition, the trainers and teachers at the existing structural competency programs are predominantly physicians and medical students, as well as social scientists and other academics. They usually represent and mediate the voice of the marginalized patients. The program that we discuss in this article integrates patients from disadvantaged groups, such as people with intellectual and psychiatric disabilities, as trainers in the structural competency program alongside nurses and social scientists.

The following section briefly explains the concept of structural competency. We then discuss the structural competency training model that we have developed for nursing students—the TOLERance model—and its results at the Jerusalem College of Technology (JCT).

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## STRUCTURAL COMPETENCY

Building on Metzl and Hansen's 2014 definition, Neff et al. (2020) define structural competency as "the capacity for health professionals to recognize and respond to health and illness as the downstream effects of broad social, political, and economic structures" (p. 2). Clinicians, health researchers, and health policy makers who have the perspectives and skills needed to achieve structural competency can work alongside disadvantaged communities to address the upstream determinants of the health of those they are seeking to help (Hiam et al., 2019). The medical teams' ability to identify health gaps, illness disparities, and the structures that create them improves treatment and patient experience, as well as the involvement of caregivers in the community and in policy change processes (Bourgois et al., 2017). In addition, structural competency allows health care professionals to understand the social, economic, political, legal, and policy forces that affect clinical interactions and medical decisions (Metzl & Hansen, 2014).

A widely recognized concept that is related to structural competency is the social determinants of health. While the social determinants of health model focuses mainly on poverty and inequalities that cause health disparities, the concept of structural competency expands the perspective and includes the variety of structural factors that produce and maintain inequality and inequities, often along lines of race, ethnicity, religion, class, citizenship status, language, geography, gender, and age (Metzl & Hansen, 2014). Neff et al. (2019) called it "structural determinants of the social determinants of health" (p. 62).

### THE STRUCTURAL COMPETENCY MODEL: TOLERANCE

JCT, established in 1969, has one of the largest nursing schools in Israel, with approximately 1,200 undergraduate and graduate students. This school has been ranked the best nursing school in Israel by the Ministry of Health.

To advance the structural competency of undergraduate and graduate students at JCT, we developed a model that includes five components: Theory, Observations, Learning from patients, Engagement, and Research, which we refer to as TOLERance. These components have been incorporated in the different undergraduate (baccalaureate [BSN] and RN-to-BSN) and graduate (master's and nurse practitioner) programs in varying ways according to each program's structure, pedagogical goals, academic requirements, and students' characteristics. Since 2017, 200 undergraduate and graduate students have been trained according to the TOLERance model, and approximately 750 undergraduates have learned the principal ideas of structural competency as part of the course Sociology of Health. Five faculty members and several additional guest lecturers have been involved in teaching the courses and in the trainings that the two authors have led.

The following sections provide an analysis of the model's five components. To demonstrate the students' perspective, we incorporated several quotations from reflective accounts that the students have written during and after the training, particularly in the context of the field observations. The students' texts

were analyzed inductively, using qualitative content analysis and grounded theory, including an iterative search procedure for expressions and ideas (Corbin & Strauss, 2014), and were anonymized. The cited students consented to the publication of quotations from their texts.

### Theory

The theoretical component of the model was based in part on the trainings developed by the Structural Competency Working Group (SCWG) in the San Francisco Bay Area (Neff et al., 2017, 2019, 2020; <https://www.structcomp.org>). As a visiting scholar at University of California, Berkeley, the first author (Z.O.) took part in their training and discussed its contents and methods with the scholars and health professionals who had developed it. We translated some of the SCWG materials that they have generously provided to us and adapted them to the Israeli health care system, as well as to nurses and nursing students. The original SCWG training materials were published in full in 2020 (as online appendices in Neff et al., 2020). This curriculum includes key concepts in structural competency, such as structural violence, naturalizing inequality, structural racism, structural vulnerability, and intersectionality, which we incorporated in our curriculum. For instance, structural violence articulates how power structures and social hierarchies lead to unnecessary bodily and emotional suffering among vulnerable individuals and communities (Neff et al., 2020, p. 2). Another example is the concept of naturalizing inequality, which refers to "The ways in which health disparities are often attributed to the behaviors or innate characteristics of the individuals or groups of people most affected by these disparities. Such naturalization causes the social origins of health disparities and structural violence to be de-emphasized or overlooked entirely" (Neff et al., 2020, p. 2). We and a professional translator translated the relevant original English materials into Hebrew, and this translation underwent content validation by experts in this field who are fluent in both languages.

In the next stage, we incorporated locally adapted content into the translated parts and also added new content. For example, we presented a variety of research-based evidence that demonstrates the multidimensional gaps in health care in Israel based on ethnic categories (Jewish versus Arab health care recipients), socioeconomic status, education, geographic region, religion, degree of religiosity, and so on. Then we held discussions with the students about the social, economic, and political structures that lead to such gaps. We also provided information about health gaps on the global scale, between continents and countries, using measures such as life expectancy, infant mortality rates, under-five mortality rates, prevalence of HIV and disabilities, and again analyzed the underlying structural forces that created and maintain these disparities.

Working with nursing students who had undergone structural competency training, we created clinical case studies that would be used for analysis. In keeping with SCWG's method, the case studies corresponded to three different levels. The initial level corresponds to information that is obtained in the course of a routine anamnesis—this is the default option, when the medical team has no structural competency. The second level includes more detailed information about the patient, such as

personal history, environment, and difficulties. This type of information can be obtained using structural competency instruments, such as the structural vulnerability assessment tool that helps clinicians to quickly gauge aspects of a patient's structural vulnerability and to create a comprehensive treatment plan that interfaces with resources outside the clinic (Bourgeois et al., 2017). The third level corresponds to information pertaining to the structural level, indicating macrolevel factors that influenced the patients' lives and health status. This level links the theoretical concepts with the clinical reality and opens the door to a discussion about ways to change the structural elements underlying the specific clinical case.

The fact that these clinical cases were selected based on an ongoing reciprocal discussion with the nursing students ensured that these cases were relevant to students' lives and thus particularly effective pedagogically. Thus, for example, one of the cases proposed by the students was that of their classmate who had immigrated to Israel from Ethiopia many years ago. As she began her nursing school studies, she had to undergo the Mantoux tuberculin test, which came out positive yet unreliable. Without conducting any further investigation as the conventional practice requires, the treating physician instructed her to take antibiotics, which ended up causing liver damage. The students claimed that in this case, a combination of prejudices and racist beliefs about people of Ethiopian descent, along with economic structural considerations, led this physician to assume that this student was in fact positive and to refrain from any further medical investigation, something this physician would not have done were the patient a native Israeli.

Another case raised by the nursing students was also about a patient who had immigrated from Ethiopia and in Israel presented with type 2 diabetes. No explanation about the disease was given in Amharic, no effort was made to ensure that the patient understood instructions, and no follow-up was scheduled to oversee the stage of the disease. As a result, the patient's condition deteriorated.

The cases presented by the students facilitated a discussion about the relationship between the health care professional's personal perceptions, racial discrimination, and structural racism. Structural racism refers to:

The ways in which historical and contemporary racial inequities in outcomes are perpetuated by social, economic, and political systems, including mutually reinforcing systems of health care, education, housing, employment, the media, and criminal justice. It results in systemic variation in opportunity according to race or ethnic background—for example, in racial differentials in access to health care. (Pallok et al., 2019, p. 1491)

Examining these cases with the students in the context of structural competency training led to highly emotional discussions regarding the issue of structural racism in the health care system in Israel and its manifestations (Groto et al., 2018). Moreover, these cases also led to the discussion of past cases involving immigrants from Ethiopia—for example, when women immigrants from Ethiopia were pushed into using Depo-Provera injections for birth control without being given other options (Eyal, 2009), and the discarding of blood donations made by Ethiopian-Israeli citizens and immigrants (See-

man, 1999). The health care system is still coping with the implications of these cases to this day (Groto et al., 2018).

These additions to the curriculum were translated into English by a professional translator and were sent to experts in the United States in the field of structural competency for content validation. The experts' comments were then integrated into the training materials.

We adopted an international comparative approach using examples and clinical cases from both the Israeli context and the U.S. and other contexts. This comparative approach was effective in reducing the students' antagonism toward discussing political issues in the Israeli context (Golan & Shalhoub-Kevorkian, 2019). Students had a much easier time discussing oppression and marginalization in other political contexts. Using the relevant theoretical concepts within a broader comparative discussion helped students to see the Israeli reality in new and unexpected ways.

We conducted the trainings in a pedagogical process that included the students as active participants. In one of the training programs, students who are active nurses and studying for their bachelor's degree in nursing (RN-to-BSN) went on to train graduate students. They were initially given the structural competency training in their research seminars. After acquiring familiarity with the subject, they adapted the structural competency training course by drawing from patient case studies that they experienced in their work as nurses. In the last stage, they conducted the trainings that they developed with a group of master's students in nursing.

This process relied on an established body of literature that pointed to the effectiveness and student-related benefits of peer teaching and learning in health care higher education in general (Burgess & McGregor, 2018; Tai et al., 2016) and in structural competency training in particular (Rabinowitz et al., 2017). Health professionals are increasingly required to teach peers and colleagues, as well as to educate patients; hence, teaching is increasingly recognized as a core professional skill (Burgess & McGregor, 2018). The fact that the RN-to-BSN students were trained by the faculty to teach the graduate students, who are experienced nurses with critical thinking, resulted in an exceptionally thorough learning process. Furthermore, the RN-to-BSN students who had been qualified as trainers could use their newly acquired skills and experience to teach the structural competency concepts in other frameworks as well, such as their workplaces.

### Observations in the Field

The graduate students who went through the structural competency training participated in tours that explored how embedding structural competency in medical and nursing practice can improve treatment quality and accessibility to medical and nursing services. The students visited two Palestinian hospitals in East Jerusalem, as well as two Israeli hospitals where many patients are Palestinians from East Jerusalem and the West Bank.

Given the state of segregation in Jerusalem, these students, most of whom are experienced nurses working in the Israeli health system and a few of whom hold administrative positions in the system, had never before visited Palestinian hospitals in the city. Some had no idea that such hospitals even existed. Stu-

dents shared that in the Palestinian hospitals they felt foreign and alienated. Interestingly, this alienation and estrangement helped them understand what they learned in the trainings in the classroom. This, for example, is what Leah (all names used in this article are pseudonyms), a graduate student who is a native speaker of English, wrote after visiting a Palestinian hospital:

Walking into the hospital was eye opening for me. In the entire hospital I did not see any signs in Hebrew. All of the signs were in Arabic and English. I had absolutely no trouble understanding the signs (my English is better than my Hebrew) and yet I felt lost. Not seeing Hebrew on the signs made me feel very uncomfortable; it made me feel not at home. It showed me how important signage can be not only on an intellectual level but on an emotional one. I could communicate with the staff in English but all I wanted to do is to speak in Hebrew—and that was not an option. I cannot even comprehend how difficult it must be for people who don't speak Hebrew or English to go to medical facilities where those are the only options. Where it's not only a matter of not feeling "at home" but also a matter of not understanding where to go or what to do.

Leah's words reflect the discomfort felt by many of the students due to the fact that the Hebrew language was completely absent from a hospital located in Israel's capital, Jerusalem. However, this feeling is not related to functional considerations, but rather to Zionist ideological considerations and questions of national identity and resource allocation, as the following quote from a different student demonstrates:

I felt that I was invading a space that was not mine. As if I had entered a hospital in a different country... I felt uncomfortable and even angry that a hospital that was established in my country is unequipped to serve the Jewish population.

Having said that, Leah's quote, which emphasizes the issue of language, echoes the principles of cultural competency, a concept that is well-established in nursing education (e.g., Chen et al., 2018; Govere et al., 2016). The cultural competency model focuses on identifying clinician bias and improving communication at the clinical encounter, whereas structural competency encourages health professionals to recognize how social, economic, and political conditions produce and maintain health inequalities in the first place. Therefore, researchers suggested the structural competency framework as an additional layer to cultural competency (Metzl & Hansen, 2018). In line with this approach, in the field observations the students learned about the main structural problems that impact the health of Palestinians in East Jerusalem and the West Bank, such as the implications of the West Bank barrier and the military checkpoints on the Palestinian patients' access to health care (Fahoum & Abuelaish, 2019).

Palestinian patients living to the east of the West Bank barrier (including some of the Palestinian neighborhoods in Jerusalem) are forced to wait at the checkpoint on their way to Israeli hospitals in the western part of Jerusalem. Ambulances of the Red Crescent are not permitted to drive beyond the checkpoint and usually the patient must be transferred to an Israeli ambulance. In some cases, Israeli police will accompany the Red Crescent ambulance all the way to the hospital. These delays take a heavy toll when it comes to medical emergencies. Following a tour of a Palestinian hospital in East Jerusalem, one of the students wrote the following:

We were made aware of the difficulties that the Palestinian patients and medical teams encounter because of the West Bank barrier and the need to go through checkpoints to get to the hospital. To cope with these difficulties, the hospital maintains a nearby motel for patients receiving radiation treatment and are unable to cross into Israel on a daily basis. The same solution is offered to hospital staff from the West Bank...and many of them avail themselves of this option and stay overnight for a period between several days and a week.

As they learned about the effects of the West Bank barrier on patients and medical staff, the students also emphasized the Jewish Israeli perspective regarding the security concerns that are addressed by the construction of the West Bank barrier, as one student noted: "We have known terrible periods of terror attacks in Jerusalem... These walls can protect my life and the lives of my family members."

In the course of the hospital tour, the students learned about the enormous gap between the hospitals on either side of the city and the disparity in terms of the resources allocated. These gaps affect the quality of care given in hospitals in East Jerusalem. Moreover, the implications of these gaps became more evident during the coronavirus pandemic. In April 2020, the mayor of Jerusalem wrote a letter to the Ministry of Health's Director General, warning that the hospitals in East Jerusalem were on the verge of collapsing due to "a severe lack of basic medical equipment" (Hasson, 2020).

During the hospital tour, the students first discovered that their colleagues—nurses working in East Jerusalem hospitals—earned much less than they do and that the same is true for the physicians. One student wrote that in their hospital visit in East Jerusalem, she discovered the following: "The salary is much lower than that paid in Israeli hospitals, [although] the workload is heavier and less flexible than in Israeli hospitals.... That's another thing: employees' rights and the lack of equality in medical institutions."

Another structural difficulty that affects Palestinian patients in East Jerusalem is the fact that many of the services rendered in East Jerusalem through the Israeli public health maintenance organizations (HMOs) are outsourced to external health care providers. Many of the East Jerusalem residents claim that the health care they receive is less professional and less comprehensive than the services rendered in West Jerusalem and in other parts of the country. Indeed, the Ministry of Health (2017) does not permit the HMOs to outsource the provision of clinical services, with the exception of East Jerusalem.

Another sociopolitical structure is demonstrated in the following text that was written by a graduate student after a conversation with Mustafa, a Palestinian nurse, in one of the field trips:

Mustafa gave an example that when his wife gave birth in the hospital [an Israeli hospital]..., they were charged a fee of 15,000 shekels, even though they are exempt from this fee.... Mustafa described the way he was able to right this wrong by using personal connections to delete the charge, but the question remains—why were they charged in the first place, and if this is the case, how many patients and families choose not to seek medical treatment for fear of running into unnecessary

hassles.... We all live side-by-side, but really there is no equality.

This case demonstrates the legal and humanitarian complexities related to the rights (and the abuse of rights) of Palestinians living in East Jerusalem. The greater part of the Palestinians living in East Jerusalem do not hold Israeli citizenship but have the status of permanent residents. As such, they cannot vote in elections to the Israeli Parliament and they are required to prove to the authorities that their “center of life” is in Israel. Otherwise, their residency status can be revoked, and they can be deprived of all social benefits. Mustafa is a resident of Israel who moved to a neighborhood located outside of the Jerusalem municipality’s jurisdiction before his son was born. As a result, the authorities claimed that his center of life is not in Jerusalem, despite the fact that at the time he was working in an Israeli hospital in the western part of the city as a nursing student. As a result of the authorities’ decision, he and his wife lost all social benefits, including the right to give birth in an Israeli hospital funded by the government, a right that is afforded to all Israeli citizens and residents. His colleagues in the hospital helped him reestablish his status by demonstrating that his main occupation was in fact in Israel and, as a result, the fee for giving birth in the Israeli hospital was canceled.

These examples demonstrate a variety of sociopolitical structural issues that are rarely discussed in Israeli nursing schools as well as in Israeli hospitals. In both, the staff and faculty prefer to refrain from engaging in any political issues. The structural competency framework allowed us to openly learn and discuss these significant yet silenced topics.

### **Learning From Marginalized Patients**

Structural competency implies the development of structural humility (Metzl & Hansen, 2014). Structural humility encourages reflective approach and working with patients and the community to develop an understanding of structural vulnerability and appropriate response (Neff et al., 2017). Structural humility helps understand individuals’ motivations behind their behaviors rather than simply recognizing the structures influencing their decisions (Donald et al., 2017). Yet, most structural competency trainings are designed and enacted merely by academics and health professionals rather than by disadvantaged patients.

Following the first trainings, we recognized the need to incorporate the knowledge, experience, and voice of disempowered patients. Much of the training program is based on client case studies, but these case studies draw from the experiences of the nurses and nursing students rather than the clients’ experiences. Furthermore, initially the trainings did not include opportunities for the students to meet with clients. To overcome this deficit, we established a group of fourth-year nursing students who met and worked with individuals with intellectual or psychiatric disabilities. The students together with one of these individuals who has a mental illness went on to shape the training curriculum and cotrain the nurses, drawing on community members’ experiences in their encounter with the health care system.

This element in the program was designed and executed in collaboration with a civil society organization called

ACHLAH—Association for the Quality of Life for People with Special Needs (<https://www.achlah.org.il/>). ACHLAH is a holistic center that serves as a case manager for people with disabilities and works with them and their families to find creative solutions to their broad array of challenges. Since 2015, some of our nursing students have volunteered at ACHLAH, supporting and assisting people with disabilities on the individual level. The structural competency program allowed them to go beyond the individual-level work, with which both the nursing students and ACHLAH are familiar and comfortable, to address the structural level, which was new to both of them. Thus, the structural competency training that engaged community members with disabilities strengthened the campus–community partnership and made it multilayered, reflecting the inherently close interrelations between the individual level, the community level, and the public policy level.

The following quote from graduate students written after the completion of the structural competency training demonstrates the effect that seeing a patient encounter structural violence, had on their awareness of the need for structural change:

Since the lesson in which we heard from David, a person with a mental disability, about the devastating harm that the health care system caused him, we started recognizing cases of structural violence reported in various types of media.... Hearing these reports...is extremely aggravating and calls for a significant change in public policy.... There is a need to raise awareness to the various types of offenses.

### **Students’ Community Engagement**

Structural competency includes the understanding that the structural factors that affect health are not eternal but rather changeable by structural interventions (Metzl & Hansen, 2014). Structural competency trainings encourage health care professionals to get engaged in building the counterhegemonic structures and policies needed to reduce health disparities and foster health equity (Bourgeois et al., 2017; Hansen & Metzl, 2016). Advocacy for systemic sociopolitical change, which requires collaboration between disciplines and institutions, is considered a key aspect of structural competency (Kirmayer et al., 2018).

Similarly, efforts by nurses to promote policy change in the United States are often founded on an ethos of advocacy. This is particularly true of National Nurses United (NNU), the largest nurses’ union in the United States. Although it is true that advocacy is mentioned in the Israeli National Association of Nurses’ ethical code, it seems that this term’s meaning in Israel is largely restricted to the individual patient level. In our pedagogical process with the students, we tried to use the professional ethos of advocacy, expanding its meaning and leveraging it as a tool for activism on the part of nurses. Examples of social change work by NNU were an inspiration to us in this context. Thus, the students learned about NNU’s campaign “Medicare for All,” which calls for a “single-payer health care system that would end health disparities, effectively control costs, and assure that everyone has equal access to an excellent standard of care” (<https://medicare4all.org/>). Another example is NNU’s campaign for environmental and climate justice that states: “As nurses, we recognize that bold action is needed to address the catastrophic health impacts of global warming.... We are com-

mitted to supporting policy measures to protect air, food, and water services for all people” (<https://www.nationalnursesunited.org/environmental-justice>). NNU’s humanitarian actions also connect the humanitarian crises with their underlying socio-political structures (<https://www.nationalnursesunited.org/blog/answering-call-registered-nurses-provide-critical-care-migrant-families>).

However, in the U.S. context, and even more so in the Israeli context, nursing education related to policy change and public health advocacy usually does not focus on experiential learning, such as engagement in political advocacy and community mobilization, that is required for acquiring public health advocacy skills (Morris et al., 2019). Our program has emphasized experiential learning, civic engagement, and community-engaged courses (Golan et al., 2017; Orr, 2016, 2017; Vardi et al., 2019). To enable students to devote time to their activism, scholarships were awarded to the best advocacy and social change projects that were initiated, planned, and run for over a year by a student. These included, for example, a project related to the end of life and advanced care planning, particularly the right of disadvantaged Arab community members to determine their present and future medical treatments. Another graduate student initiated and conducted a project targeting her community of Jewish immigrants from the Caucasus region, a community that has been socioeconomically marginalized. Her project demonstrates how nurses can become leaders of their communities.

### Students’ Research

Involving nursing students in empirical ethnographic research where they can encounter the structural determinants of health first-hand is extremely important. This type of experience should be encountered early in the course of their studies, as part of the pedagogical processes and the professional socialization of nursing students. Although students are likely to encounter structural issues also in the course of their clinical experience, this framework does not allow for the systematic processing and analysis that these issues demand. By contrast, involvement in research pertaining to the social, economic, and political structures that influence patients enables the students to gain a new perspective on their patients and to respond to them accordingly. It also allows them to connect the insights gained through the theoretical study of structural competencies with concrete clinical cases that they encounter in hospitals or community clinics.

Hence, we established research seminars for small groups of up to 10 students. Throughout the year, each group planned and performed all the steps of the research project, under the guidance of faculty researchers. The students were trained by the academic staff on the topic of methodologies and received constant and close guidance in planning the research, reviewing the literature, the formulation of research questions and hypotheses, data gathering and analysis, as well as in drawing conclusions and preparing a research report. Participating students had no prior background in research; hence, this was a significant and intensive course of studies on researching structural issues, which in turn made them more sensitive to these.

Thus, second- and fourth-year students conducted qualitative and quantitative research studies regarding the social and struc-

tural aspects that affect both the patients and the medical staff’s work in the emergency department (ED) of a general hospital in Jerusalem. They interviewed patients, as well as physicians, nurses, and students in the ED and studied the stigmas that ED staff have regarding Arab patients, Jewish ultra-Orthodox patients, and patients with mental illness. They examined the structural aspects that determine whether various patient groups will seek help in the ED, the kind of treatment they will receive, and the nature of their experiences in the ED.

Other students conducted a survey to determine the effects of a training program that they ran with nurses on the subject of structural competency, by comparing the responses of the study group to preintervention and postintervention questionnaires, as well as comparing their responses with those of a control group. As a result of the training, both the quantitative and qualitative research findings pointed to a marked increase in the nurses’ knowledge, familiarity with, and awareness of structural determinants of health.

### CONCLUSION

In his autobiographical book *Who Killed My Father*, Édouard Louis describes how specific health and social policies in France over the years were severely detrimental to his father’s health. He names the politicians who made these destructive policies, writing to his father: “The history of your body is the history of these names, one after another, destroying you. The history of your body stands as an *accusation* against political history” (Louis, 2019, p. 79, italics in original). For Louis’s working class family, he writes, politics was a matter of “life or death” (p. 73).

Nurses’ ethical commitment to their patients demands that they do not ignore these structural political, social, economic, and policy forces that are detrimental to their patients’ health. In medicine, this perspective has been mainstreamed in recent years, as reflected in leading medical journal publications. Thus, in 2018–2020, the *New England Journal of Medicine* published a series of 15 case studies in social medicine (e.g., Pallok et al., 2019), which demonstrates that “without the skills to identify and respond to those [social] forces, physicians are at risk of misdiagnosing, mistreating, and ultimately causing harm” (Holmes et al., 2020, p. 1083). By contrast, the structural competency perspective is still not common in nursing and nursing education, despite nursing’s deeply rooted tradition of advocacy for patients.

We propose that the TOLERance structural competency training model allows to incorporate an essential element in nursing education programs that is often overlooked. It increases the understanding of the interconnectedness between the individual clinical level and the sociopolitical structural level. It encourages nurses and nursing students to actively engage in social, political, and policy issues that affect their patients’ health and to advocate for policy transformation.

The concept of structural competency was developed in the United States and is rarely applied beyond its borders. We believe that the TOLERance model can be beneficial to a wide variety of societies and countries, as it combines the study of

theoretical concepts with their demonstration in clinical cases. The observations expose the students to areas with which they are not familiar and that are not part of the standard nursing curriculum. Disadvantaged community members are significant actors in this module. Nursing students are involved as active learners and teachers of other students, and they are even involved in researching structural issues. Thus, a new generation of motivated nurses emerges that is well equipped to study and conduct research in fields that until recently were considered peripheral in the nursing profession, despite their crucial effect on health care.

Students' reactions during the coronavirus pandemic crisis underscored the importance of learning about structural competency in the field of nursing. Discussions held with students who had completed the training provided evidence of their ability to apply the ideas and concepts of structural competency to issues related to the pandemic. They suggested research hypotheses that posited a relationship between structural factors and the discrepancies between White and African American people in the United States in terms of their morbidity and mortality rates. Similar hypotheses were posed in regard to various social groups in Israel, and the students even proposed structural solutions. They demonstrated a critical approach and were attentive to alternative voices that were not heard in the established media, which consistently repeated the government's message that "We are all in this together." Thus, particularly during a crisis, when emergency conditions require obedience and nurses are under a tremendous and intensive workload, the structural competency of nurses and nursing students acquires a special significance, as they serve as organic intellectuals for the disenfranchised (Gramsci, 1971).

In the words of George Orwell (1946), "To see what is in front of one's nose needs a constant struggle." The TOLERANCE model provides nursing students with the set of skills and competencies that is required to see the social forces that are "in front of their noses" but are often obscured, masked, and neglected. Nurse educators should have a professional and moral commitment to acknowledge these forces and make their teaching part of the curriculum. This will promote true solidarity with patients like Édouard Louis's father, who are unable to escape the structural forces that have a tremendous influence on their body and health.

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