



Structural vulnerability and new perspectives in social medicine on the health of immigrants: Interview with James Quesada and Seth M. Holmes

La vulnerabilidad estructural y las nuevas perspectivas en medicina social sobre la salud de los migrantes: entrevista a James Quesada y Seth M. Holmes

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ABSTRACT A decade ago, a number of English-speaking authors focused mainly on the analysis and intervention of processes of social determination of health of migrants developed the concept of *structural vulnerability* as a way to combat individualism, biologism, the invisibilization of processes of structural determination and the blaming of victims. As part of the historical contributions of social medicine, the current developments of the structural vulnerability approach have been disconnected from the discussions of the collective health movement and Latin American social medicine in general, among other reasons due to linguistic barriers associated with the scarcity of publications in Spanish. The present interview, conducted with two of the primary representatives of the structural vulnerability approach, investigates its historical origins and seeks to explore the specific contributions that are being made today, as a way to bring them closer to Spanish-speaking readers and so enable dialogue with the proposals of Latin American social medicine.

KEY WORDS Vulnerable Populations; Social Medicine; Human Migration; Medical Anthropology; Social Determinants of Health.

RESUMEN Desde hace una década, varios autores anglófonos, centrados principalmente en el análisis e intervención de los procesos de determinación social de la salud de los migrantes, forjaron el concepto de *vulnerabilidad estructural*, como una forma de combatir el individualismo, el biologismo, la invisibilización de los procesos de determinación estructural y la culpabilización de las víctimas. Siendo parte de las contribuciones históricas de la medicina social, los actuales desarrollos de la aproximación sobre la vulnerabilidad estructural han quedado desconectadas de las discusiones del movimiento de la salud colectiva y la medicina social latinoamericana en general, entre otras razones, por las barreras lingüísticas asociadas a la escasez de sus publicaciones en español. La presente entrevista, realizada a dos de sus principales representantes, indaga los orígenes históricos de dicha aproximación y busca explorar las contribuciones específicas que hoy está realizando, como una forma de acercarlas a los lectores de habla hispana, favoreciendo el diálogo con las propuestas de medicina social latinoamericanas.

PALABRAS CLAVES Vulnerabilidad en Salud; Medicina Social; Inmigración; Antropología Médica; Determinantes Sociales de la Salud.

PRESENTATION

Structural vulnerability has been defined as a positionality that imposes physical-emotional suffering on specific groups and individuals in a structured manner, as a product of economic exploitation based on class and cultural, gender/sexual and racial discrimination, as well as on complementary processes of formation of depreciated subjectivity.⁽¹⁾ Developed by James Quesada and other contemporary English-speaking authors, this concept has had unparalleled development in the hands of researchers in California, including researchers from the Berkeley Center for Social Medicine (James Quesada and Seth Holmes), the University of California-Los Angeles (Phillipe Bourgois), the University of California-San Francisco (Kelly Knight), San Francisco State University (Felix Kury), and the Structural Competency Working Group (Joshua Neff, Shirley Strong). Structural vulnerability as an approach is vigorously expanding to the rest of the world, addressing the health of migrants and the “wretched of the earth” in general. It places a strong emphasis on the importance of economic-political processes of determination and draws out the practical consequences of recognizing these processes in dialogue with the previous or parallel theorizations of social medicine in Europe, Latin America, and the rest of the world.

The developments of structural vulnerability arise in the framework of a decided critique of the sociocultural approaches^(1,2) and have as an antecedent the works of US critical medical anthropology (Baer, Singer, etc.), critical-interpretive medical anthropology (Scheper-Hughes, Bourgois, etc.), structural violence (Galtung, Farmer, etc.), and social suffering (Kleinman, Das, etc.), among others. They share the diagnosis that in the cases of the health issues of migrants (but not only of migrants), what is at play is always “more than culture,” as summarized by Villa-Torres et al.⁽²⁾ They also engage in dialogue with the proposals of critical race theory^(3,4,5,6) and feminist contributions from the concept of intersectionality.^(7,8) From all these fronts

they seek to address in a renewed way the determination of class, gender, and ethnicity-racialization on health, emphasizing the structural character of these different “conjugated oppressions.”⁽⁹⁾

These works are largely driven by the need to develop an approach, language, and methods that allow a fruitful dialogue with health professionals and that is relevant for the *clinical care* of health problems. As specified by Quesada et al.⁽¹⁾:

Our qualification here is that vulnerability must be addressed not only in the political domain but also in the clinical encounter. We need to respond to critical medical anthropology’s challenge to move beyond the academy and to propose practical interventions that have immediate consequences.

What could be called a *pragmatic-critical relationship with the clinic* (and not only with prevention, promotion, administrative-bureaucratic aspects or advocacy) constitutes one of structural vulnerability’s distinctive impulses, giving rise to a relatively systematic proposal that pushes for the development of *structural competence* (instead of “cultural” competence) in health personnel.^(3,10,11,12)

This interview was conducted by Dr. Carlos Piñones Rivera on October 8, 2018, while he was a visiting scholar at the Institute for the Study of Societal Issues of the Berkeley Center for Social Medicine, within the framework of the Fondecyt Postdoctoral Fellowship (Project No. 3180173). The interview looks into the historical origins of this approach and seeks to explore its specific contributions, as a way to bring them closer to Spanish-speaking audiences and enable dialogue with the proposals of Latin American social medicine.

DIALOGUE

Carlos Piñones Rivera: So, first question is for you, Jim. Your work has been intimately bound in a deep reflection about structural violence. Can you tell us about how you came

to the concept of structural vulnerability considering that background?

James Quesada: Well, interestingly enough, the first time I ever heard “structural vulnerability” was from a Mexican anthropologist, Daniel Hernández Rosete.⁽¹³⁾ In the early 2000s we were working on a bi-national study of migrant agricultural workers. I remember asking him about it and it was still formative, it was still embryonic the way he was talking about it. So, the way that I understood it was really taking into account all of the social factors and structural forces that impinge, that shape and influence people’s lives, often to their detriment.

It’s sort of like cultural competency when we think about cultural competency as culture that needs to be taken into account for understanding a person’s wellbeing or ill health. Structural forces, as “structural competency” would argue, seem even much more important to take into account and particularly in the population we were working with, undocumented Latino laborers who do not have a steady income, the residency where they live is problematic, they’re doing day labor which is not a steady job at all. They’re looking over their shoulders because *la migra*, ICE (Immigration and Customs Enforcement), can get them and it’s that whole kind of constellation of issues that they deal with on a daily basis that we wanted to take into account. So, initially this whole thing came up in dealing with migrant agricultural workers but the more we thought about it, this is applicable to all kinds of people throughout society and numerous different populations and not just perhaps one of the populations that is really most vulnerable today, which is undocumented Latinos in this country.

Carlos: I read in your presentation on the university’s website that you align yourself with a critical medical anthropology tradition. What was unsatisfactory in the production of critical medical anthropology that led you to develop your own approach, namely “structural vulnerability?”

James: Critical medical anthropology is about taking seriously the whole history of critical theory in examining the world about us. It means taking political economy seriously, it means taking history seriously, it’s really about understanding the social basis and social distribution of ill health and wellbeing. Biomedicine and biomedical approaches, while absolutely important and while they have to be taken into account, cannot be seen as isolated or siloed from these other factors. So, the critical medical anthropology approach is trying to more systematically take account of all these other forces, the factors that shape people’s lives towards either positive or negative consequences and outcomes.

Seth Holmes: It sounds like part of what you’re saying, Jim, is that in a way “structural vulnerability” is a concept or a theorization that fits well within the history of critical medical anthropology.

James: Yes, yes.

Seth: And from my perspective as a medical anthropologist and as a physician, one of the things that you, the person you mentioned, Daniel Hernández Rosete, Philippe Bourgois and Laurie Hart did was take on the way that vulnerability (both within society in general, but especially within the health professions, public health and biomedicine) is understood to be either a result of individual characteristics, demographic characteristics, or individual choices, behaviors, health beliefs and what you did was make a strong counter to that: vulnerability is largely and importantly produced by structures of domination, structures of extraction, structures of exploitation, who owns the capital, and how that is racialized and gendered and citizenshiped in multiple ways. And part of what I’ve appreciated about structural vulnerability is that it’s been helpful not only to the social sciences of health and medicine, where a lot of people have started using that frame but also, it’s relatively understandable to health professionals in a way that really counters the assumption that vulnerability is an individual entity.

James: Yeah, one of the things that I think is under-theorized and not really thought about seriously, is when we think about health, we tend to either biologize or psychologize it and the whole realm of the social is kind of assumed, or secondary, or not even taken into account. And I think the social dimension, the social production and distribution of ill health, has to be seen in its own right. We talk about a biopsychosocial model that's used, but the social is usually kind of left out, or secondary, or minimized in terms of its importance. I'm not necessarily trying to say that the social predominates, but what I'm suggesting is that it needs to be taken quite seriously, that's number one.

Number two is to get away from stigmatizing and *blaming the victim*, blaming the people because of their own behaviors. That's where the psychology comes in to play, where often times the kind of interventions that occur in health settings are where the patients and the clients have to recalibrate and change their behaviors in ways to maximize better health, without taking into account all of the social conditions and circumstances that might prevent people from being more responsible.

However, what I think is important about structural vulnerability, is that it should really contribute to reformulating the way we offer medical care. It is good that we make diagnoses, that we understand the dilemmas and the deficiencies that people have, why they cannot obtain the medication they need, why they do not have a more nutritious diet, etcetera, etcetera. We can figure that out diagnostically, what their social status and conditions are. But what are physicians and healthcare professionals and practitioners supposed to do with that information? And that's the challenge, because what it does is make us rethink: What is actual health care? And what are healthcare interventions? To return to critical medical anthropology, when I think of health I can't help but think about great physicians who care a great deal for their patients but often times find themselves in institutions and have to adhere to institutional practices that limit the effectiveness of what they can

do. Structural vulnerability is not just for diagnostic purposes, it's for challenging biomedicine to really think how it institutionalizes practices.

Seth: One thing I was thinking in relation to what you were saying is that part of what structural vulnerability does to health care is reminds us that there's so much evidence of the social determination of health, of the structural production of vulnerability, that the appropriate response, or the most appropriate response, is not only intervening on the individual, either through clinical prescriptions or through public health and health education programs, but also importantly – and perhaps even more importantly – is intervening on the social-political-economic structures that place people in harm's way in a systematic manner in the first place.

I think that's what's really helpful about it and one kind of response perhaps has been *structural competency*. Jonathan Metzl is the first person I know who kind of came up with that term in his book *The Protest Psychosis* about eight years ago, but didn't really develop it as a field yet, and rather suggested instead of cultural competency we actually need structural competency. Because we know that these social processes are what are making people more or less sick in different ways. And since that time, Jonathan Metzl at Vanderbilt, Helena Hansen at New York University, Kelly Knight at University of California-San Francisco, a group of people including myself and Joshua Neff, Shirley Strong and a bunch of other people in the Structural Competency Working Group and Sam Dubal and people at Oregon Health & Science University and now people in Frankfurt, Germany and Vienna, Austria and all over South Africa and Australia have been thinking about: How do we implement structural competency? What might it actually look like? How do you train doctors who are focused so much in the biological and behavioral models to think now structurally, imagine structural production of health, and structural responses or structural interventions?

A lot of us have been working on developing trainings, thinking through how it might work to see if they help health professionals interact differently with their patients. In the Structural Competency Working Group here in the Bay Area, we developed a four-hour training for medical students, residents, and physicians. After the first training, the people who did the training said *"this is really important," "it gives me a language to think about things I've been seeing," "it helps me see them differently than I had before,"* and *"I keep thinking about it all the time."* But they also said, *"I feel overwhelmed because I'm not sure how to respond."* So, then we changed the training and added a significant section of examples through history that we could find of physicians, healthcare providers, and of different communities and different patient populations and neighborhoods doing things that we might say are kind of *structural interventions* that affect health so that they could think of examples and they could see that sometimes the responses are individual – helping an individual find resources for housing or something. But sometimes the interventions are collective – a neighborhood gets together, or the critical psychology collective in Tarapacá gets together and supports the people from Alto Hospicio after they're violently expelled or whatever. So oftentimes change happens collectively. And then what we've seen in the responses to the new version of the training is that people find the language and ideas helpful for them in interacting with their individual patients. They often feel more empathy or solidarity with their patients; instead of feeling like *"I'm working really hard for you and you keep smoking even though I'm telling you not to and I'm really frustrated with you,"* the physicians and healthcare providers often start to feel, or they say that they've been feeling more like *"you're experiencing structural violence and you're vulnerable because of these societal structures and I'm being impinged on by societal structures because I only have ten minutes or fifteen minutes to see you and the health insurance system in the United States is a very clear example of a structure that's*

confusing and broken for a lot of people." So there's less antagonism and more kind of *"we're in the same boat together."* And they've been feeling less overwhelmed because they have examples of both individual doctors and of communities and collectives that have responded.

James: I'm going to use an example: *La Clínica Martín-Baró*. It's a pro-bono clinic that is open and accessible to people on Saturdays and is located in the Mission District [San Francisco], which is the main Latino *barrio*. The people that maintain the clinic are both University of California-San Francisco medical students and San Francisco State undergraduate and graduate students in psychology, in Latino/Latina studies, in social work and what have you. What they have done is not only created a clinic that is accessible to people who do not have health insurance, but also they do outreach in the community to let people know that there's this clinic that's available for them. They not only provide basic primary health care but they have in liaison created relationships with local pharmacies, with San Francisco General Hospital, which is just blocks away. What they have done is just really network and try and create viable linkages with other services to the point where, for instance, within the clinic, you have what's called the patient navigator. And what that is, is an advocate, a person who works there who accompanies the patient to the pharmacy, or to the hospital, or to the clinic, or to the dentist. You know, a person who not only takes on the responsibility of making sure that they make appointments, but that they get to their appointments. It's going a step beyond the kind of conventional way we think about the delivery of health care where you go in and you wait 20 minutes or so, you're in, you're seen for about 15-20 minutes, you're given a prescription and you leave and they say maybe you have an appointment a month from now. Or they refer you to a specialist that you have to make a call for.

The practice of *La Clínica* is completely different. It's much more hands-on, much more from advocacy, a patient advocacy

position. With respect to the population that I work with, which is undocumented Latino day laborers, *La Clínica* has made wonderful outreach to that group of usually older, day laborers who have been in the country for years and years and for whatever reason they cannot return back to Mexico or Nicaragua or Honduras. They have all kinds of problems, do not have a steady income, do not have health insurance, and yet *La Clínica* has gone to them, done outreach. And a good portion of the people that go to *La Clínica* are undocumented day laborers who really do not have other alternatives or places to get the kind of health services that they need.

Seth: Could you say a little more about where you've seen structural vulnerability being used in a helpful way?

James: Yeah, I mean there's a book that's coming out next, early 2019 and it's a School of Advanced Research book, on cancer and structural vulnerability. I was teamed up with a number of both medical anthropologists and other medical social scientists who work in the realm of cancer. They invited me to see just how they might be able to mobilize and deploy the idea of structural vulnerability regarding cancer patients and survivors. And it was quite a remarkable group of cancer researchers that work in France, Puerto Rico, Vietnam, also here in the United States, to try and determine how in the experience of having cancer, trying to deal with cancer, getting the requisite therapy and treatment that they need, structural vulnerability might assist in understanding the cancer experience.

So, for instance, one thing that comes up invariably is that for many cancer patients and survivors, their whole world is turned upside down. If they were working, they maybe have to compromise the kind of work they do, cut hours, or altogether quit. The relationship with their family, the social networks which they rely upon is going through a whole renegotiation of how to deal with someone who has cancer. Whether they have health insurance and the kind of health insurance they have, and if the health insurance covers

the requisite medication. And the different kinds of treatments, chemotherapy, radiation, what are the shortcomings there? Turning to the state, will Medicare cover it? In Vietnam, will the state really be viably able to care for people who have cancer? What we did with respect to cancer was to understand that the social world that the cancer patients have to contend with is so turned over that it requires taking a patient-centered perspective of just how the world has been changed. And to try and work out the different kinds of ways by which people can be actually supported to go through their treatment and hopefully be able to survive and move on.

I'll give you an example, there's Carolyn Sargent and Peter Benson who did work with Malian refugee women in France. Among Malian refugee women, there was a high incidence and prevalence of breast cancer. In France usually, you cannot ask questions regarding about race, and I think it comes out of a French history of *égalité* and egalitarian ethos, where you don't ask those sorts of things. However, many epidemiologists and many cancer researchers found themselves kind of hindered in being able to study how the cancer was being clustered in particular populations and here we're dealing with a population that was mostly West African, plus the fact that many of them were not documented. So the issue was what ought to be the clinical intervention, because they had cancer, they had access to health care, and yet many were reluctant to get health care because if in fact their immigration status were known, even if they went through the treatment, even if they got cured, they could be immediately sent out of the country. They could be deported.

The question came up: How do we get health care practitioners to acknowledge that and document that? How do you actually negotiate a way to provide the necessary care and treatment for the people with whom you're dealing without jeopardizing their familial status, their work status, their residency status? And it continues to be a challenge in France, with particularly progressive health-care clinics and physicians and nurses and

social workers. How are you able to deliver these services in a way that is overt and open but at the same time does not jeopardize the status of the very people that you're trying to help?

This is where, again, we need to think of health care outside of a purely biomedical intervention and to think also in terms of social determinants of health. It's also an institutional practice that has social ramifications, social consequences, as well as individual personal consequences. And the question arises: What is the responsibility of health practitioners in addressing not just the biological problems that people present with, but everything else that surrounds that? So again, I don't know if I'm answering your question.

Carlos: Yes, that's very interesting. It connects with one of the deep problems that I'm interested in and that we have talked about with Seth. In my country, a public health policy about the health of the immigrants is being developed, and looking at the proposal of the policy from the point of view of structural vulnerability and the political determination of health issues, we can see that one of its biggest problems is that reduces racism to an exclusively interpersonal issue, not a structural one. So, I really want to hear your ideas about how a structural vulnerability framework can contribute to the formulation of better public policies.

James: I think that, speaking mostly from a public health perspective, to my mind public health is a subversive science. If it were really to take on the mantle of doing what is necessary for wellbeing and making sure that both individuals and populations are able to realize better health, public health is in an extraordinary position to make the argument that we need to not only take the social determinants of health seriously but we really need to rethink policy and rethink practices.

In order to make this change – and I think both in terms of structural vulnerability and structural competency – we have to acknowledge for instance how physicians, in

particular, doctors have extraordinary medical authority. With that medical authority and that sort of symbolic capital that physicians have, what would be possible if they were to use it, not just individually, but collectively? Like if the American Medical Association reached a point of acknowledging that we need to be talking about how people live, about whether people are getting a viable wage where they can actually care for themselves, figure out why it is we find tremendous food deserts in urban areas, understand that policy has to address what might be seen as housing or retail issues or what have you, but no, in fact, they are medical health issues.

And it's about being able to educate the general population, the citizenry, to understand these things from a public health point of view and not strictly as political issues that seem disconnected. So I think that taking the perspective of structural vulnerability, we can see how it's not just undocumented day laborers and it's not just Malian refugees in France, it's all people who have been subject to what I call the “-isms.” And this is where structural violence comes in. The “-isms” – racism, sexism, ageism – all of those things are generated in populations and have to be addressed adequately. I think they can be addressed formidably by public health people, not using moralizing arguments or even politicized arguments but using a health argument and health perspective that will contribute to the moral considerations and political considerations that ought to be taken into account as well.

But I think from a health and medical perspective, you have that power of really accentuating how all these other forces, social and structural forces, have to be taken into account and have to be addressed as problems in themselves, because in not dealing with them you are generating greater and greater ill health of all kinds.

Carlos: I have seen that here in Berkeley you're interested in what has been the theoretical and practical discussion in Latin America, specifically, in Latin American social medicine. So, really, I want to hear about that interest in the

framework of the theoretical and practical discussion you are carrying out here.

Seth: In a certain way, I'm a little bit embarrassed and think that we in the United States and the anglophone world are behind Latin American theorization of the social determination of health. Here we tend to talk about the social determinants of health, as variables that people look at, and it's important to look at them. But often times, those inequities, those inequalities are taken for granted - they exist in the world. And then we in the anglophone world usually just look at the mechanisms between the inequalities, the hierarchies, and the outcomes and we think about how to change those mechanisms, but we don't think about what engines within society are producing those inequalities in the first place or making those demographic differences matter in a certain way that makes people sick or die.

So, sometimes we have talked about the structural determinants of the social determinants of health to get people to go another step further, but I think the way Jaime Breilh and other people from Latin America have written about the social determination of health to really make us think about who owns the means of production and who doesn't, and who is being exploited and who isn't, and how that is racialized, and how it relates to indigenous people is very important. The move that Jim Quesada, Philippe Bourgois, and Laurie Hart and others have been making towards structural vulnerability

here is trying to bring some of that awareness of the political and social determination of health that Latin America has done a lot of thinking about, more to the anglophone world in a certain way. And especially, to do it in a way that clinical people, health professionals, public health professionals might actually start to understand and take on as something that matters, that might change their practice.

There are a lot Latin American social medicine theorists who have been thinking about these issues in many ways that are really helpful, and perhaps structural vulnerability in a certain way fits within critical medical anthropology but also within social medicine. It fits together with those other ideas. But when I think about what it adds to a social determination lens, I don't know exactly. From my point of view, structural vulnerability focuses on the social and political determination of health to enrich the health sciences in themselves, as well as to challenge institutional health practices to implement true social medicine. Structural vulnerability improves the demographic, individualized, privatized and behavioral understanding of vulnerability with an understanding of how social structures systematically produce vulnerability in different people in different ways. I hope that this important expansion to understanding the social determination of health leads to a change in the education of health professionals, in the practice of medicine and public health and, ultimately, in society.

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