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Diversity and difference: health professional training challenges

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Abstract *This paper aims to discuss the issue of diversity from its incorporation into the training of health professionals through the analysis of the National Curriculum Guidelines (DCN) of two Brazilian undergraduate health courses: medicine and psychology. Thus, it debates the concept of diversity from the contribution of the social sciences, considering the multiple concepts in the nature of social and cultural differences, breaking with essentialist concepts of difference. Reflecting on how diversity appears in the curricular guidelines of these courses, it analyzes from recent studies how this has been considered in training and the main challenges. Intersectionality is an essential political theoretical framework to apprehend the articulation of multiple differences and inequalities acting in a dynamic, fluid, and flexible way from particular historical contexts. Thus, it is sensitive to address the issue of diversity in the training of health professionals. We highlight the importance of studying differences, suggesting an analytical framework that articulates discourses, practice, subjectivation, and social relationships.*
Key words *Diversity, Difference, Health professional training, Intersectionality, Medical education*

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Introduction

What is meant by diversity and difference? How can understanding these terms impacts care for specific groups in the health system? How do stereotyped concepts about diversity influence health professional training? Multiculturalism and difference topics have become central in recent years, particularly with the escalating capitalist globalization. Understanding differences, how to work for the recognition of rights and otherness and overcoming situations that cause discrimination or prejudice have occupied debates in critical educational theories, social movements, and the construction of inclusive social policies[1-3].

Multiculturalism is linked, especially, with its development in Anglo-Saxon tradition countries or its former colonies, with the action of national states in delimited territories. It is based on recognizing the existence of different groups in interethnic or gender relationships, guided by affirmative policies and the recognition of identities in a given territory[1]. In this context, cultural diversity underscores differences, accepting heterogeneity. Multiculturalism-based policies gave greater visibility to discriminated groups and enabled the expansion of some democracies through initiatives such as schooling universalization or public support for languages other than those of the national state. Appreciating difference occurs by reinforcing a universalist ideal of democracy, equality, and citizenship[4]. However, as a relativist cultural-political practice, it blocked problems of interlocution between groups by sometimes expressing vague support for tolerance and respect for diversity[5].

A dynamic and contradictory process, globalization has promoted a set of changes, transforming local and personal social experience contexts. Expanding economies, communication technologies, and transport changed space and time concepts, modifying the social position of individuals. Globalization divides and unites, integrates and disintegrates, includes and segregates, which are some of the main attributes of its ambivalence[6]. In this sense, the development and transnational expansion of economies started to involve several countries, blurring cultural and ideological boundaries, affecting labor relationships, consumption, and the construction of subjectivities.

These changes resumed the debate on differences, insofar as national legislation and social and educational policies are insufficient to address the expanding intercultural exchanges. In other words, to address difference, each nation-state moved from integrative projects to selective and excluding processes on a global scale for which difference and inequalities can be seen as system components. In this sense, understanding difference stemmed from negotiations, assimilations, and confrontations, no longer seen as problems to be overcome[1]. The terms to be employed were revised. The word exclusion started to broadly express people without work ties, housing, and connection[7].

This globalization-borne context of transformations harbors situated historical feminist, black, LGBTQ (lesbian, gay, bisexual, trans, transvestite and queer) social movement mobilizations for the recognition of their rights, influencing and being influenced by them. Thus, for example, the use of the Black category can acquire a signal dependent on different political circumstances and particular socio-historical experiences, such as the expression of a colonial code, racialized discourse, displacement of the 'immigrant' and 'ethnic minority' categories or a political, of resistance against racism[3].

The term "diversity" has been employed to refer to a wide range of differences considering gender, age, sexual orientation, race/ethnicity/skin color, culture, religion, and nationality. A recurring issue is that these markers have been addressed by the essentialist perspective, which disregards historical and cultural dimensions. Often situated as body constituents, differences have been perceived as the domain of nature, a reality historically monopolized by life sciences. From the perspective of biomedical knowledge, the body is understood as the seat of vital processes[8]. Social sciences will criticize this reference, defining the body from its socio-anthropological composition, breaking with its naturalized view. The body is a socio-historically constructed symbolic reality at a given time and social formation.

Returning to the issue of difference, expressing a given identity, on the other hand, other identities and differences can be denied. As Tadeu da Silva observes, "assertions about difference also depend on a usually concealed chain of negative statements about (other) identities"[5]. Identity is understood as a construction, a constant work of fabrication, negation, and affirmation, which is subject to power relationships and dispute, as Butler rightly pointed out[9]. This "difference/identity" approach allows us to recognize tensions and transformations within contemporary activisms, where the expression of subjects

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who articulate themselves concerning "experience" and "body" prevails, resorting to the concept of intersectionality to make their trajectories and self-experimenting experiences[10].

Thus, the non-essentialized reading of identity indicates its transient nature, always expressing a "stance" shared with other groups of people, albeit ideally or symbolically. As with language, identity production seeks to establish and stabilize itself. However, it always escapes or identifies processes that prevent it from being fixed[5], which will involve different dynamics to reinforce a given markup. In the case of gender identities, for example, biology is often used to "outline", establish, and justify a normative parameter, while cultural essentialisms tend to prevail in the case of national identities. In this sense, as a rule, the strength of identity recognized as a parameter is not socially visible. Other identities taken as 'different' receive the identity's mark as an expression of differentiation. Thus, being white is not understood as a racial identity in a predominantly white society, but being black is.

The debate on the issue of diversity and difference is fundamental in a country like Brazil, which is historically marked by a diverse population and profound social inequalities. The general principles that govern the guidelines of the health courses include the importance of developing the necessary skills to ensure the defense of life and the Unified Health System (SUS), fundamentally reinforcing the reduction of health inequalities and meeting the real social health needs of the population[11]. We should consider the historically marginalized and socially invisible populations[12] to implement these principles.

From this context, this paper aims to discuss the inclusion of diversity in health professional training from the National Curriculum Guidelines (DCN) analysis of two undergraduate health courses: Medicine and Psychology. We selected the courses because of their recurrent strategic position in formulating concepts and explanatory categories about body, difference, and diversity. The choice to analyze the DCNs is justified by their importance and centrality in the organization, development, and evaluation of undergraduate courses in Brazilian Higher Education, specifically by their influence on Pedagogical Political Projects.

Intersectionality is understood as a useful analytical tool to understand and act on the issue of diversity in the training of health professionals, as it investigates "how intersectional power relationships influence social relationships in societies marked by diversity"[13]. The intersection of social markers of difference, such as gender, ethnicity/skin color, class, nationality, sexual orientation, and generation, can be worked in a contextualized and non-exclusive way in the social processes of domination and oppression and their impacts on health-illness processes, questioning the dynamics and complexity of their interactions at the individual, institutional, and structural levels.

This is a critical essay through which we initially analyze how the issue of diversities is found in the psychology and medicine professional training as established in the DCNs. The selection of papers for this analysis was based on the years of publication of the current DCNs for Medicine and Psychology training in Brazil (2011 and 2014, respectively). Based on these landmarks, we searched for empirical papers to support our reflections, using the interfaces between the terms "professional training", "medical education", "psychology", "medicine", "difference", and "diversity". We searched SciELO, PubMed, and Web of Science databases and selected publications that articulated the terms addressed with our manuscript's objectives. Thus, based on analyses in the literature on the subject, we debated the main challenges concerning how the theme of diversity has been incorporated into these processes.

The issue of diversity in the training of Psychology professionals

Psychology and other "psy" knowledge (psychoanalysis and psychiatry) held a privileged position in explaining what is currently grouped under the aegis of "diversity", especially gender- and sexuality-related[14,15] issues. From a historical viewpoint, the main nosologies for classifying non-heterosexual sexualities or non-cisgender gender identities derive from psychoanalysis and psychiatry[16]. More specifically, Psychology stands out in its historical role in the "assessing and diagnosing" trans people, with direct interference in the access to specialized health care for bodily transformations[17]. Therefore, and not by chance, criticisms have been directed at the theoretical-epistemological dimension of psychology, which produces a discourse for "differences" and assumes a universal subject "without any" race/ethnicity, class, sexuality, or gender[18] as a model.

Suppose it is true that psychology, with some exceptions, has produced individualizing approaches and perspectives consistent with the

naturalization of social inequalities and attribution of abnormality to certain social groups[19]. In that case, we observe the commitment of the (Federal and Regional) System of Councils to the promotion and guarantee of Human Rights, especially from the 1990s onwards[20]. The enactment of Resolution No. 1, of 1999[21], by the Federal Council of Psychology (CFP), is a crucial milestone in this process and establishes the work standards of psychologists regarding sexual orientation, reinforcing the role of professionals in promoting well-being and confronting stigma and prejudice, prohibiting pathologization and offering "conversion therapies" of sexual orientations.

The second milestone in this process is Resolution No. 1 of 2018[22], also issued by the CFP. Almost 20 years into Resolution No. 1/1999, this second document proposes another horizon of principles and commitments for professional work with transsexuals and transvestites. In opposition to pathologization, the Resolution takes a critical stand against discrimination and prejudice based on gender identity. At the center of the Resolution, in Art. 7, the text emphasizes that there should be no pathologization of trans and transvestites and reinforces the commitment to recognize the self-determination of these people vis-à-vis their gender identity. Outside the field of gender and sexuality differences, Resolution No. 018/2002[23] also establishes a commitment to fighting racism and the inferiorization of black people.

Such landmarks are responsible for a historical review of psychology, which recognizes social differences' political, historical, and sociocultural nature. However, considering the history of "psy" knowledge, a question may be: *how have psychology professionals acted in the face of issues related to "diversity" and "difference"?*

In research with psychologists, the belief in a supposed "psychosocial nature of homosexuality, bisexuality, and transsexuality"[24] was observed. Respondents did not infrequently associate sexual orientations and non-hetero and cisgender gender identities, respectively, with perversion, poor resolution of parental conflicts, or sexual abuse suffered in childhood, which was also found in the study by Vezzosi et al.[25] Based on both studies, we can identify some "psychological essentialisms" about sexual and gender "diversity", which coexist, in turn, with a rather general discourse on "respect for differences". This situation has led some authors[20] to state that, especially in the academic space, individualistic psychology that naturalizes sociocultural relationships and reinforces social inequalities persists.

The debate on the role of professionals leads us, in particular, to the topic of training. Some authors have highlighted the importance of reviewing traditional concepts and approaches in the light of criticism concerning gender and sexuality standards[25,26]. However, the DCNs of undergraduate Psychology do not directly mention sexuality, gender, ethnic-racial, and other dimensions as part of the mandatory curriculum[27]. The document embodies an emphatic concern with interdisciplinarity, the multi-determination of the "psychological phenomenon", and understanding of social, economic, cultural, and political aspects. However, interpretative flexibility of the DCN principles is possible and can account for different emphases and perspectives in teaching psychology.

Considering the above and, above all, the inexistence of more specific incorporation of aspects related to gender, sexuality, race/ethnicity in the current DCNs[27], we see an essential contradiction: on the one hand, there is a significant commitment, especially by the Psychology Council Systems, to review their approaches and practices based on the Human Rights framework and publication of action guidelines; and, on the other hand, traditional approaches in psychology, with a robust normative vocation around aspects related to "diversity" and "difference", which persist in training without, however, a review of their theoretical-epistemological aspects.

Thus, we could ask: *to what extent the debate on professional practice in the face of aspects related to "diversity" (of gender, sexuality, and race/ethnicity), while essential and included in resolutions, affects the theoretical-methodological bases of the profession?* As a result, we would like to question the use of the "diversity" category and its eventual limitations when essentializing groups without, however, promoting a critique of the theoretical-epistemological assumptions of psychology, which, to a large extent, tend to naturalize certain stands: that of a subject, white, universal, cisgender, and heterosexual. Thus, without a critique of heterosexuality, cisgenderness, whiteness, and other matrices of differentiation in social life, reflected also in Psychology, the uses of the "diversity" concept can acquire a generic and ineffective meaning before the real health needs of people and groups.

We should highlight that this contradiction between the formation and the frameworks and guidelines of the Council System fits a setting of

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contestation and dispute. Different bills have been filed since 2003 to amend or invalidate Resolution No. 1/1999 and allow the provision of "conversion therapies" of sexual orientation[20]. Besides the legislative offensive, psychology faces an internal dispute among professionals linked to fundamentalist religious sectors[19]. This aspect enhances the political dimension of the discussion on education and links this debate to the dispute between moralities and specific societal projects.

The issue of diversity in the training of medical professionals

When we searched for the word diversity in the DCNs of the undergraduate medicine course[28], we found six references to it and, except for the mention of preserving biodiversity, the term appears linked to the need for future doctors to understand and respect the diversity named in the "biological, subjective, ethnic-racial, gender, sexual, socioeconomic, political, environmental, cultural, and ethical dimensions and other aspects underlying the spectrum of human diversity". Of course, regulations governing the undergraduate Medicine course should express the need to look at the multiple health needs of the population, thus considering that diversity can and should permeate different aspects and spheres of contemporary life. However, how do the DCNs produce meanings for what is called diversity through the instructional language of this document?[3]

A careful reading of this document reveals the attribution of characteristics that speak of diversity in a global, generic way, differentiating people from presumed and unexplicit standards[29]. Perhaps a look focused solely and exclusively on the technical purpose of the document could say that the DCNs should not focus on scrutinizing what diversity they speak of when establishing Medicine graduation standards. However, we know that they generate a crucial institutional discourse, and we argue that the non-signification of what is called diversity can produce the opposite effect to the desired one, making it invisible instead of visible. After all, all diversity is encompassed in the same broad spectrum that does not predict intersectionality. Thus, even diversity would fall into the essentialism of being one, as if gender, race, political, and socioeconomic conditions were not determined and mutually determine themselves.

This broad mention of diversity leads us to the discourse of non-difference, pointed out in the study by Paulino et al.[30] When arguing the (non) care for the LGBTQ population in Primary Care in the SUS, family and community doctors participating in the study conjured the discourse of non-difference, claiming to make no difference between LGBTQ people and the other people cared for by them. In order not to promote prejudice in the discourse, they ended up making the differences, inequalities, and health conditions affecting the lives of the LGBTQ population in the SUS invisible.

Understanding the DCNs as a political discourse, we anchored ourselves in Brah[3] for a reflection we want to raise in this essay. The author points out that politicians could trigger the discourse of "ethnic difference" as a way of consolidating a power base without giving power to those whose needs would be better met with the elimination of the term "black". In other words, suppressing the term "black" in a discourse of "ethnic difference" can gain the sympathy of those who defend attention to diversity and, at the same time, of those who do not want to see the power relationships established in our society rebuilt. In the end, we know that the last ones win since the discussion of difference does not exceed the walls of what is well-seen and well-accepted. In other words, it does not face the need to produce a specific (and utopian?) social justice. Thus, diversity seems to gain space and time in Medicine without, in fact, winning, since the body control biomedical concept of a Cartesian, white, affluent, and heteronormative science keeps in the direction of which bodies (and diversities?) matter or not[9,31,32] for medical education in Brazil.

On this issue, we ponder that, in undergraduate Medicine, especially with the 2014 DCNs, Public Health disciplines play a crucial role in questioning diversity-related issues from an intersectional perspective, transcending traditional teaching that focuses on the pathological processes of illness. From the teaching-learning of Public Policies in Public Health, emphasizing knowledge in Social and Human Sciences in Health, one can create opportunities to recognize diversities in a critical, contextualized way, identifying the relevance of learning and intervening on them due to their effects on people's living and health conditions.

Furthermore, we should consider that internal contradictions underpin each difference – one does not start from the idea that there is absolute wholeness in each group or culture perceived as diverse. Moreover, we should consider the existing power and force relationships that transcend and determine them[4]. Thus, the reflec-

tions we propose in this essay are not intended to disqualify a more progressive and inclusive medical education but rather to discuss elements that aim to prevent diversity from being lost in an institutional discourse that can void the real needs of people in social places that are divergent-diverse to hegemonic models, in a relationship of invisibility and domination in our country.

Challenges to the training and practice of Medicine and Psychology professionals

The 2014 DCNs point to the need to train a medical professional with a reflective profile, assuming a resignification by strengthening the commitment to the SUS (through the importance of extra-hospital practice settings) and the doctor's social responsibility[28]. These changes aim to formalize a change in the profile of medical graduates; however, they are less directive and have broader guidelines. We will point out below some paths and challenges for the change in medical training and practice: in the teaching format and profile of first-year students and professors.

Regarding the teaching format, the DCNs point out the need to increase the practice load, shifting its central location to primary health care (PHC). As a result, PHC is appreciated as a gateway to getting in touch with social reality and preparation for humanist training. A clear challenge emerges at this stage: the barriers to access for the population in many locations. Some hurdles are imposed by the local operation, whether due to opening hours or even a lack of professionals. When thinking from a broader perspective, we see that the multiple experiences also change the obstacles faced: for example, for migrant populations, facing problems with documentary evidence, cultural and language barriers[33]; women deprived of their liberty, with difficulties in obtaining outpatient and hospital care, including prenatal and childbirth care; inmates from the prison system, with difficulty in maintaining care, especially regarding mental health[34]; indigenous populations[35,36], young quilombolas[37] from rural areas, and the black population[38] often suffer discrimination in care, racism and other violent actions that drive the population away from the search for adequate care. Depending on the population at hand, we have outpatient clinics for specific care intended to have trained professionals, such as the trans population, which has the provision of care as one of the barriers the access to health itself, which wards off the population[39-41].

Outpatient clinics with specific care segregate care given due to the specific health care needs. However, this segregation reduces the possibility of contact with the population, which depends on these clinics and, for the students, the possibility of attending them. Moreover, the focus of care for the Trans population in the SUS is located in the Transsexualizing Process, often restricting care to the focus of medical-surgical procedures[42]. The courses are not responsible for changing the care format. However, it is possible to establish relationships with the service to devise strategies to reach the desired audience, as the recognition of social reality and the possibility of working toward change is part of reflective training.

Part of thinking about reality and knowing the specific needs of different populations will stem from the knowledge and support mainly of the specific policies developed by the Ministry of Health with social movements, as was the case of the National Policy for the Comprehensive Health of Lesbians, Gays, Bisexuals, Transvestites, and Transsexuals.

One of the challenges for teaching medicine lies in breaking paradigms and shifting from disease-centered rationale to understanding the human as a social, historical, and multiple being. Some content translation stages will be in place until the student participates in a class that addresses these subjects: from the DCNs to the curricular, pedagogical plans, subject menus, and classes. Therefore, there will be a wide variety of proceedings as institutions autonomously decide how these contents will be approached, which is essential for contextualization, especially considering the different realities regarding health needs, access, and care nationwide.

Although the DCNs emphasize the importance of this approach and the policies themselves consider social aspects, the challenge is teaching and learning about diversity without reinforcing stereotypes or simply focusing on epidemiological arguments, which, when taken from population studies and brought to the individual plan, can be used as an oppression tool[43,44].

The transient nature of DCN guidelines, whose material aims to guide, can restrict the social aspect of the subjects because there is a risk of reducing social issues to a purely epidemiological issue when they are transcribed into a menu, stigmatizing or not being addressed: for example, using the homeless population as an example of teaching tuberculosis or chemical dependence, or teaching classes on Sexually Transmitted Infections (STIs) using the LGBTQ population as

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an example[44]. Another potential limiting factor for teaching these populations is relegating the content to elective courses, so only students interested in the subject will enroll. These inappropriate actions are possible and expected precisely because of the lack of delimitation in the courses' documents.

If there are groups with health needs and experiences that are not taught, who is the human being talked about in medicine courses? There is a hiatus in the taught body, the body that is intended to be universal and is studied in Medicine and the multiple bodies that exist in social reality. How do you teach and think about socially distant communities? One way of approaching this discussion is the quota policy itself and the internalization process of Medicine courses, which can diversify the profile of newcomers, thus becoming a facilitator of the estrangement of this being that is intended to be universal and of the 'boxes' in which each group is placed in isolation as if there were no intersections of lives[45]. This recent and still-in-progress process will even allow diversifying the teaching profile and can be a possible facilitator of reflective teaching.

Returning to the profile of the expected graduate with reflective training and ethical and social responsibility, how can one be reflective when the courses mirror the social structures that sustain inequalities? How can it be strange to be immersed in this self-sustaining reality? How to defend citizenship without concepts of rights?[46]

What are the challenges in the field of psychology? Vocational training is on the agenda and accompanies the ongoing review of the DCNs. Although not approved, the document Revision of the DCNs[47] of the course reinforces the importance of professionals being trained to assume an ethical and scientific commitment to Psychology with an explicit emphasis on the duty to know and respect "the Universal Declaration of Human Rights". In short, we identify the incorporation of a horizon politically committed to recognizing social differences and the fight against inequalities.

Unlike the previous and still-in-force version[27], the text of the DCNs under analysis admits as the central idea the "respect for personal, social, cultural, and ethical diversity" as part of the values and commitments that professionals in the field must adopt. Despite controversies about the elaboration process, the text seems to reflect the advances and milestones around professional performance in the face of issues such as gender, race/ethnicity, class, and sexuality. However, given the discussion developed, the question remains: *how to ensure that professional training includes such aspects?*

One of the challenges we can imagine is, in particular, the review of explanatory models and approaches in psychology, which – in their constitution – reflect conditions of production of knowledge historically committed to specific normativity. In the absence of a critique of epistemological concepts and bases and, in particular, their commitment to specific values, moralities, and worldviews, adopting a framework of commitments and principles based on respect for "diversity" can, in short, lose out its transforming power and lead to new essentialisms.

Intersectionality can play an essential role in addressing the issue of diversity by providing a synergy between knowledge, research, and critical praxis, providing an intersection structure "between social inequalities and economic inequality"[13], acting as an analytical tool in health-illness processes. As no intersectional structure as a model can be applied to all situations, we find a field that can feed different approaches. Working at intersections allows us to understand "the experiences and struggles of people deprived of rights"[13], collaborating with the exercise of autonomy by communities and individuals by giving visibility to historically marginalized populations. Furthermore, this approach can foster new questions and investigations in academic disciplines.

Final considerations

Despite having achieved fundamental advances in expanding access to higher education in the country and including the issue of diversity in the DCNs, barriers remain in the training process, and the appreciation and respect for diversity to ensure that the university is not a space for reproducing prejudice, but being more equitable. One of the reasons for this situation is that the teaching environment often perpetuates educational inequalities.

Regarding teaching-learning structures, we understand that the approach to diversity demands improvement, considering intersectionalities as a critical epistemological and political tool. Medicine and Psychology training should be established in practice as training focused on the social aspect through the social construction of being a doctor and a psychologist as a matrix

of experiences, in which diversity is not only discourse but the axis of the training of these professionals.

Collaborations

R Machin, DB Paulino, and JC Pontes worked on the design, methodology, analysis, and final writing. RRN Rodrigues worked on the methodology, analysis, and final writing.

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