Teaching Diversity in Healthcare Education: Conceptual Clarity and the Need for an Intersectional Transdisciplinary Approach

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Abstract

In this chapter, we explore the complexity of difference and the implications of this complexity for diversity education in healthcare. Drawing on fundamental ontology and epistemology from philosophy, education, and healthcare, we explore the importance of concepts, theories, and vocabularies in the development and delivery of diversity education in healthcare. We discuss the need for conceptual and theoretical clarity in many areas of diversity education, the

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importance of intersectionality in this respect, and the discord that exists between theory and practice in this context.

With this in mind, we then go on to consider solutions to the challenges of teaching and researching diversity education by evaluating the importance of transdisciplinarity as a vector for transforming understandings of complexity. With reference to the work of others as well as our own, we conclude by exploring the possibility of using an intersectional transdisciplinary approach to teaching and researching diversity education in healthcare. The implications of such an approach are considered in relation to institutional commitment and holistic working practices, thereby suggesting that conflict, debate, and subjective experience are important for bridging the divide between theory and practice.

Keywords

Diversity · Education · Healthcare · Intersectionality · Transdisciplinarity · Complexity · Difference · Self

Introduction

Concepts of diversity challenge global, historical, and political understanding of identity, power, and belonging. The UK population is richly diverse and ever developing. However, changes in the demographic landscape of the UK (Census Data 2017) present complex challenges for healthcare professionals and policy makers in achieving equitable care (Napier et al. 2014). Diversity education is designed to address these challenges by attempting to improve the knowledge, skills, and attitudes of healthcare professionals in serving culturally diverse populations (General Medical Council (GMC) 2009; Nursing and Midwifery Council 2015; Department of Health. Success Measures 2012). However, beyond broad agreements, how to teach diversity education has become a conundrum with questions about how, when, where, and why it should take place (George et al. 2019a, b).

In this chapter, the authors critically disentangle the vocabulary used in diversity education providing conceptual clarity about terms such as diversity. An overview of landmark theoretical frameworks is presented, highlighting the range of educational and political influences that have permeated our evolving understanding of diversity in healthcare education. Using examples from our practice and that of others, we discuss the discord between theoretical and practical applications of diversity education and the need for an intersectional, transdisciplinary approach in the future.

Diversity: How It Is Conceptualized, Theorized, and Taught in Healthcare Education

Conceptual Clarity: The Journey from Cultural Competence to Diversity

Understanding of self and others is important for constructions of identity and social norms and through debate and subversion, questioning of those social norms. As Butler discusses, "the terms by which we are recognised as human are socially constructed and changeable" (Butler 2004, p. 2). Although changeable, categorization of people through terms such as gender, race, ethnicity, and sexual orientation can make some individuals appear more socially desirable than others. If we are able to dismantle these categories, we open the possibility of difference, but if not, it is difficult for individuals to recognize themselves within these categories and live their lives to the fullest (Butler 2004). Definitions related to diversity are therefore important to critically understand in order to avoid simplistic categorization.

Relating this to healthcare, diversity education is a term synonymous with labels such as "cultural competence"; "equality, diversity, and inclusion"; and "unconscious bias." The assortment of vocabulary for these types of educational teaching reveals the lack of consensus concerning the "correct" terminology. These terms also vary across healthcare contexts with "diversity" being used more in the UK (Dogra et al. 2015), "culture" and "ethnicity" frequently applied across Europe (Sorensen et al. 2019), and "cultural competence" remaining prominent in the USA (Betancourt and Cervantes 2009). Definitions of diversity are complex, nuanced, and varied depending on the context and discipline in which they are utilized. The considerable variation and lack of conceptual clarity of these terms results in different diversity educations with differing intentions and educational objectives. Therefore, to better challenge our understanding and use of diversity in healthcare education, the terms cultural competence, culture, and equality must first be explored.

Early diversity education in healthcare proceeded within the remit of cultural competency training. The literature demonstrates several descriptions of cultural competence, the most commonly cited being "a set of congruent behaviours, attitudes and policies that come together to enable that system, agency or those professionals to work effectively in cross-cultural situations" (Cross et al. 1989, p. 1). The concept of cultural competence became prominent in healthcare as increasing numbers of studies showed significant disparities in health outcomes among minority ethnic groups. Initial healthcare training followed the premise that particular races and ethnicities had certain cultural beliefs and attitudes that impacted the delivery of healthcare services. Based on this early conceptualization, learners were expected to acquire knowledge about "other" cultures, i.e., their history, traditions, and core beliefs.

This traditional notion of cultural competence was reflected in definitions of culture, which favored group-based distinctions, categorizing people based on factors such as religion, race, or ethnicity, with an assumption of homogeneity in their healthcare needs (Bhui et al. 2012). However, cultural competence models

attracted negative criticisms about their assumptions that a healthcare professional can learn all they need to know about any one cultural group (Shen 2016). Criticisms were made of the disregard for the complexity of culture and that one could become "culturally competent" by learning a "shopping list" of generalized facts pertaining to assumed homogenous groups.

Culture is a highly debated concept with no single agreed definition. One definition of culture defined by Diversity in Medicine and Health is, "culture is a socially transmitted pattern of shared meanings by which people communicate, perpetuate and develop their knowledge and attitudes about life. An individual's cultural identity may be based on heritage as well as individual circumstances and personal choice and is a dynamic entity" (Dogra et al. 2015, p. 323). The manner and variation upon which shared meanings of culture are understood and practiced by individuals give rise to differences in understanding of health and illness. While values, beliefs, and practices can be shared in a "culture," "diversity" recognizes the heterogeneity among cultures and identifies characteristics that are autonomous and distinct. This acknowledgment of difference is vital in avoiding categorization that can create imbalances of power within shared social systems and stops the "undoing" (Butler 2004) of dominant discourses.

For instance, categorization of the gendered body in many shared cultures encompasses a compulsory heterosexuality (Butler 1990). This is congruent with heteronormativity (a societal understanding of relationships in which the perceived dominant structure is heterosexuality (Jeppesen 2016)) and heterosexual discourse, discourse being "bodies of ideas that produce and regulate the world in their own terms, rendering some things commonplace and other things non-sensical" (Youdell 2006, p. 36). However, this does not reflect the range of difference present in peoples' conceptions and expressions of gender and reveals the fiction of gender categorization (Butler 1990).

Many cultures inherently use such categorization in part because it creates the illusion of stability and understanding. However, those whose discursive gender performativity (the construction, rehearsal, and expression of gender within discourse (Butler 1990)) means they lie outside of heteronormative discourse can be othered. This creates a *dominant* heterosexual discourse in which categories of normal and pathological (Foucault 1969) based on sexual orientation and gender identity are made possible and nonheterosexual identities are seen as deviant.

In its broadest sense, any "difference" can be regarded as diversity and can include "all facets that define the way individuals perceive themselves" (Dogra et al. 2015, p. 323). Diversity is a term often associated with the concept of "equality" a widely acknowledged notion, which aims to ensure fairness in the distribution of healthcare services and practice, and describes "treating all individuals the same" (Bogg 2010, p. 2). Hand in hand with these concepts of difference and equality is legislation. The first cohort of equality legislation included the Sex Discrimination Act (1975) and was centered on the concept of "formal equality," meaning "likes must be treated alike" (Hepple 2010, p. 2), which referred to the need for identical clinical practices and heath provision to all individuals irrespective of their diversity.

Gradually, a growing transition toward the concept of "substantive equality" was reflected in legislation, which describes the need for practical adjustments within public bodies to cater for the diverse needs of individuals. The Equality Act (2010) streamlined all previous discrimination Acts and attempted to codify the numerous array of Acts and regulations, which formed the foundation of anti-discrimination laws in the UK. It provides a single Act, which draws attention to a variety of differences and aims to strengthen the protection of individuals. However, the Equality Act (2010) is not without its criticisms. For instance, in an important and necessary move, transgender identity was included in the protected characteristics of the Equality Act in 2010. However, there is evidence to suggest that despite this change, people who identify as transgender continue to experience significant discrimination in many areas including healthcare (Hudson-Sharp and Metcalf 2016). In a parliamentary report on transgender equality (House of Commons Women and Equality Committee 2016), it was stated that the definitions used in the Act were unclear and included outdated language such as "transsexual." This created confusion and contributed to certain individuals being left outside of legal protection.

Many authors in the field have acknowledged that diversity education is driven by political motives associated with equality legalization as opposed to clinical and educational need, resulting in diversity education being perceived as a legal "tick-box" requirement. The strong political influence on the development of diversity education has resulted in many unintended consequences, one being the compartmentalization of diversity characteristics such as race or sexual orientation as single, static facets of identity. This compartmentalization discounts the importance of the *interplay* between different facets and contextual, sociohistorical factors.

As equality legislation became broader in scope, the concept of "diversity" originated and new ways of conceptualizing "equality" began. It is widely acknowledged the "one-size-fits-all approach" is not appropriate for most clinical groups. "Diversity" became a favorable concept as it broadened the notion of "cultural competence" and was articulated in a manner that did not minimize racial inequalities but drew focus on the health needs of the entire population. Diversity and equality therefore became more inclusive of the complexity of identity and attempted to identify the intersections of diversity issues.

Intersectionality (Crenshaw 1990) is a term borne out of third-wave feminist and antiracist movements and is acknowledged in diversity education literature, although more emphasized in social identity theories and health inequalities literature. Collins and Blige describe intersectionality as "a way of understanding and analysing complexity in the world, in people and in human experiences. The events and conditions of social and political life and the self can seldom be understood as shaped by one factor. They are shaped by many factors in diverse and mutually influencing ways" (Collins and Blige 2016, p. 2).

As Crenshaw comments in her seminal article on intersectionality, "When the [antiracist and feminist] practices expound identity as 'woman' or 'person of colour' as an either/or proposition, they relegate the identity of women of colour to a location that resists telling" (Crenshaw 1990, p. 1242). Collins (1998) developed this theory

further, arguing that diversity is experienced to differing degrees at different times and because race, gender, and socioeconomic status are more visible, this visibility disproportionately compounds their impact. In this way, issues of diversity have the potential to enable layers of oppression that are not additive but multiplied. These layers of oppression are related to hierarchy and access to power and create specific social locations for those affected, which in turn are dynamic and constantly changing.

Intersectionality has strongly pushed against the notion of *blaming the victim* referring to the simplicity of attributing healthcare disparities to cultural or social behaviors alone. Instead, it recognizes healthcare disparities as part of a reciprocal web of problems associated with inequality, inequity, and oppression. It illuminates the *convergence* of experiences in a given sociohistorical and situational landscape.

Intersectionality draws upon a range of disciplines and overtly discusses social determinants of health. This is in contrast to decontextualized biomedical approaches present in healthcare education, which have influenced traditional notions of cultural competence and emphasize the behaviors of groups of patients as a source of healthcare disparities. This biomedical approach also has the propensity to create a power imbalance in favor of the healthcare professional. In Foucault's (1975) discussion on the subject in *The Birth of the Clinic*, a doctor's medical gaze strips away non-biomedical patient information and creates a power relationship that for the healthcare professional is doctor, and not patient, orientated.

This is in part because the biomedical model "assumes that all illness is secondary to disease" (Wade and Halligan 2004, p. 1398) and can therefore be treated by members of the medical profession. This has implications for patient care including an underappreciation of the patient's experience of illness, body-mind dualism, and a perceived priority of cure over care (Crowley-Matoka et al. 2009). Foucault argues that the power imbalance created by this approach affects communication, decision-making processes, and the treatment and labelling of different diseases. This, Canales (2010) argues, leads to exclusionary othering, where power relationships between people (in this instance patients and healthcare professionals) lead to subordination, which creates the potential for discrimination.

Various theoretical frameworks have been used in healthcare curriculums to teach diversity. While the authors describe their theoretical models or frameworks, the literature describing diversity education infrequently refers to a clear theoretical position, which is attributable to the lack of conceptual clarity of key terms. In the next section, we build upon the conceptual clarity of the term diversity and its key associated concepts to provide theoretical clarity on the purpose of diversity education in healthcare.

Theoretical Clarity: The Journey from "Other" to "Self"

We have seen so far how conceptual confusion has enabled discrepancies in how diversity education should be understood, theoretically framed, and delivered. However, by critically exploring theoretical frameworks used in diversity in

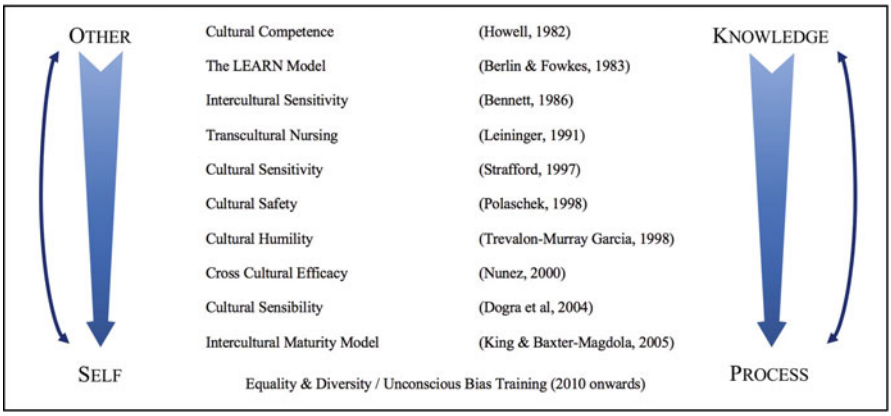

Fig. 1 Overview of theoretical frameworks used to teach diversity in healthcare, developed by R.E. George, 2017 (2017)

healthcare, we can see how and why there has been a movement from traditional notions of cultural competence to process-oriented models, where understanding the self takes precedence over gaining expertise about others (Fig. 1).

The notion of cultural competence stemmed from evidence suggesting racial and ethnic disparities in healthcare. Howell's model of cultural competence (Howell 1982) was one of the earliest theoretical frameworks in the 1980s. It defines a developmental four-stage approach of consciousness and competence that individuals progress through in becoming culturally competent, through the delivery of knowledge about "other" cultural groups. This model was influential in illustrating the need for staged learning in the development of cultural competence, which was later inherited by the frameworks developed by other authors (Campina-Bacote 2000; Bennet 1986). The structure of this theoretical framework suggests that achieving cultural competence is a linear process, failing to consider that individuals may regress back to previous stages or advance forward to the latter stages and that some may not transition through all stages.

The theoretical frameworks during the 1980s attempted to operationalize the stages in which cultural competence is developed (Bennet 1986); however they are abstract in their descriptions of the types of educational strategies and materials to achieve the proposed stages of development. The theoretical frameworks during the 1990s to 2000 illustrate the distinct fusion between cultural competence models and the emerging frameworks eliciting the importance of self-awareness.

Transcultural nursing emerged in 1991 (Leininger 1991) and was centered on culturally based care, values, and practices. Leininger's 'theory acknowledges the cultural dynamics that influence the nurse-client relationship, with the goal of providing culturally congruent holistic care. Care modalities are re-patterned toward the specific cultural needs of the patient and require co-participation and working together. However, it does not specify the skills necessary to elicit culturally relevant information from the patient nor does it stipulate how to work cooperatively to

achieve culturally congruent care. Furthermore, the model appears to pay an unbalanced attention to the cultural aspects of the patient as opposed to the healthcare professional. These criticisms were raised by other authors, including the lack of significance about the influence of the provider's cultural background in their understanding of the patient's cultural needs (Duffy 2001). Duffy argued that "greater critical self-reflection and acknowledgement of self" (Duffy 2001, p. 2) should be included.

Cultural sensitivity (Stafford et al. 1997) begins to advance the notion of "cultural competence" and proceeds by accepting the fact that there are cultural differences and similarities between individuals and those cultural differences are of equal value. Stafford defines cultural sensitivity as "being aware that cultural differences and similarities exist and have an effect on values, learning and behaviour" (Stafford et al. 1997, p. 78). In contrast to theoretical frameworks in the 1980s, it does not advocate a staged developmental continuum to achieving cultural competence and appears closely compatible with the notions of transcultural nursing.

Cultural safety (Polaschek 1998) developed as a subsidiary model of transcultural nursing, specifically addressing nursing practices toward different ethnicities and the needs of indigenous minority communities. The term "safety" had not been mentioned previously in theoretical frameworks concerning culture and sheds light on the status of certain groups and how they are perceived and treated in society. It argues that no healthcare interaction is ever simply objective. Rather a health professional operates from their own cultural mind-set, which influences how they relate to those they care for. This model is unique in explicitly drawing attention to the clinical relevance and safety of acknowledging cultural factors and the consequence of failing to do so for incorrect diagnoses, poorer quality of care, and unsuitable care plans. Nonetheless, it is developed specifically for indigenous populations, and although it may allude to the diversity within specific ethnic groups, it appears to assume that attitudes and practices may be culturally similar.

Cultural humility (Tervalon and Murray-Garcia 1998) is a theoretical model, which challenges the concept of learning finite bodies of knowledge about "other" cultural groups, which are typically expected in cultural competence models. Cultural humility proposes that "self-humility" allows professionals to engage in a lifelong commitment toward self-learning, evaluation, critique, and understanding of the power dynamics involved in the practitioner-patient relationship. It echoes the principles of patient-centered care and challenges professionals to grasp the importance of learning with and from patients. In comparison to models of cultural competence, cultural humility is a philosophy and an approach to practice and continual professional development.

More recent theoretical frameworks developed in the twentieth century demonstrate a move toward broader conceptualizations of culture and the introduction of the term "diversity." For example, the cross-cultural efficacy model (Nunez 2000) asserts that neither the caregiver's nor the patient's culture offers a preferred view. Nunez describes clinical encounters as a "tri-cultural" interaction, where the culture of the patient, healthcare provider, and the organization coexists. Nunez actively

recognizes the shared, multidimensional dynamics involved in clinical practice, allowing for a broad appreciation of differences at play rather than a knowledge-based approach.

The cultural sensibility model (Dogra 2004) focuses on encouraging healthcare professionals to understand their own sense of self and how this affects their perceptions of others. Akin to the cultural humility framework (Tervalon and Murray-Garcia 1998), it begins with professionals developing self-reflection and humility in order to help them make sense of their interactions with others. The cultural sensibility model is one of the few models where the approach is framed within a sound educational background. However, it does not explicitly address the necessity of interpersonal skills in cross-cultural interactions. Although it acknowledges the significance of context, it pays little attention to the cultural dynamics involved in clinical interactions. In comparison with the cultural humility model, both the cross-cultural efficacy and cultural sensibility models place less emphasis on the importance of the relationship between practitioners and their colleagues and the organizational/institutional factors influencing their personal and professional identity.

The intercultural maturity model (King and Baxter Magolda 2005) was developed shortly after the cultural sensibility model and adopts a constructive development approach (Kegan 1994; Piaget 1952). This refers to an individual's ability to internalize, interpret, and make sense of an experience. It is also developmental in accounting for the growth of increased capacity in one's ability to construct meaning in a more adaptive way over time. This model recognizes that achieving competence in cross-cultural settings is not an endpoint but a developmental process that adopts a continual cyclic practice. As with its predecessors, this model also emphasizes the importance of continual self-reflection, awareness, critique, and evaluation of one's understanding of personal culture and that of others. It emphasizes the impact of power, privilege, and oppression (issues highlighted in the concept of intersectionality), which affect the construction of knowledge, images of self, and interactions with others.

The different theoretical frameworks suggest a more pluralistic way of thinking about cultural differences than was originally proposed in cultural competence models. There is also inevitably some borrowing and cross-fertilization as understanding grows and frameworks develop. This cross-fertilization can be useful in developing ideas from multiple theoretical traditions and adds perspectives about the sociopolitical-historical context in which they are being produced. This departure from other to self and knowledge-based to process-oriented models can be seen in institutional requirements and healthcare expectations concerning diversity education (Fig. 2).

Despite theoretical frameworks related to diversity education gravitating toward the importance of the self, the concept of intersectionality has not been exploited and is challenging to identify in diversity education literature in healthcare. While the principles associated with intersectionality have been acknowledged in some theoretical frameworks, they are not overtly addressed. Furthermore, categorical approaches to identity continue to prevail in diversity education, and models such

Fig. 2 Overview of institutional requirements and policies in healthcare education for diversity teaching (developed by R.E George, 2017) (George 2017)

as transcultural nursing and cultural safety superficially address these issues (often only in a political manner by providing reference to equality legislations) despite commendable theoretical underpinnings to the contrary. This results in applications of these models unintentionally perpetuating dehumanizing stereotypes among patient groups and highlights the discord between theory and practice.

Evaluation and Curriculum: The Mismatch Between Theory and Practice

Despite progress in diversity education, learning objectives remain unclear and the associated literature remains limited. Price et al. (2005) conducted a systematic review of the methodological rigor of studies exploring healthcare-related diversity education and found studies were of low to moderate quality and of small value for the development of approaches in this field. In the UK (as well as the USA, Canada, and in certain parts of Europe), the quality of the literature does not appear to be consistently improving, and although an increasing number of healthcare guidelines encourage diversity education, there is little consistency in terms of delivery.

Diversity education has few robust evaluative mechanisms that appropriately capture the experiences of those involved and rarely includes long-term effects on patient outcomes. There is limited evidence to indicate whether the impact of diversity education is known or even being measured (Anderson et al. 2003). This is in part because of the heterogeneity of curriculum designs, which makes evaluation complex. There are no two studies that could evaluate the same diversity education experience (Price et al. 2005), and the lack of uniformity in educational designs makes it challenging to identify specific knowledge, attitudes, and skills, which should be measured.

Furthermore, many of the theoretical frameworks used in diversity teaching in healthcare are challenging to translate into an educational setting. Authors have criticized diversity education for oversimplifying identity, perpetuating categorization, stereotyping, and assuming homogeneity of people within diverse groups (Dogra et al. 2015; Sorensen et al. 2019). In addition, the lack of senior institutional support in establishing diversity curriculums remains an ongoing issue. Institutional buy-in without meaningful commitment runs the risk of enabling tokenistic, politically driven diversity interventions something, which could perpetuate simplistic understandings of diversity issues (George et al. 2015).

This is compounded by the educational philosophy on which higher education bases its understanding of health, illness, and education. Biomedical approaches remain deeply entrenched in healthcare education, which posit the idea of absolute truths and that there are "fixed truths about cultural groups that can be learned" (Dogra et al. 2015, p. 324). Driven by a positivist approach, these fixed truths give the illusion of objectivity through the separation of subject and object. Debates about the complex nature of subject and object, subjectivity, and their relationship to the self are considerable, ongoing, and beyond the remit of this chapter. However, a subject can be defined as an embodied entity (i.e., a human) and is used to

differentiate subject from object, where the object is the entity, which is observed (i.e., reality). However, Foucault discusses how the representation of the object, the dynamic nature of the subject, and the influence of power on the relationship between these entities make simplistic categorization of the subject and object problematic (Foucault 1983); as we have seen above, simplistic categorizations can be destructive.

Furthermore, Nicolescu (2014) argues that the separation of subject and object (in this context humans from reality) is artificial, causing simplification and categorization of reality. Therefore, the complexity of the space between the subject and object is something that intersectionality and transdisciplinarity can provide educators and researchers with an opportunity to reconsider.

Intersectional Transdisciplinarity in Healthcare Education: Thinking Beyond Models and Frameworks

Transdisciplinarity: Theory, Application, and Challenges of Using this Concept in Healthcare Education

Transdisciplinarity is often described in relation to research methodologies and sustainability science and was first discussed by social reformers and education scholars in the 1970s, including Piaget. The concept has gone through several periods of popularity and subsequent obscurity, each peak of activity coinciding with sociopolitical events including the end of the cold war, changes in global communication, and climate change (Bernstein 2015). Generally, there appear to be two schools of thought concerning transdisciplinarity. Nicolescu, a theoretical physicist and leading scholar in this area, described it as transcending the constraints of disciplinary silos, thereby enabling people to look beyond the essentialism of subject and object and embrace the philosophical complexity of the space in between these entities (Nicolescu 2002, 2006, 2014). He describes transdisciplinarity as, "That which is at once between the disciplines, across the disciplines and beyond the disciplines … one of the imperatives is the unity of knowledge" (Nicolescu 2014, p. 187).

Another school of thought emerged at a similar time to Nicolescu and is arguably more practical as it concentrates on directly answering real-world problems using experience across a range of disciplines. Gibbons et al. (1994) worked collaboratively using their "Mode 2" transdisciplinary framework to solve context-specific issues of the day. The Mode 2 framework utilizes a range of transdisciplinary perspectives to formulate key research questions and associated research agendas. Their concept was highly analytical and helped in the establishment of transdisciplinarity in research methodologies and policy production (Bernstein 2015) and is associated with the Zurich approach to transdisciplinarity (Klein et al. 2001).

McGregor (2015) argues that the Zurich approach that emerged from Gibbons et al.'s (1994) work assumes that scientific knowledge creation is the highest in terms of academic value and that a transdisciplinary research approach is designed to use

stakeholder expertise to enhance *scientific* knowledge creation. Nicolescu (2014) also argues that Gibbons et al.'s (1994) understanding of transdisciplinarity constrains the approach to the interaction of disciplines within social limits in part because of its concentration on transdisciplinary problem-solving and because it limits understanding of people to within social systems.

Due to the complex nature of this approach, like intersectionality, the term transdisciplinarity is used interchangeably with interdisciplinarity and multi-disciplinarity, which are often ambiguously defined. Choi et al. (Choi and Pak 2006) describe these terms as being on a spectrum of multiple disciplinary approaches with overall aims being to resolve complex issues, create multiple perspectives on issues, and provide excellent healthcare through research and guidelines. However, transdisciplinary approaches do this in a holistic manner, drawing on expertise inside and outside of academia.

Transdisciplinary approaches have been used in healthcare for decades (Kessel and Rosenfield 2008) in areas such as population science, curriculum development, and HIV medicine. However, limitations exist that constrain the use of transdisciplinarity in this context. As Gehlert et al. (2010) discusses, transdisciplinary approaches often represent an ideal as opposed to a reality in medicine and medical research. Challenges in using a transdisciplinary approach include people having to work outside of their comfort zones and conflict between individuals. The value placed on the knowledge created by different collaborating disciplines was also identified as a challenge, as was the rigid nature of higher education and funding structures for individuals and groups. We argue that another challenge with using transdisciplinary approaches in *diversity* education and research is the considerable disagreement that exists within disciplines. If single discipline cannot find agreement (even to disagree) about how to discuss the complexity of diversity and difference, how can we expect those in different disciplines and those outside of the academy to do so either.

Intersectional Transdisciplinarity: An Alternative Approach to Diversity Education

The simultaneous acknowledgment of an intersectional transdisciplinary approach addresses the aforementioned limitations in these two schools of thought. In making this argument, it is not our intention to artificially combine these two concepts in a hope to find a solution to all of the challenges described. Instead, using a range of theories, models, and practical examples, we aim to reconsider difference as both a philosophical and practical issue. We define intersectional transdisciplinarity in diversity education as a way of challenging illusions of stability related to understanding and categorization of difference within human experience. Intersectional transdisciplinarity strives for unity of knowledge about existence that utilizes perspectives from across, between, and beyond disciplines in relation to inequality, inequity, and oppression outside of the constraints of isolated social systems.

Intersectionality and transdisciplinarity are complementary in approach and application. Both consider the complexity of human experience and the multilayered factors that play a part in this multifaceted experience. Both have also been applied to global issues such as social injustice and climate change, respectively. However, the relationship between intersectionality and transdisciplinarity is less linear than it initially appears. Authors have argued that intersectionality is a transdisciplinary theory (Blige 2010), but it is arguably true that intersectionality explores issues within social systems, something which transdisciplinarity would encourage moving beyond (Nicolescu 2014). There have therefore been discussions about the need to reconsider understandings of "systems" within intersectionality and how this reconsideration could apply to the complexity of difference (Walby 2007).

This debate is complex and ever-evolving, and therefore we argue that a theoretically driven combination of these two approaches can enable a reconsideration of difference outside of social limits. We also argue that this could help us rethink assumptions about the space between the subject and object (Nicolescu 2014). This creates the opportunity for transformation: the creation of new theory and methodologies that are borne out of the conflicting and complementary elements of both approaches.

This combination also enables a reconsideration of the self as contiguous with time, space, and place and in so doing re-evaluates the value of co-constructing knowledge using experience spanning history, space, and sociopolitical contexts. This fundamental approach also leaves room for conflict and disagreement and the exploration of inequality within micro, meso, and macro levels in, for instance, higher education institutions. In higher education, both intersectionality and transdisciplinarity also face difficulty with institutional commitment bought about by conflicting educational priorities and challenging funding structures. However, through an intersectional transdisciplinary approach, the individuals involved would represent a range of people, some of whom will be in powerful institutional and political positions, making it more likely that interventions would be valued.

Examples from the healthcare literature illustrating a similar combination of approaches are limited. In one example, Clark et al. (2015) argue that intersectionality and critical reflexivity provide the methodological and theoretical basis on which transdisciplinarity can be developed as a source of knowledge creation in their discipline, addiction research. They discuss the utility of transdisciplinarity for researching "real-world problems," and using examples from their own practice, they illustrate the gaps in care that are made clear when applying this approach, most notably institutional and governmental policy development. How our approach differs from Clark et al. (Clark et al. 2015) is that we include intersectionality and transdisciplinarity within one approach that encompasses all three of ontology, logic, and epistemology (Nicolescu 2014) relating them to the complexity of difference. We argue that this approach needs to include debate, providing a space to discuss uncomfortable issues and through this debate transform our understanding about the issues. With this in mind, our main aim is not knowledge production and transdisciplinary problem-solving but a collaboration that takes all those involved to a new, holistic understanding of the complexity of diversity.

BRAIDE: An Example of Intersectional Transdisciplinary Diversity Education in Medicine

An example of using intersectional transdisciplinarity from our own practice is BRAIDE (Bringing Resources and Awareness In Diversity Education). BRAIDE is an eLearning platform designed to explore diversity with staff and students and feeds into existing diversity curriculum content in the medical degree in our institution. Multimodal teaching approaches were used to challenge the biomedical model and enable those accessing the site to explore and discuss the "self" more generally in relation to diversity.

We worked with collaborators such as BARC (Building the Anti-Racist Classroom (BARC) Collective 2019) using their Student Journey Game. This can be played by both academics and members of professional services staff and has been developed for UK university staff that are committed to or involved in developing interventions that address racial discrimination and inequalities in higher education. The BARC Student Journey Game has been designed in collaboration with BARC artist in residence Maria D'Amico and Student Consultants, specifically the undergraduate students of color leading the Re-imagining Attainment For All 2 (RAFA2), Higher Education Funding Council for England/Office for Students project. The game was commissioned in 2019 by RAFA2 teams based at Queen Mary University of London and University of Roehampton. We also worked with an academic and documentary filmmaker (Fong 2016) to explore the complexity of identity through her film exploring the lives of transgender people in the UK. The film was used as part of face-to-face and self-directed learning sessions, and students were encouraged to discuss their subjective experience of watching and reflecting on the film in a discussion forum on BRAIDE.

As well as forming part of the core curriculum in clinical and communication skills, BRAIDE formed part of a special study component for first-year medical students in our institution. Within this, poetry and conceptual art workshops were used to encourage students to challenge their understanding about diversity. In one workshop, students were asked to use colored ribbons to weave a creative piece as a platform to talk about intersectionality, complexity, subject, and object. Students fed back that this workshop helped them think about diversity in relation to their professional and personal identity and enabled them to relate diversity to themselves, others, and the implications of healthcare inequalities in different contexts.

With internal funding and crucially senior management commitment, we were able to integrate diversity education into our medical curriculum in years 1 and 3. However, internal funding also limited us to using the platform within our institution only. The majority of content development and delivery was therefore undertaken by us as leads for the project, which was challenging with our other professional commitments. Kessel et al. (Kessel and Rosenfield 2008) advocate a "heterarchy" to overcome an overreliance on central researchers, which they define as a flattening out of hierarchical structures that can be used both as an analytical tool and the application of transdisciplinary approaches. To employ heterarchy, they suggest flexibility not just in terms of roles but also methodology and communication between stakeholders.

Another challenge was coordinating a transdisciplinary team and ensuring multiple perspectives on diversity were heard and valued. This was influenced by the support we received during the project, and Kessel et al. (Kessel and Rosenfield 2008) suggest to approach funders that appreciate the complexity of transdisciplinary projects to overcome this. They use the example of the National Institute of Health, discussing guidelines and supportive mechanisms that they have in place to make a transdisciplinary project possible. Therefore, looking forward it will be important to take account of the policy of funders in relation to the unique challenges of intersectional transdisciplinary projects.

Conclusion

We have seen that diversity is a complex term, understandings of which depend on perspective, history, and context. Diversity is a term that is defined by and defines other terms and the way in which these terms interact and influence policy, practice, and curriculum design. We have also seen that there are a multitude of conflicting and complementing theories that demonstrate the complexity of diversity and its impact on stakeholders of higher education and healthcare. Teaching diversity is challenging and needs consideration beyond politically driven, superficial interventions, and the authors argue this necessitates an intersectional transdisciplinary approach.

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