CURRICULAR VIOLENCES: THE (IN)VISIBILITY OF THE LGBTQIA+ BODY IN MEDICAL TRAINING

VIOLÊNCIAS CURRICULARES: A (IN)VISIBILIDADE DO CORPO LGBTQIA+ NA FORMAÇÃO MÉDICA

VIOLENCIAS CURRICULARES: LA (IN)VISIBILIDAD DEL CUERPO LGBTQIA+ EM LA FORMACIÓN MÉDICA

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ABSTRACT: This study is part of discussions about medical education, specifically about medical curriculum and the dimensions of body, gender, and sexuality. From the connection between these themes, the present work aimed to analyze how the body, gender, and sexuality are addressed in the Political Pedagogical Project (PPC) of the medical course of the Academic Unit of Life Sciences - UACV/CFP/UFCG (Cajazeiras Campus). To account for this research proposal, we based the theoretical and methodological framework on post-critical studies on curriculum. As the object of document analysis, we took the DCN of 2001 for the undergraduate medical course and the PPC of the course in question. Finally, we argue that multiple discursive formations - from the official norms and guidelines, scientific, biological/biomedical, social, and pedagogical - enter into a dispute in the curriculum composition for the approach to knowledge about gender and sexuality.

KEY WORDS: Curriculum. Medical education. Gender. Sexuality. LGBTQIA+.

RESUMO*: O presente estudo se insere nas discussões sobre formação médica, e de modo específico, sobre currículo médico e as dimensões de corpo, gênero e sexualidade. Da conexão entre esses temas, o presente trabalho objetivou analisar como o corpo, gênero e sexualidade são acionados no Projeto Político Pedagógico (PPC) do curso de medicina da Unidade Acadêmica de Ciências da Vida — UACV/CFP/UFCG (Campus de Cajazeiras). Para dar conta dessa proposta de investigação, fundamentamos o referencial teórico-metodológico nos estudos pós-críticos sobre currículo. Tomamos como objeto de análise documental as DCN de 2001 para o curso de graduação em medicina e o PPC do curso em questão. Argumentamos ser múltiplas as formações discursivas — das normativas e diretrizes oficiais, científicas, biológicas/biomédicas, sociais, pedagógicos — que entram em disputa na composição curricular para a abordagem de saberes sobre gênero e sexualidade.*

PALAVRAS-CHAVE*: Currículo. Formação médica. Gênero. Sexualidade. LGBTQIA+.*

RESUMEN*: El presente estúdio forma parte de las discusiones sobre la formación médica, y específicamente, sobre el currículo médico y las dimensiones de cuerpo, género y sexualidade. A partir de la conexión entre estos temas, el presente trabajo tuvo como objetivo analizar como el cuerpo, el género y la sexualidade se activan em el Proyecto Político Pedagógico (PPC) de la carrera de medicina de la Unidad Académica de Ciencias de la Vida – UACV/CFP/UFCG (Campus de Cajazeiras). Para dar cuenta de esta propuesta de investigación, nos basamos em el marco teórico-metodológico de los estúdios poscríticos sobre el currículo. Se tomó como objeto de análisis documental la DCN de 2001 de la carrera de Medicina y el PPC de la carrera em mención. Sostenemos que existem múltiples formaciones discursivas – desde normas y directrices oficiales, científicas, biológicas/biomédicas, sociales, pedagógicas – que entran em disputa em la composición curricular para el abrodaje de saberes sobre género y sexualidade.*

PALABRAS CLAVE*: Currículo. Formación médica. Género. Sexualidade. LGBTQIA+.*

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Introduction

> "One afternoon, before we started the class, a student (doctor) told us details about his consultation the day before. I was surprised by the lack of ethics and by the details that were exposed naturally, exposing extremely homophobic and transphobic content, and supported by speeches of other colleagues who were present there, who laughed and debauched gay and trans patients who came to them in search of care, in a performative staging of a true theater of horror. One of them even said: "these trans people, I don't know what, they need to be beaten up, and not to be seen by a gynecologist, no" and, right after that, a doctor finished his colleague's speech: "a beating, I think is not enough".

The report-transcribed account is an excerpt from doctoral research, and it exposes LGBTphobia by a group of physicians, moments before starting a class in a graduate course in health education in which they were enrolled. A graduate course whose teaching-learning strategies were active methodologies based on constructivism, that is, the educational activities were developed around critical-reflective analysis, dialogues, searches, encounters, and re-signification. The teacher's presence in the room did not prevent embarrassment during the report. They understood that from her white perspective (everyone there was white), she was an equal – white, heterosexual, and cisgender.

How can people to whom we entrust our lives and expose the intimacy of our bodies ridicule and distill hate with such intensity? It reverberated in our imagination how the consultation would have gone and how violent it would have been in many ways. The protagonists of the above story are doctors who act as preceptors in internship and residency programs. Thus, we are instigated to reflect on medical training and the models of teachers that accompany medical students from the beginning to the end of their academic journey.

The Brazilian Constitution, through the Unified Health System (SUS), ensures the right to health; however, when it comes to the demands and specificities in the health of socially vulnerable groups - such as the Lesbian, Gay, Bisexual, Transgender, Transsexual, Transvestite, Queer, Intersex (LGBTQIA+) population - there are barriers before a conservative and heterosexual-cisgender-normative society. Even after the implementation of the National Policy for LGBT Integral Health (PNSILGBT) in 2011, access to health services by the LGBTQIA+ population is described in the literature as characterized by obstacles ranging from discriminatory care by health professionals, misinformation regarding the specificities and rights of this population, and even physical violence during a consultation with the doctor, which can give rise to an insurmountable barrier in accessing these essential services (SAADEH

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et al., 2018; GIANNA; MARTINS; SHIMMA, 2018; CALAZANS *et al.,* 2018; LONGHI, 2018).

In parallel to the challenges of enforcing the rights acquired by the LGBTQIA+ community, most scientific articles published on the implementation of PNSILGBT bring information about the implementation in capitals and large urban centers (SENA; SOUTO, 2017; CALAZANS *et al.,* 2018) and it is recurrent for authors to highlight the need to include in the training of medical professionals, aspects that are not merely biological about human sexuality and health care with sexual minorities, either still in the undergraduate course or the professional path in health services (RUFINO; MADEIRO, 2017; NEGREIROS *et al.,* 2019).

The guarantee of trained health professionals who understand the demands of the LGBTQIA+ population, who recognize the free exercise of sexuality as a human right to be respected and promoted, who know that the health field is a space for welcome and respect, especially when the people who seek it are in a situation of vulnerability, should be reflected in the curricular guidelines, as well as in the Pedagogical Course Project (PPC) and described in the menus of the theoretical and practical disciplines of health courses (BOLONHA *et al.,* 2022). This reflection corroborates Lionço (2008), who points out that health professionals must have greater proximity to public policies and the specific issues of the LGTQIA+ population to qualify for services the various areas provide.

From this perspective, the present work aims to problematize how medical training, expressed mainly in curriculum documents, creates an environment of violence - we bring as an example the LGBTQIA+phobia by doctors described at the beginning of the article, and by the "absent debates" in the context of professional training - especially regarding the denial of diversities, the endorsement of binarisms and the positioning of life in the scenario of unequal and excluding capitalist relations. Therefore, we take as the object of investigation the official curriculum for the training of students of the Undergraduate Medical School of the Academic Unit of Life Sciences - UACV/CFP/UFCG, where we will analyze how the dimensions of body, gender, and sexuality constitute the Pedagogical Course Project (PPC); we aim to identify what kind of medical subject is produced by this curriculum and if this subject dialogues with the performance required by the Unified Health System (SUS) regarding the care of the LGBTQIA+ population.

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Methodological inspirations

To achieve the proposed objectives that investigate the relations that are present in the curriculum, body, sexuality, and gender, the methodological inspirations were in the theoretical and methodological approaches of post-critical research in education. The post-critical theories in education question the knowledge (and its effects of truth and power), the subject (and the different modes and processes of subjectivization), the educational texts (and the different practices that these products and institute), and discussed, also, issues of gender, ethnicity, race, sexuality, age (PARAÍSO, 2004; SILVA, 2017). Thus, studying the curriculum by this post-critical theory promotes looking at any curriculum or discourse as an invention. And more, it instigates us to make other inventions to enrich this curricular territory with new meanings. In the wake of the relations of knowledge and power, science, the university, especially the curriculum and the healthy subjects, are constituted.

We carried out a documental analysis of the National Curricular Guidelines (NCG) for the undergraduate course in Medicine and the respective PPC. We emphasize that the DCN that led to the elaboration of the PPC were those published in 2001; thus, these documents constitute the central objects of this analysis.

In the discussion proposed here, the medical course curriculum functions as the articulation device between asymmetric power relations headed by the State, the Market, and the practices of knowledge materialized in medical procedures that affect the bodies of subjects and populations. For Foucault (2017), the body is essential to power - "All power is physical, and there is a direct connection between the body and political power" (FOUCAULT, 2017, p. 15, our translation). The organizer, the inflection point of this circulation of knowledge, and the regime of truth produce what is false and what is true. In the words of Veiga-Neto (2002, p. 165, our translation), "[...] to the extent that the curriculum operates the distribution of knowledge - placing and arranging it, hierarchizing it, tinting them and classifying it, assigning values to it - it establishes the background for everything else (in the world) to be understood geometrically".

The curriculum results from how education is seen, with hegemonic socioeconomic, political, and cultural contexts and references at a given moment. It plays a role in forming and guiding professional practices involved in a web of relationships, conflicts, power, interests, normativity, and possibilities.

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We can understand, in this way, that education has been a strategic instrument to meet a (given) model of normativity, whether religious or secular, liberal or neoliberal, serving the current sociopolitical order.

The DCN for the medical course and the management of the PPC - which meetings and mismatches are promoted?

The DCN for health courses resulted from a political, cultural, institutional, and educational process. Examples of these processes are the Federal Constitution of 1988, which made public the creation of a health system - the SUS, and the Law of Directives and Bases for National Education (LDB) No. 9394/1996 allowed the flexibility of educational curricula. Between 2001 and 2004, the Ministry of Education (MEC), in partnership with the Ministry of Health (MS), through meetings of the National Health Council (CNS) and the National Education Council (CNE), approved the DCN (2001). They are official documents that guide Higher Education Institutions (IES) to prepare the PPC of health courses and, therefore, were instituted with "the goal of offering a training that enables the qualification of health care, contemplating the principles of the SUS" (COSTA *et al.,* 2018, p. 2, our translation).

Social movements, organized around the sanitary reform, contributed to the institutionalization of the process of health training in the country so that the Federal Constitution establishes, in its article 200, that the Unified Health System (SUS) is responsible for "ordering the training of human resources in health" (BRASIL, 1988, our translation). Raimondi *et al.* (2020) also note that the training of health professionals should therefore be in line with the real health needs of the population. For this, the inclusion of the social accountability[3] perspective was promoted as a central element for the paradigm of health education for the new millennium. This reference is absent in the DCN of 2001 because it was published in 2010.

The DCN of 2001 for the undergraduate medical course was revised and expanded - a document composed of six pages and 14 articles was expanded to 14 pages and 41 articles in the new DCN of 2014. The PPC of the undergraduate medical course at UACV/CFP/UFCG approve in 2017, ten years after the beginning of the course, and it had the DCN of 2001 as its

[3] This term must still be translated because it is not restricted to social responsibility. It is a commitment to accountability, to a relationship that begins by welcoming the social and health concerns of communities, regions, or nations for teaching, research, and service activities. It is characterized, therefore, by the need for educational institutions to be engaged in improving the performance of health systems, adapting the essential professional competencies to specific contexts and scenarios (FERREIRA *et al.*, 2019).

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theoretical reference. In addition to this point, the DCN of 2001 does not mention biological, subjective, racial-ethnic, gender diversity, or sexual orientation. The absence of these terms in the DCN of 2001 strengthens the discourses that fuel the medical curriculum that builds its PPC based on these guidelines and whose basis is formed by hegemonic masculinities, which make clear the gentrified and heteronormative potential of the behaviors presented.

According to these perspectives, the formative processes in health - teaching, research, and extension - and the offer of health services should be built and guided in line with the community's health priorities, including the most vulnerable. Remembering that the SUS brings equity as one of its doctrinal principles, this refers to recognizing the diversity of population groups with their specific needs, welcoming up to the limit of what the system can offer to all (BRASIL, 1990). It is consensual the expectation that, in this way, the graduation in Medicine must assume a commitment to training professionals capable of recognizing such differences among their patients to promote care guided by equity.

To dialogue in consonance with the principles of the SUS, the first National Curricular Guidelines (DCN) for the Medicine Course were created in 2001 (Resolution CNE/CES no. 4, of November 7, 2001). However, it is worth remembering that every curricular reformulation uses symbolic strategies to create strong rhetoric to achieve the desired changes and to direct the creation of knowledge, subjects, and realities. In the case of Medicine, these strategies are expressed in the institution of the National Program of Incentive to Curricular Changes in the Courses of Medicine (PROMED), which occurred in 2002 in a partnership between the Ministry of Health and the Ministry of Education (BRASIL, 2002), and the National Program of Reorientation of Professional Training in Health (Pro-Health I) in 2005[4] . These programs aim to encourage medical schools all over the country to incorporate significant pedagogical changes in the curricula of medical courses, reaffirming the National Curricular Guidelines of 2001. Finally, it is evident the imminent articulation between Educational Institutions, Public Policies in Education, and Health to adapt health education according to the population's needs, demands, and characteristics.

These Directives assume a regulation and control profile observed when defining the curricular contents of the PPC of the undergraduate course in Medicine, affirming:

> Article 6º. The essential contents for the Medicine Undergraduate Course must be related to the entire citizen, family, and community health-disease process, integrated into the epidemiological and professional reality,

[4] Available at: https://www.pucsp.br/prosaude/sobre_o_pro_saude.html. Access: 10 Dec. 2022.

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> providing the integrality of care actions in medicine (BRASIL, 2001, p. 03, our translation).

By calling the contents they select essential, this curriculum includes specific forms of knowledge and expertise in its proposal. When defining the contents considered adequate for medical education, this curriculum excludes other knowledge or places them as less important in its proposal, such as, for example, fixing itself in biologizing contents about the bodies without considering human diversity. Thus, the content takes disease as a natural, biological process and do not give due importance to the social, the collective, the public, and the community as fundamental to medical education, nor see them as implicated in the health-disease process. By excluding this knowledge, by considering it inadequate or less important for medical training, an immeasurable amount of the population suffers the violence of invisibility, of having their health care underestimated and inefficient. That is, it is fundamental, for example, the debate about violence against women, sexism, racism, and LGBTphobia in articulation with the social markers of difference in the health-disease-care process and health care organization.

After the elaboration of the PNSI-LGBT in 2011, this content was reviewed by the DCN of 2014, and its importance is recognized, being incorporated into the new DCN; however, without guidance on how should address it and in which curriculum components it should be worked (BRASIL, 2014). In addition to selecting content, the curriculum under discussion here specifies what content should be related to a citizen, family, and community health-illness; child and adolescent health; women's health (UFCG, 2017, p. 31). Thus, it imposes that medical professionals should perform their services, taking into account that the responsibility of health care does not end with the technical act but, rather, with the resolution of the health problem, both at the individual and collective level.

According to Meyer (2003), in education, the curriculum is one of the central elements in the debates about the school - in a broad sense and its social meaning. The critical educational theorization, long ago, consolidated the idea that the curriculum does not involve only technical issues related to teaching content, teaching procedures, methods, and pedagogical techniques, as it was conceived by the technicist pedagogies of the 70s or '80s, emphasizing that it is a social and cultural artifact that needs to be understood and discussed considering its historical, social and linguistic determinations. It is emphasized that to guarantee this expanded view of health care by physicians, the DCN defines strategies to be incorporated into medical curricula, aiming to lead to the acquisition of skills and attitudes by graduates of medicine. This is

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observed in the determinations provided in Article 12 of the 2001 Resolution, which determines the early insertion of students in practical activities.

Here it is valid to point out that since this guideline calls for the insertion of students in the health service networks, it aims to form a subject that is not restricted to the isolation of the private office. This is reaffirmed in the course's PPC, which describes in its profile "[...] that its central formative axis is primary and secondary health care, in addition to the technical competence that involves intervention in what is most prevalent in the field of urgencies and emergencies and tertiary care" (UFCG, 2017, p. 27, our translation).

On the other hand, placing students as responsible for performance in topics denied to them in theory and, in practice, such as gender, diversity, and sexuality, without compromising the learning and quality of care provided is arguably unfeasible. It is also worth mentioning that students are supposedly being invited to visit the "reality" of the medical service and, thus, "put their hands to the wheel" and learn, also, from the model of preceptors and other health professionals who, in all probability, had a deficient medical training curriculum in these topics and reflections, generating a deficient and excluding health care. The responsibility of a practice without a theoretical foundation is then transmitted to the students. The expectation of the existence of a medicine sensitized to the diversity of biological and social bodies, diversity in its broadest sense, is generated, but it is not realized in theory or practice.

The students and most of the Brazilian society is deeply marked by heterosexual-cisgender-normativity, with preconceptions and readings of bodies conceived within this normative standard. To promote humanized, integral care with equity and efficiency, it is unquestionably essential to work with curricular contents that promote the deconstruction of this normativity before these students call to the practice field. Furthermore, we observe that the students who graduate from this PPC are denied academic life experiences that bring them closer to the profile of the generalist doctor, humanized, who places themself in practice and existence beyond the asymmetrical relations of knowledge and power.

The dimensions of body, gender, and sexuality are inserted in the PPC

Analyzing the PPC, we observe that these dimensions are mixed - body, gender, and sexuality are inserted in diffuse discourses; in some moments, I captured the body in the analysis, and, therefore, this crosses gender and, consequently, crosses sexuality. When thinking about the history of producing knowledge about the bodies, Veiga-Neto and Lopes (2007) point out that, for Michel Foucault, the forces he named power to act on what the subjects

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have of most concrete and material; that is, their bodies. If it was possible to constitute knowledge about the body, it was through a set of military and school disciplines. And from a power over the body, possibly a physiological, organic knowledge (FOUCAULT, 2014, p. 148-149, our translation).

The body structure, without identity, appears in the menus of the disciplines loaded with a biological vision, marked by morphofunctional regulations of the human body and, corroborating this statement, I bring the examples: Objectives of discipline M3 - "Physical and Chemical Principles of the Human Being" CH: 180, Cr: 12: "Describe and distinguish the molecular components of the human body"; Objectives of discipline M4 - "Cell and Tissue Biology and Physiology" CH: 120, Cr: 08: "Describe and distinguish the organization and functions of the different cellular and tissue elements of the human body"; Syllabus topic and Objective of discipline M6 - Human Anatomy CH: 60, Cr: 04: "Division of the body (planes and axes); macroscopic anatomy of the different body systems; identify, name and characterize the various structures of the human body" (UFCG, 2017, p. 49, our translation).

This body as structure, as an object, is presented to medical students in the first period of the course through anatomy pieces, histology slides, and molecular descriptions in biochemistry. It is not the body like the ones the students see on the street, at home, on television, in social networks, and in their social relationships. It is a body, structure, or object only in the practical and theoretical classes of these disciplines and books. About this body, an object is taken as "unique" and "true" at the beginning of the course; my thoughts go towards bodies that occupy places that do not belong to any space.

Foucault (2013) calls the utopian body the body without a body, the embodied body, and in this sense, he uses as an example the bodies of mummies, which persist through time, a utopia of the dead. What are the parts and devices for simulations related to the physical examination in the clinical skills laboratory (UFCG, 2017, p. 17); the synthetic anatomical parts, the cadavers, and their mutilated parts used in anatomy classes (UFCG, 2017, p. 55), the histological slides, if not utopian bodies, dead people whose utopia of bodies is offered for academic study, of medical students? This questioning arises from the fact that utopias narrate a place that does not exist (the body of the deceased and its butchered limbs; the histological slides) and blossom in an imaginary space and, therefore, "lie in the straight line of discourse," for, language intersects with space. In this way, students start the course in utopias and heterotopias, among discourses and knowledge that articulate the visible and the enunciable - language, the look, and space. In this way, health is not only the absence of disease since the

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human being is a body that is a machine, and all explanations about the patient will be given from an "empty body" and divided into parts whose mysteries of functioning only the doctor masters. Healthy means functioning perfectly in the predictable machinery accessible to the physician's understanding - but only to him as a professional, not to other health professionals. And even less to the patients themselves.

We consider it essential that, concomitant to the study of the "incorporate" body, the body in its historical, social, and cultural aspects and its diversities be worked on. The sum of these aspects that make up the bodies that the students will find in the articulation between theory and practice of the course because to work on merely biologized and gentrified bodies is to refer to the use of utopias in which bodies emerge and others that annul bodies.

Later in the course, the students enter the clinic and see "real bodies" in the theoretical and practical classes, never meeting the objectified body they have learned so far. Bodies, among them, that of the woman; it is observed in the PPC that there is the construction of a stigma of "natural" / "normal" differences between bodies, which implies the attribution of a particular body to women. And this calls attention to the fact that the medicalized body has become a privileged referent for constructing gentrified personal identities. We refer to the subject Women's Health that is intended to teach Gynecology and Obstetrics (UFCG, 2017, p. 90) offered in the 8th period of the course, being marked by terms such as "pregnancy diagnosis"; "Physiological modifications of pregnancy"; "Childbirth"; "Obstetric surgeries"; "Gynecological semiology"; "Physiology of the menstrual cycle"; "Infertility"; "Breast diseases"; "Vaginal discharge"; "Sexually transmitted diseases"; "Cervical, Vulva, Vagina and Ovarian neoplasms" (UFCG, 2017, p. 90, our translation).

This reading shows that women's health is reduced to the merit of "Clinical, diagnostic and therapeutic approach to the main diseases in women's health". The very definition of women's health seems distorted to me. The objectives of this discipline reveal the mechanistic view of the reproductive system - how the parts are, how they fit together, how they work to reproduce, and allocating the knowledge to the ability to reproduce, without discussing sexual organs, but rather, reproductive organs/system. It is also possible to recognize that, from the 2nd to the 8th period of the course, the student continues to be led by a reading of bodies destined to serve as reproductive matrices, objects of the patriarchy installed in Brazil since the colonial period, reduced to their genitals and breasts.

Women's medicine has no correspondent for men. Men are pulverized throughout the curricular components, broken down into prostate and sexual performance: "Basic androgeny:

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impotence, male infertility, and premature ejaculation" (UFCG, 2017, p. 80, our translation) - excerpt from the menu of Surgical Clinic I in the Urology unit. Bearer of a phallus, the man is summarized to this and prostate; that is, he is seen as a body that must enjoy (potency) and fertilize. Also, women should gestate and breastfeed, disregarding any other aspects that refer to their sexuality. The course students are not provoked to reflect and expand the reading about female bodies when female orgasm, sexual orientation, contraceptive methods, family planning, optional and elective hysterectomy, transgender women, transgender women, travesty, and transgender men, for example, are excluded.

Supported by this essentialism, naturalism, and biologics, misogynistic thinking confines women to the biological demands of reproduction on the assumption that by certain specific biological, physiological, and endocrinological transformations, women are somehow more bodily and more natural than men. Above all, by ensuring the reading of men's bodies as Urology (Surgical Clinic I) (UFCG, 2017, p. 80) and women's bodies as Women's Health, this curriculum updates forms of heteronormativity in medical discourse, presupposing two types of bodies gentrified as natural and complementary to each other and organizing the very nature of sexuality.

One can also observe a pulverization of the age dimension of the body in the curricular components, not paying attention to the specificities of the elderly body about the crossings of gender, sexuality, and health. Contradictorily, these groups excluded from the curriculum have their specificities masked from the concept of family health, which works as a biopolitical instrument since it intends to be directed to a normative group of people and not to the specificity of each one of their bodies. Many times, the LGBTQIA+ person is thrown out of the house, resigning the concept of family, and what is the concept of family for Family and Community Health? We run into another hegemonic standard, that of family formation.

Analyzing speeches in the objectives of the subject Child and Adolescent Health, offered in the 8th period of the course, with 120 hours of course load, we highlight "risk factors,"; "etiopathogenesis of diseases,"; "physiology and pathophysiology"; "set of complementary tests" and "appropriate therapy, pharmacological or surgical" (UFCG, 2017, p. 89, our translation).

The observed discourses are biologizing and deal with these bodies as reservoirs of diseases and comorbidities, bodies with urgency for treatment and normalization. Themes such as transgenically, intersexuality, homosexuality, and transvestism, bisexuality in a way beyond age group arise in a taxonomy that hierarchizes, subalterns, pathologizes, medicalizes, and

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mutilates subjects, automatically considers abnormal, out of place, strange, abject and, therefore, treatable/correctable by Medicine. A course that aims to provide a general education based "[...] also in humanistic sensitivity and social responsibility [...]" (UFCG, 2017, p. 258, our translation) does not achieve this goal when it silences these bodies throughout the analyzed PPC. It is violently denying the existence of these people and denying doctors in training and graduates the knowledge about these existences and weakening the formation of these professionals. Thus, LGBTQIA+ subjects continue to be invisible in health issues and actions in our society.

In the curriculum, "different cultures and languages confront each other, and teachers, students, and administrators often differ about the learning and practices that should be chosen and valued" (MEYER; KRUSE, 2003, p. 337, our translation). My search for intersex bodies, using descriptors such as hermaphrodites and gender ambiguity, yielded no results. Perhaps one justification for the absence of content on hermaphroditic beings may be associated with biological theories, which hold that there is no room for someone with both sexes/genders, only people with one sex and its assumed corresponding gender. Thus, it is in the body of people with sexual ambiguity or who leave room for this kind of doubt that Medicine will focus its attention, promote intervention and create a way to interpret the sexes.

From the 9th to the 12th period of the course, students go through the supervised curricular internship corresponding to the internship. The internships are in Clinical Medicine I and II - this occurs in Emergency Departments, ICU, and Wards; Clinical Surgery; Pediatrics I and II and in this context, there is a repetition of the content and objectives of the internship in Clinical Surgery, and I believe it is a documentary error because the purposes of this internship (Pediatrics) are defined as "apply theoretical and practical knowledge in medical procedures in general surgery and anesthesia" (UFCG, 2017, p. 95, our translation) however, the basic and complementary bibliography is specific to pediatrics and neonatology; Gynecology and Obstetrics whose objectives are to apply theoretical and practical knowledge acquired in Women's Health and finally, Collective Health I and II whose objectives are:

> Promote the integration of students into primary health care services, focusing on integrality, valuing the development of technical competence, humanistic sensitivity, and social responsibility necessary for the general practitioner (UFCG, 2017, p. 97, our translation).

It is evident that, at this stage of the undergraduate course, the internship student is the preferred medical subject, who, in theory, dialogues with the profile of the medical subject

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required by SUS and determined by the DCNs. In this way, a cycle involves the SUS with its Public Health Policies, the Public Education Policies along with the DCNs, the Higher Education Institutions along with their PPCs, and the health professionals along with their performance in the SUS.

However, we observe that the medical subject that this training curriculum produced was a normalized and normalizing medical subject whose gaze and actions were directed to normalized bodies in their biology and sexuality.

We take the PPC of the undergraduate medical course at UACV/UFCG as a pedagogical artifact that constitutes the subjects in formation. The observed discourses are biologizing and without guidelines of gender, sexuality, age, or social aspects. Since the curriculum is a powerful tool that shapes the thoughts, behaviors, and decision-making of the subjects, it demonstrates a path of construction of medical subjects conditioned to a selective, purely biological, and gendered look over these bodies - bodies with vulva, vagina, uterus, and ovaries; bodies reduced to the phallus and its performance; bodies of the child or adolescent and the elderly.

We recognize that a medical training curriculum cannot be made without the curricular components about the biological dimensions (for example, the disciplines of anatomy, histology, embryology), pathophysiological, propaedeutic, therapeutic, and finally, this is unquestionable. However, what is debatable is, do we need only these teaching-learning dimensions to train our physicians? This content excludes lives, excludes dissident bodies, and this exclusion prevents us from having effective, humanized, generalist graduates capable of working in the SUS and exercising the principles of equity and integrality. In this way, the health system's quality is supposed to be synergistic with the training of its professionals because the training of health professionals should reflect the constantly changing reality. Thus, it would guarantee universality, where the specificities of a nation would be, on the other hand, contributing to the effectiveness of the system that receives and serves it. It was in the biological that the curricula were kept for a long time, and it is desired to move to the biopic social model. However, they are still laden with biologizing and masculine discourses, where power relations operate and hold strong, embracing an effective system.

The course analyzed follows the norms committed to a logic where there is valorization of reproductive biological life that promotes the basis of health care - the DCN of 2001. And these subjects produced in this masculine, heterosexual, cisgender normative norm, are constituted as professionals of fragmented care, because they follow a health training model

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strongly influenced by the biomedical model of teaching. It is not only this biological worldview that easily dictates the rules in curriculum, but by the way it relates to other formative aspects, creating an image that is set for social relations. What we observe is a biological base that is often placed isolated and dictating the paths. A medical training curriculum that selects the bodies it will welcome into its care is an example of curricular violence that reinforces and perpetuates the system of asymmetrical power relations.

Final considerations

Medicine dominates a knowledge - legitimated by scientific power - about the human body, imposing an ideal and healthy state - the norm - of how we should be and be in the world. Suppose, by any chance, we deviate from the idealized "natural" state in which we should present ourselves and behave. In that case, we are soon surrendered and led to the clinical gaze of medicalization, the only "gaze" capable of (re)leading us to the greater imperative of normalization. We are always being watched; our bodies are always being watched and labeled, normalized, and disciplined. We are born, and we die in disciplinary institutions - we are born in a hospital, we are educated in schools and universities, we are "kidnapped" by the army and the church, and we have to be trained for insertion in the labor market where we spend the rest of our lives. If we go astray, we are led to insane asylums, rehabilitation clinics, and prisons, and finally, we die in a hospital. We are always in one or some of these institutions that aim to make us docile, useful, healthy, and disciplined individuals. In this microphysics, the medical discourse acts as an authorized, unquestionable expression of knowledge power.

Let's pay attention to the fact that the choice of content to be worked on in the classroom is not a neutral field. Instead, it is connected, among other things, with the personal points of view, moral values, with the political and religious choices of the professionals involved in this process.

We understand that there are multiple discursive formations - from official norms and guidelines, scientific, biological/biomedical, social, and pedagogical - that enter into the dispute in the curricular composition for the approach of knowledge about gender and sexuality that end up silencing LGBTQIA+ bodies in medical education, silencing diversity or difference. Following this argument, we identify that the production of doctors by the curriculum of the UACV/UFCG triggers articulated strategies and techniques of power, still centered on the

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biomedical model, ensuring, as an institution of power, the maintenance of relations of domination and effects of hegemony.

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