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Health Care Professionals' Competencies in Caring for the Neurodivergent Population

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Abstract

Providing health care to neurodivergent individuals requires professional competencies that extend beyond diagnostic knowledge to include accessible communication, respect for autonomy, and organizational adaptations. This essay aims to critically discuss the competencies required to deliver inclusive care in health services, considering barriers identified in the scientific literature and their implications for professional training. A theoretical-reflective approach was adopted, drawing on empirical studies, reviews, and institutional documents, with the arguments organized thematically. The discussion addresses neurodiversity literacy, attentive listening, individualized communication, informed consent, sensory sensitivity, interprofessional coordination, continuity of care, and service users' participation in quality improvement. Available evidence, derived

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predominantly from studies involving autistic people, indicates that access barriers also arise from unsuitable environments, inflexible procedures, and stigmatizing interpretations. Individual competencies depend on supportive institutional conditions, including continuing professional development, accessible communication channels, adequate time for care, and mechanisms for quality assessment. It is concluded that equitable care requires the integration of technical knowledge, ethical attitudes, and organizational transformation. Further research is recommended to encompass a wider range of neurodivergent profiles and to evaluate, with the participation of neurodivergent people themselves, the effectiveness of adaptations implemented across different clinical and geographical contexts. This approach strengthens safety, trust, and the quality of therapeutic relationships in health care settings.

Keywords: Health Personnel; Clinical Competence; Autism Spectrum Disorder; Access to Health Services; Health Communication.

Introduction

Neurodiversity refers to the variability of human neurological and cognitive functioning, while the term *neurodivergent* is commonly used by people whose neurological or cognitive functioning differs from socially established norms. In health care settings, the term may encompass autistic people, individuals with attention-deficit/hyperactivity disorder (ADHD), dyslexia, and other conditions, without implying clinical homogeneity. Adopting this perspective requires distinguishing individual differences from specific support needs and recognizing that diagnoses, identities, and language preferences are not interchangeable (KAPP et al., 2013; WORLD HEALTH ORGANIZATION, 2025).

Access to health care depends on more than the availability of appointments or health professionals. Environments with excessive sensory stimulation, overly implicit communication, difficulties scheduling appointments, and stigmatizing attitudes can turn formally universal services into inaccessible spaces. Studies involving autistic adults have identified barriers associated with anxiety, interactions with health professionals, information processing, and the organization of care pathways (DOHERTY et al., 2022; RAYMAKER et al., 2017).

The professional competencies required for inclusive care encompass technical knowledge, communication skills, ethical attitudes, and the ability to adapt institutional processes. Training focused exclusively on symptom identification may be insufficient when

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it does not address active listening, shared decision-making, sensory accommodations, and interdisciplinary collaboration. Reviews of studies on access to health care suggest that organizational and interpersonal barriers interact with individual characteristics and needs (MASON et al., 2019).

This essay aims to critically examine the competencies health care professionals need to care for the neurodivergent population, emphasizing accessible communication, individualized assessment, environmental accommodations, ethics, and continuing professional development. Particular attention is given to the literature on autism, which is more established in this field, while acknowledging that its findings cannot automatically be generalized to all forms of neurodivergence.

Methodology

This paper is a theoretical-reflective essay based on scientific literature and institutional documents addressing neurodiversity, accessibility in health care, and health care professionals' competencies. Research articles, reviews, and recommendations issued by recognized organizations were prioritized, with particular attention to evidence concerning the experiences of autistic people in primary and hospital care settings. The literature was selected purposively according to its conceptual relevance and does not constitute a systematic review or an exhaustive synthesis of the scientific literature.

The analysis was organized into the following interpretive themes: foundations of a neurodiversity-affirming approach; professional literacy; communication and consent; sensory and organizational accessibility; continuity of care; and professional training and quality assessment. The sources were examined in terms of their study designs and evidentiary scope, distinguishing observational studies, reported experiences, and normative proposals. No participant recruitment, primary data collection, or meta-analysis was conducted.

Discussion

The first domain of competence concerns literacy about neurodiversity. Knowledge of characteristics commonly associated with autism or attention-deficit/hyperactivity disorder (ADHD) is useful, but it does not justify inferring individual needs solely from a

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diagnostic label. Competent practice begins by asking service users directly which communication methods, environmental conditions, and forms of support facilitate their care. Intragroup diversity should guide individualized assessments rather than rigid protocols (WORLD HEALTH ORGANIZATION, 2025).

A second competency involves recognizing the impact of professional biases. Assuming that individuals lack decision-making capacity, do not experience pain, or are uninterested in treatment because of differences in self-expression can compromise clinical assessment. Qualitative research involving autistic adults describes the effects of professionals' misinterpretations and resistance to simple accommodations, including written communication (NICOLAIDIS et al., 2015).

Accessible clinical communication requires direct language, predictable structure, and confirmation of understanding without infantilizing the individual. Vague questions can be replaced with specific questions, accompanied by sufficient time for information processing. Providing information about the purpose of the appointment in advance, together with written information, may constitute a useful accommodation, provided that it is tailored to individual preferences. These measures address barriers documented in interactions between patients and health professionals (DOHERTY et al., 2022; NICOLAIDIS et al., 2015).

Communication competence also includes flexibility in the communication channels used. Some individuals prefer to respond orally, whereas others communicate more effectively in writing, through augmentative and alternative communication (AAC) devices, or with support from a person of their choice. Health professionals should address the service user directly and negotiate the role of accompanying persons while safeguarding privacy, autonomy, and confidentiality. The use of support should not be mistaken for the automatic substitution of the individual's own will (NICOLAIDIS et al., 2015).

During medical history-taking and physical examinations, sensory sensitivity requires explicit consideration. Bright lighting, noise, odors, unexpected touch, and prolonged waiting may increase discomfort and hinder participation. Explaining each procedure before initiating it, asking permission, and offering feasible alternatives are practical competencies with implications for patient safety and the care experience (MASON et al., 2019; RAYMAKER et al., 2017).

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Predictability throughout the care pathway represents an organizational dimension of professional competence. Clear information about appointment times, approximate duration, consultation stages, and possible delays can reduce uncertainty. Whenever feasible, digital appointment scheduling systems, appointments during less busy periods, and quiet waiting areas should be included among the available accommodations, without assuming that all individuals prefer the same arrangements (DOHERTY et al., 2022).

Another essential competency is conducting clinical assessments without improperly attributing symptoms to neurodivergence. Pain, gastrointestinal symptoms, psychological distress, and chronic health conditions require appropriate investigation, even when symptom expression differs from the health professional's expectations. A person-centered approach prevents a pre-existing diagnosis from becoming a universal explanation for new or potentially serious symptoms (MASON et al., 2019).

Shared decision-making requires presenting treatment options, benefits, risks, and uncertainties in an understandable manner. Informed consent is a relational process, not merely the signing of a document. Additional time, accessible materials, and opportunities to ask questions after the consultation can support autonomous decision-making. The need for communication accommodations does not, in itself, indicate an inability to provide informed consent (NICOLAIDIS et al., 2015).

Interprofessional competencies become particularly important in situations involving concurrent clinical, psychological, and social needs. Physicians, nurses, psychologists, therapists, and social workers should share relevant information in accordance with confidentiality requirements and avoid unnecessary repetition of assessments. Care coordination has been identified as an important component in reducing barriers to health care access for autistic adults (MASON et al., 2019).

Primary health care occupies a strategic position because of its continuity of care and its potential to establish knowledge of individual preferences over time. Clinical records documenting agreed-upon accommodations can facilitate future consultations, provided that they are updated regularly and not turned into permanent stereotypes. Continuity supports trusting relationships and allows strategies to be reviewed as needs and circumstances change (DOHERTY et al., 2022; WORLD HEALTH ORGANIZATION, 2025).

Continuing professional development should extend beyond lecture-based sessions on diagnostic criteria. Consultation simulations, case discussions, reflective supervision, and

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the analysis of real-world barriers can facilitate the transfer of learning into clinical practice. Materials developed with the participation of autistic people, including tools for identifying necessary accommodations, provide examples of approaches informed by service users' experiences (NICOLAIDIS et al., 2016).

The participation of neurodivergent people in professional training and service improvement is also an institutional competency. Listening to accounts of adverse experiences and involving service users in the design of educational materials, care pathways, and evaluation processes can reveal barriers that might otherwise remain invisible to health care teams. Such participation should be remunerated and made accessible when appropriate, thereby avoiding merely tokenistic consultation (NICOLAIDIS et al., 2016; WORLD HEALTH ORGANIZATION, 2025).

Health service management has a direct responsibility to create the conditions necessary for inclusive practice. Individual sensitivity cannot be demanded when excessively rigid schedules, unsuitable environments, and single-channel appointment systems prevent reasonable accommodations. Organizational competence encompasses flexible protocols, training, material resources, and mechanisms for responding to complaints, guided by indicators of accessibility and service user experience (DOHERTY et al., 2022; RAYMAKER et al., 2017).

Quality assessment should consider not only overall satisfaction but also specific barriers, including missed appointments resulting from communication difficulties, the need to repeat information, environmental accessibility, and patients' understanding of the guidance they receive. Barrier assessment tools developed with the participation of autistic people demonstrate the importance of capturing dimensions that conventional indicators may overlook (RAYMAKER et al., 2017).

Finally, the limitations of the available evidence must be acknowledged. A substantial proportion of the studies cited focus on autistic adults, use non-probability samples, and collect self-reported experiences. Consequently, they do not allow causal effects to be established for all the proposed accommodations or provide a representative account of the entire neurodivergent population. Future research should include other neurodivergent profiles, different age groups, and diverse health care settings, incorporating participatory assessments of clinical outcomes and equity (DOHERTY et al., 2022; MASON et al., 2019).

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Conclusion

Competent care for the neurodivergent population depends on integrating clinical knowledge, accessible communication, respect for autonomy, and the ability to adapt the environment and the organization of care. The evidence examined indicates that barriers to health care do not arise solely from individual characteristics; professional practices, administrative procedures, and sensory conditions can also create obstacles. Accordingly, quality care requires an individualized, rights-based approach developed with the participation of the people receiving care.

Continuing professional development and institutional responsibility must advance in a coordinated manner through flexible protocols, accessibility assessments, and meaningful service user participation. Given the concentration of the existing literature on autism, further research is needed to investigate other neurodivergent experiences and evaluate the effectiveness of the proposed interventions. The central commitment is to replace generalized assumptions with attentive listening, shared decision-making, and health services capable of responding to human diversity.

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