

No Echo in the Ghetto:
Lived Experiences of Gay and Lesbian Paramedics in Australia

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Abstract

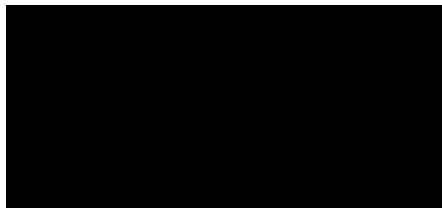
Paramedicine is a relative newcomer to academia, with paramedic education programs existing in Australian universities since the turn of the century. As such, minimal research exists into the experience of paramedics in general. Gay and Lesbian people are an under researched minority group within the workplace, despite their high participation rates in employment. This research sets out to redress the gap in the literature by investigating the current workplace experience of Gay and Lesbian paramedics in Australia. Using a qualitative approach informed by a bricolage of critical theory and hermeneutic phenomenology, the experiences of inclusion and marginalisation of participants was explored. Experiences of the accounts of the hidden population of 10 Gay and Lesbian paramedic participants provide the first known account of the culture of the paramedic workplace in Australia from a non-heteronormative perspective. Participant experiences also give form to the impacts of practices that exclude and marginalise Gay and Lesbian people in the paramedics' workplace.

The findings of the study indicate that these participants were marginalised within their places of work. The practices that marginalised them had a detrimental impact on the paramedics themselves. These practices were also detrimental to their colleagues, paramedic organisations and the communities they support. The heteronormative nature of the culture of the paramedic workplace was not found to be supportive of Lesbian paramedics, and even less so of Gay paramedics. This resulted in subtle pressure to work in less favourable ghetto areas and, more distinctly, negative experiences in rural areas. Paramedic organisations that participants worked for failed to capitalise on the attributes of these employees for the benefit of the community.

Declaration of Authenticity

I, Georgia Clarkson, declare that the PhD thesis entitled “No Echo in the Ghetto: Lived Experiences of Gay and Lesbian Paramedics in Australia” is no more than 100,000 words in length including quotes and exclusive of tables, figures, appendices, bibliography, references and footnotes. This thesis contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my own work.

Signature:



Date: 7 / 11 / 2014

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Glossary

Closet – Commonly used metaphor to describe space in which one hides one's sexuality.

Coming out – Declaring or being open about a minority sexual identity.

Country – In the context of this thesis, the word country is used to refer to areas outside of Australian state capital city metropolitan areas.

Downtime – Time paramedics spend at work where they are not utilised by responding to incidents.

Echo – Slang term some paramedics use to refer to meal breaks.

Gay man – Male who is attracted to other males in intimate, romantic and/or sexual terms.

Ghetto – Commonly used in Australia to indicate a space in which a minority or marginalised group is forced by social pressures to occupy.

Heteronormativity – View that heterosexuality is the only legitimate sexual orientation, and the consequent construction of social and cultural agencies and practices around this assumption.

Heterosexual – Attracted to the opposite sex in intimate, romantic and/or sexual terms.

Heterosexism – Structured forms of gross and subtle discrimination promoting heterosexuality in the community.

Homophobia – “Irrational fear, hostility or distrust extended to anyone who is not heterosexual” (McKenna 2009, p. 361).

Internalised homophobia – Lesbian or Gay person's inward direction of homophobic attitudes, such “internalization of negative attitudes is theorized to lead to conflicts within the individual, lowered self-regard, and self-deprecating attitudes” (Newcomb & Mustanski 2010, p. 1020).

Lesbian – Female who is attracted to other females in intimate, romantic and/or sexual terms.

LGBT – Abbreviation used to refer to Lesbian, Gay, Bisexual and Transgender people. Although the terminology ‘Lesbian and Gay’ has been adopted as the preferred form of reference to participants in this thesis, the term LGBT is used on occasion where it is the terminology favoured within the literature referenced.

Microaggressions – “Brief, everyday exchanges that send denigrating messages to certain individuals because of their group membership” (Sue 2010, p. xvi).

Othering – Defining a person as different by virtue of locating them outside a social group considered by the majority as ‘normal’.

Out – Open to others in relation to sexuality may vary between individuals as to who they are open to with regard to sexual orientation.

Pansexual – “A multiple and flexible identity that exists in stark opposition to binaries of sex and gender” (Gonel 2013, p. 36). Self-identification as pansexual infers that one is attracted to a person, not a gender or sexuality.

Passing – Presenting oneself as having a particular sexual identity. Usually refers to a Gay or Lesbian person as presenting themselves to the world as a heterosexual person.

Patient-centered care – Healthcare practices which promote the inclusion of the individual patient in decision making in the management of health issues and treat the individual in a holistic way with regard to their personal needs.

Ramping – Practice of paramedics waiting for lengthy periods of time to hand over a patient to other healthcare workers at a hospital.

Straight – Term commonly used by non-heterosexual people to refer to heterosexual people.

‘You’topia – Play on the word ‘utopia’. Fictional inclusive workplace, in which the individuality of workers is celebrated, and their capabilities, skills and experiences capitalised upon.

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Prologue

I have been a paramedic since 1997. In this time I have had training devoted to management of medical issues and some training related to communication. Some organisationally based training I have undertaken has been aimed at dealing with culture, in the understanding related to ethnicity. Some organisational training I have undertaken (presumably as a mandated statutory requirement and inevitably delivered as a 'process') has related to equity and diversity, in the dimensions of gender, ethnicity and sometimes religion. At no point in my initial or ongoing training has sexuality been addressed.

What about me and my 'tribe'? Hello, we are here.....

In my time as a paramedic, I have worked with numerous Gay and Lesbian colleagues. To the best of my knowledge, they have also experienced silence in relation to their matters of sexuality, and in both initial and ongoing training.

There is a void.....

CHAPTER 1: INTRODUCTION

This research will investigate the issues of organisational and systemic inclusion and participation of Lesbian and Gay paramedics in the workplace in Australia. The aim is to consider the impact of heteronormative cultural practices on this group while appreciating the unique and different experiences of the individuals in this study. Additionally, this research will explore the impact of heteronormative cultural practices on straight colleagues in the workplace, their families and friends, the patients they attend, the organisations they work for and the communities in which they live.

As the workplace culture of a paramedic in Australia is unique, particular emphasis will be given to the characteristics of the culture of the Australian paramedic workforce and the impact such characteristics have on the inclusion or exclusion of Lesbian and Gay People in this workforce. The central theme of this research is to consider the challenges generated by an increasing need for tolerance of diversity in the context of a workplace culture demanding conformity. A further key feature of this research is that it will attempt to identify differences in the experiences of Lesbians in the paramedic workforce, so as to contrast those of Gay male paramedics. Furthermore, this body of work aims to identify the inherent characteristics of the culture of the paramedic workforce, which contribute to such differing experiences.

In essence, this work is about three phenomena: points of view, human rights and good sense. This work sets out at its core to explore an alternative perspective and to give voice to the points of view of those individuals who have life stories which are often silenced. It aims to allow the expression of this alternative point of view, because it is a fundamental human right for the individuals in this alternative group to express their point of view and be heard. It makes good sense to allow this group of individuals their human rights for self-expression because they are part of the community in which we live. Allowing these individuals input into discussions is to allow this 'community' the opportunity to capitalise on their rich experience and skills. It is nonsensical to silence their voices; however at present these points of view are not heard. In the context of this research, these voices represent a small group of Gay and Lesbian paramedics working in Australia. From an in principle perspective, allowing these voices to be heard draws attention to and furthers the cause of any marginalised population. Empowerment gained by interrupting the oppression of any group is known to disrupt the oppression of other marginalised groups. Listening to the voices of these groups is then about presenting points of view, human rights and good sense.

With these principles in mind, this study takes a qualitative approach to explore the unique lived experiences of a small group of Gay and Lesbian paramedics. Despite frequent and

regular assertions, from heterosexual paramedics, that Gay and Lesbian paramedics 'have it good' in their places of work, this has not been my experience. Due to this experience, I have not been deterred in the face of some colleagues' 'rolling their eyes' and the trivialisation of this research project as futile or lacking in significance. My experience as a Lesbian and a paramedic has led me to believe that I, and other non-heterosexual paramedics, have a different experience of the workplace which needs to be documented and which forms the basis of this research. Gay and Lesbian will be alternated in this thesis in terms of the order in which these words appear, so as not to privilege one gender over the other.

Staying true to my belief that my experience has been different to that of my heterosexual colleagues has required resilience. This resilience has been sustained by interactions with participants along the way, who were supportive of my views. In contrast to the points of view of many heterosexual paramedics, these interactions have led me to believe there was some truth in this belief: that I was not alone. It was invigorating for me to be exposed to points of view that corresponded to those of my own. This position is exemplified by Saxon's statement, a participant in this study:

I certainly do believe that we have a unique experience. But then, even within Lesbians and paramedics, you can break those groups down and they probably have unique experiences as well and then within those groups, not everyone's experience is going to be the same either.

His insights bolstered my beliefs and have given me confidence. The more people I have spoken to who have expressed similar ideas to those of Saxon, the more I have been convinced I am not alone.

This work is important. It is important for me. It is important for the Gay and Lesbian paramedic participants. It is important for other Gay and Lesbian paramedics. It is important for Gay and Lesbian people. It is important for heterosexual people and for the community. Finally, it is significant from a human rights perspective, as the fundamental principle of being heard should be afforded to all people. Having established these principles, I turn from motivational factors and the rationale of the study to giving consideration to the context of the research. I then address the manner in which this study aims to put into action the aforementioned underpinning principles to achieve its goals.

It is critical to consider some of the fundamental aspects of the present social and political context in which this body of work has been conducted. From my point of view as a researcher, there is hypocrisy inherent in the social fabric at the time of writing (2014). This influences the way in which Gay and Lesbian people are socially positioned. Additionally there is a sense that paramedicine as an occupation is in a state of flux in Australia. These

factors create an opportunity to capitalise on the underpinning foci of this study. They also relate to the paradigmatic choices that inform some of the key decisions in this work.

Nothing encapsulates the ironies and hypocrisies of feelings toward people who are perceived to be sexual and have gender anomalies. For example, the 2014 Eurovision Song Contest saw the victory of Conchita Wurst. Conchita cannot go without mention in this research for she is the embodiment of irony, both in herself and in the feelings she generated within the international arena. In a contemporary world which we view as progressive, it was a joy for me to see a bearded Austrian drag queen cheered on to victory. This challenges current perceptions of gender and sexuality. The downside is the conservative responses to her and attempts to refute her right to self-expression. Her victory came only after considerable objection from Russia and other nations on the basis that her performance would *encourage sodomy*. This is a graphic international example of misperceptions replicated domestically. The present Liberal/ National government in Australia is overtly opposed to Gay marriage and is in a more general sense leading a wave of conservative backlash against minority groups from a range of echelons. The remaining elements of this thesis will explore this more fully, but it is noteworthy in the context of this introduction to question the current values of a society which is trending towards conservatism (McKnight 2006).

In the context of paramedicine as an occupation, much contemporary discussion in the industry relates to its dynamic state. This discussion relates to several identity issues in the industry including recognition as a profession, registration, development as an academic discipline, scope of practice, paramedic roles and expansion into non-traditional areas of private industry. It is the dynamic and changing nature of this industry, the composition of this workforce and the roles such workers will perform, for a changing Australian society, which creates an opportune moment for reflection that is the basis for this research. This reflection affords an ability to take stock of the capabilities of Gay and Lesbian paramedics and consider a reappraisal of work practices that impact negatively on them. To view from a critical lens here will inform best practice for future paramedic workplaces.

The initial part of this thesis sets the scene in terms of establishing the academic framework for this study. Chapter 2, the literature review, positions this study in relation to previous literature in the field of paramedicine, healthcare, Gay and Lesbian rights and workplace relations. As will be demonstrated, this establishes the significance of the present study as the forerunner to workplace experience of Gay and Lesbian paramedics in Australia. Chapter 3 explores the paradigmatic, epistemological and methodological underpinnings of this research. It justifies the chosen qualitative methodology as appropriate for the current study.

Critical phenomenology is identified as a unique and appropriate methodology to be employed. Chapter 4 is my story as a Lesbian paramedic. Following discussion of the methodological approach, and in remaining consistent to its principles, chapter 4 facilitates the necessary level of personal transparency for me (as the researcher) by exploring the key life experiences that have led to the development of the inalienable points of view, which have influenced the selection of data and its re-presentation in this thesis.

After setting the framework in the first four chapters, chapter 5 explores the lived experiences of the 10 Gay and Lesbian paramedic participants in this research. These experiences give voice to these life stories. Their stories and experiences are presented in relation to significant reflections of the experience of Gay and Lesbian paramedic participants in their places of work. As previously stated, the aggregation of these experiences will demonstrate that they are not the same as those of heterosexual paramedics. The participants in this research have unique experiences. And whilst unique, they universally encounter exclusion and practices of marginalisation. Some circumstances leading to marginalisation are blatant and overt while others are subtle and covert. Despite the differences in the means by which participants are excluded, in essence they share the experience of being *othered*. Their points of view have been silenced. Chapter 6 leads to a discussion of the impact of *othering* on participants, individuals with whom they share their personal lives, their colleagues, and workplaces and the communities they serve. This chapter demonstrates that failure to make sense of their experiences and listen to this silenced group has destructive and negative consequences for everyone.

The remaining chapters aim to explore more fully why the participants have had the experiences they highlight as significant to them. Chapter 7 explores identity, its importance within the contemporary climate and more specifically, sexual identity. It considers the desire for expression of this sexual identity from the point of view of participants within their heterosexualised places of work. It considers strategies used to manage identity and introduces the concept of *closet fatigue* to describe the substantive burden these Gay and Lesbian paramedics carry with them in their places of work and beyond. Chapter 8 adds to the existing literature on paramedic workforce culture using a non-heteronormative lens. A description such culture has not been previously documented from this perspective. Based on participant experiences it establishes that paramedic culture is heterosexist and heteronormative by nature. Chapter 9 explores the array of fundamental stereotypes that exist in relation to gender and sexuality, and those that are subscribed to and perpetuated by the culture of the paramedic workplace.

The primary theme in the preceding chapters is the tension between the contemporary desire

for authenticity and self-expression of individual identity and forces of collectivisation. It became apparent throughout this study that collectivism was a fundamental structure within the current culture of paramedicine in Australia that seeks to position 'right ways' of appearing in the workforce. Chapter 10 explores the nature of understandings of patient-centred care and the subtle and insidious way in which Gay and Lesbian paramedics experienced enforced silencing, leading me to coin the phrase *closet fatigue*. Chapter 11 more fully explores the theme highlighted by participants of variances in rural and metropolitan paramedic workplaces. This chapter highlights the less negative experiences of metropolitan paramedics when compared to their rural colleagues.

Chapter 12, the final data chapter in this thesis, explores the views of Gay and Lesbian paramedics on the potential contributions they could make within paramedic organisations if these organisations supported and included them. As will be demonstrated, capitalisation on their unique qualities and abilities potentiates a positive experience for Gay and Lesbian paramedics, their colleagues, other minority groups and the community in general, as well as for paramedic organisations. On the basis of positive potentials highlighted in this chapter and the synthesis of the essences of previous chapters, the concluding discussion in chapter 13 draws together findings of the research and makes recommendations for the future. It is my hope that affording this group of participants their human rights to express their point of view provides an opportunity to inform change. And that this good sense approach contributes to better health outcomes for Gay and Lesbian paramedics, and for the community in general.

The next chapter, the literature review, surveys the existing body of knowledge in which this study is contextualised.

CHAPTER 2: LITERATURE REVIEW

History of Ambulance Services in Australia

Contemporary paramedics respond to a range of pre-hospital issues and are skilled in a range of pharmacological and non-pharmacological interventions. At a national level, paramedics are currently struggling for recognition as a professional group and there is much discussion of the future direction of this group of 'professionals', especially in terms of the scope of their roles.

The term 'paramedic' can be used in a range of contexts and refers to a range of allied health workers. Although there are several non-government providers of paramedical services, this thesis focuses on government providers. In that context, paramedic is used to refer to a person who is employed by a government run or controlled paramedic organisation, and whose occupation is to provide pre-hospital care to the community they serve.

Role of a paramedic

Typically a paramedic is required to perform a number of tasks. These include the management of traumatic, medical and psychiatric conditions, independent work attending to public emergencies, and performance of a range of clinical interventions including drug administration (Caroline 1995). The paramedic needs to work with other health professionals, community members and emergency services in undertaking these tasks.

The organisational climate in which a paramedic operates can be a complex one. A number of changes that have evolved in recent years have placed additional demands on paramedics. Such changes include increased case load, fewer opportunities for rest breaks and increased wait times at hospitals¹ (Whitelaw 2011). These issues result from increasing strain on health resources in Australia as demand increases in line with changing demographics. Paramedics are required to work shifts in order to facilitate 24-hour service coverage (Ambulance Victoria 2010; SA Ambulance Service 2011), and attend a number of physically and emotionally challenging events which put them under a unique type of work-related stress (Porter 2013).

¹ Commonly referred to as 'ramping'.

Evolution of a 'profession' from military and voluntary roots

The provision of ambulance services in Australia has evolved from a semi-skilled first aid model using volunteers to a highly complex system today that provides paramedical services to a growing and increasingly diverse community of consumers. During this time the workforce has evolved from a quasi-military (Australian Learning and Teaching Council 2009) group of predominantly Anglo-Australian heterosexual males to an increasingly diverse mix of people of other genders, ethnic groupings, religious affiliations, cultural, age and sexual identities.

Ambulance services in each of the Australian states and territories share similar origins but have developed independently due to the nature of the federal system of government. Today, although organisational structures and clinical practices vary from one organisation to another, similarities exist in the workplace cultures of these state based organisations.

In the 1880s St John Ambulance, a voluntary humanitarian organisation, began as an organisation which was at that time primarily focussed on delivering first aid training. This was the generic stem from which ambulance services in Australia evolved. The Australian Capital Territory service is the only service in Australia never to have had formal links to St John (Howie-Willis 2009). Such courses flourished at the time as they responded to the needs of an industrialising and urbanising society. Courses were directed at members of the public as well as police and fire officers who were likely to encounter medical emergencies in their operational roles (Howie-Willis 2009). This shared past resulted in kinship between people completing first aid courses and members of police and fire services due to sharing responsibility for attending to the community's emergency needs. The training of an increasing number of people in first aid and the organisation of such people into local 'units' saw allegiance develop between local ambulance organisations and the army medical corps with an active exchange of ideas between these organisations (Howie-Willis 2009). In some locations, private ambulance services also developed to respond to the needs of specific industries and localities, and some degree of cross-membership of the two types of groups was common and continues with paramedics and St John even today (Howie-Willis 2009).

Until the 1970s there was no unified approach to prescribed training for the employees of ambulance organisations across Australia. In addition the majority of organisations maintained the usual pathway to employment via the military or St John (Howie-Willis 2009). Some states had introduced formalised training. For example, in Victoria a formal training program run by medical and nursing staff at Geelong hospital was introduced in 1961 (Wilde & Ambulance Officers' Training 1999). Other states in Australia followed suit at various points with the introduction of a range of approaches for specialised training of employees who

would now be referred to as paramedics. St John still remains the organisation responsible for paramedical services in Western Australia and the Northern Territory. Following this period of localisation and inconsistency in approaches to education of paramedics at a national level, a nationally consistent approach to entry level training and education was created. Few state vocational training programs remain and they are being phased out. For entry into the field, a university undergraduate program is now required by most state ambulance organisations.

As the Australian community has developed and grown, so too have the medical services of various state governments in an attempt to meet such needs. In a geographically and demographically diverse community, this has meant embracing technology as it has evolved and formalising ambulance organisations as independent organisational entities. Thus each of the states and territories has developed its own unique health and emergency services system. There has been local divergence in relation to clinical practices but commonality in the general principles of paramedic care and objectives of treatment. Clinical practices are guided with the assistance of guidelines or protocols developed by each of the states or territories, which paramedics are expected to adhere to in the management of their patients.

Today the work of operational members of ambulance services is trending towards the emergence of a specialised paramedical profession (Howie-Willis 2009). At a national level, some interplay between various state and territory organisations is facilitated by the Council of Ambulance Authorities (CAA). This body brings together the executive heads of the various organisations to enable collaboration and exchange of ideas (Council of Ambulance Authorities 2009). Paramedics Australasia (PA) also facilitates the exchange of ideas across state boundaries as a professional organisation seeking to promote paramedic professional development (Paramedics Australasia 2014).

Australia's ambulance organisations have now evolved to the point where they are typically large and complex. These large organisations govern and guide the structure and standardisation of work practices. Typically these "large, complex and highly differentiated organisations.....do not respond easily to the demands of the surrounding environment" (Yen 2009, p. 173). They also have the characteristic of developing 'cultural control' as a result of informal norms that develop within a workplace in which everyone is expected to conform to standardised work practices. Out of a desire to fit in, individuals will tend to adopt this culture (Yen 2009). The pressure to adapt to this culture can create various degrees of friction and strain on employees whose values may conflict with those of the dominant culture.

Women

One of the most significant changes to the paramedic workforce has been the relatively recent entry of women. This is a recent change in Australia in a workforce that up until the 1980s was completely male in terms of paid operational workers. For example, the first female paramedics were employed in Victoria in 1987 (Department of Human Services 2008). Internationally, the first female paramedic was employed in the United States as recently as 1975 (Gonsoulin & Palmer 1998). Women now comprise a significant proportion of the paramedic workforce. Available statistics on female paramedics indicated they comprised 38.2 percent of the paramedic workforce in Victoria in 2009 (Ambulance Victoria 2009), 35 percent in New South Wales in 2010 (Ambulance Service of New South Wales 2011), 25.2 percent in Queensland in 2005 (Queensland Government:Department of Emergency Services 2005, p. 48) and 44 percent in South Australia in 2010 (SA Ambulance Service 2010). Statistics relating to other state and territory services in Australia were unavailable at the time of writing, but are likely to be similar in range to those quoted here. This change in the composition of the workforce has posed some challenges to the culture of the workforce and been met with various levels of opposition. Despite such rapid feminisation of the workforce in terms of the proportion of women employed as paramedics, it retains a culture that is characteristically masculine (Reynolds 2009).

It is noteworthy that one detailed history of paramedic training in Victoria fails to mention women at all, despite the fact that it covers the period in which women were introduced as operational employees (Wilde & Ambulance Officers' Training 1999). In discussing the culture of paramedics, Reynolds (2009, p. 35) only refers to their contribution as volunteers. This takes note of the fact that women are commonly subject to sexual harassment and the manner in which some female paramedics emasculate themselves in order to 'pass' in the masculine culture of the workforce. The lack of literature from a feminist perspective here is telling of the cultural values within the 'profession' and academic body of work evolving around it. This is a significant gap for future research. In part, this research addresses the hitherto invisible female paramedics with a specific focus on Lesbians within this group.

One United States (US) study of the Emergency Medical Service (EMS – US equivalent of a paramedic organisation) revealed that some EMS professionals echoed the traditional view of some policemen that women were "physically, psychologically, and emotionally" unsuited to the work (Gonsoulin & Palmer 1998, p. 42). Female employees also reported higher levels of sexual discrimination at work (Gonsoulin & Palmer 1998, p. 42). The results of a survey completed by 49 participants in relation to workplace partner preference indicated that 90 percent of women and 74 percent of men indicated that the gender of their work partner makes no difference to their work (Gonsoulin & Palmer 1998, p. 43). Whilst this indicated that

the majority of participants had no stated preference in relation to the gender of their partner, the remaining participants indicated a preference and had some ongoing biases and beliefs based on gender. Respondents to the proposition that there are some things men do better than women that were in the affirmative were mainly based on reasons of physical strength (Gonsoulin & Palmer 1998). One respondent to the questionnaire reported that women must continue to “prove themselves in a ‘man’s profession’” (Gonsoulin & Palmer 1998, p. 44). Some EMS providers had no separate accommodation for females and maintained policies preventing two women from working together (Gonsoulin & Palmer 1998). One female respondent in the study said there was a need to “walk the walk and talk the talk to be a successful paramedic” and “a butch is what the public expects of a female paramedic” (Gonsoulin & Palmer 1998, p. 46). In this study it was shown how gender was also used to assign female paramedics to roles that are traditionally seen as the work of women, and thus perceived to be typically “soothing and nurturing” tasks (Gonsoulin & Palmer 1998, p. 46).

Gender and sexuality – interplay of stereotypes

Whilst gender and sexuality are two separate aspects of the identity of an individual, they are often *perceived* to have a strong correlation. Women who are paramedics are not given voice in the current body of literature. Similarly, the experience of Gay and Lesbian paramedics is not documented. The patriarchal lens through which the history of the profession is viewed is also revealing of some of the characteristics of the culture of the workforce that are present today. In gender terms, women remain other in the sense of the word first used in 1949 by Simone de Beauvoir (1989) and the “corporate definition of competency” is still presumed to be based on being a white male who is married with children (Anastas 1998, p. 86). Paralleling the dominance of male leadership in the corporate world, this domain of work remains overwhelmingly male and heterosexual, despite increasing workforce diversity (Sinclair 2005). In historical terms, where does this leave the voice of non-heterosexual people and, in particular, what does this say about the cultural tolerance of non-heterosexual people in the paramedic workplace? Can perceived connections between gender and sexuality mean that there is a difference in which Gay male paramedics experience the workplace as opposed to Lesbian paramedics?

Paramedic culture, conformity, diversity and tension

Prior to attempting to characterise paramedic culture, clarification of the understanding of what is meant by ‘culture’ within this work is imperative. Culture is used in a variety of ways in a number of contexts. Culture is rich and multifaceted. Culture might be understood as high culture, reflective of elitism (Jameson 1979). This is not the intention of this study. It can be understood as being associated with a specific ethnic group or as something that binds

and unites such a group and intrigues those who do not have insight into its operation for these groups. Culture can be understood as popular culture and can be defined as “the systematic sets of codes, narratives, discourses and practices which structure the interpretation of social life and social action” (Back et al. 2012, p. xiv). Culture can be unique to specific workplace groups as “organizations develop distinctive sets of emotionalized, collectively held beliefs that impel members of these organizations to act in certain ways....in essence, ideologies” (Trice 1993, p. xi). As previously mentioned, it can also be unique to a group with specific social needs such as the Gay and Lesbian community.

Culture in this work is about the *values* held by a group and it can be evident in symbolism, language and behavioural practices common to that group. From a sociological standpoint culture describes patterns of thinking, feeling and acting (Hofstede, Hofstede & Minkov 2010, p. 5). These patterns govern the behaviours of particular cultural groups, and some groups ‘codify’ aspects and make overt statements of behavioural expectations associated with belonging. These behaviours become the basis for belonging in or out of the group. A statement relating to organisational values, a religious document or body of legislation are all examples of overt codification of cultural values. However, much of the culture of a group is not codified, but contained in unwritten mores (Hofstede, Hofstede & Minkov 2010, p. 6).

When attempting to define the culture of a particular social group and on considering codified definitions that ‘capture’ meanings it is associated with, one needs to also consider its covert, dynamic and coded nature alongside the further compounding difficulties of cultural “ambiguities, paradoxes and contradictions” (Trice 1993, p. 21). As it is common for people to belong to multiple cultural groups, whether based on work practice, sexuality, gender, ethnicity, religiosity and/or innumerable other factors, ‘fitting in’ to a culture can involve wearing many ‘different hats’. The principle that these sets of cultural values can be in conflict with one or another is central here. Values and behavioural expectations of various cultures can be poorly subscribed to, clandestine or coded. This can lead to the inclusion of some groups and exclusion of others within such a culture.

Many definitions of what constitutes culture exist in the literature. Culture can be defined as what a particular group agrees is reality: it is learned (not innate), has interrelated facets, is shared amongst a group and evolves over time (Carr-Ruffino 1999, p. 19). Reynolds (2009, p. 28), a key author on paramedic culture in Australia, defines culture to include “artefacts as well as assumptions, values and beliefs of a particular group”. Hofstede, Hofstede & Minkov (2010, p. 5) refer to this as *software of the mind* in terms of how cultures develop as a product of mental programming acquired from experience. Group culture contains a set of commonly understood rules of behaviour. These rules of behaviour and group understandings can distinguish the members of one group from another (Hofstede, Hofstede

& Minkov 2010, p. 6). Such culture is dynamic in nature and is created by the interaction of members of the organisation (Shnurr 2008, p. 80). Consequently, specific behavioural rules exist within paramedic organisations and these rules distinguish them from other cultural groups.

Organisational cultures differ from national, local, ethnic and other types of culture in that the members of an organisation usually do not grow up in that culture and make a conscious decision to become part of the organisation (Hofstede, Hofstede & Minkov 2010).

Organisations develop frameworks of rules, values and procedures which are adapted to distinct workplace practices (Shnurr 2008, p. 80). This element of choice can lead to difficulties adjusting to workplace culture when there is conflict with their previous cultural programming. Central to the current work is the understanding that the research participants in this study belong to two distinct cultural groups – both paramedics and non-heterosexual people. As a result they will have been required to adopt (at least) two sets of cultural values to various extents. This will obviously depend on the individual's level of engagement with Gay and Lesbian subcultures that have evolved out of perceptions of being different (Cruikshank 2014, p. 119).

This means valid description of the culture of a group is dependent on selecting a clear model as a framework to guide the articulation of its characteristics. In terms of the definition of culture subscribed to here, the model of the “onion” used by Hofstede, Hofstede & Minkov (2010) has been adopted within this work as a framework for understanding the culture of the paramedic workplace. Cultural practices are grouped in this model into symbols, heroes and rituals forming a shell around the values of a culture. Such symbols, heroes and rituals are indeed apparent in the culture of the paramedic workplace and reflect the core mutual values of these organisations.

Masculine, heroic, homogenous

The outermost layer of the Hofstede et al. (2010) “onion” is that of organisational and occupational *symbolism*. In terms of symbolism in paramedic culture, the wearing of uniforms provides the strongest example (Reynolds 2008, pp. 123-4). From its beginnings pre-hospital emergency medicine has been a male-dominated occupation due to the early influence of military medicine and its association with fire and other emergency services (Gonsoulin & Palmer 1998, p. 41). Most paramedic organisations are dominated by men in leadership (Reynolds 2008, p. 127). They are structured using “masculine points of departure”, for example, men's uniforms adapted for women (Gonsoulin & Palmer 1998, p. 47). This is symbolic of their hegemonic masculinity (Boyle 1997). Women have historically taken a role in the “sick room” and as volunteers (Reynolds 2009, p. 35), mimicking of the gender roles of

men and women in general society. Such legacy is evident in the symbolism of these organisations with the media often projecting depictions of ambulance work as 'heroic and masculine'. The stereotypical symbolism of a paramedic driving down a suburban road with lights flashing and a wailing siren reinforces the heroic symbolism associated with the occupation frequently and publicly. As with military organisations, variations in status within an organisation are also symbolised by differences in uniforms, also reflecting the hierarchical nature of these organisations. Use of occupation specific technical language is also symbolic and distinguishes this group of workers from others.

The archetype of the *hero* is omnipresent in the organisational culture of paramedics. Heroes exist in the popular mythology associated with a work environment that is "unpleasant, disorderly, dysfunctional and filled with repugnant and unnatural stimuli" (Reynolds 2009, p. 34). Heroes exist at local levels in the stories and folklore, stories of individual paramedics who have 'saved' people in a range of circumstances and the *bravery* and *clinical skill* involved in such acts. These heroes are common in media portrayals and sometimes also *self-report*. Kennedy (1999) in *You Must See Some Terrible Things*, a compilation of stories of paramedic work in Australia, makes continual reference to the heroic acts of many of his colleagues. This is evidence of the importance of these individual heroes in paramedic culture. This emphasis on heroism also seems to promote a dominant male "I can cope with anything culture" (Steen, Naess & Steen 1997, p. 57). The importance of these heroes also reflects the nature of paramedic organisations. They are usually hierarchical with these heroes being prized for their clinical qualifications and technical skills, as opposed to their humanistic and caring qualities (Reynolds 2008).

Rituals are also manifestations of the cultural values of an organisation. As paramedics are generally viewed as an "adjunct" to the medical profession (Reynolds 2009, p. 36) and dominated as such by medical authority, rituals include clinical interventions that are driven by regulatory guidelines and protocols. Adherence to these guidelines scaffolds rituals that guide the paramedics' behaviour, especially when undertaking most aspects of clinical work. The rationale for these work practices is rooted in the need to provide rapid clinical care which requires teamwork. This teamwork is heavily driven by guidelines that attribute roles to individuals that are generally based on technical skills and hierarchy. The performance of these rituals is often seen to require high levels of masculine stoicism (Reynolds 2009, p. 32). Formalised and public rituals such as the wearing of uniforms to honour members of the cultural group at events, such as medal ceremonies, are also commonplace. Subtle ritualistic language used to cope with stressors in the workplace includes language that is "cathartic and therapeutic", black humour, technical and coded language and rationalisation of events (Reynolds 2009, p. 33).

Obscured by the onion layers are the core cultural values that impact on the workplace of the paramedic. These visible manifestations of symbolism, heroism and ritualism within an organisation are telling of the values that are affirmed by the organisation. As the examples cited in previous paragraphs show, paramedic organisations tend to favour values that favour masculinity, homogeneity, bravery, hierarchy and uniformity. It is the case that particular individuals within an organisation may not adhere to these values, or that they may explicitly or implicitly challenge dominant values. This leads to the question of how these organisations and individuals within them respond to such challenges to organisational ethos. Cultural values external to those of the workplace are acquired at early stages in life (Hofstede, Hofstede & Minkov 2010, p. 9). As such, there is potential for inherent conflict between core personal values and an organisation's core values. In terms of Gay and Lesbian paramedics, organisational values that champion masculinity, homogeneity, bravery, hierarchy and uniformity may be incompatible with individual values, which are a product of an evolution that is potentially not 'mainstream'. This thesis seeks to redress conflict through making public the experiences of participants and to consider how their professional spaces could be constructed differently in order to better accommodate their individual needs.

It is imperative to remember that in large organisations there are typically a number of subcultures that can and do co-exist (Shnurr 2008, p. 81). As such one would expect a number of 'exceptions to the rule' from the mainstream organisational culture and its rituals of practice. These subcultures can differ markedly from the core culture; this core forms a backdrop to them and can enhance or deviate from the core ideology (Trice 1993, p. xi). And given that paramedic organisations are large and geographically dispersed one would also expect a number of 'exceptions to the rule' from the mainstream organisational culture. On considering the impact of such variances on the experiences of Lesbian and Gay paramedics, it is reasonable to expect variations in the experiences of these individuals, depending on the characteristics of the subculture of the location in which they work. Previous research has documented the tendency for Gay and Lesbian people to work in 'ghettos', both in terms of their chosen occupation and its perceived alignment to the characteristics associated with their sexuality and in terms of the physical space they may work in (Lee Badgett & King 1997, p. 77).

Gender manifestations and interplay in the work arena

A provocative aspect of the culture of paramedic organisations is highlighted by Boyle (1997). Boyle describes this as a dissonance between the culture of the dominant masculine workforce and the fact that paramedics are performing what she defines as "feminine" work practices in the respect that they are in essence caring and emotional encounters (Reynolds

2009, p. 31). Boyle's (2002) ethnographic study on the Queensland Department of Paramedical Services (DPS), explores the tension related to the masculinity of the organisation and what is characterised as emotional, caring, traditionally feminine work. This study defined "feminine" work as caring for patients. It found that the form of masculinity that was dominant within the DPS was the form played out behind the scenes, that is, when "feminine" work was not in focus. Behind the scenes military and technical forms of masculinity were privileged even in the context of an organisation whose primary function is to carry out caring, "feminine" work (Boyle 2002). Boyle also explored how male workers who engage in "feminine" emotional labour reconcile this way of being within the context of an organisation that prioritises militarised and technical forms of masculinity. This emphasis on technical care as opposed to emotional care is also documented in the work of Reynolds (2008, p. 127). The dominance of these masculine models of workplace practice is said to be "contingent on the symbolic annihilation of femininity, homosexuality and disembodied forms of masculinity" (Boyle 2002, p. 132). As such, female paramedics were expected to both behave like their male colleagues in order to fit into the workplace whilst also bringing 'softening' qualities (Boyle 2002, p. 133).

The work of Boyle (2002) adopted Fineman's (1993) notion that organisations have physical spaces in which different kinds of "feeling rules" apply. Applying this notion to the work of a paramedic means that it is acceptable within the dominant ethos to perform the "feminine" role of patient care in the context of the front line. However, behind the scenes, where the *real* power lies, one needs to switch to other more acceptable and powerful forms of masculinity.

Masculinity is essentially defined as heterosexual and oppositional to homosexuality; masculinity is also oppositional to femininity (Flood & Hamilton 2008, p. 27). Gay masculinities are found to be situated at the lowest levels of the hierarchy of masculine behaviours (Boyle 2002, p. 133). As such this invokes the core question of this thesis. What is the nature of the experience of Gay and Lesbian paramedics within paramedic organisations? Furthermore, are linkages made between gender and sexuality by means of stereotypes in these organisations? Moreover, what is the impact of masculine dominance in an organisation on the experience of Gay and Lesbian paramedics?

Despite increased numbers of women in the workplace, women and femininity are not part of the power structure of these organisations. Lesbian paramedics, by virtue of their gender, stand outside the masculine organisational power structure. Common stereotypes of the effeminate Gay male and the butch Lesbian continue to prevail in Australian society. Ironically masculine qualities are sometimes associated with Lesbians by virtue of

stereotypes applied to their sexuality (Golebiowska 2001, p. 539; Taylor, 1983, p. 51). This can have the effect of potentially acting in 'favour' of Lesbians in the context of fitting into a masculine organisation. Conversely, a Gay male who is *perceived* according to these oppositional stereotypes (Golebiowska 2001) as effeminate, can fall to the bottom rung of the ladder.

Sexual identity v masculine homogeneity

A number of openly self-identified Gay and Lesbian paramedics now work in an environment that had in the past, either tacitly excluded or intentionally closeted them. It is difficult to identify the proportion of such people in any workplace due to variations on who is 'out' in such contexts (Irwin 1999, p. 43). Gay and Lesbian paramedics have probably always existed as Gay and Lesbian employees have existed as a proportion of the workforce. Gay and Lesbian people have the unique ability to conceal or make ambiguous their sexual identity. Being 'in the closet' means censoring all the time with everyone (Winfeld 2005, p. 47). However, closeting oneself to pass as heterosexual and be accepted in a culture is a common practice for non-heterosexual people in many contexts. This quality is also a dual edged sword: whilst it enables people to 'go undercover' it also has the potential to expose them to the real homophobic opinions of others. This exposure serves to reinforce negative opinions and expressions and therefore perpetuates the practice of *closeting* oneself. People from other groups that do not have this ability are in some respects less likely to be exposed to negative opinions due to their inability to hide such qualities. This is because in the contemporary climate of political correctness it is not considered acceptable to express discriminatory views; these may remain obscured from view in order to meet with social expectations (Embrick, Walther & Wickens 2007, p. 758).

Gay and Lesbian rights in Australia and internationally

"Lesbians, Gay men, Bisexuals and Transgender people (LGBT) have been among the most socially excluded minority people. Arguably, they have faced more legal penalties than any other disadvantaged group" (Fish 2006, p. 28).

In relation to the types of disadvantage Gay and Lesbian people experience, a clear distinction must be made from the outset between the use of the word 'homophobia', referring to discrimination at a personal, interpersonal or institutional level, and the term 'heterosexism', which describes the more structured forms promoting heterosexuality in the community (Flood & Hamilton 2008, p. 16; Onken 1998, p. 10; Robinson 2008, p. 3). In many modern societies, the rights of non-heterosexual people are overtly legislated and acted against and at the very least pressures to adhere to heterosexual norms are imposed

(O'Faherty & Fisher 2008, p. 208). As the Yogyakarta Principles remind us, despite perceptions of progression and egalitarianism in the modern age "Many States and societies impose gender and sexual orientation norms on individuals through custom, law and violence and seek to control how they experience personal relationships and how they identify themselves" and "the policing of sexuality remains a major force behind continuing gender-based violence and gender inequality" (The International Panel of Experts in International Human Rights Law and on Sexual Orientation and Gender Identity 2007, p. 6).

At an international level, human rights for those who are *not* heterosexual are still an issue in many societies, both in legislative and practical terms. Many countries maintain laws making consensual same-sex relations between adults a criminal offence. According to O'Faherty and Fisher (2008, p. 210) this numbered more than 80 countries in 2008. Some current examples of existing social constructs, which discriminate against non-heterosexual people, include at least seven countries maintaining the death penalty for "consensual same-sex practices" (O'Faherty & Fisher 2008, p. 208). Violence and discrimination against those who seek to affirm diversity in relation to their sexual orientation are common (O'Faherty & Fisher 2008, p. 211). There is discrimination in relation to economic, cultural and social rights on the basis of sexuality (O'Faherty & Fisher 2008, p. 211) and "medical treatment" related human rights violations, such as institutionalisation and shock therapy to "treat deviances" (O'Faherty & Fisher 2008, p. 212), have been a feature of the history of human rights in relation to Lesbian and Gay people. As noted earlier and in response to this discrimination, in 2007 the Yogyakarta Principles were launched in an international attempt to protect the human rights of people regardless of their sexual orientation or gender identity. These principles responded to the fact that "human rights violations targeted toward persons because of their actual or perceived sexual orientation or gender identity constitute a global and entrenched pattern of serious concern" (The International Panel of Experts in International Human Rights Law and on Sexual Orientation and Gender Identity 2007, p. 6).

In Australia, the 1950s saw a considerable amount of effort being applied by police in relation to the entrapment of homosexuals and police saw homosexuality as a major problem (Willett 2008, p. 121). In the 1960s discussion of homosexuality remained a "taboo" unless it was framed in terms of solving a social problem or treating a medical problem (Ustinoff 2008, p. 128). In the 1960s and '70s homosexuality in Australia was commonly viewed as a neurotic disorder within a medical framework (Wilson 2008, p. 148). Homosexuality was 'treated' in this period with drugs, electro-convulsive therapy and surgery (Wilson 2008, p. 150). Such views of homosexuality as a 'disorder' were often embraced by the person 'suffering' from such a disorder and hoping for a 'cure' (Wilson 2008, p. 150). Distinction was even drawn between 'classes' of homosexuals as to whether they were 'treatable' or 'incurable' (Wilson

2008, p. 158). It is noteworthy here to consider the legacy of these views on the culture of paramedics as health workers who also work in roles strongly aligned to police in historical terms.

Commonly, historical artefacts relating to Gay and Lesbian history have been destroyed or concealed, making documentation of the experiences of Gay and Lesbian people difficult (Willett 2011, p. 5). Over the last 20 years, however, there has been an increasing visibility of homosexuality; the erroneous associated assumption is that homosexuality is now 'accepted' by mainstream society. This is contested by accounts of violence and discrimination still directed against Gay and Lesbian people in the community (Robinson 2008, p. 2). One-third of the Australian population still believe homosexuality is immoral and these homophobic attitudes are more severe in country areas (Flood & Hamilton 2008, p. 16). Social structures and practices continue to privilege heterosexual people (Flood & Hamilton 2008, p. 17). This unquestioned privilege is "an invisible package of unearned assets which can be cashed in daily" (Fish 2006, p. 12).

In present day Australia there is a failure to recognise same-sex relationships (O'Faherty & Fisher 2008, p. 213) in the same manner as heterosexual relationships. In 2007 the Human Rights and Equal Opportunity Commission found 58 federal laws, which discriminate against same-sex couples and their children (Robinson 2008, p. 11). In recent times, the Labor Party amended 84 federal laws to remove instances of discrimination on the basis of sexual orientation (Australian Labor Party 2009, p. 16), but stopped short of legislating in support of Gay marriage. Under the present control of a conservative Liberal/ National Party government, marriage remains a purely heterosexual sociocultural structure. The *Marriage Act 1961* continues to define marriage as "the union of a *man* and a *woman* to the exclusion of all others, voluntarily entered into for life" (Australia 1961), codification of an 1866 English case law definition. Whilst marriage is only an example of a social structure, which is inaccessible to people in non-heterosexual relationships, it is an example of an overt display and formalised social structure which renders non-heterosexual people as being outsiders or being seen as other.

Gay and Lesbian people in the workplace – exclusion and disadvantage

Workplaces are microcosms of society. The same mechanisms, which function to support forms of discrimination in society function in the workplace. Countering this is the requirement for employers to adhere to social equity legislation and principles that exist in all states and territories of Australia banning discrimination on the basis of sexuality. Such legislation is the key mechanism for dealing with discrimination, but it is only able to target the most blatant forms (Fish 2006, p. 7). Many more subtle and institutionalised forms of

subjugating people to discrimination based on their sexuality still operate and are difficult to capture and control.

Very little emphasis is placed on social reactions to homosexuality as a source of problems and such reactions do not often receive attention in discussions or literature (Thompson 2003, p. 109). This allows many organisations to have compulsory heterosexual ideologies and practices. This leaves Gay and Lesbian people with a choice between 'coming out' and facing discrimination or concealing their sexual identity (Thompson 2003, p. 189). Such organisational 'compulsory heterosexual ideologies' function as a significant part of *heterosexism*, which regards non-heterosexual people as inferior. Such heterosexist views are exemplified by the commonly held view that "homosexuals are not safe to work with children" (Thompson 2003, p. 189). Concerns falsely relating to Gay and Lesbian people, who work with children in terms of influencing and 'recruiting' these children, in addition to associations with paedophilia and molestation are common (Anastas 1998, p. 86). This view impacts upon workers in professions, such as teaching (McKenna 2009), medicine (British Medical Association 2005) and nursing (Zurlinden 1997), and logically could be used as part of a heterosexist repertoire in paramedic organisations.

Gay and Lesbian people constitute between 4 and 17 percent of the workforce, but very little is known of their experience (Ragins, Cronwell & Miller 2003, p. 45). Between 16 and 44 percent of Gay and Lesbian people have encountered workplace discrimination and those in employment have limitations imposed upon them by the "lavender ceiling" (Anastas 1998, p. 85). Anti-Gay attacks are frequently faced by people, whether or not they are 'out' at work and may be in the form of direct attacks, as well as more indirect forms such as graffiti and jokes (Anastas 1998, p. 86). At the most destructive end of the scale such homophobia is a cause of psychological harm and is linked to higher suicide rates (Robinson 2008, p. 11). Connotations associated with homophobia as a disorder can mean that homophobes should be treated with "compassion and leniency" as a response to homosexuality and form the foundation of homophobic panic as criminal law defence for murder in some cases (Fish 2006, p. 5). Such discrimination can be seen as a form of violence, which "denies full participation in essential social and economic activities and institutions, perpetuates economic injustice, and reduces their [Gay and Lesbian] opportunities for fulfilling human potential" (Anastas 1998, p. 84).

Strategies for coping with discrimination usually centre on *identity management* relating to non-disclosure or limited disclosure of sexuality (Anastas 1998, p. 90). This can result in the presumption of heterosexuality which can create more strain on Gay and Lesbian people in the workplace in terms of them feeling isolated and marginalised (Anastas 1998, p. 91).

When not 'out' in the workplace, the strains of concealment are considerable and part of an ongoing process which requires choices relating to disclosure to be made continually (Anastas 1998, p. 91). The process of concealing and switching identities is painful and confusing (Carnevale & Stone 1995, p. 416) and puts Gay and Lesbian people in a vulnerable position. This is compounded as these women and men continually question what others around them know in relation to their sexuality (Anastas 1998, p. 91) and whether those others will choose to pass such information on to those who can act in a manner which is detrimental to their presence, advancement and wellbeing in the workplace. Some evidence has suggested that openness about sexuality in the workplace correlates to increased job and life satisfaction; however, those who concealed their sexuality were happier with their pay and had slightly higher salaries (Anastas 1998, p. 92). Strategies of concealment also take their toll on the organisation as they result in decreased productivity (Carnevale & Stone 1995, p. 418). Gay men and Lesbians are affected by society's homophobic attitudes and this may lead to internalised homophobia. Such internalisation leads to negative feelings of shame, guilt and self-hatred (Flood & Hamilton 2008, p. 19).

Identity

The heterosexualisation of desire endorses the enactment of the opposition stance between masculine and feminine. The cultural matrix requires gender identity to follow sexual identity and the associated sexual practices that are male or female in focus. To act otherwise remains, if unexamined, unintelligible for the non-homosexual majority (Butler 1990, p. 17).

As further articulated by Butler:

Inasmuch as 'identity' is assured through the stabilizing concepts of sex, gender and sexuality, the very notion of 'the person' is called into question by the cultural emergence of those 'incoherent' or 'discontinuous' gendered beings who appear to be persons but who fail to conform to the gendered norms of cultural intelligibility by which persons are defined. (1990, p. 17)

In this sense, heteronormativity shapes predominant social structures as well as organisational structures (Acker 2011, p. 71). Lesbians and Gay men present a direct challenge and are thus perceived to be a threat to traditional gender roles. The construction and control of gender and sexual orientation is rooted in the unquestioned traditions and values of a heterosexist and patriarchal society (Griffin 2006, p. 190). A "compulsory and naturalised heterosexuality" (Butler 1990, p. 22) therefore strongly influences the construction of identity and an individual's inclusion/exclusion within or without a group.

These dominant heteronormative assumptions pervade workplaces. If the culture of a workplace is not accepting or supportive of sexuality as an identity attribute, one must

consider if, why and how this impacts on an individual. Potential rejection of the authentic identity of an individual within the context of the workplace is a tension underpinning this research.

Social inclusion and support are amongst the top ten determinants of health defined by the World Health Organization (Barkway 2009, pp. 8, 80). To some extent an individual has control over the attributes they disclose in order to project a personal and social identity that implies inclusion and acceptance into a group. Moreover, an individual has greater control over what they conceal or reveal when the relevant social traits are invisible, as opposed to visible. The result is that an individual may choose to conceal aspects of their identity which they may perceive that the dominant culture considers 'undesirable'. This suppression of sexual identity means that the interface with other workers is potentially dangerous as it involves potential exchange of personal details (Griffin 2006, p. 195). This editing and self-concealment can sometimes be effective as a survival strategy. However, to do so requires the expenditure of energy and can generally lead to feelings of internal conflict (Griffin 2006, p. 196).

Despite having some personal influence over what is 'known' within a particular environment about an individual's sexuality, part of this constructed identity is also at the mercy of external perceptions. This is in part controlled by labels that others sharing a common environment choose to apply to various individuals. Labelling theory relates to dominant groups imposing standards of acceptable behaviour and identity onto subordinate ones (Griffin 2006, p. 189). In the context of this research this essentially means that, as the dominant group, heterosexual males have control over the acceptance of individuals in the workplace. As a result, where an individual may choose to conceal aspects of his or her sexual identity to promote social inclusion or acceptance, external perceptions can and do actively interfere with and frequently override this choice. The dominant forces therefore not only construct silence in the discourse but can further disempower the Lesbian or Gay paramedic by taking away the right to choose to remain silent. These expectations are often controlled by stereotypes, where there is a lack of other information because of compulsory heterosexuality which is used to negatively stigmatise Lesbian and Gay people. The silence in the discourse around non-heterosexual sexualities means that reference is made to stereotypical characteristics which produce additional stigmatised labels to 'describe' people with non-disclosed sexualities.

Identity is a relatively recent area of academic exploration in sociological psychology (Taylor 1991; Weigart, Teitge & Teitge 1986). In the past, where societies were more defined by kinship, the need to examine identity was not so prominent. Instead cultural and social

recognition was intrinsically linked with status within a rigid and well-defined cultural hierarchy and social order (Muldoon 2010, p. 678). In contemporary society we have a responsibility for shaping our own identity in a way not seen in previous points in history, where destiny was more closely aligned with social identity structures (Willis & Elmer 2011, pp. 222-3). It is important to highlight that the contemporary concept of identity emerged after the formation of paramedic culture, characterised by its preoccupation with homogeneity. Where an organisation has an operational culture, which promotes a collective identity over individual identity, this can impact an individual's ability to be *authentic*. This historical incompatibility of the individual concept of 'self' over the collective concept of 'self' can create tension when the inherent individual characteristics of identity fail to resonate or synergise with the characteristics of the affirmed collective culture.

Identity refers to a "fundamental defining characteristic of a person or group" (Muldoon 2010, p. 678). It is complex in that numerous qualities and characteristics intersect to form a person's sense of self. These qualities transform a biological individual into a human being (Weigart, Teitge & Teitge 1986, p. 31). It is "the constellation of characteristics, such as values and beliefs, which people regard as part of their self but that are derived from social forces" (Van Krieken et al. 2010, p. 536). These qualities or characteristics can include marital status, age, eye colour, physical strength, height, weight, parental status and of course profession, gender and *sexuality*. These identity attributes are aggregated by individuals and by others (Weigart, Teitge & Teitge 1986, p. 31) within the parameters of sociocultural structures (Weigart, Teitge & Teitge 1986, p. 2). Identity is therefore composed of a complex matrix of intersecting characteristics relating to the range of personal qualities, either self-ascribed or ascribed by a group external to an individual. Identity is defined both at a micro, interactional level by self and others on a situational basis and on a macro level, systemically and structurally as part of the social repertoire maintaining social order (Weigart, Teitge & Teitge 1986, p. 27).

The struggle for an identity is by implication the struggle to work out a stable concept of self and embrace an ideology which provides a clear sense of direction (Weiten 2013, p. 456). The tapestry of self-identity is not only extremely complex but dynamic in nature, as it evolves with interaction in a range of contexts. As such, humans can be seen as forever "selfing" (Weigart, Teitge & Teitge 1986, p. 40) or struggling to adapt and define their identity in a dynamic context. As stigmatisation is relative to the cultural context of these identity characteristics (Clair, Beatty & MacLean 2005, p. 81), some aspects of a person's identity will have positive and negative connotations, depending on this context.

From this perspective it therefore follows that self-esteem depends on both personal identity and social identity; threats to either have the potential to undermine self-esteem (Weiten 2013, p. 555). Within an organisational structure there are also factors that influence notions of identity that have the potential to impact an individual's self-esteem. Within many organisations there are mechanisms of control that privilege some individuals over others. These influences can be direct or indirect, obvious or hidden, internalised or external to the individual (Acker 2011, p. 75). Such institutional norms can also operate on the basis of perpetrating acts of inequality. For example, forces of exclusion, whether overt or covert, can strongly impact on this sense of *authentic* identity when sexual identity is deemed as dysfunctional or abnormal.

Coming out and authenticity

Authenticity has featured historically in discussions of the politics of difference and the politics of recognition and equal dignity (Cooke 1997, p. 258). In a similar sense to concepts of identity and individuality the parallel concept of authenticity is a recent phenomenon (Taylor 1991, pp. 25-9). The concept of autonomy in the context of the politics of difference centres around the ability to define one's own identity and is based on the concept that individuals each have a unique identity to which they must be true (Cooke 1997, pp. 259-60; Salmela 2005, p. 218). Once a person is clear about what it is they understand to be authentic, this authenticity should then be allowed to be expressed in an open and public way (Kreber 2010, p. 183). Authenticity involves living from the qualities of genuineness, openness, self-awareness and the commitment to realise one's fullest individual potential. Authenticity is seen in humanistic psychology as being essential to happiness (Medlock 2012, pp. 39-40). Following this definition of authenticity, it is essential to the wellbeing of an individual to be able to live life in a manner consistent with his or her inherent personal values. For some individuals, 'coming out' allows this sense of authenticity to come to the fore. This study thus investigates the ability of Gay and Lesbian paramedics to be *authentic* in their workplace.

According to individual perceptions as to the value of living authentically, Lesbian and Gay employees make conscious decisions about whether to reveal their sexuality at work (Chobrot-Mason, Button & DiClementi 2001, p. 322). Maintaining a façade requires constant vigilance and frequent deception (Griffin 2006, p. 189). Arguably, coming out means leaving silence behind and reconciling social identity with self-identity in terms of sexuality (Ward & Winstanley 2003, p. 1276). This can be a liberating experience and emancipatory for non-heterosexual people who emerge from their self-imposed and socially constructed enforced silence. It can also release an individual from a sense of internal conflict relating to tension of managing sexual identities in the workplace (Griffin 2006, p. 192). Whilst coming out can be

perceived as a choice that is liberating, it is not always the individual's choice as they can be 'outed' by those around them. Coming out, however, is a process that has to occur every day as you measure the manner in which you are accepted or rejected.

Generally people take social identities at face value based on norms and assume 'normal' in the absence of visual or behavioural cues to indicate otherwise (Clair, Beatty & MacLean 2005, pp. 80-1). If one wants to come out, because of the dominance of compulsory heterosexuality and the presumption that he or she is heterosexual, it is something that has to be done in every new work situation and every day (Ward & Winstanley 2005, pp. 451-2). Coming out is therefore another form of a repetitive, risky performative act; whilst a choice, it needs to be enacted in new contexts daily. Coming out needs to happen with new people and only when it is considered relative to the risks involved in the act of disclosing. When all circumstances have been taken into account the act of coming out requires a considerable amount of energy. In some ways it requires as much energy as does remaining closeted. You can never be fully in the closet, as you do not know how successful you have been at concealing your sexuality, and you can never be fully out as those privy to the information of your sexuality can treat such information as their secret (Ward & Winstanley 2005, p. 450).

A 'homonegative' environment creates barriers to an individual's ability to live authentically (Fjelstrom 2013, p. 801). Such an environment promotes compliance to the dominant cultural expectations in ways that do not challenge norms and expectations (Kreber 2010, p. 182). Conversely, a culture that encourages diversity and promotes an individual's ability to be authentic and autonomous is more likely to succeed than a stifling culture that oppresses and silences individuals (Medlock 2012, p. 42). Translated into the context of the workplace, organisations that provide a sense of cultural safety for those who are not heterosexual promote the wellbeing of these individuals. Additionally, they foster a culture in which an individual can remain authentic and therefore *flourish*.

Examples of exclusion and disadvantage

The value of a workplace culture overtly supportive of Gay and Lesbian diversity is recognised in a number of organisations. However, research into various fields of practice indicates workplace habits that exclude and disadvantage non-heterosexual people. These studies are framed in the context of teaching (McKenna 2009), policing (Miller, Forest & Jurik 2003), the military (Carnevale & Stone 1995; Sinclair 2005; Winfeld 2005), nursing (Harding 2007; Zurlinden 1997) and medicine (British Medical Association 2005).

McKenna (2009), for example, conducted research into the experiences of Gay and Lesbian teachers in Western Australia. He found that the stories of participants were a reflection of cultural norms of the place and time. Participants shared their experiences of discrimination, which was a product of them not being heterosexual. McKenna notes that this kind of discrimination can be viewed as the product of heteronormative practices that “illuminate heterosexual predominance” (2009, p. 273). Some of the findings related to participants’ experiences of fear, anger, insecurity and lack of confidence in speaking out in the schools in which they worked (McKenna 2009, p. 276). The school based practices which played out as acts of homophobia and heterosexism were found to be diverse and insidious. The net result of these practices is that Gay and Lesbian “educators are not to be seen” (McKenna 2009, p. 333). This has far reaching consequences for educators as well as their students, whose educational needs they serve. This impact included making the Lesbian and Gay students who are inevitably present in their schools invisible and denying them a voice.

As previously discussed, emergency services workers, such as police and firefighters, have strong similarities to paramedics in their workplace culture and practices. Another example is a qualitative study of 17 Gay and Lesbian police in a midwestern city in the United States who found policing to be a hostile “gendered, sexualized and racialized” work environment (Miller, Forest & Jurik 2003, p. 356). Research findings indicated that policing was found to be an activity for “masculine men” and is dependent on the subordination of femininities as well as less than dominant masculinities including “Gay masculinities” (Miller, Forest & Jurik 2003, p. 358). Increasing numbers of ‘outsiders’ in policing, including women, non-whites and non-heterosexual people, were found to have challenged and triggered hostility amongst many traditional white male officers (Miller, Forest & Jurik 2003, p. 359). As a result of these forces of hegemonic masculinity, it was found that homosexual police officers were subordinated (Miller, Forest & Jurik 2003, p. 360). The study noted that heterosexual people established boundaries that excluded Gay and Lesbian police through a range of techniques including verbal reminders of sexual difference (Miller, Forest & Jurik 2003, p. 365). Many police officers were found to believe that their sexuality influenced the opinion of other officers in relation to their policing skills (Miller, Forest & Jurik 2003, p. 368).

Although repealed in 2011, there has been considerable public discussion in recent times in the US relating to the “Don’t ask, don’t tell” policy of the military. This public policy was highly homophobic in that it has at its core the assumption that homosexuality is something that needs to be hidden from the public gaze (Carnevale & Stone 1995, p. 430). This policy allowed people to serve in the armed forces and protect their country, provided their homosexuality was *unspoken*. This effectively required people to swear an oath on entry into the forces and then immediately lie about their sexuality by being unable to declare it

(Winfeld 2005, p. 26). Furthermore, it has been established that elitism dominates in specific sectors of the military and the hierarchy produced by this elitism is maintained by aggressive macho-heterosexuality (Sinclair 2005, p. 159). Not only are non-heterosexual people denied their rights to speak out in relation to their sexuality in this field, but predominant heterogendered elitism acts in a manner that limits their ability to progress.

A qualitative US study reported instances of discrimination against Lesbian and Gay nurses from both patients and co-workers (Zurlinden 1997, p. 35). The process of coming out is a carefully considered question for many Lesbian and Gay nurses (Zurlinden 1997, p. 37). The conscious process of coming out, compounds the stress experienced by nurses in an already stressful occupation (Zurlinden 1997, p. 65). This study refers to the “lavender ceiling” as a metaphor for the career limitations placed on Lesbian and Gay nurses (Zurlinden 1997, p. 183) in a similar manner to the “pink ceiling” concept discussed by Irwin (1999). Discussion of the lavender ceiling also raises the point that discrimination on the basis of stereotypes used to label people as Lesbian or Gay, affects all people. These stereotypes included those that attributed Gay men with effeminate qualities and characterised Lesbians as masculine women. This is because these stereotypes are often applied to heterosexual people and can therefore become limiting in terms of how they impact on their careers (Zurlinden 1997, p. 198).

Extending the focus to medicine, a British Medical Association (British Medical Association 2005, p. 5) survey found that only 1 percent of health professionals were ‘out’ to their superiors, despite also quoting that 1 in 20 of the population identify as Lesbian, Gay or Bisexual (British Medical Association 2005, p. v). This study also found that sexual orientation can be a barrier or perceived barrier to career progression in medicine in the United Kingdom (British Medical Association 2005, p. 1). Added stress, seen to be the product of not being ‘out’ at work (British Medical Association 2005, p. 5), was noted as having negative consequences for the doctor, patient and workplace. The study also highlighted the need for further research in the area relating to barriers to career progression for Lesbian and Gay doctors (British Medical Association 2005, p. 20).

The aforementioned research indicates that Gay and Lesbian people were marginalised within the contexts of several occupations similar to paramedicine. From this foundation, it is likely that conditions are not favourable for Gay and Lesbian paramedics in terms of providing a workplace culture in which they can flourish.

HIV and the shadow of the 'Grim Reaper'

One of the greatest obstacles Gay and Lesbian people have to overcome is the discrimination they experience as a result of perceptions that they are the "sole carriers" of AIDS (Henderson 1996, p. 163). Gay men may face discrimination based upon their presumed HIV status (Anastas 1998, p. 89) and this can also impact their experience in the workplace. Gay men in masculine occupations, particularly those that bring men together in intimate spaces, such as sports and the military, may be subject to more intense harassment (Anastas 1998, p. 89). This is because of the perceived, and often erroneous, risks associated with the transmission of HIV. The extension of this is that Gay male paramedics may therefore be affected by presumptions related to their HIV status. As other paramedics with which they work may have misconceptions related to transmission of this disease, the close physical proximity in which they work may heighten fears of HIV infection.

Understandings of patient-centred care

Modern approaches to healthcare have tended to take on a more 'service oriented' approach. In line with the emergence of notions of informed consent, the ageing population, increased prevalence of chronic illness and management philosophies, including total quality management, there has been a shift in the way in which patient care is perceived (Lambert et al. 1997, pp. 29-30). A more service oriented approach to care has resulted in a stronger emphasis on patient centeredness whereby the needs of the patient as a whole person is taken into consideration. This contrasts with previous models where an individual's biological needs were the primary focus (Lewin et al. 2001, p. 1).

A more consultative and holistic approach that focuses on the psychosocial needs of the patient leads to greater inclusivity and participation in healthcare. Wanzer et al. (2004, p. 380) support the premise that this movement towards patient-centred care has generally resulted in a more positive patient perception of their care when dealing with the healthcare sector. The inclusion of the individual patient in formulating plans to manage health issues is increasingly advocated by healthcare as a result of this recognition of the value of holistic and inclusive care practices. As such, these approaches are incorporated into training delivered to healthcare workers (Lewin et al. 2001, p. 3; Wanzer, Booth-Butterfield & Gruber 2004, p. 364).

Although commonly discussed, this notion of patient centeredness is difficult to define or measure (Lewin et al. 2001, p. 2). The literature does not reach consensus on what patient-centred care actually is; however, there is some agreement on some of the elements involved (Bertakis, Franks & Epstein 2009, p. 540). Lewin et al. (2001, p. 1) define patient-centred care as:

a philosophy of care that encourages: (a) shared control of the consultation, decisions about interventions or management of the health problems with the patient, and/or (b) a focus in the consultation on the patient as a whole person who has individual preferences situated within social contexts (in contrast to a focus in the consultation on a body part or disease).

Other definitions essentially promote partnership between the healthcare worker and the patient in decision making in a more egalitarian fashion than that promoted by the biomedical models favoured in the past (Bertakis, Franks & Epstein 2009, p. 540; Lambert et al. 1997, pp. 28, 30).

A patient-centred approach to care requires a relationship to develop whether it be short term (generally the case with paramedics), or longer term (with other healthcare workers).

Groome (2009, p. 149) described this as a “shared sense of humanity” constructed between patient and carer. Whilst it is valid to promote the needs of the patient over the needs of the carer, the care experience is contemporaneously dependent on the quality of this very relationship. In this understanding there is no overt mention that a healthcare worker must subvert all details of their own identity. In order to feel valued and therefore perform effectively in performing a healthcare role, some of the needs of the care provider do need to be considered. Where the needs of one party are constantly minimised, it is plausible that the quality of the relationship – and therefore the quality of the care – can be affected. Even if beneficial for patient relationship in the short term, longer term effects can damage reserves of empathy and skills in the repertoire of the healthcare worker. In the context of this study, depletion of this pool of personal resources may ultimately be detrimental to those patients a Gay or Lesbian paramedic may be required to care for into the future.

Gay and Lesbian healthcare workers may hold a belief that disclosure of matters related to their sexuality may prove controversial for a patient. They may believe that an employer has an expectation that they adhere to understandings of patient-centred care which evade patient discomfort by preventing healthcare workers from disclosing non-heterosexual sexualities. This can present a dilemma for workers. This has previously been documented in literature relating to Gay male nurses (Harding 2007) and Lesbian nurses (Giddings & Smith 2001). Harding (2007), for example, found a tendency for Gay male nurses not to disclose their sexuality to patients and for this to have negative implications for patient care. Giddings and Smith (Giddings & Smith 2001) found Lesbian nurses would not reveal their sexuality to elderly patients or parents of paediatric patients, as they believed that this was necessary to maintain patient comfort. Furthermore, Eliason et al. (2011) found that the notion of patient-centred care remained undefined in the context of workplaces of many nurses. This research

identified a need for policy clarification in terms of what it is fair for nurses to reveal to patients in relation to their sexuality, in order to alleviate this sense of uncertainty.

Differences between Gay men and Lesbians in the workplace

Anastas (1998, p. 85) found that, despite stereotypes, most Gay men and Lesbians work in jobs that are typical for their genders. It was also found that women in non-traditional work roles face higher levels of harassment due to assumed associations between their sexual orientation and choice of work role (Anastas 1998, p. 88). Sexist views that align roles in the military with masculinity meant that women more often than men presumed homosexuality (Anastas 1998). Ways in which anti-Gay prejudices were experienced was found to be different between Gay men and Lesbians (Anastas 1998, p. 87). Women have the added layer of gender discrimination. Anastas (1998) also found that Lesbians are more likely to condemn unwanted sexual remarks and advances than heterosexual women. Lesbians, simply because they are Lesbians, are subject to more advances by men to impose heterosexual sex upon them.

Whilst women, with their 'glass ceiling' arguably experience less overt discrimination, they continue to be subjected to subtle forms of discrimination in the workplace (Sue 2010, p. 210). Consequently Lesbians can be viewed as being on the receiving end of a 'dual edged sword' of discrimination related to both gender and sexuality. It is therefore noteworthy to consider how the experiences of Gay male paramedics may therefore differ from those of Lesbian paramedics. Are Lesbians able to 'pass' in the masculine culture of these organisations by virtue of the stereotypes associated with their sexualities? Do Gay male paramedics have a different experience of the workplace resulting from the gender characteristics that are commonly associated with their sexualities? This research sets out to investigate these previously unexplored issues.

Legislative and policy frameworks

Heteronormativity permeates the majority of workplaces inasmuch as they mirror general society. Individuals who deviate from the desired or 'prescribed' social type for a job or organisation may confront barriers to work performance (Miller, Forest & Jurik 2003, p. 357). A sexual double-standard exists in workplaces. This is because they are seen in general as 'non-sexual'; however, they are in fact rich with symbolism and tolerant of heterosexual relationships and expression whilst making Gay and Lesbian relationships taboo (Carr-Ruffino 1999). Irwin's research (1999) provides evidence of a range of social constructs, which contribute to the limitations each of the above groups face as newcomers to workplace. The 'pink ceiling' as a concept describes the way in which Lesbian and Gay people can be discriminated against in a workplace, with one Australian study revealing that

59 percent of such participants experienced harassment or prejudice in their workplaces (Irwin 1999, p. 6). This report also concluded that this behaviour was more common in both male dominated industry (Irwin 1999, p. 66) and large organisations (Irwin 1999, p. 39). Ambulance organisations in Australia meet both of these criteria.

Western societies have embedded belief systems of what is 'normal' in terms of sexual behaviour. These beliefs are reinforced by moral and medical paradigms, commonly associated with religion and procreation, and challenges to such paradigms are often viewed as assaults on social order (Onken 1998, p. 7). More explicit acts of violence against sexual minorities at an institutional level are slightly more tangible and consequently easier to deal with. Such acts are prohibited by legislation, common law, policy and overt organisational practice. Exponents of such acts can be controlled, at least superficially, by these legal and policy instruments.

Some of the legislative and policy frameworks that are, in part, designed to level the playing field for Gay and Lesbian people include federal and state equal opportunity legislation. These are applicable to all states and territories in Australia and include specific mention of sexual orientation, sexual preference or sexuality as grounds upon which discrimination is unlawful. Sexual orientation relates to all people, consequently laws that prohibit discrimination on such a basis also protect heterosexuals (Winfeld 2005, p. 3).

Legislative and policy attempts to control discrimination against marginalised groups cannot control the intangible actions and rituals that proliferate in workplaces. Intangible and insidious practices impact on Lesbian and Gay people. Benokraitis (1997) refers to these less tangible beliefs and behaviours as 'subtle sexism'. This term acknowledges that sexism still exists but that it has come to take a less tangible form. Sue (2010) uses the term 'microaggression' in a similar sense. This term refers to the more subtle and less tangible forms of exclusion and marginalisation that take place and collectively function to exclude specific groups and maintain power imbalance.

Stereotypes also function in an intangible way to disempower and *marginalise* some groups. Stereotyping is the filtration and simplification of information in such a manner that it provides rigid, negative and oppressive views of a person or group of people. Such stereotypes become ingrained in such a way that there is a tendency not to notice them influencing our perceptions and actions (Thompson 2003, p. 84).

Of particular relevance to Lesbian and Gay People is the notion of *invisibilization* (Thompson 2003). This concept refers to the way groups are referred to in language and imagery. It is

notable that dominant groups are constantly represented and are associated with power, prestige and influence, whereas other groups are rarely or never seen is such a light (Thompson 2003, p. 86). The absence of Lesbian and Gay people in the media is a good example. *Infantilization, welfarism, medicalization, dehumanization, trivialization* also function to reinforce stereotypes and maintain social inequities in practice (Thompson 2003). Such techniques are evident in practices that minimise complaints about or reactions to heterosexist jokes and dismiss them as being overreactions in addition to perceptions that complaints about mistreatment are acts of troublemaking. Despite inherent difficulties in eliminating these practices, some workplaces have introduced successful strategies to minimise such pervasive practices.

Successful models of inclusive practice

Several models of inclusive practice are noted in the literature. These are examples of what is viewed as a “lasting route to corporate success through the inclusion of all available talent” (Pollitt 2006, p. 6). Positive models of diversity management have many elements. They value employees, provide education on equity and diversity issues and ensure equal opportunity for professional development. Inclusive models also enable promotion of staff, and offer employment challenges commensurate with experience and qualifications (Pollitt 2006, p. 30).

Strategies that may be used to deal with issues relating to sexual identity in the workplace include the mandating of policies of non-discrimination, educating employees on inclusive practices, and the establishment of domestic partner benefits. Provision of employer supported employee networks for LGBT workers, marketing to the LGBT community, internal and external outreach, availability of internal resources and reference material (Winfeld 2005, p. 25) are also measures that are critical to facilitating inclusive employment practices. Management support and continual demonstration of commitment to these strategies is critical to their success (Winfeld 2005, p. 35). A vital element of the success of workplace education programs is that they are viewed as part of a holistic strategy for dissemination of information and not just a knee-jerk reaction to the ‘problem’ (Winfeld 2005, p. 59).

Several well-known international companies have proactive models of diversity management. These include Shell (2010), which developed LGBT specific policies for inclusion and practice. These policies relate to non-discrimination, transgender health benefits and domestic partner benefits. They flow from Shell’s acknowledgement of the benefits of inclusive practice in the workplace. Barclays Bank (Barclays Bank PLC 2011) has a relationship with Stonewall, a Lesbian, Gay and Bisexual equality charity as well as “Barclays Spectrum Network” which spans the organisation and supports Lesbian, Gay, Bisexual and

Transgender (LGBT) employees including offering mentoring programs. In the US Microsoft, Lotus and Levi Strauss have all implemented diversity policies aimed at the recruitment and retention of members of the Lesbian and Gay community (Carr-Ruffino 1999, p. 231). For example, although not required by US legislation, Levi-Strauss offers bereavement leave to those with “domestic partners” (Henderson 1996, p. 164).

In Australia, IBM recognises

Diversity means feeling comfortable, valued and included: making it safe for people to be out at work. We know that all employees, including Gay, Lesbian, bi-sexual and transgender (GLBT) employees, will only reach their full potential and make their fullest contribution to our clients' success if they are comfortable to be who they are (IBM Australia 2011).

IBM Australia has also won several community awards for the proactive approach it takes towards supporting GLBT employees (IBM Australia 2011).

In the US, targeted recruitment of Gay and Lesbian police officers has taken place in Boston, Minneapolis, Madison, Seattle, Portland, Atlanta, Philadelphia, San Francisco, Los Angeles, New York City and Chicago for reasons including better understanding and reflection of the community served (Miller, Forest & Jurik 2003, p. 358). In order to recruit and maintain a workforce that reflects the community and maximises the benefits of a multicultural workforce, Victoria Police (VicPol) have targeted the Lesbian and Gay community in recruitment campaigns (Magnusson 2010; Noonan 2010). VicPol also recognises the benefits of diversity in the workplace and employs a number of Gay and Lesbian Liaison Officers (GLLOs) to ensure the organisation is sensitive to the needs of this sector of the community (Victoria Police 2011).

The BMA has developed policy measures specifically aimed at supporting Lesbian and Gay doctors, aspiring to structure a health service in which “every doctor can achieve their aspirations and full potential” (British Medical Association 2005, p. v). It recognises that “sexual orientation can stand as a barrier or perceived barrier to career progression” (British Medical Association 2005, p. 1). As a result, the BMA has developed a policy and education strategy specifically aimed at “changing the homophobic nature” of some workplaces employing doctors and tackling issues of harassment and bullying (British Medical Association 2005). Such measures include the development of Gay and Lesbian support groups for staff (British Medical Association 2005, p. 9), zero tolerance and training packages (British Medical Association 2005, p. 19).

A controversial British measure aimed at the inclusion of Lesbian and Gay paramedics was paying them to participate in a pride festival in Brighton in 2009 (Kisiel 2009). Although reported as more of a health promotion measure, this shows some steps toward inclusive practices to support Lesbian and Gay paramedics. In 2010 the National EMS & Firefighters Pride Alliance was set up in the US as a support group “to support, defend, and protect the interests and the general wellbeing of Gay, Lesbian, Bisexual, and Transgender Emergency Medical Service and Firefighting professionals and volunteers” (National EMS & Firefighters Pride Alliance 2011). These interventions are examples of institutions taking positive steps to redress disadvantages Gay and Lesbian people may experience, and the importance of such strategies for support and education. In its exploration of the experiences of Gay and Lesbian paramedics in Australia, this study has the potential to inform practices of support and education which promote inclusion and wellbeing.

Consequences of non-inclusive practices

A number of negative effects occur as a result of non-inclusive workplace practices as they impact Gay and Lesbian people in the workplace. In addition to having an intra-personal effect, these impact at interpersonal, organisational and community levels (Onken 1998, p. 6). This intra-personal impact is noted and commonly labelled as internalised homophobia. Internalised homophobia refers to “the distress, lack of social support, maladaptive coping behaviours, greater alcohol consumption and low self-esteem experienced by some Lesbians and Gay men when they encounter hostility and rejection from heterosexuals” (Fish 2006, p. 5). Intrapersonal violence is manifested in shame, self-degradation, self-doubt and suicide (Onken 1998, p. 19).

At the interpersonal level people may seek refuge in specific areas or perform particular roles within a workplace. These are often more hands-on and better defined roles in which performance can be clearly measured in which the ‘lavender ceiling’ plays a more active role (Carr-Ruffino 1999). There are obvious consequences in relation to interpersonal relationships when an individual is devalued and disrespected in the workplace, which impact their relationships with partners, family and friends.

In organisational terms the negative impacts of practices which exclude Gay and Lesbian employees are complex: practices which result in people feeling undervalued and disrespected in the workplace and can potentially *drain* talent from an organisation. These *drains* result from Gay and Lesbian people looking for workplaces or places within workplaces in which they can feel comfortable. This may mean exodus from a workplace or self-location within a ‘ghetto’ space. These practices of self-suppression and management of one’s personal identity also consume energy and drain productivity. Prejudice and

discriminatory work practices set up limitations on all workers within a workplace. This creates insecurity and limits participation of all employees and these practices have widespread implications in terms of obvious effects on productivity (Carr-Ruffino 1999, pp. 226-30). When actions of employees are strictly monitored and edited for any behaviour that may be seen as 'Gay' there is limitation on freedom of expression and input in the workplace. Practices which promote self-expression in turn promote workplace participation.

Ceiling colour selection and microaggressions in practice – a framework

The impact of legislation and the enactment of policy measures is that whilst arguably less overt discrimination is experienced, people continue to be subjected to subtle forms of discrimination or "microaggressions" in the workplace (Sue 2010, p. 210). These are "brief, everyday exchanges that send denigrating messages to certain individuals because of their group membership" (Sue 2010, p. xvi). While policy and legislative changes are a positive force in the quest for equality for Lesbian and Gay people, much 'underground' discrimination and violence still exist. Insofar as a parallel can be drawn to black market economies, the brokerage of such violence is more difficult to control as it is more hidden. Furthermore, beliefs as to what is 'normal' in terms of sexual behaviour are reinforced by moral and medical paradigms and challenges to such paradigms are often viewed as assaults on social order (Onken 1998, p. 7).

Van Soest and Bryant (1995, p. 550) define violence as any act or situation where a person injures another. Violence can include both direct attacks on a person's physical or psychological integrity and "destructive actions that do not involve a direct relationship between the victims and the perpetrators". Onken (1998) adopts this definition of violence in developing a conceptual model of anti-Gay violence, which identifies three levels of violence – individual, institutional and structural-cultural. The third is the insidious level consistent with the concepts of "subtle sexism" defined by Benokraitis (1997) and applied to the Lesbian and Gay population by McKenna (2009), as well as the concept of "microaggressions" exposed by Sue (2010) in his exploration of subtle forces of marginality applied to a range of disempowered groups.

The difficulty of dealing with subtle, 'minor' embedded beliefs that are unjust and 'violent' is that the violence 'goes underground' and becomes insubstantial. Often such violent acts and beliefs are accepted as being "the way things are" (Onken 1998, p. 7). Such acts of violence can be by means of omission, repression and alienation (Onken 1998, p. 8). Similarly, Thompson (2003, p. 110) sees oppression based on sexuality as operating at three levels – personal, cultural and structural and asserts, "Gay affirmative forms of practice are...an

essential part of challenging and undermining the oppression of heterosexism” (Thompson 2003, p. 111).

Exclusion of non-heterosexual people on moral grounds is sanctioned on a structural-cultural level: to some extent beliefs that are derivative of those in Christian doctrines in western societies (Onken 1998, p. 11). Medical models of structural-cultural violence see non-heterosexual forms of sexual expression as “conditions” that require fixing or restoration (Onken 1998, p. 13; Thompson 2003, p. 109). Those who do not conform to heterosexual norms are stigmatised, on moral and medical grounds with such stigmatisation acting as a form of structural-cultural violence (Onken 1998, p. 16).

In developing an understanding of the experience of Australian Lesbian and Gay paramedics in the workplace it is essential to consider the inherent contradictions between ‘overt’ legislative and policy practices in relation to discrimination and practical realities of the ‘underground’ practices of “microaggressions” (Sue 2010) and acts of “subtle discrimination” (akin to Benokraitis’s (1997) concept of “subtle sexism”). Exploration of this phenomenon is located in Irwin’s (1999) research, which gives voice to the workplace challenges faced by Lesbian and Gay workers. Irwin (1999) also gives consideration to how these practices may construct a “pink ceiling” in the workplace. The colour of this ceiling in the US is lavender (Carr-Ruffino 1999).

Changing demographics

Current needs and future directions

The reasons for working toward inclusive workplace practices are numerous. They can be divided into the broad categories of *humanitarian and social motivations* and *organisational and economic motivations*. In this context, *humanitarian and social motivations* are those, which promote the inclusion and enforce the human rights of those workers who are marginalised within the workplace. In terms of Gay and Lesbian paramedics, this means promoting policies and practices that have the impact of including them because it is the *right thing to do*. These go beyond the current equity legislation measures, as they need to aim at the reality of what goes on in practice, and address the dichotomy of public policy and private reality epitomised by Sue (2010) and Benokraitis (1997) and in the marginalising effect of hegemonic heteronormativity. Failure to address and respect issues associated with sexual orientation is to “engage in heterosexist discrimination” and such an omission in itself may “cause, reinforce or exacerbate oppression” (Thompson 2003, p. 112). Some measures, which are effective in doing this, were examined in considering effective models of practice. These include diversity training, specifically looking at Gay and Lesbian People (typically

overlooked in the past), tapping into the Gay market and development of policies of non-discrimination (Carnevale & Stone 1995, p. 429).

People do not work at their best if they work in fear (Winfeld 2005, p. 21). In *humanitarian and social* terms it is wrong to have people working in such conditions. Extending this to *organisational and economic* considerations; there are broader benefits by working towards inclusive workplaces for Gay and Lesbian people in the paramedic workforce specifically and in society in general. Evidence suggests that inclusivity functions reduce stress and consequently increase work performance (VicHealth 2006, p. 7). Fear, resulting from discrimination, costs companies in terms of lost productivity and includes costs of rehiring and retraining employees due to attrition (Henderson 1996, p. 163). Policies, which counter discrimination, may improve productivity in this way (Henderson 1996, p. 164) and make “good economic sense” (VicHealth et al. 2009, p. 7).

Lack of understanding can lead to conflict and division in the workplace. This conflict is a source of occupational stress. Stress affects learning and productivity in the workplace and significantly impacts sustainability and the evolutionary growth of a profession. In relation to the client base serviced by paramedics, stress can result in poor clinical outcomes for patients. As paramedics are charged with the responsibility of making critical clinical decisions in attending to patients in a range of emergency situations, stress can be a contributing factor in influencing decisions made in this context.

Organisations represent a response to a wide range of factors emanating from the context they operate in, and consequently are interdependent on their environmental context (Yen 2009, p. 167). As a consequence, their survival is dependent on serving the needs of their community. Looking at the future of the US workplace, *The American Mosaic* (1995) highlights the benefits of managing diversity to ensure employees reach their full potential, arguing the benefits of this process to both the employee and the organisation on the basis of productivity. In community terms, the ability to give a quality service relies on the ability of workers to empathise with their customer base and requires effective interaction between diverse groups of workers (Carnevale & Stone 1995, p. 53). In the context of Gay and Lesbian paramedics, this means reduced organisational costs associated with sick leave and absenteeism for employees, longer careers and reduced recruitment costs, lower social and psychological stress for the employees themselves and better health outcomes for patients.

Australia currently has an ageing population (Kudrna & Woodland 2011, p. 53) and such demographic change means that recruitment and retention of healthcare workers is a critical issue. Participation of large numbers of workers is critical to the survival of the healthcare

sector. An understanding of issues, which relate to healthcare workers, can help address issues of attrition, recruitment and retention within the industry. Research suggests a higher turnover from minority groups (Carnevale & Stone 1995, p. 58). Insight into the issues as they relate to experiences specific to marginalised groups can further enhance inclusive practices within the sector, and consequently lead to improved rates of recruitment and retention within these groups. One study estimated that 12 percent of Gay and Lesbian workers surveyed work in the health sector (Carnevale & Stone 1995, p. 419). Given the high representation of Gay and Lesbian employees in this sector, improved respect and greater inclusion may improve participation in employment in the healthcare sector in general, and more specifically in the area of paramedicine.

A further barrier to improving the health and social care of LGBT community is lack of information about their specific needs (Fish 2006, p. 30). On the basis of a number of measures the health of this community is poorer than that of the heterosexual community (Willis & Elmer 2011, p. 137). Promoting the inclusion of Gay and Lesbian paramedics within the workforce and drawing upon their insights as to the needs of this sector of the community is a step towards better serving the health needs of Lesbian and Gay People in the community. This Gay, Lesbian and Bisexual “new minority” of workers are said to be the least understood (Carnevale & Stone 1995, p. 415) and inclusive practices can provide a means of drawing on what they have to offer in the workplace and to the community.

Challenges

When compared to other western countries, Australia in general is seen as having a particularly masculine-dominated culture. This culture “enshrines workers, capitalists, miners, soldiers, fighters and lifesavers” (Robinson 2008, p. 5). And this masculine quality of Australian culture is reflected in the culture of masculine *lifesaving* paramedic organisations. Disclosure of deviation from heterosexuality can be seen as a conscious and considered process. People who declare they are not heterosexual depart from the *heteronormative* values of modern Australia and the hyper-masculine values of paramedic organisations.

It is essential to aim towards the development of inclusive workplace practices. Such practices improve outcomes for individual Gay and Lesbian paramedics, those with whom they have personal relationships, employing organisations, the Gay and Lesbian community and the community in general. Barriers to the development of these values and practices exist at individual, group and organisational levels (Carnevale & Stone 1995, p. 96). Leadership must be committed to such change or they are the biggest obstacle (Carnevale & Stone 1995, p. 97). Strategies aimed at improving in this area face the challenge of how to address current work practices of paramedic organisations, where they may be inconsistent

with social justice and equity principles (Reynolds 2008, p. 167). The required cultural transformation (Carnevale & Stone 1995, p. 93) faces the obstacle that most organisations have top-down control methods (Carnevale & Stone 1995, p. 95); therefore strong and sensitive leadership is required to lead such cultural transformation (British Medical Association 2005, p. 5). In terms of the culture of paramedic organisations, the leadership often has the masculine, heterosexist, militaristic qualities that seem to play out against fostering diversity and inclusive practices. This is a compounding issue.

It is important that organisations are managed so they are able to respond to the changing environments in which they operate (Yen 2009, p. 168). Such diverse organisations are more agile and resilient (Carnevale & Stone 1995, p. 61). Practices aimed at greater inclusion of Lesbian and Gay paramedics in the workplace are of wide ranging benefit and essential to the sustainability of a dynamic society in which diversity is inevitable (Carnevale & Stone 1995, p. 59).

This research is predicated on recognising and valuing diversity as beneficial for individual wellbeing, organisational, demographic and economic reasons. In order to achieve this, and due to my location as researcher in the context of the study, examination of the experiences of Gay and Lesbian paramedics is conducted using a non-heteronormative lens. The methodology associated with exploration of this area is considered in the chapter that follows.

CHAPTER 3: METHODOLOGY

The previous chapter identified the gaps in the literature to date and the reasons for further research into the workplace experiences of Gay and Lesbian paramedics in Australia. Having considered the rationale for this study, this chapter further explores the aims of this research and the methodological stance adopted.

This research aims to address the following three overarching questions:

- What are the current workplace experiences of Lesbian and Gay paramedics in Australia?
- What are the impacts of these experiences on intrapersonal, interpersonal, organisational and general community levels?
- Are there differences in the experiences of Lesbian paramedics as distinct from Gay men?

My aim is to explore the experiences of the Gay and Lesbian paramedic participants in this study from their own lived perspectives. My goal is to 'give voice' to these participants whose pronouncements are frequently dulled or silenced by the sociopolitical boom of a heteronormative society. It is my hope through highlighting and documenting their experiences these 'voices' will encourage other paramedics to come forward to share, make sense of and voice their own experiences.

My study is conceptualised as being phenomenological in nature. I also have a further fundamental aim in undertaking this research. I aim for it to play an emancipatory role for the group that I see from the outset as 'oppressed'. A foundational premise of this inquiry is the recognition that "research is already both moral and political" (Denzin & Lincoln 2008a, p. 3). Emancipatory change is key to underlying principles of critical social research where the researcher can "dig beneath the surface of historically specific, oppressive social structures" (Harvey 1990, p. 1) to give voice to participants. Therefore this research will be described as 'critical phenomenology' in methodological terms because beyond seeking to describe the essence of the lived experiences of participants, it investigates, critiques and asks the question 'what could be otherwise?' One of the objectives of undertaking this study is to highlight structures that marginalise the least advantaged. Identifying these structures of oppression has the potential to bring about emancipation via inequities previously defaulted to the realm of silence.

My aim is to describe and interpret the experiences of the participants in relation to their inclusion or exclusion in their place of work as paramedics. As emancipation is central to my

agenda, my interpretation is informed by my own critical voice and as such, this description and interpretation is extended by locating avenues for change.

The reality of how I am positioned in this research and my experiences as a Lesbian and paramedic (who is also the researcher) facilitates my aim of giving voice to such individuals. I am transparent in relation to the emancipatory aspects that are also featured in the study that follows. My motivation is and always has been to allow the lived experiences of participants to be communicated with authenticity – a premise philosophically located in and consistent with phenomenology. My experiences will filter my interpretation of what participants authentically recount, and what aspects of these I choose to *re-present* in this body of research.

This research also has a self-reflexive component in that it takes into account my experiences as a co-participant in the study. My position and experiences shape and inform this work, which is a co-construction of knowledge I have produced and that of participants (Findlay 2002, pp. 211-2). This element of self-reflexivity is described in the methodology section of this chapter. The details of my personal experiences which were the basis for undertaking this work are explained in chapter 4, following the present methodological discussion.

My past experience as a Lesbian and paramedic is incontrovertible. Some aspects of my experience were disempowering and isolating. I am of the view that where exclusion and negativity exists and impacts the experience of Gay and Lesbian people in the workplace or wider community, underlying factors, which facilitate this negativity, need to be addressed. Therefore, there are prominent paradigmatic features of critical research in this study, as social change underpins my agenda (Taylor 2006a, p. 364). I hold that drawing attention to negative experiences has the potential to assist with the process of change. I also hold to the notion that some Gay and Lesbian people in the current order of society are made to feel somewhat comfortable with tacit and overt, conscious and unconscious subordination. This is a premise underpinning critical social research (Kincheloe, McLaren & Steinberg 2012, p. 14). Critiquing the structures that contribute to creating this feeling of comfort in this study has the potential to highlight issues of relative disadvantage to people and therefore move them from a position of passive subordination to one of empowerment.

As noted above, giving precedence to voices and lifeworlds that are typically silenced, I have adopted a qualitative approach theoretically informed by hermeneutic phenomenology (van Manen 1990) as well as critical social research. Focused interviews were used to acquire participant data. This is discussed in more detail further into this chapter, which also

discusses recruitment of participants and data analysis techniques. The critical features of this research (which are intrinsically, inseparably and fundamentally linked to my position as a researcher) and the essence of my experiences and views are presented as critical discussion following participant data in each chapter predicated upon the main themes.

Epistemological and paradigmatic decisions

Before turning specifically to the qualitative methodological stance adopted and methods used to implement this study, some consideration must be given to the epistemological and paradigmatic stances that underpin these choices. Therefore this section examines epistemology or “what it means to know” (Crotty 1998, p. 20).

In epistemological terms, this research rejects objectivist approaches and is informed by a constructivist standpoint. It is noted that, from a constructivist point of view, *truth* here is composed of meaning attributed to experiences and objects associated with engagement with the world (Crotty 1998, p. 8). In this case the *truth* is the truth constructed by the participants and reconstructed by the researcher. The reconstruction of the lived experiences of participants, whilst aiming to maintain the authenticity of their voices, also has a ‘critical overlay’ which is my own voice. My experience of truth in the field of paramedicine is that there is a tendency to privilege truth in the objectivist sense. As such, some discussion of my epistemological and paradigmatic choices is appropriate. The nature of *truth* needs consideration in terms of the forms of knowledge that can be privileged within different contexts.

Truth, science and bricolage: ‘defence’ in the context of paramedicine

Knowledge in the modern era has championed objectivist paradigms as *truths*. Such views of knowledge and *truth* continue to hold favour in many of the scientific disciplines: “The belief that there is objective truth and that specific methods can bring knowledge of this truth has been the epistemological grounding of western science” (Crotty 1998, p. 42). One could argue that paramedicine is one such discipline area that continues to champion objectivist views of truth and positivist notions or models of enquiry, inherently expressed within the medical culture. Some research supports this in the respect that the culture of paramedicine privileges technical forms of knowledge (Reynolds 2008, p. 127). In contrast to this, I adopt a constructivist view of truth.

It is pertinent to consider the meaning of the concept of *truth*. Truth is defined in philosophical terms as “the relation that holds between a statement and the world” (Cook 2009, p. 294). Major bodies of academic work in the discipline of philosophy have been produced around

the concept of what constitutes truth (Burgess & Burgess 2011, p. xi). A detailed discussion of the concept of truth however is beyond the parameters of this thesis. It is important though, in the context of the developing health discipline of paramedicine (in which the bulk of research is quantitative in nature), to articulate the version of *truth* I seek to produce in this thesis. I take this stance in anticipation of criticisms from those using positivistic research paradigms, which are more traditionally thought to uncover *truth* in clinical contexts.

Truth

In some informal preliminary discussions with heterosexual paramedics who have enquired about this project in its formative stages, many have alluded to the belief that such a study is 'a waste of time' as 'there is no discrimination or negativity in the workplace towards Gay and Lesbian people'. As this view conflicts strongly with my personal experience, this actually supports my underlying premise rather than refuting it. Indeed, it could be argued that the implicit silencing of Lesbian and Gay people is a norm rather than an exception. As a far smaller proportion of the adult population than the heterosexual proportion, the enforced silencing of these women and men occurs frequently or unintentionally. The unintended element of this silencing is the most intriguing and insidious. It is integral to the norms of society that this silencing of claims of inequity is dismissed or minimised in the most casual of conversations. This popular belief also conflicts with Irwin's (1999) study which indicates that discrimination in the workplace on the basis of sexuality is *commonplace*.

My *truth*, which is a personal and subjective experience, in this workplace context conflicts with these views. Consequently, my own experience as a Lesbian paramedic has been a further factor in my choice to use qualitative methods to explore the questions that drive this research. Similar 'surface level' beliefs have been identified in past research in relation to attitudes toward homosexuality where heterosexual participants attempt to "mirror in themselves...false egalitarianism" (Embrick, Walther & Wickens 2007, p. 764). Such a shroud of espoused opinions provides further motivation for 'lifting the veil' of political correctness in the context of paramedic workplaces, and exploring actual workplace behaviours and realities concealed by such a veil.

The circular nature of the philosophical debate surrounding the nature of *truth* means that in reality, there are a number of understandings of the concept of truth, which are sought after and applied for a range of reasons: "It is doubtful that there is any such thing as *the* truth" (Burgess & Burgess 2011, p. 1), just versions thereof. As such I need to emphasise that the version of *truth* I seek in my research is that from the perspective of the participants and me as a researcher. This *truth* is constructed out of the synthesis of multiple *truths* as each of the individual participants will have a unique experience of the workplace as a Gay or Lesbian

paramedic. This research is an aggregation and provides synthesis of these truths where possible to identify common themes in individual experiences.

Philosophically this research aims, as noted above, to *re-present* the experiences of participants in an authentic and rich manner. As such, the primary focus is ontological: the experience of the participants themselves, their *truth*, their essence. The emphasis is on presenting the experiences of participants rather than making judgements about their authenticity or *truth*. I therefore take an ontological approach in this research in as much as it is a study of the existence itself of these experiences (Taylor 2006c, p. 320). I do not seek to examine the *truth* of the data presented, but rather *re-present* the experiences of the participants themselves from their perspectives, a return “to the things themselves” (Crotty 1996, p. 79). This constructivist view of *truth* has underpinned the methodology employed in this research.

In political terms, I seek to represent the voices of the participants in as authentic terms as is possible, to represent their ‘lifeworlds’. Superficially it would appear that I should subscribe to a subjectivist epistemological approach in order to achieve this. However, as I decided which pieces of information to re-present, this is not realistic. To represent this research as authentically subjective is as flawed as representing it as an objective ‘unearthing’ of the truth. Constructivism is therefore the underpinning epistemological approach here. Constructivism is the view that all knowledge, therefore all meaningful reality is constructed out of human interaction and developed and transmitted within a social context (Crotty 1998, p. 42). This view on truth informs phenomenology and the two can be viewed as intrinsically linked (Crotty 1998, p. 12), akin to phenomenology, constructivism mirrors and the concept of intentionality. This concept brings objectivity and subjectivity together in that an act of consciousness invariably has a relationship to an object (Crotty 1998, p. 44).

Bricolage

It must be recognised that “every piece of research is unique and calls for a unique methodology” (Crotty 1998, pp. 13-4). In terms of the underpinning realities as a researcher driving this work, I:

- aim to put participants at the centre in *re-presenting* their experiences
- act as a filter that has power over what is re-presented
- subscribe to a constructivist view of truth and knowledge
- have inalienable experiences, which mean I believe changes need to be made.

Flowing from this, and consistent with epistemological underpinnings, I have adopted a hybrid methodology, labelled as ‘critical phenomenology’. Essentially this bricolage blends interpretive phenomenology and critical social research. Adoption of this approach attempts

to authentically re-present the experiences of individual participants in recognition that this is merely an interpretation. Furthermore, this hybridisation will facilitate the critical layering of the views in employing critical social research as a paradigm. As such the approach of the 'bricoleur' (Crotty 1998; Denzin & Lincoln 2008b; Kincheloe, McLaren & Steinberg 2012) is adopted here to craft an appropriate strategy for achieving these multifaceted goals. This approach is consistent with the view that "multiple kinds of knowledge, produced by multiple epistemologies and methodologies, are not only worth having but also demanded if policy, legislation and practice are to be sensitive to social needs" (Lincoln & Cannella 2004, p. 7).

Qualitative approach

Adopting a qualitative research methodology allows the stories of Gay and Lesbian paramedic participants to be told, which is appropriate for this research. The 'truth' I seek to present here is an aggregation of several individual 'truths' of participants who have unique experiences of interactions with others in the world. The real value of this research, as noted previously, is to make public the experiences of a group of Gay and Lesbian paramedics marginalised by heteronormative society: "Statistics are human beings with the tears wiped off" (Lather & Smithies 1997, p. xxvi). I wish to retain these emotional truths and focus on the development of insight and understanding. In my opinion, these 'tears' are an appropriate lubricant for social connection and understanding. I do not wish to hide these negative experiences or remove the more optimistic aspects of my participants' experiences. This desire informs my deliberate choice to take a qualitative approach. I am not interested in an approach that reduces the experience of people to a data set or statistical sketch. Such a reductive approach will not and cannot add value to the 'truth' I seek.

According to Speziale & Carpenter (2007, p. 21), qualitative research emphasises six significant characteristics: belief in multiple realities, commitment to identifying an approach to understanding the phenomenon studied, commitment to the participant's viewpoint, conduct of inquiry in a manner that limits disruption of the context of the phenomena of interest, acknowledged participation of the researcher in the inquiry process, reporting the data in a literary style rich with participant comments. This research is guided by these characteristics, given it explores the experiences of Gay and Lesbian paramedics in Australia and the impact of these experiences. Furthermore, data acquired in past research suggests that more qualitative research needs to be done in relation to attitudes of heterosexual employees toward homosexual employees in workplace contexts (Embrick, Walther & Wickens 2007, p. 764). Taking a qualitative approach allows for deeper and more thorough insights to be gained, penetrating deep beyond the surface of political correctness in the exploration of more subtle and 'grey' areas.

This research is necessarily qualitative as the participants at its centre are the prime source of information (Taylor 2006d, p. 399). Lincoln and Guba (1985) describe qualitative research as “naturalistic” approach, meaning that research strategies adopted parallel actions in the real world. As this research is about peoples’ life perceptions and emotions it adopts a naturalistic or humanistic approach to comprehensively explore real experiences of being a Gay or Lesbian paramedic in Australia. It also accepts that *all* research is conducted with subjective bias (Speziale & Carpenter 2007, p. 23) and locates the observer or researcher in this world (Denzin & Lincoln 2008b, p. 4). I embrace subjectivity in this research and acknowledge my personal experience as a Lesbian paramedic. This approach allows me to bring my lived experience to the forefront and integrate it into this study. This intentionally makes participation overt and transparent, rather than selecting a positivist paradigm that claims to produce an objective *truth* without overt references to the experiences of the researcher (Smith & Osborn 2003, p. 53).

My role as researcher and an out Lesbian paramedic has the potential to be problematic. Contrary to this view, self-disclosure at the outset adds to the validity of the research. My story is presented in chapter 4 to ensure this transparency. Aspects of my personal attributes and experiences as a researcher strengthen mutual understanding with participants. As a product of my personal experience, I am in a strong position to identify and empathise with them. As “qualitative researchers empathise and identify with the people they study in order to understand how these people see things” (Taylor & Bogdan 1998, p. 7), making my personal position clear is a strength in this research. Furthermore, previous research has indicated that the sexuality of the researcher is important, as it is likely that participants are more open to someone who “may be seen to be more likely to empathize with their perspective” (Ward & Winstanley 2006, p. 205). As a Lesbian and a paramedic, I have experienced firsthand biases and discrimination in the workplace. This is in part what has led me to pursue this study which illuminates like experiences and draws attention to challenges that Gay and Lesbian paramedics face.

Revealing this commonality and individual variance to participants arguably facilitates trust that allows access to participant experiences. For those who do not identify as a Gay or Lesbian paramedic this would be off limits. Thus I contend this approach adds *depth* to participant data, and enables a layer of intuition when interpreting such experiences. This quality makes a qualitative approach appropriate in terms of gaining rich data. Qualitative researchers stress the constructed nature of reality and the intimate relationship between the researcher and what is studied (Denzin & Lincoln 2008b, p. 14). This stance is indeed important to the nature of this research, in which I share a level of intimacy as both a paramedic and a Lesbian.

In contemporary society, which emphasises 'political correctness', it is increasingly unacceptable to disclose prejudices. As a result, people are more likely to hide unacceptable societal points of view and opinions from public scrutiny. This is a potential limitation and conversely an impetus for conducting more qualitative research (Embrick, Walther & Wickens 2007, p. 758). Such research is of great value in attempting to arrive at the *emic view* or the insiders' perspective (Speziale & Carpenter 2007, p. 22). The choice of a qualitative approach enables me to look under the shroud of political correctness for the participants' *truth*. This pursuit of the *truth* acknowledges the subjective nature of qualitative information gained, which *does not* claim to be true for all people in all times and spaces (Taylor 2006d). Thus challenging the *truth* has the potential to re-construct a more inclusive and holistic version of life world and what constitutes the truth for these Gay and Lesbian paramedics.

It is my strong contention that I am unable to extricate myself from the model of my practice and inquiry, and therefore noteworthy that I hold to the notion that all research is an interactive process shaped by personal history, biography, gender, social class, race and ethnicity of both researcher and participants (Denzin & Lincoln 2008b, p. 8). Whilst I note the omission of sexuality in the previous statement, my own sexual identity thoroughly shapes the process of this research, and I acknowledge and celebrate this. I celebrate the role these individual qualities play as I listen to participants in re-constructing a truth not contested and informed by the forces of heteronormativity. As an 'insider' I am relatively free of the 'filter' of heteronormativity, which is a product of institutionalised ways of thinking and normalising. The approach I have chosen allows me to look beneath surface level beliefs and examine actions which may contradict the words, phrases and terms used that relate to attitudes toward Gay and Lesbian people (Embrick, Walther & Wickens 2007, p. 764).

Due to the under-reporting of incidents of discrimination, non-compliance for Lesbian and Gay people in the workplace is not readily revealed in organisational data (Irwin 1999, p. 58). This is especially the case in a politically correct society that masks issues and reports organisational compliance to equity legislation in a regular, routine and 'cold' concrete fashion (Embrick, Walther & Wickens 2007, p. 758). Allowing people to recount their stories and experiences in an emotive and subjective way is the best modality for injecting change into people's perception of 'truth'. In order to represent the 'truth(s)' of participants in this research it was necessary to identify a target population and employ a qualitative approach (Denzin & Lincoln 2008b, p. 35).

Methodology – critical phenomenology

In my approach to the selection of a suitable research paradigm, I initially selected the broad field of phenomenology and, more specifically, hermeneutic phenomenology. I have come to reflect on this methodological approach and question the validity of this choice. This critical aspect has evolved as a *self-reflexive* element, in that it was conceptualised out of a response to my own experience as a Lesbian paramedic. Such an approach draws strongly on my personal experience and my belief that participant experiences are not given due attention in a general social context. In a heteronormative society where heterogendered privilege prevails, the voices of Lesbian and Gay participants are almost always silenced or subjugated as other. As such, I wish to allow these voices to be heard in authentic and individual terms using a researcher as a conduit, hence the selection of hermeneutic phenomenology as a vehicle. I also want to examine the social structures that give rise to these experiences, hence the need to borrow from critical social research.

This research therefore employs bricolage in the manner of selecting approaches specific to the questions it attempts to address and the context in which these questions are located (Crotty 1998, p. 2; Denzin & Lincoln 2008b, p. 5). My personal history as a researcher in this study is highlighted as it plays a central part in the production and interpretation of the knowledge the study proposes (Kincheloe, McLaren & Steinberg 2012, p. 21). As a *bricoleur* then I can be seen to borrow paradigmatically from interpretive phenomenology and critical social research to create what is ultimately a form of 'critical phenomenology' (Langridge & Ahern 2003, p. 35).

Phenomenology

"It is frequently argued that the main contribution of phenomenology has been the manner in which it has steadfastly protected the subjective view of experience as a necessary part of any full understanding of the nature of knowledge" (Moran 2000, p. 21). As the aim of this research is to present authentic experiences with a measure of subjectivity for participants, I hold that phenomenology is the most appropriate methodology to facilitate this aim.

Phenomenology is both a philosophical discipline and a research method (Dowling 2007, p. 131; Wojnar & Swanson 2007, p. 172). In broader terms phenomenology is the theoretical point of view that advocates the study of an experience "at face value" (Cohen & Manion 1994, p. 29) or "of the things themselves" (Taylor 2006c, p. 336). The phenomenologist is committed to understanding social phenomena from the perspective of the informant and examining such perceptions (Taylor & Bogdan 1998, p. 11). Furthermore, phenomenology values the meanings people ascribe to their own existence (Taylor 2006c, p. 336). In terms

of my research methodology it is an approach that can be applied to study the lived experience of Gay and Lesbian paramedics in this study.

In order to employ phenomenological research methods, a thorough fundamental understanding of the associated philosophy and associated philosophical assumptions is required (Speziale & Carpenter 2007, p. 25; Taylor 2006c, p. 337; van Manen 1990, p. 7). As a philosophy, phenomenology has many schools of thought, including that of hermeneutic or interpretive phenomenology, which is concerned with the interpretation of the structures of experience and how these are understood by those who live through them and study them (Wojnar & Swanson 2007, p. 173). In this work I adopt hermeneutic phenomenology as the primary research methodology to realise my aim of understanding the lived experience of Lesbian and Gay paramedics in Australia. This school of phenomenology recognises the role of the researcher in constructing data with transparency and pragmatism. In making this choice I have consciously steered away from the main alternative choice of descriptive phenomenology (Giorgi 2009). This is fundamentally due to the congruency of my philosophical perspective with the philosophical school of thought in which this phenomenological approach is founded. I hold that my choice of interpretive over descriptive phenomenology allows for greater transparency, as my past experience as a researcher cannot be expunged from the manner in which I interpret and re-present participant data. Phenomenology offers a 'window' to view the essences of participants. As the view of their experiences is filtered by the opacity of my experience, I believe the most transparent and authentic way of explaining the re-presentations made is to discuss opacity itself. This is symbolic of my experiences and such description of its qualities is only achievable by employing hermeneutic phenomenology as one approach.

Phenomenology as a philosophy and main schools of thought

Phenomenology is best understood as a radical, anti-traditional style of philosophising, which emphasises the attempt to get to the truth of matters, to describe the *phenomena*, in the broadest sense as whatever appears in the manner in which it appears, that is as it manifests itself to consciousness, to the experiencer (Moran 2000, p. 4).

From a philosophical perspective, phenomenology attempts to illuminate the phenomena of human experience (Wojnar & Swanson 2007, p. 173). It is a science with the purpose of describing the appearance of things, or phenomena, as lived experience (Speziale & Carpenter 2007, p. 76). Phenomenology is a difficult philosophical position to articulate. It aims to look at the experiences of others in authentic terms.

In order to develop further insight into phenomenology, an understanding of the main schools of thought and central philosophical premises is required. The first main school of philosophical thought is Edmund Husserl's (1859–1938) Duquesne School of phenomenological research, often referred to as descriptive or transcendental phenomenology, which looks at things from a more existential and transcendental philosophical perspective (Langdridge & Hagger-Johnson 2009, p. 390). The second main school of thought is Heideggerian hermeneutic or interpretive phenomenology. Historically, Heidegger, a student of Husserl, departed from the descriptive approach on the basis of key philosophical differences.

Central to the understanding of phenomenology is the concept of *intentionality*: the premise that the mind and the world are inseparable (Langdridge & Hagger-Johnson 2009, p. 388; van Manen 1990, p. 5). *Intentionality* concerns the fact that consciousness is always of something, with an act of consciousness always having a *relationship* to an object (Langdridge & Hagger-Johnson 2009, p. 387; Moran 2000, p. 16). Putting this into action as a philosophy which informs research methodology, the focus of any investigation is what is between people or between people and the world. In this respect, the focus of research is on the essence of the experience of a participant, according to their perception of an experience, and *does not* question such experience. The philosophical aim is to arrive at an essential understanding of human consciousness and experience (Dowling 2007, p. 132). In this respect it has both an ontological and epistemological emphasis.

The concepts of *idealism* and *realism* are also central to the understanding of the philosophical arm of phenomenology. *Idealism* refers to the belief that what we perceive as reality is the product of our own minds and as such we cannot have an unmediated experience of such reality (Langdridge & Hagger-Johnson 2009, p. 388). *Realism* as a concept assumes that there is a real world and one can know about it in an unmediated fashion (Langdridge & Hagger-Johnson 2009, p. 389). The essential difference between *idealism* and *realism* can be conceptualised in terms of subjectivity and objectivity. Idealism emphasises the inalienability of the subjectivity of an experience or perception and *realism* advocates that experiences and perceptions can be objectified. Phenomenology transcends this debate and places its emphasis on *perception* of the world (Langdridge & Hagger-Johnson 2009, p. 389). Phenomenology presumes that when one perceives the world, that is all there is to investigate (Langdridge & Hagger-Johnson 2009, p. 389), consequently buying out of the philosophical debate relating to *realism* and *idealism*. Thus phenomenology focuses on the *intentionality* of a phenomenon and describes the intentionality of the object of enquiry (Langdridge & Hagger-Johnson 2009, p. 389). Here I seek to present the experiences of individual participants in authentic terms. Through repeated examination of

multiple perceptions we can discover aspects of the shared experiences of that perception (Langdridge & Hagger-Johnson 2009, p. 389). That is, through trying to understand commonalities in multiple perceptions of a particular experience, themes and patterns will emerge in terms of the essence of that experience. This essence is what is sought in phenomenology. In this thesis I also seek to identify commonalities in the experiences of Lesbian and Gay paramedics.

Husserl's descriptive phenomenology argues that *epoché* is achievable (cited in Langdridge & Hagger-Johnson 2009, p. 390). *Epoché*, the process sometimes referred to as *bracketing*, is a Greek term meaning the process by which an attempt is made to abstain from presuppositions or preconceptions relating to things that are being investigated (Cohen & Manion 1994, p. 30; Dowling 2007, p. 132; Langdridge & Hagger-Johnson 2009, p. 389; Moran 2000, p. 11; Speziale & Carpenter 2007, p. 80; Taylor 2006c, p. 337). Descriptive phenomenology argues that representing a person's experience, from their perspective, is dependent on bracketing by means of the suspension of the ego of the person who is investigating it. This approach attempts to meet the phenomenon as unprejudiced as possible so that it can be precisely described and understood (Dowling 2007, p. 132). Descriptive phenomenology thus focuses on the concept of *intentionality* and the meaning of a lived experience from a first-person perspective (Wojnar & Swanson 2007, p. 173). The purity of the experience of the subject of the research is emphasised in descriptive phenomenology. This form of phenomenology advocates that the researcher abandons his or her own lived experience in order to describe the experience of the participant with purity or essence. Whilst this may be a desirable attribute in philosophical terms, one wonders whether such a goal is achievable in real terms. In light of my personal attributes as a researcher in the context of this study, I do not see bracketing as possible.

The other main school of thought, hermeneutic phenomenology, is a personal or individual philosophy, which we pursue against the background of understanding the evasive character of 'other', the community or social interactions (van Manen 1990, p. 7). Central to hermeneutic phenomenology is the belief that the researcher and participants come to an investigation with a preconceived understanding, shaped by their respective backgrounds. And that in the process of interaction and interpretation they co-create an understanding of the phenomenon being investigated (Wojnar & Swanson 2007, p. 175). This interpretative style of phenomenology is used to search out the relationships and meanings that knowledge and context have for each other (Lincoln & Guba 1985). The process of interpretative phenomenology acknowledges the "interrelationship between epistemology (interpretation) and ontology (interpreter)" (Denzin & Lincoln 2008b, p. 112). "Interpretive phenomenology is most useful as a framework for examining contextual features of a lived experience as

generated from a blend of meanings and understandings articulated by the researcher and participants” (Wojnar & Swanson 2007, p. 177). In the context of this study I see hermeneutic phenomenology as the appropriate approach to adopt.

The pivotal difference between descriptive and hermeneutic phenomenology is the Heideggerian premise that the understanding of individuals cannot occur in isolation from their environmental, social or historical context (Wojnar & Swanson 2007, p. 174). The concept of *dasein*, or presence, is emphasised in hermeneutic phenomenology in recognition that humans cannot isolate themselves from the contextual factors that give their experiences meaning; attempts are made to address the relationship of individuals to broader sociopolitical and cultural contexts² (Wojnar & Swanson 2007, p. 174).

Hermeneutic phenomenologists maintain that before conducting an enquiry on a particular phenomenon, a researcher must reflect on his or her past experiences of aspects of such a phenomenon (Wojnar & Swanson 2007, p. 174). Thus the goal of hermeneutic inquiry is to identify each participant’s meanings from a blend of the researcher’s understanding of the phenomenon, participant-generated information and data from other sources (Wojnar & Swanson 2007, p. 175). It assumes that “Interpretation presupposes a shared understanding between the researcher and the participant” (Wojnar & Swanson 2007, p. 175). This makes this philosophical approach to phenomenology the most compatible with my research. I am located in relation to this approach as a researcher, as I share aspects of identity attributes with participants. Adopting this approach allows me to acknowledge my participation and construction of the “truth”. I believe that acknowledgement of this co-creation makes this work more trustworthy, meaningful and reliable.

Hermeneutic phenomenology

The preceding discussion explored the philosophical perspective of phenomenology. Hermeneutic phenomenology was selected as the appropriate approach to this research because findings are created through interaction of the inquirer and subject of the inquiry (Guba & Lincoln 1994, p. 107). As the best vehicle for the purposes of this research, hermeneutic phenomenology is also appropriate for some practical reasons. First, as a research method it attempts to understand the experience of the participant by means of written evidence, or by means of unstructured or semi-structured interviews (Langdridge & Hagger-Johnson 2009, p. 392) which correlate well with the methods used in this research.

² A middle ground exists in existential phenomenology which follows the premise that one should try and achieve *epoché*, but this can never truly be achieved (Langdridge & Hagger-Johnson 2009, p. 390).

Research of this kind typically looks at 6 to 12 participants (Langdridge & Hagger-Johnson 2009, p. 392). This is consistent with the number of participants in this study.

In specific reference to my orientation, interpretative or hermeneutic phenomenology is “most useful as a framework for examining contextual features of a lived experience as generated from a blend of meanings and understandings articulated by the researcher and participants” (Wojnar & Swanson 2007, p. 177). This branch of phenomenology employs a reflexive notion of *epoché*, which recognises the role of the researcher in co-constructing findings (Langdridge & Hagger-Johnson 2009, p. 390). As I am unable to ‘bracket’, acknowledgement of my role and influence is central to this research. With an emphasis on lived experience, hermeneutic phenomenology is conversant with having the goal of interpreting contextualised human experiences (Wojnar & Swanson 2007, p. 179).

This thesis is constructed in such a way that it is a process of evolution of the data collected from participants. I adhere to the axioms of hermeneutic phenomenology in my attempt to represent the essence of the experience of participants with a diligent and rigorous aim for it to remain ‘true’. I also acknowledge that the evolution of this data into themes is by necessity highly subjective: a process based on what I identify as important as a researcher.

Self-reflexivity

“Phenomenology provides researchers with a framework for discovering what it is like to live an experience” (Speziale & Carpenter 2007, p. 24), and to clarify their beliefs on a topic as well as their personal biases (Speziale & Carpenter 2007, pp. 26-7). This examination of my beliefs and experiences provides structure for chapter 4, which focuses on my experiences as a participant in the study and the impact of this on the interpretation of data.

This quality of reflexivity assumes a key role in current discussions in the field of interpretive phenomenology. Reflexivity is appropriate as it embraces a human perspective of intersubjectivity both in methodological and philosophical terms (Dowling 2007, p. 137). The self-reflexive aspect has been critical in informing the development of the methodological approach adopted here. My part in recreating my *truth* produced in this research is an integral part of the process that requires examination and articulation. This integrity is dependent on presenting the data for examination, whilst rigour in qualitative research requires that such data is transparent. This approach along with trustworthiness is necessary for the research to be considered valid and reliable.

Data collection was by means of a journal kept for personal reflections. I have used a journal to discover issues of importance to me. The writing space has given me a canvass from

which to document a range of issues that have emerged as a product of undertaking this research (Dowrick 2007, p. 2), reflecting on any emotions I have in association with these thoughts (Rose & Glass 2010, p. 1407). Keeping a journal has enabled me to better engage with and reflect on my thoughts and feelings as a researcher (Dowrick 2007, p. 15). Journal writing and participants' interviews have also enabled me to capture patterns, which emerged in my thinking over time (Dowrick 2007, p. 18). Using such a technique of data collection in relation to recording my own thoughts has enabled me to reflect and analyse the information. It has also been a self-therapeutic tool (Rose & Glass 2010, p. 1408).

Emancipation as a goal – critical overlay

I am located inside this research as both the researcher and participant. Therefore my story influences the interpretation of lived experience of other participants, and reflects worldview and political biases. This research is an interactive process shaped by many facets of my identity (Denzin & Lincoln 2008b, p. 8) and that of the participants. At the core of this process is my desire for change in relation to social structures, which may produce negative experiences for both me and the other participants. My desire for change also extends to other groups beyond this study including Gay and Lesbian people, paramedics and others in the community in general, as all of these groups are impacted upon by heteronormative, heterosexist and homophobic practices and structures. I hold to the intention to 'empower' research participants by adding a layer of critical social inquiry to this research 'blend'.

I am not only setting out to explore and describe these experiences but to deconstruct and problematise the status quo with a view to bringing about progressive change in the workplace (Kincheloe, McLaren & Steinberg 2012, p. 20; Taylor 2006a, p. 364). In doing so, I am addressing the complacency that can be seen and does exist in modern post industrialist societies. This complacency and indifference to Gay and Lesbian paramedics is constructed within a complex system of practices of 'acceptance'. For Habermas this 'conflict zone' is a place of concealment:

For only here is it possible to buttress the concealment of the difference between progress in systems of purposive-rational action and emancipatory transformations of the institutional framework, between technical and practical problems. And it is necessary for the system to conceal this difference. Publicly administered definitions extend to *what* we want for our lives, but not to *how* we would like to live if we could find out, with regard to attainable potentials, how we *could* live (1971, p. 120).

Therefore I aim to achieve my goals by introducing a critical overlay to the themes addressed in this research.

I use the approach informed by critical theory to question assumptions that contemporary affluent societies are unproblematic and free. I hold to the notion that individuals within these societies have become acculturated into feeling comfortable with domination and subordination (Kincheloe, McLaren & Steinberg 2012, p. 14). I call into question the power structures that combine inequitably to produce oppression. I aim to assist people to feel the effects of that oppression and to feel their own desire for liberation (Taylor 2006a, p. 365). Critical scholarship should be “governed by the intent to bring about emancipation from the relations of dependence that ideology in particular has set in place and that come to appear as natural” (Crotty 1998, p. 143). I hold to the idea that current ideology should be called into question and that this process should lead to initiatives for social justice (Crotty 1998, p. 157). And I hold that mainstream research approaches are actively implicated in the overt reproduction of class, race and gender oppression (Crotty 1998, p. 158). As such, these approaches are not appropriate in meeting the aim of liberation of oppressed people.

This research has change at its core in embracing an emancipatory agenda. I am not only seeking to explore and describe using the phenomenological approach previously described, but to question assumptions related to the “way things are” (Taylor 2006a, p. 364). This description has the potential to be emancipatory (Taylor 2006a, p. 365). The view that Gay and Lesbian people experience disproportionate social vulnerability is an underlying theoretical viewpoint within this work. The existence of this inequity is supported by a number of studies relating to non-heterosexual people in a variety of contexts (Bernstein & Kostelac 2002; British Medical Association 2005; Chobrot-Mason, Button & DiClementi 2001; Embrick, Walther & Wickens 2007; Ferfolja 1998, 2007, 2008, 2009, 2010; Griffin 2006; Humphrey 1999; Irwin 1999; Liddle et al. 2004; McKenna 2009; Miller, Forest & Jurik 2003; Myers, Forest & Miller 2008; O’Faherty & Fisher 2008; Ragins, Cronwell & Miller 2003; Ragins, Singh & Cornwell 2007; Ward & Winstanley 2005, 2006; Willis 2011; Zurlinden 1997).

Critical theory has seven underlying assumptions:

- Some groups within a society are privileged over others
- Oppression has many faces so one must look at the participation of all groups that create oppression and their interaction
- Language is central to the formation of subjectivity therefore voice is a key to the empowerment or disempowerment of individuals
- Relationships between concepts and objects are fluid and are often mediated by capitalist systems
- Thought is mediated by historically and socially constructed power relations
- All ‘facts’ about human relations and behaviour are socially constructed and open to interpretation

- Mainstream research practices are unwittingly implicated in the reproduction of oppression in terms of class, race and gender (Kincheloe & McLaren 1994, pp. 138-57).

These assumptions underlie and direct this study.

In paraphrasing the critical scholar Paulo Freire in “Pedagogy of the Oppressed” (2005); in order to emerge from an oppressive situation, beings must perceive their fate not as inexorable. They need to reflect on their worldview (Crotty 1998, p. 150) and not merely see this view from a limited perspective. They ultimately need to turn on the oppressors to address the issues relating to their oppression. From a Freireian point of view, this process of waking up to oppression or conscientisation is about ‘giving voice’ to the oppressed. ‘Breaking the silence’ relates to the culture of enforced silencing of the oppressed group (i.e. Gay and Lesbian paramedics in this thesis). Giving voice can address the unacceptable situation whereby those oppressed are not even aware they have no voice (Crotty 1998, p. 154). One example is internalised homophobia. This research offers a means of reflection for Lesbian and Gay people working as paramedics in Australia and elsewhere. It must also be noted that emancipation is about liberating the oppressor (Crotty 1998, p. 152). In the case of Gay and Lesbian emancipation, this is about educating (and therefore liberating) oppressors from the fear and ignorance that leads them to practices which are oppressive, discriminatory, bullying or violent.

Critical theory cannot be reduced to formulaic pronouncements or strategies (Kincheloe, McLaren & Steinberg 2012, p. 15). As such, a predefined ‘ism’ is not adopted as a vehicle within this study. A number of ‘isms’ were given consideration in relation to the possible framing of this research: *feminisms*³ (Glass 2000, p. 357), Marxism, queer theory and a range of other approaches.⁴ Aspects of Queer theory, for example, can be drawn upon to criticise the constructs and categorisation of gender and sexuality in the same fashion as feminist theory. I subscribe to the view that power is “exercised from innumerable points in the interplay of non-egalitarian and immobile relations” (Foucault 1990, p. 94) and therefore do not wish to adopt a framework that may restrict my gaze. Therefore I dismiss these ‘isms’ here. I assert that whilst they focus on elements functioning to label and disempower members of non-dominant groups, the lens chosen can favour a specific element. Gender, class, race and a range of other elements combine in a complex fashion to influence behaviours and replication of systems of domination within society.

³ Glass (2000) states “there is no one feminism; feminism is feminisms”.

⁴ In the context of this research it would be tangential to consider the intricacies of each of these theoretical approaches in further detail.

The aim of this work is to question 'overt' social structures and more subtle forms of social organisation that reproduce oppressive experiences. In a contemporary manner, this critique is informed by the theory of subtle sexism espoused by Benokraitis (1997), the understanding of microaggressions articulated by Sue (2010) and the operation of stereotypes considered by Steele (2010). All of these theories have at their centre a more subtle, complex and insidious form of maintaining inequity as it functions in contemporary society. The *bricoleur* approach is employed in this 'critical overlay' just as it has been used to form a hybrid 'critical phenomenology' in a similar fashion to Langridge and Ahern (2003).

The underlying aim of my inquiry is to allow the voices of participants to come to the fore. The critical element of this research, which is bound with my worldview, is presented as a secondary aim in each of the chapters so as to privilege the lived experiences of participants. A valid approach to this proposed emancipation can and should come through dialogue, as this must be created with the people, not for them (Crotty 1998, p. 154).

Ethics

This study was granted Human Research Ethics Committee ethics approval through the Faculty of Arts, Education and Human Development at Victoria University on August 18, 2011 (AEHD HREC 11/124). This approval enabled data collection to commence on January 15, 2012. Participants were not paid for being involved in this study. The final participant was interviewed on February 14, 2013.

This research adheres to the general ethical principles of beneficence and non-maleficence. As this research is potentially sensitive in nature and deals with hidden populations, purposive sampling (Patton 1990; Smith & Osborn 2003, p. 56) of participants (who were known to the researcher and publically identified as Lesbian or Gay) was used. Snowball sampling (King et al. 2003) was then used to invite further potential participants to contact the researcher, should they wish to be involved in the study.

Confidentiality

At no point were initial study participants asked to provide contact details for potential participants. In this respect their anonymity was maintained until they chose to make contact with the researcher. Furthermore, this meant that no undue influence was imposed on potential participants by the researcher.

Once participants contacted the researcher and indicated an interest in participating in the study, consent and information to participant forms were distributed by email. If potential participants wanted to engage in additional research on being informed of the risks, a time and place of interview was arranged.

Participant comfort

All participants in this study were interviewed face to face at various locations across Australia. I travelled to a place nominated by the participant. The primary reason that participants were given control of the location of the interview was to ensure their comfort (i.e. that they felt safe). As a result, some interviews took place at my home, or in public places or in the homes of participants.

Risks

The comfort and safety of the participants was given first and foremost consideration due to the sensitivity of the subject matter and their potential vulnerability. It was felt that by being interviewed participants feared they would alienate people in their workplace. Furthermore, consideration was given to the possibility that participants may feel a range of negative emotions including anxiety, false hope, guilt, self-doubt or depression in recounting their stories. Also of concern was the risk of disclosure of data collected from interviews, identifying them to others in their workplace and/or social circles. For those who are not open or 'out' in relation to their sexuality on a personal and/or professional basis, this may have evoked a fear of negative consequences, should their sexuality be disclosed to others.

Risk management

Participants were given the option of withdrawing from the study at any time. Due to the possibility that following interview participants may be embarrassed about disclosure of personal information, or may regret what they have said, all transcripts were returned, giving them an opportunity to amend, withdraw or approve interviews prior to analysis and publication.

The psychological and social wellbeing of participants remained a paramount consideration in all aspects of this research. In terms of psychological harm, to alleviate the fear that participants may alienate co-workers with consequences for their personal and professional lives, these risks were minimised by making participants aware of the confidential nature of the research. Pseudonyms were used in analysis of interview data. All data was de-identified by using generic terms where location specific terms may have identified or located participants geographically.

Participants were given the option of counselling or discussion of issues arising out of their participation through the project counsellor and psychologist.

Beneficence

The potential social and psychological risks aforementioned were important considerations and management strategies were introduced to address them. In ethical terms the potential benefits of the research were thought to outweigh such risks. It is hoped that by virtue of participation in the research the individuals supplied information on workplace culture and practices through recounting their experiences. This information has the potential to inform policy makers and organisational managers to improve the workplace experience for participants as well as for other Lesbian and Gay paramedics in the present and future.

Data saturation

Principles of data saturation (Guest, Bunce & Johnson 2006) were used to inform decisions as to the appropriate number of participants for this study. The underpinning ethical consideration here was that no further participants should be recruited and exposed to the inherent risks in the project if no further unique themes were emerging from participants. At this pivot point in the research potential risks would outweigh the benefits.

Conflict of interest

As a current operational paramedic working for an Australian paramedic organisation, there is a risk that I may have a pre-existing personal or professional relationship with one or more of the participants in the study. These pre-existing relationships were considered and not thought to pose any additional risk in the context of the study due to confidentiality.

Data security

To establish reliability and validity, or “trustworthiness” (Lincoln & Guba 1985, p. 290), a secure audit trail was established by retaining original documents in the form of interview transcripts (Speziale & Carpenter 2007, p. 49), digital recordings and consent forms. All electronic and print based data related to this research is stored by the principal supervisor in a locked cabinet and this material will be destroyed five years after publication of this thesis.

Methods

There is no “simple methodic recipe for doing critical social research” (Harvey 1990, p. 2). An extension of this view is there is no formula for doing what I earlier referred to as ‘critical phenomenology’. It is possible to combine a number of methodological approaches as has been argued because this creates a broader, deeper understanding (Taylor 2006c, p. 329)

and qualitative research is “inherently multimethod in focus” (Denzin & Lincoln 2008b, p. 7). Furthermore, in some cases more than one qualitative approach or strategy may be necessary to fully understand a phenomenon (Speziale & Carpenter 2007, p. 21). Consistent with the paradigmatic underpinnings of this research, the critical phenomenological approach taken produces a *bricolage* (Denzin & Lincoln 2008b, p. 5; Kincheloe, McLaren & Steinberg 2012, p. 20) by employing various methods of data collection appropriate to the context and nature of the inquiry itself. The methods used to conduct this research will now be detailed.

My approach to data collection and contextualisation of this research is by means of interview in conjunction with document search and analysis. This is consistent with the methods used in practical terms by qualitative researchers (Speziale & Carpenter 2007, p. 22). The interview method employed in this research for data collection is explored. With these principles in mind, this research combines historical inquiry and interview to develop an understanding of the experiences of Lesbian and Gay paramedics from their own perspectives within the framework of the research questions. A critical analysis is then undertaken.

Historical inquiry

Descriptions are meaningful only if put into a social and historical setting (Crotty 1998, p. 54). The nature of paramedicine in terms of its evolution, historical development, associations, identity and current work practices is unique and not well understood by those external to it. As a result, some development of the historical elements of modern ambulance organisations in Australia is essential to understanding the “stage” in which much of the interaction described in this study takes place. As “all data are shaped by the context and by the individuals that produce them” (Kincheloe, McLaren & Steinberg 2012, p. 16), some understanding of context is essential. Consequently, historical inquiry is the first method employed here and this underpinned a proportion of the literature reviewed in chapter 2.

Selection of participants

The objective of this research was to develop a rich description of the experiences of participants and no intention to extrapolate findings beyond the participants in the study. However, this study aims to re-present, critique and lead to the emancipation of Gay and Lesbian paramedics as well as achieve the more general research aim of beneficence. There may be some theoretical generalisability as a possible outcome (Smith & Osborn 2003, p. 56). As a result, a number of participants in this study were identified by means of purposive sampling which increases the scope of data exposed.

Purposive sampling also increases the range of data that can be unearthed (Manns & Chad 2001, p. 796). These individuals were selected by virtue of the fact that they identify as Lesbians or Gay men who were, at the time of interview, employed in an operational capacity as paramedics. This technique of purposive sampling represents a commitment to obtaining information from people who have had experience of the topic of interest (Speziale & Carpenter 2007, p. 30). Furthermore, as a technique, purposive sampling is used most commonly in phenomenology (Speziale & Carpenter 2007, p. 94).

As an adjunct to this method of participant selection, as previously mentioned, snowball sampling (King et al. 2003) was used. Participants were asked to solicit other potential participants known to them. It is arguable that snowball sampling is the most widely used method in a number of social science disciplines using qualitative research methods (Noy 2008, p. 330). This method enabled identification of a 'second wave' of participants through participants' networks.

Snowball sampling is a form of purposive sampling that is particularly useful when potential participants in a study may be difficult to locate (Speziale & Carpenter 2007, p. 30) or in accessing "hidden populations" (Noy 2008, p. 330). This method of sampling has been employed successfully in previous studies looking at non-heterosexual women (Browne 2005). In relation to Gay and Lesbian paramedics, this method was productive in finding participants who remain closeted: those who do not overtly identify as Lesbian or Gay, for various reasons.

The 'hidden' nature of participants in this study was one of the factors that meant the inquiry had a small sample of 10 participants. Smith & Osborn note that this is typical of interpretative phenomenological studies (2003, p. 55). Data saturation also became apparent after interviewing participants, whose accounts are presented in subsequent chapters that deal with research findings. This was another factor guiding the decision to limit the number of participants to the cohort considered here.

Data capture and collection – interviews

The interview method was used for data collection in this research. Collecting data in this manner is an approach consistent with generating data in the case study reporting mode favoured by naturalistic inquiry (Lincoln & Guba 1985, p. 42). The style of interview adopted reflects a more unstructured, discursive and tangential approach required to elicit subjective data in qualitative research, as opposed to the reductive and controlled approach preferred in quantitative research. This style was desirable, as qualitative interviews tend to be more conversational than interrogational. And epistemological assumptions of qualitative research

favour a less structured approach to interviews in order to encourage deep and rich understanding (Taylor 2006d, pp. 413-4). A range of labels is adopted and used interchangeably in literature to refer to the process of gathering information by interview; but in general, research interviews can range in style from formal and structured, less guided and conversational to unstructured and non-directive (Cohen & Manion 1994, p. 271).

There are four common kinds of interviews that can be used as research tools: structured, unstructured, non-directive and focused interviews (Cohen & Manion 1994, p. 273). Interviews in this study were designed to explore specific aspects of the experiences of participants deemed to be of importance to myself as a researcher. A focused interview identifies persons who are known to have been involved in a particular situation, explores elements in the situation that the researcher deems significant, have previously been identified and compiled in an interview guide and remains focused on the subjective experiences of the participants (Cohen & Manion 1994, p. 289). This style of interview was the most suitable to meet the objectives of this research.⁵ Furthermore, this style of interview is suitable to guide data collection in interpretive phenomenology (Smith & Osborn 2003, p. 58) as well as one of many methods I chose as a *bricoleur* to adopt in critical social research (Denzin & Lincoln 2008b, p. 5; Kincheloe, McLaren & Steinberg 2012, p. 20).

Focused interviews will have guiding questions to be asked of all participants with room to move, depending on how a participant is responding, inviting participants to talk with relatively freedom but keep them on track or focused (Taylor 2006c, pp. 416-7). Focused interviews require some guiding questions to maintain direction but not so many that breadth of coverage is sacrificed (Taylor 2006c, p. 416). Some overlap exists between these interview styles and sometimes these terms are used to refer to the same process. Further to discussion in this research, I have chosen to label the style of interview I have employed as *focused*.

Some debate exists in the literature in relation to the most appropriate question style as a vehicle for gathering information about a qualitative project. Some discussions favour the use of open-ended questions as a way of facilitating the participant's voice (Speziale & Carpenter 2007, p. 94). In aiming to achieve this goal, stimulus questions used in this research were developed to focus the discussion. Responses of participants, however, were not capped. The aim here was to maintain as much subjectivity of the participant's experience as possible.

⁵ It must be noted that some literature refers to this style of interview as "semi-structured" and even "structured interview" (Speziale & Carpenter 2007, p. 37) by virtue of its use of a set of pre-selected questions prepared by the interviewer.

The series of interview questions (see Appendix 1) were posed to 10 Lesbian and Gay paramedics who were working in an operational capacity throughout Australia at the time of interview. The study group consisted of equal numbers of Lesbians and Gay men. These interviews took place between March 2012 and February 2013. Pre-determination of the number of participants was not possible and data collection ended when saturation was achieved, that is, when no new themes or essences emerged and the data became repetitive and confirmed previously discovered information (Speziale & Carpenter 2007, pp. 31, 95). The practical constraints and timeline parameters of this research also constrained the number of study participants. Some of these constraints included cost and time limitations related to project completion.

These interviews were recorded electronically and transcribed. Participants were de-identified on the transcripts using pseudonyms. An offer was extended to them to comment upon the final transcript prior to publication. To ensure authenticity of data analysis, processes for “member checking” (Speziale & Carpenter 2007, p. 49) or “validity” (Taylor 2006c, p. 321) were adopted. Transcripts were returned to participants to ask if the description reflected the experience of the participant concerned, and were revised as required (Speziale & Carpenter 2007, p. 97). One participant requested a minor amendment regarding identification concerns and it was amended.

Whilst attempting to compose a structured analysis of the methodology, it is necessary to point out the difficulty of defining where the data capture process begins and ends in interviews. Conceptions of an interview vary. It can be perceived as purely an ‘exchange’ of information and therefore objective and/or being an interpersonal transaction with inherent and inevitable biases *which can be eliminated*, enabling a sharing of ideas with inherent and inalienable subjectivity (Cohen & Manion 1994, pp. 272-4). Some data analysis necessarily begins when data capture commences. This is inherent in the subjectivity of the participant selection process and the recording of the data and needs to be recognised in the context of this study.

The nature of interviews means there are interactions between the researcher and participant, which on a number of levels impacts the quality of the data collected. It is arguably the responsibility of the researcher to examine their influence on all aspects of qualitative inquiry (Speziale & Carpenter 2007, p. 36) and to ensure transparency. Furthermore, it is pertinent to highlight that the investigator must possess qualities that allow access to participant’s data. This is more likely to occur when the researcher is able to communicate and make participants feel comfortable (Speziale & Carpenter 2007, p. 94). I

believe that shared aspects of my identity with the participants in this research – being a paramedic and a Lesbian – have afforded me greater access to and appreciation of the participant's data on multiple levels. By virtue, this is part of our shared experience and common identity, with my ability to empathise with participants and understand the often 'coded' and technical language. As a result, it could be argued that the data obtained is more rich and thick, than if obtained only by a researcher as an outsider – one who did not have elements of shared identity with participants. A previous phenomenological study on paramedics in the United States concluded that the researcher's experience as a paramedic "lent variants of authenticity, intuition and bias to the final report" (Nicholson 2010, p. 55).

The style of interview chosen to gather data for this research recognises the interdependent nature of the researcher and participant as an integral part of their success (Speziale & Carpenter 2007, p. 36). The style selected is consistent with the approach of hermeneutic phenomenology in that it recognises this as a practical and interpersonal phenomenon, and does not aim to produce a purely descriptive account of the experience of participants on the basis of an idealistic state of *epoché*.

Reflective journaling

Reflective journaling was employed as a method in this research for a number of reasons. First, it provided a means of capturing data generated out of my reflections on past events and a means of reconstructing these. Second, it facilitated the process of reflexivity. In being able to recall the experiences that have informed and motivated me in the research process, I was also able to identify shifts required in the methodological approach adopted. In real terms this meant I have evolved as a researcher in the process of undertaking this project. I have also come to question 'ways of knowing' – both my own and those of others. I have therefore tailored my methodology to suit my personal philosophy underpinning this study. Third reflecting in this fashion has been paratherapeutic. It has acted as both a tool for "therapeutic conversation" and a "useful self-healing strategy" (Rose & Glass 2010, p. 1408).

Journaling facilitated an ability to interrogate my assumptions, experiences and understanding in relation to this research and hence increase the transparency and authenticity of this study. Paralleling Soohoo (2006, p. 12) I have adopted and continue to adopt this strategy, similar to her "tofu worldview" as an Asian woman. My own journaling facilitated a means of self-examination of my worldview as a Lesbian paramedic and of reflection upon the assumptions inherent in this view.

Data analysis – thematic analysis

As stated in the previous section, data collection and data analysis are inseparable (Speziale & Carpenter 2007, p. 96). Analysis of quantitative data is a hands-on process and begins when data collection begins (Speziale & Carpenter 2007, p. 46). The starting point to this analysis requires that researchers become immersed in the data (Speziale & Carpenter 2007, p. 96). In terms of the overlap with the data collection process, this immersion began whilst interviewing, at both conscious and subconscious levels. Whilst I recognise this process, explicit discussion of the data analysis strategies employed in this research is the focus of discussion in this section. Methods are required to bring findings together whilst preserving the essential context and complexity and thematic analysis is one of a range of potential methods for research synthesis (Thomas & Harden 2008, p. 3). The primary method was thematic data analysis to identify thematic networks to further analysis emergent relationships in the data.

In order to address the main research question a consistent approach was required to synthesise questions and themes inherent in the interview data. Thematic analysis allowed for an appropriate degree of flexibility for the coding of data to identify common trends (Cassell & Symon 2004). This overarching approach allowed for the identification of themes or patterns in the transcribed text (Taylor 2006b, p. 459). Thematic analysis drew out overarching themes (Langdrige & Hagger-Johnson 2009, p. 382). This approach to data analysis synthesised well with the goals of hermeneutic phenomenology in its aspiration to uncover the *essence* of lived experience.

This approach to data analysis was also consistent with the endpoint of descriptive phenomenological investigation in attempting to present a theoretical model representing the essential structures of the phenomenon under investigation (Wojnar & Swanson 2007, p. 177). Interpretative/ hermeneutic phenomenological analysis typically involves analysis of narrative text and isolating paradigm cases, identifying repetitious themes within and between cases, and selecting exemplary quotes to illustrate themes (Wojnar & Swanson 2007, p. 177). This approach to data analysis is a form of pattern recognition with a prescriptive and systematic approach. In general terms this approach usually takes the form of clustering similar data (Speziale & Carpenter 2007, p. 47). In order to address this question a structured process of data interrogation was required and applied. These approaches enabled analysis of the data relating to workplace experiences of 10 Gay and Lesbian paramedics to be presented in a rich and authentic fashion with the identification of common themes.

Thematic analysis seeks to identify salient themes at different levels (Attride-Stirling 2001, p. 387). The development of a model of thematic networks systematises the extraction of *basic themes*, grouping them together into *organising* and *global themes*, which are the principal or recurrent metaphors in the text as a whole (Attride-Stirling 2001, p. 388). The thematic network model developed helped to synthesise the interrelationships of aspects of information in this thesis. Texts may produce more than one global theme depending on their complexity, but these are core thematic networks in-text (Attride-Stirling 2001, p. 389). Steps in creating thematic networks include coding the material, identification of themes, construction of networks in visual/ illustrative terms, description, exploration and summary of networks and exploration of patterns (Attride-Stirling 2001, pp. 390-4). Analysis of qualitative material is a subjective process. And one of the principal reasons for using thematic networks as a method is to bring to light “meaning, richness and magnitude of the subjective experience of social life” (Attride-Stirling 2001, p. 403).

The fact that data analysis is more than a process of superficial textual analysis requires consideration in this discussion. Text has two dimensional elements: *what* it is saying and *how* it is said. Both forms of meaning are of critical importance to hermeneutic phenomenological inquiry in methodological terms (van Manen 1997, p. 346). Data that emerges may use explicit words to link ideas to specific themes and provide direct answers to research questions (Taylor 2006b, p. 461). Furthermore, implicit themes also emerge from the textual data and may be apparent in-text by inclusion of synonyms or more general hints as well as being implicit in the context of the exchange (Taylor 2006b, p. 461).

A writer who aims to bring the object of focus into presence is involved in a tensional relation between what is presented and represented in a form mediated by words (van Manen 2006, p. 718). This means that the process of interpretation is dynamic (Taylor & Bogdan 1998, p. 12) and highly subjective, despite the rigour of data analysis technique applied. van Manen (2006, p. 720) conceptualises this process of interpretation, which is bound up in the process of writing as “a certain attitude and practicing a certain attentive awareness to the things of the world as we live them rather than as we conceptualize them or theorize them”.

Thematic analysis of data was assisted by means of NVIVO 9.0 software. This was of assistance in identifying the main themes and patterns in the data obtained from individual interviews and coding this data (Bazeley 2007, p. 187). Once coded, clusters were identified across individual cases to identify themes. As such, the use of NVIVO allowed the themes to be “driven by the data rather than the researcher’s assumptions” (Bazeley 2007, p. 188).

Summary

This research is a qualitative study which uses a *bricolage* of hermeneutic phenomenology and critical social research – a ‘critical phenomenology’ to investigate the workplace experiences of a small sample of Gay and Lesbian paramedics working in Australia. The challenge of this study was to use data collection plus an analysis approach that gives voice to meanings felt and grasped at the core of the participant’s being (van Manen 1997, p. 349). In order to meet this challenge I have attempted to generate and validate findings around social phenomena that embody “concreteness, evocativeness, intensity, tone, and epiphany” (van Manen 1997, p. 368) in order to recount the experiences of participants in authentic terms.

For reasons previously discussed, I have chosen a research approach which best gives voice to study participants. Whilst results are not intended to be generalised, I feel that allowing the experiences of this cohort to have space in this research produces a level of evocativeness not supported by alternative approaches. Strong cases have been made in relation to the value of qualitative research for its potential to inform policy and practice (Thomas & Harden 2008, p. 2), and to evaluate programs and policy (Taylor & Bogdan 1998, p. 6). I am hopeful that some of the themes identified in this research will be considered in the development of more inclusive and supportive workplace policies, practices and attitudes. The findings will be of benefit to Lesbian and Gay paramedics, their co-workers, families and friends and the community they serve.

The following chapter explores my experiences as a Lesbian paramedic. It aims to make transparent my life experiences and worldviews in keeping with the reflexive methodological stance adopted in this research.

CHAPTER 4: ME

In order to expose the significant aspects of my life experiences and how they have informed, shaped and motivated this research, I have used journaling as a self-reflexive strategy to refine and contextualise my thoughts and emotions. This chapter considers some of the experiences that are significant in contextualising why this research is important to me. In this chapter I recall moments of significance in my life. I show the challenges and strengths of my story and factors that have led to the emergence of the research question.

I was born in a working class suburb of Melbourne and attended a public high school. I went on to university where I completed an Arts degree and a Graduate Diploma in Education in a bid to follow my passion of becoming a teacher. During this stage in my life, my confidence was not strong and, in retrospect, this lack of self-assuredness was associated with my personal sense of identity and *otherness*. I followed various career pathways and travelled various parts of the world. Upon resettling in Australia, I became a student paramedic with what was then the Metropolitan Ambulance Service (MAS) in Victoria. I worked as a paramedic in a full-time capacity for over 11 years during which time I experienced many highs and lows. After this, I returned to a role that allowed me to pursue my passion for teaching. This time my teaching was in the context of a tertiary institution, teaching undergraduate paramedic students.

Georgia – Even though I would now describe myself as out...on some levels I find it [my sexuality] really frustrating and I don't like myself for it, at 43 I still am measured about what I reveal to who. I am in some ways a little bit ashamed of that in myself. I don't know how you can be any other way in our society, and if you are the other way, then you get accused of....

Magnus (research participant) – Putting it in [other people's] face and 'how dare they shove that down my throat'. I understand, absolutely.

I am much more than my sexuality, but *part* of the reason I have not been entirely comfortable in reaching my life potential is because of my sexuality. My sexuality has a quality of voice, a troubled and criticising voice that makes me 'second guess' myself and my acceptance by others around me. This is more so when I mention my 'partner' or other elements of my personal life. It is the heteronormative practices and constructs in society that have in some respects stifled me and impacted on me realising my fullest potential. By creating social practices and structures, which normalise heterosexual people and relationships, heterogendered privilege has silenced and thwarted the potential of others similar to me. As noted in the literature, non-heterosexual people are *othered*. It is this inequity of being diminished which led me to undertake this research. I have been compelled to improve my understanding of the social practices and structures that have contributed to

my experience of marginalisation, leading to my own doubts. My view on beginning the process of undertaking this study was that only by investigating and making sense of the structures and practices that give rise to inequities could I gain the insight and understanding required to begin the process of personal and professional change.

On being a Lesbian

When I was in my early twenties I was like many non-straight people, grappling with my sexuality, my individuality and my differences. During this period in my life I also struggled to deal with a tragedy surrounding a family friend who committed suicide. He was slightly younger than me and in the army. In the suicide note he left for his family he revealed he was Gay and explained that his sexuality had been the primary reason for his death. He had grown up in a similar context to me, went to a similar school and had similar perceptions of and battles with his 'difference'. In life you move on and forget many things, but there are key incidents that have a habit of resurfacing. It was possible at the time that his self-perception was that he was abnormal in a similar way to my own self-perception. The difference between us was that I did not take similar actions. Although this event took place over two decades ago, suicides of Gay and Lesbian people continue to occur. We also have a higher incidence than the general community of depression and other mental illnesses (Hatzenbuehler 2009; Hatzenbuehler et al. 2010; Meyer 2003; Newcomb & Mustanski 2010; Williamson 2000). Although these things are always complex, it has always struck me that army culture *may* have contributed to his actions. It *may* have made him feel a little more isolated and he *may* have been a little more bullied, to the point where perhaps he felt a little more freakish and worthless.

It is the death of this friend and the senseless and cruel waste of a life that was an emotional driver for embarking on this research. The impact this death had on his family was devastating for me. Even more devastating was my feeling that our society was culpable and complicit in constructing many of the subtle and not-so-subtle messages and practices of exclusion which 'informed' his choice to die. Experiencing *othering* was undoubtedly influential in this young man killing himself. Many contemporary social practices still produce experiences of *othering* for Gay and Lesbian people. I find it infuriating that discussions of the issues of marginalisation of Gay and Lesbian people continue to be pushed into a space of silence in the discourse (Ward & Winstanley 2003). In relation to this work, the army shares some of the features of the culture of the paramedic workplace. Similarities between these cultures are a key driver in undertaking this research.

To grow up as anything other than heterosexual means a constant struggle for acceptance. This directly impacts one's sense of self-worth and self-esteem. This relates both to struggles

with those close to you and those more distant, in social terms. Members of my family are homophobic. It gives me the shits. Although I am superficially supported and accepted by them, on some levels I am still considered *other* in terms of my sexuality. Constant slips of the tongue show that my relationship with my partner will never be considered as equally valid, respected, or as 'robust' as those of my married or heterosexual siblings. For example, my partner still sometimes remains subjugated in the use of terms such as my 'friend', especially when younger, presumably more *vulnerable* members of the family are present. Even in family terms *heteronormative* practices and beliefs prevail and constrain my freedom.

In situations of conflict my sexuality has often been used as part of the armoury of weapons to attack me, when it is unrelated to the issue being contested. To be called a 'dyke' or a 'leso' when walking down the street, minding my own business, is something to which I have sadly become accustomed. The comments made are considered benign by those using them; these thought patterns are strongly embedded in some people's subconscious that these incidents of abuse are not perceived as such in the minds of the perpetrators.

I have not considered myself to be an overly serious person in the past. In fact, in order to have evolved to this point, I have had to develop quite a tolerant sense of humour. In a similar manner to many Gay and Lesbian people I have had to laugh at myself and learn not to take myself too seriously. I am pretty funny. One of my brothers still thinks it is hilarious to give me a drink called 'Cowboy Cocksucker' for my birthday as a Lesbian joke. This is funny on some levels however I am bored by this behaviour from him and others like him. Any equivalent heterosexual jokes are unlikely to be received with the same sense of unconditional acceptance and joviality. Historically, despite the monotony of such behaviour, to challenge it is commonly seen by others as hypersensitivity or an overreaction to a 'harmless' interaction. It has therefore become my practice to let these types of encounters go. These 'harmless' practices do however add up over time. What I have now come to understand is that these are actually microaggressions (Sue 2010) that have power and impact on my identity. It has been my experience that this constant negative social exchange, however 'well-intended' takes its toll, as my research findings will illustrate.

It is the injustice of the aforementioned interactions that has progressively taken shape and structure in my mind. The most striking feature of undertaking this research is that it is a personal adventure. The more I learn about the work that has preceded this study, the more skilled I have become at examining social constructs and practices. The more I learn and critique the more injustices I see. The process of undertaking this project has been an enriching personal experience and one that has vindicated my pre-existing belief that

heterosexual people do not experience these types of oppressive behaviour. Whilst this has sometimes been exhausting for me at a personal level and an emotional burden, it has also propelled me forward. The silences on matters of sexuality need to end, and become part of routine discussions of diversity and marginalisation in all possible forums. I hold that only then can socially constructed issues of difference be extinguished.

On being a Lesbian and a paramedic

As a new paramedic I was working at a busy inner suburban branch at which several other paramedics were located. A senior paramedic who was working in a managerial role returned to the branch at which he and I were both working and recounted to those present matters of the job he had just attended. The recount of the job was along the lines of “....fucking disgusting Lesbians wasting my time with some [medical condition I have forgotten]...” Not one paramedic at the time challenged the statement this person made, including me. The others present seemed to blindly accept what this person had said and laughed at additional jokes, which he wove into his derogatory statements. As a new paramedic lacking in confidence and trying to adjust to the culture of the workplace, this was devastating. I was terrified at that point and became extremely self-conscious. I had until this point monitored my expression of my sexuality and the behaviour I enacted. I had been careful about what I disclosed to others based on past experiences and the assumption that it was not alright to be identified as a Lesbian in *any* workplace. At this point in my work history I became *terrified* about disclosing information about my sexual identity. These statements, combined with the fact that they seemed to be shared by several other colleagues who I worked with, were stifling and destructive to me. I felt I was certainly *other* and at this point potentially alone in my new occupation. I felt I could not be accepted in my new workplace.

My experience as a new paramedic impacted my sense of identity and could be described as *microaggressions* (Sue 2010) in the same sense as those experienced in the context of the ‘Gay jokes’ previously mentioned. Such *microaggressions* induced fear in me and in the workplace. With overt statements such as these the safety of the workplace was compromised. At the point of interaction I described, my ability to do my job as a paramedic to its fullest capacity was compromised. I felt fearful. This fear meant I was on edge. Feeling on edge meant I did not have the confidence and emotional capacity needed to care for others. The thwarting and erosion of my professional potential had begun. My ability to properly care for those in the public sphere was compromised. Paramedics are responsible for looking after people in need and bestowed with the unique privilege of seeing others in states of vulnerability. It is a sad irony that a workforce with these inherent responsibilities of

care has acquired 'acceptable' cultural practices that potentially give rise to malfeasance towards Gay and Lesbian people.

Georgia – I wonder if sometimes I kind of just leave a piece of myself, there's a piece of myself that I almost keep in reserve. It's that consciousness, pushing something down all the time which is maybe not healthy.

The legacy of this interaction is strong. Although I have developed increasing confidence and now feel I would defend myself (or others) against this type of homophobic behaviour, I carry with me a sense of disappointment. I am disappointed in myself. How did I let this person behave like this? This disappointment is also a reflection of the society in which I live. How can a society let people behave like this? Although some of this work is personally therapeutic, restorative and vindicating in nature, it has also magnified my sense of disappointment. As has been explored in the relevant literature, my sense of injustice has grown. *None* of the literature supports the premise that it is alright to behave in the manner of the aforementioned paramedic. Current social norms and standards of political correctness certainly do not *overtly* support these behaviours. The sense of irony, injustice and offence I feel stems from the fact that these behaviours continue to occur with a monotonous regularity. The increasing magnitude of my frustration has correlated with the interaction I have had with the participants in this research. Whether their *othering*, marginalisation, stigmatisation, discrimination or abuse they have experienced is deliberate or unintended, overt or covert, direct or indirect, they have *all* highlighted the injustice and hypocrisies of our current 'progressive' society.

My conviction and realisation that Lesbian and Gay paramedics do experience inequity has strengthened in the process of my legitimising this research to myself. I have had the privilege of participants supporting me by allowing me into their personal spaces and sharing their experiences. Although many of the aspects of these narratives have resonated strongly, many have been unique, different and have on occasion shocked me into disbelief. Ultimately, participants have encouraged me to trust my instinct: that my own experience as a Lesbian and a paramedic is different to that of my heterosexual colleagues. It was not my imagination that I was excluded in my workplace and I was treated as *other*. This has reinforced my conviction that exclusion and marginalisation is a common experience for Gay and Lesbian people, including those who work as paramedics.

My experience as a Lesbian and a paramedic is inalienable in the context of this research. The research focuses on the issues and challenges I have faced, and the social constructs and practices that have created them. As previously mentioned, this lived experience and the inalienable beliefs and attitudes I hold have informed my choice to adopt the methodological stance of this study. These structures continue to influence the experience of Gay and

Lesbian people in many facets of their lives including the workplace. Central to these challenges is the reluctance of society to deal with issues related to sexual minorities. These social inequities are sustained by silencing the voices that challenge robust social practices that hold and maintain heterosexuality as *normal*, where departure from the status quo is seen as *abnormal*. This *heteronormativity* continues to influence social practices which *others* me and many other Gay and Lesbian people.

The impact of the subtle and complex forces and practices which combine to produce this experience of *otherness* are poorly documented, poorly understood. They are often left in the realm of silence in terms of the discourse of marginalisation and exclusion (Ward & Winstanley 2003). This research aims to break some of these silences.

On being a Lesbian, a paramedic and academic

One of the further motivations for my transition from clinical practice to academia was my perception that I would have the opportunity to work in a context that I believed would be more open, tolerant, progressive and embracing of diversity. Despite my assessment of being more 'worldly' at that point, in addition to believing I had a fresh and progressive workplace before me, I was again somewhat disappointed. I have now worked in a number of universities and things do not really seem to change on a number of levels from one institution to another.

A recent workplace interaction highlights for me the more subtle inequities that operate. Recently I walked past my boss's office and happened to overhear an exchange with a relatively new lecturer. The door was open and the conversation was about their heterosexual partners. The conversation was casual and transparent. These types of discussions do some of the fundamental work of forming relationships that are essential to conviviality within workplaces. They can be used to open doors for some people and create a friendly workplace. Heterosexual people are able to be 'whole' in the workplace in this sense and this 'wholeness' can lead to trust. Despite the fact that I have been in my more senior position for considerably longer than this person, I have *never* had this type of open and effortless conversation. I have never had a comfortable discussion about my partner and what she does, nor have I discussed or been privileged to hear about my boss's personal life. Whilst I cannot claim that I would necessarily ever be disadvantaged by this, it is thought provoking to speculate as to whether this could influence future decisions made by my boss or others in relationship to me as a person. I am aware that I am not able to be 'whole' in the way heterosexual people are. I am always conscious of what I reveal about myself, how I reveal my intimate life and who I reveal it to. This process of filtering and editing has proven to be an almost subconscious default position I have adopted over time – a survival and

safety assessment strategy. This is similar to those strategies of filtering and editing adopted by Gay and Lesbian people and previously documented in the literature (Carnevale & Stone 1995). This process has been both a burden I have carried and a motivator for this research, but I am sick of filtering and editing.

A further example of my experience in academia encapsulates the essence of this experience for me. Following a debate in a staff meeting, a colleague remarked “fancy taking on the angry Lesbian”. Again, this was not challenged by anyone else present at the meeting. This experience was in a sense similar to the situation I described earlier in the context of being a new student paramedic. Feeling stronger as a person, I felt I was able to discuss this with the colleague who had made these remarks. I highlighted to this colleague that I did not feel my anger had a relationship to my sexuality but to the issue being discussed. I asked her why she had felt that ‘Lesbian’ was a necessary adjective to describe me. Her response was “I just think it is funny”. Even with my newfound strength and the range of mechanisms I used to redress this issue, I felt it better to ‘let it go’. Such interactions demonstrate that many people in society still commonly characterise homosexuality as different, and feel it is their right to highlight this difference in public and in professional contexts. They assume they have the right to speak inappropriately and this is not questioned by those around them. Such forms of discrimination are undertaken in a manner which is often accepted in the social or institutional context in which they are conducted. These moments parallel the concept of “subtle sexism” as referred to by Benokraitis (1997). As discussed in the literature review chapter, these are the constant, small, intangible instances of being treated differently due to an identity attribute. Their subtle and insidious nature makes them difficult to distil, capture and combat.

In a more positive sense, the privilege of working in academia provided another motivation for choosing to focus on matters relating to Gay and Lesbian paramedics in my research. Although I do not go out of my way to ‘advertise’ my sexuality, communication within the university and in the field of paramedic practice means that a number of students have become aware of this aspect of my identity. This is both a burden and a privilege. The burdensome aspect has been my increased visibility plus a sense that I have the responsibility of ‘role-modelling’ and being a champion for students who do not fit into dominant moulds. The privilege and trust that has been invested in me by several students has led to the formation of strong bonds. This trust has also meant that on countless occasions I have had students at my door finding an excuse for a casual conversation. These conversations inevitably lead to these students revealing being exposed to homophobic or heteronormative practices whilst on clinical placements with paramedic organisations. Such encounters have instilled a sense of fear in them. This fear relates to

their belief that it is not safe for them to practice in their chosen career as paramedics, if they are Gay or Lesbian, or that if they disclose their sexual identity they will experience exclusion, discrimination and marginalisation in doing so. These fears add a further layer of challenge to the difficulties all students experience in transitioning into a new career that, I do not believe, heterosexual students experience.

The research experience

When I started this research I was scared. I live in a society that minimises the issues associated with marginalisation of non-heterosexual groups. I was scared to 'rock the boat'; both in general terms and in the context of paramedic practice. I have evolved in a world that laughs at me when I raise my sense of *otherness* and unpack the personal implications of my experience as *other*. Part of me still believes that research such as this is 'being a drama queen'. As these are the types of response I have encountered all my life when I have dared to speak the unspeakable, they are extraordinarily difficult to dissociate.

I have also feared organisational reprisals. As with others who question cultural practices of the dominant group, I expose myself to eviction from the group by doing this research. I fear exclusion from a group, paramedics, with which I still strongly identify. I fear they will see much of this research as critical of paramedic culture. I have also feared bringing up painful feelings for participants in this research as a result of discussing past experiences. I liken this to 'picking at scabs' to open up wounds that have previously healed. However, I think that from an ethical perspective the benefits of breaking the silence in relation to experiences of Gay and Lesbian paramedics outweighs the inherent risks associated with re-opening such wounds. Further, I have feared alerting participants to the injustices they have experienced to which they may not have been otherwise conscious of. However with this fear I have grown to appreciate the nuances of research, having evolved from a personal perception that research was inherently a cold, detached, inhuman and rigid process to my richer understandings of research as a range of tools and strategies that can be applied to afford insight into *truth*. Facing my fears has made me braver and has hopefully served to achieve some my objectives.

One of the initial fundamental underestimations of this research has been the degree to which it has been a painful vehicle for self-examination. This research is about difference and social exclusion, and the implications and outrageous and destructive consequences. The destructiveness of social exclusion impacts everyone and causes deep destruction to those excluded. The more progress I have made towards completion of this research, the more I realise the depth of harm I have personally experienced as a result: not of my sexuality, but of the social responses to it. To this day I lack confidence and experience levels of

unhappiness that I do not feel heterosexual people experience. This discomfort, whilst it ranges in severity, is mirrored by all of my participants and is not unique to me. Even the most confident of my participants have expressed a tendency to monitor disclosure of their sexuality. This choice to withhold personal information varies in terms of both the personal timelines in their life and the social context they are in, but all participants report personal censure and disclosure management in some shape or form. Even the most 'proud and out' of participants, whilst reporting feeling accepted on the basis of sexuality at work, also reported editing disclosure of her personal information to patients. Whilst other groups of people may experience levels of exclusion and discomfort for various reasons, heterosexual people do not experience this marginalisation *because* of their sexuality.

Georgia – People [patients] say, 'are you married?' and they look at me and they think, you're obviously in your 40s. You must be married...it's my internalised homophobia...I just say 'no' and hope to leave it at that because I just don't want to go into it.

This research has at times been emotionally exhausting. Whilst I have been conscious that aspects of my sexuality have provided a driving force for this study; on commencing the work I had been unaware of the depth of the impact of social exclusion I have personally experienced. I had little insight into the way the practices described here had influenced my current identity and image, the latter of which is the product of my personal evolution and professional experiences. I have been surprised by how I have been pushed into zones of self-examination in response to what my participants have reported. This has caused me a measure of discomfort. In a similar fashion to some participants, and with some regret, I have come to question whether I have constructed barriers to my own success as a result of internalised homophobia.

The more insight I have gained into psychology and other disciplines, the more I have come to understand the process I am undergoing. Undertaking this research is to some extent a negative reflective process, and this type of rumination has been identified as a risk factor for poor mental health (Hatzenbuehler et al. 2009, p. 1319). Having the insights I now do has provided additional fodder for my own rumination. Whilst in some manner this is burdensome for me, it also underscores the issue. Heterosexual people simply do not need to ruminate about matters of exclusion because of their sexuality. I see it as ironic that if I do not reflect and ruminate the opportunity to challenge the status quo's blindness to *other* sexual identities goes unquestioned. My not speaking out serves to contribute to the socio-structural constructs that tacitly endorse bias and prejudicial behaviour based on the privilege of a heteronormative lifestyle.

I *do not* claim that other minority groups of paramedics do not have negative experiences in the workplace. Unfortunately they do. The nature of such a research project is to narrow the

focus to a specific area to make it achievable. In order to do so, I have made the choice to focus on Gay and Lesbian issues in paramedicine and not the experiences of other marginalised groups. I believe this specific focus is the best fit from my personal experiences and therefore the context in which I can maximise the beneficence of such a research endeavour.

No student should be knocking at my office door to unpack their fear of being bullied in the workplace. No paramedic should be discussing their experience of being harassed or mimicked by co-workers with me. This endpoint will not be reached by undertaking this work; however, if I reduce some of these fears and produce some better experiences for people, then I have contributed something to the body of knowledge which puts *us* at a point further towards equality and justice: "Whilst cultural and institutional heterosexism remain largely unchallenged, it is difficult to provide nurturing and supportive environments for all Lesbian and Gay people" (Williamson 2000, p. 106). My goal here is to challenge underpinning understandings that 'everything is alright' when it clearly is not. My hope is that this work contributes to the increasing body of literature that provides evidence through these narratives, and my summations of the real inequities Gay and Lesbian people experience beyond a general sense. I also hope that this is the beginning of the discussion of inequity for sexual minorities in the relatively new academic area of paramedicine, and provides an opportunity to integrate the issues of sexually diverse minorities into paramedic education and practice in a specific, explicit and structured way.

My experience has now been tabled in the interests of transparency and in keeping with my methodological stance.

The next chapter turns to the experiences of the 10 Gay and Lesbian paramedics in this study. It is their willingness to share their lived experiences that has given form to this research. The stories they have elected to share add to the body of knowledge and some are vulnerable stories. The manner in which their stories have been presented has been informed by my personal experience as a Lesbian paramedic. As I desire change to emanate from this study, I have consequently chosen the methodological approach described in chapter 3 as 'critical phenomenology', with a view that this work will contest the understanding of what it is that happens and happened for my participants.

CHAPTER 5: EXPERIENCES OF EXCLUSION

The preceding chapter aimed to 'lay my cards on the table' in terms of my experiences as an individual and how they informed some of the fundamental decisions I have made in conducting this research and structuring this thesis. As discussed in chapter 3, in remaining true to the underpinning methodological approach used to guide this study, my story needed to come first.

This chapter introduces the participants and their attempts to encapsulate the essence of their lived experiences as Gay and Lesbian paramedics in the workplace. I aim to bring these experiences to the foreground and give voice to these previously silenced individuals. I am abundantly grateful to them for sharing their stories. Whilst I recognise the requirement for relative brevity within the practical confines of this thesis, I am flooded with disappointment in not being able to present their entire stories and to do appropriate justice to their experiences of being *other*. I am hopeful that I have told the stories of these participants in a manner that presents the essence of their experiences as faithfully and respectfully as possible. Burning in me is a hope that their willingness to share their stories with me, to trust me with their experiences of pain and vulnerability, will be to move one step further towards Gay and Lesbian paramedics experiencing a sense of inclusivity, equity and wholeness as they go about their critically important work within the community.

With my hopes for the future in mind, what follows is an account of the present life worlds of the participants. At present established and accepted social practices underpin the baseline disadvantage and inequity that Gay and Lesbian people in a heteronormative and heterogendered Australian society experience. As previously discussed in the literature review, marriage provides a clear and overt example of such a heteronormative sociocultural structure. As mentioned in chapter 2 and discussed further in chapter 8, the dominant culture of the paramedic workplace exacerbates some of the hyper masculine and hyper heterosexual qualities of its foundation; in doing so this dominant workplace culture extends the degree of disadvantage that Gay and Lesbian paramedics' experience. Dominant stereotypes within the workplace culture also act as a mechanism to marginalise Gay and Lesbian paramedics in that they generate understandings that 'naturalise' heterosexuality in a biological sense. Some of the dominant stereotypes in paramedic culture will be considered further in chapter 9. These dominant stereotypes and cultural characteristics underpin the tension between some elements within paramedic organisations and the Gay and Lesbian paramedics working within them. These tensions are rooted in the dissonance between contemporary needs for recognition of individuality, identity and authenticity for all

people (a concept considered in chapter 6), and the dominance of pressures to conform within the culture of the paramedic workplace as considered in chapter 7.

As will be demonstrated, the levels of experience of participants in this study range from covert and subtle discrimination and marginalisation to downright bullying behaviours. There are overt instances of homophobic discrimination that are discussed in this chapter based on the data findings. There are also subtly crafted and subconscious experiences of exclusion encountered by the participants and discussed in some detail in the body of this chapter.

Notably, *all participants* gave accounts of their individual experiences of exclusion, discrimination, bullying and marginalisation. These accounts provide strong evidence that the life world of these Gay and Lesbian paramedics is fraught with inequities and frequent experiences of *othering*.

Participant experiences

The aim of this section is to capture the essence of Gay and Lesbian paramedics. The participants' experiences are presented in order of interviews. Their stories cover the spectrum of bullying, harassment, exclusionary rituals, marginalising and demeaning and diminishing practices that lead to *othering*, as will be demonstrated.

As a rule of thumb and in relation to a key line of inquiry underpinning this research, evidence of participants in this study indicated that, whilst they all experienced practices which marginalised them, Lesbian paramedics experienced less overt forms of discrimination and exclusion than their Gay male counterparts. Participants gave accounts which indicate there are more extreme and blatant forms of discrimination that occur in the lives of Gay male paramedics.

Michelle – just not an open feeling

At the time of interview Michelle had been working as a paramedic for one year in a rural and remote town, quite a distance from her home. Michelle was 32 years of age and, whilst she identified as pansexual⁶ as opposed to identifying as a Lesbian, she was in a relationship with another woman at the time of interview. In her words she was a “Lesbian” in the “social sense”. Michelle was not *out* in her workplace at the time of interview. Over the course of the interview, Michelle said several times that she did not feel that she could link particular negative experiences to her sexuality in the workplace. As she was not out and presented

⁶ “A multiple and flexible identity that exists in stark opposition to binaries of sex and gender” (Hale Gonel 2013), thus self-identification as pansexual infers that one is attracted to a person, not a gender or sexuality.

herself in a manner that was not stereotypically “Lesbian”, Michelle had been able to keep her sexual identity private.

Michelle felt that this ability to ‘escape suspicion’ had afforded her some protection on a personal level. This protection meant she was assumed to be heterosexual and as a result was not personally treated as ‘different’ by her colleagues. Michelle’s account of her experiences in the workplace and her exposure to what she called “just not an open feeling” had led her to believe it was not *safe* for her to come out, should she wish to do so. The feeling she sensed in her workplace was that multiple forms of difference were not accepted or tolerated in her workplace. This feeling was underpinned by instances described by Michelle when she called the behaviours she experienced “open racism”. She gave the impression that her workplace was “sort of out and out Aussie”. Her colleagues were not open to accepting people from diverse groups. Michelle therefore reflected that to come out would be to expose herself to homophobic and discriminatory practices that she knew existed within her workplace and consequently she decided it was better to “keep [her] mouth shut” in relation to her sexuality.

Michelle had been exposed to behaviours and language from work colleagues that were blatantly “racist and sexist” in nature. She noted that some of the discussions in her workplace contained “open racism that you would never do in the city because someone would slap you in the face”. She had also detected more subtle threads of homophobia from her work colleagues in “just the way they banter and talk with each other”. Although she said she had experienced “no specific difficult incidences” related to homophobia that she was able to articulate, Michelle extrapolated from the more subtle threads present in her workplace that to “come out as Gay would be a whole new thing”. She also believed that coming out would lead to being treated differently by her work colleagues. Michelle had surmised from the behaviour and subtle remarks from others that if you were “a 22-year-old Gay male you would probably be sitting in a corner all day, just hoping that no-one outed you”. Michelle said that due to this marginalisation she “wouldn’t want to be a Gay male”. While she indicated she felt there was greater intolerance of Gay men than Lesbians in her workplace, she chose to remain silent in terms of her own sexuality. This enforced self-silencing was due to her sense that it was “just not an open feeling” within her workplace that encouraged Gay and Lesbian people to openly share their sexual identity, a perception that it was unsafe for her to be ‘out’. From discussions she had overheard and her summation of the culture of her workplace, Michelle’s feeling was that to disclose this information would be controversial and that this would mean that “blokes would be sort of all over it”. It is clear that she had deduced in her workplace that her sexuality would be an issue for her colleagues, and she felt this would lead to a level of unsolicited negative attention and personal ridicule.

We see this when she states that one of the main reasons she hadn't come out was she couldn't "be bothered with their minds and their jokes and their anything so I find it just easier not to say anything".

Michelle thought that if she was to come out at work she "wouldn't be ostracised" but would "just be uncomfortable". This potential discomfort illustrates that Michelle thought it was unwise for her to come out at work. In response to a fear of self-exposure to paramedic colleagues, Michelle remarked she managed her sexual identity by editing various aspects of her personal life at *all* times. She was "constantly conscious" of her behaviour at work. Michelle was hyper aware and managed her text messages and phone calls in a way that meant the gender of her partner was not discovered. Her female partner was by default gender neutral. Michelle did this by "walking around and making sure no-one knows what I am talking about" and constantly talking in 'code'. Michelle found this editing and filtering associated with silencing her sexual identity whilst at work "frustrating" as she had to "constantly sort of sidestep things". These comments are an indication of the constant hyper-vigilance Michelle needed to maintain and energy she needed to expend to ensure she did not inadvertently reveal her sexual identity to her workmates. The mental strain of this constant monitoring is a burden and one that heterosexual paramedics do not need to carry in relation to their own sexuality. Michelle carried the weight of a shroud of secrecy at all points in her worklife and she saw the inequity in having to constantly behave in this manner in order to feel safe. She said she found having to act this way "annoying because if it was with a guy I wouldn't care" and that "he'd be my screensaver on my computer and I wouldn't care about anything". Michelle identifies a clear distinction in the way she is made to feel in that she did not have "that freedom" her heterosexual colleagues enjoyed.

Michelle's experience of more subtle and indirect discrimination is more difficult to extract than the more overt acts. For Michelle, even in explicit terms, it proved difficult for her to explain the nature of the subtle judgements in her workplace. The data drawn from the evidence provided by Michelle often referred to the "feel" of her workplace as opposed to concrete examples of events. Her choices at work were influenced and controlled by the microaggressions (Sue 2010) that existed, and were reinforced by the culture of her workplace and the behaviour of colleagues within this context in many ways. Although this was an early point in her career, Michelle could see the impact of this marginalisation. When exploring this area, she initially stated "I don't feel like it affects my work at all". She qualified this and said it affects "just the 'social' side of work", as opposed to the actual manner in which she conducted herself in a clinical capacity. Heterosexual paramedics are not excluded in this manner in their places of work. They do not need to edit and manage phone

calls and texts to ensure they do not 'out' themselves and they are not excluded from the 'social side of work' unlike Michelle, who expresses this concern.

Jacob – If they found out....

In a number of ways Jacob's experience was similar to Michelle's. Jacob had been working as a paramedic for a period of 12 months and the majority of his work experience was in a rural town. On his days off Jacob lived in the city and commuted to and resided in the rural town where he worked for his days rostered on at work. He identified as Gay and was not in a relationship at the time of interview. Jacob was not out to those he worked with. In a similar sense to Michelle, Jacob's decision to remain silent with regard to his sexuality was informed by the 'feel' of the small town in which he worked. This was particularly the case in relation to Jacob as a Gay male. The striking feature of Jacob's experience as a Gay paramedic was the intense fear he expressed in relation to co-workers finding out about his sexuality.

Jacob had been exposed to a significant amount of negativity in relation to Gay and Lesbian sexuality in his workplace. In terms of the way Gay and Lesbian people were viewed, he said "I think they're both seen as negative things in the organisation". Jacob's statement was based on insight, or "feel", to use Michelle's words. Presumably because of the lack of visibility, Jacob said "I haven't really heard anyone speak about Gay paramedics". Jacob had however heard discussions about Lesbian paramedics and had been directly exposed to negative opinions held by other paramedics. These negatively focused discussions tended to essentialise Lesbian paramedics on the basis of their sexuality, which was always seen from the position of being 'deficit' or other. Jacob said he had overheard conversations about Lesbian paramedics in which other paramedics would "sort of speak down upon them or about them or sort of palm them off like '....she's a Lesbian or what not....'". As a result of this explicit disapproval he felt that if those around him found out he was Gay "you wouldn't be treated very nicely".

In addition to specific negative remarks about Lesbian paramedics, Jacob also provided evidence that in work contexts Gay and Lesbian people in general were stigmatised and visibly disrespected by his colleagues. This meant that Jacob had developed a strong fear of coming out at work due to the discussions he had overheard. One of these discussions related to some Gay men living in the town. Jacob stated that this paramedic "didn't speak at all positively about them, it was all negative" and noted disapproval in the content of the conversation. Part of this conversation led Jacob to believe that Gay people were not wanted in the area. Jacob developed this view as the paramedic involved in the conversation stated he was happy that these Gay men were "fucking gone now". Similarly to Michelle, Jacob noted in his interview that as a result of these types of conversations, he was on guard and

hyper vigilant. He stated, "You can't fully be yourself at work because of the fear of coming out" and "You can't 100 percent relax while you're at work". This fear of coming out is further expressed by Jacob:

...you want to be able to relax at work and be yourself and feel like you are working in a safe environment. At the moment I feel like I work in a safe environment but that might change if you came out. I don't think I would be, you know, physically harmed or anything like that but just maybe talked about and then maybe bullied.

As previously ascertained, experience of feeling unsafe as described by Jacob has been recognised as draining on the individual worker (Carr-Ruffino 1999, pp. 226-30). The lack of a safe workplace is also a limitation on the potential of the worker to support and fulfil the goals of an organisation (Carr-Ruffino 1999, pp. 226-30).

Jacob had surmised from the comments and attitudes of those around him that "if a Gay or a Lesbian came along they'd sort of be looked and sort of like segregated, like put in the corner and not being included I suppose". Rather than wait until his colleagues did this, Jacob chose to 'quarantine' himself and in a sense, self-segregated his work and private selves by staying in a self-imposed workplace closet. A factor that compounded Jacob's fear was that employment opportunities were limited to one service within the state his of residence. Jacob saw being negatively received by co-workers due to his sexuality as a career limiting factor. He saw losing his career as a potential consequence of coming out and he was not prepared to take such a risk.

I suppose the unknown of what will happen if people find out in the service and because there's only one service in the state. If it gets out and people find out and it's a bad experience then what do I do with my career?

It is possible that Jacob's statement indicates a lack of awareness of the legal and policy avenues available in his workplace to protect his rights, or perhaps it was his lack of faith that they would be enforced that led him to assume he was unable to be open. Even if Jacob had an appreciation of workplace discrimination and faith that he would be protected by such mechanisms, it is possible his view of being ostracised on an informal cultural level may present a barrier to him pursuing measures to enforce interventions. For Jacob the stress of working in such an uncomfortable and unpleasant environment could potentially cause him to leave his employer. Additionally he assumed there are limits put upon his career progression as a Gay man. To his way of thinking, there was little he could do to make his workplace experience more tolerable.

Holley – Less

Holley had significant experience as a paramedic, having worked in the role for fourteen and a half years at the time of her interview. Her experience was also relatively broad, given she

had worked for two state ambulance services, both in rural and metropolitan locations. Not only was her work experience as a paramedic varied, but the roles she had played in her life were varied. Holley identified as Bisexual. She had lived part of her life as a heterosexual in a social sense having been married for a period of time. She had also lived the most recent part of her life as a Lesbian in a social sense having spent several years in a relationship with a female partner and having two children out of this relationship until a recent breakup of this relationship. The fact that this partner was also an out Lesbian paramedic in the same organisation she worked in meant that Holley was unable to keep her sexual identity private. Although Holley actually self-identified as Bisexual, she was still seen in a fixed manner by her colleagues as a Lesbian. This was despite the fact that she was no longer actively involved in a Lesbian relationship.

In contrast to Michelle and Jacob who choose to remain closeted, Holley chose to be open about her sexuality. As a result, Holley had been exposed to several instances of explicit and direct discrimination. This discrimination was enacted in regards to matters relating to Gay and Lesbian paramedic colleagues. She, as with all 'out' Lesbian and Gay people, has no ability to step back into the closet (Harry 2010, p. 29). She had on occasion felt supported by the organisation she worked for inasmuch as being provided with carer's, sick and maternity leave in line with the industrial award in her workplace. Holley appreciatively noted that she had "reaped the benefits of the organisation" she worked for in terms of having obtained various leave entitlements. Holley and her female partner had accessed these entitlements and she stated she "didn't have to *fight* for any of them". She had known of other Gay and Lesbian paramedics who in the past "had to *fight* to be recognised" to access these entitlements, as their relationships were not viewed as valid from an organisational perspective. Holley stated she was "a very grateful recipient of the fight that's come before me" in this respect. It is noteworthy that she expected to have to 'fight' for her entitlements. The heterosexual paramedics with which she shared the workplace do and would not hold the expectation that they would need to fight in this manner. For them workplace leave entitlements were an unchallengeable entitlement.

Despite having her rights afforded to her on an official level, Holley was still socially excluded in many respects. Holley experienced a general sense that she was considered what she called "less" than the heterosexual paramedics with whom she shared her workplace. She noted that some oppressive behaviour still took place on many levels in the workplace. This included instances of exposure to homophobic language and feelings that she was excluded from social interactions on the basis of her sexuality. She noted in her interview that some of these behaviours and practices led her to "feel ostracised sexually from the rest of [her] organisation". This dichotomy meant that official organisational enactment of workplace

rights and entitlements took place whilst Holley was in the milieu of being socially ostracised. She went on to say that this “made [her] feel really unattractive.....and whacked [her] self-confidence and [her]....sense of self”. She had been told by colleagues that this exclusion was “because people think I’m Gay.” This polarising experience provided strong evidence of the detached nature of her workplace. Holley’s perception was and remains that her employer was essentially supportive of her. As a result, she maintained a sense of ‘company loyalty’ and in a sense forgave the paramedic colleagues who tacitly enacted institutionalised homophobic behaviours.

Perceptions that Holley was both single and a Lesbian meant she experienced a different physical dynamic to other colleagues. She said in the past in her organisation that if she encountered someone she knew she would feel comfortable to “give them a big hug, a kiss on the cheek” and say “oh, I haven’t seen you in ages”. After becoming single she sensed this changed. She was no longer approached by colleagues in such a physical sense. Holley experienced this as a “disconnect as well”, indicating that she experienced this physical form of isolation as yet another layer of social exclusion. She felt this was due to the fact that in physically interacting with her in this manner, she thought people felt they may give her “the wrong idea”. Her interview illustrated how she believed their ‘hugs’ were seen in their minds as encouraging her to want a physical or sexual relationship. As such, she noted this lack of physical contact with her work colleagues had led to “a real different dynamic” in her work relationships. In this sense, Holley felt she was excluded from normal patterns of behaviour that took place at work.

Holley felt she was valued within her workplace but the manner in which she was valued was “less” than heterosexual colleagues. Her perceived need to constantly explain her past relationships to colleagues led her to believe she was considered *other*. This additional layer Holley found invasive, tiring and irritating. She remarked “I don’t like feeling that I have to explain myself, or excuse myself, or justify myself”; however she indicated that this was a common experience for her due to her true sexual identity and because her past relationships were not seen as ‘normal’ by her colleagues. Holley was very conscious of this being a different experience to that of her heterosexual colleagues. She referred to the intimate relationships her straight colleagues were in, and stated, “They don’t have to explain themselves, I do.... well, I don’t have to, but, there’s no need for them whereas there is a need for me and I find that frustrating”.

Compounding factors which further marginalised Holley and added to her frustration originated in the work experiences of her Gay and Lesbian paramedic colleagues. She was aware of some paramedics who had had experiences of “...harassment, bastardisation [and]

open hostility". She had heard "a lot of derogatory comments" made towards a Lesbian paramedic evidenced by "a desire for a lot of people not to be rostered to work with her". Holley's perception was that she too had frequently been rostered with this other Lesbian because those making decisions about rostering thought Holley could "identify with her". In the act of making a rostering decision based on sexuality, Holley was experiencing an organisational practice that was discriminatory. In relation to her Lesbian colleague, she added that "People would actually leave the room when she came in, and [make] a lot of derogatory comments behind her back, which I found really uncomfortable". Some of the terms that had been used to refer to this person included "raving leso...butch dyke" and "pussylicker". Although Holley was not the *direct* victim of these exchanges, indirectly this had a strong impact on her experience in the workplace. We see this evidenced when she says:

Probably because I thought, well if they're saying that about her, well what are they saying about me? And it made me feel uncomfortable about my relationship in terms of, well, do people say that about me, do people not want to work with me. Do people call me dykey and leso?

In relation to common workplace language sanctioned by her colleagues, Holley also stated that the word "poofter" was used frequently and commonly and that it was always used as "a derogatory term". This also had an impact on Holley in terms of contributing to her sense of being "less" than her heterosexual colleagues in the context of her workplace.

Behavioural change was also noted by Holley when working with a known Gay male paramedic. Holley felt one of the contributing factors to this behavioural difference was the forced intimacy of the workplace, requiring these men to be "trapped in a small space with this poofter for hours". Holley felt that this meant the heterosexual men had to "posture and pose" in a way that communicated they were actually not Gay. According to Holley, they had been "that extra bit butch and blokey and arm-thumpy and cracking crass jokes to prove that they're not a poofter". She added that "some of them feel the need to emphasise their own masculinity, especially when faced with Gays". She saw this treatment of Gay men within her workplace as a reflection of the fact that they were seen as being diminished models of masculinity. Holley stated that Gay men were "definitely less" of a man when being judged by their heterosexual paramedic colleagues. Regardless of the value judgements that underpinned these behaviours, according to Holley, Gay males were treated differently to heterosexual paramedics by many colleagues. From Holley's point of view, there was also more intolerance for Gay men than for Lesbians in her workplace.

Holley's interview qualitatively measures the treatment of differences. She noted that the outcome of all of these negative discriminatory experiences was that she felt she was seen

as being “less”. She had been privy to violent and aggressive acts of discrimination and had felt the vicarious and direct impact of these acts in her work life. Holley noted that she felt disconnected and marginalised in the workplace due to these contaminating practices. Holley felt she had been “labelled” as other and less valued than her heterosexual colleagues. This marginalisation was now taking its toll on Holley’s sense of psychological health and wellbeing.

Mack – People don’t perform well when they’re being bullied

Mack identified as Gay and had been a paramedic for 17 years in which time he had worked consistently for the one ambulance service in a suburban setting. Although not initially out to those he worked with, a series of incidents in the workplace had led to him come out over time. At this point in time he believes that the majority of those he worked with were aware of his sexuality. Because he was open around his sexual identity, Mack experienced overt and systemic discrimination and bullying over the period of his employment as a paramedic. He was the victim of similar acts of discrimination to those described by Holley and more subtle forms of marginalisation described by other research participants.

Mack’s interview recounts his experiences and provides the reader with some of the most blatant and extreme examples of maltreatment provided by Gay and Lesbian paramedic participants. As a result of these experiences Mack had suffered emotionally and professionally and this had limited his career progression. His story warrants a separate telling, but with the constraints of this thesis it is impossible to explore all of the dimensions and details of his experience. This section of the chapter is a narrative that sets out to lift Mack’s experience out of enforced silence. The story interrupts the silence around this extreme form of bullying.

In a similar sense to Michelle and Jacob, Mack remained in the closet in the early stages of his career. He believed that his hostile work environment did not provide a safe and supportive space for him to come out. Mack did however, confide in “one or two people” he had trusted in relation to his sexual identity. He revealed that with “the gossip tree being what it is” these people promptly spread the news about his sexuality within the workplace. Despite this disclosure Mack still presented at work as though he was “closeted”. To the best of his knowledge at the time he was still closeted. Distressingly, unknown to Mack, there was however a “whole group of people out there who sort of knew” about his private life and his sexual identity. As a result of this unsolicited disclosure and the inherent abuse, he was at this point in his career where he was “experiencing a fair amount of bullying and it was all nasty”. Mack related an interaction he had with one woman in his training group, saying that she “actually used to sit in class and block me out of her view”. As a result of Mack’s belief

that his work colleagues were not privy to information related to his sexuality, he was confused as to the origin of the types of behaviours. He experienced “nasty comments”, such as he “wasn’t a paramedic’s bootlace”, from colleagues for the first three years of his paramedic training. During this time some people refused to work with Mack, yet he did not know why. As a result of this behaviour, Mack assumed he was incompetent in his work and in fact questioned himself in his “ability to do the job”. It was years later, when a colleague communicated to Mack that he had been subjected to this behaviour, stating “they just hated you because you were Gay” that he became aware of the reasons for these painful exclusions. Mack was alerted to the fact that his paramedic colleagues “were homophobes” in retrospect, but this was long after he had sustained significant personal psychological damage.

The severe negative behaviours directed toward Mack came from many colleagues and were played out in a range of varied work contexts. Mack describes some of the intimidating behaviour he was subjected to by a colleague responsible for his early training in this phase of his career as follows:

I remember I worked with one particular guy. He was a little small ex-military sort of bloke...he would pick on everything that I did. You know, the way I spoke, he would actually mock me. He’d comment on my weight, comment on my appearance, how I spoke to the patient, he’d sort of make a mock poofy voice. You’re just like, ‘you know people don’t trust you and’....I knew he was talking to management [about Mack]....He knew he was treating me badly, he knew...It was that real, almost classic, redneck bullying crap.

Mack’s experience of this incident and others indicates that not only was this person bullying him on a daily basis, but that he was openly colluding with management in such a way that further disempowered him. Other paramedics supported this behaviour as they were “all part of the same group”. Mack called the group “the coven”. This “coven” acted in concert with a series of behaviours which were ultimately detrimental to Mack in terms of enforcing his continued exclusion.

Mack described another incident with another paramedic around this time. He sensed this colleague’s opposition and remarked that he was “just was getting negativity off him all the time”. This paramedic happened to be on duty and Mack called on him to assist with a patient who was experiencing a life-threatening condition. Mack said the response from this paramedic was that they “refused to come urgently and stood there”. When he finally arrived, this paramedic did not “even look like he was paying attention” to Mack when he attempted to handover and acted “to the [clinical] detriment of” this patient. As Mack had had “numerous sorts of experiences with this guy like this” he decided to discuss this with the

Ambulance Chaplain. The explanation the Chaplain offered for this served to reinforce and endorse the life-threatening misbehaviour of the colleague. The Chaplain's view was justified as Mack's colleague was "a born again Christian". The Chaplain stated that he felt the behaviour towards Mack was justified, explaining he was being treated in this manner "because you're Gay". Rather than support Mack, the views of the Chaplain echoed the systematised conservative *Christian* heteronormative structures within his organisation, indirectly excusing this behaviour.

At one point Mack managed to complain to management about a person who was bullying him and with whom he had been rostered. This roster had been fixed for an extended period whilst undertaking a phase of his training. Mack got to the point with this paramedic where he was unable to continue to "work with this fellow" as he was "having a terrible time with him". This was only after Mack had previously tried to "approach a manager about working with this person who was a bully". On making his complaint, Mack had not pursued the line of discrimination, because at that point he was unaware of the underlying reasons for this individual's behaviour. Without warning Mack then found himself in a meeting with managers and the person he had complained about. Mack felt he was being "ambushed really by all of them and basically being told I was wrong". In this meeting all of his complaints were "not given any validity". The result of this meeting was that Mack was told he had no choice but to continue to work with this colleague. The rationale given was that "He's gonna do the best thing for you". The inference made was that this colleague would correct some of Mack's clinical issues by forcing him to do things in a particular way. One of the underpinning reasons Mack was given for this was that he was "not performing well". Mack felt at this point he was in a "no win" situation and had no one on his side. The issues he had raised were trivialised and reframed as being problems associated with Mack's lack of clinical competence and experience. Mack went on to assert that during this period he was "pretty naive about my rights" and therefore "played the game" in order to get through this training phase of his career. Mack stated that he actually agreed at this point that he had not been performing well and he knew the reason why. Mack points out "I was being bullied and people don't perform well when they're being bullied". At no point was the underlying reason for Mack's performance issue sought, but instead he was made to feel as though he was to blame for the negative situations he had experienced.

Although Mack's experiences of bullying and direct systemic discrimination were in the past, after they were resolved he continued to be affected by more subtle forms of homophobia. Mack described situations where he was not rostered for holidays over the Christmas period or on school holidays because of assumptions that as a Gay man he would or could not have

children. As he had no family he would not “necessarily want those” holiday periods. As a result “heterosexual paramedics were given priority over these periods”.

Mack’s evidence also included descriptions of events such as the occasion when he “...was driving along with someone [a work partner] and someone cut us off, and the other fellow was driving and he just screamed at him ‘you poofter’”. Because of the tendency to trivialise these types of events, it is even more difficult to make concrete such acts of discrimination. These acts are subtle and covert when compared to overt acts of discrimination that Mack endured. Mack’s interview might be seen as an example of evolution of the forms of expression of homophobic values. In his workplace the oppressive commentary and behaviours have moved from more overt and direct interactions to more covert, subtle and indirect engagement. The shift in the way in which homophobic and heterosexist values were expressed in his place of work is indicative of evolution in terms of the manner of expression of these values only and not a change in the values themselves. Heterosexist and homophobic values still formed part of the cultural fabric of Mack’s workplace but these values had effectively ‘gone underground’ and taken a more subtle and insidious form.

Latoya – No real word for us

At the time of her interview Latoya had been a paramedic for four and a half years. She was 45 years old and identified as a Lesbian. She was in a long-term relationship with her female partner. Latoya worked in a rural setting and spent considerable periods of time working on her own in remote areas. Latoya was out at work.

In stark contrast to Mack’s experience, Latoya claimed that apart from some of the heteronormative and masculinised structural aspects of her workplace as a paramedic, the practices and behaviours she experienced didn’t impact on her “for five minutes”. These factors will be explored in chapter 7, which sets out to examine paramedic culture in more detail. In her interview Latoya speculated she didn’t “think it would be very easy to be a Gay man in the country”. Indeed, many of the participants and especially Jacob, as noted earlier, highlight the disparity between the work of country and city Gay and Lesbian paramedics. Chapter 10 explores this theme in greater depth.

The remote area that Latoya worked in and the consequent geographical isolation meant she did not have any other visible Gay and Lesbian paramedics around her; as such all she was able to do was speculate about the manner in which she felt they would be treated. She had inferred however, from conversations conducted between other paramedics which had taken place in her presence, that Gay men would not be welcomed by her colleagues. This was evident when Latoya remarked:

...they're always calling, everyone's a poofter, a poofter this and a poofter that. It would be awful if you really were one, to hear that all day, especially if you were in the closet. And if you were out, they would not take it easily.... You'd have to be fricken strong in yourself.

Latoya went on to maintain, in speculative terms, that such difficulty for a Gay male was for reasons noted in the discussion of previous participants in this chapter (i.e. Gay males were and are perceived as more of a threat within the conservative culture). Latoya also noted this, as in her remote workplace Gay paramedics would be subject to exclusion and marginalisation.

Latoya's individual experience contrasts in some respects with the experience of other participants in this study. As an 'out' Lesbian within the culture of a masculine workplace, aside from her disenfranchisement from sociocultural structures, Latoya did not have a negative perception of her experience as a Lesbian paramedic. She suggested that she had not been personally affected by homophobic actions at the time of her interview. She did however have a strong appreciation of the compulsory heteronormative structural factors which dominated her workplace. Latoya felt that "ambulance is such a family oriented profession" and admitted being alienated in her workplace when "everyone's always banging on about their kids". She was also aware of the tacit manner in which the use of the term "family man" was a device to describe colleagues in a positive sense. She took this to illustrate, by implication, that there was a culture in the workplace that has a distinctive pecking order. As will be further discussed in chapter 6, Latoya's awareness of silencing was evident in the assumptions operating within her workplace. This was evident when her colleagues assumed that when she used the term "partner", Latoya was referring to her work partner, not her life partner. In her interview she revealed "there's no real word for us".

Calliope – He's so upset because he's delicate

In a similar sense to Latoya, Calliope did not feel she had ever been the victim of explicit discrimination or exclusion due to her sexuality. Calliope was 25 years old at the time of interview. She had worked as a paramedic for four and a half years. She identified as a Lesbian, was in a relationship with another female paramedic and was out to everyone in her place of work. She had "never been conscious of any issues" relating to her sexuality in the workplace. Calliope worked in the inner suburbs of a large city and worked in close proximity to many other Gay and Lesbian paramedics. Calliope did not have the same experiences or observations as Latoya in terms of feeling silenced or geographically isolated. This was because she felt there was a sufficient Gay and Lesbian paramedic presence in her workplace for her to 'have a voice'. Her sense of confidence in her sexual identity and her awareness of her right to visibility as a Lesbian was clear. This was demonstrated by the fact

that she had been a key organiser of representation of a paramedic group at a local Gay pride event in her home location.

Calliope had been privy to matters relating to other Gay and Lesbian paramedics where their sexuality was a key factor in decisions that had unfavourable outcomes for them. Calliope believed that Gay male paramedics were treated with less tolerance than Lesbian paramedics and those Gay male paramedics who were more “effeminate” experienced the greatest difficulties in the workplace. Calliope supports this assertion when she states, “they probably do get it a bit rougher I would say and particularly have been left more vulnerable and not had people go into bat for them for whatever reasons”. Calliope affirmed that in general Gay male paramedics, particularly those who appeared “more on the sensitive side or more camp”, were treated less favourably when compared to their heterosexual counterparts by some co-workers and by managers in her organisation. Calliope also noted some instances of social exclusion in her work location. She was aware of “some heterosexual guys who do not interact with ‘out’ guys”.

Calliope recounted one specific issue that had arisen relating to a Gay male paramedic colleague. This was in her opinion a specific instance of discrimination. This matter related to the handling of a clinical issue that arose in which the serious complaint of the Gay male paramedic was trivialised on the basis that he was “delicate”. The matter Calliope described related to a dispute over who was to blame for an incident where a patient was poorly managed. This incident led to a negative clinical outcome for the patient. Despite the fact that the clinical error had been made by another paramedic who had attended to the patient, the blame had been attributed to the Gay male paramedic concerned. The paramedic responsible for the error and some of their colleagues went about “bullying him and blaming him” for the matter when he “legitimately had nothing to do with it”.

The expectation was that this Gay paramedic would readily accept the blame for the other paramedic’s error on behalf of the others involved. The unforeseen response of this Gay paramedic was in fact to defend himself and not accept the blame for this incident. The reaction of his managers and the other paramedics to his defence was to trivialise his response. They went as far as to falsely blame the Gay paramedic and he was told he was being “just a bit sensitive”, “a bit delicate” and “a big girl”. As a result of the trivialisation of this matter, the complaint was never pursued in a formal manner and the Gay male paramedic was silenced. Calliope said that effectively the “sensitive” paramedic concerned was told to “go over there and don’t say anything”. The clear result of this matter was that the paramedic was seen as hypersensitive and that this was the reason he was “upset about the bullying”. The bullying he had been subjected to by colleagues was not in and of itself seen

as the critical issue in this interaction. The focus was shifted to the response of the Gay male paramedic as being “sensitive”; his way of being was the fundamental problem. This managements’ response was associated with his sexuality and as such should be seen as disproportionate and unjustified. He was afforded “nothing from management” in terms of protection and the enactment of workplace rights. Even in a context Calliope saw as ‘inclusive’ for Gay and Lesbian paramedics, acts of bullying and discrimination were openly condoned by management. As a result of this incident the Gay paramedic concerned has gone on to experience serious health impacts.

Magnus – Just a continual putdown

Magnus had been on the receiving end of several types of social exclusion, bullying and discriminatory behaviours, similar to those described by Calliope. Magnus was 42 years old at the time of his interview. He identified as Gay and described himself as “completely out” in terms of his sexuality at work. Magnus worked in a busy city setting at the time he was interviewed and had worked for two ambulance services over ten and a half years in a range of locations within these services. Magnus’s experience of marginalisation began in the initial phases of his training under the ‘in house’ vocational system. During his time as a paramedic he had experienced a stream of incidents. These involved both subtle and overt discrimination which occurred because of his sexuality. Magnus saw these behaviours as “a continual putdown”.

In his interview he stated that these experiences began with immersion in a hyper-masculine and heteronormative culture. He felt there was not “a hope in hell I’d mention that I had a partner or a boyfriend” as he would not be accepted. After a period of time Magnus began to develop trust and “came out to certain people”; however, he continued to ‘manage’ the vigilant disclosure of his sexual identity over the years until he got to a point where he was completely open. At the time of interview Magnus considered himself to be out. In response to being out however Magnus had the occasional reaction from colleagues to the effect of “how dare they shove that down my throat”. This assertion from colleagues intrigued Magnus as it was not his intent to publicise his sexuality or push it upon others, but to be honest about his sexual identity. Such an ability to be open in respect to sexual identity is assumed as a right by heterosexual people with a natural affinity for heterosexual constructs within their workplaces (Skidmore 1999).

The fact that Magnus was out was as a result of becoming tired of having to “filter” in terms of what he disclosed in his interactions with colleagues. Magnus was aware of the disproportionate vulnerability he carried as a Gay paramedic in terms of the information he

exchanged in casual conversations with others in the workplace. Magnus made his awareness of this clear when he stated:

If you come out to somebody, a partner in the ambulance or whatever work environment, you are very aware that the moment you tell them you have a boyfriend, you are very aware that you are telling them a lot more than what they have just told you about being married.... You are aware that they will possibly go 'oh my god, he's Gay'. You're conscious of what they are thinking. Whereas if someone tells you they're married, it's just like, 'whatever', there's not a conscious thought that goes into that. So, it affects, it affects long term.

Magnus was tired of carrying this burden of not being his authentic self. He felt it was the way things would be for the rest of his life in general and in particular his career as a paramedic. He stated "I can't see us being completely normalised within my generation".

Aside from the experience that Magnus describes in relation to his sexual identity not being seen as 'normal' in the workplace, he also experienced incidents of a 'chivalrous' yet discriminatory nature from male heterosexual colleagues. He believed these acts were related to his sexuality. On occasion Magnus's colleagues had felt they had to take a masculine lead at various clinical scenes. Magnus describes this behaviour as follows:

I remember I worked with a paramedic before, oh yeah, you're one of the boys, and then he got wind of the fact I was Gay and you kind of notice that they go, 'I'll go in' or if someone's aggressive they kind of take the lead. It's kind of like, you know, fuck off, I'm perfectly capable.

Magnus felt this behaviour was a manifestation of the false assumption that he was physically weaker due to his *sexual* identity and this perception was aligned to a disrespectful stereotype of the Gay male. This erroneous presumption had led to Magnus feeling he continually needed to prove his physical strength to colleagues. He also alluded to other more subtle instances of discrimination where he believed rostering decisions had been made on the basis that "someone doesn't want to work with you because they don't know you yet". Magnus stated "you don't know whether it's based on your sexuality but sometimes you kind of wonder, but nothing [is] overt". Whilst he had no evidence to support this assertion he did suspect some homophobic discriminatory practices had taken place in the rostering of his work and allocation of his work partners. He believed that the subtle and insidious nature of these workplace practices made the actions very difficult to detect.

Magnus also likened these experiences of his exposure to discriminatory terms used to refer to Gay and Lesbian people in his workplace. He had on a number of occasions been working with paramedics who used offensive language such as "ah, you fuck'n faggot", "you fuck'n poofter" or "she's a dyke" in his presence. This led Magnus to believe that the sexuality of a

Gay or Lesbian paramedic is “discussed behind people’s backs”, leading him to believe that in his case “obviously that it’s [his sexuality] discussed.....behind my back”.

Continuing on the theme of subtle bullying, Magnus spoke about his experience with another paramedic early in his career:

I worked with a paramedic who just put me down consistently for the whole roster that I was working with him. I don’t know whether that was related to my sexuality, I never made it clear to him. I felt very uncomfortable working with the man so I certainly never outed myself. So, whether he knew and was being an arsehole or whether he was just a plain arsehole....

The subtle and continual ways in which Magnus had been treated by this paramedic made his behaviour difficult to describe. This is consistent with what other participants describe variously as a “feel” or a sense they are being treated differently in the absence of tangible evidence. This ‘underground’ form of discrimination is consistent with the notions of subtle sexism (Benokraitis 1997) and microaggressions (Sue 2010) described in the literature review.

Magnus further described an incident in which a colleague’s behaviour changed towards him, that he believed was associated with his sexuality. Magnus had been responsible for addressing some training needs of another paramedic. The paramedic in question had asked Magnus early in their pairing if he was married. Magnus responded, “I’ve got a boyfriend” to which the response of the paramedic making the inquiry was “I’m sorry”. Magnus could “see the shock in his face”. Magnus felt that from this point on, his sexuality bothered this paramedic to the point that it affected their working relationship. We see this when Magnus discussed the deterioration of his relationship with this colleague:

He hated me. He wouldn’t talk to me at the station, in the cabin in the ambulance, only if it was directly work related.

Magnus related this behavioural change to the disclosure of his sexual identity and said that their working together was “definitely the worst experience working with someone” he had encountered.

After a significant period working as a paramedic Magnus experienced behaviours and practices which made him aware he was never going to be seen as ‘normal’. He experienced continual subtle indirect acts of discrimination and overt acts of exclusion, which he believed were simply related to his sexuality. Magnus was resigned and complacent when he said:

You are kind of like, what do you do? You have every right to turn around and go ‘how dare you’. That’s an aggressive, abusive behaviour that you shouldn’t have to put up with at all and it’s officially zero tolerance but....

As a result of his career long experience of widespread and systemic social exclusion Magnus experienced several consequences that resulted in him actively looking for work in another field. Rather than fight, Magnus was resigned to resign – looking for alternative forms of employment.

Saxon – Wondering about who's going to stick the next knife in

Saxon had been exposed to similar acts of discrimination and marginalisation described above. He identified as Gay and was 32 years old at the time of interview. He had been a paramedic for seven years and had worked for two different ambulance services. He had experience in city, urban and rural settings. Saxon was out at work, though he did not 'publicise' his sexuality nor did he hide it. In addition to subtle and covert forms of bullying and discriminatory behaviour, Saxon had endured a prolonged period of exposure to forms of overt and systematised bullying, harassment and discrimination, which could only have occurred because of his sexuality. At the time of interview Saxon was on leave from his role as a result of the stress that had followed a recent experience noted below. Saxon intended to leave the organisation he worked for because of the series of incidents he had faced. He felt it was unsafe to return to work and was experiencing very significant emotional health issues.

Saxon began his career as a paramedic in the closet, stating he was "very cautious" about his sexuality and as a result he "managed it" in a hyper-vigilant and cautious manner. This caution was heightened when he was new to his role because in his words he was "disempowered when you're the new kid and you're being scrutinised". As he had previously worked as a nurse and had been openly Gay in that role; early in his career he had been 'outed' by some colleagues and exposed to the homophobic behaviour of other paramedics. He describes this when he says:

...a couple of them [paramedics] recognised me, knew me from being a nurse, knew that I was Gay and I was given the name 'Priscilla' by my instructor. So when they required something, it was never 'Saxon', it was 'Priscilla'. Some of the paramedics did not want to have anything to do with me.

As a result of these types of remarks Saxon said he felt he was "not safe" within his work environment and thus had a different experience to his heterosexual counterparts.

As a result of being 'outed' and labelled as Gay by his colleagues, Saxon felt the pressure to prove his capabilities to other paramedics in a clinical capacity. As a former nurse, he said he was able to do this "very early when we had a complicated job in the first week and my supervisor had never done a similar job before". After "proving" himself Saxon felt that his colleagues were able to put his "sexuality aside"; however, they still referred to him by the

nickname “Priscilla”. In order to feel safe and accepted, Saxon responded to group pressure early in his career to move to work in “Poofters’ Paradise”. The term “Poofter’s Paradise” was used within Saxon’s paramedic organisation to describe a station or branch location with a large concentration of Gay and Lesbian paramedics. This was effectively a Gay ghetto. Saxon worked in this high stress high workload area for a considerable length of time where he attended “people on the edges of society” and “a lot of sex on premises venues where people do engage in risk taking type behaviours and take drugs and drop”.⁷

Working in this taxing area led Saxon to seek a reprieve. He applied for a role with a different ambulance service. Shortly after beginning as a paramedic within his new service, he applied for a management role and was successful. Saxon said it was “a merit based selection process” and he “was the successful candidate”. His selection into this role was not well received by some of the other current heterosexual male managers with whom he was working. These men “took dislike to this” appointment and got Saxon “into a corner in an open office environment”. Saxon explained what then transpired:

They placed themselves in such a position that I was backed into a corner and I couldn’t get out. It was prompted by an email that came around saying stuff along the lines of welcoming me to my new position and asking staff to support me. These people started asking me about my background and where I’d come from. It started off as an approach from that point of view and very quickly moved into an allegation that the only way that I’d actually managed to get this position was to have the boss with his pants down around his ankles. It moved on to them saying I had him with his pants down around his ankles kissing his arse. They then went on to mime me in front of a number of people kissing his arse. It went into a tirade of homophobia. They would say ‘we didn’t know he was Gay’ but I’m quite open about my sexuality at work. I have no doubt that they were unhappy about me being in that role but the first thing.... They ran around to try and dig up dirt on me. The thing is, I don’t believe my sexuality is what sparked it, but it was very quickly what they reverted to as a means to try and insult me.

As a result of this extreme homophobic bullying behaviour, Saxon felt “shameful”, “embarrassed” and “humiliated”. The incident of mimicking him had occurred in an open office “in front of a large number of people” who had failed to intervene. Saxon said he was in such a position that he could not physically escape from the perpetrators of this incident, and that he was “very lucky that there was another manager who stood up and said it was inappropriate and cleared a space for me so I could get out”.

⁷ To ‘drop’ means to collapse, usually following the self-administration of drugs.

After this the bullying did not abate. Saxon stated that these men had been working for the organisation for a longer period of time than him and as such had “a well-established support network”. Saxon felt that this “network” was closing in around him to such an extent that there was a “little vendetta against” him and “a lot of ill feeling”. And this had been confirmed through a number of sources of information within Saxon’s workplace. He dreaded going back to work on the road in his clinical role as a paramedic. He noted that other paramedics had actively conspired against him and the message to him was “wait until he’s back out on the road, [then] we’ll show him who’s boss”. Saxon had also received phone calls from people harassing him and had threatening voicemail messages left. He described his experience as “absolutely horrific”.

As a result of these incidents Saxon recognised he had the choice of putting “some really strict safety things around who I will and will not work with” or he had to elect to leave the state he was working in. He believed that if he was to return to work, there would be “fictitious complaints” and other paramedics would “try and shaft me out of my job”. The bottom line was that Saxon did not “feel safe” in his “own working environment”. Given the horrific experience noted above his feeling of being unsafe is more than understandable. Saxon had endured multiple forms of discrimination in the past and was strong and resilient, yet this incident and the colleague’s abhorrent behaviour had destroyed his confidence and sense of safety at work. After this incident he felt the only realistic option was to move to another state. Saxon stated, “...for my protection, I need to leave and to work with people I feel comfortable with”. He did not wish to spend the rest of his paramedic career “....wondering about who’s going to stick the next knife in”.

Joe – I do like him as a person

Joe’s experience of homophobia was not as overt as that described by Saxon. He was however the recipient of subtle and systematised forms of homophobic discrimination. Joe was 40 at the time of interview and he had previously worked in a number of other roles including as a nurse and a hairdresser. Joe had worked in a rural environment as a paramedic for four years at the time of interview. Joe identified as Gay and said that he thought most people he worked with knew he was Gay, although he had not made any proclamations. He said that being Gay was a private aspect of his life.

Joe experienced negative stereotypes of Gay men in his workplace. Chapter 8 will explore this theme in more depth. His story shows how the stigmatised stereotypes of Gay men in the context of workplace culture led Joe to develop a sense that it was unsafe for him to ‘be himself’ at work. This fear led Joe to take extreme measures to adjust to the way he expressed himself. Joe sent himself off to what amounted to a ‘boot camp of masculine

behaviour' due his feeling that he was not safe. He felt the need to attend football training in an attempt to adjust his personal communication style in order to 'butch up' and feel safe and accepted at work. Although this was in part a response to the workplace culture, it was also a response to some more subtle forms of discrimination and *othering* of Joe in the workplace. He had another paramedic, who was responsible for some aspects of his early training, point out to him that he was "extremely polite" and assert that at times this "politeness" detracted from Joe's "ability to be assertive on a job". As a result of this Joe felt he was "being forced to behave as someone that I wasn't". These types of criticisms gave Joe a sense that he "stuck out like a sore thumb" and as a result he "would try and not talk much". As Joe stated, this is "difficult when you are treating a patient". As a result, he tried to change the way in which he communicated.

Joe's approach to changing his communication style was ultimately ineffective, as is the case for any aversive activity that is not authentic. The impetus for his desire to change himself was to comply with the compulsory heteronormative communication style that had been 'prescribed' by one of his colleagues as *the* model of effective paramedic communication. Aspects of Joe's communication style which were inconsistent with this model had been pointed out to him as being 'flawed'. Not only did Joe start from a position of self-consciousness but when he spoke, he was criticised. Joe indicated that regardless of his style he still was exceptionally able to do his work:

I still got the job done, yes. At no point in time in any of my training reports was there ever a question about my clinical abilities or my knowledge or my professional conduct. It was all about...how I conducted myself on the job.

Joe had therefore been singled out, not due to any clinical issue or a professional performance matter, but on the basis of a stylistic difference in relation to the manner in which he chose to communicate. This personality difference had led to Joe being "performance managed" by superiors within his organisation. He said that he then "came to be scrutinised so incredibly closely that it was just a downward spiral and it just became worse". The stylistic difference in his form of communication, as perceived by his heterosexual managers, almost led to Joe losing his job. Joe could not eliminate the suspicion that the initial flagging of his communication style as "too polite" was in point of fact homophobic in nature and this was a "strong possibility". This was subtle, insidious and indirect discrimination. In contrast to Saxon's obvious homophobic bullying, this subtle form of discrimination was very difficult to make tangible and therefore was a difficult enemy to fight.

In addition, an instance of more overt homophobic behaviour was highlighted. Another paramedic had "imitated" Joe when responding in casual conversation with a "Gay

mannerism” that was modelled on Joe’s behaviour. Joe was “mortified” by this paramedic’s behaviour. He describes his response to this incident as follows:

I pulled him aside and I actually said ‘we need to have a discussion, only because I enjoy our working relationship and I want to be able to preserve our working relationship and if I don’t get this off my chest it’s going to eat away at me’. I said ‘I felt like before I was being ostracised and ridiculed because I was Gay’ and I touched upon a few experiences that I had had when I first entered this workforce and I had a really horrible time because I was Gay. I said ‘it makes me feel like crap, it makes me feel like shit, it makes me feel like a second rate citizen and I don’t appreciate it and please don’t treat me that way’. I said ‘I absolutely take ownership of the fact that obviously that is how I present but it is not deliberate and I don’t mean to act with certain mannerisms and I also believe that it wasn’t your intention to be malicious, however I felt hurt and I felt like I was being ridiculed and while it wasn’t your intention, this is my feeling’.

Joe’s response to this aggressor was brave and there were several other paramedics present who saw this exchange. Whilst they were effectively complicit in the initial behaviour, as they had not taken any action to correct it, Joe could see they were “actually quite appalled”. Joe had not expected that they would act to defend him as he believed “they thought I was grown up enough to deal with it myself”. Joe overlooked the fact that all parties to this behaviour were actually complicit and it was regrettable that Joe needed to make clear that such behaviour was unacceptable. He states his reasons for acting in this manner:

Part of my reason for actually doing this with the person who offended me was if he was not made aware of it and did it again, I feel it could actually backfire on him and that staff would actually start to turn on him for being nasty to me which I wouldn’t want to happen to him because he is a nice guy. He could actually end up with accusations of harassment or bullying. I don’t want that to be the case because I do like him as a person.

As disempowered and marginalised as Joe had been, he in reality forgave another act of violence from a colleague “because he is a nice guy”. Joe’s colleagues had in fact not been accepting of Joe with the heteronormative and homophobic behaviours they subjected him to.

Janine – The odd stupid comment

Unlike Joe, Janine felt that negative aspects of her workplace experience as a Lesbian paramedic had been restricted to “the odd stupid comment”. Janine was 32 years old at the time of interview and had worked as a paramedic for five years for the same organisation in an urban setting. She identified as Lesbian, was in a long-term relationship with her partner

and out in her workplace. Despite the manner in which she dismissed these homophobic interactions at work, Janine had been the victim of direct and indirect acts of discrimination on the basis of her sexuality.

Janine described herself as 'out' in most aspects of her work and certainly had the sense that it was safe to be out at her regular station, where there were "a few other Lesbians". She had concealed her sexuality "a couple of times" as she did not feel comfortable disclosing it to specific individuals. Some of the fear around it was not safe to disclose her sexuality had come from instances of homophobic conversation, which included "crude comments" she had "occasionally" overheard from other paramedics. These conversations included content relating to the HIV status of a Gay male colleague who was told "you'll never be able to donate blood". The rationale was that he was "a poofter".

Apart from these indirect homophobic acts Janine described what she called "a few stupid comments". She alluded to one of these comments when she remarked:

I get the odd stupid comment from a straight guy about turning me or whatever else but I haven't had anything that's been confronting for me.

Despite dismissing these comments about "turning her" into a heterosexual as isolated and "stupid" they are in fact direct acts of homophobic workplace harassment. Janine's work colleagues think it is alright to effectively say they will have sex with her to 'alter' an 'errant' choice on her behalf in terms of who she has sex with. This amounts to a form of heterogendered privilege tantamount to imperialism, in which there is some justification for making sexual advances toward a woman because in the perpetrator's mind Janine has made an invalid choice. When dismissed as flippant remarks, these more subtle attacks are again somewhat more difficult to capture and act upon than instances such as those described by Saxon. The organisation in which she works feeds the process of normalising these offensive and damaging behaviours by not acting upon them. Janine's sanctioning of these acts of violence as mere silly remarks is a reflection of this insidiousness behaviour in her workplace. Janine's story illustrates she is powerless.

Critical discussion and summary

Although these stories range in severity and style, all Gay and Lesbian paramedic participants reported instances of social exclusion and exposure to homophobic values and demeaning acts in their places of work. As these responses ranged in their levels of sensitivity and resilience, so did these responses to acts of homophobia vary. In a society or in workplace cultures that normalise compulsory heterosexuality, some of these acts were not even consciously seen as homophobic by participants or perpetrators. Some homophobic behaviour was even dismissed by Janine as mere "stupid comments". Other

instances of homophobic aggression were seen as *not* worth acting upon. The underlying belief was that to do so would be to act upon a trivial matter or interpreted as vexatious by others in the workplace. Some of the more extreme and overt instances of homophobic discrimination and bullying provide evidence that the 'old school' style of harassment of non-heterosexual people is alive and well in the context of paramedic organisations in Australia. More subtle and difficult to 'nail down' are acts of microaggression so embedded in daily interactions between paramedics, but these too are also thriving. These microaggressions (Sue 2010) or acts of 'subtle heterosexism', parallel Benokraitis's concept of "subtle sexism" (1997) and represent a new enemy for movements to address in advancing workplace equity and social inclusion. The 'underground' and subversive nature of this enemy makes it more difficult to combat.

The lack of awareness that these behaviours are demonstrable acts of aggression and violence on the part of Gay and Lesbian paramedic participants is a further justification of the significance of this research. Participants highlighted a number of instances in which they had been marginalised; however, they seemed to be either tolerant of or exhausted by interrupting those who had perpetrated such acts of violence against them. Saxon was prepared to move to another state rather than try and redress an extreme and damaging situation. Magnus was looking for another job. Joe in reality forgave acts of homophobic aggression on the basis that his colleagues were 'nice' people. Janine was prepared to tolerate sexual harassment as she viewed these as silly comments. Holley demonstrated how she tolerated isolation and *othering* and was *thankful* for receiving her *entitlements*. Latoya remained blissfully unaware of the hostile nature of sectors of her organisation in relation to non-heterosexual people and paramedics and was not bothered for "five minutes". Moving beyond behaviours and into structural and cultural factors, all participants were marginalised by constructs that made heterosexual people 'normal' and themselves 'other'.

Some positive indications of acceptance of Lesbians in the masculine culture of the paramedic workplace were provided by participants in this study. Despite this disclosure, multifaceted acts of discrimination, both subtle and overt, still perpetuate and dominate the workplace to ensure that heterosexual paramedics are privileged. The relative tolerance of Lesbians on some levels within the workplace should not be a precursor to complacency. It would be naive to allow this to lead to a perception that conditions are inclusive for minority sexual identities in the field of paramedicine. The 'underground' nature of many contemporary forms of homophobic behaviour means that equity legislation and organisational policy strategies are somewhat ineffective in their influence on workplace behaviours. The perception that paramedics in Australia operate in a workplace that is fair

and equitable is a fallacy. The fallacious nature of this belief needs to be addressed so that workplace change and education can take place to address these inequities.

As illustrated, participants' evidence indicated that a number of subtle and overt acts of homophobic discrimination and violence occurred in their places of work. These practices and behaviours commonly lead to social exclusion, marginalisation and disproportionate psychological and emotional stress for Gay and Lesbian paramedics. Failure of organisations to enforce legislative and policy structures available to combat these behaviours will continue to allow these acts to occur. This means these dangerous work practices will perpetuate, consolidate and duplicate in a fashion that is injurious to Gay and Lesbian paramedics. These matters need redressing for the women and men described above as well as all of those they interact with at work and beyond into their personal lives. Until such time as these matters are addressed, Gay and Lesbian paramedics will continue to be impacted and others with which they interact. These impacts will be explored in the next chapter.

CHAPTER 6: IMPACTS

The previous chapter aimed to provide a snapshot of the essence of the lived experiences of participants in terms of their inclusion and exclusion because of their sexuality. As previously stated in chapter 2, it has been recognised that a non-inclusive environment in a healthcare context has negative implications for the practitioner, for patients and the total workplace (British Medical Association 2005). Despite the potential benefits of inclusion of diverse groups within workplaces, participants in this research are excluded and marginalised because of the tacit and overt privileging of predominant heteronormative structures and practices. Whether the forces of exclusion operate in a direct or indirect manner, these complex matrices of exclusion will be shown to have a negative and destructive impact across personal and professional levels.

The goal of this chapter is to focus on the various impacts of participant experiences of existing practices within paramedic workplaces. In workplaces with institutionalised cultural practices which act as forces of exclusion, several negative consequences are set in train. Oppressive practices of exclusion are multifaceted, yet lived out daily in the lives of these Gay or Lesbian paramedics. They are people who share interpersonal relationships, interact and work in paramedic organisations, with patients and the wider community. Hence the following exploration addresses these impacts and is divided into four areas: personal, interpersonal, organisational and community impacts.

While it is not possible to explore the entire scope of the impact of social exclusion, the aim here is to give a 'snapshot' of the impact on participants as well as that felt beyond these individuals. Serious personal damage is caused to individual Gay and Lesbian paramedics by structures and practices which continue to silence, exclude and marginalise them. The impact on these individuals correlates with established evidence that members of stigmatised groups, including Gay and Lesbian people, are at increased risk of health problems (Hatzenbuehler et al. 2009, p. 1316; Newcomb & Mustanski 2010, p. 1019). These mental health burdens are disproportionate to those of heterosexual people (Hatzenbuehler 2009, p. 708), who do not experience many of the encounters noted earlier and in the forthcoming discussion.

Furthermore, practices of social exclusion affect close interpersonal relationships in the workplace. There is also direct impact on paramedic organisations and on the provision of optimal primary healthcare to the community. Healthcare in a diverse community should

utilise the skills, knowledge and capacities of its human resources to provide relevant and effective intervention to provide optimal levels of holistic care to the community.

Chapter 12 extends this discussion, focusing on the potential benefits of inclusive practices, and will demonstrate that failure to lift the veil of enforced silence around Gay and Lesbian paramedics in Australia perpetuates a culture does not capitalise on the positive capacity of this diverse group.

Intrapersonal

As considered in the preceding chapter, participants described a range of ways in which they were treated as 'other' within their places of work. These experiences were the product of some of the cultural constructs – the essentialised heteronormative practices and systemic structures that lead to bullying and discrimination in various forms within their individual work contexts. These experiences were detrimental to the wellness, psychological and emotional health of individual participants.

The response of many Gay and Lesbian paramedics to hostility and exclusion within their places of work was to remain in the closet. This response will be further addressed in chapter 7, but as Saxon related, it can lead to a complete suppression of sexuality. Saxon stated, "I've seen a number of paramedics who are not out and who have tried to live the straight lifestyle and are blokey-blokey and with the alpha male type groups, how unhappy they are...deeply unhappy and they are shitty, they don't want to be at work because they are not being authentic in their own life". He believed that this unhappiness "carries through into their job as well" and contributed to "inner turmoil about not being authentic". Saxon gave a specific example of a Gay colleague who was suppressing his sexuality, largely because it was not acceptable to be a Gay paramedic within his workplace. He saw this suppression manifest "in a really unhealthy way". This "particular guy who was a paramedic was dating one of the local [female] nurses but he was Gay". Saxon stated that this paramedic started "engaging in behaviours like doing shifts at the Poofers' Paradise and he started making out with one of the Gay guys when there was no one else around, but still had this whole thing of having this girlfriend and this turmoil, and it was backwards and forwards for him". Saxon held that this paramedic "ended up assaulting someone in the end because he was such an angry person".

Magnus stated the marginalisation he experienced in his workplace "definitely affects me". He added "it affected me when I originally started in my original service" and that it had impact 10 years on. At this point Magnus had "kind of kept it to myself until I felt comfortable

with the people I was working with". Despite the fact that Magnus was more open about his sexuality at the time of interview, he still felt that "the subtle stuff kind of makes you keep things to yourself a little bit more" and that he still would "certainly consider every time you come out to somebody at work, you make a conscious decision about whether you are going to do that". This meant that he still carried the burden of a "constant, conscious filtering of what you are telling people". Magnus stated that for him, this was a manifestation of "the last little internalised homophobia that I have". He added "you kind of feel a bit ashamed of yourself that you don't have that confidence to say, 'you know what, fuck you, this is who I am, it's perfectly normal'. But the fact that I am conscious about it is kind of frustrating". Magnus concluded his interview by saying the impact for him personally was that "from a long-term perspective that [behaviour] almost kind of nibbles away at people". This was his "last little issue to do with being Gay and coming out". Magnus stated "I can't see us being completely normalised within my generation" meaning he felt he would never be seen by society as being 'normal' as a Gay man. Magnus compared this interaction to the unchallenged relative comfort of a heterosexual paramedic in the same context, and he went on to state that "if you're a straight person with a family there's absolutely no filtering". He reminds us that heterosexuals do not have to create a fraudulent response and make up stories in response to patients' questions. It is clear that Magnus was conscious of the impact this filtering has had on his mental health. He acknowledged, "...to me the only healthy option is when you can honestly come out to anybody in any situation and not have to filter yourself and not even be aware that you didn't filter yourself". He indicated he did not feel he was able to choose such a healthy option in his role as a paramedic.

Jacob carried the psychological burden that he could not "100 percent relax at times" and that he felt he needed to "put on a front". He went on to explain an instance where he felt he had to misrepresent himself to be accepted and maintain the privacy of his sexual identity within the workplace. Jacob made the following statement in relation to a situation where some fellow male paramedics had been commenting on some women in a sexual capacity:

...if someone's sort of talking about females walking down the street you sort of have to [say] 'I agree' and don't say anything more and just sort of leave it as that. You leave it fairly open and don't say, 'No – I'm into guys'.

His sense of safety at work was dependent on his ability to keep his sexuality a secret and he noted that this sense of safety "...might change if you came out", feeling this would potentially lead to being "talked about and then maybe bullied". He was aware that in the longer term this would potentially affect him and "would affect the mental side" of his wellbeing.

The psychological impact of her exclusion in the workplace also impacted Michelle's sense of comfort. She reported that for her it was "frustrating having to constantly sort of sidestep things" in relation to many aspects of her personal life. To do otherwise would make her sexuality perceptible to colleagues. As a result, Michelle was "constantly conscious" of *all* of her actions in the workplace as they related to potentially revealing her sexual identity. Michelle stated in interview that concealing her sexuality had not been "long term enough for it to have had an impact"; however, she felt it was foreseeable that continued suppression would have a deep-rooted impact on her psychological wellbeing, if she continued to maintain such a facade for much longer. She stated "I think if I had to stay in the closet for like years, I'd go bananas".

Joe's attempt to change how he was perceived by others illustrates the motivation for change can be out of the need to be accepted by others in the workplace and thereby be seen to "blend" in. He was attempting to live a mistruth by behaving in the same manner as his heterosexual colleagues who blend effortlessly into the culture of the workplace. He illustrated he had undertaken a number of 'aversive' activities which he felt would expose him to "a real blokey kind of environment" and take him outside his "comfort zone" including enlisting in the army reserve and joining in football training. Joe thought that by undertaking these activities he would be able to "toughen...up". He recognised the "massive effort" he had undertaken in engaging in these sorts of behaviours when he exclaimed "imagine going to that extent! I think that's a pretty massive effort, to want to put yourself outside of your comfort zone that much." Joe's desire to "blend" and "to conform" in order to be accepted within his workplace were aggravated by the sense of isolation he had felt. He explains the ordeal he underwent at the time:

It was traumatic. I mean I moved to the country for the job. It's not like I could go and talk to people. You could phone them, like I could phone my family and stuff but there were times that I felt like I was without support. That was horrible, mentally and emotionally.

This disturbing experience of trying to fit in strongly impacted Joe's mental and emotional wellbeing. Joe stated that his objective in undertaking these activities was they would "get me using my voice". Joe however had been using his voice. The characteristics of Joe's spoken voice had been aligned by Joe's colleagues to the stereotype of a Gay man. In order to avoid being identified as a Gay man, Joe had been trying to modify his voice tone, range and style to the more 'acceptable' and less 'Gay' tone in order to fit in. The psychological trauma associated with this unfavourable intervention was too great for him. In addition to the psychological trauma he experienced out of his attempts to change his natural way of being, Joe had experienced insecurity in his job which had distressed him emotionally. This insecurity was directly related to views expressed by colleagues that Joe was not a good 'fit'

for the role of a paramedic. Although it was never overtly stated, Joe suspected this belief that he was a poor 'fit' was related to flawed conclusions colleagues had come to in relation to his sexuality. That is, as a Gay paramedic he was by definition unable to perform the work adequately. In one of the discussions he had with a paramedic who was training him in relation to his appropriateness for the role, Joe said "I remember just tears streaming down my face and he wouldn't know about it because it was dark".

Calliope was "not 100 percent" comfortable in situations where inquiries from patients in relation to her personal life and her sexually identity came up. Discussions which centred on her personal life and sexuality made her feel "a bit restless and a bit hot and bothered". Although she considered herself to be an out Lesbian she was unable to explain why she felt a level of psychological discomfort on occasion at work. This was clear when she stated "you feel like you take a little bit away of yourself just for your workplace" and "you feel like you have to edit your personal life and who you really are". Experiences of recurrent discomfort were a burden that Calliope felt she had to carry. The burden of these repeated interpersonal inauthentic exchanges that gave rise to these feelings of discomfort impacted Calliope's ability to be authentic in the workplace and caused her some psychological discomfort. The concept of authenticity will be further addressed in chapter 7.

Mack also felt that his experience of exclusion in his workplace had impacted his mental health. He said at the height of his bullying experiences he "certainly wasn't healthy" and that this led to "a lot of sick leave in that couple of years". He had been drinking a lot to cope with the ordeal in his workplace and a lot of his sick leave was "hung over" and some of this leave was also associated with the feelings that he could not "face working with whoever [he had] been rostered with". Mack states "I think that my mental wellness, my mental health is far better these days than it used to be". The link between increased alcohol consumption and internalised homophobia has been previously documented (Fish 2006, p. 5). It is clear that the bullying negatively impacted his mental health.

Interpersonal

Beyond the intrapersonal impacts felt by the participants in this study, their experiences of exclusion and *othering* in the workplace had an effect on those people with whom they shared close relationships. This meant that the impact of those practices that exclude workers was felt by other people including the paramedics' partners, close friends and significant others as well as workplace colleagues. This ripple effect is a further negative aspect of the realities of compulsory heteronormative structures and practices. These

interpersonal encounters provide evidence that heteronormative practices lead to not only the exclusion of Gay and Lesbian paramedics but impact all people (Blumenfeld 2001).

Mack spoke of the manner in which his treatment at work caused him to isolate himself from those close to him. He said, "I think I isolated myself more and more...I felt more removed.... I did sort of isolate myself from family a lot more..." For Mack this experience was intensified by his coping behaviour of drinking to deal with what he was experiencing in the workplace. Mack's subsequent self-identification as an alcoholic meant his drinking at the time further isolated him from family. He believed his workplace experiences "accelerated the problem" of his illness. He stated "I don't think I would have 'peaked' as early" in terms of his drinking if it were not for his treatment in the workplace. He also believed this would not have impacted his family relationships at the time.

Mack's experience of being the prey of another paramedic's bullying also meant he felt he was unable to work with this individual at all. When reporting for a shift on one occasion he told his manager "...you move me or I'm going home because I'm not working with that cunt". In a follow-up discussion with the manager Mack was told, "we can't have people...not working with people because they don't like [them]". Mack pointed out at this point that "people who hate each other cannot work well together". Allowing bullying practices and unquestioned discriminatory arrangements to dominate the workplace allows this cycle of animosity to continue. In addition to his direct refusal to work with certain individuals, Mack stated that his perception of his difference was such that he would sometimes withdraw and not "necessarily involve myself in all the 'social side' of ambulance". This signified that he did not take place in the one dimension of work life that is necessary for close working relationships, that is, the formation of 'bonding' relationships. This is a taken for granted activity for his heterosexual colleagues. Holley also indicated she withdrew from some social contacts at work as she "started to get sick of" her colleagues' "raised eyebrows" and she did not want to openly discuss her sexuality. Her response was to withdraw from several important workplace encounters that build relationships and strengthen notions of workplace being and belonging.

Isolation from support structures and damage to important close relationships was also reported by Saxon. He stated, "I've got a decent support structure.... But, for quite some time I was pushing them away because I was so angry and I didn't want to talk about any of it". Saxon said his interpersonal relationships were strained at the time because "People would ask me [about my sexuality] and I was exceptionally irritable". This destructive irritability at the time was attributed to "psychological trauma" of the workplace experience. This trauma had originally manifested in Saxon as diagnosed "depression and anxiety". He added, "I went

and saw a psychologist and they said it's *just* psychological trauma, you'll be right and we'll get you through this, package it all up and leave it behind".

Magnus pointed out that the attitudes to other Gay and Lesbian people he had been exposed to in his place of work meant he was 'careful' about opening up to people in general. He said, "every time you work with someone new, you're always a little bit tentative". The subsequent damage to his relationships with colleagues was that he felt his evasion of personal intimacy held him "back a little" in developing essential key working relationships with colleagues. Magnus said this was because "I know that my normality is not necessarily their normality and can sometimes make things uncomfortable at least until we've developed a rapport or relationship with the person I'm working with".

The "boys club" mentality in Janine's workplace meant a failure to recognise the presence of Gay and Lesbian paramedics. Janine felt there was a view from her management "clique" that "there are no Gay and Lesbian workers" in the workplace. Whilst she was recognised as a Lesbian by a number of her colleagues on a local level, this invisibility at the organisational level meant she was excluded from forming some key relationships. These relationships were with members of the group critical to her success should she wish to enter the "management circle" that was dependent on the "buddy sort of management system going on there". She felt her sexuality would not be accepted by this group and hence she had not pursued any such professional relationships.

Joe pointed out that his ability to form key supportive workplace relationships had been affected by the views others had of his sexuality. Joe stated that "the perfect point of acceptance is heterosexual male or female" and that in his context he did not feel he formed the same quality of relationships at work as did his heterosexual colleagues. Even when some colleagues had expressed "we don't give a shit what you are" this acceptance had been, in his estimation, conditional. The condition placed on this was "you can be Gay, that's fine, just don't crack onto me or anything". This conditional acceptance continued to have an impact upon his ability to form healthy and functional work relationships. This is something heterosexual people hardly ever experience. Joe also referred to the previously mentioned offensive incident in which he was subjected to a colleague mimicking his stereotypically 'Gay' mannerisms in front of him and some other paramedics. Joe emphasised the impact that this act of aggression had on the other paramedics who witnessed the incident. He maintained that the "others actually saw his response to me and they were actually quite appalled". And he added that this encounter had ramifications in terms of the sense of camaraderie and support in his work environment.

Organisational

The impact of behaviour that excludes minority groups of workers is wide ranging. As indicated in the literature review chapter; equity legislation and policies of social inclusion have in part evolved from a human rights perspective with an aim of improving the experiences of individuals in marginalised groups. These legislative changes have also evolved in recognition of the reality that failure to capitalise on diversity in the workforce is failure to capitalise on the skills of its human resources (Kormanik 2009). Failure to protect the rights of minority groups leads to conflict and costly processes of resolution required to resolve such conflicts. This 'wastage' equates to organisational inefficiency. The lack of attention paid to these behaviours is a risk in terms of organisational functions and objectives. As demonstrated in this study, several Gay and Lesbian paramedics identified that their careers were limited as a result of their sexuality. This meant several intended to look for other work, or did not intend to pursue opportunities for promotion and advancement within their workplaces. Such attrition within organisations detracts from their ability to build capital associated with experience. Taking a purely clinical focus, in paramedic organisations, such capital is represented by the clinical experience of paramedics. A lower aggregation of this skill can mean a lower level of healthcare for the wider community.

Several Gay and Lesbian participants expressed ambivalence towards advancement in their career or the desire to look for alternative employment in another field. Saxon's experience of having been employed in a management role and bullied in that role meant he felt "shameful" and "embarrassed" on reflecting upon the context of the initial attack upon him. He was "absolutely humiliated in front of a large number of people". As a result he stepped out of his management role and back into an on-road paramedic position. Thereafter, even having reverted to a different position, he felt there was "a little vendetta" against him and "a lot of ill feeling". Because of the resulting anxiety and fear that was present at work and at home, he made a decision that "for my protection" he would leave the state in which he worked. On recounting his experience, he said "I'll be leaving it at the border as I drive away".

Mack felt the experience of bullying led him to develop confidence issues and this meant he would often be "second guessing" himself. This lack of confidence meant that he did not have what he saw as the "aggressive" nature needed to succeed as a paramedic. He noted that, as a result, he "wouldn't want to be in a managerial position". Mack referred to this as a "self-generated lack of confidence, lack of esteem thing" and felt that it was a manifestation of both his upbringing where he got "that whole lack of self-esteem purely by being Gay in the first place" combined with damaging workplace experiences as a Gay paramedic. Mack specified "the negative experience that I had in some ways reinforced my negative view of myself at the time". As a result of these encounters he had let go of any ambition to progress

in his career. Mack's perception was it's "something that's sort of stuck in my head that I can't really get anywhere as a Gay man in this service, so why try?" He added "I now have a fairly low profile" and this was because he did not want to be "held up as a target". This had prompted in him a desire to "stay under the radar". He said that as a Gay paramedic "we already have a bit of a higher profile being...a minority" and Mack did not want to become more prominent by taking on leadership roles.

In a similar self-limiting manner, Magnus had let go of aspirations to progress as a paramedic. He stated "I used to have a lot more aspirations than what I do now". Despite the fact there were opportunities for advancement within his service and while he may have thought "I'd be interested in that" in the earlier stages of his career, Magnus now stated:

...you kind of look at the people you'd be working with and me... whether I'm right or wrong, the perception I have of it is that I would not fit in at all. Because I wouldn't be one of 'the boys' so to speak.

For Magnus, this sense of not belonging was palpable, "even with the upper echelons of management and climbing the ladder". He did not feel he fitted into the management culture either. As a result, Magnus had made the decision not to pursue avenues of career progression and to look for work outside paramedicine.

Latoya considered, in terms of her career progression, "there's nowhere to go anyway...no progression". Opportunities that were available within her workplace had not even been a viable consideration. She added, "I don't think it is to do with me being Gay", yet others in her workplace with similar skillsets and experience were pursuing these lines of opportunity. She however had closed herself off to these career prospects.

Joe also did not believe that he fitted the 'mould' required of him to work as a manager in his organisation. He revealed, "thinking hypothetically" that he would not "fit the norm of what they would maybe want" and therefore this was not a career opportunity he felt would be open to him. Jacob's view conflicted with that of Joe's in that he thought if he were to "do an education or instruction role or go and do intensive care level training or management" he would not see his sexuality as being an issue. Jacob did however feel insecure in general in the workplace due to his sexuality. As stated in chapter 5, he was concerned about the potential impact of his sexuality on the longevity and stability of his career.

Patient care

The most discernible effect of marginalisation in the workplace is unhappiness. This unhappiness and pessimism can be career limiting, as described in the preceding section of

this chapter. In addition, some of the Gay and Lesbian paramedic participants described feeling uncomfortable in their places of work for a variety of reasons. One reason was the need to manage their sexuality in the workplace (a burdensome process elaborated on in chapter 7 as *closet fatigue*). When a worker is experiencing these types of stressors, they are limited in their capacity to effectively perform their role. The role of a paramedic is to provide care to members of the community. Where the capacity to provide such care is limited, the flow on effect is to provide suboptimal, acute healthcare to consumers of paramedic services. Several participants provided evidence of how such limitations on interaction with patients (e.g. limitations in clinical expertise due to increased attrition and silences in interactions with patients and colleagues) impacted on their capacity for providing quality patient care.

Joe described an interaction with a patient in his care and how their perceptions of him as a Gay man meant he felt limited in his capacity to provide optimal care. He stated that “because of how she [the patient] was perceiving me.... I wasn’t going to be able to conduct the clinical assessments in such a way that would be of benefit”. He stated “I wasn’t actually...able to do my job, simply because she was focused on me and trying to find out about my sexuality, rather than me trying to find out her chief complaint”. This experience led him to feel uncertain about future positive interactions with other patients. Joe began to think that other people’s perceptions of his sexuality were “going to impact” on his “ability to treat people”. Joe believed that “Lesbian and Gay paramedics have a harder time” and this meant, in some instances, they were inhibited in their ability to provide optimal care to patients. He felt at times that he was “forced to behave as someone that [he] wasn’t” and this greatly impacted on his provision of care. Joe added “there are still small instances where I will be scared to speak just because of the sound of my voice and how I’m perceived”. He had clearly held back somewhat in his interactions with some patients. He stated that he was “still a little bit apprehensive that one day I might just get that odd patient that might say, ‘fucking poofter, I don’t want you dealing with me’”. And this apprehension had on occasion impacted on his interaction with patients and the care he was able to provide. Joe’s fear was particularly strong when “dealing with kids”, despite his belief that he was able to establish an “excellent rapport” with them. He stated “sometimes I feel like if I am dealing with kids and their parents are nearby, I’m scared that people might think they don’t want a ‘poofter’ treating their kids because ‘all poofsters are paedophiles’”. Joe added that this was “a horrible thought and it really is disturbing”; but this thought led to him holding back somewhat in terms of the care he provided when working with paediatric patients.

The impact on patients of choosing to remain in the closet was also addressed by Jacob. As he did not wish to be identified as Gay in the workplace due to his fear; Jacob was very

careful in his interactions with patients. He stated that if he was to encounter a patient who was “another Gay or Lesbian” or “suspected” that he was Gay, then it would “make it a little bit more difficult” for him to maintain his silence around his sexuality. In this instance, Jacob said he would “maybe not be asking them as many questions or trying to interact with them as much...as I would other patients”. This was due to Jacob’s “fear that they might make a comment” that related to Jacob’s sexuality and that his paramedic “partner would hear it”. Because of this fear Jacob said, “...maybe I wouldn’t do a full examination of their history” when dealing with a Gay or Lesbian patient. Sadly, failure to perform such an examination could lead to poorer patient outcomes. This also meant that potentially an inferior quality of care would be provided to Gay and Lesbian patients than to heterosexual patients by Jacob.

In a similar sense to Jacob, Calliope described feelings of discomfort when attending to Gay or Lesbian patients. She stated “Sometimes I find it conflicting when you know that your patient’s Gay for whatever reason, their partner’s there or whatever”. She described this feeling of conflict as her “one little wall”. Although Calliope did not state, as Jacob did, that this meant there were aspects of a patient clinical examination that she did not perform as thoroughly, she instead described feeling discomfort when interacting with a Gay or Lesbian patient. It is possible that this discomfort could lead to a lesser quality of care being provided to this group. Calliope could potentially treat Gay and Lesbian patients differently to others in terms of the quality of care provided, due to her “one little wall”.

Magnus felt that on occasion his sexual identity and the lack of acceptance of this identity within his workplace had led to a lessening in the quality of patient care. Magnus said that although he felt this certainly did not impact in a direct sense on the purely clinical procedures he underwent with his patients; his self-editing and trepidation around some patients meant that he was sometimes limited in his ability to establish a rapport and this further inhibited his ability “in relaxing someone, calming someone”, which he felt was clinically important and could “help in certain situations”. Magnus went on to state “...I think we’re [Gay and Lesbian people] probably good at working out other ways” of relating to people and that this potentially bridged the gap with some patients. Nonetheless, in these instances the lack of acceptance of his sexuality within his workplace meant that on occasion sub-optimal care may be received by some patients. The paramedic is required to employ strategies aimed at establishing the rapport required to ensure high quality clinical care. In Magnus’s case the inverse was noted.

Latoya’s experience was similar to Magnus’s. She, on occasion was inhibited in her ability to establish a rapport with patients. This was because of the attitudes of those around her and their non-acceptance of her sexuality. When discussing the process of establishing rapport

she observed that her heterosexual colleagues were able to move “straight onto an area of building rapport, straight onto kids, whatever and it all moves on to something else....” when they were caring for a patient. She felt she was not as capable of doing so, as “if we are talking about our same sex partner, you can feel it in the air, a certain.... I don’t know”. Latoya felt that this sense “in the air” meant there were some limitations in her ability to establish a sound therapeutic relationship with a patient and therefore provide optimal care.

Saxon pointed out that “In some ways” being part of a sexual minority “works against us”. Saxon stated that one of his Gay paramedic colleagues, in particular, had “more than anyone else” come up against instances of “heterosexual homophobic behaviour from patients” who had said “...‘I’m not being treated by a faggot’”. It is obvious that this sort of direct aggression from patients limits the ability of a paramedic to do their job in terms of providing clinical care to such a patient and damages the sense of self-worth the paramedic may have.

Critical discussion and summary

It is a commonly held perception that Australian contemporary society is egalitarian and inclusive. These views are the product of greater visibility of elements of Gay and Lesbian sexuality. It is possible, however, that with this perceived increased tolerance and visibility, homophobic behaviour has indeed become more subtle in nature (Newcomb & Mustanski 2010, p. 1027). This situation is unacceptable. Due to the absence of a supportive work environment and in the context of a community culture that does not support Gay and Lesbian people, participants in this research were forced to remain silent when their sexuality was on the agenda. In some instances the participants suppressed elements of their self-expression for fear of the consequences of being open or ‘out’. This editing and self-silencing is further explored in chapter 7 and will be shown to have serious impacts on these paramedics as individuals. The practice of Gay and Lesbian paramedics concealing stigmatised identity attributes requires the conscious act of suppression of emotions (Hatzenbuehler et al. 2009, p. 1317). Rumination and suppression of emotions in this manner are risk factors for mental health problems (Hatzenbuehler et al. 2009, p. 1319). This suppression, often also linked to internalised homophobia was disclosed by several of the participants in this study. Internalised homophobia has been incontestably linked to poor mental and physical health (Newcomb & Mustanski 2010, p. 1019). The ‘subtle’ nature of ‘modern’ homophobia is no less detrimental in its effects on the mental health of those who are victim to it (Newcomb & Mustanski 2010, p. 1027). In the context of an industry with a disproportionate burden of mental health issues and physical injuries (Maguire et al. 2014), this additional element of internalised homophobia impacts on the wellbeing of Gay and

Lesbian paramedics. Beyond the individual, poor mental health has the potential to impact on others with which the paramedic needs to interact.

Gay and Lesbian paramedics in this research have recounted experiences in their workplaces tantamount to exploitation and dehumanisation. The reality is that at present, explicit policy measures are in place aimed at ensuring equity; yet, more covert, subtle and insidious behaviours and practices within the workplace and the community can undermine the effectiveness of these policy and legislative measures. As such the effective marginalisation and *othering* of Gay and Lesbian paramedics has wide-ranging negative ramifications. These impacts are felt not only on an individual level by participants in this research, but by individuals with whom they share close professional and personal relationships. On this interpersonal level such individuals include friends, family, partners and significant others, paramedic colleagues and of course their patients. This experience has a great cost in terms of organisational failure to capitalise on these men and women as human resources. These acts of marginalisation can also lead to workforce attrition. Homophobia also has cost to the community in terms of optimal provision of clinical care.

The next chapter of this thesis explores in more detail the concept of identity and its importance. It looks at the individual need to express a whole and authentic identity. This sense of individuality can be compromised within the context of a workplace that fosters a culture of conformity. Chapter 8 extends understandings of paramedic culture previously addressed in the literature review, from the point of view of the lived experiences of Gay and Lesbian paramedic participants. I hold that it is this tension of needing to conform to perform that is central to the marginalisation of Gay and Lesbian paramedics.

CHAPTER 7: IDENTITY AND CLOSET FATIGUE

The previous chapter focused on the impact of homophobic experiences on Gay and Lesbian paramedic participants in this research at intrapersonal, interpersonal and organisational levels. The remaining chapters are devoted to analysis of the data with the aim of addressing *why* participants have experienced the situations they recount, by exploring more fully the theme of identity and its importance in the context of the workplace. Here I consider the concept of identity, its elements and its importance to individuals. As this research is contextualised in the workplace culture of paramedicine and focuses on Gay and Lesbian people who work in this environment; the main attributes of identity considered in this chapter relate specifically to professional, gender and sexual identity. The importance of the distinctiveness of participants in this study is considered in terms of self-identity and group identity. Chapter 8 examines the collective character of the workplace and taken-for-granted assumptions of what professional identity ought to look and feel like. As will be seen, some disharmonies exist and can potentially be explained by the tension between individual ways of being and collective ways of thinking. It will be shown that these incompatibilities have the potential to negatively impact both individuals and institutional workplace structures.

The aforementioned tensions are in part explicable by exploring the ways in which identity is socially defined. As such, some of the categories of human identity (as described here) are inextricably tied to the concepts of stigma, stereotyping and negative discourse. As a result these concepts are given further consideration. The concept and process of 'coming out' are also reintroduced alongside stigma, negative stereotyping and negative discourse. Preceding exploration of these concepts however, some consideration must be given to the nature of identity itself.

Identity and its importance

In the context of this research, some examples of the tension between wanting to fit in as a member of a group with a shared identity and having characteristics incompatible with this identity were evident. Two participants, Joe and Saxon, are men that demonstrate reasons why they felt they did not belong in their workplaces. Joe discussed one of the problems he had early in his career with aspects of his identity being inconsistent with the dominant identity attributes of the other paramedics he worked with. He referred to the 'blokey' culture of paramedics and felt he "stuck out like a sore thumb". Despite his inherent desire to fit in, his lack of 'blokeiness' and the acceptance of an unquestioned hegemonic masculinity meant that he felt as though he did not belong. This had an impact not only on him but also on his ability to interact with patients. He stated:

*...because I was so conscious about my speech I would try and not talk much....
which is difficult when you are treating a patient.*

Similarly Saxon highlighted the importance of his desire to assimilate when he alluded to how he compromised his identity in order to connect with his colleagues. Saxon discussed how he actually invented a persona, stating he “adopted the mentality of the people I was working with so I would fit in”. Saxon asserted that a major reason why he took on this persona from the early stages of his career as a paramedic was so he could endure those around him. His identity as a ‘junior’ in his role also contributed to this choice to adopt some of the attitudinal features of the paramedics around him.

In effect, Saxon felt that it was easier to compromise his rightful identity, inclusive of his sexuality, so as to build a connection with those around him. This was evident when he stated, “When you’re in that very junior type role you just stand back because it’s easier”. In the initial stages of forming a professional identity, those newer to a role may choose to adopt attributes and behaviours they perceive to be accepted by the more established members of a group in order to feel accepted. This can sometimes mean that they will hide or downplay aspects of their authentic identity that they feel may be incongruent with those acceptable to the established group.

Personal and social identity

Construction of identity is an ongoing process and involves continuous renegotiation (Willis, & Elmer 2011, p. 61). Some identity attributes are more fluid than other traits, which are more concrete and inalienable as they are a person’s core sense of his or her self. These more concrete or essential aspects of identity may be more strongly defined as attributes assigned by the individual. Shared socially constructed identity factors may be more fluid and may change, depending on the context and the social group in which the person is immersed at a particular time. As such, the personal identity of an individual can adapt to accommodate another identity trait in a new social circumstance. This happens whilst maintaining the more concrete, core and fundamental qualities of the personality. This process of acculturation is the “modification, adoption or accommodation of attitudes, values and behaviours as a result of becoming part of, a different cultural setting” (Willis & Elmer 2011, p. 157). This is aligned to the process of ‘selfing’ as previously mentioned in the literature review chapter of this thesis. Saxon’s experience provides a good example. He describes this as being the manner in which he adopts the attitudes of others around him for the purpose of *passing*.⁸ His stipulation that this was “for a while” is an indicator that his core individual attributes

⁸ ‘Passing’ refers to presenting oneself as having a particular sexual identity. Usually refers to a Gay or Lesbian person as presenting themselves to the world as a heterosexual person.

remained fixed, but hidden, for the purpose of wanting to fit in and be seen to adopt the group mentality of his workplace.

This process of acculturation can appear to be 'seamless' where there is compatibility between personal identity attributes and the favourable identity characteristics of the social group into which one is seeking to acculturate. Where such resonance does not exist, this can lead to compromise and/or conflict. Such compromises and conflicts are both internal and external for the individual. In the context of this research the acculturation process of a paramedic, working to serve the community, means there is an inextricable link between workplace and community acculturation. Joe's narrative provides a good example of the link between community and professional identity as seen when he discussed his need to project an image of being "an upstanding member of the community" who is making "a really positive contribution". It is important for him to fit in as "the local ambo".

Joe's acculturation in the workplace as a paramedic, as any other workplace, is simultaneously global and local. Paramedics work both within a small local team to attend to the needs of the local community and they are sometimes public identities within these communities. They also work within the context of a larger organisation which serves the needs of a broader community. As this workplace is linked with and embedded in a broader social structure, where inequality covertly and overtly exists it is important to note that workplaces do not produce a sense of inequality in isolation (Acker 2011, p. 70). A workplace can simultaneously be a place that reflects the values of the community around it and a manifestation of cultural values specific to it. Acculturation of the individual can be dependent on integration of their personal identity into the social identity favoured and privileged by the workplace culture. Saxon's willingness to adopt the demeanour and attitude of those around him, as well as not disclosing his sexuality, demonstrates the power of his desire to acculturate.

Where aspects of one's personal identity do not fit with the favoured and preferred social identity within the workplace, the process of acculturation can be problematic. Depending on identity attributes that underlie this dissonance; some conscious decisions may need to be made as to whether to 'hide' such a characteristic, where possible, or risk social exclusion. Such social exclusion in turn has the potential to critically impact the individual's self-esteem, psychological wellness and identity.

Holley discussed identity within the workplace and the advantages of fitting in or belonging. She expressed this by saying that "each roster group carries an identity and you have to fit in". Her beliefs around this compulsion are illustrated when she said "these are the people

that you will work with for the rest of your career". She added that the need to fit in was intrinsically linked to her experience in the workplace in terms of the types of locations she would be selected to work at. Her ability to fit in would impact on who she would be rostered to work with and what roles she would be selected to perform. One of the factors used as part of the selection criteria was what Holley referred to as "mini mafias". These groups had an informal control over some aspects of organising the workplace in terms of inclusion in particular rosters, work locations and social groups. Sexuality was used by these "mini mafias" as a criterion of acceptance or non-acceptance, whereby heterosexual people were strongly favoured over those with other sexualities.

Holley's desire to fit in with those around her demonstrates that feeling valued and accepted in the workplace can contribute positively to a person's sense of self-worth. Feeling that your authentic identity is accepted socially means that a person does not have to manage or filter aspects of his or her identity to integrate with identity labels favoured by the dominant workplace culture. Joe had previously worked as both a hairdresser and a nurse and his identity as a Gay male was embraced as 'normal' in both roles. It is possible that this acceptance was a result of perceptions that his sexuality made him more 'feminine' and this resonated better with roles traditionally seen as feminine ones. Joe referred to the sense of safety he felt when his personal identity was supported within those two workplaces. He stated, "they just loved me" and "in that environment I felt safe". Joe's feelings of safety and authenticity in his workplace in previous roles seemed to contribute to his wellbeing as an individual and arguably allowed him to perform his role effectively. This was not the case for him in his current role as a paramedic, where he felt the need to manufacture an identity in order to feel accepted.

Occupation is an indicator of status, social standing or value in society and may result in improved access to resources as well as social networks (Parry & Willis 2009, p. 94). The resultant desire to fit within an occupational group is driven by individual desires to be accepted within that specific group. This leads to an increased sense of self-worth and impacts on how an individual may be regarded by the broader community. As paramedics are often drawn to the occupation through a desire to assist others, this recognition of their role and importance in society is significant. Their role is an indicator of status in the broader community. The desire of many of the participants of this study to fit in to the workplace culture can also be linked to a broader desire for community recognition, as noted by Joe's desire to make "a positive contribution" as the "local ambo".

A socially inclusive society is one where all people feel valued, have their differences respected and their basic needs met, so they can live with dignity (Keleher 2011, p. 194).

Fundamental to this sense of inclusion is acceptance of identity, both individually ascribed and socially prescribed. Paramedics are visible figures within the community and they are often driven by a need to serve members of the community. As such, feeling a sense of acceptance into this broader community is important. As the public identity for a paramedic is fairly visible and intrinsically linked to the 'betterment' of the surrounding community, an extra pressure can sometimes be felt, that is, to be accepted in the community and the workplace.

There is no more visible embodiment of the 'publicness' of paramedicine as an occupation than the wearing of the uniform. Wearing a uniform can add pressure to perform in a particular 'organisationally endorsed' way, especially whilst in the public eye. Joe added he felt the pressure to behave in a consistent way that was 'acceptable' as a paramedic, even when he was *not* wearing the uniform. According to Joe, even without the uniform he was still a public figure and as such, needed to behave in a way that was consistent with the values enforced by his profession. He observed that constant public scrutiny was a conscious burden for him. His sense was that being Gay was not supported by the organisation. This meant that at all times when in the public eye, he felt the need to be vigilant and hide his sexual identity.

Visible and invisible attributes

It can be seen as both fortuitous and problematic that sexuality is essentially an invisible identity attribute. In contrast to visible attributes, choice plays a part in an individual's decision to disclose an invisible attribute which may be stigmatised socially (Chobrot-Mason, Button & DiClementi 2001, p. 322). As a result, individual choices not to disclose information relating to an invisible identity attribute can potentially avoid the marginalisation, social exclusion and discrimination that may result. This stealth-like ability can be seen as a more desirable outcome than what is associated with having a visible identity attribute. It can also be viewed as being more problematic in that choices to actively conceal such identity attributes can perpetuate 'silence' and lead to a sense of vulnerability. There is also failure to resolve unfair or unjust social practices and values because of the hidden attribute. Greater visibility of a personal characteristic at least has the potential to make issues more evident and lead to open discussion, where inequities exist with discussion more likely to lead to emancipatory action than silence.

Further, a fragmented and 'managed' sense of identity can be problematic for individuals in terms of the amount of energy they need to expend in concealing their authentic self. The inability to be 'whole' or 'authentic' is taxing and enervating. Identity management which becomes a conscious performance requires vigilance and energy on the part of the individual who is 'performing'. This is often amplified by the fact that such stigmatised people often feel

they are being closely scrutinised by others (Chobrot-Mason, Button & DiClementi 2001, p. 323). For some of the participants in this study, 'management' of their sexual identity required such intentional action and ultimately meant they were in a state of hyper-vigilance or over diligent self-surveillance whilst performing their roles as paramedics. The energy is expended on managing their identity; it is not available to be devoted to the performance of the paramedic. As the evidence in chapter 5 previously demonstrated, this untruthful performance can and does impact both the individual paramedic and those to which they are socially connected in the workplace and beyond.

Gender

Gender and sexuality are two separate characteristics of identity. With this in mind a discussion of sexuality in terms of its relevance to social identity cannot be conducted without due consideration of gender. Western societies, including Australia, define gender in cultural terms as a product of biological 'sex'. The result is that in Australia there are cultural expectations that a person will possess and project the traits associated with being a member of one of only two gender groups. This is an inflexible binary construct. Social expectations to conform to and perform according to the expectations associated with being a member of one or the other gender groups are exceedingly strong and complex.

A combination of personal identity attributes may lead to a compounding experience of inequity for specific individuals. As such, it is necessary to consider the intersectionality of these foundations of inequality in an effort to truly, appropriately and authentically represent the lived experiences of participants. Consideration of the importance of identity with a focus on sexuality includes consideration of the impact of gender identity on social inclusion, exclusion and personal sense of self. Different expectations apply to the two socially recognised gender groups and these expectations are derived from the culture in which masculinities and femininities are 'played out'. In the context of this study, the culture of the paramedic workplace prescribes very specific expectations for men, which are different to those of women. There is a tacit model of hegemonic masculinity which is privileged and more prevalent than in some other professions. This was considered in the literature review of this thesis and will be explored in more detail in chapter 8.

Lesbians and Gay men present a challenge to such stereotyped traditional gender constructions, especially when this is an inherent set of expectations on workplace performance as in paramedicine. Any attempts to conform to heterogendered social expectations and complex and subtle social structures set up practices that regulate heteronormative sexuality as the only legitimate form of sexual expression. The proliferation of such workplace values serves to reproduce inherent inequities to the detriment of non-

heterosexual employees. This is reinforced by social understandings that gender is biological and such performative acts therefore have a scientific basis: “gender is performative, that is, constituted by the ‘expressions’ that are seen as its results (Butler 1990, p. 25). The accounts of the experiences of Calliope, Magnus and Holley in the following sections of this chapter draw attention to sexuality and the intersectionality of sexuality and gender support this position.

Sexuality

Gender constructs shape our society and govern and impact a set of social expectations. The presumption is that all individuals will conform to an expectation that they will behave in particular ways. These performative expectations of being a man or a woman are aligned with biological sex and dominant social expectations mean that one should be ‘naturally’ attracted to the opposite gender. In the context of this study, the extension of this is how the paramedic plays out their sexuality where there is an assumption that one is by default only heterosexual and this is the unexamined norm. The extension of this is that exceptions to this norm *need* to be explained and rationally justified. Calliope gave a good example when she said it was always assumed she was heterosexual, “...It’s always, ‘have you got a man?’”

Magnus’s narrative highlighted the importance of sexuality within his identity matrix and how this played out for him in the workplace. Despite the fact that Magnus indicated he was ‘out’ at work, he stated “I never discuss it unless I’m directly asked”. Unlike his heterosexual colleagues who by virtue of the fact that their sexual identity was considered ‘normal’, may have the luxury of being able to discuss aspects of their sexual identity at any time, Magnus felt he had to wait to respond to a direct question. He stated:

I think that always puts you...it holds you back a little bit if that makes sense. Like if someone asks me ‘are you married?’ my answer would be ‘no’. And so they go ‘are you seeing someone?’ [and my answer would be] ‘oh yes I am’. I’d answer that and if they wanted to know more then...whereas if someone’s married it’s just straight out with ‘oh, my wife does this’. They’re quite comfortable because for them it’s completely within the realms of normality. Whereas, I know that my normality is not necessarily their normality and can sometimes make things uncomfortable at least until we’ve developed a rapport or relationship with the person I’m working with.

Magnus’s experience illustrates the heteronormative nature of his workplace and the conscious energy he puts into restraining his responses to direct questions. Despite labelling himself as ‘out’ in the workplace, a discourse of silence still surrounded and controlled aspects of his ability to reveal elements of his identity. This impingement on a persons’ ability to be authentic and whole in the workplace is something heterosexual workers do not experience, or usually even need to consider.

Intersectionality

The concept of intersectionality centres on the fact that multiple identity attributes function together and coalesce to produce a unique social experience (Acker 2011, p. 68) for every individual. Again, there is limited space to devote a detailed discussion to intersectionality in this study, other than to note there should be an appreciation of the fact that each individual has a distinct experience steeped in their ontological and historical evolution. Whilst to generalise is to essentialise, some categorisation of the intersection of these identity traits is important. Such categorisation assists in the development of an appreciation of the complexity of the social fabric playing out in this study. It also assists in gaining insight into how the workplace includes and excludes participants on the basis of their personal, perceived, real or social identity. This can go part way to helping us appreciate difference in regard to the experiences of Gay men and Lesbians in this research.

Magnus believed that gender and sexuality produced different experiences for individuals in his workplace and alluded to the complexity of some of the constructed understandings that produced this difference in experience. Whilst he stated he was making a generalisation, he said that for “a lot of the women that have come through, the Lesbian women, it almost seems like for straight men, they’re just one of the boys”. This was in spite of the fact that women were still seen as somewhat less physically strong than men and therefore less capable of performing some of the more physically demanding tasks: “they still have that same process of you know, you lift the patient, ‘I’ll take it because I’m the strong one’”.

The erroneous beliefs that women are physically weaker because of their biological makeup and that Lesbian women are more masculine took an interesting twist for Magnus. He felt “as a Gay man, you almost feel like they are looking at you as one of the girls”. This indicated that his sexual orientation had some influence over aligning him more with women in the workplace than men, in spite of the fact that physically he is a very strong, fit male. The intersection of gender and sexuality in this respect seemed to mean that both being a woman and being a Gay male led to a perception of physical weakness, despite obvious physical characteristics that would indicate otherwise.

In contrast to Magnus’s experience, Holley discussed the interplay between gender and sexuality in her workplace. This was in terms of difference of experience that seemed to be produced in her work environment. By virtue of being a female and a Lesbian, people seemed to be more accepting as they shifted more towards the hegemonic male stereotype. Holley stated it was “a lot easier to accept a woman in a man’s role if they’re more blokey and Gay woman equals blokey to most of them”. Along with this perception that Lesbians

were blokey was the assumption they have greater physical strength. The counterpoint in Holley's view is that whilst in terms of gender identity men were generally more accepted, for Gay men their sexuality negated their gender. Holley stated that for heterosexual males it is "a lot harder for them to accept a Gay man".

Silence

As society and the workplace are constructed in such a manner that heterosexuality is perceived as the norm; there are inherent risks associated with non-heterosexual identity traits. Silence exists when it comes to deliberation on the 'elephant in the room' or consideration of the variety of non-heterosexual sexualities. Research indicates that the workplace is indeed a sexual place, but almost always *only*, a heterosexual place. The workplace is a site for playing out compulsory heterosexuality (Skidmore 1999, pp. 510-11). Other sexualities are rendered invisible (Griffin 2006, p. 201). In Joe's words "unless you don't appear to be Gay at all in terms of mannerisms or speech or no-one knows anything about your personal life and people believe that you are heterosexual".

This silence exists at all organisational levels and even organisations with progressive approaches to management of diversity have tacit silence as a continued premise in relation to sexuality (Ward & Winstanley 2003, p. 1258). Internal conflict between living in fear and self-integrity when choosing whether to come out (Griffin 2006, p. 192) adds an additional burden. The combined effect of this construct on the individual can frequently lead to experiences of isolation and internal conflict and energy is required to maintain the silence (Griffin 2006, p. 196). In this respect, silence acts as an agent of power (Ward & Winstanley 2003, pp. 1259-60). This power agent is illusive and difficult to identify. Silence means not knowing where the boundaries lie: not knowing what is acceptable behaviour in a particular context.

In her narrative Latoya highlighted she felt this silence "when you are talking about your partner there's no real word for us". This was noted when she exclaimed, "When I say 'my partner', they think I'm talking about the person that I'm working with for the day instead of my love of my life for 15 years." Although she was open about her sexual identity, she was compelled to agree to be silenced. Her difficulty was also connected in her representation of her partner and her use of language that seeks to de-identify someone whom she cares about deeply from her workplace conversation.

Negative systemic silences such as these require energy. Silence means self-editing, extreme hyper-consciousness around selfhood and vigilance. As previously discussed, Michelle felt she needed to use gender neutral references to her partner in what could be

viewed as 'casual' interactions. She was careful to maintain the silence around her sexuality because "I just wouldn't want them to know" and stated she was "constantly conscious" and careful. Magnus reaffirmed Michelle when he too stated "everything to do with your personal life, you're constantly filtering depending on which paramedic you are working with". Magnus went on to explain how he saw that heterosexual people did not have to expend this amount of energy: "I don't think a straight person would batter an eyelid. You're asked a question, you tell them an answer. Whereas if we're asked a question, tick, tick, answer."

Saxon shared similar sentiments to Latoya when he stated that he was not comfortable telling his patients about his sexuality, and added "I think that probably stems a bit from that shame that I felt to start with within general society". Saxon also said "because for a lot of years of our lives we concealed who we were. I was living an act for so long." He goes on to note that the fear of disclosure and self-silencing is self-perpetuating, "it's about me not wanting to give them the information they need to make a judgement. It's fear of retaliation, that it's going to have a negative outcome." This point of view is tacitly reinforced by understandings of patient-centred care, explored in more detail in chapter 10. The vicious circle of fear, non-disclosure, then fear, then silence feeds the 'invisible elephant' in the room. Jacob also talked about the fear he had in relation to the consequences of disclosure that had led to his silence. He stated "If it gets out and people find out and it's a bad experience, then what do I do with my career?"

Managing identity is tiring. Reading every situation in terms of nuances to know what is safe to disclose and who it is safe to disclose to requires an output of energy that heterosexual people never need to expend in their workplace. Over time this expenditure of energy takes its toll. In the health sector the concept of caring for individuals and the cumulative effect of the expense of this compassion over time has been termed 'compassion fatigue'. This concept is well recognised in the 'caring' professions for the impact it can have on practitioners (Figley 2013; Todaro-Franceschi 2012). It is a form of depletion of energy and diminution of the capacity to care that occurs over time. Similarly I feel that hiding, editing and harbouring fear can surely have a long-term deleterious effect. This effect is what I am calling, *closet fatigue*. Staying in the closet is exhausting. Coming out might alleviate some effects of *closet fatigue* however complete relief does not necessarily flow from coming out.

Coming out

Constant, perpetual risk assessment is exhausting. In the same sense as with 'compassion fatigue' the process of managing one's sexual identity can take its toll on individuals. This is especially true for those charged with the constant caring for others. *Closet fatigue* can take its toll on Lesbian and Gay individuals. People with stigmatised invisible social identities

struggle with revealing them in an organisational setting, resulting in stress and anxiety in the workplace (Clair, Beatty & MacLean 2005, p. 79). *Closet fatigue* is an organisational cost in the toll it takes on Gay and Lesbian employees and other employees in the teams they interact with. It adds a further substantial cost to the community, as paramedics affected by *closet fatigue* are not in a position to provide optimal care as they do not have optimal reserves of energy.

Several participants in this research indicated they make constant daily decisions in relation to which aspects of their identity they are compelled to conceal and reveal. This monitoring of self can and does occur in a range of situations and requires hyper-vigilance in some of the most seemingly mundane situations. Michelle for example discussed self-management in her work location. She described this as, “annoying...not having that freedom” and added that if her partner was “a guy I wouldn't care...he'd be my screensaver on my computer and I wouldn't care about anything”. She went on to say that she concealed aspects of her personal identity as she felt she would be uncomfortable if she were to reveal them. Her experience provides a good example of how people can isolate themselves in an attempt to keep personal relationships hidden (Clair, Beatty & MacLean 2005, p. 79).

The choice described by Michelle is one that non-heterosexual people make and they make this choice incessantly. Decisions to reveal their true selves have both negative and positive consequences (Chobrot-Mason, Button & DiClementi 2001, p. 322) as there is not a completely assured outcome. Choosing to remain in the closet then, as Michelle did, can provide a sense of ‘safety’; however, the result of people remaining in the closet is that whilst employees seem more ‘integrated’, an important aspect of their identity is ignored, and this can negatively impact self-worth and self-esteem (Ward & Winstanley 2005, p. 450). People experience feelings of authenticity when they can fully be themselves and concealing personal information to avoid stigma interferes with this authenticity (Clair, Beatty & MacLean 2005, p. 79). Evidence suggests that ‘coming out’ to co-workers (if this can ever be achieved) can however be detrimental, especially for Gay men (Chobrot-Mason, Button & DiClementi 2001, p. 334). Even on the most overt or ‘unhidden’ point of the ‘outness’ spectrum, energy is required. This takes its toll on the individual and the organisation. Strategies for concealment can be isolating, take energy and result in a loss of productivity (Chobrot-Mason, Button & DiClementi 2001, p. 325).

Michelle also provided a good example of the *closet fatigue* she experienced in what could be the most ‘out’ of all occasions imaginable in this research data. She attended the local Gay pride event in her state in her paramedic uniform. This had been organised by some local paramedics with the endorsement of her employer. She described the thought

processes in the lead up to her decision to take part in this event. Her decision was made on the basis that she would probably have an appropriate level of anonymity at the event, which took place in the city, in order to maintain her privacy at her work location in the country. Her decision to be 'out' in a performative sense was counter balanced with the fact that she presumed she would then *not* have to be out on an ongoing basis at work. Her description of performing self that was publicly out for a short while as a proud Lesbian and a paramedic was laden with descriptions of further analyses. These related to the reasons why there were so few paramedics present at the event and the minimal level of internal workplace advertising of this event, which she linked to organisational suppression. Michelle also described her observations of this event in terms of numbers of male and female participants, stating it was clear to her that more women were out than men and she gave a number of possible explanations for this. Even whilst out in this environment, Michelle seemed to be taking in information around her, deliberating on her personal level of security while addressing future consequences of her public outing. Even though Michelle was 'out' in a momentary sense, she expended conscious energy surveying her safety and the composition of the group around her. This is wearing. This is *closet fatigue*. Coming out does not redress *closet fatigue* but can add further emotional anxiety to the experience of the Gay or Lesbian paramedic.

Critical discussion and summary

This chapter has shown how inequalities are often invisible, especially to those who are *advantaged* by them (Acker 2011, p. 73). These inequalities that exist, which are shrouded in silence, will perpetuate and continue to disadvantage individuals, if not addressed. In keeping with the methodological stance of this thesis, the silence needs breaking as it relates to the experiences of silence and lack of recognition of Gay and Lesbian paramedics. Precisely because these inequalities are invisible to those not affected by them, this research aims to give voice to the people affected by this invisibility.

Identity, authenticity and autonomy are important to a sense of self. This wholeness or authenticity of being and belonging in the world is able to be fully experienced by heterosexual people in the workplace, especially in terms of the dimension of their privileged compulsory sexuality. A workplace is not a gender or sexually neutral space but both a microcosm and macrocosm of values which reflect back to the community the predominant values of the surrounding society. The chapter has shown how silence maintained in workplaces is based on heteronormative matrices which marginalise those who are seen as being other. Stereotyping, stigmatising and labelling influence the choice of a non-heterosexual person to remain silent and closeted on matters of sexuality which perpetuate

the lack of 'normality'. Internal conflicts in relation to whether to take action to publicly perform an 'authentic' Gay or Lesbian self can potentially provide a moment of relief from the burden of fragmentation. Such action is however often based on incessant, vigilant and careful surveillance of the environment in which individuals are employed.

An individual does not become 'rejuvenated' from this *closet fatigue* upon declaring that they are Gay or a Lesbian. Coming out is an open-ended, ongoing, lifelong process which means that non-heterosexual people constantly need to choose whether to reveal their sexual identity in a range of changing situations and to a range of people they may encounter. For paramedics this means making judgements about what they say to different work partners, to their patients, bystanders and others in a constantly changing environment. The discussion shows how all participants in this research have provided a diverse range of illustrations of how they did and did not break their silences. The challenge to speak out about their identity is something heterosexual people would normally never experience. This enforced silencing is at worst a process that inhibits workplace participation and effective performance of life-saving tasks.

This chapter has focused on identity and its importance in shaping the individual and the workplace as a community. It has been constructed to uphold the belief that "identity achievement is associated with higher self-esteem, conscientiousness, security, achievement motivation, and capacity for intimacy" (Weiten 2013, p. 457). The flow on effect for enhanced self-esteem should be employees demonstrating greater happiness, enhanced self-esteem and optimal productivity. It is therefore logical that organisations would wish to promote inclusivity and diversity to ensure a happy and productive workplace, in particular when that organisation is in the business of caring for others in the community, as many progressive and reflexive organisations already have. This chapter illustrated that silence continues to surround the issue of sexuality in the paramedic's workplace specifically and generally. Participants in this research reiterate the experience of silence and marginalisation that Gay and Lesbian employees experience from the point of view of paramedics in Australia.

The next chapter examines the culture of the paramedic occupation and the characteristics of the industry in Australia. It narrows the lens in an attempt to articulate in more specific terms how this workplace culture creates a tension between the needs of the individual and the needs of the paramedic organisation as a whole. It sets out to question the manner in which organisational and occupational cultures of compliance and conformity manoeuvre against this wellness and authenticity for Gay and Lesbian paramedics.

CHAPTER 8: PARAMEDIC WORKFORCE CULTURE

The workplace culture of a paramedic has definitive features. As the literature review (see chapter 2) demonstrates, previous literature has identified the elements and features of paramedic culture. If one is to accept these descriptions as a starting point, it is of interest to see how such definitions are confirmed or refuted by the participants in this study.

Documentation of the perceptions of Gay and Lesbian paramedics in relation to their workplace and the impact of heteronormative culture on notions of 'professional self' is limited in current literature. With this in mind, in this thesis I aim to develop an understanding of the lived experiences of a small but not inconsequential group of Gay and Lesbian paramedics in their field of employment.

This chapter adopts the definition of culture as masculine, heroic and homogenous from the literature reviewed. Using this definition as a starting point, it will confirm or refute these characteristics of paramedic culture using the non-heteronormative lens of Gay and Lesbian paramedics. Further, it will extend these understandings by highlighting additional characteristics of the culture of the paramedic workplace previously undocumented. The heteronormative nature of paramedic culture and the impact of this culture on participants as they experience exclusion will be considered. This chapter both discusses data findings that offer a critical appraisal of workplace culture for paramedics and unpacks the notion of ghettoism in line with notions of environmental isolation.

Paramedic culture to date

Previously discussed literature has provided insight into specific 'wedges' of paramedic culture using the 'onion' model suggested by Hofstede et al. (2010). This model refers to the symbols, heroes and rituals present within a culture which are artefacts of its values. Using the language adopted by Hofstede et al. (2010), these 'wedges' of masculinity (i.e. emotional resilience, homogeneity/ uniformity, heroism, hierarchy and militarism) form only part of the picture. With the aid of a non-heteronormative lens, a number of additional 'wedges' associated with the culture of paramedics were identified by participants in this study. An optimistic view would be that inclusion of these additional 'wedges' gives a more complete description of paramedic culture.

Under the onion layers are the core cultural values. As previously discussed, paramedic organisations tend to favour values of masculinity, homogeneity, bravery, hierarchy and uniformity; paramedic structures also influence how these values get played out in organisational practices. If we accept current documented insights into mainstream paramedic culture (i.e. as being masculine, heroic and homogenous) and the evidence that

these qualities are tied to organisational artefacts (in the form of symbols, heroes and rituals), are these validated by the participants in this study? The section that follows addresses their perspectives and uses the model of the 'onion' to confirm or refute the presence of the various 'wedges', which can be perceived as representing the underlying values of paramedic culture.

Paramedic culture – the lived experience of participants

The majority of participants echoed the existence of previously identified ideas, themes or practices previously identified as elements in the culture of the paramedic workforce. They were however able to add another element – *heterosexuality* – which served to exclude or alienate them on some levels and in some instances. The significance of the use of stereotypes in influencing the development of culture was obvious. Stereotypes concerned with masculinity as a quality have been a central pillar in the creation of paramedic culture and they have played a gatekeeper function of acceptance or exclusion from this culture. Dominant stereotypes will be further considered here.

Whilst homogenous culture can serve to unify a group and therefore serve to scaffold such a group in meeting some key common objectives, non-conformity can factionalise and prove obstructive in meeting these objectives. Until now consideration has not been given to the tension created when an individual sits outside of these boundaries of privilege as an Australian paramedic. More specifically, consideration has not been given to how the sexuality of an individual may serve as a defining element in terms of embracing or excluding the individual from a cultural group in the context of the paramedic workplace. The issue of such tension for Australian paramedics and how sexuality defines their presence is at the core of this thesis.

In keeping with the underpinning philosophical and methodological stance of this thesis, focus here turns to commonly perceived features and artefacts of paramedic culture *from the perspective of the research participants*. Furthermore, it looks at some of the features which are unique to specific subgroups, again from the perspective of the research participants. Whilst there is some commonality with previous descriptions, use of a non-heteronormative lens allows for focus on areas not previously documented.

Echoes and dittoes – participants' affirmations of previous observations relating to paramedic culture

The ideal paramedic is male, heterosexual with three kids, married, nice garden, all of that kind of thing (Joe)

Masculinity

The majority of participants spoke of the prominence of masculinity as a key feature in paramedic culture, either directly or by inference. In terms of her interactions with colleagues, Calliope said that when she encountered confronting or challenging situations, she did not feel she was able to seek support, but instead she was expected to “man up”. This expectation related to the male stereotype of emotional resilience and she was expected to display this trait at the expense of her more ‘female’ character traits. Mack echoed Calliope’s experience of there being a dominant form of masculinity in paramedic culture when he stated that “generally, it’s very male oriented.” Holley supported these sentiments when she described what she felt was expected of her in her work practices as a paramedic. Holley, a petite woman, felt that her physical stature had led to perceptions from colleagues that she was not capable of performing the physical role of a paramedic. This perception was associated with the ‘masculine’ tasks that may be required of a paramedic. The privileging of these ‘masculine’ tasks by those she worked with, as being at the core of her role, gives some telling insights into the dominant values of the culture of her workplace. This is evident in Holley’s description of what she felt was expected of her when she stated:

This is a man’s world, you’re a woman, man up, do your stuff, carry heavy people, lift heavy shit...you’re a girl, you’re small, what are you doing here? You can’t do this, lift that heavy person, carry that heavy piece of shit, reach the back of the ambulance door; come on, fucking keep up.

Holley’s experience is further testament to the masculine nature of paramedic culture. Janine’s observations of her workplace as “still definitely male dominated and army kind of mentality” corresponded with Holley’s description of the manner in which masculinity was championed. Building on these narratives, Janine went on to describe how she saw herself as being part of this masculine ethos in the way in which she projected herself when she said, “I think we are quite a crude, rough and outgoing bunch”.

Another masculine feature of paramedic culture is evident in the description of it being a ‘boys’ club’. Jacob had developed his insights into paramedic culture progressively through his exposure to the workplace beginning with clinical placements as a student. Jacob had inferred that having such masculinity as a cornerstone of culture meant those who were not

perceived by the larger group of paramedics as 'one of the boys' would consequently be excluded from 'the club'. Jacob described his perception of this 'club' when he revealed:

When I first started uni I saw it as like a massive boy's club, the job.... Like male dominated, all straight, um all really into the footy and...sort of that side of things. Whereas, sort of, if a Gay or a Lesbian came along they'd sort of be looked and sort of like segregated, like put in the corner and not being included I suppose.

Having commenced his career with such a perception that he may not be 'male' enough to be included in the workplace due to his sexuality and the lack of 'maleness' associated with it, Jacob was naturally very guarded about this aspect of his identity.

After a number of years as a paramedic, Magnus echoed Jacob's observations relating to the 'boys' club' within his workplace. He saw this manifested in certain workplace changes including "even changing from the GMCs to the Mercedes⁹, with the boys like losing their trucks". The GMC truck had become a symbol of masculinity in the workplace and the loss of this truck for another kind of vehicle was akin to taking away some of the 'macho' quality the truck symbolised.

Previous literature relating to the masculine nature of paramedic culture alluded to the symbolism present in the use of masculine points of departure, adapted in an attempt to fit the needs of the female proportion of the workforce. This has the impact of making 'non-males' feel that their needs are secondary to that of privileged males. Latoya saw this as being strongly enshrined in the facilities at the branches she had worked in. In relation to the toilets she said, "the girl's always get the disabled toilets in the branches.... The boys always get the good, nice peaceful place...yeah, even at this new branch, huge branch". She likened being female in this environment to being disabled when she said, "they still just build a boy loo and then they build the disabled one and the girl's one, in the middle, like wheelchair accessible, with remote control doors, you know that open as you walk past". Latoya's observations relating to the secondary nature of the needs of female paramedics were also a theme in her discussion of the equipment used in the field. She described "The height of the stretchers, the height of everything" as being suitable for the majority of male paramedics and yet unsuitable for the majority of females in that the height was "just a little bit higher, like built a little bit high I reckon". In a similar sense to Latoya, Holley saw the uniform she wore as a constant proximal reminder of the hypermasculine workplace when she stated "it's blokey, you dress in overalls and wear steel-capped boots and you go out and you carry heavy shit and you deal with people spewing and pooing".

⁹ This refers to the response vehicles used in some of the services. There was a change in the early 2000s in most organisations from "truck style" Ford or GMC ambulances to "van style" Mercedes Benz.

Latoya also described how she felt the culture needed to change to better reflect the composition of the workforce. She believed that those in charge of the organisation she worked for also knew this. She stated:

They know the culture's changing. They know that now, or just before now, the average was 6 foot high white men, and they know that, within 10 years or so, it will be 5 foot 4, blonde, 22-year-old girls.

Despite Latoya's observations which relate to how the workplace could be made better for her and other female paramedics, the prevailing and privileged male ethos seems to continue to dominate and is actively obstructing changes to a more inclusive workplace.

Despite the need for change that Latoya highlighted, Magnus also saw masculinity in artefacts within his workplace. He described these symbols of masculinity in his experiences in some of the stations he worked in. He said, "You walk into the station and there's still pictures in the toilets of naked women and stuff like that". He added an association between masculinity and (hetero)sexism when he stated "...it presents that whole male, heterosexual sort of thing. Yes, it's not offensive to me as far as 'oh my god, there's a naked woman' but it kind of shows what the culture is with those men in that sort of environment...." Magnus went on to describe the subtle, complex and difficult to articulate manner of this heterosexism, describing it as "just that vibe, that feel.... It's like walking into a certain type of pub with a certain type of demographic or whatever".

The predominance of masculinity in the paramedic culture was obvious for Latoya in the lack of femaleness apparent in the *heroes*. All of the *heroes* she saw in her workplace were male which reinforced the second-class nature of female paramedics. She stated, "...there's no women managers out there, there's no women intensive care level paramedics.... They're all men, everywhere, everything." Her observations also related to how this lack of visible female *heroes* in her workplace helped to bring about a patriarchal power structure. She commented that she had a feeling that she would be less likely to be successful with choices to advance her career than would her male colleagues. This is evident when she asserts, "Well, it just sets the scene and it sets the scene for them to be normal, to pick the next manager.... Like they couldn't find anyone to fill a management position at a branch, but, they don't ask us".

Emotional resilience

Yep, suck it up. Deal with it; you're a paramedic (Calliope)

Calliope's statement "suck it up" encapsulates what she perceives to be expected of her by her colleagues in her role as a paramedic. Testimony provided by Calliope demonstrated that

emotional resilience continued to be a defining feature of the workplace culture. She said there was an expectation of her and others she worked with to be “a bit tougher, a bit more of a hero or whatever... Tougher, stronger, whatever... got the tougher mindset.” Holley had also been exposed to work practices that carried an expectation that she would be more emotionally resilient. She also saw emotional resilience as having a strong affinity with masculinity. Holley described the initial phases of her career when she responded to workplace expectations which meant that she “took it on the chin and I probably took far more risks than I should have in terms of personal safety, personal health, um.... because I was in a man’s world.”

The negative implications of the expectation that a paramedic is emotionally resilient were evident when Magnus described an incident where he had significant conflict with a co-worker. As previously discussed, this colleague had refused to meaningfully engage with Magnus. Magnus believed this was because of his sexual identity. Despite feeling the need for assistance and support, Magnus declined an offer of such managerial support. He had declined this offer of support due to feeling that paramedics were expected to deal with these issues independently. He maintained, “I was like, no, I’m going to stand up for myself and get through this.” In declining the offer Magnus had a difficult time resolving the workplace conflict and this had taken its toll on him.

Saxon described how he consciously projected a tougher, more resilient self in response to the cultural expectations of him at work. He stated he was “probably a little bit softer outside of work” and changed his style of interaction at work to one which was “very direct, it’s less emotive”. Saxon explained, “At work, I put my uniform on and it’s, ‘I’m Saxon from the ambulance service...why have you called the ambulance, what’s happening?’” He did this because he believed that to display the communication style he may use in other contexts, one which could be perceived as more ‘feminine’, would make him more vulnerable. He felt that this vulnerability could be exploited by some of the groups he interacted with. These groups included patients such as a “group of rowdy, pissed blokes”. He also believed that this masculine form of emotional resilience was essential in dealing with colleagues. To show a more feminine and less stoic character trait would give these individuals “the opportunity to bastardise.” He added that “if you’re not a strong individual, that can break you.”

Although this cultural expectation to be more emotionally resilient had negative consequences for some, Latoya saw it as having some positive and instructive value. Her exposure to male dominance meant she was now felt more capable of standing up for herself. She said, “Anyone who doesn’t stand up for themselves will get shat on more quickly, from upwards [management]”. She stated she had now learned how to “stand up for yourself”

and knew that as a result “everything backs off a bit” when there is an issue. This had helped her to continue to do her job effectively in some respects, as she had learnt from her male colleagues about “how to put something behind you and move on.”

Homogeneity and uniform(ity)

The most visible artefact of the culture of the paramedic workforce is the uniform. The uniform is a symbol of unity, *uniformity* and homogeneity. It promotes the identity of the organisation over that of the individual. Whilst it serves the functions of the organisation in some respects in *unifying* and identifying its member to the community, this can come at the expense of the individual worker’s values. If there is a resonance between these values and those of the organisation whose uniform they wear, this can serve to embrace such a person. If there is dissonance, this can be alienating. Participants indicated that the uniform was still seen as an embodiment of the homogenous nature of their workforce, the impact of which was sometimes to put additional pressure on paramedics to downplay their need for self-expression.

Several participants spoke about the effect of wearing a uniform on the manner in which they behaved. Joe for example described how wearing a uniform added to his level of self-consciousness as a result of being more visible to the public. He felt he had to be mindful of not displaying any stereotypically ‘Gay’ behaviour whilst wearing his uniform, as this may reflect poorly upon his employing paramedic organisation. As he worked in a small community Joe also felt that this meant he had to conform to specific organisationally endorsed standards of behaviour when he was out of uniform. He felt that his public role meant he was identifiable even when not wearing his uniform. Joe affirmed “you are sort of always wondering who is watching you and you manage your behaviour because of that”. Calliope also alluded to the association between the uniform and behaviour modification when she said “We put on a uniform; you’ve got a certain perception that you have to live up to, be professional, stop swearing, whatever”.

This ‘branding’ of paramedics in such a visual sense can be seen to promote behaviours which are more conducive to fostering patient–paramedic relationships. Mack described the way in which he changed his behaviour when he was wearing his uniform. For example, in terms of the language he used, he maintained, “I just get used to saying ‘swearwords’ at work instead of saying fuck or shit or cunt.... I got used to sort of, not swearing because of years gone by, you actually swear in front of a patient and like, I have trained myself to go, ‘oh – swearword’”! In this sense Mack saw the need to put his own urge to swear behind the need to promote a better relationship with his patients as he was the ‘face of the

organisation'. In contrast Saxon saw the authority associated with the uniform. He said "because we wear a uniform, people think, the paramedic said so we must be right."

Heroism, militarism, hierarchy and public image

Depending on the geographical location of the ambulance service employing paramedics, there can be a number of levels of clinical capability or training. In general terms, most ambulance services in Australia operate a tiered system, providing a more basic level of paramedic training and with additional training, paramedics can progress to a higher level of skill in intensive or advanced care. Ambulance organisations also tend to use a hierarchical structure of management which scaffolds and amplifies the clinical hierarchy.

To Magnus, the military flavour of his workplace was very apparent. He gave a detailed description of the historical relationship between the military and ambulance services. There were a number of ex-military people now working as paramedics in Magnus's organisation. These people deliberately made themselves visible within the workplace as this was seen as prestigious by a proportion of his paramedic colleagues. Magnus said "some of the paramedics will wear service medals and stuff like that, if they've been in the defence force. They tend to be people who want to keep this paramilitary kind of structure to the service and stuff like that". Magnus added "I don't get it because I just can't get it.... we refer to them as badge tappers". Magnus also described the response from the 'badge tappers' when, for occupational health and safety reasons, they were told they were no longer able to wear the badges they had "made up themselves". When the service ruled they could not wear these badges, Magnus stated "They were up in arms over it and everyone else was thinking, 'oh, for fuck's sake', you know". Magnus added to his observations about the hierarchical nature of his workplace when he maintained: "Do you have that in any other workforce? This macho symbolism, 'I'm in charge', 'I'm senior', 'I'm this'". Magnus went on to make some further statements about the militaristic nature of his workplace when he said:

...the service still is structured like that, it's still very chain of command. You look at how everything's worded in protocols and procedures. It is very 'you must report, follow the chain of command'. It's not the fucking army but that's how it is, a different world man!

The hierarchical nature of the workplace was demonstrated for Michelle in the behaviour and attitudes of some of the paramedics she worked with, who had obtained a higher level of clinical qualification. She felt that these intensive care paramedics could be "very headstrong and egotistical" and had a perception that paramedics with her level of training were seen as "below them" in the hierarchy of the workplace. She had sometimes arrived at incidents where she had felt an increased level of stress, where she was required to work at incidents necessitating interaction with "an arsehole intensive care level guy". She stated that on these

occasions “that’s the end of it” in terms of her feeling a comfortable level of competence and autonomy in the workplace. The intimidating, hierarchical and domineering behaviour of these colleagues was seen as just in some ways by Michelle. She stated, “Maybe they kind of need to be for their job, or maybe we get led to believe they need to be for their job”.

Saxon supported Michelle’s hypothesis about the hierarchy by relating it to the functional needs of his workplace when he stated “So you have this culture already, you know, you have a command and control structure within ambulance because that’s what we have to do in order to be able to perform our job”. Despite his perception that this hierarchical nature was a necessity, Saxon also saw the negative consequences of this as ‘bastardisation’, defined as bowing to authority and putting professional judgements on reserve to privilege the opinion of more senior people in the hierarchy. He summed this up by saying:

The culture in our workplace is command and control. The senior person tells you to do this, you do this, you don’t answer. Someone else comes in that’s senior, you hand over. It’s command and control and with that comes bastardisation.

In the sense that Saxon pointed out, bastardisation can be at the expense of collaborative and consultative work practices.

New layers, new wedge

Participants in this research reinforced that elements of the culture have previously been identified in the literature (Boyle 1997; Gonsoulin & Palmer 1998; Kennedy 1999; Reynolds 2008, 2009; Steen, Naess & Steen 1997). They also added a layer not previously documented, indicating that the workplace culture also privileges heterosexuality. This layer has not been previously documented in relation to the paramedic workplace in Australia. Mack encapsulates the heterosexism prevalent in the service he is employed by, when he states:

...it’s a very heterosexual service generally. So it’s that whole, and I’m not necessarily sure if I would call it a difficulty, but just knowing your life is quite different to others. For me being double income, no kids sort of thing; there’s that expectation that you won’t take leave during school holidays and, at peak times that...you won’t necessarily want those....

His experience of marginalisation in a cultural context that privileges heterosexual paramedics and their needs over non-heterosexual paramedics is echoed in the accounts of the other Gay and Lesbian paramedic participants in this research. This heterosexism was exacerbated by some of the unique workplace characteristics of paramedic organisations. Themes of workplace intimacy, the culture of language, styles of workplace humour, patterns of alcohol abuse, ghettos and the concept of patient centredness were arenas in which the

participants identified specific associations with heterosexist, homophobic and/ or heteronormative practices and values.

Heterosexism, homophobia and heteronormativity

According to participants in this research, the culture still tended to be masculine, and *heterosexual*. Several participants saw heroes, rituals and symbols which were indicative of values that reflect heterosexism, homophobia and heteronormativity in their workplaces. Some of these were obvious, some less apparent.

The more subtle forms of heterosexism were highlighted by Michelle and James. Both were relatively new to their workplaces as paramedics. Michelle said she had a 'feel' for people having homophobic attitudes. She said she developed this feel by deducing from some of the content of their conversations conducted by other paramedics in her presence, that is, that 'difference' was in general not embraced. By 'difference' she meant a deviation from the ideal characteristics of an archetypical paramedic. Michelle stated:

...if you came through as a 22-year-old Gay male you would probably be sitting in a corner all day just hoping that no-one outed you. They are nice people but I don't think.... I mean they are racist and sexist and to come out as Gay would be a whole new thing for them.

Janine's experience was not dissimilar to Michelle's. She said she had not experienced any overt homophobia as she hadn't "had anyone approach me and say anything negative"; however, she still was fearful of coming out in the workplace due to some of the interactions she had been exposed to. Janine stated that due to this fear "You can't fully be yourself at work because of the fear of coming out. You can't 100 percent relax while you're at work."

Mack spoke of a number of people refusing to work with him. Although he was only made aware of the underlying reason for such refusal in retrospect; people blatantly refused to work with him due to their abhorrence of his sexuality. Mack stated "There was a group that, when I was on a particular roster group, refused to work with me, and a couple of other people, but they all refused to work with me and I really couldn't get why". He had speculated at the time and attributed all sorts of reasons to the behaviours of his colleagues. These behaviours marginalised and isolated him. Ultimately he had surmised incorrectly that such refusal to work with him was a lack of clinical competence on his behalf. This was evident when he stated, he "just questioned my ability to do the job and all that sort of thing". As noted earlier, it was a number of years later that it was drawn to Mack's attention that these acts of exclusion were in fact founded on homophobia. Mack stated:

It wasn't until years later, you know, quite a long time later and I actually said I think it was actually just the way I was at the time and it was one of the other women who

said 'no, bullshit Mack, it was all about you being Gay, they just hated you because you were Gay'. They were just, they were homophobes.

In an attempt to rationalise this sort of behaviour, Saxon drew some parallels to gender in highlighting the reasons behind the instances of direct discrimination and homophobia he had experienced. Saxon saw this as an extension of the masculine nature of the culture. He felt that due to the dominance of masculinity, a number of paramedics see “any feminine type influence, whether it comes from them assuming that a Gay man is feminine or caring, as a threat”. He felt that this threat was borne out of fear of difference. He stated that such threats were met with “an amount of challenge and inflexibility” by his colleagues.

As previously stated, this homophobia, heterosexism and/ or heteronormativity were heightened when seen against the backdrop of the key characteristics features of paramedic workplace practice.

Intimacy

Paramedics commonly work rotating shifts covering a 24-hour period to provide an emergency response to the community they serve. A range of combinations of shift patterns are used in various services; however, they are generally a combination of days, afternoons and nights. These are generally long shifts. Paramedics also commonly work as part of a ‘crew’, generally a team of two, however a number of single responder roles also exist. Paramedics working as part of a crew can be partnered together for extended periods, as Jacob explained: “You’re partnered up with one person for a month at least and you work in a very close environment”. This leads to unique relationships between paramedics and this is mirrored in very few occupational fields. These relationships can develop out of the ‘coupling’ of paramedics as a crew for long periods of time. This means prolonged exposure to specific individuals, which provides an opportunity to ‘bond’ and exchange personal information. As stated by Holley, this meant “Everyone knows your business, everyone” and in the words of Magnus, “You know who’s socialising”. This work pattern, combined with frequent exposure to occasional adverse and challenging clinical and social events associated with patients, tends to encourage intimate relationships between paramedics which may not be seen in other fields.

Holley supported this feature of intimacy within the paramedic workplace when she highlighted her experience of prolonged exposure and physical proximity to the paramedics she worked with. This was evident when she stated:

...it’s a very unique working environment in that you’re trapped in a car or an office or a branch or whatever with someone for a long number of hours straight during the day and an even longer number of hours during the night.

Holley went on to relate how this close work arrangement had led to her heightened sense of self-scrutiny and self-monitoring. Although Holley was in fact Bisexual, her workmates perceived her as a Lesbian. As a result of these perceptions she believed that other women had been uncomfortable sharing sleeping quarters with her on nightshift. Holley described how she felt some of the females she worked with reacted when rostered with her. She felt that her colleagues felt insecure and had expressed thoughts such as “if I have to be on station with someone at night over a period of time and I’m a woman and they’re [referring to Holley] Gay....how’s that gonna be?” Holley also felt that the intimate nature of her workplace led to it being “incestuous” in the sense that “everyone roots everyone, everyone picks up on everyone, everyone hits on everyone”. Her sense that her workplace was incestuous and that intimate relationships were frequent, only served to heighten her sense of discomfort when paired with other women.

Holley’s sense of insecurity and hyper-vigilance was echoed by other participants. Jacob also spoke of how a work arrangement necessitated extended interactions with a co-worker, and this made Jacob feel he needed to be extra careful about what aspects of himself he could be transparent about. He stated that he found this “intimidating and scary” and it put him at increased risk of exposing his sexuality.

Several participants discussed how the intimate nature of their work meant not only did they carry a sense of hyper-vigilance, but they felt limited in their ability to keep matters relating to their sexuality private. Latoya encapsulates the relationship between this cultural ethos in her workplace and her sense that, even if she chose to, she would be unable to be closeted when she stated:

...the other cultural weirdness of this job is it’s not like other jobs in that you are stuck in a fricken ambulance with someone for so long. Not only at least 10 hours a day, but more likely 14 hours a night which usually goes to 16 hours, day-in, day-out. Like, how well do you know these people? Like, too well. It’s not like any other job where you’re doing your own thing. You sleep with them, you eat with them, you drive with them, you make decisions together, you buy lunch together, you talk shit all day. It really surprised me when I started this job how that was actually the most challenging part of it, was having to get to know people so well, so quickly, whether you want to or not.... Imagine if you had to be closeted, like why would you bother? Imagine how much effort you’d have to put in to? And how long would it last? Three minutes.... Well, you’re sleeping right next to each other.

In a similar fashion to Latoya, Janine also felt limited in her ability to maintain her own privacy by virtue of the intimacy prevalent in her workplace. She stated “it does come out when you are in a truck with someone for 12 hours.... You tend to talk a lot about personal shit and

everything comes out.... I wouldn't want to be dishonest or anything." Janine also believed that the physical proximity of the workers within an ambulance exacerbated her inability to keep matters private relating to her sexuality. The limitations of this space meant that when patients enquired about her personal life, she was unable to respond without giving consideration to the fact that "you know the person in the front driving is listening". This relates also to the theme of patient centeredness discussed towards the end of this chapter and in more detail in chapter 10.

The majority of participants supported assertions in relation to the intimate nature of their workplace. As indicated by the evidence previously stated, they believed that this led not only to a propensity for Gay and Lesbian paramedics to be hyper-vigilant, but ironically to a contemporaneous inability to maintain their privacy. Although somewhat tangential to the context of this thesis, Magnus extended this argument. He believed that the intimate nature of his workplace had a propensity to impact on clinical care given to patients. He had seen instances where conflict had arisen over clinical matters and decisions in dealing with such issues which favoured people in particular social relationships. He spoke of the nepotism he had experienced when he said:

Even jobs, they say it's impartial or whatever and then you kind of realise who's who and who's got what and you know there's been some manipulation of stuff. You just know it. But that's the way it is.

The impact of the intimate nature of the paramedic workplace on the delivery of appropriate clinical care, although beyond the scope of this research, is an important area for future research.

Language

Language is a cultural artefact (Cunliffe & Shotter 2006). Several participants spoke of the language used in the workplace. This ranged from the use of technical language to the acceptable use of other forms of expression in more informal contexts. Language also acts as a 'gatekeeper' in subtle and unspoken ways to monitor boundaries in everyday workplace interactions (Holmes 2007). As the previous research considered in the literature review chapter documented the use of technical language to characterise workplace culture, the focus of this discussion will be on the nature of less formal language used in the paramedic workplace. Some of this language has been characterised as crude, sexist, 'blokey', racist and homophobic by participants.

Latoya and Janine both spoke of crude language they had been exposed to in the course of carrying out their duties. Janine mentioned casual 'downtime'¹⁰ conversations which took place "when we get back to the station and everyone is sitting on the couch". She said "the guys feel comfortable talking about their cocks or sex or whatever else and it can be really crude and disgusting". For her this had made for a "bit of an uncomfortable workplace". Janine went on to speculate about whether what she called the "dick thing" related to the fact that some of her colleagues knew about her sexuality: "I don't know whether that is because of my sexual preference that they feel comfortable doing it". In a similar fashion to what Janine called the "dick thing", Latoya had also been exposed to some crude jokes at work. She said her male colleagues didn't "mind telling me them" and felt it was appropriate to do so. In some respects this had for her engendered a sense of social inclusion. She added that she also felt somewhat excluded however by virtue of her response to these jokes which was not the "response that they want".

A further feature of the language used in the workplace was highlighted by Joe, who felt the language used by colleagues was "blokey" and frequently included Australian slang. Joe said it was common for his workmates to use such phrases as "g'day mate, how's it going?" in their interactions and with patients. Joe went on to describe how the use of this style of language had somewhat alienated him and referred to a "particular vocabulary that isn't normal for me to use because I'm more well-spoken". Thus he did not fit in.

In addition to crudeness and 'blokeiness', some language used in the workplace also revealed a degree of sexism. Latoya's experiences are evidence of the sexist nature of this language. We see this when Latoya described the discussions of some of her male paramedic colleagues.

I've worked with blokes who've commented on every woman's looks outside the ambulance as you drive around. Like, 'oh, I'd marry her, I wouldn't marry her, I'd fuck her, I wouldn't fuck her'; that's pretty tedious, it's pretty boring... when [they] comment on 'I'd fuck her, and I'd fuck her'.

Latoya closed this discussion by saying that "people would be just horrified if they knew what these paramedics were driving around saying about girls on the street".

A final theme related to language use in the paramedic workplace borne out of the experiences of participants was that the language had both homophobic and heteronormative characteristics. This was sometimes obvious and at other times less explicit

¹⁰ 'Downtime' is a term used frequently by paramedics and is commonly understood to mean the time at ambulance branches or stations spent waiting to be dispatched to cases.

for participants. In the sense of heteronormativity, as previously stated, Latoya pointed out how her usage of the word 'partner' was misconstrued. She explained that "When I say 'my partner', they think I'm talking about the person that I'm working with for the day instead of my love of my life for 15 years". Even when she was transparent about her sexuality, heteronormative assumptions in the workplace silenced her. Michelle had deduced that her workplace was homophobic in nature by some of the language used and because of "just the way they banter". Although the specific language was not overtly homophobic, in her view it reflected an intolerance of difference. She said the talk implied that in this environment she "wouldn't want to be a Gay male". Michelle added "...there's still people in there who walk into work and start being completely racist against" a number of groups of people. She implied intolerable racist language contributed to her assessment that it was not 'safe' to be open about her sexuality.

Humour

Previous literature has identified the style of humour used by paramedics and notes this is one tool in a repertoire of coping strategies. Humour was used to break the ice in stressful situations and as a coping mechanism. Holley gave a detailed description of the prevailing style of humour within her workplace. She described this form of humour as "crass" or "black". It was apparent in the telling of "really off jokes". Holley not only described the "crass" nature of this humour but its homophobic nature:

We have a lot of derogatory names for our patients or types of patients, or clientele, which ever you want to call them, and for each other. You know, he's a superhero, he's a wanker, he wears his undies on the outside of his pants, and that's about our colleagues because they have a superhero complex. Or, he's a complete dumb arse and I wouldn't want him treating my dog, or, you know, we've got the leso crew on today, or, you know, the leso and the poofter are working together today.... It's a very crass, earthy way we reference a lot of things, our patients, each other, it's a lot of crass humour.... Um, there's a lot of, um, people talk about sex and conquests and use 'poofter' as a derogatory term, a lot...'ah, ya poofter, what are you doing?

Although Holley went on to justify the evolution of this expression as "a coping mechanism for all the really awful and disturbing things we go and see", she also alluded to such language as a manifestation of a culture that is "very primitive I think and can be quite confronting I think for a lot of people". The homophobic nature of this 'humour' meant Gay and Lesbian paramedics, as Holley stated, "would be quite hesitant to reveal that they were Gay or Lesbian, they'd keep quite quiet about it until they felt comfortable in themselves and their place in the organisation before they let that slip".

Alcohol

Some participants referred to the propensity towards alcohol use and abuse within the culture of the workplace. The nature of what Mack described as a “boozy” workplace can be seen to have correlations to both the intimate and social nature qualities of the culture and the tendency to use alcohol as a way of coping (Porter 2013, pp. 144-5). Magnus and Holley highlighted alcohol as a ‘conduit’ for some of the social relationships previously considered here. Mack saw the over use of alcohol as a negative aspect of the culture of his workplace, stating “people behave badly” as a result of its use in “the social side of ambulance”. Mack saw alcohol abuse as a prominent feature of the culture of his workplace:

...for me as an alcoholic, you know, I think that's you know, something that I feel more than I do the Gayness. You know, I'm very much aware that a lot of these things, you know, you go out and people are getting drunk and I'm not comfortable around alcohol.

Ghettos

It is imperative to remember that in large organisations typically there are a number of subcultures that can and do co-exist (Shnurr 2008, p. 81). Participants spoke of the existence of work locations where they felt safer to be open about their sexuality. These provided a ghetto space and were tolerant of subcultures such as Gay and Lesbian paramedics. These ghettos tended to be found in specific inner city locations. There tended to also be a link between the location of the ghetto and the demographic of the surrounding community. These ghettos were not only geographical or spatial in nature, but they could be temporal with some rostering practices of ‘pairing’ Gay or Lesbian paramedics.

In terms of geographical ghettos, Saxon spoke about the predominantly heterosexual and the Gay branches. Saxon remarked that in the city “there are locations that are predominantly filled with Gay and Lesbian paramedics”. He went on to articulate that this was public knowledge within his organisation: “I worked at what was known as ‘The Poofers’ Paradise’ because there were such a high proportion of Gay and Lesbian paramedics”. This was in contrast to earlier experiences in his career where he had found things “quite hard” as he was “on the outskirts of the city”. Magnus also stated that he experienced a sense of increasingly being in a minority, the further he was from the inner city. This is evident when he revealed “my work location is probably a little bit on the outer so I’m the only Gay man that works there and there’s one Lesbian, we are a small station”. Saxon’s evidence relating to the outer suburbs being less ‘Gay friendly’ is corroborated by Magnus who confirmed that:

The more you go out, my experience here as a general rule, most of the Gay men who work in the outer suburbs, it's because they are still training and it's just the work

locations they've been posted to so they haven't had a choice of where they want to work.

The tendency for Gay and Lesbian paramedics to work in the 'ghettoes' originated from a sense of comfortable 'likeness' in these work spaces. There was a sense of safety and these ghettoes were an escape from the pressure experienced in the heterosexual dominant space. Saxon spoke of this pressure when he stated "the highest concentration of Gay men is [there] because in outer areas there is not the same tolerance". Magnus highlighted the 'comfort in likeness' quality of the ghetto space when he provided his description of 'Poofter's Paradise':

...if you head in closer to the city the stations probably have a 30, 40, maybe even 50 percent ratio of Gay and Lesbian staff. One in particular would be maybe 40 percent and that varies a bit as there's always rotation of staff.

This meant Magnus experienced both a sense of comfort and inclusion in an immediate or proximal sense, and a sense of isolation and exclusion in terms of the bigger picture.

In addition to the boundaries and ghettoes created in a geographical sense, Holley highlighted boundaries that were temporal in nature. These were imposed upon her and had a similar effect of 'ghettoising'. Holley worked in a geographical location which afforded limited ability to divide work locations into ghettoes. She did, however, find that another spatial and temporal ghetto was structured for her. Referring to a Lesbian colleague, she stated, "I actually found that I was rostered with her more often than other people". She thought this was because those responsible for rostering felt "I could identify with her" as she was "another leso" and therefore they felt it was appropriate to "put the lesos together...because she's a raving leso and...Holley can put up with that".

Ghettoes tended to be located in areas where the demographic mix of community they served was more diverse and tended to have a higher proportion of Gay and Lesbian people as residents. In this sense, the paramedics working in these locations tended to better reflect the community demographic and better serve their needs. Magnus illustrated this when he asserted:

I certainly think that within a geographical radius of the stations within 5 kilometres of the city there's a lot of Gay men, there's a lot of Lesbians. The culture is very different but it is almost like they are isolated to where the Gay and Lesbian populations are in the city as well.

Saxon felt this was a positive phenomenon when he explained working in these ghettoes meant "you also need to be tolerant of all of these people on the edges of society that you're going to, these patients".

The nature of the type of work paramedics were exposed to by working in these areas meant a greater number of cases and the type of case was often not categorised as desirable.

Saxon explained:

On the outskirts they kind of see the city as a shitebags' place anyway because you go to narcotic overdoses, lots of assaults, lots of pissys on the weekend...within that area, there's a lot of sex on premises venues where people do engage in risk taking type behaviours and take drugs and drop and then we're expected to go and then carry them out.

Magnus concurred with Saxon but added that a lot of paramedics, "just can't fathom that and they just don't want to be in the city and they don't want to have to be faced with that, whereas I think we are a lot more accepting of that." Magnus's statement indicated that heterosexual paramedics have a lot more control over where they work and a greater ability to work in the lower exposure, more affluent and low case load areas. Saxon stated in relation to this undesirable type of paramedic work that heterosexual people "don't want to be doing that work".

Magnus highlighted the issues associated with the ghetto effect in his organisation. He had previously worked in a 'ghetto'. This had afforded him a sense of comfort and inclusion; however, he felt that working in a 'ghetto' for a prolonged period put him at risk of burnout. Magnus moved to a quieter location to counter this risk. He highlighted the tension between the desirability of inclusion in a (sub)culture and having a manageable workload:

I moved out, not even 3 kilometres because that location is a bit quieter, I just need a little bit more of a reprieve from the workload so, just slightly different demographics. And the guys down there are alright with me I think.

Whilst often there is benefit to the community in having paramedics attracted to such locations, as they tend to reflect the local demographic, these locations are not often desirable. As they tend to be close to the centre of major cities, they also have a high workload and deal with cases that can be more violent, involve drugs and alcohol and other factors that take its toll on paramedics. It follows that working in these locations often means higher caseloads, greater exposure to specific types of jobs and ultimately burnout. Heterosexual paramedics have a greater chance of working at the less busy branches with lower utilisation rates, more rest and therefore career longevity.

Patient centeredness

A strong theme that emerged was the concept of 'patient centeredness'. This generally emerged in relation to discussion around coming out to patients. Participants suggested that one of the cultural expectations of their workplaces was that the patient is central to any interactions. Thus the needs and identity of the attending paramedic is distinctly secondary to

the patient. In the context of this chapter, which aims to address the additional characteristics of paramedic culture, the majority of participants stated that whether they were 'out' in the workplace or in other areas of their lives, they generally did not expose their sexual identity to patients. Commonly, participants stated that the 'patient-centred' manner in which they were required to interact with their patients as healthcare professionals was the underlying reason. Holley believed the encounter she had with a patient was "about them, their illness or their situation or their need at the time". This viewpoint was echoed by several other participants. Whilst a strong feature of paramedic culture; it is probable that heterosexual paramedics do not tend to evade questions and obscure realities under the veil of the doctrine of patient-centred care in the same way as these 10 non-heterosexual paramedics do.

Chapter 10 provides further exploration of 'patient centeredness'. The emphasis of this exploration here is to consider whether it is a true representation of the original notion in healthcare, or simply another way in which heteronormative approaches and interpretive constructs in the culture of paramedicine silence Gay and Lesbian paramedics.

Critical discussion and summary

A strong, cohesive work culture can serve both community and organisational needs. From a critical perspective, one of the functions of such culture can also be seen as the maintaining of a harmonious workplace for a heterosexual majority, by providing a complex, coded and systemic way of excluding and silencing *others*. These *others* do not fit cultural stereotypes. *Others* may not feel an affinity with such a culture. The lived experience of participants reinforces previously identified characteristics of paramedic culture and constructs new ones. These insights relate to a range of factors, most notably in the context of this work to elements of the symbols, heroes and rituals within the heterosexual culture that reflect homophobic and heterosexist values. Very often the presumption is that in general terms only heteronormative symbols, heroes and rituals matter. These aspects of the heteronormative culture function in a complex manner to exclude, marginalise, silence and 'other' non-heterosexual paramedics.

Culture can be divided into two distinct categories in the context of the workplace that includes individuals and group culture. In organisational terms, culture can perform a positive function, that of 'cultural homogenisation'. When the organisation has an interest in delivering a consistent product, service or commodity, there is an obvious benefit in having a homogenised workforce to deliver it. This means quality control and a greater ability to have a standardised expectation of behaviours where actions and responses tend to be more predictable.

It is my view that this is a form of acculturated collectivism which obviously serves the purposes of an ambulance service provider, which employs paramedics by encouraging a more consistent and measurable approach to common tasks and objectives. This is particularly the case when such paramedics work in a temporally and geographically disparate climate and respond to a diverse range of situations in an environment understood in the industry as 'uncontrolled'.¹¹ At least in such an uncontrolled and disparate environment, a collective culture is an influential force that ensures a paramedic will attend a particular incident, be presented in a particular fashion, survey and manage a situation using particular guidelines and be less likely to deviate from organisational directives. Such cultural homogeneity is to some extent potentially inalienable from the needs of an ambulance service provider and this is certainly evident in organisational artefacts. The 'flipside' of this groundswell of collectivism is potentially that it comes at the expense of individual wellbeing.

Workplace culture can be viewed as serving specific organisational needs. If the culture is not dynamic or inclusive in terms of its responsiveness to *others* it can quickly become dysfunctional. In the context of paramedicine, a culture that does not respond to the changing needs associated with changing demographics of its workers can produce a rigid and out-of-touch workforce. That sort of workforce is a poor match for the social needs of its employees. In the case of paramedics, this is likely to result in individual workers who are alienated and feel disenchanting in their work environment.

Saxon believed that the current culture of his workplace was a place where he felt disharmony between the realities of the paramedic's role and the dominant organisational culture.

I think that a lot of the older, predominantly male, alpha male type personalities that are attracted to the job for the high drama, high adrenaline, you know, cutting people out of cars.... That's just not our work anymore, we don't, you do very little of that, there's the frustration that comes with that as well. So I find them quite hard to work with. I'm quite happy to go and pick nanna up off the floor and take her to hospital and make sure she's comfortable. I get just as much reward out of that as cutting someone out of a car.

Although historically a male dominated field, in more recent times paramedicine has employed an increasing number of women. In NSW, for example, 35 percent of paramedics

¹¹ Paramedics respond to cases in a range of environments which distinguish them from other groups of workers who work within a set, preconfigured and purpose built environment. As a result, paramedics will often refer to their work environment as 'uncontrolled'. The 'uncontrolled' nature of the paramedic workplace is one factor that paramedics arguing for a separate professional identity highlight in terms of it functioning as a unique and distinguishing workplace feature that sets paramedics aside from other health providers.

are women (Ambulance Service of New South Wales 2011). In data from Open Universities Australia it was reported that the percentage of women nationally is 30.1 (Open Universities Australia 2013). Despite increasing participation of women in terms of numbers employed, arguably this process of 'feminisation' does little to feminise the culture. The contemporary ever-present and dominating model of masculinity within the ethos is testament to form of masculinity, which appears to be replicated to some extent by female paramedics who respond to the pressure to 'man up' in order to operate in a 'man's world'. This performance of the paramedic 'archetype' can serve to perpetuate and reinforce less favourable models of masculinity. Female paramedics are thus forced to adopt a survivalist strategy in order to merely gain acceptance.

Masculinity is the male performative construct of gender and therefore one might argue that this has little relationship to sexuality; however, the stereotypical male is heterosexual. Masculine dominance is therefore kindred to heterosexual dominance. They are cultural bedfellows that ensure poofers really only have a place in 'Poofers' Paradise'.

Does this serve the needs of maintaining social cohesion within the workplace or does it become a divisive aspect of the culture? Reynolds (2009) has argued there is incongruence between the function of a paramedic in caring for those in need and the dominant culture. Can such a conceptualised dissonance be attributed to the heterosexist, homophobic and heteronormative aspects of this culture also? Not only does this potentially exclude and alienate paramedics in their place of work, but it does not resonate with the 'feminine' role of a paramedic. One could argue that the culture is out of touch with the realities of the work of paramedics in a number of ways and hence, until significant cultural change happens, the workplace will remain antiquated, whilst continuing to be problematic and organisationally dysfunctional.

It is also questionable as to whether such heteronormativity performs any function whatsoever, for anyone who is known as 'the enemy' can go into 'stealth' mode. Gay and Lesbian people have the unique ability to conceal their sexual identity or make it ambiguous in a way that other groups with visible identity attributes are unable to conceal (Clair, Beatty & MacLean 2005, p. 78). Sexual identity management strategies can be adopted (Chobrot-Mason, Button & DiClementi 2001; Ragins, Singh & Cornwell 2007) to ensure this stealth, to some extent. Closeting oneself to pass as heterosexual and to be accepted is a common practice for non-heterosexual people in many contexts, but the rift created is not productive.

Gay and Lesbian paramedics are silenced by practices which exclude and marginalise them. Ironically, this exclusion and marginalisation forces *us* undercover. Gay and Lesbian

paramedics who operate 'undercover' can be privy to these attitudes, which contemporaneously expose *invisible* Gay and Lesbian paramedics to heteronormative, homophobic attitudes and behaviours. These behaviours would commonly be suppressed if those behaving in such a manner were aware of the presence of a Gay or Lesbian person. Those individuals who enact this heterosexism which contravenes modern legislation and workplace equity policy therefore sit outside the matrix of officially acceptable behaviours and are therefore at risk. In this sense, cultural practices which silence Gay and Lesbian people can serve to undermine people in the workplace of all sexual persuasions and as such, contribute to insecurity and dysfunction within organisations.

The need to prove worth and fit into the dominant culture of the workforce was a recurrent theme in the data. Whereas paramedics who fit the cultural archetype are embraced within a workplace that champions their identity; those that do not fit seamlessly with such stereotypes often have to pass through a process of scrutiny constructed by their colleagues. As a result, Gay and Lesbian paramedics often face an unofficial and arbitrary 'selection process', which is culturally biased, that heterosexual paramedics never need to pass through. Success in this 'selection process' can be extremely localised and subjective. As participants in this research indicate, sexuality is one of the criteria used by those in control as to whether or not an individual will be included or excluded. This construct is not governed by paramedic organisations, but by unofficial gatekeepers who preserve the dominant culture. It is therefore not controlled by policy and procedure, but by subtle behaviours, which are often inconsistent with explicit organisational policy. One example is the fact that Magnus felt he had on occasion needed to prove he was physically capable of certain tasks alongside the heterosexual men he worked with. Passing these sorts of 'selection tests' was something Magnus's heterosexual colleagues did not have to do. The covert nature of these practices means they are difficult to counter on all levels. This perpetuates poor practice and increases the gap between the official 'politically correct' line and the reality on the ground.

Several participants made reference to situations where they had to 'prove their worth' to de facto scrutineers in the workplace. There are numerous points of difference that put a paramedic in the position of having to prove their worth when they do not fit the archetype. Gender is one of these points of difference, sexuality is another. The focus of being accepted into the paramedic culture seems to be predicated on what an individual *does not* have in terms of attributes. If an individual is *not* male, is *not* white, is *not* heterosexual and does *not* have children, they need to prove their worth and receive the rubber stamp from those that possess such attributes.

As previously highlighted, the Gay and Lesbian paramedic participants in this research stated they did not reveal their sexual identity to their patients. Participants commonly

rationalised this as being due to the need to practise using a model of patient-centred care. This concept of patient centeredness has an insidious and pervasive political edge. The long-term impact of this concealment on the individual paramedic is an interesting area for further exploration. This theme is considered further in chapter 10.

Despite evidence indicating that the mainstream culture of the paramedic workplace tended towards being masculine, heterosexual and 'blokey', participants spoke of the existence of geographical pockets where the culture was overtly Gay friendly. Participants stated that 'Gay branches or stations' existed mostly within the inner city suburbs. This is consistent with the notion developed by Fineman (1993), that is, that organisations have physical spaces in which different kinds of "feeling rules" apply. These subcultures can differ markedly from the core culture which forms a backdrop and can enhance or deviate from the core ideology (Trice 1993, p. xi). These 'Gay' work locations generally mirrored the population patterns of the areas they service. Whilst on some levels the 'acceptance' provide by a ghetto can provide comfort, it is subject to the approval of the dominant culture, which has a strong influence over the locations of such ghettos.

This choice between social inclusion in the workplace and working in a more desirable location from a work-life balance point of view is something heterosexual paramedics do not experience. Whilst these ghettos to some extent alleviated some of the 'closet fatigue' associated with censoring oneself all the time with everyone (Winfeld 2005, p. 47), confinement can be exhausting. The practice of ghettoising in the paramedic workplace is a manifestation of a heteronormative culture. Until a culture that is more inclusive of diversity is promoted, championed and adopted within the paramedic workplace, cultural practices which encourage ghettoism will continue to disadvantage Gay and Lesbian paramedics. These paramedics are disadvantaged by their relatively higher caseloads and less choice in terms of selecting a *comfortable* and *inclusive* work location. This leads to less opportunity for rest when compared to their heterosexual counterparts. It is busy in the ghetto. There is *no echo*¹² *in the ghetto*, and this has a negative effect on the wellbeing of Gay and Lesbian paramedics.

The 'onion' framework aforementioned was adopted to conceptualise the complex matrix of paramedic culture in the literature review and here from the perspective of participants. This facilitated the description of paramedic culture as masculine, homogenous, brave, hierarchical and uniform in terms of its values on the basis of previous research. Participants in this research illuminated artefacts in the form of symbols, heroes and rituals related to further core values within the culture. Some of the evidence provided echoed what has

¹² 'Echo' is the word used by some paramedics to refer to meal breaks.

previously been documented through a heteronormative lens. Participants in this study gave greater depth to some additional themes as follows:

- Heterosexism, homophobia and heteronormativity
- Intimacy
- Language
- Humour
- Alcohol
- Ghettos
- Patient centeredness.

These qualities are not easy to quarantine into neat divisions or ‘wedges’, and numerous interpretations can be applied to how each of these characteristics fit together and their interrelationships.

Within the context of this research, which focuses on the workplace experiences of Gay and Lesbian paramedics, a new ‘wedge’ to this onion can be modelled. This is the wedge related to heteronormativity, heterosexism and homophobia, all of which appear to be influential within paramedic culture. This wedge of heteronormativity is diagrammatically represented in figure 8.1 below. Indeed, these factors continue to be influential in the broader community.

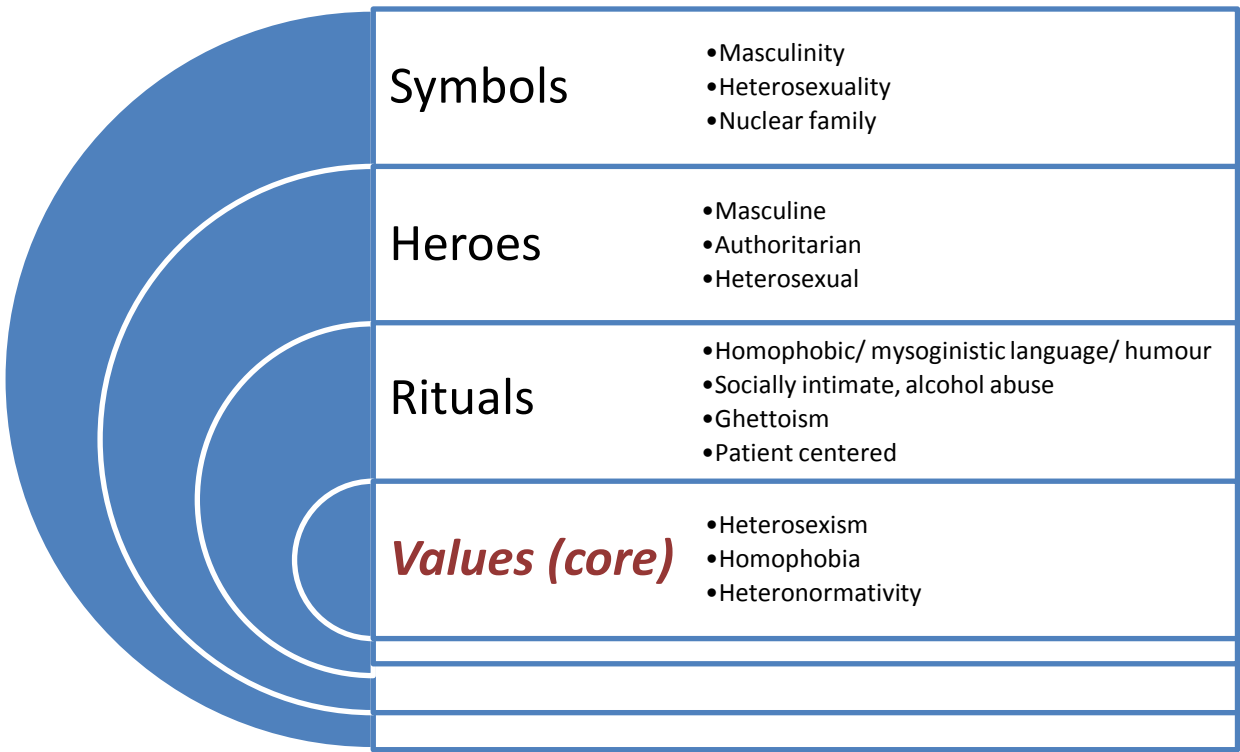


Figure 8.1: Wedge of heteronormativity

CHAPTER 9: STEREOTYPES

The previous chapter focused on the nature of the paramedic workforce culture from research participants' perspectives. In chapter 7, a similar approach was taken with a focus on the importance of individual identity. Discussion in these chapters indicated that culture that values masculinity, heterosexuality, heroism, homogeneity and heterosexuality is, in a prima-facie sense, at odds with the contemporary belief in birthright: that we can and should have an identity that is both authentic and individual.

A range of contemporary legislative and policy measures are levelled at social inclusion of a number of vulnerable groups, and here they are Gay and Lesbian people. Despite this, underreporting of instances of bullying and discrimination in the workplace as they relate to Gay and Lesbian people is commonplace (Irwin 1999). Figures reporting the frequency of instances of bullying, harassment and discrimination experienced by Gay and Lesbian people in Australian workplaces (Irwin 1999) show that some organisations unconsciously subscribe to or implement these policies in order to meet compliance targets. And as such they act upon equity and inclusion in the workplace in a tokenistic sense. Some research into the disjuncture between overt statements of practice in relation to employment policies around stigmatised groups and actual practice supports this notion of tokenistic compliance (Pager & Quillian 2005). Without serious organisational strategies and programs aimed at ensuring compliance with these equity initiatives, what 'really goes on' can be left to the unofficial cultural gatekeepers operating at the 'shop floor' level. These less tangible behaviours are difficult to control in terms of the manner in which they marginalise vulnerable groups (Benokraitis 1997; Sue 2010).

Stereotypes as defaults

In instances where organisational strategies are inadequate, responsibility for adherence to social inclusion policy in the workplace defaults to the gatekeepers of the culture; these gatekeepers make up and inform workplace boundaries and interactions in an 'everyday' sense (Holmes 2007, p. 1993). As such, the values inherent within the culture can dictate local workplace practice and behaviour. In geographically dispersed paramedic organisations, the nature of practice from one location to another can vary widely based on local custom as mentioned in the previous chapter. Some of these behaviours and practices can be out of step with social justice initiatives and function in a complex, clandestine and coded 'underground' manner to exclude or marginalise vulnerable groups. As a result Gay and Lesbian employees, including the Gay and Lesbian paramedics in this research, can experience social exclusion and marginalisation. Holley likened the gatekeepers of her workplace culture to a "mini mafia" and was clear that these groups used sexuality as a

criterion of exclusion. The fluid, dynamic and unpredictable nature of these cultural practices impacts upon Gay and Lesbian paramedics who may not be 'out' in relation to their sexuality. Due to their silencing, stereotyping and stigmatisation are commonly used to identify, exclude and marginalise these paramedics. These stereotypes of sexuality were inextricably linked to those of gender performance.

An idealised model of the culturally 'ideal' paramedic that emerged was that *he* was white and heterosexual. The closer a particular individual was to having the requisite characteristics of such an ideal, the more likely they would be embraced within the workplace. As stated in chapter 6, this had implications in terms of the career progression of participants. Additionally workplace culture impacted their experience of positivity, inclusion and wellbeing at work. As reported by participants in this study, survival and wellbeing within the workplace was in some cases dependant on an individual's ability to reflect those attributes commonly desired in the construction of the 'ideal' paramedic.

A number of dominant workplace stereotypes were identified in this research. Several participants spoke about the way in which stereotypes functioned in their place of work in relation to gender and sexuality. These frequently had the impact of making them 'other' in the context of a workplace culture which, as previously discussed in chapter 8, privileges the white, heterosexual male as the required model of a paramedic. In some instances, various deviations from the ideal were *tolerated*. Being a woman, for example, was acceptable under the *right* circumstances; but only if she was the *right* type of woman. Similarly, being Gay or Lesbian may be acceptable in the *right* place or for the *right* type of Gay or Lesbian person. One of the difficulties in this system of coding (of what is *right* in terms of gender and sexuality) is its fluidity and the way coding is subjected to arbitrary variations. What is *right* is subject to significant variation from one paramedic organisation to another and from one geographical location to another. The *right* type of Gay or Lesbian person may be accepted conditionally. As participants in this research state, some of the conditions applied to such acceptance include not being 'in your face', not being too threatening in terms of being too open in relation to their sexuality, and not challenging or undermining the dominance of the white, male, heterosexual paramedic. Despite varying levels of acceptance of Gay and Lesbian paramedics, stereotypes where subscribed to within the culture meant that these paramedics were not embraced for the quality of diversity they added to the workplace. Instead, their social experience in the workplace tended more towards tolerance or acceptance as opposed to being valued and embraced. Furthermore, this tolerance or acceptance was commonly unpredictable and unreliable. For the Gay and Lesbian paramedic participants, the random and unpredictable nature of this tolerance of difference led to feelings of needing to be hyper aware and undertaking constant surveillance of

situations that might be perceived as a threat to their wellbeing. There was also a great deal of self-monitoring in a bid to remain 'safe' in the workplace.

Participant experiences of dominant stereotypes

Research participants highlighted a number of stereotypes they had encountered in the course of their employment as paramedics. Some of these were linked to gender and others to sexuality. These stereotypes had functioned to exclude the Gay and Lesbian paramedics from mainstream acceptance in a number of subtle ways in their places of work.

Stereotypes relating to sexuality

All participants attested to the existence of stereotypes of Gay and Lesbian people that were prominent in their workplaces. Commonly, discussion of these stereotypes was prefaced with a reference to how exposure to negative consequences of such stereotypes had been limited. The data findings also indicated that this minimalisation or trivialisation seemed to make these workplace dynamics and practices more palatable and acceptable to the Gay and Lesbian paramedics affected by them. Janine gives an example when she prefaces her discussion of her experience as a paramedic with the statement, "I haven't had too much negativity personally in the workplace". Prefacing her discussion in this fashion almost indicated she had expectations of significant negative experiences on a regular basis, "apart from a few stupid comments, there haven't been any issues". Holley stated she was prepared to "encounter negativity from my colleagues, from the organisation, from, you know, the people that I interact with at the hospitals" due to her sexual identity. While Holley did articulate several instances where she felt excluded, she had not been exposed to what she believed were overt instances of discrimination. This meant she was pleasantly surprised. This was evident when she stated, "Because only the opposite has happened it's been quite a pleasant surprise for me". Holley's statements indicate that having negative experiences is 'par for the course' for Gay and Lesbian people.

Despite Janine's perception that language and behaviours within her place of work meant there was no concrete evidence of homophobia, she went on to explain an experience of homophobic stereotyping in relation to a colleague. In an interaction previously discussed in chapter 4, Janine referred to a male paramedic who had come out after having been in a heterosexual marriage. The exchange centred on the belief of her colleagues that this Gay paramedic would "never be able to donate blood" on the basis that "he's a poofter". This negative stereotype relating to Gay males having HIV/AIDS was prominent in the 1980s at the height of the initial AIDS epidemic (Henderson 1996, p. 163). Ironically, this very erroneous stereotype does *not* seem to have shifted, despite the medical understanding required of paramedics in relation to transmission of communicable diseases.

A further example of a stereotype prevalent within her workplace was highlighted by Janine. She felt that the fact she had experienced “few issues” related to her sexuality was related to her appearance:

...when I tell someone I'm Gay, they are surprised as well. It is maybe the way that I look, I don't have the short hair and typical looks, so....

As a result of the prevalence of the stereotype of what a Lesbian typically looks like, Janine's exposure to negative experiences had been minimised. Michelle reported a similar ability to ‘fly under the radar’ because of her physical traits. She stated she was not suspected of being a Lesbian by her workmates “because I look very straight...I'm small and feminine”.

Joe gave a few examples of stereotypes within his workplace related to sexual identity. The first example related to the previously discussed interaction he had with a patient he was attending. This patient asked Joe “Why are you talking like that?” When Joe inquired as to what they meant by this question, the patient stated “You sound Gay”. The way in which Joe expressed himself met with the Gay stereotype. Presumably, this stereotype functions in a wider sense in the community in which they are both immersed. Such a stereotype can be used to mimic and caricature Gay people in a not-so-subtle and condescending way. This stereotype also disempowered Joe in a sense, as it enabled his patient to use a stereotype that had the effect of ‘outing’ him. Joe illustrates this when he says, “...while I feel that I handled the situation remarkably well and while I didn't agree or confirm her suspicions, I felt like I was outed”. Joe also highlights how this exchange was essentially an act of violence and aggression on behalf of the patient when he states, “this patient was actually aggressive to some extent, so I then had to take an entirely different stance with the job.” In this sense Joe's ability to function at optimal capacity in his role had been compromised by a patient adopting a negative Gay stereotype. Joe explained this sense of vulnerability:

I almost felt as though because of how she was perceiving me, I wasn't going to be able to conduct the clinical assessments in such a way that would be of benefit.... that I wasn't actually be able to do my job simply because she was focused on me and trying to find out about my sexuality rather than me trying to find out her chief complaint. Then I felt at some point that I was actually going to have to swap roles with my partner, which would have made me feel inadequate.

Gay stereotypes, as experienced by Joe in the workplace, were not limited to his interactions with patients. Joe had also been identified as Gay because of the misconception and enforced stereotypic belief that all Gay males are effeminate in their interaction with others. Some of his colleagues subscribed to this principle. Joe described the interactions he had with some of his patients as follows:

I can specifically remember multiple occasions where I would say to my partner, 'would you mind popping the monitor on Mrs Jones?' which to me is just a nice way to be.

Reacting to Joe's form of self-expression, some of his workmates corrected him in relation to interacting with patient's in this manner, claiming he was not appropriately assertive in his approach. Joe says "I was then told, 'don't do it that way; the way you need to do it is say to Mrs Jones my partner is going to put the monitor on you'". Joe saw this as "just semantics, just ridiculous" and added, "If Mrs Jones is a mature woman that identifies with courtesy and politeness; to be a bit softer around the edges is only going to help to build rapport".

Interacting with patients in this way eventually led to an investigation and the management of Joe's work practices, as his communication style was presumed to have some impact on his clinical competence. Joe stated he "still got the job done" so one must question the relationship between the stereotype of the polite, effeminate Gay male that functioned in his workplace and the clinical investigation that ensued.

Although in a contrasting sense to the experience of Joe, Magnus's experience highlights the existence of the same stereotype in his work location. Magnus makes this clear when he recounts one particular interaction with a colleague:

I remember even at one location I'd been at for six months and was out if anyone asked and the manager, a strong guy with tattoos, I got on famously with. He comes storming into the lounge room where I was watching tele and goes 'hey, Magnus, are you a poofter?' And I'm like, 'yes mate', thinking he knew because I was out at that station. He goes 'oh, for fuck's sake, you're not supposed to be like that'. And I'm 'like what?' He goes, 'oh, you look straight'. I've gone, 'I know your type mate' and I took a line from the Simpsons 'you like your beer cold and your homosexuals flaming'. He's been great, but just that initial like someone with a booming voice like 'you fuck'n poofter', it's like what? It can potentially...it pricks up, just the fact that he felt the need to come storming in too..

Magnus's account illustrates that it is probable that the manager he speaks of would be more comfortable in some ways, if Magnus presented in a more stereotypical Gay male way, so that he was more identifiable and visible to those around him.

Holley's experience of the reaction of various colleagues to the sleeping arrangements on nightshifts can be seen to link to the stereotype that Gay and Lesbian people are sexually promiscuous (Ferfolja 2007, p. 148; Humphrey 1999, p. 135). Holley had been "just accepted" initially in her workplace and was at that point a married, heterosexual woman. When she entered a Lesbian relationship she experienced "a few raised eyebrows" but she noted this did not change the way she was treated. As previously stated, Holley did note a

different response from work colleagues when she was required to sleep at a station with a female work partner, observing that other female paramedics sometimes appeared to be insecure and uneasy about this practice. Holley's perception of this reaction from female colleagues was that they thought she may make sexual advances toward them when they were alone together at night and in bed at work. The common link with stereotypes of sexual promiscuity and predation is the erroneous association with Gay and Lesbian people as illustrated in these statements.

The existence of this stereotype of presumed sexual promiscuity is also picked up by Mack. He described some situations at work where he felt "the blokes do behave a bit differently around me than they do the other blokes". Mack explained how he was excluded from conversations in relation to "sex and who you fancy" which commonly took place at the branch. Mack felt he was excluded on the basis that he "could make them very uncomfortable". This sense of vulnerability related to the stereotype that Gay males were sexual predators. On occasion Mack was secure enough in himself to turn this type of interaction around. He stated that on entering into these conversations:

Every now and then I decide to [enter the discussion] anyway, just for the fun of it. Or I pretend I'm straight, mockingly straight and try and have a go at what they might be saying, so yeah, as a bit of a mockery of them.

This statement indicates Mack's propensity to 'play' at the edges of this type of interaction. The conversation illustrates his awareness of the way in which stereotypical perceptions of the nature of his sexually functioned in his workplace and underpinned his ability to play in this way. In addition to challenging his colleagues around play, Mack maintained an awareness he had "quite a different interaction with the other guys in the service than they have with each other".

The stereotypic theme which characterises Gay men as sexual predators and sexually promiscuous is also evident in Magnus's experiences. Magnus had been approached by a number of other male paramedics who had said directly to him, "we don't give a shit what you are". Despite the 'permission' these colleagues had 'granted' Magnus to be Gay, there were conditions attached. He went on to explain that Gay paramedics had been accepted on the proviso that they did not "crack on to straight men". Magnus was not perceived by his colleagues as having the propensity to overstep this boundary. He explained the uncertain culture of his workplace and the stereotypes that function within it:

...you sometimes get that heterosexual culture that says 'you can be Gay, that's fine, just don't crack onto me or anything', is that what you are saying, or is it, 'you're Gay, whoopy doo?' It was too hard to work out.

From this statement Magnus still seems to lack clarity in terms of whether he is in point of fact accepted or not by his work colleagues.

Participants also highlighted some of the dominant stereotypes relating to the physical characteristic and capabilities of Gay men and Lesbians. These stereotypes seemed to echo those in the general community in following the pattern of Lesbians having more masculine features and capabilities and Gay males having more effeminate qualities. Holley demonstrated this view when she states “for a woman to be a Lesbian just makes them more masculine”, adding “they’re quite butch”. Holley then added that the corollary of this within the context of her workplace is that men “become less masculine by being a Gay man”. Holley noted the association within these stereotypes to characteristics of physical strength required to perform particular tasks. Calliope also spoke of the dominance of the stereotype of the ‘butch’ Lesbian in her workplace. She described the perception that Lesbians were more capable of a number of physical tasks as well as those requiring more stoicism, “because a lot of Gay women, yeah, whether you’re more masculine or whatever, you’re probably of that persona of being a bit tougher, a bit more of a hero of whatever....Tougher, stronger, whatever...got the tougher mindset”. Joe also made the connection to the dominant stereotype within his workplace, which was prescriptive in the sense of Gay men using specific mannerisms. Joe felt his workmates used these stereotypical “mannerisms as well, because...I would never openly talk about being Gay” to identify that he was, adding “I obviously look Gay” in reference to the existence of another thread of this stereotype, that of having more feminine features.

The stereotypic assumption that Gay men were not as physically or emotionally strong as heterosexual men or Lesbians, *and therefore not as clinically capable*, had implications for Saxon. He noted that this perception meant he constantly had to display his masculinity so as to prove himself competent in front of his colleagues. Saxon stated “newer paramedics kind of get a hard time...but certainly I think being Gay there was a couple of extra things put in there”. Saxon felt that because he was Gay and a former nurse, his colleagues had perceived him as weaker in some respects. He stated “I proved myself very early to those people” when he showed proficiency in dealing with clinical challenges. Saxon stated that as a result his colleagues were able “to put my sexuality aside”. Despite his sense of acceptance generated by now having proven himself, Saxon continued to be labelled by his colleagues with the behaviours that exemplified a negative Gay stereotype. “They still called me ‘Priscilla’”, which led him to continue to feel marginalised, despite having been accepted by colleagues in some respects.

Stereotypes relating to gender

The focus of this research is sexuality and how sexuality relates to inclusion or exclusion in the paramedic workforce. The previous section highlighted the experiences of Gay and Lesbian paramedic participants as they relate to the impact of negative stereotypes in the workplace. Inherent in these stereotypes of sexuality was stereotyping that aligned to heterogendered understandings that were dominant in the workplace. These stereotypes assigned characteristics to each gender. The dominance of these stereotypes functioned to include or exclude individual paramedics on the basis of how closely they mirrored the dominant stereotype or *archetype* of a paramedic within the workplace.

Some of the female participants in this study highlighted negative experiences they had encountered and attributed these experiences to being the result of their gender, as opposed to their sexuality. This was the case for Janine who commented, “I think definitely there might be a bit of a barrier there, but I think more so being a female than a Lesbian”. The barrier referred to her sense of acceptance, equality and inclusion within a paramedic workplace culture that positioned women as less capable than men.

Similar to Michelle, Holley felt her physical size and femininity meant there was a perception that she was not strong enough to perform a number of the physical tasks required of a paramedic. As noted in chapter 8, Holley “had a lot of gender issues” and these were underpinned by the dominant stereotype that women are physically weak. Also, in a similar way to what Saxon described in relation to his sexuality, Holley needed to prove her worth. She needed to prove her capability in a range of physical tasks to be accepted as capable by her male colleagues and this also had a direct relationship to the dominance of the ‘women are weak’ stereotype within her workplace.

Mack highlighted a positive stereotype that was associated with paramedics who were women. When discussing the lack of acceptance in the workplace related to his sexuality, Mack said he did “very much prefer working with the girls” as this meant it was “less of a pissing competition” when he did so. He related this to the common understanding that women were less aggressive and collaborated more as part of a team, whereas men tended to exert more aggression and competitiveness. His remarks were echoed by Saxon when he stated it was “less comfortable, it is less dynamic, and there is less interaction” when he worked with a male and due to this lack of collaboration he said, “I prefer to work with female paramedics than male”.

Interplay of gender and sexuality – stereotypes in stereo

The evidence provided by participants indicated that in general terms dominant stereotypes within their workplace attributed a range of characteristics to individuals in specific gender

and sexual identity groups. The characteristics associated with each of these groups that emerged from the data findings are noted below in table 9.1. In terms of ordinance, these were arranged in 'order of merit' according to Joe in terms of the "ladder of acceptance" within his workplace. This 'ladder' privileges categories of people according to corresponding rank.

Table 9.1: Hierarchy of acceptance and associated stereotypical traits

Rank	Category	Associated stereotypic attributes
1	Heterosexual men	aggressive, competitive, physically and mentally strong
2	Heterosexual women	collaborative, diffident, physically and mentally weak
3	Lesbians	physically strong, physically present in a similar fashion to males, emotionally stoic, promiscuous and sexually predatory
4	Gay males	physically weak, effeminate, HIV infected, polite and courteous, prone to specific mannerisms, talk in a particular way, promiscuous and sexually predatory

With reference to the way these stereotypes operated, and despite some overlap, they had the impact of marginalising all but those whose primary identity was that of a male, heterosexual paramedic. Joe felt that these stereotypes provided a system by which a "ladder of acceptance" was produced in the workplace. Joe felt that in his work as a paramedic "Gay men are right down" the bottom. He went on to elaborate on the levels of acceptance this system of coding scaffolded. Joe explained that he felt on a "scale of acceptance, perfect acceptability is heterosexual male or heterosexual female". He added, "I think that Lesbian women are possibly equal to heterosexual females, possibly maybe down a rung...but I do tend to think that Gay men are right down the ladder of acceptance." As a final reflection on this "ladder of acceptance", Joe noted that the closer a Gay male tended to be to the negatively stigmatised model of a Gay male, the less accepted they were. He said that a Gay paramedic was more likely to be accepted if "...you don't appear to be Gay at all in terms of mannerisms or speech".

The hierarchy associated with dominant stereotypes, described by participants, had the ability to produce a 'dual edged sword' for some groups. This operated in a complex and abstract sense. Using a female paramedic as 'subject' here, she could be marginalised by co-workers because stereotypes relating to her physical size meant she was perceived as 'substandard' in her ability to perform certain physical tasks. If she happened to be a Lesbian, she may have the stereotypical qualities of strength assigned to her by colleagues. She may also be marginalised or excluded on the basis that she may be seen as a sexual predator or a genderless anomaly that sits outside the space of heterogendered binaries (Butler 1990, p. 17). Her location outside of these boundaries, ironically, could be made more obvious by presenting herself in a fashion that is a product of the stereotypes crafted for her by heterosexist society. This 'no win' situation is inextricably bound to the complex systems of stereotypes operating in the paramedic workplace.

Holley's experience brings to life the complexity of these stereotypes and the way in which their intersectionality meant identity characteristics exposed her to multiple and fluid layers of exclusion. Holley identified as heterosexual when she became a paramedic. As a result of her sexual identity she felt accepted in a social sense. She was however contemporaneously subjected to scrutiny by some of her work colleagues who perceived her as not being physically capable for the job. When Holley eventually came to be identified as a Lesbian by her colleagues she felt she was excluded socially at that point in subtle ways, which related more to her sexuality. Holley believed she was excluded and marginalised by those in the dominant group. This group she claimed was the male heterosexual paramedics.

Function of stereotypes in the context of intimacy in the workplace

The intimate nature of the paramedic workplace has been previously discussed in chapter 8, which explored paramedic culture. The nature of the workplace meant, in Holley's words, "Everyone knows your business". This characteristic of intimacy tended to amplify a particular trend in stereotypes related to Gay and Lesbian people in general. This amplification related to the belief that Gay men and Lesbians were, by nature, sexually promiscuous and/ or predators. This was particularly strong in relation to Gay males.

Magnus said that "with two men, one Gay, one straight" there was a sense that heterosexual men felt threatened by the requirements to work closely together. He said that these heterosexual men sometimes felt a Gay male partner would be "checking me out". Latoya also highlighted this unique feature of her workplace in relation to how it heightened the insecurities of some of her heterosexual male colleagues when they shared confined spaces over lengthy periods of time, particularly in respect to sharing sleeping quarters. She felt that this "cultural weirdness" in her workplace made the stereotype of the Gay male as a sexual

predator more concrete, as she felt “men are so much more frightened of poofers, of anal penetration”.

Outness

As previous sections illustrated, participants indicated there were clear stereotypes of Gay and Lesbian people subscribed to in the paramedic workplace. The dominance of these negative stereotypes and associated stigmatisation of Gay and Lesbian people meant they felt limited in their ability to control what they disclosed about their personal sexual identity within the workplace. Some participants who did not fit the characteristics of these stereotypes managed to ‘fly under the radar’ and remain undetected to some extent. As opposed to these participants, other Gay and Lesbian paramedics ‘did sexuality’ in a manner that reflected the characteristics of the dominant stereotype and they came to be ‘suspected’ of being Gay or Lesbian by their colleagues. This was a result of the resonance between the way they ‘did’ their sexuality and commonly held stereotypic views of how a Gay or Lesbian person looks or behaves. Sometimes this meant being subjected to an additional layer of scrutiny and assessment by other paramedics and managers, as Joe’s experience attests. On other occasions this meant they were subjected to a subtly crafted matrix of pressures to work in the relative safety of ‘ghetto’ locations. These locations are described further in the section in this chapter focusing on ‘critical mass’ (see Saxon and Magnus’s accounts of “Poofers’ Paradise”).

Subscription to these stereotypes within the Gay and Lesbian paramedic workforce limited the extent to which personal choice controlled the disclosure of one’s sexual identity for Gay and Lesbian paramedics. This put these paramedics in a perplexing position of vulnerability. Dominant stereotypes provide a vehicle to cast suspicion on those with identity attributes that correlated with dominant stereotypes of Gay and Lesbian people, even where these paramedics have chosen to keep their sexual identity private. This can have the effect of ‘outing’ a Gay or Lesbian person, when it is not their choice to ‘out’ themselves, by casting suspicion. When suspected of being Gay or a Lesbian by those around them, a person is vulnerable to ‘outing’. When ‘outed’ a person is vulnerable to homophobia and heterosexism, which act in a fashion which silences them. When ‘in’, and presumably silent, a Gay or Lesbian person carries the burden of self-editing and hyper-vigilance as a constant stress (Clair, Beatty & MacLean 2005). The net result of this is a process that puts pressure on Gay and Lesbian people to reveal their sexuality and thereafter silences them. Stereotypes can be used to ‘make suspect’ individuals with having stereotypic characteristics and thereby can result in applying social pressure to ‘come out’ (Steele 2010). As such, stereotypes are a social construct, which provide a further means of leverage and influence, which is outside of the control of Gay and Lesbian people. This social mechanism limits their ability to exercise control over their own ‘closet space’ in that others around them may label them as Gay or

Lesbian, even when it is an individual's desire to remain in the closet. These limitations in their ability to control their choices extend upon the notion of *closet fatigue* explored in chapter 7. Not only is the closet a stressful and emotionally challenging means of seeking sanctuary, but also it is often 'invaded' by heterosexual people who use stereotypes to make its walls transparent.

Joe's account of his experiences bring to life the way in which stereotypes can function to produce trepidation, marginalisation and vulnerability for Gay and Lesbian people in the workplace. Joe perceived that others suspected he was Gay due to the manner in which his speech reflected the Gay stereotype, dominant within his workplace. Because he did not feel safe being 'out' in his workplace Joe chose not to disclose his sexuality. It was unfortunate that he feared inadvertently outing himself, so much so that he became "too scared to talk". He used his silence as a way of staying 'in the closet' in an attempt to feel safe. Joe elaborated: "I was too scared to interact with other paramedics, with other professionals, police, nurses, managers...because I thought I was being judged I was too scared to talk and because I was too scared to talk and how I was being perceived, I talked the minimum amount possible which led to me almost losing my job". In taking these measures, he did so in order to maintain his sense of personal safety, and this put his job at risk. Joe's ability to keep his sexuality private was severely compromised by the stereotypes of a Gay male commonly subscribed to in his place of work. Some of Joe's colleagues subscribed to dominant stereotypes of Gay and Lesbian people. Adherence to these understandings meant that some of Joe's identity traits led his workmates to believe he was Gay, even when it was Joe's desire to remain in the closet.

Chapter 8 explored the existence of 'Gay and Lesbian ghetto' spaces existing for paramedics in city locations. As discussed in this chapter, participants reported that Gay and Lesbian paramedics tended to be located in these branches or stations, due to a combination of pressure from other paramedics and a sense of wanting to 'belong' in a workplace culture where they did not need to manage their sexual identity in a hypersensitive way. Magnus and Saxon felt that a greater sense of belonging meant that "Poofter's Paradise" was perceived as a safe space to work in. Magnus said "Poofter's Paradise" was a work location in his organisation, which afforded him an opportunity to have "a more comfortable area, just to be a little bit more natural and be yourself".

Whether or not a ghetto space existed within the paramedic work environment, several participants reported an increased propensity for other Gay and Lesbian work colleagues to be 'out' when there was a critical mass of other Gay and Lesbian paramedics around them. This concept of 'safety in numbers' had a dual impact. Those paramedics who did not believe there were other Gay and Lesbian paramedics within a relatively close proximity tended not

to be 'out' and, conversely, those who believed there were other Gay and Lesbian paramedics close by were more likely to be 'out'. In discussing his experience in the former category, Jacob stated one of the factors that had influenced his silence around his sexuality was he was not aware "of other Gay paramedics around him." Jacob added that due to this and other factors "I still haven't told anyone". Joe also spoke of the loneliness and lack of support he experienced whilst at university as a result of feeling he was the only Gay person in the institution.

I remember being at uni and never seeing one other Gay male student. Yes, Gay female students, Lesbian female students, but certainly not Gay males. In all my years at uni, never saw one or never met one.

This had an isolating effect on Joe that led to his perception that he was in an absolute minority group. This experience according to Joe influenced his decision to not come out when he started working as a paramedic.

Diametrically opposed, Janine attested to the level of comfort she felt at work. She was confident in her ability to remain open about her sexuality within the station she was assigned to. This level of comfort was facilitated by the fact that colleagues with whom she worked identified as being in same-sex relationships. This good fortune is expressed by Janine in the following way, "I've been pretty fortunate in terms of there being a few other Lesbians at my station as well, so I feel comfortable with that". In a similar manner to Janine, Calliope stated that one of the reasons she was comfortable and open about her sexuality was because "there's a lot of other Gay ambos around me". Calliope went on to discuss how this critical mass had led to others around her being open in relation to their sexuality.

A few, guys in particular, who hadn't planned on coming out but realised that it's pretty comfortable, because there's so many, particularly women...they've just gone, bugger it, I'll come out, and they're pretty good, pretty comfortable now.

A noteworthy additional theme developed out of the threads of discussion around 'outness' and having critical mass. There was a tendency for paramedics to be 'out' less commonly in rural areas. This was due to both lack of critical mass and the homophobic and heterosexist nature of rural and remote cultures. Chapter 11 is devoted to discussion of this theme.

Gender differences in outness

In the context of discussion focusing on stereotypes, a final strong area of focus flowed from the critical mass theme. This discussion needs to be prefaced with the notion that whilst work relationships tended to be more favourable for one sub-group, that of Lesbian paramedics, the perception of participants in general was that Gay and Lesbian paramedics were in general marginalised and vulnerable. Jacob illustrated this when he remarked, "I think they're both seen as negative things in the organisation". Saxon also highlighted this notion: "No

matter how much we strive for equality, we are still the minority at the end of the day” adding that this meant things “can be very, very difficult for a Gay or Lesbian paramedic”. Another phenomenon of the work life world was that Lesbians tended to be more visible or ‘out’ in the workplace than Gay males. Participants gave two main reasons: the increased critical mass of visible Lesbian paramedics, and the relative compatibility of stereotypes of Lesbians as having qualities of masculinity with the archetype of the ideal paramedic, which meant that Lesbians were more accepted in relative terms. The net result was that Lesbians tended to be more visible in the workplace *and* experience fewer issues.

Janine picked up on the ‘critical mass’ aspect of this theme when she said “I know definitely it is a smaller demographic for the male Gays than it is Lesbians so I think it’s harder on them”. Calliope provided a similar account of the tendency for Gay male paramedics to be more hidden than Lesbians.

I guess my theory would be that guys generally feel a bit more vulnerable and it’s probably socially not as accepted yet. It probably just reflects on that I think. I don’t know why. I guess a lot of the guys I know that wouldn’t be as vocal as others would generally be more withheld in their private lives and not as comfortable with their families and things like that. I know that a couple of them aren’t even out to their families but they are out at work.

Regardless of reasons, the effect was that Gay male paramedics tended to be less visible. Mack’s experience encapsulates this phenomenon. He had been a paramedic for 17 years. In all of that time he was “the only openly Gay man” in the service he worked for. Mack was aware of several other Gay male paramedics in his workplace over this time that chose to keep their sexuality a secret; he was not the only Gay male paramedic, but the only visible one.

Latoya also theorised as to why the Lesbians she worked with seemed to be more visible and “have it way easier compared to Gay men”. As mentioned in chapter 4, Latoya associated this visibility with the threat that heterosexual men perceived Gay men posed to them and the homophobic language commonly used in her workplace. Janine supported Latoya’s rationale: “They feel a lot more threatened, heterosexual blokes, by Gay men than Lesbians”. That Lesbian’s had it somewhat better than Gay men was also a theme supported by Jacob who asserted that, “in my opinion that Lesbians in the organisation are a lot more accepted than Gays...because that’s what I’ve seen, like there’s a lot more Lesbians or people that are out...than males”. Jacob did not theorise as to the basis for this in the same way that Latoya and Janine did, but he noted, “I don’t know how they’re accepted or what their experiences are, but they seem to be comfortable being out”.

Joe's take on the increased acceptance of Lesbian paramedics compared to Gay male paramedics in the workplace related to the fact that the stereotype of a Lesbian in his workplace matched more closely the ideal identity characteristics of a paramedic championed within the culture. Joe makes the point: "I do think that, as a massive generalisation, I do think that Lesbian women fit in better simply because they blend better with men than what Gay men do". When comparing his experiences as a Gay male, Mack's perception of the more visible nature of Lesbians and acceptance of them in his workplace was also apparent: "The girls, you know there were always a lot of girls who were Gay and I just didn't see them having that sort of problem, that sort of issue". Mack adds "they haven't experienced the same sort of open aggression necessarily that I have". He also attributed this to the manner in which the stereotypical Lesbian seemed to fit better in the culture of the paramedic workplace.

I can only put it down to it being a very male...culture in ambulance. And it's sort of like...Gay women seem to be less threatening to the blokes than Gay men are...because it tends to be a male culture it tends to sort of be a bit putdowny [sic] or more aggressive to another male.

Joe added another layer to this in terms of the influence of gender. In an interesting twist, he believed that being female provides an additional 'safety net' in his place of work. Joe asserted that even if Lesbian women are not seen to fit in the workplace culture by virtue of their sexuality, they are forgiven due to an anomaly. Joe believed that this anomaly was explicable in the context of the workplace culture as "they are still female and they are accepted because they are female". Joe explains further:

...if they are a Lesbian that doesn't fit that stereotype; well they don't have to because they are female anyway. Whether or not they are perceived as a Lesbian or straight, well they are a Lesbian and they are blokey in their demeanour, well then they blend but if they don't, well they don't have to.

Magnus also stated "Lesbian women tend to be a little bit more accepted". The rationale provided by Magnus for this extended the theme of the senseless threat that heterosexual men perceived Gay males to be and added: "I think homosexuality with straight men, if they are at all uncomfortable with their own sexuality, it makes them uneasy". He qualified this by saying that this discomfort "settles" after a period of time but adding that this meant Gay men have to prove themselves "a little bit more".

Saxon was very explicit in the way he related and understood why there appeared to be an increased acceptance of Lesbian paramedics stating "I really think there is a difference and that comes from stereotypes...that a Lesbian woman is going to have a more masculine type feature, and a Gay male is going to have more feminine type features". Saxon believed that Lesbians integrated more seamlessly within the culture of his workplace because "of the

culture, which is a masculine culture with paramedics”. The opposing dominant stereotype of a Gay male as being someone having “feminine attributes” was met with an “amount of challenge because it’s different, and it’s not right, and it’s not part of ambulance, and this is not how it’s supposed to be, so don’t challenge this culture”. As a result, Saxon felt that Gay men “probably have a more negative experience” than Lesbian paramedics. He did recognise in this discussion however that “it may not always be the case as well, because some people, for whatever, their background, may not like Lesbians as well”.

Critical discussion and summary

The workplace of the paramedic is a microcosm of society. As such, it is predictable that paramedic organisations in Australia would embrace values, practices, institutional constructs and behaviours that are manifestations of heteronormative values, as established in chapter 8.

Stereotypes are cultural and social constructs of dominant groups. They can be seen to have the function of providing guidance and comfort to people in a social context, by assisting with the identification of predictable patterns of behaviour and therefore guiding appropriate social conduct in a range of situations. In reality stereotypes function to further empower dominant groups by often constructing erroneous beliefs. The manner in which stereotypes provide coded generalisations and falsely constructed ‘social clarity’ means they essentialise, categorise, label, stigmatise and marginalise particular social groups. It is clear from the evidence of participants in this research that stereotypes applied to them meant they were commonly *othered* on face value and put in a position where they had to prove their worth within the workplace. This subjected them to an additional layer of scrutiny their heterosexual counterparts did not have to endure and this is an inequity. Where participants were able to evade being stereotyped due to their physical or behavioural attributes, they became self-scrutineers. They did this by editing and managing the way in which they projected, ‘sheltering’ in the shanty of the closet space. Seeking asylum in this closet led to prolonged periods of *closet fatigue*.

Prevailing stereotypes were reproduced and reinforced for the paramedic participants by social agents in the guise of both colleagues and patients. This constant, multifaceted and inescapable reinforcement increases the impact of the way in which stereotypes function to normalise or naturalise social constructs as biological realities. To compound this issue, organisations and courts are more likely to support appearance norms that support traditional gender stereotypes (Trautner & Kwan 2010, p. 127). In this sense, the stereotypical construct of a Gay male as effeminate, for example, is seen as a product of nature (Butler 1990). Those whose traits are consistent with the dominant stereotype are therefore socially

marginalised. Those who do not fit with the stereotype, such as the more 'feminine' Lesbian participants in this research, are in a sense granted a 'licence' to hide.

In the current study, these contemporary heteronormative, heterosexist and homophobic social practices were scaffolded by the intersectionality of sexuality and gender constructs founded in social practice. *Naturalised* understandings of heterogendered constructs meant that males and females were attributed with specific traits by virtue of the dominant gender stereotypes within their places of work. These stereotypes meant that fixed understandings of physical capacities were prevalent in the paramedic organisations they worked for. These understandings were aligned to accepted understandings as to whether or not a member of a particular gender group was physically capable of being a paramedic. According to these stereotypes, the weaker or less capable gender group in the paramedic workplace context is women. This is consistent with the historically militaristic evolution of paramedicine, which favours a command and control approach to leadership. Having similar historical roots, similar marginalisation is seen in prevalent stereotypes in the food industry with female chefs being seen as poor leaders, too emotional, not cut out for male dominated work and having to prove they were capable (Harris & Giuffre 2010, p. 66). *Naturalised* understandings of normalised heterosexuality meant that another set of values were attached to paramedics who were identified as Gay or Lesbian. Non-heterosexual paramedics were, in general, perceived with various levels of threat, predation and deficit of capability. The qualities stereotypes assigned varied depending on whether the paramedic was Gay or Lesbian.

The practice of stereotyping seems to have a particular affinity within the culture of paramedicine. The hierarchical and militaristic nature of this culture acts as a fertile host for a system of stereotyping that superficially makes identified patterns of behaviour acceptable and 'normal'. What undermines the integrity of the bond in this relationship between militaristic and hierarchical culture and the practice of stereotyping, which effectively assigns a social 'rank' however is the inaccurate nature of these stereotypes. This inaccuracy and rigidity grants a licence to non-stereotypical Gay and Lesbian people to 'hide' from their colleagues. As such, those Gay and Lesbian people that do not conform to commonly understood stereotypes escape suspicion and undermine their primary function as a tool of exclusion and maintenance of social privilege.

Stereotypes also underpinned the evidence of participants in this research, suggesting that whilst non-heterosexual people are in general disadvantaged in the workplace within paramedic organisations, Gay male paramedics seem to have more disadvantage than Lesbians. Paramedics responded in different ways to pressures within the workplace to hide their sexuality. There was a lower visibility of Gay male compared to Lesbian paramedics from the point of view of participants. A study of Gay and Lesbian police officers report

similar occurrences whereby they can feel pressure to keep their sexuality hidden or “unadvertised” is more apparent in males (Sklansky 2006, pp. 1222-3). The counter pressure to this social coercion to keep matters of sexuality private contributes to the manner in which stereotypes can ‘make suspect’ particular individuals, and give others around them the means of ‘flushing them out’ and revealing their sexuality. Joe’s experience in this study provides a good example. This ‘dual edged’ marginalisation of Gay and Lesbian people in the workplace amplifies their vulnerability. It also influences the control they have over their privacy and identity. Despite their relative vulnerability in comparison to heterosexual people; Lesbians in paramedicine seem to be more accepted by virtue of their propensity to be seen as ‘social men’ in a male dominated field (Barlow & Barlow 2000, p. 275; Harris & Giuffre 2010, p. 60). Barlow and Barlow (2000, p. 275) also showed that Lesbian police are less threatening to male heterosexual police than Gay men, because they pose no threat to “heterosexual police officer’s self-image”. Participants in this research support this premise in the context of their workplaces as paramedics in Australia.

This chapter focused on the stereotypes prevalent within the workplaces of Gay and Lesbian paramedic participants in this research. The evidence of participants indicated that a number of heterogendered and heterosexist stereotypes were common in their workplaces. Combined with the culture of the paramedic workplace and in the absence of widespread and consistently implemented and enforced programs of social inclusion, these negatively stigmatised stereotypes influenced many practices and behaviours within various paramedic organisations. These practices and behaviours commonly lead to social exclusion, marginalisation and disproportionate psychological and emotional stress for Gay and Lesbian paramedics. These stereotypes disempower and further *marginalise* groups who do not share the characteristics deemed as appropriate and ‘normal’ by the dominant group. Stereotypes are a difficult enemy to fight as they are in practice the filtration and simplification of information in such a manner that they provide rigid, negative and oppressive views of a person or group of people, which becomes ingrained such that there is a tendency not to notice them affecting our perceptions and actions (Thompson 2003, p. 84). Governance of paramedic organisations which is overt, appropriately resourced, supported and enforced and aimed at including and supporting Gay and Lesbian paramedics is essential in ensuring inequities on the basis of sexuality are addressed. In the absence of such a structured and considered approach these ingrained stereotypes will continue as the default cultural practice, which ‘governs’ these workplaces. The evidence of Gay and Lesbian paramedic participants in this study demonstrates how allowing such a default workplace cultural ‘governance’ of these matters leads to unfair, inequitable and exclusionary practices. Gay and Lesbian paramedics are not the only victims of these practices. Participants provided evidence that organisations, other workers and the community are also impacted.

Based on the voices of the participants in this study, strategies to educate paramedics and develop specific equity and inclusion strategies are needed to promote the rights of Gay and Lesbian paramedics in the workplace. These strategies should aim to produce a positive workplace culture to ensure that *all* people with diverse sexual identities are valued and treated respectfully by *all* people within an organisation. This inclusion will most likely have a positive effect in terms of workforce retention and healthcare outcomes for the community.

CHAPTER 10: PATIENT-CENTRED CARE

In the context of preceding discussions, several participants revealed they were 'out' to co-workers, managers and other healthcare workers. In relation to disclosure of their sexuality to their patients, they approached this quite differently, with the majority indicating they did not reveal this aspect of their identity. Safety was commonly cited, with a number of participants feeling that revealing their sexuality to patients may lead to threats. Those who perceived that to respond to such enquiries with affirmation would create an unsafe environment for them, described instances of being 'accused' of homosexuality by patients in various contexts. Some stated that it was simply not relevant to the relationship they had with their patients. Others stated they were not out in relation to their sexuality at work in general, and to reveal this aspect of their identity to patients was a potential compromise.

Frequently cited as a reason for not disclosing sexuality was the notion of patient-centred care. Choices to reveal matters of any healthcare worker's personal identity are governed by both the doctrine of patient centeredness and the individual's prerogative. For non-heterosexual people, however, heteronormative assumptions mean that casual exchanges of information in interpersonal interaction and rapport building may risk disclosure of personal information, which may prove controversial to a patient, and consequently damage a therapeutic relationship. This interpretation of practicing a patient-centred model of care meant non-heterosexual paramedics did not tend to reveal their sexuality to patients in the same fashion as heterosexual paramedics do. This practice of 'sparing' the patient knowledge that they are being cared for by a non-heterosexual person potentially perpetuates heteronormativity. A holistic model of healthcare is a different entity to one that requires limitation on the disclosure of personal details from the health provider, as it may 'upset' the patient.

Establishment of a good rapport between patient and carer is highly dependent on the quality of the relationship between such individuals. A quality relationship based on a model of patient inclusivity can have a positive impact on the quality care provided. The personal nature of such a relationship can often be humanistic, intimate and co-constructed between the parties involved. A health assessment often involves a paramedic enquiring about various matters relating to the personal life of the patient. Further, with an increase in 'ramping'¹³ or hospital waiting times, there is more time opportunity for interaction. 'Ramping' can open up communication and conversation between paramedics and their patients. This

¹³ The term used to refer to the increasingly common occurrence of waiting at hospitals with patients for a bed to become available to enable them to be handed over to hospital staff.

can lead to patients asking a number of questions or polite enquiries in relation to a paramedic's personal life.

For a heterosexual person a polite enquiry from an elderly patient as to whether he or she is married or has children presents no real anxiety. Responses along the lines of "yes Mrs Jones, I am married and have three kids" are easily forthcoming and generally assist with the process of rapport building and trust development. For paramedics who are not heterosexual, such a casual enquiry can initiate a cascade of mental processes calculated at producing the 'appropriate' response. Calculated and managed responses to patient enquiries also potentially damage rapport and trust, if they are seen by the patient to be inauthentic. Several participants provided examples of these types of managed responses. The architects of these 'cognitive acrobatics' cited their justifications within the doctrine of patient centeredness. Construction of a quality patient-carer relationship for these paramedics required considerations that their heterosexual counterparts were never required to make. Managing disclosure in this fashion is a conscious act, which draws energy from the pool available to an individual. In this sense it can contribute to *closet fatigue*.

Any explicit policy directive on the appropriateness of disclosure of sexual identity within the concept of patient-centred care does not exist. Notions that a paramedic must remain silent in relation to their sexuality where it is made topical in the patient-carer relationship seem to be governed simply by heteronormative assumptions. An overt organisational policy supporting the choice of paramedics to disclose their sexuality where relevant to patients can minimise the mental strain of the personal editing process. This has the potential to minimise the *closet fatigue* experienced by paramedics.

Notions of patient centeredness in health

Several participants held the belief that the sexuality of the paramedic must be shrouded from the patient for their betterment and that this has justification in the patient-centred care movement. This can be conceptualised as an example of a structural microaggression (Sue 2010) that non-heterosexual paramedics experience. This belief is based on an assumption that a patient will be offended or disturbed by essential aspects of the identity of their carer, and that this will interfere with the relationship required to promote a positive patient care experience and therefore be detrimental to the patient's wellbeing.

In order to include the patient in formulating care plans to manage their health, patient inclusivity is required. This often relies on the rapport established between both parties. A degree of trust is required in order to build such rapport. This trust often develops out of

exchange of information in terms of 'humanistic' interaction. Whilst it is not contested that this relationship is not focused on the healthcare worker involved and revealing aspects of personal lives to patients is not promoted (Groome 2009, p. 150), the intimate and humanistic nature of these interactions means that sometimes information is exchanged. It is arguable that such exchanges assist in the establishment of good rapport and therefore better quality patient care.

Practitioner health is increasingly becoming a focus within paramedicine and other sectors of the health workforce. Notions of work–life balance and workforce sustainability are becoming more commonly accepted. The good health of healthcare workers means quality care for consumers. Biopsychosocial models of health similar to those informing notions of patient-centred care also inform theory and practice related to practitioner health. Such models of wellbeing highlight the interdependency of the physical, psychological and social aspects of health on the overall health of the practitioner. In terms of psychological and social health, an ability to be authentic and present a holistic and positive self-image is important. Tension can develop where a person is put in a position where they consider subjugating aspects of their personal identity in order to avoid compromising patient care. Superficially, a focus on paramedic practitioner health can be seen as a counter force to models promoting patient-centred care; however this does not need to be the case as a healthy practitioner is better possessed of the ability to care for a patient.

Aside from the justifications for not revealing aspects of sexuality to patients often aligned to notions of patient-centred care; a failure to respond to enquiries can be a result of internalised homophobia on the part of the paramedic. The assumption that speaking truthfully about one's personal relationships and sexual identity may evoke a negative response from the patient can underlie the choice not to disclose. This heteronormative assumption not only exists in the heterosexual population, but is also internalised by non-heterosexual people and serves to perpetuate silence in the discourse around homosexuality. This internalised homophobia can combine forces with external sources to prolong oppression (Eliason et al. 2011, p. 237). Internalised assumptions that patient perception is likely to be negative and lead to difficult patient-paramedic relationships reveal issues of internal moral judgements similar to those revealed in some studies of Gay nurses (Harding 2007, p. 640). Magnus described his experience of withholding information about his sexuality from patients as being both about the patient and himself. "I don't want to make them feel uncomfortable" he noted, nor do "I don't want to feel uncomfortable". Magnus's experience highlights presumptions of moral judgements from his patients and associated risks: "If I come out to them and they feel uncomfortable that's actually going to make me feel uncomfortable". Magnus added his insights into the injustices here by saying "I should

go...‘you asked the question, it’s normal for me to be in a Gay relationship just as it’s normal for a straight person’”.

Experiences of paramedics

The participants in this research in dealing with patient enquiries employed a range of different strategies. Participants varied in their approach to disclosure and management of information; however, the common thread between them was that this process of patient interaction was always managed, a conscious act and involved various degrees of risk. These strategies ranged from openness to outright lying. The weight of evidence provided by participants leant towards strategies of editing, filtering or obscuring their true identity.

Openness

Holley described times with her patients when she was open about her sexuality. She discussed how she handled patient enquiries about her parental status. When they inquired, she would sometimes reveal to them that she had children. Assumptions then followed as to the gender of her partner. Holley describes these kinds of interactions: “In some cases I’ve said, their other parent is a woman, my children have two mothers”. This had led to responses from patients such as “oh, oh, well that must be nice for them”, “I’m sorry, I didn’t realise, what an assumption” or “I’m really sorry”. These experiences meant she felt that “some people can feel quite uncomfortable.” As a result of this discomfort, she was very measured about what she chose to reveal to patients in subsequent interactions. Holley stated:

I’ve had a couple of reactions where they have been uncomfortable and, you know, they’re already in the back of an ambulance and are unwell or in pain. I don’t need to make them psychologically uncomfortable as well. That’s not, that’s not my job. I don’t see my primary job as an advocate for equality, it’s about healthcare.

Holley’s openness had met with some negative responses from patients. Due to her perceptions of how they failed to accept her, she now edited or remained silent about her sexuality in response to patient enquiries. It can be implied from her statement above that this silencing has a relationship to the delivery of patient-centred care.

Editing, dodging, weaving

When discussing her ‘outness’ Calliope was out to everyone in her life. She had also been very ‘public’ in arranging paramedic presence at her local Gay Pride event. Although ‘out and proud’, Calliope *stopped short* of revealing her sexuality to patients. She said she felt that her relationship with patients was about their needs, but there was a need for “mutual respect for

each other as well". Calliope was not prepared to accept behaviours that put her needs second in general terms where conflict or abuse may arise. She stated, "It's about us as well. I guess in an ideal world probably but it's not all about them. It's like, I'm not a verbal punching bag, you can't tell me to 'f-off you c-bomb', it's not alright by me". Despite her strong assertion of her rights in the context of other situations of conflict or potential conflict, she remained guarded about her sexuality when leading questions arose.

In a similar manner to Calliope, while there had been a desire to be open and honest with patients in relation to her sexuality, Holley too was very selective in how her sexuality was presented as a product of previous negative experiences. She was now "quite guarded in what I say to my patients". She was prepared to discuss some aspects of her personal life such as her children. She was happy to disclose that she had children, but when asked who was looking after her children, she would use gender-neutral language: "My children are with their other parent". She said the reason she used gender-neutral terms was because she did not want to be "in their face" about not being heterosexual because "my encounter with my patients is about them, their illness or their situation or their need at the time".

Holley's experience of non-disclosure due to anticipated emotional discomfort is similar to Joe's example mentioned in chapter 8. He described a distressing encounter with a patient who had a psychiatric condition. The patient asked him "Why are you talking like that?" When Joe enquired as to what the patient meant she said "Don't talk like that, you sound Gay". Joe felt confronted and somewhat fearful of this patient and employed a strategy of evasiveness in order to keep control of the situation. Joe's response to the patient was, "we are here for your needs, not for you to assess me; I'm here to assess you and your needs and why you've actually called for help today, so let's keep this focused on you". Joe was skilful in diffusing this situation and recounted his understanding of the doctrine of patient-centred care to 'sell' his response to the patient.

Magnus gave a further example of where a patient had behaved aggressively towards him because of presumptions about his sexuality. Magnus had chosen not to confirm 'accusations' of being Gay due to fear. When subjected to abuse from particular patients he chose to avoid further confrontation. He stated, "You have every right to turn around and go 'how dare you'. That's an aggressive, abusive behaviour that you shouldn't have to put up with at all and it's officially zero tolerance but..." Despite his apparent level of discontent at this level of abuse, Magnus used silence as a protective strategy. The reason is obvious here: he did not want to challenge a patient in such a way that may have exposed him to further aggression. Tolerance of such aggression, hardly 'micro' in nature, is another example of the microaggressions and silences a non-heterosexual paramedic is subjected to.

Saxon said “I wouldn’t be comfortable telling a patient about my sexuality”. He added that he did not feel that it was appropriate and that his own internalised homophobia was one of the possible causes of this discomfort. Saxon explained, “I think that probably stems a bit from that shame that I felt from the start, within general society”. He also said that he did not want to be subjected to patient judgements stating “I don’t want to put myself in a position where that patient has the right to judge me because it doesn’t fit with their ideals of life”. As a result, Saxon chose to dodge the questions from patients relating to his marital and parental status and would say things like “I’m living the dream, living the single life” when questioned. Saxon responded essentially out of fear:

If you give them that bit of information, there’s a chance it could be controversial for that person. It’s actually about the fact that I’m making myself vulnerable and I’m not willing to do that within my work environment where I need to be in charge of what’s going to happen in the back of that car. I’m directing what’s happening, I’m sounding like an alpha male now, but it’s about my safety and it can be exceptionally inflammatory for people.

Despite relating the management of his responses to fear, Saxon also considered the rapport element in his patient–paramedic relationship in terms of his transparency in relation to his sexuality. He stated, “your clinical care of a patient can be as simple as the attitude that you have and a failure to establish a rapport and stuff, that impacts on your clinical care I think”.

Opacity (lying)

Calliope described herself as ‘out and proud’ but stopped shy of revealing her sexuality to patients. She said she was happy to “go halfway” when patients made enquiries, stating that when asked if she was married, “My usual response is ‘I’m halfway there’. Because I have a rock...and they normally see that and say ‘oh, you’re engaged’...it’s like I don’t want to deal with that. I don’t want to deal with a patient who’s supposed to be putting all of their trust in me at that particular time to be reliable and knowledgeable to then judge me on it. I’m not sure why, but that’s just how I feel about it”. Calliope went on to say, “I just don’t come out with it completely, but I guess that’s just another form of lying really”.

Magnus also gave examples of what he described as ‘filtering’ of aspects of his personal life in his interactions with patients. Magnus however did not justify this in terms of it being all about the patient, but with his own discomfort at times. He stated that he often deflected questions from patients as it led to him revealing his sexuality. He gave the example of a friendly inquiry:

You’ve got some 95-year-old lady who’s a beautiful old dear and wants to talk to you and, you know ‘have you got children?’ and ‘are you married?’ and all that sort of

thing. Again, the filtering comes up. Whereas if you're a straight person with a family, there's absolutely no filtering. It's just like, 'oh yeah'. I've been asked the question, 'oh, a young man like you, why aren't you married?'

Magnus was conscious that he had offered an edited response to his patients, which was akin to lying. He justified this by saying:

You don't turn around and say 'because I'm Gay and I'm not allowed to get married'... You are obviously very tactful and I'm used to dealing with people, used to those conversations coming up and you just deflect it and ask them another question. So you're very adept at deflecting it, but you certainly modify what you're doing without a doubt.

Magnus also gave an example of where revealing his sexuality meant danger for him and was acutely aware of the need to occasionally conceal the truth for his own safety:

...with the young, you know, a young drunk fella, I've more than once been, you know 'you're a fuck'n faggot'. And you're not going to turn around and go (although I have once) 'actually yes I am'. You've got a drunk, aggressive young fella or female.

Magnus was aware of the fact that heterosexual people did not need to deal with these issues.

My response to patient enquiries as to my sexuality has generally been to lie. Although at times I feel a bit conflicted about this approach, for me there is less emotional energy when I tell patients I have a husband and two children. When giving this response there is no need to filter information or disclose the truth and risk responses I presume to be unfavourable. I have tired over the years of filtering information and being on the receiving end of negative responses from patients, which can impact on both my experience and their experience of a healthcare interaction. This can be explained in part by fear, in part by internalised homophobia, in part by heteronormativity skewing notions of patient-centred care. Ultimately the conscious processes of editing and filtration require a level of consciousness and maintenance that can be exhausting. *Closet fatigue* takes its toll. Ultimately I cannot be bothered explaining, morphing or justifying my identity so it is easier to just lie. If this is easier for a patient maybe the means justifies the end. It is certainly easier for me. Janine said that one of her colleagues also took this approach. Janine remarked that she had a similar rationale in that she was "so fed up with people asking". Janine also went on to expand upon how her colleague had turned this into a bit of a game, stating "It is her routine to make up a big story and get creative about it".

Latoya sums up the dilemma when she said she felt the following way when confronted with personal questions from her patients:

...you're forced into kind of a closet by not answering...I keep banging on about, it then becomes about me, it's not about them. It's meant to be about them and all of a sudden, my choices...make it about me or remain in the closet sort of thing. It's weird, but it's not huge, but it's noticeably something whereas if you're a het[erosexual] you could just say that. Or if homosexuality was respected: it should be.

Critical discussion and summary

Regardless of the 'outness' of participants, most of them were not 'out' to patients the majority of the time. Although a range of reasons were cited, the concept of patient-centred care was frequently used to justify this position. The essence of these views seemed to be based on a heteronormatively reconstructed notion of the doctrine of patient centeredness. This reconstruction shifted the concept from involving patients in their care and constructing an egalitarian patient paramedic relationship *primarily* focused on the patient, to denying aspects of the identity of the individual paramedic. It is unlikely that a heterosexual person would not discuss matters of their personal life that were sufficiently superficial on the basis that this would interfere with patient-centred care. A casual discussion of the marital status of a heterosexual paramedic is unlikely to be edited for what is perceived to be beneficial to the patient and more likely to be interpreted as establishing a good rapport with the patient.

It is commonplace for patients to inquire about some of the superficial personal details of healthcare workers in a casual way. In a model of care that is truly all about the patient, such a practice of enquiry would be uncommon. If a patient-paramedic relationship is all about the patient, why is it acceptable within the wider culture for a patient to enquire about the personal life of a paramedic? Why is it acceptable within the concept of patient-centred care for a heterosexual paramedic to respond by revealing some aspects of their personal life and not acceptable for a non-heterosexual paramedic to do so? Gay and Lesbian paramedics have been denied the privileges of heterosexual paramedics as the result of a subtle twist embedded in the notion of patient care. This is similar to another study aforementioned about Gay nurses (Harding 2007, p. 642). It is also possible that there is some alignment to what has been found in other studies in terms of the 'appropriate' sexuality for a profession. In looking at Lesbian nurses, Lesbianism was seen to be contrary to the image of nursing as a caring and humanistic profession (Giddings & Smith 2001, p. 19). There is a possibility that being Gay or Lesbian is also seen as contrary to the caring or humanistic qualities of a paramedic. It is also possible that there is some alignment to the notion that Gay men are sexual predators (Harding 2007, p. 639) and therefore sexuality should be suppressed. This is consistent with the constructed archetype of the paramedic as male, white and heterosexual.

A paramedic may choose to conceal his or her sexuality as a result of the risk assessment he or she makes. Whilst it is unfortunate that this needs to be the case, it is possible that regardless of progress towards social enlightenment some homophobia may exist in particular individual patients, especially when they are distressed or compromised. This does however need to be left to the choice of the individual paramedic, as it would be where aggression exists for reasons associated with any other personal attribute. In terms of promoting the right of a non-heterosexual paramedic to reveal personal details in relation to their sexuality to patients when they choose, some re-education around the notion of patient-centred care would assist in supporting paramedics to be 'authentic' in their responses to patients where it is their choice. Clear messages of support are needed from organisations and employees to ensure that paramedics feel safe where patient interactions lead to disclosure of certain personal details. This may assist Gay and Lesbian paramedics to alleviate some of the layers of editing and filtering in the workplace and lessen the burden of *closet fatigue*.

This chapter focused on the ways in which Gay and Lesbian paramedics manage their responses to patients and to the notion of patient-centred care. With a few exceptions (Eliason et al. 2011) little previous research has explored the experiences of discrimination from patients. Whether overt or covert, responses from patients do impact on the ability of a paramedic to be authentic or, in some instances, comfortable doing their job. Fear of the response of a patient who may be volatile is a valid reason to want to edit personal details as a matter of self-preservation. This is part of the wider community patterns of homophobia and heteronormativity, which society still has a long way to go towards addressing. The more subtle behaviours and understanding, in particular those embedded in notions of patient-centred care, require systematic and supported organisational education approaches in order to be overcome. A positive impact on the workplace experience of authenticity and inclusivity for Gay and Lesbian paramedics may be the ultimate product of such strategies.

CHAPTER 11: COUNTRY AND CITY VARIANCES

The previous chapter focused on the concept of patient-centred care and the impact of this concept as a sociocultural structure on Gay and Lesbian paramedic participants in this research. The concept of patient-centred care influenced the experience of all study participants. A further theme that emerged in participant data in relation to workplace inequity was that being marginalised by colleagues in the workplace depended on where paramedics were located. This geographical variance has previously been discussed in chapter 8 where the phenomenon of Gay ghettoisation was considered. Extending upon this concept of the ghetto was the significant difference in attitudes toward Gay and Lesbian people between metropolitan and rural areas. This theme is consistent with literature documenting that homophobic attitudes are worst in country areas (Flood & Hamilton 2008, p. 16). These attitudes related to both Gay and Lesbian people in general and specifically to Gay and Lesbian paramedics. This attitudinal difference strongly influenced the experience of participants working in different locations.

Obvious geographical and cultural characteristics influenced this difference in workplace culture between urban and rural areas and therefore produced variances in participant experience. These included the size and remoteness of a particular location, the composition of the local population and a range of other factors. In addition to these more general demographic and structural characteristics, participants highlighted specific local workplace cultural factors that influenced dominant attitudes in more remote locations. Two primary factors which influenced this local culture were the age composition of the local paramedic workforce and the tendency towards religiosity in rural areas. Religious views and practices had a strong influence on the levels of acceptance of Gay and Lesbian people and therefore the experiences of paramedics, where religion was more influential.

Experiences of paramedics

In general terms, Gay and Lesbian paramedics in this study tended to have a more negative (or less positive) experience in the country when working, compared to working in larger metropolitan areas. In particular, these experiences were more positive in cities with larger populations and greater numbers of openly Gay and Lesbian paramedics. Working as a paramedic in communities where Gay and Lesbian people and other diverse groups were more visible was also noted by participants as having a positive impact on their sense of identity. Although some of these paramedics worked in what they described as a 'Gay Ghetto', there was also a more general sense of 'safety in numbers' in the larger metropolitan areas. The increased anonymity within these areas also acted as a safety buffer

for some Gay and Lesbian paramedics. Busier areas meant more paramedics, with more dilute interaction with other paramedics, other healthcare workers and members of the community. This dilute of professional contact led to a greater ability to remain anonymous and *private* within a larger, and therefore more difficult to track, group. This privacy could afford the paramedic an ability to evade personal questions and keep their sexual identity a private matter, as the nature of interactions with others tended towards being more transient and superficial. The converse was the case for Gay and Lesbian paramedics working in smaller rural locations. They tended to be more isolated from other Gay and Lesbian paramedics and the Gay and Lesbian community. They also worked in locations in which people tended to have greater knowledge of each other's personal lives. They were therefore not able to 'shield' themselves in terms of anonymity in the manner of their city counterparts.

Rural v metropolitan

Some of the variables between the paramedics in this study who worked in rural and metropolitan areas related specifically to the work patterns of paramedics. These included the type of incidents attended to in clinical terms, the volume of jobs attended, transport times to hospitals, the approach to rostering staff and frequency with which paramedics may have to work with community volunteers and casual staff with a more restricted skillset. Aside from work pattern variables, other differences included the attitudes and composition of the local community and the paramedic staff they were surrounded by.

The increased comparative visibility of paramedics working in smaller towns was noted by a number of participants as a factor that made them more self-aware of how they were perceived by others within their organisation. Holley described her work location as having a "mentality" that was "very much rural" where in "such a small place" it means that "Everyone knows your business, everyone". As a result, Holley felt "just about everybody" knew about her sexual identity "because we are a small organisation". The inability to keep her sexual identity private made Holley vulnerable in many ways. The degree to which her co-workers would "accept and support you or not" had a significant impact on her workplace experience. Determinations of whether to include or exclude individual paramedics on a social level were largely in the domain of what Holley has previously described as "mini- mafia" in her workplace. These groups of paramedics influenced many aspects of her working life. To Holley it was particularly important to 'fit in'. The importance of fitting in was intensified for Holley "because we are so small" in terms of the number of paramedics within her organisation. Feeling marginalised by numbers and not having the relative solace of a paramedic ghetto to feel comforted by, Holley was left to feel there was "no hiding in the organisation".

Holley's experience of feeling less privacy and a greater pressure to conform to local expectations related primarily to her encounters with her work colleagues. Joe noted that he felt a greater pressure to present the image of "upstanding member of the community" and "make a really positive contribution" within his local area. He felt that being "known as the local ambo" in the area he worked made him a kind of "low key public figure" within the community. As such, Joe felt the impact of this pressure to present in a particular manner *at all times*. It is clear that being a paramedic "does impact how you present in your own personal life, even when you are not wearing the uniform". Joe contrasted this with anonymity, which is more accessible within metropolitan locations where he would not feel such pressure. Joe felt that "in the metropolitan areas, the likelihood of you running into patients that you might know" was minimal and therefore he would not feel that he had to be as constantly conscious of the way he was presenting himself. He added, "I am sure it happens everywhere, but the likelihood of it happening in a rural area is much greater".

Joe's sense of public visibility naturally extended to his sexuality, which was something he had to manage in public in the rural environment. He felt that this would not be the case if he worked in a more populated centre. His level of self-consciousness and how he manages his sexuality in the public sphere is captured in the following statement:

...if I saw a Gay friend in the street....if I actually wanted to greet a friend with a hug, that would not take place in a rural area, whereas that could happen in the city, probably more the inner city suburbs. So that does impact my behaviour and that's because the fact that I'm a paramedic places an extra stress or burden on me.

Joe's perception of his public role in the community had led him to feel that he had to manage his sexuality in *all situations* and at *all times*. Based on Joe's experience, in rural areas *closet fatigue* is likely to have a greater impact on Gay and Lesbian paramedics. This increased impact is due to the perception that a paramedic working in a rural area needs to remain closeted, not only when performing their duties as a paramedic, but when going about their private business within the community. The increased likelihood of being identified as a paramedic when off duty in a smaller community, in Joe's view, led him to remain hyper-vigilant *at all times* in the public context. This meant more time in the closet and therefore increased susceptibility to *closet fatigue* as a result of more sustained and continuous energy requirements than his metropolitan counterparts.

In contrast to Joe, Latoya had positive things to say about her work in a rural area. She had been surprised about the way in which the community had received her sexual identity, as she had initially harboured reservations about working there:

Well, I was surprised, coming to the country, working in the country and meeting the people that I was most nervous about, you know the animal shooting, non-recycling,

racist, whatever people...they don't give a shit. They really don't give a shit. I haven't had one problem with any bastard, noticeably, to my face. I haven't had one person, especially those ones that I was most concerned about. You know, if you are talking about Gay marriage or something, they're all for it...you think would be most give a shit, they don't. They tell me they don't and I've never really had one problem.

In addition to feeling well received within her local community, Latoya felt that working in the area she did was “pretty liberating because you're free...especially in the country”. Latoya often worked on her own and with the assistance of volunteers. As a result, she often didn't “see anybody for ages” and she liked the fact that this meant there was “no-one to bother” her.

The experience described by Latoya provides a provocative contrast to Joe's account of working in the country. Whilst Joe felt the location in which he worked burdened him with a pressure to present a public persona in order to be accepted, Latoya felt liberated by her more remote location. This difference could potentially be explained by Latoya's different approach to her sexual identity. Whereas Joe felt a need to be accepted and that he would only be accepted if he kept his sexual identity to himself, Latoya took a different tack. She said, “...working in the country, knowing you're the only one, you might as well just get one with it, get on out there and see how it goes”. She chose to be out. Latoya's contrasting view on acceptance of her sexuality within the workplace was clear when she said that to be in the closet for her would mean she

...would go mad. You'd develop something. Anxiety-depression at least, you'd die, get cancer, you'd die 10 years earlier. Add to that the 10 years earlier you're gonna die from fuck'n working shift work. I don't know how people could do it. I couldn't do that. I couldn't be bothered doing that. What for? Whose feelings are we protecting? What are they gonna do? Oh, I don't want to work with you, great, go away then. Send me someone else. What could they do? I don't know how people could do that but maybe in the city they're so busy actually working? Well, maybe that's a myth too.

Whilst Latoya personally felt that it would be an unsustainable and destructive choice to stay in the closet, as previously stated in chapter 5, she did offer an explanation for managing sexuality as a Gay *male* paramedic in a rural area: “I don't think it would be very easy to be a Gay man in the country...You'd have to be fricken strong in yourself”. Latoya's statement suggests that the view of Gay men in rural contexts is more negative than the views of Lesbians in rural areas and also more negative than the view of Gay men held by paramedics in urban areas.

Jacob also highlighted the particular difficulties experienced by Gay men in country areas. Jacob felt that in relation to Gay and Lesbian people in general, people in the country were

“really negative” and that Gay and Lesbian people in the community in which he worked “wouldn’t be treated very nicely”. His fear was exacerbated by his sense that “Lesbians in the organisation are a lot more accepted than Gays”. Jacob was very guarded about his sexual identity as he felt he would have negative experiences within the community and with his work colleagues if they knew he was Gay.

Mack also spoke of the hostile and homophobic nature of the rural community he worked in. He described his place of work as having a mixed mentality somewhere between country and city, stating “you get a real mix here of that real sort of rural attitude and city”. Adding to this, Mack felt that when working with his colleagues their previous life experiences influenced how they worked together and how receptive they were to his sexuality. He spoke of an incident that had occurred in a nearby town that demonstrates the less favourable reactions to his sexuality. One of the paramedics he worked with was directed by his mother to “go inside and put on long pants” when he mowed the lawn. This direction had been informed by the belief in the local community that the neighbours, who were Gay, would look at his bare legs in a predatory way unless he covered up. Mack believed these types of events in his upbringing led this paramedic to feel uncomfortable and develop a perception that Mack would behave towards him in a sexually predatory fashion. He believed that these types of misunderstandings, common in the local rural community, compromised his working relationship with this heterosexual male paramedic.

Extending upon his discussion of Gay Ghettos, which tended to be found closer to the inner city, Magnus spoke of some of the experiences of Gay paramedics he knew of in rural areas. Magnus said “I do know a couple of Gay guys who have had to get special permission to come back to the city because they’ve felt that they’ve been harassed [by paramedic colleagues] because of their sexual identity”. The instances highlighted by Magnus here support the evidence provided by other participants that there are fewer acceptances of Gay and Lesbian paramedics in rural areas, in particular Gay male paramedics. Magnus goes on to state, “...my experience here as a general rule, most of the Gay men who work in the outer suburbs, it’s because they are still training and it’s just the work locations they’ve been posted to so they haven’t had a choice of where they want to work”. Saxon attested to a lack of acceptance of diversity in these outer suburban fringe locations, referring to the dominant attitudes within these environments as a “thug mentality”. This “thug mentality” was not accepting of difference and tended towards bullying and exclusionary behaviours. Magnus added that colleagues who returned from postings in the country tended to be exposed to more conservative attitudes in a general sense where there is less of an acceptance of them and “a high degree of sexism and that sort of thing”. These more conservative attitudes

where sexism, racism and other 'isms' thrive have a strong affinity with heterosexism and homophobia.

Michelle made similar inferences in relation to her work environment when she noted things were difficult for Gay and Lesbian paramedics "particularly in the country". As previously mentioned in chapter 5, the "feel" in her rural workplace was such that she believed that Gay and Lesbian paramedics were not welcome. Michelle also felt that this was particularly the case for Gay males. She had developed this insight after being exposed to a workplace that was "racist and sexist" in nature. Michelle contrasted this with her experience in city settings where she felt "if you work in an inner suburb or something you wouldn't care who was who" but this was not the case in the country. This meant that Michelle chose to keep her sexual identity private at work, whereas she believed that "in the city I probably wouldn't care as much". In fact, as noted earlier, it was Michelle who had felt safe enough in the city to be part of a paramedic presence at a public local Gay Pride event. She had attended this event, as she assumed "it's the city and no one's going to know anyone" and therefore she felt safe with the level of perceived anonymity.

In her discussion Michelle also highlighted the effect of increased 'downtime' as part of the daily work pattern for country paramedics. Paramedics in rural areas tended to spend a greater amount of time waiting to respond to incidents due to the lower population density of their surrounding community. This downtime provided greater opportunity for discussion between paramedics and had opened her eyes to some prevailing attitudes. Michelle said some of the discussions during this downtime had included the topic of the rights of Gay and Lesbian people to marry. Michelle recounted one discussion she had with a work colleague who indicated that general community attitudes in the local area were in extreme opposition to Gay marriage in that it "shouldn't happen". Michelle likened these heterosexist attitudes to Gay marriage to the greater influence of religion in the country. Religion is discussed in the final section of this chapter.

Taking the aforementioned evidence of participants into consideration, to my mind it is not co-incidental that the more extreme and overt instances of bullying and discrimination recounted by Joe, Saxon and Mack all occurred in regional areas.

Workforce composition

According to participants in this research, the composition of the workforce varied between country and city locations, not just in relation to the proportions of Gay and Lesbian paramedics, but also in terms of the age of paramedics within the workforce generally. Historically, the nature of paramedic work patterns has varied significantly between these

locations. One of the primary variations in these work patterns has been utilisation rates of paramedics, which are generally lower in rural areas and, as such, there is a comparatively higher 'downtime' in rural areas. As a result of less demanding work patterns, it is common for careers in rural areas to be more sustainable. Consequently, paramedics from inner urban areas often move to the country as their length of service and age increase in seeking a 'quieter' and less busy working life. As a result, the workforce composition in rural areas tends toward a higher proportion of older and more experienced paramedics. As a general rule older people hold conservative attitudes and are less likely to view homosexuality in a favourable way (Knauer 2011, p. 76). This response to difference may influence attitudes in these remote locations.

Jacob noted that it was predominantly older colleagues that expressed negative views of homosexuality in his rural location, in that "...it seems to be more the older generation that talk that way rather than the younger generation". Jacob's explanation for this was that "Maybe the younger people have been educated and have grown up with it, but maybe the older people not so much". As a result, he felt the younger generation "don't seem to talk about it or don't seem to care about it in general". Despite this disparity in points of view between various people in his workplace, Jacob remained in the closet. Presumably this was because the views of the older generation of paramedics in the rural context he worked in still remain dominant.

Janine did not work in a rural area, but offered some insight into the dominance of the older generation of paramedics. She said that it was "often the older guys that have been around for a while" who when considering homosexuality "sort of struggle with it and feel quite confronted". On a positive note however Janine had observed that things were improving: "With the influx of the new uni students...I think times are changing a little bit". Janine believed that the newer generation of university educated paramedics were more open minded and less inclined to have issues with homosexuality. This influx of fresh point of view from younger paramedics had helped to open up "people's minds" in her workplace to some extent. And as a result she said "some of the older guys around are sort of now more accepting of Lesbians at work". Despite this influx of a younger more accepting generation of paramedics who were more inclined to voice support for Gay and Lesbian people in general and Gay and Lesbian paramedics specifically, Janine indicated that the dominant voices within her workplace were still that of the older generation. They still had a stronghold in her local area, which meant they had not necessarily "changed their behaviour on road at all". Janine's experience reflects a transition in terms of workforce composition *and* the values and attitudes adhered to within the culture of her workplace. Despite alternative attitudes finding a voice, these attitudes were yet to impact on the behaviours of some of the older

paramedics she worked with. Such behaviours continued to be aligned to the values of the dominant paramedic culture.

Saxon also ascribed the more conservative and homophobic belief systems to the older generation of paramedics. He identified them as the same group of male paramedics who were “very long in the tooth and really should leave the job”. He added that many did not believe that “women belong in the job”. According to Saxon, this group of male heterosexual paramedics would on occasion set women “up to fail” by saying to them at incidents they were attending “...if you want to take all that gear, then you can take it yourself”.

According to Magnus the rural workforce tended to be “all boys, older generation”, thus more conservative. As such, he had found that less Gay and Lesbian friendly views were held in rural areas. These views had influenced the choices of some of his Gay male paramedic colleagues to move from rural locations to the ‘safe haven’ of the Gay ghetto in more densely populated areas.

Religiosity

Another feature noted by some of the Gay and Lesbian paramedic participants in this research, was a greater propensity towards religiosity within the rural workforce when compared to the metropolitan workforce. Previous research documents a stronger negative relationship between religiosity and attitudes to homosexuality (Johnson, Brems & Alford-Keating 1997). Religiosity generally took the form of affiliation to various Christian beliefs and denominations. This tended to be a more dominant part of the culture of paramedics in country than city areas. Joe said that in his rural area the paramedics were “usually family men, a wife with kids, nice house, into property, involved in the community, *go to church*”. He added that in his “particular station, there are a lot of church going people”. Joe believed that the religious beliefs held by many of his colleagues meant acceptance of his sexual identity was difficult.

The thing that kills me is that, whilst I do believe that I am sincerely liked and all of that, if I actually got into a discussion with them about religion and what the religious perspective is on being Gay, they will say that it is still unacceptable. In their mind they could still justify why it is unacceptable. I guess that is where I find it hypocritical because they still like me as a person: I don't get it.

It appears that Joe was accepted only on the condition that his sexuality remained unspoken and unconfirmed. This silence meant not only leaving hypocrisy unchallenged but denied Joe his right to a voice, therefore privileging the rights of his heterosexual colleagues in a similar sense to the ‘don’t ask, don’t tell’ policy of the US armed forces (see chapter 1).

People holding more orthodox Christian beliefs had also posed issues for Mack in the workplace. In his most recent experience Mack had come across one colleague who had posed specific difficulty for him. This experience had been “the one with that Christian fellow” and this was ‘the last really negative experience’ he had. His experience with this person who was “very, very Catholic” involved being referred to in the following way, “...oh, he’s a really lovely bloke but, oh, that poofter business, I can’t come at that”. In Mack’s mind this explained the unpleasant and uncomfortable experiences he had with this individual on an ongoing basis.

Magnus spoke about his awareness that “inherently” some of the paramedics he worked with had “a doctrine that’s not compatible with” his sexual identity as they were “very devout Christians”. Magnus said, “The service even has pastors or whatever they call them... chaplains”. The role of these chaplains was to deliver ‘pastoral care’ to the paramedics in the service when they were exposed to a range of critical incidents. Magnus felt alienated and insulted by the use of chaplains in this capacity.

They’ve been sent to jobs. I feel insulted, really uncomfortable when they’ve been sent to jobs. You think, well no, I won’t talk to you; I won’t talk to a chaplain whereas others will. Because if it gets to anything that involves a very invasive conversation that is going to mean revealing a little bit more of myself, why am I going to risk? They may well be fine but I don’t know that, so...

It is clear that the inclination of the service that he worked for to use religious people to service Magnus’s ‘care needs’ was out of step with his actual needs. The impact was to further alienate and exclude Magnus rather than support him during times of need.

Finally, Michelle noted the influence of religion in her workplace. In relation to the paramedics in the country location in which she worked, she stated:

...there’s a bit of religion in some of them as well and that kind of throws the table over again. Mmm, don’t ruin Christianity. Go marriage. I read some, what was it someone said the other day? Christians being offended by Gay marriage is like being offended that someone bought an ice-cream because you are on a diet. It’s so true, anyway...

This religious leaning also influenced Michelle’s actions in terms of her reluctance to come out in her rural work location. She expressed strong intentions to move to the city where she did not feel she would be exposed to such homophobic attitudes.

Critical discussion and summary

Participants who worked in rural or semi-rural environments reported experiences of homophobic attitudes and behaviours, which were disproportionate to their metropolitan counterparts. These experiences led to social exclusion, silencing and disenfranchisement within their places of work. The increased exposure to homophobic values within the workplace for these Gay and Lesbian paramedics meant they tended not to be open in the workplace. With this fear came a need to be vigilant in terms of their sexual identity. This increased comparative level of homophobia is a barometer of some of the attitudes of local communities in general, and more specifically, that of the paramedic population working in a particular rural environment.

The rural environment provided a 'pressure cooker' for negative attitudes to be more apparent. A range of points of difference were spoken of around gender, race and sexuality. This is potentially a reflection of the pervasiveness of a stereotypical patriarchal, heterosexual, white culture in these areas where there is often great resistance to change. Although some participants alluded to a more recent influx of younger paramedics with more progressive and inclusive views, the tendency for these views to be not well received in rural areas meant that although the principles of diversity and inclusivity may be gaining more of a voice in relative terms, the practices of those who subscribe to 'old school' viewpoints remain opposed to progression.

Participants have touched upon the concept of 'critical mass' and the comfort and support this provides them to be 'out' in the workplace. In rural areas, such critical mass of Gay and Lesbian paramedics does not tend to exist, and those who do work in such a context tend to be less visible than their city counterparts. As such, it is unlikely that these attitudinal features of the workplace of rural paramedics are likely to change over time, especially when compared with progress that may be taking place in the metropolitan context. These less progressive viewpoints have many impacts. They tend to silence and closet Gay and Lesbian paramedics who may be posted to one of these locations. They also create reluctance on the part of Gay and Lesbian paramedics to transfer to work in these locations and concurrently push existing Gay and Lesbian paramedics back into the more accepting spaces within their organisations. This creates a syndrome whereby they are less likely to be present and visible within rural areas. The flow on effect is that attitudes in these areas are less likely to change and therefore the work environment remains a more hostile place for Gay and Lesbian paramedics.

The prevalence of what I will refer to as 'attitudinal stagnation' in remote areas leads to dislocation, silencing and exclusion for paramedics who are not heterosexual. The work patterns and consequent tendency for some of these rural locations is to attract older paramedics and act as zones for transition towards retirement for paramedics. This means a tendency towards concentration of some less progressive attitudes. This continuum acts in some respects as an attitudinal 'time lock' in this demographic cycle. Hence there are fewer tendencies to embrace more progressive and inclusive attitudes. 'Topping up' these rural workplaces with older paramedics who are more likely to have conservative viewpoints can be seen as providing 'guardianship' for this cycle of exclusion. The distillation of these attitudes alongside the tendency to further marginalise more progressive and inclusive points of view has the effect of providing something of a 'time capsule' of values and ideals. This is commonly scaffolded by the views of the surrounding community of which the local paramedic workplace can be seen as a reflective microcosm.

An increased religiosity in rural areas reinforced the combative relationship Gay and Lesbian paramedics have with such attitudes in rural or remote workplaces. Barnes and Meyer (2012, p. 510) assert that such non-affirming religious settings present a hostile environment to Gay, Lesbian and Bisexual people. This hostility was apparent to several participants. Such hostility has been linked to greater incidence of internalised homophobia and negative health effects including depression, low self-esteem, anxiety and problems in forming intimate relationships (Barnes & Meyer 2012, pp. 506-9). Added to the more general patterns of marginalisation and exclusion Gay and Lesbian paramedics in rural areas experience, the concurrent orthodox religiosity in these areas puts an additional edge of disproportionate burden of suffering into the mix.

With the exception of paramedics, such as Latoya, who chose to be out and remain resilient; rural work contexts are more hostile and isolating for these paramedics. Despite this negative feature, the attraction to work in these locations is that paramedics can experience lower utilisation rates and greater periods of rest. These factors can be career sustaining. Conversely, the sanctuary that can be provided within the bigger metropolitan centres, commonly in Gay ghettos, can provide a sense of safety and acceptance whilst concurrently minimising the effect of *closet fatigue*. In general terms exposure to a higher caseload means less 'downtime' and less rest. These factors can equate to a greater incidence of 'burnout' and less sustainable careers. Heterosexual people are not influenced by these same factors when making choices about where to locate themselves geographically within a paramedic organisation. Whilst several other lifestyle factors are influential, sexuality does not influence or limit heterosexual choices. The cultural contrast

between country and city adds another layer of complexity in the marginalisation of Gay and Lesbian paramedics in Australia.

Geography influences the experience of Gay and Lesbian paramedics markedly. They do not tend to challenge dominant views, which marginalise them. Paramedics who work in rural environments even seem to accept the notion that country areas provide a 'hostile' environment and to navigate within this environment one must remain silent or move away. Tolerance of pressures to move out of a rural environment that has many positive features highlights that this indifference contributes to acceptance of inequities as being just 'the way things are'. In all geographical areas of paramedic organisations, particularly rural locations, inequities need to be highlighted and social inclusion strategies embedded and enforced in order to address this marginalisation.

This chapter emerged from a theme of difference in the workplace experience of Gay and Lesbian paramedics in rural and metropolitan environments. Evidence provided by participants suggested that workplace experiences were less negative for city paramedics on the basis of their sexuality and rural paramedics tended to report more exclusion and isolation. This experience of disproportionate marginalisation logically leads to disproportionate psychological and emotional stress for Gay and Lesbian paramedics in the rural subgroup. Failure to adopt and implement policy structures aimed at creating organisations that enable choices of work locations based fairly on factors *other than* sexuality is necessary to ensure a fair workplace for paramedics.

The next chapter focuses on the potential benefits that could be capitalised upon in the context of a supportive and inclusive environment for Gay and Lesbian paramedics. It sets out to explore the views of participants in terms of what they would be able to offer in a workplace that celebrated their individuality and more fully appreciated the assets they hold in their repertoire as Gay and Lesbian people. These benefits are wide ranging for industry and community.

CHAPTER 12: TOWARDS 'YOU'TOPIA

Previous thesis chapters, which have been assigned to exploring data, have focused on the experiences of Gay and Lesbian paramedic participants in terms of their inclusion and exclusion within the workplace in addition to considering the mechanisms which govern inclusion and exclusion. This is the final chapter that explores participant data. The goal of this chapter is to highlight what participants see as the potential benefits of a paramedic workforce that both supports and capitalises on diverse sexual identities of its employees. All participants expressed strong views on the contribution they made or could potentially make to their patients and to the wider community because of their sexuality. They also had clear ideas about the potential benefits of having *empowered* and enthusiastically supported Gay and Lesbian paramedics within ambulance organisations. The views expressed provided a sketch of what could be in an equitable and inclusive world. The idealist nature of this projected world could be viewed as 'utopian' for participants, celebrating the unique identity of these individuals. I have chosen to use '*you'topia*' to refer to a just and inclusive workplace that not only celebrates individuality but capitalises on Gay and Lesbian capabilities and experiences.

Benefits of diversity ('you'topia)

It is well recognised within a range of occupations that industry practices that aim to include diverse groups of workers have a positive impact on a multitude of levels. A number of examples exist of workplaces that have recognised the benefits of practices which include and support Gay and Lesbian employees. Some of the organisations which use models of inclusion have already been referred to in the literature review chapter. These include Shell (Shell 2010), Barclay's Bank (Barclays Bank PLC 2011), Levi-Strauss (Carr-Ruffino 1999, p. 231) and IBM (IBM Australia 2011) in the corporate sector. In sectors better aligned to the operational requirements of ambulance organisations, targeted programs aimed at the recruitment, support and inclusion of Gay and Lesbian employees have been put into practice by the British Medical Association (British Medical Association 2005) and several police organisations both in the United States (Miller, Forest & Jurik 2003, p. 358; Sklansky 2006, 2007) and Australia (Victoria Police 2011). Equity and inclusion legislation, policy and practice are a codified way of not only protecting individual rights but also encouraging practices that bring potential benefits to all. These codes of practice may have a positive impact only if supported consistently and reliably by organisational practice and culture. Legislation, policy and practice are less likely to achieve their inherent goals if not acted upon in a consistent, strategic and holistic way.

The participants in this study reinforced the views that there are tangible and explicit benefits in supporting Gay and Lesbian employees. They highlighted a number of areas of potential benefit that would result from measures implemented to support, include and empower Gay and Lesbian employees within ambulance organisations. All participants in this study asserted the need to give voice to these paramedics and to celebrate their sexual diversity. Further, feelings of wellbeing for them would be produced by organisational practices that embraced their sexuality. Participants believed these practices would also benefit other employees with which they share the workplace in addition to making a positive contribution to the community whose diverse needs they serve. In terms of benefits to the community, participants identified advances that directly impact quality of care for Gay and Lesbian consumers of primary healthcare. They identified further benefits to other minority community groups by recognising and including Gay and Lesbian paramedics. These groups included a number of staff from religious and ethnic minorities.

Gay, Lesbian and other sexually diverse consumers

Gay and Lesbian and other 'sexually diverse' minorities living within the community have specific needs and a number of measures indicate the health of this cohort is poorer than that of the heterosexual community (Willis & Elmer 2011, p. 137). Individuals within this group are entitled to have their specific needs unconditionally met by healthcare workers including paramedics. There remains a significant multiplicity of identities within the Gay and Lesbian community. In a broad sense however individuals in this group have specialised needs, unique interpersonal relationships and common associated health presentations. Having an appreciation of, empathy towards and sensitivity to the specific needs of sexually diverse minorities arguably leads to tailoring care to their needs with better health outcomes. This is consistent with concepts of 'person' or 'patient centred' care that are now championed as being at the core of contemporary healthcare delivery. Overwhelmingly, participants in this study felt the insights they had gained in identifying as a Gay or Lesbian person had the potential to benefit Gay and Lesbian patients they attended in their role as paramedics. Participants identified these benefits as being derived from their ability to more fully identify with and be sensitive to the Gay and Lesbian patients they attended. Being supportive to this cohort of patients was the key message here.

Calliope saw the value of her experience as a Lesbian as having potential benefits for her Gay and Lesbian patients as she felt she had "more empathy for Gay related issues" whether these issues were "Gay bashings" or depression and suicide of Gay or Lesbian people who were "struggling with their sexuality". This empathy she felt was a product of the fact that "a lot of Gay people, not all, have sort of gone through their own issues" in coming to terms with

their sexuality “whether it’s in their head or out publicly or with a psychologist”. She also asserted that “most Gay people...they’ve had a bit of a battle, a bit of inner turmoil, whether it’s for 30 seconds or 30 years”. Janine’s views were consistent with Calliope’s in that she felt “from my perspective working in the inner city as well, I have gone to plenty of jobs involving Lesbian, Gay and transsexual people. I think there is a sensitivity there that can’t be matched by others, so that definitely helps.” She felt that in situations where she was attending a Gay or Lesbian patient she was able to provide better care than her heterosexual colleagues, stating “I think that you can definitely do it well in those situations where maybe a straight guy couldn’t because he hasn’t got that life experience.” Magnus also supported these views in terms of the care he was able to offer Gay and Lesbian patients.

So, certainly if I go to a Gay or Lesbian patient that’s got some issues, whether they be HIV positive or relationship issues or mental health issues related to sexuality or whatever, certainly I think I’m coming from the perspective where I understand them a little bit more. I can perhaps show them more compassion than maybe some of my straight counterparts. That’s an individual thing, but I certainly think that coming from the perspective of being outside the norm it just gives you that little bit more awareness.

Magnus felt his ability to empathise was a product of his experience of being “outside the normalities of the community” and that this had made him “a little bit more aware of differences in people” he dealt with. He was therefore better able to meet the needs of his patients. Magnus disclosed that as a Gay male when attending to Gay or Lesbian patients, “I’ve never actually turned around and said ‘it’s alright, I’m Gay’, but I think just the mere fact of the way I’ve treated some of the patients, they’ve worked it out...I might sort of say ‘I love this or that’ and they can kind of work me out and they relax”. In spite of the benefits he was able to offer his patients by virtue of his sexual identity, Magnus was forced into self-silencing and to communicating with his Gay and Lesbian patients in a coded manner.

Holley provided the following example of how she was able to support a patient she had attended as a direct result of her own experience of being a non-heterosexual person:

I remember in particular one young lady that I went to see and she’d taken a handful of tablets because she was completely and utterly miserable...but she clearly needed to go to hospital and see someone about her mental state. I got her in the back and said um ‘what’s going on?’ and she said, ‘oh, you wouldn’t understand’. I said, ‘oh, I probably wouldn’t, but I’m actually interested if you’d like to tell me about it’. She said ‘oh, I’ve had a fight with my ex-partner and I can’t go and see our children and you know it’s really hard because I’m Gay...’. And I said, ‘Well I can actually identify, I’m separated from my ex-partner and she’s a woman and we have two children’ and she goes ‘oh really, how are you managing and where can I get advice and where can I

get help?’...I was able to give her some of the pathways that I used in establishing some of the things that we set up, to help her. I don’t know if it helped, but just knowing she wasn’t the only person going through something like that in a similar situation made a big difference.

Holley asserted that she felt this level of care would not usually be forthcoming from her heterosexual colleagues who had monotonously experienced heterogendered privilege.

Holley’s personal experience as a Bisexual person, who had at various stages been engaged in heterosexual and Lesbian relationships, provided an interesting and unique insight. She said that by virtue of “having been married and in a heterosexual relationship and then in a Lesbian relationship” she could “identify with both sides of the fence”. Holley went on to state that when she encountered “people who are having trouble with people who are having problems with their husband or their children or their [same sex] partner” that “in some ways it makes it a great deal easier to identify and build a rapport with some of my patients.”

Jacob also saw the benefits of his experience as a Gay man as potentially benefiting the care he was able to give to Gay or Lesbian patients as it “provides a difference in the workplace”. Jacob stated that if he were to attend a patient who “was a homosexual and is having maybe difficulties like in mental health or depression or just in general they had a problem and they identified as a homosexual” he would “be able to relate to them more”. As a result of this ability to relate to this group of patients Jacob felt, in a similar sense to Holley, that he would be able to “give them strategies or refer them to services that other people may not be aware of”.

Mack also supported the views of these Gay and Lesbian participants. Mack said, “...we encounter Gay and Lesbians as patients quite frequently” and feared that “if I ever got really sick with something they’d say ‘he’s only a poofter, it doesn’t matter if he’s sick or dying’ or something like that”. However Mack was of the view that Gay and Lesbian people “don’t do that to each other” and this was beneficial to this specific group of patients within the community. Mack saw the virtues of Gay and Lesbian paramedics working in paramedic organisations in terms of the unique care they were able to provide to Gay and Lesbian patients in the community. Although he did not view the present situation as ideal in terms of the level of support and inclusion of individual Gay and Lesbian paramedics, he was able to see some current benefit to this sector of the community. In a ‘*you’topian* world where Gay and Lesbian paramedics were celebrated and included, he felt this potential benefit could be fully capitalised upon.

Latoya recalled a situation where she attended to some transgender people in the area in which she worked. Despite her view that she was limited in her insight into the experience of these patients, she felt she was able to provide better care than a heterosexual paramedic to such a group. The response from her colleagues when she was sent to the relevant incident was “you’re going to the transvestites”. Latoya conceded that she was herself confused about the gender identity of her patients and said, “I was calling them ‘him’ or ‘her’ and I was still confused” and that due to this confusion she was “so embarrassed”. Latoya stated that in this instance she “got it all wrong”. On reflection she thought “that’s fucked...you’re the diverse ambo who has attended in the middle of nowhere and even I fucked it up”. Despite her views of her shortcomings here she saw the positive impact of her Lesbian sexual identity and said “...at least I said sorry”. Latoya was of the view that her heterosexual colleagues would not have extended such an apology to their patients. She felt flawed but a more empathetic approach to caring for transgendered patients resulted from the fact that she had “seen plenty more than people that live in their little het[erosexual] world”. She said “...I have friends who have changed genders” and felt that she knew the “LGBTI community”. As a result, she felt she had better insight and understanding and was able to offer care in a manner that better met the needs of patients having diverse sexual and gender identities. Latoya stated “I had some empathy for my transvestites”. Compared to her heterosexual colleagues she “probably [made] more effort to be nice to people from diverse communities because I know that they may not feel comfortable with the normal people they get everywhere in every service they turn up for”. She was an accessible and informed paramedic because of her values. Latoya had experienced a life that informed her empathetic and caring capacity to serve the diverse community in which she was immersed.

Participants were able to clearly see the potential benefits they could provide to Gay and Lesbian patients they may be called on to attend. Despite the clarity of this view, optimisation of specialised care to Gay and Lesbian users of ambulance services is dependent on the ability of Gay and Lesbian paramedics to be open about their sexuality in the course of care provision. Without this explicit visibility, this care is dependent on rituals, coding and innuendo, as described by Magnus. Heteronormative practices and cultural understandings, which served to silence the paramedics in this study because of their sexual identity effectively, obstructed a good deal of potential benefit to patients. There were and are many opportunities for Gay and Lesbian paramedics to care for members of the Gay and Lesbian community in the course of their duties. Due to the institutionalised silencing of Gay and Lesbian paramedics, *‘you’topian* opportunities to optimise the level of care available to Gay and Lesbian users of ambulance services often remain a shortcoming in the care available to these patients. Organisational practices which are supportive of Gay and Lesbian

paramedics and give voice to this group can go some way towards redressing this situation, providing better quality care for Gay and Lesbian users of ambulance services.

Wider community inclusive of other diverse groups

In addition to the ability of Gay and Lesbian paramedics to better understand the specific needs of sexually diverse patients, participants also highlighted other specific attributes they brought to their role as paramedics. Numerous participants stated that their personal experience as members of a marginalised group meant they experienced instances of discrimination and social exclusion. As a result of these more general experiences of marginalisation, they believed their ability to empathise with other marginalised groups was accentuated. This greater affinity meant they were able to provide a better quality of care to patients that may be members of other minority or marginalised groups. Some participants noted if it were possible to have a more visible cross-sectional representation of diverse groups in paramedic organisations, it would lead to a greater awareness of the needs of these diverse, marginalised groups within these organisations. This awareness was seen by some participants to be a factor with the potential to contribute better primary healthcare experience for members of such groups.

General empathy, tolerance, non-judgemental approach

Mack saw the positive effects of being a member of a minority group upon the way he interacted with others. He stated "...if I hadn't been Gay, I might have been far more racist or bigoted or intolerant than I actually am..." This inferred that his sexual identity made him far more open minded and thus empathetic towards minority or marginalised groups than his heterosexual colleagues. Mack felt that Gay and Lesbian people "tend to be a bit more open minded". He believed that this open mindedness meant he was more empathetic towards patients and less judgemental in a range of situations in his paramedic work. Mack said that this open mindedness was because "we've been in a minority group and we know what it's like to be treated like shit...just for being who you are". He said that as a result "we tend not to do that to others" and that whilst "it's always difficult to not be judgemental with certain people" he felt he was "more aware that people are allowed to be different, so whether it's religion or what have you, gender, colour, obesity...whatever." Both Joe and Calliope echoed Mack's sentiments. Calliope recounted how her personal experience meant she had "more empathy for people who are struggling". Joe felt that "in some jobs I think I have a bit more empathy because I am Gay and I look a bit further beyond a shallow surface" and that being Gay meant he had "a bit more patience with other people". From the point of view of these participants, their lived experience of marginalisation and exclusion had resulted in them possessing the qualities of empathy, patience and tolerance. They felt that these attributes

were not as apparent in their heterosexual colleagues, who had not had the same experiences of marginalisation due to heterogendered privilege.

Magnus thought that “people who for whatever reason sit outside the normalities of the community in general, always tend to be a little bit more aware of differences in people they deal with”. Although Magnus’s experience as a member of a marginalised group had been as a Gay man, he felt he was able to identify with others from quite distinct groups and this assisted him in doing his job.

I’m very strong in my atheist beliefs, very anti-organised religion. However, you know, we have a large Muslim population and I get it, I get that things are different for them. They’re fronted with me and their first view of me would be a white, authoritative, heterosexual male from western culture. So I get that I’ve kinda got to let them know that your normalities are different from mine. And I really do try with most people to work out what works for them, what makes them comfortable. I think it has a huge impact.

Saxon saw his experience as a Gay male as fostering in him a greater tolerance of “these people on the edges of society that you’re going to”. He believed that as a result of being from a minority background he was able to better identify with people with diverse, and often marginalised, cultural and religious beliefs. Saxon felt this was beneficial in terms of giving him the ability to put individual needs at the centre of patient care. He said that many of his colleagues who had not shared his experience as being part of a marginalised group were less tolerant in attending to some of the more unpleasant types of work he encountered in ghetto locations. Saxon felt that in general this propensity to be more accepting was a product of the fact that “we’ve come up against our own challenges in our lives.” He said that due to these challenges “I wouldn’t ever want anyone to feel that shame that I felt so I don’t tend to judge other people on their behaviour the same as other people may who have had the idyllic upbringing.” He also felt that, due to this lived experience of marginalisation, other Gay and Lesbian people behaved similarly.

I think for a lot of Gay men, and probably Lesbian women as well, if you’ve hidden something for so long because it’s not going to be accepted, and you’ve felt that feeling of shame, I honestly don’t believe that later on in your life you’re going to make other people feel like that.

He believed that this meant Gay and Lesbian people were “more empathetic towards other people, non-judgemental because we’ve come from this background where we’ve had to, if you’re out, stand up for who you are” and that “having an understanding of what it feels like coming from a minority group is really helpful” when providing care to a member of a minority group as a paramedic.

Holley also took a non-judgemental approach. She felt her experience as a member of a minority group in terms of her sexual identity meant she was “a lot less judgemental”. She stated she did not “place a lot of right or wrong on things, they just are” and that from her point of view there was “no good and bad, there just is”. She believed her non-judgemental approach was a product of “living a non-social norm life”. Holley was able to suspend value judgements as a product of her lived experience as a member of a minority group. She felt this had a positive impact for her patients as it meant she was less likely to pre-judge them and impose stereotypes, and more likely to listen to their stories and respond to their individual needs. This amounts to a more individualised and person-centred care experience.

Cross-sectional representation

Michelle saw the importance of a paramedic workforce that was well represented from a range of social groups, effectively mirroring the composition of the community. Her rationale was “...because we are all different and when you’ve got someone walking into your house at a time where you think you’re either gonna die or you’ve cut your finger you want someone that you can relate to.” Michelle went on to say that in order to achieve this level of representation, there needed to be “a really broad spectrum of people’ working as paramedics. She stated:

I think it's really important for the community to see that paramedics aren't all blonde haired, blue eyed, Aryan, stock standard, picture perfect people. They need tattoos and they need to be on an obvious Gaydar and wear turbans and all that stuff. Not just in a Gay and Lesbian sense but in every sort of sense so that they are not stereotyped as too straight. So, yeah, I think the community would feel...a lot of the community in a lot of the city areas would feel a lot more comfortable with a diverse paramedic population.

Some of the benefits of cross-sectional representation highlighted by Michelle were also alluded to by Calliope. She felt that having visible Gay and Lesbian paramedics meant “you’ve got just another healthy cross section of society”. Calliope went on to say that representation from this cross section “just throws another little colour in the rainbow of the little bits of everyone”. She drew parallels to other minority groups in terms of the healthy representation provided by a visible presence of Gay and Lesbian paramedics when she said “I guess it would be much the same with different nationalities and different religions, just healthier I guess” and this meant there were “different opinions here and there”. Jacob also saw the benefits to the community in the general sense of the visibility of the paramedic workforce. He felt that “not just having straight people in the workplace” but also having visible groups of paramedics who were “Gays, Lesbians [and] different cultures” would be beneficial. Targeted recruitment policies are one measure that paramedic organisations could pursue to achieve this goal of diversity.

Mirroring the diversity of the community serviced by paramedic organisations in the aforementioned manner was thought to be beneficial for minority sexual identity groups. Jacob felt that this was because people within the community would be more likely to develop a perception that diverse sexualities were accepted and supported within paramedic organisations. He felt that because these organisations were publicly visible, this would set a good example for other sectors of the community and promote the acceptance of sexual diversity in a more general sense. He also felt it would mean Gay and Lesbian people may be more likely to be comfortable calling paramedics in times of need. He felt an openly Gay or Lesbian paramedic would be “able to relate to” a Gay or Lesbian patient and therefore “provide a better outcome” than a heterosexual paramedic.

Colleagues

Some participants indicated they felt the presence of a group of Gay and Lesbian paramedics in the workplace could have a positive effect on heterosexual paramedics. Janine stated that the presence of Lesbian paramedics in her work location had “definitely” opened “other people’s minds”. As previously stated in chapter 10, her observation was that their presence meant “some of the older guys around are sort of now more accepting of the Lesbians”. Michelle also saw the benefit of diversity within her workplace in a general sense. She stated “by working with people as paramedics we can learn stuff from each other and hopefully that would open up people’s minds”. Michelle used the analogy of working with a person from a minority religious background. She stated “If I worked with say a Muslim person for a month then I would be trying to get every bit of information I could out of them about their religion, so that I could better work with their community if I was to go to a Muslim place”. She added “we are in the job because we want to help people and because we want to do what’s right for them.... I think there’s a lot of us who want to learn from each other and learn how to make life easier for someone else”. From this statement it is clear that Michelle felt that if she were able to be open in relation to her sexuality she would be able to assist other paramedics around her to gain insight into aspects of the Gay and Lesbian community and therefore better meet their healthcare needs.

Jacob highlighted the fact that arrangements had been made from within his ambulance service to have a group of Gay and Lesbian paramedics represented in the local Gay Pride event. He felt that this would potentially “put the issue out there into the service and not sort of hide it away in the corner” and therefore potentially assist his paramedic colleagues to develop some insight into Gay and Lesbian issues.

Empathy can be seen as a product of past experiences of marginalisation and Mack related his past experience of being bullied as informing his supportive and empathetic approach with the students under his instruction on the road and with his colleagues. Mack stated “I actually think my experiences of being bullied and that period, I just thought I’ll never ever treat a student the way I was treated by some people and I don’t believe I ever have”. Mack conceded this meant that he had “probably gone to the other extreme where I’m probably a bit softer with the students I work with” and as a consequence “Most of them really enjoy working with me”. Mack asserted that this way of interacting with students led to a better quality of learning for them and they were able to pass this positive effect on to patients in the form of better quality care. Mack was able to in fact see a positive product of his past experiences of being bullied because of his sexual identity. He stated, “That’s where I feel professionally...that’s where I’ve got strength. I know how to treat my workmates, I know what it feels like to be treated with disrespect, so I like to think I treat my workmates with respect.”

Critical discussion and summary

It is clear from the point of view of the Gay and Lesbian participants in this research that there is potential benefit to a wide range of stakeholders in promoting robust and sustainable workplace practices that ensure inclusion of sexually diverse minorities within the workplace. The potential product emanating from a serious and cohesive focus on workplace inclusion is *‘you’topia* that has no perceivable negatives for individual paramedics, patients, organisations or community groups. This *‘you’topian* environment would mean that Gay and Lesbian paramedics are able to feel comfortable and supported within their places of work and be able to provide optimal care to the patients they attend in the course of their jobs. This *‘you’topia* would mean that the recognition of individual difference facilitates supported discussion and empathy and allows education of heterosexual paramedics within the workplace on matters relating to minority sexual identity. This has the potential to produce a greater ability to empathise with patients from a range of minority groups and therefore better quality care. It potentially means less conflict in the workplace, lower organisational costs and greater organisational efficiency due to less need for conflict resolution. This *‘you’topia* can mean that paramedics are happier in the workplace and therefore take less sick leave, are more productive and more willing to commit to longer, sustained and fulfilling careers. This commitment can mean not only more satisfaction for the individual Gay and Lesbian paramedic, but ‘money in the bank’ for a paramedic organisation as a product of effective capitalisation on available human resources and the commodity of experience that is built up within such an organisation.

Some other sectors of the workforce have recognised the need to both care for their workers and to capitalise on the unique qualities diverse groups can contribute to enriching their core organisational agendas. Some police forces in the United States have recognised the benefits of diversity produced by embracing the uniqueness of their workforce composition in leading to “a decline in the monolithic white, male, heterosexual police subculture with one that is segregated and divided” (Sklansky 2006, p. 1231). Such segregation and internal division, despite seeming undesirable on the surface has opened up space for dissent and disagreement (Sklansky 2007, p. 35). This transitional dissent and disagreement is a product of a shift from cultural homogeneity to diversity. The increased number of openly Gay or Lesbian police challenges endemic homophobia in these organisations, and this can build identity based links to outside groups (Sklansky 2007, p. 36). Whilst a shift from the status quo means a shift to temporary, transitional discomfort, the longer term outcome can be inclusivity and enrichment for paramedics in the workplace and for the communities they care for. Several organisations, such as the aforementioned policing bodies, are exemplar models of the benefits of tolerating the short-term discomfort of the transitional measures required to aspire towards *‘you’topia’*. Paramedic organisations in Australia have the opportunity to follow suit.

This chapter has illuminated what participants see as the potential benefits of a paramedic workforce, which both supports and capitalises on the diversity of sexual identity of employees. Participants articulated their views on the contribution they made to patients they attended. They also discussed what they saw as the benefits of having paramedics with diverse sexual identities to the wider community. Participants explored what they foresaw as the potential benefits of having empowered and supported Gay and Lesbian paramedics working within ambulance organisations to Gay and Lesbian and other sexually diverse users of ambulance services, the wider community inclusive of other diverse groups and to their colleagues. It is depressing that despite the preceding views of a *‘you’topia* that celebrate individuality benefits all and harms none, the current reality is that Gay and Lesbian paramedics can remain excluded and *othered* that has profoundly negative impacts on them as individuals and those individuals with which they interact, both in and out of the workplace. Paramedics in this research felt compromised in their ability to provide care for their patients. They felt at times oppressed and unable or unwilling to capitalise on their full potential in terms of caring for their patients or furthering their careers. The cultural elements and heteronormative constructs within their places of work as well as fears emanating from instances of outright bullying in some instances constrained many participants. Discomfort and fear associated with interactions from a combination of patients, colleagues and organisational structures meant there was a clear deficit between *‘you’topia* and current reality.

The reality of the contemporary climate of the paramedic workplace in which Gay and Lesbian paramedic participants were located meant that at present, whilst there are overt policy measures in place, aimed at ensuring equity, some of the more covert, subtle and insidious behaviours and practices within the workplace and the community can undermine these policy and legislative measures. As such the effective marginalisation and *othering* of Gay and Lesbian paramedics has wide-ranging negative ramifications. These impacts are felt not only on an individual level by participants in this research, but by individuals with whom they share close professional and personal relationships. As with other forms of oppression, people who they work with and who have found themselves in the majority do not see anything beyond their own experience. This experience has an organisational cost in terms of failure to capitalise on human resources and workforce attrition. It is also a cost to the community in terms of optimal provision of clinical care.

Chapter 13 draws together the experience of participants with further insight into the current legislative and policy framework in Australia in relation to workplace equity and inclusion. This section will make recommendations on the basis of participant data in terms of how things must be improved for Gay and Lesbian paramedics from a social inclusion and human rights perspective, as well as from the perspective of organisational efficiency and community health.

CHAPTER 13: CONCLUSION AND RECOMMENDATIONS

This research explored the workplace experiences of 10 Gay and Lesbian paramedics and recounted their stories through the lens of the researcher, a Lesbian paramedic. My research aimed to give voice to the paramedics who participated in this study. At its core the objective of this research was to explore these alternative viewpoints. It is the right of all people to be heard. And it makes no sense to silence Gay and Lesbian voices that can inform a better way of doing things.

In undertaking this exploration, this study aimed to answer the following overarching questions:

- What are the current workplace experiences of Lesbian and Gay paramedics in Australia?
- What are the impacts of these experiences on intrapersonal, interpersonal, organisational and general community levels?
- Are there differences in the experiences of Lesbians paramedics as distinct from Gay men?

Conclusion

Australia currently has an ageing population. Such demographic change means that recruitment and retention of healthcare workers is a critical issue. Participation of large numbers of healthcare workers, many of whom will come from diverse backgrounds, is critical to the survival of the sector. An understanding of issues which relate to healthcare workers can help address attrition, recruitment and retention within the industry. Insight into these issues as they relate to experiences specific to marginalised groups will further enhance inclusive practices within the sector, and consequently lead to improved rates of recruitment and retention within these groups. This must include the needs of Gay and Lesbian workers in the health sector.

Social exclusion is frequently related to discrimination based on fear of difference. Practice which leads to social exclusion leads to lower levels of personal control, loneliness and unhappiness and resultant higher levels of stress, morbidity and mortality (Keleher & MacDougall 2011, p. 37). Organisations that value diversity in the workplace can support Gay and Lesbian employees in deciding whether to come out (Chobrot-Mason, Button & DiClementi 2001, p. 334). Workplaces which are tolerant of diversity provide culturally safe environments for people to autonomously choose to reveal information in relation to their sexual orientation and identity. This allows an individual to be their authentic self and to

experience inclusion. This leads to greater individual wellbeing, and to a happier and more productive workplace. This effective management of diversity means acknowledging difference (Kormanik 2009, p. 24) rather than silencing the celebration of such difference. Only the complete removal of silence will allow for an engaged, informed and ethical discussion of the barriers to inclusivity in the same way as other more visible identity attributes. This eradication of silence will lead to greater inclusivity and support from families, friends and communities. This is a factor associated with better health outcomes for employees (Keleher & MacDougall 2011, p. 36).

In this research, the Gay and Lesbian paramedic participants held that they had a different experience of their workplace when compared to their heterosexual colleagues. These differences are exclusively based on their sexual identity. The differences in experience, based on their sexuality, mean these participants were in many ways silenced, marginalised, excluded or treated as *other*. It was shown in chapter 5 that this experience of *othering* varied in terms of the mechanisms that led to such an experience. The commonality within the participant group was that they all experienced their workplaces as spaces that privileged heterosexual paramedics who enjoyed unquestioned authority and power. This meant that to various extents these men and women experienced personal damage and interpersonal relationships were strained or damaged. Gay and Lesbian paramedics were seen as less effective at working with their heterosexual colleagues, had less effective patient-carer relationships in some instances, and were limited in terms of career progression and sustainable employment. This had potential impacts for the level of paramedic care available to the community. These impacts and limitations were further explored in chapter 6. The remaining data chapters (7, 8, 9, 10, 11 and 12) explored the contextual reasons for these impacts as final products of the tension between individual sexual identity, and the more collective and homogenous nature of heteronormative paramedic culture.

In this research, Lesbian paramedics were *less disadvantaged* than Gay male paramedics. This account remained uncontested and it was commonly postulated that this difference was attributable to the manner in which dominant stereotypes of sexuality within the paramedic culture functioned. These stereotypes were commonly subscribed to as default understandings of what a Gay or Lesbian person looks like and how they behave, which relates to workplace culture. These stereotypes were due in part to the enforced silencing of Gay and Lesbian paramedics in the discourse of the workplace. As this message was loud and clear, it was a deliberate choice not to devote discussion in the form of a separate chapter, but to take a more naturalistic approach and allow discussion of the issue to arise at relevant junctures.

Gay and Lesbian paramedics are disadvantaged and silenced due to multiple reasons incorporating workplace culture. Although Lesbians are less disadvantaged than Gay men, this has negative implications for all. The heterogendered, hierarchical, masculine and homogenous nature of the culture was found to impact Gay and Lesbian paramedics in the management of their sexuality. There were always conditions placed upon how much they could reveal to colleagues. This added another layer of stress on the participants, described as *closet fatigue*. This thesis has at its core the power of *closet fatigue* to minimise optimal functioning on all levels of the profession. To escape or seek temporary reprieve from this fatigue, many paramedics sought sanctuary in likeness. The Gay ghettos that existed in many organisations in selected ways allowed for some relief of this *closet fatigue*. Despite providing some relief, a more sinister longer-term effect of working in the ghetto space was rooted in the nature and patterns of work in these physical locations. For some paramedics this meant that after having sought an escape from the *closet fatigue* present within their organisation, they were then subjected to increased work fatigue. In the longer term, the limited availability of rest and *echo* breaks in these locations was a further inequity for Gay and Lesbian paramedics. This thesis illustrates that the inequities permeate multiple contexts and not encountered by heterosexual colleagues. The title of this thesis, *No Echo in the Ghetto*, is a deliberate reference to this issue. There is no 'rest' from the insidious oppression experienced by these women and men.

It is a commonly held perception that Australian contemporary society is egalitarian and inclusive. These views are the product of greater visibility of selected elements of Gay and Lesbian sexuality. This research establishes that in the context of the workplaces of the Gay and Lesbian paramedics who participated in this study, despite superficial perceptions of increased tolerance and visibility, homophobic behaviour has become more subtle in nature (Newcomb & Mustanski 2010, p. 1027). This situation is unacceptable. Due to the absence of a supportive work environment and in the context of a community culture that does not support Gay and Lesbian people, participants in this research remained silent. They suppressed elements of their sexual self-expression due to fear of the consequences of being open. This self-editing and enforced silencing leads to *closet fatigue* and this state of exhaustion has serious impacts on these paramedics as individuals and those with which they come into contact.

Limitations

Conclusions drawn from this research do not aim to speak for all Gay and Lesbian paramedics or for all Gay and Lesbian people. The inquiry is an attempt to reconstruct the uniquely individual experiences of those who took part in the research and to identify

dominant themes revealed. The methodological approach has ultimately spoken for these 10 Gay and Lesbian paramedics. It was never the intention to generalise the data. This is because lived experience should always be considered important. This study is, in essence, about celebrating individuality and diversity, and not reducing ontological views produced by unique experiences to a set of rules, which can be extrapolated to all Gay and Lesbian paramedics. In focusing on the research sample of 10 Gay and Lesbian paramedics, it can be seen how difficult it can be to identify such people in a simple way that generalises all people. This is exemplified by the fact that two participants in this study, although social Lesbians, actually described themselves as Pansexual and Bisexual respectively, highlighting the difficulty of categorising people on the basis of any attribute. This study is about bringing their stories to the readership. From the outset, my understanding was that all research sets out to effect change.

For this reason this work is significant. It establishes that, for at least the group of Gay and Lesbian paramedics whose stories have informed this research, their experience of their places of work is more negative and challenging than that of their heterosexual colleagues. This difference is predicated principally on their sexual identity. In order to stay true to the emancipatory goals of this research, a number of recommendations are informed by these stories and experiences.

Recommendations

On the basis of this research, the following recommendations are made to redress existing inequities in a systematic, comprehensive and consistent way. These recommendations are educational, operational, policy and support innovations aimed at redressing inequities as they relate to Gay and Lesbian paramedics in Australia. Such strategies have been introduced with demonstrated success in several previously mentioned organisations including IBM, Shell and Victoria Police. Interventions and strategies that relate to education are recommended for both the continued and mandated professional development activities within paramedic organisations and in the undergraduate education of paramedics in Australian universities.

University education

Sexuality be explicitly included in documentation governing accreditation of undergraduate programs by the Council of Ambulance Authorities

At present paramedic curricula and the majority of contemporary health programs are constructed so they set out to address issues of social justice, including paramedic programs in Australia, in a general way. They do not specifically address or support issues of sexuality. The inclusion of social justice, diversity, inclusion, population health, determinants of health and other terms of reference in overarching curricula within various university programs give academics 'licence' to address issues of sexuality; however, operational failure to develop and present curricula specific to sexuality, means there is a perpetuation of silence, especially on matters of sexuality and social injustice. This translates into a poorer understanding of the needs of sexually diverse minorities in the health field and in turn poorer outcomes for non-heterosexual patients. It also means poorer outcomes for sexually diverse minorities in their workplace and failure to capitalise on specialised understandings of this sector of the workforce.

The Council of Ambulance Authorities (CAA) accredits the curricula of university programs in Australia and New Zealand. On the basis of all of the readily available information on the currently accredited curricula from 15 accredited universities (Council of Ambulance Authorities 2014), *none* have made specific reference to affirming sexually diverse groups. The accreditation documentation of the CAA (Council of Ambulance Authorities 2013), which governs the accreditation of the aforementioned programs, makes specific reference to "sexual preference" in only one of its competency standards; but the program does not include further reference when moving to address other key social justice content and inequities as this thesis shows. Sexually diverse minorities need to be put on the paramedic and health education agenda and curriculum in a very specific sense. Only then can their needs be addressed in the health context. The net result is that there will be compulsion to deal with issues related to Gay and Lesbian paramedics in all university curricula at an essential pre-employment, foundational level.

Paramedic professional development and workplace education

The introduction of structured programs of education around sexuality and identity as part of the diversity of the workplace

Paramedic organisations currently deliver ongoing professional development training programs to their employees. These programs are essential in responding to evolution within the industry based on clinical and technological advances in addition to remaining responsive to community needs.

Training all paramedics within their program of professional development is necessary to address issues related to sexuality and exclusion. By doing so, homophobia will be interrupted, and this openness has the potential to increase awareness and empathy of this

hitherto silenced group. There is a possibility that these paramedics, by being informed, can operate with more empathy towards minority groups. It is possible that this education could also impact in such a way that heterosexual paramedics would be more effective in working in 'ghetto' areas and therefore have an impact on the ghetto effect in paramedic organisations, which this study shows is a no-win and inequitable situation.

Workplace equity and inclusion programs

Introduction of workplace equity and inclusion programs which specifically deal with Gay and Lesbian employee issues

Systematic programs that are positively focused and aim to encourage dialogue on the benefits of inclusive practices have a range of potential benefits for all minority groups. A positive focus on the potential contribution made to workplace practices which celebrate, rather than oppress, diverse groups can add to the available body of knowledge within an organisation. For paramedic organisations, this can have a positive impact on both harmony within the workplace and quality of patient care provided. The attributes of all diverse groups need to be included in such policy and programs and specific mention of these groups made, so that such groups are not overlooked at any point. In the context of this research, this means specific practices related to the inclusion of Gay and Lesbian paramedics in the workplace and the consequent benefits of their inclusion need to be highlighted.

Employer supported paramedic networks

Development of networks of Gay and Lesbian paramedics

In order to combat feelings of isolation for Gay and Lesbian paramedics within their workplaces, it is recommended that paramedic organisations provide support for the development of employee support networks. This organisational infrastructure has the potential to limit the sense of isolation felt by some Gay and Lesbian paramedics, particularly in rural networks. A formalised network also has the potential to override the phenomenon of working in ghetto areas, which by default provide a sense of inclusion and support. Removal of pressures toward working in ghettos can mean a more equitable workplace for Gay and Lesbian paramedics. There is also a potential to reduce burnout as a consequence and therefore influence attrition levels.

Gay and Lesbian liaison paramedics

Assigning Gay and Lesbian community liaison roles to paramedics

Best quality outcomes in healthcare are dependent on organisational practices that are sensitive and reflexive to the needs of the community they serve. In relation to serving the needs of the Gay and Lesbian community, it is vital that organisational policy and practices are informed by the Gay and Lesbian community. Ensuring organisational policy and practice keeps abreast with contemporary community needs means educational materials available within workforces are relevant and realistic in their reflection of the lived experience of these consumers of services. This translates into a general level of respect for the Gay and Lesbian community, which can be paralleled in practice, with respect to the views and experiences of Gay and Lesbian paramedics.

Resources and reference material

Widely available and consistently distributed materials on Gay and Lesbian lifestyles and issues

As paramedic organisations are dispersed across wide geographical areas, there is potential for local inconsistencies in practices and cultures to develop. As this research has demonstrated, there are significant differences in localised practices which are notably non-progressive in rural areas. Ensuring 'just in time' educational resources, such as pamphlets, posters and web-links on Gay and Lesbian matters, are readily and plentifully available at all worksites and this has the potential to expose paramedics to the unique attributes of Gay and Lesbian people in general, and Gay and Lesbian paramedics in particular. This also sends the more generalised message that organisations are committed to and serious about protecting the rights of Gay and Lesbian people and paramedics.

Overt managerial support and 'zero tolerance' policy and practice strategies

Overt and specific policies that are protective of Gay and Lesbian employees and consistently enforce matters of inequity, discrimination and marginalisation

As paramedic organisations favour 'top down' or 'command and control' organisational structures, managerial support is essential in ensuring that interventions aimed at cultural change are successful. This leadership needs to be consistent between all of those in leadership roles within these organisations. In order for policies that are protective of the rights of Gay and Lesbian employees not to be seen as tokenistic, a consistent, 'zero tolerance' approach is required. Allowing the subtle and insidious heteronormative discriminatory cultural practices that marginalise or *other* Gay and Lesbian paramedics to

continue, despite overt policy stating such practices are not tolerated, renders such initiatives impotent. This 'zero tolerance' approach needs to be consistent across all work locations within an organisation.

Overt organisational policy related to patient-centred care

Statements which clarify for paramedics what delivery of patient-centred care means, with particular reference to appropriate disclosure of sexual identity

Confusion within the industry as to the meaning of patient-centred care was found to be present. Organisational statements which are explicit in terms of what an organisationally endorsed level of personal disclosure is are needed to clarify this. In relation to Gay and Lesbian paramedics, these statements need to be explicit in terms of the organisation's willingness to both allow disclosure of the sexual identity of the paramedic, where deemed relevant, and protecting the individual paramedic, where such disclosure is a contentious issue for patients they attend. This sends a strong message of support to Gay and Lesbian paramedics.

References

- Acker, J 2011, 'Theorizing gender, race and class in organizations', in EL Jeanes, D Knights & P Yancey Martin (eds.), *Handbook of Gender, Work, and Organization*, Wiley, West Sussex, pp. 65-80.
- Ambulance Service of New South Wales 2011, *Our women – our service, women play a major role in the Ambulance Service of NSW*, Sydney,
<<http://www.ambulance.nsw.gov.au/Media/docs/20110308womensday-5b8dc4b6-0140-4b9d-8156-1223da8b9370-0.pdf>>.
- Ambulance Victoria 2009, *2008-2009 Annual Report*, Melbourne.
- 2010, *Careers - Jobs at Ambulance Victoria*, viewed 7/7/2010 2010,
<<http://www.ambulance.vic.gov.au/Ambulance-Victoria/Careers/Jobs-at-Ambulance-Victoria.html>>.
- Anastas, J 1998, 'Working against discrimination: Gay, Lesbian and Bisexual people on the job', in L Sloan & N Gustavsson (eds.), *Violence and Social Injustice Against Gay, Lesbian and Bisexual People*, The Haworth Press, New York, pp. 83-98.
- Attride-Stirling, J 2001, 'Thematic networks: an analytic tool for qualitative research', *Qualitative Research*, vol. 1, no. 3, pp. 385-404.
- Australia, CGo 1961, *Marriage Act* Commonwealth Government of Australia,
http://www.austlii.edu.au/au/legis/cth/consol_act/ma196185/s5.html#marriage,
<http://www.austlii.edu.au/au/legis/cth/consol_act/ma196185/s5.html#marriage>.
- Australian Labor Party 2009, *National platform and constitution 2009*, Barton, ACT,
<<http://www.alp.org.au/australian-labor/our-platform/>>.
- Australian Learning and Teaching Council 2009, *Paramedic education: developing depth through networks and evidence-based research*. Final Report.
- Back, L, Bennett, A, Edles, LD, Gibson, M, Inglis, D, Jacobs, R & Woodward, I 2012, *Cultural Sociology: an introduction*, Wiley-Blackwell, West Sussex.
- Barclays Bank PLC 2011, *Sexual orientation*,
<<http://group.barclays.com/Citizenship/Diversity-and-our-people/Sexual-orientation>>.
- Barkway, P 2009, 'Health and health psychology', in P Barkway (ed.), *Psychology for Health Professionals*, Elsevier, Chatswood, NSW, pp. 65-84.
- Barlow, DE & Barlow, MK 2000, *Police in a Multicultural Society: An American Story* Waveland Press, Long Grove.
- Barnes, DM & Meyer, IH 2012, 'Religious affiliation, internalized homophobia, and mental health in Lesbians, Gay men, and Bisexuals ', *American Journal of Orthopsychiatry*, vol. 82, no. 4, pp. 505-15.
- Bazeley, P 2007, *Qualitative Data Analysis with NVIVO*, Sage, London.
- Benokraitis, NV 1997, *Subtle Sexism: Current practices and Prospects for Change*, Sage, Thousand Oaks, CA.

- Bernstein, M & Kostelac, C 2002, 'Lavender and blue: attitudes about homosexuality and behaviour towards Lesbians and Gay men among police officers', *Journal of Contemporary Criminal Justice*, vol. 18, no. 3, pp. 302-28.
- Bertakis, KD, Franks, P & Epstein, RM 2009, 'Patient-centered communication in primary care: physician and patient gender concordance', *Journal of Women's Health*, vol. 18, no. 4, pp. 539-45.
- Blumenfeld, WJ 2001, *Squeezed into gender envelopes*, in W Blumenfeld (ed.), *Homophobia: How We All Pay the Price*, Beacon Press, Boston, MA, pp. 23-38.
- Boyle, M 1997, 'Love the work, hate the system : a qualitative study of emotionality, organisational culture and masculinity within an interactive service workplace', PhD thesis, University of Queensland.
- 2002, '"Sailing twixt Scylla and Charybdis": negotiating multiple organisational masculinities', *Women in Management Review*, vol. 17, no. 3/4, pp. 131-41.
- British Medical Association 2005, *Sexual Orientation in the Workplace*, British Medical Association, London.
- Browne, K 2005, 'Snowball sampling: using social networks to research nonheterosexual women', *International Journal of Social Research Methodology*, vol. 8, no. 1, pp. 47-60.
- Burgess, A & Burgess, J 2011, *Truth*, Princeton University Press, Princeton, NJ.
- Butler, JP 1990, *Gender Trouble*, Routledge, Chapman & Hall, Inc., New York.
- Carnevale, AP & Stone, SC 1995, *The American Mosaic: An In-Depth Report on the Future of Diversity at Work*, McGraw-Hill, New York.
- Caroline, NL 1995, *Emergency Care in the Streets*, 5th edn, Lippincott, Williams & Wilkins, Philadelphia.
- Carr-Ruffino, N 1999, *Diversity Success Strategies*, Butterworth-Heinemann, Woburn.
- Cassell, C & Symon, G 2004, *Essential Guide to Qualitative Methods in Organizational Research*, Sage, London.
- Chobrot-Mason, D, Button, SB & DiClementi, JD 2001, 'Sexual identity management strategies: an exploration of antecedents and consequences', *Sex Roles*, vol. 45, no. 5/6, pp. 321-35.
- Clair, JA, Beatty, JE & MacLean, TL 2005, 'Out of sight but not out of mind: managing invisible social identities in the workplace', *Academy of Management Review*, vol. 30, no. 1, pp. 78-95.
- Cohen, L & Manion, L 1994, *Research Methods in Education*, 4th edn, Routledge, London.
- Cook, R 2009, *Dictionary of Philosophical Logic*, University of Edinburgh Press.
- Cooke, M 1997, 'Authenticity and autonomy: Taylor, Habermas, and the politics of recognition', *Political Theory*, vol. 25, no. 2, pp. 258-88.
- Council of Ambulance Authorities 2009, *2008-2009 Annual Report*, Council of Ambulance Authorities.

- 2013, *Paramedic professional competency standards*,
<<http://www.caa.net.au/education/accreditation-resources>>.
- 2014, *Stages of accreditation*, <<http://www.caa.net.au/education/accredited-courses>>.
- Crotty, M 1996, *Phenomenology and Nursing Research*, Churchill Livingstone, South Melbourne.
- 1998, *The Foundation of Social Research*, Meaning and Perspective in the Research Process, Allen & Unwin, Sydney.
- Cruikshank, M 2014, *The Gay and Lesbian Liberation Movement*, Taylor & Francis, New York, NY.
- Cunliffe, AL & Shotter, J 2006, 'Linguistic artifacts in organising and managing', in A Rafaeli & MG Pratt (eds.), *Artifacts and Organizations: Beyond Mere Symbolism*, Lawrence Erlbaum Associates, New Jersey, pp. 119-37.
- de Beauvoir, S 1989, *The Second Sex*, Vintage Books, New York.
- Denzin, NK & Lincoln, YS 2008a, 'Introduction: critical methodologies and indigenous inquiry', in NK Denzin, YS Lincoln & LT Smith (eds.), *Handbook of Critical and Indigenous Methodologies*, Sage, Thousand Oaks, CA, pp. 1-20.
- 2008b, *Strategies of Qualitative Inquiry*, 3rd edn, Sage, Thousand Oaks, CA.
- Department of Human Services, V 2008, *Paramedic women celebrate 21 years of ambo service*, State Government Victoria,
<<http://www.health.vic.gov.au/archive/archive2010/humanservicesnews/sep08/para.htm>>.
- Dowling, M 2007, 'From Husserl to van Manen. A review of different phenomenological approaches', *International Journal of Nursing Studies*, vol. 44, pp. 131-42.
- Dowrick, S 2007, *Creative Journal Writing*, Allen & Unwin, Sydney.
- Eliason, MJ, DeJoseph, J, Dibble, S, Deevey, S & Chinn, P 2011, 'Lesbian, Gay, Bisexual, Transgender, and Queer/ questioning nurses' experiences in the workplace', *Journal of Professional Nursing*, vol. 27, no. 4, pp. 237-44.
- Embrick, DG, Walther, CS & Wickens, CM 2007, 'Working class masculinity: keeping Gay men and Lesbians out of the workplace', *Sex Roles*, vol. 56, pp. 757-66.
- Ferfolja, T 1998, 'Australian Lesbian teachers – a reflection of homophobic harrassment of high school teachers in New South Wales government schools', *Gender and Education*, vol. 10, no. 4, pp. 401-15.
- 2007, 'Schooling cultures: institutionalizing heteronormativity and heterosexism', *International Journal of Inclusive Education*, vol. 11, no. 2, pp. 147-62.
- 2008, 'Discourses that silence: teachers and anti-Lesbian harassment', *Discourse: Studies in the Cultural Politics of Education*, vol. 29, no. 1, pp. 107-19.
- 2009, 'State of the field review: Stories so far: an overview of the research on Lesbian teachers', *Sexualities*, vol. 12, no. 3, pp. 387-97,
<<http://sexualities.sagepub.com/content/12/3/378.abstract>>.

- 2010, 'Lesbian teachers, harassment and the workplace', *Teaching and Teacher Education*, vol. 26, pp. 408-14.
- Figley, CR (ed) 2013, *Compassion Fatigue: Coping With Secondary Traumatic Stress Disorder In Those Who Treat The Traumatized*, Taylor & Francis, New York.
- Findlay, L 2002, 'Negotiating the swamp: the opportunity and challenge of reflexivity in research practice', *Qualitative Research*, vol. 2, no. 2, pp. 209-30.
- Fineman, S 1993, 'Organisations as emotional arenas', in S Fineman (ed.), *Emotion in Organisations*, Sage, London, pp. 9-35.
- Fish, J 2006, *Heterosexism in Health and Social Care*, Palgrave MacMillan, New York.
- Fjelstrom, J 2013, 'Sexual orientation change efforts and the search for authenticity', *Journal of Homosexuality*, vol. 60, no. 6, pp. 801-27.
- Flood, M & Hamilton, C 2008, 'Mapping homophobia in Australia', in S Robinson (ed.), *Homophobia: An Australian History*, The Federation Press, Annandale, pp. 16-38.
- Foucault, M 1990, *The History of Sexuality: Volume I: An Introduction*, Vintage Books, New York.
- Freire, P 2005, *Pedagogy of the Oppressed*, 30th anniversary edn, The Continuum International Publishing Group Inc., New York.
- Giddings, LS & Smith, MC 2001, 'Stories of Lesbian in/visibility in nursing', *Nursing Outlook*, vol. 49, no. 1, pp. 14-9.
- Giorgi, A 2009, *The Descriptive Phenomenological Method in Psychology*, Duquesne University Press, Pittsburg, PA.
- Glass, N 2000, 'Speaking feminisms and nursing', in J Greenwood (ed.), *Nursing Theory in Australia*, Pearson Education, Frenchs Forest, NSW, pp. 349-376.
- Golebiowska, EA 2001, 'Group stereotypes and political evaluation', *American Politics Research*, vol. 29, no. 6, pp. 535-65.
- Gonel, HA 2013, 'Pansexual identification in online communities: employing a collaborative Queer method to study Pansexuality', *Graduate Journal of Social Science*, vol. 10, no. 1, pp. 36-59.
- Gonsoulin, S & Palmer, E 1998, 'Gender issues and partner preferences among a sample of emergency medical technicians', *Prehospital and Disaster Medicine*, vol. 13, no. 1, pp. 41-7.
- Griffin, P 2006, 'Identity management strategies among Lesbian and Gay educators', *International Journal of Qualitative Studies in Education*, vol. 4, no. 3, pp. 189-202.
- Groome, M 2009, 'Communication in healthcare practice', in P Barkway (ed.), *Psychology for Health Professionals*, Elsevier, Chatswood, NSW.
- Guba, EG & Lincoln, YS 1994, 'Competing paradigms in qualitative research', in NK Denzin & YS Lincoln (eds.), *Handbook of Qualitative Research*, Sage, Thousand Oaks CA, pp. 105-17.
- Guest, G, Bunce, A & Johnson, L 2006, 'How many interviews are enough?: an experiment with data saturation and variability', *Field Methods*, vol. 18, no. 1, pp. 59-82.

- Habermas, J 1971, *Towards a Rational Society*, Heinemann, London.
- Harding, T 2007, 'The construction of men who are nurses as Gay', *Advanced Nursing*, vol. 60, no. 6, pp. 636-44.
- Harris, DA & Giuffre, PA 2010, "'Not one of the guys': women chefs redefining gender in the culinary industry', in Williams & K Dellinger (eds.), *Gender and Sexuality in the Workplace*, Emerald Group Publishing Limited, Bingley, UK, pp. 59-82.
- Harry, J 2010, 'Being out', *Journal of Homosexuality*, vol. 26, no. 1, pp. 25-40.
- Harvey, L 1990, *Critical Social Research*, Contemporary Social Research, Unwin Hyman, London.
- Hatzenbuehler, ML 2009, 'How does sexual minority stigma "get under the skin"? A psychological mediation framework', *Psychological Bulletin*, vol. 135, no. 5, pp. 707-30.
- Hatzenbuehler, ML, Dovidio, JF, Nolen-Hoeksema, S & Phills, CE 2009, 'An implicit measure of anti-Gay attitudes: prospective associations with emotion regulation strategies and psychological distress', *Journal of Experimental Social Psychology*, vol. 45, pp. 1316-20.
- Hatzenbuehler, ML, McLaughlin, KA, Keyes, KM & Hasin, DS 2010, 'The impact of institutional discrimination on psychiatric disorders in Lesbian, Gay, and Bisexual Populations: a prospective study', *American Journal of Public Health*, vol. 100, no. 3, pp. 452-9.
- Henderson, G 1996, *Human Relations Issues in Management*, Quorum Books, Connecticut.
- Hofstede, G, Hofstede, GJ & Minkov, M 2010, *Cultures and Organisations: Software of the Mind*, 3rd edn, McGraw Hill, New York.
- Holmes, J 2007, 'Monitoring organisational boundaries: diverse discourse strategies used in gatekeeping', *Journal of Pragmatics*, vol. 39, pp. 1993-2016.
- Howie-Willis, I 2009, 'The Australian ambulance system: a historical introduction', in P O'Meara & C Grbich (eds.), *Paramedics in Australia: Contemporary Challenges of Practice*, Pearson, Frenchs Forest, pp. 1-23.
- Humphrey, JC 1999, 'Organizing sexualities, organized inequalities: Lesbians and Gay men in public service occupations', *Gender, Work, and Organization*, vol. 6, no. 3, pp. 134-51.
- IBM Australia 2011, *Diversity at IBMGLBT – Gay Lesbian Bi-Sexual Transgender*, <<http://www-07.ibm.com/employment/au/diversity/glb.html>>.
- Irwin, J 1999, *The Pink Ceiling is Too Low', Workplace Experiences of Lesbians, Gay men and Transgender people*, Australian Centre for Lesbian and Gay Research, University of Sydney, Sydney.
- Jameson, F 1979, 'Reification and utopia in mass culture', *Social Text*, vol. 1, Winter, pp. 130-48.
- Johnson, ME, Brems, C & Alford-Keating, P 1997, 'Personality correlates of homophobia', *Journal of Homosexuality*, vol. 34, no. 1, pp. 57-69.

- Keleher, H 2011, 'Social inclusion', in H Keleher & C MacDougall (eds.), *Understanding Health*, 3rd edn, Oxford University Press, South Melbourne, pp. 193-202.
- Keleher, H & MacDougall, C 2011, 'Understanding the determinants of health', in H Keleher & C MacDougall (eds.), *Understanding Health*, 3rd edn, Oxford University Press, South Melbourne, pp. 33-46.
- Kennedy, P 1999, *You Must See Some Terrible Things*, Kangaroo Press, Sydney.
- Kincheloe, JL & McLaren, P 1994, 'Rethinking critical theory and qualitative research', in NK Denzin & YS Lincoln (eds.), *Handbook of Qualitative Research*, Sage, Thousand Oaks, CA, pp. 138-57.
- Kincheloe, JL, McLaren, P & Steinberg, SR 2012, 'Critical pedagogy and qualitative research: moving to the bricolage', in SR Steinberg & GS Cannella (eds.), *Critical Qualitative Research Reader*, Peter Lang Publishing, New York.
- King, M, McKeown, E, Warner, J, Ramsay, A, Johnson, K, Cort, C, Wright, L, Blizard, R & Davidson, O 2003, 'Mental health and quality of life of Gay men and Lesbians in England and Wales: controlled, cross-sectional study', *The British Journal of Psychiatry*, vol. 183, no. 6, pp. 552-8.
- Kisiel, R 2009, 'Paramedics paid extra to go on Gay pride march... regardless of their sexuality', *Mail Online*, <<http://www.dailymail.co.uk/news/article-1194277/Paramedics-paid-extra-Gay-pride-march--regardless-sexuality.html>>.
- Knauer, NJ 2011, *Gay and Lesbian Elders: History Law and Identity Politics in the United States*, Ashgate Publishing Group, Aldershot, UK .
- Kormanik, MB 2009, 'Sexuality as a diversity factor: an examination of awareness', *Advances in Developing Human Resources*, vol. 11, no. 1, pp. 24-36.
- Kreber, C 2010, 'Courage and compassion in the striving for authenticity: states of complacency, compliance, and contestation', *Adult Education Quarterly*, vol. 60, no. 2, pp. 177-98.
- Kudrna, G & Woodland, A 2011, 'Economic effects of population growth and ageing in Australia', in A 'Sustainable' Population? – Key Policy Issues – Roundtable Proceedings, Canberra.
- Lambert, BL, Street, RL, Cegala, DJ, Smith, DH, Kurtz, S & Schofield, T 1997, 'Provider-patient communication, patient-centered care, and the mangle of practice', *Health Communication*, vol. 9, no. 1, pp. 27-43.
- Langdrige, D & Hagger-Johnson, G 2009, *Introduction to research methods and Data Analysis in Psychology*, Pearson, Harlow, New York.
- Langridge, ME & Ahern, K 2003, 'A case report on using mixed methods in qualitative research', *Collegian*, vol. 10, no. 4, pp. 32-6.
- Lather, P & Smithies, C 1997, *Troubling the Angels: Women Living with HIV/AIDS*, Westview Press, Boulder, CO.
- Lee Badgett, M & King, MC 1997, 'Lesbian and Gay occupational strategies', in A Gluckman & B Reed (eds.), *Homo Economics: Capitalism, Community, and Lesbian and Gay Life*, Routledge, New York, pp. 73-84.

- Lewin, S, Skea, Z, Entwistle, V, M, Z & Dick, J 2001, 'Interventions for providers to promote a patient-centred approach in clinical consultations (Review)', *The Cochrane Database of Systematic Reviews*, no. 4.
- Liddle, BJ, Luzzo, DA, Hauenstein, AL & Schuck, K 2004, 'Construction and validation of the Lesbian, Gay, Bisexual, and Transgendered climate inventory', *Journal of Career Assessment*, vol. 12, no. 1, pp. 33-50, viewed 17/11/10, <<http://jca.sagepub.com/content/12/1/33.full.pdf+html>>.
- Lincoln, YS & Cannella, GS 2004, 'Dangerous discourses: methodological conservatism and governmental regimes of truth', *Qualitative Inquiry*, vol. 10, no. 1, pp. 5-14.
- Lincoln, YS & Guba, EG 1985, *Naturalistic Inquiry*, Sage, Newbury Park, CA.
- Magnusson, M 2010, 'Victoria Police out to recruit Gay and Lesbian officers', *Melbourne Community Voice*, 17 March, viewed 23 March 2010, <<http://www.mcv.gaynewsnetwork.com.au/news/victoria-police-out-to-recruit-gay-and-lesbian-officers-007711.html>>
- Maguire, BJ, O'Meara, PF, Brightwell, RF, O'Neill, BJ & Fitzgerald, GJ 2014, 'Occupational injury risk among Australian paramedics: an analysis of national data', *Medical Journal of Australia*, vol. 200, no. 1, pp. 477-80.
- Manns, PJ & Chad, KE 2001, 'Components of quality of life for persons with a quadriplegic and paraplegic spinal cord injury', *Qualitative Health Research*, vol. 11, no. 6, pp. 795-811.
- McKenna, T 2009, *Heteronormativity – Workplace Discrimination in Australian Schools: Gay and Lesbian Teachers in Australia*, VDM Verlag Dr. Muller, Saarbrücken.
- McKnight, D 2006, 'Modern Australia: the ascendancy of the right in modern Australia', *The Sydney Papers*, vol. 18, no. 1, pp. 201-5.
- Medlock, G 2012, 'The evolving ethic of authenticity: from humanistic to positive psychology', *The Humanistic Psychologist*, vol. 40, no. 1, pp. 38-57.
- Meyer, IH 2003, 'Prejudice, social stress, and mental health in Lesbian, Gay, and bisexual populations: conceptual issues and research evidence', *Psychological Bulletin*, vol. 129, no. 5, pp. 674-97.
- Miller, SL, Forest, KB & Jurik, NC 2003, 'Diversity in blue: Lesbians and Gay police officers in a masculine occupation', *Men and Masculinities*, vol. 5, no. 4, pp. 355-85, viewed 17/11/10, <<http://jmm.sagepub.com/content/5/4/355.full.pdf+html>>.
- Moran, D 2000, *Introduction to Phenomenology*, Routledge, London.
- Muldoon, P 2010, 'Identity', in M Bevir (ed.), *Encyclopedia of Political Theory*, Sage, London, pp. 678-82.
- Myers, KA, Forest, KB & Miller, SL 2008, 'Officer friendly and the tough cop', *Journal of Homosexuality*, vol. 47, no. 1, pp. 17-37.
- National EMS & Firefighters Pride Alliance 2011, *National EMS & Firefighters Pride Alliance*, <<http://www.mynefpa.org/>>.

- Newcomb, ME & Mustanski, B 2010, 'Internalized homophobia and internalizing mental health problems: a meta-analytic review', *Clinical Psychology Review*, vol. 30, pp. 1019-29.
- Nicholson, SL 2010, 'Exploring the lived experience of long-term paramedics: a phenomenological study', PhD thesis, Capella University.
- Noonan, A 2010, 'Vic police want Gay recruits', *Star online*.
- Noy, C 2008, 'Sampling Knowledge: The hermeneutics of snowball sampling in qualitative research', *International Journal of Social Research Methodology*, vol. 11, no. 4, pp. 327-44.
- O'Faherty, M & Fisher, J 2008, 'Sexual orientation, gender identity and international human rights law: cotextualising the Yogyakarta Principles', *Human Rights Law Review*, vol. 8, no. 2, pp. 207-48.
- Onken, S 1998, 'Conceptualising violence against Gay, Lesbian, Bisexual, Intersexual and Transgendered people', in N Gustavsson & L Sloan (eds.), *Violence and Social Injustice Against Lesbian, Gay and Bisexual people*, The Haworth Press, New York, pp. 5-24.
- Open Universities Australia 2013, *Career Advice*, viewed 14/6/2013 2013, <<http://www.open.edu.au/careers/healthcare-medical-pharmaceuticals/paramedics-ambulance>>.
- Pager, D & Quillian, L 2005, 'Walking the talk? What employers say versus what they do', *American Sociological Review*, vol. 70, pp. 355-80.
- Paramedics Australasia 2014, *Who we are*, <<https://www.paramedics.org/our-organisation/who-we-are/>>.
- Parry, Y & Willis, E 2009, 'The social context of behaviour', in P Barkway (ed.), *Psychology for Health Professionals*, Elsevier, Chatswood, NSW, pp. 85-103.
- Patton, M 1990, *Qualitative Evaluation and Research Methods*, Sage, Beverly Hills, CA.
- Pollitt, D 2006, 'Beyond age discrimination to leveraging human capital', *Human Resource Management International Digest: Diversity in the workforce*, vol. 14, no. 3.
- Porter, S 2013, 'An exploration of the support needs of ambulance paramedics', PhD thesis, Victoria University.
- Queensland Government:Department of Emergency Services 2005, *Annual Report 2004-2005*, Queensland Government: Strategic Management Unit, Brisbane.
- Ragins, BR, Cronwell, JM & Miller, JS 2003, 'Heterosexism in the workplace: do race and gender matter?', *Group & Organizational Management*, vol. 28, no. 1, pp. 45-74, viewed 17/11/10, <<http://gom.sagepub.com/content/28/1/45.full.pdf+html>>.
- Ragins, BR, Singh, R & Cornwell, JM 2007, 'Making the invisible visible: fear and disclosure of sexual orientation at work', *Journal of Applied Psychology*, vol. 92, no. 4, pp. 1103-18.
- Reynolds, LC 2008, 'Beyond the front line: an interperative ethnography of an ambulance service', PhD thesis, University of South Australia.

- 2009, 'Contextualising paramedic culture', in P O'Meara & C Grbich (eds.), *Paramedics in Australia: Contemporary Challenges of Practice*, Pearson, Frenchs Forest, pp. 28-43.
- Robinson, S (ed.) 2008, *Homophobia: An Australian History*, The Federation Press, Annandale.
- Rose, J & Glass, N 2010, 'An Australian investigation of emotional work, emotional well-being and professional practice: an emancipatory inquiry', *Journal of Clinical Nursing*, vol. 19, pp. 1405-14.
- SA Ambulance Service 2010, *Annual Report 2009–10*, SA Ambulance Service, Adelaide.
- 2011, *SA Ambulance Service - Careers*, viewed 29/7/2011 2011, <<http://www.saambulance.com.au/Careers.aspx>>.
- Salmela, M 2005, 'What is emotional authenticity?', *Journal for the Theory of Social Behaviour*, vol. 35, no. 3, pp. 209-30.
- Shell 2010, *Diversity and Inclusion at Shell*, company report, Shell, viewed 17 August 2011, <http://www-static.shell.com/static/environment_society/downloads/commitments_standards/diversity_inclusion_brochure_2010.pdf>
- Shnurr, S 2008, *Leadership Discourse at Work : Interactions of Humour, Gender and Workplace Culture*, Palgrave Macmillan, New York.
- Sinclair, A 2005, *Doing Leadership Differently: Gender, Power and Sexuality in a Changing Business Culture*, 2nd edn, Melbourne University Press, Melbourne.
- Skidmore, P 1999, 'Dress to impress: employer regulation of Gay and Lesbian appearance', *Social & Legal Studies*, vol. 8, no. 4, pp. 509-29.
- Sklansky, DA 2006, 'Not your father's police department: making sense of the new demographics of law enforcement', *The Journal of Criminal Law & Criminology*, vol. 96, no. 3, pp. 1209-44.
- 2007, 'Seeing blue: police reform, occupational culture, and cognitive burn-in', in M O'Neill, M Marks and AM Singh (eds.), *Police Occupational Culture: New Debates and Directions*, Elsevier, Oxford, pp. 19-45.
- Smith, JA & Osborn, M 2003, 'Interpretative phenomenological analysis', in JA Smith (ed.), *Qualitative Psychology*, Sage, London, pp. 53-80.
- SooHoo, S 2006, *Talking Leaves: Narratives of Otherness*, Critical education and ethics, Hampton Press, Inc., Cresskill, NJ.
- Speziale, H & Carpenter, D 2007, *Qualitative Research in Nursing*, Lippincott Williams & Wilkins, Philadelphia.
- Steele, CM 2010, *Whistling Vivaldi: and Other Clues to How Stereotypes Affect Us*, WW Norton & Company Inc., New York.
- Steen, E, Naess, AC & Steen, PA 1997, 'Paramedics organizational culture and their care for relatives of cardiac arrest victims', *Resuscitation*, vol. 34, pp. 57-63.
- Sue, DW 2010, *Microaggressions in Everyday Life*, Wiley, Hoboken.

- Taylor, A 1983, 'Conceptions of masculinity and femininity as a basis for stereotypes of male and female homosexuals', *Journal of Homosexuality*, vol. 9, no. 1, pp. 37-53.
- Taylor, B 2006a, 'Qualitative critical methodologies and postmodern influences', in B Taylor, S Kermode & K Roberts (eds.), *Research in Nursing and Health Care: Evidence for Practice*, Cengage, South Melbourne, pp. 363-92.
- 2006b, 'Qualitative data analysis', in B Taylor, S Kermode & K Roberts (eds.), *Research in Nursing and Health Care: Evidence for Practice*, Cengage, South Melbourne, pp. 455-85.
- 2006c, 'Qualitative interpretive methodologies', in B Taylor, S Kermode & K Roberts (eds.), *Research in Nursing and Health Care: Evidence for Practice*, Cengage Melbourne, pp. 318-62.
- 2006d, 'Qualitative methods', in B Taylor, S Kermode & K Roberts (eds.), *Research in Nursing and Health Care: Evidence for Practice*, Cengage, South Melbourne, pp. 393-436.
- Taylor, C 1991, *The Ethics of Authenticity*, Harvard University Press, Cambridge, MA.
- Taylor, SJ & Bogdan, R 1998, *Introduction to Qualitative Research Methods: A Guidebook and Resource*, 3rd edn, Wiley, New York.
- The International Panel of Experts in International Human Rights Law and on Sexual Orientation and Gender Identity 2007, *The Yogyakarta Principles: Principles on the Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity*, Yogyakarta.
- Thomas, J & Harden, A 2008, 'Methods for the thematic synthesis of qualitative research in systematic reviews', *BMC Medical Research Methodology*, vol. 8, no. 45, pp. 1 - 10.
- Thompson, N 2003, *Promoting Equality: Challenging Discrimination and Oppression*, 2nd edn, Palgrave MacMillan, Houndmills.
- Todaro-Franceschi, V 2012, *Compassion Fatigue and Burnout in Nursing : Enhancing Professional Quality of Life*, Springer, New York.
- Trautner, MN & Kwan, S 2010, 'Gendered appearance norms: an analysis of employment discrimination lawsuits, 1970-2008', in C Williams & K Dellinger (eds.), *Gender and Sexuality in the Workplace*, Emerald Group Publishing Limited, Bingley, UK, pp. 127-150.
- Trice, HM 1993, *Occupational Subcultures in the Workplace*, ILR Press, Ithaca, NY.
- Ustinoff, J 2008, "'Hit him with your handbag!": homophobia in Australian magazines of the 1960s', in S Robinson (ed.), *Homophobia: An Australian History*, The Federation Press, Annandale, pp. 128-47.
- Van Krieken, R, Habibis, D, Smith, P, Huthcins, B, Martin, G & Manton, K 2010, *Sociology*, 4th edn, Pearson, Frenchs Forest.
- van Manen, M 1990, *Researching Lived Experience: Human Science for Action Sensitive Pedagogy*, State University of New York Press, Albany.
- 1997, 'From meaning to method', *Qualitative Health Research*, vol. 7, pp. 345-68.

- 2006, 'Writing Qualitatively, or the Demands of Writing', *Qualitative Health Research*, vol. 16, pp. 713-21.
- VicHealth, Onemda VicHealth Koori Health Unit, McCaughey Centre: VicHealth Centre for Promotion of Mental Health and Community Wellbeing & Victorian Equal Opportunity and Human Rights Commission 2009, *Building on our strengths - A framework to reduce race-based discrimination and support diversity in Victoria*, VicHealth, Melbourne.
- Victoria Police 2011, *Gay and Lesbian Liaison Officers (GLLOs)*, <http://www.police.vic.gov.au/content.asp?Document_ID=30300>.
- Wanzer, MB, Booth-Butterfield, M & Gruber, K 2004, 'Perceptions of health care providers' communication: relationships between patient-centered communication and satisfaction', *Health Communication*, vol. 16, no. 3, pp. 363-84.
- Ward, J & Winstanley, D 2003, 'The absent presence: negative space within discourse and the construction of minority sexual identity in the workplace', *Human Relations*, vol. 56, no. 10, pp. 1255-80.
- 2005, 'Coming out at work: performativity and the recognition and renegotiation of identity', *The Sociological Review*, vol. 53, no. 3, pp. 447-75.
- 2006, 'Watching the watch: the UK fire service and its impact on sexual minorities in the workplace', *Gender, Work, and Organization*, vol. 13, no. 2, pp. 193-219.
- Weigart, AJ, Teitge, JS & Teitge, DW 1986, *Society and Identity: Towards a Sociological Psychology*, Cambridge, Cambridge University Press.
- Weiten, W 2013, *Psychology: Themes and Variations*, 9th edn, Wadsworth, Cengage Learning, Belmont, CA.
- Whitelaw, A 2011, 'Transfer times under fire as patients wait in ambulances', *The Age*, 12 June, viewed 29 July 2011, <<http://www.theage.com.au/victoria/transfer-times-under-fire-as-patients-wait-in-ambulances-20110611-1fyce.html>>
- Wilde, S & Ambulance Officers' Training, C 1999, *From Driver to Paramedic : A History of the Training of Ambulance Officers in Victoria*, Ambulance Officers' Training Centre, Melbourne.
- Willett, G 2008, 'From "vice" to "homosexuality": policing perversion in the 1950s', in S Robinson (ed.), *Homophobia: An Australian History*, The Federation Press, Annandale, pp. 113-27.
- 2011, 'Making an exhibition of ourselves: GLQ history as public history', *The La Trobe Journal*, no. 87, pp. 4-17.
- Williamson, IR 2000, 'Internalized homophobia and health issues affecting Lesbians and Gay men', *Health Education Research*, vol. 15, no. 1, pp. 97-107.
- Willis, K & Elmer, S 2011, *Society, Culture and Health – An Introduction to Sociology for Nurses*, 2nd edn, Oxford University Press, Melbourne.
- Willis, P 2011, '"Laboring in silence": young Lesbian, Gay, Bisexual and Queer-identifying workers' negotiations of the workplace closet in Australian organisations', *Youth & Society*, vol. 43, no. 3, pp. 957-81.

- Wilson, E 2008, 'Someone who is sick and in need of help': medical attitudes to homosexuality in Australia, 1960-1979', in S Robinson (ed.), *Homophobia: An Australian History*, The Federation Press, Annandale, pp. 148-71.
- Winfeld, L 2005, *Straight Talk About Gays in the Workplace: Creating an Inclusive, Productive Environment for Everyone in your Organization*, 3rd edn, Harrington Park Press, Binghamton, NY.
- Wojnar, D & Swanson, K 2007, 'Phenomenology: an exploration', *Journal of Holistic Nursing*, vol.25, no. 3, pp. 172-180.
- Yen, M 2009, 'Working in ambulance service organisations', in P O'Meara & C Grbich (eds.), *Paramedics in Australia: Contemporary Challenges of Practice*, Pearson, Frenchs Forest, pp. 165-80.
- Zurlinden, J 1997, *Lesbian and Gay Nurses*, Delmar, New York.

Appendixes

Appendix 1: Interview questions

Interviews were guided by the following questions:

- What have been your experiences in the workforce in relation to interaction with other people in your organisation?
- Have you encountered difficulties in the workplace? What have these difficulties been?
- How do these experiences impact on the performance of your duties on a day-to-day basis?
- What contribution, if any, do these experiences have on your long-term mental, physical and emotional health or career progression?
- What strategies have you used to try and overcome issues you encounter? Have such strategies been effective? If so, why and if not, why? Do such strategies extend to concealing your sexuality?
- In your opinion, are there benefits for the community in having paramedics with diverse sexual identities? If so, what are they?
- What elements of the culture of the paramedic workforce have posed particular difficulties for you as a Lesbian or Gay paramedic?
- In your experience are there any differences between the experiences of Lesbian paramedics and Gay paramedics? If so, what cultural characteristics of the paramedic workforce account for this difference?



INFORMATION TO PARTICIPANTS INVOLVED IN RESEARCH

You are invited to participate

You are invited to participate in a research project entitled Gay and Lesbian paramedics in Australia – Case studies in workforce participation.

This project is being conducted by a student researcher Georgia Clarkson as part of a Master in Education study at Victoria University under the supervision of Dr Marcelle Cacciattolo and Associate Professor Tarquam McKenna from the School of Education in the Faculty of Arts, Education and Human Development.

Project explanation

This research aims to investigate the issues of inclusion and participation in the workplace of Lesbian and Gay paramedics in Australia. It gives consideration to the impact of workplace practices that are constructed around the assumption that heterosexuality is normal on non-heterosexual people. It also attempts to characterise the culture of the Australian paramedic workforce and consider the impact of such characteristics on the inclusion or exclusion of Lesbian and Gay People in this context. This research will also explore the impact of workplace practices and culture on those people personally and professionally associated with the participants.

Data findings from this research can be used to inform programs aimed at improving the experience of Lesbian and Gay paramedics in the workplace. In the context of an ageing Australian population a sustainable workforce in the health sector is becoming an increasingly prominent issue. Improved recruitment and retention of Lesbian and Gay paramedics is a possible consequence of better understanding of the experiences of this group and development of education strategies and policy instruments aimed at improving their workplace experience. Reduced stress on Lesbian and Gay paramedics as a function of development of more inclusive workplace practices has the potential to result in improved work performance by this group. Productivity improvements may also result from development of policies and practices which counter discrimination towards this group.

What will I be asked to do?

You will be asked to participate in an interview relating to your workplace experiences as a Lesbian or Gay paramedic. It is anticipated that this interview will take approximately 30 minutes to complete. Questions will relate to your workplace experiences as a Gay or Lesbian paramedic working in Australia.

What will I gain from participating?

There is no payment available for your participation however the information you supply has the potential to inform policy makers and organisational managers to improve the workplace experience both for participants as individuals as well as for other Lesbian and Gay paramedics in the present and into the future.

How will the information I give be used?

Information collected in this research will be used by the Student Researcher to form the basis of a thesis to be submitted for assessment in the School of Education at Victoria University. This thesis will be submitted for assessment for admission to the degree of Master of Education.

What are the potential risks of participating in this project?

As a result of your participation in interviews you may fear that you will alienate people in your workplace. You may feel a range of negative emotions including anxiety, false hope, guilt, self-doubt or depression in recounting your story. You may also fear that there is a risk of disclosure of data collected from interviews to others in your workplace or social circles. For participants who are not open in relation to your sexuality on a personal and/or professional basis this may evoke a fear of negative consequences for you should your sexuality be disclosed to others.

Following an interview you may be embarrassed about disclosure of personal information. If you disclose to others in the workplace that you have taken part in this research you may risk alienation by other workers and unfair treatment within your organisation by virtue of the view some may hold that you are disclosing and making public information relating to inequitable workplace practices. This could have negative consequences for you in terms of your experience in the workplace.

Participants taking part in this research who experience negative consequences as a result will have access to a psychologist to assist them. Her details are –

Anne Graham
Psychologist
9919 2159
Anne.Graham@vu.edu.au

How will this project be conducted?

Interviews will be conducted with up to 20 participants who identify as Gay or Lesbian and are currently employed in an operational capacity as a paramedic in Australia. These interviews will be conducted either face-to-face or using Skype by the student researcher Georgia Clarkson and take approximately 30 minutes. Research data will be analysed using a range of currently accepted qualitative research methods.

Who is conducting the study?

Victoria University

Principal Researcher – Dr Marcelle Cacciattollo
Phone 9919 5903
Mobile 0402 472 550
Email – Marcelle.Cacciattollo@vu.edu.au

Student Researcher – Ms Georgia Clarkson
Phone 9919 2379
Mobile 0404 022 527
Georgia.Clarkson@vu.edu.au

Any queries about your participation in this project may be directed to the Principal Researcher listed above. If you have any queries or complaints about the way you have been treated, you may contact the Ethics and Biosafety Coordinator, Victoria University Human Research Ethics Committee, Victoria University, PO Box 14428, Melbourne, VIC, 8001, phone (03) 9919 4148.



CONSENT FORM FOR PARTICIPANTS INVOLVED IN RESEARCH

INFORMATION TO PARTICIPANTS:

We would like to invite you to be a part of a study into the workplace experiences of Gay and Lesbian paramedics in Australia. This research will aim to investigate the issues of organisational/ systemic inclusion and participation in the workplace of Lesbian and Gay paramedics in Australia. It will give consideration to the impact of heteronormative cultural practices on this group. It will also attempt to characterise the culture of the Australian paramedic workforce and consider the impact of such characteristics on the inclusion or exclusion of Lesbian and Gay People in this context. This research will also explore the impact of workplace practices and culture on those people personally and professionally associated with the participants.

CERTIFICATION BY SUBJECT

I,

of

certify that I am at least 18 years old* and that I am voluntarily giving my consent to participate in the study "Gay and Lesbian paramedics in Australia – Case studies in workforce participation" being conducted at Victoria University by student researcher Georgia Clarkson under the supervision of Dr Marcelle Cacciattolo and Associate Professor Tarquam McKenna.

I certify that the objectives of the study, together with any risks and safeguards associated with the procedures listed hereunder to be carried out in the research, have been fully explained to me by Georgia Clarkson and that I freely consent to participation involving the below mentioned procedures:

- An interview with Georgia Clarkson lasting approximately 30 minutes responding to a number of questions relating to my experience as a Gay or Lesbian paramedic

I certify that I have had the opportunity to have any questions answered and that I understand that I can withdraw from this study at any time and that this withdrawal will not jeopardise me in any way.

I have been informed that the information I provide will be kept confidential.

Signed: _____

Date: _____

Any queries about your participation in this project may be directed to the researcher Marcelle Cacciattolo on 9919 5903. If you have any queries or complaints about the way you have been treated, you may contact the Ethics & Biosafety Coordinator, Victoria University Human Research Ethics Committee, Victoria University, PO Box 14428, Melbourne, VIC, 8001 phone (03) 9919 4148.

[*please note: Where the participant/s are aged under 18, separate parental consent is required; where the participant/s are unable to answer for themselves due to mental illness or disability, parental or guardian consent may be required.]