

AN AUTOETHNOGRAPHIC LENS ON THE IDENTITY WORK OF LESBIAN AND GAY
RADIATION THERAPISTS IN PRACTICE

by

AMANDA BOLDERSTON

B.Sc., Anglia University, 1997
M.Sc., Anglia University, 2004

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The following individuals certify that they have read, and recommend to the Faculty of Graduate and Postdoctoral Studies for acceptance, the dissertation entitled:

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submitted by Amanda Bolderston in partial fulfillment of the requirements for

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in Educational Leadership and Policy

Examining Committee:

Dr. Claudia Ruitenberg, Educational Studies
Supervisor

Dr. Deirdre Kelly, Educational Studies
Supervisory Committee Member

Dr. Paris-Ann Ingledew, British Columbia Cancer Agency
Supervisory Committee Member

Dr. Sally Thorne, School of Nursing
University Examiner

Dr. Michelle Stack, Educational Studies
University Examiner

Additional Supervisory Committee Member:

Dr. Heidi Probst, Sheffield Hallam University
Supervisory Committee Member

Abstract

The healthcare environment reflects and embeds sociocultural norms, including heteronormativity, which pervades workplaces through policies, cultural norms and informal interpersonal interactions. Coming out is a process of continual identity management. Subsequently, there is evidence that lesbian and gay (LG) patients and healthcare professionals (HCPs) engage in significant identity work to manage who they tell about their sexual identity, and in what circumstances. For patients this can result in barriers to healthcare that can substantially affect their health and wellbeing. Radiation therapists (RTs) are a group of healthcare professionals who treat people diagnosed with cancer using radiation therapy. HCPs, including RTs, are subject to explicit and implicit bias, and may feel they need to disguise or downplay their sexual orientation at work. This research explored the issues of LG RTs and their experiences with managing sexual identity in the workplace, and how this has impacted their relationships with co-workers and patients.

The research used an autoethnographic narrative inquiry approach. Three LG participants from a large Canadian urban cancer centre worked with the researcher to co-construct stories of coming out at work using their shared personal histories. An iterative development process was used.

The co-constructed stories include fictionalised narratives of identity management as a radiation therapist at work, relationships with patients and peers, the experiences of sexual minority patients and the researcher's accompanying lived research journey. The results showed the participants engaged in highly contextualized and continual identity

work and utilized a series of different strategies or tools. Additionally, it was clear that both the discourse around professionalism, and the pervasive biomedical healthcare culture served to further inhibit disclosure at work.

There is growing evidence that some patients from minority groups, including LG patients, feel more comfortable and may have better health outcomes when treated by healthcare professionals from the same background. For RTs, coming out at work might be a risky business. However, it seems likely that focused attention on improving the work environment, so RTs can be open about their identities in the professional setting would be beneficial for both patients and staff.

Lay Summary

Lesbian and gay (LG) patients and healthcare professionals (HCPs) can experience discrimination in the healthcare environment. They may thus choose to disguise or downplay their sexual orientation. For patients, this can result in barriers to healthcare that affect health and wellbeing. Radiation therapists (RTs) are a group of HCPs who treat people with cancer using radiation therapy. This dissertation examined the experience of the author and three LG RTs from a Canadian urban cancer centre using an autoethnographic narrative inquiry approach. The results were presented as fictionalised narratives and showed participants engaged in highly contextualized and continual identity work, in line with the existing literature. There is evidence that some patients from minority groups (e.g. LG patients), feel more comfortable when treated by HCPs from the same background. It therefore seems likely that improving the work environment, so RTs can be open about their identities, would benefit patients and staff.

Preface

The research in this dissertation received a Behavioral Research Ethics Board Certificate of Approval, H17-01780, September 6th, 2017.

This dissertation is an original, unpublished, independent work by the author, Amanda Bolderston.

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List of Abbreviations

AHP	Allied Health Professional
EBP	Evidence Based Practice
EdD	Doctorate in Education
GL	Gay and Lesbian
GLBT	Gay, Lesbian, Bisexual and Transgender
HCP	Healthcare Professional
IRB	Institutional Review Board
LG	Lesbian and Gay
LGB	Lesbian, Gay and Bisexual
LGBTQ	Lesbian, Gay, Bisexual, Transgender and Queer
LGBTQ+	Lesbian, Gay, Bisexual, Transgender and Queer +
LGBTQI+	Lesbian, Gay, Bisexual, Transgender, Queer and Intersex +
LGBTQ2	Lesbian, Gay, Bisexual, Transgender, Queer and Two Spirit
LUCC	Large Urban Cancer Centre
NHS	National Health Service
NI	Narrative Inquiry
OT	Occupational Therapist
POC	People of Colour
QLB	Queer, Lesbian and Bisexual
RT	Radiation Therapist
SGM	Sexual and Gender minority
TGDNB	Trans, Gender-Diverse, and Non-Binary
UBC	University of British Columbia

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Dedication

For Kim, who holds my heart and makes all of this possible.

Chapter 1: Introduction

He is one of them and all of them, my next patient

The bluff King of Orangeville, or Orillia, or far away Bobcaygeon

Doesn't like the traffic, supports the Jays (don't we all) and this disease

This indignity has caught him, like a poleax, right between the eyes

He's warming up on day 3, unlike my hands – but you know what they say

We cover the weather (seasonal), the traffic (catastrophic) and his daughter's wedding

He needs a suit, the wife is asking if he'll be well enough, will he, will he?

How about that diarrhea, that pain, will he last, will he last, what do I think?

I demur, I support, I encourage. I pat his hand as we leave the room

Not long, keep still, we can see you on the cameras, wave if you need us.

Then we're back, he smiles – my girls, my girls, you take good care of me.

How lucky your husbands are, to have such kind and clever girls.

I pull up his pants; lift him as he grips me tight, catching his breath

He looks at my bare hand, smiles. I should introduce you to my son.

By the time the words come, he has left the room. Same time tomorrow.

I move the machine back around. Seen and not seen, there and not there.

(Bolderston, 2016a).

1.1 Preamble

I am a radiation therapist, part of a group of healthcare professionals that care for people affected by cancer. Not many people have heard of us, unless they or a loved one has been treated with radiation therapy. About half of people diagnosed with cancer have radiation therapy at some point, often alongside chemotherapy and surgery. The incidence of cancer is rising, and we see an increasing number of patients every year. We tend to work in the basements of cancer clinics, tucked away from the main hospital, because our machines need a lot of heavy lead shielding.

I am also a lesbian and, working in healthcare, with patients and colleagues, I felt like my sexual orientation was something that had to be covered up and sometimes led to some awkward situations (like the one above). This bothered me, because I felt it was an important part of who I was (and who I am) and also because sometimes I treated patients who were gay or lesbian, and I felt a connection with them. I could see that occasionally they were treated differently, or they were also covering up who they were. The few times I did come out to patients, I felt it had helped them to cope a little bit better. I've wondered about this on and off, as I moved away from directly working with patients. This research project is the result of those wonderings.

1.2 Problem and significance

In most Western countries, social attitudes toward and legislative advancements for lesbian and gay (LG) people have undergone a dramatic shift in the last few decades. LG issues and individuals are progressively more visible, including in social services such as healthcare. However, despite these recent advances, embedded cultural and institutional heteronormativity persists, which can have a negative effect on the lives of LG patients and healthcare professionals (HCPs) (Institute of Medicine, 2011). The term heteronormativity was first coined by Warner (1991) and describes a heterosexually dominant environment that promotes heterosexuality (and

traditional male-female gender norms¹) as the usual and/or preferred sexual orientation and that silences LG perspectives and discourses. Heteronormativity “defines a horizon of expectations for human life, a set of ideals to which people aspire and against which they measure the value of their own and other people’s lives” (Halperin, 2012, p. 450). While overt discrimination of LG people is diminishing (at least in the Western world) heteronormativity persists, partly because of its “veneer of harmlessness” which makes it more insidious and harder to detect (Murphy, 2016). As Kitzinger (2005) states, “a heteronormative social fabric is unobtrusively rewoven, thread by thread, persistently without fuss or fanfare, without oppressive intent or conscious design” (p. 478).

Heteronormative healthcare spaces can be inhospitable to LG patients and their loved ones, with many left “feeling anxious, unwelcome, ashamed, and distrustful in healthcare encounters” (Dean, Victor, & Grimes, 2016, p. 557). Likewise, some LG HCPs experience prejudice and discrimination and may choose not to disclose their sexual identity (“come out”) in the workplace to colleagues and/or patients (Burke & White, 2001; Eliason, Dibble, & Robertson, 2011; Falzarano & Pizzi, 2015; Irwin, 2007; Rondhal, Innala, & Carlsson, 2007; Somerville, 2015).

Radiation therapists (RTs) are part of the professional group called medical radiation technologists. RTs are members of the cancer treatment team who plan² and deliver³ radiation therapy (the use of high-energy beams of radiation that shrink tumors and kill cancer cells). RTs work in small teams of three to six people (depending on the type and length of work day) who make up “the nexus of care for patients receiving radiation therapy” (Bolderston, Yendley,

¹ For many queer people gender and sexuality “operate intersectionally and relationally” – thus I use the term heteronormativity to express the confluence of expectations around normative sexual and gender expression (Bryson et al., 2018, n.p.).

² Using imaging equipment (like CT scanners) and specialised computers to map out where the treatment is going to be delivered in the patient’s body to maximise the dose to the tumour and minimise the dose to the surrounding normal tissues.

³ Usually with machines called linear accelerators that use megavoltage x-rays many degrees of magnitude higher than diagnostic x-rays (like a chest x-ray) delivered using tightly circumscribed radiation beams.

McGregor, Slowey, & Manship, 2015, p. 299). Positive team relationships and mutual support are integral to the working environment of RTs (Probst, Boylan, Nelson & Martin, 2014). In this blog entry⁴ I explain why:

Our workplace culture is based on tight-knit teams...The closest model I can think of is an operating room. The nurses, anesthetists, surgeons have to work in a kind of dance...Verbal interaction is key, most errors can be traced back to not talking to each other. It's similar for radiation therapists. We have innumerable checks and balances, quality assurance steps and protocols, and many of them are verbal. But we also have to, fundamentally, have each other's backs. It's a dance of physical movement (moving the patient, moving the treatment couch, moving the equipment) and verbal interaction (I'm doing this now, this next, have you done that?). When we do it well, it flows seamlessly, between ourselves and the patient. When not done well it can cause friction, delays, a lack of patient care and, sometimes, errors.

There may be three of us on a treatment unit, or sometimes more. With breaks and shifts, sometimes just two at a time. If we don't get on, talk to each other, the work gets harder. We don't have a choice of who we work with, and we may be working with someone for months at a time. We sit close to them (the treatment consoles are small), check their work (and they check ours), lift and move patients together, and arrange our days (this patient is new, this one is finishing, we need to follow up on this, did you call about the weird noise the machine is making?) We have to trust each other, we have to know the steps.

If you work with someone like this for a few weeks, you often get to know a lot about them. What TV shows they watch, how their commute went, what they have for lunch, what their weekend plans are, their kid's activities and their upcoming vacation plans. Between patients we chat, we get to know each other, we pass the time, we build our relationship. Our "private" and "professional" lives are not binary – they merge into each other. We need these interpersonal bonds when it gets stressful, when that patient breaks our heart a little, when we have to vent. They can help sustain us. When we don't get on, or when we can't be ourselves at work, it makes what we do harder as well as less safe. The dance slows down, we stumble. (Bolderston, 2019)

The role involves planning and/or treating about 30 people a day who have been diagnosed with various types of cancer (most commonly breast, prostate, head and neck and lung) and thus in a vulnerable emotional (and often physical) state. The combination of complex technology, high-energy radiation use and the care of people with life-threatening diseases can lead to a uniquely stressful work environment (Probst & Griffiths, 2007). Patients are treated for up to six weeks

⁴ For the duration of my doctoral studies I have been blogging about the process and my research. I have used sections from the blog ("Doctoral Brain Dump" on the WordPress site) here and in Chapter 3 (Methodology).

(usually on a daily basis), which can result in a close relationship between RT and patient (Merchant, O'Connor, & Halkett, 2017). Individual treatment appointments are fairly brief, usually 10 to 20 minutes in length. Although the work is highly technical in nature, “patient-centred care, respect for the patients' values, expressed needs and physical comfort; emotional support; and continuity with information are key” (Egestad, 2013, p. 586). RTs who demonstrate empathy and compassion can decrease patient anxiety and make a difficult experience more bearable, and supportive relationships with radiation therapists can have a significant positive influence on patient care (Egestad, 2013).

For LG RTs, the heteronormative work environment may affect workplace relationships. In my clinical practice my sexual orientation was a source of dissonance for me. I found being a lesbian affected my relationships with some of my colleagues and patients. In general, the impact was negative because I felt I had to hide an important part of my identity and I was unable to do the “heteronormative small talk” that is part of putting patients at ease (Heyes, Dean, & Goldberg, 2015). However, occasionally I would encounter an LG patient and their partner/friends/family whom I felt that I had helped by coming out and being a point of connection and support. I am no longer working as a clinical RT with regular patient contact; in the past fifteen years I have been working as a healthcare leader and educator. I wondered if what I had experienced is still true, and how RTs today manage their sexual identity at work. I was also curious about the connections LG RTs make (or not) with their LG patients and whether this might be an unexplored source of patient support.

1.3 Purpose and research questions

My research explores the lived experiences of a small group of LG RTs as they negotiate the complexities of coming out in their daily professional practice. The participants are three purposefully selected friends and colleagues whom I have known from twelve to almost thirty

years. There is little in the literature looking at the experiences of LG HCPs, and none specifically looking at RTs. The research that does exist generally looks at homophobia and the attitudes of heterosexual colleagues. Related writing tends to be from a positivist perspective and uses a deficit framework, i.e., the view that the sexual orientation of LG HCPs and patients creates problems that need to be addressed by (for example) education for better understanding of LG issues (Eliason et al., 2011; Irwin, 2007; Parameshwaran, Cockbain, Hillyard, & Price, 2016). This viewpoint of so-called cultural competence training for HCPs working with diverse populations regards the (straight, White etc.) HCP “as an unproblematic null point around which various Others are arrayed” (Heyes, Dean, & Goldberg, 2015, p. 143). Of that body of research, there is a limited amount that looks at how HCP sexual orientation impacts patient relationships.

A common motive for doing this kind of work is to show people from a social minority that they are not alone, and this is also my primary reason. HCP sexual orientation and, particularly, the invisibility of LG RTs, is an issue that is unexamined in my practice, but one that has implications beyond the individual lives of LG RTs. I also hope that telling the stories of non-heterosexual HCPs and how they navigate coming out will encourage awareness of the ways that identity can manifest in the healthcare workplace. I hope it can open up conversations in workplaces and illuminate the space where straight people say that sexual orientation “makes no difference” but where LG people know that it can sometimes make all the difference.

There is evidence that minoritized patients may feel more comfortable and even have better outcomes when cared for by HCPs with the same background (Spitzer, 2004). There is a dearth of research examining patient-HCP interactions in sexual and gender minority populations, but HCP disclosure could help build trust, facilitate patient comfort and perhaps improve LG patients experiences within the healthcare system (Sanchez et al., 2015). For LG patients, having out LG staff can offer a feeling of support and solidarity. A recent UK project that examined the experiences of lesbian, gay and bisexual (LGB) cancer patients showed that many LG HCPs are

reluctant to come out to patients, but when they do it can provide LGB patients with a sense of comfort and support (Nagington, 2016).

Many HCPs have had a dual role as both patient and provider—and this has been explored in the health science literature as a trigger for transformative learning (e.g., leading to a more compassionate practice after illness) (Rowland & Kuper, 2018). This transformation may be more nuanced for LG HCPs who might have had negative experiences on both sides of the healthcare system. Their experiences might empower them to anticipate and mitigate systemic barriers for LG patients, as well as work for and with individual patients. In this way, my research may contribute to improving LG patients' experience in the health care system.

To make this issue visible I have produced a resource that can be used to educate undergraduate students and post-licensure HCPs. This is a series of short stories (that constitute my results section) about coming out in cancer care involving RTs and patients. The stories are accessible and written to “reach wider and more diverse mass audiences that traditional research usually disregards” (Ellis et al., 2011, p. 277). I intend to publish and promote this research in academic venues but, in addition, would like to create an accessible, free, downloadable version of the study that can be used as a basis for classroom discussion, in radiation therapy departments for continuing professional development or by anyone who is interested in learning more about LG people in healthcare.

1.3.1 Research questions

My overarching research question is: How do LG RTs negotiate the complexities of sexual orientation disclosure (“coming out”) in daily practice? More specifically, I will investigate:

- What influences LG RTs' decisions regarding coming out at work?
- How do disclosure decisions affect LG RTs' relationships with their co-workers?

- How do disclosure decisions affect LG RTs' relationships with their LG patients?

1.4 Limitations and labels

My research focussed primarily on the experiences of LG RTs. The most pragmatic reason why I did not extend the study, and the acronym, to include bisexual or trans, gender-diverse, and non-binary (TGDNB) RTs is that none of my three participants identify as bisexual or TGDNB (all identify as either gay or lesbian alone). I am aware that the issues of gender identity are not the same as sexual orientation and to conflate the two would do a disservice to TGDNB people. However, there are clear links between the oppression of TGDNB people (cissexism) and the homophobia experienced by LG people as both encompass the concept of contravening male-female binary gender norms (Chacha Enriquez, 2016). Additionally, for many queer people “gender and sexuality operate intersectionally and relationally” (Bryson et al., 2018, n.p.). Gender and sexuality are often discussed together because “straight culture reads much of the public expression of gay identity as gender transgression” and there is evidence that gender expression differences among LG people contribute to healthcare experiences and impact health behaviours (Califa, 2003, p. 246; Hiestand, Horne, & Levitt, 2007). Bryson et al. (2018) conducted research with queer, lesbian and bisexual (QLB) women (who did not identify as TGDNB) and found that in questions about gender identity and expression participants provided “a highly diverse set of genderqueer identity terms.”⁵ These commonalities may mean that this work could also make space for TGDNB people in healthcare—it is possible that TGDNB patients may be more comfortable with a cisgender LG HCP than a cisgender heterosexual provider.

Labels can be useful in bringing people together but can also be misused and problematic. I use the subgrouping LG when referring to my research questions, research experiences or my

⁵ For example, punk femme, genderfluid, butch, soft butch, tomboy

participants. This aligns with my theoretical framework of critical theory; I am working with “lesbian” and “gay” as more or less stable identity categories that frame people’s lives, rather than the deconstructions and undoing of identity implicit in the concept of queer, and in queer theory. In the literature, and the real world, groupings and labels are slippery. I therefore occasionally use the term queer as an indicator of the wider “community” (with all its factions and fractiousness). However, the patients I have worked with most of my life are older people, and I am aware that for many of them (and others) the word queer cannot be liberated from its historic use as a homophobic slur or insult (Segal, 2016). Likewise, the term “homosexuality” itself, while still very prevalent in the healthcare literature, carries the burden of medicalization and pathology. I use it cautiously where it seems appropriate and/or historically accurate. To replace long and potentially non-inclusive acronyms, I use the term sexual and gender minority (SGM) for the panoply of queer identities such as Lesbian, Gay, Bisexual, Transgender, Queer and Two Spirit (LGBTQ2). Finally, if a study uses a particular acronym to refer to their study population I will use the same one to accurately reflect the focus of that study.

1.5 Theoretical perspective

This research is based on my understanding of sexual identity that is framed using critical theory, more specifically gay and lesbian theory and feminist research practice.

1.5.1 Gay and lesbian theory

Critical theory assumes that unequal power relations influence and distort people’s interpretations and experiences (Biesta, Allan, & Edwards, 2011) and that “there are dirty problems like racism, sexism, classism, homophobia and poverty to be solved in the world” (Sikes, 2006a, p. 45). Although there are many evolving branches within the critical tradition, including gay and lesbian theory, commonalities among critical schools of thought exist with underlying basic assumptions that:

All thought is fundamentally mediated by power relations that are social and historically constructed; that facts can never be isolated from the domain of values or removed from some form of ideological inscription; that the relationship between concept and object and between signifier and signified is never stable or fixed and is often mediated by the social relations of capitalist production and consumption; that language is central to the formation of subjectivity (conscious and unconscious awareness); that certain groups in any society and particular societies are privileged over others and, although the reasons for this privileging may vary widely, the oppression that characterizes contemporary societies is most forcefully reproduced when subordinates accept their social status as natural, necessary, or inevitable; that oppression has many faces and that focusing on only one at the expense of others (e.g. class oppression versus racism) often elides the interconnections among them. (Kincheloe & McLaren, 2005, p. 304)

Critical theory a good fit for my study because I am concentrating on the experiences of a minoritized group, LG HCPs, and examining how their sexual orientation affects their relationships and experiences within a heteronormative workplace. Gay and lesbian (GL) theory interrogates “the position of ‘outsiderness’” (Fuss, 1991, p. 2) and seeks to bring (out) non-heterosexual identities “into the metaphysics of presence, speech and cultural visibility” (p. 4). The heteronormative healthcare environment effectively renders LG HCPs (and patients) invisible; I turn to critical theory to make seen what is traditionally unseen and am drawn to its emancipatory characteristics to suggest ways to improve the current and future state.

Critical theory also assumes that “mainstream research practices are generally, though most often unwittingly, implicated in the reproductions of class, race and gender oppression” (Kincheloe & McLaren, 2005, p. 304), a position which is close to my heart. As someone socialised into the primarily positivistic environment of healthcare, the research I want to do supports the “identity work” that I have always done as a lesbian in a heteronormative workplace—and my subsequent research aligns with what I think is important and what needs to be changed (Sikes, 2006b).

GL studies speak to the need to have non-heterosexual identities recognized, both personally (e.g. issues of coming out), and in the broader social and political context (e.g. advocating for anti-discrimination legislation on the basis of human rights). This area of critical

theory also seeks to understand how the binary categories of "normal" (heterosexual) and "deviant" (homosexual) are constructed, how they operate, and how they are enforced, in order to challenge them (Kaczorowski, 2015). Gender identity in traditional GL studies, when included at all, tends to be an afterthought— and bisexuality is often similarly invisible. As GL studies evolved into queer theory, the focus has become simultaneously broader, to include a multitude of identities and orientations, and more refined, with the growing understanding that different groups often had very different viewpoints, needs and experiences of oppression. Queer theory deconstructs the traditional hetero/homo binary, seeing identity categories as at best “invariable stumbling blocks” and at worst the “instruments of regulatory regimes” (Butler, 1991, p. 14).

The shift to queer theory also parallels the increasing acceptance of intersectionality as foundational to any critical theory. Intersectionality entered the public consciousness in 1989, when American critical legal race scholar Kimberlé Williams Crenshaw (1991) identified the double bind of simultaneous racial and gender prejudice faced by Black women. The theoretical and political use of the term has since expanded to encompass “interlocking and mutually reinforcing vectors” of class, ability and sexuality (Nash, 2008, p. 3). In a similar way, it is difficult to tease apart the effects of patriarchy and heteronormativity – my experience as a woman is inseparable from my experience as a lesbian. As Rebecca Solnit (2017) explains, “misogyny and homophobia are both forms of hating that which is not patriarchy” (p. 53).

1.5.2 Feminist research practice

A feminist perspective feels like comfortable “epistemologically friendly clothes” to don for my research journey (Scheurich & Young, 1997). Or as, Lather (2006) puts it, to help me “claim the status of knowledge producer after so long being positioned as the knowable object of powerful others” (p. 42). As a healthcare practitioner and researcher, I believe that we need feminist research practices that counter the views of traditional scientific research, with the underlying and

unarticulated assumption that the knower is male, white and heterosexual allowing the privileged group to believe “they are autonomous individuals without specific locations (i.e. gendered or raced) *even* in their position of privilege” (Goldenberg, 2010, p. 2625). Feminist research methodologies begin from the assumption that research is inherently value-laden, from who gets funded to how “subjects” are viewed in the research process. As Lather (2006) comments, “far more than the inclusion of gender as a variable, this is about how gender structures our very sense of what is possible in the name of research”, an approach that overtly values “women’s messy subjectivity” (p. 49).

My research methodology is both feminist and critical in orientation; my researcher stance explicitly examines and incorporates my own experiences in the process, analysis and writing. Interviewing my participants was done collaboratively, with focus on the relational aspects of the process. My participants are my long-term friends and I was aware of the importance of “emotional attentiveness, engagement and the degree of reciprocity in the conversation” (Riessman, 2008, p. 24). The development of narrative inquiry (and the autoethnographic sub-genre) that is my methodology was arguably led by women writing about the diversity of women’s experiences, moving them from the object of study to the agentic centre and focusing on “narrator-interpreter relations, context and narrative form” (Riessman, 2008, p. 16). Finally, women make up the majority of radiation therapists (about 80%). Heteronormativity involves the expectation that rigidly defined male-female gender norms are followed. Looking at the issues of lesbians working in this environment demands a feminist lens.

Tracy (2010) discusses the concept of feminist communitarianism, which prioritizes nurturing relationships, emotionality and collaboration in research. She comments that “those who follow such a model keep their promises, provide readers with a moral compass, and concern themselves with human flourishing” (p. 847). As my autoethnographic methodology involved my

own perspectives and experiences, I often related to Elizabeth Adams St Pierre's (1997) comment: "As I write and theorize the lives of my participants, I theorize my own" (p. 181).

1.6 Methodological framework

The methodological approaches that I engaged with are narrative inquiry (NI) and its sub-genre, autoethnography. NI is a qualitative research method that examines individual experience and how social, physical and cultural environments shape how we see the world (Clandinin & Rosiek, 2012; Haydon et al., 2018). NI was initially used in sociology and education, but has been more recently adopted by numerous healthcare areas such as nursing, mental health, medicine and allied health (Haydon et al., 2018). According to Bell (2002),

narrative inquiry rests on the epistemological assumption that we as human beings make sense of random experiences by the imposition of story structures. That is, we select those elements of experience to which we will attend, and we pattern those chosen elements in ways that reflect the stories available to us. (p. 207)

As with much qualitative research, the contribution of NI is more often intended to be the creation of a new sense of meaning and significance with respect to the research topic, than it is to yield a set of generalizable knowledge claims. Both NI and autoethnography have been extensively used by feminist researchers who advocate for writing from personal experience and using narratives to do "political work" (Riessman, 2008). Clandinin and Rosiek (2012) claim that the most significant feature of NI is the study of lived experience where researchers "cannot subtract themselves" from their relationship with their participants (p. 72). Similar to critical theory, autoethnography views research as a political and socially conscious act. Attention to the stories of marginalised groups can be a way of responding to social oppression, as well as disrupting the silence that often surrounds inequality and injustice (Clandinin & Rosiek, 2012). Researchers are often members of the communities they are researching and are interested in the co-production of narrative, using stories to spur social change for oppressed or disadvantaged groups. As Carr (1986) comments, "what is grasped as common experience can be met by common action" (p.

128). The alignment with theory and method is important because “we choose how we write. These choices have poetic, ethical, and political implications” (Richardson, 2000a, p. 131). Additionally “the multiple influences that overlap and shade into one another” are a strength of narrative inquiry and contribute to the richness of the method (Clandinin & Rosiek, 2012, p. 75).

Autoethnography is a “an approach to research and writing that seeks to describe and systematically analyze (graphy) personal experience (auto) in order to understand cultural experience (ethno)” (Ellis et al., 2011, p. 1). The boundaries between academic writing and fiction are consciously blurred, in order to “acknowledge and accommodate subjectivity, emotionality, and the researcher’s influence on research, rather than hiding from these matters or assuming they don’t exist” (Ellis et al., 2011, p. 274). The production of autoethnographic texts can be shaped by a variety of literary conventions; they typically contain “concrete action, dialogue, emotion, embodiment, spirituality, and self-consciousness” (Ellis, 2004, p. 38). As my intent was to produce accessible research texts (in the form of stories), autoethnography is a good fit because this kind of “artful and evocative” writing can potentially reach a wider and more diverse audience than the traditional dissemination methods of scholarly publication and presentations (Ellis & Bochner, 2000).

I echo nurse-researcher Sarah Wall (2006) as she describes how she came to autoethnography:

As a woman in a man’s world, a nurse in a doctors’ world, and a qualitative researcher coming from a positivistic discipline (health services research), I find that the relentless nudging of autoethnography against the world of traditional science holds wonderful, symbolic, emancipatory promise. It says what I know matters. (p. 3)

My work life is likewise governed by evidence-based practice (EBP), which Goldenberg (2006) locates squarely in the realm of positivism. She claims that EBP has eliminated “culture, contexts, and the subjects of knowledge production from consideration”, which is the direct opposite of my

research focus (Goldenberg, 2006, p. 2622). Similarly, I am fluent in more traditional academic discourse, the clipped and well-referenced passive-tense prose that can satisfy peer reviewers and journal editors. But my first love is literature, the sly turn of phrase, the heart-stopping crisis sliding into the satisfying denouement and (most of all) the unexpected sideways step into someone else's life. As law scholar Kenji Yoshino (2006) says "literature has a power to get inside us, to transform our hearts and minds, in a way law cannot" (p. 26). I borrow from him when I say that this dissertation also uses both languages.

1.7 Methodological and theoretical tensions

Qualitative researchers often take the position of a *bricoleur*, one who draws on a variety of disciplines, uses multiple strategies and thoughtfully adapts their approach to what works (Brown, 2019). Or as Clandinin and Rosiek (2012) remind us, in most areas of research "we find ourselves drifting, often profitably, from one paradigm to another" and "philosophical exactness is often a luxury" (p. 52). Clandinin and Connelly (2000) described these as "bumping places"—where different traditions come together. I encountered a few bumping places in the course of this work, in the use of theory and in my own understanding or (mis)interpretation of the use of narrative as method.⁶

1.7.1 Gay and Lesbian Theory/Feminism

Using the lens of only GL theory and feminism can serve to disregard or background other issues and subordinated groups. Additionally, queer theory (compared to GL theory) aligns with post-structuralism in that identity is deemed performative, founded in social and discursive processes (rather than emerging from the individual) and ultimately mutable. For the purposes of this research, I use GL theory, with the understanding that these terms may seem exclusionary to

⁶ See for example footnote 44.

other-identified people who see themselves better accommodated in less stable and binary identity classifications.

GL theory also tends to conflate the experiences of gay men and lesbians. Lesbian criticism, like feminism, has roots in the opposition of patriarchal oppression. Using GL theory and feminism recalls tensions within the gay and feminist movements. Heterosexual feminists were traditionally uneasy with lesbian feminism – I am thinking, for example, of Betty Friedan’s infamous “lavender menace” separatist stance of the 1970s (Calhoun, 1994). Lesbians as one letter of the growing LGBTQI+ acronym are further marginalised by the second class status of women in society, and made more invisible as growing numbers of young women now identify instead as “queer” which can be “a statement of political worldview rather than sexual orientation” (Cauterucci, 2016, n.p.). Although gay men seem to be surviving and thriving as a subgroup, there has been recent concern with “the disappearing L” and the growing eradication of lesbian spaces and culture that may be “buried within the topical hierarchy of queer studies, gay marriage, gender identity” (Morris, 2016, para 7). My use of the acronym LG deliberately keeps lesbian identity and experiences visible. How, or whether, this erasure impacts the experiences of lesbians working as radiation therapists remains to be seen.

1.7.2 Narrative inquiry

Researchers from a critical theory background who adopt a NI methodology may view life stories through the lens of an oppressive social structure (be it patriarchy, heteronormativity or other) and may experience conflict as they attempt to separate their participants’ narratives from the processes of institutionalised oppression. Many researchers are engaging in research with members of their own communities and may feel the need to respond in some way to the conditions of oppression threading through their participants’ stories (Clandinin & Rosiek, 2012). Offering “no easy solution” to this tension, Clandinin and Rosiek instead offer words of caution:

Ultimately the narrative inquirer travelling in this borderland will find it necessary to steer between the Scylla of political naivete and the Charybdis of collecting stories from participants only to treat them as an example of an oppressive social structure. The former can render narrative inquiries irrelevant to the most pressing social concerns. The latter can end up dismissing the lived experience of personas as a possible source of insight and thus simply replacing one habit of silencing voices from the margins with another similar habit. (p. 70)

Listening to my participants' stories, and sharing my own, I was always aware that it was easy to slip into a "deficit view" of our experiences, i.e. focussing on the incidences of heterosexism or homophobia that threaded through our lives. However, I also heard funny and positive stories that demonstrated both our resilience and times when our "outsider" roles had improved care for our patients.

1.8 Dissertation outline

This first chapter introduces the study's problem and significance, purpose, research questions, as well as the theoretical and methodological approaches that guide the research. The relevant literature is reviewed in Chapter Two. Chapter Three details the methodology, including issues of reflexivity, trustworthiness and ethics. The results are presented in Chapter Four. Discussion of the results in light of the research questions and broader socio-cultural lens are found in Chapter Five. Chapter Six is a final story containing recommendations for practice. Conclusions and suggestions for further study are outlined in Chapter Seven.

Chapter 2: Literature review

Samuel Taylor Coleridge's *Rime of the Ancient Mariner* (1863) depicts a sailor whose penance for shooting an albatross is to repeat the story of how he killed that bird of good omen. He instinctively knows who must hear his tale and transfixes them with his 'glittering eye'. He is compelled to speak, and they are compelled to listen. So, he tells and tells, hoping one day to tell the story well enough, or often enough, that he will no longer need to tell it.

We all have a story we must repeat until we get it right, a story whose conveniences must be corrected and whose simplifications must be seen through before we are done with it, or it with us. For gay people, that story is often the story of how we came out. There are times when I feel like the Mariner, wondering how many more times I will have to tell my tale. Sometimes the parallel seems so close I worry I will have to do so in rhyme. Each time I tell my story, I am released, yet this is also the story from which I yearn to be released. But who could release me? Release implies compulsion, and no one is forcing me to speak. Even those who ask when I came out generally expect—and want—no more than the one-line answer I often give—"The year after college." Like the Mariner, my compulsion is internal. I experience my one-line answer as true, as it describes when I came out to my parents. Yet I also experience it as incomplete. Coming out is a process as endless as its audiences. If I were to give a true accounting, the kind that might free me to tell other tales, I would need to describe a series of audiences, a series of moments. (Yoshino, 2006, p. 51)

2.1 Introduction

Exploring the issues of lesbian and gay healthcare professionals (radiation therapists) and their experiences with managing their sexual identities in the workplace touches on several areas that are explored in the following literature review. The first is the issue of "coming out": what does this mean and how might this manifest for radiation therapists in the unique healthcare environment? Also pertinent is the question of how lesbian and gay people experience healthcare generally as staff and as patients – and whether those different positions interrelate. Finally, healthcare professionals have professional interactions with their patients (ideally) predicated on an empathetic and caring relationship; what role does coming out play here (if any)?

2.2 Coming out

“Coming out” is a commonly used term that is generally assumed to mean the process of realizing, accepting and communicating a non-heterosexual identity. To claim such an identity is to disrupt the assumption of “normal” heterosexuality, where homosexuality is seen as deviant or other:

The emergence of the idea of “sexual orientation” does not position the figures of the homosexual and heterosexual in a relation of equivalence. Rather it is the homosexual who is constituted as having an “orientation”: the heterosexual would be presumed to be neutral. (Ahmed, 2006, p. 69)

The original use of the term referred to someone coming out to other gay people borrowing from the historical practice of debutantes from upper-class families coming out to society at a formal debut⁷ (Orne, 2016). Around the time of Stonewall⁸, the term was combined with the metaphor of the closet as the place of hiding or invisibility prior to coming out; indeed “the closet has become a central category for grasping the history and social dynamics of gay life” (Seidman, Meeks, & Traschen, 1999, p. 9). Thus the focus of coming out shifted from disclosure of a gay identity to peers to the revelation of that identity to straight people (Orne, 2016).

Coming out has been called “the central narrative of positive gay experience”, typically framed as a redemptive tale of difference and shame resolved by embracing an LGB ‘lifestyle’ (Kong, Mahoney, & Plummer, 2002, p. 242). Telling the coming out story is seen to affirm the gay person’s group identity, and the story is typically a way that individuals make sense of the process, “isolating and recalling the defining events, contexts or ideas to give a “symbolic order” to their identity” (Stein, 1997, p. 71). In this way, coming out is seen as a rite of passage into a new world,

⁷ Chauncey (1994) however, contends the phrase refers to a gay man’s first same-sex sexual experience (as cited in Moore, 2012).

⁸ The Stonewall riots in 1969 were precipitated by a police raid on the Stonewall Inn in the West Village in New York. After years of harassment and intimidation, the SGM patrons fought back. Stonewall is generally assumed to mark the beginning of the organised fight for SGM equality.

a journey from an “uncharted shore” to “gradually arriving home” (Plummer, 1995, pp. 83-84, as cited in McLean 2007, p. 152).

In the common discourse, coming out is positioned as ‘good’ and ‘honest’ as it enables the healthy development of sexual identity, while non-disclosure is positioned as ‘bad’ and as such many LGB people experience a “disclosure imperative” or pressure to come out (McLean, 2007). Not coming out is thus seen as “hiding in the closet” and even “living a lie” (Orne, 2011). The typical image of the closet implies an oppressive existence, and being “difficult, unnatural, dark, precarious, isolating, and probably doomed to failure” (Kushnick, 2010, p. 678). Thus the closet is “conceptualised as a repressive space that censures and constrains LGBTQ people” and is designated “a trope for heterosexual oppression” (Moore, 2012a, n.p.). Despite the disclosure imperative, coming out can be “exhausting emotional work” and invoke unwanted personal questions or stereotyping (Orne, 2016, p. 249). Additionally, the phrase ‘coming out’ suggests a single act—presumably the closet door is closed behind you—but in reality, the coming out process is more complex.

Despite the prevalent paradigm of coming out, namely that it is an essential liberatory step for SGM people, some contend that the concept is itself fundamentally heteronormative. Moore (2012a) for example, claims that defining SGM people against the heterosexual norm positions them as “spectacle and/or deviant bodies in need of acceptance” (n.p.). It follows, then, that the closet as a metaphor for self-awareness perpetuates the oppressive assumption that everyone is heterosexual unless they specifically name a non-normative sexuality (Hill, 2009). Additionally, the idea of the closet is inherently contradictory, in that it is impossible to know whether the “secret” of a non-heterosexual sexuality has been kept (Sedgwick, 1993). The fact that there is a disclosure imperative can be seen to limit individual agency and the ability to name oneself as one sees fit. Moore (2012b) posits an alternative to coming out which she frames as “inviting in”. This reframing, rather than positioning SGM people “in a system organized around the

heteronormative binaries of straight/LGBT, regulated/deviant” allows the individual to choose when, and to whom to disclose their sexual identity (n.p.). Moore cites Sekneh Hammoud-Becket’s (2007) definition of “inviting in”:

I don’t view myself as in the closet, in a dark place that I must escape from. Far from it, this closet is full of precious things, like things you could never afford to buy! It’s my treasure chest. The way I see it, rather than me needing to move out of the closet to make my sexuality public to everyone, including my parents, instead I get to choose who I open the door to, and who to invite to come into my life. (as cited in Moore, 2012b, n.p.)

The concept of “inviting in” repositions the locus of control to the individual and may subvert the heteronormative disclosure imperative by shifting the direction of the metaphorical movement from out (of the closet) to in (to a person’s life-space).

Families play a crucial role in maintaining social (and sexual) conformity. A unique difficulty for people who disclose their non-heterosexual identity is managing rejection from their family, and the pressure to stay in the closet may be great. Having an openly gay child can perversely force uncomfortable parents into their own closet when dealing with unaccepting family and friends (Sedgwick, 1993). This exclusion is not usually the same for other marginalised identities:

While most people who share familiar characteristics across generations have a safe refuge among their families, gay people often do not. Latino kids are not rejected by their parents for being Latino, nor are most Muslims disowned by their parents for being Muslims, but those who are gay are often the target of their families’ disapprobation or outright hostility. (Solomon, 2017, n.p.)

2.2.1 Theories and models of coming out

Before the nineteenth century, homosexuality as a discrete identity did not exist; there were only (what we would now call) homosexual acts. The criminalization of sodomy, for example, stemmed more from the notion of non-procreative sexual activity than policing the object of sexual desire (Rubin, 1993). Women who had sex with women were historically punished for “unnatural acts” but these were usually based on perceived gender transgressions (i.e., appropriating the dress

and privileges of men) rather than their erotic object choices (Sullivan, 2003). At the end of the nineteenth century, with the emergence of proto-sexuality research, “the homosexual was now a species” (Foucault, 1980, p. 43, as cited in Sullivan, 2003). Halperin (2012) describes this as “the transformation of homosexuality from a sexual perversion into a social identity” (p. 77).

Common modern cultural consciousness usually holds that homosexuals are “born this way” (Laursen, 2011). Models and theories of homosexual development typically arise from medicine and psychology. However, much current sexuality research is founded in symbolic interactionism (the idea that identity is formed by societal interactions) and encompasses concepts such as “identity work”—the process by which an individual actively shapes their social identity⁹ (Khanna & Johnson, 2010).

The term “coming out” has entered cultural consciousness, and other marginalised groups often use the term coming out to signify embracing a stigmatised identity. Yoshino (2006), for example, found that “the news is peopled with closet poets, closet Republicans, closet gamblers, closet artists, and closet fans of the Tampa Bay Devil Rays” (p. 73). However, perhaps because of this increasingly casual use, some researchers claim that the term suffers from conceptual inflation. Orne (2011) defines conceptual conflation as using concepts “without acknowledging prior theoretical assumptions that allows opportunities for folk definitions to overwhelm scientific considerations” (p. 682). In this case, the developmental history of coming out has added new concepts and constructions, but old assumptions often linger in new models (Orne, 2011).

A common trope about coming out is that it is an (often emotional) one-time, public, verbal disclosure. Orne (2016) calls this the stereotypical “Mom, Dad, I’m gay of coming out strategies” (p. 248). However, most of the early attempts to conceptualise coming out assumed a (multi-

⁹ The work of Erving Goffman was key to the development of the idea of “stigma management” which is fundamental to many theories of LGB identity development. Goffman (1959) showed how the adoption of discrete identities by individuals enable “others to know in advance what he will expect of them and what they may expect of him” (p. 13).

staged) linear developmental trajectory based on Erikson's (1982) model of identity development. The most influential was Vivienne Cass's (1979, 1984) Homosexuality Identity Model (HIM). The HIM posits a six-stage process "by which a person comes first to consider and later to acquire the identity of 'homosexual' as a relevant aspect of self" (Cass, 1979, p. 219). The individual traverses the stages to reach a state of "identity synthesis" or a fully realised integration of their public and personal sexual identities. Cass describes the use of "passing" (presenting a public persona of heterosexuality) which she claims, along with "selective disclosure" (coming out to a small group of trusted people) can provide homosexuals "a satisfactory way to live their lives" (p. 232). Most of the other so-called stage models include at least three stages: awareness of same-sex attraction, exploration of these feelings, and coming out (Shapiro, Rios, & Stewart, 2010).

Because these early theorists were generally psychologists, the research was viewed within a particular frame of reference, perhaps stemming from early medical or pathologised categorizations of homosexuality (Foucault, 1976/1980). Since the early 1900s, lesbians, bisexuals and gay men have been categorized as insane, degenerate and defective or, as Butler (1991) puts it, "traditionally designated as impossible identities, errors of classification and unnatural disasters" (p. 16). Until 1973, the American Psychiatric Association classified homosexuality as a mental illness in the Diagnostic and Statistical Manual of Mental Disorder, and conversion (or reparative) therapy still persists¹⁰. Thus, early coming out theorists tended to focus on the mental health aspects of identity, with the implication that mental health problems would persist as long as the individual had not fully accepted their non-heterosexual identity.

Later theorists like Troiden (1989) built on Cass's HIM, adding a more multi-dimensional spiral element to show the iterative nature of coming out, where people may move backwards

¹⁰ Conversion therapy, or sexual reorientation, is an attempt to convert non-heterosexuals to a heterosexual orientation using techniques like hypnosis, aversion therapy, group therapy and religious guilt (to "pray the gay away"). Although widely discredited by the psychiatric community, it is still commonly available in most countries ("Conversion therapy," 2018).

and forwards in the process. D'Augelli (1994) proposed a model that aligns with typical life stages such as exiting a heterosexual identity, becoming a gay offspring and entering a gay community. Many of these models still place the individual at the centre, and often minimise or ignore culture, relationships and community in the coming out process (Manning, 2015) . They also tend to “retain a stage-like linearity, as though one simply accumulates disclosures until one is ‘out’” and mainly presuppose an endpoint where the individual is out to everyone, which is unlikely (Orne, 2016, p. 246).

Recent interdisciplinary research has questioned whether these older models are representative of most coming out experiences (Manning, 2015). Later models assume people are inseparable from their various emotional and social connections and examine how and why people come out to others (rather than the development of their individual gay identity). Coming out is seen as a process of ongoing identity management, where people make continuous decisions about which social contexts warrant disclosure, and because society assumes heterosexuality, in many cases “the possibility of coming out is always there” (Orne, 2016, p. 248).

An LG identity often encompasses more than declaring a same-sex attraction. Coming out involves adopting a social identity whose community members may participate in particular discourses and act in certain ways (Stein, 1997). McCarn and Fassinger's (1996) model of lesbian identity development, for example, is derived from models of racial and women's identity development and contains two distinct developmental branches. The first branch is the development of individual sexual identity (similar to the linear models already discussed) and the second is the process of developing minority group membership. Fassinger (1997) subsequently validated her model with a sample of gay men which suggests its wider applicability. Thus “gayness comprises much more than sexual partners and practices” (Fellows, 2004, p. 262 cited in Halperin, 2012). This fashioning of a lesbian or gay self often involves coding and erotising gender norms (Phelan, 1993; Stein, 1997). For example, one of the common lesbian signifiers is

an androgynous appearance, perhaps a lingering effect of the lesbian feminist movement's conscious attempt to minimise gender differences in the 70s and 80s¹¹. Halberstam (1998), in discussing female masculinity, contends that "historically within what we have called lesbianism, masculinity has played an important role"¹² (p. 119). Some gay men may likewise express gender in a way that is different from canonical masculinity; Halperin (2012) claims this "femininity" evidenced by some gay men is a kind of proxy identity, a way of expressing a type of "gay male gender dissidence" (p. 318).

As we have seen, there are myriad and sometimes conflicting models of coming out and researchers may not specify what assumptions they are using for their work. The model that most resonates with me is "strategic outness" proposed by Orne (2011)¹³. Orne conceptualises coming out as being inseparable from, and contingent upon, an individual's situational social circumstances. Rather than a simple linear progression that presupposes a one-time developmental event, strategic outness is a process of continual identity management. This concept has some similarities to "inviting in" discussed earlier (for example, treating the individual as a strategic actor in the sharing of their own identity), but strategic outness uses the traditional concepts of coming out without reframing identity management as a subversion of compulsory heterosexuality.

¹¹ "The practice of femininity, they believed, constrained women and encouraged them to display sociability rather than technical competence, to accept marriage and caring for children rather than combat labor market discrimination against women, and to organize their lives around themes of 'sexual receptivity' and 'motherhood'" (Stein, 1997, p. 80).

¹² While the term "butch" can be seen as a "master signifier" for masculine-identified lesbians, it has a troubled socio-political history (e.g. been viewed as a mimicry of heterosexuality by some lesbian feminists in the 1970s and 1980s (Halberstam, 1998)

¹³ Orne (2011) developed his model based on Goffman's (1963) identity management theory and consciously turned away from the predominantly psychological focus of much previous coming out research. He analysed essays written by 13 gay men and weaved previous research in with his findings "to demonstrate that scholars have implied facets of strategic outness, but they need to be theoretically synthesized" (p. 685).

The framework of strategic outness incorporates the following ideas:

1. People use different strategies or management tools at different times for coming out. Beyond the “actual declarative statement,” clues and degrees of concealment are used to manage disclosure.
2. Motivations for coming out “are situated contextually within strategic discourses and personal experiences” (Orne, 2011, p. 688) and negate simple binary definitions of being “out of” or “inside” the closet.
3. Social distance and social context are important to sexual identity disclosure. People may come out to their ‘inner circle’, and not to those they feel are more ‘distant’. However, social distances do not necessarily dictate a particular method of identity management. For example, someone may not be out to a parent, but be out to strangers online.

Although I usually declare myself “fully out”¹⁴ I recognise that in a heteronormative society I might be read as straight by people who don’t know me. In some situations, I might manage my identity by not (for example) correcting a misassumption. The simple binary declaration that I am “out of the closet” does not fully reflect the reality of how I (sometimes) still internally monitor my level of comfort in any contextual social situation and may use different tools to manage my sexual identity.

2.2.2 Coming out and staying in: Methods and strategies

In many cases coming out is ongoing work and risks “upsetting a precarious balance of what is and is not acceptable, of what people know and don’t know about you.... This balancing act may never end” (Bronksi, Pelligrini, & Amico, 2013, p. 146). The balancing act often necessitates the

¹⁴By this I mean that I would consider all of my friends and family (that I know of) are aware that I am a lesbian.

use of various identity management approaches or methods. These methods are used by most SGM people “not only to manage their identity, but also to regulate their distance from others in their life” (Orne, 2016, p. 249). The different approaches are used according to context, depending on the situation and the audience (Mosher, 2001).

Conversations:

The verbal self-disclosure has been the most examined by researchers (Orne, 2011). Manning (2015) analysed narratives from LGB individuals to develop a typology of seven common coming out conversations. He defined these as:

- Pre-planned: Typically beginning with a statement like “I have something to tell you”, these conversations are planned in advance.
- Emergent: If coming out revelations emerge as part of a normal conversation, the recipient is not (seemingly) aware of the initiator’s sexual orientation prior to the event.
- Coaxed: These conversations are initiated by someone “nudging, hinting, or even asking an LGB person to come out” and it is not usually the LGB person who initiates the discussion (Manning, 2015, p. 129).
- Confrontational: Rather than being coaxed, some LGB individuals are confronted about their sexuality in a negative way. In Manning’s study most of these exchanges involved parents confronting their children and were angry and chaotic events.
- Romantic/sexual: This is a coming out scenario where the individual’s sexuality is revealed by an expression of attraction (e.g. “I would like to kiss you”).
- Educational/activist: A sexual identity can be declared to raise awareness or inform, often in a public context (e.g. a conference panel).
- Mediated: Coming out communication can happen through non-verbal and distance methods, such as emails, texts, social media etc.

Clues, flagging and speculation:

Members of social groups often use symbols or gestures to affirm membership in that group (Goffman, 1959). Dropping hints (or flagging) is a common, subtle way of coming out. Lane (2016) writes that “queers have always used flagging—subtle codes invisible to non-community members but visible in the community—as signifiers of belonging and identity so that we know how to spot each other in a mixed crowd” (p. 129). For example, Orne (2016) comments that a woman wearing a flannel shirt may be read as a lesbian by other members of the group. However, clues are dependent on social context, and the same woman may be seen as a lesbian in a large West Coast city but not in a Midwestern rural environment. In Giddings and Smith's (2001) study of lesbian nurses, they described participants “putting out an opener to see if a woman responded” when they sensed a patient or colleague might be a lesbian (p. 18). SGM people accenting their sexual identity might involve similar strategies, for example alluding to typical cultural signifiers (Halperin, 2012). Clues and hints might be strategically managed to restrict knowledge to chosen people or groups, for example using social media networking profiles visible to select individuals or adding “gay-compliments” (e.g., volunteering with queer organisations) on a resume (Orne, 2011).

Leaving it up to other people to ask about sexual identity has been described as using “speculation” (Orne, 2011). In this case, the sexual identity is not actively concealed but not brought up by the individual, leaving it up to others to ask if they want to know. Yoshino (2006) describes this as “the open secret” and references a situation with a friend who knew he was gay (and he knew that she was aware) but “because I would never acknowledge our collective knowledge, she could not do either” (p. 62).

Passing and covering:

Passing was first described in the context of racial identity work. In the Jim Crow¹⁵ era anyone who was multiracial was defined as Black and thus subject to segregation as well as harassment, violence and subjugation. Racial passing (commonly held to be the practice in which someone of one race¹⁶ presents as another race¹⁷) can be a form of resistance to the lack of rights and opportunities afforded by current social standards (Khanna & Johnson, 2010). This definition has been contested under the assumption that it presents claiming White ancestry as somehow fraudulent. A more nuanced definition by Kennedy (2003) is that passing is “a deception that enables a person to adopt specific roles or identities from which he or she would otherwise be barred by prevailing social standards” (as cited in Khanna and Johnson, 2010, p. 283). It is clear from this definition that the concept of passing could be applied to sexual identity.

Sociologist Erving Goffman (1963) described passing in his influential work *Stigma*. He claims that stigma management is a feature of any society where there are identity norms. Goffman identifies “important stigmas¹⁸” where the individual needs to be “carefully secret” and may attempt to pass as normal. However, many stigmatised individuals, instead of passing, “make a great effort to keep the stigma from looming large” (p. 102). Stigmatised people may “cover” their identities to minimise the visibility and significance of their differences to be more accepted into society. Goffman claims that “many of those who rarely try to pass, routinely try to cover” (p. 102).

¹⁵ A systemic and codified collection of laws enforcing racial apartheid in the American South that were in effect from the late 1800s to the middle of the last century. Racial segregation was mandatory in almost every aspect of daily life (PBS, 2018).

¹⁶ Usually Black

¹⁷ Usually White: although the recent case of Rachel Dolezal —the woman who attracted negative media attention by calling herself Black—is a notable exception (Johnson, Pérez-Peña, & Eligon, 2015)

¹⁸ Such as those that “prostitutes, thieves, homosexuals, beggars and drug addicts have” (Goffman, 1963, p. 73)

Gay legal scholar Kenji Yoshino takes up this concept further and claims that covering is the dark side of assimilation. Society supposedly values “diversity” (in individuals) but not diversity as evidenced by a broader minority culture (Halperin, 2012). Yoshino (2006) argues that when stigmatised minorities accede to these (often implicit) covering demands, systematic homophobia, sexism and racism remain unchallenged. For SGM people, they may ostensibly be out of the closet, but to be successful they might cover to ensure their identities “do not obtrude flamboyantly on the consciousness of straight people” (Halperin, 2012, p. 411). Thus, gay people can be gay, but not too gay, and to cover is to refrain from “flaunting” one’s sexual identity.

2.2.3 Coming out as experienced by different groups

Much of the coming out research has focused on White gay men as a subgroup and has ignored ethnic and racial concerns (Manning, 2015). Likewise, for lesbians, bisexuals and those outside the Western political systems, beliefs, values and cultures, coming out may be contextualized differently. Other groups such as “drag queens, effeminate men, butch women, prison punks” would also experience sexual identity disclosure in alternate ways (Ross, 2005, p. 183).

Racial and ethnic minorities:

Ross (2005) argues that “race and class become traditionally invisible when the putative origins of modern homosexuality are disclosed” (p. 175). It has been contended that gay men may have relatively easier time coming out because of the social privilege afforded to them, and White men more so (Orne, 2016). Intersectionality theory would indicate that women, Black and ethnic minorities and other stigmatised groups may experience greater hardship as a sexual minority. For those who do come out, “the calculus of benefits and costs vary considerably depending on how individuals are socially positioned” (Seidman et al., 1999). Indeed, some people in diverse populations may find the process of coming out more harmful than helpful (Moore, 2012b).

James Baldwin¹⁹, in a *Village Voice* interview, commented:

A black gay person is a sexual conundrum to society already, long before the question of sexuality comes into it, menaced and marked because he's black or she's black. The sexual question comes after the question of color; it's simply one more aspect of the danger in which all black people live. (Goldstein, 1984)

Additionally, there is evidence of racism within the queer community, which may further compound negative experiences as People of Colour (POC) struggle between two stigmatised groups (Icard, 1986). A recent example is the conflict between Black Lives Matter-Toronto and Toronto Pride regarding police representatives marching in the Pride parade, described as “a queer civil war” (“Black Lives Matter, police and pride: Toronto activists spark a movement” 2017). Terminology may differ in the Black community, and some men who have sex with men do not identify as gay and may have sexual relationships with other men “on the down low” (Martinez & Hosek, 2005).

Research in the area of sexual identity development in ethnic and racial minorities indicates that there are disclosure differences compared to White people. For example, Latino youths are less likely to come out publicly as gay, and women of colour who identify as lesbian tend to disclose less than White lesbians due to intersecting oppressions and privileges related to sexual orientation and race-ethnicity²⁰ (Parks, Hughes, & Matthews, 2004; Rosario, Schrimshaw, & Hunter, 2004).

Two-spirit (indigenous) people:

The term “two-spirit” was popularised in the 1990s and is thought to be a translation of the Anishinaabeg (Ojibwe) term *niizh manidoowag* referring to a person who holds both masculine and feminine traits (Pyle, 2018). Two-spirit is used by some Indigenous peoples to describe their

¹⁹ Baldwin famously rejected being called gay or homosexual; feeling the terms were simultaneously too modern and too White to capture his own experiences.

²⁰ Although a 2012 Gallup poll of 121,290 Americans found that non-White (males) are more likely than Whites to identify as lesbian, gay, bisexual or transgender. This led one columnist to comment: “On the one hand, it's a positive statistic. It shows that the gay and lesbian community is more diverse than many believe, and it shows that many young men of color feel empowered to identify as they feel most comfortable. On the other, the causes behind it remain a mystery” (Blow, 2012, n.p).

gender, sexual and spiritual identity situated as part of a historic tradition: “When we say that we are two-spirit, we are acknowledging that we are spiritually meaningful people. Two-spirit identity may encompass all aspects of who we are, including our culture, sexuality, gender, spirituality, community and relationship to the land” (Wilson, 2008, p. 193). Tafoya (1997) reports that of the 250 or more Aboriginal languages spoken in the US, at least 168 have different terms to describe people who possess both female and male spirits.

Although two-spirit identities were often respected and honoured in traditional Indigenous societies, modern urbanization, colonization and the influences of Christianity (e.g. heteronormativity and homophobia) have repressed these historical beliefs in many communities (Brotman, Ryan, Jalbert, & Rowe, 2002). Wilson (2008) also discusses the lingering negative impact of residential schools that stripped Aboriginal children of language, history, culture and identity and severed the sense of connection to sexuality and spirituality embodied in two-spirit people. Thus, coming out for two-spirit people can be lengthy and complex, as they may face exclusion and marginalization from their Aboriginal communities for being LGBTQ, from queer communities because of their indigeneity, and from “mainstream” communities because of their dual marginalized identities (Brotman, Ryan, Jalbert, & Rowe, 2002). This is consistent with the experiences of other ethno-racial SGM groups (Rosario, Schrimshaw, & Hunter, 2004).

Wilson (1996), a Cree researcher, comments that in much of Western and Eurocentric culture, sexuality is seen as a discrete identity predicated on sexual object choice. However, the sexuality of two-spirit people is impossible to separate from the rest of their identity. Typical linear developmental trajectories based on sexual behaviour cannot accurately describe the experience of two-spirit people. Two-spirit individuals need to find support and integration within their traditional communities; rather than coming out they will therefore “come in” to “an empowered identity that integrates their sexuality, culture, gender and all other aspects of who they understand and know themselves to be” (p. 197).

Other non-Eurocentric viewpoints:

The Western/Eurocentric dominance of queer discourses serves to privilege and proliferate certain ideas, ideologies and identities but may silence others. Language and concepts vary; for example, Thai women who love other women "don't usually say they are lesbians because the word lesbian is Westernized. They don't like the word so they create their own words like 'tom' and 'dy'" (Thongthiraj, 1994). Outside the West, revealing a stigmatised identity can be a highly risky act, particularly in the 74 countries where same sex intimacy is illegal (Fenton, 2016)²¹.

It has been claimed that the closet itself as a primary understanding of sexual identity expression is a fixation of White queer theory and history (Ross, 2005). Ross (2005) posits that the development of the coming out narrative by elite White Western theorists ignores other-located racialized experiences and that "gender of object choice and the closet paradigm arise as the 'ubiquitous'—that is, the global—definition of sexual orientation simply because of the political, economic, and cultural dominance of the West globally" (p. 169). Sexual identity may be an open secret in a community, which challenges the assumption of "coming out" as a necessary stage of identity development (Hawkeswood, 1996 cited in Ross, 2005).

Coming out as bisexual:

For bisexuals, coming out may be complicated by the general social under-representation and invisibility of bisexuality²² (Monro, Hines, & Osborne, 2017). Additionally, there are many misconceptions and inaccurate stereotypes about bisexuals. These include the belief that bisexuality is a "stage" or a transition to a "real" gay or lesbian identity, or that bisexuals are simply confused (McLean, 2007). Recent research posits that bisexuals, in general, are less likely to be

²¹ There is also no shortage of LGBTQ-motivated hate crime in Canada, despite less structural discrimination. A 2015 Statistics Canada report of police-reported hate crime described violence against LGBTQ people as the most severe of all forms of hate crime in Canada (H. Kennedy, 2017).

²² Or bi-erasure.

“out²³” and may experience identity development in a different way to lesbians and gay men. Instead of the final stage of an integrated identity, bisexuals are more likely to experience “continual uncertainty” – an ongoing questioning of the validity of their bisexual identity (Weinberg, Williams, & Prior, 1994). This uncertainty, combined with the misrepresentation of bisexuality as a number of harmful stereotypes, may be reasons why many bisexuals chose not to come out (or manage their identity with selective disclosure). McLean’s (2007) research identified that some bisexuals may have several “personas” they use in different contexts, a heterosexual one, a bisexual one (if they are out as bisexual) and a gay and lesbian one if they were part of the LGB community where people didn’t know that they were bisexual.

Coming out as lesbian:

Lesbians, as a social group, have a complex political history. Some early lesbian feminists identified themselves as lesbian as a political act: coming out was “coming into consciousness” where “homosexual desire was not necessarily a prerequisite” (Stein, 1997, p. 70). Today, there is still evidence that, for some women, there may be a mutually reinforcing relationship between choosing women as sexual partners and political identity (Shapiro et al., 2010).

Early lesbian identity development models followed a similar linearity to those of Cass et al. (Cass, 1979, 1984; D’Augelli, 1994; Troiden, 1989). However, more recent approaches focus on the fluidity of women’s sexuality²⁴ and don’t assume that identity is relatively fixed over time. For example, Diamond’s dynamical systems theory views women’s sexuality as changing through the stages of life (into middle and late adulthood), social groupings, and love relationships (Farr, Diamond, & Boker, 2014). Thus, some women don’t view their sexual identity development as steps or stages or see themselves as intrinsically heterosexual, lesbian or bisexual. Importantly

²³ A 2013 Pew Research Centre Survey demonstrated that 28% of bisexuals say that they are out, compared to 77% of gay men and 71% of lesbians (Taylor, 2013).

²⁴ Based on the research that indicates that “the female sex drive is more malleable than the male in response to sociocultural and situational factors” (Baumeister, 2000, p. 347).

this involves not necessarily identifying an end-point (to come out) in the same way that has been previously theorized (Shapiro et al., 2010). Additionally, McCarn and Fassinger (1996) suggest that women coming out as lesbian face unique sociopolitical challenges that are ignored in typical androcentric models based on White gay men. For example, many women have been socialized to believe that expressing sexual desire is wrong, thus may come out in the context of a relationship (and later in life) rather than the process of acting on and articulating sexual desire for women.

2.2.4 Coming out as a political act and “outing”

The first wave of the gay rights movement was mainly assimilationist and appealed to a common humanity. Early civil rights groups attempted to downplay differences or make them secondary (Sullivan, 2003). Social contact with minoritized groups has been shown to change attitudes (in terms of individuals’ previously held stereotypes and prejudices) more than education and protest strategies (Corrigan & Matthews, 2003). Thus, coming out was usually an attempt at reassurance to the world that “we are just like you”. However, from Stonewall onwards, activists generally took a more liberationist approach. Coming out was seen as a necessary individual political act and a move away from a previous stance of victimhood towards a transformed “out and proud” identity. Typical of that stance is the famous speech by San Francisco gay mayor, Harvey Milk (2013) at the Gay Freedom Day Parade in San Francisco in 1978:

Gay brothers and sisters... You must come out. Come out... to your parents... I know that it is hard and will hurt them but think about how they will hurt you in the voting booth! Come out to your relatives... come out to your friends... Come out to your neighbors... to your fellow workers... to the people who work where you eat and shop... break down the myths, destroy the lies and distortions. For your sake. For their sake. (p. 217).

Public SGM visibility is still used as a political tool; for example the practice of “kiss-ins” to demonstrate peacefully for civil rights harks back to the 1970s and is still used today to protest global violence against SGM people (Amendolare, 2018).

Outing public figures in the 1980s and 90s for political reasons was (and continues to be) a controversial method of revealing the sexual orientation of well-known individuals who (for example) actively opposed LGT rights and interests. Activists have promoted outing as a way of forwarding an anti-prejudice agenda, but the practice generates a strong ethical debate (Corrigan & Matthews, 2003).

2.2.5 Coming out as what? Post-gay and post-closet

The 1990s onwards have given rise to the multi-faceted concept of queer—where queer can be taken up as a position or act by anyone who feels that they fall outside the rigid binary categories of gay/straight, woman/man and female/male. Coming out in a post-modern age might be viewed as easier (because of better legislative protection and improved social attitudes) and simultaneously more complicated (due to the deconstruction of labels and the binary concepts of gay/straight).

“Coming out” has its benefits and its disadvantages, but either way, the call to come out presupposes that such an action is in itself transformative and that the identity that one publicly declares is unambiguous—assumptions that poststructuralist theorists find inherently troubling. (Sullivan, 2003, p. 31)

The “post-gay” or “post closet” scholarship that emerged in the 1990s and onwards claims that LGB people should not only be defined in terms of their sexuality, and that LGB identity should move away from being defined by oppression and anger (Ghaziani, 2011). Because gay rights and gay identity had become increasingly normalised, and mass-market media representations of LGB people are increasingly common, there was seen to be less of a need for LGB people to hide in the mythical closet (Seidman, 2002).

This is a contested and evolving area, with some contending that the post-gay/post-closet era is a myth and that identity will always be an ongoing and socially managed process. Ward and Winstanley (2005) have called the post-gay concept a “semantic hoax and linguistic trick” (p.

449)– arguing and citing Butler (1991) that identity is still “performed” regardless of the growing proliferation of labels, identities and concepts. Seidman (2002) commented in *Beyond the Closet* that the majority of the people he interviewed were still “concealing their homosexuality in specific situations or with particular individuals” (p. 8). In addition, it is claimed that much of the post-gay discourse was driven by White, middle and upper class gay men who enjoy a relatively privileged position. Their experiences were not the same as those with different gender, racial and class positions (Alimahomed, 2010). Thus “post closet rhetoric is grounded in a system of stratification” and “not all closets and experiences are treated equally” (Brown, 2011, p. 23).

There are undoubtedly people who consider their sexual identity as unimportant, and coming out somewhat irrelevant (Orne, 2011). Situations where this is true certainly exist, although post-closet or not, it’s clear that many LGB people are still managing their non-heterosexual identities (Williams, Giuffre, & Dellinger, 2009). Despite claims of a post-gay era young people continue to show group affiliation and use labels, albeit new and expanding ones (Orne, 2016). Coming out as a metaphor can still be a useful way to understand how LGB people negotiate their differing identities, although a metaphor that should be used cautiously given the problem of conceptual inflation (Orne, 2011).

2.3 Sexual orientation in the work environment

As Hearn and Parkin (1995) explain, “organizational life clearly compromises part of the public domain. Sexuality is often considered primarily biological, and socially part of the private domain” (p. 7). Sexuality at work tends to be both “known and obscure, seen and unnoticed”, where workers are by default heterosexual males and women, then, outliers to be managed (p. 45). Thus, much organizational and managerial sexuality research focuses on the sexual harassment of women by men. “Invisible” diversities, such as LG workers, are “under-theorised and under-

researched” compared to more visible identities such as race/ethnicity and gender (Ward & Winstanley, 2005, p. 449; Colgan & McKearney, 2011; Colgan & Rumens, 2015).

The decision to be out at work (to cover, or not) is part of everyday reality for many LG people. Colgan and Rumens (2015) contend that there is a false assumption that “the workplace is a neutral zone into which such things as sexual orientation and gender are imported” (p. 1) and argue that organisational heteronormativity plays an integral part in perpetuating workplace inequalities. This heteronormativity renders the dominant heterosexuality of organisational experience effectively invisible, and employers are left to manage non-heterosexual orientations with tools such as equity and diversity policies and initiatives.

Yoshino (2006) argues that the workplace pressure to cover a stigmatised identity is one of the most important civil rights issues today:

The demand to cover is anything but trivial. It's the symbolic heartland of inequality—what reassures one group of its superiority to another. When straights ask gays to cover, they are asking us to be small in the world, to forgo prerogatives that straights have and therefore to forego equality. (p. 107)

He claims companies that promote diversity and inclusion actually consciously or unconsciously influence employers to minimise parts of their identity. This doesn't just include SGM employees, but people cover their religion, class, history of mental and physical illness and so on. In his 2014 Deloitte report, 61% of the 3,129 professionals surveyed reported covering one or more of their identities and 73% of “coverers” felt that doing so was detrimental to their sense of self (Yoshino, 2014). Tsai (2018), discussing medical training, agrees that covering isn't just related to sexual and gender minorities, it's endemic:

Women are taught to emulate men (but not too much) Some are asked to scrub their tongues free of accents or Ebonics, while queer and transgender students are trained to quiet their identities. Trainees struggling with chronic illnesses or disability learnt early on not to associate too closely with their diagnoses, and black and brown students feel pressure to suffer explicit racial insults in silence (n.p.)

Organizational research has tended to show “how numerous work environments have been characterized by homophobia and heterosexism with the effect of marginalizing, excluding, silencing, and persecuting LGBTQ employees” (Rumens, 2016, p. 1298). This aligns with Hearn and Parkin’s (1995) sexuality in organisations perspective that demonstrates how heteronormativity pervades workplaces through policies, cultural norms and informal interactions between workers. As legislation and societal acceptance of LG identities have evolved (for example, to include anti-discrimination legislation in some countries), research into LGBTQ workers has moved from examining the negative effects of homophobia and heteronormativity, to managing disclosure at work and, more recently, to the effects of biphobia and transphobia.

There is evidence that LG people in the workplace engage in significant identity work to manage who they tell about their sexual orientation, and in what circumstances. Coming out at work involves the same strategies discussed previously, such as passing and covering (Woods & Lucas, 1993 as cited in Colgan & Rumens, 2015, p. 8). Hill (2009) comments that “we are bearable as long as we ‘cover’ and do not ‘flaunt’ ourselves” (p. 38). Adkins (2000) notes that although many workplaces today openly accept lesbians, they are still expected to enact “rigidly defined workplace performances” including how to style their hair and how to dress, leading her to conclude that being a lesbian at work is “omnirelevant” (as cited in Williams et al., 2009, p. 212). Employees who chose to stay in the closet and carve a stark division between their work and “personal life” can experience significant work stress and disengagement (Buddel, 2011). Specific factors influencing disclosure at work²⁵ include supervisor support, co-worker support and organizational support. A survey of 99 LGB employees indicated that of these three factors, strong organizational support is more likely to be associated with sexual identity disclosure (Huffman, Watrous-Rodriguez, & King, 2008). A recent survey-based study of 431 respondents

²⁵ As well as those discussed earlier.

demonstrated that SGM employees are more willing to come out in organizations where policies and practices generate trust (Capell, Tzafrir, Enosh & Dolan, 2018). In general, disclosure is linked with higher job satisfaction and lower workplace anxiety (Buddel, 2011). Additionally, for SGM workers, having a queer community at work is associated with job satisfaction and commitment to the organization (Trau & Hartnel, 2007 cited in Buddel, 2011).

In studies of non-normative sexuality at work from the 1990s onward, issues of “fitting in” begin to emerge, as well as the concept of the “normal gay”, where “normal” means “like a heterosexual”. This might mean straight-acting, being partnered and monogamous and not overtly sexual (Rumens & Kerfoot, 2009). Seidman (2002) has tracked this concept with a critical discourse analysis of popular American movies²⁶. He cites a shift in the 1990s from the idea of the “polluted homosexual” to the “normal gay” but comments that this comes with a price, as “the normal gay is expected to exhibit specific kinds of traits and behaviours. He is supposed to be gender conventional, well-adjusted and integrated into mainstream society; she is committed to home, family, career and nation” (p. 14).

Managerial research examined ways to help LG employees participate in workplace life to “produce desirable personal and organisational outcomes” (Colgan & Rumens, 2015, p.7) that included increasing job satisfaction, improved productivity and retention. This normalisation of LG sexualities involves LG employees aligning with a managerialist organisational culture that is concerned with increasing productivity and decreasing employee turnover, rather than the active transformation of heteronormative work environments²⁷.

²⁶ Although critical discourse analysis is often associated with text-based methods, the analysis of visual forms of communication (such as film) is now relatively common (Wodak & Meyer, 2015).

²⁷ This is similar to Sara Warner's (2012) concept of “homoliberalism”—a conservative assimilationist approach (compared to the past gay liberation radical politics of social change) that offers acceptance to “certain normative-leaning, straight-acting homosexuals” (p. xi).

More recently, in so-called “gay-friendly” organisations, some SGM sexualities are actively prized as visible indicators of a diverse workforce (Buddel, 2011). Elements considered by employees to be gay-friendly include an accepting culture, SGM groups or networks, diversity training and support for SGM communities (Rumens, 2016). For example, the UK group Stonewall offers a Diversity Champions initiative for organizations to increase staff motivation, satisfaction and productivity as well as equality benchmarking, an annual top 100 diverse employers list and an SGM role models program (Stonewall, 2017). In the US, the Healthcare Equality Index has become the standard tool to evaluate organizational facilities and policies (Radix & Maingi, 2018). However, these seemingly progressive initiatives can veil the fact that the same gay-straight binary is still privileged and often avoids examining who benefits from the status quo (Colgan & Rumens, 2015). Even in gay-friendly organisations, there is often an implicit pressure to enact the role of the “normal gay” discussed above. In Williams et al.’s (2009) study of LGB individuals who described their workplaces as gay-friendly, respondents demonstrated a tension between being “normal” (defined as being conservative in political views and sexual mores and enacting traditional ways of doing gender) and being “visible” (being “openly gay” by talking about their sexuality or behaving in a non-socially prescribed way relating to gender). Even in gay-friendly organizations heteronormativity remains deeply embedded.

2.3.1 The “professionalism” discourse

For all those positioned as the “Other” in white, male-dominated work organizations, be they women, gays, lesbians or people of colour, the taking up of professional identification is a process constrained by numerous gates, most of which remain formally and informally ‘manned’ by white male gatekeepers. (Dent & Whitehead, 2002, p. 6)

Embedded in our discourses of the workplace is the traditional concept of the professional. Who constitutes a professional is an evolving and disputed territory, with many occupational groups competing to control areas of work, and expand their jurisdiction with standards and scopes of practice and regulatory authorities (Abbot, 1988). Radiation therapists (RTs) are a subsection of

a broad occupational group known as allied health professionals (AHPs), traditionally defined as all healthcare professions other than nursing, medicine, and pharmacy. AHPs are generally classified as semi-professions, to differentiate them from the classic professions of law, medicine or theology. Semi-professions include social work, teaching, medical radiation technology (including RTs) and many developed as “handmaidens’ of the professions” (for example nursing with medicine) (Hearn, 1982, p. 197). They tend to have a high percentage of female workers, which shifts to a greater number of men in upper managerial and leadership roles (Adams, 2010). Gender balance is changing in both the traditional and the semi-professions, but gender-specific gaps in earnings and a greater concentration of men in high-status specialty areas (e.g., surgery), suggest inequalities still exist (Adams, 2010). Radiation therapy evolved as an assistant role to physicians (radiation oncologists²⁸); in the early part of the last century, the work was usually carried out by nurses. The 1940s onwards in Canada saw the emergence of local and national professional associations, a national entry to practice exam, the shift from diploma to degree education and other hallmarks of professionalization.

Common definitions of professionalism include access to a specialised knowledge base and a high degree of competence. The traditional association of the workplace with men, and the home with women, has refined the concept as a “form of masculinity; emotionally flat, centred on a specific skill, insistent on professional esteem and technically based dominance over other workers” (Connell, 1987, p. 181). The professional is one who “keeps his emotions in check and his personal matters out of the office” (Woods & Lucas, 1993, p. 68). For healthcare workers who work directly with patients there are associated professional ethics or standards of practice that detail the boundaries of the patient-HCP relationship. Because of the provider-patient power differential and the possibility of abuse, HCPs are instructed to maintain a “professional distance”. What this means can be unclear; RTs practising in Alberta, for example, are exhorted to “establish

²⁸ The specialist physicians who assess the patient and prescribe the radiation dose.

only appropriate professional relationships with a patient, their family or a colleague” and to “avoid expression of views or information to the patient, which are not related to the professional relationship” (ACMDTT, 2014, n.p.). This can serve to discourage any kind of personal disclosure, or boundary-breaking, from the HCP²⁹. As Zingaro (2009) comments, “by the ethics of many of our roles, even in face-to-face encounters, we are expected to manage a complex compartmentalization of personal experience” (p. 106).

This discourse serves to erase female and non-heterosexual identities: the professional is “not just a man but, to a large extent, a white heterosexual middle-class man” (Grey, 1998, p. 584). However, organisational research that focuses on sexual orientation tends to demonstrate that “life and work are so interconnected from a psychology perspective as to be inseparable at the level of analysis,” and thus “keeping your private life private” would seem to be impossible (Colgan & Rumens, 2015, p. 8). The sexuality in organisations perspective confirms that homo-, but not heterosexuality, is seen as “private” (Hearn & Parkin, 1995). As Humphrey (1999) explains, there are “distinctions between private/public and private/secret respectively, which are superimposed on the hierarchy between homosexuality and heterosexuality” (p. 140).

For women, these public-private tensions have manifested in the long struggle to fit into a “man’s world” where they are often marginalised by professional masculine values that valorise control and competitiveness (Rumens & Kerfoot, 2009). For LG people this similarly results in managing their identities at work where being heterosexual is the unarticulated but powerful norm. This tension between the idea of “professional” and LG identities is neatly summarised by a participant in an interview study of LGB occupational therapists (OTs) who states, “it is better to say nothing, and stay as professional as possible” (Falzarano & Pizzi, 2015, p. 67).

²⁹ For example, HCPs rarely introduce themselves to patients, despite evidence suggesting patients value this information. In the UK this spurred a recent #hellomynameis Twitter campaign where UK patient and physician Dr. Kate Granger advocated for HCPs to demonstrate respect and empathy for patients by offering their name (Ford, 2015).

Additionally, being non-gender-normative, such as an overtly feminine gay man, or presenting as masculine for a lesbian, can be seen as “unprofessional”. For example, in Rumens and Kerfoot’s (2009) study of National Health Service (NHS) workers in the UK, Ryan (a hospital doctor) explained that:

The hospital is not ready...for a camp acting doctor...because it brings sexuality into the public eye, and is the workplace the right place to do that? I think the answer is no because it's at the expense of the patients. (p. 776)

The strong impetus to conform to gender norms can result in femme and butch lesbians experiencing workplace discrimination differently and/or managing their appearance to fit in with expectations of traditional feminine dress. For example, one respondent in Dellinger and William’s study (1997) commented that “women who don’t wear makeup, I guess, are thought to be either tomboys, homebodies, or ... it’s not a professional picture” (p. 158). Additionally, the experiences of lesbians and bisexual women would differ from those of gay men because of the “double jeopardy” of both gender and sexual orientation (Colgan & Rumens, 2015. p. 7).

Workers who interact with vulnerable populations (for example, patients in healthcare or students in education) can face additional challenges. The concept of professionalism in healthcare workplaces incorporates working with people who need compassionate care, blended with a culture of specialised biomedical and technical expertise which can exacerbate identity dilemmas, a concept which is explored next.

2.4 Healthcare culture

Hospitals, clinics and other healthcare organisations are places where sick and vulnerable people are often treated as disease cases rather than as unique human beings. Frank (1995) has described this as “medical colonization” – drawing an analogy to political colonization such as that described by Spivak (1985). The individual is reduced to a series of systems or body parts, a

process which ignores their personhood and silences their interpretation of their illness in favour of the biomedical paradigm. These “seemingly incommensurate idioms of biomedical knowledge and embodied experience” problematize the health care encounter, and respecting diversity in its various aspects is often an afterthought in many healthcare organizations (Barello, Graffigna, & Vegni, 2012; Nielsen, 2015, p. 51).

Despite the recent rhetoric of the “empowered patient”, “patient experience” and “patient engagement”, old-style medical paternalism (where the doctor knows best) is often still the order of the day (Thompson, 2015). As a patient, agency may be an illusion and choices restricted in various ways:

They will tell you that, in this neoliberal market of health brands and services you can make choices—the way you choose your toothpaste—and this simply is not the case. The choices are limited by the tiered health system in Canada (never “universal”), what privilege you have or how proficient you are as a patient. (Ibanez-Carrasco, 2016, p. 56)

Thus, for any patient, bringing their fully realised self to the medical encounter is difficult. For patients who identify as SGM, it is doubly so because healthcare reflects and embeds sociocultural norms, including heteronormativity, so patients often feel they “have to leave parts of who (they) are at the door in order to receive the care that (they) need” (Taylor-Shaughnessy, 2016, p. 28).

Much of medicine, and of healthcare more generally socializes its practitioners to view the body as an object to be examined and subsequently managed with therapeutic interventions. Physical examination and questioning follow a circumscribed path and result in a standard narrative (the clinical history) that can be read and understood by various HCPs. The “pathologizing” of the body is made possible by the medical gaze, taught to students and largely reinforced by the dominant biomedical culture (Davenport, 2000; Foucault, 1963/1994). Bleakley (2013) claims that the medical gaze is no longer physician-specific but “has been augmented by, and then distributed across other professions” (p. 27). The medical gaze “relies on an

epistemological separation of body from identity” and, in combination with the underlying heteronormativity of the healthcare system, allows the practitioner to “pathologize queerness in various ways” (Robertson, 2017, p. 161).

As medical students begin to interview patients for clinical history taking, they learn that “the ‘psychosocial’ aspects of most patients’ illnesses, their social histories and emotional states, and their lives outside of the hospitals and clinics are largely irrelevant” (Taylor, 2003, p. 557).³⁰ Additionally, HCPs (such as RTs) are trained to view their practices as “evidence-based” and highly objective, which results in HCPs generally ignoring the sociocultural aspects of healthcare’s “culture of no culture” where “medical knowledge is understood to not be merely ‘cultural’ knowledge but *real* knowledge” (Robertson, 2017; Taylor, 2003, p. 556). However, “there is no magical state of neutrality, no view from nowhere” (Baker & Beagan, 2014, p. 17).

Radiation therapy is embedded in the broader medical culture. The role of the RT involves a high degree of technical specialisation, where concepts of “patient-centredness” sometimes take a back seat to technocratic imperatives (Bolderston, Lewis, & Chai, 2010; Colyer, 2005). However, for RTs, an empathetic patient relationship is generally foregrounded in education and practice as an essential element for supporting patients through lengthy and physically challenging courses of treatment (Halkett & Kristjanson, 2007; Merchant et al., 2017).

2.5 Sexual identity and patients

Research into SGM patients’ experiences “describes a seemingly heterosexist view of healthcare”, regarding SGM patients as problems to be solved, underserved by traditional healthcare and wracked with depression, psychological distress and suicide (Falzarano & Pizzi,

³⁰ There is evidence, however, that medical education is experiencing a shift in line with the increasing focus on “patient experience” mentioned previously. For example, the growing interest in many medical school curricula in narrative oncology as the use of patient and caregiver stories to understand the experience of illness and suffering. Such an approach is meant to develop and improve empathy, communication skills and self-reflection in practitioners (Charon, 2001).

2015, p. 65). The barriers to equitable health care that SGM people face can “profoundly affect their overall well-being” (Institute of Medicine, 2011). SGM patients can be invisible and can feel ignored and marginalised when interacting with HCPs and the heteronormative system. Explicit bias (such as discrimination and harassment) is now deemed unacceptable in many, though not all, countries and studies have shown that comfort in caring for SGM patients continues to rise. However, despite this, implicit bias still exists in healthcare and many patients choose not to come out to HCPs (Institute of Medicine, 2011).

In general, LG patients feel that it is important for HCPs to know about their sexual orientation, while many HCPs don't feel this is relevant to health (Lockley & Fish, 2015; Somerville, 2015). In one internet-based study of 311 LGBT cancer survivors, 58% of participants revealed that they had come out to a HCP to correct a heteronormative assumption rather than being asked by a HCP (Margolies & Scout, 2013). Despite barriers to disclosure, there is evidence that SGM patients with cancer who do come out to HCPs self-report better health outcomes, thus suggesting that a safe environment to disclose could improve patient experiences (Kamen, Smith-Stoner, Heckler, Flannery, & Margolies, 2015; Radix & Maingi, 2018).

Mitigating healthcare obstacles for non-heterosexual patients requires “a skilled, culturally competent, sensitive and welcoming provider community” (GLBT health access project, n.d. p. 2). Common suggestions in the literature to improve patient experience include staff training, improvements to the physical environment (for example, specific LGB-focussed posters, safe space signage) and improving awareness and education for medical students and undergraduate healthcare professionals (Bolderston & Ralph, 2016). Other signs of an inclusive environment are “visible LGBT staff” (Radix & Maingi, 2018, p. 579). Typically, there is a dearth of education dealing with non-normative sexualities and gender expression in most current healthcare curricula (Bolderston, Watson, Thom, & Meeking, 2018). As well as formal SGM-specific education, it's important to “consider the messages about sexuality and SGM sexuality that are produced in

curricular moments that may or may not be officially devoted to these topics” (Murphy, 2016, p. 282). Murphy’s (2016) ethnographic study demonstrated how messaging that heterosexuality is natural, desirable and normal is embedded in the hidden medical curriculum in lectures, informal exchanges and role modelling between faculty and students and well-meaning attempts to teach LGBT issues.

Cultural competency training is often presented as a solution to improve the knowledge and attitudes of HCPs caring for SGM patients. While this training can improve knowledge, it often does little to address the practitioner’s “sociocultural baggage” and the embedded heteronormativity in the healthcare system (Robertson, 2017). It has also been argued that the concept of “culture” taught as a list of “traits” applied to groups such as SGM patients elides intersectional (and other) differences between subgroups and individuals (Baker & Beagan, 2014).

The responses in a study that asked LGBTQ patients what they would recommend to providers to improve care included training and inclusive environments but also:

- asking about and addressing sexual health issues for LGBTQ patients
- including support people of choice in decision making and visits
- avoiding assumptions regarding relationships (e.g. asking “how is this person related to you?”)
- providing relevant and focused support resources (Kamen et al., 2015).

There is often concern from patients about what healthcare professionals need to know, and how the information might be used. Adding sexual orientation and gender identity to healthcare forms is becoming more common and was recommended for all healthcare organisations by the Institute of Medicine (2011). In the UK, for example, the recent National Health Service England Sexual Orientation Monitoring Standard provides guidelines for health

services to consistently record patients' sexual orientation for those aged 16 years or more (LGBT Foundation, 2017). Well-designed forms and processes can help SGM patients identify themselves to healthcare professionals (if they so wish) in a routine manner and allow care to be tailored to their needs.

In the healthcare literature describing the experiences of SGM patients, there is a theme that could be entitled “gratitude for being treated normally”. When the expectation of discrimination is not met, patients may be thankful for treatment that would be considered by most to be an expected standard (e.g. having one's partner included in conversations) (Heyes, Dean, & Goldberg, 2015). In psychology, this phenomenon is termed relative deprivation—where minoritized groups have a lower subjective expectation and tend to rate positive encounters higher than more privileged groups (Smith & Pettigrew, 2014). Baker and Beagan's (2014) qualitative study of healthcare and LGBTQ women demonstrated low expectations for healthcare providers from LGBTQ women. Rather than judge HCPs on their expertise and clinical skills, women looked for clues that the provider was “queer-friendly” and instead providers were evaluated based on their open-mindedness. HCPs weren't expected to be knowledgeable about LGBTQ issues, but rather to show comfort with diverse populations and be willing to learn from the patient.

Having relationships misidentified is a fairly common experience for same sex couples, who convey a closeness that sometimes isn't recognized as a romantic attachment in a heteronormative society. Heyes, Dean and Goldberg (2015) express this as the assumption that two people of the same gender seeking healthcare who seem close “wouldn't come in together for any reason other than being blood related” (p. 149). A participant in a study by Kamen (2018) commented: “When I talked to the nurse about my dissatisfaction with how they treated my partner, the nurse apologised and said that he assumed we were just friends because my partner is both African-American and younger than me” (n.p.).

2.5.1 Queering cancer

Despite bearing “a disproportionate cancer burden”, SGM people with cancer may not come out to healthcare professionals because they don’t feel safe (Griggs et al., 2017, p. 2203). Most cancer support services are organised around the needs of straight and cisgender patients and may not be suitable for SGM people (Kamen, 2018). For example, going to support groups primarily attended by heterosexual male partners may be uncomfortable for lesbians and their partners (Macmillan, 2014). Support groups specifically organised for SGM patients and their loved ones can help them gain a sense of control and normalise some of the difficult experiences associated with a cancer journey without them having to come out or feel different (Macmillan, 2014; Sinding, Barnoff, & Grassau, 2004). After her cancer surgery, for example, Audre Lorde (1980) said: “I wanted to talk to a lesbian, to sit down and start from a common language, no matter how diverse. I wanted to share dyke-insight, so to speak” (p. 50). LG support groups are available in some larger urban centres – but are fairly uncommon.

There is a lack of readily discoverable information about and for queer cancer patients and their loved ones. Patient education materials, provider knowledge and online content are oriented towards heterosexual and cisgender patients. Written materials are beginning to change—many now use the word “partner” for example—but sexuality-related needs are often not well met. This is often because “many LGBT people engage in sexual practices that may not be addressed in printed material and may be beyond the scope of knowledge or comfort of medical and social service professionals” Kamen, 2018, p. 57). When asked what advice they would give HCPs working with LGBTQ patients with cancer, respondents recommended that staff develop a list of local services and providers that are welcoming to SGM people (Margolies & Scout, 2013).

Gay “families of choice” can be a significant source of love and help during a crisis, as birth families may be estranged or relationships problematic, and a cancer diagnosis can strain these familial bonds further. Compared to heterosexuals, SGM people with cancer are less likely to rely on support from their birth family:

Since my biological family refuses to have any contact with me, it is essential to my health and survival that they understand that my partner IS MY FAMILY and when they treat him as such my outcomes are much better. (Kamen, 2018, n.p.)

In one internet-based study, 77% of the LGBT participants stated that their friends were their primary support system during treatment, compared to 62% who said it was their partner. Heterosexual and cisgender respondents are more likely to cite their spouse as their primary source of support (Margolies & Scout, 2013; Northouse, Williams, Given, & McCorkle, 2012). Dunham (2016) describes caring for her dying partner with her “large, extremely unorthodox queer family” (p. 81) and dealing with the restrictive rules around visiting. She comments, “the staff got the partner part. What they didn’t get was who the hell all these other people were” (p. 83). Expanding how families are defined is an important element of care for sexual and gender minority patients.

Cancer survivorship is likewise complicated for sexual and gender minority patients. As patients transition from a structured and (relatively) supported healthcare environment they have to adapt to their new identity as a cancer survivor and integrate it with their other identities (Kamen, 2018). There’s some emerging evidence that the layering of a new (often stigmatized) identity on top of a sexual or gender minority identity can compound psychological distress (Knapp, Marziliano, & Moyer, 2014).

“Queering” cancer—or surfacing “queer subjectivities within dominant discourse”—also uncovers issues of how gender is constituted within the cancer narrative (Nielsen, 2015, p. 49). Many cancers are commonly designated as “women’s” (e.g. breast and gynaecological) or

“men’s” cancers (e.g. prostate and testicular). For some queer people who experience gender in a non-normative way the “restricted gendering of cancer patient care environments can cause a significant amount of distress in an already challenging period of cancer treatment” (Taylor & Bryson, 2015, p. 6). Perhaps out of all the cancer types, breast cancer is the most relentlessly gendered as well as the most common cancer treated by radiation therapy, so I will briefly discuss literature addressing breast cancer specifically.

Lochlann Jain (2007) writes, “Breast cancer demands a surrender to femininity and to the mortality doled out by the feminine body” (p. 505). Many breast cancer services are developed for, and marketed to, heterosexual and feminine-presenting women, which can be problematic for non-heterosexual, masculine-presenting women or men with breast cancer, including trans men (Ehrenreich, 2001). Additionally, treatment decisions may vary depending on the patient’s felt sense of gender. In Bryson et al.’s (2018) *Cancer’s Margins* project, for example, participants “deployed queer and trans narratives that provided them opportunities for agency in electing other outcomes, like ‘going flat’ after mastectomy” (n.p.).

Some contend that the constellation of risk factors associated with lesbians, such as increased smoking and drinking, coupled with a decreased likelihood of birthing and breastfeeding, results in an increased prevalence of breast cancer for this group (Institute of Medicine, 2011). Others disagree, but we do know that lesbians are less likely to attend for cancer screening, and generally have worse experiences of care than heterosexual women (Institute of Medicine, 2011).

Forty years ago, Audre Lorde (1980) famously protested the societal pressure exerted on her to cover up her cancer by wearing a prosthesis saying, “I refuse to have my scars hidden or trivialized behind lambswool or silicone gel” (p. 60). Today women are still pushed towards disguising the results of cancer and its treatments, and to conform to expected gender norms. In

a study by Kamen (2018), one participant wrote, “When I was crying in her office, a well-meaning oncology social worker suggested I go to a make-up class³¹....I told her, ‘I’m kind of a butch lesbian. I just don’t understand that stuff’” (n.p.). In a similar fashion, Eve Kosofsky Sedgwick’s (1992) reaction when diagnosed with breast cancer was “Shit, now I guess I really must be a woman” (p. 202). She talks about her anger throughout her breast cancer experience:

A meeting of the hospital-organised breast cancer support group, being told by a social worker that with proper toning exercise, makeup, wigs, and a well-fitting prosthesis, we could feel as feminine as we ever had and no one (i.e. no man) would ever need to know. (p. 203)

Advice and patient education material likewise generally demonstrate “traditional” gender roles, for example pamphlets that inform women how long they need to refrain from washing walls after their mastectomies (Lochlann Jain, 2007). Where do the androgynous, the butch fit in this sea of “pink kitsch”? (Ehrenreich, 2001)

2.6 Sexual identity and healthcare professionals

There is a small but growing body of literature that examines the experiences of SGM people working in healthcare (Eliason et al., 2011; Eliason, Streed, & Henne, 2018; Lim & Borski, 2016). Most work focuses on physicians and nurses, but, based on the broader organisational literature, it can be expected that other HCPs also manage their sexual identity in heteronormative workplaces that are affected by discrimination.

SGM HCPs and trainees often report higher levels of stress and lower social support compared to their heterosexual colleagues, and may experience social isolation and discrimination (Eliason et al., 2018; Gubric & Sondheimer, 2014). In a recent US survey of LGBTQ+ HCPs, 38% reported they were not out at work, and (of those who were out) 41% said

³¹ Look Good, Feel Better” is a common class available in cancer clinics sponsored by the cosmetics industry that teaches women to use wigs, hair wraps and make up to “give women with cancer back their womanhood” (“Look Good, Feel Better,” 2017).

that being out had caused them problems in the workplace (Eliason et al., 2018). The highest degree of harassment and discrimination was experienced by trans respondents. In a 2014 survey of medical residents, over half reported actively concealing their sexual identity at work and were far less comfortable than heterosexual residents talking about their partners or bringing them to work events (Lee, Kelz, Dube, & Morris, 2014). However, despite evidence of persistent discrimination, many of Eliason et al.'s (2018) survey participants were engaged in workplace advocacy and providing education to colleagues. LGBT trainees demonstrate a similarly high degree of involvement in LGBT activism and scholarly activities, notwithstanding an underlying lack of mentorship, grant opportunities and curricula representation (Sanchez et al., 2015).

In a study by Rumens and Kerfoot (2009), NHS workers with direct patient contact (such as physicians and paramedics) seemed to demonstrate a greater discomfort with divulging their sexual identity than those in non-clinical roles. Coming out was seen as being “at the expense of patients” (p. 776) and to be discouraged. Disclosure to patients also runs the risk of a negative reaction. Lim and Borski (2016) cite professional ethical codes that oblige HCPs to treat every patient “with unrestricted compassion and respect” (p. 49) and discuss how nurses should respond when confronted with patients who fail to treat them in the same way. One of the authors (Lim) describes a personal incident with a homophobic and abusive patient and poses the (presumably) rhetorical question “should LGB nurses hide their identity to avoid a possible confrontation?” (p. 51).

In a survey study examining the experiences of LGB occupational therapists (OTs) in the US (Falzarano & Pizzi, 2015), three major themes emerged from the data analysis:

1. Deciding when to come out: the decision to disclose their sexual orientation for many respondents “was paramount in their work or patient role” (p. 67) but depended on whether they trusted their colleague or physician.

2. The culture of the setting impacts if and to whom the OT came out: some people were open with fellow HCPs, but not students or patients. Several overtly linked disclosure (or lack of it) with professionalism. Another HCP, who treated mostly older patients, commented that “sometimes I feel I have to lie due to the fact that the older generation have less tolerance/understanding of this community” (p. 68). This concurs with the work of Giddings and Smith (2001), where lesbian nurses working with older patients felt it was inappropriate to be out in their clinical practice.
3. Shades of discrimination affect the work and patient role: many OTs had experienced discrimination at work, directed at themselves, LGB colleagues or patients. This ranged from abuse (such as being called a “homo” and morally corrupt) to respondents’ managers discouraging them from talking about their “personal life” at work (Falzarano & Pizzi, 2015).

These three themes are fairly consistent in the literature that deals with SGM HCPs at work, with some degree of discrimination being the norm, leading to “covering” at work and careful identity management with patients and colleagues (Eliason et al., 2011; Hancock & Haskin, 2015; Heyes et al., 2015; Hughes, 2004; Irwin, 2007; Lapinski & Sexton, 2014; Rondhal et al., 2007).

2.6.1 Diversity and inclusion: SGM healthcare professionals and SGM patients

There is increasing interest in attracting HCPs to care for minoritized patient populations, as well as to fulfil the growing healthcare mandate for “diversity and inclusion”. Many educational institutions are expanding their efforts to recruit (for example) ethnic minority trainees. However, despite increased recruitment, healthcare education tends to homogenize practitioners into neutral workers; the same reductionist medical gaze that is instilled in HCPs during training can likewise strip sociocultural signifiers from trainees. In Beagan’s (2000) study of LGBT medical

students, one participant remarked that “basically you could be a lesbian feminist and come out as a sort of heterosexual white male in your attitudes (laughing)...You [are] being fit into a mold” (p. 1257). Yoshino (2014) has likewise shown that organisations that actively recruit minority groups subsequently implicitly pressure them to conform, thus undermining the very diversity that the organisation needs and claims to value. Tsai (2018) comments that, once they begin training, students recruited to medical schools for their diversity “are told to leave precisely what they bring to the table at the threshold of the hospital” (n.p.). Thus many SGM students are still covering (or concealing) their identities during training (Eliason et al., 2018). Tsai (2018) suggests that “institutional inclusion is promised so long as the under-represented identified remain unobtrusive, so long as they don’t disturb the system” but also tellingly that “these systems cannot be diverse and undisrupted” (n.p.).

Robertson (2017) expands the Foucauldian concept of the medical gaze in his research with LGBT HCPs, claiming the heteronormativity inherent in the healthcare system results in a “heteronormative gaze”—where heterosexuality is the default, and patients’ sexuality only becomes relevant when it concerns pathology³². His participants were able to articulate how being LGBT affected their worldview, and their interactions with patients, but they described the HCP-patient relationship in different terms, “depending on whether they were taking the provider- or patient-subject position” (p. 165). He comments that:

When taking the provider-subject position, many informants denied the importance of their queerness on the practice of medicine, and when it did come up as affecting their work, it was often due to ways patients reacted to their queerness...on the other hand, when informants took the patient-subject position, they had a different perspective on patient-provider interactions. (p. 165)

³² For example, Robertson’s trainee study participants could only recall non-heterosexual patient case studies that involved HIV-positive gay men.

When the participants as patients had “visibilized their queerness” with HCPs who were caring for them, they acknowledged that they had been treated differently because of their sexual minority status. Additionally, many of the participants had not come out to their physicians. Thus, despite claiming that their sexual orientation was unimportant in healthcare encounters, participants recognized that HCP and patient relationships are freighted with impactful “sociocultural baggage” (p. 166).

Robertson’s (2017) participants were asked how being LGBT affected their professional identities. Nearly all said it played very little, or no role at all. Hector³³ (a fourth-year medical student) stated that “your sexuality shouldn’t be part of your profession, it’s part of you, and in that sense it’s important, but I don’t feel like me being gay affects the quality of care I give to patients” (p. 170). Some did comment, however, that being queer may allow them to notice health issues that heterosexual HCPs may miss. Similar to the “professionalism discourse” discussed previously³⁴, Robertson found that his participants strongly felt there was a separation between their professional and their home lives and failed to recognise how their sexual identities may shape their interactions with patients. This “irrelevance narrative” is important in the context of LGBT HCPs because it results in tension between reconciling workplace and non-workplace identities. The irrelevance narrative also serves to bolster the HCP’s heteronormative gaze, as HCPs view sexuality as unimportant to clinical encounters—and sexuality is relegated to pathology (Beagan, 2000).

There is growing evidence that some patients from minority groups feel more comfortable and have better health outcomes when treated by healthcare professionals from the same background (Spitzer, 2004). This kind of strengths-based research examines diversity not as a liability, but as a positive aspect of practitioner identity that can actually improve health care and

³³ A pseudonym

³⁴ See section 2.3.1.

patient experience (Mustanski, 2011; Vaughan, Miles, Parent, & Tilghman, 2014). For example, Black male patients were more likely to undergo preventative screening if it was offered by Black male physicians. The effect was more pronounced with patients who had previously had negative experiences with the healthcare system (Alsan, Garrick, & Graziani, 2018).

Is it likely that marginalised SGM patients may feel more comfortable (or even fare better) with SGM healthcare professionals? In the following example Roger, a gay man, discusses his experience in hospital:

I hardly dared mention a partner and I even found myself begging him not to kiss me when he visited me. His response, as expected, was ‘bollocks to ‘em, I love you’, but on his visits I could see the eyes taking it all in; sorting and codifying the resulting information. I found myself telling him that it was OK for him because he could take our lifestyle back home with him whereas I was left to deal with the consequences. I was profoundly disturbed by having these feelings and I felt guilty about them, but the fact was that there I felt and believed myself to be different. I pondered how much I would have loved to have had some ‘out’ LGBT staff around me, so that I didn’t feel so isolated and had more confidence to be me. (McWilliams, 2016)

A participant in the study by Kamen (2018) commented that “[one of the nurses] told me she was a lesbian, and it really made our encounters more special” (n.p.). Recently the “Rainbow Badges” project in the UK’s National Health Service has attempted to make visible “safe people” for SGM patients “to talk to about matters of gender identity and sexuality” (Rimmer, 2018, n.p.). The badge wearers are expected to educate themselves using a variety of recommended resources, while they do not have to identify as a sexual or gender minority, they need to “understand the message of inclusion that the badge symbolises and the responsibility that comes with wearing one” (Rimmer, 2018, n.p.).

For HCPs “visibilizing queerness” to support SGM patients is not a neutral activity. Coming out at work can be a risky business, depending on how the HCP is positioned socioculturally and professionally. However, clinics and hospitals are effectively social environments where building

patient rapport is important (Robertson, 2017). HCPs who can be open at work can build trust, especially with their SGM patients:

Every doctor-patient interaction is built on trust, and I believe strongly that I have an obligation to be honest. Patients often ask me personal questions about my family Up-front disclosure of my sexual orientation avoids embarrassing people who might otherwise assume I am straight...in general I try to communicate who I am non-verbally by displaying pictures of my family and having gay-friendly posters and health literature in my office. (Potter, 2002, p. 342)

Zingaro (2009) described “helping professionals” working with patients who have experienced a similar discrimination related to their stigmatised identity (such as homophobia) as inhabiting a kind of borderland³⁵. The healthcare professional can choose to purposefully self-disclose (when they feel safe to do so) and use their experience as a “rhetorical and political tool” in their work (p. 19). There is an asymmetry of power between patient and HCP that needs to be acknowledged and possibly managed. Zingaro posits that holding space between the established roles of HCP and patient should involve an ethical way of being responsible for the power that the HCP has in the relationship. Disclosure depends on the setting, the patient relationship, and is a highly contextual decision. This type of boundary-breaking is not without risk for the HCP.

Perhaps a similar concept to Zingaro’s that encourages (careful and thoughtful) self-revelation by healthcare professionals to patients is the therapeutic use of self, a model prevalent in the psychotherapy, nursing and social work literature. The practitioner is encouraged to develop a “highly present and real relationship with a client” (Edwards & Bess, 1998, p. 92). In a study examining the experiences of LGB occupational therapists, one respondent stated that she doesn’t disclose her identity as a lesbian to patients “unless it serves to contribute to the

³⁵ Drawing on the work of Gloria Anzaldúa (1987), who described border-dwellers as “those who cross over, pass over, or go through the confines of the ‘normal’” such as “the squint-eyed, the perverse, the queer, the troublesome” (p. 25). The border is inhabited as a lived space, where two worlds merge (Anzaldúa, 1987).

therapeutic process”, implying that disclosure may allow her to form a bond with LGB clients (Falzarano & Pizzi, 2015, p. 70).

It is worth noting that SGM HCPs are also likely to be SGM patients, even if only of their family doctor and dentist. Robertson (2017) has shown that some SGM HCPs are aware from personal experience that the healthcare setting can be heteronormative, or even homophobic. Despite this, they feel that their sexual orientation has little bearing on how they deliver care to patients, although some did suggest they may have a heightened awareness of SGM-specific health issues. Falzarano and Pizzi (2015), on the other hand, found that experiencing negative treatment in a patient role can influence and colour the workplace and can sometimes affect work with LGB patients for their OT respondents.

The positive aspect of disclosure at work has not been well explored from the perspective of LGBTQ patients; the majority of research sees homosexuality in healthcare as a risk to be managed. Perhaps another reason why this is a relatively unexplored area is the ability of queer patients and healthcare professionals to pass (as straight) in the healthcare system and the lingering stigma associated with SGM identities.

2.7 Summary: Going forward

LGBT health professionals, through their “lived experiences” and professional training, can help inform and lead the charge in LGBT health advocacy, research, education and community service. Moreover, the inclusion of LGBT health professionals by academic health centres can aide in meeting the unique healthcare needs of their LGBT patients. (Sanchez et al., 2015, p. 346)

It is clear that many LGB people still engage in identity management, and that coming out (or not) is highly contextual (Orne, 2011). Additionally, sexual orientation still needs to be managed at work, and disclosure is a complicated process of deciding where, when and who is safe. The heteronormative healthcare culture serves to mask queer identities in both HCPs and patients, despite recent efforts (influenced by changing legislation) to improve patient experiences. The literature that deals with LGB HCPs mainly examines the experiences of physicians and nurses, and work with allied health professionals is extremely sparse. We have also seen that the discourse of professionalism discourages “being our authentic self” at work and can make the act of uncovering a risky one for “bordered” HCPs (Zingaro, 2009). This is compounded by the “irrelevance narrative” that results in a dissonant relationship between workplace and non-workplace identities for HCPs (Robertson, 2017).

However, we know from other examples of minoritized populations that being cared for by queer healthcare professionals may help mitigate poor experiences for queer patients. There is evidence that out LGB HCPs can sometimes make a difference in the experiences of LGB patients although currently very little research exists (McWilliams, 2016). It seems likely that improving the healthcare environment so HCPs “can be open about their identities in the professional setting” would be beneficial for both patients and staff (Radix & Maingi, 2018, p. 89). Respectful disclosure by LGB HCPs to LGB patients should be, “a responsible act of agency by an ethical subject, working to create a bridge of empathy and compassion” (Zingaro, 2009, p. 156).

Chapter 3: Methodology

The truth about stories is that that's all we are (King, 2003, p. 2).

3.1 Introduction

In this chapter I discuss the methodological approaches of narrative inquiry and autoethnography as used in this research. I further comment on how (and where) reflexive analysis has been used to foreground my role as co-participant and how this may have shaped the process and results. The research process is outlined, including an introduction to my participants and the multiple audiences I hope to reach. Finally, I consider various ethical issues pertaining to narrative inquiry work.

3.2 Methodological approach: Narrative inquiry

Narrative inquiry (NI) is “the study of the ways humans experience the world” (Connelly & Clandinin, 1990, p. 2). The “narrative turn” has recently grown in popularity, especially in the social sciences, in fieldwork, conversations, stories of social change and a wide variety of other areas (Holstein & Gubrum, 2012; Riessman, 2008). People make sense of their lives through story, and narrative inquiry researchers gather these tales using various approaches (such as interviews, journaling, letters and observation) and tell stories about them; my research results are thus also presented in a narrative form.

Narratives suffuse our lives. We find them in written, oral or visual text such as “myth, fable, short story, epic, history, tragedy, comedy, painting, dance, stained glass windows, cinema, social histories, fairy tales, novels, science schema, comic strips, conversation and journal articles” (Richardson, 1990, p. 117). We make sense of our lives and our experiences through storied reflection and writing. Laurel Richardson (2000a) claims that writing is a way of knowing: “I write because I want to find something out. I write in order to learn something that I didn’t know

before I wrote it" (p. 942). Joan Didion (1979) suggests that we turn to narrative to make meaning from difficult life events when she states that "we tell ourselves stories in order to live" (p. 11). Jerome Bruner (1991) goes further when he claims that narratives actually reconstitute experience and organize memory, "constructing and representing the rich and messy domain of human interaction" (p. 4). People, Bruner argues, become the stories they tell about their lives. Thus the use of narrative, or literature, brings harmony to the dissonance of chaotic life events "by means of the invention of a plot" (Carr, 1986, p. 119).

In the simplest terms, narrative is "someone telling someone else that something happened"—thus presupposing both a teller and a listener (Smith, 1980, p. 228). Humans share the same "experiences of desire, fear, relationship, birth and death, pain and fear, joy and sorrow" (Leggo, 2011, p. 9). These stories may vary in context but are familiar to us and provide a wellspring from which to draw when we seek to articulate an experience: "We get our language back through the language of others. We can turn to the poem. We can open the book. Somebody has been there for us and deep-dived the words" (Winterson, 2012, p. 9).

There is a spectrum of research under the broad grouping of NI. At one end, the investigator treats narrative as data that is analysed in categories or themes, which may sometimes be represented numerically. At the other end, researchers gather information and present it as a story or stories. This is succinctly described by Polkinghorne (1995) as analysis of narratives, and narrative analysis respectively where "analysis of narratives moves from stories to common elements, and narrative analysis moves from elements to stories" (p. 12). NI has been used across many disciplines, including sociology, educational research, healthcare and organizational studies but is always founded in relationships and personal experience (Haydon et al., 2018).

My interest lies in the storytelling end of the spectrum, creating narratives from research “data” such as interview transcripts.³⁶ However, writing and storytelling are not neutral activities. NI aligns with the constructivist view that research cannot be done from a purely objective stance, and the writer/researcher’s positionality will suffuse each step, from deciding what stories to tell (or not tell), to the interactions with participants to the way the final story is presented (Ellis, Adams, & Bochner, 2011; Ellis & Berger, 2001).

Narratives are fictionalised versions of real life (Greenhalgh et al., 2016, p. 9). This research does not represent ‘historical truth’ but instead examines the meaning made of these historical truths by the research participants (Loh, 2013). Indeed:

Storied evidence is gathered not to determine if events actually happened but about the meaning experienced by people whether or not the events are accurately described Storied texts serve as evidence for personal meaning, not for the factual occurrence of the events reported in the stories. (Polkinghorne, 2007, p. 479)

Taking this approach has raised some eyebrows in my (mostly positivistic) professional peer group, as perhaps my peers feel that the work is “too artful and not scientific” (Ellis et al., 2011, p. 283). Moreover, examining personal identity or circumstance can risk accusations of “navel gazing” or narcissism. Ellis et al. (2011) counter with the view that research can blend *both* art and science, and also be “rigorous, theoretical, and analytical and emotional, therapeutic and inclusive of personal and social phenomena” (p. 283). Or, as Behar (1997) puts it, be a “borderland between passion and intellect, analysis and subjectivity...art and life” (p. 174).

3.2.1 Why choose narrative inquiry?

The focus of my research is *coming out*, a story that is told about the claiming of a new identity. The way the coming out story is told varies, because people and their circumstances are different,

³⁶ In my research, mutual storytelling with participants and the results presented as a series of short stories.

but telling it serves to make sense of an identity that stands outside the heterosexual norm. NI honours the significance and integrity of the narrative form in the meaning-making that occurs with the ongoing work of identity management.

The type of NI that I am using is co-constructed autoethnography because my story is interwoven with those of my participants. Autoethnography is defined as “an autobiographical genre of writing and research that displays multiple levels of consciousness, connecting the personal to the cultural” (Ellis & Bochner, 2000, p. 739). In this approach, the relationship between the researcher and participants is central; there should be a feeling of trust and connectedness as the story is told and perhaps retold. Histories are gathered “at the intersection of human experience and social context” with the researcher involved in the story in a way that challenges the traditional value-neutral claim of research (Cole & Knowles, 2001, p. 9). Autoethnography also “claims the conventions of literary writing” and uses emotion, scenes, embodiment, plot and dialogue to create a rich literary portrayal of the data (Ellis, 2004, p. xix).

Autoethnographers view research as an overtly political and socially just act that turns away from the “canonical forms of doing and writing (such as) a White, masculine, heterosexual, middle/upper classed, Christian able-bodied perspective” (Ellis et al., 2011, p. 275). This aligns with my critical theory approach and the emancipatory intent of telling the story of an often invisible group working within a heteronormative environment. Additionally, engaging myself and friends as participants feels transgressive when compared to my usual healthcare academic research framed in the reductionist logical-scientific framework. Personal and evocative writing demands a different writing style than “that academic voice that I have learned to turn on and off like a faucet” (Behar, 1997, p. 165).

I have found the work of Ellis, as well as that of Clandinin and Connelly most generative for my research. Carolyn Ellis is an autoethnographer and one of the first women to lead the shift

to narrative and evocative writing with her early work (Riessman, 2008). She continues to carry out research in areas such as death and dying and health and illness. I am attracted to her overtly feminist and emancipatory inquiry style, as well as her use of creative non-fiction to communicate her research results. She often collaborates with “intimate others” and has published highly personal accounts about her relationships, as well as turbulent events in her family, using a frank and accessible writing style. She is aware that for researchers working with friends as participants, “there is no leaving the field” (Ellis, 2007, p. 13). Her methodological textbook on autoethnography (*The Ethnographic I*) demonstrates how to layer fiction, theory and research in an extremely readable way.

Michael Connelly and Jean Clandinin are highly influential narrative inquirers with a long history of publication and academic activity. Their approach is founded on Dewey's (1938) “theory of experience” and has been used extensively in educational research. Similar to Ellis, they advocate for “living alongside” participants and “telling our own stories, hearing another’s stories, moving in and acting in the places—the contexts—in which our lives meet” (Clandinin, 2013, p. 23). According to Clandinin and Connelly (2000), narratives have three essential elements, namely temporality, sociality, and place. In this three-dimensional narrative inquiry space researchers and participants “attend to the inward, outward, forward, and backward movements that make up our experiences” (Clandinin et al., 2015, p. 24).

Clandinin and Connelly outline a three-phase (but iterative) process for narrative inquiry, using a series of texts co-created with participants; from those developed in the field to the final research text that describes “the social, and cultural, and institutional narratives within which individuals’ experiences were constituted, shaped, expressed and enacted” (Clandinin & Rosiek, 2012, p. 40). Their process was useful to conceptualise the stages of my research, allowing me to organize the practicalities of working with participants, developing texts and subsequently

writing stories in a way that was evidenced, and successfully used, by numerous previous researchers.

Ellis, Clandinin and Connelly have similarities in their approach; they all advocate for the “narrative turn” and are invested in improving institutions and promoting social justice and equality (Ellis, 2004). I saw Ellis as supporting the heart and emotionality of my work, while Clandinin and Connelly provided steady guiding hands with the logistics.

3.3 Reflexivity

Reflexivity, where the researcher thoughtfully considers how her standpoint, positionality or simply her presence has influenced the research, can sometimes be a tokenistic afterthought in qualitative research. For narrative inquiry, however, it is clear that the studied landscape can only be described through the lens of the researcher and that reflexivity is one of its defining features (Denzin & Lincoln, 2000; Finlay, 2002a). Hertz (1997) describes reflexivity as researchers having “an ongoing conversation about the experience while simultaneously living in the moment” (Hertz, 1997 as cited in Finlay, 2002b, p. viii). To demonstrate the trustworthiness³⁷ of qualitative research, inquirers must examine how their inherent subjectivity may have shaped both the process and the outcome (Finlay, 2002b).

Finlay (2002b) states that the process of reflexive analysis should begin when the research idea is being conceived. For the duration of my doctorate, to attempt to bring my research into focus, I have been reflecting on my learning, including what it means to me in my personal and professional life. I have also been considering what my final research project would involve. I was already using social media (mainly Twitter) and I would initially share what I was doing in the classroom, how I felt about our assignments, interesting papers we were reading etc. Eventually I wanted to expand on some of these ideas beyond the restrictions of the Twitter

³⁷ See section 3.4.

platform, and I started a blog on the WordPress site. For this chapter (and the Introduction), I have used sections from this blog (“Doctoral Brain Dump”).

The blog entries evolved as I became more comfortable with sharing ideas online. Eventually I began to write about topics that were linked to my research interest but that were over and above “what I was doing in my doctorate” (for example, about presenting papers on LGBTQ healthcare and revising heteronormative patient education materials to be more inclusive). This aligned with my increased comfort with my chosen topic and my involvement in other professional and personal related projects. Ellis (2004) described the use of blogging by researchers as field text³⁸, depending on the depth of discussion, interactivity with readers and intended audience. Comments on my blog posts from other researchers doing similar work have led me to papers I may have missed, as well as generated ideas, provided support and facilitated new connections.

In addition to the blog, I kept a research journal as a strategy of reflexivity (Baille, 2015). As I started to carry out my research I wrote in the journal more frequently and I have also used sections from the journal in this chapter. Reflexive analysis also occurred as I wrote field notes before and after each participant conversation and jotted down scraps of stories and poems as I thought about how the sessions were unfolding. I also took a series of pictures of the places I had met with my participants, as well as familiar spaces at the cancer centre where I carried out the

³⁸ For a further description of field texts, see section 3.6.1.

research that evoked particular memories and feelings. The images helped me recall the physical and emotional locations as I wrote my interim and research texts.

I attempted to wrestle with the idea of reflection and reflexivity and why I was blogging (including some early thoughts about co-created research and the risks of over focussing on one's own thoughts and experiences) in this post, dated March 2016:

What we're reading about in class (and what I love the idea of) is ... research as a process of joint collaboration with the participants using "cycles of mutual reflection and experience" to create the data together (Finlay, 2002a, p. 218). Examples include co-operative inquiry or interactive interviewing. This type of investigation goes way beyond reflection and plumbs the murky depths of reflexivity to expose the values, motivations, assumptions that may never have been brought to the surface. But, we are warned, there is a fine line between reflexivity and self-indulgent mental meanderings when the whole process becomes all about us. Finlay (2002a) warns us to eschew the "infinite regress"—the falling inward that paralyzes the process and loses us in the downward spiral of our own navel gazing.

It's a fascinating process—even as part of the pre-research stage we should be mulling over our "motivations, assumptions, and interests in the research" (Finlay, 2002b, p. 536). This blogging, the classroom discussions, talking it over with my friends, tweeting and journaling are all attempts to do this, to pull something coherent out of the initial ideas and concepts that are the raw stuff of my future dissertation and to find the right balance between infinite regress and simplistic reflection. (Bolderston, 2016)

Finally, I bookended the stories that constitute my research texts (my results section) with a reflexive preface (Coming Out/Coming Back) and postscript (Telling Stories) which are an explicit "self-aware meta-analysis of the research process" as well as being semi-fictionalised versions of events (Finlay, 2002b, p. 531).

3.4 Trustworthiness

As qualitative researchers engaged in contemporary practice, we accept that the researcher is a central figure who influences, if not actively constructs, the collection, selection and interpretation of data. We recognise that the data is co-constituted, a joint product of the participants, researcher and their relationship. We understand that

meanings are negotiated, within particular social contexts so that another researcher will unfold a different story. (Finlay, 2002a, p. 212)

It has been recognized that establishing trustworthiness for researchers conducting qualitative research is similar to the more quantitative concepts of validity and reliability (Creswell, 2013). Tracy (2010) comments that there are many criteria cited in the literature for establishing qualitative credibility; the proliferation of ideas and labels “undeniably illustrates the creative complexity of the qualitative methodological landscape” (p. 837). I have used one of the most established terms, namely Lincoln and Guba’s (1985) ‘trustworthiness³⁹’, as “one that is widely recognized and accepted in the broader field of qualitative research” (Loh, 2013). For narrative inquiry, Clandinin and Connelly (2000) have remarked that credibility claims are evolving and in-development and simply say they “encourage narrative inquirers to be thoughtful” (p. 188). Additionally they comment that “it is currently the case that each inquirer must search for, and defend, the criteria that best apply to his or her work” (Connelly & Clandinin, 1990, p. 7).

Tracy (2010) refers to “quality criteria” to “serve as a shorthand” for the core values of qualitative methodological best practices and concepts of trustworthiness (p. 838). She suggests a general set of eight principles that can be applied across most qualitative paradigms to provide a “parsimonious pedagogical tool” for researchers (p. 839). These are: worthy topic, rich rigor, sincerity, credibility, resonance, significant contribution, ethics, and meaningful coherence. Laurel Richardson (2000b) has additionally posed five criteria specifically related to autoethnography, namely substantive contribution to the field, aesthetic merit, reflexivity, impact on the reader and an evocative expression of a reality (lived experience). I would argue these are substantially the same as Tracy’s criteria of significant contribution, resonance and sincerity; in the following

³⁹ With the caveat that Lincoln and Guba (1985) criteria include some that are not appropriate for use in NI (e.g. audit trails).

section I use Tracy's work as an overarching frame to reflect on how this research has met these quality criteria.

3.4.1 A worthy topic

While definitions of worth may vary, Tracy (2010) contends that a topic should be "relevant, timely, significant, interesting or evocative" (p. 840). The topic of LG RTs and their professional identity work is obviously both significant and interesting to me. The research supports my values and beliefs, and strongly aligns with the "the sort of researcher/academic (I) want to be and be seen as being" (Sikes, 2006b, p. 107).

More broadly, RTs are a little-known healthcare occupational group, but even in the wider field of allied health professions, the experiences of LG workers are not well understood. There is growing interest in improving the care of LGBTQ patients and having well-supported and visible similarly-positioned HCPs. This research aims to contribute to this developing conversation and add to the evidence.

3.4.2 Rich rigor

This criterion speaks to the availability and evidence of rich, appropriate and complex theoretical constructs, data, sample, context, data collection and analysis (Tracy, 2010). I have framed this work using a critical theory lens, and I have been explicit in describing my main methodological influences and tensions⁴⁰. In this chapter I have thoroughly detailed the process undertaken, and how I moved from collecting the data (field texts) to presenting it (stories or research texts). Creswell (2013) also comments that the researcher's degree of closeness to the research

⁴⁰ See section 1.7.

participants can add rigor to the results. My use of “friendship as method” speaks to this with a high degree of involvement from my participants (Tillmann-Healy, 2003).

Tracy (2010) suggests that “a researcher with a head full of theories and a case full of abundant data is best prepared to see nuance and complexity” (p. 841). In other words, a ‘richly rigorous’ researcher ensures the data are sufficient and significant given the context of the study and that the approach and procedures are appropriate. While there is no ‘right’ amount of time in the field or amount of data, the study was conceived and designed over several years and well supported by numerous reviews and discussions with peers, university faculty and other researchers (e.g. presentations at UBC).

3.4.3 Sincerity

Sincerity refers to authenticity, vulnerability and honesty and is typically characterised by self-reflexivity and transparency (Tracy, 2010). Reflexivity is a valuable tool that foregrounds the perspective, presence and position of the researcher as well as allows the integrity of the work to be scrutinized by the reader (Finlay, 2002a). Ultimately the work should contain enough self-awareness and self-exposure to allow the reader to make their own judgement about the writer’s point of view (Richardson, 2000b). This work contains a section on reflexivity⁴¹ that details the steps taken to evaluate the ways in which my social positionality has coloured my interpretation of the research experience.

Transparency is honesty in describing the process of research, or a “methodologically self-critical account of how the research was done” (Seale, 1999, p. 468). This is exemplified by a “disclosure of the study’s challenges and unexpected twists and turns” (Tracy, 2010, p. 842). I have been transparent in laying out both what went well, and what was challenging as I carried

⁴¹ See section 3.3.

out the research in this Methodology chapter. This has been enriched with the use of notes from my research journals and blog.

3.4.4 Credibility

Tracy (2010) describes credibility as trustworthiness, plausibility and verisimilitude using strategies like thick description, multivocality and member reflections. For research that produces narrative texts, credibility is an important consideration. The result has to resonate with the reader's experience of human behaviour and "how things work" (Polkinghorne, 1995). It should also evoke in the reader "a feeling that the experience described is lifelike, believable and possible" (Ellis, 2004, p. 124). Credibility in narrative inquiry relies on such questions as "could the narrator have had the experiences described?" (Ellis, Adams, & Bochner, 2011, p. 282). Additionally, does the story "enable the reader to enter the subjective world of the teller—to see the world from his or her point of view even if this world does not 'match reality'" (Plummer, 2001, p. 401)?

Connelly and Clandinin (1990) state that truth claims of the final literary work should be based on whether they are coherent and plausible based on the contextual and situated nature of the original "data" or texts, or its "explanatory power". To increase credibility and dependability as I wrote the stories I relied on my own experience as an LG RT, my participants' stories as well as the research literature. I read a number of patient blogs, short fiction and online chat forums as I wrote "A Lesbian Breast Cancer Story". I was careful to ground the protagonist's experience in reality as much as possible. I also shared the story-in-progress with a friend undergoing treatment for breast cancer. From her comments, I felt that it was fairly accurate at reflecting the process of managing medical appointments and reactions from friends and family. The interiority of emotions associated with diagnosis and early treatment are obviously highly personal, but I

have witnessed many similar conversations in my professional life and talked to patients afterwards, and my friends and family have been patients who have undergone treatment for cancer⁴².

One of the criteria of trustworthiness described by Denzin and Lincoln (2000) is fairness. This is described as “a quality of balance; that is, all stakeholder views, perspectives, claims, concerns and voices should be apparent in the text” (Denzin and Lincoln, 2000, p. 207). This is similar to Tracy’s (2010) “multivocality” or attention to multiple viewpoints or voices and perhaps also the concept of member checking or member reflections. In checking back with my participants as I wrote the research texts, I provided them with “an opportunity to provide context and an alternative interpretation” (Patton, 2002, p. 561). Additionally, in balancing carefully the perspectives and stories of the participants, myself and the broader research community, I have provided a thick and contextually rich account of the subject (Ellis & Bochner, 2000).

3.4.5 Resonance

Resonance refers to the work’s ability to engender an empathetic response in the reader who may have no direct experience of the topic or “whether it helps readers communicate with others different from themselves” (Ellis et al., 2011, p. 282). Tillmann-Healy (2003) contends that reader engagement can occur on multiple levels, “intellectually, aesthetically, emotionally, ethically and politically” (p. 736).

⁴² There is, however, a risk in speaking for others as I have done here (Alcoff, 1991). My social location is a HCP, not a patient with diminished agency in a highly rigid and provider-centric healthcare system. In feminist work we want to give voice to the traditionally voiceless, but some view the practice of speaking for others as “arrogant, vain, unethical and politically illegitimate” (Alcoff, 1991, p. 6). However, perhaps if we have power, and we do not speak, we relinquish our political responsibility. I take that perspective with the understanding that the discursive context is a particular fictionalised piece of work (within my dissertation) and within a specific critical theory framework. I turn to Spivak who claims that privileged intellectuals (among whom I must count myself) should engage instead in a “speaking to” the oppressed group and allow what she deems a “countersentence” that might lead to a new narrative (Spivak, 1985).

Tracy (2010) states that resonance is achieved through aesthetic merit, evocative writing and generalisation or transferability. Polkinghorne (1995) asks “Does it work as a piece of fiction and provide the reader with insight and understanding?” (p. 20). As I explain further in section 3.5.3, to write the stories that constitute my results section I had to pay attention to the typical elements of story-writing including genre, scene, plot development and tempo (Clandinin & Connelly, 2000). To make the stories more “artful and evocative”, I varied the authorial points of view and used first-person at times to indicate the immediacy of an ‘eyewitness account’ (Ellis et al., 2011, p. 277). Transferability can mean that readers can relate to the experience described, or feel that they have experienced it themselves (Tracy, 2010). This is especially true in work within marginalised communities, which evoke common aspects of experience and connection (Ellis, 2004). I hope this is true and that it can serve to illuminate the experiences of LG RTs and patients in both an educative and potentially emancipatory way.

3.4.6 Significant contribution

Tracy (2010) writes that when judging a study’s contribution, we should ask if the study extends knowledge, improves practice or serves to liberate or empower. Similarly, Conrad et al. (2006) have commented that for researchers in the critical paradigm, one element of trustworthiness can be framed as whether the research “erodes ignorance and misapprehension” (p. 409). In line with my critical theory approach, I seek to expose and contest oppressive heteronormative structures within healthcare and use my privilege to effect change to improve the experiences of LG people.

Tillmann-Healy (2003) states that “as researchers, we use our speaking and writing skills and our position as scholars and critics in ways that transform and uplift our research, local and global communities” (p. 735). Since beginning this research, I have worked to improve the experiences of LGBTQ patients within the cancer care system. Specifically, I have evaluated and redesigned patient education material to improve inclusivity, advocated to redesign intake forms

to include sexual orientation and gender identity, delivered training for staff on LGBTQ healthcare and presented similar sessions at international conferences. As part of a national group involved in a project to develop a website for LGBTQ people with cancer, I been interviewed for a podcast, set up a social media profile for the endeavour, and connected with renowned international researchers. I've published two papers in this area and am currently working on a new research project to evaluate the LGBTQ content in an undergraduate curriculum for radiation therapy students. It's fair to say that my doctoral research has significantly influenced my career and interests, and I would argue my work has already made an impact in my community of practice.

Finally, Tracy (2010) claims another way of assessing significance is what she calls methodological significance, if the approach contributes towards new ways of doing things. The use of qualitative research is uncommon in my field, and publications using a qualitative approach are lacking (Bolderston, 2014). Work that uses narrative inquiry adds a much-needed perspective to the knowledge base and is readily accessible to many audiences. I hope that this project will encourage other researchers to follow.

3.4.7 Ethical

Ethics are undeniably important to all research paradigms, and ethical considerations in qualitative work include issues of reflexivity and multivocality (Tracy, 2010). However, Ellis (2007) claims that "not only are there ethical questions about doing autoethnography, but that autoethnography itself is an ethical practice" (p. 26). I provide a description of the various ethical

concerns involved in conducting this research including procedural ethics, relational ethics and exiting ethics, and how they have been addressed in section 3.7.

3.4.8 Meaningful coherence

Studies that are meaningfully coherent “plausibly accomplish what they espouse to be about” (Tracy, 2010, p. 848). This includes using appropriate methods and meaningfully interweaving the literature, research questions and findings with each other. The intent of this study was to examine the experiences of lesbian and gay radiation therapists managing their sexual identity at work and to look at how their identity work affects their relationships with other RTs and patients. Hearn and Parkin (1995) suggest that “sexuality is private, intensely felt, and often kept secret in organizations as elsewhere”; thus they suggest a qualitative approach which considers the emotional nature of the relationship of the researcher to the work (p. 41).⁴³ The research was carried out with a critical theory framework in the conception, process and analysis stages. This is extensively discussed in the introduction.⁴⁴ My literature review situated the results and discussion within the wider field and informed the shaping of the stories. I have also explicitly re-addressed each of my research questions in the discussion. My final conclusion re-visits my results section and ties up the dissertation in an appropriately narratively coherent manner.

3.5 Process and participants

The method of enacting co-constructed autoethnography that I employed was interactive interviewing, a process that positions the researcher in an overtly collaborative and participatory role, compared to the supposed neutrality of traditional interviewing. Typically, structured or semi-structured interviews are hierarchical processes that are dominated by the researcher who comes

⁴³ Hearn and Parkin (1995) continue to say, “the interaction between the qualitative nature of the topic and any methods adopted, in our experience, is such that the process of researching sexuality in organisations has a *doubly qualitative* character” (p. 44).

⁴⁴ See section 1.5.

with a specific set of questions (Clandinin & Connelly, 2000). In contrast, interactive interviewing acknowledges that the experience and insight that the researcher brings to the session are equal in importance to those of the other participants. For feminist researchers using interviews, “the specific wording of a question is less important than the interviewer’s emotional attentiveness and engagement and the degree of reciprocity in the conversation” (Riessman, 2008, p. 24). Clandinin and Connelly (2000) go further and simply call this process conversation. These types of conversations can often occur in a small group setting with people who have a past history or are friends (Ellis & Berger, 2001). The mutual storytelling can be presented by the researcher in a narrative format, for example as a series of vignettes, a short story or poetry.

To examine the issue of LG RTs and how coming out might affect their work-based relationships, I shared stories and conversation with three LGB friends and professional colleagues who are RTs (described below with names changed). I purposefully sampled, and spoke with, RTs who are known to me from a large urban cancer centre (LUCC) in Toronto, Ontario. LUCC was my “growing up place”—both as an RT and as a lesbian, the physical location as well as the long history that I have with those I “grew up” with is an important part of how the research was conceptualised and how it unfolded (St. Pierre, 1997).

The four participants are:

Amanda: identifies as a cisgender lesbian and worked at LUCC for 15 years in clinical, administrative and educational roles. I now live in Edmonton, Alberta, and I am a faculty member at the University, teaching in the Faculty of Medicine and Dentistry. I have two children and live with my partner.

Naomi: identifies as a cisgender lesbian and works in a primarily clinical role (e.g. directly patient-facing). She is recently married with a young child. Originally from a small town in Northern Ontario, she has worked at LUCC for over 10 years. I have been friends with Naomi for about 15 years.

Ben: identifies as a gay cisgender male and is living with his partner. He has a split academic and clinical role. He is from Toronto and has worked at LUCC for about 15 years. Ben and I have been friends for about 12 years; we have become closer in the last few years as I began to consider (and talk about) LGB research.

Sue: is a retired manager. Originally from outside Canada she worked at LUCC for 30 years in a series of clinical and then administrative roles. She identifies as a cisgender lesbian and is recently divorced with no children. Sue interviewed me 30 years ago in the United Kingdom for my first job in Canada; she was my long-time manager at LUCC and my friend.

I have weaved Sue, Naomi and Ben's narratives with my own experiences and presented the subsequent fictionalized stories as the results section of my final dissertation. The process that I used is based on Clandinin and Connolly's approach (2000). It involved using a series of field texts to produce interim texts and subsequently final research texts. I found that the stages were rarely linear, and that I moved back and forth between field texts, interim texts and final research texts as I navigated the process.

3.5.1 Audience

Autoethnographers possess a particular cultural identity and study their culture's values, practices and beliefs to help their audience (both cultural members and outsiders) understand the culture better. This is perhaps similar to the practice of "making the strange familiar and the familiar strange"—widely attributed to interpretivist research generally by (e.g.) Biesta et al. (2011). Autoethnographers' research experiences, presented as fictionalised and accessible texts, can "reach wider and more diverse mass audiences that traditional research usually disregards" (Ellis et al., 2011, p. 277). Their first audience are their participants, and research experiences are

written with them in mind; “we struggle to write both honestly and empathically for them” (Tillmann-Healy, 2003, p. 735).

As a radiation therapist I am part of a niche healthcare group, whose practices and norms are unfamiliar to many people. As a lesbian radiation therapist, I am a member of a subculture within that culture. My “insider” audience are healthcare students or practitioners who are interested in learning about the experiences of LG people in their workspace. I envision the stories being used in classrooms with undergraduate healthcare students and as a novel method of professional development for HCPs to help them “reimagine the way in which they practice and the ways in which they relate to others” (Clandinin, 2013, p. 51). I also hope the “outsider” academic audience who read my dissertation, subsequent journal papers and presentations will discover an accessible and evocative entry into this underrepresented area that may “open up the possibility of dialogue, collaboration and relationship” (Ellis, 2004, p. 194).

3.6 From field to research texts

The three-stage process described by Clandinin and Connelly (2000) involves progressively working with the participants using a series of texts to co-create a narrative that represents the mutual experience in an evocative and engaging way, while illuminating the cultural, social and institutional context of the research focus.

3.6.1 Gathering the data: Field texts

Field texts are described by Clandinin and Connolly (2000) as the data that constitute the working basis of the research process. Field texts can be stories, conversations, autobiographies, notes, letters, photographs, artifacts and life experiences. Texts can thus be fluid and “there is a virtually

endless list of life experiences that might be and frequently are turned into field texts of value to the inquiry” (p. 115).

I met with my three participants individually and talked about our experiences working at LUCC with patients and colleagues. Initial conversations lasted from 40 to 90 minutes per session. At this point I obtained written consent and discussed the process of co-creating stories. While I didn’t have a traditional interview protocol and set of questions, I guided the conversation to focus on issues of coming out that may have affected (or not) workplace relationships (reflecting back to my research questions). All participants knew each other, but I asked their permission to name them and use comments/stories from individual interviews with the group as a whole. We also had conversations about anonymity. We discussed how, despite using pseudonyms, they may be identifiable in the final stories. This seemed to be more of a concern to me than them. Another option would have been to use the participants’ real names, which is sometimes negotiated in autoethnographic work (e.g. Ellis, 2004). I was reluctant to do this because of the fictionalisation of the participants’ narratives; the final story characters were composites or amalgamations rather than more direct representations of real people. We discussed that, if they were uncomfortable with any part of the story, I would amend or eliminate it. I had anticipated that I might need to play with identities and situations depending on what/how much my participants wanted to share.

Rather than taking the typical researcher stance involved in conducting a semi-structured interview, I attempted to co-create a dialogue that allowed the natural flow and back and forth of normal conversation where rules like “turn taking, relevance and entrance and exit talk” apply (Riessman, 2008, p. 24). In most research interviews the roles of the participants are usually circumscribed as interviewer (active) and interviewee (passive) and not as a collaborative exchange between two people who jointly construct narrative and meaning (Mishler, 1986). I was always mindful that “we do not stand metaphorically outside the inquiry but are part of the phenomenon under study” (Clandinin, 2013, p. 24). This worked better for some participants than

for others. I found that it was easy to slip into the familiar role of “interviewer” and, for my participants, they sometimes seemed to default to the “interviewee” role, providing short answers and then waiting for me to ask the next question. Ellis (2004) comments that this is fairly common in autoethnographic research as we are used to the “authoritative interview situation” (p. 122). I did find this, and at times it was hard to judge how much (or whether) to direct conversation. As we were friends, there was a tendency to focus on catching up and being sidetracked, and the “entrance and exit talk” or transition into and out of the conversation was often extended (Riessman, 2008).

The conversations were audio-taped and transcribed and constituted the majority of my field texts. Other field texts used were my research journal, which included related personal stories and ideas sparked by the interaction, thoughts about the interview and notes on (for example) body language or non-verbal communication. While I was at LUCC, I took a number of pictures to remind me of (for example) the physical locations of the interviews. I also reread some of my blog entries and wrote some new ones as I constructed the final research texts.

After the initial meeting, I arranged a follow-up meeting with each of the participants after reading and reflecting on the transcribed dialogue. This allowed me to generate more field texts as well as to pursue promising and interesting lines of inquiry raised by one or more of the participants and explore their/our experiences in more depth than one session would allow. This is similar to the “double interview” technique described by Hollway and Jefferson (1997); the second interview can pick up on “slippages, inconsistencies, avoidances and changes of emotional tone” (p. 60). The second set of meetings lasted from 60 to 90 minutes each. The transcribed field texts were initially annotated to allow easier rereading to include dates, line numbers, broad topics of discussion, etc.

Craig and Huber (2007) have noted that “relationship is the heart of living alongside in narrative inquiry”, and I found this to be true (p. 249). Working with my participants was an emotional process. St. Pierre (1997) speculates that emotions can be seen as a kind of “transgressive data” that colours and shapes the work of qualitative research. Emotional data can engender a sense of deconstruction and allow a deeper understanding of the research experience: “I find my own validity when I write and cry and then write some more” (St. Pierre, 1997, p. 181). The work and emotional labour was intensely rewarding, but sometimes draining. At times I struggled with my (imagined) boundaries, as a researcher and as a friend. I heard stories that made me angry, and we remembered things that brought back feelings of regret and sorrow. I felt gratitude for the trust they had in me, and the time they had taken away from their lives to talk, described below in a blog entry from October 2017:

I had badgered my participants with emails, consent forms and Facebook messages ahead of time – trying to explain that this wouldn’t just be one meeting and done. At a very conservative guestimate I told them it would take up at least 10 hours of their time. Two face-to face-discussions, reviewing the transcripts, commenting on the transcripts, looking at my interim texts and working with me to shape a coherent and (hopefully) engaging story from their three individual narratives.

To further complicate things, I’ve never done this before. I feel like I am making it up as I go. It’s hard to project a feeling of authority and confidence when I really have no idea what I will expect of them two months from now, nine months from now? More emails? Phone calls? Skype? Individually? Together? My results section will be this co-joint narrative – but as I slog through the hours of transcription I still have no solid idea what that will involve.

I found myself working in the physical and emotional spaces that were left, full of uncertainty—in the coffee shop at the end of the shift, the room found at the busy conference just behind the registration desk with the loud air conditioning, and the friend’s house with the borrowed tea and cookies. My friends, my participants, made room in their lives for me—they drove miles to talk, rearranged meetings to spend an hour sharing coming out stories and arranged child care. I was acutely aware of their lives outside the coffee shop or the living room—they were all juggling prosaic day to day appointments with emotionally demanding major life events. Before the tape was turned on, and lingering after we had finished, we reflected on how young we had been when we first met, and we shared our battle scars.

It is always an honour and a responsibility to hear and share stories doing research, but a humbling realisation to begin to confront the issues that enrich and complicate working

with friends. Lisa Tillmann-Healy (2003) places relational ethics and “friendship as method” as a feminist practice with its belief that “the personal is political” and commitment to empowerment and social change. Friendship as method involves hope, caring, respect and justice. This kind of research is intensely personal, done with love, I didn’t really understand that before, but I realise it now. (Bolderston, 2017)

3.6.2 Working with the data: Interim texts

Interim texts are “designed to be shared and negotiated with the participants” and live in the space between field texts and final research texts (Clandinin & Connelly, 2000, p. 133). These texts were rough drafts of the final collective stories, and emails/messages back and forth between the four of us as I worked to clarify, understand and refine. I needed to bear in mind that the narrative “data” weren’t being analysed (as may be the case for other kinds of qualitative work) but synthesised into a coherent whole (Polkinghorne, 1995). One interim text was a presentation at the EDST⁴⁵ research institute in October 2017 (that was very much work in progress but was useful in terms of feedback and support from my EdD cohort and faculty).

As I attempted to “re-present the data of life experience as a research product” (Bleakley, 2005, p. 535) and bring numerous narratives and voices together, I continued to check back with my participants to ensure that they were happy with the result and find out if they had more to say/changes to make. I had anticipated that they would have numerous ideas, comments and changes, but this wasn’t the case. I had to change my intended approach at this point, as described below in an entry from my research journal.

I am waiting for my participants to return their transcripts. I have emailed them a couple of times, sent messages to remind them and only had one response from Ben. From the interviews and Sue’s comments (“I didn’t see anything to correct”), I suspect that they may view this process as ‘normal’ research—as in, disgorge information to be used by the researcher. Naomi’s comments when we were talking (such as “is it OK to say this?”) show that she was guarded, as she would be in an interview perhaps, and maybe I missed the mark around a normal conversation. I think I did miss the mark in managing to

⁴⁵ University of British Columbia’s Department of Educational Studies

understandably explain what narrative inquiry was and how much I would be relying on their help and participation. The idea of co-creating now seems remote and difficult.

I think I have two choices, to push them more (how when they don't answer emails?) or to readjust my ideas and focus on the co-creation being the interviews themselves and the stories that we share. I think the latter. I have another idea that I will sketch some stories and meet with all three of them back in Toronto in March. Read the stories to them; let them read them ahead of time. But how to engage them at that point? Hopefully the fact that they will see themselves in the stories will prompt a response. Otherwise it would just be me reading to them and perhaps a lukewarm reaction of "that seems fine" or maybe nitpicking that things aren't as they said because I have fictionalised things. A definite drawback of doing this at a distance.

But—I like the thought of them being my "first audience" (as Clandinin and Connelly say our participants are), so the idea of actually reading to them, with them, appeals. Plus, it is like the ultimate member checking or peer review. I could record it, use the reactions to reshape the texts. I could have food, a lunch, maybe ask (*my friends*) if I can use their place. March isn't far away though. (Dated 01.11.17)

Instead of solely working together via email as I had originally intended, we had a group meeting after I had written the stories with the intent to clarify, refine and finalise the texts.

3.6.3 Re-constructing the data: Research texts

The final research text is what Clandinin and Connelly (2000) call a "nested set of stories" that, as well as stemming from the interior life of the four participants, also brings the wider outside world back in the form of other research voices. The resulting narrative is therefore one that "at once looks backward and forward, looks inward and outward, and situates the experiences within place" (Clandinin & Connelly, 2000, p. 140). Merging multiple conversations into one narrative that encompasses the events is called *emplotment* (Polkinghorne, 1995; Tropea, 2011). Presenting research findings by *emplotment* can help to construct a summative narrative that can be easily understood by the reader (Baille, 2015).

I wrote a series of four stories, the four were framed with a preface and a postscript. Each has an introduction that serves to contextualize the story and gives a short background that relates it back to my research. Likewise, the preface and postscript describe (in a more personal and

reflective way) how the research was done and who was involved. It foregrounds the participants and the process and in this way the reader is made aware of where the ideas came from but is also able (I hope) to enjoy the four stories as stand-alone fiction.

Using NI means developing familiarity and expertise with typical elements such as genre, plot and characterisation (Clandinin & Connelly, 2000). Before and during the writing process, I went back to short story authors that I love and looked at how they had constructed their work, bearing in mind Clandinin and Connelly's (2000) question to researchers looking for a narrative form, "what do you like to read?" (p. 150). I wanted the stories to be engaging and to work successfully as satisfying and plausible pieces of work. I kept in mind Bochner's (2002) advice to follow conventions of storytelling including adding elements of crisis to provide dramatic tension, a temporal ordering of events, and the sense of a moral to give the story meaning and value.

The process of writing the research texts was neither straightforward nor easy,⁴⁶ but as I read and reread my field texts, I found "patterns, narrative threads, tensions and themes" which seemed to repeatedly appear in our discussions (Clandinin & Connelly, 2000, p. 132). I worked with these narrative threads to write stories that fit the data but at the same time presented "an order and meaningfulness that is not apparent in the data themselves" (Polkinghorne, 1995, p. 16). This means I had to be judicious about selecting parts of the participants' stories that added to the final account, while deselecting the extraneous elements; this process has been called narrative smoothing (Spence, 1986). Carr (1986) further comments that in a good story "all the extraneous noise or static is cut out", whereas in life "everything is left in" (p. 123). I also had to balance my own narrative voice and those of my participants, as well as considering my future audience—a process Clandinin and Connelly (2000) call "living on an edge" (p. 147).

⁴⁶ A section from my research journal states "the first attempt at the story section was a disaster. I defaulted to my usual qualitative analysis approach and tried to "theme" the transcripts. This was a mess!" I was reminded by Clandinin and Rosiek (2012) that many narrative inquirers try to "universalise" their participants words but that "knowledge of human experience begins and must return to the stream of particular human lives" (p. 55).

The act of creating stories in this way aligns with the use of arts-based research methods, a practice that is relatively new in healthcare (Parsons & Boydell, 2012). Arts-based research refers to inquiry “that draws inspiration, concepts, processes, and representational forms from the arts” for generating, interpreting and/or communicating knowledge (Knowles & Cole, 2008, p. xi). This can include visual forms (e.g. painting, photography and film), performative methods (e.g. drama or dance) or literary works (e.g. fiction or poetry) (Parsons & Boydell, 2012). In ethnography for example, the practice of performed ethnography (or ethnodrama) translates research findings into a play script that can be performed or read aloud to audiences. Goldstein (2016) remarks that writing up ethnographic findings in play form involves using “dialogue based on interview transcripts and personal narratives but characters who are fictional” (p. 7). She calls this approach “research-informed theatre” (Goldstein, Gray, Salisbury & Snell, 2014, p. 674). Likewise Leavy (2013) claims “fiction-based research” (as a sub-genre of arts-based research) can facilitate the sharing of experiences in a more accessible language than research published in typical academic publications and cultivate empathy in readers. Leavy (2017) remarks that fiction-based researchers can follow traditional data-collection methods (such as interviews and field research) or “use the writing process itself as the method both of inquiry and representation” (p. 196). I would position my work as “research-informed fiction” whereby the final research texts are written in an aesthetically pleasing and plausible manner typical for short stories⁴⁷.

We had a group meeting after I had written the majority of the stories. While I didn’t change the stories afterwards, I did use that experience to write a final story which (I felt) rounded off the ones that I had written. I had heard a lot about professionalism during the interviews but felt I hadn’t captured it well in the stories so far. The reactions from my participants, and the further discussions we had, also enabled me to reflect back on that theme in the postscript “Telling Stories”.

⁴⁷ See also section 3.4.5.

3.7 Ethical considerations

Ethical matters need to be narrated over the entire narrative inquiry process. They are not to be dealt with once and for all, as might seem to happen, when ethics review forms are filled out and university approval is sought for our inquiries. Ethical matters shift and change as we move through an inquiry. They are never far from the heart of our inquiries no matter where we are in the inquiry process. (Clandinin & Connelly, 2000, p. 170)

Procedural ethics involve the process of seeking formal approval for research involving human subjects from an ethical and scientific oversight group. As such I applied for, and obtained, Institutional Review Board (IRB) ethics approval from the University of British Columbia. Typical mandates from IRBs include avoiding deception, doing no harm, negotiating informed consent and ensuring participants' privacy and confidentiality (Tracy, 2010). There are limitations to standard IRB ethics procedures when carrying out qualitative research; for example, ensuring confidentiality may be problematic when working with a small group of easily identifiable individuals.

Beyond procedural ethics, working with friends and family requires a different kind of approach as well as the usual dilemmas of working in the field, one that recognises and honours the interpersonal bonds we have with others. These relational ethics involve "an ethical self-consciousness in which researchers are mindful of their character, actions and consequences on others" (Tracy, 2010, p. 847). We "intentionally put our lives alongside another's life" and "thinking relationally, then, is part of thinking narratively" (Clandinin, 2013, p. 23). Our friends trust us with their stories, and we may have to omit details, change circumstances or invent composite characters to protect them so we don't "rupture life stories that sustain them" (Clandinin & Connelly, 2000, p. 173). We negotiate issues of power, as the researcher usually sets the agenda and profits more from the relationship during the research (Ellis, 2007). I clearly had more invested in the process as the project was central to my doctoral dissertation. In addition, the emphasis on narrative inquiry's ethos of collaboration, co-creation, and egalitarianism can "disguise the inequalities actually present" (Finlay, 2002a, p. 226). The process is not straightforward and

involves improvisation, honesty, vulnerability and ensuring ongoing consent; “thinking narratively is a risky business” (Clandinin, 2013, p. 23).

Tillmann-Healy (2003) believes that “friendship as method” involves “a stance of hope, of caring, justice, even love” (p. 735). This is echoed by Clandinin and Connelly (2000), who remark on the tensions of navigating the relational aspect of narrative inquiry. We must be able to move back and forth between being fully involved and “falling in love” with participants, to what they call a kind of “cool observation” (p. 82).

I was aware of a constant feeling of ethical negotiation, in the questions that I asked, the conversational avenues I pursued and the experiences of my participants that surfaced in the stories because I couldn’t promise anonymity in any meaningful way. Tillmann-Healy (2003) warns us that we may be given access to secrets, or information that may be harmful to our participants if disclosed. In the dual role of friend/researcher, we must pay close attention to how, when and why we use such information in our research texts. I wrestled with one particular story for some time, before deciding to omit it as I felt it had been told to me as “friend” rather than “researcher”. Clandinin and Connelly (2000) note that “researchers, perhaps more aware of how texts may ultimately be read, may find themselves being more cautious about how participants are represented than are the participants themselves” (p. 177). There was also a tension in wondering how well I had communicated “what this kind of research this is,” such as how my approach would differ from typical interviewing, my expectations from the participants in terms of co-creation and how much I would be shaping/fictionalizing the data.

Finally, Tracy (2010) names exiting ethics as continuing beyond data collection to dissemination of the final results. While researchers may have little control over how others read or interpret their work, they can be mindful of how to present the work to avoid negative consequences. As I write this I pause to contemplate how best to present the research in venues where people may recognize my participants, and the sections to include in future publications.

Chapter 4: Results

Preface: Coming out/coming back

The first class of my doctoral program was our “doctoral seminar”, a brief three-week tour of some of the big ideas in the field. The course material contained some heavy hitters; many of the readings were dense with concepts and words that I couldn’t make sense of. It was summer; we did some of the work outside on the lawns, watching the young international students hurrying across the campus. We lounged under the trees, getting to know each other, comparing stories. For me, the papers and the class discussions were revelatory. I had never heard the term social justice, considered intersectionality, been in a space where feminism wasn’t dismissed with a sneer. I took the bus in everyday, an almost two-hour trip where I crammed in my reading and tried to decipher my cryptic notes. I am a fast reader, but the weight of the work was challenging.

Tucked at the bottom of the list for week three was a piece called “An Uncovered Self” by Kenji Yoshino (2006)⁴⁸. It wasn’t flagged as a mandatory text, I was tempted to skip it, but I took a quick look just in case it was interesting. It turned out to be the key to the work I had shown up to do, a look at coming out in healthcare. I had struggled with being a lesbian at times in my clinical career working with cancer patients; I was out of the closet to my friends and colleagues, but it was awkward sometimes around patients. I felt I had to hide certain things or, at least, deemphasize them.

Yoshino (2006) describes his gradual coming out in his role as a professor of law at a prestigious university. He remembers a colleague giving him advice, telling him his tenure chances would be greater if he was “a homosexual professional than if you are a professional

⁴⁸ The introduction to Yoshino’s book *Covering: The Hidden Assault on Our Civil Rights* (2006)

homosexual”, meaning Yoshino would be more successful if he didn’t focus his career on gay subjects. Initially Yoshino acceded, minimizing his gayness and presenting a “straight-acting” face to the academy. It wasn’t the same as “passing”, or pretending to be straight, because he was ostensibly out, but he lacked a concept for the uncomfortable act of muting his gay identity. He wonderfully describes the moment he finds the term and the concept of “covering” in Erving Goffman’s *Stigma* (1966) as “like Crusoe finding Friday’s footprint” (p. 18). This was echoed one morning on the UBC bus as I bumped my way along Marine Drive. I felt like Goffman and then Yoshino had been there already and marked the way.

According to Goffman (1966), those living with a stigmatised identity (including the disabled, the obese, and the elderly), use covering as “a great effort to keep the stigma from looming large” (p. 102). He calls this stigma management which he deems a normal feature of a society where there are strong identity norms⁴⁹. Importantly he claims that there is a “tacit cooperation” between who he deems “normals” and people with stigmatised identities where “the stigmatized will voluntarily refrain from pushing claims to acceptance much past the point normals feel uncomfortable” (p. 130). This explained the feeling of dissonance I had in the clinical environment; it was fine to be a lesbian (after all, we had policies) but the general feeling was that to be too much of a lesbian around patients wasn’t acceptable. No one had ever sat me down and explained this, I just seemed to know. If a patient asked me if I was married, I wouldn’t explain that I had recently had a commitment ceremony with my partner – actually, she is the therapist who you met yesterday. I would just say no and smile.

Reading Yoshino (2006) made me realise why “I wasn’t done with conformity to straight norms when I came out of the closet” (p. 18). It gave me a handle, a hook, to hang my research idea on. I came back to Yoshino a few times, I used his explanation to illustrate what patients might feel when they come into a hospital or a clinic, downplaying transgressive public displays

⁴⁹ Like heteronormativity – where the default and desirable state is seen as being straight and cisgender.

of affection in waiting rooms and hospital wards or not challenging the assumption that their partner is a “friend”. They would tell you, I said to audiences of my colleagues, if you asked them. But we rarely ask, so they are left to manage as best they can in an uncomfortable and unfamiliar environment. They cover their identities and so do we, their healthcare workers – for fear of offending, for fear of being unprofessional, for fear of being seen as other.

Coming out is never a single act. It is a spiral, from a few loved ones, to a wider group to (perhaps) people we see once, or twice. My own coming out was in my mid-twenties, in Toronto. Yoshino says that coming out is the closest that gay men will come to giving birth. Like a birth story, mine is probably only interesting to myself, but the spiral of people it affects continues to ripple outwards. To my classmates, to new friends and even to people who read my Twitter bio. Sharan and I became a couple in a small and close-knit group of friends from various countries, working at a large urban cancer center in Toronto. Most of us had arrived in early 1990, in response to a job shortage and overseas recruitment campaign. We were from the UK, New Zealand, South Africa, Australia and Hong Kong. We lived together, worked together and went out together. There were no other LGBTQ people in the group, friends’ reactions were varied, but we didn’t have any overt discrimination – just a lot of amusement and some surprise.

My memories of that time, as a couple, are intertwined with my work. Coming out to our manager, Sue, who we thought was a lesbian but who was very quiet about her ‘private life’. Going to see folk singers with Naomi, a young lesbian therapist from a small town in Northern Ontario. Our friend group became Canadians together, bought houses, had babies and began to settle down. Sharan and I worked our way up to supervisor and educator respectively. We had a wedding shower and a baby shower in the staff lounge. When my father died, I cried in an examination room, and Sue ran to get Sharan to hold me. Many of the stories we tell about our relationship are set within the walls of the cancer center.

When it came to choosing a location to explore the issue of coming out in healthcare, it seemed obvious that I should do this at the cancer centre. I had mentioned the idea to Ben, a gay therapist I knew well from various professional groups. We had a work history together back from when I was the educator, and Ben was a young keen researcher who regularly presented at conferences. We sat together on a bench in the hotel lobby at yet another conference, and I pitched my idea. Did he think it would work? Would he be interested? His enthusiasm took me by surprise, as did some of the stories he told me about his recent experiences in the workplace. I asked Sue and Naomi, explained the idea that we would be telling stories together. They also agreed and seemed keen to help.

So, after fifteen years away, I came back to listen to the stories of my friends and to try and remember what it had been like then and to discover what may have changed. I pulled out Yoshino and read him again on the plane. What struck me this time was his description of himself as a poet, his poetic thesis that led to a Rhodes scholarship, his lovely lyrical writing. I had chosen to write narratively for my dissertation, on the one hand a struggle for someone so socialised in the rigid style of scientific prose, but on the other a natural choice for an avid reader, a lover of poetry and a vocal proponent for the storytelling side of research (such as it is in healthcare).

What you are about to read are the stories written using the discussions with Ben, Naomi and Sue. The methodologies I used are called narrative inquiry and autoethnography. Narrative inquiry allows me to use storytelling to generate, shape and interpret my data. I use autoethnography to inhabit the stories alongside my participants (auto meaning about the self and ethnography as the study of a social group). Our gay and lesbian identities bound us together in some ways, although our backgrounds are different, a social subgroup within the larger work environment. When we talked for this project, in coffee shops, borrowed offices and a friend's living room, we rediscovered narratives that were intertwined, and I heard stories that

were sad, funny, heartfelt and highly individual. Some of the connected threads are here, as well as personal recollections that are unique to Ben, Sue, Naomi or me.

The stories are true in some ways and not in others, as they are a mixture of memories, ideas, theory, the academic literature and my own voice. I've written them in varied genres or voices. For example, "A Lesbian Breast Cancer Story" is written as a straightforward story in the third person from the perspective of a patient's partner. "Tegan" is in the form of an interview transcript that flips around the minority status of lesbian and gay people. I read a lot while I wrote including Margaret Atwood's short stories, along with work primarily by Dorothy Allison, Gloria Anzaldúa, Jeanette Winterson, Ruth Behar⁵⁰ and other female/queer authors as well as dipping into Zena Sharman's (2016) anthology of real-life stories of LGBT healthcare experiences *The Remedy*. All of these wonderful writers skillfully use different forms and perspectives – I don't claim to be as talented as these women, but they did encourage me to play around a little!

I hope (first of all) that you enjoy them, and I further hope that they will uncover a small part of what it was/is like for us then and now.

⁵⁰ In particular Atwood's (1992) *Good Bones* and *The Tent* (2006), Allison's *Trash* (1988) and *Two or Three Things I Know for Sure* (1995), Anzaldúa's *Borderlands* (1987), Winterson's autobiographical *Why Be Happy When You Could Be Normal?* (2011) and Behar's *The Vulnerable Observer: Anthropology That Breaks Your Heart* (1996).

Story One

Introduction:

For this story I focused on the queer patient and family experience, in this case Lisa and her partner Alex (not named in the story) as they navigate a breast cancer diagnosis and treatment. I asked my participants if they had examples of interactions with patients, and this piece was inspired by Sue's story of an "aggressive" woman who came into her office and demanded that her partner be treated with dignity and respect, an excerpt from the transcript is included below. I set the couple's story in Toronto, at a time where Sue would have been working – shortly before same sex marriage was legalised in Ontario (2003). I imagined as I wrote that the accumulation of healthcare related inequities and microaggressions had tipped this angry woman over the edge, and Sue had experienced the fallout. I further explored this example from Sue in the postscript (Telling Stories) – there she explains a little more what this encounter meant to her.

"Sue: I had one experience, they were two lesbians and they obviously had a hard time some point in their lives. One was the patient and the partner came into my office, made it perfectly clear if there were any negative comments or overt prejudice or anything like that directed at her partner she was going to come and sort us out, kind of thing.... She was quite aggressive. I said, I don't think that is going to happen. I told her, for a start I won't tolerate it, at all, whether someone is gay or black, whatever they are we won't tolerate that. Number two, I said, the department manager, me, is gay, so I don't think anybody would dare.

Amanda: Did it reassure her?

Sue: Oh yes, she backed right off. She was very aggressive when she came into my office; she was going to sort anybody out. But they, she said they had some fairly negative experiences coming through the health care system. Not in our centre but, you know, the process of being diagnosed and tests and stuff and all of that. Her being excluded, or comments and stuff. I think by the time she got to us she had just had it."

A lesbian breast cancer story

We were in the bath, our weekend ritual. Lisa was leaning back against me, and as I slipped my hands around her I found the lump. She was talking about work, I remember. About a student she had sent home, she was wondering if she'd done the right thing but sometimes there is no right thing, you know? I nodded into her hair. My hand still cupping her breast. She is going to die, I thought, she is going to die and leave me. I felt cold, I remember watching a drop of water swell on the tap, break away and fall into the cooling bath. Lisa trailed off, asked me what was wrong. I must have said something, because she sat up, water streaming off her back, and put her own fingers there. She bit her lip, looked at me, it's nothing – she said - a cyst. I had a mammogram last year, it was fine. The tech told me I had cysts – remember? It'll go away.

She frowned, rubbing at the skin. The lump was small and barely visible, just dimpling the sweet curve of her left breast. I put my hand over hers, kissed the top of her head. Sure love, I said, but maybe get it looked at anyway? Do you think? Go get it checked? Settling back into me she turned the tap on with her big toe, one of her many talents. I felt her nod against my lips, but my heart was still pounding. Despite the hot water swirling into the tub, I felt cold.

There is a breast clinic in downtown Toronto, at the big cancer hospital. She was referred there by our GP, Dr. Cohen, who has seen us through assorted illnesses and crises. She told us they could do an ultrasound and biopsy in the same day, but we'd have to wait a week or so for the results. They could fit Lisa in first thing in the morning, so she wouldn't have to miss work. We'd been looking online, and it was reassuring that most lumps turned out to be benign – but I couldn't get rid of the sense of dread. I tried to talk to her about it, what if we have to get treatment? Remember Aneeta had it; she's fine now, five years out. They can do amazing things these days, right? But Lisa brushed me off. It's nothing, she said, it'll be nothing at all.

I found when I was at work, when it was quiet, my mind went back to it. The side effects of treatment, the hair loss (would she want a wig, would it grow back the same?), the radiation (the burning, didn't it burn you?) and always the vision of a future where I would be alone – a widow – are you a widow if you can't get married? What would I be then? I hated myself for the melodrama, the self-indulgence of it. It's not my (possible) tumour, I told myself, you're not the one living with this. But Lisa was a blank wall, closed off to me. I didn't want to worry her with my fears, they seemed selfish, self-centred. So, I stayed quiet and we waited for the appointment.

They sent us a leaflet – it told her to not use deodorant on the day of the appointment, to bring someone and to wear something that will be easy to take off and on. We spent a ridiculous amount of time choosing her biopsy outfit. Bra or no bra? Buttons or a t-shirt? She ended up wearing one of my old flannel shirts, sports bra, no wires. She looked small in it, but I was glad to see her swathed in plaid, a soft old shirt that I loved, that reminded me of winter walks and that time she had unbuttoned it in our old place at Church and Wellesley, when we were still new and reverential with each other's bodies. She didn't talk much as we waited for the streetcar. I held her hand after we boarded, although we didn't usually, and as we crossed the Don Valley she leaned into me as I stared at the partly frozen river. There didn't seem to be much to say, apart from everything.

The clinic was packed, apparently, they booked everybody first thing and worked their way through the daily list of patients. The receptionist handed out clipboards and paperwork to newcomers. We sat by the fish tank and Lisa chewed on the end of her pen as she scanned the intake form. Name, address - family history was always fast as she is adopted, she just crossed it out. Next of kin, she wrote my name and "as above" in the address part. Marital history, that one was always a challenge, she ticked common law because there was no box that said "exchanged (Wiccan) vows in front of loved ones in the garden with dog as ringbearer". She

hesitated over the sexual history - pen tapping against her teeth. Sexual intercourse? Did it count, what we did together? If she ticked it, did she need to explain? The next box was birth control. If she ticked the first one, the second one followed – usually, but not with us. She left both blank, looked at me with a wry smile. How would that label her with the doctors and nurses? Did it matter for this? Flipping the page, she skipped through the next sections and handed the clipboard back to the receptionist, who took it without a smile and started transferring the data into her computer.

We waited and watched as women, individually and with husbands, partners, were called and went down the corridor. I wondered if they were all here for biopsies, or if the clinic did other things, other non-cancer things. One woman was by herself, I watched her leafing nervously through the old magazines and smoothing down her skirt. I hoped she got good news. There was a tired basket of old toys in the corner, faded blocks and a pile of books that looked like they were missing pages. I couldn't imagine having to bring children here, who would do that? Those with no other choice, I realised.

After an hour a blue-scrubbed nurse called Lisa's name - well she said, "Mrs. Peterson" but we got the drift. I stood up too, and the nurse turned to me, she'll be about an hour, I can give you a call when she's done if you like? I opened my mouth to protest, but Lisa shook her head slightly – don't make a fuss, her eyes said, I've got this. I hesitated, and the nurse gave me a cool smile. She'll be fine, in and out, it doesn't take long. I sat back down.

The wait for the biopsy result ended up being almost two weeks. We went about life as usual, walked the dog, went to work, but there was a constant buzz of worry. Every time I raised it, though, Lisa shut me down. She told me the same thing – the tech at the hospital had told her nine out of ten times it's nothing. The odds, she said, are in our favour – why waste time worrying until we know? But I did worry, and I wanted to know. So late at night I looked at websites that detailed chemotherapy treatments, surgical options, alternative medicines. I

cleared my browser histories like I'd been looking at porn. I read patient blogs, clinic guidelines and just about everything on the Canadian Cancer Society's website. While there was some advice for partners, it was mostly about men. There seemed to be a lot of concern with how the loss of a breast, or side effects from treatment, might affect the husband or the "sexual activity" of the couple. Patience was counselled, the woman might be suffering from an altered body image and be reluctant to have sex. But, the sites said, everyone is different! Perhaps painful surgery and hair loss might make your wife hornier? Nothing told me how to deal with the sick feeling I got when I looked at Lisa getting undressed or felt her curling up behind me at night pushing herself into the curve of my back.

In the end we got the diagnosis by voice mail. Well, not exactly, but Dr. Cohen's receptionist can't hide bad news. She said Dr. Cohen wanted to see Lisa urgently, could she come in? I picked up the message while Lisa was still at work and I felt oddly calm, I'd assumed it was this anyway so here we were. I phoned back and arranged an appointment for later that afternoon and called Lisa on her lunch break. She went very quiet, and we agreed to meet at the doctor's office. I took a note pad, as online advice told me I would want to take notes, for later. It turned out I wrote nothing down. Most of the words after "I am afraid it's bad news" sounded like white noise. I just watched Lisa's face, her mouth as she talked, my hand anchored on her thigh. I could hear my own heartbeat, thudding away reassuringly, and the noise from the heating ducts. I thought, this is where our life changes, this is a moment we will remember. But nothing seemed to stick.

Back at home, with a booklet entitled "tips for the newly diagnosed" we sat at the table and tried to plan. I kept asking Lisa how she was, are you OK, do you need a minute, how do you feel? Numb, she said, like when my father died. I think I should be feeling something but it's not there, I feel like a frozen lake, like the lake at the cottage with the leaves suspended in ice. I am waiting for the crack, the thaw but it's not here yet.

The list of things to do read like this:

1. Tell work. Who else? ~~Mem?~~ (No! Not yet!)
2. Surgery – when? Call Dr. Cohen ask about wait times, does waiting make it worse???
3. Radiation, where? How long?
4. Other treatments – ask Jenn about her naturopath
5. Clean bathroom (this was from me – we couldn't think of anything else to add and I thought having a scale free tub would help)

The wait for surgery made the time waiting for the diagnosis look like a walk in the park. It took three months, four phone calls to an increasingly exasperated Dr. Cohen, two to the cancer centre and an in-person visit to their receptionist (we don't have operating room space until March....no, writing to your MP won't make this any quicker) until we finally had a date. The blogs say this is a tough part but waiting doesn't really make the prognosis any worse. But how could it help, to wait until that tumour decided to throw off some cells to lodge in her brain, or her spine? It could have been there for years already, lurking, undetectable. Even a few weeks was a risk. Dr. Cohen had said she would need a lumpectomy – a tumourectomy – and she would be able to keep her breast. Like it was something she would have given away. The surgery would be followed by radiation, to sterilise the area. I kept thinking of Chernobyl, black blasted lands where nothing grows.

I think I drove Lisa crazy, asking if she was feeling alright, bringing her flowers, booklets, healing teas. She finally snapped at me one night, after I told her about our hairdresser's recommendation that we try cannabis oil. We don't fight much, usually. When you've been together this long most things have been rubbed smooth, or you agree to disagree and avoid certain things, stepping over the cracks all relationships have. But this one was a doozy. Stop tiptoeing around me, she said. Back off! This is happening to me, not you. I just want you to be

normal, for fucks sake. I have to say, despite the fact I was terrified for her life, I wanted to kill her. Weren't we in this together? But I bit my tongue, took the dog out for a long walk, and gave her some space. I figured she had enough on her plate without having to deal with my feelings.

They cancelled the surgery the first time and rebooked her three days later. When we showed up, early, there were more forms. She was changed into a blue gown and had to sit there, on a plastic chair in the waiting room, until someone called her. She went into a room for a teaching session, to tell her how to take care of herself. Does your friend want to come, the nurse said? I'm not her friend, I wanted to say, but they were letting me in so I said nothing and just listened as they told her not to lift her children (did they check the forms she just filled out?) or wash any windows in the next few days. She had to sleep with her bra on...at this my mind just stopped taking in information. Why? Wouldn't that be messy? Would there be a lot of blood? She often went braless; she has small breasts, should she wear it anyway? Could it be a sports bra? By the time I tuned back in the nurse was finished and had given Lisa a leaflet, which she handed over without looking at me. I recognized her "I've had enough" face and wanted to reach over and hug her, but the nurse would know then and did that matter? Would she care? Would it make her treat Lisa any differently? Was it worth it? So I did nothing, and watched her as she was led away.

There were some complications afterwards and the healing took longer than it should have. She didn't want to take the meds, which drove me crazy. I made the smoothies she asked for with kale and chia, but she wouldn't take the pills. Why? I asked her – you're obviously in pain? I just think I need to try and detox my body, keep it clean, she said, but she couldn't sleep because of the wound and the subsequent hematoma and I think that's what made it so slow. She ended up going back in and her surgeon drained some fluid which helped with the pain a bit. Her wound leaked a lot, we worked out that a maxi pad inside her bra worked but she was tired, cranky and mad at everything.

The house was usually full of people and it was hard to find some peace. They cleaned the kitchen, brought food and advice; some good, some not so good. I heard Aneeta's story about the great lesbian support group she had gone to for a while at the 519 community centre in the gay village, where she felt she didn't have to explain herself all the time as a dyke who hated the girly pinkness of most of the breast cancer paraphernalia. Aneeta's partner, Kris, told me about the oncologist who, despite having seen Aneeta for two years, told her she needed to make sure she used birth control while taking her Tamoxifen. Sara bought a book by Audre Lorde and some pot, both were very welcome. Our gay friends Nick and Alan came with an "ironic" tuna noodle casserole that was actually pretty good and a gift certificate for a homeopath on Gerrard who had helped a friend with lymphoma. Lisa's mom came down, and stayed for a couple of days. We don't get on that well, she tolerates me because she loves her daughter, but I am not what she had hoped for. She filled the fridge with vegetables and, weirdly, bought Lisa some pregnancy multivitamins because 'they had all she needed to heal in them'. We kept out of each other's way but having her there allowed me to escape sometimes. I walked down to the lake, or over to the library where I'd join the homeless guys paging through newspapers and car magazines.

I went back to work after the first week, and Lisa would call me during the day to tell me who had been at the house, and what they had said. We waited for the referral for the next step, the radiation treatment. She was lucky, everyone said, that she didn't need chemo, would keep her hair, if she was going to get breast cancer she had the best kind. Radiation was either much easier than chemo, or much worse – depending on who we talked to. Aneeta said it had wiped her out, but she hadn't had much of a reaction other than that. Claire from my work told me she'd been burnt from it, she'd been sore for weeks. About six weeks after her surgery Lisa's breast was still swollen but the wound was closed. We started calling it her shark bite. She hated the way it looked – her nipple was pulled up and a large part of the side of her breast was

gone. She would say they should have called it a partial amputation, the term lumpectomy was too cute and didn't reflect the reality of the pain and disfigurement. I tried to reassure her that it didn't matter to me; she was still herself, still here. But she just grimaced and avoided looking at herself, wore clothes that hung on her and hid the contours of her body.

We argued about the radiation appointment. She didn't want the treatment, according to her naturopath on Gerrard (thanks a lot Alan and Nick), her body chemistry was "naturally receptive to cancer" and she needed to make it more alkaline to stop the cancer growing. The kale and chia smoothies had been replaced with vegetables and teas and powders from Dr. Fan. All "acid foods" (anything from an animal) were off limits. This was the way she wanted to go, it was less toxic and more natural than radiation she said, a kinder, gentler cancer treatment. I tried to be supportive, which was hard as I thought she was being ridiculous. I understood that she wanted to feel she was doing something, and she did benefit from talking to Dr. Fan – she came home in a better mood, and more optimistic than she had been in weeks. I suggested she do both – two approaches are better than one, right? Yin and yang? East and West? I did some Googling – her tumour had been all removed, she had no cancerous lymph nodes – skipping the radiation would decrease her survival chances but not that much.

This went on for a few weeks, with me sneaking out for a burger occasionally to counter all the veggies, until we got the phone call telling us the appointment to see the radiation doctor was next week. She was reluctant but said she would go, but by herself. I protested – of course I wanted to be there, I needed to take notes (this time I would pay attention). No, she said, I'd rather go alone. I know you want to help but I don't want to worry about you, how you are feeling. It's easier. I argued, wheedled and finally tried sulking but she was adamant.

She had to go in for three o'clock. I was tempted to leave early and show up at the clinic anyway, but I knew Lisa would just get angry. Once she had made up her mind about something she rarely changed it. I started her a list of things to ask in her red 'cancer notebook' where we'd been tracking her meds, her questions and her appointments. How long would it take, what would the side effects be, could we still share a bed? She raised her eyebrows at this one – I am not going to be radioactive, love! Do you think I'll develop superpowers? Well, I said, ask anyway, please, just to be sure? She rolled her eyes but said she would. I kissed her goodbye and left for work.

I called at five, just before I left but she wasn't back, or not picking up. As I stood on the streetcar swaying towards home, I tried again but still no response. The house was dark as I opened the front door, maybe the clinic was running late? Wouldn't she have called me? Her coat was on the hook, shoes on the mat, I called her name. Up here, she was in the bedroom and her voice was muffled, odd sounding. She was curled up on top of the duvet, her face in the dog's side. She'd been crying.

Love, what, what is it? Are you hurt? Did you get bad news? I sat on the edge of the bed and reached over for her. She started to cry, voice hitching as she explained what had happened at the clinic. She'd filled out more forms, including another social history. I put you on it, she said, you were on there, but they didn't see me – he didn't see me. Who, I asked, who didn't see you? The doctor, he kept talking about my husband, whether he was satisfied with the results of the surgery – he said it was...what was it.... not optimal. I said it was fine, we were fine, it was a matter of getting used to it. I said, my partner...he wasn't getting it. In the end I just said it, I am a lesbian, my husband is a woman. You should have seen his face, he took a step back from me I swear. He rushed through the rest of it, I couldn't concentrate on what he was saying. I am never going back there, he couldn't get me out of his office fast enough. That's it. I told you I didn't want this.

I felt my face flame. We can call them, see another doctor, love – don't let this stop you getting the treatment. But she just cried harder and eventually I left her alone. I went downstairs and stood in the kitchen. Among the straggling spider plants and aloe on the windowsill were the pills and teas from Dr. Fan. The list of foods she could eat was fixed to the fridge with a CN Tower magnet, above the printed list of inspirational cancer quotes from our neighbour (current favourite "you can be a victim of cancer, or a survivor of cancer, it's a mindset"). Her red notebook was on the table, I opened it to the questions I had written in there yesterday ("will I glow in the dark" had been circled and a smiley face drawn next to it).

Two days later the phone rang, it was the radiation clinic. Lisa had to go in for her first appointment – the clerk said it was for preparing her for treatment and some x-rays. She was out with the dog, so I wrote down the details for her. When she came back, rosy cheeked from the walk, I handed her the piece of paper. She handed it back, shook her head. I'm not going, she said, that ship has sailed. I went through the reasons she should go again, the risk of recurrence is lower, that doctor is an asshole, we can change him – I love you, I want to love you for a very long time. The more I said, the more her face told me I was wasting my time. The "I've had enough" face – the folded arms. She busied herself taking off the dog's lead, filling up the water bowl. I put the slip of paper in my back pocket and started making dinner.

By Wednesday, radiation day, I had persuaded Lisa to at least go back to the clinic. I looked online about making a complaint, but Lisa said it might affect her care and she didn't want to do it. I called the clinic anyway, while she was out. They said she could switch doctors if she had "any issues" but she should come for her first appointment, she wouldn't see Dr. Asshole that day, just the radiation therapists.

The clinic was packed, the radiation therapy part was in the basement, so we squeezed into the elevator with a couple of ambulance drivers and a frail woman tucked up on a stretcher. There was a large sign, a bit like an airport, that announced “Unit Nine” was an hour behind. That didn’t bode well. The waiting room was busy, the TV in the corner was set to CNN, covering a bomb in the Middle East. The sound was low, but the scenes of dusty devastation didn’t help my mood. Finally a young woman in a lab coat came out, carrying a green file. She looked around the waiting room. Mrs. Petersen? Lisa stood up. I did too. The woman introduced herself, Max, a radiation therapist – she told Lisa she was going to be planning her treatment. Can I come? I asked, she’s had a rough week. Max smiled, are you.... the pause seemed to stretch as she looked at us both.... sisters? No, I stepped forward. Something on my face must have alarmed her because she stepped back, looked back at the door as if checking the exits. Oh, no, sorry, just the patient. We’re going to be using x-rays so....She trailed off. So? I said. So, she replied, just patients for this part. It won’t take long. Lisa looked at me, her face was sad. It’s fine, she said. I’ll be fine. She reached out and touched my arm. I’ll be fine.

The manager’s office was one floor up. The clinic was built like a maze, Pepto Bismol pink corridors ending abruptly with a locked door and a radiation symbol “Keep out X-rays in Use”. It took me a few wrong turns to find it. Her door was ajar, and she was on the phone, laughing. All I could see was Lisa being led away again, somewhere I wasn’t allowed to go. The phone clicked down and I could hear typing. Raising my hand, I knocked on the door.

Story Two

Introduction:

In this story I wanted to give the reader a peek into the daily lives of radiation therapists. We're a little known profession, but important as about half of people who have cancer end up having radiotherapy. I also wanted to show some of the daily ways being queer intersects with patients and peers, in positive and negative ways. For example, Ben's affirmative subtle flagging (show tunes, a slightly outré dress sense) might signal to a gay patient that here is someone who could understand which contrasts with Sue's unpleasant encounter with overt homophobia by a team member.

As I wrote this I realised my "invisible narrator" was heavily influenced by Alison Bechdel (1986), author of the Dykes to Watch Out For graphic novel series. Her comics are drawn with a wry self-awareness; a meta lens that include fourth-wall breaking frames of her as "the artist" drawing the characters and footnotes that refer back to previous editions as well current political and social issues.

Queer encounters

Come with me, dear reader, as we peek at the day-to-day lives of our brave queer protagonists as they brush off microaggressions, counter institutionalised heteronormativity and unashamedly use their sexual orientation to avoid unpleasant work. These are the hallowed halls of the Large Urban Cancer Centre or LUCC. At LUCC a dedicated team of professionals battle the deadly disease using a modern armamentarium of drugs and radiotherapy. As we pass through the automatic doors let us marvel at the modern bright atrium, filled with plants and the smell of slightly burning toast from the corner café. We see the radiation therapists relaxing on their breaks, bright in their scrubs and gathered in small groups. There is muted conversation as they scroll through their phones; we hear reflections on the recent lacklustre performance of the local hockey team, as well as more esoteric fare. One young woman complains about a broken treatment machine and the growing group of people in the waiting room who impale her with impatient stares every time she passes by. Her tirade is met with understanding noises from colleagues, some of whom raise their gaze from their iPhones to roll their eyes in sympathy.

As we inch closer we notice Ben, sitting slightly apart, sipping a coffee and paging through a journal article. Ben is mid-thirties, with the slightly rakish air of a 1920s British aristocrat. There is something of the dandy about Ben; he eschews the common scrubs for a lab coat, chinos and a startling striped shirt. Although his neck is bare, he looks like he has a bow tie tucked away in a back pocket ready to be deployed. As we watch him, he seems to feel our invisible gaze. He looks around with a mildly puzzled look and rises to his feet, tucking the article in his lab coat pocket. He heads for the elevators, and we follow close behind, trailing in the mild lemony scent of his aftershave. He is heading for the male locker room.

This is an area off limits to us, in our corporeal bodies. Today though we pass through the wall and float over the wooden benches as Ben opens his locker, reaching inside to store his phone. There are more people here. Three men who are just starting their shift, they are changing from street clothes and fishing in pockets for ID badges, pens and other work necessities. We see them look at Ben, look away, discount him. One starts promoting an impromptu baseball game that evening, who is in? Ben closes his locker and heads back to work.

The radiotherapy department is in the basement, as most are. The cumbersome machines need to be shielded, the outside world protected, and there are few windows. The machines here are named after the great lakes to remind patients that there is life outside these beige concrete bunkers. A donor has supplied money for artwork, and the water theme continues along the corridor as Ben passes a photo montage of waves lapping a stony shoreline. Outside Superior is the console area and a heavy grey door that leads into the treatment room. Patients who are allowed a glimpse backstage joke that it is all very Star Trek and indeed the multiple screens, and panel with flashing lights do somewhat resemble the deck of a spaceship. Plastic face masks used to immobilize head and neck patients sit on a shelf, gazing sightlessly at the two therapists as they enter patient data for the woman seen distantly on the screen, her arms stretched above her head like a sacrifice under the looming white machine.

We float to a halt as Ben greets his team. One (Parminder, we see from her name badge) says hello but doesn't take her eyes off the monitor. The red light is on, the machine is delivering its programmed payload of radiation to the woman's right breast, and accuracy is all. Ben checks the daily list, two down, thirteen to go, a new patient at three o'clock and nice Mrs. Jones finishing after twenty visits. She's a retired teacher and has been bringing home-baked goods for four weeks. Ben wonders if she will surpass herself today, maybe a cake? We can

follow his train of thought as he looks at the pinned thank you cards on the notice board, some homemade, some dog-eared – all heartfelt.

The machine clicks off and the team are on their feet. Parminder opens the heavy door and goes inside to release the patient from her bondage. The other (Ben greets her as Karen) uses Ben's arrival to finally hit the bathroom and hurries out of our view. Ben finds the next patient file and opens it, a document full of numbers with a small image in the top corner, an elderly man who looks at the camera with a kind of resigned confusion, his grey hair slightly askew. On the console there is a small box that controls the treatment room cameras and microphone. We watch as Ben reaches over and clicks the sound button, he hears the final grind of the treatment bed as it lowers to the floor and Parminder chatting to the patient as she slides her arms back into her hospital gown. The grimace on Ben's face suggests he doesn't approve of the music playing in the room, it seems to be what is known in some contemporary circles as "chill out" music, heavy on the panpipes and brass gongs.

As Parminder escorts her patient out (the conversational topic has changed from the advice to wear a soft cotton bra to the possibility of rain later) we see Ben open a drawer and bring out three CDs. He fans them like cards and we note one has the distinctive profile of Barbra Streisand, while the top one is the soundtrack to the Disney movie "Frozen". Ben smiles in satisfaction and heads into the treatment room, skirting the huge machine and heading for a battered CD player on a small shelf otherwise filled with boxes of surgical gloves. He flips the lid, removes the CD and replaces it with "Frozen" then skips through the tracks until he finds the one he wants. As he starts to ready the room for the next patient, we back away to let Ben get on with his work day. The sounds of the track "Let it Go" accompanied by Ben's pleasant contralto fill the room as Karen brings the next patient in, and we fade through the wall to find our next queer encounter.

Our second therapist, dear reader, can be found in the next room. Her name is Naomi, and those of us of a queer persuasion may feel a tingle in our gaydars when we view her short neat hair and lack of stereotypically feminine adornment. She seems to be involved in a heated discussion with a male colleague, let's go closer and see what's happening. They stand in front of a computer screen which lists the daily agenda. As we move in we spot the next patient is highlighted and due in five minutes. Mr. Frank's procedure is something called a planning urethrogram, which involves the manipulation of poor Mr. Frank's genitalia and the injection of some dye into a tube inserted in his bladder. It is this procedure Naomi is protesting. Her colleague, a burly twenty-something wearing navy scrubs, looks like he is on the losing end of the argument.

"It just makes sense", Naomi is saying, as Navy Scrubs shakes his head (his name is Alan). "I don't have the knowledge you do".

"We all do, just because you're....um....doesn't mean..." Alan counters, looking awkward.

"Yes, but think about it. You HAVE the equipment, if you're a straight woman you probably interact with the equipment, I never do. I am playing the lesbian card".

"Stop saying that, it's not a thing".

"It should be, come on Alan, you know you're better at it".

"Naomi, you did this last Friday. It's not right. I don't make you do all the breast patients".

"That would be discriminatory Alan, shame on you".

Alan searches for something to say, but he has already lost. Naomi's lesbian card, although technically non-existent, trumps Alan's vague sense of fairness and gender-blind practice. He knows she is playing him but she does have a point about the lack of familiarity.

"Fine", he concedes with an eye roll, "but you're doing the next one".

Naomi hides a smile and heads off for a coffee break. She doubts it.

As Naomi leaves the room, so do we. We watch her walk towards the stairs as we take a right-hand turn down another corridor towards Michigan. This treatment machine is the furthest away from the patient waiting room, outside the console area is a stretcher, swathed in an orange blanket. Two ambulance drivers lurk nearby, ready to drive their patient back to another hospital. They furtively check their phones and wait for her to be treated. The unit is running behind, thanks to an earlier breakdown. Here we see the complaining therapist from the waiting room, presumably back from her break. She's in the corner phoning people with later appointments, warning them of the delay and rescheduling some. Watching the monitors while the machine beeps steadily is Carrie, a tall woman with cats-eye glasses and a long grey bob. She's talking, occasionally glancing around to check she's being listened to. Sitting next to her is a younger woman with short blonde hair. This is Sue. Sue has a scrub top decorated with a cartoon character, we lean in to look, it seems to be Minnie Mouse. Sue is fiddling with a clunky black calculator, pressing the buttons randomly as she waits for the machine to finish so she can take the patient off the treatment couch. Her shoulders are hunched as she glances at Carrie, looks away, and looks at the monitor.

"I was just saying" Carrie turns around again, looks at Sue, "It's not like where I used to work".

Sue puts the calculator down, picks it up again.

"Homeless people all over the place here, all's I'm saying. It's not the same there".

Sue half stands, but there is a minute left.

“Homos too, homos and homeless” Carrie laughs at her own wit. “Not that I’m prejudiced but it is just nicer there, you know what I mean?”

Sue flushes. Her hands clench. We hold our collective and invisible breath. But the moment passes. The machine turns off, the red light above the door turns green and Carrie pushes herself to her feet and goes into the treatment room. The ambulance drivers follow with the stretcher. Sue looks at the woman on the phone who manages a “what can you do” shrug and eye roll at the same time. We get the impression that this is a familiar gesture. Sue manages a grimace that was meant to be a smile and follows Carrie into the room.

Our time is up. Let’s rise through the ceiling back past the waiting room with its freight of anxious patients, through the roof and out into the warm air. We must bid farewell to Ben, Naomi and Sue as they continue their daily work and manage their sexual identities as well as their patients.

Story Three

Introduction

For “Tegan” I wanted to write a piece that turned the language and assumptions that I heard about gender and sexuality from my participants upside down to see what that would look like. So homophobia became heterophobia and parents, by default, became same-sex couples. A primary aim was to try to capture the strong sense from talking to Naomi and Sue (especially at the beginning of the process) that they were fine, nothing had happened to them and that being a lesbian at work was “a bit of a non-issue”. This possible dissonance between what they said and perhaps believed (i.e. they are totally out) and what emerged later (they aren’t) was striking to me as an observer/reader.

In this story, unlike the others, I used direct quotes from all six discussions (about half of the text of the story) and shaped them into a single composite character’s voice. Each point that Tegan makes is one that a participant has made (often more than one of them). Most examples and illustrations Tegan uses are also from the participants (the co-worker who is in trouble with Human Resources, the “don’t ask, don’t tell” support from a parent etc.) I formatted it like a transcript (with the line numbers) and, like an interview, the interviewer probes for more information and more of the picture is revealed. However, the interviewer remains unseen partly to focus more on Tegan, but also to allow an uninterrupted sweep of text, with no breaks to stumble over.

Tegan transcript 1: 10.08.17

1

2 It's not like I hide it but I didn't stand on a table in the cafeteria and tell everyone I was straight,
3 why should I? It's my business. Why do I have to wear a T-shirt that says "hetero pride" or wave
4 a flag? No one cares these days do they? I shouldn't have to say, hello, my name is Tegan and I
5 am straight. It's just one of the millions of facets that make up who I am, like I am left handed and
6 have blue eyes. I mean, it's like, I am Tegan and I just happen to have a partner whom I love very
7 much and it doesn't matter if he just happens to be male or female or whatever the heck. It's just
8 the spirit that I love, it just happens to be that he is a guy. I don't understand people's obsession
9 with categorizing it.

10 My family knows. Well, they kind of do, but they don't if you know what I mean? My Dad
11 is OK with it, he's always been open minded, but Poppa is a bit more conservative. My last
12 relationship ended badly and I was really upset. Dad asked me what was wrong and I said...I can't
13 tell you, I can't tell you. He said that no matter what you tell me, it's OK. So finally, I told him and
14 he said, I might not understand but I love you and support you for whatever and whoever you are.
15 I cried my head off! Amazing, right? I don't know that I have ever overtly said anything to Poppa
16 but he knows, we just don't discuss it. I know he loves me though; it's a kind of don't ask, don't
17 tell deal. Of course, he'd prefer it if I liked women, it would just make things easier, wouldn't it? I
18 mean, people ask you when did you decide to be straight and you are like...no, no! Would I make
19 that decision if I had a choice? Right? Poppa doesn't want me to have to feel different. My
20 grandparents? Oh, well, no. They are still a bit ...you know....Adam and Steve not Adam and Eve.

21 It doesn't make any difference at work...why should it? I've never had anyone say anything
22 to me personally; I think I've been lucky that way as I said. People at work know, I mean I have
23 never said it, but they know. Really, I believe in keeping things professional. There's no need to
24 bring my private life to work, is there? A few of them think they are funny, said to me last year...you

25 never talk about girls, do you? I just said, no, I don't. They are a right nosey pair. It would be all
26 over the department in five minutes. Even if they did have an issue, we have policies. Like, there
27 was an incident a few years ago with a heterophobic staff member who made a few cracks about
28 "breeders" and it was dealt with by Julie, our manager. She told him that wouldn't fly in this
29 department and if he was going to make comments like that he would be making a visit to Human
30 Resources. She was amazing. The whole thing made me uncomfortable to be honest, I felt like I
31 should have said something before because he was known for it. But I just tended to avoid him
32 as much as I could, if I did have to work with him I just kept my head down, got on with it, kept it
33 light. It's not my responsibility to wear a badge that says hey, I am straight, be careful what you
34 say. But, I find it hard to work with him now, if I am honest. Really, what do you say when
35 somebody basically invalidates you as a human being?

36 It's the stereotypes as well. I mean ... do I wear an apron and vacuum around the house
37 and John is, what, under the car fixing the transmission? Like it's the 1950s in our house. Why all
38 of a sudden bin me with that stereotype that you see on TV? And ... let's think about the kids?
39 We'll somehow recreate the patriarchy and our daughters will earn less? The boys won't be able
40 to express themselves? It drives me crazy! It's just ignorance and prejudice. So you know, that's
41 what people expect. If you see someone who looks like a regular person you think, well, they can't
42 possibly be straight because, you know, they don't fit the box. And, I understand people's curiosity
43 maybe it's not something they understand but, I don't ask you what goes on in your bedroom! I
44 don't ask you these details of your life! Go online and readyou don't need to ask me this stuff!

45 With patients? No, it doesn't come up. Why should it? Like I said, I think we should be
46 professional. There is a line, I don't like to cross it. Some of them sometimes ask about my wife,
47 or girlfriend but I just like to say partner. I don't think it is appropriate to ever really get into anything
48 more specific than me having a partner with patients. I mean, clarifying female versus male. Yes,
49 I've seen a few straight patients over the years but generally I don't like to assume. They could
50 be brother and sister. Sometimes we sort of recognize each other, I mean, just by little clues

51 really. I don't like to think I would treat them any differently though, unless maybe they wanted
52 specific information about support groups or sexual health. There's a bit in our general booklet
53 about sex, I mean it's not specifically about straight sex, but it's written quite inclusively I think. I
54 haven't really looked to be honest. There used to be a straight support group for people with
55 cancer, years ago, but they lost the funding. I think it would have been helpful, talking about it and
56 not having to worry about coming out or misunderstandings but there is stuff online. I think it would
57 help if we had more straight couples on our posters, I mean we are always featuring patient
58 stories, but I've never seen an opposite sex couple on any of them. You notice it don't you? It
59 says we exist, there is validation for who I am. At least that's what I think.

60 I mean, I think I have been incredibly fortunate looking back, but a lot of people aren't, are
61 they? It's really been a bit of a non-issue.

62

63 *end tape*

64

Story Four

Introduction:

Coming out has been called “the central narrative of positive gay experience⁵¹” and has assumed an almost iconic place in queer culture. But where is coming out in our post-modern pansexual present? Do we still have to declare ourselves, plant our flag in the queer outlands – or is the time of labels (and closets) over?

Despite the hype that increasing numbers of young people are identifying as queer and gender fluid - there are more coming out websites, tips, hints, stories and blogs than ever. Coming out might be less risky than a few years ago (depending very much on your sources of support, cultural and ethnic background, belief system and so on) but it is still a rite of passage for many queer people. Listening to my participants’ stories (and telling my own), I heard several repetitive ideas about coming out. I realised I had internalised certain “rules” about coming out, rules that I had never really articulated but were attached to strong social mores nonetheless. The following vignettes illustrate some of them.

⁵¹ Kong, Mahoney and Plummer, 2002 (p. 242)

The rules

1994:

Picture me, a baby-lesbian radiation therapist. Spike-haired and wearing pants that are as close to leggings as I can get away with. My lab coat is overburdened with pens (for drawing on skin), a notebook (things I'm not sure I know yet), and a large scientific calculator (there's never one around when you need one). It's the mid-90s, my three-year same sex relationship is not legally recognised, I've been called a dyke for holding hands with her in the gay village, and my mother is still hoping this is all a phase. I mostly pass for straight, even though I have a tiny pink triangle pin on my lab coat – it's my secret sign, my gay handshake, my wink to others who are like me.

Patients often ask me if I'm married and I say no, not yet. Not met the right man, they joke and smile. I smile back and agree, I met a lot of nice ones, but something was missing. When I kissed my best friend, that first time, I felt dizzy with love and lust. The world seemed to shift a little bit. This is it, I knew with sudden certainty, this is what I was missing.

There's a few of us at work, not many and we're quite discreet. Last week a co-worker remarked to a friend that she "didn't approve of my lifestyle" – she's started a prayer group at lunchtime and I assume I'm not invited. We're pretty sure our supervisor Sue is a lesbian; the rumours have been circulating for some time. She ticks all the boxes, short hair, lack of obvious make up and a tendency to change the subject when weekend plans come up. She knows about me but when I talk to Sue I observe the code and don't ask questions – although I'd appreciate the sisterly solidarity I know the score. It's a one way trip out of the closet, people can make all the right noises, extend a welcoming hand, but in the end it's down to you. Those of us in the club know the drill, don't ask don't tell is alive and well in the Clinton administration and in most areas of healthcare.

Rule 1: Don't ask directly, hints are fine but don't push it.

1996:

I met a gay patient last week. He had late stage lung cancer and was in a bad way, here for palliative treatment. He was with his partner, and they held hands through the consultation with Dr. Benson. She's one of my favourites, takes her time, sits with them longer than the other radiation oncologists. I was there to take him away afterwards, to be X-rayed and marked up for treatment. Just before she left, she hugged him and his partner, handed over her card and told him to call her anytime.

When the door closed after her, he started crying. I pulled up a little stool on wheels and touched his hand. That was a shock was it, I said, No, he told me, I knew what was coming. Turned out, he was crying because Dr. B was the first doctor to treat him and his partner like a couple. They'd been mostly met with awkwardness and embarrassment, with a sprinkle of overt homophobia. His partner leaned forward, they'd have found this a lot sooner if they hadn't assumed he had AIDS. It had taken a number of negative blood tests, and lots of pushing to get them to look for other reasons for the weight loss and cough. Did they tell me all this because of my pink triangle pin? I don't know. I cried on the bus on the way home, I wasn't sure if it was sadness or fury.

Rule 2: Even if you're out, healthcare can be a shitty environment.

2005:

Ten years later and I'm finishing up my Masters, I've got an office next to Sue now and we play golf with her and her partner. I'm terrible at it, but like the camaraderie and the drinks cart that comes round with beer every few holes. I'm about to publish my first paper and I'm presenting my research at a national conference. Twelve minutes to summarise a year's worth of work. But the location is nice and there's a lot of social activities, including the so-called gala dinner. Mainly these things make me anxious. All the women wear cocktail dresses and full feminine decoration, carry tiny metallic bags that hold next to nothing. I don't generally wear heels and skirts so always feel like I've been at the dressing up box. I hate doing girl-drag. I tend to load up on the free wine at dinner, then kick my heels off under the table when I'm drunk enough to dance. This time is no different.

The talk goes well, it's out of the way on the first day and the questions are few and easy to answer. One of my work colleagues, Ben, is here. For my talk he wore a mustard-yellow cardigan and khakis, easy to spot at the back of the room. I am 98% sure he is gay but he's never come out to me. I've talked to him a few times and sprinkled in a few gay references, see if he'll take the bait, but never a tug at the line. For the gala dinner he is the only one in a tuxedo and bow tie, he looks very dapper and is having a good time on the dance floor surrounded by his female friends. I join then, sliding a little in my stockinged feet as I dance to Dancing Queen. Ben knows all the words. Of course.

I follow him back to his table and help myself to the white wine. The red is all gone, unlike my table where we're all white drinkers. I optimistically pour a glass of water from the jug as well, knowing I probably won't touch it. I lean over – so, Ben, when are you going to finally come out? He looks at me, looks away. I mean, come on, it's not a secret is it? You are gay? He fiddles with the stem of his wine glass. I laugh, but this isn't going as well as I'd hoped. I wasn't sure why I'd decided to do this, maybe I'd figured it was time? Ben clears his throat, but still

says nothing. We're alone for now – there's a large group on the dancefloor singing along to "Paradise by the Dashboard Light".

I look back at my own table, feeling increasingly awkward. Maybe I've completely misjudged him? I open my mouth – to say what? Apologise? Ask him again? He puts down his wine glass and looks at me. Well, he begins, I don't really like to label myself. Oh God, really? This? I snort – yeah, OK. So you're not gay? He looks away again. I don't do labels, I'm just myself. I don't think it matters. So – yes, I think. But not ready to come out. Right – I push myself back up to my feet – well, good luck with that Ben! Meatloaf is still playing; the women are scream-singing at the men in the middle of a wide circle. No thanks. I head outside for a cigarette.

Rule 3: Let people come out in their own time

Rule 3a: Don't harass people about being gay when you are drunk

2018:

Last year. Naomi and I are hugging goodbye after our final interview. It had been a while since we'd seen each other but she doesn't look any different from the newly-graduated therapist I worked with over twenty years ago. Naomi is a friend of Ben's and we've been mulling over visibility at work – whether it's changed, who comes out and when and why, and whether there's a support network for queer therapists. We talked about the difference it made having Sue as our manager, after she came out. How it made us more comfortable and how that's missing now. It's been unexpected, the reticence I heard about from Ben and Naomi. I'd expected that had been left behind years ago, half-wondered if I was wasting my time, but it still seems to be pervasive. Naomi talks to Ben, but that's about all. She keeps herself to herself at work, there's a group of therapists she knows to be “difficult”, but she avoids them. She knows a few gay therapists but doesn't hang out with them. I'm interested in this – who are they, I ask - then immediately follow with – oh, no, you don't have to tell me. She doesn't.

There are signs of change, one of the gay therapists at work does drag, down on Church Street, and people know – the manager and a few others went to see him during Pride. That would never have happened a few years ago. I wonder if that's support or tourism, then mentally slap myself for being so cynical. I close the door behind her and make myself more tea. This house is on a hill, overlooking the lake. I take my drink and go on the deck, looking through the trees shedding their leaves towards the distant line of blue. I've spent the last two weeks talking to my friends, then listening to them speak over and over again as I play and replay the recordings. I hear their voices in my head when I am falling asleep on the fold-out bed in the basement. I pull and tug at the skein of their words trying to find the connections, the parts where they weave together. I think a lot about Naomi, knowing who to steer around at work, scanning her environment for predators.

On my last night, I'm eating dinner with my friends, they've been together a long time and work for the school board. We talk about being out, we'd all say we were completely out – all the time, Jake tells me he loves to correct straight people's assumptions and change "wife" to "husband" when people assume he's married to a woman. I laugh, remembering our double wedding at City Hall the year same sex marriage became legal – and the clerks all joked they'd better get the couples right! How about to the kids, the ones you teach, I ask? They're old enough – how do you deal with that? Peter thinks for a moment. It doesn't come up usually, but once one of them asked me about my wife – I said, what makes you think I am married to a woman? I pause, lean across the table. And the parents? Do you tell them or correct their assumptions? No – he counters – you never know with them, different backgrounds. I wouldn't go there. Jake nods. Not worth it, he says.

Rule Four: Coming out is a continuous and nuanced act – even in 2018.

Coda:

I wonder about these rules later back home, as I type up my transcripts. This coming out code so implicit that I wouldn't ask Naomi who was gay, that I hadn't asked Sue years ago when it would have made a difference to me. I felt the sting of shame when I remembered asking Ben to come out to me, knowing even through several glasses of wine that I was crossing a line.

Shame, stigma and internalised homophobia – we know the words and why, but our feelings say be cautious, tread carefully, here be dragons. This is not generalizable – but maybe generational? Would this be different if we were all younger? Probably, possibly. What if we worked in a different field? Likely.

Ben and I talked about “the coming out circle” – how you gradually make your way from the inside out – from close family and friends to that waitress last night who asked if you were sisters. It's different professionally, despite the rhetoric we don't bring our whole selves to work, but we do know LGBTQ role models help staff and out and comfortable healthcare professionals can help queer patients. Maybe the rules need to change?

Postscript: Telling stories

Truth for anyone is a very complex thing. For a writer, what you leave out says as much as those things you include. What lives beyond the margin of the text? The photographer frames the shot; writers frame their world. (Winterson, 2011)

Where do we begin? Where does the story start? What is said, and what don't I tell you? Look closely and you see the text, on the screen or across the white space of the paper. Move back and see me – I'm a researcher, a lesbian, a healthcare worker and I am writing stories. It's late at night at a table in the kitchen of my quiet house surrounded by transcripts. I pick over my participants' words like I'm picking over a carcass, looking for the meat of the story.

The tale moves along, as tales do. We're in a house, a borrowed house in Toronto's East end. I'm telling stories to my three research participants, finishing with the tale of Lisa's cancer treatment⁵². Lisa's story is really the story of her partner, who is angered by their treatment as they navigate the healthcare system. It was inspired by Sue, who had an encounter with a similar patient partner. This is the first time we've met as a group since the discussions last fall, although we've emailed back and forth, and they've been sent advance copies, but I think only Sue has read them. Ben has been at a conference with me the last few days and tells me he meant to read them but just didn't get around to it. Naomi doesn't say but I suspect she hasn't either. Never mind, we get through the pleasantries and settle with cookies, tea and water in the sunny living room and I start to read.

When I look up, their eyes are on me but they are somewhere else. The story has them. I stop half way to see if they'd need a break but Ben gestures me to go on, Sue and Naomi nod. When I finish, there is silence for a long minute. All three of them are looking at me thoughtfully.

⁵² A Lesbian Breast Cancer Story

Naomi is stroking one of the house cats; Olive is winding herself around Naomi's legs and purring happily, tail twitching. They stir, Sue reaches for her cold tea, changes her mind (it's been cold for an hour) and shifts forward in her chair.

Too much? I say, a lot happens to this couple, is it too much? To my surprise they all shake their heads. Ben says, no, maybe not enough! Yeah, it's very familiar, Naomi this time. I look at Sue. The story came from her – I'd left out much of the after, the support that Sue had been able to give to the patient and her partner, but I remember from the original conversation it had made a lasting impression on her.

Sue frowned, thinking. I waited. I'd been so worried about the reaction from my participants, but they'd been wonderful. They understood the blurriness and crossovers from their transcripts as they had been fictionalised, and they'd enthusiastically shared with each other the ideas and stories they'd previously talked to me about. This piece has prompted the most discussion, partly because we can see ourselves in this, as patients. We've been misrepresented, mistreated, misused. We see the truth among the words, like a current pulling us along. We've all been unrecognised and made uncomfortable in healthcare, been the object of curiosity or discomfort, and we know how it feels.

I look across at Sue, she's talking – that woman, she was ready to punch someone's lights out, I remember. She was so angry. We laugh, Sue squares her shoulders. It's true! You said in the story about her being taken for the patient's sister – well I remember her saying if she'd actually been her sister, her family, she would have had a better time. Ben asks – when was this, in the 1990s? Sue nods, the story was set then right? Yes, I say. Before gay marriage, I tried to make that clear. Would it be better today? We agree it probably would be, but maybe not that much. I think about the story – Lisa, crying on the bed, facing one more obstacle as she navigates her cancer diagnosis and the building frustration and helplessness of her partner and

I feel a stab of sorrow for queer patients in our broken system. I know from my work that it's still hard, we still don't do enough.

What did you say, to her, back then? Ben asks. I remember he hasn't read the transcript, listened to the tape on the bus, on a plane over and over. I came out to her, I wanted her to know – this is not our culture, this isn't who we are, Sue states. I wasn't just another straight administrator, I understood. We watch her, she is flushed, sits up straight on the couch and she gestures to my iPad, propped up on the coffee table recording the session. It would have been unprofessional *not* to come out.

That word. That term. Professional. It came up a lot in all our conversations, the lines we draw, the lines we don't cross with patients. We've talked about being professional, right? I say and take a cookie, they're untouched so far but by the end of the afternoon they are all gone.

I remember a story, a touch point, from the first year of my studies and I tell it. I'm at a doctoral retreat, as first year doctoral students we're there to mostly listen and learn. I'm lining up for coffee in one of the breaks, and there is a UBC professor behind me. Tall, middle aged White man, exuberantly bearded, he looks like he takes the academic dress code seriously in pressed chinos and a turtleneck. As I reach for the cups he starts making what passes for small talk at this event. He leans in, I lean back, he asks - what's your research topic? I panic slightly, I don't have my elevator pitch yet, and when I talk about what I want to study I always feel simultaneously stupid and self-centred. This exchange isn't going to help. Well, probably about gay and lesbian healthcare workers, I say. I feel my voice rising at the end of the sentence as if this is a question. Coming out? How this affects relationships – for example, with patients. He stares at me for a moment, stirs sugar into his coffee. I wait for his opinion, his approbation. Hmmm, he starts. Surely that's irrelevant? I'm not sure what to say but luckily, he doesn't seem too worried about my opinion. You are professional, aren't you, in your job? Isn't that the point of

the white coat? You are just a neutral healthcare unit caring for a patient. Your personality, your sexuality shouldn't come into it, should it? Oh God, I remember thinking, maybe he's right? He has the beard...he should know. Am I wrong about this? I went back to my table deflated.

We all look at each other – that's it right? I say. That's the idea of professionalism? That white coated neutral healthcare unit? Is that what we're saying? There is a thoughtful silence. Ben shifts in his chair, you don't share everything with everyone though, right? You're not friends with all the therapists – I can have a good time in my shared office with Katie, we have fun, we're like Will and Grace – or maybe Jack and Karen. But then I spend a day on the treatment unit with these two homophobic staff members and it's the longest day of my life. So not everyone, all the time. It's....he pauses. It's situational – Naomi finishes his sentence. I think of the reading we in did in class on professional wisdom, the tacit skill that comes with experience, the flexibility to tailor the care to *this* patient, at *this* time - isn't that what we mean, or close to it? Our shared identity can help to make the encounter more human, more comfortable and isn't that professional, if by that we mean altruistic, caring? Professional isn't being clinical, Sue remarks, they're not synonymous.

No, I think, not the same. My work has always been around the relationships we have with patients, how we see them, how they see us, how we can make it better. My dissertation supervisor has listened to me ramble about this, how patients are vulnerable, afraid and how we should make that better for them, if we can. Last time we met she watched me, I was damp from the rain and flustered I remember, trying to make her see what it was like for us in the dark treatment rooms entrusted with people's bodies, marking them with ink, fastening them to the treatment bed, irradiating them. She steepled her fingers together, light glancing from her round glasses and said – you're saying, I think, that you want to know what it's like being a person who is supporting a person in a time of suffering. Where is professionalism when you reduce it to that?

It's later. We're wrapping up, the focus has shifted to people we know, an upcoming sixtieth birthday party this weekend, who is retiring, who has moved on. The stories are back in my bag and I stop the recording, stretch and look out at the bright street and see my friends walking up the hill, back from their long lunch to reclaim their house. Where do we stop, at the goodbyes, the thank yous? At the moment my friends come in, flushed from the climb up from the beach and carrying wine for us to share? Later as I fly west, looking at the clouds underneath me and think about Lisa's story and how it felt to read it to my three friends whose words and experiences had shaped it. Where does the story end?

Pull the frame back and I'm writing again, back at my kitchen table, books scattered around me. It's daytime, my son is playing a loud computer game and video chatting with friends. I touch the keyboard gently, like a blessing. Is this enough? Is this the last line?

Chapter 5: Discussion

5.1 Introduction

Having presented the stories—stories with different protagonists and settings—what elements emerge from them that allow me to answer my research questions? This chapter is where I discuss “the patterns, narrative threads, tensions and themes” from the results of my research (Clandinin & Connelly, 2000, p. 132). From the interiority of the “vulnerable self”, this chapter pulls back the autoethnographic lens to focus “outward on social and cultural aspects of (*the*) personal experience” (Ellis & Bochner, 2000, p. 739). The stories are a personal retelling of the conversations I had with the participants, Ben, Naomi and Sue. As I wrote the stories, I interpreted, judged, ignored and amplified elements of the conversations. In some stories you might hear the voices of the participants clearly, in others mine is foregrounded. However, Connelly and Clandinin (1990) note that the concept of “where the ideas came from” is problematic. For example, does an idea in a story arise directly from participant interaction, or from a reflective piece written afterwards, or from the broader conversation in the literature? As Ellis and Bochner (2000) comment, “distinctions between the personal and cultural become blurred, sometimes beyond recognition” (p. 739).

In the discussion section that follows, the six stories (including the preface and postscript) are the interpreted and shaped data, thus references to Ben, Naomi and Sue refer to their fictionalized story characters in “Queer Encounters”, “The Rules” and “Postscript: Telling Stories.” Other characters include Lisa and Alex and their friends (A Lesbian Breast Cancer Story), Tegan (Tegan Transcript 1: 10.08.17) and Amanda (The Rules). When referred to in the text, particular stories and characters are situated within their stories of origin using footnotes.

5.2 The research questions

My research questions focused on the experiences of lesbian and gay radiation therapists managing their sexual identity at work. How does this identity work manifest and what effect does it have? We also know that lesbian and gay patients are carrying out identity work as they navigate the heteronormative and de-personalising experience of undergoing radiation therapy. As I began to write the stories, I found I came back to the patient experience. I had conceptualised a potential connection between lesbian and gay therapists and similarly identified patients. This had been true in my experience, and I had assumed it held true for others. This connection seemed to be an important and mostly overlooked point in the literature, namely that we could perhaps improve the generally poor experiences of some of our patients by supporting LG RTs to be more comfortable coming out at work.

My overarching research question was: how do LG RTs negotiate the complexities of sexual orientation disclosure (“coming out”) in daily practice? Although the stories span about 30 years (from the 1990s in “A Lesbian Breast Cancer Story” to the present day in “Queer Encounters”), the healthcare workplace depicted hasn’t changed a great deal. Compounding healthcare’s institutionalised heteronormativity is the biomedical and technocratic medical culture, where HCPs learn early on to view patients as disembodied disease states and not fully realised agentic human beings (Davenport, 2000). Despite national rights-based legislation and Tegan’s declaration that “we have policies,” patients struggle with less-than-inclusive forms and processes. Additionally, staff as well as patients can still be subject to implicit and explicit homophobia as demonstrated by Sue’s colleague Carrie’s behaviour⁵³ and the actions of Lisa’s radiation oncologist⁵⁴.

⁵³ Queer Encounters

⁵⁴ A Lesbian Breast Cancer Story

Thus, it is clear from Naomi, Ben, Amanda and Sue's experience that sexual orientation disclosure is an ongoing issue at work. Whether it was deflecting patients' inquiries or working with colleagues, all dealt with the issue of managing their sexual identity at work to some degree. This is part of everyday reality for many LG people working in healthcare, where a significant number experience stress and social isolation (Colgan & Rumens, 2015; Eliason et al., 2018; Gubric & Sondheimer, 2014). Moving away from the binary idea of being either "out" or "in" the closet, however, we see that the process is considerably more complex as "there are as many closets as individuals in one's audience.... This makes coming out a Sisyphean enterprise" (Yoshino, 2006, p. 68). The heteronormative healthcare workplace environment renders non-heterosexual identities effectively invisible; LG HCPs (and patients) must make conscious decisions about when and where to "visibilize" their queerness.⁵⁵ Consider the identity work done by Alex and Lisa when they don't challenge the assumption that they are "just friends" in the clinic,⁵⁶ Tegan when she says, "I haven't ever overtly said anything to Poppa, but he knows, we just don't discuss it"⁵⁷ and Amanda's friend Jake when he delights in correcting people who assume he has a wife. These are all decisions made in the moment, in a specific context using various tactics. Following Orne's (2011) model of "strategic outness," the degree of disclosure and covering is contingent on an individual's situational social circumstances.

Various personal identity management approaches are used in the stories, including verbalising, such as Tegan's coming out statement to her Dad,⁵⁸ as well as more subtle cues like the flagging demonstrated by Ben's dress sense and choice of music⁵⁹ (Lane, 2016; Manning, 2015). Amanda's interactions with Ben⁶⁰ (when she "sprinkled in a few gay references" and later when she directly asks him if he is gay) are examples of coaxing and using "cues and hints" to

⁵⁵ Phrase borrowed from Robertson (2017).

⁵⁶ A Lesbian Breast Cancer Story

⁵⁷ Tegan Transcript 1: 10.08.17

⁵⁸ Tegan Transcript 1: 10.08.17

⁵⁹ Queer Encounters

⁶⁰ The Rules

encourage someone to come out (Orne, 2011). Finally, although the workplace rumour mill has identified Sue as a lesbian⁶¹, she is perhaps using “speculation” or “the open secret” for her identity management strategy (Yoshino, 2006).

5.2.1 Research question one: What influences LG RTs’ decisions regarding coming out at work?

Most of the RT characters consciously compartmentalised their “professional” and “private” personas to conform to the highly conservative healthcare environment. There is a strong implicit pressure at work to cover, as Amanda says:

It was fine to be a lesbian (after all we had policies) but the general feeling was that to be too much of a lesbian around patients wasn’t acceptable. No one had ever sat me down and explained this, I just seemed to know.

This pressure to conform was associated with their sense of themselves as “professionals.” Uncovering, or coming out, to patients would be seen as unprofessional and crossing a strong (albeit unarticulated) boundary. As Tegan comments⁶², “there’s no need to bring my private life to work, is there?”

Further, sexuality can be seen as irrelevant to practice or “a bit of a non-issue⁶³” which further compounds the complexity of coming out. Finally, workplace support can encourage coming out at work. Although there was some evidence of this in the stories, for example the manager going to see one of the RTs do drag, discretion seems to be the order of the day⁶⁴.

⁶¹ The Rules

⁶² Tegan Transcript 1: 10.08.17

⁶³ Tegan Transcript 1: 10.08.17

⁶⁴ A reference to “The Rules”, where Amanda remarks “there’s a few of us at work, not many and we’re quite discreet”.

The influence of professionalism: Negatively affecting coming out

One issue that strongly influences the disclosure decision is the professionalism discourse. The professionalism discourse, as described by the bearded UBC professor in “Telling Stories”, is central to modern healthcare:

You are professional, aren't you, in your job? Isn't that the point of the white coat? You are just a neutral healthcare unit caring for a patient. Your personality, your sexuality shouldn't come into it, should it?

Or as Tegan remarks⁶⁵, “there is a line, I don't like to cross it”. In the public and private sector, and especially where clients are potentially vulnerable, norms, work policies and occupational standards often dictate keeping a “professional distance”. Some rules are implicit, such as the lingering association of the professional workplace as masculine/technical/distant as opposed to the association of home with the feminine/relational/emotional (Connell, 1987). Explicit instructions are often found in professional codes of ethics or standards of practice, to attempt to manage issues of power between patient and healthcare professional that might lead to exploitative behaviour. However, as Zingaro (2009) remarks, this can lead to HCPs trying to negotiate “a complex compartmentalization of personal experience” (p. 106). Attempting to separate “personal” and “professional” life can lead to both workplace disengagement and significant stress (Buddel, 2011). As sexual minority HCPs are positioned as “other” in the heteronormative workplace, their sexuality is subsequently seen as “private” as opposed to the dominant heterosexuality (Hearn & Parkin, 1995).

As well as disappearing non-normative sexualities, the heteronormative professionalism discourse stresses gender conformity (Colgan & Rumens, 2015). LG RTs are implicitly constrained to cover gender non-conformity and “rigidly defined workplace performances” also entail dressing the part (Adkins, 2000 cited in Williams, et al., 2009, p. 212). For example, consider

⁶⁵ Tegan Transcript 1: 10.08.17

Amanda attending her work event⁶⁶, where she feels that she needs to dress according to conventional feminine ideals when she says, “I don’t generally wear heels and skirts so always feel like I’ve been at the dressing-up box. I hate doing girl-drag.”

The influence of professionalism: Positively affecting coming out

An alternative view of professionalism harks back to the classical definition of “profession as vocation” that encompasses altruism or “devotion to the public good” (Harris, 2018). In a similar fashion, Dunne (2011) argues that, as well as technical competence, professionals are distinguished by their virtues of character that include honesty, humility, caring and courage. For LG RTs, perhaps “our shared identity can help to make the encounter more human, more comfortable and isn’t that professional, if by that we mean altruistic, caring?”⁶⁷ Sue, discussing her interaction with a lesbian patient⁶⁸, remarked that, “it would have been unprofessional *not* to come out,” demonstrating both caring and courage and the fact that perhaps the sense of oneself as a professional would, at times, be an impetus to disclose.

Zingaro (2009) comments that “bordered” HCPs can use their lived experience as part of their professional toolbox. The decision to contextually use the “tool” of self-disclosure might involve the Aristotelian concept of *phronesis* (professional judgement or practical wisdom). Dunne (2005) comments that a practitioner using *phronesis* can recognise the individuality of the people involved as well as the particularity of the situation to adapt practice.

To have *phronesis*...is to be able to recognise situations, cases or problems as perhaps standard and typical... a type that has been met previously and for which there is already an established and well-rehearsed rule, recipe or formula—or as deviating from the standard and conventional, and in either case, to be capable of dealing with them adequately and appropriately...It lies precisely in the mediation between general and particular, in the ability to bring both into illuminating connection with each other. (Dunne, 2011, pp. 17-18)

⁶⁶ The Rules

⁶⁷ Postscript: Telling Stories

⁶⁸ Postscript: Telling Stories

Phronesis is “more than the possession of general knowledge⁶⁹, because it is the ability to actuate this knowledge with relevance, appropriateness, or sensitivity to context” (Dunne, 2005, p. 376). This practitioner know-how incorporates tacit knowledge that may be hard to articulate verbally but is often integral to professional practices (Polyani, 1958). In a similar fashion, Schön (1983) calls this tacit knowledge; the “swampy lowlands” of practice where situations are often complex and “incapable of technical solution” (p. 42). Professional wisdom also means subsequently exploring ways to bring the experience of the particular (perhaps messy) circumstance into the professional body of knowledge (Dunne, 2011).

Dreyfus and Dreyfus, and subsequently Benner examining the practice of nursing using the Dreyfus model, identify the fully realised practitioner who utilises their tacit knowledge/professional wisdom as an “expert practitioner” (Benner, 1984; Dreyfus, 2004). This novice-to-expert continuum is explicitly based on experience, described by Benner (1984) as “the refinement of preconceived notions and theory by encountering many actual practical situations that add nuances or shades of differences to theory” (p. 407). For experienced LG RTs, perhaps this practical wisdom allows them to be flexible and attuned to the possibilities of trusting relationships with similarly positioned patients. “Professional isn’t being clinical”, Sue remarks, “they’re not synonymous.”⁷⁰

The influence of the irrelevance narrative

Alongside the professionalism discourse, what Robertson (2017) calls “the irrelevance narrative” appears to have an influence on whether the RTs came out at work. This is exemplified when Tegan comments⁷¹ that her sexuality “doesn’t make any difference at work...why should it?”

⁶⁹ Or *techne* (technical rationality) defined as an explicit knowledge and theory base possessed by a professional with clearly formulated, generalizable and agreed procedures or rules. For RTs this might be the treatment procedures that dictate how to position a patient, how much radiation dose to deliver etc.

⁷⁰ Postscript: Telling Stories

⁷¹ Tegan Transcript 1: 10.08.17

Robertson's recent work with medical students demonstrated that most of them felt being LGBT has little or no effect on their professional identities. However, when they recalled their experiences with HCPs when they were patients themselves, they had a different perspective and acknowledged that, at times, they had been treated differently because of their sexual orientation (Robertson, 2017). There are obvious examples of mistreatment in Lisa's story⁷² and Ben, Naomi and Sue clearly identified the truth of Lisa's story⁷³: "we've all been unrecognised and made uncomfortable in healthcare, been the object of curiosity or discomfort and we know how it feels."

One aspect of the irrelevance narrative is a theme of 'presumptive outness' as exemplified by Tegan⁷⁴ when she says she won't "wear a t-shirt" or "wave a flag", but she doesn't hide who she is. Covering or managing sexual identity disclosure using various methods and being selective about who to come out to becomes the norm. As Robertson (2017) points out, however, this can also strengthen the view that sexuality *per se* is unimportant in healthcare, including patients, and can further conceal non-normative sexualities. Finally, the characters in the stories echoed the patient-related theme of "gratitude for being treated normally⁷⁵"—for example, when Tegan remarks "I think I have been incredibly fortunate looking back⁷⁶." It is obvious from her transcript that she hasn't been particularly fortunate and has, in fact, experienced significant discrimination. It's clear that many of the characters have had similar issues and have perhaps lower expectations of "being treated normally" than non-minoritized populations (Smith & Pettigrew, 2014).

⁷² A Lesbian Breast Cancer Story

⁷³ Postscript: Telling Stories

⁷⁴ Tegan Transcript 1: 10.08.17

⁷⁵ See section 2.5.

⁷⁶ Tegan Transcript 1: 10.08.17

The influence of workplace support

Organizational support is strongly associated with workers' sexual identity disclosure (Huffman et al., 2008). Indicators of so-called “gay friendly” organisations include LGBTQ groups or networks and diversity training, as well as outreach to local LGBTQ communities (Rumens, 2016). There was some evidence of occupational support in the stories; for example, Tegan⁷⁷ comments that “we have policies” to deal with discriminatory behaviour and cites her manager effectively dealing with an abusive staff member. However, policies might be an expected bare minimum in the current workplace and may not indicate actual respect for sexual diversity rather than compliance with national rights-based legislation.

For SGM patients, a welcoming environment that includes visual signs of welcome such as posters, safe-space signage and educational material is important (Bolderston & Ralph, 2016). I would argue that the same visual cues can serve to make SGM staff also feel more comfortable at work. Tegan⁷⁸ remarks that seeing oneself included in this way “says we exist, there is validation for who I am.”

Finally, SGM role models and mentors can provide workplace support. The workplaces depicted in the stories had little in the way of organised groups, but open SGM co-workers, especially those in positions of authority, can signal that the workplace welcomes diversity (Stonewall, 2018). Consider Amanda, playing golf with manager Sue and her partner⁷⁹. It is clear that for Naomi and Ben, Sue also made a positive impact in their workplace: “we talked about the difference it made having Sue as our manager, after she came out. How it made us more comfortable.”

⁷⁷ Tegan Transcript 1: 10.08.17

⁷⁸ Tegan Transcript 1: 10.08.17

⁷⁹ The Rules

5.2.2 Research question two: How do disclosure decisions affect LG RTs' relationships with their co-workers?

Relationships with co-workers for LG RTs are subject to the same issues as relationships with people outside of work. Coming out decisions are still “situated contextually within strategic discourses and personal experiences” (Orne, 2011, p. 688). However, the work context and the pressure to cover at work add an extra layer of complexity. The characters in the stories exhibit various degrees of “outness” and comfort with co-workers, from Naomi’s relaxed joking about her “lesbian card” with her colleague, to the obvious discomfort exhibited by Sue as she experiences Carrie’s homophobic remarks.⁸⁰

In addition to organizational support, relationships with co-workers are an important element of workplace satisfaction for SGM staff (Huffman et al., 2008). In the stories, co-workers can be a source of support as well as stress. Ben, for example⁸¹, enjoys working with his office mate Katie but finds working on a treatment unit with “two homophobic staff members” very difficult. Similarly, consider Naomi, who knows “who to steer around at work” and who is always “scanning her environment for predators.”⁸² She is adept at separating her “private” and “professional” life at work. This is also true of Tegan⁸³, for example when she fields potentially revealing questions from co-workers, and Sue⁸⁴ who has “a tendency to change the subject when weekend plans come up”. As we’ve seen, this disjuncture between public and private personas can be a significant source of stress and workplace disengagement (Buddel, 2011). This is important because the emotional labour required to cover can impede making and maintaining genuine friendships and connections at work (Williams et al., 2009).

⁸⁰ Queer Encounters

⁸¹ Postscript: Telling Stories

⁸² The Rules

⁸³ Tegan Transcript 1: 10.08.17

⁸⁴ The Rules

Inappropriate questioning and stereotyping can be a source of discomfort and may even prevent some people from coming out. For example, Tegan⁸⁵ comments, “I understand people’s curiosity, maybe it’s not something they understand but, I don’t ask you what goes on in your bedroom!” We see Naomi playing with this concept to her advantage as she negotiates her way out of treating a male patient who needs to be catheterised.⁸⁶

Having access to a queer community at work is associated with job satisfaction and commitment to the organization (Trau & Hartnel, 2007 cited in Buddel, 2011). Naomi finds Ben a source of support but doesn’t mix with other gay therapists. However, even LG co-workers can be a source of stress – consider Amanda chastising Ben about his perceived reluctance to come out. The implicit “rules” about coming out can serve to further separate LG RTs, perhaps because of “shame, stigma and internalised homophobia⁸⁷.”

LG HCPs often experience higher levels of stress and less social support than heterosexual colleagues, and many choose not to come out at work (Eliaison, et al., 2018; Gubric & Sondheimer, 2014). Despite the existence of “policies⁸⁸” there is little evidence of a work environment in the stories that encourages and nurtures staff diversity (such as organizational support for SGM staff), and thus it is not surprising that some degree of covering is commonly used by Naomi, Ben, Sue, Tegan and Amanda.

5.2.3 Research question three: How do disclosure decisions affect LG RTs’ relationships with their queer patients?

Encountering the gay man with lung cancer receiving palliative radiation therapy described in “The Rules” was the coalescence of my nascent discomfort with how many SGM people encounter healthcare. I already felt my lesbian identity didn’t fit with my workplace’s heteronormative

⁸⁵ Tegan Transcript 1: 10.08.17

⁸⁶ Queer Encounters

⁸⁷ The Rules

⁸⁸ Tegan Transcript 1: 10.08.17

environment but realising the broader implications for patients was a powerful moment. I had met other LG patients, some of whom came out to me, some of whom chose not to. I had also seen my colleagues (unintentionally) miss opportunities to correct wrong assumptions when caring for patients, for example misidentifying the relationship between the patient and their partner. I wasn't sure if I was told the story by the gay man and his partner because I was a lesbian, but this disclosure decision and encounter had significant long-term ramifications for me. Additionally, watching the difference the care offered by Dr. Benson made to the couple was revelatory. She treated them as she would her heterosexual patients, and although this might be an expected standard of care, it was the first time it had happened to the couple.

The stories reflect the reality of the research participants discussed in our conversations—any kind of purposeful interaction between RTs and SGM patients seems to be rare. The notable exception is Sue's encounter with Alex in "A Lesbian Breast Cancer Story". More typical was Tegan's response of "does it affect my relationship with patients? No, it doesn't come up. Why should it?"

The same barriers that prevent LG therapists coming out to each other (the unspoken "rules" about coming out, the professionalism discourse, the irrelevance narrative, etc.) can also prevent them from coming out to patients, or even making assumptions that a patient may be part of a sexual and gender minority. Tegan⁸⁹, for example, has seen a few patients "like her" over the years but "doesn't like to assume". She recognises that coming out cues can be subtle, but even if she is sure, she would only treat them differently if they needed specific information about support groups or sexual health. Then, ironically, she goes on to say that neither kind of information is readily available at her clinic; which is very common (Kamen, 2018; Nagington, 2017). This is also reflected in "A Lesbian Breast Cancer Story" where Alex finds little information or support to reflect the realities of her life with Lisa. Most of the forms, material and advice is

⁸⁹ Tegan Transcript 1: 10.08.17

heteronormative and serves to remind her again that she is marginalised from mainstream healthcare.

There are no verbal self-disclosures to patients that are apparent in the stories, only subtle clues that might be used as “signifiers of belonging and identity” (Lane, 2016, p. 139). The characters exhibit various degrees of covering, from Ben’s⁹⁰ “affirmative subtle flagging (show tunes, a slightly outré dress sense)” to Amanda’s “tiny pink triangle pin” which she says is “my secret sign, my gay handshake, my wink to others who are like me⁹¹.” Naomi’s appearance⁹² could also signal her group identity, with her “short neat hair and lack of stereotypically feminine adornment.” Depending on the context, all of these indicators “might signal to a gay patient that here is someone who might understand.”⁹³

Coming out for patients can be a “risk of condemnation of the self, risk of impaired communication, of inferior healthcare” (Bjorkman & Malterud, 2009, p. 242). Thus, many SGM people don’t come out to physicians, often because they anticipate they may be treated differently if they do (Lockley & Fish, 2015). There is ample evidence that some SGM patients do indeed receive substandard care or encounter discrimination (Institute of Medicine, 2011). Lisa’s reaction⁹⁴, that she “is never going back there” after her mistreatment by the radiation oncologist reflects the fact that many SGM people subsequently avoid accessing healthcare because of past discrimination⁹⁵. Many HCPs don’t feel sexual orientation is relevant to patient care, and won’t ask, which means that patients often come out to HCPs to correct an assumption that they are straight (Margolies & Scout, 2013). Lisa and Alex navigate each healthcare encounter depending on the circumstance but mostly downplay their relationship, which is constantly misidentified.

⁹⁰ Queer Encounters

⁹¹ The Rules

⁹² Queer Encounters

⁹³ The Rules

⁹⁴ A Lesbian Breast Cancer Story

⁹⁵ Lisa’s negative encounter with the radiation oncologist in “A Lesbian Breast Cancer Story” and her cry of “he didn’t see me” is based on two experiences with physicians from qualitative research about lesbians with breast cancer (Nagington, 2017; Sinding et al., 2004).

Even expressing love and affection in public can be difficult for SGM people, and healthcare spaces can be especially problematic (Heyes et al., 2015). At one point Alex wants to hug Lisa, to comfort her, but wonders about the reaction of the nurse: “Would she care? Would it make her treat Lisa any differently? Was it worth it?” Emotional support is extremely important for people undergoing cancer treatment. The care shown by the couple’s friends in the story is profound. Gay “families of choice” can be a significant source of love and help during a crisis, as birth families may be estranged or relationships problematic. The emotional effect of a cancer diagnosis can strain these familial bonds further (Margolies & Scout, 2013).

Lisa and Alex don’t encounter any out SGM HCPs, except for Sue at the end of the story. We know that Sue was able to make a difference to their care (discussed in Postscript: Telling Stories), but would it have helped them to interact with other out LG HCPs? We know that SGM patients may have a difficult time in our healthcare spaces, and that being cared for by similarly positioned healthcare professionals could potentially help to mitigate this. This aligns with the growing body of research demonstrating that some patients from minority groups may fare better when treated by HCPs with similar backgrounds (Spitzer, 2004). Thus, I would argue that the disclosure decisions that LG RTs make at work can fundamentally affect their relationships with their queer patients. Radix and Maingi (2018) likewise state that an inclusive environment for SGM patients includes visible queer staff. The purposeful and contextual use of a “bordered” sexual identity can be a powerful tool to enhance the patient-HCP relationship (Zingaro, 2009).

Chapter 6: Conclusion

A written document appears to stand still; the narrative appears finished. It has been written, characters' lives constructed, social histories recorded, meaning expressed for all to see. Yet, anyone who has written a narrative knows that it, like life, is a continual unfolding. (Connelly & Clandinin, 1990, p. 9)

6.1 Introduction

It's almost a year to the day since I finished the stories, since I embarked on the rest of this dissertation. Instead of writing at a kitchen table surrounded by the everyday noise of family life, I now write on another coast, in another country, watching seagulls wheel through the grey sky. Their cries mingle with the sound of the sea dragging at the sand, a storm is coming but this room is warm. My table is scattered with chapter drafts, notebooks and half-drunk cups of tea. The characters and location may change but the story continues.

A conclusion is the end of a process, or text; or a judgement or decision reached by reasoning (Oxford English Dictionary, 2019). This doesn't feel like the end, and I'm not sure I have a judgement, but I do have the sense that a few things need to be gathered together. These are the stray threads and ideas that might constitute "future directions" or (if I were writing a different dissertation) "recommendations". In this chapter I tie up a few of these loose ends, pose questions for scholars who may follow, consider the limitations of my research and speculate what the radiation therapy experience might have been like for Lisa and Alex if the clinic had been more welcoming, and if they had been lucky enough to meet Naomi.

6.2 Writing a counterstory

The story that is often told about "being a professional" is similar to that articulated by the bearded professor in "Postscript: Telling Stories", namely that, "you are just a neutral healthcare unit caring for a patient. Your personality, your sexuality shouldn't come into it". Nelson (2001)—following

Lyotard's (1979/1984) work on “metanarratives”—calls this type of story a master narrative, “the stories found lying about in our culture that serve as summaries of socially shared understandings” (p. 6). Master narratives can be oppressive (sexist, classist, homophobic, etc.) and misrepresent people, groups or situations. For the “neutral healthcare worker” master narrative, we have seen that this is not the case, and that who we are suffuses how we work and can affect the caring relationships we can build with patients.

Master narratives can be opposed by counterstories, or, in Lyotard’s (1979/1984) terms, “small narratives.” Nelson (2001) claims that counterstories are told in two steps. The first is to identify the parts of the master narrative that misrepresent the situation; the second is to retell the story to “constitute a revised understanding of a person or a social group” (p. 8). In this way counterstories act as “narrative acts of insubordination” and can alter the oppressors’ perception of the group (p. 8). Counterstories can also aim to change the storyteller’s understanding of herself—even to effect a repair to a damaged identity. In a similar way, Arthur Frank (1995), in *The Wounded Storyteller*, discusses illness narratives. He describes patients’ stories as an attempt to repair the damage wrought by their illness, and an act of reclaiming their personhood.

6.3 Wonderings

I am left with a number of what Clandinin and Connelly (2000) might call “wonderings”. Many of these are potential future research projects and could be investigated with different methodological approaches. I realize that it is hard for me to differentiate the ideas that arose from my interactions with my participants and the subsequent stories from the wider work and research that I have been doing in this area over the last few years⁹⁶. As Clandinin and Connelly (2000) comment, pinning down “where the ideas came from” is not easy.

⁹⁶ See Section 3.4.6

I wonder what it would take to make our workplaces more welcoming for LG RTs? Societal changes? Better organizational support? Supportive line managers? Queer role models? More inclusive undergraduate education? I think all of them. One of the things that surprised me, when I went back to talk to my participants, was how the day-to-dayness of working while gay, or lesbian, hadn't seemed to change much in almost 20 years. Policies are better, same sex marriage has been legalized in a number of countries, explicit discrimination is much less prevalent but some degree of covering at work is still the norm, in line with much of the literature. However, society has changed for the better, and the RTs that are now graduating have very different upbringings and experiences. They may push back against the conservatism of the healthcare environment, remembering that "these systems cannot be diverse and uninterrupted" (Tsai, 2018, n.p.). Organizations can provide a more welcoming environment for patients, links to local queer communities, and actively foster support for their SGM staff (including encouraging SGM role modelling). Finally, higher education institutions should examine both their actual and their hidden curricula to teach SGM healthcare and support their SGM trainees.

I think there are still questions to be asked about radiation therapy as a profession of predominantly woman-identified professionals. Does the fact that about 80% of RTs are women change how we identify at work? How does the false neutrality of healthcare (where an overwhelming majority of clinical staff are women, but most leadership roles are occupied by men) complicate gender roles? Does the "double jeopardy" of intersecting oppressions make it harder for lesbian HCPs to be themselves at work? Does the fact that our sexuality may be more fluid (especially in later life) affect how we present and interact in workplaces?

Additionally, our RT workplace is unique and mainly unexamined, our culture and professional identities undertheorized. In my participant conversations and the stories, and the subsequent discussion, relationships with co-workers were identified as a possible source of support, but also problematic if the co-worker was perceived as being homophobic. There is more

to be said on how a difficult relationship with a co-worker could affect patient relationships, and how allyship may help. If an RT is not out to their co-workers, they might be less likely to disclose to a patient. Over and above issues of “teamwork” and the heteronormative medical culture, how does the RT work environment affect coming out?

Finally, although my research questions were (for the most part) answered, I am left with a lingering sense that the theories of coming out can only go so far. It is clear that:

The decision to come out is not rational or linear, as if someone could follow a number of decision-making steps. We feel our way into these decisions, sometimes even surprise ourselves with coming out to someone when we hadn’t planned to, just because the conversation took a different turn and the moment felt right to drop a hint. (Ruitenberg, personal communication, 2019)

Life, work, relationships and this research project are all messy. There is no tidy model that works in all circumstances. The emotional complexity of managing sexual identity belies the binary simplification of being “in or out”. This immeasurable richness of experience complements the value of narrative inquiry, where people’s stories are told with narrative integrity and without the artificial isolation of “variables” (found in other forms of research) that, in life, are never isolated.

6.4 Limitations

The workplace setting of this research was Toronto. Thus the stories of the participants are situated geographically and socio-culturally in a large Canadian city. While the purpose of this study is not to offer generalizable findings, inquiries in small, rural centres might yield different narratives. I could likewise list other identities and individualities that were absent from the four participants. None of the participants identified as transgender, all were White. Given what we know, the stories of people that are more marginalized would likely be harder, less protected by privileged characteristics.

Another limitation of this study is myself, my imperfect and particular understanding of the methodologies I have used, and the gaps in knowledge that I am only too aware of. Richardson and St. Pierre (2005) claim that NI allows a researcher to say that she may “know ‘something’ without claiming to know ‘everything’” (p. 961). I hope that my ‘something’ will be enough.

6.5 Lisa and Alex revisited: Back to patient stories

I wondered, as I wrote “A Lesbian Breast Cancer Story”, why it was both the easiest to write and the one I seemed to be the most emotionally invested in. I think I enjoyed writing a counterstory to the usual “bright-sided” master narratives of breast cancer (Ehrenreich, 2001). I also think, for RTs and other HCPs, it always comes back to our patients. The sense that we could help, a little, by opening up to LG patients seemed (and seems) to me to be an important potential outcome to looking at the experiences of LG HCPs.

In a video project sponsored by Macmillan Cancer Support in the UK, Lesley (a lesbian living with ovarian cancer) talks about her experience in hospital. She discusses that many LGBT staff are reluctant to come out and reflects on why it matters. “They are hidden and I wasn’t...it’s kind of about equality. They know all about me but they are hiding things about themselves” (Nagington, 2017, n.p.). So, coming out at work for RTs may likewise be about equality and forging a genuine relationship with patients, as well as offering them “a signal of safety...and understanding” (Riordan, 2004, p. 1227).

In considering my findings, and the hope that my research can offer further openings for LG RTs to be out with their colleagues and patients, I decided the story of Lisa and Alex deserved a happier ending. After a pretty dismal experience during her diagnosis and post-surgery, Lisa is attending the clinic for her first radiation therapy appointment. Fortunately for them, this alternative story is what could happen if the LG therapists are better supported and the environment is a little

more welcoming. She was also lucky to bump into Naomi. It's still not perfect (the receptionist obviously needs some cultural competency training), but it's better.

A lesbian breast cancer story: Lisa and Alex revisited

Week one:

The clinic was packed, the radiation therapy part was in the basement, so we squeezed into the elevator with a couple of ambulance drivers and a frail woman tucked up on a stretcher. A flyer taped to the wall caught my eye. Framed in a rainbow flag, a picture of a group of staff members in scrubs at Pride. The sign exhorted readers to “sign up for our Pride booth...or join us for the parade on June 21st.” I nudged Lisa and she managed a small smile. I squeezed her hand a little tighter.

The waiting room was busy, the TV in the corner was set to CNN, covering a bomb in the Middle East. The sound was low, but the scenes of dusty devastation didn't help my mood. I flipped through a copy of Xtra, the local gay newspaper that was on the small side table. I looked at the announcements section at the back. There was a Womyn's Wiccan healing circle at the weekend at the 519 community centre in the gay village. I pointed it out to Lisa, thinking she might be interested. She rolled her eyes, I'm not that desperate yet, love, save it for after the treatment.

After about ten minutes a young woman in a lab coat came out, carrying a green file. She looked around the waiting room. Ms. Petersen? Lisa? Lisa stood up. I did too. The woman introduced herself, Naomi, a radiation therapist – she told Lisa she was part of the team planning her treatment. She turned to me, extended her hand. Nice to meet you, are you Lisa's partner? I nodded. Can I come? I asked, she's had a rough week. Naomi smiled, yes, of course. I'm just going to bring you to a quiet room where we can talk. I gave her a quick look, nails short, ringless, cropped hair and a steady direct grey-eyed gaze, my gaydar started to tingle. To be fair, I had a terrible gaydar, last week I had been surprised when I saw our dentist on Church

Street wearing a “Dip Me in Honey and Throw Me to the Lesbians” t-shirt. I’d assumed Dr. Nelson had a Mr. Nelson and possibly several little Nelsons at home in Cabbagetown.

Naomi-the-possible-lesbian led us to a small room with a table, some plastic orange chairs and a rack of booklets. She sat and gestured for us to pull up chairs next to her. Before I start, she said, do you have any questions for me? I looked at Lisa, she leaned forward, my doctor, she began, will I see him today? Naomi flipped open the chart. Oh, Dr. Cartwright? No, he doesn’t need to be here—unless you want to see him? Lisa interrupted with a no, no...I didn’t have a great experience with him, we’re changing to a new doctor. Naomi closed the file, looked at us both. I’m sorry to hear that. Did you have a chance to ask questions when you saw him, are you alright to carry on? I looked at Lisa, she nodded, yes but I have a few things I want to ask you. I reached into my backpack and pulled out the red notebook.

After we’d worked through the list (no, she wouldn’t be radioactive and yes, we could very much share a bed) Naomi told us today was a ‘marking and measuring’ day. Lisa was going to get tattoos to show where the treatment would go and some X-rays, but her treatment wouldn’t start for a couple of weeks. We joked about the tattoos, maybe a rose or our initials? Naomi laughed but I could tell she’d heard that one before. She said she wasn’t that good, it would be a couple of dots, but her girlfriend was a tattoo artist so if we were interested in more she could get us a discount. Aha, I thought, I knew it! We left with a handful of booklets (none of which we’d end up reading) and the phone number of the clinic’s social worker to talk to if we wanted, about how we were feeling, and maybe get the details of a lesbian cancer support group. Naomi wasn’t sure, but there used to be one at the 519 community centre, might still be one but the social worker could have a list. We should pick up her first appointment on the way out – and some cream from the pharmacy (Lisa’s skin would get sore). She wished us luck, and hoped we’d meet again, I’m going to Unit Six next week – the breast unit, I may see you there. We said we hoped so.

She was nice, I said as we waited for the elevator, Naomi? Lisa made a noise that sounded like 'humph' which I took for yes, sure, but I still hate this. Did she say breast unit, ugh. Is that what I am? A breast? Or part of one? Yep – I said, a massive walking, talking, freakish tattooed boob. Let's get you home before people start to talk, I think we should treat ourselves to a cab.

Week five:

Fourteen treatments down, eleven to go. I was back at work, but the support crew had stepped up and there was a complicated rota on the notice board at home of who was taking Lisa to her treatments. The fridge was full of food and the dog had never been more walked. The radiation therapists treating Lisa seemed to be confused about who all these people were, but had been good natured about it, calling them Lisa's Posse. She'd described it to me, what it was like to be left alone in the radiation room, arms up, under the huge machine that buzzed and swung over her. It sounded awful, but she shrugged and said it was over in minutes. Some radiation therapists are better than others, she said, and she was happy to see Naomi when she started. A familiar face. She wasn't there every day but when she was it was good to not to have to explain to yet another well-meaning person that, no, that nice man in the waiting room wasn't her husband and no, the free make up classes weren't really her thing. She'd seen her new oncologist a few times, a woman who'd obviously taken the time to read Lisa's file and used the word partner when appropriate. Her skin was sore and she was tired, but she was doing alright, so far.

That Friday I'd taken the day off work to go in with Lisa, we were planning lunch at the art gallery afterwards if she felt up to it. Nick and Alan had offered to drive Lisa in the week after, but one of the appointments was late in the day and they'd asked me to see if I could switch it. I lined up to talk to the receptionist, holding the green card they'd given us with the printed times on. The elderly man in front of me was explaining, very loudly and slowly, that he'd missed his

volunteer driver and couldn't get back to Newmarket. His machine was broken, they said, and it would be a while. Could she call? He'd been waiting more than an hour. I tried not to sigh, he turned back to me with an apologetic smile. Long wait? I asked him. He nodded and told me the girls on his machine had said it could be hours if they needed a special part. They didn't know yet. I attempted a sympathetic look, but he'd already turned back to the receptionist.

By the time he shuffled off there was a line of people behind me. I stepped forward and opened my mouth to explain but the receptionist was on the phone and didn't make eye-contact. After a few moments she glanced at me briefly and held up a finger topped with an impressive red-lacquered nail. I waited. The reception area was wrapped in a glass panel, with a small gap at the bottom like a bank. I'd seen other people instinctively lean down to talk into it, but I assumed she could hear me even though she was still talking on the phone to someone she called "dear". No, there were no spots available on that machine for a week, it was fully booked. Even for you, dear, I can't work miracles. Dr. Lloyd's emergency would have to go somewhere else. She hung up and started typing, the monitor on the desk blocked off most of her face but she was grandmotherly, softly wrinkled and grey-haired. A small gold crucifix hung around her neck above her staff identification card that was facing the wrong way. All I could see was a list of emergency codes (Code White was a violent patient). I'd begun to relax a bit, let my guard down, but for some reason she was ringing all my alarm bells. I started to do the coming out math. What were the odds she would ask me who I was? What should I say? Did she look like she'd have a problem?

After a moment that stretched just a little bit too long, she turned to me and asked how she could help. I pushed my green card through the gap and told her I'd like to switch next Wednesday's appointment if I could. She pursed her lips. That's not going to be easy dear, we're very busy and we can't usually accommodate requests. She picked up the card and typed in the identification number, looked at the screen. She raised her eyebrows. Oh, yes, the one

with all the...she paused...interesting friends. And you are? I felt myself flush as her eyes flicked over my face, my clothes. I'm her partner. Oh, she looked back at the screen with a little moue of what might have been disgust or indigestion, it was hard to tell. She pushed the card back to me with the tip of her bright red nail. I'm sorry (she wasn't), we have nothing else that day. She looked over my shoulder at the woman behind me. Was there anything else?

I turned away, face burning, pushed the card into my pocket. I could feel my hands curling into fists. Was it worth a fight? I passed the comment box with its smiley face and cheerful sign exhorting patients to "drop us a line, tell us how we did!!!!" That many exclamation marks are a sign of a diseased mind⁹⁷, I thought to myself. If I complained, it would be hard to prove she had been making a jab at Lisa, at us. It might rock the boat too much and we'd already changed doctors. I'd leave it, Nick and Alan would have to figure it out, or she could get the streetcar that day. I wouldn't tell Lisa, just that they couldn't change the time. Maybe Naomi could do something, it was worth an ask.

By the time I got back to the area for Lisa's treatment unit ("the purple waiting room"), she was coming out of the changing room, back in her own clothes. She smiled at me, her face lights up when she smiles, and I'd missed it lately. She tossed her hospital gown in the white bag by the door. Come on, she said, let's go and get some lunch, you're paying.

Week seven:

It was the beginning of April and the last day of treatment. There were still patches of snow on the streets, but in the cancer clinic volunteers were selling daffodils in small bunches. There was an end-of-treatment bell in the main waiting room and Lisa had rung it. The therapists came out to watch and to wish her good luck. We'd seen lots of other patients ring the bell, and Lisa had always said there was no way she was going to do it, she'd hate the attention, but when the

⁹⁷ This line heavily influenced by Terry Pratchett

time came she accepted the (careful) hugs, cheers and smiles. She'd been counting the days until her treatments were done, but this morning she'd told me she'd miss the routine and the daily support. I just wanted us to get back to normal, but I had a feeling normal would look a lot different now.

Naomi talked to us afterwards. She took us to the same room with the orange chairs. Someone had left a stack of booklets on the table, "Sex and Cancer". I flipped through it as Naomi talked to Lisa. If we were worried about "resuming intercourse" the booklet would have been helpful. Naomi handed us an appointment card, for a return visit in two months, and a badly photocopied sheet with some last instructions (keep out of the sun, keep slathering on the cream, keep hopeful). She'd also printed off a list of gay and lesbian cancer sites, they may be helpful, she said, if you can't find that support group.

We'd found a thank you card with a rainbow on the front, for Naomi. Thanks for brightening my world. Cheesy but appropriate. We'd also brought a box of chocolates for the team, but Lisa had wanted something special for Naomi. We'd thought about what to write—in the end she just put "it helped having you on our side". Naomi smiled as she opened it. I don't, you know, come out much to patients but you both looked like you'd had a rough time of it. I'm glad I could help. She stood up and pulled Lisa into a hug. Pop down and say hello when you come for your follow up. It would be lovely to see you. I shook her hand, then changed my mind and hugged her as well. No offense, but I hope we don't see you again. Naomi laughed, but I got the sense that she heard that a lot.

As we left the clinic I bought three bunches of daffodils and presented them to Lisa with a flourish. We'll have these in the garden soon, if the squirrels haven't eaten the bulbs again. She was smiling as we pushed through the doors to the bright outside.

6.6 Last words

We must use the relative freedom of adulthood to integrate the many selves we hold. This includes uncovering the selves we buried long ago, because they were inconvenient, impractical, or even hated. Because they must pass the test of survival, most of the selves we hold, like most of our lives, are ordinary. Yet sometimes, what is consequential in us begins to shine. (Yoshino, 2006, p. 196)

Yoshino (2006) tells us we must work to reconcile our identities, and in doing so we may find hidden treasures emerging. Writing, reading, thinking and talking about my lesbian identity, and how this has coloured my work has surfaced a rich seam of personal and professional knowledge. Likewise, Richardson (1990b) claims that the use of NI can allow the researcher to better understand themselves, while developing rich, co-constructed narratives with participants. My counterstories have possibly helped to repair a longstanding feeling that these things aren't important, that I should be quiet, not make a fuss. Nelson (2001) claims that such stories help us to reidentify who we are, to replace old ideas about self-worth, and to help us commit to future actions that define "who, morally, we take (*ourselves*) to be" (p. 20). Framed this way, the process of research and writing is and was "a project of narrative resistance" (Nielsen, 2014, p. 99).

As "bordered" HCPs, perhaps our professional wisdom can help us "to tailor the care to *this* patient, at *this* time...Our shared identity can help to make the encounter more human, more comfortable and isn't that professional, if by that we mean altruistic, caring?"⁹⁸ I would also contend that this work can offer insight to other groups of HCPs who are border-dwellers, and who may feel the need to cover at work. Their thoughtful self-disclosure may likewise improve care for similarly-positioned patients. It is important for LG RTs to be perceived as whole embodied people within the workplace, by patients and colleagues. The ability of out, confident LG RTs to improve the cancer patient journey is perhaps even more so.

⁹⁸ Postscript: Telling stories

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