Understanding heteronormativity and microaggressions in the work-integrated learning setting

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Despite the expectation that work-integrated learning (WIL) experiences will provide a safe and inclusive learning environment for healthcare students this is often not the reality for sexually and gender diverse students. Heteronormativity and microaggressions experienced by sexually and gender diverse healthcare students, are rarely considered in the context of WIL. The experience of heteronormativity and microaggressions in the WIL setting requires sexually and gender diverse healthcare students to navigate disclosure decision-making in a power-laden context where all the available options carry potentially negative consequences, which should not be the case. This discussion paper explores the experiences of heteronormativity and microaggressions by sexually and gender diverse healthcare students, identifying the risks to this cohort. Heteronormativity jeopardizes the learning of healthcare students and their wellbeing, whilst also reinforcing deeply entrenched biases, in the form of norms about professionalism. Suggestions about how sexually and gender diverse students might respond are then presented.

Keywords: Heteronormativity; heteroprofessionalism; LGBTQIA+; microaggressions; work-integrated learning

Work-integrated learning (WIL) provides students with an opportunity to gain real-world experience of the profession they are entering, while ensuring the university courses graduate competent graduates who meet the accreditation criteria imposed by accrediting authorities and professional bodies (Nagarajan & McAllister, 2015; Penman et al., 2023). Sengstock (2009) found undergraduate nursing students experienced anxiety as they tried to figure out their 'fit' within the broader profession, with this anxiety also fueling a sense of alienation in the WIL setting. It is not uncommon for students in the WIL setting to experience rejection, being ignored, being devalued, and being made to feel invisible (Curtis et al., 2007), with Sengstock and Maria (2024) finding that 22% of sexual and gender diverse students were stereotyped, and 17% experiencing discrimination. In contrast, Mackaway (2022) indicates that many students successfully engage with WIL, despite a range of barriers. In a recent study, Sengstock and Maria (2024) reported sexual or gender diverse[2] paramedic students experienced heterosexism in the WIL setting, such as sexual and gender diverse recipients of care becoming the brunt of jokes amongst healthcare professionals behind closed doors. Several participants reporting their experience of the WIL environment changed when their sexual or gender diversity became known to paramedics at the placement site, potentially impacting their academic progress and professional future due to their 'true' identity becoming known. Messinger (2004) argues while it is normal for students to experience a mix of emotions and apprehension about WIL, the anticipation of potentially negative interactions or experiences is heightened for sexually and gender diverse students. Sexually and gender diverse young people are known to experience increased levels of emotional and psychological stress compared to their cisgender and heterosexual peers as they attempt to manage a stigmatized identity, experiences of heterosexism, harassment, and discrimination (Acevedo-Polakovich et al., 2013; Higgins et al., 2021; Price-Feeny et al., 2020; Rogers, 2017; Rosenkrantz et al., 2017). While the research published in relation to the experiences of sexually and gender diverse students completing WIL activities is slowly increasing, there is limited literature discussing the

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[2] The terms 'sexually and gender diverse' and 'sexual and gender diversity' are used in this paper to represent LGBTQIA+ people in an inclusive manner and in recognition of the fact that sexual and gender diversity is more encompassing of an individual's sexual and gender identity than LGBTQIA+.

experience of heteronormativity and microaggressions in the context of WIL. This paper discusses the concept of heteronormativity and microaggressions in the workplace, paying particular attention to how these behaviors may affect sexually and gender diverse students undertaking WIL activities in the health professions. Finally, the paper considers practical actions which can be utilized by students, and universities, in response to the perpetuation of inequities in the WIL setting.

HETERONORMATIVITY AND HETEROPROFESSIONALISM

Derived from the earlier concept of 'compulsory heterosexuality' coined by Rich (1980), heteronormativity is defined in queer theory as being an ideological stance which assumes and prescribes heterosexuality as being normal, natural, and inherent (Pollitt et al., 2021). Heteronormativity prescribes heterosexuality as the *right* way, the way people *should* be (van der Toorn et al., 2020), effectively overlooking or dismissing non-heterosexual identities, devaluing these other identities to the point where they are considered inferior or deviant (Bizzeth & Beagan, 2023). Bizzeth and Beagan (2023) argue heterosexism fortifies and legitimizes heteronormativity, with those who identify outside the accepted heterosexual norms being subjected to the dominance of heterosexuality through social institutions, including the media, politics, and education. Intertwined with cisnormativity, heteronormativity insists that gender is binary and must be mapped against a presumed biological sex assigned at birth (Brady et al., 2022).

While societal change has seen an increased acceptance of sexual and gender diversity, with a perceived reduction in heteronormativity in the culture of health professions, sexually and gender diverse people continue to experience discrimination as do other groups for several reasons. Experiencing discrimination may hinder identity disclosures, leading to individuals choosing to pass as heterosexual and cisgender to avoid actual or perceived sanctions (Beagan et al., 2022). Participants in doctoral research undertaken by Clarkson (2014) suggest sanctions including segregation and being 'othered' are common approaches to maintaining a heteronormative culture in the paramedic workplace, and indeed other health workplaces. Sanctions can also take the form of discursive violence, whereby sexual and gender diverse people are differentially treated, degraded, or pathologized, to reiterate heteronormativity through questioning the legitimacy of their experiences (Willis, 2012). Despite increased human rights protections (Cleland & Razack, 2021; Eliason et al., 2018; Toman, 2019; Turban, 2019), changing societal attitudes, and improved legal protections for sexually and gender diverse people, heteronormativity remains commonplace in many workplaces (Eliason et al., 2018; Resnick & Paz Galupo, 2019; van der Toorn et al., 2020; Worthen, 2021). Nadal (2019) suggests full belonging in the workplace for sexually and gender diverse people is impossible due to heteronormative messaging. Heteronormative messaging is promulgated throughout institutions and organizations through policies, norms, and informal interactions which presume and normalize binary gender and 'opposite gender' attraction (van der Toorn et al., 2020; Williams et al., 2009). The underlying message in heteronormative messaging is that all other forms of sexuality are pathological, deviant, invisible and unintelligible (Yep, 2002). Heteronormative messaging regarding norms and informal interactions comes from colleagues and often appears to be sanctioned by managers who sustain workplace cultures which continue to support heteronormative activity at the exclusion of all others.

Overall, the professions are conservative in nature (Jenkins et al., 2021; Martimianakis et al., 2009; Violato et al., 2020), with the professional norms which constitute the accepted standards of the health and medical professions being judiciously upheld by the considerable pressure members of the professions experience to conform to the accepted norms of their chosen profession. These professional norms are often enforced by the standards to enter the profession initially, and following entry to the

profession, through the various codes of behavior and ethical principles that must be met to remain a member of the profession (Jenkins et al., 2021; Violato et al., 2020). Similar to the way in which corporate subjectivity works to silence difference through employees internalizing corporate identities through cultural indoctrination, professional indoctrination ensures the internalization of professional identity (Fleming & Spicer, 2003). Worthen (2021) purports the stigma, social exclusion, and marginalization experienced by sexually and gender diverse individuals may be increasing with a revitalization of social conservatism. Davies and Neustifter (2021) argues that it is now considered inappropriate to bring discussions about sexuality and gender into the classroom, thus making it more difficult to address heteronormativity within the institution, in order to prepare and support students before, during and after WIL activities. Beagan et al. (2022) suggest the stigma associated with identifying as or being perceived by others as sexually or gender diverse, is as prevalent in the health professions as it is in any other social context. In the discourses associated with professionalism, heterosexuality and binary gender are viewed as normal ways of being and doing are upheld as normative whilst some other ways of being and doing, some subjectivities and some bodies are denied, resulting in heteroprofessionalism. These normative ideals of professionalism are then used to uphold, reinforce and regulate the expected behaviors in relation to the profession. Thus, it is likely sexually and gender diverse staff, as well as students undertaking a WIL activity, will find themselves feeling isolated as they experience the pervasive nature of heteronormativity, heterosexism, and cissexism (Murphy, 2019). Experiences of heterosexism are not limited to sexual and gender diverse people, with 39% of heterosexual students reported experiencing heterosexism (Norris et al., 2018). Janson et al. (2009) argues undergraduate students witnessing repetitive negative behaviors scored similarly on scales of trauma reactions as the actual victims of the trauma.

Heteroprofessionalism is observed in the formal health curricula through an absence of content related to sexual and gender diversity, or in cases where there is content, it tends to be stereotyped content or pathologizes sexually and gender diverse people (Eliason, Dejoseph, et al., 2011; Murphy, 2019; Robertson, 2017; Toman, 2019). Heterosexism is also an integral component of the informal and hidden curriculum in the health professions and is particularly apparent in the WIL setting. Educational institutions tend to have less direct control and influence over the curriculum in WIL settings despite the educational institutions having agreements in place in relation to the expected learning experiences. Despite this apparent lack of control over the curriculum in the WIL setting, institutions are able to influence the curriculum through applying the principle of progressing learning for work, carefully matching this with intended curriculum, to allow for learning through work (Choy, 2018). Choy (2018) argues this approach provides learners with an opportunity to receive feedback, evaluate, and reflect on the outcomes of work, ensuring full participation in the workplace setting.

Educational institutions include professionalism and professional behavior as learning objectives to be achieved while undertaking WIL activities, with professional behavior being assessed and evaluated through a discourse of professionalism (Nel, 2024; Trede, 2012). According to Beagan (2000, 2001) and Jenkins et al. (2021), this discourse of professionalism tends to mask the demands that entrants to the profession observe not only expectations of bodies but also conduct and behavior, which are heterosexual and cis-masculine. Both formal and informal surveillance are used by those tasked with maintaining professional norms to enforce the concept that there are ways of being which are deemed to be 'correct,' such as maintaining the gender binary and being heterosexual. Any behaviors which are considered unprofessional are then cause for remedial action. For sexually and gender diverse students undertaking WIL activities, often in an unfamiliar workplace setting and away from their usual support networks, professionalism can be seen as an instrument of inequity and injustice. Mizzi (2013) suggests minority groups may be exposed to victimization and punishment to such an extent

that a culture of fear is established for individuals whose identities do not conform with the accepted norms of the profession or organization. Ross et al. (2022) argues this culture of fear may lead both sexually and gender diverse health professionals and health profession students engaged in WIL to opt to mask, hide, or moderate their identity. The clear, albeit complex power hierarchies, which exist across the health professions, tend to leave both healthcare workers and students undertaking WIL activities subject to evaluation by powerful others who are tasked with the responsibility of assuring fitness for practice. Students who are, or are perceived as being, sexually or gender diverse may experience increased challenges in meeting an assessor's evaluation of their fitness for practice, given the requirements of heteroprofessionalism.

While Eliason et al. (2018) imply there has been a reduction in the experience of overt harassment and ostracism by sexually and gender diverse health professionals over the past 30 years, the reality is they are still routinely subjected to disparaging comments and remarks which stereotype sexually and gender diverse people. Both colleagues and patients/clients have been identified as the source of these disparaging comments and remarks (Eliason et al., 2018). For sexually and gender diverse students undertaking WIL activities, witnessing the abuse of sexually and gender diverse people and their families, coupled with disparaging and stereotypical remarks, communicates contempt for their identity. In research undertaken by Sengstock and Maria (2024), paramedic students undertaking WIL activities expressed concern about the ill-treatment of sexually and gender diverse patients by paramedics. One participant reported the patient becoming the butt of jokes among the local paramedics, leading the student to indicate that they felt uncomfortable with the possibility that their own sexual identity may become known while undertaking WIL (Sengstock & Maria, 2024). Sengstock and Maria (2024) also highlight the incidence of disparaging and stereotypical remarks in on-campus simulations, with this also communicating the level of contempt for sexually and gender diverse individuals. Experiences such as these result in sexually and gender diverse students having to expend energy navigating the disclosure or otherwise of their identity.

In his seminal work on stigma, Goffman (1963) purported that individuals with a stigmatized identity may opt for 'passing,' a process whereby they assume membership of a social group which may be seen as more desirable to avoid disadvantage. In the case of sexual or gender diversity, an individual may 'pass' as gender-normative or heterosexual, despite self-identifying as sexually or gender diverse. Another impression management strategy identified by Goffman (1963) is 'covering'. As a process, covering is more about rendering an identity as less conspicuous and therefore less offensive than denying an identity. In passing, visibility is the key, visibility as gender-normative or heterosexual, whereas covering is aligned to acceptability; a stigmatized identity is conceded, but the significance of the stigmatized identity is downplayed. Yoshino (2006) proposes passing is an attempt to avoid the risks of disclosure of the stigmatized identity while covering is about mitigating the risks of disclosure. Both passing and covering require vigilance and monitoring of self-presentation, again requiring the expenditure of energy to manage the potential consequences of actual or perceived disclosure.

While decisions about passing and covering, concealment and disclosure are ongoing for sexually and gender diverse people, WIL creates unique challenges for sexually and gender diverse students as they are likely to be entering a workplace and organizational setting which is unknown to them. WIL activities, by their very nature, are temporary, short-term undertakings, requiring the student to 'slot' into a workplace or organization, with no real sense of belonging or expectation of longevity. Sexually and gender diverse students undertaking WIL are faced with the concealment of their identity on one hand, and disclosure on the other. Concealment, according to Newheiser et al. (2017), leads to a reduced sense of belonging and reduced satisfaction, with Christie (2021) suggesting that social support

is impacted by concealment. Concealment also impacts the overall wellbeing of sexually and gender diverse students undertaking WIL, with Lloren and Parini (2017) indicating that concealment leads to increased stress and anxiety. Disclosure has been understood as a positive action for sexually and gender diverse individuals, allowing them to be authentic and whole, while experiencing less stress related to concealment and reducing the requirement to be hypervigilant to avoid being 'outed' (Holman et al., 2021). Disclosure, however, is a double-edged sword, as disclosure of a concealable, stigmatized identity may lead to prejudice, discrimination, or hostility (Holman et al., 2021; Pasek et al., 2017).

WIL is an essential requirement for entry to health profession students, forming an integral component of accreditation and professional registration for students entering registered health professions. For sexually and gender diverse students, undertaking WIL activities is a high stakes experience as the disclosure of any concealable, potentially stigmatized identity could negatively impact their experience of WIL or result in an unsatisfactory grade being assigned by WIL supervisors. It is apparent from reviewing the limited literature from research investigating the experiences of sexually and gender diverse health professionals, that most chose to remain invisible, concealing their sexual or gender diversity for fear of reprisal or lost opportunities (Burke et al., 2015; Eliason, Dejoseph et al., 2011; Eliason, Dibble & Robertson, 2011; Murphy, 2019; Robertson, 2017). Murphy (2019) argues that the concealment of sexually and gender diverse identities by health professionals results in a self-perpetuating spiral whereby health profession students undertaking WIL and new entrants to the health professions, receive the message that disclosure of sexual or gender diverse identities is neither safe nor welcome. This messaging to WIL students and new entrants to the health professions reinforces heteronormativity and inequities in the professions.

HETERONORMATIVITY AND MICROAGGRESSIONS

In 2007, Sue et al. defined microaggressions as brief, commonplace daily verbal, behavioral or environmental indignities, intentional or otherwise, that communicate hostile, derogatory, or negative comments which have potentially harmful or unpleasant psychological impact on an individual or group. Nadal (2019), while relying on a similar definition to Sue et al. (2007), explicitly indicates that microaggressions are directed towards members of oppressed groups. Microaggressions exist on a spectrum ranging from microassaults in the form of overt discriminatory statements, to microinvalidations that dismiss the feelings and experiential reality of the person who is the target of this behavior (Torres et al., 2019). Vaccaro and Koob (2019) recognize the intersectional nature of microaggressions, suggesting these can be interpersonal in the form of jokes, comments, looks, or avoidance, but also environmental in the form of institutional policies and practices which invalidate and erase. According to Vaccaro and Koob (2019), the microclimate of the educational setting or institution also plays a significant role in the experience of microaggressions. Supportive or unsupportive colleagues and managers in the workplace can significantly change how individuals experience microaggressions (Vaccaro & Koob, 2019). Experiencing microaggressions may result in fear, anxiety, depression, anger, and hypervigilance (Resnick & Paz Galupo, 2019).

The experience of heteronormativity and heterosexist microaggressions has led to sexually and gender diverse individuals becoming expert risk assessors to avoid harm (Brady et al., 2022). Kelly et al. (2021) suggests the experience of suppression and erasure in the professional workplace may not be limited to those who self-identify as sexually or gender diverse, but also men who are viewed as feminine and women who are viewed as masculine. Sengstock and Curtis (2023) highlight the fact that women in paramedicine who are masculine will be accepted to a point. Stepping beyond what is acceptable or

demonstrating traits of hypermasculinity results in sanctions. While it may seem counterintuitive to sanction traits that may seem to be consistent with heteronormativity, stepping beyond the bounds of acceptable masculinity is seen as a potential threat to heteronormativity (Sengstock & Curtis, 2023). This sanctioning of behavior is often accomplished using microaggressions from colleagues or managers or, in the case of students undertaking WIL activities, staff in the workplace, including supervisors and other staff who may not necessarily have direct or indirect supervision of students. Introducing the ally approach, where a person with privilege and power, who is not the object of discrimination, can assist in interrupting oppressive systems and facilitate social justice in the workplace setting (Wernick et al., 2013).

The experiences of subtle exclusion of lesbian occupational therapists were first documented by Jeanne Jackson in 2000. The informal chit-chat in the lunchroom assumes an expectation of heterosexuality, with the lesbian therapists in Jackson's study suggesting they felt excluded or opted to absent themselves from the informal chit-chat due to feeling uncomfortable (Jackson, 2000). Despite being rife with heterosexist assumptions and expectations, this informal conversation among colleagues tended to be interspersed with sharing information and problem solving in a clinical context, resulting in mutual support and co-learning. Through exclusion or absenting themselves from this informal chit-chat, lesbian therapists missed these informal social connections, which allowed for the articulation and sharing of practice knowledge. At the time of Jackson's study, the concept of heteronormativity was still in its infancy. Despite this and Jackson's failure to use the term heteronormativity, this is what her participants were describing (Bizzeth & Beagan, 2023).

Walker et al. (2022), in a survey investigating the experiences of medical graduate trainees, found LGBTQ+ respondents reported significantly higher rates of discrimination and microaggressions than their cisgender, heterosexual peers. In a qualitative study undertaken by Bullock et al. (2021), common sources of microaggressions included patients, providers, and peers, and the learning environment itself. In a study involving paramedic students and their perceptions of discrimination in their learning environment, Sengstock and Maria (2024) found peers were the most reported source of heteronormative behaviors, with respondents identifying peers as the primary source of microaggressions towards sexually and gender diverse individuals. Sexually and gender diverse healthcare professionals and students experience microaggressions, including patients refusing to be seen by them (Eliason et al., 2018), to colleagues and, in the case of students, supervisors and other staff, making inappropriate heterosexist comments, supposedly as jokes (Eliason, Dejoseph et al., 2011; Sengstock & Maria, 2024).

In the WIL context, the informal learning which occurs through engagement with, or participation in, the social chit-chat in the lunchroom is invaluable to the development of the student's understanding of the profession and the development of social connections. Engagement with this informal, social chit-chat allows students to learn from the sharing of information and ideas, while also socializing the student in the norms of the profession (Lave & Wenger, 1991). For sexually and gender diverse students, the assumption of heterosexuality and the heteronormative nature of the discussion is likely to cause anxiety as the student is faced with the decision to 'pass' or 'cover.' Students, like the lesbian occupational therapists in the study reported by Jackson (2000), may feel excluded from the conversation even though they use 'passing' or 'covering' approaches to conceal their identity. Alternatively, like the lesbian participants in Jackson's study, they may choose to absent themselves from the informal chit-chat due to feeling uncomfortable or concerned their identity may be revealed.

Whether the sexually and gender diverse student opts to conceal their identity through 'passing' or 'covering', or to absent themselves from the informal chit-chat in the lunchroom, the outcome is they miss out on an opportunity to develop their social and professional networks. They also miss out on key information and problem-solving approaches that could assist with the development of clinical skills and understanding in the clinical setting, both in WIL and their future clinical employment. It is also concerning if students who are not sexually and gender diverse are enculturated into this culture of heteroprofessionalism and heterosexism as part of their WIL experience, as this potentially results in the perpetuation of the culture for future generations of healthcare professionals.

INTERPERSONAL MICROAGGRESSIONS

Eliason et al. (2018) and Walker et al. (2022) suggest while overt hostility appears to be decreasing, heterosexist microaggressions remain commonplace within the health professions. The apparently innocuous nature of heterosexist microaggressions makes it difficult to prove there is an issue, let alone challenge the behavior. In an interpretive qualitative study undertaken by Beagan et al. (2022) with participants across a range of health professions, experiencing interpersonal microaggressions or overt hostility was not common, although some participants did report experiencing hostility and bullying from more senior staff. Other participants reported becoming the target of gossip among peers, innuendo, and in some cases, mocking. This is further complicated by the fact heteronormativity in the health professions tends to be institutionalized and normalized, resulting in a pervasive culture of heteronormativity which portrays sexually and gender diverse health professionals as outsiders, effectively 'othering' these individuals (DePalma & Atkinson, 2010). Interpersonal microaggressions are used by those in the profession who have assumed the role of upholding the heteronormative norms of the profession such as compliance with expected gender norms to 'other' those in the profession, whether they are sexually and gender diverse or not, to ensure the (hetero)professional standards of the profession, such as the use of binary pronouns are maintained (Beagan et al., 2022; Davies & Neustifter, 2021; Soini, 2022).

Martimianakis et al. (2009) and Jenkins et al. (2021) argue that health professions are power-laden work settings where students spend substantial time subjected to high stakes assessments by powerful others when engaged in WIL activities. These high stakes assessments include the clinical competence, or otherwise, of students, as well as their 'suitability' for entry to the profession. Professionalism and compliance with professional norms and expectations are also assessed by these powerful others, who have been enculturated into their profession, in the WIL setting. The inescapable invisibility of sexual and gender diversity is particularly evident higher in the power structure of both organizations and professions. Mizzi (2013) suggests the philosophy of professionalism may be mobilized against sexually and gender diverse individuals to compel them to comply with the heteronormative expectations of the profession.

In cases where the microaggressions come from a patient/client, it may be particularly challenging to respond, given altruism is embedded in the conceptualization of professionalism (Gabrani & Pal, 2019; Sibbald & Beagan, 2022; Turban, 2019). Confronting patients or clients who make heterosexist comments or insults is unprofessional, with Davies and Neustifter (2021) proposing it is also unprofessional to disclose being sexually or gender diverse as such a disclosure equates to a discussion of sex, a violation of (hetero)professional boundaries. Once professionalism renders *professional* identities devoid of sexuality, sexuality becomes a shameful concept which is not to be mentioned in the rigid confines of the professional workplace, essentially banishing sexually and gender diverse individuals from the realms of (hetero)professionalism through their very existence (Mizzi, 2013).

Several sexually and gender diverse participants in a study involving paramedic students reported their experience in the WIL setting changed once their sexual or gender identity became known (Sengstock & Maria, 2024). Heteronormative questions and assumptions were commonly reported by participants, with casual conversations with staff at WIL sites inevitably entailing questions about relationships, marriage, and children (Sengstock & Maria, 2024). These heteronormative questions and assumptions experienced by the paramedic students in the study undertaken by Sengstock and Maria (2024) were a far more common form of interpersonal microaggressions than overt hostility, although some participants did report witnessing overt hostility directed from students towards other students.

When faced with heteronormative environments, Stenger and Roulet (2018) argue a strategic approach employed by sexually and gender diverse individuals, is to avoid disclosure to minimize the risk of being subjected to heterosexist microaggressions. While this approach may be strategic and reduce the risk of being subjected to heterosexist microaggressions, it perpetuates the erasure of sexual and gender diversity in the health professions, continuing the invisibility of sexual and gender diversity. Sexually and gender diverse paramedic students have previously reported feeling invisible in the curriculum (Sengstock & Maria, 2024). A preliminary analysis of data in a study investigating the perceptions of healthcare students in relation to LGBTQ discrimination in their curriculum suggests this perceived invisibility in the curriculum and WIL settings is also experienced by nursing, occupational therapy, and physiotherapy students (Sengstock et al., 2024). The concept of invisibility found in the study by Sengstock and Maria (2024) and Sengstock et al. (2024) is twofold as students perceived invisibility of sexual and gender diversity in the curriculum, while sexually and gender diverse students also adopted a degree of invisibility in both on-campus and WIL settings. This appears to support the findings of Murphy (2019), where it was determined that sexually and gender diverse students entering the health professions discerned that it was unsafe for them to be their authentic selves.

Those health professionals or students engaged in WIL activities who are either fully open about their sexual or gender diversity or those who are unable to conceal their sexual or gender identity may experience a different form of heterosexist microaggression. These individuals may be faced with the insistence they engage in what Bizzeth and Beagan (2023, p. 8) label “command performances of queerness,” essentially performing ‘queerness’ which fits with the viewers’ expectations of what constitutes the “right kind of queer.” This hypervisibility, as opposed to invisibility, Calvard et al. (2020) and Davies and Neustifter (2021) argue, simultaneously renders the individual as deviant and other, effectively reducing them to always or only ever being their queer identity.

RESPONDING TO HETERONORMATIVITY AND MICROAGGRESSIONS

Richards et al. (2017) propose that the use of ‘to queer’ as a verb is to challenge the normative, troubling it and creating disruptions to open spaces of possibility. To address heteroprofessionalism, heteronormativity, and heterosexism in the health professions it is necessary ‘to queer’ the health professions. To an extent, this process starts with health professional students undertaking WIL and the educational institutions which place them in the WIL setting, calling out this behavior and the microaggressions which perpetuate the spiral of silence. It is not enough for universities to simply proclaim that they value and promote equity, diversity, and inclusion. Universities must now act to meet both their legal and social justice obligations to provide safe learning and work environments. It also involves, where possible, selecting WIL supervisors who are willing and able to call out these behaviors and support colleagues and WIL students who are, or are perceived to be, sexually or gender diverse. As WIL should be a collaborative partnership between the university and the WIL placement site, organizations and workplace supervisors should be screened prior to entering into an agreement

for WIL activities. Universities can, and should, refuse to re-engage WIL sites with a track record of poor behavior. Sue et al. (2019) highlights numerous approaches advocating appropriate responses to microaggressions from the perspective of both the person being targeted and bystanders. Historically, argue Bullock et al. (2021), the target of the microaggression has been positioned as being responsible for determining how to defuse the situation, while, if possible, also educating the perpetrator about the inappropriateness of their behavior. According to Torres et al. (2019), the goal of challenging microaggressions is mutual understanding.

In the context of WIL, Bullock et al. (2021) place responding to microaggressions firmly at the feet of organizational WIL supervisors, indicating they are responsible for working closely with students who are facing microaggressions. WIL supervisors who are working within the organization, as opposed to WIL supervisors who may be 'parachuted' into a workplace by the educational institution to provide WIL supervision on an ad hoc basis, should be aware of microaggressions in the workplace and the extent to which this is problematic. Foreseeing microaggressions, WIL supervisors should engage with WIL students early in the WIL activity to 'pre-brief' them and identify preferred responses. WIL supervisors must always respond in the moment when they observe microaggressions, followed by a debrief with the student and, if necessary, formal action to address the behavior of the perpetrator. Turban (2019) suggests that healthcare professionals could signal their openness to disclosures of sexual and gender diversity and their willingness to act as an ally, using imagery and language. Both Nair and Good (2021) and St John and Goulet (2022) suggest that sexually and gender diverse WIL students may benefit from individual mentorship or, more significantly, mentorship programs facilitated at the institutional level. While facilitating mentorship programs at the institutional level for WIL students may be a challenge due to the often short-term nature of WIL activities, it may be more feasible at an individual WIL supervisor level.

Warner et al. (2020) suggests using the GRIT Framework for Addressing Microaggressions is an approach for those experiencing microaggressions in a health professional context. The framework asks those experiencing microaggressions to Gather themselves, Restate the comment, Inquire without judgment to gain clarification, and Talk about the impact on self (Warner et al., 2020). This framework, while providing an approach which could be used by healthcare professionals and WIL participants alike to address microaggressions, places a large burden on an individual who has experienced a painful, potentially threatening interaction. For WIL students, the already high stakes context of the WIL setting is unlikely to be conducive to their use of the GRIT Framework for Addressing Microaggressions.

As a leading advocate of microaggression theory, Sue et al. (2019) identify four primary approaches to managing microaggressions in what they have labeled as microinterventions. These microinterventions consist of making the aggression visible, disarming it, educating the offender, and seeking external support. It is unlikely that WIL students will be able to implement the four primary approaches identified by Sue et al. (2019), essentially placing the responsibility of addressing microaggressions on organizational WIL supervisors, institutional WIL supervisors and the universities. WIL students should be provided with the skills required to implement the approach suggested by Sue et al. (2019), prior to undertaking WIL activities. Pre-placement briefings conducted by universities should also include resilience training, as well as conflict management skills to ensure students are able to respond in the moment when experiencing negative interactions in the WIL setting. Putting in place mechanisms to allow for the reporting of incidents in a contemporaneous manner, should also be considered to ensure that there is a record of incidents, which can then be investigated by the university. Responding to microaggressions is a starting point for cultural change and

professional change in respect of heteronormativity and heterosexism, although it is not an adequate response in isolation, as the context and power relations which underpin the organizational and professional culture must also be considered in responding to microaggressions.

INVISIBILITY IN THE CURRICULUM

WIL offers healthcare students an opportunity to explore and expand upon the theoretical and practical education provided in the on-campus setting, allowing for the application of academic learning in an applied, real-life context (Abery et al., 2015; Karlsson et al., 2022). WIL is integral to the student's transition from educational practice to professional practice through experience, engagement, and reflection (Abery et al., 2015). In the health professions, WIL can include on-campus WIL-related activities and off-campus placements, variably referred to as practice, clinical experience, placement, or fieldwork, depending on the nomenclature used by an individual health profession or education institution (Nagarajan & McAllister, 2015).

According to Billett (2009), the curriculum is something experienced by students, making it something more than what educators present in the on-campus and off-campus settings. Billett (2006) considers three conceptions of the curriculum: the intended curriculum, the enacted curriculum, and the experienced curriculum. The experienced curriculum is of particular significance in the WIL setting as this relates to what students experience during WIL, as they construct their own meaning from their experience, which may or may not align with the intent of the curriculum or those who enact the curriculum. The concept of the 'hidden curriculum' was identified by Giroux (1978). In the context of WIL, the 'hidden curriculum' refers to the transmission of unstated norms, values, and beliefs through the underlying structure of WIL activities which are not formally recognized or sanctioned dimensions of the WIL experience (St-Amant & Sutherland, 2020). Sengstock and Maria (2024) recognize the absence of sexual and gender diversity in the formal paramedic curriculum, suggesting invisibility of sexual and gender diversity in the curriculum impacts the experience sexually and gender diverse students have of the curriculum. This experience of invisibility from the curriculum is further compounded for sexually and gender diverse students undertaking WIL activities in healthcare settings when they are faced with a heteronormative workplace culture and a professional culture which fails to acknowledge sexuality and gender beyond the binary. This perpetuation of invisibility in the curriculum serves to reinforce the heteronormative culture of healthcare and the healthcare professions, potentially having significant unintended consequences on the experience of the curriculum, not just for sexually and gender diverse students, but all students and ultimately the patients or clients in their care.

While WIL activities provide students with an opportunity to engage in real-life, authentic learning in a professional setting with a diverse range of clinical and non-clinical staff, not all WIL experiences are positive (Levett-Jones & Lathlean, 2009; Sengstock, 2009; Sengstock & Maria, 2024). Despite an apparent commitment in the higher education sector to equity, diversity, and inclusion, this has not always translated to the WIL setting, where the educational institutions have less direct control over the student experience despite having agreements with WIL providers. While some agreements between the educational institutions and the WIL provider may not explicitly detail the institution's expectations in relation to WIL, many do. A primary consideration of any agreement between educational institutions and WIL providers must be an expectation that students will not be exposed to harm. The Work Health and Safety Amendment Bill (2023) imposes a duty on employers to identify and manage risks to workers' psychological health and safety. Regulatory changes such as these provide an opening for universities to open up potentially difficult conversations with professions, and WIL partners, where

there are toxic cultures which harm specific groups such as sexual and gender diverse people. In respect of sexually and gender diverse students, this expectation that students will not be exposed to harm must be extended to include both the academic and WIL curriculum to ensure the visibility of sexual and gender diversity in the curriculum. It is through this visibility in the curriculum that sexually and gender diverse students will feel a sense of belongingness, safety, and security (Beagan et al., 2022; Davies & Neustifter, 2021; Sengstock & Maria, 2024). In the longer term, this increased visibility of sexual and gender diversity in the curriculum has the potential to challenge heteronormativity and heteroprofessionalism at the grassroots level through increased acceptance of diversity and the development of a culture which calls out microaggressions in the workplace, regardless of who these microaggressions are directed towards.

CONCLUSION

This article has explored the concept of heteronormativity and heteroprofessionalism in relation to the experiences of healthcare students and the experience of microaggressions, applying this in the context of sexually and gender diverse students undertaking WIL activities. Regardless of their sexual or gender orientation, students undertaking WIL activities routinely experience an increased level of anxiety as they enter an unknown learning environment, with the potential to experience negative behaviors which can significantly impact their experience of the curriculum. Sexually and gender diverse students undertaking WIL activities are faced with another layer of complexity when undertaking WIL, the need to 'pass' or 'cover' to minimize the risk of microaggressions and the potential for an unsatisfactory performance report if they are seen to challenge the heteronormative culture of the workplace or heteroprofessionalism. Undertaking constant risk assessments to ensure that they are not challenging either heteronormativity or heteroprofessionalism is exhausting and can lead to students being so focused on managing the risk of disclosure that they cannot fully engage with the WIL activity, leading to a reduction in their ability to achieve the learning objectives associated with the activity.

By their nature, the professions are conservative and behaviors which may challenge the conservativeness of the profession open an individual to sanctions as members of the profession attempt to ensure compliance with accepted professional norms, even in the case of students. While overt approaches to sanctioning apparent breaches of professional norms are less common, following the introduction of human rights and legal protections for sexually and gender diverse individuals in the workplace, covert approaches which are much more challenging to identify and prove are commonplace. These covert approaches tend to take the form of microaggressions such as jokes, innuendo, gossip, and sometimes mocking. Proving these behaviors are form of aggression or specifically aimed at a particular individual can be a challenge and WIL students may simply opt to 'ignore' the behavior due to the already high stakes associated with WIL and a desire to not rock the boat and risk failing WIL. For those sexually and gender diverse students undertaking WIL who may be open about their identity or who may be unable to conceal their sexual and gender diversity, microaggressions may take the form of being expected to perform queerness in a form which fits the viewer's expectation of the correct form of queerness.

Traditionally, there has been an expectation that the person whom the microaggression is aimed at, should be responsible for calling out inappropriate behavior. In reality, it is everyone's responsibility to address negative behavior in the workplace, and in the case of WIL students particularly, the responsibility should fall to the organization's WIL supervisor and the institutional WIL supervisor. Students undertaking WIL activities are often in a precarious position as they have no formal position

within the host organization and are already engaged in a high stakes experience. Any behavior which may be considered a breach of accepted cultural norms may result in negative sanctions, such as a failing grade for the WIL activity, adding further, undue stress on students undertaking WIL activities.

It is imperative universities, WIL organizations, and the healthcare professions continue to actively work towards fostering inclusivity, embracing diversity, and recognizing the impact heteronormativity and heteroprofessionalism have not only on sexually and gender diverse students, but all students, health professionals, patients, and clients.

FUTURE RESEARCH

Empirical research to investigate the impact of heteroprofessionalism and microaggressions on healthcare students' disclosure decision-making in the WIL setting to build on current knowledge is needed. Priorities to consider are a better understanding of the impacts which disclosure decision-making has on the development of the professional skills needed for employment and the extent to which sexually and gender diverse students assimilate heteronormativity and microaggressions in practice. Similarly, it is also important to examine the negative impacts of microaggressions on the wellbeing of students in the WIL setting. Finally, it is important to consider the preparedness of all students undertaking WIL experiences to manage experiences of heteronormativity and microaggressions in the WIL setting.

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