Trans-Inclusive Paramedic Practice: Translating Cultural Safety into Everyday Transgender-Affirming Care

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In the prehospital setting, paramedics are required to meet healthcare needs in a culturally safe manner. Transgender patients present with a unique subset of healthcare needs, and when these are not recognised it can result in trans patients delaying seeking help, being misunderstood and having unmet physical and mental health needs. The authors have undertaken a scoping literature review of research articles and policy and guideline documents, which have been published in the last eight years, to review the information and guidance available. Current studies highlight the significant lack of research, knowledge and understanding of healthcare provision for the transgender population. Furthermore, prehospital paramedic practice has little focus on this vulnerable and socially marginalised population. The literature reviewed identifies a clear link between cultural safety and competent paramedic practice, however guidance on how to apply it is in its infancy. The authors conclude that paramedics working with vulnerable populations have a moral responsibility to provide culturally safe and competent practice. Specialised training and continuing clinical education are essential to providing comprehensive gender-affirming healthcare.

KEYWORDS: cultural safety; gender identity; paramedicine; transgender; transgender-affirming; trans-inclusive

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> 'There's power in naming yourself, in proclaiming to the world that this is who you are. Wielding this power is often a difficult step for many transgender people because it's also a very visible one' (Mock, 2014, p. 144).

THIS LITERATURE REVIEW focuses on the parameters and practical provision of culturally safe paramedic care for transgender (trans) patients. The definition of transgender utilised in this review is someone whose gender identity and expressions are different from their gender assigned at birth (Grant et al., 2021). Conversely, cisgender (cis), 'refers to people having a gender identity matching the sex that they were assigned at birth' (Connolly, 2017, p. 152).

Veale et al. (2019) note the wide variation of gender identity terms that exist across cultures, including 'transgender, non-binary, transsexual, whakawahine, tāhine, tangata ira tāne, takatāpui, fa'afafine, fa'atama, fakaleiti, fakafifine, akava'ine, aikāne, vakasalewalewa, genderqueer, gender diverse, bi-gender, cross-dresser, pangender, demigender, agender, trans woman, trans feminine, trans man or trans masculine' (p. 1). Paramedics can struggle to comprehend this range of gender diversity (Barley & Tooms, 2019).

Similarly, the concepts of cultural competency and safety have been varied and vigorously debated. As a result, they have changed over time, and the historically ambiguous cultural competency and safety constructs have been replaced with increasingly explicit parameters requiring paramedics to examine their part in perpetuating health inequity and poor health outcomes when providing care for marginalised, vulnerable populations, including the transgender community (Carlström et al., 2021; Curtis et al., 2019; Davison et al., 2021; Garcia & Lopez, 2022; Grant et al., 2021; Kaphle et al., 2022; Kellett & Fitton, 2017; Kurtz et al., 2018; Lightfoot et al., 2021; Professional Association for Transgender Health Aotearoa [PATHA], 2022; Radix & Maingi, 2018; Tan et al., 2020; Westenra, 2019). The concept of cultural safety was embraced in nursing in Aotearoa New Zealand in 1992, where it was described as having a positive effect, including raised awareness, increased knowledge and a change in attitudes and behaviours (Ramsden, 1993). This arose from a number of hui held in 1988 which were aimed at addressing inequitable healthcare provisions for Māori patients (Papps & Ramsden, 1996). While some progress was made, the need to provide equitable healthcare for Māori was seen by some people as political correctness, rather than as an opportunity to remove sociopolitical barriers to healthcare. The notion of politically driven cultural safety raises questions around the thoroughness of application and motivation to commit to genuinely embedding this in individual practice (Ramsden & Spoonley, 1993). Further progress is highlighted by Curtis et al.'s (2019) suggestion that the concept of cultural safety is most strongly aligned with redressing health equity. When the need to address healthcare inequality is ignored, there is the potential for the end goal to be misconstrued as mastering cultural competence at an individual level, without considering the broader influences of power differentials and context.

Te Kaunihera Manapou Paramedic Council (2020b) defines cultural safety as:

> *The need for paramedics to examine themselves and the potential impact of their own culture on clinical interactions and healthcare service delivery … [and with the] awareness that cultural safety encompasses a critical consciousness where healthcare professionals and healthcare organisations engage in ongoing self-reflection and self-awareness and hold themselves accountable for providing culturally safe care. (p. 2)*

An additional aspect has been included: cultural humility, where 'individuals learn to recognize their own experiences and identities and acknowledge the influence these have on their perceptions of others, in order to approach individuals without judgement and/or preconceived bias' (Ashley, 2019, as cited in Lightfoot et al. 2021, p. 15).

Legislative Protection for Transgender People

The establishment of the World Professional Association for Transgender Health (WPATH) in 1979 began a global focus on transgender healthcare (Coleman, 2017). Under this umbrella, Standards of Care (SOC) were outlined and defined by international clinical consensus. Fundamental principles of these SOC include demonstrating respect, providing gender-affirming and knowledgeable care, seeking informed consent and ensuring treatment matches the patient's needs (Coleman, 2017; Coleman et al., 2012). Reisner et al. (2015) describe gender affirmation as an 'interpersonal and shared process through which a person's gender identity is socially recognised' (p. 9).

However, in the 1980 Diagnostic and Statistical Manual, Third Edition (DSM-III), being transgender was pathologized as a gender identity disorder or as a childhood mental illness (American Psychiatric Society, 1980). Doctors and other medical professionals used this diagnosis to determine eligibility for such services as hormone treatment, surgery and resource allocation (Robles et al., 2022). The term gender identity disorder persevered and existed until 2013 when it was replaced with gender dysphoria, which refers to the dissonance between gender assigned at birth and gender identity (American Psychiatric Society, 2013; Drescher, 2015). Debate continues around the validity of categorising gender identity as a mental dysfunction in the Diagnostic and Statistical Manual, Fifth Edition (DSM-5) and the distress caused by a dissonance in gender assigned at birth and affirmed gender identity (Robles et al., 2022). The definition of gender identification other than sex at birth as pathological, using the term 'gender dysphoria' outlined in the DSM-5, creates further barriers to healthcare (Davy, 2015; Bauer et al., 2009; Bockting, 2009; Garcia & Lopez, 2022; Yeonhee Ji, 2018). Definitions of gender dysphoria include the elements of 'distress associated with the experience of one's gender identity being inconsistent with the phenotype, or the gender role typically associated with that phenotype' (Wylie-Barrett et al., 2014, as cited in Connelly, 2017, p. 151).

Only more recently has the need for legislation protecting transgender people from discrimination been questioned. Heike Polster (2003) asked whether transgender people were adequately protected from discrimination under the existing New Zealand Bill of Rights Act 1990 and Human Rights Act 1993. The 2004 Human Rights (Gender Identity) Amendment Bill was heard, asking for gender identity to be a prohibited grounds for discrimination. Specific to healthcare, in 2008, Te Kāhui Tika Tangata Human Rights Commission published the results of their enquiry into discrimination experienced by transgender people in the report *To Be Who I Am*, which identified significant gaps in providing gender-affirming healthcare in Aotearoa. In 2018, comprehensive guidelines for gender-affirming healthcare in Aotearoa were developed (Oliphant et al., 2018), and the results of Counting Ourselves, the first national study of the health and well-being of transgender and non-binary people followed in 2019 (Veale et al., 2019). In November 2020, paramedic responsibilities under the Health Practitioners Competence Assurance Act 2003 were formalised with the Te Kaunihera Manapou Paramedic Council's Code of Conduct (2020a), incorporating cultural safety as a critical measure of clinical competence.

Until 2022, conversion or reparative therapies were utilised to 'cure' what was considered to be a pathological sexual or gender orientation, based on the DSM-III's definition. In Aotearoa and internationally, there was increasing resistance to such practices. Examples of this resistance included 'community building, trans pride, and normalising trans' (Hansen, 2020, p. 1). Individual dissent combined to create more organised community activism. In other words, transgender people became change agents rather than victims, which sparked the emergence of the trans liberation movement.

Over the past decade, there have been strides made in legal protections for transgender people. In 2015, the United States government, under the Obama administration, considered changes to regulations after the suicide of a transgender youth following conversion therapy. However, a year later Malta led the way, becoming the first country to introduce regulations banning conversion therapy into law (Byne, 2016). On 15 February 2022, the New Zealand Government passed legislation that banned conversion therapy on the basis of sexual orientation, gender identity and gender expression. Kris Faafoi, the then Minister of Justice, stated:

> *In banning conversion practices in New Zealand, we join other countries around the world in sending a clear message that all people, including young people, deserve to be protected, no matter their sexual orientation, gender identity or gender expression. All people, including rainbow communities, deserve to have their rights and dignity protected, and to live their lives freely just as they are. (New Zealand Government, 2022)*

RESULTS

Transgender-Affirming Care

The definition of cultural safety is described as a clinician's critical consciousness of their impact on health equity, their patients' health outcomes and their responsibility to mitigate the potential for discrimination, assumption and bias (Curtis et al., 2019; Kellett & Fitton, 2017; Kurtz et al., 2018). In a paradigm shift, the term cultural safety has been advocated for over cultural competence which was thought to promote an individualistic focus without reference to the imbalance of power between clinician and patient, or consideration of the dynamic and contextual sociopolitical influences (Ferguson, 2021).

Multiple authors mentioned the relationship between identification of the unique healthcare concerns of transgender people and professional healthcare practices which has the potential for adverse impacts and outcomes on the transgender population (Carlström et al., 2021; Davison et al., 2021; Garcia & Lopez, 2022; Grant et al., 2021; Jalali et al., 2015; Kaphle et al., 2022; Lightfoot et al., 2021; Ministry of Health, 2022; PATHA, 2022; Quaile, 2018; Radix & Maingi, 2018; Tan et al., 2020; Te Kāhui Tika Tangata Human Rights Commission, 2008; Westenra, 2019). These wide-ranging concerns included evidence of a higher incidence of mental health concerns (depression, anxiety, increased suicidality and addiction), socioeconomic hardship (poverty and homelessness), increased rates of disease (including prevalence of HIV), societal marginalisation and discrimination (actual and perceived) by healthcare providers, which negatively impacted patients' access to timely and appropriate healthcare and social services (Bauer et al., 2009; Carlström et al., 2021; Garcia & Lopez, 2022; Lightfoot et al., 2021; Radix & Maingi, 2018; Tan et al., 2020; Veale et al., 2019). It was noted that the standard of healthcare trans people received was inconsistent and poor, and that there was a lack of legislation protecting the human rights of the transgender population (PATHA, 2022; Minter & Daley, 2003 as cited in Bauer et al., 2009; Te Kāhui Tika Tangata Human Rights Commission, 2008).

Access to gender-affirming healthcare in Aotearoa is further limited by geographical location. The provision of gender-affirming healthcare in different regions, formerly operating under District Health Boards, varies widely, with some regions being completely unable to provide any gender-affirming non-surgical medical treatments (Fraser et al., 2019). Access to surgical interventions is frequently inaccessible without private funding as no public hospitals provide comprehensive gender-affirming care and waitlists for the limited amount of publicly funded surgeries can be decades long (Tan et al., 2023).

The Trans PULSE Project in Canada examined the barriers to transgender healthcare (Bauer et al., 2009). Erasure, defined as a 'condition of how transsexuality is managed in culture and institutions, a condition that ultimately inscribes transsexuality as impossible', is one schema by which those who are transgender are considered an anomaly, comprising passive erasure in which assumptions and a lack of knowledge are found, and active erasure relating to healthcare professionals' obvious discomfort or, at worst, refusal of service provision, resulting in marginalisation and vulnerability (Namaste, 2000, as cited in Bauer et al., 2009, p. 350). Similarly, marginalisation resulting from implicit and explicit forms of discrimination includes a lack of acknowledgment of individual identity and consequent feelings of invisibility (Bradford & Syed, 2019; Carlström et al., 2021; Kellett & Fitton, 2017; Radix & Maingi, 2018).

In an examination of language that perpetuates covert discrimination in relation to transgender health, Bradford and Syed (2019) studied the power of narratives, conceptualising cisnormativity as a process by which other gender identities are viewed as anomalies. Defining gender as a binary promotes the marginalisation of those who do not conform to cisnormativity (Bauer et al., 2009; Bockting, 2009; Bradford & Syed, 2019; Lightfoot et al., 2021; Radix & Maingi, 2018; Tan et al., 2020).

Another critical issue that was identified is that, when transgender patients access

healthcare, they fear discrimination based on previous negative experiences (Bauer et al., 2009; de Vries et al., 2020; Garcia & Lopez, 2022; Grant et al., 2021; Knudson et al., 2018; Lightfoot et al., 2021). Relating to the transgender population, the term 'minority stress' is used to refer to the unique stress that transgender people experience due to societal stigma and discrimination (Tan et al., 2020; Veale et al., 2019). Carlström et al. (2021) suggest that healthcare practitioners must recognise the vulnerability of the transgender community to 'violations of dignity' (p. 600), for instance use of their deadnames prior to transitioning.

Further to this, information practices create barriers to healthcare access for transgender patients by limiting accurate representation in data collection (Davison et al., 2021; Garcia & Lopez, 2022; Lightfoot et al., 2021; Radix & Maingi, 2018). Pega et al. (2017) note that the collation of 'high-quality gender identity data disrupt the familiar mantra of "no data, no problem, no action"' (p. 858). Clinician advocacy is central to improving healthcare outcomes for transgender patients (Kellett & Fitton, 2017; Lightfoot et al., 2021; Veale et al., 2019; Westenra, 2019). Specific training and education for healthcare practitioners in cultural safety was identified in the literature as being critical in caring for transgender patients (Carlström et al., 2021; Connolly, 2017; Davison et al., 2021; de Vries et al., 2020; Grant et al., 2021; Kurtz et al., 2018; Lightfoot et al., 2021).

Practical Application

A lack of research into the practical application of transgender-affirming healthcare is evident (Davison et al., 2021; Jalali et al., 2015; Lightfoot et al., 2021; Pega et al., 2017; Veale et al., 2019). Parameters of culturally safe transgender-affirming healthcare include the use of correct names and pronouns central to an individual's identity (Bauer et al., 2009; Davison et al., 2021; Garcia & Lopez, 2022; Lightfoot et al., 2021; Reisner et al., 2015). Marino et al. (2021) state, 'ask, don't assume' (p. 10). However, this alone is not enough. Reisner et al. (2015) outline the necessity of an informed consent model of healthcare which highlights the key role of gender affirmation in caring for transgender people, integrating community assessment, research, education training, advocacy and clinical care. Veale et al. (2019) state the importance of respecting and allowing informed decision-making and autonomy when working with transgender youth. Ashley et al. (2021) aligns the use of informed consent models with better health-care outcomes for transgender patients, through preserving patients' 'decisional autonomy' (p. 543), reducing distress and decrying pathologisation of the transgender and gender-diverse patients' health experience. Oliphant et al. (2018) describe the 'principle of Te Mana Whakahaere, [as] trans people's autonomy of their own bodies, represented by healthcare provision based on informed consent' (p. 88). Informed consent is key to cultural safety, as reports of privacy breaches appear common in the transgender population, both in relation to gender identity and assumption that patients are ready for their identity to be publicly known.

It was suggested that key aspects of providing culturally safe transgender-affirming healthcare are: creating a welcoming environment, gender-sensitive communication, understanding the diversity of marginalised population experiences, ensuring pathologisation and gatekeeping of resources are not accepted and engaging with the broader transgender community (Garcia & Lopez, 2022; Radix & Maingi, 2018).

Issues Transgender Patients Face

Cultural safety is recommended in the patients' history-taking, making them feel comfortable, accepted and understood; invasive questioning around unrelated topics driven by curiosity should be avoided (Connolly, 2017). Lightfoot et al. (2021) conceptualise cultural safety in clinical practice as possessing knowledge of gender-affirming interventions and the provision of tailored individual care.

What Can be Done and Changes Required

Cultural Humility

Lightfoot et al. (2021) identify that conditional to culturally safe and transgender-affirming care is the essential need for each individual provider to understand the 'depathologization of gender variance and … [adopting] cultural humility' (p. 4). The three defining attributes of this are 'patient-led care, trans-affirming culture and trans-competent providers' (Lightfoot et al., 2021, p. 15).

Power Imbalance

Fisher-Borne et al. (2014, as cited in Lightfoot et al., 2021, p. 2), Ramsden (2002, as cited in Westenra, 2019, para. 19) and Kaphle et al. (2022) highlight that key to reducing harm for transgender patients is the need for clinicians to critically reflect on and redress the power imbalance between the healthcare provider and patient.

Lack of Research and Data

Lightfoot et al. (2021) suggested that the focus on the LGBTQ+ population as one group overlooks the specific challenges faced by the transgender population in healthcare. Bauer et al. (as cited in Lightfoot et al., 2021) believe the process of erasure is in play when trans issues are neglected in 'health research, education, and policy broadly presented as "pan-LGBTQ+"' (p. 2). Concerning information practices, Davison et al. (2021) suggested that it is important that individuals can specify their terminology and identification. Te Kāhui Tika Tangata Human Rights Commission report (2020) states that poor response options when collating data limit diverse answers, which in turn reduces adequate diversity representation and targeted human rights. There was minimal evidence available when examining practical guidelines for culturally safe transgender-affirming healthcare for paramedics.

Policy and Guidelines

The Standards of Care, Version 8 provide international guidelines for delivering culturally safe healthcare to trans and gender-diverse people (Coleman et al., 2022). In Aotearoa, prehospital guidelines for paramedics are explicit about the new mandates, which require consideration of cultural safety and competency relating to gender identity (Te Kaunihera Manapou Paramedic Council, 2020a). Guidance specific to paramedic clinical practice when caring for trans patients comes from Connolly (2017) who outlines the need for sensitive history-taking and appropriate questioning, stating the need for 'a clinician that is open and aware of current challenges and changes facing the trans community' (p. 155).

DISCUSSION

Key Constructs and Definitions

The literature reviewed highlights how healthcare practitioners should not assume their patient's gender identity, as this should be disclosed by the individual. There was consistency in reporting the parameters of culturally safe paramedic practice, including that clinicians must critically appraise their own beliefs, bias and impact; they must also possess appropriate knowledge, attitudes and behaviour when interacting with trans patients.

Cultural safety is a critical component of paramedic competence and is referred to in Part C of Te Kaunihera Manapou Paramedic Council's Code of Conduct (2020a) and Standards of Cultural Safety and Clinical Competence (Te Kaunihera Manapou Paramedic Council, 2020b). These requirements are legally binding for paramedics with the Paramedic Council providing a formalised regulatory body to monitor and measure these standards.

Organisational Change

There was a paucity of research and evidence-based clinical practice with specific applications of cultural safety in the prehospital context when caring for members of the transgender community. Implications for ambulance services lie in ensuring they provide adequate response options when collecting patients' personal information. Coleman (2017) encourages us to think 'beyond the binary' (p. 71). Organisational practice also requires a reflexive approach involving transgender-led changes in paramedic practice.

Individual Recommendations

The key to culturally safe and increasingly competent gender-affirming paramedic practice is to possess specialised knowledge of transgender-affirming care; this should be a vital inclusion in the university curriculum and built on through continued clinical education and growing paramedic experience. There were significant gaps and limited evidence in the practical applications and tools for paramedics to provide culturally safe transgender-affirming healthcare. Nevertheless, critical reflection on cultural safety and humility is encouraged at an individual level (Westenra, 2019). Furthermore, a focus on advocacy suggests that healthcare providers should consider the impact of broader sociological factors (Curtis at el., 2019; Westenra, 2019). Supporting this, Tan et al. (2020) say that healthcare providers should promote 'equitable access to healthcare services and gender-affirming care for transgender people to attain the highest standard of health' (p. 12).

Recommendations for Future Research

Research is urgently needed into evidence-based practice examples with a prehospital focus to guide paramedics in how to deliver culturally safe, clinically competent, transgender-affirming care. Clinical education in the paramedic educational curriculum and ambulance service, focusing on acquiring skills in transgender-affirming paramedic practice, needs to be standardised to raise awareness of individual beliefs, attitudes and goals, furthering effective practical application on the road. Results of the Counting Ourselves survey included recommendations around ensuring the availability of 'training resources and trans-led initiatives' (Veale et al., 2019, pp. 114–115). Future research needs to involve the transgender community (Carlström et al., 2021). Collaboration ensures greater success in improving health outcomes for vulnerable populations (Kurtz et al., 2018).

Recruitment strategies for one study by Bradford and Syed (2019), which investigated the impact of the cisnormative narrative on transgender identity development, included using social media platforms, which meant that researchers could not control for specific demographics. An outcome of this was that some participants identified as non-binary, leaving hesitancy regarding whether the results also related to transgender people.

Limitations related to accurate data on transgender people and their health needs in Aotearoa were highlighted by Pega et al. (2017). They maintained that misrepresentation of transgender people's needs and experiences can occur because they are often grouped under the umbrella of the term 'gender diverse'.

APPLICATION

Paramedics have a legal and moral obligation to provide culturally safe and clinically competent transgender-affirming care. Te Kāhui Tika Tangata Human Rights Commission (2020) states that those with diverse gender identities 'have the right to the highest attainable healthcare' (p. 5). National practice guidelines require paramedics to respect cultural needs and values, which begins when we challenge our attitudes and reflect on our own bias towards those with diverse 'gender identity, sexual orientation and/or disability' (Te Kaunihera Manapou Paramedic Council, 2020a, Part C).

Cultural safety is referred to in the Standards of Cultural Safety and Clinical Competence for Paramedics, stating that patients must have full involvement in decision-making, if a culturally safe model of care is to be delivered (Te Kaunihera Manapou Paramedic Council, 2020b). Cultural safety within paramedic practice requires interaction with and knowledge of the sociopolitical issues faced by the transgender community, such as discrimination, and the resulting minority stress that leads to higher incidences of suicidality (Coleman, 2017).

Similarly, Westenra (2019) identifies the need for paramedics to think beyond their scope of practice and consider interwoven sociological variables, such as history, context and experience, that inform decision-making and impact cultural safety. She envisages cultural

safety as a step-by-step journey in which learning awareness paves the way to eventual cultural humility. Further to this, humility is described by Westenra (2023) as a dynamic state in which the clinician acknowledges the need for lifelong learning, and whose sensitivity and safety are judged solely by the receiver.

Radix and Maingi (2018) outline the impact of the organisational umbrella on cultural safety and competency as a necessary fusion between policies and structures, which encourage appropriate values, principles, attitudes and behaviours. Coleman (2017) describes clinical competence in providing culturally safe and appropriate healthcare to transgender people as 'dependent upon specialized training and continuing clinical education' (p. 70).

In Aotearoa, there is a growing body of research and guidelines on how to provide gender-affirming care in general healthcare, upon which we can build our own standard of culturally competent care in the prehospital setting. However, existing paramedic guidelines are in their infancy and further research is urgently needed to identify the needs of transgender people in prehospital paramedicine, which will require transgender-led consultation.

Practical Tools

Westenra (2023) outlines practical steps paramedics can take towards cultural safety. These include examining our beliefs and attitudes for implicit bias. Some practical elements of cultural humility include using expansive language, creating safe spaces for all patients, ensuring patient privacy and being an active advocate for the rainbow and gender-diverse community within our own sphere of influence (Westenra, 2023). Garcia and Lopez (2022) echo the need for overt signalling of culturally inclusive environments. Leonard et al. (2022) also identified that the attitudes of emergency personnel provided valuable insight into wider organisational policies and culture, and thus negative attitudes towards transgender patients need to be eliminated.

Barley and Tooms (2019) stress the need for clinicians to ask patients about their gender identity, but also that training is needed on how to do this sensitively. Questioning must be relevant, unintrusive and not driven by curiosity (Barley & Tooms, 2019; Garcia & Lopez, 2022). The 'trans broken arm syndrome' should be avoided; this is where a clinician 'incorrectly assumes that a medical condition results from a patient's gender identity or medical transition' (Wall et al., 2023, p. 1). Barley and Tooms (2019) add that best practice in the ambulance service is to use correct pronouns and gender identity in patient handover.

Garcia and Lopez (2022) assert that any physical examinations should be kept to a minimum to avoid distress. In the prehospital environment, this may include the application of electrocardiogram leads, which necessitates exposing the chest. It is paramount that these examinations are not neglected due to the provider's discomfort or inexperience with transgender patients (Hussain et al., 2023). Applying electrocardiogram leads is often medically necessary. It is important therefore to gain a patient's informed consent before exposing their chest and to ensure that this is undertaken in a private area (Hussain et al., 2023).

CONCLUSION

In Aotearoa, we have developed healthcare policies for providing culturally safe gender-affirming care, however, these are centred in the primary healthcare context, broader human rights legislation and the newly established paramedic's Code of Conduct (Te Kaunihera Manapou Paramedic Council, 2020a). None of these policies and legislation specifically mentions safe practice with the transgender population (Te Kaunihera Manapou Paramedic Council, 2020a, 2020b).

Cultural safety is necessary when paramedics provide healthcare for transgender patients, however, there is limited research, practical guidelines and focused paramedic training on how to do this and provide care that has no potential for harm. The knowledge possessed by

healthcare practitioners impacts the quality of care they can provide to transgender patients. Specialised training and continuing clinical education are crucial to developing culturally safe transgender-affirming paramedic practice. Further systematic reviews and targeted research are required to inform clinical decision-making around providing transgender-affirming care, as well as establishing how to measure the efficacy of clinically safe and competent paramedic practice through evaluation by our care receivers.

Carlström et al. (2021) include the following message from a transgender person: 'treat me with respect … accept me for who I am, treat me according to my needs, and meet me with competence' (p. 602). Finally, Bauer et al. (2009) remind us of the human cost: 'this is our lives' (p. 359).

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