Myths, Mistakes & Misconceptions in LGBTQ+ Care

A Practical Companion Guide for Clinicians

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Introduction

Even well-intentioned clinicians can carry assumptions shaped by training gaps, cultural messaging, time pressure, personal bias and outdated systems. The purpose of this guide is not to blame. It is for clarity and is a continuation of the lessons learned from the book: *First Do No Further Harm™.*

Competent care for LGBTQ+ patients does not require perfection. It requires curiosity, humility, and a willingness to replace outdated myths with better practice.

Section I: Identity & Disclosure

Myth 1: If a patient wanted me to know, they would tell me.

Truth: Disclosure is often a risk calculation for your patients. Many of them have to tread lightly until they know who is safe and who is not.

Why It Matters: Patients notice language, body cues, forms, and office culture before deciding what feels safe to share.

Better Next Step: Normalize respectful identity questions for *all* patients.

Myth 2: Nonbinary identities are new or rare.

Truth: Nonbinary people are not new. They are becoming more visible as safety and language improve.

Why It Matters: Patients can feel unseen or erased when forced into inaccurate categories.

Better Next Step: Offer space for self-identification on your forms and in conversation and avoid forcing binary choices when unnecessary.

Myth 3: Older adults are not LGBTQ+.

Truth: Inclusive care matters at every age. As people live longer, LGBTQ+ communities are aging too.

Why It Matters: Many older adults lived through eras of silence and discrimination, and some are only now feeling safe enough to come out later in life.

Better Next Step: Ask inclusive questions, including SOGI questions, in geriatric care too.

Section II: Communication & Trust

Myth 4: Using the wrong pronoun is not a big deal.

Truth: Names and pronouns matter. Pronouns are another respectful way of communicating with, and about your patients.

Why It Matters: Repeated errors can erode trust quickly.

Better Next Step: Make the correction, apologize once, and move forward.

Myth 5: Asking about sexual behavior will offend patients.

Truth: Most patients prefer respectful matter-of-fact questions over assumptions.

Why It Matters: Avoidance can lead to missed screening and prevention opportunities.

Better Next Step: Use behavior-based language, not identity-based assumptions. For example: *Are you sexually active? What kinds of sexual contact do you have? Do you have sex with men, women, both, or people of another gender?* Ask these questions routinely of all patients so no one feels singled out.

Myth 6: I will make a mistake, so it is safer not to engage.

Truth: Patients rarely expect perfection, and everybody makes mistakes. It is how you recover from it that matters.

Why It Matters: Silence creates a feeling of distance, and distance can feel like rejection.

Better Next Step: Lead with humility, make a conscious effort, and repair if or when damage is done. Example: *I might not get this right, but I want you to know that I care. How can I support you?*

Section III: Clinical Care Myths

Myth 7: Sexual orientation and gender identity only matter for sexual health.

Truth: Identity can affect preventive care, screenings, mental health, family planning, and social stressors. It truly accompanies us wherever we go.

Why It Matters: Narrow thinking creates care gaps, because it makes us fall short sometimes.

Better Next Step: Consider the whole patient, not just one dimension. Nobody is a monolith; we are all a beautiful lattice of our identities.

Myth 8: Trans patients are too medically complex for primary care.

Truth: Like any other patient, most healthcare needs for trans patients remain routine.

Why It Matters: Automatic referrals delay care, signal rejection and fragment trust.

Better Next Step: Provide whole-person primary care and refer only when truly needed.

Myth 9: Affirming care is specialty care.

Truth: Much of affirming care is simply good medicine delivered with awareness and respect. There is a difference between affirming care and gender affirming care.

Why It Matters: Treating basic dignity as specialized keeps standards low. Affirming care goes beyond hormones and surgery.

Better Next Step: Build affirming habits into everyday care for every patient.

Section IV: Systems & Equity

Myth 10: I treat everyone the same.

Truth: Equity is not sameness; it's meeting each patient where they are or where they want you to meet them.

Why It Matters: Different patients may need different approaches and different solutions to receive equally respectful care.

Better Next Step: Make care individualized rather than identical.

Section V: Common Mistakes in Practice

Mistake 1: Forms and workflows are neutral.

Truth: Your office systems communicate values.

Why It Matters: Intake forms, portals, and documentation can either invite trust or create barriers, and your patients are on the receiving end of all that.

Better Next Step: Review your systems with inclusion in mind, get a second or third pair of eyes if needed.

Mistake 2: One training is enough.

Truth: Inclusive care is an ongoing practice.

Why It Matters: Language, evidence, and community needs evolve.

Better Next Step: Keep learning, diversify your sources of accurate and vetted information and remain curious.

Mistake 3: Waiting until a patient corrects me is respectful.

Truth: Silence is not always comfort. Sometimes it is self-protection, exhaustion, or fear.

Why It Matters: Many patients choose not to correct clinicians because they are tired of teaching, worried about conflict, or unsure it will help.

Better Next Step: Notice hesitation, invite correction gently, and make it easier to speak up. Try: *Please let me know if I get anything wrong. I want to respect you and get this right.*

Mistake 4: If I apologize once, the harm is fully repaired.

Truth: Apology is a beginning, not the whole repair.

Why It Matters: Trust will need action, consistency, and changed behavior.

Better Next Step: Apologize briefly, correct the issue, and do better next time.

Mistake 5: Inclusive language matters less than clinical skill.

Truth: Language is part of clinical skill.

Why It Matters: Patients experience careless language as part of their care.

Better Next Step: Treat respectful communication as a core competency.

Section VI: Common Misconceptions

Misconception 1: Identity alone tells me what care this patient needs.

Truth: Identity is but one part of a person, not the whole story.

Why It Matters: Race, age, disability, faith, income, geography, trauma history, family context and so much more can all shape care needs.

Better Next Step: Stay curious about the individual in front of you, and never assume their identity tells you everything.

Misconception 2: If I mean well, patients will know it.

Truth: Intent does not always translate into impact. The only way we can know your intention is through your aligned actions.

Why It Matters: Patients respond to what they experience, not what you meant.

Better Next Step: Let all your actions, systems, and consistency communicate care.

Misconception 3: This topic is political, so neutrality is safest.

Truth: Respectful and affirming healthcare is clinical ethics, not politics. We took an oath irrespective of the government.

Why It Matters: Your neutrality can and definitely feels like abandonment when dignity is at stake.

Better Next Step: Anchor yourself in patient welfare and professional standards, not politics or administrations that come and go, despite your own beliefs.

Misconception 4: Young people are just following trends.

Truth: Being LGBTQ+ is not a fad. Au contraire, visibility and improved language are now helping young people describe their longstanding realities.

Why It Matters: Dismissing youth identity can damage trust and delay life-saving support.

Better Next Step: Lead with listening, assessment, and developmentally appropriate care.

Misconception 5: Small changes don't matter.

Truth: Small changes often create big ripples of felt safety.

Why It Matters: A name used correctly, a welcoming form, or a calm response can shape whether a patient returns or not.

Better Next Step: Respect the power of microbehaviors. Refer to those offered at the end of each chapter of the book: *First Do No Further Harm*™.

Final Invitation

While you do not need to know everything to begin, you *do* need to begin.

Replace fear with curiosity, assumptions with questions, and hesitation with steady practice.

That is how safer care is built, one interaction at a time.

Continue the Conversation

If this guide challenged you, helped you, or gave you language for what you already knew, pass it forward.

Share it with someone who cares and is still learning.

Safer care is built one courageous choice at a time.

Keep going.

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