Abstract. The last several years have been marked by a seemingly increasing numbers of individuals with homosexual inclinations. There are consequences to society-wide increases in disordered dispositions, and this paper presents one such consequence. Patients often enter the physician–patient relationship based on the physician’s “sexual preference.” In order to avoid sexual misconduct from a physician, patients often choose physicians that are not inclined to be sexually attracted to the patient. It is often assumed that a patient can infer a physician’s sexual inclinations by his or her gender, but this is not the case. Due to the inability to determine a health care professional’s “sexual preference” by their gender, a physician has a duty to disclose this information prior to care. National Catholic Bioethics Quarterly 13.3 (Autumn 2013): 445–450.

Over the last several years, there has been an obvious push toward societal accept ance and normalization of homosexuality and homosexual “attraction.” There remain societal consequences to the normalization of what many still believe is a disordered lifestyle, yet many of these consequences have been ignored. One consequence involves the physician–patient relationship. Many patients choose their physician based on the physician’s gender, and implicit in this choice is their desire for a physician who will not be sexually attracted to them.

In this article, I argue that because homosexuality is seemingly increasing, new rules and regulations should be imposed by state medical boards to force physicians

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(and other health care professionals) to disclose their “sexual preference” to patients or patients’ guardians prior to the patient entering into the physician–patient relationship.

To introduce the topic, we begin with two patient cases.

**Case 1**

A.T. is a physically attractive twenty-one-year-old female college student who presents to the university health center with complaints of dizziness, headaches, and stomach pain. There are two physicians on staff at the time of her presentation, and she is randomly assigned Dr. L.R. Dr. L.R. is a thirty-three-year-old male physician who completed his residency recently and is now a general practitioner. He just moved to the area and is new to the university health center. He is not married.

Dr. L.R. performs a few examinations on A.T., including an abdominal examination. He asks her to remove her shirt and lie down on the examination table, and although she is uncomfortable, A.T. follows his instructions. Dr. L.R. presses around on A.T.’s abdominals and exclaims to A.T., “You have nice abs!” A.T. knows that she is in good shape, since she spends a good amount of time exercising to stay fit. She is somewhat taken aback by the comment because she was under the impression that physicians should not say things that could be construed as subtle but obvious advances—especially from a thirty-three-year-old single man. She has been on the receiving end of harassing comments, so she is aware that some comments can possibly be sexual in nature. A.T. decides to give Dr. L.R. the benefit of the doubt, and she ignores the comment.

Dr. L.R. completes his examination and assessment of A.T., but prior to dismissing A.T., he mentions that he is a new physician, that he is new to the area, and that he does not know anyone in town. He asks A.T. what she likes to do to socialize on weekends. He then says to A.T., “Today is Friday, what do you have planned for tonight?” Again, not wanting to make the conversation awkward, A.T. simply says she has plans and ends the conversation. Uncomfortable with the situation, A.T. leaves the office.

**Case 2**

C.D. is a well-built and handsome twenty-one-year-old male college student. He presents to the student health center with complaints of headache, dizziness, and stomach pain. He is randomly assigned to Dr. M.P., a thirty-three-year-old male physician who completed his residency recently and is now a general practitioner. He is new to the university health center, and he is not married.

Dr. M.P. performs a few examinations on C.D., including an abdominal examination. He asks C.D. to remove his shirt and lie down on the examination table, and C.D. follows his instructions. Dr. M.P. presses around on C.D.’s abdominals and exclaims to C.D., “You have nice abs!” M.P. is somewhat taken aback by the comment, since it is not normal for men to comment to other men about their abdominals. Recently C.D. has also been approached by homosexual men in inappropriate ways, so he is somewhat alert to the possibility that Dr. M.P. is making an unwelcome sexual comment. Even so, C.D. gives Dr. M.P. the benefit of the doubt and ignores the comment.
Dr. M.P. continues examining C.D., and toward the end of the examination Dr. M.P. begins to tell C.D. that he is new to the area. He asks C.D. what he does to socialize, and C.D. says he enjoys attending basketball games. Dr. M.P. then asks C.D., “What are you doing tonight?” C.D. is again taken aback by Dr. M.P.’s comment, so he responds briefly, ends the conversation, and leaves the office.

Were these interactions between the physician and the patient appropriate? Or was there sexual misconduct on the part of the physician? We will first inquire into what sexual misconduct means and then return to the patient cases.

**Sexual Misconduct by Physicians**

During my pharmacy education, I took the Hippocratic Oath, which is still considered by many to be the “cornerstone and foundation of the medical profession.”  

One line in the oath states, “Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption, and further, from the seduction of females or males, of freemen or slaves.”

In today’s language, “voluntary acts of . . . seduction of females or males” in the medical profession is labeled “sexual misconduct.” While it is not necessarily the definitive source, the American Medical Association’s *Code of Medical Ethics* defines “sexual misconduct” as simply “sexual contact that occurs concurrent with the patient–physician relationship.” The *Code of Medical Ethics* does not provide a definition of “sexual contact,” but definitions of the phrase can be obtained by searching state medical statutes and rules. The state of Indiana offers this definition: “As used in this chapter, ‘sexual contact’ means: (1) sexual intercourse (as defined in IC 35-31.5-2-302); (2) deviate sexual conduct (as defined in IC 35-31.5-2-94) or (3) any fondling or touching intended to arouse or satisfy the sexual desires of either the individual performing the fondling or touching or the individual being fondled or touched.”

Would a male or female physician be aroused by touching the abdominals of a patient? The answer will vary. Most likely, however, any physical contact by the physician could result in such “arousal” or “satisfaction.” Physicians could easily disguise their intentions and internal disposition toward such physical contact. As Cherrie Galletly notes, “While some cases of sexual exploitation  

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1. “The Hippocratic Oath constitutes a synopsis of the moral code of Ancient Greek medicine and contributes to the stabilization of the tri-part relationship among the physician, the patient, and the illness, as described by Hippocrates.” Stavros A. Antoniou et al., “Reflections of the Hippocratic Oath in Modern Medicine,” *World Journal of Surgery* 34.12 (December 2010): 3075.


4. Indiana Code, title 25, art. 1, ch. 9, § 3.5.
involve predatory doctors, many other cases represent the culmination of a series of boundary crossings (non-exploitative departures from usual practice).” The “series of boundary crossings” could be described as physicians “testing the water” so to speak. The physician subtly crosses a boundary and waits for the patient’s response. These boundary crossings are misconduct in themselves, and they are unethical. John Enbom and colleagues note that “The American Medical Association Council of Ethical and Judicial Affairs (1989) addressed professional boundaries and stated that sexual misconduct violates the trust that a patient places in the physician and is unethical.” As our society increasingly abandons traditional moral codes (especially sexual codes), those professional boundaries between the physician and the patient will likely be crossed at increasing rates as well. Hence, there is a need for more rules and regulations to prevent such boundary crossings and sexual misconduct; ultimately, the patient needs more protection.

Discussion

How should we analyze the actions of Dr. L.R. and Dr. M.P. in the patient cases? Should anything in the cases be considered boundary crossings or sexual misconduct? It seems to be pretty obvious that Dr. L.R. in the first scenario was, at minimum, in the early stages of sexual advancements and was crossing professional boundaries. The increasing objectification of women by men has resulted in an increase in those types of incidents. Many women have already dealt with men crossing boundaries, and as a result they are alert to the warning signs. Hence, the actions by Dr. L.R. could easily be considered to be early stages of sexual misconduct, or “a series of boundary crossings” as Galletty labels them.

What about the second scenario? The second scenario is often not raised in the context of boundary crossings or sexual misconduct, and often it is ignored altogether. Homosexuality and “same-sex attraction” are likewise based on sexual objectification. Unlike true marital love between a man and a woman, where the love is based on the possibility of real bodily union, homosexual activity is a disordered act of pleasure that gives the illusion of bodily union. Alexander Pruss writes:

Sexual union is not arbitrarily definable as each sees fit. . . . Rather, sexual union is a physical reality at least partially constituted by the mutual cooperative striving of two bodies in the direction of procreation. Consequently, there are physical acts that cannot constitute sexual union, just as a dog cannot be a cat. For instance, homosexual acts cannot constitute sexual union simply because there is no unified cooperative striving of two bodies in the direction of procreation. It is true that each of the bodies separately may tend toward procreation (for example, ejaculation is itself a striving toward procreation) but the individual bodies’ strivings for procreation are not cooperative: the action is not truly a joint action. In order for a union as one organism to occur, the union between the two individuals must occur through such a cooperation.

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and joint action. … There is no unity as a single organism in “sodomitic”
acts. … Yet, in these unnatural acts, there is an illusion of physical union
caused by the presence of orgasm. According to Aristotle, pleasures are per-
ceptions of a good. Thus, sexual pleasure will be the perception of the good
of physical union or reproduction or both, and when this good is absent, the
pleasure will be an illusion.7

Pruss is basically saying that in order for two individuals to really unite, they must be
performing the same action together. The action the two are performing is determined
by the organs involved in the action and the end toward which those organs tend.
Sexual union is ordered to procreation, so in real sexual union the uniting organs
strive toward this same end. Only a man and a woman can realize this union, since
they each have the organs necessary for unity, and hence, homosexual acts are not
sexual unions.

If there is no possible union between individuals of the same sex, then their
attraction to each other results from sexual objectification. Same-gendered individuals
simply use the other individual’s body for disordered pleasure. Hence, another term
for “same-sex attraction” is “same-sex sexual objectification,” because in homosexual
sex both individuals are merely sexual objects to each other.

When a society labels a disordered sexual state as normal, there will be
society-wide consequences. Take, for instance, the use of contraception in marital
intercourse, between husband and wife. The impeding of procreation and bodily
unity in sexual intercourse is disordered, yet, our society has labeled it normal. The
resulting consequences can be observed and have been written about. Increases
in divorce, out-of-wedlock pregnancies, fatherless homes, and sexual assault and
rape of women have all likely resulted from the normalization of contracepted sex,
a disordered action. It is clear that women no longer trust men as much as they use
to (and for good reason) in this society where the disordered is labeled as normal.

When a man enters a woman’s locker room with the intention of receiving
sexual gratification, he is a voyeur. Those women in the locker room can reason-
ablely expect privacy and to not be sexually objectified while in that private space.
Because homosexuality is based on sexual objectification, the same consequences
would be expected by same-gendered individuals. Common sense tells us that if a
woman is “sexually attracted” to women, she is going to be invading the privacy
of other women in a women’s locker room. The women who are objectified should
regard the actions of the other woman as unjust and a breach of trust and privacy. A
person who opposes being sexually objectified in the locker room by a member of the
opposite sex will not support the same action by someone of the same gender. Sexual
objectification is unjust regardless of the gender of the individual who objectifies.

The problem with the issue of sexual objectification of same-gendered indi-
viduals is that it can be much more difficult—if not impossible—to detect. A
homosexually-inclined woman could simply walk into a woman’s restroom or locker
room and sexually objectify, while a male cannot walk into a woman’s locker room

7 Alexander R. Pruss, “Not out of Lust but in Accordance with Truth: Theological
and get away with this injustice. The man’s outward appearance as a man should indicate his “sexual preference,” and women have every right to not want a man in the locker room. Even if a man attempts to dress like a woman, he can still be detected and arrested for voyeurism.8

The same holds in the physician–patient relationship. A female physician could sexually objectify a female patient without the patient having the slightest idea that this injustice occurred. Many women choose female doctors with the assumption that the female physician will not view or touch their bodies in ways that they do not want to be viewed or touched. A female patient has every right to choose a physician who is not going to be sexually attracted to her body, and a male patient has the same right. The female patient has every right to discriminate against a physician who is sexually attracted to her gender—regardless of the physician’s gender. The same holds for male patients.

So how should Dr. M.P.’s actions toward C.D. be labeled? Did Dr. M.P. cross boundaries with C.D.? Here is a prime example of where the patient is not protected. We could argue that regardless of Dr. M.P.’s “sexual preference,” he definitely crossed boundaries. “You have nice abs!” is not normal male conversation. What if C.D. saw Dr. M.P. in public holding hands with another man? That would seem to be a clue indicating that C.D. was the victim of sexual misconduct. C.D. deserves the same treatment that A.T. would have received had she filed a complaint against the male doctor. In all actuality, C.D. deserved to be notified prior to the office visit that Dr. M.P. has a tendency to sexually objectify same-gendered individuals.

This second case brings to the fore an ignored consequence of considering homosexuality and homosexual “attraction” as normal. Homosexually inclined individuals can “hide,” so to speak, their tendencies toward sexual objectification of same-gendered individuals. Yet they still can commit an injustice, and hence, they should be held to the same standards as the rest of society. The woman who wishes to not be objectified by a male physician would most likely desire to not be objectified by a female physician either. The same holds for the man. Since voyeurism and other forms of sexual misconduct end up harming the patient as well as the patient’s trust in physicians, there is a need for protection.

Homosexuality rests on sexual objectification of same-gendered individuals. If a physician tends toward attraction to a specific gender (or even age), then the patient or the patient’s parents should be made aware of this. It seems the only way for the patient and patient’s guardian to be aware of this is for this particular information to be revealed. There is a clear need for rules and regulations that require a physician to reveal his or her “sexual preference” prior to the patient entering into the physician–patient relationship.