The Ethics of Medical Sexual Health Education and Its Provision

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Abstract

Purpose of Review The purpose of this paper is to open a discussion of the ethics of medical sexual health education (SHE) and its provision in medical education. The paper utilizes a qualitative analysis of currently available literature on medical SHE and a medical ethics framework of the four prima facie principles of (1) respect for autonomy, (2) beneficence, (3) non-maleficence, and (4) justice, together with expert opinion. The result is a review of the ethics of medical SHE as well as the ethics of the decision to provide, or not to provide, comprehensive SHE.

Recent Findings Recent literature has underscored the many ways in which comprehensive medical SHE supports trainees’ ability to provide sexual health care and improve their delivery of general health care, as well as the many ways sexual health is correlated with systemic health. The literature also provides evidence that the provision of comprehensive SHE is limited in undergraduate and graduate medical education. There is a dearth of literature specifically examining the ethics of medical SHE provision.

Summary This analysis demonstrates the ways in which comprehensive medical SHE and its provision conforms with the principles of the ethical practice of medicine. The analysis also supports that a lack of inclusion of SHE in medical education programs may be a violation of these principles and increases the risk of future unethical practice by medical professionals.

MESH Headings: Ethics, Medical, Social justice, Sexual health, Sexuality, Human, Education, Medical, Undergraduate, Education, Medical, Graduate

Introduction

The history of sexual health education (SHE) in medical education (med-ed) originates in the twentieth century. In the 1950s, a scant handful of medical schools provided a limited amount (1–4 h) on the physiology of human reproduction [1]. After the sexual revolution, by 1973, 98% of medical schools offered courses in human sexuality, and 70% of those provided SHE as part of the core curriculum [1]. Medical SHE originally incorporated some biopsychosocial focus on sexuality as well as instruction in reproductive physiology with a dual purpose of providing the basics of the education and shifting undergraduate medical students’ personal attitudes towards sexuality. Now medical SHE often emphasizes sexual engagement risk reduction, and the biological and physiological elements of reproductive biology and sexual engagement rather than a comprehensive biopsychosocial focus incorporating sexual medicine [1–15]. Unfortunately, since the 1980s, the amount of medical SHE has been decreased [5–9, 11, 15]. A 2008 study found only 51 of 92 schools that responded to a telephone survey reported having a sexual health curriculum, and the median hours provided was 8 [15]. More recently, while a few universities and programs are expanding their sexual health programs (the University of Minnesota, for example), many SHE providers note their universities are further decreasing SHE. Reasons cited for this reduction include the lack of detailed accreditation standards for SHE by supervising medical educational committees, financial difficulties, and a lack of time and/or faculty [5, 6, 9, 16•]. However, stigma attached to sexuality likely contributes as well [6, 16•].

The reduction of SHE and the lack of support for SHE by educational committees is problematic. Sexual health must be supported as it, itself, is fundamental to human health, and it is positively correlated with other health states, including financial, educational, physical, mental, and relational [16•, 17–33, 34•, 35]. More recently, this influence is increasingly shown to be bidirectional [18, 19, 25]. Without SHE, medical practitioners are ill prepared to support sexual health. Also, without

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SHE, medical practitioners may unintentionally contribute to poor sexual and general health by providing medications and other treatments with sexual side effects and by not regularly addressing sexual health as a component of all other health [7, 8, 10, 11, 13–15, 30, 36–41, 41]. The potential for physicians to engage in these negative impacts on health is heightened by lack of education and mitigated by SHE [6–9, 14, 15, 16•, 21, 36, 43–46, 47•, 48•].

Even while the amount of SHE has been decreased in medical education, sexual medicine and health have become flourishing academic subspecialties, and there is a growing body of research and literature that adds to our understanding of this facet of human health. Sexual health specialists have also examined SHE creation, current and future needs, and effects in medicine. The literature reflects an increasing focus on this education from the mid-twentieth century through the mid-1970s before declining through the end of the twentieth century.

In recent years, the focus on SHE in med-ed has been renewed. The results have been multifold; careful, considered recommendations for a structure of SHE that would enable medical trainees to competently and consistently address sexual health as a biopsychosocial phenomena and with an understanding of the basics of sexual medicine; sexual health societies and programs that provide expanded sexual health education materials for professionals; and the creation, provision, and study of discrete SHE curricula [4–6, 8–11, 14, 16•, 36, 43, 47•].

Unfortunately, there are no studies to date that have demonstrated the information provided in these SHE curricula is used or even retained over the long term. And there is a paucity of data examining whether medical students vs residents vs practicing physicians use this information when it has been provided. At least partially, the lack of data is likely due to the same strictures that have limited the provision of this education. But the lack of data is doubtlessly also due to the limited population pool available for study, given the limited amounts and non-standardization of the SHE currently being provided. In addition, even if SHE is provided and then tested in the future, the degree to which the information is retained and used will likely depend on the degree of importance assigned to the knowledge by the students. The perceived importance of any knowledge is influenced by both overt factors (such as whether the course is mandatory and included in evaluations) and covert influences (including the hidden curriculum and the value or stigma attached to the topic).

More recently, as resources for SHE have accumulated, proponents of SHE have proposed means for increasing SHE within undergraduate and graduate medical education (UME and GME, respectively), despite the multiple pressures that led to the reduction [5, 6, 8–10, 16•]. With increased provision of research-supported SHE, further studies of the retention and use of this information will be possible and will likely demonstrate that this education, similar to other important, well thought out, institutionally supported core health curricula, is both retained and used.

But, to date, the ethics of current SHE and its inclusion in education has not been an area of focus in published literature. Reasons behind the lack of discussion and study of the ethics of SHE provision are likely varied and may include that (1) given the progressive shift to a more biomedicine approach, SHE may be considered simply more scientific data, not particularly worthy of ethical debate, and (2) stigma surrounding sexuality may have contributed to the marginalization of sexual medicine and to a reluctance to consider and address the ethics of sexual health and SHE [5, 6, 8, 9, 16•]. Despite, or perhaps because of these reasons, evaluation and discussion of the ethics of SHE and its provision are important.

To open the discussion of the ethics of SHE, a qualitative analysis of the ethics of the fundamental form and purpose, application, and potential results of SHE will be performed. This analysis will utilize expert opinion, currently available literature, and an ethical framework of the “four principles plus scope” approach to biomedical ethics laid out in “Principles of Biomedical Ethics” by Beauchamp and Childress and summarized in the 1994 paper “Medical ethics: four principles plus attention to scope” by Gillon [49••, 50]. The four prima facie principles are (1) respect for autonomy, (2) beneficence (or the medical injunction of providing benefit to the patient), (3) non-maleficence (or the medical injunction to “do no harm”), and (4) justice (which may be considered to be divided into three: distributive justice, rights based justice, and legal justice) [49••].

Qualitative Analysis of the Ethical Considerations Around SHE

The Ethics of Comprehensive SHE Provision

As noted in a 2021 paper, stigma and secrecy around sexual health are common and contribute to adverse health outcomes. Sexual stigma is created by social, cultural, and institutional norms and perpetuated through a lack of or inaccurate information dissemination or secrecy and by the lack of scientifically supported education [21, 32, 37, 43, 51–54]. While stigma is countered by education and normalization” [16•].

SHE, when scientifically valid and provided without bias or misinformation, is an effective means of mitigating stigma. 

1 (including International Society for Sexual Medicine (ISSM), International Society for the Study of Women’s Sexual Health (ISSWSH), North American Menopause Society (NAMS), Sexual Medicine Society for North America (SMSNA), and American Medical Student Association (AMSA)).
both for the public and within medicine. Reducing stigma, in turn, can contribute to improvements in both sexual and other health measures [11, 30–32, 43, 55–57]. Scientifically valid medical and public SHE, when free of bias and misinformation, thus conforms with the principle of beneficence.

The core tenet of scientifically valid, comprehensive medical SHE is to counter sexual stigma and ensure trainees have the capacity to provide sexual health care. One of the benefits of comprehensive medical SHE is that it teaches trainees how to address the stigmatized topic of sexual health and the need to do so consistently. These skills, taught through sexual health, are applicable across specialties [16•]. SHE also provides trainees with the ability to educate patients, as well as diagnose and treat patients’ sexual health problems (or at least know when and where to refer) to restore sexual health [6–11, 14, 15, 16•, 32, 36, 43–46, 47•]. Medical SHE therefore doubly decreases stigma (1) by educating about and normalizing sexual health for medical trainees, leading to decreased stigma around sexual health in the medical population and (2) by supporting that physicians may decrease stigma in the patient population by education and normalization through consistently addressing sexual health as simply another component of systemic health. The provision of SHE thus doubly fulfills the principle of beneficence; benefitting trainees as an educational construct and, in turn, allowing trained practitioners to benefit patients as a professional obligation.

The role SHE plays in combatting sexual stigma must also be considered with regard to the principle of justice. Minority and marginalized populations, including gender and sexual minorities (GSM), are disproportionately affected by stigma. These populations have been found to suffer from poor health at disproportionate rates, and these health disparities occur in the context of stigma leading to social marginalization resulting in increased mental and physical health issues and multiple factors that limit access to care [52, 53, 58•, 59•, 60]. For GSM populations, it is clear that sexual stigma is the primary contributor to these health disparities [58•, 59•, 61]. However, many explanatory models of minority differences encompass sexual stigmas as well [53, 60]. One manner sexual stigma can impact health is through perceived medical professional comfort, an important aspect of perceived support, and one that is positively correlated with mental and physical health in GSM and likely in all populations [61]. Comprehensive SHE contains components designed to improve trainees’ comfort with addressing sexual health and related topics in all populations, including minorities and GSM, thereby upholding and supporting the principle of justice.

Sexual and other stigma also affects general medical care, as health care providers may be personally uncomfortable or uncertain of how to interact with various minority groups, including GSM [58•, 59•, 60, 61]. This “constellation of inequalities can systematically magnify and reinforce initial conditions of ill health, creating ripple effects that impact other dimensions of well-being… The result is a mixture of interactive and cascading effects that require urgent attention from the point of view of justice. The job of (medical) justice is to correct these defects by making the six core elements of wellbeing (1- Health, 2- Personal Security, 3- Knowledge and Understanding, 4- Equal Respect, 5- Personal Attachments, and 6- Self-Determination) embedded values in social policy” [62]. This includes enabling physicians to be better prepared to treat minority and marginalized populations and GSM, both generally and around sexual health. Comprehensive SHE encompasses this education, and thereby, its inclusion supports the principles of justice, as guidelines for SHE include objectives of knowledge of GSM populations, of personal recognition and mitigation of transference and bias with all populations, and of increasing effective communication [5, 8–11, 14, 16•].

In summary, the fair opportunity rule of social justice “demands that (disadvantaged health populations) receive help to reduce or overcome the unfortunate effects of life’s lottery” of health and the rules of redress require that compensation (in the form of increased attention to the needs of this population) be provided, and the inclusion of comprehensive SHE in medical education provides the means to this end [63].

The Ethics of The Lack of Comprehensive SHE Provision

It has been noted by some medical educators that the lack of inclusion of SHE is not an active choice, but rather a passive one secondary to the scope of medical education pressures to include too much education in too little time [16•, 64•]. Educators also note the choice to limit SHE is supported by limited guidelines for SHE inclusion from educational committees and limited inclusion of sexual health specific knowledge in evaluations [6–9, 14, 16•, 64•]. With this argument, educators suggest that within the scope of medical education they are conforming with the principle of justice (acting on the basis of fair adjudication of competing claims) to best support the principle of beneficence. This is a weak ethical argument, though, as the scope considered is self-referential and narrow. As there is now a body of work expounding the necessary components of comprehensive SHE and offering suggestions for how to achieve increased amounts of SHE despite curricular pressures, as well as multiple sources for stand-alone SHE classes, there are indisputably multiple ways to ensure SHE can be added to medical education programs [4–6, 8–11, 14, 16•, 36, 43, 47•]. Furthermore, the literature supports that sexual health is an important facet of health, therefore worthy of education, and suggests SHE improves trainees’ capacity to provide sexual...
and general health care [16•, 38, 65]. Therefore, in addition to the ways SHE meets the criteria for the principle of beneficence, the lack of SHE can be considered to be supportive of physicians violating the principles of beneficence and other medical ethical principles.

To abstain from utilizing these ready resources to at least enhance the SHE of a program can be conceptualized as an active choice to limit trainees’ ability to provide adequate sexual health care and education for their patients. To choose not to include SHE results in medical practitioners who are less able to benefit their patients in this crucial area of health, therefore less able to comply with the principle of beneficence. In addition, the well-being theory of social justice suggests the “job of justice” is to secure the core elements of well-being… in all six dimensions for each person in every society, including the global society” [62]. A lack of SHE decreases trainees’ ability to secure patients’ sexual “health” (core element #1) and their sexual health “knowledge and understanding” (core element #3). It could be argued that consequently this abstention goes against the broad principles of beneficence and of justice.

The lack of inclusion of comprehensive SHE in a program can also be considered to conflict with the principle of distributive justice. Numerous public health organizations have espoused the need for increased focus on and support of sexual health through both public health efforts and the efforts of individual health care professionals [29–32]. Comprehensive medical SHE is the means of enabling individual medical trainees to achieve this contribution to sexual health care. For UME and GME programs to not at least make a concerted effort to improve the quality and amount of SHE can be regarded as both a shirking of professional duty and conscious contribution to inequitable and limited accessibility of sexual health care. This is at odds with the principle of distributive justice. Even if an argument is made that individual medical professionals are only able to contribute to sexual health care marginally, due to constraints of practice, they still require the knowledge and communication skills necessary to determine when a sexual health problem warrants further investigation or treatment and to be able to refer. Comprehensive SHE provides this education and thus supports distributive justice.

The lack of provision of SHE may also be considered to create potential for active and passive violations of the principle of non-maleficence. As previously noted, a majority of physicians do not address sexual health on a regular basis and SHE is a proven method to increase this capacity to address and treat sexual health [2, 3, 5, 7, 9, 15, 16•, 21, 31, 38, 40, 44, 45, 66–70]. Accordingly, to limit the provision of SHE, which directly contributes to physicians continuing to not address sexual health, may be considered to be tantamount to purposefully ignoring and not treating sexual health, a contradiction of the principle of non-maleficence.

And, as noted, there is ample evidence that sexual health impacts multiple other facets of health. When we consider the causal sequence of deliberately deciding to not include SHE, we must recognize one of them to be the potential to allow poor sexual health to detrimentally impact systemic health, another contradiction of the principle of non-maleficence. Moreover, when physicians do not address sexual health on a regular basis, they may easily be seen as avoiding a stigmatized topic, thereby perpetuating or even contributing to the stigma surrounding sexuality and sexual health; an active violation of non-maleficence.

The lack of SHE, and the correlated lack of physician communication around sexual health, can also be considered oblique neglect of the principle of autonomy (core element #6). There is evidence that patients would like their physicians to initiate conversations about sexual health [2, 41, 42•, 70, 71]. If evidence supports that many patients would like their physicians to address this component of health, and if physicians must at least address the topic to determine if an individual patient wants to engage further, for physicians to not have the capacity to assess or respond to their patients’ health desires can be considered an infringement against the principle of patient autonomy.

This same lack of ability to communicate engendered by a decision to limit SHE provision can also be considered a neglect of the principle of non-maleficence in another way. When physicians do not initiate the conversation, they place the burden on patients. Evidence supports that patients who are less able to benefit their patients in this crucial area of health; and, as noted, there is ample evidence that sexual health impacts multiple other facets of health. When we consider the causal sequence of deliberately deciding to not include SHE, we must recognize one of them to be the potential to allow poor sexual health to detrimentally impact systemic health, another contradiction of the principle of non-maleficence. Moreover, when physicians do not address sexual health on a regular basis, they may easily be seen as avoiding a stigmatized topic, thereby perpetuating or even contributing to the stigma surrounding sexuality and sexual health; an active violation of non-maleficence.

There is another way a decision to not provide comprehensive SHE violates ethical principles. Sexual medicine research has provided a clear understanding of the impact of treatments, especially medications, on sexual health. This research has also shown that sexual side effects are a common reason for treatment non-compliance. In addition, the sexual medicine and sexual health communities have providers to diagnose and treat all varieties of sexual health dysfunction, whether from medical treatment or not. Comprehensive SHE teaches trainees about the sexual side effects of common medication, to be aware of this potential with all treatments.
and provides practitioners with resources so they may refer for sexual health matters. Without comprehensive SHE, many trainees are not aware of this sexual health knowledge. The result is practitioners providing treatments that cause sexual dysfunctions and disorders and not disclosing these potential side effects as part of the discussion of the risks, benefits, and alternatives [72]. This sequence of behaviors is not only a violation of the principle of non-maleficence by potentially causing sexual health harm, it may be considered a further violation of this principle as it can contribute to patients eschewing treatment they need to improve other health conditions because of the sexual health impact. This lack of disclosure of the full sexual health impact may also be considered to flout the principle of autonomy, as it undermines the basic premise of informed consent.

The last consideration in this brief initial analysis is given the intertwined nature of sexual health and systemic health, many of the behaviors and health interventions that preserve sexual health are the same as those that preserve systemic health [12, 20, 23, 25, 65]. And given that sexual health, or at least sexual activity and sexual satisfaction, is desired by many patients, the preservation of sexual health can be used as an extremely important motivation for patient engagement in systemic health preservation [12, 65, 73]. SHE provides the understanding of this motivation and encourages trainees to use sexual health as a component of a multifaceted health motivation approach. The lack of inclusion of SHE therefore can also be seen as a lack of attention to the principle of beneficence as it pertains to systemic health, not just sexual health.

Conclusion

In conclusion, this analysis demonstrates that the fundamental form and purpose, provision, and potential results of comprehensive SHE in medical education conforms with the four principles of medical ethics and support the ethical practice of medicine. This analysis also supports that the lack of provision of SHE must be considered to be a potential violation of the principles of medical ethics and increases the risk of trainees engaging in unethical practice.

Implications of this initial analysis include that medical educators, educational committees, and evaluation creators must consider incorporating increased amounts of, if not comprehensive, SHE to ensure ethical education and practice. Readers of Current Sexual Health Reports can consider this analysis when advocating for greater inclusion of comprehensive SHE in UME and GME generally, in educational guidelines, and in testing. Going forward, continued analysis and discussion of the ethics of SHE and its provision should be undertaken and offered in the literature for further understanding of this topic.

Declarations

Conflict of Interest The author discloses no conflict of interest. The author discloses she is an author and a medical advisor for Volonte.

Human and Animal Rights Statement This article does not contain any studies with human or animal subjects performed by any of the authors.

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