Final version forthcoming

Word Count (all inclusive): 7,279

**Dementia and Concurrent Consent to Sexual Relations**

In the small town of Byron, Illinois (two hours outside of Chicago), a nursing home named Neighbors Rehabilitation Center was fined $83,000 by the Centers for Medicare and Medicaid Services for an “Immediate Jeopardy” infraction, which means that regulators believed Neighbor’s noncompliance “caused or created a likelihood that serious injury, harm, impairment, or death to one or more recipients would occur or recur.”[[1]](#footnote-1) Contrary to what one might think, this fine was not imposed for practices like failing to properly vet employees for criminal backgrounds, negligence in administering medications, etc. This fine was imposed because “Neighbors allowed residents to have consensual sexual interactions and that supervisors told Neighbors’ staff that they were not to intervene or report sexual interactions unless a participant showed outward signs of non‐consent.”[[2]](#footnote-2) Ultimately, an appellate court upheld this fine. Cases like this are very common. Contrary to popular belief, many elderly people want to have sex and see sex as a regular part of their lives. Many non-elderly people believe one of two myths about elderly sexuality. First, it is common to believe that the elderly do not have sex and do not have sexual desires. Empirical evidence shows this to be a myth.[[3]](#footnote-3) Second, many people believe that elderly sexuality is perverted or *gross*.[[4]](#footnote-4) If society harbors ignorance and prejudice toward elderly sexuality, it harbors stronger views toward the sexual expression of elderly people with dementia. People with dementia are often prohibited by nursing home staff, sometimes in extreme ways, from having sex with their partners.[[5]](#footnote-5) This prohibition is motivated by the goal of protecting the vulnerable. But, cutting patients with dementia off from sex has negative health effects and is a needless restriction of their autonomy.[[6]](#footnote-6) Philosophers have become newly interested in the ethics of sex. One promising feature of this new discussion is that it has been broadening our moral lens to include individuals whose sexual interests have historically been denied or ignored. In this paper, I argue that our expanding moral lens in sexual ethics should include the sexual expression of elderly individuals with dementia and that their sexual expression should be respected.[[7]](#footnote-7) More precisely, suppose that two individuals, C and D, have been in a long-term committed relationship, and D now has dementia, while C is clearly competent. The common view in the nursing home community is that sex between C and D is not permissible, because D’s condition supposedly renders her unable to give valid consent. In this paper, I argue that this is mistaken. I begin by outlining some parameters to govern my discussion. I then I defend the view that, under certain conditions, people with dementia can give valid consent to sexual intimacy. I conclude by addressing objections.

***Parameters***

In this paper, I will use a hypothetical case involving two partners, C and D. C is the competent partner, and D is the partner with dementia. I refer to D as a woman and C as a man, but the reader can alter the genders and the sexual orientations of both people. A few general parameters are useful in discussing the case of C and D. Let us assume that C and D have been in a long-term, committed relationship with no history of abuse. Before D’s diagnosis, C and D frequently engaged in consensual sex, and they are familiar with each other’s verbal and non-verbal sexual cues. Let us also assume that C is competent. D’s dementia impairs her cognitively. Dementia includes a wide range of severity of cognitive impairment. Individuals with very mild dementia are competent to consent to a lot of things. And, individuals with *extreme* dementia (i.e. non-verbal and non-communicative) clearly cannot consent to anything. I am not discussing individuals whose dementia is so bad that they have lost all awareness and ability to communicate. It seems obvious that they cannot validly consent to sex. Rather, I am interested in whether individuals with *mild* to *severe* dementia can consent to sex. So, let’s assume that D’s dementia does not rise to the extreme level described above; rather, D’s dementia is between very mild to severe. So, although her cognition is impaired, D can communicate, has a sense of self, etc. To my knowledge the objections to people with dementia engaging in sex are meant to apply to all levels of dementia and are not restricted just to saying that people with extreme dementia should be barred from sex. I will also assume that D has *assented* to sex with C. Consent and assent are both a kind of ‘yes.’ But, assent is weaker than consent and cannot, on its own, render an action permissible when it otherwise would not have been.[[8]](#footnote-8) This limitation is crucial, as it excludes cases where D does not even assent to sex with C. I only discuss cases in which D has either asked for sex from C or has agreed to sex after being asked. I will not evaluate cases in which D *dissents* from sex with C. Sex is clearly impermissible in those cases.

I only address cases of sex between two long-term partners where one has dementia. My analysis won’t directly cover cases in which two people who both have dementia want to have sex with each other or cases in which an individual with dementia wants to begin a new sexual relationship with someone who has not been her long-term partner. For reasons that will become clear later, I think that these cases introduce a complicating feature that makes them more difficult. My view has indirect implications for these cases, which are discussed later.

***People With Dementia Can Consent***

If a person with dementia can give valid in the moment consent to sex, then it is permissible for her competent partner to have sex with her,assuming the action isn’t wrong for other reasons. Again, D has at least assented to sex with C. I now defend the claim that D can give valid concurrent consent to sex with C, despite having dementia. Assume that other consent invalidating conditions (deception, coercion, etc.) are not present. The question at hand is whether D, in virtue of her dementia, is sufficiently impaired that she cannot give valid consent to sex with C.

I argue that C and D can permissibly have sex with each other. My argument has two goals: the first is to establish that D can give valid concurrent consent to sex, and the second is to show that C can justifiably believe that D has given valid concurrent consent. Both are necessary conditions of establishing the permissibility of sex between C and D. The core principle behind my argument is this:

***Dementia and Consent to Sex:*** if, despite having dementia, D knows who she is, knows who C is, understands what sex is, can express her wishes, and has (in general) stable preferences, then D is sufficiently competent to validly consent to sex with C.[[9]](#footnote-9)

After defending this principle, I will argue that it is empirically true of people with mild to severe dementia, meaning that they are competent to consent to sex. The Dementia and Consent (henceforth DCS) principle outlines five conditions that, if D satisfies, she is sufficiently competent to give valid consent to sex.

It is important to clarify what DCS doesn’t claim. Though the competence of individuals with dementia is clearly diminished, when evaluating their competence, we must distinguish between “task-specific” and “global” capacity to consent.[[10]](#footnote-10) There is consensus in medical ethics that competence/capacity, as Lichtenberg says, “is not global but always specific to the decision in question.”[[11]](#footnote-11) For people with dementia, competence isn’t all or nothing; these individuals may be competent in certain areas and not others. A person with dementia might not be competent to manage her finances while still being competent to decide where she wants to live.[[12]](#footnote-12) DCS doesn’t claim that individuals with dementia should be considered *globally competent*; it claims that they possess *sex-specific* competency. It may be that these individuals cannot consent to complicated medical procedures while still being able to consent to sex with their partner.

With this distinction in mind, DCS is highly plausible. It claims that, if the five conditions it outlines are satisfied, an individual with dementia has task-specific competence to consent to sex with her long-term partner. It seems plausible that, if a person knows who she is, knows who her partner is, understands what sex is, can express her wishes, and has stable preferences, this person can consent to sex with her long-term partner. Beyond this bare plausibility, I offer a brief defense of each condition in DC.

To consent to sex, D must know who she is. If D doesn’t know who she is, then she lacks sufficient self-awareness to consent to something that would require her to decide what *she* wants. To know that she is the kind of person who wants to have sex with her partner, and to know who her partner is, D needs to know who she is and must have a concept of her identity and preferences. For D to know who she is, she must have awareness of her identity as a particular person, meaning that she must know that she is D. I won’t develop an account of self-identity; instead, I rely on our intuitive concept of self-identity. D knows who she is, because she is aware of her history, her desires, her beliefs, etc.[[13]](#footnote-13)

Second, D has to know who C is to consent to sex with him. Sexual consent is generally assumed to be given to a specific person. Consequently, D has to know *who* she is having sex with, not simply *that* she is having sex with someone. This is an important part of D’s general understanding of her situation; if D is having sex with someone without knowing who it is, this suggests that she isn’t sufficiently aware and rational to consent to sex.

Third, D has to understand what sex is for her consent to be valid. To consent to something, one must understand what this thing is. This is just to say that the person must be informed about what she will be consenting to. One might wonder to what degree D has to understand what sex is to consent to it. There’s no clear answer here. D must, at least, understand the nature and potential effects of the physical actions involved in the sexual acts that she consents to. So, she must know that intercourse involves penetration, etc.

Fourth, for her consent to be valid, D must have stable preferences about sex. By ‘stable preferences,’ I mean preferences that are unlikely to change from moment to moment. If D’s wishes were to change frequently and quickly, it would be implausible to suggest that C could trust that D really wants to have sex at a given moment, as her wishes could easily change from one moment to the next. For D to give consent, her desire to have sex must not be subject to quick and unstable changes. To clarify, I am not saying that D must never lose her in the moment desire to have sex. People who do not have dementia can lose the, so to speak, mood and not want to have sex even if they wanted to moments before. Instead, I mean that D’s background preferences regarding sex must be stable. It must be the case that D generally thinks that sex is something she wants to engage in. Of course, it still must also be the case that she desires to engage in sex in the moment of doing so.

Fifth, for her consent to be valid, D must be able to express her wishes, meaning that she must have some way of signaling *that* she consents and *what* she is consenting to. Additionally, an important feature of D being able to express her wishes is that she can express her wish to not engage in sex or to withdraw consent during sex.

I take it that I have established the necessity of each condition of DCS. It remains to be shown that these conditions taken together are jointly sufficient for consent to sex. Given that I lack space to eliminate all other possible necessary conditions for D being competent, I will instead appeal to the plausibility of DCS. All DCS claims is that if D has a sense of self, knows who she is having sex with, knows what sex is, and can stably express what she wants, then she is competent enough to have sex with her partner. In general, if someone knows what they are doing, who they are doing it with, has stable preferences about the decision in question, and is neither deceived nor coerced, then this person should be able to do what she wants within that domain.

For now, I take it that DCS has been established as plausible. I now turn to argue that DCS is empirically true of people with mild to severe dementia. Here, I outline empirical evidence that people at varying stages of dementia satisfy these conditions. I mainly draw empirical evidence from three studies.[[14]](#footnote-14) In these studies, individuals with varying levels of dementia were asked fact-based questions (questions about their lives, such as their birthday, how many children they have, etc.) and state-dependent questions (questions about their preferences, opinions, etc.). They were asked the same questions typically a week later to check for consistency and accuracy between their answers at the first and second interviews.

These studies refer to an individual’s MMSE score. The MMSE (Mini-Mental State Exam) is a test used to assess competence across seven different measures.[[15]](#footnote-15) I am not using the MMSE as a test for determining an individual’s capacity to consent. There is compelling evidence that the MMSE should not be used in this way.[[16]](#footnote-16) Instead, I use the MMSE as an approximation of different levels of impairment among individuals with dementia, which the test is well-equipped to do. The test has a maximum score of 30. Score ranges can be used to classify levels of dementia. Different studies set the ranges slightly differently, but they are all in rough agreement about how many points on the MMSE correlate with certain levels of dementia.[[17]](#footnote-17) For clarity, I follow Clark, who sets the ranges as follows: a person with a score of 27-30 has very little impairment, 23-26 has mild impairment, 18-22 has moderate impairment, and 13-17 has severe impairment.[[18]](#footnote-18) When I discuss levels of dementia, it corresponds roughly to this range.

It is worth noting some broad conclusions from these studies. These studies find that individuals with varying levels of dementia can give consistent (the same from interview 1 to 2) and accurate (factually correct) answers to both factual questions about their lives and to questions about their state of mind.[[19]](#footnote-19) As Clark says, individuals with dementia “were able to provide consistent responses to fact-based questions…[with] near perfect agreement between Part 1 and Part 2 responses,” with 79-96% of respondents answering nearly all questions consistently.[[20]](#footnote-20) Clark also finds that individuals with dementia “provided accurate responses to nine fact-based demographic questions,” with “five of the nine questions (birth day, birth month, birth year, siblings, and marital status)” at near perfect accuracy.[[21]](#footnote-21) Feinberg adds to this, finding that individuals “with the lowest MMSE scores [i.e. people with severe dementia] responded accurately to nearly all questions at both Time 1 and Time 2”[[22]](#footnote-22) These results show that individuals with even severe dementia can consistently and accurately answer questions about their lives and mental states. With these overall results noted, I now show evidence that individuals at varying levels of dementia satisfy each condition of competence from DCS.

*D knows who she is:*

Individuals at all levels of dementia retain their sense of self, understood as a continuity of consciousness. As Feinberg says, “a growing body of research suggests that people with dementia retain a sense of self, despite cognitive impairment, into the late stages of the illness.”[[23]](#footnote-23) This is further evidenced by the fact that (as discussed below), individuals at all stages of dementia accurately remember key facts about their lives, suggesting that they remember who they are. Clark finds that, for even the most impaired individuals, 88% accurately recall their birthdays, 93% accurately recall their birth month, 83% accurately remember if they have siblings, 88% accurately remember if they are married, and 83% accurately remember if they have children.[[24]](#footnote-24) These numbers increase with less impaired individuals. Even people with severe dementia accurately remember facts about their lives, suggesting they know who they are.

*D knows who C is:*

Individuals at all stages of dementia can correctly answer questions about their marital status. Clark finds that 100% of individuals with very little impairment can correctly remember their marital status and that 88% of individuals with severe impairment can correctly report their marital status.[[25]](#footnote-25) In terms of consistency, Whitlatch finds that 93% of individuals with severe to moderate dementia give consistent answers from time 1 to time 2 to questions about their marital status.[[26]](#footnote-26) Overall, even individuals with severe dementia know that they are married. Knowing that one is married is different from knowing who one’s spouse is. However, given the evidence that even severely impaired individuals can accurately recall facts about their life, it seems likely that these individuals remember both that they are married and who they are married to. It is unlikely that D could recall that she is married, when she was born, how many children she has, etc., while not remembering who her spouse is.[[27]](#footnote-27)

*D understands what sex is:*

None of the research I cite directly addresses what individuals with dementia understand about sex. However, based on what has been shown, we can establish that even individuals with severe dementia understand what sex is. Individuals with dementia want to have sex. As Ballard found in interviews with patients with mild to moderate dementia and their partners, “22.5% of the couples continued to have an active sexual relationship. All the partners continuing to have a sexual relationship reported that they were satisfied with the situation and thought that their partners were also satisfied.”[[28]](#footnote-28) Essentially, individuals with dementia still want to have sex and can report on their levels of sexual satisfaction.[[29]](#footnote-29) If D can report on her satisfaction with sex, it is safe to say that D knows what sex is. D cannot desire to have sex nor report her satisfaction with it without having a basic understanding of what sex is. As a further argument, even individuals with severe dementia understand questions that involve concepts like siblings, children, education, etc. These concepts aren’t substantially more complex than the basic concept of sex. If one can understand that another person has the same parents as them, it’s not a big leap to think that this person can understand that sex involves activity with one’s sexual organs. Thus, if individuals with severe dementia understand these concepts enough to give consistent and accurate answers to questions about them, then they likely understand what sex is. Additionally, I want to make it clear that I am not merely discussing consent to genetical contact but instead mean to be arguing that D can understand sexual intimacy broadly construed (including hand-holding, cuddling, kissing, etc.). Lastly, there is evidence that individuals with dementia can understand and express their preferences about their medical care. As Feinberg says, “persons with dementia possess sufficient capacity to state specific preferences and make care-related decisions.”[[30]](#footnote-30) If D understands questions about medical care, then D likely understands what sex is.

*D can express her wishes:*

Individuals with dementia can express their wishes. Feinberg says that “individuals who are mildly to moderately cognitively impaired can articulate their feelings, concerns, and preferences and provide self-assessments of their health and quality of life.”[[31]](#footnote-31) The empirical research (cited earlier) shows that individuals at all stages of dementia consistently and accurately respond to questions about their preferences and mental states, showing that they can express their wishes/desires. Additionally, an important part of D’s ability to express her wishes is that she can say ‘no’ both before and during sex. Buckles interviewed individuals with mild to moderate dementia to determine what they understand about consent; he found that “at least 90% of individuals in all groups answered correctly [‘yes’]” when asked, if they knew that they could “choose to stop answering our [the interviewer’s] questions at any time.”[[32]](#footnote-32) This suggests that they understand that they can opt out of situations that they don’t like.

*D has stable preferences:*

Individuals at all levels of dementia provide consistent answers to questions about their preferences. As Clark says, individuals with dementia gave identical answers at interview 1 and 2 to 81% of state-dependent questions.[[33]](#footnote-33) This extends to individuals in later stages of dementia. Whitlatch finds that 90% of people with dementia give the same answer from interview 1 to 2 when asked if they like to watch television, 73% give the same answer when asked if they prefer winter to summer, etc.[[34]](#footnote-34) It seems clear that preferences are stable if they can be replicated a week later.

With all this evidence stated, I conclude that the five conditions of DCS apply to D, meaning that people with mild to severe dementia can give valid consent to sex. Of course, it’s not enough to establish that D is sufficiently competent to consent. It must also be true that C is capable of justifiably believing this. If C can, with a reasonable amount of justification, believe that D satisfies the conditions of DCS, and if D says ‘yes’ to sex with C, then it seems that C may permissibly act on D’s consent. *Knowledge* of ability to consent isn’t required to act on another person’s token of consent. *Justified belief* is sufficient.[[35]](#footnote-35) I see no reason to change the standard here. Assuming that D asks for sex, says ‘yes,’ or signals agreement in some way when asked if she wants to have sex, then, if C justifiably believes that D is competent, C may have sex with D.

But, can C, with a reasonable amount of confidence, believe that D satisfies the conditions of DCS? I think so. By stipulation, D said ‘yes’ to sex with C. C can establish if D is sufficiently competent to consent by observing whether she exhibits the conditions of competence from DCS. To establish this, C can ask D questions about what she knows about herself, her family, etc. He can ask her if she knows who he is, if she understands what sex is, listen as she expresses her wishes, and wait a few weeks before engaging in sex to ensure that her preferences are stable. If C determines that D answers these questions with consistency and accuracy, then C can justifiably believe that D is competent to consent to sex. Recall that C and D have been committed, long-term partners in a relationship that involved a history of consensual sex, and both know each other’s verbal and non-verbal sexual cues. Because of this, C has considerably more epistemic access to D’s state of mind than the average person. He can read her cues, knows her preferences, etc. This means that C is best suited to know if D is answering these questions correctly.

 One might object that giving this power to C is problematic, because C has an interest in whether D consents to sex, and C might stack the deck in a way that permits him to have sex. This is an important concern. However, the fact that *some* people might take advantage of their partners is not a good reason to prohibit *all* sex between partners when one has dementia. When permitting all competent people to exercise a certain liberty results in some people abusing that liberty for immoral ends, restricting everyone’s access to this liberty would not be fair to those who would use it permissibly. Instead, we need oversight. This may take a variety of forms. Nursing home staff can investigate any suspicious cases of spouses claiming that their partners can consent when the contrary seems true. And, there can be a third-party present while C asks questions to D to ascertain her mental state.[[36]](#footnote-36) Furthermore, C can have an MMSE test administered on D. If the evidence suggests that other people with the same MMSE score can consent, and if C can confirm these results by asking D questions, then he can justifiably believe that she is competent to consent. As stated earlier, the MMSE is not a perfect guide for assessing competence to consent; I only mean that it can be used as a heuristic to assess the degree of impairment that D’s dementia has caused, which can then be used with other evidence to help make a determination. In other words, if other people with dementia who clearly meet the conditions of DCS have a score of X on the MMSE, it would be helpful to know if D has a score at or above X.

 A related worry concerns the legal obligations of nursing homes, who are tasked with (and liable for) protecting their residents from abuse. This means that retirement facilities must do some at least minimal verification that no abuse is occurring if they allow sex between partners where one has dementia. In order to do this, the nursing home can perform a background check for domestic violence charges, conduct an interview with both C and D, and have a representative present when C asks questions of D to ascertain her attitude toward sex.

Overall, I have argued that D is competent to consent and that C is able to believe this with enough confidence to engage in sex with D.

***Personal Identity***

One might wonder how my account interacts with personal identity. Some philosophers believe that, in the late stages of dementia, the person with dementia either ceases to exist or becomes a new person. Suppose D ceased to exist and D\* came into existence in D’s body. This might complicate my account. However, the evidence shows that individuals with dementia (other than extreme dementia) don’t become new people. Individuals with severe dementia accurately answer numerous questions about their memories and pasts; if individuals with severe dementia have access to their memories and a sense of self, they are the same person even into the late stages of dementia.[[37]](#footnote-37) Thus, if D were to cease to exist and become D\*, this would happen only with extreme dementia, which I have already said falls outside my analysis.

**Objections:**

*Does This Mean That D Can Alter Advance Directives?*

One might object that my position entails that individuals with dementia can change medical advance directives they made when they were competent. Although this view isn’t obviously false, it is sufficiently controversial to render my view untenable to many.

My view doesn’t imply this. To claim that D has task-specific competence to consent to sex with her partner doesn’t entail that she is sufficiently competent to consent to other, more complicated things. The competence required to make a serious, often permanent decision about one’s medical care is much higher than the competence required to consent to sex with one’s loving partner. Having sex with C is likely to benefit D’s health, but changing an advance directive is often a matter of life or death. Changing one’s advance directive or consenting to a medical procedure requires one to reason through complex, multi-step decisions. Having sex with one’s partner does not require this, because sex is simpler than a medical procedure or medical decision. When I say that sex is simpler than a medical decision, I mean that the physical act of sex is less complicated, requires less understanding and has fewer steps than many medical procedures; additionally, the risks of sex for D are typically lower than they are for medical procedures (more on this below). And, when the risks are lower, the standard for competence becomes lower. Because of this, D must be considerably more competent to consent to changing her advance directive than she must be to consent to sex. Thus, to say that D is competent to consent to sex doesn’t entail that D is competent to make complicated medical decisions, i.e. altering an advance directive. Of course, some medical procedures are fairly simple (i.e. a dental cleaning, a blood pressure check, etc.); for these procedures, I think D would be competent.

One might object that this does not account for the potential harms of sex for D. If the potential harms of sex are very high, this may raise the bar of competence for consent to sex to the same level as consent to change one’s advance directive. I in no way mean to minimize the very serious risks that sex may pose to people with dementia. If D does not actually consent, and C proceeds with sex, the harm would be severe. However, in the parameters of this discussion, these harms are far less likely. Given that the couples I am discussing are in loving, non-abusive relationships, and given that the partners with dementia meet a sufficient level of understanding and ability to communicate, and given the possibility for oversight, the harms of sex are unlikely for such individuals. Of course, there may be partners who take advantage of their spouse’s dementia to have nonconsensual sex with them. This is clearly wrong. But, we should not limit the autonomy of those who wish to carry on their loving sexual relationships because others will abuse the rules. Suppose that people have a right to freedom of movement across borders. If one immigrant were to murder a citizen, this is not a reason against all uses of freedom of migration.

*Why C?*

One might object that my account unjustifiably restricts who D can give consent to. If D can consent, then D can consent to someone other than C.

Although D can consent, the person to whom she gives consent must be able to justifiably believe that she has consented. C is best positioned to determine if D is competent. C has unique access to D’s sexual cues, her memories, her sense of self, etc. Some other person, P, likely couldn’t know if D can give valid consent to sex, because P lacks this access. To clarify, my claim isn’t that only C is capable of knowing if D is competent; my claim is that C is best positioned to know if D is competent. It is possible that someone other than C could have enough access to D’s mind to assess her competence, but is unlikely. In principle, if P had the same epistemic access as C, then D could permissibly have sex with P. Overall, my claim is that, in principle, D is competent to give consent to sex broadly, but, in practice, D is most likely only able to consent to C. Again, if it were the case that a new partner in the nursing home could develop sufficient familiarity with D, then D could have consensual sex with this person.

The objector might claim that I have excluded cases in which D wants to have sex with another person with dementia, H. The same reasons would apply to H. as he would lack C’s special epistemic access to D. Neither D nor H would be able to have a justified belief that the other satisfies the condition of the Concurrent Consent Thesis.

***Conclusion***

If certain conditions obtain, partners who have been in a committed, long-term relationship may continue having sex even after one partner develops dementia. This is the case because individuals with dementia can give valid concurrent consent to sex. The status quo unjustly prevents individuals with dementia from engaging in sexual expression.

**References**

Alzheimer’s Association. “Tests for Alzheimer’s Disease and Dementia.” https://www.alz.org/alzheimers\_disease\_steps\_to\_diagnosis.asp

Ballard, C.G., M. Solis, P. Cullen, and G. Wilcock. “Sexual Relationships in Married Dementia Sufferers.” *International Journal of Geriatric Psychiatry* 12 (1997): 447-451.

Beitchman, Joseph H et al. “A Review of the Long-Term Effects of Child Sexual Abuse.” *Child Abuse & Neglect* 16 (1992): 101-118.

Bianchi, Andria. “Sex, Dementia, and Consent.” Doctoral Dissertation (2018): <https://uwspace.uwaterloo.ca/bitstream/handle/10012/13520/Bianchi_Andria.pdf?sequence=3&isAllowed=y>

- - - “Sexual Consent, Aging, and Dementia.” In *The Routledge Handbook of Philosophy of Sex and Sexuality*. Ed Brian Earp, Clare Chambers, and Lori Watson. Routledge. 2022a. 1-11.

- - - “Sexual Consent, Dementia, and Well-Being.” In *The Palgrave Handbook of Sexual Ethics*. Ed. David Boonin. Palgrave Macmillan. 2022. 357-376.

Boni-Saenz, Alexander. “Sexual advance directives.” *Alabama Law Review* 68, no. 1 (2016): 1-47.

Buckles, V.D., K.K. Powlishta, M. Coats, T. Hosto, A. Buckley, and J.C. Morris. “Understanding of Informed Consent By Demented Individuals.” *Neurology* 61, no. 12 (2003): 1662-1666.

Centers for Medicare and Medicaid Services” Revisions to Appendix Q, Guidance on Immediate Jeopardy.” 2019: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/QSO19-09-ALL

Charland, Louis C. “Decision-Making Capacity.” *The Stanford Encyclopedia of Philosophy*. 2015. https://stanford.library.sydney.edu.au/entries/decision-capacity/#EleCap

Clark, Patricia A, Shandra S. Tucke, Carol J. Whitlatch. “Consistency of Information from Persons with Dementia: An Analysis of Differences by Question Type.” *Dementia* 7, no. 3 (2008): 341-358.

Davies, Helen, et al. “Sexuality and Intimacy in Alzheimer’s Patients and Their Partners.” *Sexuality and Disability* 16, no. 3 (1998): 193-203.

Director, Samuel. “Consent’s Dominion: Dementia and Prior Consent to Sexual Relations.” *Bioethics* 33, no. 9 (2019): 1065-1071.

Downs, Murna. “The Emergence of the Person in Dementia Research.” *Ageing & Society* 17, no. 5 (1997): 597-607.

Ehrenfeld, M. et al. “Sexuality Among Institutionalized Elderly Patients with Dementia.” *Nursing Ethics* (1999): 144-149.

Feinberg, Lynn Friss, Carol J. Whitlatch. “Are Persons With Cognitive Impairment Able to State Consistent Choices?” *The Gerontologist* 41, no. 3 (2001): 374-382.

Fyfe, Shannon and Elizabeth Lanphier. “The Moral Weight of Preferences: Death, Sex and Dementia.” *American Journal of Bioethics* 20, no. 8 (2020): 76-78.

Jecker, Nancy. “Nothing to be ashamed of: sex robots for older adults with disabilities.” *Journal of Medical Ethics* 47, no. 1 (2020): 26-32.

Kukla, Quill R. “A Nonideal Theory of Sexual Consent.” *Ethics* 131 (2021): 270-292.

Kuther, Tara L. “Medical decision-making and minors: Issues of consent and assent.” *Adolescence* 38, no. 150 (2003): 343-358.

Lichtenberg, Peter. “Sexuality and Physical Intimacy in Long Term Care: Sexuality, Long Term Care, Capacity Assessment.” *Occupational Therapy in Health Care* 28, no. 1 (2014): 1-10.

Lindau, Stacy Tessler, L. Philip Schumm, Edward O. Laumann, Wendy Levinson, Colm A. O’muircheartaigh, Linda J. Waite. “A Study of Sexuality and Health Among Older Adults in the United States.” *The New England Journal of Medicine* 357 (2007): 762-774.

Manson, Neil. “Permissive Consent: a Robust Reason-Changing Account.” *Philosophical Studies* 173, no. 12 (2016): 3317-3334.

Miles, Steven H and Kara Parker. “Sexuality in the Nursing Home: Iatrogenic Loneliness.” *Generations* 23, no. 1 (1999): 36-43.

Mills, Marie A., and Peter G. Coleman. “Nostalgic Memories in Dementia-A Case Study.” *The International Journal of Aging and Human Development* 38, no. 3 (1994): 203-219.

Mitchell, Alex J. “A meta-analysis of the accuracy of the mini-mental state examination in the detection of dementia and mild cognitive impairment.” *Journal of Psychiatric Research* 43 (2009): 411-431.

Neighbors Rehabilitation Center LLC, vs. United States Department of Health and Human Services, Departmental Appeals Board, and Centers for Medicate and Medicaid Services. 18-2147 (7th Circuit 2018).

Robinson, Janice G., and Anita E. Molzahn. “Sexuality and Quality of Life.” *Journal of Gerontological Nursing* (2007): 19-27.

Stempniak, Marty. “What Nursing Homes Can Learn From A ‘Troubling’ Court Decision on Sexual Consent.” McKnights Long-Term Care News (2018): https://www.mcknights.com/daily-editors-notes/what-nursing-homes-can-learn-from-a-troubling-court-decision-on-sexual-consent/

Tarzia, Laura, Deirdre Fetherstonhaugh, Michael Bauer. “Dementia, Sexuality and Consent In Residential Aged Care Facilities.” *Journal of Medical Ethics* 38 (2012): 609-613.

Tenenbaum, Evelyn M. “To Be or To Exist: Standards for Deciding Whether Dementia Patients In Nursing Homes Should Engage In Intimacy, Sex, And Adultery.” *Indiana Law Review* 42 (2009): 674-720.

- - - “Assessing Consent to Intimate Sexual Relations Among Nursing Home Residents with Dementia.” *Living With Dementia*: *Neuroethical Issues and International Perspectives*. Ed. Veljko Dubljević and Frances Bottenberg. Springer. 2021.131-151.

Tilvis, Reijo S., et al. “Predictors of Cognitive Decline and Mortality of Aged People Over a 10-Year Period.” *Journal of Gerontology* 59A, no. 3 (2004): 268-274.

Weeks, David J. “Sex for the mature adult: Health, self-esteem and countering ageist stereotypes.” *Sexual and Relationship Therapy* 17, no. 3 (2002): 231-240.

White, Melissa C. “The Eternal Flame: Capacity to Consent to Sexual Behavior Among Nursing Home Residents With Dementia.” *The Elder Law Journal* 18 (2010): 133-158.

Whitlatch, Carol J, Lynn Friss Feinberg, and Shandra Tucke. “Accuracy and Consistency of Responses from Persons with Cognitive Impairment.” *Dementia* 4, no. 2 (2005): 717-183.

Wilkins, James M. “Dementia, Decision Making, and Quality of Life.” *AMA Journal of Ethics* 19, no. 7 (2017): 637-639

1. Stempniak, n.p. This definition of an immediate jeopardy violation comes from CMS’s guidance. The citation was for a violation of C.F.R. § 488.301, which states that a facility must have “a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm.” [↑](#footnote-ref-1)
2. Neighbors Rehabilitation Center LLC, vs. United States Department of Health and Human Services, Departmental Appeals Board, and Centers for Medicate and Medicaid Services, p. 6. [↑](#footnote-ref-2)
3. See Lindau for a survey of the attitudes of the elderly toward sex and the frequency with which they engage in sex. [↑](#footnote-ref-3)
4. See White 138 for a discussion. [↑](#footnote-ref-4)
5. A woman was “reprimanded by a member of the nursing home staff for snuggling, fully clothed, in bed with her husband during a visit” (White, 2010, 139). [↑](#footnote-ref-5)
6. Sex can help the elderly to avoid depression and may lower risks of cancer and cardiovascular disease (Tenenbaum, 2009, 680-681). For further support of this point, see Davies et al. (1998, 195). [↑](#footnote-ref-6)
7. Although this is an undertheorized topic, there are many good initial entries regarding ethics, dementia, and sex. For discussions of whether people with dementia can give advance consent to sex, see Director (2019), Boni-Saenz (2016), and Bianchi (2018). For a helpful general discussion of the issue of dementia and consent to sex, see Bianchi (2022a, 2022b). In a 2021 article, Kukla also discusses dementia and consent to sex in the context of illustrating a broader theory of nonideal sexual consent. A related issue involving using sex robots for the elderly is raised by Jecker (2020). [↑](#footnote-ref-7)
8. There is disagreement about assent. By “assent” I mean “a yes that is morally significant but not at the level of valid consent.” [↑](#footnote-ref-8)
9. As an anonymous reviewer pointed out to me, it won’t be true that all people with mild to severe dementia satisfy all of these conditions. I agree with this. Given that, I mean to argue that our default assumption (based on the empirical evidence) should be that individuals with mild to severe dementia can consent. But, I agree that it could turn out that some of those individuals fail some conditions of my thesis, rendering them unable to validly consent to sex. [↑](#footnote-ref-9)
10. Downs, 1997, 601. I use “capacity” and “competence” interchangeably. In different areas of bioethics and law, these terms have different meanings. In other areas, they are used synonymously. For a discussion of this dispute, see Charland (2015). [↑](#footnote-ref-10)
11. Lichtenberg, 2014, 4. [↑](#footnote-ref-11)
12. Downs, 1997, 601. [↑](#footnote-ref-12)
13. I assume a continuity of consciousness view of personal identity. Additionally, I am not endorsing the view that D must engage or act in line with her values in order for her consent to be valid. For example, a devout Catholic can consensually engage in adultery. However, if I am wrong in this position, and it turns out that engagement with and acting in line with one’s values is a necessary condition of consent, then I believe my view can accommodate this. In the cases I’m discussing, having sex with their long-term partner is in harmony with D’s pre-dementia values. [↑](#footnote-ref-13)
14. Clark (et al.), 2008, Feinberg (et al.), 2001, and Whitlatch (et al.), 2005. These studies had n=213, n=51, and n=111 respectively. [↑](#footnote-ref-14)
15. The MMSE assesses “seven dimensions of cognitive functioning,” including “orientation and time,” “orientation to place,” “recall,” “attention and calculation,” etc. (Feinberg, 2001, 377). [↑](#footnote-ref-15)
16. See Mitchell (2009). [↑](#footnote-ref-16)
17. Feinberg’s study categorizes individuals with dementia in this way based on MMSE scores: “low scores between 13–15…indicating greater cognitive impairment; medium scores between 16–23…and high scores between 24–26…indicating mild cognitive impairment” (2001, 377). According to the Alzheimer’s Association “a score of 20 to 24 suggests mild dementia, 13 to 20 suggests moderate dementia, and less than 12 indicates severe dementia” (Alzheimer’s Association). Although they don’t agree perfectly, the disagreements are fairly trivial. [↑](#footnote-ref-17)
18. Clark, 2008, 346-347. [↑](#footnote-ref-18)
19. Philosophers mischaracterize the stability of dementia patients’ preferences. For example, McMahan states that “the preferences of the demented are notoriously arbitrary, whimsical, and ephemeral” (2002: 497-498). This doesn’t fit the evidence. [↑](#footnote-ref-19)
20. Clark, 2008, 348. Feinberg finds an identical result: “care receivers [individuals with dementia] were able to provide answers with significant levels of agreement to nearly every question…of the 17 questions asked of care receivers, only one (the care receiver’s age) yielded responses that were significantly different from Time 1 to Time 2. Even among those care receivers whose MMSE scores were lowest (MMSE 13–15…) [severe dementia], significant levels of agreement were obtained for all but two questions” (Feinberg, 2001, 378). [↑](#footnote-ref-20)
21. Clark, 2008, 350. [↑](#footnote-ref-21)
22. Feinberg, 2001, 380. Clark confirms this: “results show that individuals with MMSE scores as low as 13 [severe impairment] are able to provide reliable responses to fact-based and state-dependent interview questions” (2008, 355). [↑](#footnote-ref-22)
23. Feinberg, 2001, 374. Clark, 2008, 343, Downs, 1997, 599, and Mills and Coleman, 1994, 213 confirm this. [↑](#footnote-ref-23)
24. Clark, 2008, 350. Whitlatch finds nearly identical numbers in her later study (2005, 179). [↑](#footnote-ref-24)
25. Clark, 2008, 350. This is confirmed by Whitlatch, who finds that 83% of individuals with severe impairment accurately report their marital status (2005, 179). [↑](#footnote-ref-25)
26. Whitlatch, 2005, 178. Feinberg, 2001, 378 confirms this. [↑](#footnote-ref-26)
27. Ehrenfeld et al. (147) report cases in which women with dementia have sex with someone who is not their spouse but call that person by their spouse’s name, indicating that although they know the name and identity of their spsouse, they cannot correctly identify if a person is their spouse. This is potentially conecerning for my view, because it would show that knowing who one’s partner is is not sufficient to guarantee that one gives consent to their actual partner. However, this was reported in a minority of cases and could be remedied by better oversight. For example, the screening interview mentioned later in this paper could be used to determine if D can correctly identify C as her partner from a lineup of photos with other similarly aged men. [↑](#footnote-ref-27)
28. Ballard (et al.), 1997, 450. [↑](#footnote-ref-28)
29. This study only studied people with mild to moderate dementia. So, this evidence wouldn’t apply to any level of dementia beyond that. The other arguments in this section would apply to such individuals. [↑](#footnote-ref-29)
30. Feinberg, 2001, 380. [↑](#footnote-ref-30)
31. Feinberg, 2001, 375. Clark, 2008, 343 confirms this. [↑](#footnote-ref-31)
32. Buckles (et al.), 2003, 1664. [↑](#footnote-ref-32)
33. Clark, 2008, 351. [↑](#footnote-ref-33)
34. Whitlatch, 2005, 178. Wilkins confirms this: “evidence suggests…that many people with dementia, even those with more advanced disease, can still articulate their values, preferences, and choices in a reliable manner” (2017, 637). [↑](#footnote-ref-34)
35. In the consent literature, philosophers distinguish between an action being *permissible* (the consentor gave valid consent, and the consentee has a justified belief that this is true) and an action being *culpable* (the consentor did not give valid consent, but the consentee has a justified belief that the consentor did consent). [↑](#footnote-ref-35)
36. For an extended discussion of the problems posed in this paragraph, see Bianchi (2018, 85-99). [↑](#footnote-ref-36)
37. I assume a continuity of consciousness view of personal identity. [↑](#footnote-ref-37)