

TO BE OR TO EXIST: STANDARDS FOR DECIDING WHETHER DEMENTIA PATIENTS IN NURSING HOMES SHOULD ENGAGE IN INTIMACY, SEX, AND ADULTERY

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INTRODUCTION

There are many articles written about end-of-life decisionmaking for elderly adults with dementia, but few about their sexual relationships. At first blush, this disparity seems logical. The medical needs of the elderly must be addressed and decisionmaking concerns will arise when they cannot make medical decisions for themselves. However, focusing so heavily on medical concerns ignores the very real emotional needs and desires of the elderly who are living with dementia.

Those who have dementia can live with the condition for a long time and many end up in nursing homes.¹ Despite their cognitive decline, their needs for intimacy and sex continue.² But nursing homes cannot freely allow sexual relationships between demented residents. Due to their cognitive deficiencies, some sexual relationships between demented adults raise issues of consent, rape, and abuse.³ Obviously, the nursing home must intervene to ensure that unsafe and abusive relationships do not occur.

Beyond the issue of safety, there are other concerns. For example, should a nursing home allow a married resident with dementia to engage in an adulterous relationship in the nursing home? What if the nonresident spouse objects? There are no guidelines for making this decision, yet it involves complex issues concerning adultery, the weight to be given to the resident's prior values formed when competent, and the weight to be accorded the resident's current well-being. Simply ending a relationship without considering these issues would infringe on the resident's rights to privacy and autonomy.

Nursing homes must be given some guidance because this issue is likely to arise with ever-greater frequency as the elderly population increases. This past year, the movie "Away from Her" dealt with the issue of a married woman with Alzheimer's disease who was living in a nursing home and having an intimate relationship with another resident.⁴ Similarly, former Supreme Court Justice Sandra Day O'Connor's husband, who is also suffering from Alzheimer's disease and living in a nursing home, was having a "romantic" relationship with another woman in the home.⁵ In both of these cases, the nonresident spouse did not

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1. *See infra* Part I.

2. *See infra* Part II.

3. *See infra* Part III.

4. AWAY FROM HER (The Film Farm 2006).

5. Kate Zernike, *Love in the Time of Dementia*, N.Y. TIMES, Nov. 18, 2007, at 41 (Sandra

object to the resident spouse's relationship,⁶ but that is not always the case.

The Hebrew Home for the Aged, a nursing home at the forefront in encouraging sexual expression among its residents, has a policy for dealing with a nonresident spouse who objects to his or her spouse's sexual relationship in the nursing home.⁷ The nursing home will first meet with the spouse to encourage him or her to accept the adulterous relationship.⁸ If, despite counseling, the spouse continues to object to the relationship, the nursing home will take steps to discourage it, including moving the married resident to another floor.⁹ Based on anecdotal evidence, the Hebrew Home believes that other nursing homes would also take steps to end an adulterous relationship if the nonresident spouse objected.¹⁰

This Article questions whether it is right to rely solely on the nonresident spouse's opinion when he or she objects to an adulterous relationship. The Article begins by giving background information on the importance of sex and intimacy to nursing home residents, the nursing home's concerns when demented residents have sexual relationships, and the steps nursing homes can take to encourage and discourage sexual expression among their demented residents. Next, the Article addresses the pros and cons of using various standards for determining whether an adulterous relationship in the nursing home should be allowed to continue. The Article concludes by suggesting a balancing test for making this determination and for evaluating other types of sexual relationships in the nursing home. The test is designed to maximize the patients' rights to express their choices and meet their sexual needs, to take into account the implications of the patients' choices on themselves and their families, and, to the extent possible, to protect the nursing home from liability.

I. BACKGROUND INFORMATION ON DEMENTIA AND ALZHEIMER'S DISEASE

In the United States today, more than two million people live in approximately twenty thousand nursing homes.¹¹ These two million people include about five percent of Americans over the age of sixty-five and about twenty percent of those over eighty-five.¹² An American who lives to be sixty-five years of age has a twenty-five percent chance of residing in a nursing home

Day O'Connor did not object to her husband's intimate relationship in the nursing home).

6. *See supra* notes 4, 5.

7. Telephone Interview with Daniel A. Reingold, President and Chief Executive Officer, Hebrew Home at Riverdale, New York (June 24, 2008) [hereinafter Reingold Telephone Interview].

8. *Id.*

9. *Id.*

10. *Id.*

11. Ramzi R. Hajjar & Hosam K. Kamel, *Sexuality in the Nursing Home, Part 1: Attitudes and Barriers to Sexual Expression*, 5 J. AM. MED. DIRECTORS ASS'N., Mar.-Apr. 2004, at S42, S43 [hereinafter Hajjar & Kamel, *Part 1*].

12. *Id.*

before dying.¹³

More than one half of all nursing home admissions are a result of dementia.¹⁴ There are more than sixty causes of dementia, but the most common is Alzheimer's disease.¹⁵ More than four million Americans have Alzheimer's disease and, due to the aging of the baby boomers and increased life expectancy in general, this number is projected to increase to fourteen million by 2050.¹⁶

Dementia results in a progressive decline in cognitive functioning.¹⁷

13. *Id.*

14. Andrew Casta-Kaufteil, *The Old and the Restless: Mediating Rights to Intimacy for Nursing Home Residents with Cognitive Impairments*, 8 J. MED. & L. 69, 70 (2004) ("Alzheimer's disease is responsible for half of the nursing home residencies in this country.").

15. Alison Patrucco Barnes, *Beyond Guardianship Reform: A Reevaluation of Autonomy and Beneficence for a System of Principled Decision-Making in Long Term Care*, 41 EMORY L.J. 633, 642 (1992) ("Although there are more than sixty causes that produce similar mental disabilities, the principal cause of chronic dementia in the elderly is Alzheimer's Disease.").

16. ABA COMM. ON L. & AGING & AM. PSYCHOL. ASS'N, *Executive Summary to ASSESSMENT OF OLDER ADULTS WITH DIMINISHED CAPACITY: A HANDBOOK FOR LAWYERS*, at v (2005) ("With the coming demographic avalanche of Boomers reaching their 60s and the over-80 population swelling, lawyers face a growing challenge: older clients with problems in decision-making capacity."); Casta-Kaufteil, *supra* note 14, at 70 ("Today four million Americans have Alzheimer's disease, and by the year 2050, the number is expected to grow to fourteen million.") (quoting Erica Wood, *Dispute Resolution and Dementia: Seeking Solutions*, 35 GA. L. REV. 785, 788 (2001)); Joel Leon et al., *Alzheimer's Disease Care: Costs and Potential Savings*, HEALTH AFF., Nov.-Dec. 1998, at 206, 206 ("Alzheimer's disease afflicts 6 to 10 percent of America's elderly and the prevalence of the disease increases dramatically with each succeeding decade of life. Estimates indicate that Alzheimer's disease afflicts 25 to 45 percent of the population age eighty-five and older."); George Byron Smith, *Alzheimer Disease and Other Dementias*, LIPPINCOTT'S CASE MGMT., Mar.-Apr. 2002, at 77-78 ("The best evidence suggests that dementia affects approximately 5% to 8% of persons age 65 and older, 15% to 20% of persons over age 75, and 25% to 50% of persons over age 85 years. [Alzheimer's disease,] which accounts for 50% to 75% of total dementia cases, is the most common dementia type. . . . It is projected that, without a cure, the prevalence of [Alzheimer's disease] will nearly quadruple in the next 50 years, by which time approximately 1 in 45 older Americans will be affected by the disease."); Diana Lynn Woods & Margaret Diamond, *The Effect of Therapeutic Touch on Agitated Behavior and Cortisol in Persons with Alzheimer's Disease*, BIOLOGICAL RES. FOR NURSING, Oct. 2002, at 104, 104 ("Approximately four million Americans have Alzheimer's disease today with projections that this number will be more than triple by the middle of the 21st century.").

17. M. Ehrenfeld et al., *Sexuality Among Institutionalized Elderly Patients with Dementia*, NURSING ETHICS, Mar. 1999, at 144, 145 (Stage I dementia patients suffer from "deterioration of short term memory, resulting in learning difficulties and reduced intellectual activities." Stage 2 dementia patients have "difficulty with concentration, judgment, comprehension, orientation and analysis"); Martin Harvey, *Advance Directives and the Severely Demented*, 31 J. MED. & PHIL. 47, 50, 52 (2006) (at Stage 3, or severe dementia, the individual's deficits are so severe that he or she is no longer "a fully functioning person in a moral, psychological, or social sense." However the patient can still experience "pleasure and pain and express simple, transitory desires and needs.").

Individuals with dementia have impaired memories and often also suffer from communication difficulties and the inability to think abstractly or plan activities.¹⁸ As a result of these deficits, demented patients are significantly limited in their ability to make well-informed, rational, decisions and “to advocate for [their] interests and ideals.”¹⁹ Dementia can also be accompanied by changes in mood, personality, and behavior.²⁰

Alzheimer’s disease is a form of dementia²¹ that results in an irreversible, progressive mental decline due to nerve cell degeneration in the brain.²² The salient feature of Alzheimer’s is memory impairment,²³ but the disease eventually also destroys “reason, judgment, and language.”²⁴ The Alzheimer’s Association

By Stage 4, or end stage dementia, the patient is in a vegetative state).

18. Smith, *supra* note 16, at 78 (“According to the DSM-IV [*Diagnostic and Statistical Manual, Fourth Edition*], dementia is the development of multiple cognitive deficits that include memory impairment and at least one of the following cognitive disturbances: aphasia (absence of language), apraxia (impairment in the ability to perform purposeful acts), agnosia (inability to recognize familiar objects or persons), or a disturbance in executive functioning (inability to think abstractly or to plan, initiate, sequence, monitor, and stop complex behavior). The cognitive decline must be sufficiently severe to eventually lead to an inability to maintain occupational and social performance.”) (citing AMERICAN PSYCHIATRIC ASS’N, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* (4th ed. 1994)).

19. Jeffrey T. Berger, *Sexuality and Intimacy in the Nursing Home: A Romantic Couple of Mixed Cognitive Capacities*, J. CLINICAL ETHICS, Winter 2000, at 309, 311 (“Dementia, by definition, is a chronic and progressive disorder that limits one’s ability to make informed choices, and to advocate for one’s interests and ideals.”); Maartje Schermer, *In Search of ‘the Good Life’ for Demented Elderly*, 6 J. MED., HEALTH CARE & PHIL. 35, 35 (2003) (“Short- and long-term memory, capacities for understanding, information-processing and rational decision-making all decline during the process of dementia.”).

20. Karen Ritchie & Simon Lovestone, *The Dementias*, 360 LANCET 1759, 1759 (2002) (the cognitive changes in dementia are “commonly accompanied by disturbances of mood, behaviour, and personality”); Woods & Diamond, *supra* note 16, at 66 (about 80% of dementia patients in nursing homes also develop behavioral symptoms of dementia, which include screaming (disruptive vocalization), restlessness, repetitive questions, wandering, and pacing).

21. Ritchie & Lovestone, *supra* note 20, at 1760 (“High education has been associated with low rates of Alzheimer’s disease, which could be at least partly attributable to compensatory strategies that delay detection of the disease.”).

22. Smith, *supra* note 16, at 78 (“[Alzheimer’s disease] is a chronic, progressive, degenerative illness associated with neuropathological changes for which there is no cure. A definitive diagnosis of [Alzheimer’s disease] can be made only at autopsy, when the distinctive neurological changes in the brain can be seen.”); Heartspring.net, *Alzheimer’s Disease—Stages of Dementia*, available at http://heartspring.net/alzheimers_disease_stages.html (last visited Feb. 16, 2009) (“Progression of symptoms corresponds in a general way to the underlying nerve cell degeneration that takes place in Alzheimer’s disease.”).

23. Smith, *supra* note 16, at 78 (“Memory impairment is . . . a prominent early symptom [of Alzheimer’s disease].”).

24. *Id.*

divides the progression of Alzheimer's into seven stages, ranging from no cognitive decline to very severe cognitive decline.²⁵ At the final stage, "individuals lose the ability to respond to their environment, the ability to speak, and, ultimately the ability to control movement."²⁶ The Association stresses that these stages are "artificial benchmarks" and that the progression of Alzheimer's "can vary greatly from one person to another."²⁷ What is consistent is that an individual with Alzheimer's degenerates gradually over a period of months or years.²⁸

Although Alzheimer's significantly decreases life expectancy,²⁹ an individual can live an average of five to eight years after diagnosis,³⁰ and the length of survival varies from about three to twenty years.³¹ Still, "Alzheimer's disease is one of the leading causes of death in older people."³²

To summarize, more than one half of all patients in nursing homes have dementia, the number of individuals with dementia is increasing rapidly, and individuals diagnosed with dementia can expect to live for many years with gradually decreasing cognitive functioning including diminishing ability to respond to their environment.

25. Heartspring.net, *supra* note 22.

26. *Id.*

27. *Id.*

28. Smith, *supra* note 16, at 78.

29. Mary Ganguli et al., *Alzheimer Disease and Mortality: A 15-Year Epidemiological Study*, 62 ARCHIVES NEUROLOGY 779, 779 (2009) ("Clinical experience and empirical data suggest that Alzheimer disease . . . shortens life in elderly persons."); Eric B. Larson et al., *Survival After Initial Diagnosis of Alzheimer Disease*, 140 ANNALS INTERNAL MED. 501, 506 (2004) ("In all age groups, patients with Alzheimer disease in our study had decreased survival compared with survival in the general U.S. population."). "Median survival time for women with Alzheimer's disease at 70 years of age was 8.0 years compared with 15.7 years for the U.S. population." The median survival time for men at seventy years of age was 4.4 years compared with 9.3 years for the U.S. population. *Id.* at 504-06.

30. Ganguli et al., *supra* note 29, at 782 ("The mean (SD) survival was 5.9 (3.7) years from the onset of symptoms [of Alzheimer's disease] until death, but depended on age at onset. It ranged from 8.3 (4.6) years in those with onset before the age of 75 years to 3.8 (1.9) years in those with onset after the age of 85 years."); Larson et al., *supra* note 29, at 506 (In a sample taken from community-dwelling elderly people, "[m]en had a median survival of 4.2 years from their initial diagnosis, and women had a median survival of 5.7 years."); Heartspring.net, *supra* note 22 ("People with Alzheimer's live an average of 8 years after diagnosis").

31. Heartspring.net, *supra* note 22 (noting that a person with Alzheimer's disease "may survive anywhere from 3 to 20 years" after diagnosis).

32. Ganguli et al., *supra* note 29, at 779 ("Clinical experience and empirical data suggest that Alzheimer disease is a leading cause of death."); Larson et al., *supra* note 29, at 501 ("One recent study suggests that 7.1% of all deaths in 1995 were attributable to Alzheimer disease, placing it on a par with cerebrovascular disease as the third leading cause of death.").

II. THE NEED FOR INTIMACY AND SEX

People at every age have a fundamental and profound need for intimate relationships.³³ Intimate relationships are strongly correlated with life satisfaction and physical and psychological well-being.³⁴ Casual relationships do not provide these benefits.³⁵

Intimate relationships are strong and deeply rewarding and are characterized by trust, loyalty, emotional security, and respect.³⁶ They make a person feel valued and needed.³⁷ Elderly individuals with intimate relationships have a longer life expectancy and a lower risk of getting cancer or cardiovascular disease.³⁸ They also have better cognitive functioning³⁹ and are more

33. Hosam K. Kamel & Ramzi R. Hajjar, *Sexuality in the Nursing Home, Part 2: Managing Abnormal Behavior—Legal and Ethical Issues*, 4 J. AM. MED. DIRECTORS ASS'N, July/Aug. 2003, at 203, 203 (2003) (“Everyone, regardless of age, needs love, touch, companionship, and intimacy.”) [hereinafter Kamel & Hajjar, *Part 2*]; Anne-Cathrine Mattiasson & Maja Hemberg, *Intimacy - Meeting Needs and Respecting Privacy in the Care of Elderly People: What is a Good Moral Attitude on the Part of the Nurse/Carer?*, 5 NURSING ETHICS 527, 528 (1998) (“Emotional intimacy in relation to another being is a fundamental human need.”); Steven H. Miles & Kara Parker, *Sexuality in the Nursing Home: Iatrogenic Loneliness*, 23 GENERATIONS, Spring 1999, at 36, 36 (“If humane care is the goal, health professionals and long-term-care institutions caring for the elderly must begin to acknowledge the normalcy, indeed the essential nature, of the human need for intimacy.”).

34. Casta-Kaufteil, *supra* note 14, at 72 (“Though they are intertwined, intimacy has a discrete effect on one’s physical and psychological well-being.”); Miles & Parker, *supra* note 33, at 37 (“Intimacy, passionate love, companionate love, and satisfying sexual intimacy are strongly correlated with life satisfaction and psychological well-being.”).

35. Miles & Parker, *supra* note 33, at 37 (“Loneliness is not relieved by superficially talking with others or participating in civic activities. The converse of loneliness is intimacy.”) (citation omitted).

36. *Id.* (“Intimacy is a sense of being in a deeply rewarding, emotionally intense relationship in which one has a confidante for safe self-disclosure. Intimacy overlaps with the broader concept of ‘love,’ which encompasses emotional security, respect, helping and playing together, communication, and loyalty.”) (citation omitted); *see also id.* at 41 (noting that intimacy is “a place for solace, privacy, confiding, and telling and retelling one’s story”).

37. Tiina-Mari Lyrya & Riitta-Liisa Heikkinen, *Perceived Social Support and Mortality in Older People*, 61 J. GERONTOLOGY: SOC. SCI. S147, S151 (2006) (explaining that close attachments are related to the feeling of being needed and valued).

38. *Id.* at S147 (“A growing number of studies have documented the beneficial effect of social support on various health outcomes, including survival. This beneficial effect has been confirmed not only in relation to all-cause mortality, but also in relation to several causes of death including cancer, coronary heart disease, and other cardiovascular diseases.”).

39. François Béland et al., *Trajectories of Cognitive Decline and Social Relations*, 60 J. GERONTOLOGY: PSYCHOL. SCI., at P320, P327 (2005) (noting that studies suggest that strong social relations help maintain cognitive function into old age); Reijo S. Tilvis et al., *Predictors of Cognitive Decline and Mortality of Aged People Over a 10-Year Period*, 59 J. GERONTOLOGY:

independent.⁴⁰

On the flip side, there is strong evidence that the absence of close personal attachments leads to loneliness⁴¹ and depression.⁴² People who are lonely are more likely to need psychological and medical services.⁴³ Loneliness is also “a powerful predictor of poor adjustment to nursing home life”⁴⁴ and is associated with “the most common and intractable of nursing home mental health problems.”⁴⁵

Nursing home patients, like the rest of us, do best when their needs for intimacy are met.⁴⁶ Indeed, a recent study of older adults found that personal relationships were the single strongest predictor of quality of life.⁴⁷

Intimacy is closely linked to sexuality.⁴⁸ Not only is sex a natural way of showing affection, it is a basic human need that lasts throughout adult life and

MED. SCI., at M268, M272 (2004) [hereinafter Tilvis, *Predictors*] (explaining that studies show loneliness is a precursor to cognitive decline and institutionalization); Reijo S. Tilvis et al., Letter to the Editor, *Social Networks and Dementia*, 356 LANCET 77, 78 (2000) [hereinafter Tilvis et al., *Social Networks*] (noting that loneliness is a predictor of cognitive decline).

40. Lyyra & Heikkinen., *supra* note 37, at S151 (“The feeling of being needed and valued is important; it gives one the strength to take care of oneself.”).

41. Miles & Parker, *supra* note 33, at 37 (“Loneliness is the unpleasant feeling of being qualitatively or quantitatively deprived of intimate relationships.”).

42. Bonita Krohn & Brenda Bergman-Evans, *An Exploration of Emotional Health in Nursing Home Residents: Making the Pieces Fit*, 13 APPLIED NURSING RES. 214, 216 (2000) (finding that loneliness “often coexists with depression”); Lyyra & Heikkinen, *supra* note 37, at S151 (“The absence of close attachments and recognition of worth causes emotional loneliness and depressiveness.”); Sally M. Roach, *Sexual Behaviour of Nursing Home Residents: Staff Perceptions and Responses*, 48 J. ADVANCED NURSING, 371, 376 (2004) (“A lack of bonding with others in a nursing home can lead to loneliness and lack of fulfillment in life.”).

43. See Miles & Parker, *supra* note 33, at 37; Tilvis et al., *Social Networks*, *supra* note 39, at 77 (“Aged people who are lonely are often characterised by social isolation, impaired health status and increased use of health care services.”).

44. Miles & Parker, *supra* note 33, at 37 (Loneliness “is associated with aggression, confusion, feelings of confinement or desertion or powerlessness, and difficulty making decisions.”) (citation omitted).

45. *Id.* at 40.

46. *Id.* at 36 (“Like all of us, residents of nursing homes flourish best when diverse needs for intimacy are recognized, respected, and met.”).

47. Janice G. Robinson & Anita E. Molzahn, *Sexuality and Quality of Life*, 33 J. GERONTOLOGICAL NURSING, Mar. 2007, at 19, 19 (noting that a survey of 426 elderly individuals living in British Columbia, Canada, showed that “the strongest contributors to the variance of overall [quality of life] were satisfaction with personal relationships, followed by health status and sexual activity”).

48. Mattiasson & Hemberg, *supra* note 33, at 529 (“Physical intimacy is closely related to emotional intimacy.”); Robinson & Molzahn, *supra* note 47, at 25 (“In this study [of 426 elderly individuals living in British Columbia, Canada], intimacy was highly correlated with sexual activity. . .”).

continues even among frail nursing home residents.⁴⁹ While sex obviously includes sexual intercourse, it also includes touching, stroking, fondling, hugging, and kissing.⁵⁰ Humans not only need intimacy, but also need sexual contact for their health and well-being.⁵¹

Our youth-oriented culture generally ignores, or is repulsed by, the thought

49. See Hajjar & Kamel, *Part 1*, *supra* note 11, at S43, S46; see also Kannayiram Alagiakrishnan et al., *Sexually Inappropriate Behaviour in Demented Elderly People*, 81 POSTGRADUATE MED. J. 463, 463 (2005) (“Sexuality is part of human nature throughout life. Being elderly and sick does not necessarily mean that there is a decline in sexual desire.”); Helen D. Davies et al., *‘Til Death Do Us Part: Intimacy and Sexuality in the Marriages of Alzheimer’s Patients*, 30 J. OF PSYCHOSOCIAL NURS. 5, 6 (1992) (“Physical touch is a basic human need . . .”); Mattiasson & Hemberg, *supra* note 33, at 531 (“People’s sexual needs apparently last throughout life.”); Miles & Parker, *supra* note 33, at 38 (stating that while sexual activity declines with age, a significant proportion of elderly persons, including those in nursing homes, remain sexually active. Indeed, “a large plurality or majority of residents . . . believe that residents should be allowed to have intercourse.” Further, “[f]ifteen to 40 percent of men in their 80s have intercourse at least monthly, compared to 5 to 25 percent of women.”); James P. Richardson & Ann Lazur, *Sexuality in the Nursing Home Patient*, 51 AM. FAMILY PHYSICIAN 121, 123 (1995) (“At least a significant minority of the elderly want to be sexually active to some extent after admission to nursing homes.”).

50. Wendy L. Bonifazi, *Somebody to Love*, 23 CONTEMP. LONG TERM CARE, Apr. 2000, at 22, 23 (“Everyone’s definition of ‘sexually active’ differs and the intimate behavior continuum ranges from touching, hugging, and kissing to fondling, masturbation, and intercourse.”) (citation omitted); Janet K. Feldkamp, *Navigating the Uncertain Legal Waters of Resident Sexuality: Residents’ Rights to Sexual Expression Can Create Complicated Issues for Facilities and Family Members*, 52 NURSING HOMES, Feb. 2003, at 62, 62 (“The Sexuality Survey commissioned by the AARP and Modern Maturity in 1999 found that . . . [t]he older population views sexual activities as including kissing or hugging, sexual touching or caressing, and sexual intercourse.”); Mattiasson & Hemberg, *supra* note 33, at 531 (indicating that sexual activity can be expressed through “touching, stroking, hugging and warmth”); Miles & Parker, *supra* note 34, at 38 (noting that the elderly frequently employ forms of sexual expression other than intercourse, such as “caressing and touching”); Roach, *supra* note 42, at 372 (“The most commonly observed sexual behaviours in nursing homes include hand-holding, kissing, petting and masturbation.”).

51. Berger, *supra* note 19, at 309 (“[S]exual activity is common among patients through their ninth and tenth decades of life. Important components of good quality of life for many elderly persons who reside in nursing homes include having intimate relationships and engaging in sexual activity.”) (footnote omitted); Casta-Kaufteil, *supra* note 14, at 72 (“Regardless of age, sex is generally beneficial to one’s physical health.”); Davies et al., *supra* note 49, at 7 (“Observations have given a scientific basis for what we have instinctively known: human beings need to be cuddled, stroked, and touched to be healthy and survive.”) (quoting L.J. Zefron, *The History of the Laying on of Hands in Nursing*, 14 NURSING FORUM 350, 350-363 (1975)); Kamel & Hajjar, *Part 2*, *supra* note 33, at 206 (“Sexual expression in the nursing home, although a complex and challenging issue, reflects a basic human need and is important for the quality of life and well-being of nursing home residents.”).

of sexually active older adults.⁵² This leads to a devaluation of the importance of sex to the elderly.⁵³ Yet, older adults consider sexual expression to be a natural part of their lives⁵⁴ and may actually need physical contact more than younger individuals. The elderly are more afraid of losing a loved one, and therefore their need for reassuring physical contact may increase, rather than decrease, with age.⁵⁵

But sex does change with age in terms of “frequency, intensity, and mode of expression.”⁵⁶ With increasing age, the importance of sexual intercourse decreases and sexual contact is focused more on touching, stroking, and hugging.⁵⁷ Although sexual focus changes, the elderly need the freedom to progress from caressing to greater physical intimacy, if they so choose.⁵⁸ Preventing them from doing so will create feelings of “frustration and deprivation.”⁵⁹

More importantly, sexual contact should be encouraged, rather than discouraged, because physical contact leads to feelings of self-worth⁶⁰ and confirms “[b]elonging and togetherness.”⁶¹ It lets both members of a couple know they are cared for and valued. Sexual contact can “relieve depression and physical pain, promote health and healthy self-images, provide safe exercise, and

52. Douglas J. Edwards, *Sex and Intimacy in the Nursing Home: Among Many Issues, Resident Privacy Is Key*, 52 NURSING HOMES, Feb. 2003, at 18, 18 (“Our society equates sex with youth, so we don’t expect seniors to be sexually active—or even to have sexual desires.”); Ehrenfeld et al., *supra* note 17, at 144 (“Many younger people have a negative attitude toward sexuality among older people; some even view it as immoral and disgraceful.”) (footnote omitted).

53. Hajjar & Kamel, *Part 1, supra* note 11, at S43 (“In a youth-oriented culture, sexuality is attributed to the young, healthy, and beautiful, and the myth that the elderly are asexual beings predominates. Consequently, the sexual needs of the elderly are frequently overlooked and ignored. Nowhere is this more emphatic than in the nursing home setting.”).

54. See Ehrenfeld et al., *supra* note 17, at 144-45.

55. *Id.* at 144 (explaining that an elderly person is aware of the possible loss “of the object of their love” and that it is, therefore, “not surprising that the human need for touch, hugs and kisses increases with age in both men and women”).

56. Hajjar & Kamel, *Part 1, supra* note 11, at S43.

57. *Id.* (“The role of noncoital sexuality assumes an ever-increasing importance in the elderly . . .”); Mattiasson & Hemberg, *supra* note 33, at 531 (“As we age, sexual activity is reduced and is gradually expressed more through touching, stroking, hugging and warmth.”).

58. See Miles & Parker, *supra* note 33, at 38.

59. *Id.* (“[N]ursing home residents who are in emotionally intimate relationships experience frustration and deprivation when desired sexual intimacy is blocked by a lack of privacy or nursing interventions.”); see also Roach, *supra* note 42, at 375-76 (“It has been shown that lack of interpersonal intimacy—involving emotional and physical closeness—can inhibit mental health . . .”).

60. Hajjar & Kamel, *Part 1, supra* note 11, at S43 (“[S]exual identity is closely interwoven with one’s concept of self-worth.”).

61. Mattiasson & Hemberg, *supra* note 33, at 531.

prevent social disengagement.”⁶²

Although it may at first seem counterintuitive, sexual contact is especially important in nursing homes. Nursing homes are places of isolation and loss, especially for dementia patients.⁶³ By the time Alzheimer’s patients are placed in nursing homes, they may be suffering from loss of memory, self-esteem, and some ability to express themselves.⁶⁴ Physical contact is an important method of communicating with Alzheimer’s patients.⁶⁵ It is a good way to calm and reassure them and to show love and caring.⁶⁶

Nursing home patients also suffer other losses. Nursing homes are places of sickness and death.⁶⁷ Nursing home patients are separated from their families and possessions and lose control over most aspects of their lives.⁶⁸ They may have enforced dining partners and preselected roommates and can no longer choose their own lifestyles.⁶⁹

62. Bonifazi, *supra* note 50, at 23; Roach, *supra* note 42, at 372 (“[S]exuality ‘provides close, creative contact, warmth, pleasure in mastery, sexual release and reaffirmation of life.’”) (quoting Lori Kaplan, *Sexual and Institutional Issues when One Spouse Resides in the Community and the Other Lives in a Nursing Home*, 14 SEXUALITY & DISABILITY 281, 282 (1996)).

63. Bonifazi, *supra* note 50, at 23 (“[I]f anyone ever needed something mentally, physically and emotionally good for him or herself, it’s the nursing home resident. [The nursing home] should do everything possible to promote relationships because [the residents are] dealing with such isolation and loss.”).

64. Davies et al., *supra* note 49, at 7; Judith Wuest et al., *Becoming Strangers: The Changing Family Caregiving Relationship in Alzheimer’s Disease*, 20 J. ADVANCED NURSING 437, 439 (1994) (“[Alzheimer’s patients gradually lose] independence as [they lose] the ability to work, the capacities of abstract thought and concentration, activities of daily living ranging from driving to basic hygiene, self-esteem, social skills, short- and long-term memory, leisure interests, range of movement, and even the ability to sleep for an extended period.”).

65. Davies et al., *supra* note 49, at 7 (“Massage, stroking, holding hands, hugging, and kissing are a few of the ways that can be used to communicate with [Alzheimer’s disease] patients.”).

66. *Id.*

67. Casta-Kaufteil, *supra* note 14, at 73 (explaining that “life satisfaction and psychological health” are especially connected to “[i]ntimacy, passionate love, companionship, and satisfying sexual intimacy” in a nursing home environment, which is strongly associated with “death, sickness, and loneliness”) (citations omitted).

68. See Hajjar & Kamel, *Part 1*, *supra* note 11, at S43 (“Nursing home care is focused on addressing the medical and custodial needs of residents in a safe and therapeutic environment. The resulting structured and regimented environment leaves residents in a situation where control over most aspects of their lives is eroding.”); Rosalie A. Kane, *Ethical and Legal Issues in Long-Term Care: Food for Futuristic Thought*, 21 J. LONG-TERM CARE ADMIN., Fall 1993, at 66, 70 (“The litany of problems for residents include . . . enforced proximity to strangers, separation from possessions and lack of freedom to set one’s own schedule.”); Mattiasson & Hemberg, *supra* note 33, at 528-29 (referring to “the loss of social contacts, family life and other aspects that institutional living often incurs”).

69. See Miles & Parker, *supra* note 33, at 41 (mentioning “enforced dining partners, lack of

Like everyone else, demented patients need emotional support and want to assert their individuality and autonomy.⁷⁰ In this environment, where there is so much loss and isolation, choosing an intimate sexual partner is especially important in helping patients affirm their own identity and in satisfying their emotional needs. Most dementia patients will remain in their nursing home for the remainder of their lives. The nursing home is not just a medical facility. It is also the home where they live.⁷¹

Thus, to provide humane care, nursing homes must recognize dementia patients' real human need for emotional and physical intimacy.⁷² The current trend is to recognize these needs and to work towards enhancing patients' lives by facilitating sexual contact.⁷³ For dementia patients, "[s]exual sensations are among the last of the pleasure-giving biological processes to deteriorate and are an enduring source of gratification at a time when pleasures are becoming fewer and fewer."⁷⁴ Absent compelling concern, patients should not be deprived of these remaining pleasures or of their chances for rewarding, emotionally supportive relationships.

III. JUSTIFICATIONS FOR LIMITING SEXUAL RELATIONSHIPS BETWEEN DEMENTED PATIENTS IN THE NURSING HOME

Unfortunately, there are strong pressures in favor of limiting sexual relationships between dementia patients in nursing homes. Demented patients present a substantial challenge for nursing homes because they may lack the legal capacity to consent to sex and the consent they do give may be difficult to interpret.⁷⁵ Dementia, by its very nature, diminishes a patient's ability to

choice of roommate, intrusive and privacy-destroying surveillance, supervision of relationships" and other restrictive policies in a nursing home); Schermer, *supra* note 19, at 35 ("Life in a nursing home is associated with a loss of privacy, a lack of familiar surroundings and persons, and a lack of opportunity to make one's own choices or to follow one's own life style.").

70. Casta-Kaufteil, *supra* note 14, at 73 ("People with dementia want to assert their personhood and autonomy . . .") (quoting Erica F. Wood, *Dispute Resolution and Dementia: Seeking Solutions*, 35 GA. L. REV. 785, 790 (2001)).

71. See Richardson & Lazur, *supra* note 49, at 121.

72. See Miles & Parker, *supra* note 33, at 41 ("To humanize nursing homes, we will have to humanize our own perceptions of the people who live in them.").

73. See Hajjar & Kamel, *Part 1*, *supra* note 11, at S46 ("Physicians and staff caring for older persons in nursing homes should address [the need for sexual expression] as part of their duty to enhance the quality of life and well-being of their patients."); see also Davies et al., *supra* note 49, at 7 ("If it is possible to enhance a patient's life by addressing these [sexual] needs, it is a tragedy not to do so."); Robert Randal Adler, Note, *Estate of C.W.: A Pragmatic Approach to the Involuntary Sterilization of the Mentally Disabled*, 20 NOVAL. REV. 1323, 1362 (1996) ("The time has come for society to recognize that, as human beings, mentally disabled people are entitled to develop, express, and enjoy their sexuality to the same extent as anyone else.").

74. Roach, *supra* note 42, at 378.

75. See Kamel & Hajjar, *Part 2*, *supra* note 33, at 205; see also Sylvia Davidson, *Issues of*

evaluate social situations rationally and causes “disorientation, poor judgment, and loss of memory.”⁷⁶ Given these limitations, it may be difficult to determine whether a patient is consenting to sexual relations or is being abused.

Determining consent is further complicated by the limited ability of dementia patients to communicate their feelings and concerns.⁷⁷ Even when patients can communicate their general desires regarding sexual interaction, the nature of their consent and the nature of the interaction can be confusing. There are reported instances where demented women mistakenly thought their sexual partners were their husbands.⁷⁸ Some patients become disoriented and confused during sex, making the consent ambiguous.⁷⁹ And problems may arise when a sexual partner with dementia fails to understand a request to stop⁸⁰ or where one of the sexual partners has higher cognitive functioning than the other.⁸¹

Making matters worse, failure to adequately assess a patient’s consent may lead to criminal and tort liability.⁸² It is “[a] basic premise in our legal system” that sexual relations are only allowed between consenting adults.⁸³ Engaging in sexual conduct with individuals who are so mentally incapacitated that they cannot consent is a crime.⁸⁴ Although sex has been allowed between

Intimacy in Dementia Care, 27 PERSPECTIVES, Spring 2003, at 8, 12 (“A particular concern for formal caregivers is often the issue of competence, particularly when two clients are involved.”).

76. Davidson, *supra* note 75, at 9 (noting “only a few of the problems that an elderly individual [with dementia] may be struggling with”); *see also* Kamel & Hajjar, *Part 2, supra* note 34, at 205 (“As dementia progresses, the capacity to comprehend the potential far-reaching effects of sexual activity is lost.”).

77. *See* Berger, *supra* note 19, at 312; Smith, *supra* note 18, at 78.

78. *See* Ehrenfeld et al., *supra* note 17, at 147 (noting that in one case analysis, some women thought the men they had relationships with were their husbands, sometimes even calling the man by their husband’s name).

79. *See* Berger, *supra* note 19, at 312.

80. *Id.* (“[A] demented partner may not comprehend a sudden directive by a capacitated partner to halt sexual activity.”).

81. *See, e.g.*, Deborah W. Denno, *Sexuality, Rape, and Mental Retardation*, 1997 U. ILL. L. REV. 315, 391 (1997) (explaining that concerns may arise where there are sexual relations “involving lower mentally functioning women and higher functioning men”); Ehrenfeld et al., *supra* note 17, at 148 (noting that dilemmas arise where the active partner is suffering from a lesser degree of dementia than the passive partner, who is then perceived to be exploited).

82. Kamel & Hajjar, *Part 2, supra* note 33, at 204 (“Liability issues are a constant concern for nursing home administrators.”).

83. *See* Feldkamp, *supra* note 50, at 64 (discussing assessment of capacity to consent).

84. For example, in New York “[a] person is deemed incapable of consent [to a sexual act] when he or she is . . . mentally disabled.” N.Y. PENAL LAW § 130.05(3)(b) (McKinney 2008). Mentally disabled is defined in section 130.00(5) as being “incapable of appraising the nature of his or her conduct.” *Id.* § 130.00(5). Similarly, the New Jersey code states that “[a]n actor is guilty of aggravated sexual assault if he commits an act of sexual penetration with another person . . . the actor knew or should have known was . . . mentally defective.” N.J. STAT. ANN. § 2C:14-2a(7) (West 2005); *see also* *People v. McMullen*, 414 N.E.2d 214, 217 (Ill. App. Ct. 1980) (explaining

institutionalized mentally retarded and mentally ill patients, the facilities have an obligation to ensure that vulnerable residents have the legal capacity to consent and are not raped or sexually assaulted.⁸⁵

The government rarely prosecutes mentally incapacitated individuals who have sexual relations with victims who cannot consent because they do not meet the competency requirement to stand trial.⁸⁶ However, administrators and staff at a nursing home can come “dangerously close” to criminally facilitating a sexual offense if they encourage sex between demented individuals and the consent is ambiguous.⁸⁷ If families object to sexual activity, facilities may also face tort liability for failure to protect a patient from sexual assault.⁸⁸

To further complicate matters, dementia patients may suffer from sexual

that capacity to consent to sexual intercourse includes understanding the “social and personal costs of the act”); *People v. Easley*, 364 N.E.2d 1328, 1332 (N.Y. 1977) (explaining that an assessment of mental disability includes not only an understanding of the “physiological nature” of sex, but also “[a]n appreciation of how it will be regarded in the framework of the societal environment and taboos to which a person will be exposed”); *Denno*, *supra* note 81, at 340 (“Certain classes of people are prohibited from giving their consent to sexual intercourse: children up to a certain age, individuals who are related, and those who are so mentally incapacitated that they cannot provide consent.”); *Winiviere Sy*, Note, *The Right of Institutionalized Disabled Patients to Engage in Consensual Sexual Activity*, 23 WHITTIER L. REV. 545, 561 (2001) (discussing the mentally retarded and finding that “[t]here is a fine line between the capacity to consent and rape . . . Problems arise in situations where the patient is unable to consent—because of [her] low IQ—and do[es] not understand the consequences of engaging in sexual activity.”).

85. *Foy v. Greenblott*, 190 Cal. Rptr. 84, 90-91 (Ct. App. 1983) (finding that facilities for mentally ill patients should “minimize interference with a patient’s individual autonomy” including the choice “to engage in consensual sexual relations”); N.Y. COMP. CODES R. & REGS. tit. 14, § 633.4(4)(xi)(a) (2009) (“[N]o person [receiving services in a facility operated/certified by the Office of Mental Retardation and Developmental Disabilities] shall be denied: . . . freedom to express sexuality as limited by one’s consensual ability to do so, provided such expressions do not infringe on the rights of others.”); *Denno*, *supra* note 81, at 316 (noting that “most mentally retarded individuals have the capacity to consent to sexual relations”).

86. *Denno*, *supra* note 81, at 379 n.422 (“Rape or sexual abuse cases involving mentally retarded adults are unlikely to be prosecuted because such persons may be found incompetent to stand trial, or lack criminal responsibility by reason of ‘mental disease or defect.’”). If mentally retarded individuals are unlikely to be prosecuted, it can be assumed that elderly demented patients are also unlikely to be prosecuted.

87. *Id.* at 390 (“[P]rogram staff can come dangerously close to criminal facilitation of a sexual offense . . . if they encourage sexual activity between mentally retarded individuals who may not be legally capable of consent.”); *Sy*, *supra* note 84, at 570 (“In situations where a patient is not capable ‘to consent to sexual relations, . . . [but] is nevertheless permitted . . . to do so,’ a service provider could be charged with facilitating a statutory rape.”) (quoting Clarence J. Sundram & Paul F. Stavis, *Sexual Behavior and Mental Retardation*, 17 MENTAL & PHYSICAL DISABILITY L. REP. 448, 453 (1993)).

88. *See Denno*, *supra* note 81, at 379 n.426.

disinhibition.⁸⁹ Sexual disinhibition results in inappropriate, and sometimes physically aggressive, sexual behavior.⁹⁰ Such conduct is caused by the patients' deteriorating cerebral functioning, which diminishes their ability to repress sexual impulses.⁹¹ Between seven and seventeen percent of dementia patients suffer from sexual disinhibition and exhibit inappropriate sexual behavior.⁹² This behavior is more common in men than in women.⁹³ Sexual disinhibition requires nursing homes to be especially vigilant in ensuring that sexual activity is voluntary. Because sexual disinhibition generally increases with cognitive decline, nursing homes must also ensure that ongoing sexual relationships remain consensual.

Nursing homes must consider all of these complexities and balance the patients' needs and rights to sexual intimacy against their obligation to protect vulnerable residents from nonconsensual sexual contact.⁹⁴ They must provide enough supervision to protect against rape and sexual abuse while not over-supervising so that sexual intimacy is stifled.⁹⁵

89. Alagiakrishnan et al., *supra* note 49, at 463 ("Patients with dementia may become sexually disinhibited as cognitive deficits progress.").

90. See, e.g., Alagiakrishnan et al., *supra* note 49, at 463 ("The prevalence of physically aggressive behaviour increases with the progression of dementia . . ."); Chadi Alkhalil et al., *Treatment of Sexual Disinhibition in Dementia: Case Reports and Review of the Literature*, 11 AM. J. THERAPEUTICS 231, 232 (2004) (listing inappropriate behaviors resulting from sexual disinhibition).

91. See Alagiakrishnan et al., *supra* note 49, at 463 ("While most sexually aggressive behaviour/inappropriate sexual behaviour occurs in the moderate to severe stages of Alzheimer's dementia, it may also be seen in early stages of fronto-temporal dementia because of the lack of insight and disinhibition."); Alkhalil et al., *supra* note 90, at 231 ("It is reasonable to assume that dementing illnesses diminish a person's ability to appropriately repress sexual urges."); Mattiasson & Hemberg, *supra* note 33, at 532 (mentioning the problem of "uninhibited sexual behaviour in elderly persons with dementia in whom deteriorating cerebral function affects the control of impulses").

92. Alkhalil et al., *supra* note 90, at 231; see also Hajjar & Kamel, *Part 1*, *supra* note 11, at S46 ("in one study 7% of 178 nursing home residents with dementia of the Alzheimer's type exhibited sexually disinhibited behavior").

93. Alagiakrishnan et al., *supra* note 49, at 464 ("Sexually inappropriate behaviour is generally known to be more common in men than in women."); Hajjar & Kamel, *Part 1*, *supra* note 11, at S46 ("Men with dementia are more likely than women with dementia to exhibit inappropriate sexual behaviours."); Kamel & Hajjar, *Part 2*, *supra* note 33, at 203 ("Men with dementia are more likely than cognitively impaired women to exhibit inappropriate sexual behaviors.").

94. See Casta-Kaufteil, *supra* note 14, at 78; see also Kamel & Hajjar, *Part 2*, *supra* note 33, at 205 ("On the one hand, nursing homes have a duty to provide residents with liberty to associate freely with others, which includes intimate and sexual freedom. On the other hand, they must protect residents from abuse, injury, and neglect.").

95. See Denno, *supra* note 81, at 394 ("[Nursing homes should balance] the competing interests inherent in protecting a vulnerable class of individuals while allowing them their right to engage in consensual sexual relationships."); Roach, *supra* note 42, at 375 ("The outcomes of

IV. METHODS FOR ENCOURAGING AND DISCOURAGING SEXUAL RELATIONS

Some nursing homes respond to this seemingly impossible dilemma by disregarding sexual preferences and effectively forcing celibacy on their demented residents. Others take a more humane approach and work to facilitate healthy and non-abusive sexual relationships.⁹⁶

It is easy to understand why sexual relationships might be logistically difficult in a nursing home, especially between dementia patients. Nursing homes are built to efficiently provide services and a safe environment.⁹⁷ Caregivers often see demented patients as “frail, dependent, and in need of constant supervision to compensate for their physical and cognitive losses.”⁹⁸ For these reasons, nursing homes are constructed with long open hallways, flanked by the residents’ rooms.⁹⁹ The rooms are generally shared and the doors kept open.¹⁰⁰ The hallways are busy with residents, staff, and visitors and are visible from a “centrally located nursing station.”¹⁰¹ Given this setting, it is no surprise that residents and staff cite lack of privacy as the primary reason for the limited sexual activity in nursing homes.¹⁰²

Some nursing homes further limit patients’ opportunities for sexual

standing guard are ultimately avoidance of sexuality issues, and this results in lack of fulfillment in residents’ lives and subsequently a decline in health status.”); Sy, *supra* note 84, at 548 (noting that “service care providers . . . cannot feasibly provide enough supervision to prevent rape and, at the same time, not over supervise to avoid violating a patient’s privacy rights”).

96. Roach, *supra* note 42, at 374 (“The ethos of [a nursing home] can range from one that is restrictive in terms of sexual expression to one that is responsive to residents’ needs.”).

97. *See id.* at 372 (“[Many nursing homes] are geared toward institutional efficiency and the desires of the residents’ families rather than to the residents’ own needs.”); *see also* Barnes, *supra* note 15, at 643 (“Institutionalization assures that certain services are readily available when needed, and reduces the risk of accidents, such as falls through protective supervision and a controlled institutional environment.”).

98. Daniel A. Reingold, *Rights of Nursing Home Residents to Sexual Expression*, 5 CLINICAL GERIATRICS, Apr. 1997, at 52, 52.

99. *See* Hajjar & Kamel, *Part 1*, *supra* note 11, at S44-45.

100. *Id.* at S45 (“Even in resident’s own rooms, open doors, and multiple beds moderately separated by drawn curtains limit privacy.”).

101. *Id.*; *see also* Edwards, *supra* note 52, at 20 (“With shared rooms, busy corridors, and frequent visitors . . . couples can encounter difficulty when trying to find a time and place to be intimate.”).

102. Berger, *supra* note 19, at 310 (“Often, private space is limited or unavailable, despite the fact that residents and staff cite privacy as a major concern.”); Miles & Parker, *supra* note 33, at 38 (“[L]ack of partners and privacy are the greatest reasons for the lack of sexually intimate relationships in nursing homes.”); Richardson & Lazur, *supra* note 49, at 122 (“Lack of privacy was the most frequent reason given, by both residents and staff, for lack of sexual activity in residents.”); Roach, *supra* note 42, at 372 (“[A number of studies have] found that older people living in nursing homes were less sexually active than their community-living peers.”).

gratification due to liability concerns, potential burdens on staff, and a perception that families would prefer not to have resident family members sexually involved.¹⁰³ They actively prevent sexual encounters using physical and psychological means.¹⁰⁴

Nursing homes can socialize staff to devalue sexual relationships and to view them as a problem, rather than as a healthy means of expressing intimacy.¹⁰⁵ Nursing home staff are receptive to this view because inappropriate sex by demented patients can be “disruptive and burdensome”¹⁰⁶ and the staff is already concerned about reducing the risks of abusive behavior.¹⁰⁷ Moreover, the general population apparently believes that the elderly are asexual so staff may not have a realistic understanding of their sexual needs.¹⁰⁸ Staff attitudes can have a substantial effect on residents.¹⁰⁹ By showing disapproval or by threatening and punishing patients, the staff can create an atmosphere that stifles sexual expression.¹¹⁰

Nursing homes can also physically limit sexual relationships by moving one partner to another floor or another nursing home,¹¹¹ or simply by denying patients the use of private space. Some homes have resorted to more draconian methods. For example, residents who engaged in sexual activity “have been restrained, have had clothes put on backwards, and have been put in zipperless jumpsuits.”¹¹² Nursing homes may also impose curfews and have nighttime nursing checks.¹¹³

These measures unnecessarily deny patients their privacy, individuality, and

103. See Reingold, *supra* note 98, at 54.

104. Roach, *supra* note 42, at 375 (“[There were practices used to stop] overt expressions of sexuality. The barriers might be physical—for example, moving a person to another room—or they might be psychological and involve such things as threats and punishment . . .”).

105. Hajjar & Kamel, *Part 1*, *supra* note 11, at S45 (“Sexual behaviors are often perceived by the nursing home staff as problems rather than as expressions of a need for love and intimacy.”); Miles & Parker, *supra* note 33, at 38 (“[N]ursing homes socialize staff to devalue and suppress intimate relationships between residents.”).

106. Kamel & Hajjar, *Part 2*, *supra* note 33, at 203.

107. Davidson, *supra* note 75, at 12 (mentioning that “[t]he care staff are concerned about risk[s]” of a mentally incapacitated person being taken advantage of in an intimate relationship).

108. See Casta-Kaufteil, *supra* note 14, at 74 (discussing the widespread sexual deterrence in nursing homes and the tendency to correlate cognitive impairments, like dementia, with an inability to make choices concerning sexuality); Davidson, *supra* note 75, at 8 (“Uncomfortable feelings and ageist attitudes of staff, and among family members, may mean that sexual interest or activity is frowned upon.”); Kamel & Hajjar, *Part 2*, *supra* note 33, at 203, 205.

109. See Berger *supra* note 19, at 310 (“[S]taff attitudes may deter sexual expression.”); Roach, *supra* note 42, at 371-72 (“It is thought that staff attitudes have a significant impact on both the beliefs and actions of residents.”).

110. See *supra* note 104 and accompanying text.

111. See *supra* note 104 and accompanying text.

112. Miles & Parker, *supra* note 33, at 39.

113. *Id.* at 41 (discussing nursing home policies that “diminish relationships” including “curfews [and] nighttime nursing checks”).

opportunity to have satisfying sexual relationships.¹¹⁴ Some nursing homes have shown that it is possible to successfully institute policies that facilitate sexual encounters between demented patients while also protecting the safety of their residents.¹¹⁵

To create an environment that supports sexual relationships between demented patients, the nursing home must first formulate a facility-wide policy that encourages these relationships¹¹⁶ and then develop a system for assessing the capacity of those cognitively impaired residents who want to engage in sexual activity. The Hebrew Home for the Aged, a large nursing facility in Riverdale, New York, is at the forefront in developing a program to support sexual intimacy.¹¹⁷ In that facility, staff involvement in sexual relationships varies depending on the cognitive functioning of the residents.¹¹⁸ The greater the

114. Denno, *supra* note 81, at 392 n.472 (noting that “attempts to suppress sexual behavior in institutions are not only ineffective, they may backfire because the suppressed behavior ‘may manifest itself in less acceptable, more hidden and sometimes more violent ways’”) (citing DAVID A. SHORE & HARVEY L. GOCHROS, *SEXUAL PROBLEMS OF ADOLESCENTS IN INSTITUTIONS*, at xiii, xiv (David A. Shore & Harvey L. Gochros eds., 1981); Kamel & Hajjar, *Part 2*, *supra* note 33, at 205 (“Addressing residents’ needs for intimacy and sexual expression . . . may help prevent the development of . . . troubling sexual behavior.”).

115. Feldkamp, *supra* note 50, at 64 (“Most residents with some sort of diminished cognitive capacity have not been adjudicated incompetent by a probate court and do not have a court-appointed guardian.”). The discussions in this Article on nursing home policies regarding sexual expression assume that the residents have not been adjudicated incompetent. If they were, “[f]amily members [or others] serving as court-appointed guardians . . . [would] have surrogate/proxy authority.” Dallas M. High, *Caring for Decisionally Incapacitated Elderly*, 10 *THEORETICAL MED.* 83, 86 (1989); *see also* Barnes, *supra* note 15, at 636 (“Involuntary guardianship requires a finding of incompetency . . . after which a proxy decision-maker, called a guardian, is appointed to manage the property and/or personal affairs of the disabled person.”).

116. Casta-Kaufteil, *supra* note 14, at 78 (“Without a guiding policy, staff and family may decide on management response[s] that disregard[] the preferences of the residents involved’”) (quoting DEBBIE CHRISTIE ET AL., *INTIMACY, SEXUALITY, AND SEXUAL BEHAVIOUR IN DEMENTIA: HOW TO DEVELOP PRACTICE GUIDELINES AND POLICY FOR LTC FACILITIES* 1, 6 (2002), available at <http://www.fhs.mcmaster.ca/mcah/cgec/toolkit.pdf>).

117. *See* The Hebrew Home for the Aged, *Sexual Expression Policy at the Home*, <http://www.hebrewhome.org/se.asp> (last visited Mar. 11, 2009) (“The Hebrew Home at Riverdale is the first facility of its kind to develop a policy to recognize and protect the sexual rights of nursing home residents, while distinguishing between intimacy and sexually inappropriate behaviors.”); *see also* Casta-Kaufteil, *supra* note 14, at 75 (noting that the Hebrew Home for the Aged at Riverdale, in Riverdale, NY, has a staff trained to effectively deal with gerontological intimacy issues); Matthew Purdy, *A Kind of Sexual Revolution; At Some Nursing Homes, Intimacy Is a Matter of Policy*, *N.Y. TIMES*, Nov. 6, 1995, at B1 (noting that the Hebrew Home for the Aged is “a 1,200-bed nursing home and Alzheimer’s research center in the Riverdale section of the Bronx”).

118. *See* Casta-Kaufteil, *supra* note 14, at 75 (noting that, at the Hebrew Home for the Aged, “the level of staff involvement depends on the resident’s cognitive awareness”).

patients' cognitive functioning, the less involved the staff become.¹¹⁹ In dealing with residents with limited cognitive functioning, the staff ensure that sexual relationships are mutually beneficial, consensual, and safe.¹²⁰ When a resident's capacity to consent to sexual activity is in question, the staff refer the patient to a registered nurse, social worker, or physician for evaluation.¹²¹ The Hebrew Home maintains that staff assessments are highly reliable because the nursing home staff interacts with the patients on a daily basis.¹²²

To insure a successful program, the facility must also provide training to staff and residents, arrange for medical support, and alter the nursing home's generally asexual atmosphere. Staff should receive training regarding the residents' needs and desires for sexual intimacy and the negative effects of ignoring those needs.¹²³ The Hebrew Home gives this training and also provides case histories so staff can discuss the types of situations that require intervention.¹²⁴ Staff who are morally or religiously opposed to sexual relations—such as those between unmarried residents or homosexuals—can transfer to another floor.¹²⁵

Information and counseling about sex also should be provided to interested residents. Some residents may be hesitant to discuss their sexual concerns or to

119. Edwards, *supra* note 52, at 20 (“At the Hebrew Home, the level of staff involvement depends on the residents’ level of cognitive awareness. When the residents in the relationship are alert and oriented, staff involvement is minimal, unless the relationship is imposing itself on the broader resident community.”).

120. *Id.* (“[The staff members at The Hebrew Home for the Aged] are basically making a clinical assessment about consent, mutuality, and the safety and well-being of the couple”) (quoting Robin Dessel, supervisor in social services at the Hebrew Home); *cf.* Denno, *supra* note 81, at 385 n.446 (suggesting that in determining whether a mentally retarded individual can consent to sex, the following factors should be considered: voluntariness, avoidance of exploitation, avoidance of abuse, ability to stop an interactive behavior when desired, and appropriateness of time and place).

121. Casta-Kaufteil, *supra* note 14, at 80 (explaining that determiners of capacity should consider the resident’s “awareness of the relationship, . . . ability to avoid exploitation, [and] . . . awareness of potential risks”); Feldkamp, *supra* note 50, at 64 (“When a resident’s capacity to consent to sexual relations is in question, a psychiatrist or psychologist should be consulted to render an opinion regarding the resident’s ability to make an informed decision.”); Reingold, *supra* note 98, at 57 (“Cases of dementia residents engaging in sexual expression are referred to the unit RN, social worker, or physician . . . for awareness and assessment of the relationship.”).

122. Edwards, *supra* note 52, at 20 (citing Robin Dessel of The Hebrew Home who states that “residents are constantly interacting with caregivers”).

123. Berger, *supra* note 19, at 310 (“The [nursing home] should maintain an environment that is receptive to residents’ sexual needs through staff training and open forums for discussion.”); Kamel & Hajjar, *Part 2*, *supra* note 33, at 205 (“[S]taff must be made aware of residents’ need for sexual expression.”).

124. *See* Bonifazi, *supra* note 50, at 24.

125. *See id.*; *see also* Berger, *supra* note 19, at 312 (“The institution should make provisions for staff nonparticipation in direct patient care when the implications of the sexual activity in care is unavoidable and is morally or religiously offensive to the staff member.”).

accept sex as natural and beneficial without support.¹²⁶

The elderly may also need medical support to fully enjoy a sexual relationship. Complaints about sexual dysfunction should be investigated as diligently as other medical complaints.¹²⁷ Condoms, Viagra, and vaginal lubricants should be readily available.¹²⁸ The nursing home should also institute policies to avoid the spread of sexually transmitted diseases.¹²⁹

The nursing home environment can be modified easily to support sexual expression without compromising safety. For example, the nursing home can deal with privacy concerns by allowing closed doors and providing “do not disturb” signs.¹³⁰ The home should also make clear that the reasons for posting a “do not disturb” sign are “nobody’s business.”¹³¹ To be receptive to sexual contact, residents must feel physically and sexually attractive.¹³² The nursing home can enhance these feelings by providing beauty salons and cosmetic services.¹³³ The home can also encourage satisfying relationships by sponsoring

126. See Kamel & Hajjar, *Part 2, supra* note 33, at 205-06 (“Resident education is important as well, because . . . some elderly were initially hesitant to openly discuss sexual issues . . .”); Richardson & Lazur, *supra* note 49, at 121 (“Barriers to sexual expression for residents of long-term care facilities include . . . an insufficient understanding of sexuality.”).

127. Berger, *supra* note 19, at 310 (“Male residents should be screened for erectile dysfunction Dyspareunia in female residents should be addressed similarly.”); Kamel & Hajjar, *Part 2, supra* note 33, at 206 (“Loss of sexual performance may need to be investigated to identify any treatable medical conditions, and medical interventions should be offered to interested patients when appropriate.”); Richardson & Lazur, *supra* note 49, at 124 (“[P]hysicians and nurses who take care of nursing home residents should evaluate residents’ sexual complaints as vigorously as they evaluate other complaints.”).

128. Berger, *supra* note 19, at 310 (suggesting that residents have “access to . . . condoms, . . . vaginal lubricants, . . . [and] Viagra”).

129. Edwards, *supra* note 52, at 21; Berger, *supra* note 19, at 312 (noting that “[a] cognitively impaired partner may not be able to effectively protect him—or herself from [sexually transmitted] diseases . . . [and that] a limited breach of privacy may be justified in order to protect the resident”).

130. Edwards, *supra* note 52, at 20 (“At the Hebrew Home for the Aged at Riverdale in Riverdale, New York, staff try to address [the issue of privacy] by giving one of the residents in a relationship a private room, but when that isn’t possible, private time in the residents’ room is arranged for each roommate.”); Hajjar & Kamel, *Part 1, supra* note 11, at S45 (“[A]n increasing number of nursing homes are being designed so that no body [sic] shares a room with a stranger.”); Richardson & Lazur, *supra* note 49, at 123 (suggesting “‘do not disturb’ signs or allowing doors to remain shut” as methods of providing privacy for residents).

131. Bonifazi, *supra* note 50, at 23.

132. Richardson & Lazur, *supra* note 49, at 123 (noting that residents might “feel physically unattractive and, therefore, sexually unattractive”).

133. Kamel & Hajjar, *Part 2, supra* note 33, at 204 (“[M]aking beauty salons and cosmetic services available for residents may help them feel physically attractive and sexually desirable.”); Richardson & Lazur, *supra* note 49, at 123 (“Administrators of nursing homes can make beauty salons and cosmetic services available for residents.”).

social events and romantic outings.¹³⁴ All of these actions make intimacy and sexual contact a more accepted and expected part of nursing home life.

The remaining concerns involve families, a group not controlled by the nursing home, but who can have an enormous impact on the residents' opportunities for expressing their sexuality.¹³⁵ Family responses to a resident's sexuality range from asking the staff to intervene by moving a relative or otherwise stopping a physical relationship to "accept[ing] and even appreciat[ing] the happiness, security, and intimacy some residents find together."¹³⁶

Nursing homes can influence family members who object to sexual relationships by providing counseling and education about the elderly's sexual needs.¹³⁷ The Hebrew Home finds that, with staff support, counseling, and education, most families accept their relatives' sexual activity.¹³⁸

The remainder of this Article focuses on what nursing homes should do if, despite counseling, the family continues to object to a resident's sexual relationship, especially if the objecting family member is the non-resident spouse. "[A]pproximately 75% of men and 35 to 50% of women in nursing homes are married."¹³⁹ The nursing home must decide if it has an obligation to

134. See Bonifazi, *supra* note 50, at 23 (quoting a resident at The Hebrew Home who explained the need for romantic relations: "Sex is beautiful under the right circumstances. But it's not just sex, its everything else—movies, dinner, holding hands. It makes life more complete."); Kamel & Hajjar, *Part 2, supra* note 33, at 206 (noting that "every effort must be made to modify the asexual environment of the nursing home . . . [M]ore opportunity for intimate activities[,] . . . social events, and romantic outings" are acceptable methods).

135. See Bonifazi, *supra* note 50, at 26; Kamel & Hajjar, *Part 2, supra* note 33, at 205 ("Oftentimes . . . [sexual activity] is complicated by . . . family members' reluctance to accept such a relationship."); Melinda Henneberger, *An Affair to Remember*, SLATE, June 10, 2008, <http://www.slate.com/id/2192178/> (describing the impact that families can have on intimate relationships by relating an incident involving a ninety-five-year old man whose son objected to his father's relationship in a nursing home and had him transferred to another facility).

136. Bonifazi, *supra* note 50, at 26; see also Ehrenfeld et al., *supra* note 17, at 148 ("The reactions of family members [are] also difficult to generalize. Sometimes the family was not aware or displayed apathy, while at other times they were glad that their relative had found a new relationship."); Reingold, *supra* note 98, at 63 ("[Family members] have been alternately delighted, supportive, or horrified at the thought of their family member being involved in a new sexual relationship. Acceptance of such relationships appears to be most difficult for . . . families of residents who have Alzheimer's disease or other dementias.")

137. See Kamel & Hajjar, *Part 2, supra* note 33, at 205.

138. See Reingold, *supra* note 98, at 63 ("Given the opportunity for staff support and counseling, most family members do come to support and respect their family member's needs and desires for intimacy and sexual expression."); see also Miles & Parker, *supra* note 33, at 41 ("[T]he scant research available reports families to be generally supportive toward residents' needs for sexual intimacy.").

139. Hajjar & Kamel, *Part 1, supra* note 11, at S46 (citing Gerhard Falk & Ursula A. Falk, *Sexuality and the Ages*, 28 NURSING OUTLOOK 51-57 (1980)).

defer to the marital spouse's wishes or to the needs and desires of the nursing home patient. This decision is complicated by the fact that the non-resident spouse's desire to end the sexual relationship is probably based on his or her belief that the decision is best for the patient and that the patient would have made the same decision if competent.

V. A HYPOTHETICAL ADULTEROUS RELATIONSHIP

For ease of discussion, this Article poses a carefully constructed hypothetical. Later, the Article addresses the nursing homes' responsibilities given some more complicated fact patterns.

In this hypothetical, a couple with dementia live in a nursing home that actively supports sexual expression. One member of the couple has a non-resident spouse who objects to the relationship. The couple has approximately the same level of cognitive functioning, which makes an abusive relationship less likely.¹⁴⁰ The relationship is stable and the two residents obviously enjoy each other's company. The couple is having sexual intercourse.

A stable relationship was chosen because that kind of relationship is likely to be intimate, rather than casual.¹⁴¹ Moreover, if the couple consistently spend time together and appear to enjoy themselves, the relationship is unlikely to be simply "an outgrowth of dementia."¹⁴²

A. Adultery—Relying on the Nonresident Spouse

Given this hypothetical relationship, should the nursing home simply allow the non-resident spouse to determine if the relationship continues? Relying on the non-resident spouse may make sense because adultery is a crime in twenty-three states.¹⁴³

140. See *supra* note 7 and accompanying text.

141. See Denno, *supra* note 81, at 386-87 ("Far more difficult are those situations where the individuals are severely or profoundly mentally disabled, they are engaging in sexual intercourse (oftentimes with more than one partner), and it is not always clear that the parties 'like' each other.").

142. Edwards, *supra* note 52, at 20; see also Bonifazi, *supra* note 50, at 28; cf. Denno, *supra* note 81, at 386 (referring to a relationship between two mentally retarded individuals and noting that "the probability of victimization was low because [they] had known and liked each other for a long time").

143. ALA. CODE § 13A-13-2 (2006); ARIZ. REV. STAT. ANN. § 13-1408 (2001); COLO. REV. STAT. ANN. § 18-6-501 (West 2004); FLA. STAT. ANN. § 798.01 (West 2007); GA. CODE ANN. § 16-6-19 (West 2003); IDAHO CODE ANN. § 18-6601 (West 2006); 720 ILL. COMP. STAT. ANN. § 5/11-7 (West 2002); KAN. STAT. ANN. § 21-3507 (2007); MASS. GEN. LAWS ch. 272, § 14 (West 2000); MICH. COMP. LAWS ANN. § 750.30 (West 2004); MINN. STAT. ANN. § 609.36 (West 2003); MISS. CODE ANN. § 97-29-1 (West 1999); N.H. REV. STAT. ANN. § 645:3 (2007); N.Y. PENAL LAW § 255.17 (McKinney 2008); N.C. GEN. STAT. ANN. § 14-184 (West 2000); N.D. CENT. CODE ANN. § 12.1-20-09 (Michie 1997); OKLA. STAT. ANN. tit. 21, § 871 (West 2002); R.I. GEN. LAWS ANN. § 11-6-2 (West 2006); S.C. CODE ANN. § 16-15-60 (2003); UTAH CODE ANN. § 76-7-103 (West

Black's Law Dictionary defines adultery as "[v]oluntary sexual intercourse between a married person and someone other than the offender's spouse."¹⁴⁴ Every statute that criminalizes adultery conforms to this definition by making sexual intercourse with someone other than one's spouse an essential element of the crime.¹⁴⁵

It is unclear whether demented patients, who do not realize they are married, can commit the crime of adultery. Only one state statute explicitly provides that married participants are not guilty of adultery if they are unaware of their marital status¹⁴⁶ and only one statute provides married participants with the affirmative

2004); VA. CODE ANN. § 18.2-365 (2004); W. VA. CODE ANN. § 61-8-3 (West 2002); WIS. STAT. ANN. § 944.16 (West 2005).

144. BLACK'S LAW DICTIONARY 52 (7th ed. 1999).

145. ARIZ. REV. STAT. ANN. § 13-1408(A) (2001) ("A married person who has sexual intercourse with another than his or her spouse . . . commits adultery . . ."); COLO. REV. STAT. § 18-6-501 (West 2004) ("Any sexual intercourse by a married person other than with that person's spouse is adultery . . ."); GA. CODE ANN. § 16-6-19 (West 2003) ("A married person commits the offense of adultery when he voluntarily has sexual intercourse with a person other than his spouse . . ."); IDAHO CODE ANN. § 18-6601 (West 2006) ("A married man who has sexual intercourse with a woman not his wife . . . shall be guilty of adultery . . ."); 720 ILL. COMP. STAT. 5/11-7(a) (West 2002) ("Any person who has sexual intercourse with another not his spouse commits adultery . . ."); KAN. STAT. ANN. § 21-3507(1) (2007) ("Adultery is engaging in sexual intercourse . . . with a person who is not married to the offender . . ."); MASS. GEN. LAWS ch. 272, § 14 (West 2002) ("A married person who has sexual intercourse with a person not his spouse . . . shall be guilty of adultery . . ."); MICH. COMP. LAWS § 750.29 (West 2004) ("Adultery is the sexual intercourse of 2 persons, either of whom is married to a third person."); MINN. STAT. ANN. § 609.36(1) (West 2003) ("When a married woman has sexual intercourse with a man other than her husband . . . both are guilty of adultery . . ."); N.H. REV. STAT. ANN. § 645:3 (2007) ("A person is guilty of . . . [adultery] if, being a married person, he engages in sexual intercourse with another not his spouse . . ."); N.Y. PENAL LAW § 255.17 (McKinney 2008) ("A person is guilty of adultery when he engages in sexual intercourse with another person at a time when he has a living spouse . . ."); N.D. CENT. CODE ANN. § 12.1-20-09(1) (Michie 2007) ("A married person is guilty of . . . [adultery] if he or she engages in a sexual act with another person who is not his or her spouse."); OKLA. STAT. tit. 21, § 871 (West 2002) ("Adultery is the unlawful voluntary sexual intercourse of a married person with one of the opposite sex . . ."); R.I. GEN. LAWS ANN. § 11-6-2 (West 2006) ("[I]llicit sexual intercourse between any two (2) persons, where either of them is married, shall be deemed adultery . . ."); UTAH CODE ANN. § 76-7-103(1) (West 2004) ("A married person commits adultery when he voluntarily has sexual intercourse with a person other than his spouse."); VA. CODE ANN. § 18.2-365 (2004) ("Any person, being married, who voluntarily shall have sexual intercourse with any person not his or her spouse shall be guilty of adultery . . ."); W. VA. CODE ANN. § 48-5-204 (West 2002) ("Adultery is the voluntary sexual intercourse of a married man or woman with a person other than the offender's wife or husband."); WIS. STAT. § 944.16(1) (West 2005) ("A married person who has sexual intercourse with a person not the married person's spouse [commits adultery] . . .").

146. See ALA. CODE § 13A-13-2(b) (2006) ("A person does not commit a crime under this section if he reasonably believes that he and the other person are unmarried persons.").

defense of lack of knowledge of marital status.¹⁴⁷ But “the existence of *mens rea* as a prerequisite to criminal responsibility ‘is the rule of, rather than the exception to, the principles of Anglo-American jurisprudence.’”¹⁴⁸ Based on this principle, even where a criminal statute does not require mental culpability, the courts will usually find that the *mens rea* requirement exists.¹⁴⁹ Therefore, demented patients who do not know they are violating their marriage vows are probably not adulterers.¹⁵⁰

Even if nursing home residents are not technically committing adultery, some might argue that the nursing home is an accomplice to the crime. An accomplice need only encourage the conduct and know that a crime might result.¹⁵¹

These issues are mostly academic because adultery is very rarely prosecuted.¹⁵² As early as 1955, the American Law Institute found that adultery laws were “dead-letter statutes” and removed them from the Model Penal Code.¹⁵³ The public’s understanding that adultery will not be prosecuted has been repeatedly demonstrated by popular politicians who have publicly admitted

147. N.Y. PENAL LAW § 255.20 (McKinney 2008) (“In any prosecution for . . . adultery, it is an affirmative defense that the defendant acted under a reasonable belief that both he and the other person . . . were unmarried.”).

148. JOSHUA DRESSLER, UNDERSTANDING CRIMINAL LAW 95 (1987) (quoting *Dennis v. United States*, 341 U.S. 494, 500 (1951)).

149. *Id.* at 144. This is not true, of course, where the Legislature makes clear that the statute applies based on strict liability.

150. Reingold, *supra* note 98, at 63 (“[The Hebrew Home takes the position] that married residents with dementing illness, who engage in sexual relations with other partners, are neither knowingly or wittingly violating marriage vows nor committing adultery.”).

151. In order to be found guilty of a crime based on accomplice liability, a person must intentionally and knowingly engage in conduct that assists in the commission of the crime. See DRESSLER, *supra* note 148, at 417. Mere encouragement may satisfy the assistance requirement. See *id.* at 417-18. It is unclear whether the nursing home could be found guilty as an accomplice to adultery if the patients themselves lack the requisite *mens rea*. See *id.* at 420-21. To be guilty of an offense, one must act with knowledge that the aided actions constitute a crime. See MODEL PENAL CODE § 2.02 (1980).

152. For example, since 1972, there have been only twelve arrests for the crime of adultery in New York. See New York State Division of Criminal Justice Services, Criminal Justice Statistics, <http://criminaljustice.state.ny.crimnet/ojsa/stats.htm> (last visited Mar. 13, 2009). Only three of those arrested were convicted of adultery and all of the convictions resulted in a conditional discharge. See *id.* The New York State Police Field Manual now specifically instructs state troopers not to “make an arrest or initiate an investigation concerning Adultery unless directed by the district attorney.” STATE OF NEW YORK, NEW YORK STATE POLICE FIELD MANUAL 33-4 (n.d.). Similarly, in Florida, there have been only fifteen arrests for adultery in the past ten years. Only three of those arrested were prosecuted. See <http://www3.fdle.state.fl.us/FSAC/> (last visited Mar. 13, 2009).

153. Denno, *supra* note 81, at 350 n.225 (citing Martin J. Siegel, *For Better or for Worse: Adultery, Crime & the Constitution*, 30 J. FAM. L. 45, 49 (1991-92)).

to marital indiscretions.¹⁵⁴ For example, in early 2008, New York's Governor announced that he had committed adultery more than once.¹⁵⁵ There are also many divorces granted on the grounds of adultery, apparently without fear of prosecution.¹⁵⁶

Indeed, it is unclear whether adultery laws are even constitutional after the U.S. Supreme Court's *Lawrence v. Texas*¹⁵⁷ decision.¹⁵⁸ In *Lawrence*, the Supreme Court invalidated a Texas criminal statute prohibiting consensual homosexual sex based primarily on the petitioner's right to privacy.¹⁵⁹ In his dissent, Justice Scalia noted that statutes against adultery were also "called into question" by the decision.¹⁶⁰

There is no reason to hold demented individuals to a higher standard than everyone else. Indeed, there may be less reason to prevent demented patients from committing adultery. Society's disapproval of extra-marital sex is based, in part, on the problems that may arise, such as "unplanned pregnancy, single parent families, divorce, venereal disease and AIDS."¹⁶¹ Most of these concerns either do not apply to the elderly in nursing homes or are likely to be less of a

154. *Id.* at 351 n.226 ("[D]uring his 1992 campaign, then-Governor Bill Clinton did not deny 'unspecified instances of marital infidelity' when interviewed on the CBS News Program, 60 Minutes [A]n ABC News Poll conducted the next day reported that . . . 66 % [of the 790 adults surveyed] stated that they could 'vote for a Presidential candidate who had an extramarital affair,' while 80 % said that 'the accusations should not be an issue in the campaign.'" (citing Gwen Ifill, *The 1992 Campaign: Democrats; Clinton Attempts to Ignore Rumors*, N.Y. TIMES, Jan. 28, 1992, at A16)).

155. Pamela Druckerman, *After the End of the Affair*, N.Y. TIMES, Mar. 21, 2008, at A23 ("New York [G]overnor, David A. Paterson . . . said Tuesday that his own extramarital affairs ended several years ago and that his marriage was back on track.").

156. MODEL PENAL CODE § 213.6 Note on Adultery and Fornication pt. 2 (1980) ("The number of divorces granted on the grounds of adultery suggests the certainty with which the divorce-seekers foresaw no prosecution and also reflects the widespread conclusion that criminal prosecution was an inappropriate response to such conduct.").

157. 539 U.S. 558 (2003).

158. Several cases decided prior to *Lawrence* upheld the constitutionality of adultery statutes. See, e.g., *Oliverson v. W. Valley City*, 875 F. Supp. 1465, 1480 (D. Utah 1995) ("Extramarital sexual relationships are not within the penumbra of the various constitutional provisions or the articulated privacy interests protected by the Constitution."); *Suddarth v. Slane*, 539 F. Supp. 612, 617 (W.D. Va. 1982) ("[A]dultery is not protected by the First Amendment."); *Commonwealth v. Stowell*, 449 N.E.2d 357, 360 (Mass. 1983) ("[T]here is no fundamental personal privacy right implicit in the concept of ordered liberty barring the prosecution of consenting adults committing adultery in private.").

159. *Lawrence*, 539 U.S. at 578-79.

160. *Id.* at 590 (Scalia, J., dissenting) ("State laws against bigamy, same-sex marriage, adult incest, prostitution, masturbation, *adultery*, fornication, bestiality, and obscenity are likewise . . . called into question by today's decision; the Court makes no effort to cabin the scope of its decision to exclude them from its holding.") (emphasis added).

161. *State v. Soura*, 796 P.2d 109, 114 (Idaho 1990).

problem.¹⁶²

More importantly, the well-being of the patient should be the nursing home's primary concern, not the existence of "dead-letter statutes."¹⁶³ In fact, federal and state laws mandate that nursing homes respect their patients' needs. In order to qualify for reimbursement under Medicare and Medicaid, nursing homes must comply with federal regulations including the Patient Bill of Rights.¹⁶⁴ These enumerated rights require long term care providers to protect the residents' rights to privacy¹⁶⁵ and to assist residents in meeting their "highest practicable physical, mental, and psychosocial well-being."¹⁶⁶ The Bill of Rights also gives residents the right to "communication with and access to persons . . . inside and outside the facility."¹⁶⁷

These provisions do not explicitly provide a right to appropriate sexual expression, except to the extent that this right can be implied from the patient's right to privacy.¹⁶⁸ However, the intent of these provisions—protecting patients' well-being and association with others—could certainly be construed to encompass intimate sexual activity.¹⁶⁹

Various state provisions and court decisions also protect the dignity, privacy, and social preferences of those living in nursing homes.¹⁷⁰ Given the nursing

162. See Miles & Parker, *supra* note 33, at 39 (noting that, in a nursing home, "[s]exually transmitted disease is rare; pregnancy is impossible").

163. See *supra* note 153 and accompanying text.

164. 42 C.F.R. § 483.10 (2008); see Brogdon *ex rel.* Cline v. Nat'l Healthcare Corp., 103 F. Supp. 2d 1322, 1327 (N.D. Ga. 2000).

165. 42 C.F.R. § 483.10(e) (2008) ("The resident has the right to personal privacy and confidentiality. . .").

166. *Id.* § 483.25 ("[T]he facility must provide [each resident with] the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being . . .").

167. *Id.* § 483.10.

168. See Reingold, *supra* note 98, at 53 ("Although residents' rights are articulated and secured by regulatory oversight, the right of nursing home residents to sexual expression is not included as an explicit right beyond the implicit right to privacy.").

169. Of course, appropriate sexual expression would include only sexual contact that is consensual and does not negatively impact the residents involved or others in the nursing home.

170. See FLA. STAT. ANN. § 393.13(3)(a), (e), (g) (West 2006 & Supp. 2009) ("Persons with developmental disabilities shall have a right to dignity, privacy, . . . social interaction and to participate in community activities . . . [as well as the right to be free from] unnecessary . . . restraint [and] isolation. . ."); MD. CODE ANN., HEALTH-GEN. § 19-343(b)(2)(i) (West 2009) ("[E]ach resident of a facility has . . . [t]he right to be treated with consideration, respect, and full recognition of human dignity and individuality."); *id.* § 19-344(j)(5) ("Every patient . . . may associate and communicate privately and without restriction with persons and groups of his choice on his own or their initiative at any reasonable hour."); N.Y. COMP. CODES R. & REGS. tit. 14, § 27.4(c) (2009) ("Consistent with a patient's service plan, directors of facilities shall assure patients a reasonable opportunity to associate with any staff member, or patient or members of the general community in order to foster the development of the patient's social competences and preferences."); see also

home's obligation to safeguard the residents' "psychosocial well-being" and social preferences, the nursing home should not take steps to end an intimate relationship based solely on the request of the non-resident spouse.

B. Substituted Judgment

The next logical choice would be to use substituted judgment to determine if the adulterous relationship between the demented patients in our hypothetical should be allowed to continue, despite the non-resident spouse's objection. Because the nursing home's obligation is the well-being of its residents, the home would act as surrogate decisionmaker for the married resident. Substituted judgment would require the surrogate decisionmaker to reach, as accurately as possible, the same decision the married resident would have reached if competent.¹⁷¹ To make this decision, the home would gather information regarding advance directives,¹⁷² prior communications, and core values.¹⁷³ The resident's values, when competent, could be extrapolated from his or her previously-developed philosophical and religious beliefs, morals, and patterns of behavior.¹⁷⁴

Davis v. Watkins, 384 F. Supp. 1196, 1206 (N.D. Ohio 1974) (stating that patients in a state mental facility have rights to "dignity, privacy and humane care [and] . . . [to] suitable opportunities for . . . interaction with members of the opposite sex"); Wyatt v. Stickney, 344 F. Supp. 387, 399 (M.D. Ala. 1972) (finding that a facility for the mentally retarded "shall provide . . . suitable opportunities for the resident's interaction with members of the opposite sex"), *rev'd in part on other grounds and remanded by* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974).

171. Curran v. Bosze, 566 N.E.2d 1319, 1324 (Ill. 1990) ("[S]ubstituted-judgment theory . . . requires a surrogate decisionmaker to establish, as accurately as possible, what the patient would decide if competent.") (citing *In re Estate of Longeway*, 549 N.E.2d 292, 299-300 (Ill. 1989)); Jennifer K. Robbennolt et al., *Advancing the Rights of Children and Adolescents to be Altruistic: Bone Marrow Donation by Minors*, 9 J.L. & HEALTH 213, 221 (1995) ("When executing a decision based on the substituted judgment standard, a court purports to 'determine and effectuate, insofar as possible, the decision that the patient would have made if competent.'").

172. David DeGrazia, *Advance Directives, Dementia, and 'the Someone Else Problem,'* 13 BIOETHICS 373, 375 (1999) (explaining that advance directives are instructions given by a competent patient "that are to apply only at future times when she is incompetent").

173. *In re A.C.*, 573 A.2d 1235, 1250 (D.C. 1990) ("The court in a substituted judgment case . . . should pay special attention to the known values and goals of the incapacitated patient, and should strive, if possible, to extrapolate from those values and goals what the patient's decision would be.").

174. Curran, 566 N.E.2d at 1325 ("Under the doctrine of substituted judgment, a guardian of a formerly competent, now incompetent, person may look to the person's life history, in all of its diverse complexity, to ascertain the intentions and attitudes which the incompetent person once held."); *In re Jobes*, 529 A.2d 434, 444 (N.J. 1987) (noting that a personal value system can be determined by "philosophical, theological, and ethical values") (citing *In re Roe*, 421 N.E.2d 40, 56-59 (Mass. 1981)); Lynn E. Lebit, Note, *Compelled Medical Procedures Involving Minors and Incompetents and Misapplication of the Substituted Judgments Doctrine*, 7 J.L. & HEALTH 107,

Courts have traditionally favored substituted judgment, rather than a best interests test, when an incapacitated person was formerly competent.¹⁷⁵ This reflects a policy of respecting the patient's own views and preferences and, therefore, the patient's autonomy.¹⁷⁶ For this reason, the decision will be unique to the patient and need not be in his or her best interests or conform to the norm.¹⁷⁷

Applying this standard, suppose the married member of our hypothetical couple had been asked, when competent, what he would want done if he was demented, in an adulterous relationship with another nursing home resident, and his spouse objected.¹⁷⁸ He might very well have responded that he would want his spouse's wishes respected. This viewpoint is understandable because, when competent, he would probably not care very much about his future demented self, but he might care greatly about his wife's feelings.¹⁷⁹ Suppose further that his behavior—years of devotion to his wife—demonstrates the strength of his prior decision. Using substituted judgment, the husband's communication of a core value—his overriding concern for his wife—should be honored and his adulterous relationship, commenced when he was incompetent, ended.

Ronald Dworkin and other character theorists would agree with this outcome. They believe that we each create who we are by selecting a set of values that are stable over our lifetime.¹⁸⁰ These values, and our actions based upon them, make

109-10 (1993) (“The once competent person has developed a system of morals and beliefs, and patterns of behavior which the court can examine when evaluating what she would do in a particular situation.”).

175. *Curran*, 566 N.E.2d at 1325 (noting that the substituted judgment standard was not applicable when decisionmaking was required for “an infant or life-long incompetent”) (quoting *Longeway*, 549 N.E.2d at 299); *Longeway*, 549 N.E.2d at 300 (holding that where the incompetent was previously competent, the guardian must apply the substituted judgment test when there is clear and convincing evidence that can be used to demonstrate intent); Kevin P. Quinn, Comment, *The Best Interests of Incompetent Patients: The Capacity for Interpersonal Relationships as a Standard for Decisionmaking*, 76 CAL. L. REV. 897, 899 (1988) (“Traditional jurisprudence . . . has tended to focus on the patient's personal autonomy . . . [and to] apply[] the ‘substituted judgment’ standard . . . [with the intent] to ensure that the surrogate decisionmaker effectuates, to the extent possible, the decision the patient would make if he or she were competent.”) (citation omitted).

176. See Sara Lind Nygren, *Organ Donation by Incompetent Patients: A Hybrid Approach*, 2006 U. CHI. LEGAL F. 471, 482.

177. Barnes, *supra* note 15, at 740 (“The substituted judgment standard has come to be preferred [by American courts] on the theory that elderly and disabled persons need not make decisions in their best interests because an adult can choose to deviate from the norm.”).

178. This example uses a male, rather than a female, nursing home resident only because male residents are more likely to be married. See *supra* note 139 and accompanying text.

179. *Jobes*, 529 A.2d at 444 n.10 (noting that patients care about the impact of their decisions on their families and that this factor can be considered as part of substituted judgment).

180. Harvey, *supra* note 17, at 59 (“To unearth what morally matters most about a person requires us to assess their life as a whole through an appreciation of the continuity that ties his or her life together.”); Elysa R. Koppelman, *Dementia and Dignity: Towards a New Method of*

up our rational life plan.¹⁸¹

Dworkin distinguishes between experiential interests—or “brute” desires—and critical interests.¹⁸² Experiential interests are the sensations that a person feels. They include pleasure, pain, “desires, tastes, and emotional reactions.”¹⁸³ Examples of experiential interests are enjoying jazz music, sitting in the sun, or eating ice cream.¹⁸⁴ By contrast, critical interests are identity-defining values and commitments chosen by individuals based on what they believe makes their lives meaningful, and the personal attributes that they want to possess.¹⁸⁵ Critical interests are not just “brute desires,” but rather are critical judgments created by “the self’s ability to reason, its capacity for self-reflection, and its ability to create rational life plans.”¹⁸⁶ Autonomy allows each of us to base our choices on

Surrogate Decision Making, 27 J. MED. & PHIL. 65, 70 (2002) (explaining that character theorists “presuppose[] a self that is steadfastly committed to a stable set of identity-defining values and convictions, a self that expresses continuity over time, a self that is separate from all other selves”).

181. Koppelman, *supra* note 180, at 71 (“For character theorists, who a person is *essentially* is expressed in her character or in the rational life plan she expressed somewhat consistently throughout her life.”).

182. *Id.* at 70.

183. *Id.*; see also Leslie Pickering Francis, *Decisionmaking at the End of Life: Patients with Alzheimer’s or Other Dementias*, 35 GA. L. REV. 539, 581 (2001) (“‘Experiential interests’ . . . include perceptions of pleasure and pain, comfort and discomfort, along with other sensations felt by the patient.”).

184. Harvey, *supra* note 17, at 50 (“[S]everely demented individuals can[] enjoy[] . . . simple pleasures like sitting in the sun or eating ice cream.”); Koppelman, *supra* note 180, at 70 (“Experiential interests [include] . . . the fact that an individual enjoys jazz music or gets pleasure out of her relationships.”).

185. Søren Holm, *Autonomy, Authenticity, or Best Interest: Everyday Decision-making and Persons with Dementia*, 4 MED., HEALTH CARE & PHIL. 153, 157 (2001) (“[Dworkin] defines critical interests in the following way: . . . ‘Convictions about what helps to make a life good on the whole . . . They represent critical judgements rather than just experiential preferences.’”) (quoting RONALD DWORKIN, *LIFE’S DOMINION: AN ARGUMENT ABOUT ABORTION, EUTHANASIA, AND INDIVIDUAL FREEDOM* 201-02 (1993)); Koppelman, *supra* note 180, at 70 (“[Critical interests] are convictions about what makes life good on the whole. They are ideas about the kind of person one wants to be and about the kind of life a person thinks is worthwhile.”); Michael J. Newton, *Precedent Autonomy: Life-Sustaining Intervention and the Demented Patient*, 8 CAMBRIDGE Q. HEALTHCARE ETHICS 189, 190 (1999) (“Dworkin divided an individual’s interests into 2 categories: *experiential* interests, the simple pleasures of doing things because they feel good, and *critical* interests, serious convictions about what makes life significant as a whole.”).

186. Koppelman, *supra* note 180, at 70; see also Harvey, *supra* note 17, at 58-59 (“A demented grandfather may now take no interest in the future education of his grandchildren . . . [despite] the fact that prior to onset of dementia he took an interest in their education and made a commitment to it’ . . . [O]ur success or failure at fulfilling the aims of our critical interests over the course of our lives figures greatly in assessing whether we have lived well or ill.”) (quoting ALLEN E. BUCHANAN & DAN W. BROCK, *DECIDING FOR OTHERS: THE ETHICS OF SURROGATE DECISION MAKING* 163 (1990)).

our critical interests—on our self-identifying values and beliefs.¹⁸⁷

Dementia patients “gradually lose their ability to reason” and the ability “to formulate and sustain rational life plans” based on their critical interests.¹⁸⁸ Dworkin convincingly argues that decisions made on behalf of demented patients should be based on precedent autonomy or the values that mattered to them when they were able to rationally choose.¹⁸⁹ Using precedent autonomy, the values we create and nurture while we are rational—the people we choose to be—will be respected above the brute desires we act upon when we are not competent.¹⁹⁰

C. Problems with Using a Substituted Judgment Test

But the use of precedent autonomy, which is essentially substituted judgment, presents some serious problems. First, it would obviously be difficult for the nursing home to accurately predict what the demented nursing home resident would have decided, when competent, about continuing his adulterous relationship. Because the nursing home resident is very unlikely to have an advance directive covering intimate relationships,¹⁹¹ the nursing home would generally be forced to rely on the patient’s family to help determine his former

187. See Newton, *supra* note 185, at 190 (“In [Dworkin’s] model, autonomy draws its moral force from the way it allows us to express our own character, motivation, and beliefs.”); see also Harvey, *supra* note 17, at 58 (“Dworkin . . . heavily discount[s] experiential interests in favor of critical interests. For him, the duty to follow an [advance directive] presupposes a categorical principle requiring us to respect the critical interests of others . . .”); Koppelman, *supra* note 180, at 68 (“Autonomy refers to one’s ability (and right) to express, confirm, or create a self (determine *who one is*) through choice and action.”).

188. Koppelman, *supra* note 180, at 71; see also Holm, *supra* note 185, at 157 (“Dworkin . . . argues that while severely demented persons may still have experiential interests, they cannot have or, perhaps more precisely, cannot form critical interests.”).

189. See Francis, *supra* note 183, at 573 (“Ronald Dworkin takes a hard line in favor of precedent autonomy: that unless the later expressions reflect reasoned decisions, respect for autonomy requires following the advance directive.”); Koppelman, *supra* note 180, at 67 (“Character theorists, such as Ronald Dworkin, suggest that the self whose interests must be respected is the . . . self that was created and nurtured by the patient when she was able.”); see also Berger, *supra* note 19, at 311 (“Precedent autonomy is the manifestation of the patient’s pre-dementia, long-held life values in post-dementia decisions.”).

190. See Koppelman, *supra* note 180, at 70 (explaining that character theorists believe that critical interests “are what enable us to have control over the expression and creation of our selves”).

191. Rebecca Dresser, *Confronting the “Near Irrelevance” of Advance Directives*, 5 J. CLINICAL ETHICS 55, 56 (1994) (noting that even advance directives with respect to medical conditions and treatments “are relatively rare, usually vague, and frequently uninformed by the realities of the patient’s current status”); Daniel P. Hickey, *The Disutility of Advance Directives: We Know the Problems, but Are There Solutions?*, 36 J. HEALTH L. 455, 456 (2003) (noting that with respect to end-of-life care, only between “five percent and twenty-five percent of the adult population” have completed an advanced directive”).

beliefs and values. Families are usually good surrogate decisionmakers because they care about the patient and know him well.¹⁹² Elderly patients also often prefer having family involved in decisionmaking.¹⁹³

However, there are several studies documenting that family members—even those who were chosen by the patient to be surrogate decisionmakers—are often inaccurate in predicting what the patient would choose when confronted with a specific situation.¹⁹⁴ This may be partially due to a family's emotional interest in believing that a family member has values similar to its own.¹⁹⁵

The potential for family members to have a distorted perception of a patient's values may be even more of an issue when dealing with an adulterous relationship and all the emotion that situation entails.¹⁹⁶ When confronting adultery, a wife may be especially likely to assess her demented husband's values, when competent, as being similar to her own.¹⁹⁷

192. High, *supra* note 115, at 86 (noting that family members make good surrogates because they are “likely . . . concerned about the good of the elderly patient, and often will be the best source of information regarding the patient's wishes, preferences and personal value history”).

193. *Id.* (“[E]lderly patients usually prefer that family members . . . become their surrogates.”).

194. Sunil Kothari & Kristi Kirschner, *Decision-Making Capacity After TBI: Clinical Assessment and Ethical Implications*, in *BRAIN INJURY MEDICINE: PRINCIPLES AND PRACTICE* 1216 (Nathan D. Zaser et al. eds., 2007) (“Even when the surrogates felt confident that they knew what their families would want, these studies revealed a poor correlation between the surrogate's decisions and the patient's actual preferences.”); Mary Coombs, *Schiavo: The Road Not Taken*, 61 U. MIAMI L. REV. 539, 576 (2007) (noting that, in a number of studies “comparing the choices people made for themselves and those of their surrogates [usually spouses and adult children], they agreed between sixty and seventy percent of the time”); see also *Cruzan v. Dir., Mo. Dept. of Health*, 497 U.S. 261, 286 (1990) (“[T]here is no automatic assurance that the view of close family members will necessarily be the same as the patient's would have been had she been confronted with the prospect of her situation when competent.”).

195. Coombs, *supra* note 194, at 581 (“[W]itnesses are likely . . . to be family members or close friends whose perceptions and memories are likely colored by their own beliefs about what they want for the patient and, thus, believe the patient must have wanted for herself.”); Jeanie Kayser-Jones & Marshall B. Kapp, *Advocacy for the Mentally Impaired Elderly: A Case Study Analysis*, 14 AM. J.L. & Med. 353, 365 (1989) (noting that the emotional interests of family members “may conflict—consciously or subconsciously—with the preferences and best interests of the [nursing home] resident”); Marah Stith, *The Semblance of Autonomy: Treatment of Persons with Disabilities Under the Uniform Health-Care Decisions Act*, 22 ISSUES L. & MED. 39, 59 (2006) (“[F]amily proxies may be unable to isolate a patient's preferences from their own, even if they attempt to do so”).

196. Casta-Kaufteil, *supra* note 14, at 75 (noting that substituted judgment may be a problem “due to family members' reluctance to accept their parents and grandparents as sexual creatures”).

197. The wife's emotions in this situation may be especially strong because she may suffer the “double affront” of having her husband not know her and yet be able to be intimate with someone else. See Bonifazi, *supra* note 50, at 26 (quoting a social work supervisor, “It's difficult to be subject to the losses and ravages of [dementia]. It's egregious to deal with a [demented family member's] bond to another person.”).

Nursing homes have strong incentives to favor the spouse's views. Nursing homes are concerned about liability, and the demented nursing home resident, unlike his competent spouse, generally lacks the "energy, competence, or financial means" to assert his rights.¹⁹⁸ Family members may also devalue the interests of the incompetent resident and defer to the competent spouse to protect her feelings. Thus, not only is it difficult to accurately assess prior values, but where adultery is concerned, the biases in the system favor relying on the opinion of the non-resident spouse.

More importantly, a person's values and desires may change so much with disability that it no longer makes sense to base decisions on the person's prior values. It is difficult for any of us to accurately predict how we would feel with a given disability.¹⁹⁹ Indeed, "there is a large body of evidence that documents how the able-bodied, including clinicians, significantly underestimate the quality of life possible after a disability, even when they live with someone with a severe disability."²⁰⁰ The disabled often find pleasures in life that they never expected.²⁰¹

Because a non-disabled person cannot fully understand what life will be like with a disability, values formed before the person became disabled should not control.²⁰² Respecting prior values may prevent the current disabled person from having his or her needs and desires met. For example, it was easy for our hypothetical married resident to decide, when competent, that if he was demented and in an adulterous relationship to which his spouse objected, the relationship should end. He might feel very differently if he was actually demented and facing years of loneliness in a nursing home.

Rebecca Dresser goes even further and argues that prior values should not

198. Casta-Kaufteil, *supra* note 14, at 76.

199. See Kothari & Kirschner, *supra* note 194, at 1216 ("We all find it difficult, beforehand, to accurately imagine a condition significantly different from our own."); Stith, *supra* note 195, at 52 ("It is implausible to expect an able-bodied person fully to have or even understand the perspective she later may have when disabled.").

200. Kothari & Kirschner, *supra* note 194, at 1216 (citations omitted).

201. Barnes, *supra* note 15, at 742 ("An existence that seems demeaning and abhorrent to the competent patient yet may be valuable when it is all of life that remains."); Coombs, *supra* note 194, at 572 ("Advocates for the disabled note that studies seem to suggest that persons with quite limited cognitive and physical capacity to control or even interact with their environment find significant subjective pleasure in those activities and experiences that remain open to them."); Stith, *supra* note 195, at 61 ("[P]atients in a state of even extremely limited capacity may discover new, unexpected reasons to stay alive.").

202. See Barnes, *supra* note 15, at 741-42 ("[T]here is room for doubt that the incompetent patient's own treatment choice . . . would follow or include the preferences expressed when competent. Such patients would make choices that reflect their current and future interests as incompetent, severely physically incapacitated individuals, no longer involved in the pursuits of work, friendships, or good health that are paramount for most competent persons."); Stith, *supra* note 195, at 52 ("The views of the able-bodied people and people with disabilities may be very different.").

control if a person has dementia because the demented patient is not the same person that he or she was when competent.²⁰³ In reaching this conclusion, she relies on Derek Parfit's view that personal identity is linked to psychological continuity and connectedness.²⁰⁴ Although people develop and change as life goes on, they maintain their personal identities through the continuity or connectedness of their "memories, intentions, thoughts, sensations, beliefs and desires."²⁰⁵ Parfit believes that if, through disease or injury, there is sufficient disruption in memory or other psychological connections, the individual is no longer the same person. He or she essentially becomes a new and different self.²⁰⁶

Dresser applies Parfit's theories to individuals with dementia.²⁰⁷ She posits that if dementia causes severe loss of memory or other radical changes in a person's capacities, needs, and desires, the demented patient essentially becomes a different person.²⁰⁸ Basing decisions for demented patients on values they formed when competent would, therefore, be like having unrelated strangers make decisions for them.²⁰⁹ For this reason, Dresser and the experiential theorists believe that the demented patients' experiential interests—or contemporary preferences—should control, rather than the critical interests formed when they were competent.

Some theorists maintain that if the psychological continuity theory were applied to all incompetents, then no advance directives would ever be valid because advance directives are used only when the patient becomes incompetent and therefore, arguably, a different person.²¹⁰ Dresser counters that there are

203. Harvey, *supra* note 17, at 47-48 ("Dresser maintains that the formerly competent patient who authored an [advance directive] and the currently demented patient who now exists are different persons.").

204. See Julian C. Hughes, *Views of the Person with Dementia*, 27 J. MED. ETHICS 86, 87 (2001).

205. *Id.*

206. *Id.* at 89 ("[I]f a person's thoughts at one time are disconnected from his or her thoughts at another, for instance because of problems of memory, Locke and Parfit would claim that the person is, properly speaking, not one, but two.").

207. See Harvey, *supra* note 17, at 53 (noting that Dresser "draw[s] on Derek Parfit's psychological continuity thesis concerning the nature of the self").

208. *Id.* (noting that Dresser believes that "for the same self/person to exist over time a sufficient number of appropriate psychological connections, particularly in the form of memories, must obtain"); see also DeGrazia, *supra* note 172, at 378 ("In some cases . . . a demented patient will have such weak psychological connections with the pre-dementia person in question that the two are literally different persons."); Francis, *supra* note 183, at 575 ("This 'different person' argument draws on a view of personal identity developed by Derek Parfit, that identity consists in psychological connectedness.").

209. Francis, *supra* note 183, at 575 ("If the patient with Alzheimer's is genuinely 'no longer himself,' the directives of precedent autonomy are as irrelevant to him as are the choices of an entirely different human being.").

210. Harvey, *supra* note 17, at 54 ("[I]f psychological 'connectiveness' is wholly constitutive

different concerns with dementia because it is perhaps the only disease where a person can be content and have pleasurable experiences for a long time between competency and death.²¹¹ The demented patient's pleasurable experiences may, therefore, have great value.

Dresser uses Margo, a hypothetical demented woman, as an example of the danger of relying on precedent autonomy to make decisions for demented patients.²¹² Margo is severely, but pleurably, demented.²¹³ She enjoys "basking in the sun, eating peanut butter and jelly sandwiches, randomly thumbing through books, and painting sets of circles on paper."²¹⁴ When competent, she executed an advance directive requesting that no medical procedures be used to prolong her life "in her demented state."²¹⁵ Margo now has pneumonia.²¹⁶ She can easily be cured with antibiotics and will die without them.²¹⁷ Dworkin argues that the advance directive should be followed and that no antibiotics should be administered.²¹⁸ Dresser believes that Margo's experiential interests should be given precedence and that there would be egregious harm to Margo if her prior directives were to control.²¹⁹

Dresser's theories have considerable moral weight. Demented patients are human beings "capable of pleasure and pain—who here and now" have needs to fulfill.²²⁰ It seems wrong to deny these needs based on values no longer held by the patient. Applying this reasoning to our adultery hypothetical, it seems cruel to deprive a demented patient of a meaningful and intimate relationship in a nursing home based on a marriage he does not even know exists.

Given these concerns, Dresser and the experiential theorists advocate the use of the best interests test in making decisions for demented patients.²²¹ This test

of personal identity then . . . [s]eemingly no [advance directives] would be valid since such devices only come into play when their author is rendered incompetent by disease or injury.") (emphasis omitted).

211. *Id.* at 56 (finding dementia unique because "in the case of most diseases, pleasurable experiential states between competency and death do not obtain").

212. *Id.* at 52 (noting that Dworkin first discussed Margo, a "severely demented individual").

213. *Id.*

214. *Id.*

215. *Id.*

216. *Id.*

217. *Id.*

218. *See id.*

219. *Id.* at 56 ("Dresser concludes that Margo's [advance directive] ought to be overridden (or at least to remain inoperative until Stage 4) . . . [because] failing to follow the Best Interest Standard in this instance would allow an avoidable and egregious harm to befall Margo.").

220. Francis, *supra* note 183, at 578 (quoting Agnieszka Jaworska, *Respecting the Margins of Agency: Alzheimer's Patients and the Capacity to Value*, 28 PHIL. & PUB. AFF. 105, 108 (1999)); *see also* Koppelman, *supra* note 180, at 75 ("We have compassion and human empathy for the *now self* . . . the . . . patient is still an individual who deserves to be treated with respect and dignity.") (citation omitted).

221. *See* Harvey, *supra* note 17, at 48 (noting that Dresser advocates the best interests

focuses on the present and future experiential interests of the patient, rather than on the critical interests of the past.²²²

D. Best Interests

Perhaps the best choice for dealing with our hypothetical adulterous nursing home resident would be to use the best interests test. This test requires that the nursing home make decisions based on what would benefit the resident the most and cause the least amount of harm.²²³ Factors to consider include the resident's "health, safety, and well-being."²²⁴ The best interests test is objective and relies on what a hypothetical average citizen or reasonable person would choose.²²⁵ It does not take the patient's individual preferences into account.²²⁶

But there are also serious problems with this test. One of the biggest problems is objectivity. It is almost impossible for a substitute decisionmaker to take his or her own values and beliefs out of the decision-making process.²²⁷ Problems with bias are of particular concern where personal, intimate relationships are involved. It is hard to imagine an exercise more difficult—and more connected to our values and beliefs—than determining the importance of an intimate relationship to another's life and well-being.²²⁸

standard).

222. *Id.* at 57 (noting that the best interest standard "requires us to look to the present and particularly the future to insure that the severely demented . . . have their pleasurable experiential interests sustained and their painful experiential interests minimized, and where possible, eliminated").

223. *See High, supra* note 115, at 88 (noting that the best interests test is based on benefitting and not harming "the patient according to socially shared values of a hypothetical average person"); *Holm, supra* note 185, at 156 (explaining that, in using the best interests test, "[W]e prevent actions based on desires that are detrimental to the best interest of the person in question, and promote actions based on desires that are beneficial").

224. *Barnes, supra* note 15, at 738; *see also High, supra* note 115, at 88 (noting that, in determining best interests, objective factors to be considered include "prolongation of life, pain and suffering, quality of life, success of treatment and restoration to normal functioning").

225. *High, supra* note 115, at 88 (noting that, in using the best interests test, "[s]urrogates are . . . obliged to focus on the patient's presumed interests as measured by the hypothetical average citizen or reasonable person").

226. *Id.* (noting that the best interests test does not necessarily "reflect the patient's own preferences"); *Lebit, supra* note 174, at 115 (noting that the Louisiana Court of Appeals "recognized that best interests is a standard based on 'benefit' while substituted judgment is based on personal preference").

227. *See, e.g., Kothari & Kirschner, supra* note 194, at 1216 (discussing the best interest standard and noting that "a family member . . . may unconsciously project her own beliefs or values into the situation"); *Quinn, supra* note 175, at 900 (asking "how the surrogate decisionmaker is to determine the best interests of an incompetent patient whose wishes cannot be known without imposing his or her own values on the decisionmaking process.") (citation omitted).

228. *Barnes, supra* note 15, at 724 ("The nature of lifestyle and associations is as intensely

The potential harm of biased decisionmaking is highlighted by our adultery hypothetical. When deciding whether to allow the married resident's relationship to continue, the nursing home administrators and staff may believe that it is more important to the resident's well-being to have family members visit regularly, and feel comfortable doing so, than for the resident to have a relationship with another demented patient. This assessment may even be likely because the able-bodied tend to devalue the quality of life of the disabled,²²⁹ some administrators and staff may have moral and religious objections to adulterous relationships,²³⁰ and nursing homes have strong incentives to cater to families.²³¹ The nursing home may use its assessment to end the relationship even though the resident may not recognize his family and may derive enormous personal satisfaction from his adulterous relationship.

That leads to the next problem associated with the best interests test. Basing the resident's fate on the decisionmaker's "assessment[] of what a reasonable individual would choose" robs the resident of his ability to make his own choices about his lifestyle and values.²³² It elevates the decisionmaker's assessment above the incompetent resident's own personal feelings about his life and future.²³³ In this way, it limits his liberty and deprives him of respect and dignity.²³⁴

For these reasons, the best interests test should be used only when a person is so incapacitated that he lacks the competence to make the specific decision in question. Agnieszka Jaworska, a noted philosopher, agrees. She believes that demented patients maintain some capacity to make autonomous choices and that,

personal as bodily integrity in acute care. . . .").

229. See *supra* note 200 and accompanying text.

230. See *supra* notes 105-10 and accompanying text.

231. See *supra* note 198 and accompanying text.

232. *Curran v. Bosze*, 566 N.E.2d 1319, 1324 (Ill. 1990) (referring to the use of the best interests test in medical treatment cases and noting that it "elevat[es] other parties' assessments of the meaning and value of life—or, at least, their assessments of what a reasonable individual would choose—over the affected individual's own common law right to refuse medical treatment"); see also *Barnes*, *supra* note 15, at 674 ("[T]he beneficence-only model is inappropriate for all but the never-competent and the completely incapacitated person because this model de-emphasizes to the point of extinction the person's own point of view and participation in determining his or her own fate."); *Kothari & Kirschner*, *supra* note 194, at 1206 ("[E]ven if a person's choice is not in her best interest, the legal and ethical consensus is that her free exercise of will is more important than preventing any harm that may result to her from the choice made.").

233. See *Holm*, *supra* note 185, at 156 (noting that "the range of the person's liberty is restricted [by the best interest test] to those desires and choices that are either beneficial to him, according to the assessment of others, or inconsequential").

234. See *Barnes*, *supra* note 15, at 678 ("[S]ubstitute decision-making has a severe effect on personal liberty and cannot be considered entirely good so long as the individual has some capacity to determine his or her own actions."); *id.* at 736 ("The restriction of liberty created by appointment of a substitute decision-maker is severe"); *Koppelman*, *supra* note 180, at 79 (explaining that "an objective standard . . . fails to treat the patient with dignity and integrity").

to the extent possible, these choices should be respected.²³⁵

Jaworska claims that both Dworkin and Dresser are misguided because their theories are grounded in the belief that severely demented patients can no longer form critical interests or maintain consistent goals.²³⁶ Based on this premise, Dworkin and Dresser decide between favoring the critical interests of the prior—or then—self or the experiential interests of the now self.²³⁷

Jaworska points out that, except in the very late stages of dementia, patients are capable of complex thought and maintain a sense of what is of value to them beyond mere experiential pleasures.²³⁸ She describes patients with moderate and

235. See Jaworska, *supra* note 220, at 109.

236. *Id.*; see also Francis, *supra* note 183, at 573 (noting that Jaworska contends that “Dworkin is just wrong in asserting that the expressions of wishes by persons with dementia are characteristically fleeting, conflicting, or absent a link to identity”); Koppelman, *supra* note 180, at 80-81 (explaining that Jaworska believes that “the capacity to express critical interests . . . [lasts] long into the progression of [the] disease . . . [and that] [t]here are typically considerable moments of continuity between the *now self* and the *then self*”).

237. Koppelman, *supra* note 180, at 80 (“The theoretical discussion between character and experiential theorists suggests that the capacity to formulate and express critical interests is quickly lost in [Alzheimer’s] patients leaving only the expression of experiential interests. And this leads theorists to believe they have to choose which aspect of the self to emphasize . . .”). Some scholars advocate dealing with this problem by combining substituted judgment and best interests. See *id.* at 81 (“The desires, likes, and dislikes of the *now self* and the character of the *then self* should be integrated in an attempt to determine how the [Alzheimer’s] patient should be treated[,] . . . [because doing so] properly balance[s] the two aspects of a complete self.”); see also Coombs, *supra* note 194, at 584 n.202 (noting that “although the substituted judgment and best interest tests are often stated separately, ‘the tests should be viewed not as a dichotomy, but as a continuum of subjective and objective information about the patient that will support a reliable decision’”) (quoting Stewart G. Pollack, *Life and Death Decisions: Who Makes Them and by What Standards?*, 41 RUTGERS L. REV. 505, 518 (1989)). Some statutes also link best interests and prior values. MD. CODE ANN., HEALTH-GEN. § 5-601(e)(7) (West 2009) (“‘Best interest’ means that the benefits to the individual resulting from a treatment outweigh the burdens to the individual resulting from that treatment, taking into account . . . [t]he religious beliefs and basic values of the individual receiving treatment, to the extent these may assist the decision maker in determining best interest.”); N.Y. MENTAL HYG. LAW § 80.01 (McKinney 2006) (“[I]n cases involving persons with impaired decision-making capacity, efforts should be made to ensure that health care decisions are based on the best interests of the patient and reflect, to the extent possible, the patient’s own personal beliefs and values.”); UNIFORM HEALTH-CARE DECISIONS ACT § 2(e) (1993) (“In determining the principal’s best interest, the agent shall consider the principal’s personal values to the extent known to the agent.”).

238. See Coombs, *supra* note 194, at 572 n.157 (“Jaworska persuasively argues that many persons with significant loss of cognitive capacity . . . value certain activities and ways of being, not merely for their immediate experiential pleasure but because they express people’s sense of who they are.”) (citation omitted); see also Francis, *supra* note 183, at 546 (noting that cognitive deficits in demented patients, including the ability “to formulate the abstractions involved in having values . . . are not . . . predictably uniform among patients”); *id.* at 573 (explaining that some patients with

severe dementia who demonstrate a stable set of values through their behavior.²³⁹ For example, she tells of demented patients who consistently show “the desire to help others, the desire to remain independent, the desire not to go to day care, or the desire not to die.”²⁴⁰ She contends that this ability to value requires that we respect the demented patient’s current autonomous wishes.²⁴¹

Jaworska’s theories are consistent with the view that patients should be allowed to make their own decisions, except in those areas where they lack functional competence. Applying this to our hypothetical married resident, perhaps we should conclude that he has the functional competence to decide that his current relationship should continue. Because he has a stable relationship in the nursing home, he is arguably demonstrating, through his consistent behavior, that his relationship has value to him beyond mere experiential pleasure.

E. Functional Competence

Most courts no longer assess competence by making a single, global decision that a person is competent or incompetent.²⁴² Instead, they assess functional competence, which allows them to determine that a person is incompetent in some areas but not others.²⁴³ An individual with cognitive deficits may not be competent to handle complex financial transactions, but may be perfectly capable of purchasing groceries.²⁴⁴ By limiting the determination of incompetency to the

“moderate to severe dementia . . . evidence values through their behavior”); Holm, *supra* note 185, at 153 (“Except in the very late . . . stages of dementia such persons still have wishes and desires with a complex cognitive nature.”).

239. Francis, *supra* note 183, at 573-74.

240. *Id.*

241. *Id.* at 573 (“In Jaworska’s view, the capacity to value is what is critical to autonomy.”). *But see* Coombs, *supra* note 194, at 572 n.157 (noting that Jaworska does not necessarily believe a patient’s current wishes should be followed “if they are internally inconsistent or conflict with prior autonomous choices because of defects in current reasoning capacity”).

242. Francis, *supra* note 183, at 546 (“In determining the need for guardianship, courts have been moving away from a focus on incapacities generally, to more specific consideration of whether patients lack the capacities . . . to make reasoned decisions for their [medical] care.”); Michael L. Perlin, *Hospitalized Patients and the Right to Sexual Interaction: Beyond the Last Frontier*, 20 N.Y.U. REV. L. 7 SOC. CHANGE 517, 542 (1994) (“Almost all courts adhere to the catechism that competency is not a unitary status and that an individual may be competent for one activity, but not for another.”); *see also* Holm, *supra* note 185, at 154 (“Incompetence as an ethical category is thus not a feature primarily of certain kinds of persons but of certain kinds of decisions.”).

243. *See* sources cited *supra* note 242.

244. Steven A. Levenson, *Evaluating Competence and Decision-Making Capacity in Impaired Older Patients*, THE OLDER PATIENT, Winter 1990, at 11, 12 (explaining that, using functional competence determinations, “the determination that an individual is incompetent for certain purposes (such as selling property) does not necessarily mean that he is incompetent for other purposes (such as purchasing groceries)”); Richardson & Lazur, *supra* note 49, at 123 (noting that “a patient with early dementia may not be able to render informed consent to an operation that has

area where the individual cannot function—financial transactions—the court maximizes the patient’s autonomy by allowing him to maintain control over other aspects of his life, such as purchasing groceries.²⁴⁵

Competency decisions are technically made only by the courts,²⁴⁶ not by clinicians.²⁴⁷ However, clinicians regularly make similar determinations.²⁴⁸ For ease of reference, both types of decisions will be referred to as determining functional competence.

Over the past twenty-five years, many state legislatures have recognized the importance of focusing on functional competence²⁴⁹ and have revised their guardianship laws accordingly.²⁵⁰ The concept of maximizing patient autonomy has also been extended to long-term care facilities,²⁵¹ which are required to provide care in a manner that least restricts the independence and freedom of their residents.²⁵²

a significant risk of death but may be able to decide what flavor ice cream he would like for dessert”).

245. Kothari & Kirschner, *supra* note 194, at 1206 (“If a person is competent, we want to make sure that we do not infringe on their ethical and legal right to control their own life.”).

246. *Id.* (“[C]ompetency’ is a *legal* category [and] . . . only a court can find someone incompetent in a particular area”).

247. *Id.* (“[C]linicians . . . assess the decision making capacities of . . . patients, not their competence.”).

248. *Id.* (noting that if all decisions concerning capacity were made by the courts, “this would overwhelm the legal system. In the vast majority of cases, [decisions concerning capacity] can and should be made by clinicians”).

249. Barnes, *supra* note 15, at 636-37 (“Many jurisdictions have reviewed their guardianship laws in the past decade . . . to provide more legal rights to preserve remaining autonomy for wards and prospective wards . . .”); *see, e.g.*, N.Y. MENTALHYG. LAW § 81.01 (McKinney 2006) (stating the legislature declared it was “establishing a guardianship system . . . which takes in account the personal wishes, preferences and desires of the person, and which affords the person the greatest amount of independence and self-determination and participation in all the decisions affecting such person’s life”).

250. *See, e.g.*, N.Y. MENTALHYG. LAW § 81.01 Practice Commentaries, at 7 (McKinney 2006) (noting that the “most significant change” in New York’s guardianship law is its “focus[] on the functional ability of the person alleged to be in need of a guardian”). Florida’s limited guardianship statute requires the court to find and list “[t]he exact nature and scope of a person’s incapacities” and “[t]he specific rights that the person is incapable of exercising.” FLA. STAT. ANN. § 744.331(6)(a)(1), (4) (West 2005 & Supp. 2009).

251. Mental Health Systems Act, 42 U.S.C. § 9501(1)(A), (F), (G), (J) (2000 & Supp. 2005) (requiring that all state mental health facilities and programs provide treatment in a manner that least restricts patients’ rights); *Foy v. Greenblott*, 190 Cal. Rptr. 84, 91 n.2 (Ct. App. 1983) (“Numerous courts have found a federal constitutional right to the least restrictive conditions of institutional treatment.”).

252. *See Foy*, 190 Cal. Rptr. at 90 (“Every institutionalized person is entitled to individualized treatment under the ‘least restrictive’ conditions feasible—the institution should minimize interference with a patient’s individual autonomy . . .”); Barnes, *supra* note 15, at 742 (“An

Focusing on functional competence is particularly important to residents with dementia. Cognitive deficiencies with dementia can vary greatly from one person to another.²⁵³ Some demented residents, who would be deemed globally incompetent, have “large islands of competence.”²⁵⁴

The nursing home should, therefore, not simply declare our hypothetical married resident globally incompetent, but rather should assess whether he is functionally competent to decide whether his adulterous relationship should continue. Before that decision can be made, however, the home would have to know what that finding would entail. There are few standards for making a determination of functional competence, and most of the standards that do exist relate to end-of-life decisionmaking.²⁵⁵ There is almost no guidance concerning decisionmaking capacity to enter into intimate relationships.

F. A Test for Determining Whether an Adulterous or Other Sexual Relationship Should Continue

Based on the limited guidance available, this Article suggests a four-step approach for deciding whether our hypothetical married resident should continue his adulterous relationship. The first three steps enable the nursing home to determine if the resident is functionally competent to make this decision himself. The fourth step provides guidance to the nursing home if the resident is deemed incompetent to make this decision.

The first step is to determine whether the resident has the ability to express his or her desires. This threshold issue is of particular concern with dementia patients because the condition gradually robs them of their ability to communicate; thus, their communication skills may not accurately reflect their abilities.²⁵⁶ The fast pace of everyday conversation exacerbates this problem.²⁵⁷

individual’s best interests in long term care, for example, have been identified as the least restrictive form of care that meets the individual’s needs.”); *see also* Levenson, *supra* note 244, at 12 (“[H]ealth care facilities . . . should focus on *decision-making capacity* . . . rather than on global competence.”).

253. Kamel & Hajjar, *Part 2, supra* note 33, at 205 (noting that with dementia, “each case must be individualized” and “when you have seen one case, you have only seen one case”).

254. Holm, *supra* note 185, at 153-54; *see also* Stith, *supra* note 195, at 62 (“[A] single standard of capacity promises only an illusion of clarity and may cost people with disabilities their autonomy.”).

255. Levenson, *supra* note 244, at 11 (“Determining whether an older person with significant physical and/or mental impairment is competent to make vital decisions is indeed a challenge for physicians and other health professionals.”); Bernard Lo, *Assessing Decision-Making Capacity*, 18 *LAW MED. & HEALTH CARE*, Fall 1990, at 193, 193 (“There are few explicit legal standards for judging competency to make medical decisions.”); *see also* Holm, *supra* note 185, at 154 (“[N]o amount of rules will ever allow us to distinguish between competently and non-competently formed desires and decisions in the large gray zone between the obviously competent and the clearly incompetent.”).

256. *See* Barnes, *supra* note 15, at 648 (noting that “the needs and abilities of elderly people

But this issue need not be a major concern because desires need not be communicated orally; they can be communicated through a consistent pattern of behavior.²⁵⁸ Our hypothetical married resident is in a stable relationship, which both members of the couple apparently enjoy. This should be sufficient to satisfy the first step of functional competence.

The second step is to determine what critical interests or values might be affected by acting on these desires. To have functional competence, the resident should understand the consequences and implications of his decision,²⁵⁹ especially if it impacts important life values and goals.²⁶⁰ Therefore, in dealing with our hypothetical resident, the nursing home must determine the values that might be implicated by having an adulterous relationship.²⁶¹

In this case, the relevant values would include the resident's interest in protecting his family's feelings, protecting the way he wants to be remembered, and his religious beliefs. Family feelings have been considered an important interest in discussions of end-of-life decisionmaking.²⁶² Surveys of seriously ill patients demonstrate that they "show strong concern for the physical and

are poorly understood [and] Alzheimer's disease patients, cut off by their growing inability to communicate with others, receive still less understanding"); Francis, *supra* note 183, at 547-48 (explaining that "[p]atients with dementia . . . may experience difficulties in communication that do not fully reflect their underlying abilities to make choices and express their wishes").

257. Francis, *supra* note 183, at 548; *see also* Barnes, *supra* note 15, at 648 (noting that "Many elderly [patients] cannot express their wishes quickly or well").

258. *See* Francis, *supra* note 183, at 581 (noting Dresser contends that "[w]hen patients cannot communicate preferences directly, . . . [o]ne strategy is to extrapolate preferences from behavior"); *see also In re Guardianship of Ingram*, 689 P.2d 1363, 1371 (Wash. 1984) (noting with respect to medical decisionmaking that "[i]f the ward, despite her inability to understand her needs, is persistent and determined in her preference, it should be given additional weight in the determination"); ABA COMM. ON L. & AGING & AM. PSYCHOL. ASS'N, *supra* note 16, at 12 ("Expressing a choice is the ability to communicate a consistent decision about treatment.") (emphasis omitted); Lo, *supra* note 255, at 195 (noting that, in assessing decision-making capacity, "[t]he patient's decision should be stable over time").

259. *See* Amy M. Haddad, *Determining Competency*, J. GERONTOLOGICAL NURSING, June 1988, at 19, 21 (noting that a "criterion for determining competency is to confirm the patient's ability to understand the implications and consequences of the choices that are made"); Kane, *supra* note 68, at 67 (noting that medical decision-making capacity "depends on the ability to . . . appreciate the implications of the various alternatives").

260. Kothari & Kirschner, *supra* note 194, at 1208 (noting that to assess medical decision-making capacity, "a patient needs to relate the various possible outcomes to their own values" and "need to be able to imagine . . . the consequences of the various options").

261. Berger, *supra* note 19, at 311 (mentioning the importance of "appreciat[ing] the consequences of a decision to be sexually active").

262. There is some debate about whether the impact of end-of-life decisionmaking on family members should be taken into consideration. Doing so "shifts the moral focus away from the patient." Francis, *supra* note 183, at 590.

emotional burdens imposed on surrounding loved ones.”²⁶³ These findings have been confirmed by The New York State Task Force on Life and the Law, which found “such strong solicitude [by patients] for their immediate families [that] they would want such interests considered.”²⁶⁴ Family feelings are also potentially important in our adultery hypothetical. If our hypothetical married resident was devoted to his wife for many years before entering the nursing home, we can assume that his fidelity and her feelings if he violated their marital vows, might be important to him.

The importance of being remembered in a certain way has also been discussed in conjunction with end-of-life decisionmaking. As Justice Stevens wrote, “[e]ach of us has an interest in the kind of memories that will survive after death.”²⁶⁵ People care about the memories they leave behind and about how their loved ones will remember them.²⁶⁶ Our hypothetical married resident might prefer not to be remembered as an adulterer. He may want his wife and children to remember him as a moral, caring, and devoted family member, not someone who began an adulterous relationship in his waning years.

Religion is also an important value. The United States is a very religious nation. According to the 2001 American Religious Identification Survey, eighty-one percent of American adults identify themselves as part of some religious group.²⁶⁷ In all three of the major U.S. religions, adultery is forbidden.²⁶⁸ Our hypothetical nursing home resident might, therefore, have a strong interest in being faithful to his religion.

Once the global critical interests have been identified, the next step is to determine if the resident can adequately consider these interests in making his decision. He need not find any particular interest important to him, but he must

263. Norman L. Cantor, *The Bane of Surrogate Decision-Making Defining the Best Interests of Never-Competent Persons*, 26 J. LEGAL MED. 155, 197 (2005).

264. *Id.* (citing N.Y. STATE TASK FORCE ON LIFE AND THE LAW, WHEN OTHERS MUST CHOOSE: DECIDING FOR PATIENTS WITHOUT CAPACITY 109 (1992)).

265. *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 356 (1990) (Stevens, J., dissenting); see also *Washington v. Glucksberg*, 521 U.S. 702, 743 (1997) (Stevens, J., concurring) (mentioning a person’s interest in “determining the character of the memories that will survive long after her death”).

266. Cantor, *supra* note 263, at 168-69 (“[P]eople care about the image and memories they will leave behind, images in the minds of loved ones that may be soiled by the patient’s extreme mental and physical deterioration during the dying process.”); Francis, *supra* note 183, at 576 (“[People] have interests in how they will be remembered by others, memories that will surely be affected by the character of their dying process”).

267. BARRY A. KOSMIN ET AL., AMERICAN RELIGIOUS IDENTIFICATION SURVEY, at 10 (2001), available at http://www.gc.cuny.edu/faculty/research_briefs/aris.pdf.

268. Indeed, the Bible consistently renounces adultery. See, e.g., *Exodus* 20:14 (King James) (“Thou shalt not commit adultery.”); *Hebrews* 13:4 (King James) (“Marriage is honorable in all, and the bed undefiled; but . . . adulterers God will judge.”). Islam takes a similar view. See *The Qur’ān* 17:32 (Abdullah Yusuf Ali trans., 2001) (“Nor come nigh to adultery: For it is a shameful (deed) [a]nd an evil, opening the road ([t]o other evils).”).

be able to understand what the interests are and the consequences of his decision. If our nursing home resident can do this, then he should be considered functionally competent to decide for himself whether the adulterous relationship should continue. If he cannot, then the nursing home should move on to step four.

At this last step, the nursing home should decide whether the value of the intimate relationship to the resident outweighs the value of the critical interests affected. To begin this analysis, the nursing home must assess the value of the intimate relationship. The enormous value of intimate relationships has been discussed earlier in this Article.²⁶⁹ Some authors go even further and believe that our lives have no meaning without intimate relationships²⁷⁰ and that our ability to relate is “the defining characteristic of personhood.”²⁷¹ Given the importance of intimate relationships, especially in a nursing home setting, every possible inference should be made in favor of allowing the relationships to continue. Based on these general principles, we will assume that the adulterous relationship is extremely important to our hypothetical nursing home resident.²⁷²

The nursing home must next assess the value to the resident of the critical interests set forth above. In determining the value of the critical interests, the nursing home should not simply consider the patient’s beliefs when he was competent. Giving precedence to the critical interests formed when he was competent—as Dworkin suggests²⁷³—gives too much weight to beliefs established before the demented patient knew what his life would be like in a demented state. As previously stated, the able-bodied routinely underestimate the future quality of their lives with a disability and they often find pleasures that they never anticipated.²⁷⁴ Relying predominantly on prior critical interests binds a person’s fate to decisions that may have been formed when he was totally unaware of what his current needs would be.²⁷⁵

269. *See supra* Part II.

270. Harvey, *supra* note 17, at 49 (“[O]ur capacity to engage, both emotionally and cognitively, with other self-consciously aware human beings is what makes a distinctly human life worth living.”); Quinn, *supra* note 175, at 901 (arguing that “[t]he meaning and substance of life . . . is found in personal relationships”).

271. Quinn, *supra* note 175, at 930 (citing sources); *see also* Koppelman, *supra* note 180, at 81 (“The self cannot develop and cannot be nurtured and maintained without relationships.”).

272. According to Jaworska’s theories, the resident is also demonstrating a current critical interest in having the relationship continue. *See supra* note 238 and accompanying text. He has a stable relationship and is consistently showing, by his behavior, that it is of value to him. *See supra* note 258. Experiential interests should also be considered in determining the value of the relationship. *See supra* note 237.

273. *See, e.g.*, Harvey, *supra* note 17, at 52.

274. *See supra* notes 200-01 and accompanying text.

275. Stith, *supra* note 195, at 52 (noting that the President’s Council on Bioethics criticized advanced directives because they “allow a person to select a specific moment in time in which to record preferences that will dictate that person’s fate in a later disabled state . . . [and these] advance directives may not reflect a patient’s subsequent desires”).

Therefore, in deciding the value of these critical interests to the resident, the nursing home must consider the impact of the demented patient's current condition on the previously formed critical interests. This is much more important in dementia cases than in end-of-life decisionmaking, because the demented patient can live for a long time. Some critical interests are fluid and may be altered significantly based on changed circumstances.²⁷⁶

For example, as mentioned above, our hypothetical married resident may have had a critical interest, when competent, in his fidelity to his wife and in protecting her feelings. But the wife's role generally changes when her husband is placed in a nursing home. The married couple usually stops having sexual relations because "[it is] no longer the loving act that they once enjoyed."²⁷⁷ The wife often begins separating emotionally from her husband as she becomes more of a caregiver than a partner²⁷⁸ and "there is no longer any reciprocity in the relationship."²⁷⁹ With respect to our hypothetical married resident, he has demonstrated that his wife is no longer fulfilling his needs for intimacy. If she was, he would not be involved with another resident. Based on these changed circumstances, our hypothetical resident's prior critical interest in his wife's feelings may no longer be a substantial concern.

The resident's critical interest in the memories he will leave behind is also fluid. The family's memories of a demented resident are not as significant a concern as in end-of-life cases. In end-of-life cases, the patients are deciding only how to die, not how to live with a disease. The memories a demented patient can expect to leave behind will be colored by years of living with dementia. His choice may come down to being remembered as a depressed and lonely demented patient, who does not remember his family, or a happier one in an adulterous, but meaningful, relationship with another resident. Again, given these changed circumstances, his prior critical interest in these memories may not be a substantial concern.

The religious beliefs of the patient are perhaps the most difficult critical interest to assess. Our hypothetical married resident may have believed, when competent, that he should be faithful to his religion and that he would commit a mortal sin by engaging in adultery. But even this critical interest will be altered by his demented condition. In all three major religions, if the person is not aware that he is committing adultery, he is, at most, guilty of a minor offense.

Over three-quarters of American adults consider themselves members of the

276. Examples of critical interests that would not change with dementia might include providing money for a grandchild's education or wanting to provide a pension to a spouse. The character of these identity-defining interests does not change due to the nature of the condition. See, e.g., Harvey, *supra* note 17, at 58-59.

277. Bonifazi, *supra* note 50, at 28.

278. Davies, *supra* note 49, at 6 (noting that the common reasons for spouses to lose interest in sex and physical intimacy include "the patient's inability to identify the spouse or remember the spouse's name, the patient's incontinence or poor personal hygiene . . . , and the change in relationship roles such that the caregiver feels more like a parent than a spouse").

279. Wuest et al., *supra* note 64, at 442.

Christian religion.²⁸⁰ While there are numerous denominations and widely differing views within each Christian community, theological opinions can largely be drawn into two groups: Catholic and Protestant.²⁸¹

Under the Catechism of the Catholic Church, a “[m]ortal sin requires *full knowledge* . . . of the sinful character of the act [and] of its opposition to God’s law.”²⁸² Committing such a sin would be difficult, if not impossible, for a patient suffering from dementia, because the demented patient would lack the mental capacity to knowingly violate the dictates of his religion. A demented patient might be able to commit a venial sin,²⁸³ but both the gravity and punishment of venial sins are significantly less severe.²⁸⁴

Protestantism grew out of European Catholicism in the sixteenth century, based on the works of Martin Luther and John Calvin.²⁸⁵ The Protestant view of sin diverges substantially from Catholicism. For Protestants, sin is not an act, but rather a condition of human existence, a “hereditary depravity and corruption of our nature.”²⁸⁶ Therefore, according to Protestantism, sin is an inescapable reality of human life, neither voluntary nor involuntary. If sin is unavoidable, it would be difficult to measure the critical interest in avoiding it.

After Christianity, Judaism is the second largest religion in the United States.²⁸⁷ Issues of adultery and Alzheimer’s disease have been discussed by Rabbinical scholars throughout the last decade, but the issue is still unresolved.²⁸⁸ The Rabbinic authorities have, however, addressed the mental requirement of sin. The penalty for a transgression from any “commandment in the Torah . . . if committed wilfully, is *kareth* and, if committed unwittingly, a sin-offering.”²⁸⁹ Here, as in Catholicism, there is a distinction between sins committed intentionally and those committed without knowledge. While both transgressors

280. KOSMIN ET AL., *supra* note 267, at 12 (presenting statistics that 76.5% of American adults identify themselves as Christians).

281. U.S. CENSUS BUREAU, STATISTICAL ABSTRACT OF THE UNITED STATES: 2007, at 59 tbl.73 (2007).

282. See, e.g., CATECHISM OF THE CATHOLIC CHURCH ¶ 1859 (2d ed. 1997), available at <http://www.scborromeo.org/ccc/p3s1c1a8.htm>.

283. *Id.* ¶ 1855 (stating that venial sin is sin that “allows charity to subsist, even though it offends and wounds it”).

284. *Id.* ¶ 1854 (“Sins are rightly evaluated according to their gravity.”); *id.* ¶ 1875 (“Venial sin constitutes a moral disorder that is repairable by charity . . .”). By contrast, “those who die in a state of mortal sin descend into hell . . .” *Id.* ¶ 1035.

285. See CHRISTOPHER ELWOOD, CALVIN FOR ARMCHAIR THEOLOGIAN 6-7 (2002).

286. JEAN CALVIN, INSTITUTES OF THE CHRISTIAN RELIGION 251 (John T. McNeil ed., Ford Lewis Battles trans., Westminster John Knox Press 2001).

287. KOSMIN ET AL., *supra* note 267, at 13.

288. See, e.g., Lori Eppstein, *Alzheimer’s Can Shake Jewish Principles, Ethicist Says*, JEWISH NEWS WKLY. N. CAL., Feb. 27, 1998, available at http://www.jewishsf.com/content/2-0-/module/displaystory/story_id/8115/edition_id/154/format/html/displaystory.html.

289. *Babylonian Talmud: Tractate Yebamoth 9a*, available at http://www.come-and-hear.com/yebamoth/yebamoth_9.html.

are “guilty” of the offense, those who commit the sin without knowledge are guilty of a lesser offense and incur a lesser punishment.²⁹⁰

With respect to Islam, there are over one million Muslims in the United States.²⁹¹ In Islam, sexuality is the sacred act of procreation.²⁹² Marriage, or *nikah*, “gives sexuality a new significance.”²⁹³ The opposite of *nikah* is *zina*, roughly translated as fornication, which is strongly prohibited, to the point of being punishable by death.²⁹⁴ *Zina* includes several sexual taboos, the most serious of which is adultery.²⁹⁵ In order for adultery to be punishable, however, the offender must be “of age and possessing normal common sense.”²⁹⁶ While an adulterous act by a demented patient would be discouraged and described as “evil,”²⁹⁷ it is unlikely that it would be punishable under Islamic Law because the adulterer would lack “normal common sense.”

Thus, the critical interest of our hypothetical demented resident in avoiding the religious consequences of adultery are significantly lessened by his demented state. Because he does not know that he is married and having an adulterous relationship, he is significantly less culpable. Indeed, all of his critical interests are diminished due to the effect of dementia on his life.

Because intimacy is so vitally important to demented nursing home residents and because the patient’s critical interests in ending the adulterous relationship are likely to be significantly diminished due to the characteristics of dementia, the value of the intimate relationship will generally outweigh the value of the critical interests affected. The nursing home should, therefore, generally allow an intimate adulterous relationship to continue. Of course, there may be circumstances that would cause these critical interests to be given more weight or other factors that would cause this balance to work out differently. Each case must be evaluated on its own merits.

This balancing test can also be used to evaluate other types of adulterous and sexual relationships in the nursing home. For example, suppose a married nursing home resident has multiple short-term sexual relationships with different partners in the nursing home. Assume also that she and her partners apparently enjoy these relationships and that they are safe and nonabusive.²⁹⁸ Should the

290. According to the Bible, a “sin offering” is defined as a burnt offering made to atone for one’s sins. *Numbers* 15:27-28 (King James). An intentional sin is punishable by expulsion from the community. *Numbers* 15:30-31 (King James).

291. U.S. CENSUS BUREAU, *supra* note 281, at 59 tbl.73.

292. ABDELWAHAB BOUHDIBA, *SEXUALITY IN ISLAM* 14 (Alan Sheridan trans., Saqi Books 1998) (1975).

293. *Id.* at 15.

294. *Id.*

295. *Id.*

296. S. ABUL A’LA MAUDUDI, *THE MEANING OF THE QU’RĀN* 301-02 (A.A. Kamal ed., Ch. Muhammad Akbar trans., Islamic Publications Ltd. 1st rev. ed, 1999) (1977).

297. *Id.* at 291.

298. A nursing home would, of course, always have the responsibility to end relationships that are harmful to others.

nursing home discourage or encourage these relationships if the nonresident spouse objects? The short-term relationships would probably have less value to the resident than our hypothetical resident's stable relationship because these short-term relationships would be less likely to have the advantages derived from intimacy. The nursing home would, therefore, have less reason to encourage these relationships. Using the balancing test, the final evaluation would depend on the strength of the critical interests involved.

One of the goals of this Article was to find a very simple test for determining whether to encourage or discourage individual sexual relationships in a nursing home. It was hoped that a simple test would give residents more freedom to enjoy intimate relationships, while protecting the nursing home from liability. But the issue of adultery in the nursing home is not simple, which makes it necessary to weigh the various interests, with special attention to the circumstances of each case.²⁹⁹ Perhaps this is better than a simple test. The balancing test gives the nursing home guidance on how to evaluate the specific critical interests involved, while still allowing the home to tailor each decision to the unique life story of an individual resident.

CONCLUSION

Most cognitively normal people would choose to die, rather than live with even mild dementia.³⁰⁰ However, they do not have that choice. Millions of elderly Americans will end up in nursing homes; many will be demented, lonely, and depressed.³⁰¹ Society has a responsibility to ensure that the needs of these residents are met. That includes fostering rich lifestyles and making their lives as meaningful and enjoyable as possible. For some residents, intimacy and sex can go a long way towards meeting this goal. For this reason, nursing homes should attempt to meet the residents' sexual needs to the same extent that they support the residents in other areas.³⁰² This includes evaluating what is best for the resident, even if the resident is engaged in an adulterous relationship in the nursing home and the nonresident spouse objects.

299. The balancing test also fails to eliminate the problems relating to bias of family members in helping to discern the value of the resident's critical interests. Hopefully, these problems will be somewhat reduced by having the nursing home focus on the specific critical interests involved.

300. Koppelman, *supra* note 180, at 71 ("In a recent study of 'cognitively normal' people, about three-fourths indicated that they would not want life-sustaining treatment . . . if they were mildly demented. And 95% would not want such treatment if they were severely demented.").

301. *See supra* note 16 and accompanying text; *see also* Ritchie & Lovestone, *supra* note 21, at 1763 (noting that "depression occurs in about 40-50% of cases [of dementia]").

302. Berger, *supra* note 19, at 310 ("Generally the [nursing home] should extend itself in the area of sexual quality of life in parallel to efforts to support other areas of resident well-being and dignity."); Sy, *supra* note 84, at 546 (noting that patients have the "right to have the same level of services regarding their sexual needs and behaviors as with their other areas of development" (quoting Timothy L. Meeku, Sonoma Development Center Policy 3 (July 1999) (unpublished hospital administrative policy) (on file with Whittier Law Review))).