

1-1-2016

Sexual Advance Directives

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SEXUAL ADVANCE DIRECTIVES

Alexander A. Boni-Saenz*

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ABSTRACT

Can one consent to sex in advance? Scholars have neglected the temporal dimension of sexual consent, and this theoretical gap has significant practical implications. With the aging of the population, more and more people will be living for extended periods of time with cognitive impairments that deprive them of the legal capacity to consent to sex. However, they may still manifest sexual desire, so consenting prospectively to sex in this context serves several purposes. These include protecting long-term sexual partners from prosecution by the state, ensuring sexually fulfilled lives for their future disabled selves, or preserving important sexual identities or relationships. The law currently provides a device for prospective decision-making in the face of incapacity: the advance directive. The central claim of this Article is that the law should recognize sexual advance directives. In other words, people facing both chronic conditions that threaten their legal capacity to make decisions and institutional care that threatens sexual self-determination should be able to consent prospectively to sex or empower an agent to make decisions about sex on their behalf. To justify this claim, the Article introduces a novel theory of sexual consent—the consensus of consents—that diffuses the longstanding philosophical debates over whether advance directives should be legally enforceable. With this normative foundation, the Article then draws on insights from criminal law, fiduciary law, and the law of wills to fashion a workable regime of sexual advance directives that adequately protects individuals from the risk of sexual abuse.

INTRODUCTION

In May of 2007, a woman and her longtime male partner engaged in consensual kinky sex.¹ Specifically, the woman consented to erotic asphyxiation, or the practice of choking during a sexual encounter as a way to restrict oxygen flow and enhance sexual arousal.² She also consented to sexual penetration while unconscious.³ The man then choked the woman, something which they had done before, and she passed out for approximately three minutes.⁴ During that time, the man tied the woman's

1. This narrative is adapted from the facts reported in *R. v. J.A.*, [2011] 2 S.C.R. 440 (Can.) and *R. v. J.A.* (2010), 100 O.R. 3d 676 (Can. Ont. C.A.).

2. See Lisa Downing, *Beyond Safety: Erotic Asphyxiation and the Limits of SM Discourse*, in *SAFE, SANE, AND, CONSENSUAL: CONTEMPORARY PERSPECTIVES ON SADOMASOCHISM* 119, 120–21 (Darren Langdridge & Meg Barker eds., 2007) (describing the practice).

3. This is subject to some dispute in the case. She initially reported to the police that she had not consented, but later recanted that testimony, claiming that she made the allegation as part of a custody dispute over their two-year old son. See *R. v. J.A.*, 2 S.C.R. 440, at para. 5.

4. *Id.*

arms behind her back and inserted a dildo into her anus.⁵ When she regained consciousness, he removed the dildo, and they had consensual penile-vaginal intercourse as well.⁶ After they had both finished, she said her safe word—“Tweety Bird”—and he cut her free of her bonds.⁷ Despite the woman’s consent, the State still prosecuted the man for sexual assault, claiming that she could not consent in advance as a matter of law.⁸ Lower courts divided on the issue, and the case went all the way to the Supreme Court of Canada.⁹

This case presents the important legal question of whether one can consent prospectively to sex.¹⁰ Scholars have neglected this temporal dimension of sexual consent, as it is assumed to be contemporaneous with the sexual act it authorizes.¹¹ This theoretical gap has significant practical implications beyond the context of temporary incapacity and kinky sex. With the aging of the population, more and more people will be living for extended periods of time with cognitive impairments. Dementia and other conditions can deprive individuals of the legal capacity to consent to sex, effectively barring them from having a sexual life. However, sexual desire and behaviors often continue unimpeded, as increasingly depicted in popular culture.¹²

5. *Id.*

6. *Id.* at para. 8.

7. *R. v. J.A.* (2010), 100 O.R. 3d 676, at para. 17 (Can. Ont. C.A.). See Margo Kaplan, *Sex-Positive Law*, 89 N.Y.U. L. REV. 89, 117 (2014) (“The BDSM community requires the use of a ‘safe word’ that, if uttered by the submissive, requires the dominant to immediately cease his or her actions.”).

8. See *R. v. A.(J.)*, 2008 O.N.C.J. 195, paras. 34–37 (Can. On. Ct. J.).

9. The trial court convicted the man, holding that she could not “legally consent to sexual activity that takes place when she is unconscious.” *Id.* at para. 45. The appellate court disagreed, holding that there was “no basis for holding that, as a matter of general principle a person cannot legally consent in advance to sexual activity expected to occur while the person is either unconscious or asleep.” *R v. J.A.* (2010), 100 O.R. 3d 676, at para. 69. The Supreme Court ultimately sided with the State. See *R. v. J.A.*, 2 S.C.R. 440, at para. 66 (“The definition of consent for sexual assault requires the complainant to provide actual active consent throughout every phase of the sexual activity. It is not possible for an unconscious person to satisfy this requirement, even if she expresses her consent in advance.”).

10. See *infra* Part I.A.

11. See, e.g., *State v. Robinson*, 496 A.2d 1067, 1069–70 (Me. 1985) (noting that withdrawal of consent during sex still results in rape even if consent was initially and freely given). There are a couple notable exceptions. See, e.g., ALAN WERTHEIMER, *CONSENT TO SEXUAL RELATIONS* 155–57 (2003) (briefly discussing a couple of scenarios in which concurrent consent might not be morally required); Michelle J. Anderson, *From Chastity Requirement to Sexuality License: Sexual Consent and a New Rape Shield Law*, 70 GEO. WASH. L. REV. 51, 53 (2002) (critiquing how the common law disempowered women by assuming their consent had no temporal boundaries, particularly in marriage). There are also a couple general treatments of consent that touch on the temporal dimension while drawing on examples from the sexual domain. See, e.g., PETER WESTEN, *THE LOGIC OF CONSENT* 247–63 (2004); Jonathan Witmer-Rich, *It’s Good to Be Autonomous: Prospective Consent, Retrospective Consent, and the Foundation of Consent in the Criminal Law*, 5 CRIM. L. & PHIL. 377 (2011).

12. For example, HBO’s recent comedy series *Getting On* deals explicitly with issues of sex among older adults with cognitive impairments in institutions. See Willa Paskin, *Getting On: I’ve Never Laughed So Hard About the Frail and Failing Elderly*, SLATE (Nov. 22, 2013),

In this social and demographic context, individuals may want to consent prospectively to sex for a variety of reasons. They might have an interest in enabling sexually fulfilling lives for their future disabled selves, in preserving important sexual identities or relationships, or in protecting spouses from criminal prosecution for rape.¹³ These interests are particularly threatened in the context of residential care, where institutions adopt sexually restrictive policies and aggressively police sex among residents for fear of liability. Unfortunately, this is not a hypothetical issue. In 2015, Iowa state prosecutors tried a man for sexual assault because he allegedly had sexual contact with his wife, who was suffering from Alzheimer's Disease, while she was residing in a nursing home.¹⁴

The law currently provides a tool for advance decision-making in the face of expected incapacity: the advance directive.¹⁵ This legal device permits individuals to set forth consent decisions in advance or to empower agents to make said consent decisions in the event of legal incapacity. These tools have been part of the legal landscape for many years. Living wills have been used in the health-care domain to permit advance decisions about end-of-life treatment, and powers of attorney allow one to delegate financial decision-making authority as well. However, scholars have never explored whether this traditional legal device should be applied to the unique decision-making domain of sexuality.

The central claim of this Article is that the law should recognize *sexual advance directives* for people with persistent acquired incapacity living in long-term care institutions. In other words, people facing chronic conditions that threaten their sexual-consent capacity, such as Alzheimer's Disease, should be able to engage in sexual advance planning to preserve the possibility of a sexual life while in residential care, such as nursing homes. To justify this claim, the Article introduces a novel theory of sexual consent—the *consensus of consents*—that diffuses the longstanding

http://www.slate.com/articles/arts/television/2013/11/hbo_s_new_comedy_starring_laurie_metcalf_getting_on_reviewed.html (describing the sexual subplots). The issue of Alzheimer's Disease has also permeated popular culture, with Julianne Moore recently winning an Oscar for portraying a fifty-year-old diagnosed with the illness. See Steve Dove, *Julianne Moore Wins Oscar for Best Actress in a Leading Role*, OSCAR.GO.COM (Feb. 27, 2015, 12:52 AM), <http://oscar.go.com/news/oscar-news/150222-julianne-moore-wins-best-actress-oscar-2015>.

13. See *infra* Part I.C.

14. See Complaint & Affidavit at 1, *State v. Rayhons*, No. 02411 FECR010718 (Iowa Dist. Ct. Aug. 14, 2014), http://www.dps.state.ia.us/commis/pib/Releases/2014/Rayhons_Complaint_&_Affidavit.pdf (charging Henry Rayhons for with sexual assault); Bryan Gruley, *Rape Case Asks if Wife with Dementia Can Say Yes to Her Husband*, BLOOMBERG (Dec. 8, 2014, 11:00 PM), <http://www.bloomberg.com/news/articles/2014-12-09/rape-case-asks-if-wife-with-dementia-can-say-yes-to-her-husband> (describing the case); Tony Leys & Grant Rodgers, *Rayhons: 'Truth Finally Came Out' with Not Guilty Verdict*, DES MOINES REG. (Apr. 22, 2015, 7:37 PM), <http://www.desmoinesregister.com/story/news/crime-and-courts/2015/04/22/henry-rayhons-acquitted-sexual-abuse/26105699/> (discussing the eventual acquittal).

15. See *infra* Part I.B.

philosophical divides over whether advance directives should be legally enforceable. Typically, these debates focus on situations of conflict between a past self, who expressed an advance decision while still possessing capacity, and a present self, who lacks capacity but would be harmed by the implementation of that advance decision. Philosophers have vigorously debated whether the past self or the present self should prevail.¹⁶ These disputes, however, ignore the fact that the interests of the past self and present self will actually align in many situations. This is particularly true in the sexual domain.¹⁷ When the past self provides prospective consent and the present self tokens contemporaneous consent, there is a consensus of consents that makes legal recognition of sexual advance directives attractive from multiple philosophical perspectives.¹⁸

With this normative foundation, the Article then draws on insights from the law of wills, criminal law, and fiduciary law to fashion a workable regime of sexual advance directives that adequately protects individuals from the risk of sexual abuse. To ensure that prospective consent is authentic, the sexual advance directive must be executed with the heightened level of formalities typically required of wills—a writing, signature, and attestation of two witnesses.¹⁹ These formalities provide courts with good evidence of prospective consent and protect individuals in memorializing their sexual wishes. To ensure that contemporaneous consent is voluntary, the individual must verbally or nonverbally express consent to sexual contact. In other words, silence or inaction should not be taken to constitute consent, as it risks being the product of a cognitive or communicative impairment instead. This affirmative consent standard has been controversial in criminal law, but it is justified with this population to ensure that there is a genuine mental state of acquiescence to a sexual act. In certain cases, ensuring that there is in fact affirmative consent will require privacy tradeoffs in the context of institutional care.²⁰ Finally, to protect the individual with cognitive impairments against harmful consequences of sexual activity, long-term care institutions and agents acting under a sexual advance directive must comply with a duty of care, taking reasonable steps to shield the person with cognitive impairments from objective welfare threats stemming from the sexual activity.²¹

This Article proceeds in three parts. Part I provides the background for understanding the doctrines of consent and capacity as well as the advance directive as a legal device. It also provides the rationale for focusing on

16. *See infra* Part II.A.

17. *See infra* Part II.B.

18. *See infra* Part II.B.

19. *See infra* Part III.A.1.

20. *See infra* Part III.A.2.

21. *See infra* Part III.B.

sexual advance planning for persistent acquired incapacity in the context of long-term care institutions. Part II lays out the philosophical divide on advance directives and argues for the consensus of consents as the normative basis of sexual advance directives. Part III turns to issues of implementation, examining how sexual advance directives might operate in practice.

I. CONSENT, CAPACITY, AND ADVANCE DIRECTIVES

This Part provides the social and legal background for understanding sexual advance directives. Section A defines the key terms of consent and capacity. Section B examines the law of advance directives. Section C introduces sexual advance directives and explains their application to situations of persistent acquired incapacity in the institutional context.

A. *Consent and Capacity*

Consent is the linchpin of moral sex.²² It is a communication that conveys a mental state of acquiescence toward a particular sexual act,²³ and

22. See Heidi M. Hurd, *The Moral Magic of Consent*, 2 LEGAL THEORY 121, 123 (1996) (“[C]onsent can function to transform the morality of another’s conduct—to make an action right when it would otherwise be wrong. For example, consent turns a trespass into a dinner party; a battery into a handshake; a theft into a gift; an invasion of privacy into an intimate moment; a commercial appropriation of name and likeness into a biography.”). While consent makes impermissible actions permissible, it does not “imply that it is harmless, or good for either party, or good for both of them, or good for the world.” Robin West, *Sex, Law, and Consent*, in THE ETHICS OF CONSENT: THEORY AND PRACTICE 221, 235 (Franklin G. Miller & Alan Wertheimer, eds., 2010).

For the purposes of this Article, I define sex to include any activity that could be prosecuted under a state’s criminal sexual conduct statute. See, e.g., S.C. CODE ANN. § 16-3-651 (2015) (defining “sexual battery” as “sexual intercourse, cunnilingus, fellatio, anal intercourse, or any intrusion, however slight, of any part of a person’s body or of any object into the genital or anal openings of another person’s body, except when such intrusion is accomplished for medically recognized treatment or diagnostic purposes.”). Such conduct would likely be actionable under a given state’s corresponding tort law as well. See John C. Coffee, Jr., *Does “Unlawful” Mean “Criminal”?: Reflections on the Disappearing Tort/Crime Distinction in American Law*, 71 B.U. L. REV. 193, 194 n.4 (1991) (noting the strong overlap between criminal law and tort law). The reason for this particular formulation is that that this Article is addressed to the legal liability that might flow from unlawful sex, and how sexual advance directives might make such sex lawful. Sex and sexuality are obviously more expansive and diverse categories than this, influenced not only by law but also by social context. See Jeffrey Weeks, *SEXUALITY* 7 (2d ed. 2003) (claiming that “what we define as ‘sexuality’ is a historical construction, which brings together a host of different biological and mental possibilities—gender identity, bodily differences, reproductive capacities, needs, desires, and fantasies . . . which need not be linked together, and in other cultures have not been”).

23. See Emily Sherwin, *Infelicitous Sex*, 2 LEGAL THEORY 209, 216 (1996) (“Consent is two things: It is both a subjective decision and a social act—a transaction between parties.”). This definition conceptualizes consent as composed of both a mental state and a communicative act. Many theorists, however, believe that it is only one or the other. See, e.g., DAVID ARCHARD, *SEXUAL CONSENT* 4 (1998) (arguing that consent is an “act rather than a state of mind.”); Larry Alexander, *The Moral Magic of Consent (II)*, 2 LEGAL THEORY 165, 165 (1996) (arguing that consent is an intentional mental

it embodies the value of self-determination in the sexual decision-making space.²⁴ Popular culture has absorbed this understanding of consent, and it is a central theme around which activists have organized campaigns against sexual assault.²⁵

Consent is also an important part of lawful sex.²⁶ In the criminal context, the State must typically prove non-consent as an element of the crime of sexual assault or rape.²⁷ As an evidentiary matter, the alleged victim's behavior must show non-consent in some way to satisfy this element.²⁸ Some states, however, have adopted an affirmative consent standard, which requires some verbal or nonverbal evidence of consent; without it, silence constitutes non-consent.²⁹ Under either rule, the burden

state). Since consent gives notice to a sexual partner about what her obligations are, some communicative element seems essential to the legal system. *See* WERTHEIMER, *supra* note 11, at 146.

24. This self-determination value has been conceptualized in many different ways. *See, e.g.*, STEPHEN J. SCHULHOFER, *UNWANTED SEX: THE CULTURE OF INTIMIDATION AND THE FAILURE OF LAW* 99 (1998) (sexual autonomy); Kathryn Abrams, *From Autonomy to Agency: Feminist Perspectives on Self-Direction*, 40 WM. & MARY L. REV. 805, 841 (1999) (sexual agency); Alexander A. Boni-Saenz, *Sexuality and Incapacity*, 76 OHIO ST. L.J. 1201, 1225 (2015) (sexual capability); Jed Rubenfeld, *The Riddle of Rape-by-Deception and the Myth of Sexual Autonomy*, 122 YALE L.J. 1372, 1425–27 (2013) (self-possession).

25. *See* Julia Penelope, *Speaking Out*, in COUNTERBALANCE: GENDERED PERSPECTIVES FOR WRITING AND LANGUAGE 68, 72 (Carolyn Logan ed., 1997) (“In public discourse, rape has become ‘unconsented sexual activity.’”); Deborah Tuerkheimer, *Slutwalking in the Shadow of the Law*, 98 MINN. L. REV. 1453, 1475 (2014) (describing how consent is the “touchstone” of the SlutWalk movement).

26. *See, e.g.*, ARIZ. REV. STAT. ANN. § 13-1406 (2001) (“A person commits sexual assault by intentionally or knowingly engaging in sexual intercourse or oral sexual contact with any person without consent of such person.”); UTAH CODE ANN. § 76-5-402(1) (LexisNexis 2012 & Supp. 2016) (“A person commits rape when the actor has sexual intercourse with another person without the victim’s consent.”); *People v. Cicero*, 204 Cal. Rptr. 582, 590 (Cal. Ct. App. 1984) (“[T]he law of rape primarily guards the integrity of a woman’s will and the privacy of her sexuality from an act of intercourse undertaken without her consent.”). This incorporation of consent into legal definitions can be attributed to the work of feminist legal reformers. *See* Anne M. Coughlin, *Sex and Guilt*, 84 VA. L. REV. 1, 11–20 (1998) (discussing the history of rape reform). However, many criminal statutes retain requirements of force on the part of the attacker or resistance on the part of the victim, showing how the law has not kept up with social understandings of permissible sex. *See* Deborah Tuerkheimer, *Rape on and off Campus*, 65 EMORY L.J. 1, 15 n.73 (2015) (detailing the states that still retain force and resistance elements).

27. *See* *State v. Smith*, 554 A.2d 713, 717 (Conn. 1989) (“Consent is not made an affirmative defense under our sex offense statutes, so, . . . the burden is upon the state to prove lack of consent beyond a reasonable doubt whenever the issue is raised.”).

28. *See* Susan Estrich, *Rape*, 95 YALE L.J. 1087, 1126 (1986) (noting this requirement and how it differs from how the law treats nonconsent in other areas).

29. *See, e.g.*, VT. STAT. ANN. tit. 13, § 3251(3) (West 2009) (“‘Consent’ means words or actions by a person indicating a voluntary agreement to engage in a sexual act.”); WIS. STAT. ANN. § 940.225(4) (West 2005) (“‘Consent’, as used in this section, means words or overt actions by a person who is competent to give informed consent indicating a freely given agreement to have sexual intercourse or sexual contact.”); *State ex rel. M.T.S.*, 609 A.2d 1266, 1277 (N.J. 1992) (“[P]ermission to engage in sexual penetration must be affirmative and it must be given freely, but that permission may be inferred either from acts or statements reasonably viewed in light of the surrounding circumstances.”).

of proof beyond a reasonable doubt remains with the State.³⁰ In the tort law context, non-consent is also something that must be proved as part of the prima facie case in a suit for battery.³¹ Thus, the burden is on the plaintiff to prove non-consent by a preponderance of the evidence.³²

In order for consent to be legally valid, the person granting it must have the *capacity to consent*.³³ There are a variety of conditions that may render one legally incapable of consenting, including intoxication, unconsciousness, or illness.³⁴ These impairments can prevent one from processing the relevant sexual decision at the time of the sexual act. The legal test for capacity to consent to sex in most states requires that one have the mental capacity to understand the “nature and consequences” of the relevant sexual decision.³⁵ Thus, in order to have the capacity to consent to sex, one must have the capacity to understand that a particular sexual act could entail such things as pleasure, pregnancy, or sexually transmitted disease. If sex proceeds with an enthusiastic affirmative communication—

30. See *Gates v. State*, 283 N.W.2d 474, 477–78 (Wis. Ct. App. 1979) (rejecting challenges to the constitutionality of Wisconsin’s affirmative consent statute due to vagueness or shifting the burden to the defendant); NEW JERSEY CRIMINAL MODEL INSTRUCTIONS, SEXUAL ASSAULT (FORCE/COERCION), § 2C:14-2c(1) (revised 2005), <http://www.judiciary.state.nj.us/criminal/charges/sexual008.pdf> (clarifying the jury’s duties in determining affirmative consent).

31. See RESTATEMENT (SECOND) OF TORTS § 13 cmt. d (AM. LAW INST. 1965) (“The absence of such consent is inherent in the very idea of those invasions of interests of personality which, at common law, were the subject of an action of trespass for battery, assault, or false imprisonment. Therefore the absence of consent is a matter essential to the cause of action, and it is uniformly held that it must be proved by the plaintiff as a necessary part of his case.”). There is some ambiguity on this point, as sometimes consent is framed as part of an affirmative defense by the defendant. See Nancy J. Moore, *Intent and Consent in the Tort of Battery: Confusion and Controversy*, 61 AM. U. L. REV. 1585, 1604–06 (2012) (discussing the lack of clarity in the Restatement).

32. See RESTATEMENT (SECOND) OF TORTS § 433B cmt. a (“As on other issues in civil cases, the plaintiff is required . . . to sustain his burden of proof by a preponderance of the evidence.”).

33. See WESTEN, *supra* note 11, at 7 (describing the requirements of consent as competence, knowledge, and freedom). This Article deals primarily with the first of these requirements, what I call capacity. Knowledge and freedom are more loosely enforced as conditions of valid sexual consent, even if they might be upheld as necessary for consent in other areas, such as commercial law. See Jane E. Larson, “*Women Understand So Little, They Call My Good Nature ‘Deceit’*”: A Feminist Rethinking of *Seduction*, 93 COLUM. L. REV. 374, 413 (1993).

34. See ARIZ. REV. STAT. ANN. § 13-1401(7)(b) (2001) (“The victim is incapable of consent by reason of mental disorder, mental defect, drugs, alcohol, sleep or any other similar impairment of cognition . . .”); 3 JOEL FEINBERG, *HARM TO SELF: THE MORAL LIMITS OF THE CRIMINAL LAW* 316–17 (1986). Even if one has legal capacity, there are many non-cognitive conditions that may render one legally incapable of granting sexual consent. See, e.g., OKLA. STAT. ANN. tit. 21, § 1111 (West 2015) (in legal custody or under educational supervision); TEX. PENAL CODE ANN. § 22.011(b) (West 2011) (if the perpetrator is a mental health services provider, clergyman, or residential institutional staff).

35. See, e.g., *Jackson v. State*, 890 P.2d 587, 592 (Alaska Ct. App. 1995) (“To appreciate the nature and consequences of engaging in an act of sexual penetration, the victim must have the capacity to understand the full range of ordinary and foreseeable social, medical, and practical consequences that the act entails.”). States vary in terms of what consequences they deem relevant to the analysis. See Deborah W. Denno, *Sexuality, Rape, and Mental Retardation*, 1997 U. ILL. L. REV. 315, 344–46 (discussing the various tests).

the “Yes”—but the person lacks the capacity to consent, the subsequent sexual contact is still criminal or tortious.³⁶

Sexual consent is normally considered to be more or less contemporaneous with the sexual act it authorizes.³⁷ This creates periods of time in everyone’s lives in which they lack the ability to legally consent, and potential sexual partners face legal sanction for engaging individuals during those periods.³⁸ This legal prohibition has simultaneously protective and restrictive effects.³⁹ It helps to protect those who are vulnerable during temporary periods of legal incapacity, for instance in helping to prevent adults from having sex with twelve-year-olds, who lack capacity by virtue of age, or to prevent college students from having sex with their unconscious classmates, who may lack capacity by virtue of intoxication.⁴⁰ The legal prohibition also has restrictive effects, which are felt most strongly when there are persistent forms of incapacity at issue.⁴¹ For example, people with persistent lifelong conditions, such as Down Syndrome, or with persistent acquired conditions, such as Alzheimer’s Disease, may be denied sexual lives altogether, even though they might retain sexual desires.⁴²

36. See RESTATEMENT (SECOND) OF TORTS § 892A (noting that for consent to be valid the person must have the capacity for consent); 3 CHARLES E. TORCIA, *WHARTON’S CRIMINAL LAW* § 282 (15th ed. 1995) (describing incapacity as vitiating consent in the context of rape).

37. See *State v. Nowlin*, 818 A.2d 1237, 1239 (N.H. 2003) (discussing whether contemporaneous conduct indicated lack of consent). The notable exception to this is the marital rape exception, where consent to marry was deemed to constitute prospective consent to sex for the duration of the marriage. See generally Jill Elaine Hasday, *Contest and Consent: A Legal History of Marital Rape*, 88 CAL. L. REV. 1373 (2000).

38. See Boni-Saenz, *supra* note 24, at 1212–13 (discussing the four types of legal incapacity).

39. See *id.* at 1203–04. These protective/restrictive effects key into the longstanding feminist debate over how sexuality should be regulated so as to protect from danger without cutting off avenues to pleasure. See Katherine M. Franke, *Theorizing Yes: An Essay on Feminism, Law, and Desire*, 101 COLUM. L. REV. 181, 208 (2001).

40. See, e.g., ARIZ. REV. STAT. ANN. § 13-1405(A) (2001) (setting the age of consent at eighteen); 720 ILL. COMP. STAT. ANN. 5/11-1.50(b) (West 2007 & Supp. 2016) (seventeen); NEV. REV. STAT. ANN. § 200.364(6) (LexisNexis 2012) (sixteen); *Commonwealth v. Fuller*, 845 N.E.2d 434, 439 (Mass. App. Ct. 2006) (noting that prosecutors often employ incapacity doctrines in cases when consent is ambiguous or contested by defendants); *Wilson v. State*, 473 S.W.3d 889, 897 (Tex. App. 2015) (“Evidence that the complainant was unconscious due to voluntary intoxication is sufficient to prove lack of consent.”); Patricia J. Falk, *Rape by Drugs: A Statutory Overview and Proposals for Reform*, 44 ARIZ. L. REV. 131, 186 (2002) (claiming that incapacity doctrine “protect[s] and vindicate[s] the right of all citizens to be free of nonconsensual sexual exploitation.”). Note that unconsciousness still does not stop some rapists from claiming that there was still consent in the moment. See Liam Stack, *Light Sentence for Brock Turner in the Stanford Rape Case Draws Outrage*, N.Y. TIMES (June 6, 2016), <http://www.nytimes.com/2016/06/07/us/outrage-in-stanford-rape-case-over-dueling-statements-of-victim-and-attackers-father.html>.

41. They certainly also have restrictive effects for other populations. See Kate Sutherland, *From Jailbird to Jailbait: Age of Consent Laws and the Construction of Teenage Sexualities*, 9 WM. & MARY J. WOMEN & L. 313, 332 (2003) (noting that age of consent laws construct sexualities in a way to comport with “particular societal or parental values”).

42. See Denno, *supra* note 35, at 343 (“According to some advocates for the mentally retarded, these rules constitute legally enforced celibacy for mentally retarded persons”); Elizabeth Hill,

In situations when a person has, but subsequently loses capacity, the law provides a tool for prospective decision-making: the advance directive. The next section examines the advance directive, its legal status, and how it has been implemented in other decision-making domains.

B. Advance Directives

An advance directive is a legal device that permits an individual to make decisions in advance or to delegate decision-making authority in advance of incapacity. There are two general types of advance directives. The first is an *instructional directive*, which sets out particular decisions in advance.⁴³ The most famous and ancient form of instructional directive is the last will and testament, which sets forth decisions about distribution of property at death.⁴⁴ Instructional directives in the health-care arena are of more recent vintage, traceable to a law review article penned in 1969 by Luis Kutner, an Illinois attorney.⁴⁵ The living will specifies treatment decisions one might desire in a particular medical situation.⁴⁶ For example, one might prospectively refuse a feeding tube or other invasive medical treatment if one ends up in a persistent vegetative state.⁴⁷ The most recent form of instructional directive is the “physician order for life sustaining treatment” (POLST), which incorporates medical treatment preferences into doctor’s orders and medical charts for easier implementation.⁴⁸

Note, *We’ll Always Have Shady Pines: Surrogate Decision-Making Tools for Preserving Sexual Autonomy in Elderly Nursing Home Residents*, 20 WM. & MARY J. WOMEN & L. 469, 476–83 (2014) (discussing the barriers to sexual expression in nursing homes).

43. See T.P. Gallanis, *Write and Wrong: Rethinking the Way We Communicate Health-Care Decisions*, 31 CONN. L. REV. 1015, 1018 (1999) (“[I]nstructional directives allow people to put their wishes into writing for future reference.”) (emphasis omitted).

44. See Gerry W. Beyer, *The Will Execution Ceremony—History, Significance, and Strategies*, 29 S. TEX. L. REV. 413, 415–19 (1988) (discussing the history of wills in the Bible, ancient Egypt, Roman times, and England).

45. See Luis Kutner, *Due Process of Euthanasia: The Living Will, A Proposal*, 44 IND. L.J. 539 (1969); Melvin I. Urofsky, *Leaving the Door Ajar: The Supreme Court and Assisted Suicide*, 32 U. RICH. L. REV. 313, 319 (1998) (“An Illinois attorney, Luis Kutner, is given credit for proposing a formal advance directive in 1969.”). For a comparative historical perspective on the rise of health care advance directives, see Alfred Simon, *Historical Review of Advance Directives*, in ADVANCE DIRECTIVES 3, 6–11 (Peter Lack et. al eds., 2014) [hereinafter ADVANCE DIRECTIVES].

46. See Susan J. Nanovic, *The Living Will: Preservation of the Right-to-Die Demands Clarity and Consistency*, 95 DICK. L. REV. 209, 210 (1990) (“A living will, also called an advanced directive, documents a person’s treatment preferences when, after certain triggering conditions have occurred, that person is unable to communicate these preferences.”).

47. See *Schindler v. Schiavo*, 780 So. 2d 176, 180 (Fla. Dist. Ct. App. 2001) (relating the case of Terri Schiavo, who was in a persistent vegetative state for ten years, being kept alive with feeding tubes).

48. See Robert C. Anderson, *Physician Orders for Life Sustaining Treatment (POLST): Breathing New Life into End-of-Life Care Planning*, 259 ELDER L. ADVISORY 1 (2012) (describing and advocating for POLST). *But see* Stanley A. Terman, *It Isn’t Easy Being Pink: Potential Problems with*

Instructional directives fall into two general categories. First, these directives can be *permissive* in that they grant consent in advance to certain actions that would otherwise be impermissible.⁴⁹ For example, informed consent forms signed in advance of surgery give permission to the surgeon to manipulate one's body while unconscious in a particular way to promote health.⁵⁰ Second, instructional directives can be *restrictive* in that they specifically do *not* grant consent in advance to certain actions. Restrictive advance directives are necessary in situations where there is a default rule in favor of action. For example, physicians operate against a background rule that they should perform medical interventions that promote life and health, unless a patient exercises a right to refuse treatment.⁵¹ A restrictive instructional directive, such as a do-not-resuscitate order, is one way to overcome this default in favor of action.⁵²

The second type of advance directive is the *proxy directive*, which sets out a particular *surrogate decision-maker* in advance.⁵³ The most common type of proxy directive is the power of attorney, in which a person (the principal) authorizes another person (the agent) to act on her behalf.⁵⁴ Traditionally, the agency relationship ended at the incapacity of the principal.⁵⁵ In the 1950s, however, power-of-attorney statutes were

POLST Paradigm Forms, 36 HAMLINE L. REV. 177 (2013) (considering philosophical and practical objections to POLST).

49. See DAVID OWENS, *SHAPING THE NORMATIVE LANDSCAPE* 176–82 (2012) (describing how consent can transform “bare wrongings” into permissible actions).

50. See *Morgan v. MacPhail*, 704 A.2d 617, 619 (Pa. 1997) (“It has long been the law in Pennsylvania that a physician must obtain informed consent from a patient before performing a surgical or operative procedure.”).

51. Under the Emergency Medical Treatment and Active Labor Act, physicians are required to treat patients who arrive at the hospital in medical distress, or to stabilize them before transferring them to another institution. See 42 U.S.C.A. § 1395dd(b)(1) (West 2012). Further, the code of ethics followed by the medical profession requires action in such situations as well. See COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AM. MED. ASS'N, *CODE OF MEDICAL ETHICS CURRENT OPINIONS WITH ANNOTATIONS* § 8.11 (1997) (“The physician should . . . respond to the best of his or her ability in cases of emergency where first-aid treatment is essential.”).

52. See, e.g., VA. CODE ANN. § 54.1-2991 (2013) (specifically noting that do-not-resuscitate orders must be respected and do not constitute suicide). Do-not-resuscitate orders differ from advance directives in that they originate from the physician, even if they might be based on preferences of the patient. See Robert S. Olick, *On the Scope and Limits of Advance Directives and Prospective Autonomy*, in *ADVANCE DIRECTIVES*, *supra* note 45, at 56–57.

53. See Gallanis, *supra* note 43, at 1019 (“[P]roxies allow people to appoint in writing surrogate decision-makers, typically spouses or close relatives, to act on their behalf.”).

54. See FLOYD R. MECHEM, *A TREATISE ON THE LAW OF AGENCY* § 35, at 19 (2d ed. 1914) (“[W]hen the [agent’s] authority is conferred by formal instrument in writing, it is said to be conferred by ‘letter of attorney,’ or, more commonly by ‘power of attorney.’”).

55. See RESTATEMENT (SECOND) OF AGENCY § 122 (AM. LAW. INST. 1958) (“[T]he loss of capacity by the principal has the same effect upon the authority of the agent during the period of incapacity as has the principal’s death.”). The primary rationale for this is that the principal would not be able to monitor the agent’s actions. See Alexander M. Meiklejohn, *Incompetent Principals, Competent Third Parties, and the Law of Agency*, 61 IND. L.J. 115, 115–16 (1986) (“Agency is a

modified to make powers of attorney “durable,” so they would continue past the incapacity of the principal.⁵⁶ After these reforms, the power of attorney became a useful tool for dealing with incapacity, as it allowed agents designated by the principal to manage the finances of a person once she acquired cognitive impairments.⁵⁷ It was also a cheap and efficient alternative to guardianship.⁵⁸ In the last forty years, all states have since extended the power of attorney to the health-care domain through the enactment of statutes that specifically authorize health-care proxies.⁵⁹

Instructional directives have the benefit of expressing exactly what the principal might want in a given circumstance.⁶⁰ However, they do not take into account how changed circumstances might affect the principal’s decision if she were aware of them.⁶¹ The advantage of proxy directives is that they give authority to an agent to take account of those changed circumstances in order to arrive at a better choice, either with respect to the principal’s likely wishes or best interests.⁶² Their main drawback is that selecting an agent may be difficult, and agents might lack fidelity to the wishes of the principal who selected them.⁶³ As a result of these drawbacks, some advocate the use of *hybrid directives*, which designate a proxy decision-maker but also provide written guidance about the principal’s beliefs in varying levels of mandatory language.⁶⁴ In the financial domain, the trust could be seen as a type of hybrid directive. The trustee is the relevant agent, who manages the money that forms the corpus of the trust

consensual relation; it is premised on the principal’s ability to understand and either approve or disapprove of the agent’s acts.”).

56. See Karen E. Boxx, *The Durable Power of Attorney’s Place in the Family of Fiduciary Relationships*, 36 GA. L. REV. 1, 6–7 (2001) (surveying the history of durable power of attorney statutes).

57. See *id.* at 12–14.

58. See Linda S. Whitton, *Durable Powers as an Alternative to Guardianship: Lessons We Have Learned*, 37 STETSON L. REV. 7, 9 (2007).

59. See Alicia R. Ouellette, *When Vitalism Is Dead Wrong: The Discrimination Against and Torture of Incompetent Patients by Compulsory Life-Sustaining Treatment*, 79 IND. L.J. 1, 3 n.7 (2004) (compiling the relevant statutes).

60. NANCY M. P. KING, MAKING SENSE OF ADVANCE DIRECTIVES 129 (1996) (noting that the “combination of position statements and lists of preferences and choices can paint powerful, clear, and compelling portraits of patients and their treatment decisions”).

61. See *id.* at 128 (“Anticipation of every contingency is impossible. There will always arise circumstances and decisions not directly addressed by a directive.”).

62. See *id.* at 137 (noting that with a proxy directive “decisions can be made concurrently rather than prospectively, by someone who can see the situation . . .”).

63. See *id.* at 137–39.

64. See Gallanis, *supra* note 43, at 1019 (“[C]ombined directives contain both instructional and delegational elements; they name a health-care proxy but also explain the patient’s wishes, usually about the application of life-sustaining treatment.”).

with varying levels of discretion about how to invest or distribute it.⁶⁵ In the health-care domain, instructional elements are meant to provide the proxy decision-maker with information about the principal's values, without necessarily mandating an outcome.⁶⁶

The right to prospective decision-making embodied in advance directives does not appear to be protected by the Constitution. The Supreme Court notably dodged the issue when deciding *Cruzan v. Missouri Department of Health*, a landmark case that dealt with state restrictions on the withdrawal of life-sustaining treatment.⁶⁷ Despite this constitutional uncertainty, advance directives now stand on firm legal ground. All states have enacted statutes that recognize advance directives in a variety of decision-making domains.⁶⁸ In addition to this statutory authorization, legislatures have passed a variety of laws that incentivize the creation of advance directives.⁶⁹ Finally, many states allow for remedies if advance directives are not followed in either the health-care⁷⁰ or financial domains.⁷¹

65. See Deborah S. Gordon, *Trusting Trust*, 63 U. KAN. L. REV. 497, 503–06 (2015) (describing how the creation of trusts must balance the settlor's instructional directives with flexibility for the trustee to address changed circumstances).

66. See Leslie Pickering Francis, *Decisionmaking at the End of Life: Patients with Alzheimer's or Other Dementias*, 35 GA. L. REV. 539, 553 (2001).

67. See *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 280 (1990); *id.* at 287 n.12 (“We are not faced in this case with the question whether a State might be required to defer to the decision of a surrogate if competent and probative evidence established that the patient herself had expressed a desire that the decision to terminate life-sustaining treatment be made for her by that individual.”). The New Jersey Supreme Court, however, did explicitly recognize the ability of individuals to act through surrogates in another landmark case. See *In re Quinlan*, 355 A.2d 647, 664 (1976). There may also be some constitutional support for the will as an advance directive, as the Supreme Court has come close to recognizing something of a right to transmit wealth at death. See *Hodel v. Irving*, 481 U.S. 704, 716 (1987).

68. See RESTATEMENT (SECOND) OF PROPERTY, DON. TRANS. § 33.1 Stat. Note (AM. LAW. INST. 1992) (listing the wills statutes of all fifty states); Ouelette, *supra* note 59 (compiling health care advance directive statutes in all fifty states).

69. The Federal Patient Self-Determination Act requires various types of health institutions to provide patients with information about advance directives. See Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, §§ 4206, 4751, 104 Stat. 1388, 1388-115 to-117, 1388-204 to-206 (codified in scattered sections of 42 U.S.C.); Edward J. Larson & Thomas A. Eaton, *The Limits of Advance Directives: A History and Assessment of the Patient Self-Determination Act*, 32 WAKE FOREST L. REV. 249, 251–62 (1997) (discussing the history of the Act and its goals). The Act has been subject to criticism, however, for failing to meet its goals. See Thaddeus Mason Pope, *The Maladaptation of Miranda to Advance Directives: A Critique of the Implementation of the Patient Self-Determination Act*, 9 HEALTH MATRIX 139, 156 (1999) (critiquing the Act on empirical and theoretical grounds).

70. Patients' legal representatives may seek injunctive relief to force physicians to comply with the stated wishes of the person who lacks legal capacity. See, e.g., *In re Tavel*, 661 A.2d 1061, 1068–69 (Del. 1995) (ordering a feeding tube should be removed as it was consistent with the incapacitated person's prior wishes). In addition, physicians who do not honor directives may open themselves to tort liability in a variety of forms. See Holly Fernandez Lynch et. al., *Compliance with Advance Directives Wrongful Living and Tort Law Incentives*, 29 J. LEGAL MED. 133, 139–142 (2008).

71. Some states have passed laws requiring individuals or institutions to accept the authority wielded by an attorney-in-fact or face liability. See, e.g., IND. CODE ANN. § 30-5-9-9 (West 2009)

Thus, we have progressed from a time when advance directives did not even cover situations of incapacity to a point when they do so in a variety of decision-making domains. Despite this historical arc, scholars have not contemplated the extension of prospective decision-making to the realm of sexual decision-making. The next section describes sexual advance directives and how they may be of particular import to the population of people with persistent acquired incapacities in long-term care institutions.

C. Persistent Incapacity and the Institutional Context

Sexual advance directives would apply the traditional legal device of advance directives to the novel decision-making domain of sexuality. They would permit individuals either to consent in advance to specific sexual acts or to empower agents to make certain sexual consent decisions at a point in the future when the principal lacked capacity to consent to sex. As a legal matter, the sexual advance directive would fit into tort or criminal law as an essential element of a consent defense to sexual assault or battery.⁷²

There are a variety of contexts in which sexual advance directives might apply.⁷³ This Article focuses only on sexual advance directives in the context of persistent acquired incapacity, most commonly caused by conditions such as Alzheimer's Disease, dementia, or stroke. This is the traditional context for advance planning, in which one uses a period of legal capacity to prepare for an impending extended period of legal incapacity.⁷⁴ In addition, the Article focuses only on the use of sexual advance directives in the context of institutional care, such as assisted-

(requiring treble damages and attorney's fees); N.C. GEN. STAT. § 32A-41 (2015) (requiring only attorney's fees). Most states couple this with freeing financial institutions from liability for relying on power of attorney. *See, e.g.*, ALA. CODE § 26-1A-119 (LexisNexis Supp. 2015); 755 ILL. COMP. STAT. ANN. 45/2-8 (West 2007 & Supp. 2016). *See also* Whitton, *supra* note 58, at 40–47 (describing the statutory schemes in many states).

72. *See infra* Part III (discussing the elements of such a defense).

73. At the outset, two forms of legal incapacity are left untouched by sexual advance directives. Those with persistent lifelong conditions that can deprive one of legal capacity, such as Down Syndrome, and minors, who have not yet attained legal capacity due to age, cannot employ sexual advance directives as they lack the period of legal capacity needed to execute them.

74. The Article does not address situations of temporary incapacity, such as those described in the introductory example. While sexual advance directives might prove useful in this context, it is sufficiently distinct from persistent incapacity to warrant its own separate analysis. For example, the motivation to pursue sexual advance directives for temporary unconsciousness or intoxication is less clear than with persistent incapacity. The State would likely not pursue prosecutions if the individual who had sexual contact while impaired did not report it, and the case would be difficult to pursue in any case if the victim refused to cooperate because she did not perceive harm or lack of consent. Further, temporary forms of incapacity still permit one to have sex while not temporarily impaired, so the law's restrictive force does not have such a severe effect on sexual expression. Thus, while this Article draws no firm conclusions on the utility of sexual advance directives for temporary incapacity, I am skeptical that they will bring the same net benefits as in the context considered here.

living facilities, nursing homes, and continuing-care retirement communities.⁷⁵ Advance directives typically require a third party to oversee their use, such as the medical profession in the case of health care advance directives. Long-term care institutions are best equipped to perform this role here. Thus, the Article does not address the use of sexual advance directives outside of institutions where there is no possibility of third-party oversight.⁷⁶

There are several reasons for the dual focus on persistent acquired incapacity and institutional care. First, the aging of the population makes the legal implications of persistent forms of incapacity a pressing social issue. By 2050, the population over sixty-five is projected to be greater than 83.7 million, almost double its size from 2012.⁷⁷ With this shift, a larger proportion of the population will be living for significant periods of time with chronic conditions that cause cognitive impairments.⁷⁸ In addition, many of those with cognitive impairments will be living in long-term care institutions, increasing the importance of addressing the regulatory regimes that govern this space.⁷⁹ There is strong motivation for people to pursue sexual advance planning in cases of persistent incapacity and institutional care, given the extended time that individuals may lack legal capacity and the lack of control over intimate affairs that individuals may experience in residential institutions. In fact, such planning is already happening informally in some instances.⁸⁰

Second, the stakes for sexual expression are clearly significant with persistent incapacity. Adults remain sexually active well into old age, as the high rates of sexually transmitted diseases among this population

75. See Jon Pynoos et. al., *Aging in Place, Housing, and the Law*, 16 ELDER L.J. 77, 99–104 (2008) (discussing the various housing options for seniors).

76. Outside of institutions, there is less of a need for sexual advance directives. The incapacity doctrines that govern sexuality have less regulatory force in the community, as there is neither institutional worry about legal liability nor enforcement by institutional staff. In addition, without institutional oversight, there is no readily available third party to prevent sexual abuse, creating significant practical barriers to implementation.

77. See JENNIFER M. ORTMAN ET AL., U.S. CENSUS BUREAU, AN AGING NATION: THE OLDER POPULATION IN THE UNITED STATES 1 (2014).

78. See GEORGE P. SMITH, II., *LEGAL AND HEALTHCARE ETHICS FOR THE ELDERLY* 9 (1996) (“[A]s life is extended and death occurs at older ages, individuals are more likely to spend greater time in disabled or severely restricted states with mental impairment before they die.”).

79. See Ann Christine Frankowski & Leanne J. Clark, *Sexuality and Intimacy in Assisted Living: Residents’ Perspectives and Experiences*, 6 SEXUALITY RES. & SOC. POL’Y 25, 26–27 (2009) (discussing studies estimating the level of cognitive impairment among assisted living facilities as varying between 14% to 70%); Andrew Casta-Kaufteil, Comment, *The Old & the Restless: Mediating Rights to Intimacy for Nursing Home Residents with Cognitive Impairments*, 8 J. MED. & L. 69, 70 (2004) (noting the high proportion of nursing home residents with Alzheimer’s Disease).

80. See Lisa Brodoff, *Planning for Alzheimer’s Disease with Mental Health Advance Directives*, 17 ELDER L.J. 239, 279–86 (2010) (discussing life planning for Alzheimer’s Disease, including around intimate relationships).

demonstrate.⁸¹ Further, these sexual desires persist even for older adults with cognitive impairments.⁸² Sexual disinhibition is actually a feature of some medical conditions, leading to increased sexual behaviors in some cases.⁸³ Despite these continued desires, the current “nature-and-consequences” test for sexual consent capacity can effectively create a total bar on the sexual lives of people with persistent cognitive impairments.⁸⁴ This legal rule has actual regulatory force for those living in institutions, as it leads to sexually restrictive policies derived from worries about legal liability.⁸⁵ In addition, the rule has expressive force, helping to construct

81. See Stacy Tessler Lindau et al., *A Study of Sexuality and Health Among Older Adults in the United States*, 357 NEW ENG. J. MED. 762, 762 (2007) (noting that a majority of those aged 65–74 and a significant minority of those aged 75–85 were still having sex); Alexander Warso, Note, *Something Catchy: Nursing Home Liability in the Senior Sexually Transmitted Disease Epidemic*, 22 ELDER L.J. 491, 500–01 (2015) (discussing the problem of sexually transmitted diseases among older adults in nursing homes). As people age, however, the sexual contact at issue becomes less focused on genitals. See Ramzi R. Hajjar & Hosam K. Kamel, *Sex and the Nursing Home*, 19 CLINICS GERIATRIC IN MED. 575, 576 (2003). In addition, sexual expression may be somewhat gendered. See Carole Archibald, *Sexuality, Dementia, and Residential Care: Managers Report and Response*, 6 HEALTH & SOC. CARE COMMUNITY 95, 97–98 (1998) (noting that much of the expressed sexual desire among residents with dementia was from male residents towards female staff).

82. See, e.g., Melinda Henneberger, *An Affair to Remember*, SLATE (June 10, 2008), http://www.slate.com/articles/life/family/2008/06/an_affair_to_remember.html (telling the story of a ninety-five-year old man and eighty-two-year old woman, both with cognitive impairments, who found romance in an assisted living facility before being separated by institutional staff and the family of the man). This is not to suggest that conditions such as Alzheimer’s Disease do not create barriers to sexuality in and of themselves. See Lore K. Wright, *Affection and Sexuality in the Presence of Alzheimer’s Disease: A Longitudinal Study*, 16 SEXUALITY & DISABILITY 167, 168 (1998) (noting the lack of sexual expression in late stages of Alzheimer’s Disease); Helen D. Davies et al., *Til Death Do Us Part: Intimacy and Sexuality in the Marriages of Alzheimer’s Patients*, 30 J. PSYCHOSOCIAL NURSING & MENTAL HEALTH SERVICES 5, 5–10 (1992) (noting problems of memory, aggression, and erectile dysfunction).

83. See Leslie M. Lothstein et al., *Risk Management and Treatment of Sexual Disinhibition in Geriatric Patients*, 61 CONN. MED. 609, 609 (1997) (noting how sexual disinhibition is sometimes a consequence of neurological degenerative disorders); see also Tom Kitwood, *The Experience of Dementia*, 1 AGING & MENTAL HEALTH 13, 19 (1997) (“The heightened sexual desire that is felt by some people with dementia may be interpreted, at least in part, as a manifestation of this need [for comfort].”).

84. See Boni-Saenz, *supra* note 24, at 1204.

85. Liability can come in many forms. It may be imposed on institutions because they have a duty to care for those who are impaired. See, e.g., *Ayuluk v. Red Oaks Assisted Living, Inc.*, 201 P.3d 1183, 1190 (Alaska 2009) (adjudicating a vicarious liability claim for sexual assault of cognitively impaired patient by certified nurse’s assistant). The liability may also be regulatory. See JASON RODRIQUEZ, *LABORS OF LOVE: NURSING HOMES AND THE STRUCTURES OF CARE WORK* 39–44 (2014) (discussing the regulatory inspection process). Nursing homes respond to these threats of liability by restricting the sexual environments of residents. See Daniel Engber, *Naughty Nursing Homes: Is It Time to Let the Elderly Have More Sex?*, SLATE (Sept. 27, 2007), http://www.slate.com/articles/life/the_sex_issue/2007/09/naughty_nursing_homes.html (“Why are nursing-home administrators so queasy about sexual expression? They’re afraid of getting sued.”).

and limit the range of acceptable sexuality for people with cognitive impairments.⁸⁶

Third, maintaining the option of a sexual life is quite important as a legal and social matter. The Supreme Court has recognized some form of constitutionally protected sexual liberty interest under the Due Process Clause.⁸⁷ The opportunity to pursue sexual expression finds strong support in moral philosophy as well.⁸⁸ At a more basic level, sexual expression can be an important source of physical pleasure, personal meaning, and social connection.⁸⁹ For older adults with cognitive impairments in particular, it helps with the depression and loneliness that often accompanies a diagnosis of Alzheimer's Disease and an isolated social existence in an institutional context.⁹⁰ In addition, it has positive effects for caregivers who are also sexual partners.⁹¹

Finally, the planning process itself has the promise of clear desirable legal and social effects. Advance planning in the health care context has been shown to have positive effects on health-care treatment, and the same

86. See Boni-Saenz, *supra* note 24, at 1215. While potentially still affected by the expressive effects of legal doctrines, individuals living outside of institutions are not exposed to restrictive sexual policies that govern institutions and their residents.

87. See *Lawrence v. Texas*, 539 U.S. 558, 572 (2003) (recognizing some form of liberty interest of "adult persons in deciding how to conduct their private lives in matters pertaining to sex."); Randy E. Barnett, *Justice Kennedy's Libertarian Revolution: Lawrence v. Texas*, CATO SUP. CT. REV. 21, 21 (2003) (arguing that *Lawrence* stands for a broad liberty-based sexual entitlement). *But see* Katherine M. Franke, *The Domesticated Liberty of Lawrence v. Texas*, 104 COLUM. L. REV. 1399, 1400 (2004) (arguing the sexual right does not extend beyond the bedroom).

88. See, e.g., MARTHA C. NUSSBAUM, WOMEN AND HUMAN DEVELOPMENT 78 (2000) (considering the capability to pursue "opportunities for sexual satisfaction" as one of the central human capabilities necessary for a flourishing life). While Nussbaum categorizes sexual satisfaction as a part of the fundamental capability of bodily integrity, it also implicates other fundamental capabilities, such as senses, imagination, and thought; emotions, practical reason, affiliation, and play. See *id.* at 78–80; see also DON KULICK & JENS RYDSTRÖM, LONELINESS AND ITS OPPOSITE 286 (2015) (connecting a right to sex with the fundamental capabilities of bodily integrity, emotions, and affiliation).

89. See PAUL R. ABRAMSON & STEVEN D. PINKERTON, WITH PLEASURE: THOUGHTS ON THE NATURE OF HUMAN SEXUALITY 8–10 (rev. ed. 2002) (discussing the neurobiology of sexual pleasure); Rosalind Dixon, *Feminist Disagreement (Comparatively) Recast*, 31 HARV. J.L. & GENDER 277, 282–83 (2008) (describing the value of sex to women in particular); Evelyn M. Tenenbaum, *Sexual Expression and Intimacy Between Nursing Home Residents with Dementia: Balancing the Current Interests and Prior Values of Heterosexual and LGBT Residents*, 21 TEMP. POL. & CIV. RTS. L. REV. 459, 464–66 (2012) ("Sexual expression and intimacy are basic human needs that last throughout life and have an enormous impact on quality of life."); Casta-Kaufteil, *supra* note 79, at 72–74 (2004) (discussing the benefits of sexual expression).

90. See Sally M. Roach, *Sexual Behaviour of Nursing Home Residents: Staff Perceptions and Responses*, 48 J. ADVANCED NURSING 371, 378 (2004) ("Sexual 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.")

91. See Helen D. Davies et al., *Sexuality and Intimacy in Alzheimer's Patients and Their Partners*, 16 SEXUALITY & DISABILITY 193, 195 (1998) (noting that sexual expression can be a source of support and mutual exchange among couples when one partner has cognitive impairments).

could hold true of long-term care.⁹² Planning provides a forum through which to process the various issues implicated in disability and death, allowing one to express important values or recognize important relationships.⁹³ Finally, it makes decision-making easier for institutional staff and for loved ones, who benefit from guidance about the wishes of the person lacking legal capacity.⁹⁴

* * *

Consent, capacity, and advance directives are all well-recognized features of the legal landscape, but they have not yet been combined in the sexual decision-making field. Sexual advance directives may be a way of preserving the sexual lives of those who wish to plan ahead while allowing institutions to facilitate such sexual activity without fear of liability if they do so in a competent way. Demographic changes require that we explore whether they are an improvement over the status quo, and under what circumstances they might be so. Part II examines when and whether sexual advance directives are theoretically attractive, while Part III delves into the practical problems with implementing them.

II. SEX AND TEMPORAL SELVES

This Part examines the philosophical basis for sexual advance directives. There is significant philosophical disagreement over whether advance directives generally should have legal effect. Section A describes these longstanding philosophical debates, which revolve around the proper moral treatment of two temporal selves—the “Time 1 self” and the “Time 2 self.”⁹⁵ The Time 1 self is the past self who executed the advance directive, either making prospective decisions or delegating authority to an agent to

92. See Arianne Brinkman-Stoppelenburg et al., *The Effects of Advance Care Planning on End-of-Life Care: A Systematic Review*, 28 PALLIATIVE MED. 1000, 1020–21 (2014) (concluding that overall there was a positive effect on quality end-of-life care when advance planning had taken place).

93. See *infra* text accompanying notes 136–137; Mark Glover, *A Therapeutic Jurisprudential Framework of Estate Planning*, 35 SEATTLE U. L. REV. 427, 450–55 (2012) (discussing the therapeutic effects of estate planning); see also Barbara A. Noah, *In Denial: The Role of Law in Preparing for Death*, 21 ELDER L.J. 1, 25–30 (2013) (arguing that advance directives are useful as they stimulate conversations about death); Vicki Schultz, *Life's Work*, 100 COLUM. L. REV. 1881, 1958 (2000) (“Sexuality and reproduction are a part of life, for example, as are disability and aging.”).

94. See Naomi Cahn & Amy Zietlow, “*Making Things Fair*”: *An Empirical Study of How People Approach the Wealth Transmission System*, 22 ELDER L.J. 325, 331 (2015) (noting how family members expressed appreciation for guidance and emotional understanding that estate planning provides).

95. This formulation strikes many as odd, as we are used to thinking of the self in terms of unities rather than heterogeneities. See JENNIFER RADDEN, *DIVIDED MINDS AND SUCCESSIVE SELVES* 25–31 (1996). An alternative is “past self” and “present self.”

make those decisions in the future. The Time 2 self is the present self who lacks legal capacity and may be involved in the sexual contact that would otherwise be criminal or tortious without sexual consent.

Section B argues that these debates may be diffused in many situations with respect to sexual advance directives. When the Time 1 and Time 2 selves agree about the relevant sexual consent decision, there is a *consensus of consents* as between the Time 1 and Time 2 selves that makes legal recognition of sexual advance directives attractive from multiple philosophical perspectives.

Section C explores how to deal with the problem of Time 2 silence, when the Time 2 self does not assert any particular opinion with respect to the sexual decision due to communicative impairment or unconsciousness. Prohibition of sexual advance directives in those contexts rests on the dual risks of unwanted sex and objectification.

A. *The Case For and Against Advance Directives*

Advance directives facilitate decision-making across time.⁹⁶ At Time 1, an individual declares a decision or appoints a surrogate decision-maker. At Time 2 (typically when the individual lacks legal capacity to make decisions), the advance decision is executed or the decision of the surrogate decision-maker is implemented.

Advance directives are also a form of self-binding.⁹⁷ The most famous example of self-binding comes from Homer's *The Odyssey*, in which Ulysses told the crew of his ship to stuff their ears with beeswax and to tie him to a mast so that he might hear the song of the Sirens. This binding was required because his self at Time 2, listening to the Sirens' song, would be compelled to go to them, which would lead to his death.⁹⁸ Ulysses's tale brings out another important feature of self-binding, which is that it often requires third parties to enforce or implement it.⁹⁹

In everyday life, we informally bind ourselves in a variety of ways. For example, one might hand a smartphone over to a friend while eating dinner to prevent the checking of Facebook, Instagram, or Twitter during the

96. See KING, *supra* note 60, at 66 ("Part of what distinguishes humans from other animals is our ability to live in a way that encompasses not only present but also past and future.")

97. See Rebecca S. Dresser, *Ulysses and the Psychiatrists: A Legal and Policy Analysis of the Voluntary Commitment Contract*, 16 HARV. C.R.-C.L. L. REV. 777, 784–92 (1982) (discussing different views of self-paternalism).

98. See THE ODYSSEY OF HOMER 189–90 (Richmond Lattimore trans. 1967). While the character is technically Odysseus, Ulysses (who appears in the *Iliad*) refers to the same hero and has been used interchangeably with Odysseus.

99. See Ronald Dworkin, *Autonomy and the Demented Self*, 64 MILBANK. Q. 4, 11–12 (1986) (discussing the case of a Jehovah's Witness who pleads for a blood transfusion after signing a document requiring that it not be administered).

meal.¹⁰⁰ The difference between informal self-binding and advance directives, however, is that the latter employ the coercive force of the law to authorize others to impose our past will on ourselves. Such self-binding measures, often called “Ulysses contracts,” are not legally enforceable in the absence of some cognitive defect, such as being under the influence of the Sirens’ song.¹⁰¹ Thus, if I demanded back my smartphone from my friend because I changed my mind and wanted to post a photograph of my food to Instagram, her refusal to return my property would not be legally permissible.¹⁰²

This non-enforcement of Ulysses contracts has a deep philosophical basis in Western thought. John Stuart Mill regarded liberty as exercising individual judgment, “where the judgment is grounded on *actual, and especially on present*, personal experience; not where it is formed antecedently to experience, and not suffered to be reversed even after experience has condemned it.”¹⁰³ In other words, we are allowed to change our minds, particularly about personal matters.¹⁰⁴ This presumption is reflected in various areas of the law. People may revoke their wills at any time before death by destroying them,¹⁰⁵ and individuals may divorce without needing a legal reason for doing so.¹⁰⁶

100. See Caitlin Dewey, *Why You Should (Really, Seriously, Permanently) Stop Using Your Smartphone at Dinner*, WASH. POST (July 14, 2014), <https://www.washingtonpost.com/news/the-intersect/wp/2014/07/14/why-you-should-really-seriously-permanently-stop-using-your-smartphone-at-dinner/> (describing the many contexts in which people perhaps inappropriately use smartphones, including during sex, while driving, and in a house of worship).

101. See Dan W. Brock, *Precommitment in Bioethics: Some Theoretical Issues*, 81 TEX. L. REV. 1805, 1808 (2003) (“Precommitments, as the term has come to be used in the literature, need not involve any other party in the way that promises or contracts do.”); Thomas C. Schelling, *Enforcing Rules on Oneself*, 1 J.L. ECON. & ORG. 357, 359 (1985) (“We have, then, a territory in which ‘private ordering’ is about all there is. We must devise rules for our own behavior that entail little or no reliance on the courts . . . because the courts refuse to extend us their jurisdiction.”).

102. Such an action would give rise to claim for conversion. See RESTATEMENT (SECOND) OF TORTS § 222A (AM. LAW INST. 1965). Of course, it is unlikely that such a suit would occur, as the issue would likely be resolved informally.

103. JOHN STUART MILL, *PRINCIPLES OF POLITICAL ECONOMY* 960 (William J. Ashley ed., Longmans, Green and Co. 1961) (emphasis added). Mill also rejected selling oneself into slavery for similar reasons. See *id.*

104. I confine my discussion here to personal self-binding, as this Article concerns sexual decision-making. Others have explored whether self-binding is a principle that underlies constitutional law and representative democracy. See, e.g., JON ELSTER, *ULYSSES UNBOUND: STUDIES IN RATIONALITY, PRECOMMITMENT, AND CONSTRAINTS* 88–174 (2000).

105. See *In re Estate of Stoker*, 122 Cal. Rptr. 3d 529, 536 (Cal. Ct. App. 2011) (“A will may be revoked where the testator executes a subsequent inconsistent will or where he or she burns or destroys the will.”); UNIF. PROBATE CODE § 2-507 (amended 2010) (“A will or any part thereof is revoked . . . by performing a revocatory act on the will . . .”).

106. See Courtney G. Joslin, *Modernizing Divorce Jurisdiction: Same-Sex Couples and Minimum Contacts*, 91 B.U. L. REV. 1669, 1676 n.41 (2011) (describing how no-fault divorce exists in all fifty states since New York enacted it in 2010).

Contracts can in fact bind us, but they take place in the context of an *exchange* whose purpose is to ensure that you cannot change your mind without suffering consequences.¹⁰⁷ Even with contracts, however, courts are reluctant to allow individuals to bind themselves in certain ways. For example, courts are often unwilling to grant the remedy of specific performance, preferring instead to award monetary damages that do not infringe on an individual's autonomy.¹⁰⁸ Many courts even allow for a change of mind with personal contracts for surrogacy or adoption, rendering those types of contracts unenforceable.¹⁰⁹ Given this philosophical and legal background, the theoretical basis for advance directives must come from somewhere else. Without it, it is difficult to justify favoring one temporal self over another.¹¹⁰

This theoretical basis comes from the premise that the self at Time 2 has a subordinate moral and legal status.¹¹¹ In other words, Ulysses at Time

107. See Joseph William Singer, *Legal Realism Now*, 76 CAL. L. REV. 465, 483 (1988) (“Enforcement of contracts constitutes a social decision to protect the expectations of the promisee by curtailing the liberty of market participants to change their minds.”). Thus, a separate party is required. See THOMAS C. SCHELLING, *CHOICE AND CONSEQUENCE* 99 (1984) (“The law recognizes . . . the promise—the commitment, the obligation, the impairment of one’s own freedom of choice—has a reciprocal quality and is *to somebody*, somebody else. The promise requires an addressee. One may not contract with himself.”).

108. See *Clyatt v. United States*, 197 U.S. 207, 215–16 (1905) (rejecting specific performance in the employment context); Anthony T. Kronman, *Paternalism and the Law of Contracts*, 92 YALE L.J. 763, 783 (1983) (“If the breaching promisor must continue to work or live with the other party and abide by the terms of a cooperative arrangement he now regrets, he will almost certainly find it more difficult to distance himself from his original values. He is likely, as a result, to feel more directly tied to the goals he has repudiated and to be more painfully reminded of their continuing influence in his life.”).

109. See Kaiponanea T. Matsumura, *Binding Future Selves*, 75 LA. L. REV. 71, 86–91 (2014) (discussing how courts employ a “different selves” rationale to depart from traditional contract principles).

110. See Brock, *supra* note 101, at 1809 (arguing that there is no reason to favor the self at Time 1 over self at Time 2); Thomas C. Schelling, *Ethics, Law, and the Exercise of Self-Command*, in 4 THE TANNER LECTURES ON HUMAN VALUES 75 (Sterling M. McMurrin ed., 1983) (“Both selves can be authentic That both selves are authentic does not eliminate the issue. We must still decide which request to grant. But if both selves deserve recognition, the issue is *distributive*, not one of *identification*.”).

111. It is also premised on the assumption of continuous personal identity, or the idea that the self at Time 1 and the self at Time 2 are the same person. If the Time 1 and Time 2 selves were not the same person, then prospective decision-making would not be permissible, as individuals typically cannot bind others without their consent. See David DeGrazia, *Advance Directives, Dementia, and “The Someone Else Problem”*, 13 BIOETHICS 373, 374–79 (1999). Continuous personal identity has been justified by philosophers in a variety of ways. Some argue that it derives from the fact that the physical body is the same at Time 1 and Time 2. See, e.g., ERIC T. OLSON, *THE HUMAN ANIMAL: PERSONAL IDENTITY WITHOUT PSYCHOLOGY* (1997) (arguing for a biological approach to personal identity); Judith Jarvis Thomson, *People and Their Bodies*, in *READING PARFIT* 202 (Jonathan Dancy ed., 1997) (exploring the “physical criterion” of personal identity). Others believe that it is justified by the presence of psychological continuity between the self at Time 1 and Time 2. See, e.g., Sydney Shoemaker, *Personal Identity: A Materialist’s Account*, in *PERSONAL IDENTITY* 67, 89–91 (Sydney Shoemaker & Richard Swinburne eds., 1984). This is the view that has the most traction among Westerners. See Shaun Nichols & Michael Bruno, *Intuitions about Personal Identity: An Empirical*

2 was not someone to whom you should listen because he was under the influence of the mind-affecting tune of the Sirens, which would lead him to ruin. As a moral matter, we are sympathetic to his crew, who did not honor his request to be untied.¹¹² In many cases of persistent incapacity, unconsciousness or degenerative conditions plainly deprive a person of the necessary mental faculties needed to make decisions. In those situations, an individual lacks legal capacity and is no longer a legally recognized subject in the relevant decision-making domain.¹¹³ Thus, we favor the self at Time 1 (or the agent empowered by the self at Time 1) because that past self still had all her mental faculties when making the prospective decision, even if that past self might be distant in time.

Several thinkers have put forth moral justifications for this legal state of affairs, but the most influential account has been that of Ronald Dworkin.¹¹⁴ His defense of advance directives is based on the nature of the

Study, 23 PHIL. PSYCHOL. 293, 307 (2010). Still others take a more relational understanding of personal identity, seeing continuity through the relationships one has at Time 1 and Time 2. See Ho Mun Chan, *Sharing Death and Dying: Advance Directives, Autonomy and the Family*, 18 BIOETHICS 87, 99–100 (2004); Søren Holm, *Autonomy, Authenticity, or Best Interest: Everyday Decision-Making and Persons with Dementia*, 4 MED. HEALTH CARE & PHIL. 153, 157 (2001) (“My maternal grandfather kept on being my maternal grandfather, even at a time when his dementia had developed so far that he could no longer recognise me as his grandson.”).

This assumption has come under fire from Derek Parfit, who argues that personal identity is more a matter of degree—i.e. how strong the connections are between the self at Time 1 and Time 2—rather than being an all-or-nothing affair. See Derek Parfit, REASONS AND PERSONS 205–12 (1984). Parfit also critiques the continuous personal identity assumption on instrumental grounds. See Derek Parfit, *Personal Identity*, 80 PHIL. REV. 3, 3 (1971) (“It makes people assume that the principle of self-interest is more rationally compelling than any moral principle. And it makes them more depressed by the thought of aging and of death.”). Despite the power of these critiques, the law has not been too troubled in assuming continuous personal identity. Without it, it would be difficult for the law to have regulatory force in managing relationships between people over time. See Nancy K. Rhoden, *The Limits of Legal Objectivity*, 68 N.C. L. REV. 845, 854 (1990) (“The principle ‘one body, one person’ is a virtual necessity for the criminal justice system, for duties to honor one’s contracts, or to pay for one’s torts. Without unified personal identity, ‘new persons’ could spring fully formed into existence and legitimately could deny all family and financial obligations.”). But see generally Rebecca Dresser, *Personal Identity and Punishment*, 70 B.U. L. REV. 395 (1990) (arguing that criminal punishment can accommodate Parfit’s view of reductionist identity).

112. Some jurisdictions, using this logic, have enacted statutes allowing for psychiatric advance directives, which allow people with mental illness to agree in advance to forced hospitalization and medication. See, e.g., N.C. GEN. STAT. § 122C-71 (2015); WYO. STAT. ANN. § 35-22-307 (2015); Justine A. Dunlap, *Mental Health Advance Directives: Having One’s Say?*, 89 KY. L.J. 327, 386 (2001) (advocating for advance directives for mental illness). These statutes, however, remain controversial. See Dresser, *supra* note 97, at 838–46 (noting the power imbalance between psychiatrists and their patients); Robert D. Miller, *Advance Directives for Psychiatric Treatment: A View from the Trenches*, 4 PSYCHOL. PUB. POL’Y & L. 728, 737–44 (1998) (identifying several problems with these types of advance directives).

113. Capacity is not a global status. It is domain-specific, requiring “a determination of a particular person’s capacity to perform a particular decision-making task at a particular time and under specified conditions.” ALLEN E. BUCHANAN & DAN W. BROCK, DECIDING FOR OTHERS: THE ETHICS OF SURROGATE DECISION MAKING 18 (1990).

114. See RONALD DWORKIN, LIFE’S DOMINION 190–96 (1993); see also JEFF MCMAHAN, THE ETHICS OF KILLING: PROBLEMS AT THE MARGINS OF LIFE 502–03 (2002); Penney Lewis, *Medical*

different interests we might have in life and their relative importance. Specifically, he creates a dichotomy between *critical interests* and *experiential interests*. The former are those “[c]onvictions about what helps to make a life good” that reflect “critical judgments.”¹¹⁵ Critical interests are intertwined with our values, our life plan, and our narrative sense of self.¹¹⁶ They might include such things as having close relationships with loved ones, pursuing a meaningful career, or striving to be a person who tells the truth. We conclude what might be in our critical interests through the process of rational deliberation and reflection.¹¹⁷

Experiential interests, in contrast, are things we do “because we like the experience of doing them.”¹¹⁸ This might be eating good food, listening to music, or taking a walk on a warm summer’s day. Dworkin’s argument, in a nutshell, is that critical interests should trump experiential interests.¹¹⁹ Critical interests generated while one was still capable of deliberation and reflection should guide life during periods of incapacity when such deliberation and reflection are not possible.¹²⁰ This is an exercise in controlling one’s own life narrative.¹²¹

A number of theorists have challenged the presumptive legal enforceability of advance directives by attacking the moral and legal subordination of the self at Time 2. Rebecca Dresser has argued that it is not clear why the critical interests of the Time 1 self are relevant to a person who no longer has the capacity to understand or value those interests due to cognitive impairment.¹²² Instead, the focus should be on the objective welfare of the present self, even if those welfare interests are

Treatment of Dementia Patients at the End of Life: Can the Law Accommodate the Personal Identity and Welfare Problems?, 13 EUR. J. HEALTH L. 219 (2006) (suggesting that not allowing a person to have some control over their future self would infringe on human rights).

115. DWORKIN, *supra* note 114, at 201–02.

116. See Ben A. Rich, *Prospective Autonomy and Critical Interests: A Narrative Defense of the Moral Authority of Advance Directives*, 6 CAMBRIDGE Q. HEALTHCARE ETHICS 138, 144–45 (1997).

117. DWORKIN, *supra* note 114. For an interesting defense of rational deliberation on important life matters, see generally HENRY S. RICHARDSON, *PRACTICAL REASONING ABOUT FINAL ENDS* (1994).

118. DWORKIN, *supra* note 114, at 201.

119. *Id.*

120. See John K. Davis, *The Concept of Precedent Autonomy*, 16 BIOETHICS 114, 131–32 (2002) (arguing that one’s “most-informed,” “highest-order” preference should win out even if it is older because the latest preference does not necessarily reflect the highest-order preference). Agnieszka Jaworska has argued that many people with dementia are still capable of forming critical interests because they are capable of valuing. While many people with dementia lose memories of their early lives, they may still make decisions adhering to values that were formed as part of their own personal narrative or that reflect new commitments in life. See Agnieszka Jaworska, *Respecting the Margins of Agency: Alzheimer’s Patients and the Capacity to Value*, 28 PHIL. & PUB. AFFAIRS 105, 116 (1999).

121. See MARYA SCHECTMAN, *THE CONSTITUTION OF SELVES* 94–114 (1996) (describing the narrative view of self).

122. See Rebecca S. Dresser & John A. Robertson, *Quality of Life and Non-Treatment Decisions for Incompetent Patients: A Critique of the Orthodox Approach*, 17 J.L. MED. & HEALTH CARE 234, 236 (1989).

comprised only of experiential ones.¹²³ In the case of persistent incapacity, this is reinforced by the fact that there is no chance that the Time 1 self will reemerge, so the perspective of the Time 2 self should prevail.¹²⁴

Dresser's views draw support from disability activists, who have argued that legal capacity is a disabling force in society.¹²⁵ They argue that legal capacity is a human right, and a variety of laws empowering past selves or surrogate decision-makers should be reformulated to put the present self with cognitive impairments at the center of analysis.¹²⁶ This leads to supportive modes of decision-making, in which caregivers and advisors attempt to facilitate the desires and decisions of the person with disabilities to the extent possible, rather than supplanting that person's decision-making.¹²⁷ Legal scholars have extended these insights, arguing for a reformulation of the legal standard for capacity to consent to sex as well.¹²⁸

The difference between the Dworkinian view and the views of his critics can be encapsulated in the oft-discussed story of Margo, first reported by a medical student named Andrew Firlik in an article nearly twenty-five years ago.¹²⁹ Margo is a woman aged fifty-five with Alzheimer's Disease. She enjoys several of her daily activities, including consuming peanut butter and jelly sandwiches with milk, reading mystery novels, listening to records, and attending an art therapy class.¹³⁰ She experiences some of these activities differently than someone without

123. See Rebecca Dresser, *Precommitment: A Misguided Strategy for Securing Death with Dignity*, 81 TEX. L. REV. 1823, 1840–41 (2003).

124. See Rebecca Dresser, *Missing Persons: Legal Perceptions of Incompetent Patients*, 46 RUTGERS L. REV. 609, 616 (1994) (arguing for looking at decision-making from the perspective of the incapacitated person). There are, of course, those who advocate a compromise view somewhere between Dworkin and Dresser. See, e.g., Alasdair R. Maclean, *Advance Directives, Future Selves and Decision-Making*, 14 MED. L. REV. 291, 313–20 (2006) (analogizing the past-present self relationship to the parent-child relationship, in which the parent has the authority to set some of the terms of the child's life).

125. See Nandini Devi, *Supported Decision-Making and Personal Autonomy for Persons with Intellectual Disabilities: Article 12 of the UN Convention on the Rights of Persons with Disabilities*, 41 J.L. MED. & ETHICS 792, 799 (2013) (“Society must recognize that people with intellectual disabilities have their own desires, wills, and needs and are capable of making choices accordingly.”).

126. See Eilionóir Flynn & Anna Arstein-Kerslake, *The Support Model of Legal Capacity: Fact, Fiction, or Fantasy?*, 32 BERKELEY J. INT'L L. 124, 127–30 (2014).

127. See Nina A. Kohn et al., *Supported Decision-Making: A Viable Alternative to Guardianship?*, 117 PENN ST. L. REV. 1111, 1128–46 (2013) (assessing the potential of supported decision-making models).

128. See Boni-Saenz, *supra* note 24, at 1233 (“The law should recognize an individual who employs a supported decision-making network as having legal capacity on par with individuals who do not need such support.”); see also Joseph J. Fischel & Hilary R. O’Connell, *Disabling Consent, or Reconstructing Sexual Autonomy*, 30 COLUM. J. GENDER & L. 428, 487 (2016) (arguing for “sociopolitical accommodations—access, education, and assistance—to facilitate sex”).

129. Andrew D. Firlik, *Margo's Logo*, 9 J. AM. MED. ASS'N 201, 201 (1991). Firlik shared his experiences visiting with her as part of a gerontology elective. See *id.*

130. See *id.*

Alzheimer's might, as she does not seem to be reading her novel sequentially; each time she listens to a song it was as if she were listening to it for the first time; and she always paints the same picture of four soft rosy circles in art class.¹³¹ Notably though, Firlik declared the following: "Despite her illness, or maybe somehow because of it, Margo is undeniably one of the happiest people I have known."¹³²

Suppose that Margo were to get severe pneumonia, which would lead to her death if she did not receive antibiotics. If Margo left an advance directive declaring that she should not be given any health-care treatment while suffering from Alzheimer's Disease, Dworkin argues that the directive should be followed, leading to her death.¹³³ This would be a fulfillment of her wishes about how to live out the end of her life, i.e. not in a cognitively diminished state. In contrast, Dresser and many disability activists see this as an affront to Margo's humanity.¹³⁴ In their view, she deserves quality healthcare treatment, and enforcing the advance directive would deny her present interests in continuing to live, to enjoy her daily activities, and to experience happiness.¹³⁵ This debate presents compelling arguments on both sides, and it is unlikely to be resolved any time soon.

If Margo had filled out a sexual advance directive, the debate would look similar, as sexuality implicates both important critical interests of concern to the self at Time 1 and experiential interests of concern to the self at Time 2. The experiential interests are perhaps more obvious given the importance of sexual expression to physical pleasure through bodily contact and sexual release.¹³⁶ The critical interests encompass any way in which sex is important to one's life plan. For example, people incorporate their sexual practices into their identities in a variety of ways.¹³⁷ This could be represented by the identity of a heterosexual man who's "got game" or a sexual minority, such as a lesbian, who understands her identity through the fact that she only has sex with women. Sexual acts might also be connected

131. *See id.*

132. *Id.*

133. *See* DWORKIN, *supra* note 114, at 226–27.

134. *See* Rebecca Dresser, *Dworkin on Dementia: Elegant Theory, Questionable Policy*, 25 HASTINGS CTR. REP. 32, 38 (1995) ("Their loss of higher-level intellectual capacities ought not to exclude people like Margo from the moral community nor from the law's protective reach, even when the threats to their well-being emanate from their own former preferences.").

135. *See id.* at 37.

136. *See* ABRAMSON & PINKERTON, *supra* note 89, at 8–10 (discussing the neurobiology of sexual pleasure); RAJA HALWANI, PHILOSOPHY OF LOVE, SEX, AND MARRIAGE 153–61 (2010) (discussing the subjective features of sexual pleasure).

137. *See* Gowri Ramachandran, *Delineating the Heinous: Rape, Sex, and Self-Possession*, 123 YALE L.J. ONLINE 371, 386 (2013) ("Who one has sex with often signifies something important about one's social identity. It communicates what one finds desirable, who one is desirable to, even sometimes what one thinks about gender, domestic labor, and children.").

to critical interests through one's sexual relationships with others.¹³⁸ Examples might include the maintenance of a monogamous sexuality for conservative Christians in marriage to the collection of a set of friends who participate in a BDSM community.

B. *The Consensus of Consents*

This Article does not endeavor to resolve this contentious and longstanding philosophical debate, as applied to sexuality or any other decision-making realm. There is, however, a way to diffuse the tension between these two views with respect to sexual advance directives. The debates over advance directives paint a picture of the Time 1 and Time 2 selves in conflict, but it is quite possible that the two temporal selves' interests will actually align in many situations. In other words, the Time 1 self will provide prospective consent to sex, while the Time 2 self will token contemporaneous consent.¹³⁹ When this occurs, there is a *consensus of consents*, and theorists from both sides of the philosophical divide would likely agree that sexual advance directives then serve important purposes.¹⁴⁰

In the example of Margo above, Dworkin imagines that she had filled out a restrictive health care advance directive, which was necessary since the facility in which she lived operated with a default of administering medical treatment to promote health and life.¹⁴¹ The conflict comes because Margo appears to be happy and engaged with the world, albeit in a diminished way. Based on this contextual evidence, one would imagine that Margo would desire to continue to exist if the choice could be put to her.¹⁴² Picture, however, that Margo had filled out an advance directive requesting antibiotic treatment were she to lose capacity and get pneumonia. In this case, there is no potential conflict between Time 1

138. See RICHARD A. POSNER, *SEX AND REASON* 111 (1992) (noting that the sociable benefit of sex “refers to the use of sex to construct or reinforce relationships with other people, such as spouses or friends”).

139. While neither the prospective consent at Time 1 (because of lack of simultaneity with the sexual act) nor the token of consent at Time 2 (because of lack of capacity) constitutes a standard form of consent, I refer to both as consents for simplicity's sake.

140. See Elysa R. Koppelman, *Dementia and Dignity: Towards a New Method of Surrogate Decision-Making*, 27 *J. MED. & PHIL.* 65, 82 (2002) (criticizing an exclusive focus on either the “then self” or the “now self”). These consensus situations also help to resolve the problem that the law often provides insufficient guidance in evaluating capacity, as health care professionals could rely on the joint “Yes” of the past and present selves. See Marshall B. Kapp, *Evaluating Decision-Making Capacity in Older Individuals: Does the Law Give a Clue?*, 4 *LAWS* 164, 165–66 (2015) (noting the lack of guidance the law provides to health care professionals).

141. Dresser, *supra* note 134, at 32.

142. See Ralf J. Jox, *Revocation of Advance Directives*, in *ADVANCE DIRECTIVES* 73, 83 (discussing the practicalities of inferring preferences from behavior).

Margo and Time 2 Margo. In fact, such an advance directive would not even be necessary, given the default in favor of such routine treatment. No one would object to the administration of antibiotics in this case.

Identifying the alignment of interests between the Time 1 and Time 2 selves may be easier in the case of sexuality than in other areas in which advance directives are typically employed. In the case of Margo, we had to infer what her view of medical treatment might be, based on her activities and her generally happy mental state. If you asked her whether she wanted antibiotics or presented her with antibiotics to see if she would take them, it is not clear there would even be a coherent response. In contrast, Margo may actively seek out or avoid sexual contact, and that expressed preference is likely directly related to whatever experiential interests she might associate with that sexual experience. As noted earlier, people with dementia sometimes experience disinhibition of sexual behaviors.¹⁴³ If Margo reached for the genitals of her husband unprompted every time he visited her, we can safely presume that she is tokening consent to some form of sexual contact. This is not to say that communications will necessarily be as straightforward as this in all cases.¹⁴⁴ But sometimes they will, and this expressed preference is meaningful.

The default rule is also important for determining whether there is a consensus of consents. In the current sexual consent regime, there is a legal baseline that sexual contact is impermissible unless it is consented to.¹⁴⁵ Thus, *restrictive* sexual advance directives are not necessary, as the baseline will legally prohibit such sexual acts anyway.¹⁴⁶ What is at issue in

143. See Kitwood, *supra* note 83, at 19; Lothstein, *supra* note 83, at 609.

144. For example, suppose that Margo reached for her *own* genitals every time her husband entered the room. Whether or not this constitutes a token of consent to have her husband sexually touch her would require more information about her methods of communication and sexual engagement. It could represent a desire to masturbate in the presence of her husband only, without sexual touch by him, or it might be an initial part of a sexual script that she regularly employed with her husband that would lead up to sexual touch. Or it could be something else entirely. Each factual scenario will need to be considered on a case-by-case basis, which is the current methodology for assessing expressions of consent. I thank Professor Suzanne Kim for this example.

145. See WERTHEIMER, *supra* note 11, at 119 (“We start with the principle that it is morally and legally impermissible to engage in sexual relations without the other party’s consent.”).

146. Many scholars have suggested reforming the current sexual consent capacity regime to allow people with persistent cognitive impairments to have a sexual life. See, e.g., Boni-Saenz, *supra* note 24, at 1234–43 (proposing the cognition-plus test); Denno, *supra* note 35, at 355–59 (proposing a contextual approach). A strict Dworkinian would likely favor the strong enforcement of restrictive directives in such a regime, as it maintains narrative identity and supports critical interests. There are several reasons why such an analysis would be misguided. First, such a strong view of restrictive sexual advance directives runs counter to the explicit goal of these contextual tests, which is to avoid any hard-and-fast prohibitive rules on sexual expression for people with disabilities. Second, such a view does not comport with the methodology of these tests, which is typically more contextual and holistic. Both restrictive and permissive sexual advance directives, however, could play an important evidentiary role. They might be useful in understanding the favored sexual behavior or relationships of the person with cognitive impairments, or in providing good evidence of whom the person with impairments trusted.

our current regime, then, are *permissive* sexual advance directives. Such directives prospectively set forth a decision to consent to sex or imbue another with decision-making authority to consent to sex in the future. As such, they are an expression of the self at Time 1 that sex is permissible, at least under certain circumstances, or that an agent is trusted to make that call.

To make the consensus of consents concrete, consider several permutations of the case of Justice Sandra Day O'Connor and her husband, John.¹⁴⁷ The Justice stepped down from the bench in 2005 to help her husband move to an assisted living center, as he was suffering from Alzheimer's Disease. His condition led him to forget his relationship with the Justice, and he developed a new romance with a woman in the facility. Justice O'Connor magnanimously approved of the new relationship, as she saw that it made John happy and fulfilled, whereas before he was depressed. Here, the Justice was acting as an informal agent in blessing a relationship that involved spending time together and holding hands. Now consider the following example:

- John executed a sexual advance directive naming Sandra as his sexual agent, trusting her to do what was best for him when he lost capacity. Based on their behavior together, John and his new romantic partner show an interest in exploring more of a sexual relationship. Sandra, seeing how happy this new relationship makes him, consents on his behalf to some forms of sexual contact with this new woman.

In this case, John has executed a proxy directive. Normally, the facility would likely prevent this type of sexual relationship from developing, fearing legal and regulatory liability.¹⁴⁸ However, John at Time 1 and John at Time 2 are in agreement that the outcome should be sexual contact, given that Sandra consents as her husband's sexual agent. Here, the advance directive is useful in actualizing the critical interests of the pre-impairment self, as it allows John to recognize the importance of his relationship with his wife and his trust in her. But it is also important for promoting the experiential interests of the post-impairment self, by allowing John to have a sexual life and preventing the residential institution in which he resides from being subject to civil or criminal liability simply for permitting sex by residents. In other words, there is no conflict between the self at Time 1 and the self at Time 2, so there is coherence in

147. This narrative is adapted from Kate Zernike, *Love in the Time of Dementia*, N.Y. TIMES (Nov. 18, 2007), <http://www.nytimes.com/2007/11/18/weekinreview/18zernike.html>.

148. See *supra* note 85.

preferences across time.¹⁴⁹ The sexual advance directive is attractive from multiple philosophical perspectives in this case, and the traditional debate about advance directives is mooted.

Things get more complicated, however, when there is disagreement between the Time 1 and Time 2 selves. Consider the following twist:

- John executed a sexual advance directive in which he consented prospectively to intercourse with his wife Sandra in the event he lost legal capacity to consent to sex. His identity as Sandra's spouse was important to him, and he wanted to make sure that the sexual relationship continued if Sandra wanted it. Sandra initiates sexual contact with John, but he does not remember his wife and pulls away from any sexual touch.

In this case, John has executed an instructional directive. However, it seems clear that it should not have the legal effect of making this sexual contact permissible. There are two ways to justify this particular result. First, one might side with Dworkin's critics in the philosophical debates over advance directives generally. There are immensely negative welfare effects to the imposition of unwanted sex, as the literature on rape has demonstrated.¹⁵⁰ That experiential interest seems more important than any critical interest retained by a pre-impairment self in continued sexual contact. In order to protect the bodily integrity and self-determination of the individual with cognitive impairments, said individual must be able to prevent unwanted sex, even if he might not have the ability to affirmatively consent and even if there is a clear directive to the contrary.¹⁵¹ This conclusion is consistent with rejecting Dworkin's hypothesized health care advance directive that would lead to Margo's death. However, one need not take a side in these debates to resolve this particular situation. One could instead argue that one never loses the ability to *not* consent to sex, even if one might not be able to affirmatively consent. Thus, one retains a narrow legal capacity in the sexual decision-making domain, allowing for a partial

149. See JON ELSTER, *ULYSSES AND THE SIRENS: STUDIES IN RATIONALITY AND IRRATIONALITY* 65–68 (1979) (discussing the problem of temporally inconsistent preferences).

150. See, e.g., Rebecca Campbell et al., *An Ecological Model of the Impact of Sexual Assault on Women's Mental Health*, 10 *TRAUMA VIOLENCE & ABUSE* 225 (2009) (describing the long-term negative effects of rape); Lynne N. Henderson, *Review Essay: What Makes Rape a Crime?*, 3 *BERKELEY WOMEN'S L.J.* 193 (1987–88) (describing rape as negation of existence); Robin L. West, *Legitimizing the Illegitimate: A Comment on Beyond Rape*, 93 *COLUM. L. REV.* 1442, 1448 (1993) (describing rape as "spiritual murder").

151. See MICHAEL GILL, *ALREADY DOING IT: INTELLECTUAL DISABILITY AND SEXUAL AGENCY* 32–38 (2015) (noting the high levels of sexual abuse of people with cognitive impairments and the importance of respecting this population as being capable of sexual agency).

revocation of the advance directive with respect to that particular situation.¹⁵²

In either formulation, the importance of consent both at Time 1 and at Time 2 is clear. The Time 1 consent ensures that continued sexual contact comports with the values and life plans of the individual, considered as a whole. The Time 2 consent ensures that the sexual contact is actually desired in the moment. It also respects the bodily integrity of the Time 2 self. Thus, there must exist a consensus of consents before a sexual advance directive should be legally enforceable. The next section examines situations in which it might be difficult to obtain Time 2 consent and how this threatens the consensus of consents.

C. *The Problem of Silence*

The most complex situation is one in which the self at Time 1 consents prospectively to sexual contact but the Time 2 self is silent. Consider the following cases:

- Alexandra, a sixty-year-old woman, executes a sexual advance directive designating her daughter, Becky, as her agent. Alexandra has a stroke, which leaves her mentally aware but unable to communicate. She is admitted to a nursing home. Several men, who had shown romantic interest in Alexandra before the stroke, visit her. The nursing home informs Becky of this, and Becky consents to her mother having sexual contact with one of the male visitors who Becky believes her mother truly liked.
- Carlos, a law school student, is about to undergo a complicated surgical procedure. He executes a sexual advance directive in which he consents prospectively to sex with his long-term girlfriend, up to and including intercourse. The surgery leaves him in a persistent coma, unaware of his surroundings.

These cases help us to determine what the legal implications of silence should be for sexual advance directives.¹⁵³ In Alexandra's case, the self at Time 2 lacks capacity not because of cognitive impairment but because of a communicative impairment.¹⁵⁴ Establishing whether there is in fact a

152. See *People v. Thompson*, 48 Cal. Rptr. 3d 803, 810 (Cal. Ct. App. 2006) ("Even a severely disabled person may object to a sexual touching because he or she finds it unpleasant—a 'bad touch'; this does not necessarily mean he or she could give legal consent.").

153. See Peter Tiersma, *The Language of Silence*, 48 RUTGERS L. REV. 1, 2–5 (1995) (discussing the legal importance of silence in various contexts).

154. See FEINBERG, *supra* note 34, at 316–17.

consensus of consents is quite difficult here. We know that Becky has consented to sexual contact on her mother's behalf, but we lack the information to know whether we are in a situation of consensus or dissensus as between the two temporal selves. Alexandra may indeed want sexual contact, but we cannot peer inside her mind and know. This makes whether or not to honor the sexual advance directive a policy question that involves an analysis of the risk of unwanted sex.¹⁵⁵ We could leave this analysis to Becky as Alexandra's designated agent, but she is not any better situated to peer into Alexandra's mind. Given the significant risks of unwanted sex here, sexual advance directives should be prohibited in this situation.¹⁵⁶

Carlos's case presents a twist on the example from the Introduction, although the cause of the unconsciousness is different, and the incapacitating condition is persistent.¹⁵⁷ Similar to Alexandra's case, we also have no input from the self at Time 2 about what he wants. In practice, it may be difficult in some cases to distinguish whether and to what degree an individual retains consciousness of the outside world, in which case the risks described in Alexandra's case may apply to a larger set of silence cases. Assuming we do accurately know Carlos's condition, his case differs from Alexandra's situation in that the sex will not be subjectively felt as either wanted or unwanted at the moment of the sexual act.¹⁵⁸ This means the risk to the self at Time 2 of experiencing unwanted sex and all that it entails is not present. The closest analogy one could draw is to the practice of having patients sign an informed-consent form authorizing surgery while unconscious.¹⁵⁹ The self at Time 2 in that scenario would also not experience the trauma of unwanted physical intrusion at the moment of the intrusion, and that informed consent form would protect the surgeon from criminal or tort lawsuits.¹⁶⁰

There are several reasons to treat the sexual advance directive here differently from the informed consent form for surgery. First, in the case of surgery, the incapacity is only temporary, so the Time 1 self will reemerge

155. See *People v. Dancy*, 124 Cal. Rptr. 2d 898, 911 (Cal. Ct. App. 2002) (examining the risk of misinterpreted consent in the case of sex during temporary unconsciousness); Catherine L. Carpenter, *On Statutory Rape, Strict Liability, and the Public Welfare Offense Model*, 53 AM. U. L. REV. 313, 353 (2003) (analyzing statutory rape in terms of risk to the defendant).

156. The risks may be even greater here, as rape threatens the personhood of the victim, which may already be in a fragile state given the inability to communicate. See ANN J. CAHILL, *RETHINKING RAPE* 133 (2001) (discussing the personhood threats).

157. See *supra* note 1.

158. See Hilary Young, *R. v. A. (J.) and the Risks of Advance Consent to Unconscious Sex*, 14 CAN. CRIM. L. REV. 273, 285–86 (2010) (discussing the different forms of unconsciousness and their effect on perception).

159. See *supra* note 50.

160. See *supra* note 52.

to enjoy the benefits of the procedure.¹⁶¹ Here, there is no Time 1 self who will reemerge. Second, there are presumably clear benefits to the surgery, and a state of unconsciousness is necessary to perform it. In this case, unconsciousness is not a prerequisite to sexual contact and may in fact inhibit it. Third, and perhaps most importantly, sexual contact with a persistently unconscious person presents serious risks of objectification, or treating “as an object what is really not an object, what is, in fact, a human being.”¹⁶² The lack of interaction from the person with impairments highlights the likelihood that they are being treated as an object.¹⁶³ Such objectification may also serve to perpetuate harmful sexual and gender dynamics as well.¹⁶⁴ This is an independent ground on which recognizing sexual advance directives would be morally problematic in this context. Thus, unless significant actual benefits to the unconscious person can somehow be shown, sexual advance directives should not have legal effect in either of the cases of Time 2 silence.

* * *

This Part established a necessary condition for the legal recognition of sexual advance directives: the consensus of consents. While the prospective consent of the Time 1 self and the contemporaneous token of consent of the Time 2 self diffuse the traditional debate over the legal recognition of advance directives, there remain practical problems of implementation. The next Part addresses how sexual advance directives would work on the ground.

161. This is similar to the reasoning at common law for why lunatics, whose condition was temporary, should be treated differently from idiots, whose condition was persistent. See Louise Harmon, *Falling Off the Vine: Legal Fictions and the Doctrine of Substituted Judgment*, 100 YALE L.J. 1, 16–18 (1990) (describing how the Crown was limited in its control over the lunatic’s property because if the lunatic regained capacity, her property would have to be returned to her).

162. See Martha C. Nussbaum, *Objectification*, 24 PHIL. & PUB. AFF. 249, 257 (1995) (emphasis omitted).

163. Several of the notions Nussbaum describes as being involved in objectification are implicated by this lack of interaction, such as instrumentality (“The objectifier treats the object as a tool of his or her purposes”), denial of autonomy (“The objectifier treats the object as lacking in autonomy and self-determination”), inertness (“The objectifier treats the object as lacking in agency, and perhaps also in activity”), and denial of subjectivity (The objectifier treats the object as something whose experience and feelings (if any) need not be taken into account”). *Id.*

164. See *id.* at 289–90 (noting that “treatment of human beings as tools of the purposes of another” is always morally objectionable unless it takes place in the context of respect for the humanity of the person); CATHARINE A. MACKINNON, TOWARD A FEMINIST THEORY OF THE STATE 124 (1989) (describing the negative effects of sexual objectification on women in particular). *But see* Patricia Marino, *The Ethics of Sexual Objectification: Autonomy and Consent*, 51 INQUIRY 345, 355–61 (2008) (arguing that objectification can be morally permissible if consented to and if the background conditions of equality exist).

III. IMPLEMENTING SEXUAL ADVANCE DIRECTIVES

With the theoretical basis of sexual advance directives identified, what remains is a consideration of the practical difficulties of implementing them. The sexual advance directive is addressed to the non-consent element of the crime of sexual assault and the tort of battery. It would thus play a role in criminal prosecutions and tort lawsuits that involved sexual contact with a person who has persistent cognitive impairments residing in a long-term care institution. Normally a consent defense would not be possible because a person who lacks capacity cannot consent to sex. However, this Article proposes that a defendant in such an action be able to assert a defense of consent composed of two elements: prospective consent in the form of a written sexual advance directive (actualized by a sexual agent in the present, if a proxy directive is employed), and contemporaneous consent in the form of an affirmative token of consent. This is a more complex formulation for consent than is otherwise required, but this complexity is demanded by the nature of the situation involved. These elements are aimed at ensuring that there is a consensus of consents. Section A examines how to ensure this by describing the legal machinery surrounding the consents at Time 1 and Time 2.

The consensus of consents and the consent defense that it represents in a criminal or tort trial, however, are not the entire picture. There are potential problems with each of the consents given at Time 1 and Time 2. The prospective consent at Time 1 is given by someone who has their full mental faculties, but it is also given without full knowledge of the sexual facts in the moment.¹⁶⁵ The token of consent at Time 2 is good for assessing sexual desire, but it is not a consent that necessarily comes from a deliberation of the nature and consequences of the sexual act. A sexual agent empowered at Time 1 and assessing the situation at Time 2 is qualified to judge the sexual situation, but this agent may not be acting with loyalty and care in their proxy decision-making.¹⁶⁶

This points to a need for an additional layer of practical and legal safeguards to ensure that sexual advance directives do not lead to objective harm. Thus, sexual advance directives must be implemented in the context of a long-term care institution, which fills the role of third-party oversight that is present for advance directives in other contexts. In addition, sexual

165. See DANIEL GILBERT, *STUMBLING ON HAPPINESS* 101–08 (2006) (discussing how people fail to predict accurately their future emotional states); Marie-Jo Thiel, *Personal Capacity to Anticipate Future Illness and Treatment Preferences*, in *ADVANCE DIRECTIVES* 17, 24–26 (discussing the difficulties of predicting one's circumstances in the future, especially when illness is involved).

166. See Nina A. Kohn, *Matched Preferences and Values: A New Approach to Selecting Legal Surrogates*, 52 *SAN DIEGO L. REV.* 399, 408–13 (2015) (noting a “congruence problem” between individuals and their proxies’ preferences).

agents authorized under a proxy sexual advance directive must adhere to fiduciary duties of care and loyalty in making proxy sexual decisions. Section B examines these issues.

A. *Ensuring the Consensus of Consents*

The permissibility of sexual advance directives is premised on the consensus of consents that exists between the Time 1 and Time 2 selves. Thus, in order for sexual advance directives to work in practice, there must be a high degree of certainty that the consents at Time 1 and Time 2 are authentic and voluntary. That is, we want to be reasonably sure that the sexual advance directive is actually a reflection of the views of the person who created it, and we want to be reasonably certain that the consent given at the time of the sexual act reflects accurately the person's sexual desires. At Time 1, this involves ensuring that the execution of the sexual advance directive is a sound process. At Time 2, this involves ensuring that there is a valid capacity to communicate sexual desires and an actual affirmative expression of consent. As many people with cognitive impairments reside in institutions, this may also entail a privacy tradeoff, as some form of institutional monitoring may be required for people with severe impairments to ensure Time 2 consent.

1. *Prospective Consent, Execution, and Form*

At the time of the first consent decision, the execution of the sexual advance directive should comply with certain formalities to ensure that the consent is authentic and voluntary. Formalities are most common in the area of wills, where a writing, signature, and attestation of two witnesses are typically required.¹⁶⁷ Powers of attorney tend to be less stringent in the formalities required, generally needing only a writing and signature.¹⁶⁸ Health care advance directives fall somewhere in the middle, often requiring the formalities of wills but with execution requirements varying significantly from state to state.¹⁶⁹

167. See James Lindgren, *Abolishing the Attestation Requirement for Wills*, 68 N.C. L. REV. 541, 550 (1990) (noting how these three requirements have persisted in various forms).

168. See Carolyn L. Dessin, *Acting As Agent Under A Financial Durable Power of Attorney: An Unscripted Role*, 75 NEB. L. REV. 574, 581–82 (1996) (“With respect to execution formalities, durable powers of attorney are generally easier to execute than wills. Typically, the only execution requirements are that the power be in writing and signed by the principal.”). *But see* FLA STAT. ANN. § 709.2105 (West 2013) (requiring two witnesses as well).

169. See, e.g., ARIZ. REV. STAT. ANN. § 36-3221 (West 2014) (requiring a writing, signature, and notarization or a witness who affirms that a notary was present); COLO. REV. STAT. ANN. § 15-18-104 (West 2011 & Supp. 2015) (requiring a writing, signature and two witnesses for a living will); *id.* § 15-14-506 (2011) (requiring no witnesses for a durable medical power of attorney); IDAHO CODE ANN.

Sexual advance directives should be executed with the heightened level of formalities that are traditionally required of wills. These formalities serve important evidentiary and channeling functions for the court.¹⁷⁰ Because the document will be examined in the context of a civil or criminal trial with serious allegations such as rape or sexual battery, it is important that the sexual advance directive provide good evidence of the person's intent with respect to sexual consent or the delegation of the sexual consent decision.¹⁷¹ This simplifies the court's job of determining prospective consent, including what agent was trusted to carry out the principal's wishes, which sexual acts were contemplated, and with whom. Many states include a statutory form that is suggested for execution of health care advance directives, and any sexual advance directives statute should provide for this as well.¹⁷² Such a statutory form would allow the court to process such documents quickly and assess whether they were truly executed with the intent to grant prospective consent.¹⁷³

These formalities also serve important ritual, protective, and expressive functions for the individual executing the document. First, they flag the creation of the sexual advance directive as an important endeavor, since it requires some level of ceremony or ritual.¹⁷⁴ This impresses upon the person executing the document that she is creating an important record that will have legal effect. Given the importance of sexual consent decisions, this guards against the executor acting in a careless or flippant way. The formalities are also protective. Witnesses can help ensure that the advance directive is not signed under duress and that the person executing it has sufficient capacity to do so.¹⁷⁵ This brings in third parties to ensure that the signer is not intoxicated, unconscious, or suffering from some sort of

§ 39-4510 (West Supp. 2016) (requiring no witnesses for either a living will or a durable power of attorney for healthcare); N.J. STAT. ANN. § 26:2H-56 (West 2007) (requiring either two witnesses, a notary, or execution before a lawyer or other person authorized to administer oaths for a health care advance directive); UTAH CODE ANN. § 75-2a-107 (LexisNexis 2012 & Supp. 2016) (allowing oral or written proxy directives, but also requiring one disinterested witness).

170. See Ashbel G. Gulliver & Catherine J. Tilson, *Classification of Gratuitous Transfers*, 51 YALE L.J. 1, 6-7 (1941) (discussing the evidence problem in the will context, namely that the testator cannot testify as to the contents of her will).

171. See John H. Langbein, *Substantial Compliance with the Wills Act*, 88 HARV. L. REV. 489, 492 (1975) ("The primary purpose of the Wills Act has always been to provide the court with reliable evidence of testamentary intent and of the terms of the will.").

172. See, e.g., CONN. GEN. STAT. § 19a-575 (2011) (providing a suggested form); 755 ILL. COMP. STAT. 35/3 (2007) (same).

173. Langbein, *supra* note 171, at 493-94 (noting how standardization is useful to both the court and the individual).

174. See Gulliver & Tilson, *supra* note 170, at 5 ("Compliance with the total combination of requirements for the execution of formal attested wills has a marked ritual value, since the general ceremonial precludes the possibility that the testator was acting in a casual or haphazard fashion.") (footnote omitted); see also Langbein, *supra* note 171, at 494-95 (terming it the "cautionary function").

175. See Anne-Marie Rhodes, *Notarized Wills*, 27 QUINNIPIAC PROB. L.J. 419, 425-26 (2014). But see generally Lindgren, *supra* note 167 (arguing against the attestation requirement).

mental disorder at the time of execution. Finally, the execution of the advance directive presents an opportunity to formally declare one's sexual intent, which can be a meaningful process in recognizing an important relationship or sexual identity.¹⁷⁶

The content of the sexual advance directive is as important as its execution. The jurisprudence of delegation provides helpful guidance on this issue. Delegation of controversial powers typically requires a specific delegation, rather than a general delegation of authority over the entire decision-making domain.¹⁷⁷ In the financial realm, these so-called "hot powers" tend to be those that have the potential to dissipate the assets of an estate or to change an existing estate plan, such as making gifts, creating trusts, or allowing an agent to change beneficiary designations.¹⁷⁸ In the sexual context, these specific delegations take on a more personal flavor, implicating sexual decisions that might be entangled with one's life plan, rather than estate plan.¹⁷⁹

Thus, a general authorization of all possible sexual encounters or a delegation of all sexual decision-making power should not be permissible, as it does not force the individual filling out the advance directive to contemplate actively and precisely the prospective consent being given or the delegation being made.¹⁸⁰ This comports with the fact that sexual consent decisions are consents to specific sexual acts, and the structure of the sexual advance directive form should encourage thinking in these terms. Here, a lesson can be drawn from the format of the Uniform Power of Attorney Act, which lists various specific powers to be delegated with boxes to be initialed next to them.¹⁸¹

176. See David Horton, *Testation and Speech*, 101 GEO. L.J. 61, 61 (2012) (noting the ways in which wills and trusts convey important meanings).

177. See, e.g., *Tenn. Farmers Life Reassurance Co. v. Rose*, 239 S.W.3d 743, 748–49 (Tenn. 2007).

178. See, e.g., *In re Estate of Kurrelmeyer*, 895 A.2d 207, 211–12 (Vt. 2006) (finding specific authorization to create a trust).

179. See Alexander A. Boni-Saenz, *Personal Delegations*, 78 BROOK. L. REV. 1231, 1268 (2013).

180. See Linda S. Whitton, *The Uniform Power of Attorney Act: Striking a Balance Between Autonomy and Protection*, 1 PHOENIX L. REV. 343, 348 (2008) ("Requiring a specific grant of authority for these hot powers not only protects principals from the inadvertent grant of potentially dangerous powers, but also clarifies that a principal may delegate such authority if desired.")

181. Below is the relevant portion of the statutory form from the Uniform Act:

GRANT OF SPECIFIC AUTHORITY (OPTIONAL)

My agent MAY NOT do any of the following specific acts for me UNLESS I have INITIALED the specific authority listed below:

(CAUTION: Granting any of the following will give your agent the authority to take actions that could significantly reduce your property or change how your property is distributed at your death. INITIAL ONLY the specific authority you WANT to give your agent.)

Similarly, the sexual advance directive form should note whether certain sexual acts are being authorized (an instructional directive) or if the power to authorize a particular sexual act is being delegated to another (a proxy directive). It should also list a variety of sexual acts, both mainstream and non-mainstream, with boxes alongside them, allowing for an initialing of which acts one might wish to authorize in the future or allow an agent to authorize in the future. Alongside each box should be a blank line indicating if those acts are limited to particular individuals or if the choice of sexual partner is open.¹⁸² Thus, a person wishing only to preserve a vanilla spousal sexual relationship could authorize a couple of sexual acts with one person. Alternatively, the hedonist could authorize a wide variety of sexual acts with every possible sexual partner. Having myriad sexual acts represented on the form has the benefit of normalizing the many forms of sexual expression that might exist in the population. If a shorter form were desired, any shortened list should be informed by current social science research on the dominant sexual practices of the population.¹⁸³

It is worth noting that sexual advance directives are only helpful to the extent that an individual actually plans in advance, and plans in advance well. To this end, sexual advance directives will work better in a more sex-positive culture.¹⁸⁴ The execution of the directive itself requires that individuals reflect upon and put down in writing their sexual wishes. In a more sex-negative culture, people will avoid advance planning on matters of sexuality, predict badly what they might want out of their future sexual

Create, amend, revoke, or terminate an inter vivos trust

Make a gift, subject to the limitations of the Uniform Power of Attorney Act and any special instructions in this power of attorney

Create or change rights of survivorship

Create or change a beneficiary designation

Authorize another person to exercise the authority granted under this power of attorney

Waive the principal's right to be a beneficiary of a joint and survivor annuity, including a survivor benefit under a retirement plan

Exercise fiduciary powers that the principal has authority to delegate

Disclaim or refuse an interest in property, including a power of appointment

UNIF. POWER OF ATTORNEY ACT § 301 (2006).

182. Thus, each line would contain a place to initial, followed by a type of sexual act, followed by a space for partner designation. For example:

Oral sex _____

183. See William B. Rubenstein, *Do Gay Rights Laws Matter?: An Empirical Assessment*, 75 S. CAL. L. REV. 65, 83–86 (2001) (discussing different types of sex surveys).

184. See Kaplan, *supra* note 7, at 95 (“A sex-positive framework values sexual autonomy and all forms of consensual sexual activities as sources of pleasure and fulfillment. It rejects a view that sex and sexual pleasure are shameful. It respects diverse ways of expressing and experiencing sexuality and sexual pleasure, and rejects a culture that privileges male or heterosexual desire and pleasure above female or queer desire and pleasure.”) (footnotes omitted).

lives, or be less forthcoming about their sexual desires. None of these contributes to a healthy sexual advance directives regime.

Even in a sex-positive culture, it is quite possible that an individual will avoid sexual advance planning, just as individuals avoid advance planning in other contexts.¹⁸⁵ It is also quite possible that an individual might not predict with accuracy her future sexual desires, or she may select an agent who will do a poor job.¹⁸⁶ In all of these cases, the current nature-and-consequences test of legal capacity would continue to prohibit those lacking sufficient cognitive capacities from engaging in sexual activity, regardless of sexual desire or the positive welfare effects of the sexual expression at Time 2. Permitting a sexual life for individuals in these circumstances—and for those who have persistent lifelong impairments and are not permitted to plan in advance at all—thus requires reform of the existing legal regime governing the capacity to consent to sex. I have offered reforms along these lines in other work.¹⁸⁷

This Article presents an alternative solution that would enable people who did have the motivation and foresight to plan ahead to do so and control their future sexual lives on a more individual basis. This solution shares both the strengths and weaknesses of other forms of advance planning, and it will not be appealing to those who do not believe that advance planning is feasible. For those who have not given up on advance planning, however, the goal should be to find ways to increase and make effective advance planning of all types. Several commentators have suggested multiple innovative and promising ideas for accomplishing this.¹⁸⁸ This Article is also animated in part by the hope that with the aging of the population advance planning becomes a more salient and routine exercise in health care, finances, housing, sexuality, and other domains.

185. See Daniel P. Hickey, *The Disutility of Advance Directives: We Know the Problems, but Are There Solutions?*, 36 J. HEALTH L. 455, 457–60 (2003) (discussing the barriers to completion of health-care advance directives); Michael R. McCunney & Alyssa A. DiRusso, *Marketing Wills*, 16 ELDER L.J. 33, 35 (2008) (discussing reasons why people do not execute wills).

186. See Jeremy A. Blumenthal, *Law and the Emotions: The Problems of Affective Forecasting*, 80 IND. L.J. 155, 172–81 (2005) (discussing reasons why people are poor predictors of their own emotional states).

187. See Boni-Saenz, *supra* note 24, at 1234–44 (advocating a move away from a cognitive approach to legal capacity towards a network approach that would permit sexual expression among people with persistent cognitive impairments).

188. See, e.g., Joseph Karl Grant, *The Advance Directive Registry or Lockbox: A Model Proposal and Call to Legislative Action*, 37 J. LEGIS. 81, 83 (2011) (arguing for advance directive registries); Marshall B. Kapp, *The Nursing Home As Part of the Polst Paradigm*, 36 HAMLINE L. REV. 151, 168–69 (2013) (arguing for the use of POLST in nursing homes, as opposed to advance directives); Reid Kress Weisbord, *Wills for Everyone: Helping Individuals Opt Out of Intestacy*, 53 B.C. L. REV. 877, 920–24 (2012) (suggesting a “testamentary schedule” on the state individual income tax return).

2. *Contemporaneous Affirmative Consent*

While formalities help to ensure the quality of the prospective consent at Time 1, the token of consent that is given contemporaneously with the sexual act at Time 2 must also be authentic and entered into voluntarily. As a threshold matter, one must have the ability to express volition.¹⁸⁹ While many people with Alzheimer's Disease or dementia will possess this capacity, there are many who will not. Some conditions will be so severe that an individual cannot coherently communicate a token of consent at all, either through words or action.¹⁹⁰ Alternatively, one might be able to express volition, but a cognitive impairment renders one so suggestible that said expression of volition cannot be said to be voluntary.¹⁹¹ One cannot provide the necessary contemporaneous token of consent here either, as it will not be clear that this expression truly conveys a desire originating primarily from an internal, subjective mental state.

Once these basic requirements are met, there must also be actual verbal or nonverbal evidence of consent.¹⁹² This could be a verbal "Yes," but it could also come in the form of initiation or active pursuit of sexual expression.¹⁹³ It may also be specific to the individual, as every person has unique forms of communication or ways of initiating sexual encounters.¹⁹⁴ For example, one man noted that his wife with Alzheimer's Disease initiated sexual contact by asking, "Shall we play a little bit?"¹⁹⁵ To an outsider, this verbal cue would not necessarily be indicative of a desire to consent to sexual contact. This points to the importance of involving people in the sexual decision-making process who know the person with cognitive impairments well.

189. See Chunlin Leonhard, *The Unbearable Lightness of Consent in Contract Law*, 63 CASE W. RES. L. REV. 57, 67 (2012) (noting that volition is one of the necessary components of consent).

190. See Robert Audi, *Volition, Intention, and Responsibility*, 142 U. PA. L. REV. 1675, 1680 (1994) (discussing the importance of volition as acts of will or as playing an "executory role in action"). This essentially puts us in a position of Time 2 silence, which, as noted earlier, would not be a defensible context for permitting sexual advance directives.

191. JOAN MCGREGOR, *IS IT RAPE?: ON ACQUAINTANCE RAPE AND TAKING WOMEN'S CONSENT SERIOUSLY* 141–42 (2005) (describing how certain cognitive impairments make one much more vulnerable to manipulation).

192. See, e.g., *People v. Miranda*, 132 Cal. Rptr. 3d 315, 339 (Cal. Ct. App. 2011) ("A person can have the ability to give consent even though he or she responds to questions with one or two-word answers and with physical gestures.").

193. See Carole Archibald, *Sexuality and Dementia: The Role Dementia Plays When Sexual Expression Becomes a Component of Residential Care Work*, 4 ALZHEIMER'S CARE Q. 137, 139–40 (2003) (telling the story of Will and Wilma, both with cognitive impairments, who pursued a sexual relationship despite opposition from facility staff); Henneberger, *supra* note 82.

194. See MALCOLM GOLDSMITH, *HEARING THE VOICE OF PEOPLE WITH DEMENTIA* 56–59 (1996) (discussing communication strategies for individuals with dementia).

195. See Gruley, *supra* note 14.

Thus, the consent at Time 2 should be judged using an affirmative consent standard, which construes silence and lack of action as non-consent.¹⁹⁶ This standard has received plenty of attention recently, as many colleges have adopted it in response to concerns about sexual assault on campus.¹⁹⁷ It has, however, been controversial.¹⁹⁸ Many of the concerns focus on the shift of risk to the defendant that such a standard entails; proceeding with an encounter without consent in words or actions from a sexual partner now carries risk of legal liability.¹⁹⁹

Whatever one's views of the affirmative consent standard generally, the case for its application to this context is particularly strong. The population at issue is operating with some form of cognitive and possibly also communicative impairment. Thus, a more demanding consent standard is needed to incentivize sexual partners to ensure that there is a true mental state of acquiescence to the sexual act, as embodied in words or action.²⁰⁰ Because of the vulnerability of this population, it is reasonable for the law to structure the sexual transaction so that sexual partners without impairments must engage with a sense of care and caution.²⁰¹ In other words, any risk-shifting that the standard implies is justified by the disadvantaged social position of one of the sexual partners.²⁰²

196. See SCHULHOFER, *supra* note 24, at 280 (“What decent protection of sexual autonomy requires is . . . a recognition that sexual intimacy must always be preceded by the affirmative, freely given permission of both parties.”); David P. Bryden, *Redefining Rape*, 3 BUFF. CRIM. L. REV. 317, 400 (2000) (“Under the affirmative-consent rule, there would be a rebuttable presumption of nonconsent, which would be overcome by any affirmative expression of desire for sex.”); Lois Pineau, *Date Rape: A Feminist Analysis*, 8 L. & PHIL. 217, 242 (1989) (advocating for a model of “communicative consent”).

197. See Jake New, *The “Yes Means Yes” World*, INSIDE HIGHER ED (Oct. 17, 2014), <https://www.insidehighered.com/news/2014/10/17/colleges-across-country-adopting-affirmative-consent-sexual-assault-policies> (noting that 800 colleges have adopted the affirmative consent standard); see also Reid Wilson, *California to Require ‘Affirmative Consent’ Before Sex*, WASH. POST (Sept. 29, 2014), <http://www.washingtonpost.com/blogs/govbeat/wp/2014/09/29/california-to-require-affirmative-consent-before-sex/> (discussing California’s recent adoption of an affirmative consent standard for its college campuses).

198. See, e.g., KATIE ROIPHE, *THE MORNING AFTER: SEX, FEAR & FEMINISM ON CAMPUS* 62 (1993) (critiquing affirmative consent for portraying women as lacking agency to communicate their desires); Dan Subotnik, *Copulemus in Pace: A Meditation on Rape, Affirmative Consent to Sex, and Sexual Autonomy*, 41 AKRON L. REV. 847, 860–61 (2008) (suggesting that affirmative consent does not reflect current social norms around sex).

199. See Tuerkheimer, *supra* note 26, at 12–13 (summarizing the concerns).

200. See Michelle J. Anderson, *Negotiating Sex*, 78 S. CAL. L. REV. 1401, 1421–27 (2005) (conceptualizing sex as a negotiation process).

201. See Andrew E. Taslitz, *Willfully Blinded: On Date Rape and Self-Deception*, 28 HARV. J.L. & GENDER 381, 437–39 (2005) (highlighting how engaging in a sexual situation with an attitude of care can help prevent self-deception).

202. See Katharine K. Baker, *Gender and Emotion in Criminal Law*, 28 HARV. J.L. & GENDER 447, 453–54 (2005) (noting that affirmative consent is justified when there is greater risk to one of the sexual partners). Some have instead argued for implicit consent based on marital status rather than an affirmative consent standard. See generally Roy G. Spece, Jr. et al., (*Implicit Consent to Intimacy*, 50 IND. L. REV. (forthcoming 2017)). There are two major problems with such an approach. First, it seemingly reinserts a resistance requirement into rape law for cognitively impaired individuals. This

The Time 2 contemporaneous consent will take place in the context of an institution in which the person with persistent cognitive impairments resides. This both presents an opportunity to ensure a contemporaneous token of consent that is consistent with the wishes outlined in the sexual advance directive and highlights a potential privacy tradeoff in implementing sexual advance directives.²⁰³ Many institutions will understandably want both to protect residents from sexual abuse and to protect themselves from legal liability. To accomplish these objectives, these institutions may decide to monitor electronically all resident sexual activity to ensure that there is contemporaneous consent.²⁰⁴

For residents who are more severely cognitively impaired but who can still express volition, this type of monitoring may indeed be necessary for protective purposes. Individuals with significant cognitive impairments may not be able to communicate that there was sexual contact that exceeded the scope of consent, that there was a withdrawal of sexual consent during the act itself, or that some other consent-based problem was present in the sexual encounter. The privacy cost that this type of monitoring entails is one that some individuals or their partners will not be willing to stomach. Said individuals are free to make the valid choice of privacy over sexual expression. For those who are willing to sacrifice some privacy for the opportunity to engage in sexual expression and the physical and social benefits it provides, however, the tradeoff may be worth it.²⁰⁵

requirement, already inappropriate for those without impairments, is particularly unsuitable for people with persistent cognitive impairments, who often have diminished capacity to express dissent. Second, even if it were appropriate, it fails to provide a solution for those who lack a spouse or simply desire sexual contact with non-spousal partners.

203. See Kristine S. Knaplund, *The Right of Privacy and America's Aging Population*, 86 DENV. U. L. REV. 439, 442 (2009) (discussing this tradeoff).

204. This raises a similar set of issues as those that have been raised in the so-called “granny cam” debates. See generally Katherine Anne Meier, *Removing the Menacing Specter of Elder Abuse in Nursing Homes Through Video Surveillance*, 50 GONZ. L. REV. 29 (2015) (arguing for increased surveillance in nursing homes to combat elder abuse); Bradley J.B. Toben & Matthew C. Cordon, *Legislative Stasis: The Failures of Legislation and Legislative Proposals Permitting the Use of Electronic Monitoring Devices in Nursing Homes*, 59 BAYLOR L. REV. 675 (2007) (discussing legislative movement on these issues). Monitoring in the context of sexual advance directives would require a more limited form of electronic surveillance than that proposed in many states, as it would only apply to sexual encounters rather than to the entire nursing home. This would help to avoid some of the objections raised about the privacy interests of other residents and nursing home staff in the cases of general surveillance.

205. Empirical studies indicate that privacy preferences in the population are heterogeneous. See Victoria Schwartz, *Disclosing Corporate Disclosure Policies*, 40 FLA. ST. U. L. REV. 487, 502–05 (2013) (discussing the various empirical studies). In addition, privacy may be a less salient issue when one is experiencing various forms of impairment that create a need for assistance, even in intimate tasks. See Cheryl Marie Wade, *It Ain't Exactly Sexy*, in *THE RAGGED EDGE: THE DISABILITY EXPERIENCE FROM THE FIRST FIFTEEN YEARS OF THE DISABILITY RAG* 92 (Barrett Shaw ed., 1994) (“[W]e must have our asses cleaned after we shit and pee. Or we have others’ fingers inserted into our rectums to assist shitting. Or we have tubes of plastic inserted inside us to assist peeing or we have rerouted anuses and pissers so we do it all into bags attached to our bodies. These blunt, crude realities.

It is important to remember, however, that there are many levels of cognitive impairment, and those who are less cognitively impaired (but still of questionable legal capacity) may not require such invasive monitoring.²⁰⁶ This is not to say that institutional staff should ignore sexual encounters in these circumstances—and thus miss out on potential calls of distress—but they need not monitor the entire sexual encounter in detail either. This grey area of legal capacity is where sexual advance directives might be most useful, as they would permit sexual activity under relatively “normal” conditions for the sexual participants, while easing fears of liability for institutions. In sum, these privacy tradeoffs must be handled on a case-by-case basis, taking into account the level of cognitive impairment and the particulars of the sexual interaction. A blanket policy of invasive monitoring of all resident sexual activity would thus be misguided, as it may not always be necessary to reasonably ensure contemporaneous consent.

B. Third-Party Oversight and Fiduciary Duties

Advance directives always require third-party interaction and oversight for successful implementation.²⁰⁷ Instructional directives are not self-executing, creating a need for someone or some entity to interpret and implement them.²⁰⁸ The law leans heavily on trusted institutions or professions to perform this implementation function in other areas.²⁰⁹ In fact, the implementing entity is typically the one towards whom the advance decision is directed. For example, doctors are supposed to honor the treatment preferences expressed in a living will, and they are bound by

Our daily lives. Yeah, I know it ain't exactly sexy The difference between those of us who need attendants and those who don't is the difference between those who know privacy and those who don't.”). Finally, it may be the case that individuals with cognitive impairments may not even recognize the need for privacy in sexual encounters, especially if their sexual behaviors are a result of disinhibition.

206. For example, in a recent case of sex among nursing home residents with dementia in Iowa, an eighty-seven-year-old woman in the encounter had demonstrated the capacity to violently reject situations that displeased her, and in fact had expressed this capacity to fight off nursing home staff that tried to terminate her intercourse with a fellow resident. *See* Boni-Saenz, *supra* note 24, at 1214–15 (describing the case).

207. *See* Holm, *supra* note 111, at 158.

208. *See* Muriel R. Gillick, *Doing the Right Thing: A Geriatrician's Perspective on Medical Care for the Person with Advanced Dementia*, 40 J.L. MED. & ETHICS 51, 54 (2012); *see also* Holm, *supra* note 111, at 158 (arguing that we will never “be able to relieve the care giver of his or her obligation to personally assess the desires and decisions of . . . possibly incompetent patients and ethically choose which to respect and which to counteract”).

209. *See* George J. Alexander, *Time for a New Law on Health Care Advance Directives*, 42 HASTINGS L.J. 755, 760 (1991) (discussing how directives are aimed at the physician).

a code of ethics and are subject to state licensing regimes.²¹⁰ Similarly, wills are addressed to the probate court, and judges are supposed to honor the wishes of the testator as embodied in the distributional directives in the will.²¹¹

In the case of a proxy directive, the principal designates an agent who has the authority to make decisions. Even these agents, however, must interact with third parties in order to actualize their authority under the directive. Health-care agents must cooperate with the medical profession to implement health-care decisions, and financial agents acting under a power of attorney must often deal with financial institutions in order to manage the financial resources of the principal. In addition to the natural check provided by these institutions and professions, agents are further constrained by fiduciary duties, which subject them to judicial oversight. Remedies for breach of these fiduciary duties are typically quite severe, both to channel moral outrage at the abuse of trust that they entail and to act as a strong deterrent against future breaches.²¹²

Long-term care facilities, such as assisted-living facilities, nursing homes, and continuing-care retirement communities, fill this role for sexual advance directives. They house a large proportion of older adults with cognitive impairments, thus granting them familiarity with this population and its needs.²¹³ In addition, these institutions already actively manage both the social environment and intimate care of residents.²¹⁴ In serving

210. See generally TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* (7th ed. 2012) (the seminal text of medical ethics); Timothy Stoltzfus Jost, *The Necessary and Proper Role of Regulation to Assure the Quality of Health Care*, 25 HOUS. L. REV. 525, 533 (1988) (discussing the regulation of the medical profession).

211. See Alexander, *supra* note 209; see also *McLean v. Brasfield*, 460 So. 2d 153, 155 (Ala. 1984) (“The polestar to guide a court in the construction of a will is the intent of the testator . . .”).

212. See *Meinhard v. Salmon*, 164 N.E. 545, 546 (1928) (noting that fiduciaries are “held to something stricter than the morals of the market place”); Robert H. Sitkoff, *The Economic Structure of Fiduciary Law*, 91 B.U. L. REV. 1039, 1043 (2011) (“Stripped of legalistic formalisms and moralizing rhetoric, the functional core of the fiduciary obligation is *deterrence*.”) (footnote omitted).

213. Theoretically, professional sex workers could also help to fill this role, and there is some evidence that they do so successfully in other countries by specializing in populations who have cognitive impairments. See DOUGLAS WORNELL, *SEXUALITY AND DEMENTIA* 159 (2014) (noting how sex workers may have a role to play in addressing the sexual needs of older adults with dementia); KULICK & RYDSTRÖM, *supra* note 88, at 205–16 (describing how sex workers in Denmark provide services to people with cognitive disabilities). In the United States, however, sex work is generally prohibited by law, and thus has not achieved any significant level of professional organization or a separate code of ethics. See Sylvia A. Law, *Commercial Sex: Beyond Decriminalization*, 73 S. CAL. L. REV. 523, 526 (2000) (“The United States is unique among the nations of Western Europe and the British Commonwealth in imposing and enforcing criminal sanctions on people who offer sexual services for money.”). In addition, this is at best a partial solution as a person with cognitive impairments may desire sexual partners beyond those involved in sex work.

214. See Julian C. Hughes et al., *Sexuality in Dementia*, in *THE LAW AND ETHICS OF DEMENTIA* 227, 232–36 (Charles Foster et al. eds., 2014) (discussing several cases exploring the complexity of the relationships between family members, staff, and residents); Andrew Weinberg, *Risk Management and Quality-of-Care Concerns in Long-Term Care*, in 7 *ETHICS, LAW, AND AGING REVIEW: LIABILITY*

residents' various needs, these institutions should treat sexual expression similarly to other issues that are routinely managed, such as nutrition, pressure ulcers, or medical treatment.²¹⁵ Medical professionals operating in long-term care facilities are beginning to grapple formally with resident sexuality, indicating a desire to tackle this issue as well.²¹⁶

Practically, this means protecting the individual with cognitive impairments from the objective welfare threats entailed by sexual contact. This oversight is needed because such concerns could not enter into the decision-making process at Time 1 because they were not known. Nor could they enter at Time 2 because the cognitive impairment prevents their contemplation. The content of this protection depends on the situation, but examples might include providing a physical space that minimizes risk of fall or physical injury during sexual activity²¹⁷ and guarding against threats to the health of the person with cognitive impairments, such as sexually transmitted diseases.²¹⁸ As noted earlier, there will likely be some tradeoff between due care and privacy, as more intrusive measures might be needed to manage sexual expression of nursing home residents. Whether or not these privacy invasions are warranted or whether the sexual contact would still be desired given the privacy tradeoff is something that should be evaluated on a case-by-case basis by the institution in consultation with family members.²¹⁹

This is not to say that long-term care institutions are perfectly suited to perform these tasks; in fact, many institutions are substandard.²²⁰ Sexual advance directives will work best in a quality system of long-term care, and many institutions may not be prepared to implement them yet. Facilitating the sexual lives of residents is possible only if long-term care institutions

ISSUES AND RISK MANAGEMENT IN CARING FOR OLDER PERSONS 101, 103–04 (Marshall B. Kapp ed., 2001) (discussing the different areas of long-term care management).

215. See Fay A. Rozovsky, *Informed Consent as a Loss Control Process*, in 2 RISK MANAGEMENT HANDBOOK FOR HEALTHCARE ORGANIZATIONS: CLINICAL RISK MANAGEMENT 77, 92–97 (Roberta Carroll & Sylvia M. Brown eds., 6th ed. 2011) (describing the importance of these types of procedures generally).

216. See AMDA—THE SOCIETY FOR POST-ACUTE AND LONG-TERM CARE MEDICINE, CAPACITY FOR SEXUAL CONSENT IN DEMENTIA IN LONG TERM CARE (2016) (a recent white paper on this topic by the medical specialty society of health professionals operating in long-term care facilities).

217. See Marshall B. Kapp, *Resident Safety and Medical Errors in Nursing Homes Reporting and Disclosure in a Culture of Mutual Distrust*, 24 J. LEGAL MED. 51, 59–60 (2003) (discussing the problem of falls in nursing homes).

218. See GAYLE APPEL DOLL, SEXUALITY & LONG-TERM CARE: UNDERSTANDING AND SUPPORTING THE NEEDS OF OLDER ADULTS 216–20 (2012) (discussing sexual health strategies in long-term care).

219. See Evelyn M. Tenenbaum, *To Be or to Exist: Standards for Deciding Whether Dementia Patients in Nursing Homes Should Engage in Intimacy, Sex, and Adultery*, 42 IND. L. REV. 675, 694–95 (2009) (discussing the importance of involving family members in the decision-making process).

220. See, e.g., Seymour Moskowitz, *Golden Age in the Golden State: Contemporary Legal Developments in Elder Abuse and Neglect*, 36 LOY. L.A. L. REV. 589, 627 (2003) (discussing issues of abuse and neglect in nursing homes).

are cognizant of the needs for sexual expression among residents and adopt policies that facilitate sexual environments with sexual choice and freedom from sexual abuse.²²¹ Underlying the ability of long-term care institutions to facilitate sexual expression is the basic economic issue of providing adequate financing for long-term care services.²²² Such funding would assist in addressing one of the largest chronic problems among nursing homes, which is understaffing.²²³ If long-term care institutions are expected to manage the sexual lives of residents in line with sexual advance directives, they must have sufficient manpower to conduct capacity assessments and to manage residents' social and physical environments.

Sexual agents empowered by sexual advance directives must also interact with these institutions to convey and implement sexual decisions. In exercising their power under sexual advance directives, these sexual agents bear the burden of fiduciary duty.²²⁴ A fiduciary is an individual who is in a position of power and trust with respect to another person, putting that other person at risk if the fiduciary does not act in her interests.²²⁵ Because of their position of power and trust, fiduciaries have certain duties.²²⁶ The first is the duty of care, which requires the agent to "perform their services with prudence, attention, and proficiency."²²⁷ The second is the duty of loyalty, which requires that an agent act in the interests of the person for whom the agent is a fiduciary.²²⁸

A sexual agent's duty of care mimics the requirement that institutions adhere to a standard of care with respect to their residents, requiring that

221. See Winnie Hu, *Too Old for Sex? Not at This Nursing Home*, N.Y. TIMES (July 12, 2016), <http://www.nytimes.com/2016/07/13/nyregion/too-old-for-sex-not-at-this-nursing-home.html> (describing the sexual expression policy at Hebrew Home and the resulting sexual activity among residents).

222. See Richard L. Kaplan, *Retirement Planning's Greatest Gap: Funding Long-Term Care*, 11 LEWIS & CLARK L. REV. 407, 409 (2007) (discussing the problems in the funding of long-term care).

223. See MARGARET C. JASPER, HOSPITAL LIABILITY LAW 86 (2d ed. 2008) ("More than one-half of American nursing homes are below the suggested minimum staffing level for nurse's aides, and more than one-third of nursing homes fell below the suggested minimum staffing level for registered nurses. Of total licensed staff, nearly one-fourth of all nursing homes routinely fall below the suggested minimum staffing level."); Donna R. Lenhoff, *LTC Regulation and Enforcement: An Overview from the Perspective of Residents and Their Families*, 26 J. LEGAL MED. 9, 11 (2005) (noting the problem of understaffing in long-term facilities).

224. See *Vogt v. Warnock*, 107 S.W.3d 778, 784 (Tex. Ct. App. 2003) (finding that the power of attorney conclusively creates a fiduciary relationship); D. Gordon Smith, *The Critical Resource Theory of Fiduciary Duty*, 55 VAND. L. REV. 1399, 1455-56 (2002) (grouping agency relationships among the "easy" cases of fiduciary relationships).

225. See TAMAR FRANKEL, FIDUCIARY LAW 4 (2011) ("While the definitions of fiduciaries are not identical, all definitions share three main elements: (1) entrustment of property or power, (2) entrustors' trust of fiduciaries, and (3) risk to the entrustors emanating from the entrustment.").

226. See *id.* at 103.

227. *Id.* at 169.

228. See RESTATEMENT (THIRD) OF AGENCY § 8.01 (AM. LAW INST. 2006) ("An agent has a fiduciary duty to act loyally for the principal's benefit in all matters connected with the agency relationship.").

sexual agents work to eliminate objective harms to the principal generated by sexual expression. Thus, there is a convergence of interests between the sexual agent and the institution with which they deal, all geared towards protecting the principal from harm.²²⁹ The duty of loyalty means that the individual must act within the scope of the consent granted in the sexual advance directive and the consent granted at the time of the sexual transaction.²³⁰ Thus, in this context, it duplicates the requirement to honor the consensus of consents.

There is an additional wrinkle, however, in the duty of loyalty for many sexual agents. In numerous cases, the sexual agent will also be a primary sexual partner of the person with cognitive impairments, such as a spouse. This technically constitutes a conflict of interest, and the traditional understanding of the duty of loyalty prohibits such conflicts.²³¹ The consequence of adopting the traditional view would be to prohibit sexual contact and deprive many people of a continued long-term sexual relationship that was likely the goal in executing a sexual advance directive in the first place. This problem is not unique to the sexual sphere, as powers of attorney often empower agents whose economic or other interests intersect with those of the principal as well.²³² Thus, the modern view, embodied in the Uniform Power of Attorney Act, permits such conflicts if they are in the best interests of the principal.²³³ This recognizes that proxy directives are meant to be a more informal way of handling the delegation of decision-making, and that such conflicts may be an inevitable consequence of delegation to family members or loved ones.²³⁴

229. Each will serve as a check on the other to ensure that neither has become a “rebel proxy” whose judgment should be overridden because she or it is not acting in the interests of the person with cognitive impairments. See ROBERT S. OLICK, TAKING ADVANCE DIRECTIVES SERIOUSLY: PROSPECTIVE AUTONOMY AND DECISIONS NEAR THE END OF LIFE 174–76 (2003).

230. UNIF. POWER OF ATTORNEY ACT § 114 (2006) (discussing this as one of the three non-waivable elements of the agency). The other two are that the agent act in good faith and “act in accordance with the principal’s reasonable expectations to the extent actually known by the agent and, otherwise, in the principal’s best interest.” *Id.*

231. See *Hartmann v. Hartle*, 122 A. 615, 615 (N.J. Ch. 1928); RESTATEMENT (THIRD) OF TRUSTS § 78 (“[T]he trustee is strictly prohibited from engaging in transactions that involve self-dealing or that otherwise involve or create a conflict between the trustee’s fiduciary duties and personal interests.”); RESTATEMENT (THIRD) OF AGENCY § 8.01 (AM. LAW INST. 2006) (“An agent has a fiduciary duty to act loyally for the principal’s benefit in all matters connected with the agency relationship.”); see also *Strickland v. Washington*, 466 U.S. 668, 688 (1984) (“Counsel’s function is to assist the defendant, and hence counsel owes the client a duty of loyalty, a duty to avoid conflicts of interest.”).

232. See James L. Werth, Jr., *Some Personal Aspects of End-of-Life Decisionmaking*, 61 U. MIAMI L. REV. 847, 849 (2007) (discussing this in the context of the Schiavo case).

233. See John H. Langbein, *Questioning the Trust Law Duty of Loyalty: Sole Interest or Best Interest?*, 114 YALE L.J. 929, 980–82 (2005) (describing such a rule).

234. See UNIF. POWER OF ATTORNEY ACT § 114(d) (“An agent that acts with care, competence, and diligence for the best interest of the principal is not liable solely because the agent also benefits from the act or has an individual or conflicting interest in relation to the property or affairs of the

* * *

This Part has sketched out how sexual advance directives might be implemented in practice. The goals have been to illuminate how to respect the consensus of consents while also protecting people with persistent acquired incapacity from objective harm. Residential institutions have a large part to play in the implementation of sexual advance directives, and the hope is that they will be the ones to initiate serious advance planning that addresses not only sexuality but also finances, health care, housing, and other areas. This will help promote the important perspective that there are many domains that contribute to the welfare of people as they age and enter into a new stage of life that can be marked, but only in part, by cognitive impairment.

CONCLUSION

Sexual advance directives present the possibility of a sexual life for those diagnosed with chronic conditions that affect cognition. This Article has laid out the theoretical case for them, focusing on the importance of respecting both a person's past wishes and present desires. It has also laid out how the law could realistically integrate sexual advance directives into existing doctrines of consent and capacity as well as into existing residential institutions of long-term care, drawing on insights from criminal law, fiduciary law, and the law of wills. Thus, it has contributed to the theoretical literature on sexual consent and addressed an important social and legal issue, made all the more pressing by the aging of the population.

principal.”); Andrew S. Gold, *The Loyalties of Fiduciary Law*, in PHILOSOPHICAL FOUNDATIONS OF FIDUCIARY LAW 176, 191 (Andrew S. Gold & Paul B. Miller eds., 2014) (“Different types of relationship [sic] may implicate different types of trust, as we see for example when we compare director-shareholder relationships, employer-employee relationships, parent-child relationships, or husband-wife relationships.”); Langbein, *supra* note 233, at 935–37 (describing how a pervasiveness of conflicts of interest may justify the switch to a best interests rule). This type of “self-dealing” may also be explicitly permitted in the sexual advance directive itself, which establishes that the principal knew of and approved of a “structural” conflict of interest. See John H. Langbein, *The Contractarian Basis of the Law of Trusts*, 105 YALE L.J. 625, 665–66 (1995) (discussing this issue in the context of the *Rothko* case).