Granny and the Sexbots:
An ethical appraisal of the use of sexbots in residential care institutions for elderly people

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> "One resident, due to physical disability, is unable to masturbate himself. He confesses that he does become very sexually frustrated and I am at a loss as to how to address the issue for him. Unfortunately he is not in a position to be able to go and meet women of his own accord. I understand his needs, but do not know what I can legally do to assist him in his quest for sexual gratification." Quote from an eldercare nurse (Royal College of Nursing 2011: 4).

1 Introduction

By 2050, it is expected that over a fifth of the world's population will be aged over 60 (WHO 2018); this includes an expected 3.7 million people over the age of 100 (Stepler 2016). Although people's lives are increasing in duration, this does not necessarily mean there will be a proportionate increase in the number of years spent living independently. Care institutions for elderly people will be increasingly necessary, and people will spend a greater proportion of their lives in institutional care than ever before.

Noel and Amanda Sharkey (2012) wrote a paper entitled *Granny and the Robots,* in which they raise some ethical concerns associated with robotic carers for elderly people. The concerns the highlight include reductions in human contact; feelings of objectification and loss of control; loss of privacy; loss of liberty; deception and infantilisation; controlling the robots (Sharkey and Sharkey 2012). Sharkey and Sharkey lay out some preliminary groundwork for future ethical discussions of carebots for elderly people, and provide a brief cost-benefit analysis of the introduction of such robots.

My project in this paper (and my title) echoes theirs, but in the sphere of sexbots for elderly people. Some of the issues identified by Sharkey and Sharkey are also relevant to sexbot usage. These include loss of human contact, objectification, and difficulties controlling the sexbots; these questions of social justice will be discussed forthwith in addition to the question of whether sex is a good to which people are entitled, and whether care institutions have a duty to cater for sexual needs.

Sex among elderly people is one aspect of life which remains taboo. I argue that the sexual appetites of elderly residents in care institutions ought to be catered for – not least because the residents themselves feel it is an important aspect of their care (Royal College of Nursing 2011: 11). Sex and intimacy also help to improve residents' mood, health, and general quality of life (Hajjar and Kamel 2003). Importantly, I suggest that sexbots are apt to provide that service (with some caveats and modifications).[1] First, I demonstrate that sexual feelings and behaviours are an important part of elderly people's lives. Following that, I provide a brief cost-benefit analysis of other sexual options for elderly people, noting that some options are potentially morally problematic or simply impractical. I argue that although sexbots will not be a panacea – indeed, they will create some ethical issues which need to be explored philosophically, and they will require robust safeguarding protocols – they have the potential to enhance the lives of residents in eldercare institutions, and their use can be implemented whilst minimising problems.

1.1 Assumptions and terminology

I use the term 'eldercare institution' (or simply 'care institution') to refer to some sort of private or state-run residential caring environment for elderly people; this is taken to be a structured, non-familial setting, where multiple elderly people are cared for. I refer to the people who live in the eldercare institution as 'residents', although the term 'patients' may also be apt. The residents I refer to are taken to be in need of physical care due to frailty, disability, illness, infirmity, and other physical impairments, but to have full mental capacity (they are not suffering from dementia, learning disabilities,

[1] Note that this paper is an ethical argument rather than a technical manual for roboticists. I do not show *how* sexbots for elderly people should be developed, but I do make some suggestions of modifications which would help to facilitate the use of sexbots by elderly people.

or severe mental illness). Some cognitive decline becomes more commonplace as people age, and so additional safeguards and philosophical exploration would be needed to protect people without full mental capacity, should they wish to use sexbots. I do not consider arguments pertaining to such people herein. I shall use the term 'nurses' to refer to care workers, nurses, nursing assistants, personal care aides, medical assistants, patient welfare assistants, and other such similar jobs which involve looking after elderly residents in care institutions.

My argument is intended to demonstrate that eldercare institutions (or their funding bodies) should provide the sexbots, rather than merely suggesting that residents should be allowed to bring their own sexbot into an eldercare institution with them. There would seem to be less to prove in such a case where a resident already possesses, uses, and cleans their own sexbot – although my argument herein can also support the suggestion that elderly people should be allowed to have their own sexbots too. Generally, the standard of necessity and safety is set at a higher level for equipment or services which are provided by an institution, compared to things which one provides for oneself. There may be separate arguments to be made in favour of allowing residents to own their own sexbots; the argument I make here is that eldercare institutions could and should provide sexbots for use by residents.

2 Sexual desire and activity in elderly people

Residents in eldercare institutions have a range of needs, and this results in them requiring care in a range of ways. Perhaps most obviously, elderly people have physical needs which must be met via physical care from nurses. These activities may include, but are not limited to, help with washing, dressing, toileting, moving about, using equipment (such as stairlifts), sitting and standing, eating, sleeping, and personal grooming. Elderly people – like everyone else – also have social and emotional needs which can be catered for via activities such as entertainment, games, leisure, music, day trips, learning new skills, socialising, and sports which are appropriate to their level of physical ability. It seems clear that an eldercare institution which merely looks after the physical needs of its residents (whilst ignoring their social and emotional needs) is failing its residents. Depression, anxiety, and loneliness are unfortunately fairly widespread among elderly people; it is estimated that around 40 per cent of eldercare institution residents experience depression, and many of these people will experience low mood *throughout* their time in institutional care, which is generally a

number of years, until death (Social Care Institute for Excellence 2006, British Geriatrics Society 2018). Clearly, there is still much to be done to improve the social and emotional welfare of some of society's most vulnerable citizens.

Someone might be forgiven for thinking that the problem I outline herein is not really a problem at all: that elderly people do not have sexual desires, and having access to a sexbot would not improve their quality of life in any discernible way. However, there are certainly residents – like the one who was referred to by the nurse at the outset – for whom sexual frustration is a daily plight which makes life less pleasant than it needs to be. I believe that sexbots, properly utilised, could significantly improve the lives of such people. To the best of my knowledge, there are no eldercare institutions which provide sexbots for residents, so empirical evidence which demonstrates how great an improvement sexbots can make to the lives of elderly people is in short supply. What I do show in this paper is that sexuality is an important feature of physical and emotional wellbeing, and that sexbots are a viable outlet for sexual behaviour.

Although positive steps forward are being made to cater for elderly residents' social and emotional needs, sexual desire is often considered non-existent, unimportant, or even problematic. This sort of mindset is highly concerning, because an institution which ignores or trivialises sexual desire and sexual activity among its residents can cause deep unhappiness for the elderly people involved (Royal College of Nursing 2011: 7). Unfortunately, this ignoring, trivialisation, and even prevention of sexual behaviour among elderly people often does seem to occur in eldercare institutitons.

There exists a pervasive and inaccurate view of an asexual old age, yet sexual desire and sexual satisfaction remain important for many people throughout their later years, including times when they are in eldercare institutions (Gott and Hinchcliff 2003, Hajjar and Kamel 2003, Franowski and Clark 2009). It is often unacknowledged that people over the age of 70 still have sexual desires, and can and do enjoy sexual activity. There are noticeable gaps in policy documents which could address sex among elderly people directly. For example, the Strategic Action Plan for Sexual Health (Public Health England 2015) makes little mention of sexual health in old age, instead focusing primarily on young people. Training bodies could educate nurses about the issue; however, it is commonplace for no training to be provided for nurses which could enable them to adequately deal with sexual desire among the elderly

people in their care (Royal College of Nursing 2011: 3).[2] It would be possible for eldercare institutions to develop their own policies or formal guidelines on sexual activity among residents – however most such institutions have nothing in writing, and just deal with sexual behaviour on an ad hoc basis (Tarzia et al. 2012: 610). More troublingly, studies strongly indicate that frequently, eldercare institutions do not have facilities or attitudes which support or allow for sexual expression among their residents (Roach 2004, Franowski and Clark 2009, Care Quality Commission 2020: 23). For example, eldercare institutions may not have lockable bedroom doors; bedrooms may only have single beds; or residents may not be permitted to sleep in other people's bedrooms – these rules can even apply to married couples living within the same institution (Royal College of Nursing 2011: 4). This means that if a resident wants to have a sexual relationship with someone else, it would be very difficult or impossible to have private time or to spend the night together. Elderly people engaging in sexual activity with one another risk being disturbed by nurses, who may view the activity as an 'incident' which needs reporting or tackling, and nurses may even intervene to break up consensual sexual activity between two adults simply because they are elderly (Care Quality Commission 2020: 17).

The fact that sexual desire in old age remains a taboo subject (Care Quality Commission 2020: 27–33, Royal College of Nursing 2011: 3) does not demonstrate that such desire is non-existent, however. Although government strategies and institutional policies may not place much importance on the sexual desires and activity of elderly people, elderly people themselves feel that their sex lives *are* important. A study by Gott and Hinchcliff (2003) found that over 60% of respondents aged over 70 rated sex as 'moderately', 'very' or 'extremely' important to them. They also found that among the 40% who said it was not important or only a little important, a common reason cited for this lack of importance was the belief that they would not have sex again in their lifetime, whether due to ill health, disability or widowhood. It is possible that these respondents were trying to downplay the importance of sex in their lives, believing that it was no longer an option even if they wanted it. Most elderly people in institutional care believe that opportunities for sexual expression should form part of their care (Royal College of Nursing 2011: 11). This alone should be sufficient

[2] It is interesting – and disheartening – to note that this document on sex and sexuality in care homes has not been updated since its creation 11 years ago; other updated documents on care homes and nursing in the UK continue to make no mention of sex among older people.

cause for eldercare institutions to reconsider their polices and attitudes towards sexual activity among residents. Sex and intimacy are important features of elderly people's health and wellbeing; they help to improve mood, health outcomes, and quality of life (Hajjar and Kamel 2003). In short, sexual desire and sexual activity remain important for both mental and physical wellbeing while people are in eldercare institutions, just as they are important for younger adults who live independently.

The lack of infrastructure, facilities, or policy guidelines is certainly problematic, but this need not be the case: things can change. There have been moves in recent years which demonstrate that sexual needs among elderly residents are being acknowledged and accepted more often by nurses. For example, the Royal College of Nursing recommends that residents should be permitted to explore sexual relationships with others (just as people are free to do when living independently), and that private spaces should be provided to enable residents to engage in consensual sexual relations with one another (or alone) if they so wish (Royal College of Nursing 2011: 3-6). Nonetheless, even if nurses and policy documents recognise that sexual desire exists among elderly people, many residents will still have sexual desires which go unmet.

3 Ways in which sexual desires can be met: Cost-benefit analysis

In this section I consider four possible (non-sexbot) ways in which elderly people could engage in sexual activity within care institutions, and I provide a brief cost-benefit analysis of each. None of these solutions – nor sexbots – is perfect for everyone, however some of these possibilities may be suitable for some residents. My argument in favour of sexbots should not be taken to suggest that these other options should be closed off to residents: the ideal situation would be one where elderly people in institutional care have a variety of ways in which they can explore their sexuality. I am simply arguing that sexbots could help elderly people for whom these possibilities are problematic, or who would simply prefer to have sex with a sexbot. The possibilities I consider are:

- Other residents
- Nurses
- Sex workers
- Sexual aids

I have noted above that few eldercare institutions have an environment which facilitates and allows for sexual activity (such as private rooms with double beds and lockable doors); these sorts of facilities would be required for several of these other possibilities, but in the interests of brevity, I do not repeatedly cite lack of privacy as a reason against these possibilities.

3.1 Other residents

Perhaps one of the best ways an institution can cater for sexual activity among its residents is by encouraging and facilitating intimate relationships among the residents themselves. Meeting an intimate partner in an eldercare institution brings with it the possibility not just of sexual release, but of love and companionship – something which is exceptionally valuable for emotional wellbeing (Hajjar and Kamel 2003). Roboticists are working towards producing robots which offer love and companionship for users (Anctil and Dubé 2019) – or at least, the appearance of it. However, at present, a sexbot cannot provide anything like the same level of emotional companionship that a human being can, and for this reason, a human-human sexual relationship would seem to be an ideal option for residents who can manage it.

However, relationships within eldercare institutions are not a viable possibility for everyone. One reason for this is that there are far more women in eldercare institutions than there are men: in total, there are around three women for every man in institutional care in the UK – this rises to over four women for every man among residents aged 85 and over (Office for National Statistics 2014). Most people are heterosexual, and this gender imbalance greatly reduces the chance for heterosexual women to meet a suitable partner within an eldercare institution (options for homosexual people are also limited; heterosexual men are the only ones who have plenty of potential partners available). Even for those people lucky enough to meet a partner with whom they want to be sexually intimate, there still remain significant difficulties in actually *engaging* in sexual activity – after all, if residents were fully healthy, mobile, and dextrous, they would not require institutional care in the first place. Elderly residents may well suffer from frailty, stiff joints, pain, sickness, and inability to physically exert themselves too much – issues which make sexual intercourse difficult or impossible. Chronic conditions such as these do not affect sexual desire (Kalra et al. 2011), and so even people who are suffering severe physical decline may still wish to – but be unable to – engage in sexual activity with others.

The lack of potential partners, and physical inability to engage in sex means that sex with other residents is simply not an option for most people in eldercare institutions.

3.2 Nurses

A different – but deeply flawed – possibility for sexual release is that nurses could provide sexual services for residents. Given that nurses often already engage with residents in intimate ways – for example, by dressing them, bathing them, and helping with their toileting needs – it may seem like only a small additional step for them to engage in sexual activity too. However, such a move would be fraught with problems – not least because it substantially changes the nature of the relationship between the nurse and the patient. There would undoubtedly be many nurses who would view such a change to their job as a deal-breaker: if sex were to become a feature of the job, there would likely be an exodus of nurses leaving the profession, exacerbating the existing shortage of nurses.

Such a great change to the nature of nursing could also cause untold harms to the nurses themselves, such as stress, anxiety, and depression. If providing sexual services were to become a duty of the nurse, this effectively removes her right to sexual self-determination; she waives her claim to bodily integrity – something we generally view as important (Vandervort 1987). Many nurses would be unable to change their jobs, meaning that they would be stuck in employment effectively as a sex worker – a type of employment which is highly stigmatised, and has a range ethical and social problems associated with it (as we shall see in the next sub-section).

Furthermore, permitting, encouraging, or mandating sexual activity between nurses and residents would throw open the opportunity for abuse – something which would not be in the best interests of residents (or nurses). Elderly people are some of the most vulnerable members of society. Unlike children who will one day become independent and can speak out about their abusers, people in eldercare institutions will generally remain in the institution – or another like it – until death, meaning that they may never get the opportunity to report their abuser. Although statistics suggest that sexual abuse in institutional care is not commonplace (it accounts for just 3% of all abuse complaints (Care Quality Commission 2020: 6)), it is probably underreported. Sexual behaviour between nurses and residents could seem to endorse or normalise sexual abuse, giving abusers the opportunity to claim that their sexual activity with a

resident was consensual. Given the severe negative effects of sexual abuse in the eldercare sector, anything which could help abusers get away with their crimes is best avoided (National Center on Elder Abuse 2018: 2, Care Quality Commission 2020: 28-31, Age UK 2020, 2021). For these reasons, promoting sexual activity between residents and nurses would seem to cause far more problems than it would solve, and is thus not a viable outlet for sexual activity.

3.3 Sex workers

A different option, then, could be the use of sex workers. Many sex workers are highly experienced and could provide a good standard of sexual pleasure for residents. Moreover, they would be able to work around disabilities or infirmities which residents may suffer from. There are enough sex workers available so as to provide some level of choice to residents – for example, there are men and women of different ages, ethnic groups, and sexual orientations who are sex workers.

The potential spread of sexually transmitted infections (STIs) is an immediate concern when considering using sex workers. Although this is an important consideration, this could be addressed via hygiene requirements, frequent STI testing, and use of barriers such as condoms. However, there are other problems associated with the use of sex workers which would be more difficult to address.

Most crucially, institutions may rightfully be concerned about the pitfalls of endorsing prostitution. There is a huge debate about the morality of prostitution; it has been variously criticised as harmful, dangerous, objectifying, running contrary to Kantian notions of treating people as a mere means, reinforcing gender stereotypes, and legitimising sexual violence (Chevarie-Cossette 2017, Richardson 2016, Varden 2006, Westin 2014, Vicente 2016, Spector 2006, Thomsen 2015, Settegast 2018). Within the UK, for example, soliciting or paying for sex with someone who has been coerced into prostitution is a summary offence (even if one does not *know* that the sex worker was coerced into it) – although the police have the discretion not to prosecute such offenders (Crown Prosecution Service 2019). Prostitution is also often associated with human trafficking, violence, and drug and alcohol abuse – but even in the absence of these additional harms, endorsing prostitution remains morally questionable. Due to these reasons, prostitution is not something which any reputable eldercare institution – not least one which is funded by the state – could permissibly be involved

with.[3] Aside from legal worries, there is often a very strong social stigma associated with using sex workers: it is often seen as undignified, lewd, or desperate. Residents may therefore be resistant to using a sex worker on ethical grounds (such as concerns about the welfare of the workers) or simply because they do not want to suffer the social stigma which can come with using sex workers.[4]

In spite of the problems associated with using sex workers, there have been cases in the UK of (usually young) disabled people using sex workers – encounters which were set up or facilitated by nurses (Stretch 2013, Ismail 2013, Little 2007). Organisations exist which facilitate meetings between approved sex workers and disabled people (TLC Trust 2021). Depending on how one regards the moral, social, and legal issues, the use of sex workers for elderly people could be a solution for some people.

3.4 Masturbation and sexual aids

It may be the case that some elderly people are able to masturbate successfully, while others may be unable to easily or successfully achieve any satisfaction from masturbation, but have sexual desires nonetheless. The male patient referred to at the beginning of this paper, who is unable to masturbate and feels very sexually frustrated (Royal College of Nursing 2011: 4), is one such example. With nearly 300,000 elderly people in institutional care in the UK alone (Office for National Statistics 2014), there are undoubtedly many other elderly people who feel the same sexual frustrations but have not spoken to a nurse about it and had their case recounted in a policy document. For some people who are unable to masturbate but prefer to be alone for their sexual gratification, a sexual aid of some sort could be a good idea.

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[3] In the next paragraph I note some recent cases where disabled young adults *were* helped by their carers to seek out and use prostitutes. Of course, simply because it has taken place does not prove that doing so is permissible or unproblematic.

[4] There may also be a stigma associated with using sexbots which echo those associated with using prostitutes: that it is undignified, lewd, and desperate. This may change over time as robots become more commonplace, or it may not. Where robots have the edge over sex workers, however, is that we do not need to concern ourselves with the welfare of the robot (so long as it is not sentient), nor whether it was coerced, trafficked, blackmailed, or threatened into prostitution. There may nonetheless remain concerns over whether sexbots reinforce misogyny and objectification of women, as prostitution does (see Richardson 2016).

There are many types of sexual aids commercially available – battery-operated mechanical devices such as vibrators; silicone devices which mimic human genitals; swings to facilitate more comfortable movement; and a plethora of other creations to suit every taste. Some of these are capable of providing or helping to provide a satisfying sexual experience which could allow elderly people to explore their sexuality alone or with someone else. One benefit of such devices is that they are often cheap enough that residents could have one device (or multiple devices) to themselves, preventing the spread of sexually transmitted infections. Moreover, because many such sexual aids are small, they could be used discreetly and put away without nurses, other residents, or family members knowing of their existence; this would help to limit embarrassment of all parties, given that sex and masturbation are still taboo subjects among elderly people (Care Quality Commission 2020: 27-33, Royal College of Nursing 2011: 3).

One problem with such aids is that they may not always provide a wholly satisfying intimate experience, since they are generally an aid to masturbation rather than a substitute for sex. There may be large numbers of people who are unable to use sexual aids effectively, or simply do not wish to. Clearly, masturbation is not an option for all elderly people within institutional care – as Di Nucci notes when writing about sexbot usage by disabled people: "if masturbation were the solution to the problem, then we wouldn't have had a problem in the first place" (Di Nucci 2017: 77). Nonetheless, masturbation (with or without aids) is something which at least some elderly people will be capable of engaging in while in eldercare institutions, and it would certainly be ideal if nurses could endorse and facilitate this where possible (for example, by knocking and waiting before entering a resident's room).

4 Arguments against sexbot provision

I shall now turn my attention to addressing some potential arguments *against* sexbot provision in eldercare institutions, and I shall give responses and solutions to these arguments as appropriate. First I deal with a general argument against sexbots (that sexbots are morally problematic); an argument which may be relevant to the use of sexbots in any part of society, not merely in eldercare institutions. The other arguments against sexbot provision are relevant specifically to care institutions for the elderly.

One ostensible reason why people may think sexbots have no place in eldercare institutions is that elderly people do not have sexual interests – however, since I have addressed this earlier and established that such a claim is simply false, I shall not address it again here: elderly people *do* have sexual appetites. There are also numerous pragmatic reasons why sexbot provision is questionable, such as cost[5], inconvenience, and sexually transmitted infections[6]. Some people might suggest that having sexbots in eldercare institutions would be inconvenient for nurses (maintaining and cleaning the sexbots would give them another responsibility, when they are already overworked). However, it seems only humane to suggest that the quality of life for people in eldercare institutions is important and should take priority over inconveniencing nurses (Sharkey and Sharkey 2012: 37). Sexbots might offend some people who consider them shocking and lewd, but this alone is not sufficient reason why they should not be supplied in eldercare institutions. If it is the case that sexbots can improve the quality of life for elderly people, and that their quality of life is important, then the idea of sexbot provision in eldercare institutions should be taken seriously.

Below, I consider and respond to several ways in which people might argue that sexbots should not be provided in eldercare institutions. These are: sexbots are morally problematic; elderly people would not want sexbots; we do not expect sexbots to be provided in eldercare institutions; people outside of institutional care do not have constant access to sex; sex is a want rather than a need; and not all desires can or should be catered for in institutional care.

Following these considerations, I address the question of whether sexbots are up to the task – that is to say, whether they can safely and satisfyingly provide a sexual outlet for elderly people, given the fact that sexbots are heavy, rigid, and passive recipients of sex. This is not an argument against sexbot provision; rather, it is a caveat regarding the feasibility of sexbot usage by elderly people.

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[5] The cost of a typical AI sexbot is currently around £2000-4000 (Shenzhen All Intelligent Technology Co. Ltd 2022, Smart Doll World 2022). Inanimate sex dolls come in much cheaper, at around £500 (Realdoll 2021), but these may be less useful to elderly people with limited mobility.

[6] With proper cleaning, sexbots could probably be safely shared between residents, in the same way that toilets, cutlery and bedding can be safely shared when properly cleaned.

4.1 Sexbots are morally problematic

The production and use of sexbots is not without controversy, and this controversy pertains to many areas of society – not merely to sexbot use in eldercare institutions. Some of these questions are discussed in more detail in other papers in this anthology; I outline some such arguments here, but there is insufficient space to fully address them all.

It has been suggested that sexbots exacerbate and reinforce gender imbalances, misogyny, sexual exploitation, and the objectification of women (Richardson 2016). The reason for such claims, it seems, it that sex robots (which are generally female in form, and are usually used by heterosexual men) are highly lifelike, and they are of course treated as sex objects. The worry is that legitimising sexbots places us on a slippery slope towards treating or at least viewing real women as sex objects. Even 'generic sexbots' (Lancaster 2021: §2) which are not intended to resemble any person in particular may still encourage users to view women *qua* women as sex objects (and the same may be true of people who use male-appearing sexbots). Moreover, given that most sexbots have "porn star-esque" physiques (Danaher 2017a: 116), this can reinforce uncomfortable perceptions about the ideal body shape and appearance, in both men and women. Sexbots on sale seem, as far as I can tell, to depict people aged 16-30[7] (Realdoll 2019, 4woods 2018); the use of such 'young adult' sexbots by elderly people could reinforce derogatory stereotypes such as the 'dirty old man' (Royal College of Nursing 2011: 9) and make elderly people themselves feel uncomfortable. A partial solution could be to create a wider variety of sexbots – ones which appear older, and which have 'imperfections' which make them more similar to real human beings – but we should avoid creating sexbots which resemble particular people who have not consented to their likeness being used (Lancaster 2021). However, creating sexbots which appear more mundane and less like porn stars would still not address feminist concerns such as those of Richardson (2016, 2019) who suggests that sexbots objectify women and encourage misogyny. Although it may be true that the sexbot market *in general* exacerbates these problems, this argument loses its clout when it pertains to sexbot usage in eldercare institutions – this is because most of the people in eldercare institutions are heterosexual women,

[7] Some sexbots appear to depict children under the age of 16; these are prohibited under UK law, but even if they were not, such sexbots may be morally problematic (see Danaher 2017b).

who would therefore choose a sexbot which appears male.

A different problem which could arise from sexbot usage is the concern that 'relationships' with robots are asymmetrical, vacuous, and involve some form of self-deception. Although love robots (or 'erobots') are in development (Anctil and Dubé 2019) any relationship we may have with current sexbots is wholly one-sided (Sparrow 2021, Harvey 2015). Nonetheless, we have the tendency to anthropomorphise things which take humanoid form (Sharkey and Sharkey 2012: 36, Leong and Selinger 2019, Nyholm 2020) – and when these humanlike things also say some endearing phrases, move in sexually enticing ways, and we can engage in sexual intercourse with them, our tendency to anthropomorphise is understandably much greater. In some types of relationship – such as a nurse-patient relationship, it may not matter if the relationship is one-sided (Lancaster 2019, Meacham and Studley 2017) but with sexual and romantic relationships, the need for reciprocity may be felt more keenly. One might suggest that, rather than improving the wellbeing of residents, sexbots provide a false, one-sided, empty experience, whereby lonely old people come to feel unrequited love towards what is essentially an inanimate object. This is a *possibility*, but it may not be a very likely possibility; the concern that elderly people will fall in love with a sexbot may simply be unfounded. Even if a lonely elderly person *were* to fall in love with a sexbot, they may nonetheless feel an improved sense of wellbeing even if it is not reciprocated. The seal-like robot Paro has been shown to improve health and wellbeing in elderly people, reducing stress levels and increasing communication (Tamura et al. 2004, Wada and Shibata 2006) – all this is in spite of the wholly one-sided 'relationship' one has with Paro. If one-sided relationships with robot pets and robot nurses can be beneficial for the people who have them, it is not such a great leap to think that a one-sided relationship with a sexbot may also confer some benefits. At any rate, it would be overly paternalistic to prevent elderly people from having the opportunity to engage with sexbots out of the (perhaps unfounded) fear that they may get too attached to them.

4.2 Elderly people do not want sexbots

It has proved exceptionally difficult to find empirical research into whether elderly people would be willing to use sexbots. However, given that many elderly people are so frequently treated as asexual, it is not surprising that there has been so little

empirical research into this area. It may well be the case that a substantial number of elderly people – like the younger population – would not want to engage in sexual relations with one of today's sexbots. It may also be the case, however, that as robots become more ubiquitous in other facets of life – for example, carebots, shop assistant robots, and AI lawyers – that people become more accepting of the useful role which robots can play in our lives. This is particularly likely if sufficient advances take place which make sexbots more humanlike in their movements, abilities, and 'personalities', and it becomes known that sexbots can provide a satisfying sexual experience.

However, it is worth remembering that even if only a minority of residents would have sex with a sexbot, this does not mean that their desires should be ignored. There does not need to be universal uptake of an activity in order for it to be deemed useful or beneficial to overall quality of life. Activities such as yoga, painting, or singing groups can be recognised as useful and beneficial to quality of life even if only a minority of residents attend the group. This does not, of course, mean that residents have a right to yoga *per se*, but it would be reasonable to claim that residents have a right to physical activity of some description (and yoga is a reasonably good activity, as is aerobics, pilates, tai chi, etc). In this paper I am making the argument that residents in care homes have a right to sexual activity / fulfilment *of some description*, and I am suggesting that sexbots are one such option. This is not, however, equivalent to claiming that residents *have a right to sexbots* – just as suggesting that residents have a right to physical activity (and yoga is a useful physical activity) does not commit one to the claim that residents specifically *have a right to yoga*. It is my suggestion then, that some elderly people might want to use sexbots for their sexual fulfilment, and there are few reasons why this should not be permitted.

4.3 We do not expect sexbots

One potential argument against the provision of sexbots in eldercare institutions is that we do not *expect* them to provide for the sexual needs of their residents, whether through sexbots or any other means. If no one expects sexbots, then why should institutions provide them?

This sort of argument collapses at the slightest pressure, however, because it is often the case that our expectations are inherently tied to the status quo: we expect eldercare institutions to be the way we believe eldercare institutions *are*. In 1995, we did not expect eldercare institutions to provide free internet access for all residents,

but these days, we probably *do* expect it as standard; our expectations have changed as society and care provision have changed. Simply because we do not expect something as standard does not demonstrate that it would not improve residents' lives if it *were* to be provided. We do not expect eldercare institutions to have swimming pools or massage treatments – but residents who live in institutions which *do* have such facilities would probably make use of those facilities, and experience an improved quality of life as a result. If, as I suggest, sexbots have the potential to improve the wellbeing of residents, and residents have a claim to sexual fulfilment as part of their care (as I shall argue shortly), then it would seem to follow that eldercare institutions should consider providing sexbots for their residents. It is true to say that swimming pools, spa treatments, and many other facilities could also improve the wellbeing of residents, and it would make sense for eldercare institutions to also consider such facilities – the difference, of course, is that swimming pools and spa treatment rooms are likely to be more pragmatically difficult to provide, whereas sexbots are relatively easy to provide, as are televisions and computers. When something is relatively easy to provide and stands to improve residents' wellbeing, then eldercare institutions should strongly consider their provision.

4.4 Other people do not have constant access to sex

Elderly people (and younger people) who live independently do not all have free and constant access to sex (whether with people or with sexbots), so one might suggest that residents of eldercare institutions cannot reasonably expect to have all their sexual desires accommodated either. Why should residents in eldercare institutions be so privileged as to be provided with something above and beyond what people in everyday society receive?

Although this may seem to be a legitimate argument on first inspection, it is clearly flawed once one reflects on some analogues. Consider: elderly people who live independently may have little or no chance to socialise with others; they may have poor bathroom facilities which cannot accommodate someone who is frail and immobile; they may have unsanitary kitchen facilities and a poor-quality diet; they may be unable to do laundry frequently or effectively, and so may have to wear dirty clothes. The fact that many people living independently can survive in such conditions does not entail that eldercare institutions need not provide these services. It is reasonable and correct for us to expect that eldercare institutions provide social

interaction, clean clothes, a healthy diet, and suchlike. This is primarily because once an institution commits to housing a resident, failing to meet these needs would be failing in their duty of care towards that resident (by contrast, elderly people living independently have no duty of care towards themselves).[8] Additionally, most people have paid for their care (either through their taxes and national insurance contributions, or directly to the institution), and so the provision of adequate care in exchange for that payment is just and right. Institutions should and do provide their residents with clean accommodation and nutritionally balanced meals even though people outside of institutional care might not have such needs met when they are responsible for themselves. Analogously, we can maintain that eldercare institutions have a responsibility to cater for the sexual needs and desires of their residents, even though many people living independently do not have such needs met. This is because sexual gratification is an important part of life, and can improve residents' wellbeing substantially.

It is also worth noting that people outside of institutional care are free to go out and meet other people and *attempt* sexual activity with them in a way that residents of eldercare institutions are not. People living independently have the *capability* (Nussbaum 2011) to seek out relationships, use sex workers, or purchase their own sexbot if they so desire. This means that the sexual needs of people outside of institutional care can be more easily catered for by the person themselves when compared to people within institutional care. We generally consider that people have the right to pursue sexual expression and gratification[9], but care institutions effectively take away this right, by not providing facilities which facilitate sexual activity, and by limiting residents' freedom. The provision of sexbots within care institutions could therefore help to redress the balance, bringing the capabilities of residents closer to those of people who live independently (see Nussbaum's (2011) capabilities approach – this is developed further in the next sub-section). It would therefore seem reasonable for eldercare institutions to make efforts to cater for people's sexual needs, and providing sexbots is one way of doing this.

[8] Some writers such as Kant (2011, 2017) might disagree, and suggest that we *do* have a duty to care for ourselves adequately; I am unconvinced about this, but even if it were true, this is not the same as the legal duty of care which eldercare institutions have towards their residents.

[9] Assuming, of course, that this does not infringe on others' rights.

4.5 Sex is a want, not a need

I have at various points in this paper made reference to 'sexual needs', but an opponent may wish to argue that sex is a want rather than a need. Although there have been suggestions (see Maslow 1943) that sex *is* a physiological need, along with air, food, water, and sleep, it is nonetheless true that one can live well into their hundreds having never engaged in sexual activity, whereas one cannot live for very long at all without air, food, water, and sleep. Even people who used to be very sexually active can survive for many years in institutional care without sex, so in that sense sex does not seem to be a *need*.

Even though it seems true that lack of sex is not a threat to life in the same way that lack of food (etc) is, it nonetheless seems evident that sex is an important part of wellbeing. Martha Nussbaum suggests that welfare is inherently linked to the capability of people to be or do particular things. One of the central capabilities she identifies is bodily integrity, which includes "having opportunities for sexual satisfaction" (Nussbaum 2011: 33). Her argument is that societies should support this capability (among others) to safeguard the welfare of their citizens. The key feature of Nussbaum's capabilities approach is that people should be given *opportunities* to fulfil the capabilities she lists – whether or not people actually make use of the opportunity is their choice, but having the opportunity is in itself valuable.

For many people, a life *with* sex is very much preferable to a life *without* sex. The same argument can be made for conversation, friendship, leisure activities, and entertainment. Living without friendship and suchlike will not cause a person's death, but it will almost certainly make life very miserable; life *with* friendship is a lot better than life without it. I suggest that the same is true of sexual activity. One does not have to demonstrate that sex is a physiological necessity; it is sufficient to point out the simple fact that sex improves one's quality of life (Hajjar and Kamel 2003, Gott and Hinchcliff 2003, Royal College of Nursing 2011: 7), as do friendship and leisure activities.

As it happens, sex also improves one's physical health and life expectancy (Hajjar and Kamel 2003), but even if it were only the case that sex improved subjective perception of quality of life, that could still be sufficient reason to encourage institutions to facilitate its occurrence.

4.6 People cannot have everything they want

One might argue that simply because something would improve quality of life does not mean that eldercare institutions simply *must* provide it. As I noted above, a swimming pool would be a great facility if it were to exist in an eldercare institution, and would improve residents' lives, but we cannot therefore demand that all such institutions get a swimming pool. There are a great many things which elderly people may desire, and which could improve their quality of life, but which are simply not conducive to life within institutional care. Examples include the chance to be around animals, attend concerts, visit the beach every day, live with young children, keep exotic pets, attend rallies, travel abroad, and any number of other activities. I mentioned above that one of Nussbaum's central capabilities is bodily integrity – part of this includes "being able to move freely from place to place" (Nussbaum 2011: 33) but clearly, care homes limit this capability. Residents are not free to go to the beach, travel abroad, and attend rallies whenever they choose, yet we do not suggest that nurses should cater for residents' desires by taking them wherever they like, whenever they like. The financial cost and logistical difficulties involved make them untenable. Although the above activities are fun and can improve wellbeing, they are not pragmatically feasible for residents in eldercare institutions; someone may suggest that the same is true of sexual activity.

However, I believe that such a suggestion would be misguided. Allowing for sexual expression would not require a great deal of change for an institution (unlike the other examples given above, which would require extensive risk assessments and would be logistically difficult). In order to cater for sexual activity with a sexbot, institutions would merely need to provide some privacy (such as lockable doors or a dedicated room), and a sexbot which is thoroughly cleaned and up to the task (in section 5, I address how sexbots would need to change in order to be useful for elderly people). Even initiatives such as nurses knocking and waiting before entering a resident's room could be enough to provide ample privacy for sexbot usage. Eldercare institutions would thus be able to easily cater for residents who wish to use a sexbot. Although it is fair to argue that people in eldercare institutions cannot have everything they want, when a facility can be easily implemented and would provide a sufficient improvement to people's quality of life, the reasons not to provide it seem trivial. The fact that something would be an inconvenience for care providers is not a sufficient

reason not to provide it (Sharkey and Sharkey 2012: 37).

Questions of whether residents in eldercare institutions should have access to sexbots is in many ways a question of social justice. John Rawls famously suggested that justice is "the first virtue of social institutions" (Rawls 1999: 3). Given that money and other resources in care institutions are scarce commodities, the costs (both financial and socio-ethical) and benefits of providing sexbots need to be carefully weighed. It may not *always* be viable for care institutions to provide sexbots for elderly residents to use, but I suggest that their provision should at the very least be a consideration, given the potential boost to residents' wellbeing.

Thus, I suggest that sexbots can and should be provided in eldercare institutions. To be clear, my argument is not that sexbots are the *only* solution to the problem of satiating the sexual desires of elderly people, nor even that sexbots are necessarily the *best* solution for everybody. I am simply arguing that sexbots are a plausible solution that could help residents who still have sexual drives but are currently unable to find a suitable outlet for them.

5 Are sexbots up to the task?

I believe I have made a convincing case in favour of providing sexbots for elderly people in care institutions. I shall now proceed with addressing how sexbots could become capable of fulfilling the purpose I am suggesting they could fulfil – in other words, what needs to happen in order for sexbots to be up to the task. Unfortunately, it seems that today's sexbots could not be used effectively for sexual intercourse with elderly people because they are heavy, fairly inert, and not dextrous enough. These issues could cause two types of problem:

a) Elderly people getting injured.

b) Elderly people being unable to engage in (satisfying) sex with a sexbot.

The first concern echoes a prominent fear regarding the use of robots of all types (including carebots, robot nannies, military robots, and driverless cars): we worry that robots may malfunction and hurt people. Given that elderly people in institutional care may be frail or infirm, there is a very real possibility that if robots malfunctioned, the

elderly people could suffer serious injuries.

However, this alone is not a convincing argument against the use of sexbots, because there are many technological devices which are used in eldercare which also have the potential to injure residents if they malfunction. For example, motorised tilting chairs (to assist in standing and sitting), stairlifts, equipment to lift patients in and out of bed, motorised wheelchairs, adjustable beds, and exercise machines – not to mention medical equipment such as ventilators – all have the potential to seriously harm an elderly person if they malfunction.

The response, however, is not to avoid such equipment altogether, but rather, to ensure that the devices are equipped with safety features which prevent malfunctions and/or that harm is minimised in the event of a malfunction. There is no reason why sexbots for elderly people cannot be fitted with failsafe functions too. For example, they could be able to alert a nurse if: a 'panic button' is pressed; a user says a trigger word (such as "Help!"); a user has not moved for a period of time; or the sexbot detects a malfunction in itself. These sorts of functions would help to maintain privacy, whilst increasing safety. Sexbots could also be fixed in particular ways so as to prevent them from falling. Someone might suggest that sexbots are inessential, whereas the other equipment used in care institutions is essential. However, this is not entirely true. A nurse could push a resident in a wheelchair or manually pull them out of a chair or bed, rather than using motorised equipment to accomplish these tasks. Motorised wheelchairs and tilting chairs are not essential equipment, yet the benefits gained from them are substantial enough to warrant using them, in spite of the risk of malfunction. These technologies are useful for the physical wellbeing of residents, but other technologies such as televisions and computers are useful for emotional wellbeing, and they too are embraced rather than shunned on the off chance they may harm residents.

What is perhaps a more pressing and legitimate concern is that elderly people may get injured during sex with a sexbot because of the weight and rigidity of a sexbot, even if it does not malfunction. Generally, when someone has sex with a sexbot, the sexbot lies still while the human is on top and doing all the work – something which may not be safe or possible for a majority of frail elderly people in care institutions.[10] Lying underneath the sexbot is not a viable option either, because sexbots are so heavy: female sexbots are generally around 30-60kg (Smart Doll World 2021) – and male

[10] Of course, if some elderly people *can* take an active role in sex with a sexbot, then they would not need these modifications.

sexbots weigh a little more – and cannot support their own weight on their hands or legs as a human would during sexual intercourse.

Therefore, even if a sexbot is functioning normally, there is still a genuine risk that a frail or infirm elderly person could be crushed or injured by the sheer weight of it. Even if a resident *could* withstand the weight of a sexbot lying on top of them, this would not be sufficient to facilitate intercourse, because the sexbots currently available are so passive during sex. If a person were to attempt sex with the sexbot on top of them, they would have to lift or manoeuvre the sexbot repeatedly in the appropriate ways so as to achieve the feeling of sex – something which would require great upper body strength, dexterity, and stamina. This precludes frail, elderly people from being underneath during intercourse with a sexbot.

This means that today's sexbots are unable to perform the very task that I am arguing they should be utilised for, which may seem absurd to some readers. However, advances in robotic technologies can happen quickly, and it would not take too great a technological development to create a sexbot which is better suited to elderly users. A sexbot for elderly people would need to be:

a) Lighter weight

b) Able to support its own weight on its hands (or in some other way)

c) Gentle with its user

d) Able to take a more active role in sex

Technological convergence is a process whereby previously separate forms of technology merge into a single technology. This has happened with mobile phones, which can now function as a sat nav, games console, alarm clock, and camcorder, all of which used to be separate technologies. Roboticists also incorporate previously separate technologies into new models of sexbots, in order to create new sexbots which are more advanced than their predecessors. For example, whereas older sexbots were little more than dolls, some of today's sexbots have AI components which better enable them to engage in 'loving' conversations, making them not just sexbots, but lovebots too (Anctil and Dubé 2019).

A sexbot with the four modifications I suggest above could easily fulfil the brief I am outlining here, and so even if we are currently at a technological juncture where sexbot technology is unable to meet the brief, my argument can still stand. When

adequate sexbots exist, I suggest that they can and should be provided for residents in eldercare institutions.

6 Conclusion

During recent decades, significant progress has been made in providing for the social and emotional welfare of elderly people in institutional care; however, sexual activity and sexual pleasure for elderly people still remains something of a taboo. Nonetheless, research has shown that elderly people still have sexual desires, and that a life with sexual pleasure is preferable to a life without it. I have argued herein that elderly people in institutional care should have their sexual needs catered for, and that sexbots would be a useful solution to the problem. I am not suggesting that sexbots should be used exclusively and that other sexual outlets (such as masturbation, sex workers, or relationships with other residents) should be closed off; rather, I suggest that sexbots should be provided as one possible sexual outlet among many.

Sexbots in their current form are generally designed for able-bodied heterosexual men, and are therefore not well-suited to providing sexual pleasure for frail, elderly people – most of whom are women – with limited dexterity. Technologies do exist, however, which could potentially be incorporated into sexbot design to enable the most vulnerable of people to have a satisfying sexual experience. It is my suggestion that sexbot developers should make such changes to their sexbots, and that such sexbots should be provided in eldercare institutions, so that residents can continue to explore their sexuality for as many years as they wish to.

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