

# Grief, trauma and mistaken identity: Ethically deceiving people living with dementia in complex cases

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## Abstract

Across care settings, the practice of lying to or withholding the truth from people living with dementia is common, yet it is objected to by many. Contrary to this common discomfort, I have argued in previous work that respecting members of this group as moral equals sometimes requires deceiving them. In this paper, I test my proposed practice against complex, controversial cases, demonstrating both its theoretical strength and its practical value for those working in social care.

## KEYWORDS

consent, deception, dementia, lying, social care

## 1 | INTRODUCTION

Across care settings, the practice of lying to or withholding the truth from people living with dementia is common.<sup>1</sup> Often, this is defended by reference to the best interests of those in receipt of care.<sup>2</sup> So understood, if telling the truth involves avoidable harms or if withholding it creates otherwise inaccessible goods, then deception can be morally permitted.

In other cases, however, many hold the intuition that lying cannot be justified on a best interests standard. If a loved one were to ask us for a piece of information that we know would be hurtful to hear, for instance, few of us would countenance withholding it entirely—at least if that loved one is an adult. Moral philosophy in the Kantian tradition supports this intuition, tying a duty to be truthful to the idea of respecting others as moral equals. So understood, because each of us is best placed to judge for ourselves, we are owed the truth, even if others think it is not in our best interests to

know it.<sup>3</sup> If this is right, then some may be concerned that deceiving people living with dementia expresses disrespect for them as moral equals.

I have disputed this claim in previous work, defending ethical deception as a practice when it respects a person living with dementia *for who they are*, in the sense of respecting their capacity to retain and act on accurate information. I then proposed a series of techniques that carers could make use of, illustrated using a fictional but representative case.<sup>4</sup> There are a range of scenarios, however, in which the practical upshots of my proposals may be unclear. The purpose of this paper, then, is to consider thornier cases to clarify and strengthen the account. The suggestions I offer in each of the empirically-informed-but-fictional cases are not intended to be exhaustive. Rather, my goal is to demonstrate that carers *can* use ethical deception, even in complex cases, without engaging in intolerably unjust acts.

## 2 | ETHICAL DECEPTION: AN OVERVIEW

Before introducing and addressing these challenging cases, I will first summarize the arguments made in my previous work on ethical deception. In addition to recapping the relevant parts of my previous

<sup>1</sup>See: Turner, A., Eccles, F., Keady, J., Simpson, J., & Elvish, R. (2016). The use of the truth and deception in dementia care amongst general hospital staff. *Aging & Mental Health*, 21(8), 862–869; Cantone, D., Attena, F., Cerrone, S., Fabozzi, A., Rossiello, R., Spagnoli, L., & Pelullo, C. P. (2017). Lying to patients with dementia: Attitudes versus behaviours in nurses. *Nursing Ethics*, 26(4), 984–992; Mitchell, G., & O'Donnell, H. (2013). The therapeutic use of doll therapy in dementia. *British Journal of Nursing*, 22(6), 329–334.

<sup>2</sup>See: Culley, H., Barber, R., Hope, A., & James, J. (2013). Therapeutic lying in dementia care. *Nursing Standard*, 28(1), 35–39; Butkus, M. (2014). Compassionate deception: Lying to patients with dementia. *Philosophical Practice: Journal of the American Philosophical Practitioners Association*, 9(2), 1388–1396; Elvish, R., James, I., & Milne, D. (2010). Lying in dementia care: An example of a culture that deceives in people's best interests. *Aging & Mental Health*, 14(3), 255–262.

<sup>3</sup>Koorsgaard, C. (1988). Two arguments against lying. *Argumentation*, 2, 29.

<sup>4</sup>Carter, M. (2020). Ethical deception? Responding to parallel subjectivities in people living with dementia. *Disability Studies Quarterly*, 40(3).

work, this section will also serve to clarify and amend it, to offer a clearer picture of why the practice is necessary and what it entails.

Drawing on work from critical disability studies, I characterized the view that truth-telling always respects the status of persons as implicitly cognitively ableist. By this I mean, to paraphrase Licia Carlson, that it exhibits a bias towards people with particular capacities (i.e. the capacity to retain and act on accurate information) against those who do not have them.<sup>5</sup> Insisting on telling the truth to a person who cannot process or store new information easily, from this perspective, fails to respect them for the type of person they are. Thus, I argued, we should take seriously what I call a person living with dementia's *parallel subjectivity*: the subjectively consistent, if seemingly erroneous, understanding of the world they hold, which is derived from the capacities they have.<sup>6</sup>

Although I did not elaborate on this in my previous paper, this view is grounded on a relational egalitarian view of justice. Broadly speaking, this view holds that the aim of justice is to eliminate inegalitarian relationships, such as those that dominate, oppress or stigmatize.<sup>7</sup> Approaches that entirely disregard a person's parallel subjectivity can enact or reinforce such relationships. They may, for instance, contribute to unjustifiable hierarchies based on cognitive ability, by treating a person as if the capacities they do not possess are of primary importance. They may also contribute to the stigma of dementia by trivializing phenomena that feel very real to the person experiencing them.<sup>8</sup> Finally, if such approaches are commonplace and unchallenged, they may lead carers to dominate the people they are caring for, in the sense that they may license interventions that do not track their interests.

An equal dementia care relationship, then, is one that embraces the moral weight of a person's parallel subjectivity, rather than one that involves persistent disruptive corrections. Note, however, that this is a purely negative duty that attaches to care interventions. Active lying, when unnecessary to avoid disruption or meet a person's underlying needs, is not encouraged by this account. Indeed, because such unnecessary lies are unlikely to be in the interests of people living with dementia, care relationships in which they are sanctioned may themselves be dominating.

With this in mind, my previous paper set out a proposal for engaging in ethical deception through three techniques:

1. *Ethical deception by omission*: the carer avoids correcting or otherwise contradicting beliefs they consider to be mistaken.
2. *Ethical deception by distraction*: the carer avoids directly responding to a belief they consider to be mistaken and, instead, redirects the person living with dementia.
3. *Ethical deception by immersion*: the carer directly responds to a belief they consider to be mistaken in a way that reinforces or is, in some way, consistent with it.

Carers, I argued, ought to work their way through these techniques until the person's underlying needs are met. Doing so respects the person they are caring for, in the sense that avoiding contradicting a person's parallel subjectivity respects them for the capacities they have and helps to prevent the relationship from becoming problematically inegalitarian.<sup>9</sup>

## 2.1 | Case 1: A recent bereavement

Consider the following case:

Garth is a person living with dementia whose husband has recently passed away. Although he attended the funeral, he continues to inquire about his spouse's whereabouts, demonstrating a seemingly consistent belief that he is still alive.

At first glance, it may seem cruel to countenance collusion with this kind of mistaken belief. It should be noted, however, that the idea of a parallel subjectivity demands persistent misconception. Where those caring for Garth have little reason to suspect such persistence, my account of ethical deception allows for some correction: especially where doing so assists the person to process grief. Indeed, assuming that *all* those with a dementia diagnosis are incapable of retaining *all* new information would be reductive and may, itself, constitute a form of stigma or oppression.

Nevertheless, were Garth to continue making inquiries after repeated correction, it would be reasonable to conclude that this mistaken belief has become part of his parallel subjectivity. Accordingly, my account of ethical deception would demand carers embrace the idea that his husband is still alive—something many are likely to be deeply uncomfortable with. Garth, after all, will never find his husband, so it may seem particularly cruel to encourage or fail to correct this belief. Indeed, some may struggle to see how deception of this kind would be in his interests: if it inspired false hope or contributed to further anxiety, for instance.

This intuition appears less sound, however, when we consider the drawbacks of continuing to correct Garth. Recent evidence suggests that in most (if not all) forms of dementia, emotional and social memories can be retained much longer than specific details of conversations. This is to say that people living with dementia are better able to remember how they feel about a conversation, event or person than they are able to remember the details of what prompted the feeling.<sup>10</sup> If this is right, telling Garth the truth

<sup>9</sup>Carter, op. cit. note 4.

<sup>10</sup>See: Reschke-Hernández, A., Belfi, A. M., Guzmán-Vélez, E., & Tranel, D. (2020). Hooked on a feeling: Influence of brief exposure to familiar music on feelings of emotion in individuals with Alzheimer's disease. *Journal of Alzheimer's Disease*, 78(3), 1019–1031; Guzmán-Vélez, E., Feinstein, J., & Tranel, D. (2014). Feelings without memory in Alzheimer disease. *Cognitive And Behavioral Neurology*, 27(3), 117–129; Wong, S., Irish, M., O'Callaghan, C., Kumfor, F., Savage, G., Hodges, J. R., Piguet, O., & Hornberger, M. (2017). Should I trust you? Learning and memory of social interactions in dementia. *Neuropsychologia*, 104, 157–167.

<sup>5</sup>Carlson, L. (2001). Cognitive ableism and disability studies: Feminist reflections on the history of mental retardation. *Hypatia*, 16(4), 140.

<sup>6</sup>Carter, op. cit. note 4.

<sup>7</sup>Nath, R. (2020). Relational egalitarianism. *Philosophy Compass*, 15(7), e12686.

<sup>8</sup>Bryden, C. (2018). *Will I still be me?: Finding a continuing sense of self in the lived experience of dementia*. Jessica Kingsley Publishers, p. 21.

repeatedly may produce a compounding harm by repeatedly stimulating grief he cannot process through reflection. This production of negative emotions of subjectively unknown origin is unlikely to be in Garth's interests and, thus, a care relationship in which it is sanctioned would expose him to domination.

The impulse to correct, moreover, may arise out of a disrespect for difference, in the sense that it prioritizes capacities that Garth does not have over those that he does. Garth, after all, is a person who struggles to maintain new information and the details of conversations but is comparatively capable of maintaining emotional memory. Arguing that he must be told this upsetting information regardless implies that the former capacities are more important than the latter: directly reinforcing status hierarchies based on cognitive ability.

This is not just an abstract problem; self-advocate Christine Bryden bemoans the way people living with dementia are effectively marginalized from social interaction when reasonable adjustments are not made to account for their balance of capacities.<sup>11</sup> Refraining from deception in this case, therefore, may contribute to stigma and oppression, by pushing Garth out of the bounds of social recognition and reinforcing dismissive beliefs about the lives of those like him. It is in the light of such potential injustices that we have good reason to consider the value of ethical deception in this case.

It is well understood in the empirical literature that expressions from parallel subjectivity reflect genuine underlying needs.<sup>12</sup> The first duty carers have, then, is to figure out exactly what he is trying to express. The answer to this may seem obvious; he just wants to know where his partner is. However, there are many emotional needs that can be expressed by an inquiry after a deceased loved one, such as the need to feel loved, safe or close to one's family. Ascertaining the need they must meet is, then, a matter of seeing beyond the literal statement, to uncover the underlying emotional or physical needs that are prompting it.

The answer to this will be highly context dependent. If, for instance, Garth asks for his husband when he is out with carers in an unfamiliar location, one reasonable interpretation would be that he is feeling unsafe. Carers could then use *ethical deception by omission* to meet this need, by offering to take Garth home, to sit and take a break or simply by reassuring him that they will keep him safe if he wants to stay out.

Alternatively, if he makes this inquiry while resting in a familiar environment, it may be that he needs to feel loved in a general sense, or that he is missing his family in a more specific sense. In this case, ethical deception by omission make take the form of offering to call family members, holding Garth's hand, affirming that he is loved by his family and friends or looking through photographs of his loved ones with him.

It is possible, of course, that Garth may continue to inquire after his husband despite these interventions. If so carers ought to move on to *ethical deception by distraction*. Using this approach, carers can attempt to redirect Garth through the kind of 'redirection' techniques commonly used by dementia carers, such as offering to take him for a walk, shifting conversation topic or offering a cup of tea.<sup>13</sup>

This too may be uncomfortable for some; ignoring a person who is expressing a need to you is, in many cases, to ignore or fail to meet the need. This concern about neglect, however, is why the priority ordering of techniques is essential. Naturally, distracting Garth before attempting anything else would be problematic but, after intervention that makes use of omission, it can be useful for determining whether an emotional need has been met. We could imagine, for instance, Garth being soothed by the interventions above, but saying something like 'it would be nice if he were here though'. In such a case, it may be that the emotional need has become partially or fully disconnected from the erroneous information. If so, redirecting Garth by, for example, offering him a cup of tea or asking him if he would like to take a walk, may effectively shift his conscious thoughts away from his deceased spouse without ignoring the emotional need he was expressing.

If Garth continues to ask after his late husband, however, it is unlikely that the underlying need he was expressing has been met. If so, the account would demand carers engage in ethical deception by immersion: entering Garth's world and giving direct answers consistent with it. I take it that most of the intuitive discomfort with deception in this case arises from this kind of intervention. Immersion is distinct, after all, because it involves active lying, rather than passive restraint from telling the truth. Nevertheless, if there is little for Garth to gain from being repeatedly given emotionally troubling information he cannot retain and passive techniques have failed to meet his needs, then active deception is the only tool carers have left.

To reiterate; ethical deception by immersion does not offer a carer licence to construct elaborate, unwieldy lies that would unavoidably harm or disrespect Garth in other ways. Instead, it encourages carers to aim for the minimum distance from the truth necessary to meet the need being expressed. For example, 'he can't be with us right now, but he loves you very much' is a direct response, consistent with Garth's subjectivity, that says very little that is false. It is, after all, true that Garth's husband cannot be with him and he, presumably, did love him very much; though the erroneous implication that he is alive is certainly significant, it would be worse if garnished with further deception. Were this to satisfy the emotional needs being expressed, my account would not sanction further lies.

Admittedly, the account may require carers to engage in active deception beyond this. It is possible, for instance, that Garth might ask if he can speak to his husband on the phone or ask carers why he did not know that he was away. A troubling implication here is that, if Garth continues to ask after his husband, carers may believe they are duty-bound to continue lying, with increasing severity until they

<sup>11</sup>Bryden, C. (2005). *Dancing with dementia: My story of living positively with dementia*. Jessica Kingsley Publishers, pp. 139–142.

<sup>12</sup>Kitwood, T. (2019). Personhood maintained. In D. Brooker (Ed.), *Dementia reconsidered, revisited: The person still comes first* (pp. 69–71). Open University Press.

<sup>13</sup>Morgan, D., & Stewart, N. (1997). The importance of the social environment in dementia care. *Western Journal of Nursing Research*, 19(6), 749–754.

reach some absurd, inappropriate interventions. We might worry, for instance, about carers feeling compelled to pretend to be his husband or take him on a wild goose chase looking for him. Such a risk stimulates the intuitive discomfort we feel about lying, especially to people who are vulnerable and within our care.

Were carers to engage in such interventions, they would be treating Garth in a grotesque manner; most of us would agree on that. They would also, however, be interpreting my proposal erroneously. Consider first the fact that care interventions nearly always ought to be focused on *successfully* meeting specific needs. It is highly unlikely that absurd interventions of this kind will actually succeed; a wild goose chase that does not result in finding Garth's husband is likely to make him feel more abandoned, lonely or unloved. Where carers can reasonably foresee such a failure, the account does not sanction engaging in this kind of deception.

Even if there were a good case for engaging in such deception, however, carers ought to remember that needs do not exist in isolation. If an intervention is highly likely to jeopardize the meeting of Garth's wider needs: by, for instance, making him feel distrustful of his carers, further marginalizing him from others or making his environment feel less safe, then no carer would be justified in proceeding with it. This is because doing so would involve treating Garth as a series of problems that need to be solved, rather than a complete person with a complex set of needs. Such treatment is likely to be: dominating, in the sense that it does not track his interests; stigmatizing in the sense that it expresses contempt for people living with dementia; and marginalizing, in the sense that carers may not feel comfortable engaging with him. Thus, it is not compatible with a relational egalitarian view of justice.

Carers, then, need to be creative in making subjectivity-consistent interventions, but they also need to be reflective and cautious. If they can think of no other way of engaging in ethical deception by immersion without making interventions that threaten other needs, then they may have to conclude that this is a need that they cannot meet. While this may seem like a convenient or disappointing conclusion, it is not a unique one in care. For instance, a person who cannot swallow food or drink safely, but has exercised their agreed capacity to refuse other feeding interventions, has a physical need for nutrition and hydration that carers cannot meet. Carers may despair that they cannot meet these needs and they may try all they can to change their charge's mind, but they likely will remain unable to succeed. In such a situation, the carer is not automatically a dominator, oppressor or a perpetuator of stigma. It is only where they *can* meet the need in a way that is compatible with treating their charge as an equal, but choose not to do so that they express disrespect for them.

If Garth's carers find that neither omission, distraction nor reasonable levels of immersion succeeds in meeting the need he is expressing, then they may need to accept that this is a need they are unable to meet. That a specific need cannot be met, however, is not a reason to give up and tell him a truth that neither benefits nor respects him: especially if the continual use of ethical deception can offer comfort or partial amelioration of emotional pain that the truth

cannot. That Garth's emotional need cannot be fully met is unfortunate, as any case of needs that are not possible to meet is, but it does not constitute a social injustice.

## 2.2 | Case 2: A troubling hallucination

Consider the following case:

Florence is a person living with dementia who experiences vivid hallucinations. One day, while sitting in the fully occupied lounge of her care home, she appeals to her carers to get her to hospital because she is about to give birth.

Florence's hallucination is frightening, expressed with a sense of urgency and seemingly far removed from her objective reality. Though I have already stated that carers are not required to engage in inappropriate and absurd deception, some may doubt that there is any other way to deceive here. If there is not, then it seems like my account of ethical deception cannot guide carers in cases like these. As I shall demonstrate in this section, however, carers can maintain the parallel subjectivities of people living with dementia even in extreme cases like these.

As in the previous case, we must first consider whether this is truly part of her parallel subjectivity. If it is something else, such as a flashback to a traumatic incident, then respect for Florence as a person may not demand that carers engage in deception at all. If Florence has the baseline capacity to retain a sensitive correction or has enough insight into her condition to recognize a hallucination when prompted, for instance, carers do not respect her by treating her as if she has neither. Indeed, presuming this frightening experience will end, Florence's dementia diagnosis is near irrelevant; carers can simply follow the usual norms for helping a person through this kind of episode.

While the belief that she is in urgent need of maternity care is likely to be temporarily held, however, Florence's baseline belief that she is pregnant could be more consistently expressed. It is easy to imagine, for instance, that she could have been talking about her pregnancy casually throughout her time in the care facility, and that this hallucination has arisen with this belief at its foundation. Thus, this case helpfully illustrates an important component of the practice of ethical deception; not every mistaken belief involved in a care intervention is part of a person's parallel subjectivity, so carers are not required to keep every single one intact to demonstrate respect. In this case, carers may be obligated to avoid contradicting Florence's belief that she is pregnant, but it is highly unlikely that any such obligation would exist about the imminence of childbirth.

Some may still be uncomfortable with the idea that an underlying component of this hallucination must be reinforced, but we must again consider the alternative approach. If Florence cannot retain a correction of her belief that she is pregnant, then she is vulnerable to the same concerns about emotional memory that arise in the case of



Garth. Moreover, as this incident is taking place in a fully occupied lounge, an argument over something as intimate as pregnancy could be felt as highly pressurized and humiliating. As responding to her urgent cries for help by telling her she is not pregnant would be unlikely to track her interests, as well as involving risks of social marginalization and exposure to stigma, carers have good reasons to consider ethical deception in this case.

As in the previous case, the right intervention will depend on the nature of the need. If Florence is in pain, for instance, then carers could make interventions focused around identifying its source and treating it appropriately. If, on the other hand, her erroneous statement primarily reflects emotional needs, they could focus their interventions on identifying and addressing them.

On the first option, ethical deception by omission could take a fairly simple form. The carer could simply ask her directly if she is in pain, then follow normal procedures for identifying its severity and ascertaining whether emergency services need to be called. If so, then the carers may not be able to fully meet Florence's needs, but they could follow whatever instructions they have been given from emergency services while maintaining ethical deception. They could, for instance sit with her and offer emotional reassurance. If this is insufficient, they could try to redirect her from her thoughts about pregnancy by offering tea or engaging in unrelated conversation with her. If necessary, they could even immerse themselves in Florence's world by telling her the emergency services are on their way and couching any offer of pain relief in terms that do not contradict her belief that she is pregnant.

If her pain, for whatever reason, is agreed not to warrant such a call, carers can try to meet her need for pain relief in other ways consistent with ethical deception. They can, for example, use ethical deception by omission when giving pain relief or other treatment targeted at the pain, by simply offering the treatment without contradicting her subjective belief that she is giving birth. Then, engaging in ethical deception by distraction, they might similarly redirect her with offers of tea or engagement in unrelated conversation. If neither successfully meets her needs, then carers could use ethical deception by immersion while giving treatment, couching it in terms of maternity care. Additionally, provided it is safe to do so, carers could circumvent potential relational injustices connected to the public nature of the case by offering to move her into a quieter, more private area of the home. As none of these practices involves colluding with the particularly disturbing, temporary hallucination, they ought not to activate concerns about further harm.

In the event that the hallucination is not accompanied by pain, however, some may feel more discomfort about deception. After all, in the opposing case Florence genuinely requires treatment, so slightly misleading her on the purpose may not be as troubling. However, where there is no requirement for medical treatment, some may be concerned by the idea that carers should reinforce someone's belief that it is necessary. Worse, some carers might think ethical deception by immersion demands engaging in unnecessary medical treatment or, at least, leading Florence to believe she is being medically treated.

Given the caveats mentioned above, however, such troubling situations need not necessarily arise. One plausible emotional need

that may be being expressed by Florence here is the need to alleviate fear; she genuinely believes that she is about to give birth, and this hallucination is incredibly frightening for her. Ethical deception by omission might involve holding her hand, reassuring her that she is safe or using prompts like music to stimulate a sense of security and familiarity. She might then be redirected by being offered a walk around the grounds, or another stimulating activity to take her conscious thoughts off of childbirth.

Should the fear remain, active deception may be demanded to demonstrate respect, but only within a limited scope. Interventions like play acting to simulate childbirth or giving unnecessary medical treatment are already ruled out, because carers are under no obligation to reinforce Florence's belief that childbirth is imminent. Regardless, they are unlikely to actually assuage her fear and may even exacerbate it.

Instead, carers could draw from a range of plausible options they have that deny the imminence of childbirth while respecting her belief that she is pregnant. These could take the form of reassuring immersive statements such as 'it's a false alarm, but we'll take care of you when it is time', or a more active approach such as taking her to lie down and rest, ostensibly for the good of the baby.

As in the case of Garth, these interventions may not successfully meet the underlying needs. As hallucinations are merely temporary, however, that conclusion is far less troubling. Carers can do all they can to deal with pain or assuage fear using ethical deception around her view that she is pregnant, safe in the knowledge that Florence will not go on consistently believing she is about to give birth. Naturally, carers must be sensitive, must affirm the fear, panic or pain that Florence is feeling but, because this specific component of the hallucination is not part of her parallel subjectivity, they do not wrong her or treat her unjustly by contradicting it. Given the number of options I have identified here, then, extreme hallucinations like these can be dealt with through ethical deception without requiring carers to engage in absurd, harmful activities.

### 2.3 | Case 3: Persistently mistaken identity

Consider the following case:

Steve is a person living with dementia who has been newly transferred to a care home. During his first day in the home, he lashes out at another resident. When the care home staff separate the two men, Steve claims the other man stole a lot of money from him. To the best of the care home's knowledge, the two men have never previously met.

At first glance, this case seems particularly troubling for my account. To the extent that doing so puts the other resident in danger, it seems to be profoundly wrong to collude in Steve's mistaken belief. Indeed, instructing carers to do so could render them complicit in any violent acts committed. Accordingly, it is likely that many people

would have strong intuitions against deception in this case. Nevertheless, the account can deal with these concerns while maintaining respect for Steve and the capacities he has.

Before considering deception, carers must first ascertain the durability of this mistaken belief. As in each of the previous cases, my account of ethical deception would not advise against *trying* to correct Steve's beliefs in the first instance. Nor would it advise trying again if the behaviour is repeated. Respect for Steve as a person living with dementia would only demand embracing this belief if it becomes a persistent component of his parallel subjectivity. In this sense, carers need not stand by or confirm a belief that threatens the safety of another resident *when it first arises*.

Moreover, even if the belief is persistent, carers have a range of options open to them before confirming it. In line with the priority ordering I have used throughout the paper, carers ought first to try ethical deception by omission. In this case, this might take the form of refusing to confirm or deny this mistaken belief, but instead emphasizing that they have a duty to protect all of the home's residents from violence. Though this may seem troubling, in the sense that it could be taken as confirmation by omission, it is likely better than an outright contradiction of the belief. After all, if it forms a persistent part of Steve's parallel subjectivity, he is unlikely to believe them and could become angry and frustrated, putting the other resident at increased risk.

If carers are unsuccessful in meeting the underlying need expressed here—which could be a need to feel safe, to feel in control or use excess energy—my account recommends ethical deception by distraction. This might take the form of taking Steve out of the area in which the other resident is sitting, or encouraging him to engage in an activity that draws on his energy and attention, such as walking or playing a ball game. If successful, this would protect the other resident from violence, while giving Steve an outlet to meet his emotional and physical needs, all without disrupting his parallel subjectivity.

Even if both of these techniques are unsuccessful, however, my account of ethical deception need not put the other resident at risk. In this case, carers ought to move on to ethical deception by immersion, which would involve confirming Steve's belief that he is living with someone who has stolen money from him. Admittedly, doing so *in isolation* is highly likely to increase the risk of violence. However as my account would not recommend doing so unless omission or redirection has successfully met the underlying needs expressed, the threat of violence is ever present *however carers respond*.

All Steve's vital needs that *can* be met, must be met; this is a core requirement of maintaining an egalitarian care relationship. Leaving other residents at risk of violence, however, threatens their needs, risking the quality of other care relationships. In this scenario, then, my account would likely demand *transferring Steve to another care service*. Though this would likely be a suboptimal outcome, it appears to be the only way to protect the vital needs of all the home's service users. When this decision is made, ethical deception by immersion plays the important role of explaining the move in a way that is consistent with Steve's parallel subjectivity. Carers could, for instance, tell him that he should not have to live with someone who has hurt him and that they have found a much nicer place to send him to.

Though there are risks of harm involved in this kind of move,<sup>14</sup> they must be understood in relation to the risks already present in Steve's current home. No just care practice could countenance putting other service users at risk of violence, nor could it justify keeping Steve in an environment that makes him scared, angry or frustrated with no easy way to offer relief from those emotions. To the extent that this is the only way to meet the needs of their service users, while respecting their parallel subjectivities, carers would not treat Steve unjustly by organizing and facilitating such a transfer, regrettable though it may be. Thus, even in a case involving risks of violence, my account of ethical deception would not recommend severely unjust actions.

### 3 | CONCLUSION

In this paper I have sought to test, clarify and expand my account of ethical deception in the case of dementia care through the use of complex, challenging examples. I have argued that even in these cases, ethical deception respects people living with dementia for who they are, without encouraging carers to engage in severely unjust practices. The suggestions I have made here are not intended to be prescriptive, nor are they exhaustive. Rather, they serve to highlight the options open to carers when engaging in ethical deception.

Nevertheless, these cases have raised important concerns that should be taken into account when an intervention is planned. Carers ought to be aware that a genuine inability to meet a need does not, by itself, enact or reinforce a relational injustice. They also should refrain from gratuitous lying or otherwise jeopardizing other needs through their interventions. They ought to separate those beliefs that are consistently held from those that are temporary, and they should understand that they are justified in contradicting the latter. Finally, they should be cautious about confirming beliefs that put others at risk of violence and be willing to transfer residents whose needs cannot be met without threatening those of others.

Carers who engage in deception in this cautious, reflective way go some way towards meeting the demands of relational egalitarian justice. With institutional support and oversight, the practice of ethical deception can help to make dementia care non-dominating, non-oppressive and non-stigmatizing. While further reforms will be necessary to fully achieve it, this practice, as I have defended it here, stands as an important step in building a society in which people living with dementia are treated as equals.

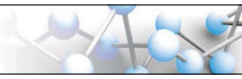
### CONFLICT OF INTEREST

The author declares no conflict of interest.

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<sup>14</sup>Coleman, E., Barbaccia, J., & Croughan-Minhane, M. (1990). Hospitalization rates in nursing home residents with dementia. *Journal of the American Geriatrics Society*, 38(2), 108–112.



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