**Caring by Lying**

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**Abstract**

When we deceive loved ones with dementia, we may view our deception as a violation of our general truth-telling obligations. I argue that this view is mistaken. This is because truth-telling obligations may be limited by the particular relationships in which they feature. Specifically, within caregiving relationships, we are often permitted (and sometimes obligated) to deceive the people with whom we share them. Our standing to deceive follows from certain features of caregiving relationships. Specifically, they are relationships that involve obligations to promote a person’s interests and values (and not simply their autonomy), that often permit us to assume the hypothetical consent of the person with whom we share it, and in which we are often entitled to act out of self-interest. Once we appreciate these features, we will be able to recognize that the truth-telling norms governing our relationships with loved ones with dementia do not represent a radical departure from our general truth-telling obligations, but are instead consistent with truth-telling norms that feature in other caregiving relationships. In addition, we will be able to understand why we may feel conflicted about lying to loved ones with dementia, even when lying is permissible.

**Keywords**

Truth, truth-telling, deception, dementia, caregiving, contractualism

**Introduction**

Kant famously proclaimed that we shouldn’t lie, not even to a murderer at the door.[[1]](#footnote-1) On the Kantian picture, lying is seen as being anathema to respect for persons. When we lie, Hill and Bok contend, we deprive people of a realistic picture of their situation, thus disrespecting them as an autonomous agent and rendering them powerless against our influence.[[2]](#footnote-2)

The Kantian picture described above sometimes has clear appeal. Even if we make an exception for the murderer at the door, we often think that lying is a serious moral wrong. But it is hard to imagine that Kant’s loved ones would have been able to live up to his picture’s demands while caring for him as he suffered from dementia late in life.[[3]](#footnote-3) When we find ourselves caring for loved ones with dementia, we often take ourselves to be permitted, or even obligated, to lie to them in the service of meeting their needs.[[4]](#footnote-4)

This assumption plays poorly with the Kantian picture. If our loved ones with dementia are still autonomous agents, then the lies we tell them will be seriously wrong according to the Kantian picture. And if they aren’t autonomous agents, then the Kantian picture has nothing to say at all, as it was never meant to apply to agents who are not, and will never again be, autonomous agents. Neither of these verdicts is wholly satisfying. Some amount of lying and deception typically seems permissible in cases involving semi-autonomous people with dementia. But this permission is not without a caveat; even if we feel that we are entitled to deceive loved ones with dementia, we still feel guilty about exercising our entitlement. [[5]](#footnote-5)

In this paper, I propose an alternative conception of truth-telling obligations to the one presented in the Kantian picture. This picture is broadly contractualist in nature, and will be used to explain both why we are often entitled to deceive people with dementia, and why we often feel morally conflicted about exercising that entitlement. On my picture, our moral obligations (including our truth-telling obligations) are shaped by the particular relationships in which they feature. Some relationships may have very strong truth-telling obligations, while others have weaker or more nuanced ones. As I will argue, within relationships that involve caregiving, certain forms of deception are often permissible, and sometimes even mandatory. Since the relationships that we have with our loved ones suffering from dementia are caregiving relationships, they are relationships in which deception may reasonably feature. Nevertheless, insofar as caregiving relationships typically also involve moral norms that recommend in favor of truthfulness, and insofar as the moral norms governing caregiving relationships involving dementia are often in flux, we are liable to experience some amount of guilt when we lie to the people with whom we share them.

My paper proceeds as follows. In Section 1, I outline what I mean by a ‘caregiving relationship’, as well as what background moral picture that I am assuming. I will then describe some of the way in which lying and deception may feature within caregiving relationships. In Sections 2-3, I offer two explanations as to why we may be entitled to lie and deceive within these relationships, and argue that both apply to caregiving relationships involving people with dementia. In Section 4, I consider what sorts of lies and deceptions are most permissible within caregiving relationships. In Section 5, I explain why we may still feel morally conflicted about lying to loved ones with dementia, even though lying and deception is common and often justifiable within caregiving relationships.

Before moving, let me offer three clarifications about my project. First, I am primarily interested in *informal caregiving relationships*, such as the relationship between parent and child, or between romantic partners. I will only discuss *formal caregiving relationships* (e.g. doctor-patient relationships) in the concluding section of this paper. Whenever I refer to ‘caregiving relationships’, I have in mind informal caregiving relationships.

Second, while there is some reason to think that moral distinctions can be drawn between lying to people with dementia and deceiving them,[[6]](#footnote-6) I will not distinguish these two practices here. This is because my argument provides a qualified justification for both practices within informal caregiving relationships.

Third, my argument is predicated on the thought that we can share a caregiving relationship with people suffering from dementia. Since dementia is a progressive illness, there may be some point in its progression in which its sufferers cannot be said to meaningfully share relationships with particular others. If this is correct, then my argument will not apply to these cases, although other arguments in favor of deception likely will.[[7]](#footnote-7)

**Section 1: Caregiving Relationships and Truth-Telling**

Before discussing the connection between caregiving relationships and truth-telling obligations, I’ll say something about how I’m understanding these relationships, as well as the contractualist background through which I will understand the moral norms that govern them. ‘Caregiving relationships’ are relationships in which one or more parties has agreed to go beyond the basic interpersonal moral obligations that we owe to everybody, and to actively take an interest in promoting the good of the person with whom they share the relationship. These relationships, as Held and Kittay have argued, are at the center of our moral lives.[[8]](#footnote-8) Further, they can take many different forms. Some are ‘formal’ relationships that are governed partially by explicit contractual agreement or professional norms (e.g. doctor-patient relationships, teacher-student relationships). Other are more intimate and informal—familial relationships, friendships, and romantic partnerships all count as caregiving relationships on my view.[[9]](#footnote-9) These informal relationships shall be the focus of my paper.

The moral norms that we observe within caregiving relationships are often different than the ones that we observe outside of them. Contractualists like Scanlon and Kumar offer one particularly fruitful way of how relationships can shape the moral norms that feature within them.[[10]](#footnote-10) Contractualism is a moral theory that aims to capture the normative standards that govern interpersonal conduct. The ideal form of interpersonal conduct is one in which both parties show appropriate recognition for the others’ value as a person. To achieve this requires us to not violate the legitimate expectations that other people may have of us.[[11]](#footnote-11) But what expectations another person can legitimately have of us is not something that can be determined in the abstract. Instead, we must appreciate the particular relationship that we stand in with them. For example, we can legitimately expect our friends and loved ones to support us in ways that go beyond the support that we can legitimately expect of a stranger.

Let’s consider the sorts of legitimate expectations that feature in the types of caregiving relationships that interest me here. As noted previously, caregiving relationships are ones that involve heightened concern for the interests and values of the people who feature within them. But in taking on these obligations, we also become entitled to certain moral allowances. For instance, caregiving relationships typically permit a level of paternalism from their participants that is impermissible within other sorts of relationships.[[12]](#footnote-12) My mother owes it to me as a daughter to offer me support during difficult times, but I also permit her to meddle in my affairs in a way that I would not allow a stranger. This permission is not endless—there are certain spheres of my life that she is absolutely *not* entitled to paternalistically meddle in—but it is nevertheless greater than the sphere that we find in more distant relationships.

Given this backdrop, it is no surprise that the moral norms that feature within them will be complicated and will often admit of more exceptions than the Kantian picture sketched in the introduction allows. We can see this clearly when we consider what sort of truth-telling norms commonly feature within caregiving relationships. On the one hand, these relationships are often ones that demand strict honesty from their participants. We expect our loved ones to tell us harsh truths when nobody else will, and we often view their failures to do so as significant breaches of trust. But at the same time that caregiving relationships often involve heightened obligations to tell the truth, so too do they sometimes permit (and even demand) lying and deception.

To see what I mean, think first about parent-child relationships. Parents may lie to their children for a variety of different reasons. Sometimes, they tell lies in the service of their children’s happiness; my own childhood was enriched by my parents’ insistence that Santa Claus, Peter Pan, and the Tooth Fairy *really existed*. At other times, lies are told with the aim of keeping children away from age-inappropriate truths; children don’t necessarily benefit from having an accurate picture of their parents’ economic situation or history of trauma, for instance. And sometimes, parents lie in order to protect important interests that their children don’t yet care about. A parent might deceive a child into thinking that it’s *illegal* to stick their head out of the window of a moving vehicle, thus reducing the chances of their child suffering a horrific accident.

We can also see suspensions of truth-telling expectations in more egalitarian caregiving relationships. A romantic partnership typically involves many caregiving activities, with partners trading off on who gives and receives care. Within these relationships, participants often suspend or manipulate truth-telling norms in the name of providing care. You might know, for instance, that your partner would prefer to be lied to than to be told bad news while at work. Or your partner might know that you would prefer deception over having a nice surprise ruined.

Given what we owe within caregiving relationships, it makes sense that they will sometimes involve deception. Caregiving relationships involve obligations of *care*. We owe it to the people with whom we share them to actively promote their interests and values; and deception is often one way of doing this.[[13]](#footnote-13) And this is exactly the sort of story that we are drawn to when trying to justify deception within dementia care. We want our loved ones’ lives to go well; and deception is often an effective way to make that happen.

But this can’t be the full story. After all, even if deceiving our loved ones can promote their interests and values, it doesn’t follow from this that it’s permissible for us to take that particular means to our end. Deceiving a perfect stranger might also promote their interests and values, but that doesn’t generally make it permissible for me to do so. What we need, then, is a story about why we’re entitled to use deception to fulfill our obligations within caregiving relationships. It is to this issue that I shall now turn.

**Section 2: Hypothetical Consent**

The first entitlement that I want to consider has to do with *hypothetical consent*. Within caregiving relationships, I will argue, we are often legitimately entitled to assume ourselves to have the hypothetical consent of our loved one.

To get started, let’s first consider what it takes to justify a suspension of truth-telling norms *outside* of caregiving relationships. Almost everyone grants that lying is at least *sometimes* permissible. First, it may be permissible in cases where one has explicitly secured someone’s *consent*: if you agree to participate in a research study that involves deception, you cannot object when a researcher deceives you.

Second, lying may be permissible in cases where an interest that an agent obviously has is under threat by the truth. If the only way that I can prevent someone’s death is to lie to them, then I generally ought to lie. Here, we need not appeal to an agent’s explicit consent to justify our deception—as we may not have it. Instead, we may justify our deception on grounds of *hypothetical consent*. That is, deception may be justified in cases where we have good reason to think that we *would have* an agent’s actual consent, had we been in a position to request it.

When it comes to strangers, the extent to which we can justify lying via an appeal to hypothetical consent is limited. I can reasonably assume that strangers have an interest in having their life preserved, in not being maimed etc. But I can’t make more nuanced inferences about their interests, or about how they would weigh those interests against their (presumed) interest in not being lied to. I simply don’t know them well enough to make such inferences. And even if I somehow did intimately know a stranger’s interests, there would still be something morally off-putting about trying to justify my lies by appeal to their hypothetical consent. This is because I don’t share the sort of relationship with a stranger that would allow me to speak on their behalf in this way.[[14]](#footnote-14)

Within caregiving relationships, the situation is different. First, we generally know the people with whom we share these relationships—and so we have an intimate sense of their interests and values.[[15]](#footnote-15) Second, these relationships carry with them the expectation that their participants will act on each other’s behalf, often without explicit consultation. Parents, for instance, don’t seek consent from their young children when enrolling them in school, romantic partners often accept social invitations on each other’s behalves, and when medical crises render our loved ones temporarily incapacitated, we may become their surrogate decision-makers even if they had not previously signed an advance directive appointing us to this role.

And so too are we often able to assume our loved one’s hypothetical consent when it comes to deception. Your adult child may know, for instance, what you *don’t* want to find out about their life. If they lie to you about how many people they’re dating, or whether they’ve ever tried LSD, they may be able to justify their lies by appeal to your hypothetical consent. Likewise, my partner need not ask whether I want to be told about minor household crises when I’m trying to meet a writing deadline (he knows I don’t). And so, when he deceives me into thinking that the furnace *hasn’t* just broken, he does so with my hypothetical consent.

How much deception can hypothetical consent actually justify? Bok has suggested very little, as it often isn’t clear whether our loved one *would have* consented to our deception if given the opportunity.[[16]](#footnote-16) I agree that there’s often genuine uncertainty here, but I think that the standard for justifying hypothetical consent is lower than Bok allows. Specifically, if I have good reason to believe that my loved one would have consented (where ‘having a good reason’ involves both intimately knowing their interests and being in a relationship that involves regularly and permissibly acting on the other’s behalf without their actual consent), then deception may be permissible even in cases where, as a matter of fact, they wouldn’t have consented.

Of course, when it comes to cases involving loved ones with dementia, we should be careful not to set the bar for ‘having a good reason’ too low lest we risk becoming unduly paternalistic or acting against our loved one’s interests. To avoid this, I think two things ought to be kept in mind. First, many people with dementia retain strong elements of personhood throughout its progression. As such, we should be careful not to default to hypothetical consent when actual consent (or at least, actual assent) is still possible. Such defaulting would not only be disrespectful to the person with whom we share the relationship, but could also undermine the trust necessary the relationship’s functioning. Ongoing conversations about what sorts of deception are and are not permissible within the context of a specific caregiving relationship may thus often be possible. Someone with dementia might, for instance, not be bothered by little white lies, but may be unnerved by the idea of being lied to about significant life events. Thus, just as the sphere in which hypothetical consent gets negotiated through actual discussions in relationships that don’t involve dementia, so too may it be negotiated in relationships that do.

Second, in cases where it is no longer possible for someone with dementia to communicate their interests and values to their caregivers, good faith efforts should still be made to discern what those interests and values are. Such efforts are already familiar within other sorts of caregiving relationships. Consider relationships between parents and young children; while children *eventually* consent to sharing a relationship with their parents, this actual consent is absent (and impossible) during the years of their lives that typically involve the greatest amount of caregiving and deception. Instead, we again rely on a notion of hypothetical consent, and try to discern whether they *would* consent to the relationship, given what they’re like, what interests they have, and the extent to which the relationship is promoting or frustrating those interests. I think we go through the same process in cases involving people with dementia who are no longer capable of communicating their interests. We do our best to figure out what those interests are, given what we know about the person that they were and the person that they are. And we consider how those interests are frustrated or furthered by specific sorts of deception. What we’ll end up with is a complicated set of truth-telling norms that are responsive to our best understanding of our loved ones’ interests.

Whether or not our loved ones with dementia can still directly communicate their interests, it follows from the very nature of informal caregiving relationships that we ought to be concerned with those interests. As I understood these relationships, part of what being in them involves *just is* a heightened concern with the interests and values of the people with whom we share them. Being too quick to assume hypothetical consent, or being too quick to brush off the possibility of actual consent, are thus both anathema to the central tenet of informal caregiving relationships.

**Section 3: Mutual Concern**

There is at least one more reason why caregivers are often entitled to deceive their loved ones. Caregiving relationships typically involve significant *mutual concern* for their participants: The caregiver cares about the care-receiver, and the care-receiver cares about the caregiver.

Here’s why this matters. We don’t lie to people with dementia simply because it is in their interest to be lied to. Instead, we often lie to them because it’s in *our interest* that they be lied to. If we hide our loved one’s medication in their food, we won’t have to go through the struggle of convincing them to take it. If we tell our mother that her deceased husband is merely taking a walk, we won’t have to suffer the anguish of watching her grapple with his death anew. Indeed, we might even trade off their interests for our own. We might think, for instance, that our mother has an interest in knowing the truth about her husband.[[17]](#footnote-17) But sheer exhaustion might nevertheless lead us to say ‘Dad’s just popped out to grab some milk.’[[18]](#footnote-18)

Some might think that it is obviously wrong to deceive people with dementia out of self-interest.[[19]](#footnote-19) On this line of thought, we might be able to justify lying to somebody with dementia by appealing to their interests, but not by appealing to our own. Withinmore distant relationships, I think this is a plausible stance to take. We generally need a very good reason for deceiving a stranger, which an appeal to self-interest rarely provides.The relationship that we have with a stranger, after all, isn’t one in which the stranger is expected to show any concern for our interests and values beyond the level of concern that they owe to all persons.

But within caregiving relationships, the story is different. Care-receivers can be expected to show serious concern for caregivers’ self-interest for at least two reasons. First, in many cases, the very fact that caregivers are willing to bind themselves by the strenuous obligations of caregiving entitles them to significant self-regard—they can, in other words, legitimately demand a certain level of self-concern given the other-concern that they have committed themselves to showing. Second, and more importantly, caregiving relationships are ones in which the interests of the parties are bound together.[[20]](#footnote-20) Our loved ones have a vested interest in being able to protect our mental and physical health. Thus, even if a person with dementia might have an interest in being told a painful truth, they may also have an interest in being told a comforting lie insofar as being told that lie might help them to protect their loved one from mental or physical burnout.

One might wonder if I’ve assumed far too much about the interests of people with dementia. After all, dementia radically alters our interests, in a way that makes us almost unrecognizable to our loved ones. Why should we think that people with dementia still have an interest in their loved ones’ self-interest? As noted at the onset of this paper, I think there may come a time when someone’s dementia is so progressed that they can’t be said to meaningfully ‘share’ in any sort of loving relationship with their friends or family. Once this happens, they will no longer be in a relationship involving the sort of mutual concern that I have described (although they may still be in a thinner, more formal sort of caregiving relationship). But I think we shouldn’t be too quick to assume that point has been reached. People with dementia regularly continue to show love and concern throughout the progression of their condition. As well, even if some people with dementia do eventually stop sharing meaningful relationships with their caregivers, I think that an appeal to the caregiver’s self-interest can still often be made. If, for instance, deception is required to make caregiving tolerable for a caregiver, then the person with dementia will have an interest in being deceived. After all, they have an interest in being cared for—and the satisfaction of that interest is predicated on allowing for the caregiver’s self-interested deceptions.

**Section 4: How Should We Determine When Deception Is Justified?**

I’ve suggested that deception within caregiving relationships can be justified on grounds of hypothetical consent and mutual concern. Of course, this does not mean that anything goes; indeed, we often feel more wronged when we are deceived by our loved ones than when we are deceived by strangers. This is unsurprising; the moral norms that govern intimate relationships like the ones that I have in mind are complicated and sometimes in tension with each other. Nevertheless, the contractualist framework that I am offering helps to shed light on what sorts of deceptions are going to be most defensible.

As noted previously, contractualism aims to offer a procedure for determining what people can legitimately expect of one another, where what counts as a legitimate expectation is shaped by the particular relationship-type that two people share. As I have previously suggested, caregiving relationships are relationships in which participants can reasonably expect each other to show a heightened concern for their interests and values. Within caregiving relationships involving dementia, satisfying this concern will often require us to work hard to figure out what those interests and values presently are. And so, truth-telling norms that insufficiently sensitive to the interests and values of a person with dementia are going to be impermissible on the contractualist framework.

To determine what sorts of deceptions *are* permissible in the context of caregiving relationships involving dementia, we need to figure out what sort of legitimate expectations we ought to have in terms of truth-telling within the context of caregiving relationships. Put more concretely, I think we ought to navigate truth-telling in caregiving relationships by considering questions like the following: what interests and values does the care-receiver currently have, how weighty are they, and how would they be promoted or thwarted by deception? What interests and values does the caregivercurrently have, how weighty are they, and to what extent can they be weighed against the interests and values of the care-receiver? What truth-telling norms have historically governed the relationship between caregiver and care-receiver, and to what extent can and should they still be operational? The answers to these questions will likely be complicated, taking into consideration facts about context, the history of the relationship, and the specific values and interests of both caregiver and care-receiver. Appreciating these factors will likely yield a set of nuanced truth-telling norms, of a sort that are different in degree, but not kind, from the sort of complex truth-telling norms that are operational within other sorts of close caregiving relationships.

**Section 5: If This Is Just Normal Caregiving, Why Does It Seem Morally Complicated?**

The deception that is involved in caring for someone with dementia does not represent a wholesale departure from our typical truth-telling norms. Rather, they are an extension of the complicated truth-telling norms that we already find within our caregiving relationships. To be sure, the amount of deception that may permissibly occur in the context of dementia caregiving is typically greater than the amount that may permissibly occur in other sorts of caregiving relationships. Nevertheless, as I have suggested above, the moral considerations that justify deception in more ‘typical’ caregiving cases can also justify it in caregiving cases involving people with dementia.

Why, then, do we feel so uncomfortable lying to our loved ones with dementia? I offer three answers here. First, there is often a familiar tension within caregiving relationships between truth-telling and deception. We are, I have argued, typically licensed to some amount of deception within these relationships. But this license isn’t unrestricted. Indeed, we sometimes find ourselves to have *heightened* truth-telling expectations within the context of caregiving relationships. We often expect our loved ones to tell us the ‘harsh truths’ that nobody else will. When it comes to our loved ones, it’s often genuinely difficult to determine whether we’re in a situation that demands radical honesty or gentle subterfuge.

Squaring these two competing norms is difficult in caregiving relationships that don’t involve dementia. But the difficulty is heightened in the dementia case, insofar as the very norms governing relationships involving dementia are in flux.[[21]](#footnote-21) This brings me to my second explanation of why lying to loved ones with dementia often feels morally complicated. Consider what norms might appropriate govern the relationship between two long-term spouses, one of whom has been diagnosed with dementia. In the early stages of dementia, the spouse with dementia might still be legitimately expected to perform many of the caregiving obligations we associate with romantic relationships—he might be expected to take an interest in his wife’s emotional health, to help her navigate stressful situations and so forth. She, in turn, might feel entitled to this sort of care at the same time that she is taking on additional caregiving burdens associated with his dementia. At some point, however, she must recognize that she is no longer entitled to expect a high degree of emotional support from him, despite having reasonably expected this support in the past, and despite still needing it in the presence. But there will likely be a long intermediary period in which there is genuine uncertainty about whether he still has these support obligations to her as a spouse.

Finally, even once the wife is certain that she and her husband can no longer legitimately hold each other accountable to the norms that once governed their spousal relationship, she may still feel the ‘moral residue’ of her past obligations, in much the same way that we may feel guilty about not helping a former friend through a difficult time, even if our friendship with them ended years earlier. That we may still feel invested in moral norms long after they have ceased to be appropriate speaks to the importance that we attach to the relationships in which they feature, as well as the people with whom we share (or once shared) those relationships.

**Conclusion: Beyond Informal Caregiving Relationships**

Caring for a loved one with dementia can seem morally fraught because it typically requires a radical departure from the Kantian picture of truth-telling. I’ve argued that, when we appreciate the role that deception already plays within intimate caregiving relationship, we’ll see that this departure not all that radical. Within caregiving relationships, we are bound by a set of norms that often permit or require us to suspend our commitment to the truth. We see these norms not only in parent-child relationships, but also within the sort of caregiving that takes place within friendships and romantic partnerships.

This does not mean that the question of whether to lie to someone with dementia is never morally complicated. Indeed, when we appreciate the complexity of the norms governing caregiving relationships, we can understand how caregiving often raises genuine moral dilemmas. But the moral dilemmas that we find within caregiving involving dementia are not unique. Instead, they are indicative of the nuanced and variable truth-telling norms that feature within our intimate relationships.

I’ll close by saying something about formal caregiving relationships, like the relationship between medical professionals and their patients. These have not been a focus of my paper. Although formal caregivers may perform many of the same activities that informal caregivers perform, they share a fundamentally different type of relationship with patients than we do with our loved ones. We can bring out this difference by considering the extent to which the two considerations that can entitle informal caregivers to lie and deceive can be extended to formal caregivers.

First, we might be able to appeal to hypothetical consent to justify a narrow range of deceptions (i.e. those that concern interests that medical professionals know their patients to have). Nevertheless, we can’t use it to appeal to the sorts of subtle, personalized deceptions that feature within informal caregiving relationships. Formal caregivers simply don’t share a relationship with their patients that allow them to make this appeal. Likewise, formal caregivers are unlikely to share a relationship with their patients that justifies an appeal to reciprocal concern. While they may still be able to justify deception on grounds of self-interest, the bar for this justification will be higher; specifically, they will need to be able to show that the *only way* that they can plausibly continue to provide care is if they deceive the patient.

Does this mean that it’s wrong for formal caregivers to deceive patients with dementia? This doesn’t follow. There may be other moral considerations that justify deception in these cases. Nevertheless, my discussion points to something important, which is that formal caregivers ought to be forthcoming with informal caregivers about the deception that is being used in their loved ones’ care. They should seek consent from informal caregivers, who are often in a position to consent to deception on their loved one’s behalf.[[22]](#footnote-22)

1. Kant, I. (1949). *On a supposed right to lie from altruistic motives*. In L. White Beck (ed. and trans.), Chicago University Press. [↑](#footnote-ref-1)
2. Hill, T. E. (1984). Autonomy and benevolent lies. *Journal of Value Inquiry*. 18, 251-267.; Bok, S. (1978). Lying to children. *The Hastings Center Report*. 8 (3), 10-13. See also Herman, B. (1993). *The Practice of Moral Judgment*. Cambridge, MA: Harvard University Press.; Buss, S. (2005). Valuing autonomy and respecting persons. *Ethics.* 115, 195-234. [↑](#footnote-ref-2)
3. Miranda, M., et al. (2010). Did Immanuel Kant have dementia with Lewy bodies and REM behavior disorder? *Sleep Medicine*. 11, 586-588. [↑](#footnote-ref-3)
4. Deception is common within dementia caregiving (James, I. et. al. (2006). Lying to people with dementia: developing ethical guidelines for care settings. International Journal of Geriatric Psychiatry 21: 800-801; Blum, N. (1994). Deceptive practices in managing a family member with Alzheimer’s disease. *Symbolic Interaction.* 17(1), 21-36). [↑](#footnote-ref-4)
5. Blum, *op. cit.* note 4; Hasselkuss, B. (1997). Everyday ethics in dementia daycare: narratives of crossing the line. *The Gerontologist.* 37(5), 640-649. [↑](#footnote-ref-5)
6. Benn, P. (2001). Medicine, lies and deceptions. *Journal of Medical Ethics*. 27, 130-134.For the opposing view, see Bakhurst, D. (1992). On lying and deceiving. *Journal of Medical Ethics*. 18, 66-63. [↑](#footnote-ref-6)
7. For instance, the simple fact that it may no longer be possible to communicate the truth to these patients may necessitate some forms of deception. [↑](#footnote-ref-7)
8. Held, V. (2005). *The ethics of care: personal, political, and global*. Oxford University Press., Kittay, E. 1999. *Love’s labor: Essays on women, equality and dependency.* New York, NY: Routledge. [↑](#footnote-ref-8)
9. Caregiving relationships, on my view, include but are not limited to relationships involving ‘dependency care’, which Kittay, Jennings, and Wasuna describe as relationships in which one party is “inevitably dependent” on another for daily care (Kittay, E., Jennings, B., Wasunna, A.L. (2005). Dependency, difference, and the global ethic of longterm care. *Journal of Political Philosophy.* 13(4), 443). Nevertheless, I intend this category to include relationships involving dependency care. [↑](#footnote-ref-9)
10. Kumar, R. (1999). Defending the moral moderate: contractualism and common sense. *Philosophy and Public*

    *Affairs.* 28(4), 275-309; Kumar, R. (2003). Who can be wronged? *Philosophy and Public Affairs*. 31(2), 99-118;

    Scanlon, T.M. (1999). *What we owe to each other*. Cambridge, MA: Harvard University Press. [↑](#footnote-ref-10)
11. Kumar, R. (2003), *op. cit* note. 10, p. 106. [↑](#footnote-ref-11)
12. Fox, E. L. (1993). Paternalism and friendship. *Canadian Journal of Philosophy*. 1993. 23(4), 575-594. [↑](#footnote-ref-12)
13. This doesn’t mean that deception is always permitted within these relationships. Often, deception *doesn’t* promote a person’s good. As well, within caregiving relationships, we generally have other obligations that make pull us towards truth-telling. For instance, I have an obligation to care for my partner, but also to respect him as an autonomous agent. The latter obligation may often require me to be *more* honest with him than I would be with a stranger. [↑](#footnote-ref-13)
14. Fox, E.L., *op. cit.* note 11, p. 578. [↑](#footnote-ref-14)
15. This doesn’t mean that we are perfect predictors of their preferences; indeed, there is good evidence to think that we are *not* (Shalowitz, D.I., Garrett-Mayer, E., and Wendler, D. (2006). The accuracy of surrogate decision makers. *Archives of Internal Medicine.* 166, 493-497). Rather, it means that, even when we don’t make the same choices that our loved ones would have made, our knowledge of them still allows us to make choices that reflect their values and commitments. As Fox (*op. cit.* note 11, p. 588, pp. 591-594) points out, however, the fact that we know our loved ones is not sufficient to justify hypothetical consent. Instead, we must also appeal to facts about the intimacy involved in certain types of loving relationships. [↑](#footnote-ref-15)
16. Bok, S., *op. cit.* note 2, p. 12-13. [↑](#footnote-ref-16)
17. This seems to be what people with early-stage dementia think (Day, S. et. al. (2011). Do people with dementia find lies and deception in dementia care acceptable? *Aging & Mental Health.* 15(7), 822-829). [↑](#footnote-ref-17)
18. Of course, part of the reason that we feel so exhausted in these contexts has to do with the fact that we hate to see our loved ones’ suffering. [↑](#footnote-ref-18)
19. Abdool, R. (2017). Deception in caregiving: unpacking ethical considerations in covert medication. *Journal of Law, Medicine & Ethics*. 45, p. 195. [↑](#footnote-ref-19)
20. Held, V., *op. cit.* note 8, p. 12. [↑](#footnote-ref-20)
21. For a discussion of how family members navigate these changing roles, see Betts Adams, K. (2006). The transition to caregiving: the experience of family members embarking on the dementia caregiving career. *Journal of Gerontological Social Work*. 47(3/4), 3-29. [↑](#footnote-ref-21)
22. This reflects the preferences of people with dementia (Casey, D., et. al. (2019). Telling a ‘good or white lie’: the views of people with dementia and their carers. *Dementia*.). [↑](#footnote-ref-22)