



The Use of Deception in Dementia Care

Jon Gilchrist, Clinical Ethicist
Covenant Health



Objectives

- Acknowledge that health professionals lie and use deception in dementia care
- Expanded awareness of the use of deception in care of the vulnerable elderly
- Revisit 'professionalism' and 'trust' and the impacts of using deception
- Examine ethical considerations and proposed 'ground rules' for using deception in dementia care



Case

- Mr. Smith is long term care resident on a unit with residents experiencing cognitive decline
- Experiences anxiousness in the evening and night
- Behaviors with anxiousness and extremely difficult to settle. Son often called to support.
- Mr. Smith makes multiple requests for inhaler and escalates when denied
- Medication management of anxiety denied
- Care team and son considering the use of empty inhaler as management tool



Defining ‘Deception’

“Generally, lying is seen as giving factually incorrect statements to mislead while deception involves misleading without using factually incorrect information (e.g. omitting the truth, giving literal truths, withholding key details)” (Elvish et al, 2010)

“Misleading others means making them believe what we ourselves do not believe...Anything done with the same intention, but without uttering a falsehood, is deception” (Schermer, 2007)



Describing Deception

- blatant lie
- little white lies
- therapeutic lie
- colouring the truth
- beneficent lies
- calming lies
- going along with
- 'getting into their reality'
- fudging the truth
- maneuvering the truth
- bending the truth
- therapeutic fib
- misleading
- tricks
- softening truth-related distress



Confessions

Prevalence of Use

- 96% of staff respondents (n=112) lied to residents lacking capacity; across various elder care contexts; across disciplines (James et al, 2006)
- 69% of Psychiatrist respondents (n=29) lied to elderly patients who lacked capacity when deemed in their best interest (Culley et al, 2013)



Therapeutic Deception

Tools & Techniques

- Silence & Redirection
- Validation
- Deceptive Aids
(e.g. Simpress)
- Environmental
(e.g. 'missing keys', doorway murals, dementia communities)



Opposition

Reasons for rejecting use of deception

- Assault on personhood and human dignity
- Can never be person-centered
- Gross violation of respect for autonomy
- ‘Treachery’, ‘disrespectful’, ‘dishonest’

Occupational Variability (Elvish et al, 2010)

- Role-based
- Proximity-based



Reasons for Use of Deception

Precipitating Factors and Motivations

- Resident/patient safety & behaviors

Staff justifications

- To ease resident distress (90%)
- To ease carer distress (75%)
- Promote treatment compliance (59%)
- Promote compliance (generally) (51%)
- Staff benefit (30%)

(James et al, 2006)



Conditions of Acceptability

The Person with Dementia

- Awareness of the lies
- The experience of dementia
- Personal beliefs

The Carers

- Who is lying and why?
- How is the lie told?
- What are the alternatives?

(Day et al, 2011)



Conditions of Acceptability

The Nature of the Lie

- Different types of lies
- Deceptive Practices
- Reframing deceptive practices (variant of truth-telling vs. deception)

(Day et al 2011)



An Ethics View

What is right?

- Deception – ‘Most fundamental form of wrongdoing to others’
- Value of being told the truth—even if it causes distress
- Truth value at the “coal face” is functional not inherent



An Ethics View

What is 'good'?

- Best Interests
- Quality of Life
- Prevention of Harm
- Benefit vs. Burden



An Ethics View

Virtue Approach—what is the *fitting* response?

- “What ought a nurse to do?” vs. “Who ought a nurse to ‘be’?” (Tucket, 2011)
- How does the routinization of the use of deception shape one’s personal and professional outlook?
- Virtues: Fidelity to Trust, Compassion, Fortitude, Phronesis, Integrity



Impacts of Deception

Patient Impact (Patient perspectives)

- “demeaning”, “patronizing
- social isolation and alienation
- disruption of emotional coping
- damage to self-concept
- erosion of personhood

(Day et al, 2011)



Staff Impacts

‘Deception Guilt’

“...the phrase to describe the caregiver feeling guilt when the deception is not authorized....many caregivers experience increasing distress at having to lie and deceive those for whom they care.” (McElveen, 2015)

“Caregivers may well be bothered by what they perceive as being dishonest, deceptive or truthful. Even if they do so from good intentions, and even if they know it actually is beneficial to patients, it may still bother them and be perceived as compromising their personal integrity, or violating basic moral rules” (Schermer, 2007)



Ethical? Guidelines

1. Lies told only if they are in the best interest of the resident
2. Specific areas, such as medication compliance and aggressive behavior, require individualized policies that are documented in the care plan.
3. A clear definition of what constitutes a 'lie' should be agreed within the care setting
4. Consideration should be given to the residents' ability to retain the truth
5. Communication with and consent from family
6. Lies must be used consistently across people and settings



Ethical? Guidelines

7. Lies should be documented to ensure accountability for 'best interest' use only
8. An individualized and flexible approach—case by case
9. Sensitivity to staff support needs related to ethical distress
10. Document and outline circumstances in which lies should not be told
11. Alertness to and safeguard against erosion of respect toward residents. Deception is a tool to enhance resident well-being
12. Staff training and supervision is essential

(James et al, 2006)



Questions, discussion

Discussion Questions

- Is it reasonable to use deception in dementia care? Is it acceptable to deceive?
- Ought deception be used in the pursuit of resident/patient 'well-being'? of happiness?
- What is the relationship between 'trust' and 'therapeutic deception'?
- What criteria would need to be met for you to consider the use of deception in care?



Bibliographic Information

Abdool, R. (. (2017). **Deception in caregiving: Unpacking several ethical considerations in covert medication.** *Journal of Law, Medicine & Ethics*, 45(2), 193-203

Culley, H., Barber, R., Hope, A., & James, I. (2013). **Therapeutic lying in dementia care.** *Nursing Standard*, 28(1), 35-39. . Source Accession or PMID: 24003817.

Day, A. M., James, I. A., Meyer, T. D., & Lee, D. R. (2011). **Do people with dementia find lies and deception in dementia care acceptable?.** *Aging & Mental Health*, 15(7), 822-829.

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.

James, I. A., Wood-Mitchell, A. J., Waterworth, A. M., Mackenzie, L. E., & Cunningham, J. (2006). **Lying to people with dementia: Developing ethical guidelines for care settings.** *International Journal of Geriatric Psychiatry*, 21(8), 800-801

McElveen, T. (2015). **Lying to people with dementia: Treacherous act or beneficial therapy?** Royal College of Psychiatrists, London, UK. Retrieved from <https://www.rcpsych-ac-uk.ahs.idm.oclc.org/workinpsychiatry/faculties/oldagepsychiatry/newsletters/enewsletterseptember2015/lyingtopeoplewithdementia.aspx>



Bibliographic Information

Pellegrino, E. & D. Thomasma. (1993) **The Virtues in Medical Practice**. Oxford University Press: NY

Schermer, M. (2007) **Nothing But the Truth? On Truth and Deception in Dementia Care**. *Bioethics*. 21(1), 13-22

Seaman, A. T., & Stone, A. M. (2017). **Little white lies: Interrogating the (un)acceptability of deception in the context of dementia**. *Qualitative Health Research*, 27(1), 60-73.

Sokol, D. (2006) **Dissecting “Deception”**. *Cambridge Quarterly of Health Care Ethics*, 14, 457-64.

Sprinks, J. (2013a). **Therapeutic lying should be avoided**. *Nursing Older People*, 25(8), 7.

Tuckett, A. G. (2012). **The experience of lying in dementia care: A qualitative study**. *Nursing Ethics*, 19(1), 7-20.

Young, J. M., & Unger, D. (2016). **Covert administration of medication to persons with dementia: Exploring ethical dimensions**. *Journal of Clinical Ethics*, 27(4), 290-297.