

## Lies of Omission and Commission, Providing and With-holding Treatment, Local and Global Autonomy - There Are Reasons For Clinical Ethicists To Attend to All of These Distinctions

Meyer argues that clinical ethicists should sometimes be active participants in the deception of patients and families, whether that involves lies of omission or commission (Meyers forthcoming). I shall begin by suggesting that there are two reasons to exercise caution with respect to the abandonment of the distinction between lies of omission and commission in medical care, even if we agree that it lacks philosophical warrant. I shall then go on to make some brief remarks about Meyer's claims regarding the context-dependent nature of the justification of deception. I shall suggest that the distinctions between (i) providing and withholding treatment and (ii) local and global autonomy provide some important conceptual boundaries to the contexts in which deception is most likely to be justifiable.

### Lies of Omission and Commission

I am sympathetic to the claim that there are few morally relevant differences between lies of omission and commission (Pugh 2020, 82–86). As Meyer acknowledges, this is a claim that runs contrary to many people's everyday intuitions. Further, there is empirical evidence to support this. In a survey study of laypersons' attitudes towards deception in medicine, my colleagues and I found that participants were prepared to support beneficent lies of omission, but they were generally opposed to lies of commission across different medical contexts (Pugh et al. 2015). If these findings generalise, it raises a question for Meyer's view; to what extent should the clinical ethicist's conduct be influenced by the views of patients and families upon moral distinctions that may lack philosophical warrant?

Another reason that it might be hasty for clinical ethicists to overlook the distinction between lies of commission and omission is the role that it can play in medical law.

A physician who lies through omission prior to treatment may be liable to a claim of negligence (but not a claim of battery) if (amongst other things) they fail to disclose information that meets the following conditions:

- i) The physician's duty of care required them to disclose it to the patient prior to treatment and
- ii) The patient's ignorance of that information did not serve to invalidate their consent to that treatment.<sup>1</sup>

Notably, the law can allow considerable scope for information that meets these conditions. For example, in England and Wales, information about many of the risks associated with medical treatment falls into this category (Cave 2020).

---

<sup>1</sup> If the information in question does not meet (ii), then the physician could be liable to battery. See (Chatterton v Gerson QB 432 1981)

Crucially though, lies of commission regarding information meeting conditions (i) and (ii) may in some circumstances be viewed as *invalidating* consent, rather than simply evidencing a physician's failure to observe their duty of care. A patient's false belief borne of unrectified ignorance could be viewed differently to one borne of active deception in this regard. Accordingly, a physician who treats a patient having failed to disclose information meeting conditions (i) and (ii) above, could potentially be in a quite different legal position to one who does so having lied by commission. Unlike the potentially negligent liar by omission in this sort of case, the liar by commission could potentially be construed as having performed the treatment without valid consent (Pugh 2020, 153–54).

The clinical ethicist may thus also have good reasons to attend to the distinction between lies of omission and commission, despite its questionable philosophical grounds. I shall now turn to Meyer's comments about the context-dependent nature of the justification of deception.

### Contextual Justification (I) – Providing and Withholding Treatment

Meyer adverts to a number of factors that can contribute to the justification of deception in a given medical situation. He writes that tailoring information “creates a hearing space in which greater understanding and autonomous decision-making can occur”. Elsewhere, he suggests that “deception can prevent harm – to patients, staff, and society”, and that in some cases deception can be beneficent insofar as it “reinforces patient's hope and healing resolve” (Meyers forthcoming).

One of the many virtues of Meyer's discussion is that it pushes back against the absolutist view that deception is (a) always an affront to autonomy, and (b) that it can therefore never be justified. However, it leaves us with difficult questions about how to balance competing moral reasons. Even if deception need not be inimical to the understanding that autonomous decision-making requires, in some cases it certainly can be. In such cases, when, if ever, are considerations of beneficence and non-maleficence sufficient to outweigh the value of autonomy?

This is a notoriously difficult question that calls for the experienced professional judgement of the clinical ethicist. However, it is possible to highlight certain contextual features that may render considerations of autonomy more or less salient in such conflicts.

One such feature is whether deception is being employed in the context of providing or withholding treatment. Meyer's example of failing to disclose side-effects of a medical treatment in order to prevent a nocebo effect is an example of the former. Yet, reasons of beneficence and/or non-maleficence may also support deception in the context of withholding treatment. Suppose a biopsy confirms that a patient has developed a premalignant tumour, but one that is very unlikely to spread, and which can be closely monitored and quickly treated if necessary. If the patient will be unduly terrified upon receiving any sort of ‘cancer diagnosis’, and will likely want to immediately pursue aggressive, risky and probably unnecessary treatment, it might be argued that there are ethical reasons to deceive the patient about the precise nature of their diagnosis.<sup>2</sup>

Crucially, considerations of autonomy that speak against deception are more salient in decisions pertaining to the provision treatment than they are in the context of withholding treatment. To

---

<sup>2</sup> For a comparable case, see Brewin (1994)

see why, it is important to be clear about the role of autonomy and consent to medical treatment. One way of understanding the role of consent here is that it is the mechanism by which patients are able to waive certain negative claim rights (such as those that they hold against bodily intervention) that would otherwise preclude the permissibility of medical treatment (Pugh 2020, 149–51). If deception in a given case means that an individual patient is not autonomous with respect to her decision to waive the relevant rights, then the performance of the treatment will involve an infringement of those rights. Naturally, such infringements have high moral costs, and any successful justification of deception in the provision of this treatment would have to be sufficient to overcome these costs.

However, whilst individuals have strong negative rights against bodily interference, they do not enjoy equally strong positive rights to medical treatment, and negative rights are also typically understood to generate much stronger duties than positive rights (Foot 2002). Of course, this is all compatible with the claim that physicians have a duty of care to provide beneficial treatment, and that the moral reasons to provide such treatment can be very strong. However, the nature of the rights involved in these different contexts suggest that it will typically take far stronger moral reasons to justify deception when providing medical treatment, than it takes to justify deception in the context of refraining from providing even a beneficial treatment to a patient.

## Contextual Justification (II) – Global and Local Autonomy

Some parties to the debate concerning the justification of deception in medicine may hold the strong view that the value of autonomy is absolutely paramount in medical ethics, and that it cannot ever be outweighed by considerations of beneficence or non-maleficence.<sup>3</sup> Whilst this strong view restricts the scope of permissible deception, it does not entirely preclude it. As Meyer notes, some forms of deception can in fact enhance autonomous decision-making (Meyers forthcoming).

However, we may also note that an individual's local autonomy (which concerns their autonomy with respect to a particular decision at a particular time) can conflict with their global autonomy (which concerns their autonomy over extended periods with respect to their diachronic plans). I have argued elsewhere that decisions about whether to use deceptive placebos in medicine may plausibly represent such a conflict (Pugh 2015).

If a holder of the strong view is to maintain that instances of deception that undermine local autonomous decision-making cannot be justified, then they owe us an account of why considerations of local autonomy must outweigh those of global autonomy in such conflicts. This is not to deny that such an account can be provided. For instance, such an account might appeal to the rights that remain intact in the medical context when they are not waived by a locally autonomous decision to consent to treatment.

However, there are grounds for holding the opposing view that considerations of global autonomy may sometimes outweigh those of local autonomy; our ability to pursue our own values and plans across time is arguably far more central to our identity, and our understanding of why autonomy should prudentially matter (Pugh 2020, 244–48). If the principle or respect for autonomy should incorporate both global and local understandings of the concept, then perhaps the most promising potential justification for deception in medicine may lie not in reasons of

---

<sup>3</sup> This is close to what O'Neill refers to as the consumerist view of autonomy in (O'Neill 2002, p.47)

beneficence or non-maleficence, or even in the idea that deception can enhance understanding. Instead, perhaps it lies in the fact that deception may be necessary for securing the global autonomy that matters most to us.

## References

- Brewin, Thurstan B. 1994. 'Telling the Truth', June, 1512.
- Cave, Emma. 2020. 'Valid Consent to Medical Treatment'. *Journal of Medical Ethics*, June. <https://doi.org/10.1136/medethics-2020-106287>.
- Chatterton v Gerson QB 432. 1981.
- Foot, Philippa. 2002. *Virtues and Vices*. Oxford University Press.  
<http://ezproxy.ouls.ox.ac.uk:2274/view/10.1093/0199252866.001.0001/acprof-9780199252862>.
- Meyers, Christopher. forthcoming. 'Deception and The Clinical Ethicist'. *American Journal of Bioethics*.
- O'Neill, Onora. 2002. *Autonomy and Trust in Bioethics : The Gifford Lectures, University of Edinburgh, 2001*. Cambridge: Cambridge University Press.
- Pugh, Jonathan. 2015. 'Ravines and Sugar Pills: Defending Deceptive Placebo Use', January, 83–101.
- . 2020. *Autonomy, Rationality, and Contemporary Bioethics*. Oxford, New York: Oxford University Press.
- Pugh, Jonathon, Guy Kahane, Hannah Maslen, and Julian Savulescu. 2015. 'Lay Attitudes Towards Deception in Medicine: Theoretical Considerations and Empirical Evidence', April, 00–00.