# DIVISION OF AUTHORITY BETWEEN ATTORNEY AND CLIENT: THE CASE OF THE BENEVOLENT OTOLARYNGOLOGIST

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*Who makes the decisions within the lawyer-client relationship? This question arises frequently in the course of representation, but it is seldom directly addressed. Because of the position of the lawyer, the client is not consulted on many decisions, a situation that may be more pronounced for individuals who are less experienced in dealing with lawyers.*

*This article takes a unique approach in analyzing the effects of the Model Rules of Professional Conduct on the lawyer-client relationship, as Professor Lubet presents the heuristic of The Benevolent Otolaryngologist. Using the heuristic as a basis for analyzing the ends/means distinction found in Model Rule 1.2, Professors Burns and Lubet analyze how the current version of the Model Rules and the proposed Ethics 2000 rules affect the division of decision-making authority. By noting the differences between the effects of the rules on a familiar decision made within a doctor-patient relationship and a decision made within the context of the lawyer-client relationship, the article attempts to take the debate into a context without our usual preconceptions.*

*Problems arise primarily when the lawyer and the client are faced with difficult decisions regarding the means of achieving a particular objective. After an analysis of the current rules, Professor Burns concludes that ethical decisions regarding the means of representation will continue to be made by lawyers, who rely on their individual notions of good practice, though clients have an argument under the current rules that many decisions as to "means" should be theirs. Professor Lubet analyzes the rules proposed by the Ethics 2000 Commission and notes the inherent inadequacy of the proposal, which would create a situation in which the client must either face the*

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*withdrawal of counsel or choose to discharge the lawyer when the two parties disagree over a method or tactic that is fundamental to the representation. Professor Lubet notes the likelihood that this problem is more likely to be encountered by individual clients, who face more severe consequences than their corporate counterparts. Professor Burns concludes by noting that the Ethics 2000 proposed changes to the Model Rules are not as likely to have an effect on the situation as are local legal cultures.*

## I. INTRODUCTION

In many ways, the "Scope of Representation" is one of the thorniest issues involved in legal practice, although it receives relatively little attention in either scholarly commentary or the popular press. It is a difficult issue because it arises every day in nearly every interaction between attorney and client: who makes which decisions? But it is often nearly an invisible issue—compared to conflicts of interest or disclosure of confidences—in part because clients are often unaware of the expansive decisions being made in their cases.

The so-called ends/means distinction found in the pre–Ethics 2000 Model Rules of Professional Conduct (Model Rules or Rules) Rule 1.2 is helpful, but only to a point.[1] As has often been noted, there is no well-defined boundary between objectives and the means of obtaining them,[2] and the rule does not speak clearly to the dilemma that can arise when the attorney and client disagree. The Ethics 2000 (now enacted and incorporated into the Model Rules) proposal confronts this problem—in a Comment—but intentionally avoids a definitive answer.

We have chosen a somewhat unusual format for this paper—an exchange of views between coauthors who do not necessarily agree with each other, beyond the fact that the problem itself is nearly intractable.

We begin with a heuristic: The Case of the Benevolent Otolaryngologist, presented by Lubet as a means of situating the problem in a context intended to remove lawyerly predispositions (and egos). In the next part, Burns explores the implications of the heuristic under the current version of Model Rule 1.2.[3] In the following part, Lubet addresses the differences that might result under the Ethics 2000 amendment.[4] Finally, Burns draws a brief conclusion about the nature of change in lawyer practice that the Ethics 2000 amendment is likely to occasion.[5]

1. MODEL RULES OF PROF'L CONDUCT R. 12 (2000).

2. "A clear distinction between objectives and means sometimes cannot be drawn . . . ." MODEL RULES R. 1.2 cmt.; *see also* Marcy Strauss, *Toward a Revised Model of Attorney-Client Relationship: The Argument for Autonomy*, 65 N.C. L. REV. 315 (1987) (arguing that objectives and means cannot reliably be distinguished, and that lawyers often define those terms to their own advantage).

3. *See infra* Part III.

4. *See infra* Part IV.

5. *See infra* Part V.

## II. A HEURISTIC (BY LUBET)

My daughter's persistent sinus infection would not clear up, so the doctor gave her a ten-day prescription of amoxicillin. As it happened, our cousin Jonah, the otolaryngologist, was visiting, and he saw the pill bottle on the kitchen counter.

"Boy, I sure wouldn't take this stuff," he said.

"Why not?" I asked. After all, various doctors had been prescribing it to our family for years.

"Because it has a huge failure rate," Jonah explained. "You could take that entire prescription without doing any good at all."

"So what's the alternative?" I asked. It had never occurred to me that a medicine might have a substantial failure rate, evidently known only to the doctors who write the prescriptions.

Jonah rattled off the name of a new, space-age antibiotic that works better and faster than trusty old amoxicillin, explaining that he used it for himself, his family, and his patients. He was obviously disdainful of our family doctor, though he would not allow himself to be openly critical. "Amoxicillin sometimes works," he said, "but there is definitely newer and more reliable stuff available. They call amoxicillin a conservative treatment," he added, "but in my opinion there is no reason to bother with it."

Then Jonah gave me a short course in the meaning of "conservative treatment." Most infections are self-limiting, meaning that they will clear up on their own in a week or so without any medication or other intervention. An antibiotic might make the problem go away quicker if it is a bacterial infection, but it will not do anything at all for a virus. On the other hand, overuse of antibiotics carries a significant social cost because they inevitably lose their effectiveness over time. That is part of the reason for "failure rates." The more a drug is used, the less effective it becomes. Consequently, older drugs have higher failure rates than new ones, sometimes much higher.

Because each prescription chips away a little bit more at the potency of the particular antibiotic, some doctors adhere to a treatment hierarchy in their prescription practices. Minor problems tend to be treated with older drugs—such as the timeworn amoxicillin—since failure is unlikely to lead to serious consequences. Newer, more powerful medications are saved for infections that do not "respond" to the first course of treatment or for more life- and health-threatening problems. The rationale is that doctors are safeguarding the usefulness of the newer drugs without really risking the health of the patients who get the feeble medication.

Doctors like Jonah do not fully share this rationale, as there are studies that show amoxicillin to accomplish only slightly more than a pla-

cebo.[6] Consequently, they prefer to prescribe either the grade-A medication when indicated or else nothing at all. Needless to say, I had no ready way to figure out which philosophy makes for better medicine, but it was fascinating simply to learn that there were in fact two distinct approaches in the first place. But after a little bit of thought, it began to trouble me that my doctor had made a decision without consulting me—or even informing me—that there were alternatives. It would go too far to say that I felt betrayed, since I understood her long-term medical objective. But I definitely felt disheartened. It was as though our doctor did not trust me to make the right choice or perhaps valued my daughter's comfort (not her health) less than someone else's. If we were not getting the advanced medication, who was? And finally, I felt powerless. After all, my daughter trusted me, even if the doctor did not. Should I have asked more questions, done more research, insisted on a more thorough explanation?

I also wondered about our doctor's professionalism. Does the medical profession endorse the tactic of providing a marginally effective treatment when better ones are available? Are patients ever told the truth about what they are getting? And what counts as truth in this situation, where public health and individual comfort are somewhat at odds with each other, and where the patient, and in this case her father, probably cannot really understand at least some of the many considerations?

Alas, I do not know very much about medical ethics. I am not even sure they have a set of rules that would address this problem in any but the most general terms (say, "do no harm"). On the other hand, I do know a bit about lawyers' ethics which caused me to wonder how the Model Rules would handle a comparable situation.

Attorneys often have to confront "the division of decision making authority between lawyer and client,"[7] to "distinguish between those matters where the lawyer must let client make the decision and those where prior client consent is unnecessary."[8] It is obvious that there must be a line somewhere—the lawyer decides whether to object on the basis of hearsay, while the client decides whether to settle or proceed to trial—but its precise location is often uncertain, and sometimes hotly debated. The argument is often phrased as a choice between "paternalism" (or professionalism) and autonomy. At what point must the attorney defer to the client's lawful wishes, even if they are ill-advised? On what matters may the lawyer exercise exclusive control, with or without the cli-

6. John W. Williams, *Amoxycillin Did Not Improve the Clinical Course of Acute Maxillary Sinusitis in Primary Care*, EVIDENCE-BASED MED., Sept.–Oct. 1997, at 152.

7. RONALD ROTUNDA, LEGAL ETHICS: THE LAWYER'S DESKBOOK ON PROFESSIONAL RESPONSIBILITY § 3-2.1, at 66 (2000).

8. *Id.* at 67.

ent's input? Model Rule 1.2 attempts to answer these and similar questions—sometimes successfully, sometimes not.

One impediment to a clear understanding of Rule 1.2 is that the discussion has occurred exclusively among lawyers and judges. In that setting, it is small wonder that the values of professionalism tend to be credited while the interests of clients tend to be minimized. The problem is actually even worse than that, because it is the autonomy of the poorest clients that naturally gets the least attention. Rich corporate clients pay their bills and call the shots. We do not need to worry about the division of decision-making authority between a large law firm and, say, General Motors. If GM wants its cases handled a certain way, there will be plenty of attorneys eager to comply, even if they might prefer to do it differently. If one law firm refuses to follow a lawful instruction, there are many others who will gladly abide. With large, affluent clients there is no imbalance in bargaining power so the risk of attorney arrogation is minimized if not nonexistent.

With individual clients, it is a different matter entirely. They are far more dependent on their lawyers, with little independent access to information. Many are unable to change attorneys, either for lack of funds or because counsel was appointed by the court. Thus, the paternalistic lawyer may, if he or she chooses, exercise nearly full control over the representation, presenting a limited range of choices to the client or sometimes none at all. In these circumstances, the only real restraint is often self-restraint, as guided by Rule 1.2.

Self-restraint, however, is notoriously hard to achieve, particularly when it requires the surrender of one's own sense of values and prerogatives. Why would a lawyer ever willingly let a client make a bad decision? A client who insists on such a choice could only be misguided or self-deluded.

In the absence of extraordinary empathy, it is difficult truly to imagine setting aside one's own best judgment in the name of client autonomy. That is where the case of the benevolent (the medical term for paternalistic) otolaryngologist comes in. It provides a useful analogy because it allows lawyers to think like clients. We have all been medical patients at one time or another. We have all experienced "doctor's orders," taking medicines and undergoing treatments based on the familiar assumption that the doctor knows best.

It can be jarring to realize that the doctor is actually making a complex set of value judgments, revealing some information while withholding much more, in order to control the patient's choices. When it turns out that some of those decisions are questionable, it sets the stage for an evaluation of our own relationships with clients.

Does Rule 1.2 truly recognize the value of client autonomy, or is it merely a facade, making a nod toward client decision making but imposing no real restraints? Is the Ethics 2000 revision an improvement or

simply more of the same? How would either version address the problem of the benevolent otolaryngologist, particularly in regard to the appropriate level of patient control? Assuming that the legal profession's rules could be applied to my amoxicillin example, what would they say to a humane otolaryngologist? And which version of Rule 1.2 would give us a better result?

## III. MEANS, OBJECTIVES, AND MODEL RULE 1.2 (BY BURNS)

First we have to ask what your daughter's doctor did and why she did it.[9] Did she make a choice about means or about the objectives of the course of treatment? It appears on first blush to have been a choice of means. Doctors prescribe amoxicillin and the newer drugs to accomplish the goal of restoring the patient to health. On the other hand, the precise objective of the patient is, in my experience, rarely explored except in the most serious of cases, if even then. I cannot recall a conversation with a physician concerning the precise balance among speed of recovery, failure rate of the course of treatment, risk of side effects, and the level of pain I wish to endure. These balances, which must be struck in every course of treatment, seem to be implicit in the physician's notion of "good medicine." The "relational contract" between a doctor and a patient seems, in our social practices, to be subject to what the medical profession has determined to be the "appropriate" goals of a course of treatment for a patient with a certain condition. There is some range for patient "autonomy" here, but not much. Concretely, these implicit "objectives" of the course of treatment are set by the doctor's moving from her own diagnosis to her recommended treatment without making the complex thought processes that join the one to the other a part of a conversation with the patient. Viewed negatively, this means that the patient is denied the information to weigh the inevitable trade-offs among the competing objectives he or she might possibly have in the course of treatment.

The examples I just gave of the sorts of balances that doctors routinely strike have one common thread. All of them involve potential burdens and benefits to the individual patient. None of them requires the balance of benefits gained or burdens borne by others as a consequence of a course of treatment. But the "objectives" that we pursue are at least limited and sometimes more affirmatively shaped by felt obligations to others. Interests, and so objectives, cannot fairly be described

9. In legal ethics, at least, the reasons matter. Lawyers may be required to take certain actions for one reason but be prohibited from taking the same actions for another reason. A lawyer may be required to keep a client whom he knows intends to commit perjury off the stand, while he is prohibited from refusing to call the client because he believes testifying is a tactical error. MODEL RULES OF PROF'L CONDUCT R. 1.2(a), 3.3(a)(3) (2000).

only through an individual hedonic calculus.[10] As Kant put it, everyone has an interest in being moral.[11] The question then is whether "good medicine" also involves socially embedded judgments about balances among the legitimate objectives of medical treatment that implicitly balance my benefits and burdens against those of others. Implicit in the practice would then be the notion that there are some objectives that an "autonomous"[12] individual may choose which are incompatible with the social practice of good medicine.

Such judgments could be absolute or be default rules enforced by raising the information costs of overriding them. A doctor might say, "I just won't do what (1) I know will reduce your suffering or (2) what you ask me to do to reduce your suffering." She might do this because she feels a moral obligation to obey a law prohibiting the course of treatment or because she thinks it offensive to her notion of "good medicine."[13] Or such a norm might be enforced somewhat more flexibly by routinely denying the patient the information necessary to make an informed (moral) judgment about the balance between his own interests, whether health or mere comfort, and the interests of others.

Even if we take your doctor's approach as a choice among means, this was not a purely technical decision. It was not a purely instrumental choice between two alternative methods of achieving a determinate end. She did not choose the amoxicillin because she believed that it would be the more effective instrument for realizing that determinate end. This decision was not an exercise of clinical judgment in that sense. If it had been, you would not have felt disheartened. You would have felt that those kinds of decisions are best made by someone with greater technical

10. Unless we resort to the kinds of expedients consistent utilitarians often use, such as translating felt moral obligation into the language of "psychic utiles."

11. *See* PATRICK RILEY, KANT'S POLITICAL PHILOSOPHY (1983).

12. Most of the discussion of client or patient "autonomy" assumes a notion of freedom as absence of external constraint, or "negative freedom." Kant, the philosopher of autonomy, had a more complex notion. Full autonomy was realized for Kant only when a person acted in a manner fully constrained by the moral law, binding on all rational beings. *See id.* at 146–52. Any behavior inconsistent with the moral law was heteronymous, unfree, compelled, usually by the compulsions of our animal nature. For Kant, however, generally the legal realm ought to foster only negative freedom, though his full doctrine on this matter was more complex and less categorical. *See, e.g.*, *id.* The appropriateness of legal norms' fostering some substantive moral ideal, rather than the greatest range of negative freedom, is one of the great issues in modern political and legal philosophy. The internal norms of professions, aspects of civil society that may have substantive internal ideals that go beyond the negative freedoms fostered by the liberal state, pose additional questions beyond those usually mooted in the debates about legal norms. From the pure liberal point of view, professions that do not simply maximize the autonomy of their clients or patients are, at best, just monopolies, at worst "conspiracies against the laity." From even a slightly more "organic" notion of society, they may add something that is not simply the sum of the parts. Even a pure liberal thinker might concede that professions' own norms might solve some problems of market failure. In my view, the big questions that are posed by the contrast between liberal and organic ideals are likely to be illuminated by focusing on the little issues such as the problem of the paternalistic otolaryngologist.

13. In the death and dying cases, the legal norms include the consistency of a course of treatment with the ethos of the medical profession as an independent criterion of legal judgment. By independent, we mean independent of the immediate interests of the patient.

knowledge. You probably would have thought it a bit odd if she had spontaneously shared her thought processes with you on these technical questions. You would probably have thought that a patient who wanted that kind of discussion was exercising a fairly idle curiosity, happened to have a vocational interest in medical matters, or was just a bit too suspicious.

It was John Dewey who said, in disputing the claims of a purely instrumental rationality, that means are ends in process.[14] I wonder, then, if the distinction between objective and means really cuts at the joints of your problem with your otolaryngologist. We would regard as mad someone who pursued any objective unqualified by any other and regardless of the means necessary to achieve it. All objectives are qualified. And so, is the question about what medication should be employed to achieve your daughter's comfort a question about ends or about means? Is your objective here to maximize her comfort at any cost to her future health and the health of others? Surely not. And isn't the definition of your objective most likely to take place in consideration of the means you are willing to employ to achieve that objective? Isn't it the *mode of rationality* necessary to make decisions—instrumental or ethical[15]—most at issue here?

Decisions that require purely instrumental or technical rationality (the daily dose of a medicine or the sequence of steps in surgery) you will cede to the doctor. You want to make ethical decisions yourself. Setting the objective of the medical treatment might be instrumentally related to some further goal (surgically using pins to set a broken hand bone rather than merely casting it, so that I can continue to play the piano). In that case you may be more likely to cede the decision making to the physician, even though it may be an (intermediate) objective. It is also possible that your doctor may not even present to you objectives that he or she believes inconsistent with the broader goals you are likely to have or, in his view, should have. Usually, however, instrumental rationality cannot set ends, and so most decisions as to objectives are ethical. By contrast, a higher percentage of decisions as to means are instrumental. Not all of them are. For instance, the choice of a conservative treatment or a state of the art treatment is not.

Ethical decisions can be about either what constitutes a life worth living or about distributional effects on other people. In contemporary moral philosophy, the former issues are considered questions of "the good," while the latter are usually considered questions of "the right."[16] Though different philosophers relate them differently, most philosophers consider both kinds of issues genuinely ethical questions.[17]

14. JOHN DEWEY, THE SUPERSTITION OF NECESSITY (1893).
15. HANS-GEORG GADAMER, TRUTH AND METHOD 278–89 (Sheed & Ward Ltd. trans., 1975)
16. RICHARD B. BRANDT, A THEORY OF THE GOOD AND THE RIGHT (1979).
17. *See id.*

There are two aspects of the doctor's decision that troubled you. One was that it might contain an implicit choice among the objectives of medical treatment. The second is, to put it provocatively, that it seemed to make a distributional judgment in which negative consequences to others of a course of treatment for your beloved daughter counted for anything at all. It just does not seem right that the doctor—a person in whose care you have placed your daughter—would herself balance her suffering, even at the level of discomfort, against the health of others and decide on a course of action that favors the others, without at least telling you. Your suggestion is that this decision is the kind of judgment about "effects on third persons"[18] that you and your daughter should make, even though you seem to believe that only the rarest sort of altruism would lead any patient to give the long-term effects on public health any weight at all in this decision.

Are there ethical decisions among means that are implicit in the profession's notion of good practice that the autonomous individual ought to be discouraged from making? I am inclined to say yes, and I think you are inclined to say no, which is why you and I tend to argue about these cases when they come up in legal contexts. What I am not sure of is whether we disagree about particular cases. Your liberal, ultimately Augustinian, beliefs seem to have two sources. First, you know that groups tend to define the common good in terms of their own interests.[19] Second, you have probably been convinced by modes of thought—law and economics is only the most visible example—that argue that the common good is the sum of individual interests. These schools of thought believe: (1) that beyond the small range of ("Pareto-optimal") decisions that maximize everybody's interests, most such decisions are about the distribution of benefits and burdens, and (2) that the modes of rationality that seek to adjudicate those distributional judgments are essentially contestable.[20] And you have very powerful arguments to support those positions. I am just a little less convinced, or a little more quixotic.[21] To put my views in the language of the history of ethics, I tend to start out as an Hegelian, but end up pretty close to Mill. You start and finish with Mill. It is true that we are suspicious of any group deciding what is the greatest good for the greatest number, at our expense. We suspect that the greatest good tends to get identified with

18. In fact, perhaps your knowledge of legal ethics may have formed this sensibility. The Comment to Rule 1.2 of the Model Rules provides that, "[I]n questions of means, the lawyer should assume responsibility for technical and legal tactical issues, but should defer to the client regarding such questions as the expense to be incurred and concern for third persons who might be adversely affected." MODEL RULES OF PROF'L CONDUCT R. 1.2 cmt. (2000). The basic thrust of the Model Rules is to require a lawyer to pursue the legally permissible goals of the client by any legally permissible means.

19. *See* REINHOLD NIEBUHR, MORAL MAN AND IMMORAL SOCIETY 141, 258, 262, 272 (1932).

20. On the notion of "essentially contestable" issues, see CLIFFORD GEERTZ, THE INTERPRETATION OF CULTURES 29 (1973).

21. Being quixotic is not usually a good thing. It is inherently irresponsible.

their own guild's interests or with the most recent academic fad that has gained a temporary hold in the medical schools or medical societies.

Well, you seem to think that the doctor was making her own quasi-utilitarian judgment about the greatest happiness of the greatest number. She had decided that your daughter's somewhat prolonged discomfort (and perhaps very small increased risk of a real threat to her health) was justified by its contribution to the prolonged potency of the newer drugs and so to their effectiveness against really significant future threats to all of us, including your daughter. She probably gave your daughter's comfort more weight than a pure utilitarian would have. The norms of professional practice she embraced allowed the doctor to violate the basic utilitarian norm that "each is to count for one and no more" in the calculation. Just as lawyers think that they should operate on a presumption that their clients are telling the truth, perhaps doctors allow themselves to give increased weight to the needs of their own patients over those of others. (Of course, this would be a systematic threat to practices that really do serve the long-term good of all patients.) I think your daughter's doctor would probably disagree with you that she was subordinating your daughter's comfort to the comfort of others. She would, I expect, tell you that comfort is simply less important than health and that increasing your daughter's comfort is a real threat to the health of all of us, including your daughter's. She might go on to say that medical practices are aimed at health, not at comfort. If she remembered her college philosophy class, she might say that health is a human excellence, while comfort is not. This subordination is implicit in medical practice, a practice that has not completely succumbed to the marketplace. Maybe that marketplace is now dominant in our society, but medicine has more traditional roots. There still are values embedded in medical practices that are more significant than maximizing patient comfort . . . or patient choice.

Because we are trying to use your doctor's decision and your reaction as a window into legal ethics, we should say something about the differences and similarities between medicine and law on the matter of patient or client autonomy and the distribution of authority between client or patient and the professional. The most obvious contrast would run something like this. The legal profession exists primarily to enhance client autonomy, to allow the client to realize his objectives, whatever they are, constrained solely by liberal law's system that seeks to maximize an equal liberty of all others. The medical profession, by contrast, exists to realize patient health. The definition of health and the paths to achieve it are not matters of individual choice and can best be determined by those with specialized knowledge. It may be true that unauthorized medical treatment may be a battery, but the important details of what treatment is provided are more appropriately determined by the professional. And what is true of the objective of health is even truer of the

means to achieve it. If an individual is not interested in achieving health, he simply should not engage a medical professional. So, the argument would go, doctors are entitled to be "benevolent" in cases analogous to those where lawyers ought not to be "paternalistic."

Furthermore, someone seeking to urge a greater range of "benevolence" for the medical profession might say that the kind of knowledge the professions possess is different, in a number of ways. Obviously, doctors' diagnoses are usually at least partly dependent upon scientific reasoning that most patients do not possess. Lawyers rarely employ scientific knowledge. On the other hand, some combination of local knowledge of legal culture and personalities and grasp of legal doctrine may sometimes give lawyers predictive powers beyond the grasp of laymen with whom lawyers have "consulted." This contrast seems a matter of more or less, and quite dependent on context. After all, the most famous American poem about the legal profession claims that lawyers "know too much."[22]

What about normative knowledge? There is embedded in medical practices value judgments about the sorts of things doctors should not do even if their patients ask (kill, for example). Lawyers, of course, have analogous knowledge about what they may or may not do even if their clients ask (sponsor perjury, for example). More interesting is the possibility that lawyers have normative knowledge that clients lack, and which can only be partially communicated, about what is good and bad, right and wrong, in the process of using state power and public norms to resolve disputes among citizens. This difference would suggest that the legal world is somewhat, just somewhat, a normative realm apart from those in which many clients move. If the latter were true, and the knowledge imperfectly communicable, would that open up a space for permissible paternalism in the legal world?

We can relativize the contrast between doctors and lawyers. Patients do not seek health as an end, but as a component in a certain quality of life. One can choose less health to achieve other important goals, goals that may be compromised by the means to achieve health. (Can you imagine Beethoven on the treadmill two hours a day?) The choice of a certain quality of life is an ethical decision, not an instrumental decision, and it should not be left to the medical profession. Likewise, the notion that the legal profession is oriented primarily to achieving client autonomy may not survive a concrete description of the actual practices of most lawyers and of a comprehensive view of all the ethical rules. Empirical studies have long documented the ways in which lawyers draw clients into patterns of action that are dictated by the professional interests or expectations of lawyers.[23] And much of the law of lawyering, no-

22. CARL SANDBURG, *The Lawyers Know Too Much*, *in* SMOKE AND STEEL 85 (1920).

23. *See, e.g.*, Abraham S. Blumberg, *The Practice of Law as Confidence Game: Organizational Cooptation of a Profession*, 1 LAW & SOC'Y REV. 15 (1967).

tably the attorney-client privilege and the duty of confidentiality, are typically justified as instruments in bringing clients into conformity with the law. So this question, too, is one of more or less.

Finally, let me say a few words about your argument that lawyer paternalism is most likely to hurt the poor. It may well be true that people of modest means employ lawyers in cases where the other party is of modest means, for example, in divorce or real estate matters. It is at least possible that lawyers who "control their clients" in such cases may prevent a race-to-the-bottom that escalates the damage that each party does to the other. If some large corporations have the bad fortune to have the power to insist on their lawyers' pursuing self-defeating courses of action, that is their hard luck. It does not necessarily follow that people of modest means are unlucky in having their worst instincts restrained by a portion of the legal profession that may not be so enslaved to market forces. And it is not necessarily "extraordinary empathy" that may lead a lawyer to set aside his best judgment in the name of client autonomy. It is more likely to be indifference or an even less worthy motive. After all, quite often client autonomy may well be in the lawyer's interest, whereas paternalism counsels a course of action inconsistent with the client's desires *and* the lawyer's self-interest. Most people invoke "doctor's orders" with a bit of gratitude for the doctor's concern. Is that gratitude all infantile?

### *A. Two Perspectives*

Let us turn now to our Rules, first to the current text of the relevant Model Rules. To decide whether the Ethics 2000 recommendations work any significant change or whether they signal "business as usual," one must look at the Rules from two contrasting viewpoints.

On the one hand, the Rules provide the quasicriminal law of the profession. As adopted by American jurisdictions, they are the standards by which sanctions up to and including disbarment are imposed on offending lawyers. Certainly, the drift of the American Bar Association's model provisions over the past century, from the very broad Canons of Professional Ethics, to the Model Code of Professional Responsibility's inclusion of "aspirational" Ethical Considerations, to the Model Rules' jettisoning the latter in favor of behavior-focused prohibitions, has been toward approximating a criminal code. Thus, the recommendations invite a reading according to the canons and maxims that ordinarily control the application of quasicriminal rules. These include a preference for strict and narrow construction that I attempt to provide below.

By contrast, the Model Rules also define ideals that stretch beyond a narrow interpretation of their prohibitions. Just as we Americans have

always transformed our political disputes into legal controversies,[24] so too we have always looked to our law to define the ideals that make us who we are.[25] Though the First Amendment, narrowly construed, controls only rights against the federal and more recently state and local governments, it also provides a source for claims respecting "First Amendment" rights in nongovernmental contexts as well. This important function of law as a moral source for Americans may be an inevitable consequence of our pluralism and lack of an ethnic or religious unity, something that makes law perhaps our strongest source of identity. Thus, the Ethics 2000 recommendations invite a reading that seeks to determine whether some new ideal of good practice or professional identity has been identified. Do they hit a new note?

### *B. The Pre-Ethics Rules*

Rule 1.2 provides that "[a] lawyer shall abide by a client's decisions concerning the objectives of representation, subject to paragraphs (c), (d), and (e), and shall consult with the client as to the means by which they are to be pursued."[26] The Comment provides, somewhat enigmatically, that *"both* lawyer *and* client have authority and responsibility in the objectives and means of representation."[27] The Comment does not itself explain the nature of the lawyer's asserted "authority" in setting objectives. The only place where a Rule, at least interpreted by another Comment, seems to impose a "responsibility" for the purpose of representation is Rule 3.1's prohibition on "frivolous" claims or defenses by lawyers,[28] taken in combination with the Comment's assertion that "an action is frivolous, however, if the client desires to have the action taken primarily for the purpose of harassing or maliciously injuring a person . . . ."[29] And it certainly seems that a "responsibility" on the lawyer's part for objectives is in tension with Paragraph (b) of the Rule itself, which provides in the much-criticized "principle of neutrality" that the "lawyer's representation of a client . . . does not constitute an endorsement of the client's political, economic, social or moral views or activities," even where the representation itself is used to further those activities.[30] After all, if a lawyer is "responsible" for objectives that further political, economic, social, or moral views of the client, it is hard to see why such representation does not indeed serve as an endorsement of

24. ALEXIS DE TOCQUEVILLE, DEMOCRACY IN AMERICA 177 (Henry Steele & Henry Reeve trans., Oxford Univ. Press 1947) (1835).

25. CHARLES TAYLOR, SOURCES OF THE SELF 11 (1989) (on the inevitable mutual interdependence of identity and morality).

26. MODEL RULES OF PROF'L CONDUCT R. 1.2 (2000).

27. *Id.* R. 1.2 cmt. (emphasis added).

28. *Id.* R. 3.1.

29. *Id.* R. 3.1 cmt. Most lawyers, I suspect, would not consider "frivolous" a legally colorable action taken simply for a base motive.

30. *Id.* R. 1.2(b).

precisely those views and activities. Perhaps that "responsibility" is exhausted by Rule 2.1's requirement that a lawyer exercise "independent judgment and render candid advice," its permission to "refer not only to law but to other considerations such as moral, economic, social and political factors,"[31] and the Comment's further step that "[a]dvice couched in narrowly legal terms may be of little value to a client, especially where practical considerations, such as cost or effects on other people, are predominant. Purely technical advice, therefore, can sometimes be inadequate."[32] And the Comment to Rule 1.2 does go on to say that the client has "ultimate authority to determine the purposes to be served by legal representation," but does not distinguish helpfully between the lawyer's authority, and so responsibility, and the "ultimate" authority held by the client.[33]

The next sentence, however, seems to qualify all that has been said about the client's ultimate authority completely out of existence: "At the same time, a lawyer is not required to pursue objectives or employ means simply because a client may wish that the lawyer do so."[34] Certainly with regard to "objectives," this cannot mean what it says. It may possibly be understood as a kind of compressed summary of the provision in Rule 1.16 that a lawyer may withdraw even if there is a "material adverse effect on the interests of the client," when the client pursues "an objective that the lawyer considers repugnant or imprudent."[35] Thus, the lawyer's alternatives when the client "simply . . . may wish" a repellant objective is to pursue that objective or to withdraw.[36] The Comment goes on to efface the distinction that seemed to be at the very heart of the Rule's provision for distribution of authority: "A clear distinction between objectives and means sometimes cannot be drawn, and in many cases the client-lawyer relationship *partakes of a joint undertaking."*[37]

The Comment's first paragraph ends with a reformulation of the distinction made in the Rule: "In questions of means, lawyer should assume responsibility for technical and legal tactically issues, *but should defer* to the client regarding such questions as the expense to be incurred and concern for third persons who might be adversely affected."[38] The latter, of course, goes beyond the Rule's requirement that the lawyer merely "consult with the client." (And it is, in any event, a bit odd that consultation is defined solely in terms of a duty to engage in a "commu-

31. *Id.* R. 2.1.
32. *Id.* R. 2.1 cmt.
33. *Id.* R. 1.2 cmt.
34. *Id.*
35. *Id.* R. 1.16(b)(3).
36. *Id.* R. 1.2 cmt.
37. *Id.* (emphasis added).
38. "Should" is usually viewed as indicating a lower level of obligation than the Rules' usually "shall." *See id.* R. 6.1 (voluntary pro bono). We will see that the Ethics 2000 provisions abandon even this lower level of normativity for a purely descriptive statement about what clients and lawyers "usually" do.

nication of information," when the most basic understanding of responsible counseling goes well beyond that.)[39]

Finally, the Comment ends with a statement that "[l]aw defining the lawyer's scope of authority in litigation varies among jurisdictions."[40] The latter point presumably goes to the legal effect in the litigation itself of actions taken by the lawyer, for example, the legal consequence of an actually unauthorized settlement of a case.

Rule 1.2 has three explicit exceptions. Paragraph (c) provides that "[a] lawyer may limit the objectives of the representation if the client consents after consultation."[41] The terminology section of the Model Rules provides that "[c]onsult" or "consultation" "denotes communication of information reasonably sufficient to appreciate the significance of the matter in question."[42] Any limitation on the lawyer's pursuit of the full range of objectives on which the client has "decided" must occur only after this kind of "consultation." We presume that "information" in this context concerns mainly the legal and practical consequences, advantages, and disadvantages of a more limited range of representation. Paragraph (d) of Rule 1.2 provides that

> [a] lawyer shall not counsel a client to engage, or assist a client, in conduct that the lawyer knows is criminal or fraudulent; but a lawyer may discuss the legal consequences of any proposed course of conduct with a client and may counsel or assist a client to make a good faith effort to determine the validity, scope, meaning or application of the law.[43]

The Comment to the latter paragraph provides that a "lawyer is *required* to give an honest opinion about the actual consequences that appear likely to result from a client's conduct," but adds encouragingly (though often not helpfully) that there exists "a critical distinction between presenting an analysis of legal aspects of questionable conduct and recommending the means by which a crime or fraud may be committed with impunity."[44]

Paragraph (d) forbids counseling a client to engage, or assisting a client, in conduct the lawyer knows to be criminal or fraudulent, though not all forms of "illegal" conduct are covered (such as breaching a contract or some kinds of regulatory infractions).[45] The difficult questions here have to do with supplying information that a lawyer suspects or be-

39. *See* DAVID A. BINDER ET AL., LAWYERS AS COUNSELORS: A CLIENT-CENTERED APPROACH 259–60 (1991). This is, of course, recognized by the Rules themselves. *See* MODEL RULES R. 2.1 cmt. ("Advice couched in narrowly legal terms may be of little value to a client, where practice considerations, such as costs or effects on other people, are predominant. Purely technical advice, therefore, can sometimes be inadequate.").

40. MODEL RULES R.1.2 cmt.

41. *Id.* R. 1.2(c). But not so much as to amount to "incompetent" representation.

42. *Id*. Terminology.

43. *Id.* R. 1.2(d).

44. *Id.* R. 1.2 cmt. (emphasis added).

45. *Id.*

lieves will or may be used by the client to avoid detection or legal consequences ("impunity") more effectively and lawyer's participation in enterprises some of whose activities may be criminal without thereby becoming essentially "criminal enterprises." And it is a bit difficult to discern from the text whose benefit paragraph (e), which requires a lawyer to "consult" with a client who expects improper assistance concerning the limitations imposed by the rules, is designed to serve—the public, who benefits from discouraging criminal or fraudulent conduct, or the client, who can make other plans!

So how would our otolaryngologist fare under Rule 1.2? To the extent that the objective of treatment may be either maximizing the patient's comfort or striking a certain balance between comfort and the patient's health or the greatest health of the greatest number, it seems that the professional would have to "abide" by the decision of the client. The rubber hits the road, however, where the professional decides what the range of possible objectives is and then either presents them to the client or "benevolently" assumes the patient has those that he thinks the patient should have. And then there is the style of counseling the physician should employ with his patient. What if the physician is *really convinced* that an objective is very likely disastrous? Should the professional try to maximize the effective "autonomy" of the patient or does the physician owe it to the patient to use methods of persuasion that, for example, exploit the psychological dependence of the patient on the professional and the patient's preference to please the professional?[46]

Probably the best interpretation of Rule 1.2 would require our physician to explain the range of the most important possible objectives available and the advantages and disadvantages of each. On the level of "psychological pressure" that our physician should use, Rules 1.2 and 2.1 shed little light.

It is much more likely that our otolaryngologist would view choice of drug as a means. In practice, the most salient aspect of Rule 1.2 itself is the contrast between objectives, where the professional is obligated to "abide by" the client's decision, and means, whereas there is only a requirement that the professional "consult" with the layman. Most professionals would draw the conclusion that the ultimate decision as to means is theirs. On the other hand, consultation requires "communication of information reasonably sufficient to permit the client to appreciate the significance of the matter in question."[47] It is also true that the Comment suggests that the professional should "defer to the client regarding . . . concern for third persons who might be adversely affected."[48] The weakening of the potency of the newer drugs going forward might well be this

46. Most parents would feel obliged to try the latter with their teenagers, were it not so frequently counterproductive. And, of course, this is precisely the natural home of "paternalism."

47. MODEL RULES Terminology.

48. *Id.* R. 1.2 cmt.

kind of adverse effect on third persons. The Comment, at least, suggests that the professional should provide the kind of explanation that your cousin finally provided and then defer to the patient's decision. The Comment, but not the Rule, seems to take a step toward suggesting that this kind of "ethical" decision about means (as "ends in process") ought to be made by the client. The corollary would be that as long as the lawyer remains the client's lawyer, and the decision is not primarily instrumental, the patient should be informed and his decision followed. I suspect that in practice most professionals would think these kinds of systemic effects on whole populations, rather than direct effects on individuals, to be properly addressed by the profession's own notions of good practice, rather than by the autonomous choices of individual patients. But the pre–Ethics 2000 Comment to Rule 1.2 at least gives a toehold to clients/patients who believe that these sorts of truly ethical decisions as to means ought to be theirs.

## IV. "IMPLIED AUTHORIZATION" AND THE ETHICS 2000 RULES (BY LUBET)

My problem is not so much with the nature of the doctor's decision—which evidently had a clear ethical component—as it is with the fact that she made it without consulting me. I can recognize that the doctor was probably subordinating my daughter's comfort to the ideal of public health,[49] and even that good practice might give her little choice, but that still leaves open the question of whether she should have told me what she was doing. Recall cousin Jonah's explanation that he would prescribe either a currently potent antibiotic or none at all, the first treatment having the virtue of effectiveness and the latter having the virtue of honesty. Instead, my physician opted for a treatment that was both ineffectual and—if not exactly deceptive—surely lacking in absolute candor.

The irony is that lack of candor might be the only way to achieve the public health objective, since most fully informed patients would probably ask for, if not insist upon, the more potent drug. I posit this not because I doubt our citizenry's ability to recognize the common good, but rather because I think most patients would recognize the "tragedy of the commons" and act accordingly. If everyone else is getting the newest antibiotic then it will wear out in fairly short order whether my daughter takes it or not. Stated otherwise, my family's use of the antibiotic would have a trivial impact on its long-term viability unless everyone else in the country, doctors and patients alike, is acting with equal altruism. Alas, I can intuit that not to be the case. After all, doctors overprescribed amoxicillin into near uselessness. Why should I think they have now

49. *See infra* Part II.

changed their profligate ways? Thus, nothing much is actually accomplished by withholding treatment from my daughter, other than prolonging her illness unnecessarily.

Faced with the near certainty of such a reaction, my public-health regarding physician rationally chooses to give me no choice. I agree that her benevolent action was moral and ethical by her own lights, and not only via utilitarianism. She made the judgment that I would have made myself, if only everyone else were to act the same. And though she cannot act for "everyone," she is able to act on behalf of a fairly large group of patients, thus aggregating altruism. But I still wonder whether a system of professional ethics should countenance such slight regard for individual autonomy.[50]

While this problem is easily framed in a medical context, it is not unique to medical practice. There are many comparisons in law. For example, the public good would definitely be enhanced if society freed fewer drug dealers by the suppression of evidence. A lawyer could reach the morally correct decision to forego challenging a bad search on the theory that the constable's blunder should not have the result of returning a dealer to the neighborhood. Such a decision could even be justified on an ends/objectives basis by reasoning that the case could still be defended on the ground of actual innocence—they were not his drugs, but someone else's; they were not drugs at all, but just powdered gypsum—in keeping with the client's "objectives."

Lawyers do not operate in this manner, of course, but why not? The usual answer is that the "greater good" is actually better served by vigorously challenging unconstitutional police practices, no matter what the consequence for successful prosecution. Accurate as that may be, it is only part of the story. In the case of the lawyer and the illegal search, the "public good" has been defined by the Constitution, as interpreted by the courts. Thus, when lawyers defend drug dealers, they are filling a role that has been democratically assigned, not one that has been defined by the profession's own internal rules, and definitely not one that is subject to the interpretation of the individual practitioner. The lawyer is not free to arrive at his or her own definition of common good—whether that would mean fewer invalid searches or more challenged cops—because the decision has been made elsewhere.

In other words, the case of the benevolent otolaryngologist exposes a professional fault line. It is easy to rationalize the self-appropriation of decision making, as lawyers often do, on the ground of allegiance to a higher command—no frivolous cases, no conflicts of interest, no tricking

50. Moreover, there is also the possibility that my doctor was motivated by ideals less noble than good practice and public health. It is well known that drug companies take extreme measures to push their products to physicians, and the makers of amoxicillin certainly have an interest in maintaining their market share even after the drug's useful life has expired. Who knows if my doctor had just returned from a golf outing or other junket sponsored by Amoxicillin, Inc.?

the court. It is harder, however, to justify the arrogation on the basis of a moral claim arising exclusively within the profession itself—objecting or not to hearsay evidence, proceeding exclusively in federal or state courts, embarrassing or coddling witnesses on cross examination. Who ultimately gets to decide? Who even gets to know that a choice is being made?

The minimum measure of any professional standard is that it must provide guidance for the perplexed. Model Rule 1.2 actually faces two tasks in this regard. First, it must set a standard for ordinary practice. What should be done in the typical situation when the client's objectives are obvious and the lawyer's choices are purely "technical and tactical?"[51] More challengingly, the rule must confront the extraordinary problem of deep-seated lawyer-client disagreement. What must be done when lawyer and client are at serious odds with one another over an issue that is neither purely technical nor self-obviously an "objective"?

As we have seen, Model Rule 1.2 handles the first task well and the second one badly. While appearing to require client "consultation," and sometimes even "deference,"[52] its ambiguity ultimately places almost no bounds on lawyer discretion. In the case of the otolaryngologist, for example, a conclusory statement—"amoxicillin is, in my opinion, the drug of choice"—could be considered counseling. As to deferring to the client concerning "third persons who might be adversely affected," that would be unnecessary if the doctor also believes it is in my family's long-term medical interest to underprescribe new medications.

The Ethics 2000 proposal recognizes the latter shortcoming in the former rule, and attempts to address it in both text and commentary. The text of Ethics 2000 Rule 1.2 contains this new provision: "A lawyer may take such action on behalf of a client as is impliedly authorized to carry out the representation."[53]

That would appear to limit even the consultation requirement to those situations beyond the lawyer's implied authorization. Ethics 2000 Rule 1.4, however, seems somewhat to the contrary, as it would additionally require that the lawyer "reasonably consult with the client about the means by which the client's objectives are to be accomplished,"[54] with no explicit exception for implied authorization.

The Comments provide only slight assistance in sorting this out. The Comment to Rule 1.2 advises that "the lawyer shall consult with the client as required by Rule 1.4(a)(2) *and may take such action as is impliedly authorized* to carry out the representation."[55] The plain

51. MODEL RULES R. 1.2 cmt.

52. *Id.*

53. ETHICS 2000 COMMISSION, ETHICS 2000 COMMISSION REPORT, R. 1.2(a), *available at* http://www.abanet.org/cpr/e2k-redline.doc (last visited Mar. 6, 2003) [hereinafter ETHICS 2000].

54. *Id.* R. 1.4(a)(2).

55. *Id.* R. 1.2 cmt. (emphasis added).

reading suggests that implied authorization therefore trumps consultation, at least at the lawyer's election, since the second clause of the sentence would be unnecessary if consultation is always required. This conclusion is underscored by the Comment to Rule 1.4, explaining that "consultation prior to taking action" depends on "the importance of the action under consideration."[56] Thus, less important actions—as determined by whom?—would therefore fall within the lawyer's sole province. Confusing matters further, however, the Comment to Rule 1.4 lists only midtrial exigency as a circumstance that obviates consultation.[57] Alas, neither Comment supplies an example, either positive or negative, of "implied authorization," and the terminology section does not define "consult."[58]

Sorting through these provisions, our otolaryngologist would be left in a quandary (assuming that she could penetrate the linguistic thicket). Must she "consult" concerning my daughter's treatment? The first level answer would be that consultation is unnecessary if the choice of treatment is "impliedly authorized." Certainly, most patients impliedly authorize their physicians to prescribe medication, so many doctors would no doubt leave it at that. If she chose to consider the matter further, however, she would have to ask whether the "importance" of the decision outweighs the presumed authorization, especially since there seems to be no exigency. But how would she determine the importance of a quicker recovery from a relatively minor, though painful, infection. Is the reference point importance to the patient? To the general public's health? To the doctor's sense of good practice? Indeed, is the doctor impliedly authorized to make her own judgments of relative importance?[59]

But if the Ethics 2000 Rules give scant guidance on the consultation mandate, they are even less helpful on the subject of eventual disagreement. Rule 1.2 retains the standard formulation that "a lawyer shall abide by a client's decisions concerning the objectives of representation and . . . shall consult with the client as to the means by which they are to be pursued."[60] New commentary recognizes that on occasion "a lawyer and a client may disagree about the means to be used to accomplish the client's objectives,"[61] which would ordinarily lead one to believe that a solution is at hand.

56. *Id.* R. 1.4 cmt.

57. *Id.*

58. *Cf.* MODEL RULES OF PROF'L CONDUCT Terminology (1983) (amended 2001) ("'Consult' or 'Consultation' denotes communication of information reasonably sufficient to permit the client to appreciate the significance of the matter in question.").

59. At one level, I obviously authorize my doctor to decide what I need to know.

60. ETHICS 2000, *supra* note 53, R. 1.2(a). Rule 1.2(a) incorporates Rule 1.4, which elaborates in this regard only to the extent of explaining that the lawyer must "reasonably consult." *Id.* R. 1.4(a)(2).

61. *Id.* R. 1.2 cmt.

Alas, no such luck. The Comment is limited to a positive description of common practice, with no normative impact at all:

> Clients normally defer to the special knowledge and skill of their lawyer [sic] with respect to the means to be used to accomplish their objectives, particularly with respect to technical, legal and tactical matters. Conversely, lawyers usually defer to the client [sic] regarding such questions as the expense to be incurred and concern for third persons who might be adversely affected.[62]

Accurate and uncontroversial, but also unhelpful. What happens in abnormal situations where one or the other does not want to defer? The Comment continues: "Because of the varied nature of the matters about which a lawyer and client might disagree and because the actions in question may implicate the interests of a tribunal or other persons, this Rule does not prescribe how such disagreements are to be resolved."[63]

In other words, the most important issue is explicitly left unaddressed, apparently because it is too complicated.[64] But this is no small matter. When lawyer and client disagree over a method or tactic, the Rules basically push the relationship to the brink:

> The lawyer should . . . consult with the client and seek a mutually acceptable resolution of the disagreement. If such efforts are unavailing and the lawyer has a fundamental disagreement with the client, the lawyer may withdraw from the representation. See Rule 1.16(b)(4). Conversely, the client may resolve the disagreement by discharging the lawyer.[65]

Thus, the client ultimately cannot instruct the attorney concerning means toward objectives, apparently even if they meet the "importance" test of Rule 1.4. Once the lawyer determines that the disagreement is fundamental, the lawyer may quit or dare the client to exercise the right of discharge. Moreover, Ethics 2000 Rule 1.16(b)(4) expansively allows a lawyer to withdraw when a client insists upon "taking action . . . with which the lawyer has a fundamental disagreement."[66] Previously, withdrawal was limited to situations in which the client insisted "upon pursuing an *objective* that the lawyer considers *repugnant or imprudent*."[67]

Once again, the otolaryngologist analogy is instructive, though this time by contrast. We can understand immediately that a physician cannot be ordered by a patient to prescribe a particular drug, antibiotic or not. Otherwise, patients could insist on narcotics, barbiturates or am-

62. *Id.*

63. *Id.*

64. Note, however, that other Rules venture into other areas notwithstanding "the varied nature of the matters" that might arise, not to mention the implications for "the interests of tribunals or other persons." Consider Rule 3.3(a)(3) which is quite specific concerning a lawyer's duties following the offer of false evidence.

65. MODEL RULES OF PROF'L CONDUCT R. 1.2 cmt. (2002).

66. ETHICS 2000, *supra* note 53, R. 1.16(b)(4).

67. *Id.* R. 1.16(a)(4) (emphasis added). Neither the Terminology section nor the Comment define "fundamental disagreement."

phetamines, or other drugs with adverse side effects or contraindications. Faced with a patient's unreasonable demand, the doctor may either resign or inform the patient to seek treatment elsewhere. Thus, the brinkmanship built into Rules 1.2 and 1.4 makes sense in the medical setting.

They make far less sense for lawyers, however, in large part because legal representation is generally longer term, and less episodic, than medical treatment. Indeed, the difference between the two practices exposes the flaw in the Ethics 2000 Rule.

Simply put, it is usually much more difficult and expensive to change lawyers than it is to change doctors. As anyone in an HMO knows full well, changing doctors is often quite routine, involving a simple transfer of records and perhaps a new interview and history. Even in cases of serious illness, the standardized nature of medical charts means that the new physician does not need to start over from the beginning.

In contrast, a legal client's case may extend over a period of months or years, with the client paying periodic bills while the lawyer engages in work that the client never sees. The work is usually cumulative, and not easily transferred to new hands. If transferred, much duplication is often necessary, resulting in dramatically multiplied fees. For poor and middle income clients, therefore, a change of lawyers may be a financial impossibility, or at best a financial disaster. A lawyer's threat to quit is seldom accompanied by an offer to disgorge past fees.

Needless to say, wealthy or powerful clients do not face this problem. A disagreement will seem far less "fundamental" to a lawyer or law firm when there is a well-paying client on the other side.

Thus, the Ethics 2000 Comment to Rule 1.2, coupled with the enlarged bases for withdrawal under Rule 1.16, essentially eviscerates the notion of client control, or even meaningful input, concerning the means of representation. Moneyed clients will enjoy exceptional influence over their lawyers, as always. Marginal clients will be told where to draw the line.

In fact, a more candid version of the Ethics 2000 Rule would read something like this: "A lawyer shall consult with the client as to the means by which objectives are to be pursued, *if the lawyer feels like it*."

Is there a fix? Can the Rule 1.2 Comment be rewritten to give the Rule itself some real meaning? Let me make one small suggestion, referring back (for one last time) to the benevolent otolaryngologist.

Assume that my distinction between law and medical practice is unconvincing, and that the "quit or dare" approach to disagreements is ultimately adopted by bar associations and state supreme courts. At a minimum, that should trigger a greater duty of investigation and disclosure on counsel's part. First, at the very beginning of a relationship, the attorney should be required under Rule 1.2 to determine precisely what is "important" to the client, with regard both to means and objectives. That is, if the obligation to "consult" depends on importance, then the

lawyer should bear the burden of investigation. Then, under Rule 1.4 it should be the lawyer's additional duty to inform the client of impending decisions (or those already made, when exigent) concerning all "important matters," with the client as the reference point. Thereafter, they may agree or go to the brink.

In other words, how can I fire my doctor if I do not know what she has done?

## V. CONCLUSION (BY BURNS)

I agree that the Ethics 2000 Rules do not seem to impose additional obligations likely to be enforced through the disciplinary process on lawyers with regard to the "means" taken during representation. If anything, they impose fewer. It is hard to know whether the Ethics 2000 version of Rules 1.2, 1.4, and 1.16 hit a new note insofar as they define an ideal of lawyer-client representation. There is certainly a tilt toward deference to the profession's definition of good practice in these matters and away from maximizing client choice. (It may be significant that Ethics 2000 would address the issue of means in Rule 1.4 [Communication] rather than Rule 1.2 [Scope of Representation].) On the other hand, the tilt may be too subtle to have an effect on the ideals that actually animate lawyer practice. Those ideals are likely to come from local legal cultures that will probably be affected only by more dramatic and sharper changes that we have found in the Ethics 2000 recommendations.