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ADVOCACY AND GENUINE AUTONOMY: THE LAWYER'S ROLE WHEN THE CLIENT HAS A RIGHT TO DO WRONG

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I.

Stephen Pepper has presented us with a disturbing scenario that is likely to be quite common. He argues that lawyers and clients often act together in ways that their moral convictions would prevent them from acting individually.¹ In cases like these, the lawyer tells herself, "I am only acting at the behest of the client. This injustice is his responsibility, not mine." At the same time, the client assigns responsibility to the attorney.² "I would never have considered doing this, but my lawyer says I should. She's the expert, she says that I am within my rights. Still, I'm glad she's the one who will actually do it and not me." The lawyer sees her role as limited to showing the client his legal options.³ She comforts herself with the thought that the responsibility rests fully on the client. The client confuses his legal options with his moral options. He comforts himself by trusting in the lawyer's expertise and experience.⁴ I will call this scenario "Pepper's Problem."

Pepper's Problem occurs, according to the author, because the law is designed to work only in the aggregate.⁵ Though our laws usually bring results that are just when one looks at the results as a whole, there are many things that one can do legally but not justly.⁶

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1. See Stephen L. Pepper, *Lawyer's Ethics in the Gap Between Law and Justice*, 40 S. TEX. L. REV. 181, 188-92 (1999).

2. See *id.* at 189-90.

3. See *id.* at 189.

4. See *id.* at 189-90.

5. See *id.* at 186.

6. See *id.* at 185.

Bankruptcy laws enable some debtors to walk away from debts that they are actually capable of paying to creditors who are financially worse off than the debtor.⁷ In cross-examination, lawyers can feign disbelief in witnesses they know to be truthful, often in ways that are humiliating to the witnesses.⁸ Divorce proceedings can be made so unpleasant that the client's spouse will accept a settlement that is actually unfair.⁹ Civil and criminal law both provide ample opportunity for attorneys to exercise their clients' right to do wrong.¹⁰ In this context, Pepper's Problem can arise despite the fact that neither the client nor the lawyer approves of their joint action.

In Pepper's assessment, as in mine, both the client and the lawyer are at fault in this scenario. Pepper argues that the client has primary responsibility for the action, but that the lawyer is also to blame.¹¹ She has the responsibility to make the client aware that *he* must take responsibility. She is obliged to ensure that the client understands the difference between a legal right and a moral right.¹² In other words, the attorney needs to make it clear to the client that he must act autonomously.

In the following pages, I would like to explore the nature of the attorney's responsibility to help her client reach autonomous decisions.¹³ To do this, I will review the work of some prominent medical ethicists on the same issue in doctor-patient relationships. Doctors are also advocates for the interests of others. They also can be obliged to enact another person's right to do wrong. Doctors and patients can also find themselves in a medical version of Pepper's Problem, where both parties feel pressed by the other to do something wrong.

The comparison with the doctor-patient relationship will help us see that autonomy is harder for a client to achieve than many lawyers recognize. If a lawyer is to be a virtuous advocate for her client, she must understand what her client needs in order to act autonomously.¹⁴

7. *See id.* at 189.

8. *See id.* at 189-190.

9. *See* Charles Fried, *The Lawyer as Friend: The Moral Foundations of the Lawyer-Client Relationship*, 85 YALE L.J. 1060, 1062 (1976) (discussing potential immoral conduct by lawyers in their relationships with their clients).

10. *See* Pepper, *supra* note 1, at 188-89.

11. *See id.* at 191.

12. *See id.*

13. Fried wrote, "The lawyer acts morally [when] he helps to preserve and express the autonomy of his client vis-à-vis the legal system." Fried, *supra* note 9, at 1074.

14. In this way, I hope to add to Robert J. Araujo's observations about the virtuous lawyer in his paper in this volume. *See* Robert J. Araujo, *The Lawyer's Duty to Promote*

When the lawyer succeeds in doing this, I will argue, she can often avoid Pepper's Problem.

II.

Like a lawyer, a doctor's job is to provide information and expertise in service of the interests of another person. A continuing debate in medical ethics is just how much control the patient should have in this relationship. A generation ago, most doctors would simply inform patients of the actions that would be taken to promote the patient's health. This paradigm has been largely overturned now by the Patient Rights movement. The new view is that the patient must be the one to make the decisions about her own health and treatments; or, where that is not possible, the patient's family should have the decision making power. Most doctors now approve of this change in the doctor-patient relationship, but there are cases that make them doubt its wisdom.

Doctors sometimes find themselves in situations where the patient makes what the doctor believes to be the wrong choice. Patients refuse treatments that could extend their lives in favor of less invasive, less powerful treatments. They refuse to consistently take medications that are important to their health but that have difficult side effects. Parents sometimes choose to let severely disabled newborns die of minor health problems (e.g., an intestinal blockage) that the doctor knows he can easily cure. In cases like these, the Patient Rights movement has given the patient, in the doctor's eyes, a right to do wrong.¹⁵

The doctor believes he has an obligation to respect his patient's autonomy. On the other hand, he also has an obligation to protect her health. These obligations can come into conflict. What can the doctor do in cases like these?

Medical ethicists Ezekiel J. Emanuel and Linda L. Emanuel have

the Common Good: The Virtuous Law Student and Teacher, 40 S. TEX. L. REV. 83 (1999).

15. The patient's choice might be seen as "wrong" in two different senses. Most commonly, doctors worry about patients making choices that are *imprudent* or *irrational*—choices that are in conflict with the patient's best interests. (On most accounts a person cannot *morally* wrong herself.) In some medical contexts, though, the doctor may be worried about choices that are wrong in the sense of being immoral or unjust. The latter include cases where medical decisions are made by family members in the name of patients who are incompetent or immature, pregnancies (where the one allegedly wronged is the fetus), or situations in which a patient's choice about her own treatment will affect the health of other people (e.g., a single mother who will die or be incapacitated because of a refusal of treatment, a person with a sexually transmitted disease who refuses to be treated and yet intends to engage in unprotected sexual intercourse).

identified four models of the doctor-patient relationship.¹⁶ Each model tries to balance the patient's autonomy and the doctor's obligation to protect the patient's life and health. The Emanuels argue that the differences between the models are best explained by different underlying theories of the nature of autonomy.¹⁷

The first model of the doctor-patient relationship is the *Paternalistic Model*.¹⁸ Here, the doctor's role is to figure out which treatments will best promote the patient's health. He then informs the patient that this is the best thing to do. The doctor considers himself an advocate for the patient because he sees himself as working in the patient's best interests. He believes he respects the patient's autonomy because he is choosing what the patient would choose for herself if only she had the medical expertise to do so.¹⁹ Note that the paternalistic doctor believes the patient's interests to be clear and objective. She needs health and long life. Given that these fall under the doctor's area of expertise, he is the one who should select the means to bring about these ends. The only thing the patient actively does to express her autonomy is assent to the doctor's decisions.²⁰

The Paternalistic Model has come into disfavor because it has come to be understood that the doctor's values and the patient's values may differ.²¹ Doctors focus on health and longer life. The paternalistic doctor assumes that these are the patient's most important values, he has taken a pledge to protect these interests, and

16. See Ezekiel J. Emanuel & Linda L. Emanuel, *Four Models of the Physician-Patient Relationship*, 267 JAMA 2221-26 (1992).

17. See *id.* at 2221.

18. See *id.*; cf. R.M. Veatch, *Models for Medicine in a Revolutionary Age*, 5 HASTINGS CTR. REP. 5-7 (1972) (describing paternalistic attitudes and their applicability to medical practitioners); A.A. STONE, *MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION* 235 (1976) (offering a brief description of the paternalistic physician).

19. See Emanuel & Emanuel, *supra* note 16, at 2224.

20. Sometimes this minimal expression of autonomy, the patient's assent, is not even required by the doctor. Paternalists will usually argue that a refusal of treatment can be overridden in cases where the patient is clearly choosing in violation of her own interests. Cf. STONE, *supra* note 18, at 237-39 (emphasizing that patients should be given the best possible care no matter what the circumstances); Gerald Dworkin, *Paternalism, in MORALITY AND THE LAW* 110-13 (Richard A. Wasserstrom, ed., 1971) (stating that an argument can be made that it is immoral not to provide patients necessary care). Other paternalists even deny the patient the opportunity to make the wrong choice by refusing to tell the patient her actual diagnosis, if it is thought that the truth will be more than the patient can bear. See Charles C. Lund, *The Doctor, the Patient, and the Truth*, in *ETHICAL ISSUES IN MODERN MEDICINE* 55-57 (John D. Arras & Bonnie Stienbock, eds., 4th ed. 1995).

21. See Emanuel & Emanuel, *supra* note 16, at 2224; Alan Goldman, *The Refutation of Medical Paternalism*, in *ETHICAL ISSUES IN MODERN MEDICINE* 58-66 (John D. Arras & Bonnie Stienbock, eds., 4th ed. 1995).

he acts accordingly. But patients value many other things besides health and long life. They want to be free from suffering. They often want to spend their final days with their families rather than in hospitals. If given the option, many will refuse a chance at a longer life if it means their mental faculties will deteriorate in such a way that they will become strangers to their loved ones and their loved ones will become strangers to them. Doctors cannot simply assume that health and long life are the main goals of treatment.²² The Paternalistic Model fails, in the end, to respect autonomy because it does not recognize individual differences in values.

Doctor-patient relationships that follow the Paternalistic Model are at high risk for Pepper's Problem. Not only do patients often value something other than long life, the doctors do as well. But doctors who see their job as preventing the patient's death feel trapped by that obligation into doing something even the doctor sees as wrong. Time after time, terminally ill patients have been subjected to long, painful deaths when all parties involved would have preferred stopping treatment.

The second model for the doctor-patient relationship is the *Informative Model*.²³ Here the doctor's role is to present the patient with all of the medical options that she has and let the patient choose from them. The doctor will describe the side effects, provide the relevant statistics regarding success and failure, and offer any other medical information that is needed. The doctor who follows the Informative Model shows respect for patient autonomy by leaving the choice of treatment to the patient.²⁴ The doctor does not presume to know what the patient values. He realizes that the patient can only make that choice in a truly autonomous way if she has all the data that she needs, so he provides the medical expertise. But then the doctor steps out of the picture and leaves the choice completely in control of the patient.²⁵

The major benefit of the Informative Model is that it recognizes that different patients have different priorities. It recognizes that health and long life are not the only factors that must be considered. But many doctors are also unsatisfied with the Informative Model.²⁶

22. See Emanuel & Emanuel, *supra* note 16, at 2224.

23. See *id.* at 2221; cf. Veatch, *supra* note 18, at 5-7 (discussing the need for medical practitioners to disseminate information to patients in a more concise, clear manner).

24. See Emanuel & Emanuel, *supra* note 16, at 2221.

25. See *id.*

26. Cf. Lund, *supra* note 20, at 55-57 (expressing the idea that patients often make irrational decisions because they are unable to fully cope with information from their

Medical information is often difficult for patients to process. Doctors worry that their patients do not really understand their options. They know that patients who are sick are also often afraid and depressed. They fear that patients will panic and run away from invasive but successful procedures. They fear suicidal impulses. They fear that patients will fall into denial and place unreasonable hope in inefficacious remedies. According to many, the Informative Model leaves the patient too much leeway to make the wrong choice.²⁷

If the patient is, in fact, ineffectively evaluating her options, her choice will be wrong by her own rights. She will likely come to regret her choices. So, here too, Pepper's Problem comes up. The action taken is one of which both the doctor and, eventually, the patient will disapprove.

Some will say that allowing the patient the freedom to make the wrong choice is the only way to respect her autonomy. But others contend that this response rests on a fallacious understanding of autonomy.²⁸ A decision made out of terror or confusion is not fully autonomous. Emotional disturbance can cause people to lose sight of their own values. If a doctor wants to help his patient make autonomous choices, it is argued, he must recognize these dangers and help minimize their effects.²⁹

The third model tries to correct this problem by giving the doctor a more active role in helping the patient evaluate her medical options. It is known as the *Interpretative Model*.³⁰ Here, the doctor is required not only to give the patient comprehensive information about different treatment options, but also to talk explicitly with the patient about how these options serve her values. The doctor tries to get the patient to identify which of her values come into play in this situation—health and long life, as well as comfort, time with her family, and so forth. He then helps her think through which of the treatments best serve these values.³¹ As the name suggests, the doctor's role is not only to provide medical information, but to help the patient interpret that information in light of her own values. The ideal interaction between the patient and doctor is dialectical. They reason together to find the solution that best fits the patient's ends.³²

physician).

27. See Emanuel & Emanuel, *supra* note 16, at 2224–25.

28. See *id.*

29. See *id.*

30. See *id.* at 2221–22.

31. See *id.*

32. See *id.*

Implicit in this model is the idea that a patient is not acting autonomously unless her actions really do connect with her values.

The fourth model, the *Deliberative Model*, also encourages the doctor to engage in a dialectic with the patient about her values.³³ Here, the doctor not only shows how the treatment options relate to the values that the patient has, he can also bring up values that the patient *should* have. If a patient is discounting her family's reaction, the doctor can argue for the legitimacy of their interests to the patient.³⁴ If the patient is inclined to abort a female fetus because she prefers to have a son, the doctor can ask her to think about the joys that can come from raising a girl, the wider opportunities girls and women have these days, etc. While a doctor following the Interpretive Model must restrict himself to discussing the values the patient *already has*, the Deliberative Doctor can discuss values the patient *should adopt*.³⁵ The doctor's goal is not to preach or coerce, but to persuade. The doctor will avoid intolerance of religious and cultural differences by limiting himself to comments that raise moral considerations any reasonable person can recognize.³⁶

Proponents of the Deliberative Model point out that people's values are in a constant state of development.³⁷ Very few of us have moral beliefs that are fully settled. Most of us will admit that there may be things of great importance that we have overlooked or misunderstood. Furthermore, a health crisis is often such a novel situation for a patient that it will require her to form completely new values. A breast cancer patient may be forced for the first time to consider the use of cosmetic surgery. Parents told that their unborn child has Down's Syndrome face a life very different from the one they have expected. A decision made on the basis of half-formed or hastily chosen values is less than fully autonomous, according to the

33. See *id.* at 2222.

34. See *id.*

35. See *id.*

36. I have broadened the Deliberative Model beyond the description given by the Emanuels. They present the Deliberative Doctor as offering persuasion only on health-related values. See *id.* at 2222, 2226. I allow for a broader range of moral concerns to be mentioned. In saying that the doctor must limit himself to raising considerations any reasonable person would recognize, I mean to require toleration of reasonable differences in religious, political and moral opinions. To fill out this notion more fully, we can appeal to John Rawls' notion of the original position and the veil of ignorance. See JOHN RAWLS, *A THEORY OF JUSTICE* 85–110 (1971). A doctor following the Deliberative Model should only raise moral considerations that would be considered relevant by parties discussing the situation from behind a veil of ignorance—i.e. parties who did not know their own religion, race, gender, sexual preference, political affiliation, wealth or social status.

37. See Emanuel & Emanuel, *supra* note 16, at 2222.

Deliberative Model.³⁸ Values themselves must be chosen autonomously if the patient's best interest is to be served. A good doctor will help the patient in this process.

III.

These same four models have their equivalents in attorney-client relationships. Lawyers might see their advocacy relationship to their clients in paternalistic terms. Here, the lawyer's role is to pick the legal strategies that are most likely to serve the client's objective interests. The interests that lawyers most frequently assign to their clients are, as Pepper writes, the maximization of wealth and freedom.³⁹ The lawyer will decide what will most likely serve those ends. The client's role in this relationship is limited to accepting or rejecting the lawyer's conclusions.

Many practicing lawyers seem to see their role along the lines of the Paternalistic Model. Unfortunately, the problems that plague paternalism in the medical context also taint its use in the attorney-client relationship. In a paternalistic relationship, the advocate simply assumes that the client most wants wealth and freedom. In pursuing these goals, there are sometimes steps that can be taken which are legal but unjust. Moreover, the assumption may be mistaken. The client may place greater weight on having a reputation for fairness, taking responsibility for his own actions, preserving a connection with the community, or protecting the environment. A paternalistic lawyer who makes a false assumption about her client's values will often end up acting in conflict with the client's true interests. In other words, the Paternalistic Model leaves the door wide open for the disturbing scenario that Professor Pepper has described. The client may not be any happier with the unjust course of action than the lawyer is.

Alternatively, a lawyer might follow the Informative Model. In this case, she will see her role as providing the client with thorough descriptions of all of his legal options. It is then left to the client to choose among these options in accordance with his own values. The lawyer provides information and expertise, but the decisions are made by the client. As in the medical context, the Informative Model is preferable to the Paternalistic Model because the advocate does not simply, and perhaps mistakenly, assume that she knows what her client values.

38. *See id.*

39. *See Pepper, supra* note 1, at 188-89.

The Informative Model may be the most commonly practiced version of the lawyer-client relationship. It also can be criticized from the point of view of client autonomy. As in the case with medical choices, legal choices are often so complex and so emotionally charged that the client may not make the choice in line with his actual values. He may misunderstand how his legal options relate to his values. He may be temporarily blinded by fear, anger, or (in more ordinary corporate contexts) simple inattention. He may lose sight of values that he actually holds dear by focusing only on short-term prospects or the excitement of legal battle. Once again, the attorney and client are left vulnerable to Pepper's Problem. Because the client might make an unjust decision in a less than autonomous way, he may come to be as regretful as the lawyer.

Pepper's Problem could be avoided in most situations if lawyers adopted one of the other two models for the lawyer-client relationship. If a lawyer followed the Interpretive Model she would have the freedom to discuss the client's values with him. The lawyer would not simply provide information about the client's options, she would also help the client evaluate how well those options fit with the client's own values. This will increase the chance that the client will make his decisions in line with his actual values, and so decrease the chance that he will later regret his actions.

A lawyer following the Deliberative Model will go one step further. She will not only talk about the legal options with respect to the client's values, but she will also try to persuade the client to adopt some important moral values that he has overlooked or discounted. The goal is to prevent a situation in which a client acts on a value that he holds unreflectively, a value that he may later come to regret.

It should be emphasized that the Deliberative Model leaves the final decision to the client. The attorney may respectfully raise new moral concerns. She can try to persuade the client of their importance. She will also be sure to help the client understand his own values and how they are served by different legal strategies. But then the decision will be made by the client. The lawyer will ensure that the client knows he has the power. She will also make sure that he understands that he will carry the full moral responsibility for his choice.

IV.

If an attorney is to be a good advocate for her client, she should

reject both the Paternalistic and Informative Models.⁴⁰ Both suffer from overly simplistic conceptions of client autonomy. The choice that the responsible lawyer faces, then, is between the Interpretive and the Deliberative Models. Which of these should shape her conception of her obligations to her client?

The Deliberative Model's more stringent conception of autonomy is appealing.⁴¹ For instance, when we were children, most of us pronounced our commitment to career choices we consider outlandish now. We wanted to be test pilots, or rock stars, or the only 5'5", 110-pound woman to play in the NFL. We do not consider our current careers as academics or lawyers to be failures or cases of "backsliding" or "copping out" because our childhood choices were not autonomous. It was not (or not only) that we lacked enough information back then to know what the life of a rock star is really like. Our childhood decisions were not autonomous because our values were not fully formed. We did not yet have the sophistication or experience to reflect properly on the importance of privacy, the rigors of travel, or the shallowness of most rock music.

People who dropped out of school or married too young often beg not to be held accountable for those mistakes because they did not know what they were choosing, or the value of what they were giving up. People who were raised with a narrow perspective on life and were never exposed to people who belong to other religions, cultures or political ideologies often resent those who over-protected them. The parent is charged with having prevented the child from fully developing as a *person*—from fully becoming an autonomous moral agent. In all these examples, a lack of reflection on values undermines autonomy. In the latter examples, we may insist that the agent's decisions are autonomous enough to hold the person *responsible* for her own choices; but, still, we recognize that the decisions fall short of our ideal of autonomy.

If full autonomy requires reflection on values, then an attorney will serve her client's interests by encouraging that sort of reflection.

40. Though she accepts one of the latter two models, a lawyer's interactions with her client may often look from the outside as though they follow the Paternalistic or the Informative Model. A lawyer who knows her client very well or who is dealing with a very simple case can act in the client's interests without having to enter into any explicit discussion about the client's options or values.

41. For other accounts of autonomy that recognize the need for reflection on values, see IMMANUEL KANT, *An Answer to the Question: "What is Enlightenment?"* in KANT'S POLITICAL WRITINGS 85 (Hans Reiss ed. & H.B. Nisbet trans., 1970) (1784); JOEL FEINBERG, *THE MORAL LIMITS OF THE CRIMINAL LAW*, VOL. III: HARM TO SELF 22-23 (1986); RAWLS, *supra* note 36, at 513-20.

However, we should recognize that there are also dangers involved in an attorney-client relationship that follows the Deliberative Model. There is sometimes a fine line between persuasion and coercion.⁴² Attorneys are often seen as authoritative by their clients. Criminal defendants whose freedom is at stake or clients involved in divorce, custody battles or other emotionally charged disputes, may be in emotionally fragile states. They may be easily intimidated and simply give in to what they perceive to be the lawyer's wishes. Clients may feel embarrassed or resentful if their attorneys express disapproval of their values. This could adversely affect the outcome of the case. Moral discussion can slide from persuasion into coercion, even if that is not the attorney's intention. In that case, the patient's autonomy (the acclaimed goal of this process) will be undermined, not enhanced.

One might argue that the possible benefits of an attorney's assistance in reflection on values are far outweighed by the dangers of coercion. From the point of view of an interest in client autonomy, the benefits of deliberation may not be worth the risk. This may well be right for a wide range of cases. Here, the Interpretive Model is best. However, I am not willing to completely give up on the Deliberative Model.

Clients differ, so do lawyers. In some cases, the delicate art of persuasion can be achieved. As Pepper has pointed out, differences in intelligence, education, strength, security, and familiarity with the law will make clients more or less vulnerable to coercion.⁴³ Lawyers with more developed personal skills will be more capable of expressing moral concerns in ways that clients will perceive as constructive and helpful. In cases where an attorney can participate in moral deliberation with little risk of coercion, she should. The attorney's obligation to be an advocate for her client's interests requires it.

In situations where coercion is a greater danger, there is still much that an attorney can do to encourage deliberation about values. An attorney who is following the less ambitious, safer Interpretive Model must limit herself to providing the client with information about his legal options and discussing how those options connect to the values that the client already has. In order to do this, the attorney must find out what the client's values *are*. Skillfully posed questions about what the client in fact values can subtly encourage reflection about what he *should* value. Moral deliberation can also be spurred by the way the attorney communicates information to the client about

42. See Emanuel & Emanuel, *supra* note 16, at 2225.

43. See Pepper, *supra* note 1, at 192-96.

the likely consequences of his choices. Consequences can be communicated flatly (e.g., “Your spouse will receive 30 % of the estate and take on 50% of the debts”), or they can be made vivid to the client (“Your spouse will receive \$10,000, leaving her nothing after the debts are paid. Most likely she will have to move in with her sister’s family, sell her car and quit school a year short of her degree.”) As Pepper has written, tone of voice and body language can also have a great, but non-coercive, effect on a client.⁴⁴ These subtle attempts to make the client reflect on her values are not manipulative, in my view, because their purpose is not to control the client, but to put him in better control of his own life. These techniques are justified—even *required*—by the lawyer’s obligation to help her client make autonomous decisions.

V.

The Interpretive and the Deliberative Models do not provide a solution to the general problem of an attorney enacting a client’s right to do wrong. Clients may choose to do wrong in ways that are fully autonomous, on either account of autonomy. In these situations, the lawyer’s obligation to be an advocate for the client will continue to cause her moral worries.⁴⁵ I have no solution to that problem. It is a cost of the advocacy system, which, on the whole, is a just and honorable institution.

However, I do think that the Interpretive and Deliberative Models offer help in the subclass of cases that I have described with the label “Pepper’s Problem.” Though there may be many clients who will autonomously choose to do wrong, there are also many who, if only they are able to achieve full autonomy with respect to the situation, will make the morally correct choice. By helping their clients make decisions in a fully autonomous way, lawyers can minimize the number of situations in which they must act on a client’s right to do wrong, and they can do so in a way that does not compromise their status as advocates for their clients’ interests. In fact, by following the Interpretive and (at times) the Deliberative Models, the attorney will be a *better* advocate for her client’s

44. *See id.* at 204

45. In many cases, the only thing the lawyer can do to avoid enacting the client’s right to do wrong is to remove herself from the case. *Cf.* Teresa Stanton Collett, *The Common Good and the Duty to Represent: Must the Last Lawyer in Town Take Any Case?*, 40 S. TEX. L. REV. 137 (1999) (asserting that attorneys should use moral judgment when deciding whether to represent a potential client).

interests.⁴⁶

46. I would like to thank the Research Enhancement Program, Office of the Vice President for Research and Associate Provost for Graduate Studies, at Texas A&M University for providing funds that allowed me to attend the symposium at South Texas College of Law. Thanks also to Heather Gert and Robert R. Shandley for their helpful comments.

