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# Medical Paradigms for Counseling: Giving Clients Bad News

Linda F. Smith

# MEDICAL PARADIGMS FOR COUNSELING: GIVING CLIENTS BAD NEWS

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The dominant paradigm for legal counseling focuses on giving the client choice. The "Ethical Lawyer" explains the situation sufficiently for the client to make an informed decision.[1] The "Client-Centered Lawyer" identifies alternatives, predicts consequences, and assists the client in choosing the course of action that best meets the client's goals.[2] This orientation has been, no doubt, an appropriate corrective to the paradigm of the controlling professional who knows best and decides what the client needs.[3]

But sometimes there are no choices that will achieve the client's goals. The abandoned spouse cannot prevent the divorce or avoid an order for visitation, the thief cannot stay out of jail, the business cannot escape paying damages, and the tenant will be evicted. Of course, the amount of visitation, jail time or damages can be greater or smaller and the eviction may be delayed a bit; but the outcome the client wants to avoid is inevitable. These are particularly hard cases for the lawyer-counselor where the formula of identifying alternatives

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[1] "A lawyer shall explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation." AMERICAN BAR ASSOCIATION, MODEL RULES OF PROFESSIONAL CONDUCT, Rule 1.4 (b) (1983).

[2] David Binder, Paul Bergman and Susan Price outline "Implementing the Basic Counseling Approach" as involving a "Preparatory Explanation," followed by "Step One: Clarifying Objectives, Step Two: Identifying Alternatives, Step Three: Identifying Consequences . . . [and] Step Four: Making a Decision." DAVID A. BINDER, PAUL BERGMAN & SUSAN C. PRICE, LAWYERS AS COUNSELORS: A CLIENT-CENTERED APPROACH xxv, 287-304 (1991).

[3] "The traditional idea is that both parties are best served by the professional's assuming broad control over solutions to the problems brought by the client. . . ." DOUGLAS ROSENTHAL, LAWYER AND CLIENT: WHO'S IN CHARGE? 7 (1974). *See also* Talcott Parsons, *The Professions and Social Structure, in* ESSAYS IN SOCIOLOGICAL THEORY 34, 43-46 (Talcott Parsons ed., 1954) and ELIOT FREIDSON, PROFESSIONAL POWERS: A STUDY OF THE INSTITUTIONALIZATION OF FORMAL KNOWLEDGE (1986), exploring the paradigm of the traditional, controlling professional.

and predicting consequences can seem like a cruel joke.[4] In these cases the lawyer must also be able to tell the client "bad news." At these junctures, the skill of informing and explaining empathically takes priority over the paradigm of offering the client choice.

The paradigm of a professional delivering "bad news," while not current in legal counseling, has become an important paradigm in the medical world. Medical professionals see counseling as typically beginning with a diagnosis; and sometimes that diagnosis is upsetting to the patient. Hence oncologists tell patients of their cancer, geneticists tell parents their infant has Down syndrome, and emergency room staff tell relatives about accidents and death. Usually these medical professionals also offer choices—choices among therapies, pain management techniques and support systems. But before the counselor offers alternatives, she must deliver the "bad news."

This paper draws upon the medical literature on delivering "bad news" to develop a new paradigm to use in legal counseling. The paper will first review the medical literature about problems in counseling patients about "bad news" and then consider critiques of legal counseling. Next, it will describe the medical model for delivering "bad news" and discuss how it can be used to develop a paradigm for delivering bad news in legal counseling. The paper will consider when and how this "bad news" counseling paradigm should be used in concert with the paradigm of identifying alternatives, predicting consequences and assisting the client to choose a course of action. The paper relies upon social science findings, individual reports and film portrayals of attorney-client counseling sessions to describe and defend this new paradigm for counseling.

## I. MEDICAL LITERATURE ABOUT COUNSELING

In the 1960s researchers began to study communication problems between medical professionals and their patients. Early empirical studies were conducted with the goal of improving both patient compliance and patient satisfaction.[5] By the 1980s studies had turned to focus on social and linguistic contexts of medical counseling. Most re-

[4] Imagine the criminal defense attorney in this counseling session: "Well, the alternatives are to plead guilty to robbery or go to trial. The consequences of pleading guilty will be a conviction and the prosecutor will ask for prison time and the judge will almost certainly sentence you to prison. Or, we could go to trial. And if the six witnesses who identified you as the robber testify, and if the jury considers your confession to the robbery, and that your fingerprints were on the cash register, you will almost certainly be convicted. And the prosecutor will ask for prison and the judge will almost certainly sentence you to prison. So those are our alternative. Which one would you like to discuss first?"

[5] Candace West & Richard M. Frankel, *Miscommunication in Medicine*, *in* "MISCOMMUNICATION" AND PROBLEMATIC TALK 166, 167 (Nikolas Coupland et al. eds., 1991).

cently empirical, theoretical and linguistic studies have considered the specific topic of how to convey "bad news."

### *A. Medical Counseling*

Many early empirical studies, both in Great Britain and the U.S., concluded that patients were "unhappy with the flow of information between themselves and their providers."[6] Studies about patients' adherence to medical advice showed nonadherence was more common when patients did not receive feedback from the physician or explanations of the cause of the illness.[7] In searching for better outcomes, it appeared that patient satisfaction was directly related to the amount of information received, and most patients wanted more information.[8] Subsequent studies indicated that simply spending more time counseling was not the solution, because the content of the counseling was often filled with medical jargon unintelligible to the patients.[9]

The absence of clear communication was most marked in the case of cancer patients. Early studies found that most doctors refrained from telling the patients their diagnoses, although most patients preferred to know.[10] Physicians were "loath to deliver bad medical news" to polio and tuberculosis patients as well as the terminally ill, citing "patients' inability to cope."[11] The doctors' beliefs and discomfort with the bad news had real consequences in terms of communication:

> [P]hysicians may phrase diagnoses in general rather than specific terms and thus obscure patients' understanding of their prognoses. . . . Their answers to questions may be put in 'such hedging, evasive or unintelligibly technical terms' as to lead patients to anticipate a more favorable prognosis than is warranted. . . . And they may well employ a language of euphemism. . . .[12]

Having identified the problem as lack of clear communications, researchers attempted to study the precise changes in the doctor-patient relationship that would enhance compliance and satisfaction. However these correlational studies yielded varied and sometimes contradictory outcomes. For example, patients taught to ask direct questions of their physicians did so and were significantly more compliant than an untrained control group. But these assertive, question-

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[6] *Id.*

[7] *Id.* at 168.

[8] *Id.* at 169.

[9] *Id.*

[10] *Id.* at 170. *See* William Fitts & I. S. Ravdin, *What Philadelphia Physicians Tell Patients with Cancer*, 153 J. AM. MED. ASS'N 901 (1953); Donald Oken, *What to Tell Cancer Patients: A Study of Medical Attitudes,* 175 J. AM. MED. ASS'N 1120 (1961).

[11] West & Frankel, *supra* note 5, at 170.

[12] *Id.* at 171.

ing patients also were less satisfied with their care![13] Researchers concluded that such correlational studies were inadequate for understanding how best to communicate with all patients.[14] A second problem was that the context of communication was not adequately considered. Not only will patients come to their doctors with different requirements for information, but a given patient's desires may change over the course of treatment. Moreover, the variable studied (e.g., total number of questions asked) ignored the sequential organization of the conversation. "In order to treat such requests for information as exemplars of good communication, one would need to know how they were responded to—and how they emerged from a given sequence of interaction in the first instance."[15] Accordingly, "a growing number of studies approach[ed] problems of communication in medicine by focusing on the social and linguistic contexts of medical discourse."[16]

Discourse-based studies have analyzed verbatim transcripts of audiotaped and videotaped counseling sessions in which difficulties in communication are directly observable.[17] These studies have shown how doctors may deliberately choose to limit the kinds of information patients receive and how use of technical as well as nontechnical terms can lead to patient misunderstanding.[18] This focus on language and social interaction in context allows researchers to pinpoint communication difficulties as they occur.[19]

Lastly, conversation analysis—focusing upon the organization of a conversation—has been employed to understand problems in medical counseling. Conversational "rules" for taking turns, responding to questions with answers, and repairing miscommunications have recently been relied upon to understand the actual physician-patient exchange.[20]

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[13] *Id.* at 175-76. *See* Debra Roter, *Patient Participation in the Patient-Provider Interaction: The Effect of Patient Question Asking on the Quality of Interaction, Satisfaction and Compliance*, 5 HEALTH EDUC. MONOGRAPHS 281 (1977).

[14] The major problem with correlational studies was that they were based on an assumption that "patients' needs, wants, resources and abilities are at least randomly distributed—if not constant— with respect to the process components [e.g., asking questions]." West & Frankel, *supra* note 5, at 177.

[15] *Id.*

[16] *Id.* at 178.

[17] *Id.*

[18] *Id.* at 179. *See* Deborah Tannen & Cynthia Wallat, *Doctor/Mother/Child Communication: Linguistic Analysis of a Pediatric Interaction, in* THE SOCIAL ORGANIZATION OF DOCTOR-PATIENT COMMUNICATIONS 203 (Sue Fisher & Alexandra Dundas Todd eds., 1983); *see also* Roger Shuy, *The Medical Interview: Problems in Communication,* 3 PRIMARY CARE 365 (1976).

[19] *Id.* at 184.

[20] *Id.* at 185-93.

### *B. Delivering "Bad News"*

Since the 1950s there have been major changes in doctors' attitudes and practices with respect to counseling their patients. "Whereas 90 percent of the physicians in 1951 did not disclose the truth to cancer patients, by 1971 90 percent did (as a general policy). . . ."[21] Today a patient's right to know the diagnosis and prognosis is accepted:

> It is now generally held that all mentally competent patients have absolute rights (ethical, moral, and legal) to any medical information that they require or request. These rights come from three interrelated sources: the expectations of society in general, the recognition of truth-telling as part of the code of ethics of the medical profession, and case precedence in law.[22]

However, recognizing that patients must be told the truth does not answer the question of how to tell it. In recent years there has been an outpouring of medical literature about this particular challenge in counseling: how to tell patients "bad news."

First, some of the literature is either theoretical or experiential. Medical professors teach their students how to engage in patient counseling and experienced physicians publish their advice on how to deliver "bad" or "sad" news.[23] Second, social science research has also been conducted to address this specific question about patient counseling. Researchers have surveyed former patients about their experiences as recipients of "bad news" diagnoses. Third, video and audiotapes of consultations (both live and mock) have been made and analyzed to discover what approaches are most effective. Although most discourse and conversation analysis has been done with a broader goal in mind, they sometimes focus upon communication difficulties in giving unwelcome diagnoses or prognoses.

One study used a combination of these approaches. It began by analyzing videotapes of residents telling actor-parents that their infant had Down syndrome to define different approaches in terms of control of the conference and the caring displayed.[24] Then the researchers surveyed parents of disabled children regarding how they were told of their child's disability and what they thought the ideal communication would be. Parents generally felt the doctor had a high degree of control over the interaction, allowed them to talk, but did not give

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[21] ROBERT BUCKMAN, M.D., HOW TO BREAK BAD NEWS: A GUIDE FOR HEALTH CARE PROFESSIONALS 11 (1992).

[22] *Id.*

[23] *See* J.T. Ptacek & Tara L. Eberhardt, *Breaking Bad News: A Review of the Literature on the Patient-Physician Relationship*, 276 J. AM. MED. ASS'N 496 (1996).

[24] Michael Sharp, Ronald Strauss & Sharon Lorch, *Communicating Medical Bad News: Parents' Experiences and Preferences*, 121 J. PEDIATRICS 539 (1992).

them much opportunity to show their feelings. Doctors were seen as confident, with about half showing caring but only about one-third showing feelings. Parents strongly wished the doctor to control the conversation, but also wished to be allowed to talk (95%) and to show their own feelings (93%). Parents preferred that the physician "get to the point" promptly and provide a lot of information (90%); they also wished to be referred to other parents. They wanted doctors to show a high degree of caring (97%), strong confidence (89%), and much of their own feelings (69%).

This same research group also studied the feelings of parents whose child had been born with a cleft lip and/or palate. The findings in this study[25] were quite consistent with the prior study. Although many parents reported positive experiences, there were significant differences between what they experienced and what they desired. Parents indicated a desire to have more information, wanted referral to other parents (67%), more opportunity to talk (91%), and more opportunity to show their feelings (89%). They wanted their physician to exercise control in the conversation (75%) but to show more caring (96%) and confidence (94%), and to try to make the parents feel better (91%).

Other researchers also interviewed parents of newborns with disabling conditions and found "remarkably consistent" preferences.[26] They preferred to be told together and early. Parents wanted a "clear, direct and honest report of the diagnostic information, including what is known and what is not known."[27] The affective tone of the interview was very important to them, as was their desire to have some positive information about the child's situation. It is noteworthy that at least a third of the group spontaneously remarked that doctors need to understand that the content of the news and the process of telling the parents the news are two different things. These researchers concluded that parental dissatisfaction was not inevitable, and that it is possible for physicians to communicate troubling diagnoses in ways that will strengthen the physician-parent and the parent-child relationship.

Yet another recent study involved interviewing families about the encounter when they learned their infants had been diagnosed with disabling conditions (Down syndrome) or serious health problems

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[25] Ronald Strauss, Michael Sharp, Claire Lorch & Geejal Kachalia, *Physicians and the Communication of "Bad News": Parent Experiences of Being Informed of Their Child's Cleft Lip and/or Palate*, 96 PEDIATRICS 82 (1995).

[26] Gloria Krahn, Ann Hallum & Cetrelia Kime, *Are There Good Ways to Give 'Bad News'?*, 91 PEDIATRICS 578 (1993).

[27] *Id.* at 581.

(congenital heart disease).[28] Families were asked how they were first told of the condition and what their reactions were. Their responses were analyzed by identifying the issues and themes that the families emphasized. These issues and themes were then systematically analyzed to identify and organize the factors that seemed most significant. These investigators also found that families preferred to be informed in person, in private, and as a family. Families identified background variables (e.g., previous knowledge) that influenced their responses to how they were informed.[29] The families reported a variety of specific and intense feelings, especially including shock, when they had not suspected a problem, and fear when there was a life-threatening condition. However, families clearly distinguished their feelings about the news from their reactions to the way they were told. Families reported proportionally more positive experiences than negative (61% / 39%). They focused on the manner in which they were informed and the quality of the information they received. They underscored the importance of providers who were supportive and sensitive to their feelings, and those who focused on their child as a whole rather than on the negative aspects of the condition. Families appreciated up-to-date information and referrals to appropriate resources.

In addition to individual studies, there have been some articles reviewing the literature on delivering "bad news" in the medical setting. Leslie Fallowfield[30] concluded that various studies indicate doctors are poorly or minimally trained to give patients bad or sad news. One study surveyed bereaved parents about how they learned of their child's death. This study found police officers (who generally receive more training than doctors in how to break bad news) to be more sympathetic than medical professionals. These bereaved parents "seemed to gain support when they perceived the informant to be also distressed. A cold 'professional' detachment tended to cause great offense."[31] Another study compared trained counselors with untrained ones. Health providers who had been taught how to inform parents in an "unhurried, honest, balanced, empathic manner" that their baby had Down syndrome were better able to counsel the parents. All par-

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[28] Ann Garwick, Joan Patternson, Forrest Bennett & Robert Blum, *Breaking the News: How Families First Learn About Their Child's Chronic Condition*, 149 ARCHIVES OF PEDIATRIC ADOLESCENT MEDICINE 991 (1995).

[29] "The variability in families' perceptions of preexisting factors underscores the importance of assessing the meanings that families attribute to the chronic illness and disability. Our findings indicate that families do not necessarily react negatively to the news. . . .Thus we recommend that clinicians listen to each family's reactions and build on their positive attributions . . . [as well as] . . . select informing strategies that build on the family's knowledge and experience." *Id.* at 996.

[30] Lesley Fallowfield, *Giving Sad and Bad News*, 341 LANCET 476 (1993).

[31] *Id.*

ents counseled by trained professionals reported that they were satisfied with the interview, while only 20% of the parents informed by untrained health professionals were satisfied. Fallowfield concluded that not only were "insensitively or inadequately handled interviews" hurtful to the patient or relative, but inept counseling might have a negative effect on treatment. "[S]tudies in several specialities of medicine have shown that [an inadequately handled interview] also impeded patients' and relatives' long-term adjustment."[32] Breast cancer patients who were displeased with their informing interviews were twice as anxious a year later than patients who had been satisfied with their interviews.

We can draw various significant conclusions from these studies. Patients learning "bad news" react not only to the content of the news, but also to the manner in which they are counseled. They prefer to be given bad news which is clear and understandable to them. They often want more rather than less information, including referrals to other sources of information. Patients want the medical professionals to control the conversation, but to respond to their questions and emotions. Their questions often depend upon their prior knowledge of the condition; their feelings and reactions are often quite individual. Accordingly, the counselor must listen to the patient and allow the patient to ask questions and to express emotions. The counselor should respond to the patient without becoming defensive, providing information relevant to the patient's questions and emotional support appropriate to the patient's reactions. Patients prefer a counselor who is not detached, but shows emotion and provides some hope for the future.

## II. Lawyers As Counselors—Some Critical Views

While patients' attitudes about their doctors and their care have been studied for quite some time, clients' attitudes about their lawyers have not garnered the same amount of attention. Surveys of client satisfaction are rare. The analysis of attorney-client communications has received more attention of late, but it is still in its infancy.

### *A. Survey Information*

Recently Consumer Reports surveyed 30,000 readers about their satisfaction with their lawyers. These former clients reported substantial problems:

> Overall, 27 percent of the people who had hired a lawyer for an adversarial matter were dissatisfied with the work done. . . . Of all

[32] *Id.* at 476.

> the services we've surveyed over the years, only diet programs have received a worse score. . . .[33]

These clients complained both about the case's outcome and about the lawyer's communications:

> At least 25 percent of the people involved in an adversarial case thought that their lawyer failed to protect their rights and financial interest, failed to keep them informed, . . . . At least 20 percent of the people involved in a variety of cases . . . claimed their lawyer didn't return phone calls promptly or paid too little attention to the case. . . .[34]

"On the other hand, most people—whatever their case—felt their lawyer was polite."[35] While it is possible that clients were dissatisfied because their lawyers were not zealous advocates, it is also possible that the lawyers failed as counselors—failed to clearly but empathically guide their clients through difficult times.

Another survey,[36] which looked at the reasons clients change lawyers, found that 71% do so because of the bad service they felt the first law firm delivered. Bad service was seen as being a lack of reliability (30%), lack of responsiveness (25%), lack of assurance (20%), and lack of empathy (18%).

These survey results suggest that there may well be problems in attorney-client communications similar to those found in doctor-patient counseling. It would be useful to have more extensive and more representative surveys of clients in order to better understand the nature of the problems as clients experience them.

### *B. Conversation Analysis*

Recent legal scholarship has begun to consider attorney behavior by analyzing the attorney-client conversation.[37] Often the initial conference (an interview and initial counseling) is studied. Perhaps the most extensive study has followed the progress of various divorce

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33 *When You Need a Lawyer*, CONSUMER REPORTS, February, 1996, at 35. While 75% of clients with nonadversarial matters (estate planning, tax planning) were "highly satisfied" with their lawyers, only 50% of clients involved in litigation were satisfied. *See also* Peter Joy, *Clients are Consumers, Too*, 82 A.B.A. J. 120 (April, 1996).

34 *Id.*

35 *Id.* at 37.

36 *See* Ronald M. Martin, *Total Utility Management: The Empowered Law Firm* 20 ABA: LAW PRACTICE MANAGEMENT 34, 40 (October, 1994).

37 Analytical approaches range from narrative accounts by lawyers to ethnomethodology to quantitative as well as qualitative sociolinguistic studies of discourse. For further description of these approaches, see Clark D. Cunningham, *The Lawyer as Translator, Representation as Text: Towards an Ethnography of Legal Discourse*, 77 CORNELL L. REV. 1298, 1300, 1345, 1349 nn.5-12, 111-60 (1992).

cases from one attorney-client conference to the next.[38] These studies have tended to focus upon (and criticize) the control exercised by the attorney during the conversation and throughout the representation.

During the initial conference, attorneys often control the definition of the problem.[39] This control can begin with the lawyer's focused questioning in the interview.[40] Then, the lawyer controls the case's progress by briefly summarizing "what can happen . . . and what the lawyer intends to do about it. This explanation is usually very brief and rarely includes any inquiry into what the client wants the lawyer to do."[41]

Control over solutions is not always seen as seriously problematic. For example, attorneys offering one or another bankruptcy solution were considered to "render proficient technical service. . . . Each lawyer was forthright about assessments of the clients' situations and about potential solutions."[42] These forthright bankruptcy lawyers were also considered "courteous."[43]

Perhaps the most extreme examples of client control and manipulation may be found in criminal cases. Extensive interviews with defense attorneys, prosecutors and judges in ten cities led one researcher to conclude that many criminal defenders approach their job as one of cajoling or manipulating their clients to plead guilty.[44] This begins with "harsh techniques to secure a confession." If the client does not admit guilt, the attorney will recite the evidence and, no matter how weak, announce that "no jury. . . would fail to convict on evidence of

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[38] *See* Austin Sarat & William Felstiner, *Law and Strategy in the Divorce Lawyer's Office*, 20 LAW & SOC'Y REV. 93 (1986) and AUSTIN SARAT & WILLIAM FELSTINER, DIVORCE LAWYERS AND THEIR CLIENTS (1995)(reporting results of study).

[39] Bryna Bogoch & Brenda Danet, *Challenge and Control in Lawyer-Client Interaction: A Case Study in an Israeli Legal Aid Office*, 4 TEXT 249, 249 (1984) ("[T]he lawyer used language to control the client's presentation of the case, and to define it in terms of convenience to the organization rather than the expressed wishes of the client."). *See also* Gary Neustadter, *When Lawyer and Client Meet: Observations Of Interviewing and Counseling Behavior In the Consumer Bankruptcy Law Office*, 35 BUFF. L. REV. 177, 230-31 (1986). Most lawyers offered one product or another (chapter 7 bankruptcies or chapter 13 plans) and clients came to the lawyer with the "product" already in mind.

[40] "The lawyer uses this repeated question form [without allowing for a reply]. . . . [Another] kind of trick question [unfounded presuppositions presented as given information . . . the well-known cross-examination technique] is used on several occasions." Bogoch & Danet, *supra* note 39, at 267.

[41] Carl J. Hosticka, *We Don't Care About What Happened, We Only Care About What is Going to Happen: Lawyer-Client Negotiations of Reality*, 26 SOC. PROBS. 598, 604 (1979). The legal aid lawyer's brief explanation about what would happen occurred during the final phase of the interview.

[42] Neustadter, *supra* note 39, at 229-30.

[43] *Id.*

[44] Albert W. Alschuler, *The Defense Attorney's Role in Plea Bargaining*, 84 YALE L.J. 1179 (1975).

this sort."[45] These "cop-out lawyers" may "go beyond misadvice and emotional cajolery. On occasion, they 'con' their clients by offering them misinformation"—claiming a routine bargain as a major concession or inflating the predicted sentence following trial or reporting threats from the prosecutor which have not been made.[46]

While such attorney control is clearly unethical, even ethically permissible strategic decisions have been criticized as inappropriately silencing the client's voice.[47] In one case a prisoner rejected appointed representation:

> He did not want us to assert *our* theory of 'the case' precisely because that theory was not *his* case.[48]

In another case, the dismissal of criminal charges was unappreciated by the client who was "upset" with the judge's patronizing attitude and with his experience of having "placed part of his life in the control of someone" else. He criticized the lawyer (who was supervising law students in the case) as follows:

> You're the kind of person who usually does the most harm. You . . . assume you know the answer. You presume you know the needs and the answers. Oversensitivity. Patronizing. All the power is vested in you. I think you may go too far, assuming that you would know the answer.[49]

Yet another commentator's account of a plea bargain illustrates how difficult it can be to tell when a client is making an autonomous decision.[50] "[I]n practice we often cannot make such distinctions [between] . . . a judgment that a client's choice is autonomous from a judgment that a choice is in the client's best interests."[51]

Perhaps the most extensive study of attorney-client discourse was conducted by Austin Sarat and William Felstiner. They studied 40 di-

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[45] *Id.* at 1191-92.

[46] *Id.* at 1194-95.

[47] Clark D. Cunningham, *Tale of Two Clients: Thinking about Law as Language*, 87 MICH. L. REV. 2459, 2467 (1989) (Attorney filed brief arguing lack of notice for hearing in prison discipline case, but client ultimately rejected representation because he wanted to make a "more systematic attack on the legitimacy of the prison's entire disciplinary system.").

[48] *Id.*

[49] Cunningham, *supra* note 37, at 1330.

[50] William H. Simon, *Lawyer Advice and Client Autonomy: Mrs. Jones's Case*, 50 MD. L. REV. 213 (1991). The author explores client autonomy by recounting his representation of a criminal defendant who had probably been wrongly charged with a misdemeanor due to racial discrimination. The defendant agreed to go to trial after the author advised that, with the proffered plea bargain, "there probably wouldn't be any bad practical consequences, but it wouldn't be total justice." *Id.* at 215. The author's experienced co-counsel then counseled the client, addressing the disadvantages of trial last, and without mentioning "justice." After that, the client agreed to the plea bargain. *Id.* at 216.

[51] *Id.* at 213.

vorce cases over a 33-month period, audiotaping all attorney-client conferences, whenever possible from initial interview through final decree.[52] They describe "the most common pattern that we observed, namely an exchange in which the lawyer persuades a somewhat reluctant client to try to reach a negotiated settlement."[53] This is done by presenting a "cynical" yet (to the lawyers) "realistic" picture of the legal process:

> In total the lawyer's description of the legal process involves an open acknowledgment of human frailties, contradictions between appearance and reality, carelessness, incoherence, accident and built-in limitations. . . .
>
> To get clients in divorce cases to move toward accepting settlement as well as to carry out the terms of such agreements, lawyers may have to try to cool them out when they are at least partially inclined toward contest. In divorce as in criminal cases, the lawyer must help redefine the client's orientation toward the legal process.[54]

A second aspect of attorney-client discourse in divorce cases was that lawyers tried to control the conversation's scope to keep it within the legally significant realm:

> Clients often seek to expand the conversation agenda to encompass a broader picture of their lives, experiences, and needs. In so doing, they contest the ideology of separate spheres that lawyers seek to maintain. Lawyers, on the other hand, passively resist such expansion . . . . They are interested in only those portions of the client's life that have tactical significance for the prospective terms of the divorce settlement or the conduct of the case. . . . [T]he lawyers that we studied did not take a broad perspective on their professional mission. They did not act as 'counselors for the situation' nor did they try to provide psychological, emotional, or moral support or guidance for their clients.[55]

While the lawyers refused to enter the clients' broader social world,

> they take an expansive, tutorial posture toward the world of law, constantly demonstrating that in that world they are on familiar terrain and can operate with flexibility, originality, and power. . . . They use this knowledge strategically to move the clients toward positions they deem to be reasonable and appropriate.[56]

Although the social science studies of attorney-client communications are not extensive, they do suggest a common theme of excessive control rather than candid communication. At their worst, lawyers are

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[52] Sarat & Felstiner, *supra* note 38.
[53] *Id.* at 96.
[54] *Id.* at 108, 116.
[55] SARAT & FELSTINER, *supra* note 38, at 144 (citations omitted).
[56] *Id.* at 145.

seen as manipulating the client to do what the lawyer "knows" is "best" for the client. At their best, lawyers are seen to struggle with "learning to understand and communicate with a stranger" over whom the lawyer "inescapably exercises power."[57]

### *C. Fictional Portrayals*

The image of the controlling (albeit often well-meaning) attorney is also presented in the cinema. (Of course the behavior of celluloid lawyers serves, first and foremost, the movie's plot and theme. Yet fictional portrayals are successful to the extent they seem realistic to the audience. And even such fictions inform future lawyers and clients by suggesting, to some extent, that the behavior presented is acceptable.) Three movies present attorney-client counseling which closely resembles that described in the social science literature: the curt controlling interviewer, the criminal defense attorney "cop out," and the domestic relations practitioner manipulating his client to be "reasonable."

#### *1. The Interview by Cross-Examination*

The Bogoch and Danet study of a legal aid interview suggests that attorneys may both control and demean the client during an interview. The lawyer (who ultimately becomes plaintiff's counsel) in *Philadelphia* presents that style of interviewing a client by cross-examining him. At the conclusion of an interview with a potential "slip-and-fall" client, the attorney summarizes the client's theory of the case in the most confrontational way possible:

Attorney: All right. Look I want you to explain it to me like I'm a 6-year-old, OK? The entire street is clear, except for one small area under construction—this huge hole that is clearly marked and blocked off.

Client: Yes.

Attorney: You decide you must cross the street at this spot, no other. You fall into the hole. Now you want to sue the city for negligence. Right?

Client: Yes. Do I have a case?

Attorney: Yes, yeah, of course you've got a case.

This attorney clearly thinks the plaintiff's case is a poor one but, except for posing cross-examination-like questions, declines to candidly tell the plaintiff so. He uses a similar approach in discussing the protagonist's desire to sue his former law firm for wrongful termination due to AIDS. After this client explains how he was fired and his theory about the firm's motivation, the lawyer attacks the

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[57] Simon, *supra* note 50, at 225.

client before he comments upon the case:

Attorney: So you were concealing your illness?

Client: That's correct.

Attorney: All right. Explain this to me like I'm a 2-year-old. OK? Because there's an element to this that I just cannot get through my thick head. Didn't you have an obligation to tell your employer you had this dreaded, deadly, infectious disease?

Client: That's not the point. From the day they hired me to the day I was fired I served my clients consistently, thoroughly with absolute excellence. If they hadn't fired me that's what I'd be doing today.

Attorney: And they don't want to fire you for having AIDS so in spite of your brilliance, they make you look incompetent, thus the mysterious lost file. Is that what you're trying to tell me?

Client: Correct. I was sabotaged.

Attorney: I don't buy it, counsel. I don't see a case.

Client: I have a case. If you don't want it for personal reasons . . .

Attorney: Thank you, that's correct. I don't.

Client: Well, thank you for your time, counsel.

Attorney: Mr. Beck, Uh. I'm sorry about what happened to you. It's a bitch, you know?

This personal injury attorney conducts interviews and counseling sessions as if they were adversary hearings. Initially he directly criticizes the client for failing to reveal his condition. When the client (also an attorney) argues that such criticism is not relevant, the lawyer switches to the technique used with the slip-and-fall client, restating the client's case as a cross-examining lawyer might do. The client confirms that theory of the case. Then the lawyer bluntly states that he doesn't believe the scenario and doesn't believe there is a case. The client disagrees with this conclusion and suggests that the lawyer really doesn't want to take the case for "personal reasons" (presumably discriminatory animus against AIDS patients). The lawyer readily agrees (suggesting that his initial opinion was not his true opinion, but an excuse to reject the case). Once the lawyer's true feelings about the client's case have been uncovered, the lawyer is able to attempt a genuine and empathic statement.

This lawyer-counselor reveals his negative opinion of a case only by playing adversary questioner, and otherwise may hide it. His ability to empathize with the client appears to depend upon the client seeing through the lawyer and in this way establishing a relationship of equals.

*2. The Criminal Defense Attorney*

Lt. Caffrey in *A Few Good Men* also manages to combine a blunt, insensitive approach with leaving his clients unclear about their situation. (In this popular courtroom drama, Marines were ordered to "discipline" a disloyal inferior and the younger Marine accidentally died. Two enlisted men are prosecuted for murder and in their defense the attorneys manage to prove the improper orders came from the highest commander.)

There are three separate interview-counseling sessions. During the first (interviewing) session, the lead defense attorney, Lt. Caffrey, asks his clients about the incident. In the course of the interview Corporal Dawson and Private Downey mention their "Code," and the lawyer asks what it is—"Unit, Corps, God, Country." At this point, Lt. Caffrey, much like a "cop-out" defense attorney, tells his clients how bleak their defense is while simultaneously insulting them:

Lawyer: The government of the United States wants to charge you two with murder. And you want me to go to the prosecution with "Unit, Corps, God, Country"?

The clients quite accurately respond by pointing out that, in defining their code, they were simply answering the lawyer's question. The lawyers shrug, dismissing the clients with: "It's their code! We'll be back."

As the case progresses with investigation and negotiation, the prosecution becomes worried about the misdeeds of the commander being brought to light. As a result they offer to reduce the charges to involuntary manslaughter and recommend a sentence of two years which will result in six months of incarceration. Quite pleased, Lt. Caffrey informs his clients of this offer. But they fail to appreciate the quite excellent deal their lawyer has, with difficulty, negotiated. They respond with silence, and then state that they cannot accept a deal when they did nothing wrong — when they simply followed orders. Lt. Caffrey responds with emotion:

Lawyer: Zippedy do dah! You and your Code plead not guilty and you'll be in jail for the rest of your life. Do what I'm telling you and you'll be home in six months!

But the clients, quite accurately, raise other consequences of the guilty plea—they will be dishonorably discharged from the Marines. And being in the Marines is the most important thing in their lives. Caffrey totally fails to focus on their primary concern — continuing with their careers in the Marines.

Instead, Lt. Caffrey attempts to privately convince Corporal Dawson, the leader of the two defendants, to agree to the plea in order to protect the private from a life in prison. And Dawson

responds by asking the lawyer whether he "thinks what we did was right." Again, Lt. Caffrey refuses to discuss what his client wishes to consider. He announces that his personal belief about the morality of his clients' actions is irrelevant, saying: "It doesn't matter" and "I think you'd lose." Failing to get an honest reply, Corporal Dawson calls Lt. Caffrey a coward. And again, Caffrey responds emotionally:

Lawyer: I'm not going to feel responsible for this Harold. I did everything I could. You're going to Leavenworth for the better part of your life. And you know what—I don't give a shit.

Ultimately at trial the defense team brilliantly proves that the commander was responsible for the improper discipline that lead to the Marine's death, and the defendants are acquitted of murder. However they are necessarily convicted of "conduct unbecoming" (since following illegal orders is such improper conduct) and dishonorably discharged from the Marines. The private stands dumbfounded, protesting the outcome with increasing emotion and pain:

Private: What did that mean? Hal! What did that mean? I don't understand. Colonel Jessup said he ordered the Code Red.

Lawyer: I know.

Private: Colonel Jessup said he ordered the Code Red! What did we do wrong? What did we do wrong? We did nothing wrong!

Corporal: We were supposed to fight for people who couldn't fight for themselves. We were supposed to fight for Willie.

Thus, one client has learned that the Marines' Code was immoral (an opinion his lawyer had refused to share with him), and the commander is brought down. But these two clients have been poorly counseled by their attorneys.

The attorneys refused to candidly communicate significant "bad news" about the case. These very dependent clients were never told that the one thing they wanted most—to continue their careers in the Marines—was going to be impossible. When one client explained the importance of their life in the Marines, the lawyer did not follow the client's concerns. Indeed, the only thing the lawyers said to the clients about their commitment to the Marines were derogatory comments about the Marine "Code." Instead, the lawyer focused upon avoiding a lengthy prison sentence—something he could accomplish. This doable goal was his focus, even to over-stating the likelihood of their conviction and sentence.

In failing to discuss the clients' concerns (their honor and career in the Marines), these lawyers were much like the Sarat and Felstiner attorneys who refused to discuss the broader social situation of their divorcing clients. In overstating the risk of conviction and prison, they resembled the "cop out" defense counsel who cajole their clients to

plead guilty for their own good. Sadly, this popular film portrays these lawyers as excellent courtroom advocates while leaving their insensitivity as counselors unaddressed.

### 3. *The Divorce Attorney*

The crusty lawyer in *Kramer v. Kramer* exhibits some of the same tendencies as Sarat and Felstiner's divorce attorneys. He tries to keep conversations in the realm of legally relevant topics (where he is knowledgeable) and he counsels his client to go along with rational plans.

During the initial interview with the abandoned single father seeking custody of his young son, the lawyer, much like the Sarat and Felstiner lawyers, asserts his inside knowledge and warns of the unpredictability of the law:

Attorney: Well, uh, first Mr. Kramer there is no such thing as an open and shut case where custody is involved. While I'm willing to bet your ex-wife has already found a lawyer and he has advised her to move back to New York to establish residency. The burden is on us to prove your ex-wife is an unfit mother. And that means that I'll have to play rough. And if I play rough you can bet they will too. Can you, uh, take that Mr. Kramer?

Client: Yes. . . . .

Attorney: Now, how old is the child again?

Client: My son is 7.

Attorney: Uh, huh.

Client: Why?

Attorney: That's tough. Well, in most cases involving a child that young the court tends to side with the mother

Client: But she signed over custody!

Attorney: I'm not saying we don't have a shot. But it won't be easy. . . .

From opining as to the likely maneuvers of the other side to announcing how tough the case will be (without knowing any facts other than the child's age) this attorney (much like the Sarat and Felstiner attorneys) demonstrates his insider knowledge while discouraging the client from expecting too much. The language used to convey "bad news" (they will "play rough" and winning "won't be easy") is neither precise nor informative. This is not a candid conversation about difficulties in the client's case; it is a subtle "cooling out" of a client who may expect too much.

The lawyer, Shaughnessey, has two telephone counseling sessions with the client in which he does give Mr. Kramer definitive "bad news" legal opinions and directives, but without ever exploring Mr. Kramer's perspective. The first conversation concerns Mrs. Kramer's request to visit with the child:

Attorney: Ted, John Shaughnessey here. I just got a call from your wife's lawyer. She wants to see the kid.
Client: She wants what?
Attorney: Huh, she's the mother. That means she's within her legal rights.
Client: How do I know she's not going to kidnap him?
Attorney: Look, uh, Ted, I don't honestly think she'd go to the trouble of suing for custody of the child if she was going to kidnap him.
Client: Alright just wait a minute now. I'm not so sure about her mental health.
Attorney: What do you mean by that?
Client: She told me she was seeing a a shrink—a psychiatrist or something.
Attorney: Well, did you ever see her talk to the walls?
Client: No, but I'm just saying, you know
Attorney: And I'm just saying that you don't have a choice. Have Billy at the boat pond in Central Park Saturday at ten o'clock.
Client: I have to?
Attorney: Yes.
Client: Thank you very much.

Here the lawyer investigates the client's concerns about kidnapping and mental illness only superficially, apparently having concluded these issues were not realistic concerns but products of the client's emotional state. He decided (much as Sarat's and Felstiner's attorneys seem to) that it was not productive to explore the client's concerns on these issues. Rather, his job was to force his more reasonable opinion on his client.

The second conversation demonstrates three different errors in "bad news" counseling:

Lawyer: Well, they've set the court date. I just heard today; it's January 9th.
Client: OK. Look, I gotta tell you something; I got fired today. They laid me off.
Lawyer: [silence]
Client: Hello?
Lawyer: Yeah, I'm still here. Ted, I won't lie to you. We don't have a hope in hell of winning a custody hearing if you're out of work.
Client: Yeah, yeah, listen. You tell that, you tell that party and you tell that party's attorney that I want a delay in the court date.
Lawyer: I'm sorry Ted. It's really too late.
Client: Fine. I'll have a job in 24 hours.
Lawyer: How the hell are you going to do that?
Client: I'll have a job in 24 hours! [end of conversation]

The lawyer's first mistake was counseling about bad news prior to fully interviewing the client. While the risk of kidnapping or mentally

deranged behavior turned out to be unrealistic concerns of the client (arguably justifying Mr. Shaughnessey in giving them short shrift), here the reason for the client's unemployment was legally significant. However, when the client raised the problem of having lost his job, the lawyer immediately analyzed what that raw fact meant for the typical case ("no hope in hell of winning") and candidly and bluntly so informed the client. Not only did Mr. Shaughnessey fail to show any empathy (not even a "too bad"), but he incompetently failed to discover the entire story so he could assess just what Mr. Kramer's losing his job actually meant for the custody case. As the viewers know, Mr. Kramer had been terminated for taking too much time away from work in order to care for his son—personal pick-ups and drop-offs at school, attending birthday parties, etc. Had the lawyer learned this, he might have seen how this sacrifice could demonstrate Mr. Kramer's devotion to parenting and formed a different assessment of the impact Mr. Kramer's unemployment would have on the case. Instead, the lawyer bluntly and insensitively conveyed this "bad news" prediction.

This motivated the client to ask for a continuance. Again, rather than discussing the pros and cons of asking for a continuance, the lawyer candidly, bluntly and definitively tells the client about this second impossibility. The twice-rejected client responds by promising to have the winning facts (a job) in 24 hours. And the most "can't-do" lawyer in movies offers no encouragement, but another prediction of impossibility—that the client won't be able to find a job.

Mr. Shaughnessey is constantly attempting to have his client view the case "realistically" and to rely upon his own expertise to do so. Although his insensitivity is perhaps extreme, his avoidance of open discussions of his client's problems and his focus on counseling the client to be "realistic" seem, unfortunately, very consistent with the Sarat and Felstiner divorce attorneys' tendencies.

### *D. Similarities of Medical and Legal Challenges in Telling "Bad News"*

This varied evidence about attorney-client counseling suggests that attorneys, like doctors, should improve their abilities to convey "bad news." The medical literature suggests three problematic approaches to delivering bad news which appear to arise in legal counseling as well. First, a doctor or attorney may not tell the client the "bad news" or may tell the client in a way which prevents the client from fully understanding.[58] The doctor would treat the condition and

[58] As doctors previously would often not tell a cancer patient the diagnosis. *See* West &

the lawyer would manipulate the client to agree to what was in the client's best interests, but without the patient or client truly understanding the situation. The Marines never understood that an end to their careers in the Marines was inevitable, because the lawyers never told them this. Secondly, a doctor or lawyer may employ "a blunt and insensitive manner,"[59] as Mr. Shaughnessey often did. This conveys the negative opinion, but then shuts down communication. The client is not permitted to ask questions; questions only seem to challenge the accuracy of the lawyer's firm opinion. Third, a lawyer might, like a doctor, take an approach of expressing sadness but without any positive support.[60] Although this might not silence the client's questions, it discourages the client's desire to jointly explore the situation with the lawyer. Both Lt. Caffrey's refusal to explore moral questions and the Sarat-Felstiner lawyers' refusal to explore fault and morality in their clients' divorces exemplify this approach of sadness without empathy. The attorney focuses on getting the client to accept good legal advice, rather than helping the client come to terms with an emotionally difficult situation.

Lawyers do err in attempting to control too much. The exhortations of various critics that lawyers must have greater respect for client autonomy are valid critiques. However, a lawyer's ability to let go of control and allow clients to direct their own cases depends upon lawyers learning better ways to process "bad news" with their clients.

## III. Models For Delivering "Bad News"

### *A. Medical Counseling*

A British author has characterized three approaches to "bad news" counseling in medicine. These are: 1) a blunt and insensitive manner, accepting that the patients will be upset no matter what, 2) a kind and sad approach, but without any positive support, encouragement or optimism, and the preferred 3) "an understanding and positive [discussion] with lots of flexibility, reassurance and empathy."[61]

Psychologists who have comprehensively reviewed the medical literature on delivering bad news set forth various conclusions about effective counseling.[62] Bad news counseling should be done in person

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Frankel, *supra* note 5.

[59] Thurston Brewin, *Three Ways of Giving Bad News,* 337 Lancet 1207 (1991).

[60] *Id.*

[61] *Id.*

[62] Ptacek & Eberhardt, *supra* note 23. They point out that most of the literature is not empirical, but based upon the experience and conclusions of the medical professionals alone. Nevertheless, both the patient studies and doctors' accounts agree about certain things which should guide counseling patients about difficult situations.

in a comfortable, private and quiet location with family members present. The actual news should be delivered in a thoughtful, caring and sensitive way, showing respect and empathy. Doctors should use simple language without euphemism or jargon. The pace of the conversation must be comfortable for the patients, in order for them to have a sense of control in coping with the news. Patients (and their families) must have enough time to express emotion and ask questions.

Ptacek and Eberhardt also set forth a step-by-step protocol for the conversation. The doctor should begin with a "warning shot" ("I have some serious news to discuss with you") in order to prepare the patient and reduce the element of shock. During the process the doctor must explore what the patient knows of the condition or diagnosis. This will allow the doctor to tailor the amount and specificity of information that the patient may require. The doctor should also explore how the patient feels about the situation. The perception of news as "bad" is a subjective one, highly dependent upon the individual patient's life experiences and attitudes. The doctor should take care not to "inadvertently pressure patients to respond in a certain way . . . without the patients' being able to decide for themselves if the news is bad."[63] Although the physician should not be less than truthful, he should always convey some hope.

> [I]n all but terminal illnesses, some measure of hope can be truthfully conveyed . . . [and] facilitate active coping with the situation. In the case of imminent death . . . hope may entail information about the physician's ability to control symptoms and minimize discomfort.[64]

Once the "bad news" has been conveyed, patients have various and sometimes unpredictable reactions. The doctor must allow the patient to express emotions and fears and should explore these reactions. Listening to patients' reactions will not only help them feel supported, but will allow the doctor to assess what other supportive services they may need. Finally, because many patients do not process all that is said after the initial shock of the bad news, it is important for the doctor to deal with this. This should involve probing for understanding as well as answering questions and then summarizing the situation at the conclusion of the meeting. The doctor may often wish to leave the patient with explanatory literature to review later or to provide for a follow-up meeting.

Doctor and Medical Professor Robert Buckman has provided a six-step protocol to deliver bad news in his recent book, How to

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[63] *Id.* at 497.

[64] *Id.* at 498.

BREAK BAD NEWS: A GUIDE FOR HEALTH CARE PROFESSIONALS.[65] The first step is "getting the physical context right" including a private, in-person setting with only desired relatives present, followed by an open inquiry into how the patient is feeling. This would allow the doctor to postpone the conversation if the patient is feeling particularly ill. Just as importantly, it signals the patient that the conversation will be two-way and allows the doctor to assess the patient's initial knowledge and concerns.

The next step is to "obtain from the patient an impression of what he or she already knows,"[66] noting the patient's impression and how close to reality it is, the patient's level of understanding and articulation of the problem, and the patient's emotional state. It is suggested the doctor begin with questions such as: "What have you made of this illness so far?" or "What did Doctor X tell you when he sent you here?"

Third, the doctor should find out how much and at what level the patient wants to understand her medical condition. The majority of patients wish to be fully informed, but this inquiry will insure that those who do not can exercise that preference. A clear understanding on this point eliminates the doctor's uncertainty that she may be overwhelming the patient with too much information.

Provided the patient wishes to be fully informed,[67] the doctor begins the "information sharing" stage. "[T]he interview in which bad news is discussed is an asymmetric one: you have information to impart that the patient does not (yet) possess. However, the patient's responses are in some respects the most crucial part of the interview."[68] For ease of analysis, however, the author deals separately with the "divulging of information" and the "therapeutic dialogue." The doctor's agenda must include informing the patient about 1) the diagnosis, 2) the treatment plan, and 3) the prognosis as well as 4) giving support.

The doctor should begin by "aligning" with the patient by reinforcing the portions of what the patient has said that are correct. This demonstrates to the patient that his views have been heard and taken seriously. The next phase is "educating" to bring the patient's understanding of the situation more in line with the medical facts. If the patient has underestimated the seriousness of the situation, the doctor

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65 BUCKMAN, *supra* note 21, at 65.

66 *Id.* at 71.

67 *Id.* at 79 ("If the patient has said that he or she does not want to know the details of the illness, we can discuss the treatment plan and the way in which the patient will be looked after. . . .").

68 *Id.* at 79.

should begin with a "warning shot," such as "Well, the situation does appear to be more serious than that. . . ."[69] Next the doctor should "give a narrative of events . . . to help the patient understand what has been happening."[70] Information should be given in small chunks, using English rather than medical jargon, and with frequent checking to see if the patient is following. ("Am I making sense?") The doctor must clarify and reinforce information by repeating important points and asking the patient to review what he has understood. The doctor will often want to use diagrams and written materials.

At the same time, the doctor must be listening for the patient's concerns and agendas. The patient's worries are often quite different from the doctor's and should be acknowledged. There may be buried worries that do not easily emerge. As the patient's concerns are raised, the doctor should attempt to blend them into the informing process. While the doctor has an agenda of information the patient should know, this agenda should be altered to include information which will address the patient's concerns.[71]

"The success or failure of the breaking-bad-news interview ultimately depends on how the patient reacts and how . . . [the doctor] respond[s] to those reactions and feelings."[72] There is a wide range of possible reactions, but common emotions and behaviors include disbelief, shock, denial, displacement, fear and anxiety, anger and blame, guilt, hope, despair and depression, over-dependency, crying, questioning "why me," threats, humor, bargaining and awkward questions. The doctor must assess the patient's reaction and consider whether it is adaptive and potentially helpful to the patient, or maladaptive and part of the problem.[73] If the reaction is unhelpful, the doctor most determine whether the reaction can be corrected and the patient thus helped to cope.

Initial reactions often include shock, disbelief and denial. A patient manifesting shock may be unable to speak, process information, or make decisions. The doctor's immediate response may be attentive silence, an open question about what the patient is thinking or feeling, or an empathic response that "this news must be overwhelming."[74]

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[69] *Id.* at 82.

[70] The suggested narrative describes the symptoms and the explanation: "When you had those bruises, your blood test showed that you weren't making some components in the blood called platelets. They're made in the bone marrow and that's why your doctor wanted a bone marrow test to see what was wrong. It was that test that showed the problem. . . ." *Id.* at 83.

[71] *Id.* at 87-89.

[72] *Id.* at 90.

[73] *Id.* at 102.

[74] *Id.* at 114-17.

Ultimately the patient in shock may need follow-up counseling sessions. If the patient expresses disbelief, he does not intend to provoke an argument about the accuracy of the diagnosis. It is best for the doctor to respond to the difficulty the patient is having in accepting the diagnosis ("It must be very hard to accept a serious illness when you feel so fit") rather than having an argument over the facts.[75] During the initial conversation, expressing disbelief and denial can be very similar. The patient may require more time to accept the bad news and be ready to cope with it. However, denial can continue and become dysfunctional, with the patient failing to take necessary action for her condition. In the case of prolonged denial, the patient will require careful negotiation.

A patient may respond to bad news by "displacement behavior"—becoming intensely focused on some activity or inquiry. Often patients undertake extensive research into their illness. Other patients may become invested in some professional endeavor or hobby. The question for the doctor is whether this displacement behavior is adaptive or not.[76] Research into the illness or keeping a diary about the illness can be either one, depending upon how they help the patient cope. Similarly, if a new activity does not prevent the patient from caring for the illness, it may be helpful displacement rather than unhealthy denial.

Fear is a normal response to bad news. However, more diffuse anxieties can be dysfunctional for the patient. "Perhaps the most important aspect of dealing with a patient's fear or anxiety is finding out what specifically the feeling is caused by. Then one can attempt to provide the relevant aid, whether it is information [or] psychological support. . . ."[77] The doctor should not give premature assurance until he has listened to the patient explain what is worrying her. Then the doctor should empathically acknowledge the patient's feelings. Only then should the doctor provide whatever information might address the fear. If the intensity of the emotion is diminished, the counseling has been helpful. If there is prolonged anxiety or depression, the patient may need to be referred to a mental health professional.[78] The one thing to avoid, however, is over-reassurance. "Over-reassurance is the most dangerous option because it pushes . . . [the doctor] further away from the true situation . . . . [T]he more anxious the patient, the stronger . . . [the] desire to alleviate the distress and the greater . . .

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[75] *Id.* at 112-13.
[76] *Id.* at 123-29.
[77] *Id.* at 131.
[78] *Id.* at 131-35.

[the] temptation to over-reassure."[79] This same approach should be followed if the patient expresses despair:

> If the despair seems to be unwarranted by the medical facts, then . . . reinforce the facts. If, however, the possibilities are serious, then do not backtrack and change the medical facts when confronted by despair. . . . You should, even under pressure, stay as close to the reality (even if it includes uncertainty) as is possible, stressing that you will do whatever you can do and will not abandon the patient.[80]

Another problem may arise should the patient become overly dependent upon the physician. While dependence may be flattering, it is also "dangerous to the patient, to the patient's coping strategies, and to your relationship."[81] The doctor should first try to separate the patient's demands from the patient's needs, to agree to do only what the doctor is truly able to promise, and to gently decline to meet every demand in order to buy peace. With respect to those things the doctor will not do, the doctor should reinforce a contractual relationship that requires the patient to do those things within her control and thus increases the patient's sense of self-reliance.[82]

A patient may cry, which is not an emotion but a symptom of one of various emotions from fear to anger to despair. However, it is very difficult for a stranger to know which emotion caused the tears. The doctor should respond to crying very simply, by moving closer, offering a tissue, and possibly touching the patient. If the cause of the emotion is obvious, empathize with the patient's feelings. If not, ask whether the patient can tell what she is feeling.

A patient may also express anger or blame, or make threats. It is useful for the doctor to understand the anger that the patient may experience: abstract anger (against the disease, loss of control, loss of potential, laws of nature), focused anger (against self, friends, medical professionals, outside forces, God) or fear masked as anger. The doctor must avoid being provoked into an angry response but remain calm and deal with the patient's feelings through questions or empathetic responses.[83] If the patient makes a threat, the doctor should calmly acknowledge it and ask the patient to suspend the threat. ("I do realize that you might want to find another doctor, and of course you are quite entitled to do that. But I find it's very difficult to talk about the situation while you are threatening to stop

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[79] *Id.* at 136-37.
[80] *Id.* 146.
[81] *Id.* at 149.
[82] *Id.* at 150-51.
[83] *Id.* at 137-42.

treatment. . . ."[84])

In an emotional counseling session, there may well develop conflicts between the patient and doctor. Although the doctor is the professional, "he or she is not neutral, but is emotionally involved . . .," which can cloud judgment.[85] Accordingly, it is best for the doctor to step back and consider his own feelings. Then, rather than displaying his feelings (e.g., "I've already told you four times . . . "), the doctor should describe his own emotion ("I'm sorry if I sound impatient, but. . . .") This may allow the conflict to be resolved. Or it may be necessary to define the area of disagreement and leave it at that. Here again, it is crucial to avoid reacting to the emotion of the conflict, but to stay as close to the facts and professional judgment as possible.[86]

Finally, however, listening and responding to the patient's feelings is not the end of the counseling session. The patient may feel bewildered or depressed. The patient is looking to the doctor "to make sense of any confusion and offer plans for the future."[87] "It is at this stage in the interview . . . that [the doctor] should offer the clinical perspective and guidance, demonstrating that [he is] on the patient's side."[88] The doctor should demonstrate he understands the problem from the patient's perspective, indicate what concerns he will address, and propose a plan for the future. The plan may have contingencies and choices, planning for the worst while hoping for the best. The doctor should also identify the patient's coping strategies and reinforce them. This may include available social services or the support of friends and neighbors. The doctor should summarize the main points, invite any final questions, and make a contract for the future.[89]

Both of these models for medical counseling and the studies of "bad news" medical counseling suggest certain basic principles to follow: *1) Be prepared.* The counselor should be able to provide the necessary information and answer the patient's questions. *2) Be self-aware.* The counselor must be aware of her own feelings and reactions to the situation, and must not assume that the patient has the same reactions. The counselor must not allow his personal feelings to interfere with the counseling responsibilities. *3) Conduct the counseling session in person, in private, and with sufficient time.* The setting should be supportive and should help the patient feel free to ask questions and express emotion. *4) Be direct, clear and candid in giving in-*

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[84] *Id.* at 155-58.
[85] *Id.* at 107.
[86] *Id.* at 107-10.
[87] *Id.* at 90.
[88] *Id.* at 90-91.
[89] *Id.* at 94-96.

*formation*. The counselor must control what information is conveyed to insure that the patient understands the situation fully. This information sharing should become a dialogue guided by the patient's level of understanding and reactions. *5) Convey empathy and caring.* The counselor should demonstrate caring and concern for the "whole person" and should communicate hope. The counselor should not appear detached but may express genuine emotion for the patient. *6) Attend and respond to the patient's level of knowledge.* The information must be tailored in light of what the patient already knows and understands. The counselor should listen carefully to the patient's questions and provide information the patient appears to need, including possible references to other sources of information. *7) Attend and respond to the patient's emotional reactions.* The counselor should be prepared for a wide range of emotional reactions and respond supportively, not defensively, to them. *8) Conclude with a proposed plan which takes into account the patient's personal perspective.* The counselor should offer the patient guidance and hope. Having listened to the patient's questions and emotional reactions, the counselor should demonstrate an understanding of the patient's concerns and goals in proposing the plan.

### *B. A Model for Legal Counseling About "Bad News"*

"Bad news" counseling in the legal arena should, as in the world of medicine, involve an understanding and positive discussion with "flexibility, reassurance and empathy."[90] While certain particulars of the medical model for bad news counseling must be altered for this distinct context, the basic principles outlined above should guide a "bad news" legal counseling session.

*1) Be Prepared.* Because clients will usually desire (and may need) a good deal of information,[91] the lawyer should avoid communicating "bad news" until she is prepared to fully explain the situation. In most instances, this may mean delaying the "bad news" counseling until after the interview and providing it during a follow-up counseling session. Even when the lawyer may know early in an interview that a client's goal cannot be achieved, it will be wise to delay that discussion. Time will allow the lawyer not only to prepare a comprehensive explanation, but to engage in creative problem-solving. The lawyer will be able to consider whether there may be alternatives to achieving the most important aspects of the client's goals.

If, during the interview, the lawyer hears a client insist upon an

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90 *Id.*

91 *See* Sharp et al., *supra* note 24; Strauss et al., *supra* note 25; Krahn et al., *supra* note 26; Garwick et al., *supra* note 28.

outcome that seems highly unlikely, the lawyer should decline to tell the client how hopeless the case is. Instead, the lawyer should empathize with the underlying feeling and encourage the client to explore what the most important aspects of a solution might be. For example, imagine a client whose spouse has left, telling the client he wants a divorce and intends to marry "the other woman":

Client: There is no way I'll let him have a divorce. Let them live in sin, but there is no way I'm agreeing to a divorce.

Lawyer: Well, since the "no fault" statute there really isn't anything you can do to prevent him from getting a divorce. If he files for divorce, he'll get one. Of course we can try to hit him up for alimony and the house, so he won't enjoy his freedom.

While the lawyer may be correct in this legal advice, providing this information to the client at this time is not necessary. The lawyer would be better advised to empathize and explore the rationale of the client's underlying goal of remaining married:

Lawyer: I can tell you are quite angry at him and don't want to just agree to his demands. Could you tell me some more about what's gone on to get to this point? Have there been problems for some time? What if any counseling have you or he had?

Alternatively, the lawyer might discuss the client's immediate needs and offer her choices about short-term goals:

Lawyer: I can see you are quite angry with him at this point. Can you tell me what's going on with the children and the bills, and what you'd like to see done in the immediate future to help you and your kids have some stability?

*2) Be Self-Aware.* Ironically, being overly prompt with bad news may come from the laudable goals of providing the client with information (e.g., no consent is required for a no-fault divorce) and performing effective service (e.g., obtaining alimony). Yet the client who is still in denial about the separation and divorce is not emotionally ready to consider this information or to make such a decision. The attorney must help her process the "bad news" that her marriage is over before they can consider various realistic options.[92]

Sarat and Feltinser criticize their domestic relations lawyers for just such a "tutorial posture toward the world of law" and their "strategic" movement of clients "toward positions they deem to be reasonable and appropriate."[93] If these lawyers are to alter their counseling, it would be well if they understood why they feel the need to take such a posture and pursue such strategies. Similarly, Sarat and

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[92] There will be calmer moments to explain the "no fault" statute to this hurt and angry client. There is time to make considered choices about alimony and property.

[93] SARAT & FELSTINER, *supra* note 38, at 145.

Feltinser conclude that these lawyers "resist" clients' attempts to "expand the conversation agenda to encompass a broader picture of their lives, experiences, and needs."[94] In order to change such behavior, the lawyer must know how she reacts to clients in pain — whether she wants to rescue them or to "talk some sense into" them. Only by becoming self-aware will the lawyer be able to interact supportively with a client instead of reacting to a client in pain.

*3) Conduct the counseling session in person, in private, and with sufficient time.* Once it is clear that "bad news" must be conveyed and the lawyer is prepared to do so, the lawyer should arrange a personal[95] counseling session with ample time for the difficult conversation.[96]

*4) Be clear, direct and candid in giving information.* The lawyer should open with a "warning shot,"[97] control the conversation and get to the point promptly.[98]

While in other settings it may be best to reflect the client's prior statement of goals[99] in a counseling session involving serious and significant bad news, it may be dysfunctional to do so. As an illustration, although the criminal defendant facing a likely conviction may have enunciated his goal of "getting this #$%! case dismissed and suing the cops for harassment," reasserting this goal at the beginning of a counseling session would mislead rather than reassure the client. Instead, the lawyer should reframe the client's goals in a way which will be consistent with both the prior session and the counseling that is to come. ("I know you want to make informed decisions about this case and your situation.")

Similarly, the client should not be invited to select which option to discuss first[100] if this will make it either intellectually or emotionally more difficult to hear the bad news. Focusing on alternatives which have a slim chance of success can dysfunctionally allow the client to avoid facing a difficult reality. Similarly, the client may need to understand the most probable but worst case scenario before

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[94] *Id.* at 144.

[95] Although the presence of relatives or friends is thought crucial in medical counseling, it is not generally advisable in legal counseling where confidentiality is important.

[96] *See* Sharp et al., *supra* note 24; Straus et al., *supra* note 25; Ptacek & Eberhardt, *supra* note 23; BUCKMAN, *supra* note 21.

[97] While some patients have no inkling of a problem (e.g., new parents of a disabled newborn), most patients and most clients will have some knowledge of the problem but under-assess the risk of a negative outcome or the seriousness of the outcome. Hence shock should not be a significant problem for legal counseling as it is for some medical counseling.

[98] *See* Sharp et al., *supra* note 24; Straus et al., *supra* note 25; Ptacek & Eberhardt, *supra* note 23; BUCKMAN, *supra* note 21.

[99] BINDER, BERGMAN & PRICE, *supra* note 2, at 290 *et seq.*

[100] *Id.* at 296.

considering compromise. Until the client comprehends the likelihood of conviction and punishment, he may be unwilling and unable to have a useful discussion of a plea negotiation. Instead, it would be preferable for the lawyer to announce the topic on which information must be conveyed. ("We need to discuss the charges you are facing so you'll understand both what is likely and what is possible in this case.")

The lawyer, like the doctor, should continue by imparting the information[101] that he has and that the client should know.[102] While the doctor "educates" the patient by giving a "narrative of events . . . to . . . understand what has been happening," the lawyer will educate the client by explaining the legal standards and how they apply to the facts of the case and by describing what will likely happen next. Lawyers, like doctors, should avoid jargon, be candid and direct, and check to see if the client is following the explanation.[103]

It seems that many well-meaning attorneys may hurry through this discussion, giving the client a negative prediction but not showing the client why the facts and the law would bring about that outcome. The lawyer may feel more powerful and affirmed if the client simply accepts his prediction. It may even feel cruel to the lawyer to draw out all the "bad facts" that have led the lawyer to conclude that "any jury would convict." Clients may argue or may change the subject, seeking to avoid difficult news. But the lawyer must not allow the client to remain in a state of denial. Only after the lawyer has communicated all his reasons for his predictions will the client be as capable as the attorney to make informed decisions.

From Lt. Caffrey predicting imprisonment for life, to Mr. Shaunnessy insisting upon visitation, a job to win custody, and the impossibility of delay, to the *Philadelphia* lawyer "not buying" the employment discrimination scenario, none of the celluloid lawyers offer their clients any explanation of their most negative and certain opinions. Of course, this is certainly partially due to the nature of the drama. An extended counseling session would be boring! But the accounts of defense attorneys "copping out" their clients and of divorce attorneys forcefully asserting their inside knowledge of the system and emphasizing their skills as seers are entirely consistent

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101 While doctors are urged to discover how much the patient knows about the condition, that approach is probably most appropriate when the doctor and patient are meeting for the first time (e.g., patient meets the oncologist). Since most legal counseling will follow a full interview and sometimes additional investigation, it seems superfluous and contrary to the need to "get to the point" to probe the client's level of understanding before giving the client information about his case.

102 *See* text accompanying notes 67-68.

103 *See* text accompanying note 70.

with attorneys giving inadequate explanations of "why" a bad result is likely.

*5) Convey empathy and caring.* Of course, while divulging this information, the lawyer should show empathy for the client and take note of the client's concerns and agendas.[104] In fact, such empathy may be necessary to help the client take in the "bad news."

A counseling session with a tenant facing a certain eviction may include the following information exchange:

Lawyer: I need to explain the legal situation you face. Since your lease requires rent be paid on the first of the month, and you were unable to make that payment three weeks ago, under your lease, here in paragraph 15, your landlord is entitled to go to court and ask that the judge order you out of the apartment.

Client: But it is so unfair—I lost my job and couldn't possibly pay this month.

Lawyer: It certainly is unfortunate that you are facing an eviction on top of your job loss. And it certainly would be a decent thing for the landlord to give you a little while to get work and catch up on the rent. But I've talked to the landlord's lawyer and he says that unless you can come up with the rent by the end of the week, they want to go ahead with the eviction case.

Client: I've told you I have no cash, no job, no one to borrow from, and I'm behind on my utilities anyway. Why can't the judge understand that?

Lawyer: It seems like they're kicking you when you're down. But the judge is required to enforce the laws on the books. The statute says that if you are behind in your rent and don't immediately catch up, the landlord is entitled to his apartment back so he can rent it to someone else. And that is almost certainly what the judge will order, even if you explain your situation.

It is most important for the client to understand the legal standard and how it applies to his case. Linking the law with the facts allows the client to understand, and requires the client to rely less upon the lawyer's forcefulness or estimated risk (99%) of loss. Moreover, in those cases where the lawyer may have performed a perfunctory interview and misunderstood some crucial facts, this presentation will enable the client to correct the lawyer and the two to reach a better analysis.

*6) Attend and respond to the client's level of knowledge.*

*7) Attend and respond to the client's emotional reactions.* Once they hear "bad news," clients, like patients, will respond in a variety of ways. In fact, studies suggest that how much patients know about the condition or treatment influences their reaction and even whether

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[104] *See* text accompanying notes 71-72.

they consider the news to be "bad."[105] Accordingly, the lawyer should be calm and empathetic, but not signal an opinion that the legal situation is a dire one. For example, a career criminal may not see incarceration as so terrible, and a tenant who can move in with relatives may prefer moving out to keeping an apartment which she cannot afford. Instead, the lawyer must listen to the client's concerns during the counseling session.[106]

Patients frequently respond with disbelief or denial; and clients who feel wronged may also respond by expressing disbelief. The lawyer should understand this as the client's emotional difficulty in accepting the situation, rather than an argument over the lawyer's analysis.[107] Accordingly, the lawyer should empathize with the client who feels unfairly treated. The lawyer should explore the client's feelings if they are unclear. If the client needs further information to understand the law and how it applies in his case, of course the lawyer should explain. But it is most important that the lawyer avoid having an argument over his analysis. If the client expresses anger at the lawyer's inadequacy or threatens to get a "real lawyer," there, too, the lawyer should empathize with the feelings and recognize the client's right to seek other representation.[108] Where the client is disbelieving, in denial, angry or blaming, the lawyer may well have emotional reactions to the client's statements and accusations. The lawyer, though a professional, is emotionally involved in his work. He should step back and consider his own feelings. The lawyer should describe his feelings rather than act them out. Rather than lashing out that the client won't find better representation, the lawyer should acknowledge his emotion and then focus upon the client's case. For example:

Client: If you're any kind of lawyer you should know how to bury this guy in paper and get him off my back!

Lawyer: I can tell this law suit is frustrating to you; and frankly it is frustrating for me when you challenge my opinions and abilities. I would like to discuss this sufficiently so that you can see why I think this guy has a good case and why I want you to seriously consider settlement.

As doctors have to avoid over-reassurance,[109] lawyers too must

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105 *See* Garwick et al., *supra* note 28; Ptacek & Eberhardt, *supra* note 23.

106 *See* Ptacek & Eberhardt, *supra* note 23; BUCKMAN, *supra* note 21.

107 *See* text accompanying notes 85-86.

108 *See* text accompanying notes 83-84. Buckman suggests that clients be asked to suspend threats while they conclude the counseling session; and lawyers may well wish to clarify what must be decided now and what can be addressed later by new counsel if the client does in fact obtain a substitute attorney. BUCKMAN, *supra* note 21.

109 *See* text accompanying note 79.

be careful to stick with their candid opinions rather than alter them to appease protesting clients. Even though the client protests "I can't believe they would convict me!" the lawyer should not alter his prediction of "almost certain conviction" to "you never can tell what a jury will do—it's a roll of the dice." Whatever the lawyer's candid considered opinion, it should not waiver because the client complains.

Patients learning of serious diagnoses prefer doctors to show their own feelings and caring.[110] This may go beyond sensitively reflecting the patient's or client's emotion. It is easy to imagine any doctor having personal feelings of concern for a parent of a disabled newborn or a person diagnosed with cancer in the prime of life. However, lawyers may not always be able to so entirely become their clients' champions. For example, a lawyer may view his criminal client as dangerous and likely to do further harm, and not regret terribly much his likely incarceration. Alternatively, a lawyer may well be able to express true emotions to the abandoned spouse or the unemployed tenant. A lawyer must thus be aware of the true feelings he has for his client and his client's situation. If the lawyer is entirely sympathetic to the client, he is entitled to tell the client so. In explaining the law, lawyers too often become its defenders. It is possible to tell the client that he has a losing case and also communicate that the law is unfair and heartless in the lawyer's eyes. If this is the lawyer's actual view, it will assist the client in maintaining self-esteem in the face of a losing case. However, when the lawyer does not entirely relate to the client's situation, he should focus upon empathizing with those aspects of the situation with which he does identify. Most clients are fearful of unknown challenges; and no matter what they did to get themselves in that situation, the lawyer can empathize with the fear of an uncertain future.

*8) Conclude with a proposed plan which takes into account the client's personal perspective.* As doctors turn to the treatment plan following the information,[111] once the lawyer has conveyed the essence of the "bad news" he should discuss how the case can be handled. Here alternatives will be discussed—but in light of the crucial information about the weakness of the client's case. In light of the likelihood of conviction, the client should consider negotiating a plea agreement and needs to know what sort of fine or incarceration will form part of that arrangement. If eviction is certain, the client must decide whether to seek more time to move or to leave as soon as possible to minimize damages. The businessman who has wrongfully terminated an employee needs to consider whether to reinstate him or

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[110] *See* Sharp et al., *supra* note 24; Strauss et al., *supra* note 25.

[111] *See* text accompanying notes 87-89.

to pay damages. Depending upon the case and the client, the choices may be equally desirable (or undesirable); or one approach may be obviously the least risky way to approach a bad situation. If one approach clearly holds greater possibility for minimizing the harm the client fears, the lawyer should be clear about that. Clients may well be overwhelmed by the "bad news" and the lawyer can assist by being clear about which option most closely approaches the client's goals.

Patients consistently report that they would like an opportunity to talk and ask questions. Although the "bad news" may be overwhelming for some clients, lawyers would do well to invite their clients' questions and concerns. A client coming to terms with a difficult legal situation and facing undesirable consequences may well need some time to explore the "what if's" and "why's" of the situation.

Doctors are encouraged to refer their patients to others who have faced similar situations and to help the patient rally his own resources. While it would be odd for a lawyer to arrange for a client to meet a homeless person before being evicted or an incarcerated person before pleading guilty, there is much to be gained from helping the client re-orient to the unpleasant reality. It is appropriate and necessary to explore the "non-legal" consequences of any course of action.[112] The abandoned spouse may benefit from referrals to therapy and social groups that serve divorced single parents. The lawyer may want to help the tenant consider whether she could stay with relatives or friends, if she would need to put her belongings in storage, how she would seek permanent housing and what shelter facilities might exist as she faces an inevitable eviction. The criminal defendant should be invited to discuss what he knows of prison and if he wants to learn more before deciding upon a plea which will involve incarceration. In these ways lawyers must be willing to enter the client's world, as Sarat's and Felstiner's attorneys typically resisted doing.

With this approach the lawyer-counselor should be able to engage in counseling sessions which, of necessity, involve telling clients that their goal is probably impossible and the outcome they most fear is likely to be ordained under the law.

### *C. "Bad News" Integrated into the Client-Choice Model of Counseling*

Of course, most counseling sessions are more like an ear infection than a cancer diagnosis. That is to say, most medical counseling and

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[112] *See* BINDER, BERGMAN & PRICE, *supra* note 2, at 295, 335-37.

most legal counseling sessions are not primarily about "bad news." The counseling session may be entirely positive, as in the "you're-in-perfect-health" check-up or the lawyer doing a desirable business deal for his client. Often there may be "good-news-bad-news" aspects when there is a problem but it is treatable without too much pain, expense or risk. How should the "bad news" aspects be handled in this more typical counseling setting?

It many instances it may be best to retain the structure of the "client-choice" counseling session. The lawyer will simply give the "bad news" in the course of describing an alternative. The negative legal prediction will be part of a much larger legal picture and explain why there is a some risk of loss or why a particular element of damages will not be available. Imagine the businessman who has dismissed an employee planning for a hearing regarding unemployment compensation:

Lawyer: Let's talk about both options — going forward with the hearing or trying to settle it at this point. Now, given that you documented the employee's absences, lack of excuses, and your warnings to improve; it is very likely the administrative law judge will find that the employee was fired for cause and deny unemployment.

Client: I would hope so!

Lawyer: However, there is one aspect to this case that may cause trouble. The Employment Manual is considered a contract between you and the employee under our state's court decisions. In the Employment Manual it states that an employee will be given written notice of any deficiencies and a two-week opportunity to correct them. The only exception is if the deficiencies create serious risk of harm to others. Here you gave a written warning, but terminated him only three days later when he took an extended lunch hour. While that could make a difference in this hearing, it could also result in this employee bringing a law suit under the contract claiming he was due the full two-week chance to improve.

Client: So that's why you're asking me to consider possible settlement as well—like paying him severance pay?

Lawyer: Good point. This is a reason we might not prevail and we might run into future problems with this guy.

In other circumstances, it may be clearer for the client to understand if the "bad news" aspect of the case is separated from an alternative and explained at the outset. Imagine the client who has various goals which can be accomplished (or are likely to be accomplished) in more than one way; however one goal is simply unachievable. The lawyer may choose to discuss that unachievable goal prior to describing any alternative. Otherwise, the lawyer will end

up predicting failure to achieve that goal each time for each alternative. Such a conversation may seem as if the lawyer is trying to hide that particular bit of bad news. It may be more emotionally supportive to directly give the one bit of bad news at the outset, and then follow with the alternatives which will be primarily positive. For example, imagine the personal injury client who has a good case for a limited amount of compensatory damages (medical expenses, lost wages, some pain and suffering) but no grounds for punitive damages that would result in an enormous recovery. Yet the client has expressed anger and a desire to get back at the defendant.

Lawyer: I'd like to discuss our options at this point—settling with the insurance company which has made an offer. Or filing suit and attempting to get a larger amount through litigation. But before we discuss either course of action, I'd like to explain damages a bit.

Client: Damages are what they pay for injuring me, right? They oughtta pay through the nose after what I've been through.

Lawyer: You've had to put up with a lot, and we'll talk about how the law compensates you for your bills and your pain in a minute—that is compensatory damages. You see, there are different measures of damages. One you may hear about is "punitive" damages. When someone who has been injured very little but gets millions of dollars from a jury, that is usually because "punitive" damages have been ordered to punish the defendant. This can happen when the defendant who injured you did this intentionally —

Client: Well I never said they meant to harm me. . .

Lawyer: Precisely, and there is no evidence they did. Nor is there evidence they were "grossly negligent" — that they should have known the risk to you and simply ignored it, not caring. If a defendant has been grossly negligent, there too, a jury can give punitive damages to punish the defendant. But in your case I haven't seen any indication of that kind of negligence.

Client: So, you're telling me I won't get rich for life from this case.

Lawyer: That's one way to put it. You stand an excellent chance of getting compensated for your losses—and that is why the insurance company has already offered to settle. But I haven't uncovered any reason to take them to the cleaners for punitive damages.

Whether the "bad news" aspects of a case with substantial choice should be communicated at the outset or during the discussion of an alternative will likely vary from case to case and from client to client. The more focused the client has been on a goal which is impossible, the more important it will be to raise it early and deal with it directly.

### *D. A Fictional Example of An Empathic and Emotionally Genuine Lawyer*

Unfortunately the movies do not provide a model of an ideal "bad news" counseling session. However, Hollywood offers at least one example of an attorney who becomes both candid and emotionally accessible to his client—Aaron Levinski in *Nuts*. In the movie, a call-girl, Claudia Draper, is charged with murder and after slugging private counsel is appointed a legal aid lawyer, Aaron Levinski, to deal with the question of competency to stand trial. Initially he directly and candidly, even brusquely, tells her bad news, without hyperbole. Later, by his words and deeds he empathizes with her situation. And most uniquely, he agrees to share his emotions with her as well as his legal analysis.

At the outset of their hospital interview he introduces himself, and when the client fails to respond he gives this possibly insane client a second simplified introduction. Hearing no response, the lawyer muses aloud about the hour, his weariness, his fear of riding the subway home late at night.[113] This inspires the client to speak. But she challenges the lawyer by asking what "kind of show" she needs to put on for him. The lawyer responds empathically by asking if something is wrong, allowing the client to angrily share her frustrations about lawyers and courts. Even though the lawyer reassures her he will do as she wishes, the client refuses to tell the lawyer about her situation. Instead, the client turns to ask personal questions of the lawyer—first, whether he is married (and he answers this question) followed by a question regarding his sex life. In response to this inappropriate inquiry, the lawyer confronts the client with the seriousness of her case.

Lawyer: You want to talk about your situation here or what? You've been indicted for manslaughter, first degree.

Client: I know all that. Tell me why you're here?

Again, the lawyer allows the client to question him and she suggests he is visiting her to "See if I'm crazy" or "To see just how crazy I am." Turning to that issue, the lawyer directly shares the "bad fact" with her:

Lawyer: Well, two psychiatrists already say you're incompetent.

The client responds by describing the psychiatrists as incompetent as well as sexually unattracted to her, and asks the lawyer a lewd question about whether he is attracted. The lawyer changes the subject by telling the client that her mother said hello. This produces

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[113] Although such a monologue may not be recommended for interviewing emotionally ill clients, it does establish a relationship of equals — two people who each have feelings and fears.

another outburst from the client and accusations the lawyer is really working for them. Again asserting he is appointed by the court, the frustrated lawyer gives the client an ultimatum:

Lawyer: Look, lady, You know you've got a choice. You can either cooperate with me and maybe it goes your way. Or you can yell at me. And I'll sign that motion to commit and that will be that.

This produces more accusations about lawyers abandoning her, and the lawyer states he is "stuck with" her. Again, he turns to counsel the client about her case. The counseling covers significant difficulties with her case, stated directly but not condescendingly, and the attorney's strong advice about what to do. But the attorney also allows the client to disagree and present her own opinion.

Lawyer: All right. The first thing is we've got to get a shrink in here to take a look at you.

Client: Wrong. No more shrinks.

Lawyer: I'm giving you some very good legal advice, here.

Client: Thank you very much. You know what I said about lawyers goes double for shrinks.

Lawyer: Mrs. Draper, there are two psychiatrists who already say you're crazy. You've gotta have at least one psychiatrist who says you're not, or you don't have a case.

Client: Sure I do. I'm my case. I get up there, I say my piece. I prove I'm competent. Look, I don't know if you believe this or not, but I'm a perfectly sane woman. And I don't bother anyone who doesn't bother me first. Get it? And I don't want any more quacks running around in my head talking about my toilet training.

Lawyer: There is only one thing that scares me—a stupid client. And you terrify me.

The lawyer's words label the client "stupid" because the lawyer thinks the decision not to hire a second psychiatrist is "stupid." However, the context of the conversation is broader, encompassing the lawyer sharing his feelings (fear) about handling the case in this way. Of course the ideal counselor would be aware of his feelings of fear in order to avoid reacting to them. Here the lawyer shares these negative feelings about the case with a client who has provocatively prodded the lawyer about his feelings. This is their first step away from the detached professional relationship to a relationship of equal people, each with emotions.

The lawyer further probes the rationality of the client's approach by direct questions which demonstrate its weakness:

Lawyer: Are you [competent]?

Client: How competent do you have to be for Christ's sake?

Lawyer: Good point. Let's say for the moment that you are not entirely incompetent.
Client: Yeah, let's say that.
Lawyer: And let's say for the moment that the doctors here are all wrong.
Client: Yeah, let's say that too.
Lawyer: Then why is all this happening to you?

This simple, direct question leaves the client silent and thoughtful.

The lawyer tentatively accepts the client's understanding and decision; he turns to counseling about the legal risks:

Lawyer: If we win at the hearing, you've got a trial. But if we lose the trial you could go to jail for 25 years.

The client agrees to take that risk, and finally—having tested the lawyer, insisted that he be genuine with her, treat her as an equal, and share his emotion with her—the client agrees to cooperate in the representation:

Client: Now you talk to me and pretend I'm sane, OK? And I'll do the same for you.

The lawyer and client continue their relationship as emotional equals, able to share feelings with one another. The lawyer brings the client a pastrami sandwich to supplement her hospital food. Prior to the hearing the client asks the attorney why he "looks nervous" and he candidly answers he would like more time to prepare. She reassures him he'll do fine. The lawyer gives the client clothing he has obtained from her apartment, and she challenges his right to invade her privacy. He tries to explain that it is for the hearing, but she becomes enraged. Then, understanding and empathizing with her feelings, the lawyer apologizes.

During the hearing the client and lawyer have disagreements about whether to call the client's mother and what questions to ask. The lawyer is frustrated, but respects the client's wishes. However, during the hearing the lawyer is able to uncover the fact that the client had been sexually abused by her step-father. Afterwards, in the hospital, the lawyer empathizes with the client's pain in this revelation and is again honest about his own emotions:

Lawyer: I'm sorry. I got so wrapped up in being a goddamn lawyer.

This allows the client to speak about the abuse and her guilt, and the lawyer tells her, with genuine emotion, that it was not her fault, she "was a little girl." She worries "Maybe I am crazy" and he reassures her that she is sane, sharing what is now his genuine opinion. She attempts to reject his caring, telling him to go home, that he should be with his wife. And he replies that no, he should be with her.

While Levinski's candid sharing of his emotions with this client

cannot serve as a model, this device suggests how important it is for the attorney to be in touch with his own feelings. As a result, Levinksi is able to be candid about bad facts and to empathize with the client.

## IV. The Importance of the Lawyer's Feelings

The medical studies indicate that in addition to information, empathy and hope, patients want their doctors to share their feelings.[114] It is certainly plausible that some clients want this as well. Of course, medical problems are usually not the result of bad or illegal actions by the patient. Hence, in most cases medical professionals should be able to feel pain or concern or empathy for the patient who is ill or the parent whose child is disabled. And genuinely sharing this feeling of sadness (rather than maintaining a cold professional distance) should be possible.

Lawyers may be disinclined to share their genuine feelings with clients, imagining that they will dislike the client or disapprove of the client's goals. In those cases it could be unwise to share such genuine negative feelings about the client's case. However, it may not always be unwise. If the attorney-client relationship is strong enough, it may be possible and helpful for the lawyer to admit his emotions. If he is frustrated with what seems like nit-picking by the client, it would be more functional for the lawyer to admit his frustration than to act in a curt and cursory way. In other cases the client may be confused and genuinely want to know the lawyer's feelings. Had Lt. Caffrey calmly shared his genuine opinion about the Marines' code of conduct, both clients might have come to a decision with less trauma (albeit less drama as well).

Of course, in many instances lawyers will agree with and approve of their clients. And in some cases the clients may want and be able to deal with the lawyer's feelings. While the lawyer may not feel sympathy for all aspects of a client's case, usually the lawyer can relate to some part of it. Thus, Levinski understood and agreed with his client's sense of being invaded when he took her clothing from her apartment which was quite different from his disagreement with her aversion for psychiatrists or her decision not to seek an additional psychiatric opinion. Where he felt genuine emotion for the client, he expressed it. The medical studies suggest that where lawyers sympathize with and approve of their clients, the clients will benefit from hearing this.

Even if lawyers try to avoid sharing emotions with clients, they will fail. Lawyers, like doctors, have emotions about their work. They want to succeed. They want the approval of their clients and of others.

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[114] *See* Sharp et al., *supra* note 24; Strauss *et al., supra* note 25.

Accordingly, when things go wrong, the lawyer's emotions of frustration may well slip out in any event. Both Mr. Shaughnessey and Lt. Caffrey were portrayed as emotional lawyers. But they usually expressed anger or frustration about their clients to the clients themselves. And they declined to share any other emotion with those clients. If a lawyer's emotions about a case intrude in a manner that could harm the attorney-client relationship, this is an additional reason for the lawyer to consider forging a genuine relationship and sharing his true feelings as well as his legal analysis with his clients.

## Conclusion

When lawyers must give clients "bad news," they should draw upon the lessons that emerge from the world of medical counseling. Lawyers must be direct and candid about the state of affairs. They must fully describe how grim the situation appears and explain why this is their opinion. They must enter into a dialogue in which the client's questions are answered and the client's feelings are respected and responded to. Lawyers must be self-aware in order to avoid responding dysfunctionally to the client's reactions. They should show empathy and communicate hope to the "whole person" who is the client. Only after delivering and processing "bad news" in this way can the lawyer counsel the client about choices and plans for the future.