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TEACHING BIOETHICS: THE ROLE OF EMPATHY & HUMILITY IN THE TEACHING AND PRACTICE OF LAW

Barbara A. Noah[†]

Atticus Finch would not recognize most lawyers who graduate from elite law schools these days. According to recent American Bar Association employment data, elite law school graduates accept offers of employment primarily with large, urban law firms.¹ By contrast, the vast majority of graduates of the small New England law school where I teach Torts and various health law courses will join small firms, work for municipal or state governmental agencies, or venture into solo practice.² In these positions, the students graduating from our school overwhelmingly work with individual clients or small businesses, not corporations,³ and must learn to serve these individual clients with compassion and empathy, as well as a thorough knowledge of the law.

† Professor of Law, Western New England University School of Law; Schulich Distinguished Visiting Scholar, Dalhousie University Schulich School of Law (Spring, 2017); J.D. Harvard Law School. Thank you to the many students in my End-of-Life Law Seminars and Bioethics & Law classes for their participation, their sharing of personal experiences, and for their generous willingness to speak and write candidly about their thoughts on dying and disability. Thanks also go to the students of Dalhousie University Schulich School of Law whose participation in a course on comparative end-of-life law during the spring 2017 term also informed this paper. Finally, thank you, as always, to René Reich-Graefe for his insights and suggestions. © Barbara A. Noah, 2018.

1. See AM. BAR ASSOCIATION, EMPLOYMENT SUMMARY FOR 2016 GRADUATES: HARVARD UNIVERSITY, <http://employmentsummary.abaquestionnaire.org/> (last updated March 28, 2017) (providing individual reports from all law schools). For example, graduates of Harvard Law School who accepted employment in law firms were overwhelmingly joining large firms. 328 of the 385 students who joined law firms upon graduation chose firms with between 251 and 500+ lawyers.
2. See AM. BAR ASSOCIATION, EMPLOYMENT SUMMARY FOR 2015 GRADUATES: Western New England University, <http://www1.wne.edu/law/career-services/doc/EmploymentQuestionnaireSummary.pdf> (last updated April 5, 2016) (providing data indicating that the vast majority of WNEU law graduates joined small firms, practiced law solo, or work for government agencies or for businesses).
3. Cf. Luz E. Herrera, *Educating Main Street Lawyers*, 63 J. LEGAL EDUC. 189, 190 (2013) (describing “Main Street lawyers” as those who “primarily offer legal services to individuals or to community business interests versus corporate interests” and more generally discussing the value of a legal education for those who are likely to become Main Street lawyers).

In general, American legal education takes a multi-tiered approach to teaching students about law. Students learn “black letter” law, the doctrinal rules from common law and statutes that govern various areas of law and that are accepted in most states.⁴ They also learn legal reasoning and the practical aspects of applying legal doctrine to specific lawyers’ tasks.⁵ We attempt to instill in our students problem-solving ability, creativity, and excellence in legal analysis.⁶ Yet another layer of legal education involves teaching students about the appropriate balance between the positive and normative aspects of law.⁷

More recently, law schools also have begun to emphasize skills training to prepare students with actual experience that will assist them in practicing law.⁸ Of course, teaching skills is very important, but it can be a rather hollow exercise without a concomitant interest in and ability to understand one’s fellow human beings. A technocratic emphasis on knowledge and skills sets lawyers apart from their clients and makes them powerful, but gives little attention to the lawyer’s role as counsellor. Instead, the popular portrayal of lawyers often celebrates the dramatic courtroom victory, the large damages payout, the vindication of the rights of the underdog client, in all such instances emphasizing the lawyer’s power to persuade using the law as a tool, or even a sword. The flipside of these portrayals vilifies lawyers as dishonest manipulators who will say or do almost anything for a win, hence the lawyer jokes that we are all familiar with.⁹ But, as we all know, the practice of law is not solely about persuasion in the context of adversarial proceedings. It is also about providing counsel, support, and comfort to individual clients in distress.

4. See *Black Letter Law*, LEGAL INFORMATION INSTITUTE: WEX LEGAL DICTIONARY, https://www.law.cornell.edu/wex/black_letter_law (last visited August 29, 2017) (defining “black letter law” as “(b)asic standard rules that are generally known and free from doubt. The black letter law on any subject consists of rules that can be applied in a very mechanical way without moral qualms or other considerations.”).

5. See Carl E. Schneider, *On American Legal Education*, 2 ASIAN-PACIFIC L. & POL’Y J. 76, 79 (2001).

6. See *id.* at 77-78.

7. See Richard A. Epstein, *Positive and Normative Elements of Legal Education*, 8 HARV. J.L. & PUB. POL’Y 255, 255 (1985).

8. See AM. BAR ASS’N, ABA STANDARDS AND RULES OF PROCEDURE FOR APPROVAL OF LAW SCHOOLS 16 (2014) (citing Standard 303(a)(3)-(b), requiring at least 6 credit hours of experiential learning and opportunities for clinical work, field placements, and pro bono work for all law students).

9. A couple of my personal favorites: Q: How does a lawyer sleep at night? A: First he lies on one side; then he lies on the other. Q: What’s the difference between a lawyer and a vulture? A: Removable wingtips.

As counsellors, lawyers frequently take care of people who are facing some of the most emotionally or financially stressful events of their lives. In the context of estate and end-of-life planning, for example, lawyers have the occasion—if they choose to use it—to help clients make and memorialize decisions about one of life’s most intimate and personal matters, and to do this in a way that is meaningful, effective, and humane. Rates of advance directive completion in the United States remain low,¹⁰ but clients who do engage in advance care planning generally do so in one of two circumstances. In one scenario, the client agrees to complete advance care planning documents such as a living will or a health care proxy as part of an effort to order their affairs for the future, often in combination with making a will. In another scenario, the client is currently confronting a life-threatening illness and chooses to make specific plans about the care and treatment they desire in the context of the particular illness.

Particularly in this second context, attorneys who practice in this area sometimes must talk with clients about end-of-life choices while these clients are in the grips of what philosophers and psychiatrists call “mortal terror,”¹¹ (a phrase which seems perversely designed to perpetuate the very idea it represents). The lawyer as counsellor (rather than powerful technocrat) supplies legal expertise and experience but also has the opportunity to sustain these clients as they exercise their legal rights of medical decision-making during a time of stress and anxiety. In any event, whether these conversations take place in the context of recently diagnosed life-threatening illness or simply as part of “ordering the client’s affairs,” the conversation between client and attorney presents an opportunity for the attorney to provide the client with some contextual information about end-of-life care delivery, along with discussion of the client’s values and goals regarding the dying process.

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10. See Angela Fagerlin & Carl E. Schneider, *Enough: The Failure of the Living Will*, HASTINGS CTR. REP. 30, 32 (Mar./Apr. 2004) (noting that less than 20 percent of Americans having living wills and that studies also suggest that living wills rarely influence the level of medical care—in fact at least a quarter of patients with living wills receive care that is inconsistent with their instructions). The most recent data suggest a slight uptick in the percentage of Americans who have completed advance directives. See Jaya K. Rao et al., *Completion of Advance Directives Among U.S. Consumers*, 46 Am. J. Prev. Med. 65, 65-67 (2014) (finding, based on survey data from 2009-2010, that 26.3% of respondents had completed an advance directive and that older age, higher income, and higher educational attainment were correlated with a higher likelihood of having an advance directive).
11. See, e.g., Max M. Stern, *Fear of Death and Neurosis*, 16 J. AM. PSYCHOANALYTIC ASSN. 3, 4 (1968); Kenneth E. Vail III, et al., *A Terror Management Analysis of the Psychological Functions of Religion*, 14 PERSONALITY & SOCIAL PSYCHOLOGY REV. 84 (2010).

I teach two courses in which students can learn about advance care planning and end-of-life decision-making: Bioethics & Law and an End-of-Life Law seminar. This essay contains reflections on what I have learned from teaching these courses, particularly the seminar, and what I hope to accomplish in educating our students about end-of-life issues and about how they can serve their clients with empathy and humility.

A comparison of medical education with legal education reveals some interesting similarities and a few compelling differences. Medical education trains students initially in the basics of medicine, such as anatomy and physiology—the “black letter” of medicine. Students also learn skills, first by dissecting a cadaver and by practicing various basic techniques on medical simulation manikins and on each other. Later, these students improve their skills through clinical rotations (similar, in principle, to law school clinics), caring for patients under the supervision of fully qualified physicians in various medical specialties during the four years of graduate medical education and later during residency in particular specialties. But, like law students, medical students receive little or no training in communication with or counselling patients.¹² This lack of training leaves new physicians with little ability to talk with patients about dying or about making decisions at the end of life. Instead, medical training, much like legal education, focuses on the role of physician as healer and problem-solver, the conqueror of illness and injury.

As new lawyers and physicians quickly learn, their black letter knowledge and skills training only take them so far. Life’s complications, both legal and medical, sometimes are susceptible to neither cure nor amelioration. Lawyers often represent clients whose problems lack a simple, obvious or sometimes even any solution. Lawyers must then help their clients to navigate a range of choices, each with its own burdens and benefits, all with unquantifiable probabilities of success and failure. Similarly, physicians treat patients for whom multiple avenues of treatment—surgery, drug therapy, watchful waiting—or palliative care only, may be appropriate, depending on the patient’s preferences, goals of treatment, and tolerance for risk. In these ambiguous and ambivalent legal and medical scenarios, training in black letter law or in anatomy and best clinical practices—even training in legal advocacy or surgical technique—does not fully equip the professional to help the client or patient. In these cases, where there is no black and white, no yes-or-no decision point, lawyers and physicians face a significant choice—to make their best recommendation, ask the

12. Even those who regularly care for seriously ill and dying patients sometimes struggle with empathy, leading to calls for teaching empathy to physicians. See, e.g., Johanna Shapiro, *Walking a Mile in Their Patients’ Shoes: Empathy and Othering in Medical Students’ Education*, 3 PHIL., ETHICS, & HUMAN. IN MED. 1 (2008).

client/patient to let them implement it, and hope for a good outcome; or to take the more difficult path and struggle with the client or patient to acknowledge the ambiguity and ambivalence of the situation and to navigate the gradations of gray.

In my opinion, our job as law professors is not only to train lawyers in black letter law, legal reasoning, oral argument skills, and the like but also to help students to develop the desire and ability to, with knowledge, skill, and compassion, appropriately counsel clients who face emotionally challenging circumstances. Legal education, like medical education, should include training in listening ability, cultural competence, and the ability to experience the problem and grapple with it through the eyes of the client. In Atticus Finch's approach to the world and his clients, empathy was his guiding principle. As he explained to young Scout, ". . . if you can learn a simple trick, . . . you'll get along a lot better with all kinds of folks. You never really understand a person until you consider things from his point of view . . . until you climb into his skin and walk around in it."¹³ The best lawyers have the requisite knowledge and skill, leavened with a dollop of genuine empathy.

The practices of law (and medicine) also require humility. Lawyers and physicians learn to be open to the fact that some problems (legal or medical) can trigger different but still valid responses in different individuals. Lawyers (and physicians) will most often earn the trust of their clients (and patients), and therefore do their best for them, when they are willing to let the client/patient challenge their assumptions in every encounter. Each time that a lawyer counsels a client or that a physician treats a patient presents an opportunity for the professional to learn from that individual in order for the client/patient to arrive at a better outcome. For law students and medical students who understand the value of empathy and humility into their encounters with clients and patients, the practice of law or medicine becomes not merely a job but a vocation.¹⁴

Human beings are, naturally, variable in temperament. Some people are patient by nature, others not. Some find it easy to communicate with words, while others struggle to express themselves. It is hardest of all for those who do not know themselves and their values (perhaps because they have evaded knowing) to express their feelings. These and

13. HARPER LEE, *TO KILL A MOCKINGBIRD* 36 (1960).

14. See generally Richard Devlin & Jocelyn Downie, *Teaching "Public Interest Vocationalism": Law as a Case Study* in *Educating Professionals: Ethics and Judgment in a Changing Learning Environment* (2015), available at <https://www.hrpa.ca/Documents/Designations/Job-Ready-Program/Educating-Professionals-Ethics-and-Judgment-in-a-Changing-Learning-Environment-May2015.pdf> (last visited 7 Feb. 2018); Shapiro, *supra* note 12, at 1-11.

other normal variations in temperament tend to become more challenging in emotionally fraught circumstances. While it is probably not possible (or even desirable) to change an individual's temperament, legal education can and should include teaching law students how to communicate with clients about emotionally challenging problems and decisions. In part, law professors can teach this skill by modelling it themselves and also by acknowledging that communication skills are as important in client care (and patient care) as knowing the law (or the medicine) itself. And teaching students about the context and the reasons *why* end-of-life decisions are so challenging can help to foster empathy and better communication with clients, even in students who are not necessarily temperamentally inclined to have these discussions with patience, compassion, and thoroughness.

A while back, I came across an article about medical education with advice to physicians on the value of connecting with their patients in order to foster good communication.¹⁵ The authors advocate that physicians take a few moments at the beginning of a patient encounter to establish a friendly connection with the patient via some non-clinical conversation. The purposes of this conversation are multifold, according to the authors: (1) it shows that physicians recognize their patients as unique individuals; (2) it allows shared experiences to break down the barrier of "otherness" of physicians; (3) it demonstrates that clinicians are attentive to detail, which reassures patients; and (4) it indicates that the physician is open to communication with the patient and has time for him.¹⁶ These same rationales apply, I think, to the establishment of trust and good communication between attorneys and clients facing any kind of daunting legal or life situation.

Bioethics as a law school topic lends itself particularly well to helping students understand the context within which the relevant law must operate and its consequent limitations in providing solutions to complex problems. I regularly offer a course in Bioethics which surveys, in cradle-to-grave fashion, topics such as the nature of personhood, reproductive rights, clinical research ethics, medical decision-making, and end-of-life law and ethics. The study of bioethics integrates ideas from ethics, law, science, and public policy with the goal of solving problems associated with the delivery of medical care.

The Bioethics course is designed to provide students with a working knowledge of the legal and ethical standards governing topics that fall under the bioethics umbrella. Although the students are asked to integrate ethical principles, policy arguments, and an understanding of the relevant medicine and science, the course focuses primarily on the law and students learn primarily by reading and discussing legal

15. See Daniel R. Wolpaw & Dan Shapiro, *The Virtues of Irrelevance*, 370 *NEW ENG. J. MED.* 1283, 1284 (2014).

16. See *id.*

materials. In teaching this course over the years, I have noticed that students more than occasionally experience an “aha-moment” when they realize the enormous consequences of the legal rules, including the huge regulatory and decision-making vacuum that the law leaves in these matters. For example, in the context of reproductive law and decision-making, they are frequently astonished to realize how the available assisted reproductive technology is racing ahead of the regulatory framework which is intended to guide it. They boggle a bit at the fact that many states’ laws with respect to parental rights and obligations are based on a uniform act that was published in 1973, before *in vitro* fertilization existed. And with respect to the state-by-state legalization of medically-assisted dying, they recognize the extent to which legalization (for those who favor it) must take into account and be guided by what is feasible from a political and public policy perspective. In this respect, some students are outraged that the option of medically-assisted dying is even legal in any state, while others bemoan the limited category of patients for whom it is available. In the context of these discussions, students also begin to understand the serious emotional toll that issues surrounding reproduction or death and dying may exert on patients, families, and physicians.

With the End-of-Life Law seminar, the goals are somewhat different. In this seminar, I am offering students a deeper understanding of particular bioethics topics and, in doing so, I rely far less on traditional law school resources such as case law and statutes (although these are included among the materials that I use for the course). The seminar places more emphasis on the clinical, ethical, and practical dimensions of end-of-life issues and students learn about these topics using materials such as medical journal articles and clinical cases. More generally, students learn in this course, through experience as well as reading and discussion, that the law is frequently ineffective in the best of circumstances in addressing the complex, emotionally challenging, and multilayered issues that arise at the end of life.

In the past, I have offered the seminar for two credits and with no pre-requisite although, in this current academic year, I am offering a three-credit version with the Bioethics & Law course as a prerequisite. In addition to several short writing assignments, students research and write a lengthy paper on a relevant topic as the main work product of the course, and a fair amount of our time is taken up with individual meetings and written feedback on the multiple stages of this substantial writing project (including a detailed outline, bibliography, and drafts). We begin with some introductory concepts relating to ethical principles, casuistry, and the “layers” of complex end-of-life decision-making that include an understanding of the relevant law, ethical principles in play, the medicine or science informing the issue, and the role of public policy and politics. We then have a series of class meetings that focus on particular end-of-life topics, including determining decisional capacity,

refusal, withdrawal and withholding of life-sustaining treatment, surrogate decision-making, advance care planning, dispute resolution, palliative and hospice care, medically-assisted dying, comparative approaches, and cognitive challenges to rational decision-making.

Students learn why the context in which the law operates and the trade-offs that it makes are important. For example, a student once asked why the Massachusetts Health Care Proxy form makes the Proxy's signature optional. There is a practical, lawyerly answer to that question and a human, contextual trade-off. The practical answer is that the person to be appointed as proxy might not be present at the time that the form is being completed and the drafters decided not to impose too many barriers to completion. At the same time, students understand that, given the human tendency to avoid end-of-life conversations, the embedded risk of requiring no signature is that an individual might appoint a proxy without that person's knowledge and certainly without discussion of the person's wishes, which somewhat defeats the purpose. The idea of the seminar is to help students understand both the legal answers and the practical compromises made in end-of-life law and policy.

We also try to understand the emotional experiences and worries of an elderly or seriously ill client. For example, when discussing the concept of health care proxies or agents, we take a moment to consider whom we would each appoint as a proxy if we were to lose the capacity to make medical decisions. This thought exercise helps students to empathize with future clients who might struggle with this choice, and a surprising number of students acknowledge that they are unsure about who in their lives would be a suitable proxy decision-maker.

Most importantly, I ask students to imagine, as much as is possible, the experience of counselling a client who has reason, whether due to age or illness, to think about planning for the end of life. It is one thing for an attorney to ask a (healthy) client, "Do you have an advance directive?" and to assist that client in filling out a simple form appointing a health care proxy or ticking boxes about preferences for or against life supportive measures on a living will form. It is quite another thing to talk specifically and with empathy with a client (in ill health or of advancing age) about *why* the process of completing an advance directive is important, even if it is never relied upon in the client's final months or weeks. Advance directives are often unavailable when needed (even if they have been completed), irrelevant to the situation presented, or over-ruled by anxious or grieving relatives (with the acquiescence of treating physicians). Nevertheless, the process of completing an advance directive or appointing a proxy, or both, provides a formal context in which clients can acknowledge their

mortality and consider (to the extent that the dying process is ever subject to control) what is most important to them at the end of life.¹⁷

Of course, much of the attorney's responsibility in these circumstances is to help the client manage financial matters, including estate planning, payment for long-term care, and making arrangements in the event that the client is unable to care for him- or herself physically or financially. But, as the students learn in this seminar, another important role for the attorney can be to counsel clients about the range of decisions that clients may face at the end of life and to assist them in planning for these decisions in advance.

Therefore, one of the primary goals of the seminar is to help students to understand these conflicts and issues from the perspective of patients and physicians rather than exclusively from a legal perspective so that these future lawyers will learn to take a more multi-dimensional view of their clients' needs. Decision-making in the context of serious illness presents unique challenges that separate it from other sorts of medical decision-making such as reproductive decisions, decisions about cancer screening or whether to undergo an elective medical procedure.¹⁸ The role-playing parts of the seminar are designed to help students understand this unique end-of-life decisional context intellectually and emotionally. In a series of in-class role-playing and drafting exercises, I ask students to form pairs and to place themselves in the role of either attorney or client facing a hypothetical clinical scenario¹⁹ in which they must complete an advance directive and appoint a health care proxy. I provide the students with a rather poorly drafted and over-simplified living will form, the Massachusetts Health Care Proxy form²⁰ and instructions, and the Massachusetts Medical Orders for Life Sustaining Treatment (MOLST), a form designed to be used by clinicians to help patients make immediate decisions about life-

17. See Barbara A. Noah, *In Denial: The Role of Law in Preparing for Death*, 21 ELDER L.J. 1 (2013).

18. In addition to the obviously high stakes, the multiple layers of uncertainty, including Knightian uncertainty, pose emotional and existential challenges to both patients and their physicians. See generally Barbara A. Noah, *The (Ir)rationality of (Un)informed Consent*, 34 QUINNIAC L. REV. 691, 691-704 (2016) (describing layers of clinical uncertainty, Knightian uncertainty, and various cognitive biases that interfere with informed decision-making about end-of-life care).

19. I have used a variety of clinical scenarios but they all have in common that the client/patient is facing a progressive and inevitably terminal disease which will potentially result in the loss of decisional capacity and so require advance care planning.

20. See generally *Health Care Proxy Form and Information*, MASS. MED. SOC'Y, <http://www.massmed.org/healthcareproxy/#.WUgYMxPyvVo> (last visited June 19, 2017).

sustaining treatment.²¹ I also hand out a Values History Form which supplies a long list of questions that provides ideas for how to discuss with the client what is most important to him or her.

I instruct the students to take turns playing the role of attorney and client with their partner. Each pair must then discuss the situation that has brought the client to the attorney's office, and the attorney must explain the benefits and limitations of advance directive completion, and walk the client through the steps of completing the forms. I also ask the student playing the role of attorney to educate the client on the existence and purposes of the MOLST so that the client can discuss the possibility of completing a MOLST with their physician. The students then switch roles. The students as clients must play the role of the patient in the clinical scenario (for which empathy is important) and must do so using their own values and preferences so that they can help the attorneys complete the advance directives. When the students play the client, the exercise gets quite personal and real for many of them.

During the course of this exercise, I stay in the classroom, but generally out of earshot from the students' conversations with each other, in order to be available to answer specific questions that often come up. For example, a number of students have asked whether they can amend or add to the advance directive form. They marvel at how poorly-written it is and how many important considerations, such as how to address evolving medical status, are outside the scope of the form. Others ask whether they have to turn the completed forms in to me (they do not) because they want to keep their answers both authentic and private. Then, in the next class, I ask students to react to their role-playing and drafting assignment and to provide anonymous written responses to some questions about what they learned from the exercise.²² Here is a sampling of their answers:

“As both client and attorney, I learned that there were questions I didn't know how to answer and didn't want to answer.”

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21. See MASS. MED. ORDERS FOR LIFE SUSTAINING TREATMENT, <http://molst-ma.org/> (last visited June 6, 2017).
22. The questions are as follows: 1. What did you learn about counselling a client regarding advance care planning? 2. What did you learn while playing the role of the client? 3. What about while playing the lawyer role? 4. If you played the role of lawyer second, do you think that your experience in the “client” role changed how you played the “lawyer” role and, if so, how? 5. What changes or improvements would you suggest to the role-playing and drafting exercise?

“I learned that it is really important to understand [the client’s] background and understand why they are making certain choices.”

“In the role of a client, you realize how much is, by necessity, unknown when you fill out advance directives. In our clinical scenario, you are forced to envision a course of events moving forward knowing that theoretically things could turn out differently.”

“I learned that it can be uncomfortable and a little awkward counselling a seriously ill patient/client. It was difficult to get the conversation started without saying something that may seem inappropriate. ‘Hey, you’re dying. What’s your plan?’ probably isn’t a good way to start but that’s really what you kind of need to say in a much more appropriate and sympathetic way.”

“As the client, I learned that it’s impossible to completely sum up a person’s desires via a simple form. People are more than paper.”

“Playing the role of client let me know how hard it would be to sit down and face the reality of my life having a high potential to end so abruptly.”

“I learned that it is difficult to express private thoughts about life and what you find meaningful to a stranger.”

“I learned that it is extremely hard to avoid such terms as ‘quality of life’ or other vague medically useless phrases. Also that in order to counsel effectively, you must have a good, even if basic, understanding of the medical procedures involved.”

“These documents are very simple and leave no room for expanding on issues that are important to the client.”

“It was difficult as the attorney to guide the client without inserting my own views into their decision-making process.”

“There has to be a strong level of trust between attorney and client.”

“The experience of playing the client role first caused me to be more thoughtful and artful in playing the role of attorney.”

“I think the most significant thing I learned about working with a client to prepare an advance care directive is that it is an impossible task to do well unless you have a real understanding of the client’s values, and that such an understanding is very

difficult to achieve in a time-constrained setting. As the attorney, I felt more like a therapist than a lawyer.”

“In the role of client, I realized how difficult it was to commit to the level of specificity demanding by the Living Will. This was true even in the context of a fictional exercise!”

Many, if not most, of the student comments demonstrate one of two lessons: that empathy is an important virtue in an attorney and that these conversations are both awkward and emotionally challenging for both participants. In both respects, the attorney-student ideally also empathizes with the client-student’s situation, which might promote a better understanding of, and anticipation for, the frustration a real-life client might experience when the attorney (and the law) cannot do more to help the client.

In the seminar, students also participate in mock meetings of a Hospital Ethics Committee to attempt to resolve disputes between patients, families, and health care providers. Students then are asked to explain their proposed resolution and the reasons behind it to someone playing the role of a patient or family member. Here is one case that I often use in this Hospital Ethics Committee exercise:

Mr. W. is a 75-year-old man whose wife, Mrs. W., also 75, has been hospitalized for multiple medical problems including kidney failure, colon cancer, and heart disease. Due to the seriousness of her illness and the effects of various medications, she has lost decisional capacity. She is unlikely to regain decisional capacity or to be able to leave the hospital to return to the long-term care facility where she has been residing. It has become apparent that one of the blood vessels that supplies her heart muscle is nearly fully blocked. A cardiothoracic surgeon, Dr. P., wants Mr. W.’s consent to place a stent in the vessel in order to keep it open. Mr. W. has declined to sign the consent form, explaining that although he loves his wife very much and wants her to live, he knows that she wouldn’t want additional medical procedures under these circumstances. Dr. P. is incensed—he believes that the stent procedure will work and will provide a benefit to Mrs. W. in the form of prolonging her life. Mr. W. and Dr. P. agree to meet with two members of the Ethics Consultation team to discuss the conflict. At the start of the meeting, Dr. P. tells Mr. W., “If your wife dies, it will be on your head!” Mr. W. begins to weep. What would you say to Dr. P.? To Mr. W.?

By the time we get to this exercise, students have already studied and discussed the relevant legal issues and approaches to resolving disputes about end-of-life care. As part of the mock Ethics Committee meeting, we start by trying to describe the relevant contextual layers of the end-of-life conflict at hand—the patient’s medical condition (with

some understanding of its implications), the relevant law, which ethical principles might be in conflict, and other issues that may impede resolution of the conflict, such as power conflicts between physicians or institutional concerns about potential liability.²³

Next, I ask the students, “What are we trying to accomplish with this ethics consultation process? What is our role here?” These are loaded questions—some students will naturally think that the goal is to resolve the dispute and achieve consensus about how to proceed. Other students will assume that the goal is to help the patient and family make the “correct” decision under the circumstances. Still, other students will mumble things about autonomy, beneficence, and futility. If students think that there is a “correct” resolution, is that belief based on some objective principle of law or ethics? Or rather on the respective students’ own personal, subjective beliefs of what is “right”? After some discussion, we usually get to an understanding that we are trying to carry out the patient’s wishes and to help those who oppose care consistent with the patient’s wishes to understand the value of protecting and implementing patient preferences (when these can be determined). This is the charge of the committee *even when* the patient’s preference is contrary to what we ourselves think is the “correct” choice or is contrary to what we would ourselves choose in these circumstances. We also discuss the limits of acceding to patient choice, for example in circumstances where the requested medical intervention cannot achieve the desired goal.²⁴

Finally, we think about how we can actually approach discussion and potential resolution of the conflict with the relevant individuals—the patient’s family members or the physicians responsible for the patient’s care, or some combination of these. I ask the students, “What will you say to the family? To the physician? How would you explain the relevant law and ethical principles to them?” This last stage in the discussion, where students try to find the words to explain to a surgeon why he must respect a husband’s refusal of a cardiac stent procedure

23. Some of the main ethical dilemmas include conflicts between principles of patient autonomy and best interests, the robustness and reliability of surrogate decision-making without judicial review, problems with medical predictions of treatment efficacy and prognosis that lead to challenges in informed consent, the broader issue of treating patients holistically versus “fixing” one problem at a time as they arise, family conflicts, and the impact of potential medical liability. As a guide to clinical dispute resolution, we use a simplified version of the Clinical Pragmatism Case Method from JOHN C. FLETCHER ET AL., *INTRODUCTION TO CLINICAL ETHICS* (2d ed., University Publishing Group, 1997).

24. We also discuss clinical cases at the opposite end of the care spectrum, in situations where the patient or surrogate decision-maker refuses effective treatment that would, in all probability, cure an otherwise serious or terminal condition.

on behalf of his wife, is the most challenging for students. When they imagine themselves in the situation and are searching for the words, they very quickly realize that these conflicts are hard, full of emotion and of awkwardness. Although we often discuss hypothetical cases in addition to actual cases that have required judicial resolution, students quickly forget the “unreality” of the hypothetical as we step into the roles of counselor, explainer of the law and its limitations, and sometimes consoler.

The role-playing exercises described above give law students some opportunity to develop and hone the skills of empathy, compassion, and communication about emotionally challenging decision-making. There are law professors who have always—consciously or unconsciously—taught and modelled empathy, but this is not a necessary or perhaps even common component of legal skills courses or of traditional doctrinal courses. Nevertheless, students who naturally are able to put themselves into others’ shoes, or whose professors encourage this thought process, can learn more than the basics of litigation or mediation or Torts. They can learn how to be a zealous advocate for their client with the goal of not only “winning” but also understanding the client’s plight with genuine empathy.

Many of our students are quite young, coming straight to law school from their undergraduate studies, and have not yet personally experienced the effects of serious illness or injury personally or among their families and friends.²⁵ They enroll in the seminar without any real idea of what we will cover. Despite its title, enrollment in the End-of-Life Law Seminar has been steady.²⁶ Students are frequently surprised to realize that they have an appetite for this not very cheerful material. By the time we get to the part of the course where we hold our mock Ethics Committee meeting, we have learned about the limitations and deficiencies of our approach to end-of-life care and decision-making in this country. And so, in end-of-semester course evaluations, they write of their surprise at their own willingness to think and write about death and dying.²⁷

25. As it happens, in one recent academic year I had two students who have survived serious childhood illness and who came to law school, and to the study of Bioethics and End-of-Life Law, with a perspective on these matters that was unusually thoughtful and personally informed.

26. One of my now-retired colleagues suggested that the title of the course is “too sad.” When I asked him for alternatives, he suggested “Welcome to Heaven!” With the idea that more humor might help lighten things up, I have been thinking of changing the course title to “Up the Styx Without a Paddle.”

27. For example, “I have to admit I was hesitant to take this course because I am one of those individuals that is afraid to talk about death but it truly has been a great experience. . . . [D]eath is an imminent part of all our

In his book, *The Art of Teaching*, Jay Parini, Professor of English and Creative Writing at Middlebury College, describes each new academic year as “a fresh chance at playing myself, with the live option to try on new personae—those brittle masks we mold to our skin, that eventually become indistinguishable from what we call the self, that many-faceted figuration we present to the world.”²⁸ He advocates taking on a teaching mask or persona and says:

One must get over the foolish notion that a mask is not ‘authentic,’ that there is something shameful about ‘not being yourself.’ Authenticity is, ultimately, a construction, something invented—much as a particular suit of clothes will feel authentic, or inauthentic, given the context. The notion of the ‘true’ self is romantic, and utterly false. There is no such thing.²⁹

With respect, I disagree. It is the fear of digging down and discovering the true self (which is of course, complex, evolving, and multivariate) that leads people to dither away chunks of their lives in meaningless pursuits in order to avoid the confrontation with what is most real in themselves and in the people that they meet. Parini is correct that people “mingle and shift, mutate, bond, break into parts, reassembling countless times a day.”³⁰ But this does not confute the fact that we each have at our core a unique and authentic reality and that only by living consistently with that authentic self and trying to improve it do we live fully—and this includes ourselves as law teachers.

One effective way to teach students humility and empathy is to model these qualities, and the only way to do so effectively is to be one’s authentic self, even at the risk of occasional embarrassment. Rather than putting on a performance in the classroom of a Professor Kingsfield figure,³¹ law professors can teach students about humility—

lives and this class has especially taught me that it is better to be prepared for it than to suffer the consequences.”

“It was a challenging, emotional, but fascinating course. I appreciate the effort . . . to familiarize us with this difficult topic.”

“I learned a lot from this class. The practical exercises were extremely helpful and taught me a great deal about myself in addition to helping me grow as an advisor/attorney.”

28. See JAY PARINI, *THE ART OF TEACHING* 3 (2005).

29. *Id.* at 59.

30. *Id.* at 59.

31. In the film *The Paper Chase*, Professor Kingsfield at Harvard Law School delighted in the opportunity to display his superior knowledge and to cow and belittle students. See *THE PAPER CHASE* (Twentieth Century Fox 1973).

for example by not pretending to know everything or getting defensive when we don't know something: "That's a great question! I don't know the answer, so let me research it and get back to you." And we can model empathy—by listening to students carefully, treating them with respect and kindness, and attempting to understand the context of the students' respective lives and how this informs their views on particular legal issues, especially issues of controversy. Bioethics certainly raises plenty of controversial issues and fostering open class discussion requires the professor to create an atmosphere of respectful listening and discussion of competing viewpoints. Both humility and empathy require careful reflection about one's approach to teaching, self-knowledge and the willingness to risk "exposure" in front of students, which could involve anything from admitting ignorance, to laryngitis that makes one's voice sound like a strangled Muppet, to walking out of one's shoe and getting halfway across the front of the room before realizing one's barefootedness.³²

It takes knowledge and empathy and communication skills and guts to talk with clients or patients about mortality and death. Lawyers, physicians, law professors and medical professors all have the opportunity to exert tremendous influence in the lives of their clients, patients, and students. Good communication in all of these relationships fosters trust and promotes candor. In all of these professions, humility can help the professional take away from the encounter as much as he or she gives.³³ Every client, patient, and student has lived through and learned from an experience that is outside of our own ken. Physicians must learn to be humble in the face of death, which is a certainty. Lawyers must acknowledge that the law always lags behind the problems that it is meant to solve or avoid and that, even with the best of will, law is oftentimes ineffective. And law professors, who begin with a superior knowledge of the law, policy, and skills relevant to the courses we teach, can always learn from their students—from the perspectives and experiences that students bring to the course and from the questions that they ask. Approaching the classroom with an attitude of humility, respect and genuine interest in the experiences of students promises equally important learning opportunities for professors.

32. I speak from personal experience with respect to each of these examples.

33. As a counselor, the attorney learns from each client and improves his or her skills as part of this learning curve so that, from a longitudinal perspective, the lessons learned from each client encounter benefit future clients.