

THE COGNITIVE POLITICS OF PROFESSIONAL CONFLICT: LAW REFORM, MENTAL HEALTH TREATMENT TECHNOLOGY, AND CITIZEN SELF-GOVERNANCE

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INTRODUCTION

Professionals who are busy fighting a previous war fail to revise their roles to accommodate current experience. This tendency is most pronounced when yesterday's foe is another professional group. One current health issue—the availability of a new anti-schizophrenia medication, clozapine—provides a case study of how obsolete professional roles block interdisciplinary dialogue and subordinate citizens.¹

Central to the case is the suspicion with which public interest lawyers and critical theorists have greeted advances in treatment technology. Their skepticism reflects both a souring opinion of technology after the heyday of Progressivism² and the macabre history of “advances” such as the lobotomy. However, this defining narrative of suspicion becomes subordinating in its own right when it delays access to safer, more effective, new medications such as clozapine,³ which promotes greater parti-

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1. The term “citizens” is used to describe people who receive mental health services. The term aptly conveys the participation in treatment by these people, which is a central concern of this Article. See Hanna F. Pitkin, *Justice: On Relating Private and Public*, 9 POL. THEORY 327 (1981).

2. See, e.g., JEROLD S. AUERBACH, *UNEQUAL JUSTICE: LAWYERS AND SOCIAL CHANGE IN MODERN AMERICA* 74–94 (1976); DAVID J. ROTHMAN, *CONSCIENCE AND CONVENIENCE: THE ASYLUM AND ITS ALTERNATIVES IN PROGRESSIVE AMERICA* 421 (1980). See also Sid Harring, *The Taylorization of Police Work*, in *CRITICAL STUDIES IN ORGANIZATION AND BUREAUCRACY* 157 (Frank Fischer & Carmen Sirianni eds., 1984); John Delaney, *Towards a Human Rights Theory of Criminal Law: A Humanistic Perspective*, 6 HOFSTRA L. REV. 831 (1978). Distrust of technology has also issued from other quarters for which the term “progressive” is inappropriate. See Catherine H. Zuckert, *Martin Heidegger: His Philosophy and His Politics*, 18 POL. THEORY 51, 68–73 (1990).

3. See Catherine E. Blackburn, *New Directions in Mental Health Advocacy? Clozapine and the Right of Medical Self-Determination*, MENTAL & PHYSICAL DISABILITY L. REP., Sept.–Oct. 1990, at 453.

icipation in the community for people with mental illness. The prohibitive price of clozapine⁴ guarantees that the people who could benefit the most from the treatment, those in institutions, are unlikely to get it without active lawyer involvement. While some advocates prodded by citizens' groups have answered this need, the talismanic mistrust of medicine among public interest lawyers and critical theorists has dulled advocacy efforts.

This Article advances a model of cognitive politics to help illuminate the terrain of professional conflict over clozapine. Borrowing from cognitive psychology,⁵ political theory,⁶ and the sociology of risk,⁷ this model recognizes the constitutive effect of community, as psychology fails to do, while accommodating issues of cognitive distortion, which political theory traditionally ignores.

Cognitive psychology teaches us that professional roles are narratives or scripts which we use as a basis for judgment. Like laypersons' scripts, professional scenarios often have little to do with rational decisionmaking.⁸ These scenarios have emotional or visual hooks which make them cognitively "available." Old belief structures swallow new facts; superficial resemblances make current debates cognitively "representative" of vintage professional conflicts. Once established, these belief structures are difficult to alter since the constitutive role of

4. Depending on the kind of monitoring system used, clozapine can cost from \$3,000 to \$9,000 per year per patient. See W. H. Reid, *Access to Care: Clozapine in the Public Sector*, 41 HOSP. & COMMUNITY PSYCHIATRY 870 (1990).

5. See Kenneth J. Arrow, *Risk Perception in Psychology and Economics*, 20 ECON. INQUIRY 1 (1982); Daniel Kahneman & Amos Tversky, *Prospect Theory: An Analysis of Decision Under Risk*, 47 ECONOMETRICA 263 (1979); Gerald P. Lopez, *Lay Lawyering*, 32 UCLA L. REV. 1, 23-26 (1984); Roger G. Noll & James E. Krier, *Some Implications of Cognitive Psychology for Risk Regulation*, 19 J. LEGAL STUD. 747 (1990); Amos Tversky et al., *Contingent Weighting in Judgment and Choice*, 95 PSYCHOL. REV. 371 (1988).

6. The earliest and perhaps still the most insightful work on politics and group behavior stems from Niccolo Machiavelli. See NICCOLO MACHIAVELLI, *THE PRINCE AND THE DISCOURSES* (Luigi Ricci trans. 1950); SEBASTIAN DE GRAZIA, *MACHIAVELLI IN HELL* (1989); HANNA F. PITKIN, *FORTUNE IS A WOMAN: GENDER AND POLITICS IN THE THOUGHT OF NICCOLO MACHIAVELLI* (1984); JOHN G.A. POCOCK, *THE MACHIAVELLIAN MOMENT: FLORENTINE POLITICAL THOUGHT AND THE ATLANTIC REPUBLICAN TRADITION* (1975).

7. See MARY DOUGLAS, *RISK ACCEPTABILITY ACCORDING TO THE SOCIAL SCIENCES* (1985); MARY DOUGLAS & AARON WILDAVSKY, *RISK AND CULTURE: AN ESSAY ON THE SELECTION OF TECHNICAL AND ENVIRONMENTAL DANGERS* (1982); BARUCH FISCHHOFF, *ACCEPTABLE RISK* (1981); Clayton P. Gillette & James E. Krier, *Risk, Courts, and Agencies*, 138 U. PA. L. REV. 1027 (1990).

8. For a dissection of narratives that scapegoat one subordinated group, see Michael L. Perlin, *Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization*, 28 HOUS. L. REV. 63 (1991).

groups ensures that shared beliefs intensify when challenged.⁹

The perseverance of established narratives conceals other stories¹⁰ and shapes professional attitudes about risk. Many public interest lawyers, for example, see themselves as guardians against government overreaching,¹¹ not as facilitators of client self-definition. For these lawyers, treatment advances only occasion new efforts to curb medical authority. Different paradigms, such as the efforts of people with AIDS to obtain new life-saving drugs, remain obscure.

Critical theorists take as their guiding narrative the unmasking of professional roles as pretexts for subordination. These antiprofessional theorists seek to ban certain activities where the risk of false consciousness allegedly corrupts citizen choice. While medical authoritarians wish to mandate psychological counseling, psychotropic medication, electroconvulsive therapy ("ECT"), and institutional care, antiprofessionals would bar these treatments.¹² Such jousting may determine

9. See Charles H. Franklin & Liane C. Kosaki, *Republican Schoolmaster: The U.S. Supreme Court, Public Opinion, and Abortion*, 83 AM. POL. SCI. REV. 751, 763-69 (1989). For other perspectives on this kind of group behavior, see HANNA ARENDT, *ON REVOLUTION* 98-111 (1963); ALBERT O. HIRSCHMAN, *THE RHETORIC OF REACTION: PERVERSITY, FUTILITY, JEOPARDY* 164-70 (1991); ALBERT HIRSCHMAN, *ESSAYS IN TRESPASSING: ECONOMICS TO POLITICS AND BEYOND* 197-203 (1981); BELL HOOKS, *YEARNING: RACE, GENDER, AND CULTURAL POLITICS* (1990); Dalton, *Aids in Blackface*, in *THE AIDS READER: SOCIAL, POLITICAL, ETHICAL ISSUES* 122 (Nancy F. McKenzie ed. 1991); Kathryn Abrams, *Ideology and Women's Choices*, 24 GA. L. REV. 761 (1990).

10. See Anthony V. Alfieri, *Reconstructive Poverty Law Practice: Learning Lessons of Client Narrative*, 100 YALE L.J. 2107, 2134-39 (1991) [hereinafter *Client Narratives*]; Anthony V. Alfieri, *Speaking Out of Turn: The Story of Josephine V.*, 4 GEO. J. LEGAL ETHICS 619 (1991); Anthony V. Alfieri, *The Antinomies of Poverty Law and a Theory of Dialogic Empowerment*, 16 N.Y.U. REV. L. & SOC. CHANGE 659 (1989); Naomi R. Cahn, *A Preliminary Feminist Critique of Legal Ethics*, 4 GEO. J. LEGAL ETHICS 601 (1990). On narrative generally, see Kim Lane Scheppelle, *Foreward: Telling Stories*, 87 MICH. L. REV. 2073 (1989); Richard Sherwin, *A Matter of Voice and Plat: Belief and Suspicion in Legal Storytelling*, 87 MICH. L. REV. 543 (1988).

11. See William H. Simon, *Legality, Bureaucracy, and Class in the Welfare System*, 92 YALE L.J. 1198 (1983). For discussions of mental health advocacy, see DAVID B. WEXLER, *An Introduction to Therapeutic Jurisprudence*, in *THERAPEUTIC JURISPRUDENCE: THE LAW AS A THERAPEUTIC AGENT* 3 (1990); Stanley S. Herr, *Representation of Clients with Disabilities: Issues of Ethics and Control*, 17 N.Y.U. REV. L. & SOC. CHANGE 609, 631-33 (1989-90); Peter Margulies, "Who Are You to Tell Me That?": *Attorney-Client Deliberation Regarding Nonlegal Issues and the Interests of Non-clients*, 68 N.C. L. REV. 213, 227-39 (1990); Michael L. Perlin & Robert L. Sadoff, *Ethical Issues in the Representation of Individuals in the Commitment Process*, 45 LAW & CONTEMP. PROBS. 161, 164 (1982); Paul R. Tremblay, *On Persuasion and Paternalism: Lawyer Decisionmaking and the Questionably Competent Client*, 1987 UTAH L. REV. 515.

12. See, e.g., George W. Albee, *The Futility of Psychotherapy*, 11 J. MIND & BEHAV. 369, 381 (1990) (proposing ban on psychotherapy); Kenneth J. Gergen, *Therapeutic Professions and the Diffusion of Deficit*, 11 J. MIND & BEHAV. 353, (1990). Cf. Martha Fine-man, *Dominant Discourse, Professional Language, and Legal Change in Child Custody*

whose vocabulary is ascendant. However, stylized dichotomies of mandate and prohibition do little to help citizens build a pragmatic repertoire of experience in a demanding world.

Establishing this repertoire of experience would transform cognitive politics for both citizens and professionals. One pathway to such a transformation is a model of participatory entitlements. Under this regime, each resident of a nursing home, a psychiatric institution, or a community residence would have an entitlement to fellow citizen, inter-professional, and judicial review of decisions to initiate, withhold, or terminate any psychoactive medication. Implementing this entitlement requires three governance devices: a citizens' caucus, an interdisciplinary dialogue circle, and a judicial hearing.

The three devices should complement each other in composition, scale, and degree of formality. Formation of a citizens' caucus, composed entirely of people who use mental health services, recognizes that citizens as a group have a singular stake and expertise in making treatment decisions. To benefit from these advantages, citizens need an environment in which they can deliberate in parliamentary fashion without being dominated by doctors, lawyers, or intellectuals. To complement caucuses, citizens need smaller, informal dialogue circles where they can deliberate, free from tokenism or condescension, with a spectrum of professionals. Citizens also need the more formal framework of judicial hearings, to counter the silencing effect of informality's uncertain climate. A governance structure with these elements will revise professional roles and renew the bonds among law, individual, and community.

This Article is in three parts. The remainder of this introduction discusses the challenges posed by new treatment technologies, such as clozapine, in light of the historical dominance of treatment professionals in mental health issues. Section I delineates how cognitive politics distorts professional and citizen dialogue. Section II outlines a program of participatory entitlements to solve the problems of cognitive politics.

Some discussion of clozapine illuminates its place in the terrain of interprofessional conflict. Clozapine helps to alleviate symptoms of schizophrenia, such as delusions and hallucinations, for people who do not respond to more traditional drugs marketed since the 1950s: haldol, thorazine, and prolixin. In addition, clozapine does not trigger the stigmatizing adverse effects of these other drugs, such as tardive dyskinesia,

Decisionmaking, 101 HARV. L. REV. 727 (1988) (arguing that therapeutic rhetoric has disadvantaged mothers); Nancy Fraser, *Talking About Needs: Interpretive Contests as Political Conflicts in Welfare-State Societies*, 99 ETHICS 291 (1989) (expressing doubts about authenticity of therapeutic discourse).

an apparently irreversible disorder of the central nervous system that produces involuntary twitching of the body, along with enlargement and rolling of the tongue.¹³

This does not mean that clozapine is a panacea. The drug has adverse effects, including agranulocytosis. Agranulocytosis is a condition in which the body's production of white blood cells, which are necessary for combatting infection, dramatically decreases. Without rapid detection, agranulocytosis may cause death.¹⁴ With monitoring, however, fatalities are extremely rare.¹⁵

Concerns about the adverse effects of clozapine gain additional poignancy in light of the tainted history of the medical community's involvement with mental disability. People with mental disabilities have suffered from being subjected to a model of medical authoritarianism. The state, in the name of therapy, has confined people in institutions that are citadels of pain and neglect.¹⁶ In this century, the Supreme Court approved involuntary sterilization of allegedly mentally retarded women, with Justice Holmes uttering his notorious aphorism, "three generations

13. For discussions of tardive dyskinesia, see 2 MICHAEL L. PERLIN, *MENTAL DISABILITY LAW: CIVIL AND CRIMINAL* (1989); David Cohen & Michael McCubbin, *The Political Economy of Tardive Dyskinesia: Asymmetries in Power and Responsibility*, 11 J. MIND & BEHAV. 465 (1990).

14. See Blackburn, *supra* note 3, at 454.

15. See Deiter Naber & Hans Hippus, *The European Experience With Use of Clozapine*, 41 HOSP. & COMMUNITY PSYCHIATRY 886, 886 (1990).

16. The rise of institutions in Jacksonian America, ironically, was linked to notions of promoting humane treatment for people with mental disabilities. See MICHAEL J. DEAR & JENNIFER R. WOLCH, *LANDSCAPES OF DESPAIR: FROM DEINSTITUTIONALIZATION TO HOMELESSNESS* 28-46 (1987); PAUL LERMAN, *DEINSTITUTIONALIZATION AND THE WELFARE STATE* 19-21 (1982); DAVID J. ROTHMAN, *THE DISCOVERY OF THE ASYLUM: SOCIAL ORDER AND DISORDER IN THE NEW REPUBLIC* 109-44 (1971) [hereinafter *THE ASYLUM*]. In practice, however, institutions typically became immersed in brutality and indifference. See ROTHMAN, *supra* note 2, at 21-23 (describing attendants' routine resort to kicking psychiatric patients, as well as to devices such as camisoles designed for confinement); *THE ASYLUM*, *supra*, at 149-50 (describing shortages of staff). For a compelling account of conditions in institutions for people with mental disabilities, see RUTH SIENKIEWICZ-MERCER & STEVEN B. KAPLAN, *I RAISE MY EYES TO SAY YES* (1989).

These conditions have prompted numerous lawsuits in the United States, largely based upon the due process clause of the Fourteenth Amendment. See, e.g., *Youngberg v. Romeo*, 457 U.S. 307 (1982) (establishing right to minimal habilitation and freedom from harm in institutions for persons with mental retardation). Cf. 2 PERLIN, *supra* note 13, at 1-214 (discussing evolution of right to treatment and habilitation in institutions for people with mental disabilities). For the most complete account of attempts to reform one institution, see DAVID J. ROTHMAN & SHEILA M. ROTHMAN, *THE WILLOWBROOK WARS* (1984). Many of the same abhorrent conditions occur worldwide. See Larry Gostin, *Human Rights in Mental Health: A Proposal for Five International Standards Based upon the Japanese Experience*, 10 INT. J. L. & PSYCHIATRY 353, 354-57 (1987).

of imbeciles are enough."¹⁷ Ex parte proceedings, which excluded the voices of people with mental disabilities were the rule. Medical "advances" often resulted in more exotic varieties of oppression. Lobotomies are a good example: Until the 1960s, surgeons simply dissected away pieces of people's brains for purported therapeutic reasons.¹⁸

The pseudoscientific character of these procedures makes it all the more piquant that medical professionals have allowed their focus on "treatment" to crowd out their concerns about the rights of patients.¹⁹ Institutions may enhance this conflict by downgrading treatment in order to stress more readily achievable custodial roles. For example, mental health professionals may administer medications with adverse effects as much to tranquilize patients as to treat them.²⁰ Psychiatrists seem to have little interest in informing patients of the risks of these medications.²¹ Yet the Supreme Court has held that the Constitution does not provide for hearings prior to forced medication of patients,²² although some states have provided for such hearings as a matter of state law.²³ Even now, however, many states lack provisions for a judicial hearing prior to forced medication, and in those states that do have such provisions, lawyers willing to represent patients are in short supply.²⁴

17. *Buck v. Bell*, 274 U.S. 200, 207 (1927). Cf. Robert L. Hayman, *Presumptions of Justice: Law, Politics, and the Mentally Retarded Parent*, 103 HARV. L. REV. 1201 (1990) (discussing parenting by people with mental disabilities).

18. See Seth Farber, *Institutional Mental Health and Social Control: The Ravages of Epistemological Hubris*, 11 J. MIND & BEHAV. 285, 288 (1990).

19. But see Robert L. Sadoff, *Patient Rights Versus Patient Needs: Who Decides?*, 44 J. CLIN. PSYCHIATRY 27, 27-28 (1983) (supporting right to treatment). Cf. Mary L. Curham & John Q. LaFond, *A Search for the Missing Premise of Involuntary Therapeutic Commitment: Effective Treatment of the Mentally Ill*, in THERAPEUTIC JURISPRUDENCE 133 (David B. Wexler ed. 1990) (arguing that empirical research has not demonstrated efficacy of involuntary treatment).

20. See *Jones v. United States*, 463 U.S. 354, 386 (1983) (Brennan, J., dissenting); Cohen & McCubbin, *supra* note 13, at 469, 478-79.

21. Cohen & McCubbin, *supra* note 13, at 477.

22. See *Washington v. Harper*, 494 U.S. 210, 211 (1990). For discussion of "right to refuse treatment" issues, see 2 PERLIN, *supra* note 13, William B. Brooks, *A Comparison of a Mentally Ill Individual's Right to Refuse Medication under the New York and United States Constitution*, 8 TOURO L. REV. 1 (1991). For a useful discussion of the roles of self-help organizations and attorneys in right to refuse treatment litigation, see Neal Milner, *The Right to Refuse Treatment: Four Case Studies of Legal Mobilization*, 21 LAW & SOC'Y REV. 447 (1987).

23. See, e.g., *Rivers v. Katz*, 504 N.Y.S.2d 74, 81 (1986); *Riese v. St. Mary's Med. Center*, 243 Cal. Rptr. 241, 253 (1987).

24. New York, similar to some other states, has a state-funded legal services program for institutionalized persons labeled as having mental disabilities. See N.Y. MENTAL HYGIENE LAWS § 47.03 (McKinney 1986) (creating Mental Hygiene Legal Service). For a comprehensive discussion of the present state of legal services for people with mental disabilities, see Michael L. Perlin, *Fatal Assumption: A Critical Evaluation of the Role of Counsel in the Trial of Mental Disability Cases*, 16 LAW & HUMAN BEHAV. 39 (1992).

Challenges to the medical authoritarian model have come from three sources: citizens (i.e., persons who have voluntarily or involuntarily received mental health services); lawyers, who have sought to introduce procedural safeguards into the mental health system; and antiprofessional theorists, who have questioned the legitimacy of the medical model. For each group, the legacy of medical oppression reinforces concerns about new mental health treatments, such as clozapine.

Resistant groups fear that mental health professionals can coerce patients, or use threats to secure "voluntary compliance" with a medication regime.²⁵ If doctors cannot coerce patients, they may "sell" patients on the merits of the drug, in the snake oil hawker's best drawl. Without access to alternative information sources, patients will act as consumer-lemmings in our commodity fetishist society. Antiprofessional theorists argue that such preferences for drug therapy are not autonomous, but rather embody a "false consciousness" which confirms the dominance of medical ideology.²⁶

The validity of these concerns, and their debt to alternative professional narratives, are the focus of Section I of the Article. A sketch of lawyers' conflicting attitudes toward new mental health treatments like clozapine may be helpful in setting the stage.

Some lawyers think efforts to make clozapine available will be harmful, because additional side effects may yet come to light that will place it in the ignoble company of haldol and the other traditional phenothiazines.²⁷ Other lawyers believe that they should affirmatively seek to

25. See *Kaimowitz v. Dept. of Mental Health*, No. 73-19434-AW (Mich. Cir. Ct. Wayne Co. July 10, 1973) (holding that involuntarily committed persons cannot give informed consent to experimental psychosurgery), reprinted in GEORGE J. ANNAS ET AL., *AMERICAN HEALTH LAW* 614, 620-21 (1990). Cf. Cohen & McCubbin, *supra* note 13, at 472-73 (discussing means of persuading patients to consent to treatment).

26. See Karl Marx, *The German Ideology: Part I*, in *THE MARX-ENGELS READER* 110 (Robert C. Tucker ed. 1972); Margaret Radin, *Justice and the Market Domain*, in *NOMOS XXXI: MARKETS AND JUSTICE* 165 (John W. Chapman & J. Roland Pennock eds., 1989); Cass K. Sunstein, *Legal Interference with Private Preferences*, 53 *U. CHI. L. REV.* 1129, 1146-50 (1986). Cf. ALBERT O. HIRSCHMAN, *ESSAYS IN TRESPASSING* 59, 66 (1981) (convenience and novelty of foreign imports has driven out indigenous handicrafts in many developing countries). Cf. Jean G. Zorn, *Lawyers, Anthropologists, and the Study of Law: Encounters in the New Guinea Highlands*, 15 *L. & SOC. INQUIRY* 271, 286-87 (1990) (discussing dependency theory). Consistent with this hypothesis, some commentators claim that environmental treatments may work just as well as drug therapy; however, these treatments are more expensive, depend on more uncertain variables, and demand more refined professional interpersonal skills. See Cohen & McCubbin, *supra* note 13, at 468-69. They are not streamlined "products."

27. Cf. Ian Hacking, *Culpable Ignorance of Interference Effects*, in *RISK AND VALUES* 136 (Douglas McLean ed. 1986) (noting that sometimes side effects only appear when new technology is grouped with older technologies in unexpected ways).

obtain the medication for clients who want it. According to this view, anything short of outright activism in obtaining clozapine is tantamount to barring access for many consumers. However, even these attorneys have generally been reluctant to represent mental health patients. Their concern is that institutions create disparities in power and information so great that the risks of access to new treatments will outweigh the benefits.²⁸

I. COGNITIVE POLITICS AND CLOZAPINE

A model of cognitive politics illuminates the conflict between citizens and professionals over new mental health treatments. A core premise is that the dichotomy between cognitive explanations of decisionmaking, which focus on individuals, and political explanations, which focus on groups, is false. Individual methods of perception and decisionmaking invariably overlap with group processes.²⁹ The posited dichotomy here is a product of how individual social scientists consider evidence, and of how a community of social scientists defines itself.

The dominant concern of cognitive politics is the dilemma of dichotomy. Many narratives define communities through stories of inclusion and exclusion. These narratives humor the human penchant for simple categories.³⁰ Some groups or ideas are favorites of the story, while others are "other." The power of such stark accounts to catalyze collective action³¹ in a world of distractions makes them a vital resource for citizens and professionals rebelling against reigning orthodoxies. The dilemma is that over time dichotomous narratives become oppressive, because their role in maintaining group identity impedes the editing that individual experience provides.

A central consequence of the allegiance to dichotomous stories is that

28. Even these lawyers, however, may seek to secure clozapine as an alternative to involuntary administration of other more intrusive treatments such as electroconvulsive therapy. See Brief of New Jersey Public Advocate, George _____ v. State (on file with author).

29. See DOUGLAS & WILDAVSKY, *supra* note 7.

30. Feminist commentators have been particularly discerning in discussing the appeal of "essentialist" theories, which exclude vital elements of context. See, e.g., Angela P. Harris, *Race and Essentialism in Feminist Legal Theory*, 42 STAN. L. REV. 581, 605-07 (1990).

31. See MANCUR OLSON, *THE LOGIC OF COLLECTIVE ACTION* (1965); James Buchanan & Gordon Tullock, *Simple Majority Voting*, in *ECONOMIC FOUNDATIONS OF PROPERTY LAW* 238 (Bruce A. Ackerman ed. 1975); see also Abrams, *supra* note 9, at 773-76 (discussing strategic advantages of arguments that women's choices are products of ideological determination rather than individual will). More contextual views may seem too equivocal to command comparable support. Cf. W.B. Yeats, *The Second Coming*, in *THE NORTON ANTHOLOGY OF POETRY* 923 (rev. ed. 1975) ("The best lack all conviction, while the worst / Are full of passionate intensity").

most discourse consists of preaching to the converted. For example, professionals develop a vocabulary³² which they seek to protect; risking interdisciplinary collaboration can endanger a profession's vocabulary through "trespassing" from other groups, or subject the risk-takers to internal criticism by the profession's doyennes and their toadies.³³

Such risk aversion in professional groups is particularly piquant because these groups often have obligations, legal or moral, to other groups. Lawyers, doctors, and critical theorists each have obligations to engage in dialogue with groups whom they purport to serve, and to nourish those groups' aspirations as a community. Yet each group of professionals tends to rely on dichotomous narratives which demonize another group: lawyers view doctors as authoritarian, doctors view lawyers as purveyors of abstract rights shorn of context, and critical theorists view both doctors and lawyers as employing professional rhetoric as a pretext for social control. Citizens who receive medical or legal services, and citizens whom critical intellectuals use as research subjects,³⁴ may wish to build their own communities of experience by taking risks disfavored by one or another professional vocabulary. They also may wish to collaborate with professionals from a variety of disciplines—law, medicine, and theory—who can help them make decisions about risk from a more unified perspective. Professionals relying on dichotomous narratives cannot meet either need.

32. See RICHARD RORTY, *CONTINGENCY, IRONY, AND SOLIDARITY* 19–20 (1989) (discussing innovation in science and art as shift in language to cope with particular problems).

33. For accounts of professionals as exercising power, see ELIOT FREIDSON, *PROFESSIONAL DOMINANCE: THE SOCIAL STRUCTURE OF MEDICAL CARE* (1970). Cf. MICHAEL FOUCAULT, *MADNESS AND CIVILIZATION: A HISTORY OF INSANITY IN THE AGE OF REASON* 241–78 (1965) (discussing ascendancy of medical profession); Marie Ashe, *Mind's Opportunity: Birthing a Poststructuralist Feminist Jurisprudence*, 38 SYRACUSE L. REV. 1129, 1158–63 (1987) (discussing Foucault's work); Anthony V. Alfieri, *The Politics of Clinical Knowledge*, 35 N.Y.L. SCH. L. REV. 7, 8–9 (1990) (discussing power in lawyer-client relationships). For an example of a "dean" of a professional community being remarkably, if reductively, frank about his own pettiness and lack of interest in dissenting views from his own area of specialization, see Stanley L. Fish, *Almost Pragmatism: Richard Posner's Jurisprudence*, 57 U. CHI. L. REV. 1447, 1466–67 (1990) (book review). Professionals also may have a normative vision, which they sincerely wish to perpetuate and enhance. Far from being a guarantee against overreaching, however, this sincerity becomes instead a license for power's exercise. For a citizen's discussion of the power wielded by well-meaning "helping" professionals, see Billy Golfus, *The Do-Gooder*, THE DISABILITY RAG, July/August 1990, at 14.

34. See Andrew Gitlin, *Educative Research, Voice, and School Change*, 60 HARV. EDUC. REV. 443 (1990).

A. Cognitive Psychology: A Framework For Analysis

Cognitive psychology helps explain the dynamics of dichotomous narratives. According to cognitive psychologists, human judgment runs on devices which simplify absorption of data in a complex world.³⁵ These devices result in decisions at odds with economists' conception of rationality as a mechanical calculation of self-interest. They also result in distortions of data which make some of the stories we tell ourselves about the world inconsistent with empirical findings. Three useful concepts for understanding this are availability, representativeness, and prospect theory.

1. Availability

Availability refers to the human tendency to ascribe disproportionate weight to data that are graphic, concrete, and emotion-laden. Here, advocates for people with mental disabilities have long waged difficult battles. Criminal acts by people with mental disabilities are memorable, while the mundane lives led by most people with mental disabilities melt into the mainstream.³⁶ Similarly, Robert Mapplethorpe has done more to shape perceptions of federally funded art than tens of thousands of obscure NEA grantees; Willie Horton has placed his stamp on public perceptions of prison furloughs where legions of uneventful furloughs did not make a dent.

2. Representativeness

A companion to the availability heuristic is representativeness, which

35. For discussions of defects in human inference, see RICHARD NISBETT & LEE ROSS, HUMAN INFERENCE: STRATEGIES AND SHORTCOMINGS OF SOCIAL JUDGMENT (1980); JUDGMENT UNDER UNCERTAINTY: HEURISTICS AND BIASES (Daniel Kahneman et al. eds., 1982); DETLOF VON WINTERFELDT & WARD EDWARDS, DECISION ANALYSIS AND BEHAVIORAL RESEARCH 530-59 (1986); Ward Edwards & Detlof von Winterfeldt, *Cognitive Illusions and Their Implications for the Law*, 59 S. CAL. L. REV. 225 (1986); Lopez, *supra* note 5, at 15-26; Gary Melton, *The Irrationality of Reasonable Persons: Implications for Mental Health Law* (unpublished manuscript on file with the author); Albert J. Moore, *Trial By Schema: Cognitive Filters in the Courtroom*, 37 UCLA L. REV. 273 (1989); Noll & Krier, *supra* note 5; Michael L. Perlin, *Psychodynamics and the Insanity Defense: "Ordinary Common Sense" and Heuristic Reasoning*, 69 NEB. L. REV. 3 (1990); Michael J. Saks & Robert F. Kidd, *Human Information Processing and Adjudication: Trial by Heuristics*, 15 LAW & SOC'Y REV. 123 (1980-81).

36. Cf. NISBETT & ROSS, *supra* note 35, at 239 (acts of people perceived to be different are more available to memory); Shelley Taylor, *The Availability Bias in Social Perception and Interaction*, in JUDGMENT UNDER UNCERTAINTY: HEURISTICS AND BIASES 190, 192-94 (Daniel Kahneman et al. eds., 1982).

refers to the human tendency to draw deep associations based on superficial similarities. For example, representativeness translates the limited disability of people with mental illness into a pervasive inability to function. The disordered public image of mental disability creates the perception that people with mental disabilities have a special potential for random violence. Popular intuition echoes the clinical judgment of supposedly expert professionals, who consistently overpredict violence by this population.³⁷

3. Prospect Theory

Prospect theory reinforces the availability and representativeness heuristics' debunking of economic models of rationality. The first observation of prospect theory is that the manner in which one frames an issue will affect people's choice of outcomes.³⁸ Framing skews choices by stating the same alternatives differently. For example, the possibility of loss in a given area can be expressed dramatically: "If this measure is taken, unemployment will jump from five to ten percent." In contrast, one can state the same facts in more prosaic terms: "If this measure is taken, *employment* will drop from ninety-five to ninety percent." Decisionmakers are much less willing to select a measure with the language of the first example than that with the language of the second, even though the two options are identical in substance.³⁹

Prospect theory also predicts that people will be: 1) more intense in feelings of loss than they will be about feelings of comparable gain (loss aversion); and 2) risk-seeking when continuation of the status quo

37. See Peter Margulies, *The "Pandemonium between the Mad and the Bad." Procedures for the Commitment and Release of Insanity Acquirees after Jones v. United States*, 36 RUTGERS L. REV. 793, 823 n.183 (1984); Saks & Kidd, *supra* note 35, at 133; Christopher Slobogin, *Dangerousness and Expertise*, 133 U. PA. L. REV. 97, 126 (1984). Cf. FOUCAULT, *supra* note 33, at 74-75 (people with mental illness were confined at sub-freezing temperatures on theory that their disability prevented them from feeling cold); SIENKIEWICZ-MERCER & KAPLAN, *supra* note 16, at 41 (person with cerebral palsy assumed to have hearing impairment); Phil Brown, *The Name Game: Toward a Sociology of Diagnosis*, 11 J. MIND & BEHAV. 385 (1990) (discussing errors and biases in psychiatric diagnoses). See generally Arrow, *supra* note 5, at 6 (discussing professionals' inability to discount findings based on small, unreliable samples).

38. See Arrow, *supra* note 5, at 6-7.

39. See George A. Quattrone & Amos Tversky, *Contrasting Rational and Psychological Analyses of Political Choice*, 82 AM. POL. SCI. REV. 719, 727-28 (1988). See also ROBERT E. ORNSTEIN & PAUL EHRLICH, *NEW WORLD, NEW MIND* 210-11 (1989).

promises even a modest loss and risk-averse when continuation of the status quo promises even a modest gain.⁴⁰

Examples of loss aversion include an experiment apparently triggered by that master of psychology and human relations, Alan Alda. The experiment revealed that research subjects seemed to favor the Equal Rights Amendment ("ERA") when it was styled as a measure to eliminate discrimination. Percentages of subjects favoring the ERA were lower when it was styled as a measure for producing gains for women.⁴¹

The final distinctive contribution of prospect theory—risk-seeking in the presence of losses—echoes Kris Kristofferson's observation that, "Freedom's just another word / For nothing left to lose." Prospect theory demonstrates, however, that people become risk-seeking even when they have much to lose. Risk-seeking occurs when one course of action will clearly result in some kind of loss, while the other course of action will yield either a gain or the loss of a much greater amount. Most people will choose the latter course.

An obvious example involves people with AIDS. For all people with AIDS, the current long-term prognosis is grim. This puts people with AIDS in the category of those facing profound loss under the postulates of prospect theory. Nevertheless, given luck and effective treatment of opportunistic infections such as pneumonia, many people with AIDS can expect to live for years. Despite the possibility of this reprieve, many people with AIDS want the opportunity to try risky new medications which may be either substantially more effective, or likely to kill them far more quickly.⁴²

What studies of human inference term "irrational" may make perfect sense if one considers the needs of a group, and the needs of individuals to join groups, rather than focusing solely on the probability of harm associated with a given risk. Groups need to maintain a sense of com-

40. See Kahneman & Tversky, *supra* note 5, at 268–69; Quattrone & Tversky, *supra* note 39, at 720–27.

41. Quattrone & Tversky, *supra* note 39, at 726–27. See also JOYCE GELB & MARIAN L. PALLEY, *WOMEN AND PUBLIC POLICIES* (1982) (speculating that argument for ERA as promoting "equity" stirred favorable response more than argument that ERA would foment role changes for women).

42. See generally Harold Edgar & David J. Rothman, *New Rules for New Drugs: The Challenge of AIDS to the Regulatory Process*, 68 *MILBANK Q.* 111, 122–23 (Supp. I 1990) (discussing views of AIDS activists); William R. Rubenstein, *Law and Empowerment: The Idea of Order in the Time of AIDS*, 98 *YALE L.J.* 975, 990–96 (1989) (book review); Andrew Sullivan, *Gay Life, Gay Death*, *THE NEW REPUBLIC*, Dec. 17, 1990, at 19, 24–25. Electoral politics may furnish another example of this phenomenon. In tough times, a risky challenger, who could either make things a lot better or a lot worse, could beat the incumbent. Quattrone & Tversky, *supra* note 39, at 721–24. The authors speculate that risk-seeking was responsible for Reagan's victory over Carter in 1980. *Id.* at 724.

munity among their members, and individuals need to be part of groups. The collective taking of risks may furnish a sense of community unavailable through other means. As suggested earlier, professionals of all stripes have often taken away this source of community building from citizens. The following section examines how cognitive politics shapes citizen attitudes and professional domination.

B. Cognitive Politics, Professionals and Citizens, and Clozapine

The interaction of the availability heuristic with professional roles illustrates one aspect of professional control over risk decisions. For professionals, roles⁴³ are quintessentially "available" narratives for dealing with a complex world. Within the specialization which typifies an efficient modernity, professionals devote themselves to artificially discrete tasks. The remoteness wrought by specialization insulates professionals from communal experience with laypersons or other disciplines.⁴⁴

For example, a traditional concern of lawyers in the liberal tradition is guarding the individual against government abuse. Consistent with this role, much of mental health law involves what government does to people with mental illness, and why government should stop.⁴⁵ For the most part, the legalist recipe for combatting this abuse is the imposition of procedural safeguards⁴⁶ requiring judicial intervention. This emphasis on judicial action, so cognitively available for lawyers, excludes other

43. On role morality generally, see DAVID LUBAN, *LAWYERS AND JUSTICE: AN ETHICAL STUDY*, 104-27 (1988); Rand E. Rosenblatt, *Social Duties and the Problem of Rights in the American Welfare State*, in *THE POLITICS OF LAW* 90, 102-03 (David Kairys ed. 1990); Robert D. Dinerstein, *Client-Centered Counseling: Reappraisal and Refinement*, 32 *ARIZ. L. REV.* 501 (1990); Simon, *supra* note 11, at 1199; William H. Simon, *The Ideology of Advocacy*, 1978 *WIS. L. REV.* 30, 67-73. For an exceptionally provocative look at comparative conceptions of lawyers' roles, see Richard K. Neumann Jr., *Thoughts After an Insurrection*, 3 *YALE J.L. & HUMAN.* 157 (1991) (discussing role of lawyers in the United States and in Czechoslovakia). Cf. Kathleen Sullivan, *Self-Disclosure, Separation, and Students: Intimacy in the Clinical Relationship* (unpublished paper on file with the author) (discussing roles of law professors and students). Narrow conceptions of role, such as the excuse that, "I was just following orders," can explain appalling crimes which would seem to be products of overweening malice. See HANNAH ARENDT, *EICHMANN IN JERUSALEM* 276 (2d ed. 1965).

44. See ARENDT, *supra* note 9, at 258-60 (discussing professional revolutionaries).

45. Challenged practices include coercive medication and seclusion, not to mention involuntary commitment itself. See WEXLER, *supra* note 11.

46. See Austin Sarat, "... *The Law Is All Over*": *Power, Resistance, and the Legal Consciousness of the Welfare Poor*, 2 *YALE J.L. & HUMAN.* 343, 351-374 (1990).

sources of connection which may better give life to procedural guarantees.⁴⁷

Exclusion is the particular fate of concern about citizens' families, health,⁴⁸ and organization. Mental health lawyers regard psychiatric care as a source of abuses of individual rights.⁴⁹ Generally unacknowledged is the notion that for some citizens therapy that alleviates the symptoms of isolating conditions such as schizophrenia and manic depression can be a form of empowerment.⁵⁰ Legalist rhetoric makes this clear: lawyers define a citizen's right to "refuse" medication, not her right to participate in her own treatment. Under this view of their role, lawyers do not have to deal with clients interested in talking about extralegal matters such as mental or physical health—lawyers can say, "Go to a doctor, leave me alone."⁵¹ The availability of this "exit line" allows lawyers to avoid questions about whether their paradigm of due process best serves people's actual needs.⁵² Many mental health advo-

47. For other views of lawyering that compare visions of liberal legalism and connection, see Cahn, *supra* note 10; Naomi R. Cahn, *Defining Feminist Litigation*, 14 HARV. WOMEN'S L.J. 1 (1991); Richard K. Neumann, *On Strategy*, 59 FORDHAM L. REV. 299, 313-19 (1990).

48. See Steven J. Schwartz, *Damage Actions as a Strategy for Enhancing the Quality of Care of Persons with Mental Disabilities*, 17 N.Y.U. REV. L. & SOC. CHANGE 651, 674-75 (1989-90). Schwartz takes a generally skeptical view of court decisions finding liability for negligent release of psychiatric patients. While it is true, as Schwartz notes, that such decisions may deter release of people who do not need institutional care, these rulings may also help voluntary patients who wish to stay in the hospital, rather than being discharged into the community with inadequate services and housing. Schwartz, however, does not even acknowledge the existence of this group.

49. When such services are sought, they are viewed through the traditional liberal lawyer's lens as means of preventing further confinement of clients for whom services could stave off institutionalization, not as means for generally improving the citizen's ability to cope with her existence.

50. Some advocates for people with mental retardation have been more open about the need for policies that recognize that mental disability, while not representative of the whole person, is a part of that person. See James W. Ellis, *Presidential Address 1990—Mental Retardation at the Close of the 20th Century: A New Realism*, 28 MENTAL RETARDATION 263, 265-66 (1990).

51. See Sarat, *supra* note 46, at 367 (describing client who wanted lawyer to assume facilitative task—coordinating payment of gas bill—which social worker might otherwise undertake). Sarat's view of the client's conflating legal and social work tasks is delphic. He notes that the lawyer, "in [the client's] mind, became a substitute social worker." *Id.* Perhaps inadvertently, Sarat uses language that suggests some delusion on the client's part. However, lawyers for poor people need to step outside an artificial legalistic definition of role to fully assist their clients. In Sarat's example, the only delusion may have been the lawyer's perception that effective advocacy was possible without some "trespassing" on other role territory. See Margulies, *supra* note 11, at 227-30.

52. Cf. ALBERT O. HIRSCHMAN, EXIT, VOICE, AND LOYALTY (1970) (discussing how availability of exit for discontented parties frees objects of discontent from responsibility).

cates still assume no responsibility for ensuring citizen access to beneficial medications.⁵³ In this fashion, lawyers' role constraints delay benefits for people who seek relief from the symptoms of schizophrenia, just as regulators' role conceptions have hindered access to AIDS treatments.⁵⁴

The same syndrome is evident in mental health advocates' conception of families as a source of overreaching control ready to outdo the doctors at their own authoritarian game of drug administration.⁵⁵ The idea that families could be a vital resource for political organization on behalf of people with mental illness does not figure into the liberal legalist story. This disdain for clients' families reflects a broader discomfort with groups of citizens participating in collective decisionmaking about each other's treatment.⁵⁶ A benefit of the deracinated individual, cherished in liberal theory, is the ease with which the lawyer can ignore her.⁵⁷ Groups, on the other hand, have annoying ways of making their presence felt.⁵⁸

53. For a thoughtful rendition of this view, see Letter from Professor Robert Dinerstein, Professor of Law, American University, to Professor Peter Margulies (Jan. 23, 1991) (on file with the author). See generally Rosenblatt, *supra* note 43, at 102-04 (discussing failures of adversarial approach to securing welfare entitlements); Simon, *supra* note 11.

54. See Edgar & Rothman, *supra* note 42, at 12-21; Rubenstein, *supra* note 42, at 995-96; Bret L. Lansdale, Note, *A Procedural Due Process Attack on FDA Regulations: Getting New Drugs to People with AIDS*, 18 HASTINGS CONST. L.Q. 417 (1991). Cf. Phyllis Freeman & Anthony Robbins, *The Elusive Promise of Vaccines*, THE AMERICAN PROSPECT, Winter 1991, at 80, 85 (discussing Food and Drug Administration's passive attitude toward vaccine development, while noting that AIDS crisis may yield more activist approach). But see ANNAS ET AL., *supra* note 25, at 93-316; George J. Annas, *Faith (Healing), Hope and Charity at the FDA: The Politics of AIDS Drug Trials*, 34 VILL. L. REV. 771 (1989) (expressing skepticism about appropriateness of expanded access to experimental medications). Public Citizen, perhaps the quintessential consumer group, has recently shifted its stance of caution on new drug approvals to join with AIDS activists in urging quicker approvals of new AIDS drugs. See Gina Kolata, *Petition Seeks to Speed Approval of AIDS Drugs*, N.Y. TIMES, Dec. 21, 1990, at A31. See generally AIDS AND THE LAW: A GUIDE FOR THE PUBLIC (Harlon L. Dalton et al. eds., 1987) (discussing issues surrounding AIDS).

55. See Cohen & McCubbin, *supra* note 13, at 473-74 (noting family incentives to promote inappropriate psychotropic drug use by relatives with mental illness); Schwartz, *supra* note 48, at 662 (depicting families as abandoning people with mental illness or as deferring to doctors).

56. For an alternative model which considers community needs, see Paul R. Tremblay, *Toward a Community-Based Ethic for Legal Services Practice*, 37 UCLA L. REV. 1101 (1990).

57. See Herr, *supra* note 11, at 611 (quoting lawyer in major institutional reform class action as boasting that, "I never met [the named plaintiff] or his aunt. And I never needed to do so. I knew what needed to be done.").

58. Cf. ARENDT, *supra* note 9, at 227 (groups display firmness instead of timidity of individuals).

Another example of liberal legalists' distrust of community self-determination is the opposition to efforts of African-American community leaders to establish schools, such as the proposed Ujamaa school in New York City, that address the needs of African-

The representativeness heuristic compounds the problem of rigid role conceptions. Representativeness—viewing superficial resemblance as an emblem of fundamental affinity—suggests that any function outside the cognitively available role is inconsistent with that role. This kind of representativeness melds with the community's need for dichotomous self-definition to discourage dialogue between professional groups.⁵⁹

Since professions evolve in a climate of perceived risk from competing disciplines, representativeness suggests that each professional community must discredit reconciliation with others: "If you're not with us, you're against us."⁶⁰ Lawyers, for example may feel in danger of co-optation by therapeutic rhetoric, in which an avowedly paternalistic notion of the "best interests" of the client trumps legalist conceptions of clients' rights.⁶¹ In this climate, lawyers challenging the rights perspective by expressing interest in clozapine or other psychotechnology

Americans. Opposition to Ujamaa schools reflects a specious "neutrality" in liberal thought which suggests that if white people should not have schools focusing on European culture, African-Americans should not have schools geared to the African tradition. See Todd S. Purdum, *Dinkins Backs School Geared to Minorities*, N.Y. TIMES, Mar. 9, 1991, at 25, col. 5, 27, col. 4 (quoting executive director of New York Civil Liberties Union). This facile dictum, paradoxically similar to arguments against affirmative action invoked by civil rights lawyers' traditional opponents, ignores the history of oppression of African-Americans which the Ujamaa plan is designed to help remedy.

59. Cf. HIRSCHMAN, *supra* note 26, at 131 (discussing polarizing public dialogue between entrepreneurs and reformers in developing countries).

60. This polarization is a pervasive phenomenon in ethnic, political, professional, and theoretical circles. See, e.g., ARENDT, *supra* note 9, at 226 (unanimity in one political faction fosters equal and opposing unanimity in another); FISCHHOFF, *supra* note 7, at 68 (discussing reluctance of professionals in one discipline to testify against one another); DAVID LEHMAN, SIGNS OF THE TIMES: DECONSTRUCTION AND THE FALL OF PAUL DE MAN 133-68 (1991) (discussing deconstructionist community's defensive reaction to revelations of a founding deconstructionist's collaboration with Fascists in World War II); JULIUS LESTER, LOVESONG: BECOMING A JEW 144-45 (1988) (noting Jews' hostility to Hannah Arendt's thesis that the Holocaust was product of obedience to role, not absolute evil) (cited in Stephen L. Carter, *Loving the Messenger*, 1 YALE J.L. & HUMAN. 317, 351 (1989)); NISBETT & ROSS, *supra* note 35, at 242-48 (cognitive psychologists disparage focus on motivation in psychoanalysis); Ian Shapiro, *J.G.A. Pocock's Republicanism and Political Theory: A Critique and Reinterpretation*, 4 CRITICAL REV. 433, 435-36 (1990) (tracing appeal of civic republican revival in political theory to communitarian theorists' distaste for liberal thought, and their rationale that "'my enemy's enemy is my friend'"); Zorn, *supra* note 26 (describing "academic wars" between anthropologists and lawyers over nature of societal norms).

61. For an example of a probably justified reaction along these lines by lawyers, see Paul S. Appelbaum, *Paternalism and the Role of the Mental Health Lawyer*, in THERAPEUTIC JURISPRUDENCE 325, 325-26 (David Wexler ed. 1990) (mental health advocates criticized general practice lawyers who substituted best interests standard for adversary stance in commitment cases). Cf. Gerald P. Lopez, *Training Future Lawyers to Work with the Politically and Socially Subordinated: Anti-Generic Legal Education*, 91 W. VA. L. REV. 305, 380 (1988-89) (discussing hostility of many progressive lawyers to economic concepts).

threaten the professional group's solidarity.⁶² In fact, however, intra-group challenges may promote the health of the group by fostering changes in stale paradigms.⁶³ On this view, lawyers' mobilization to obtain clozapine would speak to a larger concern for clients' connectedness than does the homage to procedure alone.

Lawyers are not the only ones afflicted with distortions in cognition and group behavior. Medical researchers and clinicians, along with critical theorists, experience comparable difficulties.⁶⁴ Doctors, for example, view treatment of disease as their own available narrative. Representativeness suggests that a disease is equivalent to its symptoms. Under this logic, if one treats the symptoms, one has also treated the underlying disease. Resistance to treatment becomes an interference with professional language, while explaining medical decisions to citizens becomes at best a burden and at worst a compromise of professional ideals. The problem is that mental illness often stems from a combination of socioeconomic and medical factors. The heuristic's focus on medical symptoms obscures these connections.⁶⁵

The critical theorist also participates in this minuet of roles. Antiprofessional theorists who deplore the alienation represented by roles⁶⁶ warm to their roles as critics.⁶⁷ The available narrative for the critic's

62. Securing clozapine for clients is significantly different from refusing to fight treatment that a client does not wish. My colleague, Beryl Blaustone, has told me about a lawyer who wished to initiate commitment of her client. This kind of action violates fundamental principles of legal ethics. In contrast, obtaining treatment for willing clients does not contravene these principles.

63. See THOMAS S. KUHN, *THE STRUCTURE OF SCIENTIFIC REVOLUTIONS* (1970); Steven L. Winter, *Bull Durham and the Uses of Theory*, 42 *STAN. L. REV.* 639, 674-93 (1990). Cf. MACHIAVELLI, *supra* note 6, at 441-43 (favoring republics because climate of liberty produces varied responses to meet new challenges).

64. For a discussion of the folly of judicial deference to medical professionals, see Robert D. Dinerstein, "I Have Always Depended on the Kindness of . . . Professionals?": The Problems of Professional Deference in Mental Disability Law (unpublished paper presented at American Association of Law Schools Annual Meeting, Law and Mental Disability Section, Jan. 4, 1991).

65. See Hendrick Wagenaar and Dan A. Lewis, *Ironies of Inclusion: Social Class and Deinstitutionalization*, 14 *J. HEALTH POLITICS, POL'Y & L.* 503, 514-19 (1989).

66. See Karl Marx, *Economic and Philosophical Manuscripts of 1844*, in *THE MARX-ENGELS READER* 52, 56-94 (Robert C. Tucker ed. 1972).

67. Criticism, like acting in any role, is a kind of play. See LEHMAN, *supra* note 60; J. M. Balkin, *Deconstructive Practice and Legal Theory*, 96 *YALE L.J.* 743 (1987). Unlike other professional roles, such as doctor or lawyer, the role of critic features virtually no chance of legal liability. This immunity heightens the element of play for theorists. Of course, many theorists also have serious and substantial political commitments. A tension exists between these commitments and the vicarious nature of the critic's task. Cf. ARENDT, *supra* note 9, at 259-60 (Professional revolutionaries are typically once removed from outbreak of revolution; they later assume control over a process spontaneously begun.).

role is the shared revelation that the emperor has no clothes; professional rhetoric, whether the paeans to patient care by the doctor, or the invocation of neutrality by the lawyer, masks structures of dominance.⁶⁸ Given this scenario, representativeness and group dynamics impel the critical theorist to match every mainstream professional move with an equal and opposing critique.⁶⁹ The critics are parasitic on the professional consensus they abhor: without that consensus, their role would disappear.⁷⁰

For antipsychiatry theorists, the available script unmasks "treatment" as a license for authoritarianism. This discovery triggers a rejection of therapeutic rhetoric. Representativeness decrees that since therapeutic rhetoric is bad, categorical rejection of that rhetoric is good.⁷¹

Unfortunately, defining oneself through one's opponents is both an act of liberation and of confinement. This kind of self-definition liberates because it enables a subordinated group to name its oppressor.⁷² It confines because when opponents define a group, they also control its agenda.⁷³

One consequence of ceding control of the agenda to opponents is that critical theorists in law and in psychiatry do not unite to press for change, but only react to developments within the respective disciplines. For example, critical theorists in mental health may talk about negative rights in the liberal sense, such as the right to be free of involuntary

68. See, e.g., Duncan Kennedy, *Legal Education as Training for Hierarchy*, in *THE POLITICS OF LAW* 38 (David Kairys ed. 1990); Gergen, *supra* note 12.

69. In this convenient Catch-22, blatantly oppressive moves by the profession are evidence of the professional consensus' moral bankruptcy, while more palatable postures are simply attempts at co-optation. Cf. Karl E. Klare, *Critical Theory and Labor Relations Law*, in *THE POLITICS OF LAW* 61 (David Kairys ed. 1990) (critiquing labor law as disarming radical impulse). Ironically, the arguments here echo the impeccable logic of mainstream professionals: psychiatrists would say, for example, that people who acknowledge that they are mentally ill clearly have a mental illness, while those who reject this characterization are simply in denial. Cf. NISBETT & ROSS, *supra* note 35, at 242-48 (discussing flawed premises of psychoanalysis). But see Balkin, *supra* note 67, at 764-67 (critical theorist cites deconstruction and psychoanalysis as kindred critical theories).

70. Cf. DOUGLAS & WILDAVSKY, *supra* note 7, at 182 (discussing activist groups' responses to technological change). The dependency of critique on an opposing consensus supports a deconstruction of criticism. In this light, critique and consensus are in what Derrida would call a relation of *differance*. Cf. Balkin, *supra* note 67, at 751-53 (discussing deconstructive practice).

71. Cf. ARENDT, *supra* note 9, at 98-111 (participants in French Revolution, such as Robespierre, reacted to hypocrisy of the *ancien regime* by focusing on uprooting of hypocrisy everywhere, instead of on creating workable structure of governance).

72. See Catherine A. MacKinnon, *Feminism, Marxism, Method, and the State: An Agenda for Theory*, 7 *SIGNS* 515, 535-44 (1982).

73. See DENNIS C. MUELLER, *PUBLIC CHOICE* (1979) (importance of agenda for substantive results); Frank H. Easterbrook, *Ways of Criticizing the Court*, 95 *HARV. L. REV.* 802, 817-821 (1982).

confinement, to counter the harping on the "needs" of the patient characteristic of therapeutic discourse.⁷⁴ In contrast, critics of liberal legalism criticize rights while championing needs.⁷⁵ Critical theorist camps in various disciplines often seem like groups of mice in adjacent mazes. Every group seeks to navigate its particular maze, to get the morsel of cheese which dominant professional rhetoric represents; no group can see over the maze's walls to coordinate with others.⁷⁶

These role constraints also damage antiprofessionals' credibility with external audiences. A theorist asserting that psychiatry may be practiced in an authoritarian fashion, but need not be, may sway the community at large. However, a theorist who contends that psychiatry is inherently illegitimate will not persuade enough people to secure meaningful change.⁷⁷

A further effect of role constraints shared by a critical community is the labelling of challenging voices as harbingers of corruption.⁷⁸ When

74. See Ronald Leifer, *Introduction: The Medical Model and the Ideology of the Therapeutic State*, 11 J. MIND & HUMAN BEHAV. 247, 248-249, 255 (1990); Thomas Szasz, *Law and Psychiatry: The Problems That Will Not Go Away*, 11 J. MIND & BEHAV. 557 (1990); Cohen & McCubbin, *supra* note 13, at 470.

75. See Mark Tushnet, *The Politics of Constitutional Law*, in THE POLITICS OF LAW 219, 230-35 (David Kairys ed. 1990); see also Balkin, *supra* note 67, at 764-66 (critical legal scholar praises therapeutic discourse of psychoanalysis). Cf. PATRICIA WILLIAMS, THE ALCHEMY OF RACE AND RIGHTS 146-65 (1991) (criticizing critical legal studies' advocacy of needs over rights); Martha Minow, *Interpreting Rights: An Essay for Robert Cover*, 96 YALE L.J. 1860 (1987) (viewing rights as pathway to dialogic community).

76. Cf. Winter, *supra* note 63, at 650 (discussing tangled self-definition of the "antifoundationalist" critic, Stanley Fish).

77. Critical theorists staking out such positions can respond that they are fashioning a dialectic in which their antithesis will ultimately produce some reasonable synthesis. This view begs the question of whether such antitheses are strategically effective. Empirical accounts suggest that they are not. Sending a dichotomous message is an example of what negotiation theorists describe as "positional bargaining." See Robert J. Condlin, *Bargaining in the Dark: The Normative Incoherence of Lawyer Dispute Bargaining Role*, 51 MD. L. REV. 1 (1992). According to positional bargaining theory, if one will in any case not get all of what one seeks, asking for more means one will get more. Positional negotiators have traditionally followed this route: they ask for say, \$100,000 to settle a personal injury case, assuming that the "other side" will offer \$50,000. The two sides split the difference and settle for \$75,000. However, many commentators note that this tactic does not work over the long haul. See Robyn Dawes et al., *Cooperation for the Benefit of Us—Not Me, or My Conscience*, in BEYOND SELF-INTEREST 97, 98 (Jane J. Mansbridge ed. 1990). Over the long haul, those who mate cooperation with discrete retaliation for the other side's bluffs prosper. Perpetual bluffing is discounted very quickly by the other side, and often leads to losses in credibility, which alienate potential adversaries and allies, alike. Cf. Abrams, *supra* note 9 (discussing feminist strategies).

78. See DOUGLAS & WILDAVSKY, *supra* note 7, at 40-48 (discussing Hima tribe of Uganda). See also POCOCK, *supra* note 6 (discussing corruption in civic republican theory). For an account of some activists from a subordinated community trying to control dissemination of differing views, see Ruthann Robson, *Lavender Bruises: Intralesbian Violence, Law and Lesbian Legal Theory*, 20 GOLDEN GATE U.L. REV. 567, 581-90

difference becomes impurity, potential new members cannot inform the group's agenda with their own experience.⁷⁹ The loss of fresh experience encourages stagnation.⁸⁰

Under the influence of such stagnation, the antiprofessional becomes a mirror of more avowedly paternalistic professionals. The critique of psychiatry exemplifies antiprofessionals' exchange of one brand of mystification for another. True to their professional pedigree, critical theorists diligently avoid contact with citizen groups.⁸¹ When contact occurs, citizens are "addressed"⁸² by antiprofessionals whose confident conception of citizen needs obviates the need for dialogue. For example, antiprofessionals describe people with mental illness as "agents trying to solve existential and identity problems through the construction of atypical beliefs, unusual imaginings, and bizarre speech and gestural behavior."⁸³ Interpretation of this semiological avalanche merely replaces the therapist with the literary critic.⁸⁴

Some antiprofessionals counter the medical authoritarian narrative of individual pathology with an equally reductive political analysis that

(1990) (some lesbians believe that intralesbian violence should not be reported to authorities).

79. That doyens of a group have themselves experienced this discounting of experience is almost a guarantee that they will replicate the exclusion when dealing with the experience of others. Compare MacKinnon, *supra* note 72, at 520-28 (discussing Marxism's failure to come to grips with women's experience), with Abrams, *supra* note 9, at 777-84 (MacKinnon does not appear to empathize with day-to-day struggles of women who accept less-than-equal allocation of responsibilities with men); Harris, *supra* note 30, at 590-601 (MacKinnon does not pay sufficient attention to the interaction of gender and race). Cf. Joyce E. McConnell, *A Feminist's Perspective on Liberal Reform of Legal Education*, 14 HARV. WOMEN'S L.J. 77 (1991) (teaching approach which is politically progressive in most respects may nevertheless replicate gender inequalities in its implementation).

80. Cf. DE GRAZIA, *supra* note 6, at 242-43 (discussing concept of *ozio*, or indolence, in Machiavelli's thought). Of course, my account of critical thought here is also something of a heuristic which explains broadly but sometimes does not defer to the richness of context. Some critical scholars have appreciated the need for a positive program. See, e.g., William H. Simon, *Ethical Discretion in Lawyering*, 101 HARV. L. REV. 1083 (1988) (promoting equality through professional responsibility).

81. See Judi Chamberlin, *The Ex-Patients' Movement: Where We've Been and Where We're Going*, 11 J. MIND & BEHAV. 323, 324 (1990); Phyllis Chesler, *Twenty Years Since Women and Madness: Toward a Feminist Institute of Mental Health and Healing*, 11 J. MIND & BEHAV. 313, 317-18 (1990).

82. See Fraser, *supra* note 12, at 308-09.

83. See Theodore R. Sarbin, *Toward the Obsolescence of the Schizophrenia Hypothesis*, 11 J. MIND & BEHAV. 259, 280 (1990). This theory of the nature of mental illness the author labels as "contextualism." *Id.*

84. See also RORTY, *supra* note 32, for an analogous move: Rorty seeks to free us from the tyranny of professional philosophers asking foundational questions about life and politics, only to deliver us into the hands of equally professional academic literary critics who practice "strong" readings of fiction, strong readings being those readings typified by critical pyrotechnics so counterintuitive that they appeal only to other critics.

ignores individual difference.⁸⁵ Such antiprofessionals demand the banning of certain activities where the risk of false consciousness⁸⁶ allegedly is too great to permit autonomous choice.⁸⁷ While medical authoritarians wish to mandate psychological counseling, psychotropic medication, electroconvulsive therapy ("ECT"), and institutional care, antiprofessionals want support groups to supersede these disfavored treatments.⁸⁸ Such stylized dichotomies impede citizens' using both sup-

85. See Fraser, *supra* note 12, at 306–10. See also HIRSCHMAN, *supra* note 26, at 296 (discussing reductive rhetoric in Marxist thought).

86. For a critique of the concept of false consciousness, arguing that the concept implies the existence of an essential "true" consciousness, instead of the recognition of the conventions which animate all consciousness, see Stanley L. Fish, *Anti-Professionalism*, 7 CARDOZO L. REV. 645 (1986).

87. For an exceptionally thoughtful and provocative analogue to this view, concerned with resistance to dominant social institutions, see Ruthann Robson & S. E. Valentine, *Lov(h)ers: Lesbians as Intimate Partners and Lesbian Legal Theory*, 63 TEMPLE L. REV. 511, 536–41 (1990) (advocating curbs on marriage in order to preserve independent lesbian community).

88. See Albee, *supra* note 12, at 380–81 (proposing ban on psychotherapy). For the judicial reception to attempts to ban ECT, see Northern Cal. Psychiatric Soc'y v. City of Berkeley, 178 Cal. App. 90, 223 Cal. Rptr. 609, *review denied* (1986) (state laws preempt Berkeley ordinance banning ECT); cf. Milner, *supra* note 22, at 476–77 (discussing activist-lawyer relations surrounding banning). See generally 2 PERLIN, *supra* note 13, § 5.57 (discussing ECT). ECT is an effective treatment—perhaps the only one—for people with acute depression, who may decline to eat for protracted periods, or take even more proactive steps toward self-destruction. ECT in such cases may restore a measure of deliberation that permits second thoughts and rebuilt lives. See Charles P. Miles, *Conditions Predisposing to Suicide: A Review*, 164 J. NERVOUS & MENTAL DISEASE 231, 242 (1977). Cf. Alice R. Benedict & Michael J. Saks, *The Regulation of Professional Behavior: Electroconvulsive Therapy in Massachusetts*, J. PSYCHIATRY & L. 247, 251–54 (1987) (discussing literature on ECT). But see Rhonda Copelon, *A Crime Not Fit to be Named: Sex, Lies, and the Constitution*, in THE POLITICS OF LAW 177, 179 (David Kairys ed. 1990) (ECT historically has been used on groups with disfavored lifestyles, such as gays); Leonard R. Frank, *Electroshock: Death, Brain Damage, Memory Loss, and Brainwashing*, 11 J. MIND & BEHAV. 489 (1990) (expressing skepticism about psychiatric community's claims regarding ECT). While careful safeguards, including a judicial hearing, should be necessary for both voluntary and involuntary administration of ECT, eliminating this resource for coping with major depression weakens autonomy as much as blithe resort to coerced ECT does.

A variant of this phenomenon occurs with professionals who wish to end the availability of institutional care for people with disabilities. See IVAN ILLICH, *MEDICAL NEMESIS: THE EXPROPRIATION OF HEALTH* (1976) (advocating complete deprofessionalization of all health care); Nancy Rhoden, *The Limits of Liberty: Deinstitutionalization, Homelessness, and Libertarian Theory*, 31 EMORY L.J. 375, 407–08 (1982) (discussing advocates' views). While the historic failings of psychiatric institutions counsel vast transfers of resources to community-based alternatives, the abolition of institutions would push people into Dickensian shelters, city-hospital emergency rooms, nursing homes, or prisons. See DEAR & WOLCH, *supra* note 16.

It is also possible that in the realm of diverse experience beyond the palace of theory, some people unable to cope with the anomie and entropy of the modern liberal state find community within the structure of psychiatric institutions. See R. Drake et al., *Housing Instability and Homelessness Among Aftercare Patients of an Urban State Hospital*, 40

port groups and therapy to cope with a difficult world.⁸⁹

Viewed in this light, the theorists' demand that treatment consist only of rendering the "patient" into a conscious political self is less a victory of lay passion over professional dominance than a victory of critics over medical clinicians. Both the medical authoritarian and the antiprofessional approach to citizen self-definition echo the U.S. military's excuse in Vietnam: "We must destroy this town in order to save it."⁹⁰

C. Cognitive Constructs and Clozapine

A closer look at how heuristics and biases affect professional attitudes toward clozapine does not yield great cause for optimism about professionals' potential for learning. For advocates and critical theorists, the risks of clozapine are much more cognizable than are its benefits. Agranulocytosis causes death, which is vivid to everyone.⁹¹ Even the remote risk of death drowns out benefits, particularly when the cause of death is perceived as an abnormal intrusion, such as ingestion of a drug.⁹² The vividness of death by medication also obscures harms caused by the absence of the medication.⁹³ A simple matrix illustrates

HOSP. & COMMUNITY PSYCHIATRY 46, 50 (1989); Szasz, *supra* note 74, at 561-62. See also THE ASYLUM, *supra* note 16 (discussing rationale for reformers pressing need for institutional care in early America); Robert Dinerstein, *Rights of Institutionalized Disabled Persons*, in ONE NATION, INDIVISIBLE: THE CIVIL RIGHTS CHALLENGE FOR THE 1990'S 388, 409 (Reginald C. Govan & William L. Taylor eds., 1989) (discussing possible revival of such rationales). Given these troublesome issues, antiprofessionals who wish to abolish psychiatric institutions are reducing self-rule, even as they purport to enhance it.

89. Cf. Chamberlin, *supra* note 81, at 330; Chesler, *supra* note 81, at 318.

90. Cf. Fish, *supra* note 86, at 675-77 (arguing that conceptual moves of antiprofessional theorists reinforce theorists' own professionalism). The only difference between antiprofessionals and professionals is that at least the professional roles of doctor and lawyer involve some kind of legal accountability to clients. The antiprofessional may have an impact on citizens that exceeds the clout of other professionals. Yet she alone is free to actualize the professional's fantasy: power without responsibility.

91. See Tversky et al., *supra* note 5, at 373-74.

92. People tend to underestimate deaths resulting from commonplace instrumentalities, such as cars. Cf. Paul Slovic et al., *Facts Versus Fears: Understanding Perceived Risk*, in JUDGMENT UNDER UNCERTAINTY: HEURISTICS AND BIASES, 463, 465-68 (Daniel Kahneman et al. eds., 1982).

93. It seems natural for actions to have consequences. Detecting the consequences of inaction, however, requires that one be looking already. Absent this effort, inaction fades into the background, out of focus and out of mind. See Amos Tversky & Daniel Kahneman, *The Simulation Heuristic*, in JUDGMENT UNDER UNCERTAINTY: HEURISTICS AND BIASES 201, 207 (Daniel Kahneman et al. eds., 1982). For an example from fiction, see Arthur Conan Doyle, *Silver Blaze*, in GREAT STORIES OF SHERLOCK HOLMES 84, 108-09 (Laurel ed. 1965) (only a great detective could deduce that failure of dog to bark at scene of murder indicated that dog knew the culprit).

these points:

	PATIENT IMPROVEMENT	PATIENT DEATH OR DETERIORATION
WITH CLOZAPINE	A	B (<A)
WITHOUT CLOZAPINE	C (<A)	D (>B)

The grid embodies the following empirical observations. For patients who do not respond to other drugs, clozapine will produce greater improvement than other treatment modalities. Hence, $A > C$. In addition, while some portion (around two percent) of patients risk experiencing dangerous effects because of clozapine (call this portion B), more patients are harmed when clozapine is not available. These patients are at risk in a number of respects. They experience adverse effects when they take other, more dangerous medications; deteriorate further because of the course of their schizophrenia; remain subject to neglect or brutality because the absence of an effective medication keeps them in an institution; or even commit suicide.⁹⁴ If we call this hapless group D, then $B < D$.

The matrix demonstrates how cognitive politics impoverishes public deliberation. An unsatisfying colloquy emerges on the benefits of clozapine versus its risks. Advocates and critical theorists will focus on B—the risks of clozapine—and ignore D.⁹⁵ In contrast, scientific rhetoric

94. See Peter Allebeck, *Schizophrenia: A Life-Shortening Disease*, 15 SCHIZOPHRENIA BULL. 81 (1989).

95. Cf. NISBETT & ROSS, *supra* note 35, at 91–93 (discussing people's inability to interpret matrices similar to the diagram in the text). Representativeness also contributes to this result. Just as representativeness matches up images of mental disability with images of violence, it also matches up clozapine with earlier drugs such as haldol. Advocates skeptical about clozapine associate the new drug with side effects yielded by the earlier medication. While advocates may adjust their perception of clozapine because of positive reports from doctors and clients, their "anchor" of data based on experience with haldol will obscure current wisdom about clozapine's comparative advantages. Cf. Amos Tversky & Daniel Kahneman, *Judgment Under Uncertainty: Heuristics and Biases*, in JUDGMENT UNDER UNCERTAINTY: HEURISTICS AND BIASES 3, 14–15 (Daniel Kahneman et al. eds., 1982) (discussing anchoring).

marginalizes B, by labeling adverse consequences as "side effects."⁹⁶ None of these professional groups considers the context surrounding its own preoccupation. Even more strikingly, none of these groups can shift its frame of inquiry to focus on what citizens want.⁹⁷

D. Citizens

Citizens want to develop their own pragmatic repertoire of experience.⁹⁸ This repertoire involves greater access to a range of services, vehicles for participation in designing and implementing those services, and avenues for peer group deliberation, all without categorical mandates or exclusions erected by professional classes.⁹⁹ Like other previously excluded groups, these citizens realize that making decisions about risk is an emblem of participation in public life.¹⁰⁰ In contrast, ceding

96. See Letter, *supra* note 53, at 1 (noting that a psychiatrist friend broke with the standard lingo and used the term "real effects"). Such effects certainly are not peripheral for patients, who experience them as directly as they feel therapeutic impacts. However, neither adverse effects on patients, nor annoying cavils from colleagues on the accuracy of data, will have much impact on a scientist intent on finding correlations between a drug and increased health. Cf. O'Toole, *The Whistle-Blower and the Train Wreck*, N.Y. TIMES, April 13, 1991, at A29 (discussing author's victimization by scientific superiors because she informed authorities of faulty data in study).

97. Cf. Kimberle Crenshaw, *A Black Feminist Critique of Antidiscrimination Law and Politics*, in *THE POLITICS OF LAW* 195 (David Kairys ed. 1990) (discussing marginalization of experience of African-American women in race and gender debates); Harris, *supra* note 30 (omission of African-American women from gender analysis).

98. See Judi Chamberlin & Joseph A. Rogers, *Planning a Community-Based System: Perspectives of Service Recipients*, 45 AM. PSYCHOLOGIST 1241, 1242 (1990); Judi Chamberlin et al., *Consumers, Families, and Community Programs*, 12 PSYCHOSOCIAL REHAB. J. 93, 101 (1989); see also Edgar & Rothman, *supra* note 42, at 139 (discussing consumer choice in AIDS drugs). Feminist commentators have helped revive interest in pragmatism. See Katharine Bartlett, *Feminist Legal Methods*, 103 HARV. L. REV. 829 (1990). Of course, divisions exist within groups of citizens, as they exist in professional communities. Indeed, as citizens become activists, their effectiveness in the world is matched by their greater susceptibility to the cognitive politics that afflict professionals. See Chamberlin, *supra* note 81, at 329-36.

99. Paul J. Carling, *Major Mental Illness, Housing, and Supports*, 45 AM. PSYCHOLOGIST 969, 972 (1990); Robert E. Emerick, *Self-Help Groups for Former Patients: Relations With Mental Health Professionals*, 41 HOSP. & COMMUNITY PSYCHIATRY 401 (1990); Marc Galanter, *Zealous Self-Help Groups as Adjuncts to Psychiatric Treatment: A Study of Recovery, Inc.*, 145 AM. J. PSYCH. 1248 (1988); Carol T. Mowbray et al., *Consumer-Run Mental Health Services: Results From Five Demonstration Projects*, 24 COMMUNITY MENTAL HEALTH J. 151 (1988).

100. See ROTHMAN & ROTHMAN, *supra* note 16, at 48. See generally DOUGLAS, *supra* note 7, at 73-82 (discussing risk seeking in communities). Cf. *United Auto Workers v. Johnson Controls*, 111 S. Ct. 1196 (1991) (holding that company's fetal protection policy, which limited women's exposure to risky work, violated federal antidiscrimination law); Nadine Schneider & Elizabeth M. Taub, *Women's Subordination and the Role of Law*, in *THE POLITICS OF LAW* 151, 164-70 (David Kairys ed. 1990) (discussing law's role in keeping women from choosing their own risks).

control of risk to professionals is a recipe for subordination.

The nature of citizen experience¹⁰¹ and the organizational needs of citizens' groups offer protection from the biases that afflict medical, legal, and antiprofessional professionals. Citizens lack the luxury of professionals' vicarious experience, which substitutes theory for immediacy. They experience directly both the isolation of mental illness and the intrusiveness of medical interventions. Moreover, citizens encounter the gamut of professional pathologies: the proceduralism of lawyers,¹⁰² the authoritarianism of doctors, and the elitism of critical intellectuals form a continuum of enforced citizen silence.¹⁰³ In breaking this silence, citizens can be both wary of medical claims and studious in seeking appropriate treatment.

The need to make judgments while experiencing conflicting sentiments of skepticism and engagement¹⁰⁴ is a human need that distinguishes citizens from the straw people conjured up by professionals. The conflict between citizens' short and long-term perspectives on clozapine is analogous. A person with mental illness may be concerned about adverse effects of medication, and may also feel comforted in the short term by certain symptoms, such as delusions that he is Napoleon. At the same time, this citizen may feel that in the long term such comforts get in the way of relating to others. To wean himself from these comforts,

Historically, participation in the risky business of defense of the republic was a hallmark of membership in the community. See ARENDT, *supra* note 9, at 129–30; MACHIAVELLI, *supra* note 6, at 486–88; POCOCK, *supra* note 6. For a contemporary view of community self-defense as a criterion of citizenship, see MALCOLM X, *BY ANY MEANS NECESSARY* 29–30 (1970).

101. See ARENDT, *supra* note 9, at 197 (praising experience as guide to action).

102. There are some significant differences between different citizens' groups in this area. For example, some radical psychiatric survivor groups disdain due process protections in the area of forced medication as attempts to buy off discontent without achieving fundamental change. See Chamberlin, *supra* note 81, at 332–33. Radical groups have tended to oscillate between seeking to bar all access to certain treatments, such as ECT, and making all treatments available without any regulation. Other, more consensus-oriented groups have fought hard in the legal arena for due process in medication administration, as one curb on medical arbitrariness. See *Washington v. Harper*, 494 U.S. 210, 239 n.5 (1990) (Stevens, J., dissenting) (citing brief of National Mental Health Consumers' Association seeking judicial hearing prior to forced medication).

103. See *Client Narratives*, *supra* note 10 (describing lawyers' power over clients); Milner, *supra* note 22 (describing degrees of client participation in law reform). Cf. Sarat, *supra* note 46 (noting that welfare clients in study seemed to view bureaucrats and legal services lawyers as part of a process of professional domination). But see Michael Walzer, *Liberalism and the Art of Separation*, 12 POL. THEORY 315, 328–29 (1984) (downplaying role of professionals, and stressing state abuse and class inequities).

104. Cf. Anthony T. Kronman, *Living in the Law*, 54 U. CHI. L. REV. 835 (1987) (discussing attributes of judgment).

the citizen decides, knowing the risks, to participate in a therapeutic regime involving clozapine.¹⁰⁵

The need for practical judgment in the face of conflict shapes citizen attitudes about risk. The status quo relegates people with schizophrenia, like people with AIDS, to dwindling days with a degenerative disease. Changing the status quo through access to clozapine may bring relief. For these citizens and their families, the benefits of clozapine make the risks worthwhile.¹⁰⁶

The organizational needs of consumer groups also discourage the kind of dichotomized thinking that afflicts professionals—the “if you’re not with us, then you’re against us,” approach. Since citizens have many reasons *not* to organize, including the pressure of events in their own lives and a suspicion of hierarchy,¹⁰⁷ citizens’ groups need every member they can get. Shooing away potential members who defy antiprofessional dogma by using clozapine would elevate political correctness over group survival.¹⁰⁸ These factors help explain why organized citizen groups have fought to make clozapine accessible to citizens who want it.¹⁰⁹

105. See Amartya K. Sen, *Rational Fools: A Critique of the Behavioral Foundations of Economic Theory*, in *BEYOND SELF-INTEREST* 25 (Jane Mansbridge ed. 1990). See also IMMANUEL KANT, *FOUNDATIONS OF THE METAPHYSICS OF MORALS* 99–100 (1959 ed.) (true autonomy requires renunciation of short term interests). Cf. ALBERT O. HIRSCHMAN, *SHIFTING INVOLVEMENTS: PRIVATE INTEREST AND PUBLIC ACTION* 68–74 (1982) (discussing relevance of narrow and broad perspectives to political action); Sunstein, *supra* note 26, at 1158–66 (justifying some government measures as means of enhancing role of long-term perspectives). The psychological root of conflict has been explored by Freud, in his familiar division of the self into ego, superego, and id. See SIGMUND FREUD, *THE EGO AND THE ID* (James Strachey ed. 1960).

106. See Gina Kolata, *FDA Urges Special Access to Rejected Alzheimer Drug*, N.Y. TIMES, Mar. 23, 1991, at 7, col. 1. This assessment assumes that citizens as a group participate in all phases of treatment.

A number of factors already present will tend to reduce the incidence of problems which cautious advocates fear. First, the risk of newly discovered adverse effects of clozapine may be lower, since the drug has been used in Europe for twenty years. See Naber & Hippus, *supra* note 15. Second, both denial of illness and just plain good sense about side effects, demonstrated by attempts to secure a right to choose one’s course of treatment, will stop citizens from buying into exaggerated medical claims about clozapine. Third, the high cost of clozapine will minimize its overuse by clinicians.

107. See Chamberlin, *supra* note 81, at 334–35.

108. For the reverse of this phenomenon, see TONI MORRISON, *SULA* 153–54 (1973). Morrison describes how the fictional community of Medallion, which had shown concern for all of its members when the temptress Sula lived to entice people away from the community, fell into indifference toward its members when Sula died. Indifference was a rational reaction of the community to the plight of disaffected members who no longer had any place else to go.

109. See Brief of New York Lawyers for the Public Interest, Inc., Amici Curiae in Support of Plaintiff, *Visser v. Taylor* (App. No. 90–3291) (10th Cir. 1991) (appeal dismissed) (coalition of radical and liberal citizens’ groups joins with disability lawyers, family groups, and organized psychiatry to urge affirmance of district court decision holding that

E. The Professional Frame

In contrast, cognitive politics has led professionals to expose citizens to too much risk, or too little. Doctors, for example, frequently recommend risky treatments on the view that a gamble is better than sitting still as a patient's condition deteriorates. While this approach seems unexceptionable, problems arise because the availability heuristic also makes risky action more appealing for doctors than conservative inaction.¹¹⁰ Doctors achieve fame within the profession through "daring" treatment strategies.¹¹¹ There is no celebration of the doctor who decides to wait, rather than treat. Difficulties with this asymmetrical system of incentives become acute when, as in psychiatrists' touting of hazardous drugs such as haldol, doctors discount unduly the risk of adverse effects from treatment. In addition, because psychiatrists often do not tell their patients about risks, the communal meaning created by citizens sharing risk has no chance to develop.¹¹²

For lawyers and antiprofessional theorists, however, too much risk aversion, not risk seeking, is characteristic. Lawyers' views stem from liberal legalism's traditional risk aversion¹¹³ and apprehension about government abuse. Risk aversion favors a scheme of negative liberty, in which the government leaves people to their private pursuit of happiness. The heady passion of positive liberty, in which citizens share the risks of

clozapine should be covered under Medicaid; case was settled on terms favorable to plaintiffs).

110. See *supra* text accompanying note 93 (discussing availability and action).

111. Cf. Nancy Rhoden, *Litigating Life and Death*, 102 HARV. L. REV. 375, 419-29 (1988) (discussing physician's orientation toward providing treatment).

112. At the same time, psychiatrists historically have been unwilling to let patients assume risks that the patient feels are necessary for self-definition, such as the risks associated with independent living outside of institutions.

113. See ALEXIS DE TOCQUEVILLE, *DEMOCRACY IN AMERICA* 243 (J. P. Mayer & Max Lerner eds., George Lawrence trans. 1966); Robert W. Gordon, *The Independence of Lawyers*, 68 B.U. L. REV. 1, 14-15 (1988). Cf. *Client Narratives*, *supra* note 10, at 2146 (discussing distortions caused by lawyer's stress on winning, rather than on facilitating client's telling of story in manner that secures client's own voice); Cahn, *supra* note 47, at 19 (same); Lucie E. White, *Subordination, Rhetorical Survival Skills, and Sunday Shoes: Notes on the Hearing of Mrs. G.*, 38 BUFF. L. REV. 1, 45-47 (1990). Cf. Bruce A. Green, "Through a Glass, Darkly": *How the Court Sees Motions to Disqualify Criminal Defense Lawyers*, 89 COLUM. L. REV. 1201 (1989) (courts act paternalistically when they disqualify defense counsel who has fully disclosed conflict of interest to client). But see Stephen Ellmann, *Lawyering for Justice in a Flawed Democracy*, 90 COLUM. L. REV. 116, 187-88 (1990) (book review) (justifying certain kinds of paternalism on the part of law reform advocates).

self-governance, breaks too much china for the legal mind.¹¹⁴ For this reason, lawyers' view of a favorable status quo is someone not taking clozapine or any other medication and thereby avoiding the abuses of medical authoritarianism.

The need to preserve a shared vocabulary leads antiprofessional theorists to the same view. Since mental illness is merely a social construct, taking a risk to cope with it represents the kind of false consciousness which the theorist cannot permit. Moreover, supporting use of clozapine expands the reach of the therapeutic vocabulary. The dichotomous nature of interprofessional debate suggests that this expansion could only be at the expense of critical rhetoric. In a society dominated by professional consensus, a rhetoric is all the critics possess. Without the prospect of some greater stake in society,¹¹⁵ critical theorists have little reason to risk the only thing they have. The tragic element of this drama is that critical theorists often take great risks in developing their own vocabulary.¹¹⁶ Keeping that vocabulary, however, requires depriving subordinated citizens of the right to take risks in constructing a vocabulary of their own.¹¹⁷

Cognitive politics makes professionals think about preserving their own community's discourse before they think about citizens or society. In the matter of clozapine, liberal legalists and antiprofessionals seem most culpable.¹¹⁸ The irony here is that their attachment to rigid roles

114. Cf. ARENDT, *supra* note 9, at 115-40 (discussing difference between public and private happiness).

115. See Zorn, *supra* note 26, at 302 (arguing that granting greater stake to warring tribes in Papua New Guinea would promote harmony).

116. See Richard L. Abel, *Evaluating Evaluations: How Should Law Schools Judge Teaching?*, 40 J. LEGAL EDUC. 407, 409-10 (1990) (discussing problems of critical legal scholars in securing tenure).

117. For example, some critical theorists assert that heterosexual sex is inherently coercive. See MacKinnon, *supra* note 72, at 532-41. Cf. Abrams, *supra* note 9 (discussing and critiquing MacKinnon); Celina Romany, *Ain't I a Feminist*, 4 YALE J. OF L. & FEMINISM 23 (1991). Under this view, women should not run the risk of coercion by participating in heterosexual relationships, whether or not those relationships are abusive in a less metaphysical sense. Cf. Naomi R. Cahn, *Civil Images of Battered Women: The Impact of Domestic Violence on Child Custody Decisions*, 44 VAND. L. REV. 1041 (1991) (consent is illusory in abusive relationships); Joyce E. McConnell, *Beyond Metaphor: Battered Women, Involuntary Servitude and the Thirteenth Amendment*, ____ TEX. WOMENS L. J. ____ (forthcoming 1992). The groundedness that some women may feel in heterosexual relationships, which may help them continue to struggle for equality, is suspect in the critical essentialist's state.

118. The relative helpfulness of physicians, however, seems like more of a coincidence of role conception and correct result than a general proof of the superiority of medical discourse. Conversely, some lawyers have pursued a more activist approach. Consumers represented by New York Lawyers for the Public Interest have sued successfully to require Medicaid reimbursement for clozapine, see *Alexander L. v. Cuomo*, No. 40389/91 (S. Ct. N.Y. Co. April 4, 1991), as have advocates in Kansas, see *Visser v. Taylor*, 756 F. Supp. 501 (D. Kan. 1990), and Iowa, see *Doe v. Palmer*, C 90-4101 (N.D. Iowa). The federal

promotes the kind of medical overreaching which they fear. If lawyers and theorists merely react to the introduction of clozapine in institutions, they will have to catch up with doctors while abuses continue to occur. Mental health professionals will have become attached to the power they wield in setting the terms for clozapine administration. Departures from the medical authoritarian model will be less cognitively available than the status quo of deference to mental health professionals' judgment. Cognitive "politics as usual" will be the rule; as usual, citizens will suffer.

II. A MODEL OF PARTICIPATORY ENTITLEMENTS

The way to cope with the vagaries of cognitive politics is through a model of participatory entitlements.¹¹⁹ The premise of the model is that citizens deliberating together and with a spectrum of professionals, subject to judicial review, can uncover the perspectives obscured by cognitive politics.¹²⁰ This model enhances dialogue, protects rights, and nurtures the community of citizens which contending professional groups generally suppress.

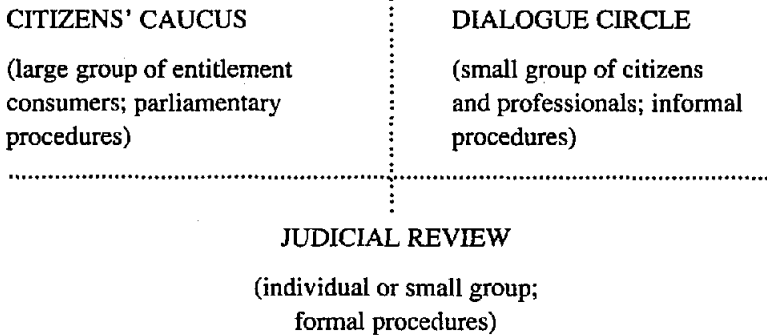
Under the model, medication decisions are made by three governance bodies—a citizens' caucus, a dialogue circle, and a court—which com-

Department of Health and Human Services has subsequently agreed to provide Medicaid coverage for clozapine. Nevertheless, Medicaid does not cover most residents of psychiatric institutions. The Pennsylvania Protection and Advocacy for the Mentally Ill office, along with a relatives' organization, has negotiated a consent decree that provides for prescription of clozapine in all appropriate cases and for citizen and family participation in clozapine monitoring. Pennsylvania had been operating with a lottery which selected only a limited number of the pool of appropriate cases for treatment. See *Alliance for the Mentally Ill of Pennsylvania v. White*, 1991 WL236483 (E.D. Pa. 1991).

119. Ideas of participation and membership have become a vital force in contemporary political and legal theory. See PITKIN, *supra* note 6, at 299–306; Frank Michelman, *Law's Republic*, 97 YALE L.J. 1493 (1988); Cass K. Sunstein, *Beyond the Republican Revival*, 97 YALE L.J. 1539 (1988). Participation has often been a theme in disability and mental health law. Federal legislation has consistently cited notions of membership as a justification for bars on discrimination, and for reasonable accommodation requirements. See Fair Housing Amendments Act, 42 U.S.C. §§ 3601–3631; 134 CONG. REC. S10,556 (daily ed. Aug. 2, 1988) (remarks of Sen. Cranston). Moreover, the whole community mental health movement has as a cornerstone notions of participation—promoting the interaction of formerly institutionalized citizens and other elements of society. See ROTHMAN & ROTHMAN, *supra* note 16.

120. Cf. NISBETT & ROSS, *supra* note 35, at 291 (arguing that increased participation is an effective remedy for cognitive distortions); Baruch Fischhoff, *Debiasing*, in JUDGMENT UNDER UNCERTAINTY: HEURISTICS AND BIASES 422, 438–39 (Daniel Kahneman et al. eds., 1982) (restructuring problem can reduce cognitive distortions). For discussion of another kind of transition from one legal paradigm to another, see McDougall, *Lawyering and the Public Interest in the 1990's*, 60 FORDHAM L. REV. 1 (1991).

plement each other in composition, scale, and degree of formality.¹²¹ The model looks like this:



Each setting is designed to flush out a different deliberative element necessary for sound decisions. Judicial review offers fairness and ritual. Dialogue circles provide attention to individual context. Citizens' caucuses provide passion.

The following subsections discuss how the model would work.

A. The Citizens' Caucus

Citizens' caucuses would serve as self-governance groups¹²² in institutions and community residences. Caucuses would have veto power over mental health professionals' decisions to administer or terminate medication.¹²³ In review of medication decisions, an appropriate stan-

121. This mix of deliberative settings is roughly analogous to the ancient republican structure of "the one, the few, and the many." See ARENDT, *supra* note 9, at 150-54; MACHIAVELLI, *supra* note 6; POCOCK, *supra* note 6; THE FEDERALIST No. 10 (JAMES MADISON) (McLean ed. 1788); Cass K. Sunstein, *Interest Groups in American Public Law*, 38 STAN. L. REV. 29, 38-45 (1985). The signal difference is that there is no chief executive, consul, or prime minister in this Article's formulation. For the kind of adjudicative functions at issue here—whether or not a citizen should take a given medication—a chief executive is unnecessary and would only distort the process.

122. Cf. ARENDT, *supra* note 9, at 232-81 (describing virtues of self-government); OLIVER SACKS, *SEEING VOICES: A JOURNEY INTO THE WORLD OF THE DEAF* 125-59 (1989) (discussing rebellion of deaf students at Gallaudet University over administration's refusal to hire deaf president); Edgar Cahn & Jean Cahn, *Citizen Participation*, in *CITIZEN PARTICIPATION IN URBAN DEVELOPMENT* 211 (Hans B. C. Spiegel ed. 1968); *Client Narratives*, *supra* note 10, at 2136-37 (discussing power of client group discourse); Chamberlin, *supra* note 81, at 325-26 (advocating exclusion of professionals from citizen groups).

123. Caucuses, as well as citizens' relatives, would also have the right to monitor citizens for the presence of harmful effects from treatment. Letter from Jay Centifanti, Pennsylvania Protection & Advocacy for the Mentally Ill, to Gilbert Honigfeld, Sandoz

dard would permit medication only in an emergency involving imminent danger to self or others, or when the citizen was incompetent to make a decision herself.¹²⁴ Parliamentary procedure would govern deliberations of the caucus. Each citizen in an institution would be a member; if members chose, they could exclude professionals.

Caucuses redress some of the power imbalance that renders the citizen naked before medical authoritarianism. The development of a community clothes the consumer in the fabric of shared experience.¹²⁵ Participation provides an avenue for passion that would otherwise dissipate in unfocused acts of resistance,¹²⁶ while the adoption of parliamentary procedure insures some structure.

While a skeptic might suggest that such a scheme involves letting "the inmates run the asylum,"¹²⁷ giving people with mental disabilities a substantial voice in treatment decisions makes sense in terms of fairness, efficiency, and therapy. Fairness suggests that if the state requires people to live together, it should give them an opportunity to make collective decisions that affect their common interests.¹²⁸ Efficiency concerns tell the same tale. Only the cognitive politics of representativeness—viewing superficial similarities as emblems of inevitable connections—lead to the view that people with mental illness lack *all*

Pharmaceuticals, February 25, 1991 (on file with the author) (discussing citizen and family involvement in monitoring).

124. See *Rivers v. Katz*, 67 N.Y.2d 485 (1986).

125. See generally MICHAEL J. SANDEL, *LIBERALISM AND THE LIMITS OF JUSTICE* (1982) (discussing constitutive nature of groups); Dawes et al., *supra* note 77 (empirical study of cooperative behavior). For examples of peer group education as community-building activity, see Shaw, *Preventing AIDS Among Women: The Role of Community Organizing*, in *THE AIDS READER: SOCIAL, POLITICAL AND ETHICAL ISSUES* 505 (Nancy F. McKenzie ed. 1991); Bambi Sumpter, *We Have a Job to Do*, in *THE ACT-UP/NY WOMEN & AIDS BOOK GROUP, WOMEN, AIDS & ACTIVISM* 223 (Cynthia Chris & Monica Pearl eds., 1990); Gitlin, *supra* note 34. See also SUSAN M. OLSON, *CLIENTS AND LAWYERS: SECURING THE RIGHTS OF DISABLED PERSONS* (1984) (discussing lawyer and client involvement in efforts to secure accessible transit for people with disabilities); Milner, *supra* note 22 (discussing interaction of organizing and lawyering in right to refuse medication cases).

126. Cf. Regina Austin & Sharon Dietrich, *Employer Abuse of Low-Status Workers: The Possibility of Uncommon Relief from the Common Law*, in *THE POLITICS OF LAW* 350, 353, 357–58 (David Kairys ed. 1990) (discussing isolated acts of resistance such as employee pilferage and excessive bathroom breaks).

127. Cf. BROOKS, *supra* note 22, at 53 (describing objection to right to refuse medication).

128. The imagery of individual patients, each involved in an individual therapeutic interaction with the physician, is as misleading as the notion that each college student in a history survey course has a purely individual relationship with the professor. In both settings, group interactions—patients with other patients, students with other students—determine the effectiveness of the program. Cf. Dawes et al., *supra* note 77 (discussing role of collaboration in reaching mutually meaningful decisions).

judgment. Looked at dispassionately, patients have access to much better data about themselves, and about other patients, than do mental health professionals.¹²⁹ In addition, therapy is enhanced by the participation that results from citizen self-governance. The current regime of medical authoritarianism removes responsibility from the person with mental illness. Since coercion will enforce the physician's wishes in any case, the citizen can "participate" only by playing a role of resistance. When the person with mental illness has concrete authority, however, such role playing is a luxury she cannot afford.¹³⁰ The all-citizen composition of the caucus accomplishes the same result. While cognitive politics encourage polarized citizen responses to professional descriptions of citizen "needs," the same comments made by other citizens become a basis for dialogue.

B. Dialogue Circles

Decisions of citizens' caucuses would be sent to dialogue circles—small groups with two-thirds professional and one-third citizen membership.¹³¹ Professionals would include critical theorists, lawyers, and mental health experts, while citizens would include people with physical disabilities,¹³² as well as people with mental disabilities. Informal pro-

129. Professionals, particularly doctors, spend the bulk of their time in offices, far removed from patients. In contrast, psychiatric in-patients interact constantly; they cannot exit from one another. Cf. HIRSCHMAN, *supra* note 52 (noting that necessity can induce participation).

130. Cf. MACHIAVELLI, *supra* note 6, at 236–37 (accession to authority shifts perspective).

131. The citizen dominance of caucuses, which would name citizen representatives to dialogue circles, justifies the majority status of professionals in the latter body. However, some consumers might feel that professional advantages of power and information require even greater consumer representation. For discussions of citizen-professional collaboration, see *Client Narratives*, *supra* note 10, at 2107; Joel F. Handler, *Dependent People, The State, and the Modern/Postmodern Search for the Dialogic Community*, 35 UCLA L. REV. 999 (1988). See also Robert Cole, *Work Reform and Quality Circles in Japanese Industry*, in CRITICAL STUDIES IN ORGANIZATION AND BUREAUCRACY 421 (Frank Fischer & Carmen Sirianni eds., 1984) (discussing collaborative approaches); William H. Simon, *The Politics of "Cooperation" at the Workplace*, RECONSTRUCTION, Winter 1990, at 18 (critiquing such approaches); Clarence J. Sundram, *Informed Consent for Major Medical Treatment of Mentally Disabled People: A New Approach*, 318 NEW ENG. J. MED. 1368 (1988) (discussing interdisciplinary approach to bioethics); see generally Susan Bryant, *Collaboration, Models of Joint Work* (unpublished manuscript on file with the author) (discussing collaboration).

132. Citizens with physical disabilities can offer a narrative of technology as empowerment to balance mental health law's ancient story of technological oppression. See SACKS, *supra* note 122, at 152 n.* (discussing uses of technology in mobilizing deaf community); Ellen M. Saideman, *Helping the Mute to Speak: The Availability of Augmentative Communication Devices Under Medicaid*, 17 N.Y.U. REV. L. & SOC. CHANGE 741 (1989–90); Mary Johnson, *Mother Theresa and the Elevator*, THE DISABILITY RAG,

cedures would govern deliberations.¹³³

Dialogue circles complement citizen caucuses. Small groups can be less intimidating, and less alienating—the possibility of persuading others seems more concrete, while only the most angry or assured feel that they can move a crowd. Just as a seminar compares with a large classroom, everyone in a small group feels some healthy pressure to express herself, making it more difficult to rely solely on the input of voluble colleagues.¹³⁴

The need to engage with other members of the group on an ongoing basis also promotes productive interchange, with less of the posturing which plagues larger groups.¹³⁵ For example, the citizen can assist the antiprofessional parries of liberal legalist or medical authoritarian rhetoric.¹³⁶ While the critical theorist provides a structure for the citizen's experience of professional domination, the citizen can supplement theory with experience.

Consider a citizen and a critical theorist presenting a case to the dialogue circle. If the critical theorist claims that an acutely depressed patient who has not eaten for days is engaging in behavior that is functional

Jan.-Feb. 1991, at 29, 31 (quoting the head of New York City Mayor's Office for Persons with Disabilities as noting that technology has given people with disabilities greater mobility and flexibility). See also *Southeastern Community College v. Davis*, 442 U.S. 397, 412 (1978) (technology will create opportunities for employment and participation for people with disabilities).

People with physical disabilities can also form political coalitions with people with mental disabilities, based on these groups shared consciousness of exclusion. See Chamberlin, *supra* note 81, at 335. See generally OLSON, *supra* note 125, at 47–51 (discussing difficulties of uniting disparate groups of people with disabilities).

133. On the virtues and drawbacks of informal procedures, see Beryl Blaustone, *Training the Modern Lawyer: Incorporating the Study of Mediation into Required Law School Courses*, 22 SW U. L. REV. _____ (forthcoming 1992); Harry T. Edwards, *Alternative Dispute Resolution: Panacea or Anathema?*, 99 HARV. L. REV. 668 (1986); Marjorie A. Silver, *The Uses and Abuses of Informal Procedures in Federal Civil Rights Enforcement*, 55 GEO. WASH. L. REV. 482 (1987).

134. See Jane Mansbridge, *Feminism and the Forms of Freedom*, in CRITICAL STUDIES IN ORGANIZATION AND BUREAUCRACY 472, 477–78 (Frank Fischer & Carmen Sirianni eds., 1984); OLSON, *supra* note 31, at 53–57. Cf. MORTON M. HUNT, *THE COMPASSIONATE BEAST* 132–37 (1990) (in “bystander effect,” diffusion of responsibility among large number of people inhibits response to person in need).

135. Cf. Cahn, *supra* note 10, at 23–51 (discussing relational contracts). See generally Bruce Ackerman, *Why Dialogue?*, 86 J. PHIL. 5, 16–22 (1989) (discussing rules for political deliberation).

136. Cf. Charles R. Schwenk, *Effects of Devil's Advocacy and Dialectical Inquiry on Decision Making: A Meta-analysis*, 47 ORG. BEHAV. & HUM. DECISION PROCESSES 161 (1990) (introducing critical element into decision-making improves results over reliance on monolithic expert group).

from the patient's point of view,¹³⁷ the citizen may tactfully observe that eating at some point will help the patient continue to function. If, in another case, a physician wants to medicate a patient whose pathological lack of ambition manifests itself through sitting all day and watching reruns of "The Love Boat," the critical theorist and the citizen can point out that such a standard might result in much of the country being medicated.

Together, the citizen and theorist can resist professional domination. The opportunity for such concrete resistance gives each a stake in collective decisionmaking.¹³⁸ The presence of professionals also gives citizens access to information that caucuses cannot develop efficiently on their own.¹³⁹ In sum, the combination of caucuses and dialogue circles amplifies conversations muffled by the usual routine of cognitive politics.¹⁴⁰

137. See Gergen, *supra* note 12, at 366.

138. Confidentiality problems would arise from having patients hear and read details about the clinical conditions of other patients. One possibility would be to permit patients with matters which a work group wished to address to consent to this sharing of information. Of course, such a decision might not be truly voluntary, since appearing before a dialogue circle or citizens' caucus would be the only way to counteract a ward physician's recommendation. The more honest approach might be to acknowledge the problem, but argue that having true peers exercise a substantial decisionmaking role would be worth a loss in privacy. Privacy here is a relative term in any case. What privacy really means in this context is that one discloses all to professionals, such as lawyers, doctors, and judges. The only thing necessary about professional involvement is that society has decided it is necessary. Society could also decide that peer input is at least as important as professional input.

139. Citizen groups which exclude professionals pay a price. For example, ex-patients groups came late to the struggle for passage of the Americans With Disabilities Act. See Chamberlin, *supra* note 81, at 335. Professional input may have speeded up this process.

140. Courts could mandate formation of these governance bodies as one element of informed consent or as a remedy for violations of the right to treatment. *Cf.* Handler, *supra* note 131, at 1002-05 (discussing nugatory impact of informed consent as practiced). For a pioneering case on informed consent, see *Salgo v. Bd. of Trustees*, 317 P.2d 170 (Cal. Dist. Ct. App. 1957). The right to treatment guaranteed by the due process clause requires that the state treat someone whom it confines in the mental health system. To pass muster under the due process clause, professional judgment must support the treatment provided. See *Youngberg v. Romeo*, 457 U.S. 307, 323 (1982); *Society of Good Will to Retarded Children v. Cuomo*, 902 F.2d 1085 (2d Cir. 1990). Due process may also forbid confining someone in the mental disability in-patient system if such confinement leads to deterioration of skills which the person had before entering an institution. See *Romeo*, 457 U.S. at 327-29 (Blackmun, J., concurring). An institution's failure to dispense clozapine in cases where clinical indications favor its use violates the professional judgment standard. This failure deprives citizens of *any* meaningful treatment, since other possible treatments are not effective for this group. A person with schizophrenia confined without clozapine will deteriorate in the institution. The result is that confinement becomes custodial, not therapeutic. Making clozapine available with peer monitoring and consultation is one way of remedying this problem. See *Alliance for the Mentally Ill of Pennsylvania v. White*, No. 90-6389 (E.D. Pa. 1991) (consent decree).

C. Judicial Review

Judicial review is vital for protecting these conversations between professionals, theorists and citizens. Even with the complementary governance bodies described above supplying a new richness of perspectives, cognitive politics will surely corrupt some decisions. The hegemony of medical authoritarianism will persist, if committed mental health professionals dominate apathetic citizens. Moreover, the relatively informal procedures of the governance structure may trigger passivity in certain groups, such as women, whose socialization stresses deferential modes of conversation.¹⁴¹ Danger will arise also because oppressed people sometimes oppress each other, learning the lessons of the master too well.¹⁴² Seduced by the representativeness heuristic, governance bodies may view difference as an emblem of impurity.¹⁴³ Governance bodies may end up as the plaything of a few citizens who have a grudge against one of their peers.¹⁴⁴ Citizens' caucuses, far from being the merry band of treatment refuseniks of whom psychiatrists' nightmares are made, may actually be more eager to medicate than their white-coated keepers.¹⁴⁵

De novo judicial review of governance decisions to initiate or terminate medication¹⁴⁶ will curb such excesses. The judiciary can at its

141. See DEBORAH TANNEN, *YOU JUST DON'T UNDERSTAND: WOMEN AND MEN IN CONVERSATION* (1990); Mansbridge, *supra* note 134, at 476; White, *supra* note 113, at 14-19.

142. Cf. Harris, *supra* note 30, at 599-601 (describing white women's historical involvement in using rape laws as device for subordination of African-American males).

143. For example, in the last 150 years, nonprofessionals, as well as professionals, have stigmatized gay and lesbian orientations. See Copelon, *supra* note 88.

144. Cf. ARENDT, *supra* note 9, at 88-100 (describing how passion of French Revolution facilitated will to power of few); HIRSCHMAN, *supra* note 105, at 101 (describing how participation creates attachment to exercise of power); HIRSCHMAN, *supra* note 26, at 242-43 (activists can engage in self-dealing at expense of constituents).

145. Prospect theory suggests that citizen councils may be more concerned with the risk of loss than with the prospect of gain. For those who have to live with the results, medicating someone who seems to present a threat is a more salient imperative than avoiding unnecessary medication.

146. Due process rights should apply to termination of clozapine treatments, as well as involuntary medication. While initiation spurs risks, such as agranulocytosis, termination can also create problems: withdrawal of the medication can trigger relapses in symptomatology, with manifestations even worse than they were prior to treatment initiation. See Blackburn, *supra* note 3, at 455. In addition, due process in termination of medication will enhance physician autonomy by giving physicians leverage against cost-cutting bureaucrats who wish to churn clozapine recipients to reduce costs. See generally B. Eichelman & A. Hartwig, *Ethical Issues in Selecting Patients for Treatment With Clozapine: A Commentary*, 41 HOSP. & COMMUNITY PSYCHIATRY 880, 881 (1990) (mentioning that due process rights for termination would be appropriate).

best discern common interests through the haze of cognitive politics.¹⁴⁷ The rhetoric, procedures, and ritual of courts combine to complement the decisional settings already discussed.

Courts provide more formal procedures and the clear opportunity to be heard. The noise of groups—many people talking at once, with speakers and decisionmakers commingled—is not present in court, where a judge, if she wishes, can speak directly to the claimant, and vice versa.¹⁴⁸ This characteristic of courts encourages the involvement of people ill at ease with the more amorphous qualities of participatory governance.¹⁴⁹ Courts also offer a rhetoric of neutrality that reflects some commitment to decisionmaking detached from wars over professional vocabulary.¹⁵⁰ The heavy dose of ritual in judicial proceedings—the gown, the gavel, the oath—adds further legitimacy.¹⁵¹ Because of these elements, judicial review enhances the quality of citizen education and deliberation. A citizen may be more amenable to hearing from a judge that she should take medication, rather than hearing the same message from a citizens' caucus or dialogue circle. These bodies may be partial; by design, they substitute involvement for impartiality. While citizens can discount their decisions by arguing that they were interested in the result, the same claim is less persuasive with a judicial finding.¹⁵² Moreover, without judicial review, citizens who disagree

147. See LUBAN, *supra* note 43, at 364–80 (arguing for judicial intervention to solve collective action problems); Michelman, *supra* note 119; Frank I. Michelman, *The Supreme Court 1985 Term—Foreword: Traces of Self-Government*, 100 HARV. L. REV. 4 (1986).

148. On the participatory promise of due process generally, see *Goldberg v. Kelly*, 397 U.S. 254 (1970); William Brennan, *Reason, Passion, and "The Progress of the Law,"* 10 CARDOZO L. REV. 3, 19–22 (1983); White, *supra* note 113, at 3–4, 57–58.

149. An exhaustion requirement would promote citizen participation in caucus and dialogue circle decisionmaking.

150. This rhetoric may mask the judge's selection of the professional view which seems most reliable, typically the medical view. See Chamberlin, *supra* note 81, at 332–33. Cf. Tom R. Tyler, *Justice, Self-Interest, and the Legitimacy of Legal and Political Authority*, in BEYOND SELF-INTEREST 171 (Jane Mansbridge ed. 1990) (respect for courts hinges on perceptions of neutrality and detachment). But see Joseph W. Singer, *The Player and the Cards: Nihilism and Legal Theory*, 94 YALE L.J. 1 (1984) (critical legal scholar argues that law is frequently indeterminate, not objective).

151. Judicial findings, rather than a simple yes or no order, should be required, to ensure the judge's consideration of public values and protect the judge's appearance of impartiality. Cf. MACHIAVELLI, *supra* note 6, at 156–60 (discussing importance of ritual); McLean, *Social Values and the Distribution of Risk*, in VALUES AT RISK 75, 86–88 (Douglas MacLean ed. 1986); Lawrence H. Tribe, *Trial By Mathematics: Precision and Ritual in the Legal Process*, 84 HARV. L. REV. 1329, 1368–77 (1971). But see Zorn, *supra* note 26, at 289 (ritual of courtroom can legitimize hegemonic interests).

152. See David B. Wexler, *Grave Disability and Family Therapy: The Therapeutic Potential of Civil Libertarian Commitment Codes*, 9 INT. J. L. & PSYCHOL. 39 (1986); F. Courmos et al., *A Comparison of Clinical and Judicial Procedures for Reviewing Requests for Involuntary Medication in New York*, 39 HOSP. & COMMUNITY PSYCHIATRY 851, 855 (1988). Cf. Mark Amaya & W. V. Burlingame, *Judicial Review of Psychia-*

with governance decisions will engage in risk-seeking behavior that is dangerous to others, such as acting out. These citizens have nothing left to lose. In contrast, by holding out the prospect of gain without requiring risk-seeking behavior, judicial review creates a climate that permits citizens to resolve differences without harming others.¹⁵³

To attain these benefits without creating additional distortions, only citizens' appeals should be reviewable. Review should not be available for decisions to overrule treatment professionals' recommendations. This limitation has two purposes. First, it redresses the lingering power imbalance between doctors and citizens. Second, it obliges doctors to make their best case to citizens' caucuses and dialogue circles, instead of relying on courts to ratify the medical agenda.¹⁵⁴ By the same token, citizens will have to accept responsibility for difficult decisions, instead of relying on courts to order medication when governance bodies have rejected it.

The foregoing model presents a repertoire of decisional strategies. The passion of citizens' caucuses complements the pragmatism of dialogue circles, while judicial review insures fairness. The shape of procedural safeguards dissolves desperation, but preserves sufficient risk to drive participation in governance bodies. As the polarizing forces of cognitive politics fade, the real work of dialogue can begin.

CONCLUSION

The regime set out above involves a restructuring of the way professionals talk to citizens and to each other. The concept of cognitive politics, particularly the study of heuristics and attitudes toward risk,

tric Admissions: The Clinical Impact on Child and Adolescent Inpatients, in THERAPEUTIC JURISPRUDENCE 281, 289-90 (David B. Wexler ed. 1990) (discussing one salutary experience in hearing, although generally disapproving of judicial review of clinical decisions). *But see* Franklin & Kosaki, *supra* note 9 (judicial decisions, such as abortion rulings, which confront shared beliefs may polarize environment).

153. *Cf.* MACHIAVELLI, *supra* note 6, at 130-34 (discussing "faculty of accusation" in Roman republic); Minow, *supra* note 75, at 1907-08 (discussing effect of rights on dialogue). To the extent that judicial review creates more certainty for citizens, it may encourage greater participation in the entire governance system. *See* John E. Sawyer, *Effects of Risk and Ambiguity on Judgments of Contingency Relations and Behavioral Resource Allocation Decisions*, 45 *ORG. BEHAV. & HUM. DECISION PROCESSES* 85 (1990) (greater certainty promotes expenditure of more time and effort). *But see* Tushnet, *supra* note 75 (invocation of rights can eviscerate participation in governance).

154. *See* HIRSCHMAN, *supra* note 52 (barring exit from some activities increases incentives for participants in activities to make their voices heard); William H. Simon, *Contract Versus Politics in Corporation Doctrine*, in THE POLITICS OF LAW 387, 396 (David Kairys ed. 1990).

help explain the dynamics of traditional interprofessional and citizen-professional dialogue. Professional roles are cognitively available narratives that impose order on an unruly body of experience. The representativeness heuristic suggests that differences from these available narratives are not complementary, but hostile.

This polarized dynamic influences how professional groups frame questions, and how they act in the face of risk. Lawyers view risk as any instrumentality outside the client that can harm the client. Doctors focus on the inside of the patient and ignore external risks rooted in sociopolitical inequality. Antiprofessional theorists view risk critically, as anything proposed by other professionals. The only common ground of these vocabularies is that each seeks to control decisions about the risks citizens take.

Clozapine illustrates the potential for conflict between citizen and professional conceptions about risk. For lawyers and critical theorists, seeking clozapine requires revision of a favorable status quo in which stories about distrust of state power and professional dominance shape functioning professional communities. As long as these communities do not face a fundamental loss of credibility, the benefits of revising their narratives of suspicion are not worth the risk that such a revision will undermine their reason for being.¹⁵⁵ Citizens, in contrast, often do not view symptoms of mental illness as part of a favorable status quo. Because assertion of some control over symptoms is essential for their participation in any community, taking clozapine may be worth the risks. The professional monopoly on decisions about risk defeats citizen visions of community, both when doctors underestimate the risks of treatment technology, and when lawyers and critical theorists underestimate the risks of mental illness.

Participatory entitlements are an alternative to this conflict between professionals and citizens. Through three complementary governance bodies—the citizens' caucus, the dialogue circle, and the judicial hearing—citizens assume the risks of responsibility, and receive professional input without professional dominance.¹⁵⁶ For professionals, participatory entitlements remove the artificial constraints of role. Lawyers see citizens as members of a community, not as the deracinated rights-bearers of liberal theory.¹⁵⁷ Doctors accustomed to prescribing obedi-

155. Some lawyers define themselves in a different light, as facilitators of citizen participation. They will be more activist about obtaining clozapine.

156. This model may also be useful in other settings, such as government benefits, housing, general health care, the workplace, and education.

157. Lawyers may feel some tension between zealous advocacy for a citizen and a therapeutic conception of the citizen's best interest. However, the most serious enemy of the zealous advocate is not knowledge of other disciplines, but a general lack of diligence. Cf. Benedict & Saks, *supra* note 88, at 264–67 (demonstrating empirically that negligent doc-

ence learn about listening. As antiprofessional theorists participate in decisions that affect citizens' lives, they produce less glib theorizing and more grounded theory.

The conversations that characterize this revision of roles will not be risk-free. Passionate disagreement and vituperation will be frequent visitors. However, for participants with mutual commitments to collaboration, anger is cathartic.¹⁵⁸ Indeed, games such as "sandbagging the psychiatrist," "carping at the critic," and "attacking the attorney" should be recurring features of the discourse of governance.¹⁵⁹

To transform cognitive politics, all participants must be willing to seek a further risk—the risk that their roles will change fundamentally. For many, this risk is the hardest of all to accept. Embracing it, however, is the best hope for meaningful dialogue entering the cognitive politics of citizen-professional discourse.

tors are least likely to apply lessons of professional literature). Moreover, since doctors are not immune from the appeal of rights-based rhetoric, *see* Sadoff, *supra* note 19, professional tensions should wash out.

158. *See* MACHIAVELLI, *supra* note 6, at 118–21; MALCOLM X, *THE LAST SPEECHES* 33–34 (Bruce Perry ed. 1989).

159. *Cf.* *Client Narratives*, *supra* note 10, at 2136–37 (discussing importance of "play").

