Law and Medicine

The Case Against Role Blurring

NILS CHRISTIE – *University of Oslo*

Some standard conflicts seem to appear again and again in the relationship between law and medicine. Lawyers are accused of showing undue concern for the past, for formalities, for retribution, and for deterrence, as well as having a basic lack of skill in the handling of human needs. Medical people are accused of disregarding law and the needs of society, and also of often overstepping individual rights in their eagerness as "good-doers." Imperialists within both camps demand more scope for their particular approach. Delinquents, drinkers, psychopaths, or drug abusers—a continuous battle rages between these major professions as to whom these problems belong. There are property claims in human and social problems as well as in land.

And who is right? Who *ought* to own these problems? Lawyers, doctors, or maybe social workers? I think none of them. Let me try to show why through an analysis, admittedly oversimplified, of some major characteristics of law and of medicine. I will take as my point of departure a description of these institutions within their core areas, when they are working with traditional clients within their traditional organizational framework. Lawyers and judges in the courtroom setting and doctors and nurses in the operating room might be well-suited examples. Admittedly, these situations give a somewhat exaggerated

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picture of the differences between law and medicine. Preventive work—pretrial and public health work, for example—is ignored. On the other side, court trials and surgery are dramatic ideal types. They symbolize and influence much of the daily activity within these institutions. They are situations where the role incumbents do what they are particularly trained to do while enrolled in professional schools as well as in the first years of apprenticeship. Here they live up to some celebrated public images. And here they function in an organizational setting shaped through generations of trial and error.

There are other core roles and settings both for doctors and lawyers, but the operating room and the courtroom have particular advantages as settings where the role incumbents work together as groups of experts rather than as individual performers.

Law is an institution geared to handle conflicts. Lawyers are, in the great majority of cases, confronted with parties having real or potentially conflicting interests. Their major task is to prevent or solve these conflicts. Basic features of the institution of law are geared to fulfill this need and have no meaning except in relation to this task.

Prevention and solution of social conflicts play no major part in the daily workload of medical personnel. In their case parties have a substantial amount of shared interests. What a doctor does may create more pain for clients than the decisions of a judge. A doctor's act may even cause death. But the doctor's pain-producing activities are still carried out within an institution designed for cooperation between consenting parties. It is more difficult to find a brief expression to characterize the major activity here. Let me tentatively suggest the primary goal as "restoring health" through a system organized for maximum efficiency with regard to information retrieval.

Long-established social institutions display a considerable amount of internal harmony. Their elements are integrated to take care of the basic goal or goals. Perhaps this can be seen most easily within the institution of law, where conflict solution is taken care of through several basic mechanisms. Let me spell out three such mechanisms and suggest ways in which they differ from medicine.

ORGANIZATION OF THE DECISION-MAKING BODY

Not only must conflicts be solved; the solutions must also be accepted. One party is bound to lose. It will hurt. Of course, this is no great problem in a society with maximum distance between ruler and ruled. When the role of judge merges with that of king (or maybe God), little difficulty results. But, in more egalitarian societies, it matters indeed. In such societies social control works both ways, for the judge also is judged by his people. In such societies, numerous mechanisms operate to protect both the judge and the people judged by him.

Most of them are obvious. The strong representation of lay people within the courts, through juries, for example, is one instance. By keeping the layman in, we keep out or neutralize the normatively deviant judge, and we safeguard a

platform of shared norms to legitimize the result and assure its acceptance by the party who is to suffer a painful loss. The resistance within the institution of law to the creation of special courts is another example of an almost instinctive defense of the common ground. Special courts for driving offenses, housing quarrels, or problems of delinquency will presumably lose track of the general normative development in a society and thereby lose contact with potential clients. The defense of the common ground is also reflected in legal education. In contrast to medicine, we find here a very limited acceptance of specialized knowledge. The law is supposed to be basically unitary. All law professors are supposed to understand—often also to evaluate—all other law professors' writings. Similar claims cannot be made within faculties of medicine.

But the conflict-solving potential of law is seen most clearly if we compare a traditional court session—deciding, let us say, who owns a house—with a traditional medical setting where, for example, the doctors must remove an appendix. For important tasks, both systems use highly educated personnel. They use professionals, often several at the same time. The big difference has to do with diversity in qualifications within the two teams. In the courtroom, diversity is kept at the absolute minimum, while in the operating room, it is maximized. It is typical in the courts that each professional participant has a fund of knowledge which is the same as that of all other professional participants. It is a social system where each role incumbent easily can—and often does—play the others' roles. Defenders can next week act in the capacity of prosecutors, prosecutors as judges, judges as prosecutors. In *this* system, special qualifications, knowledge not shared by the rest of the group, do not count.

In the contrasting case of the hospital, however, each participant will have his own special knowledge in addition to the basic fund of skills. He will have some knowledge *not* shared by any other participant. This is why he is there. The team of doctors will in this way have at its disposal a much larger body of knowledge than a group of lawyers with an equal number of years of education.

On the other hand, the law people are able to control each other—and to show the whole world that they are doing so—to a considerably greater extent than is possible among doctors. This lack of informal mechanisms for control is probably some inconvenience for doctors, particularly in cultures where it is common to sue them. Generally, however, the relationship between doctor and patient is one of trust, and both share the basic goal of setting the patient back on his feet. In this system, internal control can be kept at a minimum. But within courts where conflict solution is the goal, high visibility and shared knowledge become paramount in importance. The courts cannot draw on the same fund of knowledge that is usually gathered around the operating table, but the wounds that are to be healed in the courts demand other types of organization. They also demand other types of information. Let me turn to this problem.

CHARACTERISTICS OF INFORMATION ADMITTED TO THE SYSTEM

Law, again in some contrast to medicine, is a relatively *closed system* with regard to the amount and quality of information accepted. The courts are engaged in a complicated procedure of weighing conflicting considerations. Their task is immensely simplified if the volume of information to be taken into account is kept *as low as possible,* and also if rules about relevant information and argument are *decided in advance* and rigidly adhered to.

Law students, therefore, are to an overwhelming degree trained through books, and books alone. Sometimes they play a court game, but even then students play all the roles–including that of the ignorant layman. Some teachers might take their students into a real court or even a real prison. But generally this is not done. Real, live clients have no important part in legal education. Lawyers, at least in a legal system of the continental tradition, know better than clients what the important concepts and elements are in a case. The training of lawyers is to a large extent a training in discrimination between acceptable and nonacceptable bits of information. There is no obviously "right" solution. Students are gradually acquainted with a legal culture containing a slowly assembled set of rules and agreements. Clients cannot do more than draw attention away from these agreements. They are useful to illustrate to the future lawyer how difficult it is to get clients to "understand" the law's decision on what is relevant, but they cannot help him learn to clarify the issues: in the closed system of law, everything of relevance can be decided beforehand.

Recent trends in law schools in the United States are not contrary to this description. Law students are going out into the "real world" to serve poor people. They learn by doing, and, from the perspective of social reform, it is all to the good. Reform is hopefully what such student activities will accomplish. These recent trends are more examples of new areas brought to the attention of the institution of law than of new openings in legal education. Students would probably have learned poverty law much faster inside the universities if legal training there had been geared to the legal needs of the poor to the same extent as to those of the rich.

In contrast to the traditional situation in legal training, the medical student is of course soon brought into close and personal contact with sick people. The institution of medicine also contains a set of predetermined rules defining sicknesses and methods of coping with ill health. But this system is less clearly delimited. New information is more easily admitted. Acceptance of experimentation is greater. And all factors cannot easily be described through books. The patient is needed in all his complexity. The rules of reading an electrocardiogram are as rigid and predetermined as reading any legal rules. But still, it is only one part of the job. Decisions are made not in the library, but at the bedside. New factors, not previously thought of, might give useful insights into the patient's

condition. The borders of the unknown are not definitely set and can never be set in an empirical science. This brings us to the third major difference between law and medicine.

SOURCES AND CRITERIA FOR DECISIONS ON RELEVANCE

Law, again in relative contrast to medicine, is a system looking more at the past than toward the future. It is a reactive system where the jurist's personal responsibility for the outcome of proceedings is less than the doctor's. This is most apparent in judges of criminal cases. The judge is not responsible for a normal sentence. The criminal is responsible: he started it all. The recidivism of a safebreaker does not influence the reputation of the judge, nor does the case of a first offender. It is only if the judge leaves his usual legal framework and experiments with alternative measures selected according to their claimed treatment potentials that he becomes personally responsible for the outcome (Aubert, 1958). Then he is looking into the future. Civil cases contain much of the same protection for the judge. A decision might, in the long run, prove fatal for both complainants, but not for the judge. He can attribute it all to the law.

The positions of defense counsel and prosecutor with regard to responsibility for the outcome of criminal cases (civil cases create particular complications into which I will not go) are less clear. They are in the same position as the judge with regard to the long-range outcome of the case. It is none of their business if in the long run the man charged with a crime gains or loses, if he goes straight or ends up as a recidivist. But the immediate outcome is of considerable importance for the lawyers. They win or lose with their parties. Even here, however, several mechanisms soften the blow. This is probably an area with considerable national variation, well suited for comparative studies. In the Scandinavian case, prosecutors are protected against feeling the losses through a strong ideology of being caretakers of justice in general. Their task is not only to get a conviction, but to see to it that justice is done. Their role absorbs some elements of impartiality from the judge, probably an outgrowth of the strong organizational framework around the prosecutors in these countries. The defender is protected by the ideology that even the Devil deserves a strong defense—who should take the losers if not the best among lawyers?—and also by being tied into a closely knit peer system of other lawyers. This, together with the fact that all participants are looking at past acts and established laws in a situation well designed for internal control, makes for a prestige system based not so much on the outcomes for one's clients as on the ability to behave according to intricate rules of the game.

The doctor is not personally responsible for the outcome either. But he is definitely more responsible than the judge. The patient's recovery is a source of pride. The danger for him is that nonrecovery might turn into his shame, the

obvious case being when malpractice can be proven. This seldom occurs, however, since the system makes malpractice difficult to allege or prove. The doctor is also protected by the general acceptance that death is man's ultimate fate and that he is operating within a complex system of rapidly changing information. Thus, there must exist some tolerance for error. The doctor, happily, can cash in on his successes–and yet disclaim responsibility for failures.

These differences lead to others. Most fundamental is probably the difference in the degrees of development of auditing systems in law and medicine. In law we find elaborate procedures for discovering whether or not certain (but not all) rules have been adhered to. There exists, in particular, a pyramidal structure with higher courts controlling courts below. Medical decisions, relative to the situation within law, are only very infrequently overturned through appeal.

Some of these basic differences between law and medicine penetrate into their respective institutions for recruitment. In medical education, the grading of students becomes both more difficult and less important except as a technique for keeping some individuals outside medicine altogether. With the openness toward new information in medicine, and also with the greater acceptance of special knowledge, grading is more difficult. A bad student in biology might turn out to be outstanding in psychiatry. Fast feedback from nature on whether a cure or technique was correct also means that final assessment of students and their accomplishments is not terribly important. A young doctor will soon show whether he is capable in the field. Turning to law, the contrast is most striking. The homogeneous curriculum here makes it possible to distinguish the good law students from the poor ones. Furthermore, the lack of importance attributed to the consequences of legal decisions for law personnel also makes it very *important* to distinguish the good from the poor law students. Law needs the functional equivalent of the patient who dies at an unsuitable time.

This is so both in and out of law schools. Parliament, Supreme Courts, and law professors are all major sources of help to students (as well as lawyers) in establishing a complicated set of priorities among norms. But they cannot program all future behavior, they cannot foresee all potential legal conflict. Even the most detailed system of norms will prove insufficient in some new situations, or in some old constellations in new situations.

What is then the "right" solution? I do not know any other answer than that the right solution is the solution advocated by the best lawyers. And the best lawyers are simply those whom the other best lawyers think are the best. In most systems I know of–but I would like to know more, for this is indeed a tempting field for simple comparative studies–this means that the decision is referred back to the rating system created by the educational institutions. Here it is done either through an elaborate system of grades, or in large countries, through an elaborate prestige scale for law schools–or both in combination. The system of grades (in my country a more complex one than found within any

other field of study) has some obviously important functions also within the law schools. Students probably learn more law from other students than from any other source. But since law has so few external criteria for validity, it becomes as important for students as for practicing lawyers to know who is worth listening to.

The two institutions I have described represent ingenious and internally consistent approaches to the solution of basic human problems. But this very fact also sometimes creates problems, particularly within fields that do not seem completely to fit any of them. The legal solution often seems inappropriate in cases where a deviant act is difficult to define, and where it is the future, not the past, that seems essential. The traditional therapeutic approach is felt equally inappropriate where parties with conflicting interests are involved in the health problem. In such situations, two major solutions are often attempted. I will call them respectively, "borrowing" and "construction from scratch."

Borrowing

This is the least ingenious and also the best-known type, so I will limit myself to just a few remarks. First of all, *problems* might be borrowed. Disliked behavior may be defined as sickness and completely given over to (or stolen by) the institution of health. History has given us many examples. Occasionally, political enemies are efficiently neutralized by commitment to mental institutions.

Techniques may also be borrowed. Some judges have so great an interest in treatment that they try to convert the court hearing into some sort of therapeutic gathering. They try to establish a warm and personal relationship with the client; they try to reduce or abandon what they perceive to be characteristic legal "limitations." Similarly, family doctors attempt on occasion to act as judges. The much celebrated dictum that doctors ought to treat the whole family contains at the same time a tremendous potential for forcing them into contact with traditional legal problems, with which they are ill-equipped to deal.

More typically, perhaps, the two systems borrow rather cautiously from each other in a somewhat more conscious, deliberate fashion. Some elements of the one type of control are systematically taken out of their traditional frame of reference and given a place in the other system. The so-called "special measures" applied against some types of offenders in Scandinavian countries are characteristic. These are operated within the institution of law, and sentences are usually served in penal institutions. But since the offense is more often a nuisance than a serious transgression of an important law, the reasons for the sanctions are drawn from a medical framework. A Norwegian law professor in 1893 spoke of a new law against vagrants and skid-row alcoholics in these terms: "What

according to the rules of justice cannot be used as punishment, cannot be refused when the measure is seen as social service for one that cannot or will not support himself?" (Hertzberg, 1894: 111).

Nearly exactly the same point of view was expressed in defense of new measures against juvenile delinquents in Scotland. In an address given at Glasgow University in 1968, Lord Kilbrandon said (1968: 238):

> It is one of the defects of a system which assesses treatments for children in trouble on the same principles as it assesses the disposal of adults that, as our report put it, "the present arrangements may sometimes inhibit the application of measures which, on an educational principle, are clearly needed, but which cannot readily be justified on the basis of the offence viewed in isolation as a mere infraction of the criminal code."

The borrowing of terms such as social service, education, or the queen of all sweet words, "treatment," has proved very efficient as a means to legitimize measures that otherwise would be extremely difficult to justify on strictly legal grounds. The same has been the case when personnel from other institutions are put to service within the legal institution. Forensic psychiatrists are increasing society's strictures on the deviant, often by using his behavioral deviance–his criminal act–as an indicator of mental deviance as well. He gets a sort of double treat based on the same act.

Construction from Scratch

Here I have in mind the construction of completely new organizations or roles to cope with old problems. The whole collection of public boards that have evolved within welfare states are probably the best example of such new constructions. Child welfare boards are one example; the so-called temperance boards in most Scandinavian countries are another. These boards are so far removed from the usual construction within law or within medicine that "borrowing" is an unsuitable characterization. Let me again turn to the Honorable Lord Kilbrandon (1968: 239):

> But I wonder whether some form of the inquisitorial system is not more appropriate to the work of the panels than is our current dogma. Certainly we hear nothing about "due process" in the nursery or the schoolroom, where it would be totally out of place.

The same view was vigorously expressed in the Norwegian Parliament, when temperance boards were to be given power to deal with drunks:

> The intention is to get people *away* from the contention that this is a *judicial court* and that the person is to be punished. Legal procedure and punishment in criminal law cases, unhappily enough, do not always have the intended consequences. On the contrary, it

> gets the opposite effect. The client grows worse and worse. What is intended here is to get the treatment of alcoholics away from the law courts, and also to get out of people's minds that this is a court that is passing a legal sentence over anybody. . . . We must emphasize that this is not ordinary legal action, but medical treatment of sick people (Christie, 1965: 417).

To accomplish this, the boards were empowered to help all parties, both the drinker and his family (including their surroundings), to use power in difficult cases, but also to proceed without formalities or the stigma of police and courts. But this meant also that the organization constructed was without clear loyalties. The board member in most municipalities is a neighbor, an equal, a judge, and a "treater"—but at the same time, and particularly because of the combination of tasks, badly protected in playing any of these roles. The natural solution is to withdraw, to keep off, to act only when forced to, or at least to wait until the client has drunk himself into such a low rank in local society that he has no possibility of striking back. The lawmakers created in this case a partially paralyzed role by forgetting that social control works both ways.

STRONG ROLES—AND THEIR LIMITS

Let us return to our point of departure: the institutions of law and medicine. In contrast to most of the compromise solutions, the personnel within these classical institutions have three joint features: (1) They all have, within their core areas, clearly defined loyalties. (2) They are all well known. (3) They all have the potential for great accomplishments. Together, this means that these roles are *strong* roles. They can take a lot of strain without being redefined by those they interact with. The family doctor can take the burden of having both the wife and the husband as his patients because his traditional loyalties are that clear; he will usually work for the best interests of his patients, and he will usually have much to offer. He solves many problems outside the border of usual medical activity just because he is so safely glued to his strong role. The same is often true for law people. Policemen, in particular, often perform effectively as helpers just because of their safe base as police.

However, there are limits to how far even the strongest of roles can be stretched. If the family doctor became a family judge, some members of the family would stop seeing him as a doctor. The image of doctor behind the forensic psychiatrist can likewise fade. Trust in a judge might evaporate when he is too consumed by visions of a therapeutic society. Strong roles allow more room for combinations than weak ones. But the belief that they can take everything, that they can be given any task inside or outside their core area, seems badly founded, at least in a society where the distance between the controller and the controlled is not so large that clients are completely without power.

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