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From one reform to the next. The ambiguities of the professionalization of forensic medicine in France

Romain Juston is a post-doctoral student at the Centre for the sociology of organizations (Sciences Po school) and doctor of sociology at the Printemps laboratory (University of Versailles-Saint-Quentin). In December 2016 he defended a dissertation in sociology on forensic doctors in France and the expert's reports they deliver to the judge. Work for his thesis was conducted in the framework of cooperation between the CESDIP and the UVSQ University Hospital Centre. In the present paper he describes the recent transformations of this professional group in France, between a reform, in 2011, of the organization of forensic medicine and the current reform of medical studies making forensic medicine a full-fledged specialty

Introduction

Forensic doctors requisitioned by the Prosecutor's office perform quite a variety of medical procedures: they determine the causes of a suspicious death, measure the functional discomfort produced by a victim's wounds, determine the age of an unaccompanied individual, assess whether a person's health is compatible with police custody, and so on. They deal with the living and the dead, victims and suspects. Forensic doctors are truly a unique group within the medical profession, in that their job is not to heal, but to work day in and day out as legal auxiliaries at the interface between the medical and the judicial spheres.

Although a great many TV series feature these "experts" in prominent roles, forensic doctors still remain a largely unrecognized professional group¹. Very little is known about these physicians and their everyday professional life, or about the ways in which forensic medical evidence is produced, although the latter is used daily by criminal justice professionals. Furthermore, the discipline is presently undergoing a number of transformations. A reform of French forensic medicine was enacted in 2011, the objective being to generalize the introduction of forensic medicine in hospitals by setting up hospital services in which "professional" forensic scientists (rather than doctors collaborating occasionally with judges) perform judicial expertise on a day-to-day basis. In addition, medical studies have been reformed as of October 1, 2017, to include a specialized diploma (DES) in forensic medicine, thus giving it *de facto* recognition as a specialty in medical practice rather than an adjunct specialization necessarily added to and combined with other residency training.

Our research delves into the different logics of forensic medicine, a little-known universe, the object of much fantasizing and

Methodology

This research is based on a survey design combining observation of forensic medicine as practiced in France within the criminal justice system (some thirty-odd autopsies and about one hundred forensic consultations, in particular), interviews of physicians (n=55) and judges (n=15), and work on archives. The various locations studied (autopsy rooms, doctors' offices, ministry-level administration, decentralized government agencies, Prosecutor's offices, criminal courts, a forensic medicine conference) constitute the forensic medicine apparatus, examined on two different levels: first, the protocols aimed at organizing and defining forensic medicine activities at all levels, from the ministries down to the different departments; secondly, the reports established by forensic doctors, followed up from the forensic medicine departments to the courts.

As for our inquiry into the organization of forensic medicine and the figure of the forensic doctor its structures, it is more specifically based on a study done at the Head Office for the Provision of Care (*Direction générale de l'offre de soins – DGOS*) during the years subsequent to the difficult enactment of an master plan for forensic medicine, with special attention paid to a series of inspection reports which were instrumental in transforming that master plan so as to adjust it to the constraints encountered during its implementation.

now undergoing transformation. The forensic medical body can be approached from three angles. First of all, it designates the group of actual forensic doctors, shaped by the acts they must be able to perform, the ways of acting and thinking they internalize during a long socialization process. Next, the expression refers to brutalized bodies, as they are explored, described, measured and experienced by forensic doctors when they are commissioned as experts for the justice system. Last, the forensic medical body designates the professional group formed by forensic doctors. It is the latter sense

¹ One noteworthy exception: a special dossier devoted to « the identity of the forensic doctor » in a recent issue of *Déviante et Société*, 2017, vol. 41, n° 3. I am the author of the article devoted to « *Les médecins légistes en France : un groupe professionnel segmenté entre expertise judiciaire et spécialité médicale* », (« Legal Medicine in France : An Occupational Group Segmented between Judicial Expertise and Medical Specialty »), *Déviante et Société*, 2017, vol. 41, n° 3, pp.387-413.

which is studied in the present paper, which describes the discipline of forensic medicine as one that is riddled, so to speak, with problematic professionalization processes which turn these forensic doctors into either *judicial experts* occasionally called on to collaborate with judges, or into *specialized physicians* working full-time in a forensic medical capacity within specialized hospital services. This tension is examined through first the 2011 then the 2017 reform, which aimed respectively at establishing forensic medicine as a hospital-based discipline and as a medical specialty rather than one fashioned according to the judicial expert model, which forensic medicine had actually contributed to create a century earlier².

1. The lengthy constitution of forensic medicine as a hospital-based discipline

A detour through history: from the figure of the physician-as-expert to the forensic doctor

The history of forensic medicine shows that this discipline develops within a tense relationship between two figures, that of the *physician-as-expert* and that of the *forensic doctor*. The options relative to the organization of forensic medicine activities have oscillated between two conflicting conceptions, from the *Ancien Régime* to the present day. There is the figure of the physician who is a judicial expert, and who collaborates occasionally with judges, and that of the specialist in forensic medicine, a professional in the discipline. Viewed with reference to the judicial expert model, the physician requisitioned by a judge is above all an expert in forensic medicine, just as there are specialists in a great many technical and scientific specialties. The forensic doctor, on the other hand, defined with respect to the chart of medical disciplines, is first and foremost a specialist in the discipline of forensic medicine, a professional possessing university diplomas enabling him or her to be a registered practitioner of that specialty in a hospital or a university hospital. The present nomenclature of lists of experts retains an indication of that tension, since experts of dead bodies and of live bodies come under the heading "Specialized medical-legal field" (G1), whereas there is another heading, "Medicine" (F1). The coexistence of these two headings points up the debates that have presided over the constitution of forensic medicine as a discipline over the last two centuries. Can forensic medicine be dissolved in judicial expertise, or conversely, does the institutionalization of this discipline also lean on the medical institution?

At different times, the interplay between the two regimes – judicial experts and medical specialists – has varied. This oscillation between two poles may be seen as structuring the organization of the discipline, since its creation up to present-day debates around reforming forensic medicine (see Table 1).

Putting forensic medicine back in the hospital: the establishment of a "revolutionary" master plan

A swing has taken place since the 1970s, replacing a definition of forensic medicine derived from the overall framework of forensics by a definition rooted in the universe of the hospital³. The trend crossed a major ford in 2011, when that definition received a strict, lasting framework with the implementation of a *master plan for forensic medicine*. This reform provides recognition of a series of actors conducting expert missions demanded by *three ministries on which they depend*: Health, Justice and the Interior. The department of Health, in the form of specific structures designated by the scheme, implements the forensic medical procedures ordered by the courts. In practical terms the investigating agencies, via *Officiers de Police judiciaire (OPJ)* (criminal investigators) coming under the authority of both the Ministry of the Interior and the Prosecutor's office, *requisition* the forensic medicine departments. The Ministry of Justice *finances* forensic medical procedures. This remittance originates in an annual allocation of 56 million euros paid to heads of university hospitals (CHU) who are charged with using this allocation to finance a forensic medicine department. The Ministry of Justice also pays a number of medical procedures, charged to legal costs via a court budget, either because they were not covered by the allotment or because the reports were done by physicians working outside the hospital structures identified in the plan (owing to their participation in a "neighbourhood network" or because they are general practitioners with a private practice). These three authorities in charge of forensic medicine are therefore the three pillars of the reform, interacting with the forensic medicine departments, in view of organizing most expert medical procedures.

The master plan is based on three levels of organization – a regional level, a *département*⁴ level and a local level, articulating thanatological and clinical forensic medicine, with the first dealing with the problem of highly technical acts whereas the second faces the requirement that victims of violence be given easy access to medical examiners.

The regional level is relevant for the entire field of thanato-

Table 1. The expert and the forensic doctor: two figures of forensic medical practice

	<i>The physician-as-expert figure</i>	<i>The forensic scientist figure</i>
<i>Professional market</i>	<i>Open</i> Any physician can be requisitioned, and the judge can overstep the limits of the list.	<i>Closed</i> A specialized diploma or a contract with a specialized department is required.
<i>Type of regulation of the profession</i>	<i>By the justice system</i> One enters the group by registering on an appellate court list (under the heading of experts or on the list of hospitals).	<i>By the medical profession</i> One enters the profession by passing a diploma certifying specialization in forensic medicine.
<i>Place of practice</i>	<i>Widespread</i> All private doctors' offices or departments in which requisitioned physicians work.	<i>Restricted</i> Forensic medicine (hospital) department.
<i>Type of funding</i>	<i>Ministry of Justice</i> Legal costs remunerating a freelance professional activity.	<i>Ministry of Justice via the Ministry of Health</i> Allocation to the hospital charged with organizing a forensic medicine department.
<i>Professional associations</i>	Interdisciplinary societies of judicial experts attached to the appellate court.	Scholarly forensic medicine societies.

² Laurence Dumoulin, *La Médecine légale aux fondements de l'expertise judiciaire, de l'activité de médecin légiste à la profession d'expert*, *Equinoxe*, 1999, vol. 22, pp. 65-77.

³ On this, see *La médecine légale en France. Rapport du groupe de travail chargé d'étudier les problèmes de la médecine légale*, Paris, Ministère de la Justice, 1975.

⁴ One of the territorial administrative subdivisions: there are 95 *départements* in European France.

logical forensic medicine. Autopsies are in fact performed in thirty hospitals known as “hub centres” as well as in morgues (*Institut médico-légal IML*). These forensic medicine departments also perform forensic medical procedures on living persons within a legal medicine unit (*Unité médico-judiciaire - UMJ*) attached to the institution, in accordance with the polyvalence model promoted by the reform, according to which a forensic scientist who performs autopsies is obliged to provide consultations for live victims as well. The hub centres are also in charge of running a neighbourhood network active at the local level, and of training physicians.

Clinical forensic medicine is structured at the *département* level, so as to guarantee victims' relative proximity to these centres, and to reduce the number of such locations in order to achieve economies of scale, since these activities do not demand sophisticated technical means. There were forty-seven such UMJs in 2011, with three types of organization (O1, O2, and O3) depending on their level of activity.

The local level is mentioned in the reform, which intended to assign it a secondary role. This “neighbourhood network” depends on private practitioners, and the physicians who participate in them (general practitioners, those working for the emergency medical service, private UMJs or various sorts of doctors' associations) are paid by the act, with their fees covered by the legal costs. Paradoxically, this network, which was expected to be called upon only exceptionally, already covered over half the French population from the outset and during the following years.

One of the reform's primary rules, applicable to the first two levels, is that *forensic doctors are to be paid a salary*, like professionals in other hospital specialties. They then perform forensic medicine under a variety of statuses: hospital practitioner, under contract or as *attaché* for those in hospitals, senior clinician, lecturer or university professor/hospital practitioner for those in university hospitals. There are, in addition, non-resident and resident students doing training periods in forensic medicine departments in the course of their residency, which we must remember involves another medical specialty since forensic medicine could not be chosen as a specialty for residency until 2017.

In the last analysis, the reform represents a shifting of competences from judges to heads of CHUs and heads of hospital departments, in the sense that rather than naming an examining physician of their choice and paying on a fee-for-service basis, the former must accept the choices made by hospital professionals. This reform has been analysed as a new historical phase by forensic doctors, who view it as a genuine “revolution” signalling a definite break with an “ancien régime” in which forensic medicine was first and foremost perceived as a form of expert work⁵. Although the distinction between an *Ancien Régime* and a revolution is appealing, it requires considerable nuancing, since forensic medicine continued to oscillate, during each of those periods, between a judicial and a medical pole. In addition, what appears to be a budgetary reform actually ratifies a situation already in existence in some court districts. Thirdly, and this is the subject of the following development, we may advance the hypothesis that what is at stake right now is a reinstatement of the judicial expert model for some types of forensic medicine procedures.

“Reinstating” the physician-as-expert model? Revisions of the master plan

This master plan may be nuanced by the rapid revisions it has undergone since 2012. These do indeed tend to show that the ju-

dicial expert's regime applied to professionals consulted occasionally by the criminal justice system is maintained for some forensic medicine procedures (such as checking compatibility with police custody – *garde à vue*, or *GAV* – for instance). This is shown by our bottom-up study of the reform within the court district where we did the most thorough fieldwork. We see that the protocol for local implementation prescribed by the 2011 ministerial order, far from achieving the shift from activity as an expert to specialized activity within a hospital, contains a revival of independent practitioners-as-experts.

This is the case, in particular, for assessing compatibility of a detainee's state of health with police custody, which some people would like to have removed from the province of the reform. The local neighbourhood network echelon contained the seeds of this *revival of a judicial experts regime* for that segment of the activity, a prospect clearly formulated in an interdepartmental inspection report dated 2013, one of whose key recommendations says: “Study the practical details required for setting up a network of private practitioners with the title of judicial medical *attachés* and identified by their registration on a list drawn up by the Public prosecutor”⁶. The establishment by the Public prosecutor of a list⁷ identifying such private practitioners is equivalent to introducing a revival of a regime of practitioners-as-experts for a portion of forensic medicine applied to the living. Similarly, there is a proposal to resort to examinations *in situ* in police stations, with the reasons advanced here clearly differing from those advanced by the 2004 *Consensus conference on the attendance of doctors on detainees in police custody*⁸. Indeed, the idea is not so much to enable a physician to decide *in situ* whether the custody is compatible with the suspect's health as to avoid having to send out a squad of officers to take detainees in police custody to the hospital.

Over and beyond these types of examination, in the entire field of forensic medicine applied to the living, the rationale of professionalization of a body of specialized forensic doctors cohabits with the rationale of expert missions, in which any physician can respond to a requisition by a judge. Some judges we observed in their work on real-time treatment (TTR) of an average-sized “*correctionnel*” court⁹ allege a “*concern with efficiency*”, according to which “*you can't tell the police and gendarmerie that all victims must be sent to the UMJ. On the other hand you can send them to the UMJ when you have an unusual situation. When some weapons have been used, for instance...*”, then going on to say: “*you're not so strict about granting an ITT (total incapacity to work¹⁰) when the legal proceedings are not so serious. Conversely, if prosecution is intended, like making a COPJ (summons by an investigating police officer) or bringing the case to an investigating magistrate, you're more cautious about granting an ITT.*”

Despite the difficulty in implementing the master plan for forensic medicine, it is clear that the *idea of hospital-based forensic medicine is progressing* and is propitious to the *development of a forensic medicine specialty* which is being achieved with the 2017 reform of medical studies, which is discussed in the next section.

2. Emergence of forensic medicine as a medical specialty

Forensic medicine as an adjunct specialty

Forensic medicine as part of the medical school curriculum is – until the 2017 reform of medical studies produces its first specialists – an adjunct specialty which must necessarily be combined with training in another specialty, ranging from pathological anatomy to occupational medicine and including paediatrics,

⁵ Renaud Bouvet and Mariannick Le Gueut, *La médecine légale au XXI^e siècle : une nouvelle étape historique*, *Droit, déontologie et soin*, 2013, vol. 13, n° 1, pp. 59-65.

⁶ *Les bonnes feuilles de l'IGA*, n° 2014-17, October 2014.

⁷ « Public Prosecutors' lists » exist for expert interpreters. They differ from those of the appellate court by their unofficial nature. See Jérôme Péliasse (ed.), *Des chiffres des maux et des lettres : Une sociologie de l'expertise judiciaire en économie, psychiatrie et traduction*, Paris, Armand Colin, 2012.

⁸ https://www.has-sante.fr/portail/upload/docs/application/pdf/garde_a_vue_gb.pdf

⁹ The French *tribunal correctionnel* is competent for the trial of *délits*, a level of offence gravity more or less corresponding to misdemeanours.

¹⁰ This notion is used in French civil and criminal law to estimate the severity of bodily injury.

general medicine, orthopaedic surgery and public health. Consequently, forensic doctors have extremely varied specialized training, which they may invest, more or less, in the practice of forensic medicine. Between these numerous specialties and the variable ways in which the legal aspects of their activity are put to use, observing the process of professional socialization of forensic doctors points to the importance of the type of medical specialty in the day-to-day practice of forensic medicine.

In other words, the physicians' position with respect to forensic expert work depends on the way they attune this assistance to criminal justice to their original medical training. The description of the professional itinerary of respondents working in forensic medicine provides an explanation of why, according to several of them, *"there are as many forensic medicine itineraries as there are forensic doctors"*. Actually, one encounters the entire spectrum of the medical profession within forensic medicine, ranging from general practitioners to specialists, from hospital personnel to private practitioners, from casual workers to people with a permanent contract with a public hospital, from professionals to occasional examiners. Our inquiry did nonetheless uncover a few typical careers associated to some segments of the profession. The logics presiding over these itineraries reflect a range of motivations for embracing the career, with some passionately interested in law whereas others are disillusioned with care. These varied motivations are encountered in different time frames, with some people whose vocation had been stimulated since their adolescence by reading detective stories, whereas for others it was a chance encounter within a medical routine when they were requisitioned by the justice system, and still others were assigned a position when a forensic medicine department was created within the framework of the recent reform. The study of concrete practices produced an enriched map of these experts by studying how their original specialty influences their practice as forensic doctors.

The research then identified two main professional models, which may be called the "good expert" model¹¹ and the "good doctor" model, on the basis of which forensic doctors arrange the relations between their specialized training and the justice department's expectations, which tend to turn them into technical auxiliaries of judges. The tension between these two models – of a medical specialty and of a judicial expert – is resolved variously by physicians, who structure their practice with reference to one or the other. For the "good experts", the shift from their original specialty to a forensic medicine practice is somewhat like a change of profession, as if their original specialty was merely a pass to enter the forensic doctor activity, and did not modify its content. For the others, who are not so much "good experts" as "good doctors", the forensic doctor capacity tends to combine with their specialist capacity, rather than replacing it. For them, socialization as an expert is rooted in an earlier, powerful socialization, which is that of the way these professionals learned to practice medicine, up to now.

A reform of medical studies to bring forensic medicine into medical school: introduction of a Specialized Diploma (DES)

A second reform, in force as of October 1, 2017, prolongs the professionalization trend begun with the introduction of forensic medicine hospital departments. A Specialized Diploma (DES) in "forensic medicine and expert medical examination" has been created within the framework of a broad reform of medical studies, which transforms a number of medical fields that were previously adjunct specialties into full-fledged specialties. This profes-

sionalization is nonetheless problematic, since these attempts to "improve the efficiency of training schemes, and to strengthen their links to the relevant labour markets"¹² generate a tension between expert work and specialty. In fact, the entire system articulating specialty and expert activity is reversed. Whereas the curriculum of forensic doctors had been constructed around the notion that physicians with various specialties would have an additional specialty in forensic medicine, we are now heading for a model in which specialists in forensic medicine will probably need an adjunct specialty in various other medical fields, so as to acquire the competence required by the specific characteristics of the brutalized bodies to which they must attend.

Conclusion: a professionalization of forensic scientists through the specialization of their discipline

The present paper clarifies the process of professionalization of forensic medicine, by shedding light on two recent sequences through which forensic medicine has achieved the status of a medical specialty. These original professionalization processes are of interest for reasons that greatly exceed the discipline itself, which is at the intersection between judicial experts' work, the medical profession and criminal justice. Its position as an interface helps us understand the dynamics of these institutions. We have shown that forensic doctors are not judicial experts in the traditional sense of the term, but that the procedures they perform daily belong within the hospital framework and are constructed by increasingly specialized training. Forensic medicine is no longer an activity steered exclusively by the justice system, to which it is attached and which finances and uses forensic doctors' reports. It now tends to become an independent medical discipline regulated by university hospitals like any other specialty. Forensic doctors are less "experts", and on their way to becoming "specialists".

Romain Juston (romainjuston@gmail.com)

¹¹ Laurence Dumoulin, *L'Expert dans la justice : de la genèse d'une figure à ses usages*, Paris, Economica, 2007, p. 151 and ff.

¹² Didier Demazière, « Professionnalisations problématiques et problématiques de la professionnalisation », postface to the special report on « Les processus de professionnalisation », *Formation Emploi*, 2009, vol. 108, pp. 83-90, 89.