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A comparative perspective on legal and clinical reasonings

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Abstract: The increasing encounters of clinical science and the rule of law in and outside the courtrooms is one distinctive characteristic of our modern era. At first glance, legal analysis and clinical reasoning could be either completely different or substantially similar. Should we consider the issue through the lens of our scientific revolution legacy, a common rational framework would be a defining converging point drawing together a step-by-step analysis from proven or known facts to the applicable standards, whether it be of law or medicine. However, key differences cannot be overlooked between two disciplines which purport to answer different sets of "what is" vs "should be" questions. This text provides an in-depth comparative analysis of the premises and processes underlying both the legal and clinical reasonings. It highlights cultural differences between the two disciplines which extend beyond the need to translate between two distinct languages, that of law and of medicine. Rather, it can be fairly stated that a court trial involving medical expertise should be ordering a fair and structured translating process between legal and medical cultures.

Keywords: legal reasoning, clinical reasoning, comparative analysis, cultural translation.

Une perspective comparative des raisonnements juridiques et cliniques

Résumé : Les rencontres croissantes entre le raisonnement clinique et la primauté du droit à l'intérieur et à l'extérieur des salles d'audience ont une

caractéristique distinctive de notre ère moderne. À première vue, l'analyse juridique et le raisonnement clinique pourraient être complètement différents ou sensiblement similaires. Devrions-nous considérer la question à travers le prisme de notre héritage de la révolution scientifique ? un cadre rationnel commun serait un point de convergence déterminant rassemblant une analyse étape par étape des faits avérés ou connus aux normes applicables, qu'elles soient de droit ou de médecine. Cependant, les principales différences ne peuvent être négligées entre deux disciplines qui prétendent répondre à différents ensembles de questions « ce qui est » et « devrait être ». Ce texte propose une analyse comparative approfondie des prémisses et des processus qui sous-tendent à la fois les raisonnements juridiques et cliniques. Il met en évidence des différences culturelles entre les deux disciplines qui vont au-delà de la nécessité de traduire entre deux langues distinctes, celle du droit et celle de la médecine. Au contraire, on peut affirmer à juste titre qu'un procès impliquant une expertise médicale devrait ordonner un processus de traduction équitable et structuré entre les cultures juridiques et médicales.

Mots clés : raisonnement légal, raisonnement clinique**,** analyse comparative, tradition culturelle

The increasing encounters of the rule of law with clinical science both within and outside the courtrooms is one distinctive feature of our modern era. It can be fairly stated that high-quality evidence leads to high-quality justice as an integral part of a better society. To be sure, law cannot be applied in a fact vacuum, but intrinsically connects to relevant and demonstrable facts. In contrast to eyewitness accounts or subjective memories, findings of fact based on scientific expertise are generally viewed as more accurate and less amenable to human biases or misperceptions. Compared to other kinds of scientific evidence, medical evidence has been more frequently called for in high-stakes litigation and disputes involving human well-being up to life-and-death situations. Increasingly clinical practice guidelines have contributed to defining the appropriate standard of care incumbent upon healthcare professionals in medical malpractice cases and entitlement-to-benefits claims (Rosoff, 2001)[1]. As well healthcare professionals are governed by stringent ethical standards binding on disciplinary hearings and at times criminal trials.

[1] Indeed, a standard of care does not refer to what a particular medical expert would have done in a particular case, but "what others in the profession commonly would do in such a situation" (Rosoff, 2001, p. 332).

This phenomenon, that is, the intricate interrelation between law and medicine, compels a critical and comparative analysis on the similarities and differences between clinical and legal reasonings. Indeed there is more at stake than bridging the gap between two distinct languages, that of law and medicine, each beset with its own idiosyncrasies. Rather, both reasonings are imbedded in their respective culture, assumptions, experience and prejudice. Taking into account this cultural component in the translation process - from legal language to medical terminology and vice versa - is a daunting but necessary exercise. Indeed, many a law expert has been struggling to cope with the legal implications of medical reports (Canelas et al., 2019; Iacobucci & Hamilton, 2010; Faigman, 1999) that are drafted in a sophisticated language and concluded on the basis of unfamiliar methodology. As well, many a medical expert is baffled by the peculiar requirements of legal causation Skolnik (2019) in contrast to scientific and statistical approaches to causation (Freckelton & Mendelson, 2017). In light of these differences, bridging the gap between legal and clinical reasonings, that is, between legal and medical languages, can benefit from the insights of cultural translation theories (Katan, 2012; Yan & Huang, 2014). The cultural component impinges on the understanding of languages by relating texts to contexts, and by bringing distinctive perspectives and frames of interpretation to apparently similar textual requirements. After an overview of the legal reasoning as legal professionals understand and apply it (1), as well as the general steps of the clinical reasoning as implemented by clinicians (2), we will dwell on some of their key similarities (3) and differences (4).

Legal Reasoning at a Glance

Legal reasoning moves from the applicable law to a particular fact situation in order to advise or implement the best or the least prejudicial, course of action.

The applicable law chiefly comprises statutory provisions, judicial precedents and (doctrinal) interpretations thereof, as supplemented over time by legal (ly recognized) customs and generally accepted practices, if applicable. One should bear in mind that no

applicable law is devised in a vacuum. Rather it is conceived considering hypothetical/theoretical factual situation. At hand differs from hypothetical scenarios, the less clear is the legislator's intent in this respect, and the more amenable to interpretation, i.e. uncertainty, are the *a priori* applicable provisions.

Legal interpretation forms thus an integral part of legal reasoning. It is the first step thereof and refers to the sometime arduous process of deciphering the intended meaning of an ambiguous legal text (e.g. statute) as applied to new or complex fact situations, bearing in mind the underlying objectives sought in the applicable provisions. In most cases, the legislator has in mind at least one (problematic) scenario in particular when adopting a specific statute or provision. More often than not however, the legislator could not have foreseen every potential scenario that could ever occur over time with changing societal imperatives, mindset and technical possibilities. At the risk of quoting out of context: "the old ideas and assumptions, which once made our great institutions legitimate, authoritative, and confident, [may be] fast eroding" (Lodge, 1974).

At all events, legal interpretation is warranted only in case of textual ambiguities or when upon its reading the legal text calls for alternative understandings. When the text is clear albeit out of date or even outrageously unfair, legal professionals cannot override the plain meaning of a legal provision so to understand and apply it as they see fit. In the absence of legislative amendments, only a declaration of unconstitutionality can justify not giving effect to duly adopted legal provisions. If the interpretation stage may be optional, going through the applicable law necessarily implies a filtering process, consisting of identifying legally relevant criteria to be taken into account in the subsequent fact analysis. Legal relevance is defined in light of assumptions necessary to bring about the statutory legal consequences.

If understanding the applicable law can be challenging, even more so could be a thorough understanding of the relevant *fact situation*. Again, legal relevance is different from the relative emotional relevance of the conflict in the eyes of the litigant parties. Only those fact elements that qualify for being legally relevant in answering the requisite assumptions are to be taken into account in assessing a particular factual outcome. In contested matters, the difficulty is compounded by the need to take into account the quality of available evidence and, if need be, to weigh up differential outcomes according to alternative fact-proven scenarios.

To conclude, legal reasoning consists of a deductive process based on a good grasp of - and in some cases thorough analysis of - the law as applied to particular fact situations.

Clinical Reasoning: An Overview

Through the lens of modern scientific medicine (Custers, 2018), **clinical reasoning** can be defined as a process by which health professionals (e.g. doctors, nurses, and other clinicians) comes to an understanding of the patient's therapeutic situation in order to recommend or implement the best or the least prejudicial, therapeutic interventions in light of up-to-date scientific and technological research.

Understanding a patient's therapeutic situation typically requires a thorough knowledge of the patient (familial) clinical history and the ability to recognize specific clusters of signs and symptoms compatible with - or determinative of - distinct pathology classes and diagnostic categories. This is an ongoing process as health in itself is an ever-evolving condition susceptible at any time of improvement, deterioration, and sudden reversals.

Once a patient's medical condition has been ascertained, the choice of the best treatment options would often necessitate full collaboration from the patient and their family. The well-known placebo effect stresses the importance of psychological factors like subjective expectations, fear, and trust vis-à-vis the health care professional, in influencing treatment outcomes. The intervention stage is thus a two-way process, calling whenever possible for reciprocal exchange of clinically-relevant information and beliefs between the clinician and their patient. True, the choice between alternative treatment options should be made after having compared the pros and cons of each. That being said, the patient has to consent to treatment and in some cases a refusal of or resistance to consent can be (mostly) driven by psychological barriers, societal or community pressures originating outside the medical field but that nevertheless can have a determinative effect on treatment outcomes and the quality of the patient-clinician relationship. A clinician has to be mindful of these *a*

priori extraneous factors and take them into account in the course of a therapeutic assessment.

Evidence-based medicine (EBM), from its genesis in ancient Greece (Kleisiaris et al., 2010; Sallam, 2010), has been concerned with testing the efficacy of different medical treatments. As EBM is being applied nowadays with the advances in statistics, probabilities and data analytics, what connects the situation of a particular patient to relevant clinical interventions is being increasingly driven by the best available scientifically-tested evidence (Higgs et. al., 2001). Results obtained from EBM typically evolves into "evidence-based recommendations of guideline groups, which aim to be based on the highest quality knowledge-randomized clinical trials (RCTs) and meta-analyses" (Sniderman et al., 2013). In other words, the best treatment options are assessed from the results of RCTs and meta-analyses conducted on large population samples. The more a treatment option has been extensively studied on a large or diverse samples of population, the more likely would the same therapeutic option achieve the best outcome with respect to the next particular patient. Typically, clinical recommendation development process involves an expert panel that frames key questions (Chakraborty et al., 2020) guiding the retrieval of relevant evidence and provides a summary of the supporting evidence as well as a justification of the panel's recommendations. To use the recommendations optimally, clinicians "must understand the implications of the recommendations, assess the trustworthiness of the development process, and evaluate the extent to which the recommendations are applicable to patients in their practice settings" (Brignardello-Petersen et al., 2021).

The diagnosis and the intervention stages of the clinical reasoning process do not follow a sequential one-way pattern from diagnosis to treatment. Rather, they form a recurrent cycle through which the health condition of a particular patient is being continually (re)assessed in light of their reaction to and complications experienced from ongoing treatment. The occurrence of treatment-related complications may call for a reassessment of the patient's whole clinical situation, from reviewing available evidence-based recommendations in relation thereof to a renewed scrutiny of (alternative or complementary) therapeutic options. Any change of the patient's health condition may warrant from a slight adjustment to complete alteration or even cessation of the course of a treatment.

Legal and Clinical Reasonings: A *Pro Forma* Agreement

Clinical and legal reasonings undoubtedly share a number of common features.

- They are both mostly a deductive process progressing from generally accepted premises – be it the applicable law or evidence-based medicine - to specific fact/patient situation. The best treatment plan or legal advice is drawn from previous tested cases, in the same manner that legal advice or course of action recommended in a particular case is justified in light of the outcome experienced in past judicial renderings.

- Mostly but not always, inductive reasoning is also rampant in clinical and legal settings. The thrust of inductive reasoning is to move contrariwise from the particular to the general.

  This is especially the case in common law jurisdictions, where the *stare decisis* doctrine allows for the incremental building of well-established legal theories from individual cases. The result reached in an individual case can serve as a precedent for that of subsequent similar cases. Especially in the early days of the common law or in nascent legal theories, the issue rests in determining how similar or different a case can be to previous ones so to mandate a decision in like or different manners. The exercise requires a careful reflection about the objectives that concurrent theories seek to achieve, the rationale behind them, and an ongoing cost-benefit analysis against an evolving moral, social, political and economic background.

  In clinical setting, inductive reasoning is as well essential for studying and predicting therapeutic effectiveness in future cases. Quantitative studies even on representative large samples may amass a host of correlations and even established causation through randomized controlled experiments. That being said, innovation comes from inductive reasoning from an innovative experience drawn from, or a particular set of reactions observed from individual cases. Quantitative studies show how different health conditions and therapeutic strategies interact, but do not tell which other element may be relevant in like cases. This is the problem of generalizability and points to the need of ensuring the external

validity of controlled clinical trials (Andreoletti et al., 2019). Inductive reasoning from idiosyncrasies observed in individual cases is key to finding the "significant other" relevant factor that may warrant subsequent studies. A purely deductive methodology does test different hypotheses, but only by inductive reasoning can health care professionals generate new hypotheses to be tested or make educated guesses about a patient's novel or rare condition.

- Both reasonings are thus scientific in nature, as they require transparency and intelligibility with the decision-making process. For either health care professionals or legal practitioners, the end result has to be justified sensibly in terms of tested hypotheses, by setting out how the proposition A leads to the propositions B, C, D up to the conclusion. Paraphrasing Karl Popper (1935), both reasonings are "falsifiable" or "testable" as the ultimate (legal or therapeutic) decision depends on a set of hypotheses or premises which have to rationally connect to the conclusion.

  The rationality principle is key, as it displaces to a large extent the argument of authority even in the case of well-established judicial precedents. Indeed, even a Supreme Court pronouncement can be set aside (more easily) should its rationale not being convincingly expounded in the text of the published judgment. It is only in cases (like in most cases) where two or more concurrent rationales exist that the authority of precedent comes in to tip the balance in favor of the position advocated by a higher court of justice. Otherwise, it's not enough anymore to refer blankly to the "authority of the Supreme Court" as the "authority of the Bible" to justify any decision. The God-said-it-and-it-was-so era is over. The more detailed are the justifications provided in support of a particular conclusion, the more reliable such a conclusion becomes in the eyes of colleagues and the more likely would it stand the test of time.

- Legal and clinical reasonings are indeed conflated with critical thinking. They require a critical assessment of the relevance of the best available evidence, instead of unconditional submission to established dogmas or adherence to one version of the story.

Mere logical reasoning - consisting of establishing explainable relationships between different facts - is the easy part of the problem-solving process. The real difficulty lies in discovering, understanding, deciphering and interpreting relevant facts in light of contradictory versions, apparently unmeaningful cues. More often than not, assessing the truthfulness, coherence or completeness of (conflicting) narratives require a delving into probable motives for telling lies, for concealing meaningful events or peculiar family medical history, or for bypassing important details that could have altered the whole story / the disease diagnosis, as well as educated guesses about unconscious biases, oversights and even malice. Moreover, an accurate interpretation of ambiguous facts frequently requires extensive knowledge about the social, economic and cultural background against which the disputes arise. The same knowledge and that of the human nature are essential for weighing the relative strength of competent arguments, and the truthfulness of different accounts of the same events if only to underline consistencies, and suggest alternative interpretations and even new relevant facts to investigate.

- Both clinical and legal reasonings require as well a set of relational skills, as the quality of both types of professional alliance largely depend on the professionals' abilities:
    - to actively listen actively and deeply so to gain an in-depth understanding of the whole situation;
    - to communicate effectively;
    - to build trust by having empathy while managing emotion.
    - lawyer to communicate effectively with the parties concerned.

In the context of litigation, apt questioning may have a great impact on the quality of the witness' testimonies "extracted" at the evidentiary stage. Many an uncertainty, willful oversight and failure to mention essential details have been dug out through artful cross-examinations. These, to complicate things, can as well be misleading to lay juries and even judges that are either not familiar with legal customs / parlance or not

sufficiently cognizant of a specific practice context. An insightful grasp of human nature also helps to frame appropriate hypotheses offering new investigative leads as regards less-than-obvious or apparently ambiguous situations. In contexts other than litigation, building trust with clients is key to knowing about them more than the bare minimum so to give comprehensive recommendations and flag potential issues; the bare minimum may be only one side of the picture and even misleading at times. As the president of the American Bar Association once said:

> Ultimately, lawyering is a delicate balancing between a constantly evolving world and the fundamental principles that define our legal system. It calls upon your compassion as well as your intellect, your heart as well as your head ... [C]aring is as much a part of the legal profession as intelligence ... [I]t is *every* lawyer's responsibility in *every* setting to serve others (Gerdy, 2013).

The same holds true in therapeutic settings. Patients' trust and an open / sympathetic attitude from physicians foster effective two-way communication: it encourages patients to speak out their concerns and discuss them with their healthcare professionals; on the other hand, it is essential that physicians maintain an understanding attitude as regards their patients' distresses – whether scientifically founded or frivolous – and their preferences towards complementary and alternative therapies outside conventional medicine.

These relational skills are not only complementary to legal and clinical reasonings *per se*, but may influence the outcome thereof. Indeed, in either case, the outcome is fact-specific, and the process of discovering all relevant facts – be it family and medical antecedents or industry-specific background – is vital to shaping distinctive fact backgrounds, understanding the patients' needs and managing the clients' expectations. Just as two (2) apparently identical legal disputes may be fueled by completely different underlying conflicts that may be resolved more effectively in ways alternative to traditional litigation, similar symptoms may point to different pathological conditions calling for (completely) different treatments.

Legal vs Clinical Reasonings: Distinctive Features

Despite their many apparent similarities, **key differences can be found between clinical and legal reasonings:**

- The first difference would be the potential conflict between the subjective interests of individuals and that of the wider society. Typically, law is concerned with how a legal dispute should be resolved in light of concurrent social, political, and economic imperatives; the balancing of concurrent interests is of trite occurrence in daily law practice, whereas the medical profession is concerned unequivocally with the well-being of the patients, with only an incidental notice at the conflicting well-being of certain family members. In other words, the "best law" is one that provides for the most equitable solutions to reconciling conflicting claims, the equity of which is assessed as well in view of public interest imperatives overriding the subjective interests of the parties involved. Likewise, a "good" judgment is one that applies the law even though that does not favor the position advocated by one or even both parties. This is the reason why conflicting claims should eventually be adjudicated by an independent, neutral and authoritative third party.

  No such overriding public interest is directing a clinician's decision-making process nor the issuance of clinical guidelines or recommendations. Rather, the one overriding public interest indeed coincides with the best interest of the specific patient. Hence, save in the particular context of psychotherapy or family / couple therapy (Woolley, 2016), there is no need for a neutral and independent third party to be involved in the normal therapeutic process.

- Most fundamentally, legal and health care professionals are answering different types of questions on an epistemological level.

  Law professionals are wont to answer "should-be" questions. Given a set of factual prerequisites, what <u>should</u> be the "correct" solution or "win-win" scenarios to the conflict in light of the constraints imposed by the applicable law? Against

a specific social and economic background, what should the law be so to achieve the best outcome in light of its underlying objectives. In today's world, law no longer amounts to a mere list of prohibitions. As an instrument of social and economic policy, it is also creating incentives for (economic) agents to act in a certain way or to engage in specific behaviors (e.g. ecoresponsibility, affordable housing, amicable dispute resolution). In either case, law is sustaining an ideal world of Kantian imperatives which the real world is forever striving to follow. Although there remains much to be done to bridge up theory and practice, in litigation law theory takes precedence over practice up until the end of a sometimes successful - but always painstaking - constitutional challenge.

On the contrary, healthcare professionals deal with fact-driven, "what-is" situations. An ideally best treatment plan matters less than what actually works in the case of a specific patient. Whereas a clear and unambiguous law (e.g. minimum fines) is binding on subsequent cases in a way that leaves no room for individual preferences nor the exercise of professional discretion, clinical guidelines remain but recommendations which never mandate the choice of a treatment plan in a particular clinical scenario:

> External clinical evidence can inform, but can never replace, individual clinical expertise, and it is this expertise that decides whether the external evidence applies to the individual patient at all and, if so, how it should be integrated into a clinical decision. Similarly, any external guideline must be integrated with individual clinical expertise in deciding whether and how it matches the patient's clinical state, predicament, and preferences, and thus whether it should be applied (Masic et al., 2008).

Yes, the more similar a particular clinical scenario is to the clinical recommendations' setting, the more likely would the recommended therapeutic option achieve the best health outcome. Yet even discounting the delicate issue possibly raised by conflicting clinical practice guidelines issued by different authoritative professional groups, probability is never certainty, and the whole medical art (Panda, 2006) is that of spotting relevant factors to be considered while making appropriate distinctions. In some cases, following a good guideline in a wrong context can lead as well to professional

liability than not following clinically-recommended guidance at all.

- Indeed, clinical reasoning relies more heavily on statistical analysis and probabilities whereas for legal professionals, the number of precedents does not necessarily make up a good case. This would be the main cultural trait that distinguishes lawyers from clinicians.

  Nowadays evidence-based medicine largely depends upon quantitative analysis on representatively large samples of patients. The more a particular treatment or therapy has been tested over a large number and diversity of patients, the more likely the same intervention would produce the expected result upon the next individual patient. As well, the more a specific kind of complications have been associated with a particular treatment cycle, the more likely would the same complications happen in a specific patient following the same treatment plan. In this realm of probabilities and statistics, the chain of causation matters less than the likelihood of occurrence. Whatever the exact causation particulars between a set of complications and treatment, to ignore this association is likely to trigger professional liability. That being said, unlike discrete legal criteria, the number of variables susceptible to influencing a therapeutic outcome is theoretically infinite, and no clinical trial or study can comprehensively test or control for each of them. This is the reason why a probabilistic or even statistically significant therapeutic success never accurately predicts the same in regard to the case of a particular individual. Our next patient may be an outlier whose case has never been satisfactorily explained in previous clinical trials. Thus, leaving aside potential biases undetected from previous trials or (meta-)analyses, there always remain disquieting unknowns in every therapeutic process.

  For its part, legal reasoning is less amenable to quantitative analysis, for each legal case is unique, with a distinct factual background and, sometimes, social wider context modeling (comforting) a particular understanding of the applicable law. In most instances, such peculiarities can be ascertained - albeit laboriously - by browsing through the text of each and every available judgment. With the possibility to

plead apposite fact distinctions, even well-established judicial precedents are not determinative in every case. Where the legal text is ambiguous or in the absence thereof, even the Supreme Court can, over time, overturn its previous rulings that have "a mortality rate as high as their authors" (Banks, 1999). Where the legal text is clear, legislative and regulatory changes over time are common place, which displace as well past holdings based on similar or even identical facts. Whatever their number or consistency then, previous decisions are no longer binding on subsequent cases following judicial reversal or legislative amendments / updates. So, there is a distinct limit in applying purely statistical analytics to predict the outcome of future legal cases. This limitation stands out much more than in the case of applying evidence-based medicine since, all fact variables being identical, a (slight) change in the applicable law may alter the outcome conclusively.

It should be noted as well that our legal tradition, notably in matter of tort / professional liability, is (still) especially concerned with proof of causation, between the defendant's wrongful conduct and the harm suffered by the plaintiff. Despite (nearly) universal coverage being conceded in certain cases (e.g., car accident, workplace injury), proof of causation is essential to substantiate a traditional liability claim. This focus toward proof of causation makes many a medical expert uneasy at trial, since in many cases, causation, unlike correlations, has not been conclusively determined in a sufficiently large number of medical studies. In civil and professional liability litigation, proof of causation is typically complicated by the interrelating influence of co-existing risk factors, the most frequent of which include the patient prior health conditions and comorbidities (Valderas et al., 2009). Typically, there could be as many studies that have investigated the causation between a specific treatment plan and a particular health outcome, as well as researches focusing on the effect of specific comorbidities; however, fewer studies could have been found which delve into the effect of a treatment plan on sufficiently large samples of patients affected with specific or several comorbidities.

- Another pivotal difference between legal and clinical reasonings lies in the number of relevant premises to be factored into the decision-making process.

  In the legal realm, the applicable law is relatively straightforward; it governs the number of relevant legal criteria to be considered in a given case. From there, a lawyer can confidently predict the (possibly mixed) outcome of a case in light of relevant case law, or when there is predictably room for judicial discretion; the uncertainties mainly rest in the quality of evidence tendered at trial. Only in very exceptional and rare cases would the applicable law be altered through a reversal of judicial precedents or a declaration of unconstitutionality. In any event, an experienced lawyer can predictably outline the sources of uncertainty that beset his case.

  Conversely, a clinician is constantly facing the uncertainties intrinsic to the human condition. Despite the abundance of literature review and (meta-)analyses, not all factors susceptible of influencing the progression of a medical condition or that are associated with the occurrence of (different types of) complications can be comprehensively assessed. Aside from the sheer likelihood of a defined prognosis, clinicians do not have at hand a comprehensive list of all relevant biological, psychological or pharmaceutical factors. There still are some factors that have not yet been (carefully) studied, so the sources of uncertainty are *a priori* unpredictable. This may be the reason why inductive reasoning is more important in clinical rather than legal settings, so that experienced clinicians may suggest new hypotheses and correlations / causations to be tested in future studies.

- As well, legal professionals have to hone their text analysis skills much more than the clinicians. As neither the legislator nor the judges are wont to give interviews about the reasons underlying their written decisions or the wording of a particular provision, legal professionals have to rely heavenly on the text of written decisions, relevant statutes and other parliamentary documentation to extract meaningful information about the legislative history and rationale for the decisions. A so-called "golden rule" has been developed by (Canadian) courts specifically for the interpretation of statutes (Beaulac & Côté,

2006). In view of the fact that a purely literal approach could be misleading at times, the "golden rule" calls for consideration of the whole context of a statute, including its purpose and the legislator's intention, in order to assess its true – that is, most probative – meaning (Sullivan, 2003). That being said, the particular wording of a statute always takes precedence over other materials where the text is unambiguous and does not point to alternative interpretations.

For their part, the main focus of clinicians is on the actual patient, with his or her dynamic symptomatology and evolution. True, evidence-based medicine would require from clinicians a new set of skills on efficient literature-searching from professional dabatases and filtering critical information about diagnoses, prognoses, therapies and complications (Masic et al., 2008). On the other hand, clinical practice guidelines are less prone to interpretation than legal texts. More importantly, in case of ambiguous or unclear recommendations, clinicians do not have to "resolve" the ambiguity at all costs. Such guidelines would at most be considered "unhelpful", and clinicians are justified to refer to other materials or to review relevant systematic studies not referenced in the guidelines themselves. Indeed, clinicians rely less on the particular wording of the guidelines. Only "the best evidence" matters, and, if necessary (as in case of rarely diagnosed conditions), better or more robust references can be found in other materials than in the guidelines themselves. More importantly, these "other materials" could have equal or even more weight than the clinical guidelines *per se*.

- Legal reasoning revolves around the decision to be rendered by a reasonably predictable judge, whereas clinical reasoning should be centered on managing the well-being of the consultant patient.

  Even though lawyers have the best interest of their client at heart and should act in accordance therewith, a good legal reasoning rests not on soothing the anxieties of our client at all costs, but also involves managing the client's reasonable expectations and legal needs. The ultimate decision, in case of litigation, is to be delivered by a judge of the competent tribunal. The ultimate objective of a legal reasoning is thus to

accurately predict how a judge or the Supreme Court of the country would review the case. The best a competent and dedicated lawyer can do would be to boost the case of his client and to give to the latter every chance of success, but the final decision does not rest with the lawyer. As for judges, despite all the empathy that (s)he can feel towards a claimant, a good legal reasoning is one that applies the law, follows relevant judicial precedents and does not depart from well-established legal principle.

- In contrast, in clinical settings there is no overarching concern for the health care professionals than the patients' well-being. Their responsibilities mostly centered around a patient's medical condition without having to care about the opinion of a more authoritative third party. One may argue that the overarching judge in a patient's case would be the end course of the diagnosed disease (i.e. recovery, recurrence, progressive / sudden decline) which does not fall under a clinician's control as in the case of a lawyer-client relationship preparing for an actual or contemplated litigation. The analogy is flawed since there still remains a part of the development of a medical condition which lies outside of all human control, this being the hard-red line distinguishing natural sciences from humanities.

- Finally, whereas legal reasoning may deal only with past situations not susceptible to further changes, health care professionals have to manage evolving patient experience in view of devising the best therapeutic action. A great deal of legal efforts is spent on assembling available evidence in order to substantiate the (past) occurrence of relevant facts, while health care professionals are set on altering the existing health condition of their patient. This time gap should not be overlooked: what is past cannot be altered, and litigation lawyers are often being presented with *des faits accomplis*, such as the amount of alcohol consumed in the course of an evening, the building's condition at the time of sale, or the density of the traffic on a particular day. A legal consultation could be purely remedial in nature, so to redress or to minimize the consequences of past choices or conduct. This is not to say that healthcare professionals would not have to take into

account the patient's treatment history or family antecedents, but a health consultation always involves an actual medical condition which is still susceptible of (further) change.

Conclusion

To conclude, the alliance between law and medicine does not exclude key distinctions being found between the two types of reasonings.

Assuredly, legal and clinical reasonings are not waterproof categories. They both rely on the scientific method, which consists of 1) identifying the issues in dispute / stating testable hypotheses, 2) doing background research on the applicable law (existing statutes, judicial precedents, and doctrinal comments) or the relevant clinical practice recommendations, 3) gathering the relevant facts / symptoms in a particular client or patient situation, 4) critically analyzing the connection between the applicable law and the relevant facts or between clinical practice recommendations and the symptomatology at hand, 5) suggesting and implementing the best (least prejudicial) course of action so to optimize the client's / the patient's legal or therapeutic outcome. In this process, raw facts are being filtered in both sides so to leave only relevant facts to be considered in a schematic way, in light of case law and statutory requirements or previous clinical research. In spite of there being mainly deductive in nature, inductive reasoning is also warranted, occasionally, to suggest innovative solutions, raise new hypotheses, and make appropriate distinctions from previous cases.

That being said, legal and clinical reasoning differ by the type of questions they seek to answer. Legal scholars are answering "should-be" questions ("how a legal situation should be resolved") while health care professionals are interested in "what is" ("what is the best treatment option for a particular patient"). As there is no necessary connection between what "should be" and what "is", this is indeed an epistemological gap that plagues most of the medical evidence tendered in legal settings. Besides, due to the inherent complexity of interwoven contributing factors, clinical literature is less concerned with causality than correlations, whereas litigation mostly arises in cases warranting evidence of causation between a particular misconduct and the damage sustained. This especially underlies the limit of applying clinical

evidence to demonstrate some of the legally relevant facts necessary to solve legal disputes.

These cultural differences highlight the need to take into account contextual differences (Risager, 2012) that shape dissimilar understanding of apparently identical concepts and of similarly-worded questions from law and medical professionals. They as well invite a renewed look at a court trial involving medical expertise, as a fair and structured translating process between legal and medical cultures.

Conflict of interest

The author declares that there is no conflict of interest.

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