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Institutionalized ignorance in court: Involuntary care and citizenship(s)☆

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A R T I C L E I N F O

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A B S T R A C T

When changes in Swedish law were proposed that affected the professional jurisdiction regarding involuntary care, reactions from the medical community were strong. The chairman of the parliamentary committee responsible for the proposal described how he was met by “a thousand psychiatrists booing” when presenting the suggestions to a Swedish psychiatry congress four decades ago. That psychiatrists would have to make an application in court arguing for the necessity of involuntary care measures was regarded by the profession as deeply subversive. Fast forward to today, where several studies have shown that the administrative courts rule according to the psychiatrist's recommendation in nearly 100% of cases. This state of affairs has warranted attention from several fields. In this paper I discuss findings from a transdisciplinary project on decision-making practices regarding involuntary care. Applying the lense of empirical ethics, my examination focuses on how the central value of *legal certainty* [rättssäkerhet] is achieved as a matter of practice, that is how it is *enacted* when a variety of actors discuss decision-making and assessment in and around court hearings. Heeding the call for careful and symmetrical tending not only to practices and institutional arrangements of *knowing* but to those of *not knowing*, I draw on work from agnotology and the sociology of ignorance (Proctor & Schiebinger 2008, McGoey 2007; 2012). I argue that for legal certainty to be brought about *it requires acts and infrastructures of not knowing.*

1. Introduction

In this paper, I focus on the enactment of *legal certainty* [rättssäkerhet] in Swedish mental health courts as a core value that serves to protect the patient-as-party (Sjöström, 1997) or, if you will, the patient-as-citizen. Theoretical resources are drawn from empirical ethics, agnotology and sociology of ignorance. Discussing findings from a Swedish transdisciplinary study of decision-making practices in court cases regarding involuntary care, I argue that for legal certainty to be brought about *it requires acts and infrastructures of not knowing*: for judges as well as public defenders to stay in narrow and self-imposed lanes; for the temporal perspective in court proceedings and legal requisites to focus on the here-and-now of a patient's state and their current need for care rather than for questions to center on whether or not the care provided is of good quality and moving apace; and for a discursive construction of a seemingly singular court that keeps a regular eye out to protect and guarantee patient-parties legal security, rather than a series of interchangeable judicial actors moving in and out of a process in which the only permanent actors are the patient (if they participate) and the applying senior consultant psychiatrist. One effect of this enactment of legal certainty is a repurposing of the court's role: as an arena providing pedagogy and care, as well as reassurance that society functions and has not forgotten its citizen(s).

In the Swedish context, *rättssäkerhet* is a widely invoked and normatively loaded concept, commonly understood as denoting the assurance, predictability and fairness of legal decision-making. It is closely associated with the protection of individuals against the arbitrary exercise of power, and with the expectation that public authorities

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should act in consistent, transparent and accountable ways. Importantly, *rättssäkerhet* functions not only as a legal principle, but also as a broader societal value that is frequently mobilized in public debate, policy documents and professional practice as a marker of legitimacy and trustworthiness.

While *rättssäkerhet* is commonly translated into English as *legal certainty* (and will be in this paper), the two terms are not fully equivalent. In English-language legal discourse, *legal certainty* is often discussed in relation to the clarity and foreseeability of legal norms and to limits on interpretive discretion, whereas *rättssäkerhet* is more frequently invoked in relation to the stability, reliability and predictability of the legal order as experienced by individuals.[1]

In this paper, *rättssäkerhet/legal certainty* is not approached as a fixed doctrinal standard or as a set of legal requirements to be assessed against formal criteria. Rather, it is treated as an avowed value whose meaning and force emerge through institutional practices. The analytical focus is therefore on how legal certainty is enacted, invoked and made operational in decision-making processes concerning involuntary psychiatric care, and on the forms of knowing and not-knowing on which these enactments rely.

To examine how legal certainty is enacted in practice, the paper draws on material from a Swedish transdisciplinary research project on decision-making in cases of involuntary psychiatric care, based primarily on qualitative interviews with professional actors involved in administrative court proceedings. The paper advances three interrelated arguments. First, it shows that the well-documented asymmetry between medical and legal authority in mental health courts must also be analysed as an outcome of institutionalized arrangements of not-knowing. Second, it demonstrates how legal certainty is enacted through practices that prioritise procedural reassurance, present-oriented assessments and role restraint, rather than sustained scrutiny of treatment content and progression. Third, it argues that these arrangements contribute to a repurposing of the court's role, in which patient participation is valued less for its capacity to influence outcomes than for making the legal order visible and trustworthy.

The paper proceeds as follows. The next section situates the study within Swedish and international research on mental health tribunals, followed by a brief historical overview of the negotiation of professional jurisdiction in involuntary psychiatric care. The theoretical framework is then outlined, drawing on empirical ethics and the sociology of ignorance. The analysis presents findings from the interview material and a comparative “alternative casing” contrasting involuntary care proceedings with assessment practices in the Swedish social insurance system. The discussion examines how arrangements of knowing and not-knowing shape the enactment of legal certainty, before the paper concludes by reflecting on implications for citizenship and care in court.

2. Mental health tribunals

Involuntary psychiatric care in Sweden is primarily regulated by two central acts; The 1991 Compulsory Mental Care Act (1991:1128), and the 1991 Forensic Mental Care Act (1991:1129). These two Acts are grounded in different legal logics; one in civil and administrative mental health law and the other in criminal law. The results for the individual are however similar in terms of circumscribed autonomy regarding medication, coercive measures and personal freedom. Questions regarding the continuation of involuntary care (under both acts) are handled by administrative courts.[2] Actors involved in administrative court proceedings are a judge, three lay judges, a court-appointed expert psychiatrist, the applying senior consultant psychiatrist, a public counsel and the patient concerned.

Numerous studies in Sweden have established that court proceedings dealing with matters of involuntary care tend to privilege medical perspectives over judicial concerns and rule against patients' stated interests. The very way ‘interest’ is conceptualized and how court actors understand the ontological state of the person whose health and rights is to be adjudicated – are they a ‘patient’ or a ‘party’ – has been discussed extensively by Sjöström (1997). The role and practices of the court-appointed expert psychiatrist in oral hearings has been examined and problematized (Eriksson et al., 2017; Sjöström et al., 2017), and a study of 541 involuntary community care decisions spanning a period of 6 months showed how both the courts and court-appointed psychiatrists agreed with treating psychiatrists in 99% of cases (Zetterberg et al., 2014). Another study focused on legal representatives in administrative court hearings relating to involuntary care showed that the roles of ‘spokesperson’ and ‘therapist’ trumped that of ‘defender’ (Hollander et al., 2007). Relatedly, drawing on interviews with patients, Pedersen et al. (2020) show how the introduction of a therapeutic logic in mental health law proceedings may undermine procedural safeguards by recasting legal processes as instruments for care rather than for contestation. A recent study by Söderberg et al. (2023) investigated patients' experiences of participating in administrative court hearings, summarizing them as both practically and existentially disorienting. In her extensive mapping of legislation concerning involuntary psychiatric care and the conflicts of interest inevitably contained within it, Kindström Dahlin et al. (2017) highlights a taken-for-granted contradiction in how we approach autonomy of body and mind respectively.

A systematic review of the international empirical literature on mental health review tribunals (Thom & Nakarada-Kordic, 2013) resonate with such findings. In it, 11 common themes were identified, among them “inadequate legal representation”, “clinicians inadequately prepared”, “the health context dominates” and “enhancing therapeutic outcomes”. The manner in which judicial actors understand and approach their roles in such settings has long since been problematized, poignantly encapsulated in Holstein's (1993) description of how public defenders would sometimes “let the patient hang themselves” by letting them speak freely in court, a shorthand for getting out of the perceived ethical dilemma of representing clients for whom a win in the short-term

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[1] For an insightful reflection on what language and translation will do to our analyses, see Mann and Mol (2018).

[2] The Compulsory Mental Care Act (LPT) applies to individuals not suspected of any crime, and the Forensic Mental Care Act (LRV) governs forensic psychiatric care as a criminal sanction. While the two Acts differ in their legal foundations, both rely on assessments of severe mental disorder and the need for compulsory psychiatric care, although the statutory formulations of necessity differ between the two Acts.

Proceedings concerning the continuation of involuntary psychiatric care are, in most cases, institutionally scheduled rather than individually initiated. Under LPT, continued involuntary care beyond an initial period requires that the applying senior consultant psychiatrist submit an application to the administrative court. Under LRV, judicial review of continued care is mandatory where the care is combined with special discharge review [*särskild utskrivningsprövning*, SUP], which entails regular court involvement in decisions concerning continuation, termination, or changes in the form of care. Court permission is time-limited and must be renewed at regular intervals, resulting in recurring court hearings as long as involuntary care is maintained.

Patients have procedural routes to bring their case before the court, primarily by appealing decisions concerning involuntary care or refusals to terminate such care. However, the court proceedings referred to in this paper - as described by participating professional actors - largely arise from the statutory requirement for periodic judicial review initiated by the applying senior consultant psychiatrist, rather than from patient-requested applications. The present analysis does not quantify the proportion of proceedings initiated by patients, as such distinctions are not systematically recorded in available administrative data.

might in actuality represent a loss as they need the (involuntary) care that they are contesting. This feeling among professionals of knowing what is really needed and selectively trailing towards that outcome instead of assuring a process in which assessment and evidence is scrutinized, is described in studies spanning over many jurisdictions (Brockman, 1993; Diesfeld & Sjöström, 2007; Peay, 1989; Perkins, 2003).

The asymmetrical weighting of epistemic power is thus an important issue in medicolegal decision-making regarding involuntary care. In this paper the focus is on *how* the much-reported lopsidedness in mental health courts comes about. That, I argue, has as much to do with institutional arrangements of *not knowing* as it has to do with *knowing*. In the first section I introduce the twin resources of empirical ethics and agnotology/sociology of ignorance, which have been applied to an interview study in which professional actors in involuntary care cases reflect over decision-making practices. I then sketch out a brief history of how the professional jurisdiction (Abbott, 1988) over involuntary care has shifted in Sweden over the course of a century, after which the empirical case, method and analysis is described.

3. Empirical ethics, agnotology and ignorance

Empirical ethics, broadly conceived, is concerned with questions of how ethical norms and values are manifested, negotiated and applied in real-world contexts. This stands in contrast to a principle-based ethics that concentrates on which ethical norms and values that ought to be manifested in an endeavor or arena, why that is or how that should be done. When applying an empirical ethics lense, values or normativities are analysed and understood as *outcomes* of processes or relational networks, rather than as pre-fixed entities guiding actions and making them ethical to a greater or lesser extent (Dussauge et al., 2015; Pols, 2015). This is what Dewey (1913), and a century later Muniesa (2011), call a flank movement, a pragmatist approach by which values are understood as action rather than essence. If shifting the question from “what is a value” or “how can we achieve certain values”, to “how are values made” or “what is being valued”, institutional practices become interesting to explore.

One pertinent example of how empirical ethics can be applied is medical anthropologist Jeannette Pols' examination of psychiatric nursing in long-term mental health care. In her analysis, Pols demonstrated how different work practices contained within them ideals of citizenship that enacted the patient-as-citizen in different ways (Pols, 2006). Different nursing practices to do with washing and cleanliness each performed a version of citizenship, for example cleanliness as a basic skill to become an *independent* citizen, or cleanliness as a basic *precondition for citizenship* and learning to live among others. When comparing two psychiatric hospitals, Pols observed how formal changes in law can radically change day-to-day care practices. Contrasting how the hospitals handled a newly instigated law aimed at strengthening patients' rights in dispute with a caregiver, she identified two competing standards of good: a juridical mode and a caring mode (Pols 2033). Empirical ethics, then, aims at examining how different normativities or *versions of good* are brought about through practice.

Thus, when approaching an avowed value such as the Swedish notion of rättssäkerhet/legal certainty, my focus is on conditions, practices and infrastructures that bring about or enacts a particular version of good and discuss its effects. In examining the system put in place to oversee and safeguard the medicolegal terrain of involuntary care, and listening to the professional actors operating within it as they describe their practices and pressure-points, I want to know how legal certainty is made. Through descriptions of individual cases and general practices, my focus is on tracing how the Swedish administrative court system produces that avowed core value to which all citizens are said to be entitled. The initial focus in the overall project was on different kinds of knowledge and expertise, in particular the broad notions of medical and judicial expert knowledge. This would be an interesting epistemic terrain to map out, the reasoning went, as the standards for what constitutes key notions such as evidence, certainty and standards for how you go about to attain them would differ between the professions. By interviewing people with different types of expertise and experience of working within this system, we would get a handle on things. As will become clear, in following this track the analysis increasingly came to center as much on *not knowing* as it did on knowing.

This brings us to a second theoretical resource, that of agnotology. The term – derived from the Greek agnosis (not knowing, ignorance) – is a wordplay on epistemology. It was first used in the context of cancer research and referred to the deliberate and strategic cultivation of ignorance on part of the tobacco industry (Proctor, 1995). It gained more widespread prominence when Proctor and Schiebinger launched a call to action in their 2008 book *Agnotology: the making and unmaking of ignorance,* promoting the study of ignorance in a multitude of settings and guises. The central tenet of agnotology is that we should pay as close attention to the conditions, practices and infrastructures that enable *not* knowing as we do to the conditions, practices and infrastructures that bring about different types of knowledge. Importantly, ignorance is not merely an *absence* of knowledge, but - like knowledge - a product, an effect, an outcome of different orderings in our society. And while epistemology has been the focus for our collected attentions for centuries, agnotology has been overlooked. As discussed by Pinto (2015), much work on agnotology and ignorance has tended towards a normative slant, tracing self-serving motives or agendas to actors or organisations. One influential example is Oreskes and Conway's (2010) *Merchants of doubt*, analysing how science has been (mis)shaped through connections between scientists, market forces and weak media.

Paul and Haddad (2019) propose instead to analyze the production of ignorance in a symmetrical fashion, in the same vein as knowledge has been approached in Actor Network Theory and sociology of scientific knowledge (Bloor, 1976; Callon, 1986; Law, 2004). They point to McGoey's studies of ignorance as necessary infrastructure for institutions or practices as good examples, focusing on political and social effects (McGoey, 2007, 2012). McGoey points to the importance of *scale* when considering what she terms strategic ignorance, and how institutions can benefit from ambiguity: “[S]trategic ignorance is often more institutionally advantageous the more widely it is individually mobilized.” (McGoey 2012:570). This is the approach that I adopt in my analysis of decision-making practices regarding involuntary care. Importantly, the term *ignorance* is not used here in a pejorative sense, nor is it treated as a trait displayed by individuals.

Ignorance should, then, be studied in its many shades and forms. Croissant (2014) identifies several attributes to apply when studying ignorance across cases or disciplines, among them intentionality. In a paper discussing socially harmful ignorance in democracies, Williams describes “motivated ignorance” as “cases in which ignorance is motivated by the anticipated costs of possessing knowledge” (Williams, 2021:7807). Bovensiepen (2020) differentiates between levels on intentionality and notes that ignorance does need to be consciously employed as way to achieve something. She invokes James Scott's (1998) *Seeing like state* when discussing different forms of epistemic disconnect and how the blindness of seeing like a state can become a naturalized part of a job. In the context of vaccine registries, Paul and Haddad (2019) label as “convenient uncertainty” the (in)action of not finding out or collecting information that could have been collected. This was not an example of deliberate ignorance but rather a form of “ritualized neglect”: not the result of an agenda but also not just accidental (Paul & Haddad, 2019: 305).

In the vein of empirical ethics, it is not my errand here to attribute intention, nor to make judgments of whether outcomes are right or wrong, but rather to examine different and at times conflicting versions or modes of ‘good’ within practices (Pols, 2003, 2015). As will be seen later in the paper, and as described by my colleagues and I elsewhere, when working with “psych cases”, judicial actors in our study continuously wrestled with how to meet standards of justice as ordinarily practiced while at the same time protecting clients who they understood to be sick and in need of care (Kindström Dahlin et al., 2017). The way this conundrum was negotiated is, I believe, well worth examining and discussing. I will refrain from making judgments on whether the enactment of legal certainty is correct and instead discuss my analysis in the context of citizenship, exploring renderings of legal certainty as notions that constitute the relationship between individual and state in different ways.

4. A brief history of involuntary care in Sweden

Legal questions concerning the rights and protection of individuals subjected to involuntary psychiatric care have been debated in Sweden for more than a century. At the turn of the twentieth century, psychiatric care was predominantly coercive in character, and the principal concern was not treatment or recovery but social control. Physicians were granted extensive authority to detain individuals in mental hospitals, often with minimal external oversight (Nyström, 1895). Early criticism of this system was propelled by public scandals that exposed the risks of unchecked medical power. One oft-cited example is the so-called Tufwa case, in which a farmer was committed to a mental hospital without medical examination or documentation, following pressure from relatives. The case became emblematic of a system unable to protect citizens from the combination of medical authority and private interests, and it fuelled demands for legal safeguards against arbitrary detention (Nyström, 1895). In response, discharge boards were gradually introduced, incorporating legal expertise and lay representatives.

Mid-twentieth-century debates further reinforced concerns about institutional power and accountability. In the 1950s, a series of scandals discussed under the heading of"judicial rot" illustrated how psychiatric commitment could be instrumentalised to neutralise dissent, including cases in which individuals were committed following conflicts with powerful judicial actors. While these events did not lead to immediate structural change, they contributed to a growing consensus that psychiatric detention required stronger legal oversight (Grönwall & Holgersson, 2018).

A more substantial shift occurred in the 1980s and early 1990s, when reforms were proposed that would formally transfer decision-making authority over involuntary care to administrative courts. These proposals were highly contentious. Members of the psychiatric profession strongly opposed what they perceived as an encroachment on medical jurisdiction, a position memorably illustrated when the chairman of the parliamentary committee responsible for the reform was met by "a thousand psychiatrists booing" while presenting the proposals at a national psychiatry congress (Grönwall, 2012).

Despite this resistance, the reforms were enacted, marking a principled reconfiguration of professional authority: continued deprivation of liberty would now require judicial approval by an administrative court. Notably, even before the full reform package came into effect, a procedural change introduced in the early 1980s required senior consultants to regularly report continued involuntary care measures to the courts. In the years following this change, the number of patients held under such measures decreased markedly. While courts rarely rejected applications outright, the very requirement to account for ongoing detention appears to have affected clinical practice, suggesting that the presence of judicial oversight – rather than its active intervention - was sufficient to reshape decision-making (Grönwall & Holgersson, 2018).

Since the acts came into effect, empirical studies have consistently shown that administrative courts almost invariably follow the applying senior consultant's recommendations in cases concerning continuation of involuntary care (Gustafsson, 2009; SOU 1998:32, 2026). A review conducted by the societal programme *Agenda* of cases from one Swedish district in the autumn of 2012 found that the court deviated from the applying senior consultant psychiatrist assessment in only one out of 200 cases. Similarly, an analysis of administrative court decisions in Malmö between 2011 and 2012 showed that all 103 applications for continued involuntary care were granted (Wahlberg et al., 2015).

Taken together, this historical trajectory foregrounds a persistent tension between medical expertise and legal oversight in the governance of involuntary psychiatric care. The introduction of judicial review represented a significant symbolic and institutional shift, yet it did not dissolve this tension. Instead, it reconfigured how authority, responsibility and scrutiny are distributed across professional domains.

As the following sections demonstrate, it is through this reconfiguration that legal certainty comes to be enacted in practice: shaping which questions are asked, which forms of knowledge are prioritised, and which aspects of ongoing involuntary care remain institutionally unexamined.

5. Material and method

This paper draws on material from a transdisciplinary research project titled *"Expertise, Evidence and Ethics in Decisions on Compulsory Care – an Investigation of the Epistemic Borderland between Medicine and Law"*.[3] The wider project drew on several strands of qualitative material, including interviews with patients and professional actors. The present paper draws on a subset of 30 interviews conducted with professionals involved in, or closely connected to, administrative court proceedings concerning involuntary psychiatric care. Of these 30 interviews, 23 were conducted with professional actors who regularly participate in administrative court proceedings concerning involuntary care: senior consultant psychiatrists ($n = 5$), court-appointed expert psychiatrists ($n = 4$), judges ($n = 8$), and public counsels ($n = 6$), most of whom were active in two larger Swedish administrative court districts. These interviews constitute the primary empirical material for this article, as they focus directly on courtroom practices, professional roles, and decision-making in involuntary care cases. The remaining 7 interviews were conducted with clerks, lay judges, prosecutors, and civil servants at the National Board of Health and Welfare. While not analysed systematically in this paper, these interviews informed the broader understanding of the institutional context and were used to contextualise and triangulate interpretations emerging from the core interview material.

Participants were recruited on the basis of their professional involvement in administrative court proceedings concerning involuntary psychiatric care. Initial access to the field was facilitated through one administrative court, which distributed a general invitation describing the research project; individuals who were interested then contacted the research team directly. Further participants were recruited through referrals from interviewees. In these instances, care was taken to identify actors occupying different professional roles and positions within the proceedings, rather than only those perceived as particularly experienced or well-functioning. The resulting group of interviewees consisted primarily of professionals currently active in administrative courts in two larger Swedish court districts. Participants varied in terms of professional seniority and years of experience; this variation contributed to breadth in perspectives across the material but was not treated as a separate analytical dimension. Demographic characteristics were not treated as analytically salient, given the study's focus on institutional roles and practices.

The interviews analysed in the present paper were conducted with professional actors and focused on their roles, experiences and practices in relation to administrative court proceedings concerning involuntary psychiatric care. The interviews did not involve sensitive personal data as defined by Article 9 of the EU General Data Protection Regulation (Regulation (EU) 2016/679), nor did they concern information about identifiable individuals. Rather, they addressed general medico-legal considerations, professional roles and decision-making practices. As such, they did not fall under the Swedish Act concerning the Ethical

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[3] The project was funded by the Swedish Research Council, project-id 421–2013-1349.

Review of Research Involving Humans (SFS 2003:460), which requires formal ethical approval.[4] Verbal informed consent was obtained prior to all professional interviews. Participants were informed about the purpose of the study, the voluntary nature of participation, and their right to withdraw. All interview material was anonymised in transcription and analysis.

Interviews lasted approximately 1.5–2 h. Participants were initially asked to describe their own role, as well as that of the other participants in the courtroom, and discuss their experiences of mental health law cases. The comparatively long interview sessions aimed at generating material with both scope and depth: scope in the sense that participants had the opportunity to identify and define central aspects of the process and assessments at the heart of decisions on involuntary care, thus resulting in data that is governed by the actors' own understandings of their practices. Towards the end of the interviews the conversation was increasingly guided by the interviewer to render possible comparative aspects and depth of analysis. The study design was iterative with interviews being conducted in stages, alternating with analysis of the material and calibration and development of interview questions and themes. Interviews were recorded, transcribed verbatim, and imported into NVivo, a software developed for qualitative research. An initial exploratory analysis using open coding was followed by a phase of grouping codes and continuously checking prospective themes against the overall material. Themes were iteratively developed and refined through collaborative analysis, including analytical workshops conducted as part of the wider research process.

The analytical framework employed in this paper is abductive analysis (Timmermans & Tavory, 2012). Abductive analysis recommends combining techniques associated with constructivist grounded theory (Charmaz, 2000, 2006, 2009) with a pragmatist recognition of the limits of inductive reasoning. It rejects a notion of inductive, incremental theory construction grounded in data alone and emphasizes that a central tenet of all qualitative research must be to allow for puzzles and observational surprises.

In setting out methodological steps of abductive analysis, Timmermans and Tavory recommend a process of revisiting, defamiliarization and alternative casing. The emphasis on *revisiting* is in recognition that interpretation of a phenomena changes over time as we learn and experience more. This rhymes well with the iterative logic that is part and parcel of most qualitative analytical approaches, albeit the underlying rationale is not primarily to build an incremental understanding by way of bringing back new data. Revisiting is an analytical principle developed to allow for time to elapse and for interpretation to evolve as fieldwork and analysis progress, going back to the data and seeing it anew.

Defamiliarisation is likewise an analytical move with a long lineage in social theory, often captured in the anthropological adage of making the familiar strange and the strange familiar (cf. Berger, 1963; Brecht, 1974). Here, fieldnotes and memo writing serve not only as means of recording observations and capturing ideas, but also as techniques for creating generative distance between the researcher and the object(s) of their perception.

Finally, *alternative casing* is a way to encourage researchers to think laterally. One way of doing this is to attempt to reexperience observation as part of different cases, thinking through bits of data with perspectives adopted from theories derived in relation to other concerns, taken from literature or to compare empirical cases. Contrasting cases and theories are used as a larger interpretive horizon, to avoid empirical nearsightedness and to encourage rethinking of data. In this sense, alternative casing also operates as a form of defamiliarisation, with the potential to throw taken-for-granted observations in a different light.

6. Results

In this section, I first present results from interviews with professional actors with experience of administrative court cases regarding involuntary care. This is followed by.

an alternative casing (as laid out above) by comparing assessment practices in involuntary care cases to those used when assessing if a person is entitled to claim paid sick leave. While seemingly different differing decisions regarding different matters, it is illuminating to compare the two adjacent medicolegal practices in a Swedish governance landscape.

6.1. *A mere judge*

A predominant theme in interviews with legal professionals, be they judges or public counsels – was what knowledge they did *not* possess. Interviewees made frequent references to their lack of medical qualifications and hence inability – and unwillingness - to query the basis for the medical assessment. In the quotes below, three judges explain how they lack the knowledge required to enable scrutiny of the applying psychiatrist's case:

If we continue on this knowledge track, I mean, I have to be interested, but I cannot believe that I can acquire specialized knowledge that I can use in my job. It's not possible. Instead, I must have a legal perspective. But it is impossible to completely separate it from the medical world since we are forced to incorporate concepts into our legal assessments that are medical. Like insight into illness, for example. And structured risk assessments and risk factors. But it's impossible to ignore that. It's two worlds that merge. You cannot keep them entirely separate. So I think my role should be interested, humble, and respectful, but I shouldn't think that I can acquire specialized knowledge that I can use. But it's good if I am somewhat familiar with the field, but it has to be more of a general background, and not something I give importance to in individual cases. That's how I see it. [D7]

Well, you're only a lawyer [jurist]. You're not a clinician. […] I mean … without a medical expert, it would've been an impossibility for the courts to adjudicate in these matters. [D5]

[I]t is still the case that I cannot make a medical assessment in the same way that a doctor can, and I cannot… if the doctor says that this diagnosis produces these symptoms and requires this treatment, then I cannot… it is very difficult for me to question that… [D1]

"The medical assessment" in proceedings presented in interviews as a black boxed object that was any "medical" statement that the senior consultant psychiatrist made in court. The terms for what the relevant medical factors to consider are, and how such factors should be established, were within the remit of the applying senior consultant to decide. The court-appointed expert psychiatrist can ask questions but there are no standards setting out how assessments should be made.

6.2. *Treatment alliance and atmosphere*

A variety of reasons were presented for this judicial positioning vis-à-vis the psychiatrists in the room. One was protection of the "treatment alliance" between applying senior consultant and patient, that might suffer from the former's assessment being questioned in front of the latter. This is connected both to the idea of the psychiatrist as a trusted actor whose judgment must not be second-guessed, and to the importance of patients' fidelity to a prescribed treatment program. Should, for example, the basis for the assessment that the patient suffers from a severe mental disorder require clarification and discussion in court, there was a fear that this might sow doubts in patients' minds regarding the need for care. In the same vein, dwelling on the enforced medication and potential uncomfortable effects of it was viewed as treacherous territory due to the perceived risk of undermining the applying psychiatrist and encouraging rebellion in the patient. Closer examination of the basis for assessing that the requisites for involuntary care are

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[4] Ethical approval was obtained for interviews with patients as part of the wider research project from the Regional Ethical Review Board in Gothenburg (dnr 247–15). Written informed consent was collected prior to these interviews.

fulfilled was thought to require sensitivity on part of judges in order not to agitate the patient and inadvertently setting up the psychiatrist as the opposition, as described in the quote below:

If it's a case that almost everyone realizes is clear as day then it is perhaps stupid to start arguing a lot and raise hopes and other things in the patient. […] You may also consider the treatment alliance and such towards the clinician. If you start to drive a wedge between doctor and patient and that might upset the trust […] if there's a trust between doctor and patient […] then perhaps it is not for the better for the patient to do that. A prerequisite for successful care is that you have a trust, that there's an alliance between doctor and [patient].” [D6]

Below, the same judge describes what the hallmarks are of a good public counsel in these sorts of proceedings. The patient's “opinions” should be put forward but should not “clash” with the assessment put forward by the applying psychiatrist.

Yes, but I think when you present the patient's opinions, it's important that… well, how should I describe it? That you still do it in a good way. But also that you don't completely clash, just take… it should still try to be more of a conversation, and more about maintaining a good atmosphere as well. Of course, it is the chairperson's responsibility to ensure this, but that you don't take on the role of a criminal defense attorney, so to speak, without trying to keep it… yes, so that you maintain a good atmosphere and create a positive dialogue in the courtroom. [D6]

6.3. *Supportive and suitable public counsels*

One of the strongest themes that emerged in interviews with public counsels was that they too lack the knowledge and therefore professional mandate to challenge medical assessments. Instead, they portrayed themselves as translators for their clients. Clients put forward their views and public counsels' task is to help dressing such views in legally palatable language. Conversely, they explain to their clients in clear and accessible terms what it is that the other actors in court are arguing and deciding. A clear line was drawn when it came to putting forward arguments that challenges “the medical assessment”. One consequence of the notion that “psych cases” are of a particular nature and that the individuals concerned require special treatment in court, was that the role of the public counsel was implicitly – and in some cases explicitly – circumscribed. Critical questioning of the case put forward by the senior consultant psychiatrist was considered counterproductive and to represent a failure to protect the client's best interests. Below, a public counsel discusses how the local administrative court appears to keep record of “suitable” public counsels to engage in involuntary care cases. A colleague that he admired was asked not to take on such cases, in his reading because she was too effective when arguing her client's position.

[One colleague] she had a few of these hearings and in the end she talked to the administrative court and they agreed that she probably shouldn't have those cases because she got really quite frustrated during these proceedings that … cause I think that if you're to have these cases you sort to have to accept that your role is limited. Because I think otherwise, I know she somehow ended up in a discussion with the court about the fact that she's very procedurally skilled and she's tough in a conflict, and that doesn't quite fit … well I don't know how to put it. It's not how it's done in this sort of process, even if perhaps it should be.”[A4]

The public counsel's task in the proceedings was portrayed primarily as providing support for a distressed and confused client. If done skillfully, and in concert with the rest of the actors in court, this could have therapeutic benefits: clients would feel that they are being heard, which in turn may lead to developing a more positive attitude towards institutions and authority, characterized by trust. If done poorly, that is if the public counsel questioned the judgment or expertise behind the medical case put forward in support of involuntary care, the result might be that the client's long-term prospects were harmed, as a key aspect in all successful rehabilitation is trust between the patient and the caregiver. In the quotes below, a judge and a public counsel frame the role of public counsels as one of providing orderly calm and reassurance:

Well, the public counsel is there to help the patient, you know. Partly to… and to be a support in the process as well. They do that by sitting beside [them], so to speak, and turning towards the patient and sort of taking it in there… Then they also sometimes help me, the public defenders, for example when the doctor is going to talk, we want to hear what the doctor thinks and then it can happen that the patient sometimes says, “no, that wasn't right” then the counsel can say, wait a minute, you will have a chance to speak later. And of course, it's for the patient's own good too, so that… well, otherwise the hearing would be a bit chaotic [lite rörig förhandling] if the patient were to interrupt all the time. [D4]

[M]y understanding is that they are there to support the patient during the actual hearing. Sometimes the patient can also have an additional support person with them, for example, a healthcare professional whom they feel comfortable with. Yes. Well, that's the mission they have, I guess. [D4]

Yes. Well, I feel that beyond… that the important task is to establish a relationship with the client in this short time, and that the client still feels that “I have someone representing me,” that's my most important role. But, apart from that very particular case where I could fight for the client and actually achieve success… it's such a special […] case in itself, I don't feel like my arguments are being listened to. Instead, they listen to the doctors, and they do as the doctors say. [A6]

6.4. *Showing the illness*

In the interview material, judges, public counsels and applying senior consultant psychiatrists all pointed to the role of the court appointed expert psychiatrist as the procedural warranty for the soundness of the medical assessment. In contrast, the expert psychiatrists themselves described the oftentimes perfunctory character of their contribution to the proceedings, due to a lack of clarity as to what their actual task is and, importantly, the absence of instructions for how an assessment should be made and what – if any - documentary material that they should provide to the court. One interviewee explained that one of the reasons that the assignment was considered attractive is precisely that it does not require any paperwork, which is almost unheard of in a medical line of work.

The court appointed expert psychiatrists further described the difficulties in relation to closely examining whether the legal requisites for involuntary care are fulfilled, both in terms of it posing a threat to the treatment alliance, and because it is a pedagogical challenge to translate clinical observations into legally useful terms. This implicit translational responsibility sometimes gave rise to a practice by which either the senior consultant or the court appointed psychiatrist attempted to put a patient's psychiatric problems on display, for the court to “see for themselves”. A common strategy was therefore to “talk around” the issue in proceedings where the patient was present and pose questions to prompt reasoning or behavior that would serve to demonstrate to the court the severe mental disorder and indispensable need for care. The questions asked were not intended to obtain actual information from the concerned party, instead the statements were used to illustrate that the criteria for involuntary care were fulfilled.

Interviewer: What would you say that the questions [that you ask in court] aim to achieve?

EP3: I often want to illustrate the problem, for example severe mental disorder and [lack of] clinical insight surrounding it, then you can ask the patient “have you got an illness? Right, what sort of illness and how does it affect you? What kind of symptoms do you or do you not have, and so on. And then they get to talk about that that fairly freely. And sometimes immense delusions emerge, really clearly. Some are acting in both a manic and psychotic manner there and then, making it a bit of an own goal, if indeed they are contesting the application. But I try not to expose a patient unnecessarily or subject them to suffering, but at the same time make clear to the court so they understand that the patient is ill.

Interviewer: But you tend to know already?

EP3: Yes. Yes, absolutely. I know.

Interviewer: So it's more to do with providing some sort of …

EP3: Information, really. Yes, to show.

6.5. *An arena to feel seen and heard*

One effect of the asymmetrical distribution of agency surrounding medical assessment was that professional actors construed the court hearing as an arena for patients to feel seen, in contrast to what they themselves recognised as the court's normal role of interrogating evidence and scrutinising arguments. Public counsels' role was reconfigured to function as neutral conduits, translating whichever argument their client puts forward to legalese, but not helping the client to make a legal case for the outcome that they were seeking. Another task was to provide emotional backup and to explain. The court was presented as a civic space that provides a sense of citizenship and belonging, by dint of there being a public counsel and judge present that listen to the patient's voice and thar bear witness to the involuntary care. Below two senior consultants and a judge explain why they think it is important that patients' attend their court hearings, even if the outcome is pretty much a given.

L4: We usually try to persuade them. I think it's important for the patient to be involved, but sometimes I understand that they don't want to or don't have the energy.

Interviewer: Why is it important?

L4: I still think so, it's still society's… control over their healthcare, the involuntary care they undergo, and it's important for them to see that it works. It can also be important for them to have the second opinion that the expert psychiatrist assessment represents. That they have a chance to talk to a public defender. I think it's important.

I think it is very important for the patient… the hearing itself, or… they are in a very vulnerable situation, and I believe it would be difficult… they don't always understand what is happening anyway, but… yes. I think it's important how the patient has experienced the hearing when they leave, for the acceptance of the decision, and that they feel they have been heard, that someone knows they are there, and so on." [D5]

Yes, they can choose [whether to attend]. I mean, it's voluntary. But I try to motivate them and say that it's very important. This is, so to speak, a legal process, and it's the opportunity where you can influence or try to influence the proceeding, and they are interested in knowing what you want. It's also interesting because it can show to some extent how involved you are in your own healthcare. Because our goal is to work… I mean after all, the goal is ultimately to try to reintegrate these individuals back into society, to foster understanding that they have an illness.[L1P]

In summary, interviewees tended to describe the medicolegal terrain of involuntary care hearings in terms of a pronounced absence of knowledge and epistemic mandate for judicial actors, while simultaneously underlining the importance of patients participating in the hearings and for them to feel seen and heard. This duality resonates with qualitative studies of lived experience in forensic psychiatric care, where participation in legal and institutional processes is described as simultaneously meaningful and constraining, supportive yet disempowering (Pedersen et al., 2020; Söderberg et al., 2023). In the section that follows, I use Timmermans and Tavory's technique of alternative casing to further the analysis.

7. An alternative casing – comparing medicolegal terms, practices and objectivities

When working with the interview data, the apparent contrast between how two types of medicolegal decisions were made in the Swedish welfare state was striking. Two types of assessments, made in seemingly similar epistemic terrain where medicine and law meet to adjudicate and operationalize co-owned terms, appeared to be practiced and scrutinized in quite different manners (Eriksson, 2015; Eriksson et al., 2014a, 2014b).

Around the same time as the two new acts regarding involuntary psychiatric care were signed into law, a new decision-making support tool for sick leave had been introduced. The reason for introducing the decision-making support tool was to enable a more "stringent" sick leave assessment process. Sick leave numbers and attendant costs in Sweden were way up and something needed to be done. The basis for what constituted legitimate claims to sick leave needed to be more strictly defined and assessment practices standardized. Doctors, who had previously tended to recommend sick leave based on presence of illness, were now to learn how to appropriately assess their patients' "work capacity". This assessment would then be scrutinized by a social insurance officer who would grant or deny the claim. One sticking point was to identify the underlying reason for the diminished work capacity: was it "medical" or "social" in character? A new and tighter definition of "medical" was co-produced with new practices for assessing "work capacity" (Eriksson, 2015).

The medicolegal term "severe mental disorder" used in relation to involuntary care is similar to that of "work capacity" used in social insurance matters: both terms are set out in law and operationalized by medical practitioners, an operationalization that then needs to be accepted by another party that has the ultimate say and makes a decision (the Administrative court and the Social Insurance Agency respectively). In the case of sick leave, if there is disagreement or uncertainty regarding the original assessment made by a physician claiming that a patient can be said to have a decreased work capacity, the social insurance officer can consult a medical insurance advisor.

The medical insurance advisor's status is similar to that of the court-appointed medical expert in involuntary care cases in that they are understood as parties with the same kind of medical expertise as the doctor responsible for the initial assessment, and whose role it is to function as a resource for the decision-making body. Here, however, the similarities end. The medical insurance advisor's remit is strictly defined: the task of the advisor is to examine the documented evidential basis on which the treating physician has based their recommendation. In this context, the central question is whether it is reasonable to recommend a certain period of sick leave based on the data and documentation presented by the treating physician. It is not the task of the insurance medical advisor to assess whether the patient is ill or not, nor if the patient's ability to work is impaired or not, but solely to examine the medical documentation on which the treating physician has based their assessment (Eriksson et al., 2014a; Eriksson et al., 2014b; Vahlne Westerhäll et al., 2009).

Like the social insurance administration, the administrative courts appoint a medical expert. Interviews with psychiatrists who had acted in this role, as well as with legal professionals with experience of involuntary care proceedings, indicated that court-appointed psychiatrists were afforded considerable latitude in how they defined and enacted their role. Depending on what they considered the case to require, this could involve providing a second opinion, acting as a "medical translator" to guide jurors through psychiatric terminology, or posing critical questions to the applying senior consultant psychiatrist.

Inquiries with the National Board of Health and Welfare confirmed that there is no formal guidance regulating how court-appointed medical experts should carry out their role in involuntary care cases.

In sum, when it comes to assessments regarding "work capacity", any interpretation is narrowly prescribed by way of guidelines, devices such as a “medical insurance decision-making support tool” and considerable efforts to train physicians in correctly assessing patients' need for sick leave. The sick leave practices were reminiscent of what Daston and Galison (2007) term mechanical objectivity, as well as Megill's (1994) procedural objectivity, where epistemological warranty is provided by way of following a correct process according to strict and predefined rules (Sager & Eriksson, 2015). The involuntary care proceedings were more similar to disciplinary objectivity (Megill, 1994) or trained judgment (Daston & Galison), when agreed-upon standards for robust knowledge are developed within a field or profession.

The following table (Table 1) summarises key contrasts that emerged through the alternative casing. Rather than offering a complete interpretation, it should be read as an analytical heuristic that highlights differences in how assessment practices are organised across the two settings, which are taken up and discussed in more detail in the subsequent analysis.

Table 1
Institutionalised ignorance in court.

SICK-LEAVE PROCESS/ ASSESSMENT	INVOLUNTARY CARE PROCESS/ASSESSMENT	ANALYTICAL IMPLICATION
Shared – if tense - professional ownership of process, structured by templates and decision-making support tool.	Judicial process dominated by medical actors and perspectives.	Sick-leave: professional tension is institutionalised and worked through procedurally. Involuntary care: tension is muted through judicial self-effacement and deference.
Translatable measurements essential, staircase tests etc.	No translatable measurements required, few or no external tests to point to. If necessary patient would be "unpacked" in court.	Sick leave: legitimacy is produced through compulsory translation into commensurable categories. Involuntary care: legitimacy is produced through display and performative demonstration.
Medicolegal concept strictly defined in assessment practices.	Medicolegal concept flexible in assessment practices.	Sick leave: strict definition constrains the object of assessment and disciplines how judgements are made. Involuntary care: flexibility keeps the object of assessment open-ended, limiting the conditions under which judgements can be meaningfully contested.
Tug-of-war between two professional groups.	Self-effacing boundary-work on part of judicial actors.	Sick leave: professional conflict over cognitive jurisdiction is articulated and institutionally accommodated. Involuntary care: any conflict is muted and rendered inappropriate.
Strong emphasis on documentary foundation for medical claims.	Little focus on foundation for medical claims, apart from the necessity of documents being filed on time.	Sick leave: documentation functions as an epistemic check. Involuntary care: timeliness functions as a procedural substitute for epistemic checking.
Heavily standardised process to ensure legal certainty understood as predictability and geographically distributed sameness.	The hearing in itself portrayed as a symbolic enactment of legal certainty, co-producing values such as dignity and sense of belonging.	Sick leave: Legal certainty as predictability and sameness. Involuntary care: Legal certainty as ritual, reassurance, and moral performance.

7.1. *Legal professionals lacking knowledge - reversed boundary-work?*

The apparent leeway in involuntary care cases compared to other decision-making practices made in the borderland between medicine and law stuck out as interesting. I had entered the field expecting to find strong professions at odds over what constitutes evidence, relevant documentation, and how boundaries should be drawn around terms such as indispensable need of care and severe mental disorder. “Boundary-work” is a common term used in the field of Science and Technology studies. The imagery is drawn from cartography and describes how scientists or other professional groups stake out their domains. In that process actors define what constitutes relevant knowledge, how it must be measured or exercised and, consequently, who owns the jurisdiction over a particular question (Gieryn, 1983).

Some boundary work did occur in the early days, when the issue on the table was whether it was appropriate that members of the medical profession should be able to deprive citizens of their liberty with impunity. When examining that process, starting in the late 19th century, developments can be traced where checks and balances were gradually added and voices other than the medical got included. Some of these changes were scandal-driven, propelled by public outcry in response to cases where abuse of power and the absence of legal remedies had been glaringly obvious, and initially focused on designing a system capable of protecting citizens from individual medical professionals acting on hidden agendas or allowing themselves to become tools for other actors lurking in the background.

The general question of what constitutes sufficient grounds for infringing a person's autonomy and who should adjudicate it received less attention. That changed with the introduction of the current acts that shrunk psychiatrists' mandate substantively and placed the decision-making in the remit of administrative courts. As might be expected, the preceding period was rife with boundary-work, colourfully if unusually exemplified by the thousand booing psychiatrists referenced in the opening section of this paper. Considering the hard-won territorial dispute that had placed judicial actors at the centre of medicolegal decision-making concerning involuntary care, I had expected a continuation of such boundary-work in the court proceedings. One of the core values at stake upon introducing the acts had been legal certainty for patients subjected to involuntary care measures. My assumption had been that court practices would centre on providing checks and balances on medical claims. Actors such as public counsels and court-appointed expert psychiatrists would carefully examine the case put forward by the applying psychiatrist, guided by a judge that could adjudicate on matters such as which type of information or documentation that was relevant. Instead, I met judicial actors focusing heavily on the limits of their own expertise in their description of court practices and the roles and mandate of other actors.

8. Discussion

McGoey's view of ignorance as a resource that can provide necessary infrastructure enabling smooth running of institutions or practices is pertinent when looking at how decision-making regarding involuntary care is designed. For hearings to run smoothly it requires institutional arrangements that allows for judicial actors not to know and not to find out: a division of labour between medical experts providing assessments and judicial actors casting themselves as non-experts who cannot query the medical underpinnings for such assessments. Despite this, they all point to the court being the body with the absolute mandate to decide. A compromise of sorts appears to have been reached. Medical professionals accept that the formal decision to (continue to) deprive someone of their liberty must lie with the judiciary. Legal professionals recognize that their role is very limited in practice but point to the fact that there *is* a system in place as a warranty for legal certainty. The system is, in a sense, its own answer.

8.1. *Chronicity and institutional presentism*

In her study of ignorance and absence, Croissant (2014) identifies several attributes to apply when studying ignorance across cases or disciplines, among them *chronicity*. In the case of involuntary care, time looms large as a very scarce resource. The interview material contains vivid descriptions of the high caseload that is fitted into one “psych round”, and how logistically and administratively demanding it is to ensure that the right documents relating to each case are in place. It is not uncommon for a court to deal with an excess of 15 cases in a day, leaving a narrow timespan for each case from beginning to end.

A pressed schedule may appear trivial, if unfortunate, but it is central in the production of not-knowing.[5] For practical and logistical reasons, the court will appoint one public counsel to handle all cases on a given day. In the comparatively rare cases when a patient asks for a particular public counsel this will be accommodated, however the standard procedure is such that mostly patients will meet new judges and public counsels each time and vice versa. While actors' *roles* in court hearings remain the same from one session to the next, the individuals serving in those roles do not. The notion of a singular court in place to continuously oversee and examine the case for involuntary care is thus somewhat illusory and, importantly, the lack of permanence is unevenly distributed. The only regular individual actors tend to be the applying senior consultant and the patient (if the latter opts to participate in the hearing).

A further temporal aspect concerns how the legal and clinical questions described by professional actors as central to the decision favour a synchronous reading of a patient's state over a diachronic assessment of how care is progressing. In both LPT and LRV proceedings, continued involuntary care hinges on whether the patient is still considered to suffer from a severe mental disorder and to have care needs of such a kind that they cannot be met on a voluntary basis, criteria that are assessed as present or absent at the time of the hearing, although the statutory formulations of necessity differ between the two Acts. The medical assessment by the applying senior consultant, as well as the opinion from the court-appointed psychiatrist, are therefore framed to establish the patient's current condition rather than to evaluate how treatment has unfolded or with what effects.

Combined with an institutional arrangement in which ‘new’ judicial actors are repeatedly rotated into the arena while the medical actors remain more or less the same, this framing paves the way for proceedings in which questions concerning the content, quality and efficacy of ongoing involuntary treatment remain largely unexamined. A safeguarding system that knows only that a patient needs care, but systematically refrains from asking how that care unfolds over time, produces a form of institutional presentism. In this arrangement, necessity is continuously re-established in a series of isolated ‘nows’, while questions concerning the substance and effects of involuntary treatment are rendered temporally irrelevant and, consequently, institutionally ownerless.

8.2. *Institutional arrangements and their values*

An analysis of institutional ignorance in decision-making regarding involuntary care could end there. But if examining renderings of legal certainty as different modes of *doing good* (Pols, 2003), we might access a register that allows us to discuss each rendering on its own terms. A focus on rights and wrongs can at times risk obscuring rather than throwing light on matters of importance. Rather than framing the arrangements described above in terms of intentions or outcomes, this section adopts a symmetrical approach. Following McGoey, and as emphasised by Paul and Haddad, the analytical task is not to uncover hidden motives or failures, but to examine what is enabled, protected and foregrounded when particular forms of knowing and not-knowing are stabilised. In that same vein, ‘doing good’ is not approached as a question of benevolent intent, but as an analytical shorthand for the effects produced by particular configurations of practice. In the following section, I examine what is being protected and produced by an institutional arrangement through which legal representatives renounce their claim to interpretive authority.

The contrast highlighted by the alternative casing is not only procedural but also reflects differences in governing rationales. In the context of sickness benefit assessments, decision-making is shaped by explicit policy goals aimed at regulating access to benefits and limiting sick leave, which institutionalise contestation and scrutiny. In involuntary psychiatric care, by contrast, decision-making is shaped less by explicit policy objectives than by a confluence of care-oriented, protective and legitimising concerns. These conditions favour procedural arrangements oriented towards stabilisation rather than contestation.

One worth that is produced or protected is ‘treatment alliance’: the relationship of trust between patient and psychiatrist, understood as crucial for any progress to be made in the care. That can be threatened if the applying senior consultant is forced to speak of the patient's illness in a manner that the patient does not recognize or agree with. Moreover, questioning of the medical assessment can undermine the senior consultant's authority as a credible knower in the eyes of the patient. Recent empirical-ethical work has similarly highlighted how forensic practitioners navigate dual-role tensions, and how values such as trust, alliance and future-oriented protection are enacted and prioritised in everyday decision-making (Pedersen et al., 2025). Importantly, the analytical point here is not that a therapeutic alliance is always present or intact, but that it is treated as a value worth protecting within the institutional arrangement. Analytically, this requires resisting the assumption that a therapeutic alliance exists as a stable feature of care relationships. Instead, the practices described in the material operate to uphold the therapeutic alliance as a normative reference point even where relational conditions are fragile, strained, or already compromised.

As discussed earlier, Pols' study of psychiatric nursing distinguishes between a juridical mode of ordering and a caring mode of ordering, depending on whether the emphasis lies on autonomy or relationality. In one of the hospitals she studied, a “patient advocacy” role allowed nurses to divide work—or rather, divide roles—so that they did not have to handle the patient's legal complaints and the relational tensions that might ensure from that (Pols, 2003). In the material presented here, a similar ethos can be discerned. I understand the practice to “bring out and show” patients' thoughts and behaviors to the court as a way to compensate for the court's limitations and assuage unease about making decisions based on trust (see also Eriksson et al., 2017).[6]

From a symmetrical perspective, the treatment alliance can be understood as a protected object within this institutional arrangement. References to trust, authority and continuity do not merely express professional concern, but point to a configuration in which the stability of the therapeutic relationship is prioritised over the contestability of medical claims (cf. Sjöström, 1997; Sjöström et al., 2017). The reluctance to interrogate assessments in court, and the careful management of how illness is spoken about in the patient's presence, can thus be read as practices aimed at preserving this alliance as a condition of possibility for care. Analytically, this resonates with work that approaches care not as a unitary good, but as a practical arrangement that foregrounds

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[5] Although the analysis in this paper concerns decision-making practices under both the Compulsory Mental Care Act (LPT) and the Forensic Mental Care Act (LRV), the temporal effects discussed here take on particular significance in LRV cases. Given the often very long durations of forensic involuntary care, the absence of a diachronic assessment of treatment content and progression risks becoming especially consequential.

[6] Such demonstrations fit well with both the medical and legal field's epistemological traditions, which strongly emphasizes the visible and observable.

certain concerns while rendering others less attendable (Lydahl, 2024).

8.3. The patient's role in the courtroom

In her work, Miranda Fricker combines questions of knowing with questions of justice in interesting and stark ways (Fricker, 2007). Fricker describes as "testimonial injustice" when someone is being undermined in their capacity as knower.[7] Most empirical studies of court proceedings regarding involuntary care point towards a situation in which the individual whose mental state and need of care is being adjudicated is being treated as a very different kind of knower, or not a knower at all, than are the other actors in the courtroom.

A central question is, then, what role patients have in the courtroom: why are they there, what function do they fulfil? If they are not there in their capacity as a knower then what value is being enacted by them being there? When public counsels in the interview material expressed the importance of allowing the patient's voice – regardless of how delusional that voice may appear to others – they were insisting on their client's humanity or dignity. At the same time, that very voice can be used as a tool in hearings when the expert psychiatrist tries to tease out and put on display that the requisites for involuntary care measures are met. The patient is enacted less as a subject whose rights are at stake, and instead as a subject whose dignity and emotions are central. In this sense, the hearing offers a form of participation that is oriented less towards immediate legal effect than towards familiarisation with legal procedures and institutional authority.

Against this backdrop, the patient's presence in court can be understood as performing a specific function. Patients are repeatedly described as central to the hearing, yet not primarily in their capacity as knowers or as legal subjects whose claims are to be adjudicated. Instead, participation is framed as important for what it enables the patient to recognize: that a legal process is in place, that professional actors are attentive to their situation and whereabouts, and that continued deprivation of liberty is subject to regular review. In this configuration, the hearing functions less as an arena for contestation and more as a site of institutional reassurance. The significance of the patient's attendance lies not in epistemic contribution or legal argumentation, but in making the ongoing presence and orderly operation of the state perceptible.

The repeated emphasis on courtroom atmosphere should be understood as more than a matter of interpersonal sensitivity. Atmosphere functions here as both an epistemic and a moral technology: it stabilises trust in the medical assessment by discouraging adversarial questioning, and it enacts a form of care in which calm, order and reassurance are treated as values in their own right. Through the careful orchestration of interaction, atmosphere helps sustain the legitimacy of the proceedings, even as questions concerning the substance and progression of involuntary care remain bracketed. In this sense, atmosphere operates as an infrastructure of not-knowing, enabling decisions to be made without opening up questions that might disturb the fragile alignment between care, authority and legality.

The emphasis placed by court actors on atmosphere, participation and acceptance resonates with strands of legal scholarship that have conceptualized such concerns in terms of therapeutic jurisprudence and procedural justice. From these perspectives, legal proceedings are evaluated not only by their formal outcomes, but also by their capacity to provide voice, reassurance and a sense of being treated with respect (Lind & Tyler, 1988; Tyler, 1990; Wexler, 1992; Wexler & Winick, 1991). In this literature, a caring courtroom and an orderly process are often framed as means of enhancing legitimacy and compliance (Tyler, 2003). These approaches have, however, also been discussed critically for tending to leave the institutional conditions underpinning care, legitimacy and authority analytically underexplored (Bottoms & Tankebe, 2012; Petrila, 1993).

What the present analysis adds to these accounts is an attention to precisely such institutional conditions. Rather than treating therapeutic or procedural qualities as unproblematic goods, the analysis shows how they are sustained through specific arrangements of knowing and not-knowing, including the bracketing of questions concerning the substance, quality and progression of involuntary care. In this sense, the courtroom practices described here do not simply exemplify therapeutic jurisprudence or procedural justice, but reconfigure them. Care, pedagogy and reassurance are not additional layers added to adjudication; they are achieved through a redistribution of epistemic responsibility that renders certain forms of scrutiny institutionally unavailable.

9. Conclusion

Regulation of the relationship between subject and state is a constitutive part of how citizenship is defined and enacted. Seen through the lens of empirical ethics, legal certainty does not appear as a fixed principle, but as something that is made in practice through particular institutional arrangements. In this article, I have examined how legal certainty in involuntary care proceedings is accomplished through acts and infrastructures of not-knowing: through a division of labour that limits interpretive authority, through a present-oriented temporal framing, and through practices that bracket questions concerning the content, quality and progression of care. This institutional ignorance enables the protection of certain values that are treated as central within the proceedings, such as trust in medical authority, the preservation of treatment alliance, and the maintenance of a calm and caring courtroom atmosphere. Legal certainty is thus safeguarded not by expanding scrutiny, but by stabilising a particular order of knowing and not-knowing. One effect of this arrangement is a repurposing of the court. Rather than functioning primarily as an arena for sustained interrogation of coercive care over time, the court is reconfigured as a space that provides pedagogy, reassurance and care, alongside the formal decision to deprive someone of liberty. In this repurposed court, the presence of the patient takes on a particular significance. Participation does not primarily serve to render the patient visible as a knower or as a rights-bearing party whose claims are to be examined. Instead, the hearing functions as an occasion for the patient to witness the court: to see that a legal process is in place, that authority is exercised with composure, and that the deprivation of liberty is embedded in an orderly and caring institutional frame. In this sense, legal certainty is enacted less through the court bearing witness to its citizens, than through citizens being invited to bear witness to the court.

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Lena Eriksson: Writing – original draft, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization.

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[7] The mere attribution of lesser credibility does not, in itself, constitute testimonial injustice, as differential credibility assessments may at times be epistemically warranted.

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References

Abbott, A. (1988). *The system of professions: An essay on the expert division of labor*. Chicago: Chicago UP.

Berger, P. (1963). *Invitation to sociology: A humanistic perspective*. New York: Anchor and Doubleday.

Bloor, D. (1976). *Knowledge and social imagery*. London: Routledge & Kegan Paul.

Bottoms, A., & Tankebe, J. (2012). Beyond procedural justice: A dialogic approach to legitimacy in criminal justice. *The Journal of Criminal Law and Criminology, 102*(1), 119–170.

Bovensiepen, J. (2020). On the banality of wilful blindness: Ignorance and affect in extractive encounters. *Critique of Anthropology, 40*(4), 490–507. https://doi-org.ezproxy.ub.gu.se/10.1177/0308275X20959426.

Brecht, B. (1974). *Brecht on theatre: The development of an aesthetic*. New York: Hill and Wang.

Brockman, B. (1993). Preparing for mental health review tribunals: Reports and dilemmas. *Psychiatric Bulletin, 17*, 544–547.

Callon, M. (1986). Some elements of a sociology of translation: Domestication of the scallops and the fishermen of St Brieuc Bay. In J. Law (Ed.), *Power, action and belief: A new sociology of knowledge?* (pp. 196–223). London: Routledge.

Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 509–535). Thousand Oaks, CA: Sage.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London: Sage.

Charmaz, K. (2009). Shifting the grounds: Constructivist grounded theory methods. In J. M. Morse, P. N. Stern, J. Corbin, B. Bowers, K. Charmaz, & A. E. Clarke (Eds.), *Developing grounded theory: The second generation* (pp. 127–154). Walnut Creek, CA: Left Coast Press.

Croissant, J. L. (2014). Agnotology: Ignorance and absence or towards a sociology of things that Aren't there. *Social Epistemology, 28*(1), 4–25. https://doi-org.ezproxy.ub.gu.se/10.1080/02691728.2013.862880.

Daston, L., & Galison, P. (2007). *Objectivity*. New York, NY: Zone Books.

Dewey, J. (1913). The problem of values. *The Journal of Philosophy, Psychology and Scientific Methods, 10*(10), 268–269.

Diesfeld, K., & Sjöström, S. (2007). Interpretive flexibility: Why doesn't insight incite controversy in mental health law? *Behavioral Sciences & the Law, 25*(1), 85–10.

Dussauge, I., Helgesson, C.-F., Lee, F., & Woolgar, S. (2015). On the omnipresence, diversity, and elusiveness of values in the life sciences and medicine. In I. Dussauge, C.-F. Helgesson, & F. Lee (Eds.), *Value practices in the life sciences and medicine* (pp. 1–28). Oxford University Press.

Eriksson, L. (2015). Diagnosis at work – On sick leave in Sweden. *Social Theory & Health, 13*(2), 162–179. https://doi.org/10.1057/sth.2015.1

Eriksson, L., Kindström Dahlin, M., & Radovic, S. (2017). Att visa upp en patient : Utsagor och bedömningar vid beslut om tvångsvård. *Retfærd: Nordisk Juridisk Tidsskrift, 3–4*, 149–166. Retrieved from http://urn.kb.se/resolve?urn=urn:nbn:se:uu:diva-429706.

Eriksson, L., Sager, M., Staland-Nyman, C., & Hensing, G. (2014a). Expertis, sjukskrivning och mötet mellan normal och post-normal vetenskap. *Socialvetenskaplig tidskrift, 21*(2), 160–174.

Eriksson, L., Sager, M., Staland-Nyman, C., & Hensing, G. (2014b). Kunskap och bedömningar i sjukskrivning: En vetenskapsteoretisk studie av det försäkringsmedicinska beslutsstödet. *Socialmedicinsk Tidskrift, 91*(4), 323–331.

Fricker, M. (2007). *Epistemic injustice: Power and the ethics of knowing*. Oxford University Press.

Gieryn, T. F. (1983). Boundary-work and the demarcation of science from non-science: Strains and interests in professional ideologies of scientists. *American Sociological Review, 48*(6), 781–795.

Grönwall, L. (2012). *Lagstiftning om tvång förr och i dag - Anförande vid Socialpsykiatriskt Forums årskonferens 20–21 March 2012*.

Grönwall, L., & Holgersson, L. (2018). *Psykiatrin, tvånget och lagen : en lagkommentar i historisk belysning*. Stockholm: Norstedts Juridik AB.

Gustafsson, E. (2009). *Psykiatrisk tvångsvård och rättssäkerhet: en rättsvetenskaplig monografi om LPT*. Lund: Studentlitteratur.

Zetterberg, L., Sjöström, S., & Markström, U. (2014). The compliant court — Procedural fairness and social control in compulsory community care. *International Journal of Law and Psychiatry, 37*(6), 543–550.

Hollander, A., Jacobsson, M., & Sjöström, S. (2007). Defender, spokesperson, therapist: Representing the true interest of the client in therapeutic law. *International Journal of Social Welfare, 16*(4), 373–381.

Holstein, J. A. (1993). *Court-ordered insanity: Interpretive practice and involuntary commitment*. Hawthorne, NY: Aldine de Gruyter.

Kindström Dahlin, M., Eriksson, L., & Radovic, S. (2017). Att visa upp en patient: Utsagor och bedömningar vid beslut om psykiatrisk tvångsvård. *Retfaerd: Nordisk Juridisk Tidsskrift, 40*(3–4), 149–166.

Law, J. (2004). *After method: Mess in social science research*. London: Routledge.

Lind, E. A., & Tyler, T. R. (1988). *The social psychology of procedural justice*. New York: Plenum Press.

Lydahl, D. (2024). Good care and adverse effects: Exploring the use of social alarms in care for older people in Sweden. *Health, 28*(4), 559–577. https://doi.org/10.1177/13634593231185260

Mann, A., & Mol, A. (2018). Talking pleasures, writing dialects. Outlining research on Schmecka. *Ethnos, 84*(5), 772–788. https://doi-org.ezproxy.ub.gu.se/10.1080/00141844.2018.1486334.

McGoey, L. (2007). On the will to ignorance in bureaucracy. *Economy and Society, 36*(2), 212–235. https://doi.org/10.1080/03085140701254282

McGoey, L. (2012). Strategic unknowns: Towards a sociology of ignorance. *Economy and Society, 41*(1), 1–16. https://doi.org/10.1080/03085147.2011.637335

Megill, A. (1994). *Rethinking objectivity*. Duke University Press.

Muniesa, F. (2011). A flank movement in the understanding of valuation. *The Sociological Review, 59*(2_suppl), 24–38. https://doi-org.ezproxy.ub.gu.se/10.1111/j.1467-954X.2012.02056.x.

Nyström, A. (1895). *Om sinnessjukdomar och hospitalsvård jemte antydningar om sinnessjukas rättsliga skydd*. Stockholm: C. & E. Gernandts f.-aktb.

Oreskes, N., & Conway, E. M. (2010). *Merchants of doubt: How a handful of scientists obscured the truth on issues from tobacco smoke to global warming*. Bloomsbury Press.

Paul, K. T., & Haddad, C. (2019). Beyond evidence versus truthiness: Toward a symmetrical approach to knowledge and ignorance in policy studies. *Policy Sciences, 52*(2), 299–314. https://doi.org/10.1007/s11077-019-09352-4

Peay, J. (1989). *Tribunals on trial: A study of decision-making under the mental health act 1983*. Oxford: Clarendon Press.

Pedersen, S. H., Nilsson, T., & Eriksson, L. (2020). Potential pitfalls of applying a therapeutic logic in mental health Law proceedings. *International Journal of Forensic Mental Health, 19*(4), 354–364.

Pedersen, S. H., Radovic, S., Nilsson, T., & Eriksson, L. (2025). Dual-roles and beyond: Values, ethics, and practices in forensic mental health decision-making. *Medicine, Health Care and Philosophy, 28*(2), 199–211. https://doi.org/10.1007/s11019-024-10247-2

Perkins, E. (2003). Mental health review tribunals. In K. Diesfeld, & I. Freckelton (Eds.), *Involuntary detention and therapeutic jurisprudence. International perspectives on civil commitment* (pp. 221–240). Aldershot: Ashgate.

Petrila, J. (1993). Paternalism and the unrealized promise of therapeutic jurisprudence. *New York Law School Journal of Human Rights, 10*(3), 877–904.

Pinto, M. (2015). Tensions in agnotology: Normativity in the studies of commercially driven ignorance. *Social Studies of Science, 45*, 294–315. https://doi.org/10.1177/0306312714565491

Pols, J. (2003). Enforcing patient rights or improving care? The interference of two modes of doing good in mental health care. *Sociology of Health & Illness, 25*(4), 320–347. https://doi.org/10.1111/1467-9566.00349

Pols, J. (2006). Washing the citizen: Washing, cleanliness and citizenship in mental health care. *Culture, Medicine and Psychiatry, 30*(1), 77–104. https://doi.org/10.1007/s11013-006-9009-z

Pols, J. (2015). Towards an empirical ethics in care: Relations with technologies in health care. *Medicine, Health Care and Philosophy, 18*(1), 81–90. https://doi.org/10.1007/s11019-014-9582-9

Proctor, R. N. (1995). *Cancer wars: How politics shapes what we know and don't know about cancer*. New York, NY: Basic Books.

Sager, M., & Eriksson, L. (2015). Objectivities of a post-normal guideline project: The introduction of a guideline for sick-listing practices in Sweden. *Evidence & Policy, 11*(3), 351–376.

Scott, J. C. (1998). *Seeing like a state: How certain schemes to improve the human condition have failed*. New Haven, CT: Yale University Press.

Sjöström, S. (1997). *Party or patient?: Discursive practices relating to coercion in psychiatric and legal settings*.

Sjöström, S., Jacobsson, M., & Hollander, A. (2017). Collegiality, therapy and mediation—The contribution of experts in Swedish mental health Law. *Laws, 6*(1), 2. Retrieved from https://www.mdpi.com/2075-471X/6/1/2.

Söderberg, A., Wallinius, M., Munthe, C., Rask, M., & Hörberg, U. (2023). Forensic psychiatric patients' experiences of participating in administrative court proceedings concerning the continuation of forensic psychiatric care. *Frontiers in Psychiatry, 14*, Article 1134567. https://doi.org/10.3389/fpsyt.2023.1134567

SOU 1998:32. (2026). *Rättssäkerhet, vårdbehov och samhällsskydd vid psykiatrisk tvångsvård*. Stockholm: Socialdepartementet.

Thom, K., & Nakarada-Kordic, I. (2013). Mental health review tribunals in action: A systematic review of the empirical literature. *Psychiatry, Psychology and Law, 21*(1), 112–126. https://doi-org.ezproxy.ub.gu.se/10.1080/13218719.2013.790004.

Timmermans, S., & Tavory, I. (2012). Theory construction in qualitative research: From grounded theory to abductive analysis. *Sociological Theory, 30*(3), 167–186. https://doi.org/10.1177/0735275112457914

Tyler, T. R. (1990). *Why people obey the law*. New Haven, CT: Yale University Press.

Tyler, T. R. (2003). Procedural justice, legitimacy, and the effective rule of law. *Crime and Justice, 30*, 283–357.

Vahlne Westerhäll, L., Thorpenberg, S., & Jonasson, M. (2009). *Läkarintyget i. sjukförsäkringsprocessen : styrning, legitimitet och bevisning*. Stockholm: Santérus förlag.

Wahlberg, L., Dahlman, C., Sikström, S., Sarwar, F., & Åkerman, S. (2015). *Rättslig prövning av skälen för sluten psykiatrisk tvångsvård: Bör domstolarna lita på den medicinska expertisen?*.

Wexler, D. B. (1992). Putting mental health into mental health law: Therapeutic jurisprudence. *Law and Human Behavior, 16*(1), 27–38.

Wexler, D. B., & Winick, B. J. (1991). Therapeutic jurisprudence as a new approach to mental health law policy analysis and research. *University of Miami Law Review, 45*(5), 979–1004.

Williams, D. (2021). Motivated ignorance, rationality, and democratic politics. *Synthese, 198*, 1–21. https://doi.org/10.1007/s11229-020-02549-8