Brit. J. Psychiat. (1982), **140**, 551–557

Lecture

The Impact of Legal Modes of Thought upon the Practice of Psychiatry

The Fifty-fifth Maudsley Lecture, delivered before the Royal College of Psychiatrists, 20 November 1981

SIR JOHN WOOD

Almost invariably, a professional man becomes the captive of his chosen profession. His training and his subsequent experience in practice leave an indelible mark. It is often said that married couples grow to look like each other, and in extreme cases like their dogs. So lawyers, accountants, bank managers, doctors and perhaps even psychiatrists appear to take on a stereotyped form. The cartoonist spots the uniform clothes, the rimless glasses or the mid-European accent, as the trade mark of the particular profession. But more crucially there is also the growth of stereotyped modes of thought, of common assumptions and traditional patterns of argument which are to a large extent subconscious and so more likely to pass unnoticed.

A teacher of law does not need to search far to illustrate this point. Indeed it would be surprising if he did, since he may be said to begin the process in his own profession. Part of the task of a teacher is to mould the thinking of professional students along traditional lines. Put more starkly it is to ensure deviation from 'commonsense' towards a properly structured approach that is the result of decades of professional experience. Even the most radical teacher will be more effective if he puts forward his ideas within that mould. The iconoclast has to seek a different audience, his fellow professionals will fail to grasp much of what he is saying.

Examples are easy to find. Early in the course on the law of contract the student will be told that goods placed in a shop window are not offered for sale. In law the intending purchaser enters the shop and makes an offer, rather than accepts one. Thus the shopkeeper retains a right of refusal to sell. In legal jargon, which both hides and heightens the special mode of thought, goods in a shop window are 'an invitation to treat'. The law has good and sufficient reasons for this rule. Everything in a shop window is not necessarily for sale. Most people looking into a dress shop realise that it is the dresses that are for sale and not the dummies—except perhaps for a handful of your patients. Most shopkeepers, imbued with the entrepreneurial spirit, are indeed offering what they put in the window for sale—the right price would even secure the dummy. But the legal rule prefers the safer, more cautious approach. So the student, after the lecture, is able to astound his grandmother that things are not as she has always found them to be and he can, if he's lucky, enjoy a furious argument on the point with his father. They have normal practice and commonsense on their side—he knows the law.

The law has reached its conclusion largely because it is concerned not so much with the generality of transactions as with those of difficulty. The commonsense rule, based on the generality, would work less well in cases of difficulty. The best rule to lessen those problems has almost no effect upon the normal transaction, so it is adopted. This is but one example of the process by which experts develop their own frames of reference which quickly become more or less different from the layman's way of looking at things. It is arguable, but by no means certain, that this is both inevitable and does no great harm, although the process needs to be constantly reviewed and checked, otherwise professional services cease effectively to serve. But unless the process is recognized, it becomes a serious obstacle where the spheres of two professions clash.

This point can be put in two ways. The professional man in one area is usually a layman in others. In areas outside his expertize he expects his rules of commonsense to apply. He is likely to be disappointed. If he is a narrow professional he assumes that his own specialized modes of thought will be present everywhere. He will not only be disappointed, he may well be completely alienated. The same conclusion arises if each

https://doi.org/10.1192/bjp.140.6.551 Published online by Cambridge University Press

profession is regarded as deviating differently, depending upon its own internal pressures, from lay thinking. The possibility of understanding where there is direct communication between differing professional standpoints inevitably becomes difficult.

So it has always been between the law and medicine. Nowhere is it clearer than in the relationship between the law and psychiatry. That is not to say that individual psychiatrists and individual lawyers do not have a fair and understanding grasp of each others' approach. Many indeed do. But the corpus of professional rules and the bodies and organizations which put them into effect have a life, or at least a momentum, of their own. At that level the particular professional approach will predominate and indeed be reinforced. Individual rapport will be crushed, unwittingly it is true, by the unthinking professional apparatus.

Two underlying and fundamental concerns of the law, the legal profession and its institutions, can be selected to illustrate the problem and to suggest ways in which a better interface may be possible. They are probably the most important, but they are by no means the only ones available. First and essentially the law is based upon the need for clear distinctions; it demands precision and certainty. This requirement is of profound impact when the law and psychiatry interact. Secondly, the legal process, the procedure by which legal disputes are resolved, is almost totally grounded in the adversarial system. One party must argue a proposition before a judge, the other deny its validity. The judge umpires a debate. This characteristic has its impact, not so much on psychiatry directly as upon the individual psychiatrist who finds himself involved in the process. His experience may then be indirectly absorbed into the general approach.

The law's use of psychiatry

First it must be noted that the criminal process has turned increasingly to psychiatry to help to solve some of its own intractable problems. The first call was made before the profession as such had been born. In the nineteenth century there was a shift of legal concern towards the personal responsibility for the criminal act. Insanity was an obvious condition negativing personal responsibility, indeed the difficult dicotomy between mad and bad fitted well with the Victorian mixture of scientific advance—to identify the mad, and of moral standards—to condemn the bad.

Although the underlying issues of responsibility remain as controversial as ever the reign of M'Naughten insanity is virtually over—killed by the end of capital punishment and the advent in 1957 of diminished responsibility[1]. The relationship between legal attitudes and medical opinion led to the isolation of the M'Naughten rules as hopelessly outdated. The difficulties of coping with the concept of irresistible impulse illustrate this tension. It is an area which has attracted a great deal of critical periodical literature[2]. Despite this the importance of the psychiatric approach was undoubted, indeed at times overdone. The diagnosis of kleptomania, for example, played a major part in shoplifting cases yet disappeared almost overnight when the result of the plea changed from an acquittal to possible remand to a mental hospital.

It was, however, the advent of the idea of the apparently sensible and humane use of detention in a mental hospital as an alternative to more condign forms of punishment that put psychiatry into the front line of penal policy. Traditionally the part of the criminal trial that follows the finding of guilt has been relatively free from the fierce clash of the accusational system. Where an order under S.60 of Mental Health Act 1959 is thought appropriate the recommendations of forensic psychiatrists provide the basis and are rarely staunchly challenged. The role of the psychiatrist has become central. That is not to say that judicial scepticism is completely suspended nor is the occasional judge unwilling to express the view that the decision on sentence is entirely his. Yet the role of the forensic psychiatrist was firmly established. If the term had previously lacked clear definition it might be now said that it should be applied to the psychiatrist with the skill to make the complexities and uncertainties of his discipline appear simple and certain to a judge.

These two important interventions into the criminal process have been overshadowed by the use of psychiatry in what is perhaps the most intractable problem of all. Whilst the law naturally plays the central part in the basic requirement fo society for 'law and order', it also has a prime responsibility to protect the individual against the use of autocratic power by the state, a responsibility that the common law of the Anglo-Saxon legal systems has discharged zealously and with pride. These aspects of the law's concerns clash hopelessly where the individual becomes a persistent offender. The predominant concern for the individual makes it difficult to take preventive action. Punishment, and there is none now more serious than the deprivation of liberty, must follow the crime. And it must also fit the crime. Although there is no strict tariff and the individual criminal's personal circumstances play an increasing part in the determination of the appropriate sentence, this only provides variation within somewhat narrow limits[3]. The prison gates are bound to open to release a prisoner whose next crime can be fairly surely predicted.

The legal process has of course tried several devices to meet this dilemma. None has been a success. Two

https://doi.org/10.1192/bjp.140.6.551 Published online by Cambridge University Press

examples are preventive detention[4] and the extended sentence[5]. Neither fitted well into the law's preconceptions. The problem of the recidivist remained a severe challenge. It was the medical approach which appeared to give the most likely, if partial solution. The concept of detention in a mental hospital seemed at first sight humane. Its initial justification rested upon two concepts to be found in the Mental Health Act—mental abnormality and dangerousness. Continued detention was ameliorated by the thought that it was for treatment.

It is easy to overstress the use of this device. In terms of numbers and in relation to the prison population the hospital order under S.60 and transfers from prison under S.72 are not extensively used. But in the light of the cardinal civil liberties concept that no one must be improperly detained the numbers are a constant potential worry. The statistics[6] show the numbers of orders were, for example, never as high as 2000 per annum and have steadily decreased to just over 1000. The total number detained under these sections, resident in hospitals (including special hospitals), in 1979 was in the region of 2500. In 1979 just over 7000 patients in all were compulsorily detained, merely 5.5 per cent of the total of patients in mental health and mental handicap hospitals.

The roles played by psychiatry can be said to have the unfortunate characteristic that they lie generally in areas of great difficulty and tension. It was inevitable that a great deal of attention and criticism would be given to the way that they operated. Before turning to these criticisms it is necessary to look briefly at what must be accepted as an underlying weakness. It is doubtful whether the discipline was, or indeed now is, strong enough to withstand that scrutiny, much of which, and that is the theme of this paper, is inspired by legal modes of thought and not necessarily fair.

The uncertainties of psychiatry

It is inevitable that a medical specialization concentrating especially upon the human mind and the individual's personality should find firm ground to be elusive. The mysteries of the mental process and the infinite complexities of personality offer endless scope for argument and interpretation. Yet this is the raw material of the psychiatrist. No wonder there are fundamental difficulties at so many levels. The intellectual superstructure that every discipline erects to formalize and classify its territory has many internal tensions. Even the key concept of 'mental illness' is itself challenged. As Dr Clare says . . . "given the fractious and acrimonious debate (to which incidentally he is keen to contribute) which rages over its legitimacy it is hardly surprising that there have been attempts to abolish the concept of mental illness . . ."[7]. The very title of Professor Szasz's famous work "The Myth of Mental illness" underlines this sad doubt[8]. Many of the central concepts, such as schizophrenia and psychotherapy, attract a lively debate as to both their characteristics and validity. In 1975 the Butler Committee could say of psychopathy—'from the medical and legal points of view the historical development of the concept of psychopathy has given rise to serious confusion'[9]. It cannot honestly be said that the Committee's proposal to change the label to 'personality disorder' did anything to clear that confusion.

It is not necessary to emphasise the competing schools of psychiatry. Although an eclectic approach is possible it is difficult to reconcile the differing approaches—the psycho-analytical, bio-chemical and behaviourist for example. Even commonly used treatments such as ECT offer similar problems. The justification, 'that it works' may satisfy a recovered depressed patient but it will fare badly in academic debate or against legal challenge.

Criticism from a legal standpoint

Although the law was using psychiatry as we have seen as an increasingly important part of the criminal and penal process the tensions were apparent but should not be over-emphasized[10]. It is possible to recall occasionally sharp remarks by a judge indicating that psychiatric evidence is 'bought' by the accused. Such an attitude is particularly severe and unfair since that is the way the law uses experts, as we have seen in the recent Down's syndrome case.[11] The clash of competing experts is inevitable and the difficulty of reconciling differences, or explaining them in the atmosphere of witness boxed cross-examination is pretty remote.

More fundamental is the judicial reluctance to allow, or to make it appear to have permitted, major decisions to be taken by the expert rather than the court or jury. It is this feeling that makes the judge happiest with conflicting opinions. It also causes the appeal courts to remind trial judges that evidence of experts should be tested. Thus in a diminished responsibility case, *R.* v. *Ahmed Din* (1962)[12], Lord Parker C. J. emphasised that "the matter must be fully tested" and "every case must be probed". The psychiatric evidence was that the accused's mental abnormality could be deduced from his mistaken suspicion of his wife's infidelity. Whether there was any objective evidence of such infidelity was said to be a crucial basis for the expert evidence. It was "not a matter for the doctors" but for the jury. This artificial distinction between fact and fantasy: between the so-called factual base of judgment and the expert judgment itself is supremely characteristic of the law. And very

https://doi.org/10.1192/bjp.140.6.551 Published online by Cambridge University Press

artificial and impractical. It has recently been brought to the fore in the trial of Peter Sutcliffe where all these factors came together[13]. First there was the obvious reluctance to allow the issue to be decided 'by experts'—even where the 'rival' experts agreed. This both took the decision out of the hands of the judge and jury and it dodged the challenge deemed so essential in the accusatorial system. So the evidence was 'fully tested' and in effect the jury were asked to determine highly technical questions after listening to differing views, with the sharpest divergence coming from the cross questions of lawyers.

Once it turns to the content of the law in this area the judicial system has predictable difficulties. The slow step by step way in which the 'disease of the mind' under the M'Naughten rules was extended to arteriosclerosis—*R.* v. *Kemp* (1957)[14] and not to hypoglycemia induced by insulin prescribed to counteract diabetes—*R.* v. *Quick* (1973)[15] illustrates the difficulties. The reaction to uncertainty is also expected and rather bizarre—in a case that concerned the criteria for admission under S.26 of the Mental Health Act. Lawton L. J. said in the Court of Appeal:

> "The facts of this case show how difficult the falling of particular instances into the statutory classification can be . . . there is no definition of mental illness. The words are ordinary words of the English language. They have no particular medical significance. They have no particular legal significance. How should the Court construe the . . . ordinary words of the English language should be construed in the way that ordinary sensible people would construe them".[16]

The rapidity with which judges avoid the quagmire of technical difficulties and hope to reduce all matters to the level it is felt a jury should operate at is both understandable and frightening. The balance between this traditional legal approach—illustrated by Lawton L. J., and a more sophisticated willingness to tackle some of the complexities—as with Lord Devlin in *Kemp* is a difficulty. It is not one that should be left to the personality of the judge—as it appears to be at present. Structural changes in the form of trial would help.

The strongest use of legal concepts as criticism of the work of psychiatry and its role in the criminal process comes not, however, from the Courts and judges but from the bodies such as the NCCL and MIND one of whose primary functions is the protection of the individual. Their concern covers an area far wider than the purely criminal detention. It covers also all detention that is against the individual's will and has an increasing concern as to the incidents of detention, particularly certain forms of treatment.

The arguments are familiar. What needs stressing are the underlying principles that support and direct the approach. In two important volumes entitled 'A Human Condition', Larry Gostin has set out both the concerns and proposals for reform by MIND[17]. The overall impression is clear. The law is seen as protection against the infringement of personal rights and dignity. Lines of reform are suggested to ensure proper control against this danger. The law itself must be as clear as possible and must limit intervention to circumstances where they are absolutely necessary. The attitude to medical intervention is one of guarded suspicion. Possible wide or open-ended legislative provisions are attacked. The excessive use of discretion is condemned. The legal powers granted have to be applied narrowly. These views are reinforced by reference to individual cases where it is easy to show that the individual has been treated unfairly, where for example judicial or administrative or expert discretion has been exercised in a way that can be easily criticised.

It is difficult to find a clear statement of the principles which direct these criticisms at the practical level. The overriding aims are clear though inevitably expressed in rather grand phrases such as 'justice', 'liberty of the individual' and so forth. The detailed proposals for reform are equally clear. But guidance in the area of grey—where major concerns such as the health and safety of the patient and the liberty of the individual clash,—is hard to find. It is unfair to expect it perhaps, but the solution—control by law—is only one of the alternatives and itself is open to debate.

The most recent attempt to contribute to that debate is to be found in Ian Kennedy's Reith Lecture entitled oddly "The doors of mental illness".[18] Here the ethical complexity is generously recognized. The list of considerations that must go to supply the answers put forward is daunting:

> ". . . our sense of right and wrong, of propriety, of normality, of order, of law and authority, and perhaps most significant, our sense of freedom and responsibility . . ."

Basically, as his starting point, Kennedy rejects 'the disease approach to mental illness'. In this he is making the obvious point that there is a world of difference between diseased cells and a diseased imagination. His quarrel with the concept of mental illness is not that of Professor Szasz, it is his fear of its open-endedness, its 'will-o-the-wisp' quality as he says. And within a few sentences he is disclosing his fear of the expert—"All power lies with the expert, and we must hope and trust". His demolition of the basis of that expertize is swift and easy. "What are normal thoughts?" he asks: "is the abnormality important enough to warrant invoking the judgment 'mental illness'?": "what does important mean . . . ?" and so

https://doi.org/10.1192/bjp.140.6.551 Published online by Cambridge University Press

on. He establishes without difficulty "the shaky intellectual basis on which the concept of mental illness rests".

The problem then, as he sees it, is the risk society runs of injustice in any one of the 20,000 or more individuals compulsorily admitted to hospital each year. For their protection he seeks greater legal safeguards which involves him inevitably in a search for certainty and precision, in an area where he knows full well, and has said so, there is but little. His conclusions, in three crucial words are that the *criminal*, those who *seek* help, and the *helpless*, are the only categories who may justifiably have their own wishes overridden.

Current proposals for reform

Before looking at the wider conclusions that can be drawn from these considerations it is worthwhile glancing at recent and especially current proposals for reform bearing in mind the attitude that the legal approach is bound to foster.

There is in fact little comfort to be gained in the hope for greater certainty. The Butler Committee was particularly disappointing here. As is so often the case, its discussion of psychopathy was excellent as long as it was analysing the notion critically.[19] Its major conclusion, to change this head of abnormality to 'personality disorder', was a classic example of avoiding practically every difficulty. The criticisms have gone home though, and some change is obviosuly required. The proposed reform in the recently published bill shifts emphasis markedly from diagnosis to susceptibility to treatment. On reflection this is a strange, but not inexplicable, reaction. Kennedy's rejection of the medical illness analogy need not be accepted. The matter need only be turned on its head —if it is treatable, as we must believe physical disease is treatable, then it is plainly analogous to a medical condition.

If that was all it would be fine. But treatment itself is as solid a notion as most of those that bedevil the topic. What does it mean? At first sight and this is an unworthy thought, it cannot be unfirm ground because there is a statutory definition and if need be the Oxford English Dictionary to help us. The definition is in S.147 of the Mental Health Act 1959 and is simple —"medical treatment includes nursing and also includes care and training under medical supervision". But all the definition does, is to include within the definition what would otherwise arguably be outside it. And the Mental Health (Amendment) Bill[20], having shifted the focus to treatment, by "substituting a test of likelihood of benefit from treatment for age limits for admission for treatment of those suffering from ... psychopathic disorder"[21] further widens the definition of treatment by the substitution for the words "care and training under medical supervision" the phrase "care, habilitation and rehabilitation under medical supervision".[22] Not by any means certainty. Indeed the term "habilitation" is new to me and frighteningly newspeak. Perhaps its European sound arises from the entry of mental health cases into Europe.

The other area where those with legal considerations in mind are looking for reform is the strengthening of the right to challenge. There has been a great deal of pressure, for example from MIND, for a recasting of the procedural rules governing Mental Health Review Tribunals to make more explicit the rights of challenge and to provide easier and earlier opportunities to mount such a challenge.[23] Indeed under the current proposals[24] the right to challenge is to be extended to S.25 admissions for observation.[25] The new proposals also go part way to meeting the desire to challenge certain forms of treatment, but in an administrative rather than a legal form—thus attracting severe early criticism.[26] In the wider context of what is being discussed it is essential to note these significant criticisms and coming changes. It is impossible to look on this occasion at the details but the basic conceptual issues must be faced.

The fear of the expert, so obvious in those who take a critical stance, is partially met by a formalized challenge to his powers. The model of challenge most usually suggested, and almost invariably suggested by legal commentators, is the familiar gladiatorial concept of the courts. Its elements can be speedily, if slightly unfairly summarized. There has to be a proposition and counter proposition. Evidence on each side has to be formally presented and subjected to cross-examination. The issues have to be reduced to clear justiciable issues. In the process hesitations and qualifications tend to be regarded as weaknesses rather than intelligent caution. The process ends in a 'decision'—the point is won or lost.

It will be appreciated that the impact of any significant movement towards that model will change both the working environment of psychiatrists and the nature of the rules within which they work. It is a familiar process—other areas of life have been subject to this type of treatment. The list is endless—workmen's compensation, divorce, unfair dismissal, medical negligence. As with so much else its full effect can be best seen by a study of American practice. The results are always deeply disturbing to any professional working in any field becoming to a greater or lesser extent overrun by professionals from the law.

This discussion cannot be extended here. It is the secondary effect of the underlying problem: the lawyer's imposition of his procedural ideas. Before that can be tackled the more central substantive

https://doi.org/10.1192/bjp.140.6.551 Published online by Cambridge University Press

problems must be resolved. If legal challenge grows it will be absolutely disastrous if the underlying concepts such as 'treatment' or 'mental abnormality' or whatever are uncertain. Collapse is ensured.

Conclusions

It seems essential that psychiatry must recognize that modern attitudes appear to be pressing towards greater legal control of all aspects of society. As the coherent national consensus is diminished, so group suspicions seek expression in legal process. Movement is not all one way—there has been, to take but two examples, less legal control of industrial injuries (where insurance has largely replaced individual litigation) and of divorce. But movement is generally to the direction of control. What then should the response be?

Although the ethical debate of the role of psychiatry is of endless interest and medical ethics has a strong hold on academic and intellectual life, it is surely to the level of practical ethics (perhaps that means pragmatism) that real attention should be turned. The big ethical issues are insoluble because they arise where two basic concepts conflict. In practice it is getting the balance between the conflicting approaches as right as can be that is important.

It is essential to recognize the clash of principles and to debate not the principles but the practicalities. Given that individual liberty cannot be accepted unchecked by the medical specialist, concerned above all with the paternalistic welfare of his patient, how can the two acceptable viewpoints be reconciled? It is arguable that autocratic medicine hiding behind the portcullis marked 'clinical' has escaped the rigour of challenge. It is equally possible to say that the lawyer's challenge in the individual case can quite deliberately do untold harm to the fabric of good practice.

The characteristics of each professional approach must be fully understood for two reasons. Only in that way will the internal debate within each profession be constructive in the area where they meet. Only in that way will each be albe to offer constructive criticism and demand necessary reform. Too often the inward looking debate produces the wrong result. Two examples, one from each side will illustrate this.

Psychiatrists have rightly viewed with concern the criticism, of international dimensions, that they have been used by the legal systems of many states as 'white coated jailers'. The results of this has been an understandable desire to withdraw the bounds of the profession to avoid any possibility of such contamination. The concept of 'treatment' has been used as the justification. Yet it is arguably an unstable basis for new delineations as the proposed statutory redefinition clearly shows. The real question: how far has medical (i.e. psychiatric) supervision a role to play in the problems of the recidivist has been side-tracked —yet it needs a clear answer.

The lawyer, following the individualistic philosophy of the common law that is used and heightened by pressure groups concerned with civil liberties, has a stark problem. If by his knowledge of the law, his mastery of procedure or his advocacy he is able to secure the release from detention of his patient-client, should he do so where it is obviously unwise, being plainly not in the interests, speaking from the viewpoint of health and social welfare, of his client? Faced with this dilemma, which a lawyer often meets in various aspects of his work, the classic reply is 'I am advocate not judge'. That of course is a piece of professional humbug.

If each profession recognizes the weaknesses of central tenets of its own approach—clinical autocracy and legal impartiality—then both professions ought to unite against the real weakness of the system. The work of both professions is in one sense peripheral. Each concentrates best upon one aspect of the many problems, the psychiatrist upon the acutely ill or disturbed, the lawyer upon the patient who is truly suffering in the system. But the whole fabric of detention, treatment and care is a huge, twenty-four hour machine. Its administration is of the essence. The administrative rules and practices, affecting as they do the system as a whole, have far and away the most influence upon the humanity or inhumanity, the fairness or unfairness, the relative success or failure, of what is being attempted.

The administrative aspects of the problem have so far escaped rigorous attention. Butler[27], Boynton[28], wherever one looks, the theoretical and ethical and professional concerns have diverted attention from the two crucial problems. The first is conceptual, seeing the whole as an interdependent continuum. Courts, prosecution policy, prisons, clinics, hospitals, aftercare, home support, all play an interconnected but as yet largely haphazard part. The second is practical, welding the diverse elements into an efficient and humane machine. It demands flexibility within a coherent system. It demands frequent and constructive decisions, carefully made and cautiously but expeditiously acted upon.

To achieve this is difficult almost to the point of impossibility. My concern here is that the greater recourse to legal challenge will increase rather than lessen the difficulties. The most predictable reaction to challenge, mounted in the public and abrasive ways of the legal system, is an increase in defensiveness.

It is essential that a dialogue between the professions concerned should be encouraged so that the

https://doi.org/10.1192/bjp.140.6.551 Published online by Cambridge University Press

harmful effects of the greater recourse to legal challenge can be mitigated. The two key characteristics that have underpinned this discussion—the rigour of the absurd far search for black and white certainty and the harmful impact of outmoded methods of challenge in open court, 'Old Bailey style', are the principal weakness in the way of the psychiatrist's attempt to integrate such challenge into a harmonious system.

There remains one other major problem. At heart the lawyer has only one skill to offer. The application of rules to different facts. It is a technical skill. Most English lawyers would insist that it is a skill without any need for value judgments. It is for 'good lawyers' not 'wise men'. Indeed those who take a different view, Lord Denning is the supreme example, evoke fierce controversy. Indeed he especially illustrates the sad fact that wise men are only wise and venerated when their decisions favour one's viewpoint. But that cynical assessment cannot close the debate. Lawyers must be convinced that the very essence of work such as the practice of psychiatry must be based to a large extent on careful judgment by wise men. Psychiatrists must be allowed room to act: the impossibility of consistent and unerring rightness must be accepted. The law has a choice, it can either patrol the edges of discretion in which event those boundaries must be widely set and firmly kept in place, or it can enter, in a special way, into the search for methods of improving the decision-making itself by playing a constructive role, using its professional strengths to supplement, rather than to challenge, the strength and weaknesses of others engaged in the same ceaselessly difficult task of providing the right balance between individual right, and essential care.

Footnotes and References

1. There is an interesting, full study of M'Naughten (1977) *Daniel McNaughten, His Trial and the Aftermath*, (eds. Donald J. West and Alexander Walk). Gaskell (Royal College of Psychiatrists). Ashford: Headley Brothers.
   There is, for collectors of curiosities, a reported case on how to *spell* M'Naughten (*sic*)—see *Pigney* v. *Pointers' Transport Services Ltd* [1957] 1 W.L.R. 1121 a civil case of damages for negligence.
2. The concept was basically rejected in M'Naughton insanity—*Att. Gen. for South Australia* v. *Brown* [1960] A.C. 432, but accepted in diminished responsibility, *R.* v. *Byrne* [1960] 2 Q.B. 396.
3. For an excellent analysis of sentencing policy see *Principles of Sentencing*, D. A. Thomas, 2nd Ed. 1979.
4. Created Criminal Justice Act 1948, s.21—abolished Criminal Justice Act 1967, s.37(1).
5. Created Criminal Justice Act 1967, s.37(2).
6. Recent useful tables are to be found in the White Paper—*Reform of Mental Health Legislation*, Nov 1981, Cmnd 8405.
7. *Psychiatry in Dissent*, (1976). By Anthony Clare, p 2. London: Tavistock.
8. *The Myth of Mental Illness*, (1974). By T. S. Szasz.
9. *Report of the Committee on Mentally Abnormal Offenders*, Oct 1975, Cmnd 6244, Ch 5, Psychopaths. London: HMSO.
10. *Reported* cases tend to be those of unusual difficulty, thus giving a false impression of normal working.
11. The Trial at Derby Assizes of Dr L. Arthur for murder of a baby born with Down's Syndrome—he was acquitted.
12. [1962] 1 W.L.R. 680. See also *R.* v. *Turner* [1975] Q.B. 824. There is a recent survey of the law in this—*Psychiatric Evidence*, Alex Samuels [1981] Crim L.R. 762.
13. The so called 'Yorkshire Ripper' case. The content and handling of the psychiatric evidence will repay careful analysis.
14. [1957] 1 Q.B. 399.
15. [1973] Q.B. 910.
16. *W* v. *L* [1973] 3 W.L.R. 859 at p 865.
17. Volume 2, 1977 deals with offenders.
18. Published in *The Listener* but also incorporated as Chapter 5 (pp 99–115) of the book of the lectures—*The Unmasking of Medicine*, (1981). Ian Kennedy. London: Allen & Unwin.
19. Ch 5, see f.n. 9 above.
20. Published 10 November 1981.
21. Runs through the new provisions, e.g. Clause 4 and especially Clause 34.
22. Clause 44(2).
23. See MIND's submission in reply to the green paper on reform of the Mental Health Act in 1976.
24. Clause 3.
25. To be renamed 'for assessment'.
26. The Mental Health Act Commission (Clause 42(1)) has a general supervising role and some statutory control is set out in Clause 38.
27. See f.n. 10.
28. *Report of the Review of Rampton Hospital*, Nov 1980, Cmnd 8073. London: HMSO.

Sir John Wood, *Professor of Law, University of Sheffield, Crookesmoor Building, Sheffield, S10 2TN*

https://doi.org/10.1192/bjp.140.6.551 Published online by Cambridge University Press