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### Edward Oxford (law and insanity)

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Edward Oxford, who attempted to murder Queen Victoria, was a young man of 18 years when the offence occurred in 1840. He knew what he was doing, and as the law stood at the time, this could have been sufficient to result in the death penalty. He described in his notebooks how he was to be the instrument of a plot of an imaginary secret society, and to this end, had purchased the pistols and had practised with them. When he came to trial in 1840 he excited a degree of compassion because of his youth and the pointlessness of the attack, made more so by doubts as to whether or not the pistols were loaded. Chief Justice Denman allowed evidence in abundance in support of the pleas of insanity. Lay witnesses testified to the abnormal behaviour of Oxford's forebears, and a number of distinguished medical witnesses lent their support. Because of, or in spite of the medical evidence, the defence succeeded and a verdict of 'guilty but insane' was returned by the jury; this verdict was then incorporated in the Act of 1800, which had been passed to deal with the case of Hadfield. Oxford was admitted to Bethlem, where he prospered. Any evidence of insanity that he might have manifested evaporated and never returned. Any suspicion that he was of doubtful intelligence was vitiated by the fact that he became an accomplished linguist and learned to play the violin. He also showed a distinct aptitude for chess and draughts. Oxford was one of the early transfers to Broadmoor after it opened in 1863 and in 1868 he was discreetly released with the proviso that he emigrated; it is alleged that he changed his name to Cambridge.

## Law and psychiatry

During the 19th century, the interface between the law and psychiatry was an area of considerable friction between lawyers, journalists, and the public on the one hand, and asylum doctors on the other. Medico-legal concerns which frequently surfaced in presidential addresses (MPA and RMPA.) were: issues of wrongful confinement, procedures of certification, and the lack of conformity between doctors and lawyers in the legal definition of insanity, particularly in relation to the insanity plea and the boundary between mental illness and criminal responsibility. Kirkman protested against ‘hazy legislation’ in the area of the lunacy laws, ‘which would hazardously interfere in purely medical questions and encroach upon the full prerogative of medical men to judge of mental sanity,’ Laycock expressed the general feeling of asylum doctors about their vulnerable position when he declared that:

‘Whether you restrain the personal freedom of the insane in the interests of society, or plead for a kindly and charitable consideration of them in the interests of justice and mercy, you are held to be equally in the wrong.’

Sir Charles Hastings (1859) admitted that the connection between crime and insanity was intricate to unravel, that knowledge on the subject was imperfect, and that there were sometimes ambiguities in the medical testimony in such cases, which led the public to place less reliance on medical evidence than it deserved. Sir James Coxe (1872) succinctly summed up the dilemma, as seen by most asylum doctors:

‘It is a matter of extreme difficulty to determine where sanity ends and insanity begins; and it is remarkable that, although it is generally considered to be the duty of the physician to fix that point, it is,

nevertheless, the lawyer who decides the question whenever anything more than the mere liberty of the patient is involved. In fact, the lawyer then sits in judgement on the physician, and determines, or directs the jury to determine, whether the acts of the patient, as observed and reported by the physician, afford proof of sanity or insanity.'

Rogers (1874) concurred: 'the diagnosis and definition of insanity, instead of being treated as a purely medical question, has been a sort of battle field, or at least neutral ground, between the lawyers and doctors'. (Strictly it is the jury that decides *mens rea* in a trial.)

Skae (1863) advocated that members of the Medico-Psychological Association should use all their energies and influence to bring about a revision of the law regarding insanity, so as to get the distinctions and definitions of lawyers in conformity with theirs, that is, 'in conformity with nature and facts'. Rogers (1874) agreed: 'It is time that we made an effort to claim for the profession of medicine the right to determine what does and what does not constitute insanity, whilst we leave to the lawyers the legal questions affecting the insane.' Sankey (1868) also proposed that doctors should be exempt from cross-examination in the witness box, because 'It is well known ... that the whole process of cross-examination is mere trickery, a carefully laid pitfall; it cannot elicit truth, and is as often intended to confound it.' Similar sentiments were expressed almost 20 years later by Needham (1887), who suggested that part of the explanation for the continuing low esteem of asylum doctors was that in court they were frequently 'brow-beaten by opposing counsel and depreciated by the bench and juries.'

The final example of the disagreements between the Judiciary and psychiatrists comes from the *Journal of Mental Science* in 1888:

'Now comes the extraordinary feature of the case from the judicial point of view. Mr. Justice Field, in addition to treating the medical witnesses with studious rudeness, refused to receive their opinion as to the sanity of the prisoner. When Dr Needham had given his evidence and expressed an opinion that he was insane, his lordship said he was determined not to allow a medical gentleman, however eminent, to be substituted for the jury. Again, when the gaol surgeon was asked whether he formed any opinion as to what the prisoner was suffering from, and he replied that when first brought in he thought he was imbecile, the Judge objected "that is answering the question that I did not wish you to answer". When counsel asked whether he might inquire whether the prisoner was suffering from disease, his lordship replied, "Bodily, Yes; mentally, No". When Mr. Bucknill suggested that the opinion of a medical man regarding the prisoner's state of mind now might assist the jury in arriving at a conclusion as to his state when the act was committed, Mr. Justice Field said, "I shall rule clearly not. The jury see what his conduct and appearance are and have been. I don't see that the opinion of a medical gentleman carries it a bit further. *He could no more dive into a man's state of mind than I can*.' (*Journal of Mental Science*, 34, 1888)

There was also frustration at the complete lack of autonomy afforded to asylum doctors as medical witnesses in the courtroom, which appeared to confirm their inferior status compared with doctors in other branches of medicine (Smith, 1981).

The threat of wrongful confinement was an abiding Victorian fear and was the subject of novels such as *Hard Cash*, written by Charles Reade, a friend and collaborator of Charles Dickens, and published in 1863. Most cases of alleged wrongful confinement involved the affluent, and critics therefore tended to concentrate their attacks on private asylums and doctors, whereas public asylums were frequently ignored (McCandless, 1981). A number of presidents (Hastings, 1859; Bucknill, 1860; Munro, 1864; Wood, 1865; Rogers, 1874; Fielding Blandford, 1877; Crichton-Browne, 1878; and Lush, 1879) attempted to allay this public fear by denying that wrongful confinement was common. Wood (1865) also complained that public suspicion about the motives of asylum doctors often resulted in their reluctance to diagnose and treat patients showing early signs of mental illness, to the detriment of the patients and also their families.

Although the number of such cases was relatively small, perhaps the greatest medico-legal concern of asylum doctors in the second half of the 19th century was the question of crime in relation to insanity. As Smith (1981) has described, the newly emerging psychiatric profession was at a considerable disadvantage in a court-room, compared with lawyers, when dealing with the issue of criminal responsibility. Asylum doctors had no agreed conceptual framework for the diagnosis and classification of mental illness and were unable to demonstrate any underlying physical basis to the conditions which they described in court. They were thus open to the accusation of being biased in favour of diagnosing mental illness when it did not exist, and also of being deceived by simulation. Also, public court-room disagreements between asylum doctors on whether or not mental illness was present in the accused inevitably undermined the credibility of these ‘expert’ witnesses. The language and milieu of the court-room was that of the lawyer and not the doctor, and asylum doctors consequently had considerable difficulty in communicating their ideas in this formidable setting. Finally, few doctors had sufficient training and experience to cope with counsel’s incisive cross-examination of their evidence. Any rejection of individual medico-psychological evidence also had the unfortunate effect of appearing to undermine asylum doctors’ professional expertise in other areas of mental illness.

Little has changed in the 21st century. A White Paper and draft reform of the Mental Health Act suggested a new legal framework for the compulsory treatment of people with mental disorder in hospitals and in the community. The White Paper had an over-riding emphasis as public safety with a suggested new category of patient ‘Dangerous people with severe

personality disorder'. (This diagnosis might be considered similar to the term 'sluggish schizophrenia' used to incarcerate dissidents in Russia.)

## References

- Rollin, H. (1996) Forensic Psychiatry in England: a retrospective. In *150 Years of British Psychiatry* (vol. 2, *The Aftermath*) (ed. H. Freeman & G.E. Berrios), pp. 243–267. Athlone Press.