MEDICAL CULPABILITY *

B. CROWHURST ARCHER, M.D.

Durban

In a criminal case when the plea of insanity is raised by the defence, most medical men find particular difficulty over the criteria of irresponsibility laid down in the McNaughton rules.

They feel that these rules savour of the outmoded academic doctrine of the mental faculties—according to which mind was thought to be divided into a series of independent compartments, the cognitive faculty being one of the larger subdivisions. Medicine has come to recognise 'mind' as a whole and that however partial a mental disorder may appear the whole mind is affected. The Doctor does not accept a purely intellectual conception of responsibility, for even if intellect as intellect were unimpaired, emotion could alter its effect on conduct. Conversely, intellectual defect produces deficient emotional control.

In other words, the legal concept of mind, as Peskin (1954) has pointed out, is based on the ecclesiastical and philosophical concept that man possesses a free will, is capable of deliberately choosing between good and evil, and is therefore accounted fully responsible for his choice of action. On the other hand, the study and practice of psychiatry incline its adherents more and more to the doctrine of Determinism, i.e. that behaviour is largely, if not entirely, determined by factors which are really beyond voluntary control. The 'will' is dictated to by unconscious strifes and motives which in turn owe their origin to a combination of circumstances—heredity, constitutional and environmental.

There is therefore no allowance in law for such well-known mental states as the disconnection between thought, feeling and action and the absence of a goal idea resulting in impulsive action in cases of schizophrenia and post-hypnotic and epileptic automatism, the overpowering depression of affective disorders which cause a parent to murder the children whom he loves, knowing full well that it is morally wrong to kill, to say nothing of the behaviour disorders that may follow encephalitis lethargica.

It is only fair to remind ourselves that the McNaughton case did not come before the House of Lords in its judicial capacity, and the well-known questions of the Judges and the answer of the Lords only referred to the effect of insane ignorance and insane delusions, and that the Court of Criminal Appeal, when refusing to accept a plea of insanity, which the jury had disregarded at the trial, frequently calls attention to the fact that the Secretary of State has special powers to enable him to order a medical enquiry concerning the mental condition of appellants convicted of murder.

I find myself in agreement with those who believe that if a medical formula of criminal responsibility were introduced we might be called upon to adhere rigidly to its specifications, with resulting hardship to offenders and embarassment to psychiatrists. The immediate need is not a reform in the law regarding criminal responsibility but an improvement in the evidence we give as forensic psychiatrists.

MEDICAL CULPABILITY

Criminal Courts are courts of law, and not courts of morals, and the psychiatrist may well leave the problem of criminal responsibility to the lawyers and direct his attention to the concept of 'medical culpability'.

East (1949) has expressed the opinion that psychiatry has advanced sufficiently to justify the acceptance of the principle of modified culpability in convicted offenders suffering from a

* A paper read in a symposium on 'Criminal Responsibility and the Psychopath' at the South African Medical Congress, Durban, September 1957.

recognised minor mental abnormality, if the degree of blameworthiness lies somewhere between that attached to the unlawful act of a normal person and one who is insane according to the law. For this purpose a clear mental classification of offenders would be necessary, separating the normal, the sub-normal, the mentally defective, the psychopathic, the psychoneurotic and the psychotic groups from one another.

The mentally normal group of offenders comprises at least 80% of receptions. Statistics for Great Britain show that the proportion of mentally defectives is about 0·5% and of the insane 1·0%. Research is necessary before estimates can be made of the proportion of offenders who are sub-normal, psychopathic personalities, and psychoneurotics.

The criminal psychopathic personalities include the unstable drifter, the sexually perverse, the cold and emotionally callous, and the 'epileptoid'; as well as the epileptic with psychopathic trends and psychopathy resulting from cerebral injury and other organic diseases of the brain.

Henderson (1950) said of the psychopath that he believed that such cases should be treated not necessarily with greater severity but under more special conditions and for such time as to prevent possible recurrence of the offence. His plea was for an indeterminate sentence until a sense of social responsibility became established. If the attitude of the courts were more in keeping with this opinion the defence of psychopathic personality might understandably become less popular.

R.N.A.H. Cholmondeley Castle

During the war I was Medical Officer-in-Charge of a castle in the North of England used as a Royal Naval Hospital for Neuropsychiatric Disorders. The conditions of admission were that prospective patients had had a reasonably sound personality before entry into the Service and that they were considered by the psychiatrist recommending the case to have a reasonable chance of returning to duty. The methods of treatment and the reason for the successful results obtained are a little outside the scope of our discussion, save to say that the patients were resocialized against a background of service discipline by every modern means of psychiatric treatment. Something, however, may be said about my 'opposite number'—a special camp known as *H.M.S. Standard.*

H.M.S. Standard

The cases drafted to this establishment included men possessing such low morale or such a degree of temperamental instability as to make them unemployable as combatants. They included those ranging from the constitutionally timid to the rank coward and the malingerer—men showing no symptoms that would make them legitimate subjects for survey on purely medical grounds while their release from the Service on any pretext would have had a bad effect on the others. These men were recommended by medical officers, and were returned to their Port Division for examination by the depot psychiatrist, the final decision whether to draft them to the Camp resting with the Commodore of Barracks, who acted as a magistrate.

The men were under ordinary naval discipline, but the routine was sufficiently severe, especially in the earlier stages of treatment, to act as a deterrent to men whose chief object was to avoid arduous service. Men were employed on hard physical work most of the time. Education in the broadest sense and lectures formed part of the routine. Organized games on Saturday afternoon were permitted but solitary recreations were discouraged except on Sunday afternoon, which was mostly devoted to letter writing.

Contrary to expectation at the end of the first 6 months, 25% returned to sea and 25% to shore and harbour service. I merely mention this to show what was done by different methods of rehabilitation.

Belmont Social Rehabilitation Unit

Soon after the war Maxwell Jones (1952) established a Social Rehabilitation Unit at Belmont Hospital in Sussex, England. This Unit consisted of 100 beds, which were reserved for the treatment of character disorders of both sexes. Maxwell Jones's aim was to subject the anti-social individual to a social experience which might lead to some modification of his behaviour by lessening his social tensions and thus help him to gain greater satisfaction from his social relationships.

The patients consisted of the misfits in industry and were admitted from the employment exchanges, but others were referred by psychiatrists and by the Courts. Their stay in hospital varied up to a period of 12 months. It is claimed that in this atmosphere of group endeavour the psychopath develops concern about the disturbance his anti-social behaviour has caused in the community, and that as his feelings of guilt increase he begins to identify himself with the aims of the Unit.

Institute for Criminal Psychopaths

The experiment at present being carried out at the Institute for Criminal Psychopaths at Herstedvester in Denmark is of particular interest in this connection. Under Section xvii of the Danish Criminal Law, patients suffering from mental disorder other than insanity or mental defect may be sent to this Institute on an indeterminate sentence, where their discharge can only be sanctioned by the Court which convicted them.

The routine of this establishment differs from that of *H.M.S. Standard* in that work is not compulsory but luxuries such as cigarettes can only be obtained by voluntary labour. Organized games, entertainment and opportunities for further education are part of the ordinary routine. The ability to adjust himself to the work and social background of the Institute is one of the criteria of the man's fitness for discharge. So far as discipline is concerned, the only mitigation accepted for anti-social behaviour is great emotional stress.

On admission patients are usually over-optimistic, but after a few months this optimism gives way to despair as they begin to realize that they are serving an indeterminate sentence. It is at this juncture that individual psychotherapy is added to the already existing methods of group therapy. An all-out attempt is now made to socialize the individual against the background of the Institute. This background is built up on laws which resemble those that exist in the outside world but which are more logical and just. I cannot help feeling from my own experience that the successful results that have so far been claimed in this experiment—and they are good, about half the cases admitted having been satisfactorily settled in the outside world—are due to the background of the establishment. This background seems to have promoted a high degree of *esprit de corps* amongst the staff, which has in turn been imparted (in some instances unwittingly) to the inmates.

Sturup (1952) has pointed out that difficulties might arise in such an organization because the doctor-patient relationship would be overshadowed by the physician's responsibility to society. But if it is the background of the establishment rather than the individual doctor alone that is responsible for the success of the experiment, then this criticism is not nearly as important as it would first appear.

The director of such an establishment would of course have to be carefully selected. It might be found that the most suitable director was a Physician-Superintendent who had had previous administrative experience in the fighting services, and who had developed to a high degree what General Wavell referred to as 'the art of man mastership'. On the other hand, one could envisage in certain circumstances a kind of joint directorship, consisting of an experienced head of a progressive Borstal Institution and an administrative psychiatrist.

If you doubt the wisdom of this last suggestion, I can remind you of the organization of hospital ships in the Royal Navy Here the Master of the ship and the Surgeon Captain are in joint command. It is true that the Master is master of the ship in every sense of the word, but the Principal Medical Officer has no difficulty, for instance, in requiring the Master to reduce speed in the interest of the sick. So far as human relationships are concerned, hospital ships are renowned throughout the fleet as 'happy ships'.

It is generally agreed that the criminal psychopath is as much out of place in a mental hospital as he is in a prison. A special institution is required for such persons but it is not suggested that in the present state of our knowledge either the criminal psychopath or the homicidal lunatic is likely to be very amenable to treatment, particularly as most forms of therapy require some cooperation from the patient. First offenders and those guilty of less serious crimes are much more likely to respond to treatment.

With the provisions of such an institution and the greater use of the indeterminate sentence, the much-needed research could be carried out. We know that instinct may act with ordinary, diminished or excessive force, or it may be perverse, but so far these variations cannot be accurately measured. It might be shown that perverse aggressive and acquisitive conduct, like perverse sexual conduct, is variable in form and causation, and is based on a special type of personality which to a large extent is unaffected by ordinary penal methods.

In conclusion, it appears that the psychiatrist can best help the Court in determining the medical culpability after the accused has been found guilty and, while it is felt that our profession can offer sound advice in cases of psychosis and neurosis, a great deal more research will have to be done before we can evaluate criminal behaviour beyond the region of mental disease. Expert evidence in these cases should be given by trained psychiatrists and they should take care under examination not to overstate their case and advance theories and hypotheses that have not been generally accepted by the profession. Above all they should never forget when they testify that they themselves and the profession they represent are on trial (Kozol, 1949).

In the present state of our knowledge it can only be said that the more nearly a crime appears to be in the nature of a character defect as distinct from a recognized mental disorder, the more likely is the accused to be responsible for his actions.

For a certain proportion of offenders, the practical measure would be an indeterminate sentence, which would protect society, and the establishment of an Institute for Criminal Psychopaths which, incidentally, would provide the much-needed facilities for research.

REFERENCES

East, N. (1949): *Society and the Criminal*. p. 38. London: H.M. Stationary Office.
Henderson, D. K. (1950): Brit. Med. J., **2**, 311.
Jones, M. (1952): *Social Psychiatry*. London: Routledge.
Kozol, H. L. (1949): Amer. J. Psychiat., **106**, 420.
Peskin, M. (1954): J. For. Med., **1**, 189.
Sturup, G. K. (1952): Brit. J. Med. Psychol., **25**, 31.