I am indeed sensible of the honour which you have conferred upon me, first, by including me among the honorary Fellows of the Royal College, and further by inviting me to deliver the 1979 Maudsley lecture. Equally am I conscious of my conspicuous lack of qualifications for these honours. My original university degree was in economics, a subject which hardly impinges upon psychiatry. My interest in your profession derives primarily from 44 years' experience as a magistrate (more often than not presiding) in London adult or juvenile courts, and, secondarily, from service as the former head of a University Department training social workers. Through these experiences I have not only had contacts with numerous psychiatrists about court cases and students, but have also got to know many of them personally, both at home and abroad. In this country my particular friends were the late Aubrey Lewis and our much beloved Peter Scott whose premature death has left a gap which many of us feel can never be filled. But I stand before you as a layman without any relevant professional qualification.

One of my academic colleagues once described a professorship in social studies as a "licence to trespass". Perhaps, therefore, you may think it appropriate that, as a former professor and now honorary Doctor in the University in which Henry Maudsley himself once held a chair, I should introduce my trespass with two quotations from Maudsley's own lecture to aspiring medical students delivered just 21 years before the present Lecturer was born.

The first of these quotations expresses the hope that "the medical science of the future will have a great deal to say . . . respecting the highest concerns of man's nature and the conduct of his life", and will "enter a domain which has hitherto been given up exclusively to the moral philosopher and the preacher" (1).

That hope has, I think you will agree, been in some degree fulfilled. Psychiatrists are certainly accustomed to be asked for advice on moral questions, particularly concerning marriage, abortion and other sexual matters; the courts also rely greatly on their expertise in dealing with offenders; and general practitioners are now constantly asked to advise patients on moral problems, even if this role has often been thrust upon them rather than acquired of their own volition. But more of that later.

The second quotation has proved a less successful prophetic exercise. Advising his students not to look for worldly wealth or recognition, Maudsley added that "peerages don't come our way". Students should not therefore be tempted "to spoil the simple intrinsic nobility of our vocation with the outworn decorations of a childish stage of human
progress" (2). I say nothing about the money, nor do I quarrel with his scornful description of a peerage, though I would excuse myself and others on the ground that, so long as the House of Commons passes legislation some parts of which it has never even scrutinized, the childish decoration is the price paid to others willing to complete the job; and as for the share of the medical profession in this task, I would mention that to-day there are at least seventeen medically qualified men and women in the House of Lords, of whom only three hold inherited titles.

All professions have their ethical problems, but medical men have more than most, and psychiatrists more than their colleagues in other branches of the profession. Every doctor accepts that his objective is to promote the health, relieve the suffering and preserve the lives of his patients; but on occasion he may be faced with difficult moral issues where the prolongation of life can only mean the prolongation of suffering, or when, as sometimes in childbirth, the preservation of one life endangers the health or survival of another. But the psychiatrist faces additional problems. In the first place, it now seems to be accepted policy that, in the words of the late Government's review of the 1959 Mental Health Act published last year (3), "people suffering from mental disorder should, as far as possible, be treated in the same way as those suffering from physical illnesses". Nevertheless mental disorder is still a much more elusive concept than physical illness. Secondly, the psychiatrist has in certain circumstances wholly exceptional powers to deprive his patients of their personal freedom.

The analogy between physical and mental illness originated, as Larry Gostin has said, from a reaction against "laws relating to lunacy and mental deficiency devised in the social ostracism of the late Victorian era" (4). But the analogy must not be pressed too far. The functions which nature intended most of man's physical organs to perform (please do not read any theological implications into this phrase) are plain enough. Disease is diagnosed when these organs fail to fulfil those functions. The function of the eye is to enable its possessor to see, of the ear to enable him to hear, and of the digestive system to enable his body to receive nourishment and to dispose satisfactorily of waste matter. If a man becomes blind or vomits incessantly, the medical profession does its best to find the reason, and to restore the organs affected to what is called a healthy condition in which they resume normal functioning. These are indeed platitudes. But which of us can give a comparable definition of the natural or healthy functioning of the mind? If we confine ourselves to the strictly intellectual level, this may not be too difficult. The function of articulate speech, with which our species is endowed, enables us to communicate with one another. It is therefore reasonable to infer that persons successively known as "mentally defective", "subnormal" and now (commonly but not yet statutorily) as "mentally handicapped" whose intellectual inadequacy severely limits effective communication, are suffering from a disorder of a specific function.

Psychiatrists must, however, be presumed (at least on etymological grounds) to concern themselves with the health of the whole 'psyche' or the 'mind' as it is more often called, including its emotional elements; and as to the health of this complex I fear that we are quite at sea. Twenty or more years ago it was fashionable (particularly on the other side of the Atlantic) for psychiatrists to outbid one another in producing definitions of mental health. You will find a remarkable collection of these in an article by Kingsley Davis published in 1938 (5). I refrain from re-producing any here, but will add Davis's own comment that "After all the verbiage has been laboriously sifted", one can at least detect the recurrence of certain themes. "Mental health tends to be equated with happiness, preferably of a 'higher' order, with vigour, with the full use of capabilities, with integration in the sense of freedom from conflict within oneself, and with harmonious adjustment to the environment". Thus a "reasonably identifiable portrait" emerges of the mentally healthy person as one who is "happy, who exerts himself to the full and is not at war either with himself or his neighbours".

Of recent years, however, the passion for verbalizing psychiatry's objectives seems to have faded, slapped down perhaps by such strictures as the late Henry Miller's delightful reminder that a psychiatrist is a person who treats
“disease with mental symptoms”, not one who offers to “transform the normally abrasive relations between men into a tedium of stultifying harmony” (6). Or perhaps it has come to be accepted that any definition of mental health in purely medical terms is unattainable. But the impact of those definitions remains in the contemporary psychiatric vocabulary, first in the frequent references to ‘maladjustment’, and, second, in its pejorative use of the word ‘disturbed’. The first of these usages provokes the question, adjustment to what? and therewith betrays the presence of cultural elements in the concept of mental health, together with the implication that what is regarded as healthy in one society may be unhealthy in another; while the current use of ‘disturbed’ appears to ignore the fact that the most valuable experiences in human life, such as falling in love, artistic creativity, or reforming zeal are all highly disturbing. Who could have been more disturbed than Florence Nightingale?

The problem is not, as Dr Szasz (if I dare mention that name in present company) has so persistently argued, that mental illness is a myth. Illness with mental symptoms is certainly real. Depressions are real. Behaviour out of character is real. But the fundamental problem is that mental health is still undefinable in scientifically objective terms that do not involve social or moral values. Until we can define the function of the mind as satisfactorily as we can specify the function of the eye, the analogy between mental and physical disorder will break down, except in cases where the illness is traceable to some organic factor such as demonstrable brain damage. Meanwhile in our desperate search for physical aetiology new theories flash and fade on the screen—such as the link between aggression and the extra Y chromosome and the image recently publicised by the BBC of allergy as the mother of depression. To-day only those who are wholly emancipated from a dualist philosophy can escape all worry about the medical profession extending its empire over matters in which the body plays no known part.

Some years ago I asked a young woman who was soliciting a contribution in aid of ‘mental health’ flag day, if she could tell me what was meant by mental health. She was not un-
not so qualified. There may indeed be circumstances in which a medical man can contribute expert knowledge that assists judgements on difficult moral issues, as when he estimates the chances that an unborn child will be gravely disabled or handicapped. In the light of that estimate he might himself approve an abortion; but if the foetus's mother holds on moral or religious grounds that in all circumstances it is wrong to cut short a life that is already on its way, there is a conflict of absolute moral principle in which neither party can claim priority over the other, and which cannot be resolved by any logical argument or empirical evidence.

Undoubtedly what psychiatrists can and commonly do do is to help patients to realize their own goals. But in the absence of any acceptable criterion of mental health to what common objective is the psychiatrist addressing himself in each case? In relieving severe clinical depression, simple compassion will provide a ready answer. But what if he is, as so often, expected to deal with 'maladjustment'? Again the question of 'adjustment to what?' clamours for an answer. How far can the psychiatrist legitimately use his skills to promote a patient's efforts to maintain standards which he does not himself accept?—to help, for example, a patient to refrain from using drugs which the psychiatrist himself thinks harmless, or to maintain a marriage which he thinks would be better dissolved? In practice, 'adjustment' generally seems to amount to acceptance of what might roughly be described as the conventional code of the prevailing culture. But psychiatrists who uncritically accept this role run the risk of acquiring the image of apostles of conformism. (Should we perhaps here take an awful warning from Russia?).

Nor is that the end of the psychiatrist's ethical problems. Not only is his goal of mental health indefinable, but his methods of reaching it are also peculiarly liable to be called in question. It is not for me to enlarge on the all too familiar controversies that rage round the use of ECT, insulin or aversion therapy. I can only emphasize that owing to the psychiatric patient's relatively weak position for refusing treatments which he fears, distrusts, or just dislikes, choice of treatment in psychiatric practice raises ethical problems that go beyond their parallels in other branches of medicine.

As might be expected, these ethical problems have been intensified since psychiatrists have begun to poke their noses into the criminal justice system which has for centuries been a sphere sacred to theologians, moralists and lawyers. This intrusion has recently been described by Robert Smith of the University of Maryland as a "courtship of psychiatry and the law" (7). Others, however, see it differently, less as a courtship than as a battle between science and pre-scientific modes of thought and action. In this contest the first stage, it has been suggested, was won by Charles Darwin and Thomas Huxley in their defeat of religion's claim to solve the riddles of the Universe. In the second stage, psychiatrists since Freud are seen as fighting a similar battle against moralists and the law in relation to both the personal problems of their patients and the social problems of criminality and other unacceptable behaviour.

Since illnesses cannot be invented or abolished by Act of Parliament, crime itself cannot be an illness. But consider the position of a psychiatrist in the context of criminal procedures. If he advises a court about the treatment of an offender, or is employed in the prison service, he is in effect accepting law-abiding behaviour as a working equivalent to what in the case of any physical disease would be regarded as a cure. Yet he may well disapprove of many laws, those relating to drugs perhaps, or to the age of consent, to prostitution or to the remaining limits on the legalization of homosexual behaviour. In such cases it is, in his eyes, the law, not the person who breaks it, that needs remedial treatment; but it is the law-breaker and not the law-maker whom he is called upon to treat.

Even if all these hurdles are safely passed, there remain profound differences between the psychological assumptions and attitudes with which the criminal law and the psychiatrist (or indeed any medical men) interpret their respective roles in relation to offenders. The criminal law assumes that we are normally responsible for our actions in the sense that we could have acted otherwise than as we did. It further presumes that we intend the natural
consequences of our actions (though I doubt if that presumption goes so far as to assume that anyone intending to commit a crime also intends the natural consequence that he will be apprehended by police and taken to court). Generally speaking, a crime is not a crime unless criminal intention is proved. After conviction, according to tradition, a criminal must be punished with a severity proportionate to the gravity of his crime so as to discourage him from repeating his offence and others from copying him. In addition, he must, if possible, be reformed. On this last matter, however, experience has been so disappointing that the reforming zeal of penologists in the early years of this century seems to have largely evaporated; and there has been a notable reversion to the older and more punitive policy of treating every man according to his supposed deserts, or, as Roger Hood puts it, to a system based on “moral evaluations” which would “appeal to the sense of social justice on which any system of acceptable social control must be founded” (8).

Justice is, of course, a primary consideration in the courts, as witness the figure which tops the Old Bailey, together with the current legal vocabulary’s usage of the word and its derivatives, ‘judge’, ‘judicial’ and so on. Finally, the court must have regard to the protection of society by confining in a place of safety persons whom it has reason to believe would, if at liberty, be a serious danger to themselves or others.

Contrast this picture with the procedure normally adopted by a doctor in treating any patient. First, he hears the symptoms which have caused the patient to seek his advice. Next, he tries to locate the malfunctioning of whatever organs may have given rise to those symptoms or to any other pathological signs that he may himself have observed. Then he prescribes whatever treatment he thinks most likely to cure or at least to relieve the patient’s condition. From start to finish his interest is centred on the welfare of his patient, except in cases in which he too, like the court, may have to take into account any risk to the safety of the public.

As for the justice of his decisions, the doctor does not care a fig for that. Only in the courts do we demand justice, complaining if one offender has been treated more harshly or more leniently than another whom we consider to have been equally guilty. But if my neighbour and I both consult a doctor about abdominal pains, and if she is advised to have a large part of her inside surgically removed, while I am only instructed to take sundry tablets, no one blames the doctor for the injustice of this discrimination. No one expects justice from a doctor’s treatment in the way that we look to the courts for it. We ask only that he should treat us all with equal skill and care. (Incidentally I have sometimes been tempted to believe that the need to do ‘justice’ is something of a millstone hanging round the neck of the courts, and that judges and magistrates might be more successful in dealing with crime if they too could, like doctors, be relieved of it).

This simple comparison brings out the essential differences between the normal role of any doctor treating any patient and that of any criminal court dealing with any defendant. Since, moreover, the psychiatrist is primarily trained as a physician, the model of the doctor–patient relationship is stamped on his mind from an early stage in his training, and remains there regardless of his subsequent specialism. His first and generally his last thought must be for the future welfare of his patient; which is more than can be said for a judge or magistrate in respect of the offender whom he sentences.

The naivete of the traditional rationalistic psychology of the courts is, I think, largely based on introspection. Judges and magistrates seem to think that offenders’ mental processes are much what they imagine their own would be in similar circumstances, and they envisage both the man in the dock and themselves as, potentially at least, liable to similar temptations. In looking into his heart, they appear in fact only to see what lurks in their own. Legislators likewise, in drafting the criminal law, seem equally disposed to draw upon introspective evidence: as when advocates of capital punishment project images of how they would refrain from carrying guns on a robbery if to do so would put their own lives at risk.

Up to a point, of course, this works. The motivation of much law-breaking is self-explanatory to even the most respectable citizen. Even he appreciates the temptation not
to be over-scrupulous about the details of his income tax return or his business expense account. In our acquisitive society the desire to get to the top is regarded as an honourable ambition; but, as Terence Morris has reminded us in a timely article (9), for some people the crooked way is the only road that gets them there.

So far, then, so good—the attraction of crime is at least intelligible, even if some psychiatrists find these explanations unduly simple. But the point at which the courts' traditionalist psychology really breaks down is in relation to what are often called 'motiveless crimes', that is to say crimes which we cannot imagine ourselves committing or even being tempted to commit. To illustrate: when I used to hear shoplifting cases on a London West End bench, offenders who came from overseas seemed to fall into two classes: the first consisted of European students collecting useful articles either for themselves or for presents. They would usually have only about £5 left and were due to return home next week, so no effective penalty could be imposed. The others generally came from further away and had committed more trivial thefts, but often carried substantial sums of money. Within the horizons of our criminal justice system, the first lot are comprehensible (but intractable), the second merely incomprehensible.

So also with vandalism, hooliganism and 'senseless' violence, and the eccentricities of thieves who incessantly steal bicycles and nothing else. By these the courts are defeated. And even more are they defeated by particularly horrible crimes—the Ripper's murders, or savage assaults on small children. And the same goes for those persistent offenders whom the Mental Health Act labels psychopaths—there must, we say, be something wrong with people who can behave like that. So call in the psychiatrist!

Thus we reach the paradoxical position in which anyone guilty of a good clean theft, burglary or fraud (provided that he does not make too much of a habit of it) is wicked and should be punished; while those who commit the most repulsive or inexplicable crimes, or who pursue their criminal ways in total indifference to the whole criminal justice system or to the commonly accepted codes of morality—all these, whom one might suppose to be even wickeder than the straightforward burglars, are not wicked at all, but sick. Therefore they must not be blamed or punished (outside Samuel Butler's Erewhon), any more than they could be blamed for developing cancer or typhoid, or for uttering obscenities while in a state of delirium, due to high fever. Instead of being punished, they should be nursed in hospital until their doctors can convince the authorities that they have recovered from their illness, and can safely be released.

That at least is the theory: the law has accepted that its rationalistic moral code simply does not work with everybody, in particular not with people suffering from any of a wide range of mental disorders. But we all know that practice lags far behind theory.

In practice, the mentally disordered offender, instead of being relieved of the burden of guilt and responsibility for his wrongdoing, and enjoying the privileged role assigned to the sick in our society, may well end up in less happy circumstances than those whom the courts have treated as responsible for their wicked actions. Many of these anomalies, however, are no doubt attributable to the difficult times in which we live. In happier circumstances practice might approximate more closely to theory, and the treatment of the supposedly abnormal offender become more obviously non-punitive.

Nevertheless, I would submit that there is something wrong with the theory itself. The law demands hard and fast lines, whereas nature recognizes only minute gradations. I suspect that we took the wrong turning when we allowed the law to differentiate sharply between the normal and the abnormal offender, crediting the former, but not the latter, with full responsibility for his wrongdoing, and therefore as a proper subject for punishment according to the traditional code of the criminal law. Is it not time that we recognized that moral responsibility is not an all-or-nothing condition, but that the degree of responsibility varies between one person and another and also in the same person at different times? (Some of us no doubt suspect this about ourselves). Yet only in relation to homicides have degrees of responsibility been
explicitly admitted by the law, inasmuch as a murder charge can be reduced to one of manslaughter if the accused successfully pleads diminished responsibility. In practice, however, this has become mainly a devious way of getting round the mandatory life sentence for murder, which, of course, allows no mitigation, whereas in cases of manslaughter the whole range of sentences from life imprisonment to absolute discharge become available. Apart from this one exception, serious offenders are at present rigidly classified as either mentally normal and therefore morally punishable or else as ‘abnormal’, and therefore medical cases.

To-day less than one tenth of one per cent of the persons convicted of serious crimes are committed to hospital under Section 60 of the Mental Health Act, nor does this figure show any tendency to rise in keeping with the increased crime rates of recent years. This I take to be evidence not only of the inadequacy of hospital facilities, but also of the reluctance of the medical profession to adopt the somewhat drastic measures provided by Section 60, except in extreme cases. Thus the line between the responsible sheep and the mentally disordered goats is now drawn so as to keep to a minimum the numbers in the latter category. Hence it seems unlikely that many who would qualify for punishment rather than treatment are included amongst the sick; but it is difficult to be equally confident that, amongst a total of about half a million offenders annually sentenced for intentional criminality, there do not pass unnoticed a considerable number whose ‘intention’ is impaired by some mental incapacity.

In this context the views of the recent Butler Committee on Abnormal Offenders may be a portent for the future. The Committee’s terms of reference required them to consider “to what extent and on what criteria the law should recognize mental disorder in a person accused of a criminal offence as a factor affecting his liability to be tried or convicted, and his disposal”. Thus, inescapably landed with the task of deciding where in relation to criminal behaviour normal responsibility ends and abnormality begins, the Committee proceeded to tackle this problem in the most acute form in which it arises, namely, the case of offenders diagnosed as psychopaths. Some of their witnesses had proposed (what I think some of you would to-day prefer) that psychopathy should be deleted from the types of mental disorder recognized by the Mental Health Act, on the ground that its definition involves a circular argument, inferring “mental disorder from anti-social behaviour, while purporting to explain the anti-social behaviour by mental disorder” (10). Reluctant, however, to abandon the concept altogether, the Committee first considered, but turned down, the popular contemporary practice of euphemistic re-naming, and decided against the substitution of “personality disorder” for psychopathic ditto as liable to “potentially too wide interpretation”. (Of course the word ‘psychopath’ might even so be retained, not as a diagnostic term, but as a convenient label for a recognizable pattern of behaviour. That shorthand usage would carry no more diagnostic implications than calling a person who is covered with spots ‘spotty’ would imply a diagnosis of measles).

In the end, however, the Committee conceded by implication that the behaviour of persons diagnosed as psychopaths, and therefore as mentally disordered, may be indistinguishable from that of others regarded and sentenced by the courts as normally responsible persons. So, with remarkable defiance of the intention, though not the letter, of the law, they recommended that “properly used, the prison environment can possibly provide the situation within which dangerous psychopaths can most readily be helped to develop more acceptable social attitudes” (11).

Thus did Lord Butler and his colleagues frankly obliterate the distinction between the sick and the wicked, and so bring us one step nearer to the imaginary world of his famous namesake, the author of Erewhon, to whom he tells me he is himself related “at a suitable distance”.

Revolutionary though the Butler recommendations are in principle, they no doubt merely endorse what already happens in practice. Many diagnosed psychopaths in fact are already sent to prison. But the Committee’s readiness to accept this blurring of the line between the wicked and the sick encourages the hope that we may be moving towards a system
more in keeping with nature's gradualism than with the law's absolutes. Confidence in those absolutes demands, I submit, a capacity to see into other people's minds and to measure the power of other people's temptations (particularly those which do not affect ourselves) which is still beyond the skill of even the most distinguished members of your profession.

Perhaps I should conclude what may have seemed a meandering tale by reviewing its course. We started from the premise that the analogy between mental and physical health must not be pressed too far because we still know too little about the natural function of the mind to be able to define its health with a scientific objectivity comparable with the precision with which bodily health can be identified. Those who have attempted to capture the essentials of mental health in words have produced only statements of subjective preferences or moral judgements, on which psychiatrists are no more competent to pronounce than any layman. This makes the psychiatrist's position more difficult than that of other medical men, for whom the restoration of their patients to physical health is a more precise objective. Psychiatrists can, however, often alleviate the miseries of the mentally ill, and assist the 'maladjusted' to attain their own goals or to conform to society's demands; but in so doing they may have to face ethical problems affecting both their objectives and their methods of treatment, particularly where convicted offenders are concerned.

We end with the hope that in the fullness of time the present distinction between the wicked and the sick will be regarded as largely irrelevant to the classification of anti-social behaviour: that the boundary between penal and medical territory will be obliterated, along with the consequential distinction between the punitive and the remedial institution. Then we shall no longer feel bound by court decisions as to whether or to what degree a criminal act is the result of mental disorder. Only then shall we escape from the paradox that, at a certain degree of gravity or irrationality, a crime ceases to be wicked and becomes merely a medical symptom. Once that is accomplished, we could look to every offender's future, not to his past record, concentrating on the search for whatever method (medical or other) of dealing with each individual case looked most promising. Places of detention would cease to be labelled as 'hospitals' or as 'prisons', but would combine the best features of both; nor would their inmates be classified either as wicked or as sick. Switches from one treatment regime to another would be pragmatically determined within the same institution in the light of results, and without the formalities of Section 73 of the Mental Health Act.

If this sounds like either a reversion to eighteenth century practice, or a Utopian dream for the future, I can only repeat what I have often said before, that in the course of a long life I have well and truly learned that to demand reforms while they are still Utopian is the best way to ensure that they will eventually become accepted as commonplaces.

References
(1) MAUDSLEY, HENRY (1876) The Introductory Lecture delivered at University College, London, October 2nd, p 20. (Bacon, Lewes).
(2) —op. cit., p 6.
(3) CMND 7320, September 1978.
(5) DAVIS, KINGSLEY (1938) Mental hygiene and the class structure, Psychiatry, February. Some of the examples are reproduced in my Social Science and Social Pathology (1958), p 211.
(9) MORRIS, TERENCE (1979) The crooked way to the top, New Society, August 2nd.
(10) REPORT OF THE (Butler) COMMITTEE ON MENTALLY ABNORMAL OFFENDERS (1975) para 5.20(b), HMSO, Cmnd 6244.
(11) —para 5.38.

The Baroness Wootton of Abinger, C.H., House of Lords, London SW1
Psychiatry, ethics and the criminal law.
B Wootton
Access the most recent version at DOI: 10.1192/bjp.136.6.525

References
This article cites 0 articles, 0 of which you can access for free at:
http://bjp.rcpsych.org/content/136/6/525.citation#BIBL

Reprints/permissions
To obtain reprints or permission to reproduce material from this paper, please write to permissions@rcpsych.ac.uk

You can respond to this article at
/letters/submit/bjprcpsych;136/6/525

Downloaded from
http://bjp.rcpsych.org/ on June 25, 2017
Published by The Royal College of Psychiatrists

To subscribe to The British Journal of Psychiatry go to:
http://bjp.rcpsych.org/site/subscriptions/