Lesion of the Will: Medical Resolve and Criminal Responsibility in Victorian Insanity Trials

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Analysis of courtroom testimony heard in London's Central Criminal Court in the 10 years following the McNaughtan acquittal (1843) reveals the effort of medical witnesses to establish a distinctive and essential voice in the Victorian insanity trial. Three trials that illustrate this effort are examined for the manner in which practitioners of mental medicine distinguished their opinion from the layperson's fact and, in the process, engaged pivotal issues for the determination of criminal responsibility. Their testimony and the attorneys' questions that elicited it suggest that whatever reliance the judiciary might have placed on the McNaughtan Rules to confine testimony to the defendant's capacity to "know right from wrong," medical witnesses devised ways to circumvent and indeed dismiss the relevance of this particular inquiry.

The difference between asking a witness, "Did the boy not tell you something about his grandfather?" and "Do you consider when he did this, he did not know that poisoning his grandfather was a wrong act?" is the difference between asking a witness to report a fact and asking him to deliver an opinion. Although all witnesses in Anglo-American jurisprudence are ostensibly limited to reporting only their direct sensory perceptions to the court, there exists a class of witnesses entitled to draw inferences, form opinions, and advise the jury in matters thought to be beyond the ken of the ordinary citizen. The only skill required to answer the first question is the possession of auditory sensation: What was it the witness actually *heard*?[1] The second question asks for the most subtle of judgments: an opinion that the defendant could commit an atrocious crime without knowing that committing it would be wrong. What does the phrasing of this ques-

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[1] In the words of John Henry Wigmore, the witness must speak as a knower, not a guesser. He must see an action, not merely believe it took place (Wigmore 1978:2). See also Bushell's case (1671), quoted in Hand (1901:45): "A Witness swears but to what he hath heard or seen, generally or more largely, to what hath fallen under his senses. But a Juryman swears to what he can inferr and conclude from the Testimony of such Witnesses by the act and force of the Understanding."

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tion—and indeed the fact that it was asked at all—suggest about the common law's willingness to entertain a body of opinion that claimed unique insight into the mind of the mad?

Both questions cited above are found in an 1848 insanity trial heard at the Old Bailey, London's Central Criminal Court. That a self-proclaimed expert in mental medicine appeared in court to answer questions about mental derangement was not a novel occurrence. Physicians, surgeons, and apothecaries had been appearing in English courts to comment on the medical features of insanity since at least 1760. And it was hardly unusual for the defendant's mental derangement to be associated with physical pathology, as would be the case with the youthful poisoner. Neighbors, lovers, and co-workers of the allegedly insane routinely commented on physiological anomalies ranging from head wounds to fevers, war wounds to riding accidents, head sores to fits. What would set mid-Victorian insanity trials apart was the medical witness's venturing into the *moral* consequence of such physical ailments. In the case cited above, the young defendant's ringworm had purportedly penetrated his brain, not only driving him mad but "prevent[ing] him from distinguishing right from wrong." To be sure, laypersons were in the habit of associating physical anomalies with aberrant behavior, but they confined their testimony to the presence of insanity. The emerging specialist in mental medicine, in contrast, endeavored to construct a more ambitious connection, one that speculated on the implications of physical and moral lesions for the mental contemplation of a crime. This effort to delve into the mental consequence of disease was one way the medical specialist distinguished his testimony from the layperson's. A second, and more consequential, undertaking was his challenge of the juror's belief that there was anything self-evident in discovering madness. By questioning the conventional signs and assumed meanings of bizarre action, the medical witness presented a construction of *nonintentional* behavior that would eventually bring him into direct conflict with the law's criterion for assigning criminal responsibility.

In making his claim to unique insight into the *mind*—not just the behavior—of the mad, the medical witness was to learn that his entry into the court did not necessarily betoken his acceptance. As a field of proffered technical knowledge that has historically lacked a materialist base, mental medicine has never been free from its rival, folk wisdom, asserted by laypeople eager to pronounce an opinion on their neighbor's mental soundness. Indeed, before the "coming of the doctor," English courts commonly relied on just such *neighborly* impressions to inform the jury about the accused's customary behavior. The historical emergence of the medical expert was thus predicated on convincing laypeople that they could not trust their eyes and ears and on persuading the court that there was something rather

more to madness than acting like a madman. Although this article concerns the 19th-century courtroom testimony that chartered a new and highly vexed role for the specialist in mental medicine, suspicions surrounding the grounds for psychiatric diagnosis as well as the layperson's lingering faith in his own, conventional wisdom regarding the signs of madness remain the enduring and, some would say, defining ingredients of today's contentious insanity trial.

The Insanity Defense

When the first medical witness entered an English court to comment on the properties of lunacy, there had already been a functioning defense of insanity for at least 250 years. Nigel Walker (1968) traces the first acquittal based on mental derangement to 1505 and the first courtroom participation of a mad-doctor to 1760 (pp. 25–26, 58–62).[2] In that year, Dr. John Monro testified on behalf of Earl Ferrers (Lawrence Shirley), on trial for the murder of his servant. The defendant alleged that his derangement amounted to "occasional insanity," a diagnosis with which Dr. Monro concurred. The earl's eventual conviction in the House of Lords serves to underscore the law's insistence that only a total insanity—a total want of memory and understanding—could serve as the basis for an acquittal on the grounds of mental derangement. Occasional insanity—in effect, lunacy—was rejected by the law as a condition that was too labile, too likely to leave the afflicted in a "lucid interval." In such a state, a lunatic defendant was as culpable for his wrongdoing as any person. Until 1800 it was only complete and utter delirium—a "total want of memory and reason"—that the law entertained as grounds for an acquittal.[3]

Not surprisingly, this standard of conspicuous and dramatic madness positioned neighbors, co-workers, and acquaintances in a fine position to advise the court about the accused's characteristic behavior. Employing such concepts as head wounds, brain fever, fractured skulls, and paralytic strokes, intimates and friends of the defendant described the accused's state of distrac-

[2] Thomas Rogers Forbes (1985:168–69) argues that a medical man's appearance in a 1601 witchcraft trial should serve as the first instance of forensic-psychiatric testimony, but his courtroom evidence speaks rather more directly to hysteria and possession than to madness.

[3] The exclusion of partial insanity (lunacy, "occasional insanity") dates to Matthew Hale's celebrated treatise, posthumously published in 1736. In writing about partial insanity, Hale (1736:36) averred that "the best measure I can think of is this: such a person as labouring under melancholy distempers hath yet as great understanding, as ordinarily a child of 14 years hath, is such a person as may be guilty of treason, or felony." The introduction of various states of *partial* insanity, delusion for example, was part of the 19th-century attorneys' efforts to question that only a total insanity should acquit, although they refrained from using the term "partial" in their description of the defendant's mental state.

tion, both on a daily basis and at the time of the offense. As Michael MacDonald has written, "insanity is defined by experts but discovered by laymen" (1981:113), and it was the content of these discoveries that laypeople brought into the court.

The discovery of madness, however, grew to be a more subtle judgment at the turn of the 19th century as gradations of insanity became the focus of both medical writers and medical witnesses. Significantly, it was the insanity trial that marked this departure; ironically, it was an attorney, Thomas Erskine, who created the first qualification in the legal standard of "total insanity." The defendant in this 1800 trial, James Hadfield, had fallen under the sway of a religious cult, eventually becoming convinced that his death at the hands of the state would effect Christ's return. Hadfield's attempted assassination of George III introduced the concept of delusion into English law and was deftly employed by the attorney to challenge the notion that a man totally deranged could even be capable of committing a crime.[4] Delusion suggested a state of *partial* derangement—"total" to be sure when the subject of the delusory fear or belief was touched upon—but absent when any other subject was invoked. The fit of delusion with the defense of insanity is apparent throughout the early decades of the century: Circumscribed delirium surfaces as the term of preference for the early 19th-century mad-doctor (Eigen 1991). Indeed, delusion was the focus of the century's most celebrated insanity defense, Daniel McNaughtan's, whose acquittal resulted in the judicial instructions that bear his name. Although a host of nondelusory, nondelirious states was also introduced in the years that separated the Hadfield (1800) and McNaughtan (1843) trials, the Rules that followed the McNaughtan verdict exclusively addressed the state of intellectual confusion that must attend an acquittal: an inability to know the nature and consequences of one's acts, to know the difference between right and wrong.

Defendants tried under such a stricture were variously described as insensible, "being out of one's wits," and in time delusional. The possibility of circumscribed derangement such as McNaughtan's was certainly not news to the lay witness, who often reported a link between a mistaken belief and a crime: "[the] devil came to him and said . . . he must murder." But what the layperson could not address were issues that ventured beyond the *fact* of the delusion to explain the mental state of someone who was aware at some level of *what* he was doing, yet was profoundly confused about the *nature and consequences* of what he was doing. "Do you think he was so insane as not to know right from wrong?" is a question that requires something more than

[4] The Hadfield trial is discussed in Walker 1968:74–79; Moran 1985; Eigen 1995:48–52; and Quen 1969.

acquaintance with a particular defendant; it calls for systematic familiarity with a *class* of distracted persons. The need for such day-to-day observation set the stage for questions that probed the defendant's various planes of awareness and intention: "Do you think he was so deranged as not to know that it was a dreadful crime to fire at a fellow creature?" "Do you mean to swear that he was in that state of mind, as not to know right from wrong; or that he did not know it was harm to cut a man's throat?"

The Emergence of the Forensic-Psychiatric Expert

How could someone *not* know that it was harm to cut a man's throat? What sort of experience could equip a medical observer with the expertise to explain such a mystery to the court: the separation of physical act from its mental contemplation? It was exactly this sort of counterintuitive phenomenon that one finds in medical testimony delivered by men of skill called to the English court since the 14th century. By dint of particular knowledge or experience, these court-appointed specialists were deemed capable of sifting through confusing or conflicting evidence brought by ordinary witnesses.[5] In time, these specialists became known as "expert" witnesses, a term that has obvious problematic associations, not least for the insular manner in which professions bestow credentials. For the law's historical purposes, however, the term *expert* was relatively straightforward, used (simply) to denote uncommon skill or knowledge gained through advanced learning, artisan crafts, or unique occupational experience. Medicine, as both a skilled craft and a growing body of knowledge, was particularly useful to the court due to the continuing presence of suspicious deaths that suggested the possibility of foul play. Why were the lungs of a drowned man free of water? Was the death of an infant the result of a stillborn birth or due to suffocation within hours of delivery at the hands of his unwed mother?[6] Though laypeople might be thoroughly familiar with the presence of wounds, they were not in a position to explain, for example, the *absence* of blood in a *particular* wound. It was precisely by placing the specific features of a particular death into the context of the "general case" that medical men came to be valued by the court.

Such questioning of the layperson's "facts"—both directly and indirectly—adds historical framing to Judge Learned Hand's (1901:50) classic delineation of the two types of courtroom evidence: "Fact and opinion [are distinguished] by merely a practical consideration, i.e., whether the inference is one which is

[5] For a comprehensive survey of the historical emergence of medical testimony in the English courtroom, see Crawford 1987.

[6] The participation of medical men in coroner's inquests is examined in Forbes 1977a, 1977b.

within the fair range of dispute, or whether, given the impressions of sense, the inference from them is so self-evident as to make any attempt to question it frivolous." When physicians, surgeons, and apothecaries first entered the courtroom to speak about insanity as a medical condition, nothing could have been more "frivolous" than to question the signs of madness, so clearly readable were they by the accused's neighbors and acquaintances. No one needed a skilled practitioner to decode the verbal pandemonium and behavioral histrionics of the deranged. What the medical witness could supply was the likely course of the illness: whether it would recur and with what intensity. In time, medical witnesses began to distinguish their testimony by charting the odyssey of derangement as moving inward, becoming a matter of hidden and circumscribed distraction that the casual observer was likely to overlook. Surface calm was thought to particularly mislead the causal observer. The neighbor's impressions of sense were deemed unreliable specifically because he failed to "persist in the interview."

Medical witnesses in insanity trials appeared to benefit from a growing acceptance of early 19th-century claims to expert knowledge in forensic matters in general, as illustrated by dramatically escalating participation rates of medical witnesses in London's most conspicuous criminal trials. By the 1840s, three homicide trials in four featured a medical witness. In the late 1840s, the frequency grew to nine in ten (Forbes 1985:21–22). What may not have been so obvious was the rapid rise of medical testimony in insanity trials as well. Appearing in only one in ten trials in the mid-18th century, medical witnesses by the 1840s offered testimony in half the insanity trials animated by a property offense and 90% of the prosecutions that concerned assault.[7]

Although medical witnesses certainly participated in insanity trials with ever growing frequency, one wonders what authority their opinions carried when the issue at hand was not a "dry" drowning, a bloodless wound, or a stillborn child. Madness, after all, was anything but mysterious: few people doubted nature's legibility (Porter 1987:35).[8] Not surprisingly, it was just this un-

[7] These data were assembled by examining the universe of insanity trials between the years 1760 and 1843, dates that bracket the Ferrers and McNaughtan trials. A survey of trial narratives (described below) yielded a total of 331 trials. For medical participation rates by decade, see Eigen 1995:18–30.

[8] Assessing "authority" is a question of examining individual courtroom testimony, cross-examination, and the emergence of new medicolegal conceptions of behavior. The notion that "success rates" can be computed according to whether medical witnesses appeared at a trial is highly problematic. The reasons for any one verdict vary enormously: An acquittal might result from a jury's suspicion that the victim had brought the action out of spite or the jurors were unable to decide the proper ownership of a disputed item. In such cases, medical testimony would have had little to do with trial outcome. Even in those cases in which an acquittal on the grounds of insanity resulted, witnesses may have selected such trials because the evidence of derangement was so compelling that they could rely on a relatively friendly reception. One could hardly attribute an acquittal to their courtroom participation alone. The true influence of their testimony, it would seem,

problematic belief in insanity's conspicuous features that medical writers endeavored to dispel. John Haslam, Apothecary to Bethlem, disparaged in print the "ordinary persons [who] have been much deceived by the temporary display of rational discourse . . . let him protract the discourse, let him touch the fatal string which throws the mind into discord . . . and he will be surprised if not alarmed by the explosion . . . the map of his mind will point out that the smallest rivulet flows into the great stream of his derangement" (Haslam 1817:15–19). That opinions of "ordinary persons" should *even* be sought in matters pertaining to insanity was the subject of another medical writer's complaint: "No man is considered competent to give an opinion on a complicated question of mechanics who has not paid some attention to the science[, and yet] medical knowledge is thought to come by intuition" (Winslow 1843:vii).

Despite the forcefulness of these sentiments, they were only just that: professional assertions (or pique?) uttered with no demonstrable evidence. Absent scar tissue to point to, wounds to examine, or poison to detect, little separated lay from expert medical testimony when the issue at hand was the defendant's periodic descent into madness. To understand the courtroom forces that encouraged the rapid rise of medical participation in the 1830s and 1840s, one must look instead to the emerging defense counsel, for 19th-century courtroom narratives reveal just how adroitly the attorney could employ medical opinion to secure an acquittal. Faced with such questions as "The old delusion, acting on his mind, will lead him to any act . . . not conscious that he is doing wrong," and "Is it not a common symptom of derangement of one man to suppose that another man means to deprive him of his estate, and, under that delusion of mind, they would proceed to vengeance?" one would be hard put to say whether the jury was more influenced by the attorney's questions or the medical answers that followed. Attorneys made particular use of the increasing experience claimed by medical witnesses in treating mad persons: "From the opportunity you have had many years of observing insane persons, have you any means of discerning when they are dissimulating and when they are not?" The scope of such questioning widened noticeably with the passage of the Prisoner's Counsel Act of 1836, which extended the attorney's powers beyond simple questioning of the witness, to the fashioning of a more fully developed defense case, including the right to address the jury directly.

The widening scope of a more activist defense occurred during the same decade that witnessed a changing occupational base cited by mad-doctors in court. Physicians, surgeons, and apothe-

is the manner in which their testimony challenged lay—and hence, juror—perceptions of *self-evident* madness. It is for this reason that retrieving courtroom narratives of medical testimony presents such a rich vein for historical reconstruction.

caries in the 18th and early 19th centuries testified about neighbors or patients who had sought medical services for a physical complaint that only in time revealed a dominant psychological feature. By the 1830s, most medical witnesses meeting the offender in prison or a jail cell, were employed either by the court to visit defendants thought likely to plead insanity or by family members in an effort to help construct a defense case. These jail visitors prominently included asylum medical men, for one finds by the 1830s and 1840s, the predominance of asylum superintendency as the occupational experience leading to the witness stand.[9] Beginning their testimony by directly invoking the opportunity for sustained familiarity, "Among my patients at the Institution . . ." or "I have 850 patients under my care and some experience in the treatment of disorders of the mind," asylum physicians expressly brought their professional experiences directly into the courtroom. They represented a generation of early madhouse keepers attempting to become something more than mere custodians of the distracted. And they revealed in their courtroom testimony—sometimes in response to deft questioning, sometimes ventured without prompting—a concerted attempt to fashion themselves into scientific observers and chroniclers of the *essence* of insanity. Their claims to such knowledge, however, would have been exceedingly difficult to sustain were it not for the first generation of defense attorneys who actively solicited medical opinions in court, making explicit courtroom reference to the asylum physician's (unique) occupational experiences.

Once in court, medical witnesses did not always discover insanity; indeed, they might conspicuously distance themselves from lay witnesses by detecting "counterfeited" madness. One could, after all, be just as forceful in asserting privileged insight into madness by uncovering *sanity*—and thereby bemoaning the layperson's gullibility when confronted with Shakespearean antics—as by detecting the more recondite pockets of delusion. That medical witnesses did not always discover madness is perhaps attributable to their opposing courtroom roles, as well as their subscribing to differing schools of medical psychology. The most ubiquitous medical man in insanity trials was Gilbert

[9] In the years from 1760 to 1843, 127 medical men appeared in a total of 331 trials. A variety of venues brought the prisoner and mad-doctor together: private acquaintance, private professional association, the prison or asylum interview. By the 1830s and 1840s the asylum and jail cell served as the most frequent meeting place. This finding underscores the role of the institutionalizing of social deviants as a precondition for the rise of the "corrective" human sciences. Criminology, social work, and psychiatry could hardly have emerged without a captive population available for daily scrutiny and study. In the case of forensic psychiatry, it was the asylum physician who could base his testimony in court on an extended familiarity with the deranged: He knew what to expect from a madman's behavior precisely because he was acquainted with insanity in its *true form*. For an examination of the changing ways in which the prisoner met the doctor, see Eigen 1995:122–32.

McMurdo, Surgeon to Newgate Jail. Making no fewer than 17 court appearances in the early decades of the 19th century, Surgeon McMurdo was employed by the court to visit prisoners thought to be contemplating an insanity plea.[10] Most often, he denied finding any convincing evidence of mental derangement. Privately retained mad-doctors, on the other hand, usually found the prisoner insane, but here as well, they sometimes failed to find a sufficient degree of mental impairment.

Courtroom affiliation, however, should not be invoked as the sole reason to explain the difference of opinion. The definition of insanity—never a stable signification—was undergoing a particularly dramatic change in the early to mid-19th century. A century that began with the introduction of delusion as the first significant qualification of the total insanity concept witnessed, by 1840, the introduction of a form of insanity that featured no delirium, no delusion, indeed no confusion at all. This was not an intellectual but a moral insanity, in which the afflicted was carried away by perverse sentiments although conscious to some extent of what he was doing. He was suffering, quite literally, from a will out of control. This species of insanity—first introduced in French medical texts and later elaborated by the school of Common Sense Philosophy—would prove to have broad ramifications for mad-doctors in court.[11] As long as medical opinion resonated with lay observations regarding insanity's familiar forms—delirium, insensibility, being "out of one's wits"—the expert broke no new conceptual ground and threatened no courtroom division of labor. But it becomes clear from the tone of courtroom questioning alone that this new species of insanity threatened to engage the very foundations of criminal responsibility and to place the medical expert in a qualitatively enhanced role. As the first judge to be confronted with this *moral* insanity asked, "Do you consider this is a medical question at all?"

A Will Out of Control

Even before they introduced a species of insanity confined exclusively to volitional chaos, medical witnesses in the early decades of the 19th century had begun to hint at the autonomy of passions aroused by profound errors in belief. Delusion, the term of preference for medical witnesses in the early 1800s, often carried with it a spur to action: shooting one's supposed nemesis,

[10] McMurdo describes this assignment during a trial in 1833: "[T]he clerk of arraigns told me it was very likely I should be wanted; and I had better be in attendance, on one occasion the Lord Mayor met me and said, Mind you see that prisoner, for it is very likely we shall want your evidence. . . . I go to the Compter daily to see the prisoners." *Old Bailey Sessions Papers* (hereinafter *OBSP*), 1833, 4th sess., case 815, 402. For more on *OBSP*, see text at note 22.

[11] Goldstein (1987) presents the most comprehensive analysis of the French school of *médecine mentale*.

forging a signature, attempting to kill a neighbor thought to be cooking up plots. Such confusion about the accused's supposed enemy's intention rendered his or her own actions tragic but not necessarily criminal. Without a sufficient level of understanding, one could not be said to have exercised a choice, to have acted with intent. And without intent, regardless of the harm done, one was not culpable. The accused may have secured a firearm, hidden behind the tree, and severely wounded an innocent party, and yet the jury could decide that it was the delusion, in effect, that pulled the trigger.[12]

Medical testimony offered in the 1840 prosecution of Queen Victoria's would-be assassin Edward Oxford, however, revealed the presence of a qualitatively different form of mental derangement: one that resulted in motiveless, irrational, and self-destructive criminality. The possibility that a form of insanity existed that left the afflicted's mental capacity intact while propelling him into motiveless criminality had first been proposed by Philippe Pinel. *Manie sans délire* described a state in which an individual was dominated by an abstract fury yet suffered no accompanying "lesion of understanding":[13]

> No sooner was the brain invaded, than the patient was suddenly seized by an irresistible propensity to commit acts of barbarity and bloodshed. Thus actuated, he felt, as he afterwards informed me, a contest terrible to his conscience arise within him, between this dread propensity which it was not in his power to subdue, and the profound horror which the blackest crime of murder inspired. The memory, the imagination, and the judgment of this unfortunate man was perfectly sound. He declared to me, very solemnly, during his confinement, that the murderous impulse, however unaccountable it might appear, was in no degree obedient to his will. (Pinel 1806:85)[14]

The possibility of an insanity limited to affect or instinct was further explored by Pinel's two students, Jean-Etienne-Dominique Esquirol and Etienne-Jean Georget, whose asylum-based diagnoses carried penetrating legal significance. *Monomanie homicide,* Esquirol's contribution, made a rather spectacular entrance into French jurisprudence in the mid-1820s;[15] Georget's formulation,

[12] These events derive from a trial in 1812 that did indeed end in acquittal, with delusion serving as the focal point for the medical testimony: "[The defendant] was subject to various acts of violence where there is delusion on the subject." Asked by the judge, "Not conscious that he is doing wrong," the medical witness answers, "most likely." *OBSP* 1812, 6th sess., case 527, 331–32.

[13] Pinel's 1806 treatise announced the existence of particular variations to global derangement: delirium on one subject only (melancholia), derangement independent of "any lesion of understanding"; and an insanity in which the will was diseased. See esp. pp. 150–286.

[14] Pinel's theorizing not only broke with a long-standing conception of insanity as an intellectual disease but also introduced a novel concept: the use of clinical materials to generate typologies. The role of Pinel's clinical experience is explored in Weiner 1990.

[15] Esquirol's neologism *monomania* was a partial reworking of the centuries-old concept of melancholia. Monomania retained melancholia's preoccupation with a particular

"lesion of the will" would have direct impact in the Oxford trial. Fifteen years before the prosecution of Queen Victoria's assailant, Georget used "lesion of the will" to characterize a state of mental derangement in which the will, itself diseased, had propelled the afflicted into bizarre, criminal activity. No attempt was made to elude detection, no motive lay behind the outrageous acts. Why would someone act so obviously against his own interests, and for no reason? The culprit appeared to be an autonomous, pernicious will: "Je ne puis m'en empêcher, [Georget's patients told him], c'est plus fort que moi!" (I cannot help myself, it is stronger than me) (Marc 1840:88).

In England, authors James Cowles Prichard and John Conolly found common cause with the idea of autonomous passions and consequent deficiencies in self-control. Prichard's particular focus was *moral insanity*—a term also invoked in Edward Oxford's trial—that denoted a perversion of the natural feelings and sentiments rather than an intellectual error such as delusion. The morally insane were not *unmindful* that they were carrying out some horrible deed; they were instead oblivious to the mental thought that linked them to the role of "offender." Wrote Prichard (1835:12): "The loss of voluntary power over the succession of ideas [which] is so great in a certain period of dementia, that the individual affected is incapable by an effort of mind of carrying on the series of thoughts to the end of a sentence or proposition." The loss of volition, according to Prichard, was also revealed in the self-destructive nature of the morally insane's criminality—stealing unwanted items, for example, or killing a beloved infant—which suggested the degree to which the accused was not in control of his own behavior. In the end, the singular lack of motive defined moral insanity—the want of any logical reason for the act—revealing a blind force that "neither reason nor sentiment determine" and which the will was powerless to control.[16]

Medical witnesses in Edward Oxford's trial mentioned each of these elements in their testimony. The Queen's assailant harbored no resentment against her; indeed he considered the sovereign to be "a very nice lady." No delusion and no motive linked

notion or fear—hence the contemporary adjective, monomaniacal—but exchanged the brooding proclivities of the melancholic for an expansive disposition. The novel features of this form of mental distraction were its variety of expression: *monomanie instinctive, monomanie affective.* Clearly, elements of the human psyche could be separately deranged and, in the process, override the intellect. As Esquirol (1845:351) explained, monomaniacs "perform acts and hold odd, strange and absurd conversations, which they regard as such, and for which they censure themselves." For the explosive use of *monomanie homicide* in a celebrated French trial, see Goldstein 1987:165–66, 180, 180–85.

[16] Moral insanity consisted in the suspension of the mind's faculties but not an absence of consciousness. It was the suspension of the former that theoretically rendered the accused not blameworthy at law. One must add that the precise nature of the afflicted's consciousness is difficult to grasp: he does not *understand* why he is engaged in the activity, yet he is not unmindful that he is carrying out some horrific deed either.

him to the assault; indeed it was the complete absence of any reason at all to want to harm Victoria that served as the basis for the medical claim that the accused suffered from a "moral insanity." One medical witness described his affliction to the court as a "lesion of the will . . . [which] means more than a loss of control over conduct—it means morbid propensity—moral irregularity is the result of the disease" (*OBSP,* 1840, 9th sess., case 1877, 505). A final mad-doctor added, "I think that, committing a crime without any apparent motive is an indication of insanity."

The rhetorical irony of a term such as lesion of the will is that in appearing to suggest something tangible and material about the *organ* of volition—an irritation, an abscess—it actually renders the insanity totally invisible, at least to the untrained eye. If mental coherence remains intact while the afflicted is carried away by his passions, how can one discover the presence of a *nondeliberate* crime by mere observation? How may an assassin's autonomous will reveal itself to the casual onlooker? The answer—according to medical witnesses who appeared at the trial of the man who fired two pistols at Queen Victoria—was that it cannot.

Beyond serving as the forum that introduced a novel species of insanity into the courtroom, Oxford's trial also provided a strategic opportunity for medical witnesses to extend their cognitive territory. When asked by the judge, "Why could not any person form an opinion whether a person was sane or insane from the circumstances which have been referred to?" a medical witness answered, "Because it seems to require careful consideration of particular cases, more likely to be looked to by medical men, who are especially experienced in cases of unsoundness of mind." Medical testimony that claimed to understand this particular form of insanity excluded lay witnesses precisely because they were likely to take the accused's behavior at face value. Where an acquaintance or on-scene witness might describe Oxford's attack on the sovereign as an act of senseless *cruelty*, an experienced asylum superintendent could recognize the unmistakable elements of moral insanity. To John Conolly, Superintendent of Hanwell Asylum, Oxford resembled "other imbeciles who set fire to buildings . . . commit crimes without motive other than a vague pleasure in mischief" (*OBSP,* 1840, 9th sess., case 1877, 505, 506). Further examples of the ravages of moral insanity were cited at the Old Bailey to reveal the irrationality of moral insanity: an assault on a beloved brother, an attack on a complete stranger, the inexplicable theft of postal letters. The effort to explain such counterintuitive phenomena not only further distanced the expert's *opinion* from the layperson's *fact* but engaged the common law directly, since this new form of insanity implied a suspension of human agency.

By its very definition, moral insanity challenged the legal construction of intent: willfully chosen behavior. This direct assault on the common law's conception of guilt came at a time when concern with the will had particular social and political significance. The bedrock centrality of self-control to the maintenance of civilization resonated with all manner of cultural thought and expression for the Victorians, who not only accepted the idea of will—of a *free will*—as a psychological reality tout court but also as the necessary and sufficient condition for the maintenance of public order. Their belief in free will meant particularly that the individual had real, sovereign power in the formation of his own character. By the cultivation and exercise of his will, he could modify and form habits of correct behavior.[17]

The fostering of inner boundaries capable of guiding citizens in exercising self-control was a crucial element not only for maintaining social order but for socializing all citizens to the importance of law-abiding behavior. Criminal courts had a critical role to play in this regard, for it was by holding citizens *responsible* that a society produced *responsible citizens,* able to restrain their passions and regrettably stimulated appetites.[18] The entire project of fostering self-governing, self-equilibrating citizens would be therefore put at risk with the sanctioning of a medicolegal concept such as moral insanity, which appeared to give an impulsive will dominion over human behavior (and accountability).

Finally, an insanity of affect and instinct not only challenged prevailing cultural norms about individual responsibility, it also materially enlarged the range of the medical man's professed expertise and the *significance* of that expertise, confronting directly the division of labor in the courtroom. Before Oxford, it was the jurors' task to construct a conceptual bridge between insanity and the crime: the probability, for example, that a state of delirium brought on by a fever had animated an assault or the likelihood that a ruling delusion had led to the theft of spoons. With the prosecution of the Queen's would-be assassin, however, no bridge was necessary. Medical witnesses supplied the missing connection between the etiology and the effect: namely, the perversion of will. It was doubtless the recognition of the medical witness's expanding job description that prompted the judge in this trial to ask if moral irregularity was "really a medical question at all."

[17] Mill 1869. For a discussion of the power of the will over ideas, see esp. pp. 327–95. An excellent analysis of the Victorians' views of the will and its role in maintaining physical and mental health is offered in Haley 1978.

[18] Smith 1981, see esp. pp. 72–74. Martin J. Wiener's (1990) survey of contemporary popular literature, the influence of "social statistics," and tracts in political and social theory further demonstrates the extent of cultural anxiety attending radically shifting hierarchies of tradition, work, and community, and thus the consequent importance attached to the individual will for the maintenance of public order. What other force was powerful enough to battle instinctual passions and appetites (see esp. pp. 14–45)?

The judge's sentiments were shared by other members of the judiciary who reacted to Oxford's acquittal—and Daniel McNaughtan's three years later—by formulating a set of rules designed to guide the prosecution of subsequent insanity trials. McNaughtan's trial had been the occasion for the unprecedented participation of nine medical witnesses in a single Old Bailey prosecution. Private practitioners, asylum superintendents, medical authors, *and* the now familiar jail surgeon McMurdo described the prisoner's insanity in terms suggesting a lack of "moral restraint," of the irresistible nature of an act that "flowed out of that delusion." The fatal shooting of Edward Drummond—believed by the defendant to be the Prime Minister—was said to be an "act . . . placed beyond his moral control," a derangement that "carrie[d] a man quite away." Rarely had medical witnesses ever characterized a crime as the inevitable consequence of insanity or rendered impairment in such graphic terms: "I mean that black spot on his mind." The images and the testimony were unequivocal: moral liberty was destroyed.[19]

In response to McNaughtan's acquittal and the consequent disquiet at the Palace—this was the fourth assault on a head of government since 1800 *and* the third acquittal—the House of Lords invited the three presiding McNaughtan judges to respond to a series of questions about the prosecution of insanity defendants. Their answers, and the Rules that resulted, conspicuously sidestepped contemporary opinion in medical texts arguing for the existence of moral insanity and the possibility of a separate derangement of the passions, distinct from intellectual delirium. The McNaughtan Rules make no mention of the will, emotions, or the passions, in effect, restricting courtroom inquiry to the impact of some pathological state on the cognitive capacity of the defendant. Did the accused know the nature and quality (i.e., the consequences) of his act? Did he know the difference between right and wrong? Insanity, at least as far as these judges were concerned, was not a matter of an inability to restrain one's will or of finding oneself "out of the pale of self control." Moral irregularity—whether termed lesion of the will, *manie sans délire,* or moral insanity—was given no home in the McNaughtan Rules.

Considered in light of the increasing medical participation in insanity trials and the expanding scope of medical testimony offering images of a diseased will, the Rules appear as a judicial solution to a too user-friendly conception of criminal insanity that could accommodate any wicked person's "unmotivated" as-

[19] *OBSP*, 1842–43, fifth sess., case 874, 756–63. The medical witnesses who testified represented a host of occupational origins, from prison surgeon McMurdo, to asylum doctors Edward Thomas Monro, Alexander Morison, and William Hutchinson, to London surgeons William M'Clewer and Aston Key, to John Crawford, a "lecturer in medical jurisprudence," and a Dr. Sutherland with no professional designation at all. Differences in institutional affiliation do not appear to have affected the professional *gaze.* Medical opinion was unanimous: McNaughtan was insane and delusion was the culprit.

sault. The legal historian cannot help but wonder what sentiment prompted the judges to fashion the McNaughtan Rules. Were they meant to be an effort to restrict the scope of medical testimony specifically, or limit in a general way the courtroom inquiry into the nature of an accused's alleged derangement? Was this the first of many efforts to limit the use of the insanity plea altogether? Although there is little way of knowing for certain what purpose guided the creation of these Rules, one should be able to gauge their effect in compelling medical witnesses to speak to one specific question: the defendant's capacity to know the difference between right and wrong. To be sure, this query had often been asked in trials that preceded McNaughtan, but never with the explicit requirement that all other testimony address this one inference. How did the post-McNaughtan medical witness accommodate evolving notions of volitional insanity and moral irregularity to the McNaughtan stricture? And where would one look to find evidence of such courtroom negotiation?

History and Legal Evidence

The history of criminal insanity has long been written as a chronicle of Famous Trials: attacks on a sovereign or a prime minister, or an assault by a nobleman such as Earl Ferrers, tried in the House of Lords.[20] One can certainly understand the legal and medical attention these trials received, given the celebrity of the targets and likely drama the perpetrator's execution would bring. But what of the trials of the ordinary offender and noncelebrated victim? What sort of medical testimony attended the prosecution of the decidedly nonposh in the years after McNaughtan, when the Rules that followed the acquittal of the notorious Scotsman were put into effect? The conviction that the trials of the famous can offer but a limited glimpse into the evolving jurisprudence of insanity has prompted recent efforts to search the legal record for the prosecution of offenses that fell noticeably short of political assassinations, in order to gain an appreciation of the frequency and substance of medical opinion bearing on criminal insanity in the English courtroom. Over time, historians of 18th-century crime have unearthed a range of documents and registers including indictments and jail delivery lists to explore the universe of the types of crime that grand juries were likely to consider most often.[21] Indictment records and jail delivery lists can then be supplemented with fragmentary assize reports to examine the decisions that followed the grand

[20] The most comprehensive review of celebrated 18th- and 19th-century insanity trials may be found in Walker 1968:52–103. For accounts of individual trials, see Quen 1969; Moran 1981, 1985, 1986.

[21] For a discussion of the utility and limits of indictments for historical reconstruction, see Baker 1977:30–31.

jury's action to bring formal charges. Such outcomes, however, provide only the barest outline of the most dramatic forum in 18th-century London society: the criminal trial. Although contemporary theatre, newspapers, and novels tried to capture the stark morality tale on display at the Old Bailey, such standard literary and journalistic devices were selective and rarely explored the assertions of self-proclaimed experts who claimed to possess a unique capacity to understand the mind of the mad.

Fortunately, legal historians have a curious publication known as the *Old Bailey Sessions Papers* (*OBSP*) beginning in 1674 and running to the early years of the 20th century, which report the trial outcomes and much of the courtroom testimony of every prosecution at London's Central Criminal Court. These papers record the language of everyday London citizens through direct quotation of courtroom testimony and offer a glimpse into an array of interactions available in no other source: the direct and cross-examination of witnesses (invaluable for the historical reconstruction of the emergence of medicine's claim to expertise in the courtroom), occasional instructions to the jury by the judge (again, a priceless source for contemplating the images of derangement the jury was actually asked to consider), and a record of the (purportedly) mad prisoner's defense uttered at the end of the trial.[22] Unfortunately, many trials are severely compressed, so one does not know what sort of detail may have been lost. As disappointing as these deletions are, the *OBSP* represent the best source we are likely to have of the day-to-day, trial-by-trial universe of 18th- and 19th-century crime and punishment. Their importance for the historical reconstruction of the emergence of new understandings in criminal insanity is particularly critical. As legal historian John Langbein has written, "the *OBSP* emphasize the factual detail of witness and defense statement, especially in sensational cases," an observation that reinforces their vital scholarly importance for the atypical criminal prosecution likely to capture the imagination of the reader, such as the extravagant display of frightening mental states.

The significance of such display—both inside and outside the court—was the subject of Nigel Walker's pioneering study, *Crime and Insanity in England* (1968), a survey of 18th- and 19th-century insanity trials that brought to light the curious appearance of medical witnesses in day-to-day hearings. It is the infrequent mention of medical participation in the late 1700s and early 1800s that catches the reader's attention. Why should newly arrived specialists in mental medicine grow so numerous by the mid-19th century, when common law courts had experienced little difficulty adjudicating insanity pleas for hundreds of years

[22] A comprehensive account of the Old Bailey Papers is given in two works by legal historian John H. Langbein (1978, 1983a).

without such expert witnesses? What exactly did medical men have to offer the court that distinguished their testimony from that of the defendant's neighbors and relatives, who after all were in a far better position to comment on the aimless wanderings and verbal pandemonium of the seriously deranged? Finally, how could medical witnesses enlighten a court that was not hearing tales of fantastical political conspiracy but rather crimes that ranged from forgery to bigamy, from assault to rioting, from spoon stealing to sheep stealing?

It might come as a surprise to learn of an insanity plea raised in trials of such mundane property offenses, but there was nothing mundane about the theft of spoons in London in the late 18th century. English society faced a criminal code that punished more than 200 offenses with death, most concerning property thefts of any item that exceeded 30 shillings.[23] An inspection of the verdicts in this time period, however, reveals a curiously high proportion of offenders found guilty of thefts valued by the jury at *29* shillings. These verdicts suggest either a concerted effort on the part of the jury to circumvent the draconian criminal code or a remarkably uniform pricing policy. Assuming it was the former, one could well argue that the profusion of what were called "partial verdicts"—the determined effort to undervalue the worth of the purloined goods—provides an enlightening context in which to situate the growth in insanity prosecutions.[24] As jurors appeared to have been willing to consider *sane* offenders as meriting mercy—due perhaps to poverty, immaturity, or dire family considerations—a further constraint on behavior, mental derangement, also appears to have entered jury deliberations.

Perhaps the awareness of social and mental constraints on behavior can also help to explain the apparent willingness to listen to outside experts who appeared at the Old Bailey with increasing frequency. Pre-McNaughtan physicians, surgeons, and apothecaries were given wide latitude in describing the defendant's condition and in answering a host of courtroom questions. Medical men who appeared after McNaughtan, however, were bound to answer one specific question. Regardless of whatever else they had to contribute to the court's understanding of the defendant's mental state, they were compelled to address the fol-

[23] The disposition of prisoners, however, was nowhere as certain as the "Bloody Code" might lead one to suspect. Convicted felons routinely received the Royal Pardon, an exercise in magisterial largesse that has sparked a lively debate among historians regarding the purposes animating the extension of mercy. See Hay 1975 and Langbein 1983b. Empirical data used by Langbein can be found in King 1984.

[24] A number of historians have brought to light a host of factors that might have prompted juries to downvalue the worth of stolen goods and thus to "sentence by conviction." Although it is of course hazardous to speculate on the thought processes of jurors (then as now), these research results suggest that the insanity plea was one of several contrivances used by juries to circumvent the hangman's noose. For studies of such *partial verdicts,* see King 1984; Green 1985:356–63; and Hay 1982.

lowing: "Did the prisoner, in your opinion, know right from wrong?" How did they respond?

To answer this question, a survey of criminal trials 10 years after the McNaughtan verdict was undertaken by employing trial narratives found in the *OBSP*. This effort yielded a total of 86 insanity trials, or approximately eight trials per thousand, a percentage that parallels the incidence of insanity prosecutions in the early to mid-1800s (Eigen 1995:9). The McNaughtan Rules certainly did not curb the frequency with which medical men participated in the 19th-century English insanity trial; three out of four cases featured a mad-doctor, surgeon, or apothecary. Beyond the simple fact of their participation, however, there is the more intriguing question of the content of their testimony, particularly in light of the strictures purportedly imposed by the McNaughtan Rules.

The following three trials have been selected for discussion because they are indicative of the post-McNaughtan medical witness's efforts to assert a distinctive—and independent—voice for mental medicine in the avowedly legal forum in which he found himself. The first two trials provide insight into the ever widening scope of physical agents thought to produce madness—agents never mentioned before 1843. The third case alerts us to forensic psychiatry's effort to (re)introduce moral insanity into the English courtroom. Most critically, these trials are illustrative of medical witnesses' ambitious attempt after McNaughtan to expand the scope of their testimony directly into the issue of criminal responsibility, even to the point of rewording the judge's own questions regarding the nature and effects of madness.

Insanity and "Women's Problems"

In 1846, Mary Ann Hunt, aged 30, was tried at the Old Bailey for the willful murder of an aged neighbor, Mary Sowell. That the defendant was painfully aware of the wrongfulness of her deed was evidenced by the lengths she took to elude police discovery. When hiding was no longer possible, she tried to kill herself, again revealing her understanding of what she had done. Lay testimony about her mental state was divided: some intimates "observed nothing in the least peculiar about her manner," others claimed she was prey to violent fits and delirium. As one neighbor commented, "I mean, she was quite absent" (*OBSP*, 1846–47, tenth sess., case 1797, 666). In the long tradition of lay witnesses speaking easily in the realm of physical etiology and medical terminology, the defendant's neighbors explained, "the cause of her illness was suppressed menstruation. . . . it was an hysterical fit—she fainted and went into hysterics—she was quite insensible, like a dead person." In an attempt to elicit the mental consequence of such a fit, the judge asked, "Do you mean that

the convulsive action nearly struck you; or that she had powers of mind about her, and intentionally struck you?" The witness answered simply, "She was violent towards the parties round, struggling—in struggling she struck us" (ibid., 673–74). How was the servant to discern the possession of intent or indeed the requisite degree of mental coherence that would permit purposeful resolve? As far as he was concerned, a physical blow was a physical blow.

Initially, the prosecution in Mary Ann Hunt's trial produced only one medical witness, the ubiquitous Gilbert McMurdo, Surgeon to Newgate Jail, who explained to the court that he had been "desired to pay particular attention to [the prisoner] with a view to ascertain her state of mind." Jurors at the Old Bailey were accustomed to hearing the surgeon's opinion, which almost always went against finding any signs of significant derangement. Sometimes this refusal reached risible levels. McMurdo testified in 1833 at the trial of a ship's captain who, at the mere mention—and *only* at the mention—of the name of his nemesis, threw off his clothes, danced barefoot on broken glass—the result of his breaking window panes with his bare fists—then topped off the episode by jumping on the back of a passing whale (*OBSP,* 1833, 4th sess., case 815, 399–402). Such a clear case of circumscribed delusion was rarely met with in court, and rarely supported by such credible witnesses as fellow naval captains. Yet Surgeon McMurdo declined to find insanity in the whale-jumping captain of the *Sophia,* and he found none in Mary Ann Hunt, either.

After giving his opinion, however, McMurdo is asked a highly unusual question, the first time in fact such a question is asked of any medical witness during an insanity trial: "You have no doubt had considerable experience with reference to the diseases of women?" "I am aware," he answers, "of disorders more or less mischievous, arising out of irregularity of menstrual discharges—the interruption or temporary stoppage of these discharges sometimes affects the brain. . . . I have not known of women becoming permanently mad from that state of disorder." The judge at this point interrupted by asking "Do you follow the question, that temporary insanity is a frequent consequence of irregularity in that matter?" McMurdo answers, "I should not term it insanity . . . but that the mind was not sound during that time" (*OBSP,* 1846–47, tenth sess., case 1797, 670–72).

Apparently the prosecutor had guessed the substance of Mary Ann Hunt's case because witness after witness for the defense affirmed that her illness resulted from suppressed menstruation. Although generally a kind and humane creature, the defendant's wildness during fits accompanying menstrual irregularity was apparently something quite unearthly. Unlike Surgeon McMurdo, who had to admit under questioning that he had but limited ex-

perience with women's afflictions, the medical witnesses presented by the defense were the senior surgeons at a lying-in institution. They described Mary Ann's violent episodes as hysterical fits in which the brain could not escape being affected: "I do not believe that a person would be able to distinguish what she was doing . . . during the fit." That opinion was reinforced by the second surgeon, who added that women suffering "obstruction of the menses . . . would not be capable of knowing what they are about and would not be answerable for it" (ibid., 678–81).

The testimony of these medical witnesses for the defense is noteworthy for two reasons. First, neither of them had treated the prisoner professionally or in confinement. Their familiarity with the effects of suppressed menstruation was gained through experience with the *general case,* not with her particular clinical symptom. As such, they were continuing the tradition set by earlier medical witnesses who asserted, "I have had many cases under my observation in which this form of insanity existed." The surgeons in Mary Ann Hunt's trial were in fact testifying about *other* women in similar menstrual difficulty. "I have known persons suffering from these fits, arising from the same cause, who have lost their reasoning powers for short periods while under the influence of the fit, and for a short period afterwards while the brain was recovering itself." It was within this context that one of the surgeons asserted that he did not believe a person in such a fit "would be able to distinguish what she was doing, or the circumstances surrounding her."

Another element key to the evolution of expert testimony bearing on insanity was also on view in this trial: the carefully crafted question asked of the medical witness: "I suppose in the course of your experience, your attention being particularly directed to diseases of women, you have met with innumerable cases of women suffering, more or less inconvenience from any obstruction of this kind?" The next medical witness built upon this public acknowledgment of professional experience by extending beyond mere description of the course of the illness to engage the legal question surrounding the malady: "I should say during the period of that excitement, they [i.e., the women so afflicted] would not be capable of knowing what they were doing, and would not be answerable for it." Rather than challenge in any way this bold assertion, the prosecuting attorney then asks the medical man the following: "If I understand you, assuming that the brain has been so far acted upon to induce mania, these are the consequences?" The surgeon answers, "Not in all cases, of course—I should think it very likely under excitement—these are the consequences that would very possibly follow."

At this point in the trial, the prosecutor—who normally would have ended his case before the defense case began—decided to call two further medical witnesses to comment upon—

and one suspects, to refute—the medical experts schooled in "women's difficulties." The defense attorney objected, averring that the "proper time has passed as the nature of the defense had been anticipated." The judge, however, ruled the testimony admissible, citing "the learned judges in [McNaughtan's case] expressly stating that after all the witnesses had been examined, and after all the facts had been stated, persons of skill might be called upon to give their opinion whether, assuming the facts deposed to be true, the accused was sane or insane at the time" (ibid., 681).

The next medical witness to appear informed the court that he had not interviewed the prisoner but was at the Old Bailey because "I received directions from the Government at ten o'clock this morning to attend here." Alexander John Sutherland, the son of a noted madhouse keeper, testified about fits brought on by defective menstruation, also engaging the legal question surrounding these sorts of mental infirmity. "I have known persons whose disposition has been naturally very mild and humane, to become almost ferocious when under these attacks—they are sometimes incapable of judging between right and wrong; but those sort of cases are usually accompanied with delusion . . . hysterical fits arising from imperfect menstruation [are] not calculated to affect the brain." When asked by the prosecuting attorney if he had ever heard of a case in which a woman "apparently in her senses" at two fixed points in time had been seized in the interval "with an attack which had deprived her of her intellectual power and caused her to commit a violent crime," the medical witness answered, "I never knew of such a case, nor have I ever read a case exactly parallel to it" (ibid., 681–82). Following this testimony, Mary Ann Hunt was convicted and sentenced to death. Several months later, the following note appears in the *OBSP:*

> Placed at the bar on Saturday and being asked whether she had anything to say in stay of execution, Mary Ann Hunt pleaded that she was pregnant. A jury of Matrons was accordingly summoned, who, after having retired and examined the prisoner, found she was not quick with child. The learned judge stated that the law must take its course. (*OBSP,* 1848, 6th sess. (no case #), 1088)

The trial of Mary Ann Hunt is illustrative of post-McNaughtan testimony that could invoke professional experience either to affirm or to deny the presence of insanity. In both cases, the medical witnesses commented on the implications of insanity for the legal question of knowing right from wrong, often in response to adroit legal questioning. It is noteworthy that none of the medical witnesses except the newly marginalized McMurdo had actually interviewed the prisoner. Of course, it was not unheard of for the defense to employ such witnesses—the

use of two surgeons at the lying-in hospital, for example—but it was most unusual for the government to subpoena a physician not in the regular employ of the court. But then, there *had* been a highly unorthodox bit of medical testimony given by the second surgeon at the hospital. When he suggested that a woman suffering obstructed menses "would not be answerable" for her actions, he was in effect diagnosing (ir)responsibility. Such testimony marked a departure from pre-McNaughtan testimony that centered on delusion, revealing a newfound readiness to engage directly the law's conception of culpability.

Arsenic and Old Scrofula

Few types of killing seem more diabolical, and appear more premeditated, than slow poisoning, with numerous opportunities afforded to reconsider the crime as the ravages of toxic death by degree become plainly obvious. When one adds to the mix the fact that the offender is but 12 years old and the victim is a beloved grandfather, one can hardly be surprised at the detail afforded such an atrocious crime by the *OBSP.* The trial of William Newton Allnutt provides historians of law and psychiatry with still further intriguing elements: the prison surgeon's admission that his expertise was limited in light of the growth in the specialty of mental medicine and the willingness of its practitioners to distinguish "derangement of conduct" from "confusion of intellect." The former was, in essence, moral insanity: a form of derangement supposedly restricted from use by the McNaughtan Rules.

The young poisoner's trial in 1848 began with his mother telling the court of her son's hearing voices that had preceded an earlier episode of larceny: "do it, do it, you will not be found out." After a medical witness testified about the evidence pointing to arsenic poisoning, the judge asked whether the boy's wakefulness was a sign of a disordered mind. The physician agreed, referring to the mother's testimony about her son's having heard voices. He suggested that two likely causes for both the voices and the sleeplessness were blows to the head Allnutt suffered as a young—or one should say, *younger,* child—and the scrofulous condition of his scalp. The next medical witness, Gilbert McMurdo, observed, probably to no one's surprise, "nothing about him which induces me to doubt his being of sound mind."

McMurdo's unassailable perch as surgeon of Newgate had placed him in close proximity to defendants coming to trial, giving him the advantage of daily observation and consequent familiarity with a variety of forms of derangement. Testifying in the trial of William Newton Allnutt, however, his work experience for the first time came up short: "You have not, I believe, particularly studied matters of this sort." McMurdo was forced to concede, "I have been obliged to do it, in connexion with this prison, but not

besides that—it has been made a branch of itself for many years." Despite his limited experience, he proceeds to contradict the earlier medical witness—"it is not within my experience that scrofula driven inwardly is liable to produce a certain character of insanity" and then disputes the writings of Forbes Winslow, a noted author and witness at the McNaughtan trial:

> ATTORNEY: Am I right in supposing that almost in every case of insanity, the moral faculties are the first to be implicated in the disorder? I am putting the question from Dr. Winslow's book, which I conclude is one of high authority.
>
> MCMURDO: I have read it, it is not of very great authority, but I should be sorry to detract from it—I should consider that in an infant the mind is rather a matter of feeling than of understanding—they understand from others that a thing is right or wrong and do not reason upon it.
>
> [McMurdo digresses here to comment on an earlier case, in which he had concurred with John Conolly, asylum superintendent and fellow expert witness]
>
> I consider Dr. Conolly a person of very high authority, my opinion is that the prisoner shows no indications of insanity whatever. (*OBSP,* 1847–48, 2d sess., case 290, 289)

The next medical witness to appear was the brother-in-law of the victim, who pointedly contradicted the prison surgeon, asserting:

> the irritation of ringworm might indeed have the effect of disturbing an already excited and disturbed mind, the nature and character of scrofula is calculated to affect the mind . . . [and] . . . when he was suffering from it, [it] would prevent him from distinguishing right from wrong. . . . I do not actually say that a boy who would murder his own grandfather must be insane . . . [but] when I saw him in prison, he spoke of a voice inducing him to do what he was charged with . . . I consider that to be a delusion. (Ibid., 291–92)

It was not the sway of delusion that marked a departure in this testimony but the images presented by the following doctor of medicine. When asked whether the boy's derangement had gone a sufficient length to injure the intellect so that he did not know that he was poisoning a person when he did it, the physician responded,

> He might know [the difference between right and wrong] as a principle of hearsay, but not as a controlling principle of his mind—I think he would understand that he was poisoning his grandfather, if explained to him, but at the time the sense of right and wrong was not acting with sufficient power to control him—I mean a morbid state of the moral feeling, of the sense of right and wrong—I think he knew what the act was that he was doing, but that he did not feel it is as being wrong—I am speaking of moral feeling. (Ibid., 293)

The medical witness not only succeeds in placing deranged moral sentiments at the center of the boy's insanity but also engages the legal standard of knowing right from wrong on an un-

expected plane. In this form of madness, the forces of self-control—represented by the knowledge of right and wrong—could not *restrain* the young boy's poisonous impulses. The principle of right and wrong simply failed to *inform* the boy's moral universe: the self-evident evil of his actions was lost to him. Such insight into character could only be gained by the "six or seven visits the prisoner paid me" and by "my knowledge of his constitution." With this level of familiarity, the opinion—"I do not believe him to have been in a sane state of mind at the time this occurred"—resonates with the possession of unique occupational experience. Lacking such acquaintance, lay witnesses were likely to have been confused by the illogical nature of the crime; there was, after all, no apparent motive, no hesitation, no sensible reason for the outrageous act. These were, in short, the very *unreasonable* features one also found in Edward Oxford's crime, features that revealed the defining elements of moral insanity to the medical witnesses.

And, as in the case of Queen Victoria's admirer, albeit would-be assassin, Allnutt's was a derangement in moral sensibility, not intellectual coherence. Madhouse keeper (and witness at the Oxford trial) John Conolly was again on hand to make the case for this particular species of madness:

> I am physician to Hanwell Lunatic Asylum, and have for some years applied my mind exclusively to these matters. I have visited this boy in prison, and have heard [the courtroom evidence regarding wakefulness, scrofula, his "shrieking out at night in his sleep"]; the opinion I have formed is, that his is imperfectly organized; and taking the word "mind" in the sense in which it is used by all writers, I should say he is of unsound mind. . . . [his] is not a healthy brain . . . that the future character of his insanity would be more in the derangement of his conduct than in the confusion of his intellect. (Ibid., 293–94)

What finally distinguished lay from expert evidence in this trial was not the proffered cause of insanity or indeed the behavioral consequence of ringworm. A police officer had earlier offered dramatic testimony of the boy's reported voices urging him on, and a next-door neighbor had read to the court a letter written by Allnutt replete with religious delusions and visions. For all the descriptive detail, neither of these lay witnesses could account for the boy's senseless attack on his own grandfather. Some force impelled the young boy's conduct, but the source of that impelling power was not to be found in his intellect. Indeed, the medical witness who ventured the furthest in describing Allnutt's insanity as a derangement in moral feeling freely acknowledged that the defendant knew he was poisoning his grandfather. And yet, asserted the physician, this knowledge was insufficient to restrain him. Such allusion to human agency—or rather to the *lack* of human agency—was the medical witness's

alone. This sort of *moral* derangement was a terribly difficult concept for the court to respond to. Unlike evidence that turned on physical defect or disease, which necessarily compelled medical witnesses to explain the precise consequences of brain concussion or the supposed relation between "women's problems" and sudden physical violence, the court had only one way to respond to the proffering of moral insanity: "Was the prisoner capable of distinguishing right from wrong?"

"Under any circumstances . . . not a Gentleman"

At first notice, it must have seemed a tall order to try to convince a jury that an arsonist was not aware of his crime when, caught at the scene, he refused to answer a policeman's question, asserting that he must decline because he himself was a suspect. James Huggins was apparently *very* aware of the criminal law, cautioning the officer that he lacked the authority to take him into custody: a summons or a warrant from the Lord Mayor would be required. If the trial of the juvenile poisoner served as the occasion for medical men to address the failure of "knowing right from wrong" to necessarily constrain behavior, the prosecution of arsonist James Huggins would witness the medical man's wholesale (and derisive) rejection of this legal standard altogether.

According to his neighbors and relatives, the life of James Huggins was replete with sudden outbursts of violence that, although having nothing to do with the arson, suggested a tenuous hold at best on mental stability. "He would throw his papers down, burst into tears, and rush from the table." In time these sudden outbursts turned violent, "I heard him beating his wife . . . it has left bruises, for which she has been confined to her bed four days—I have seen him throw chairs and knives at her—when he was treating her in that way, he would tremble, his eyes would bolt as if they would leave their sockets, and he would growl like a savage dog." No cause was suggested for these outbursts, although one servant noticed their concurrence "every month for three or four days, when he would be in a violent temper, and then would be very calm again." She had apparently suggested to the defendant's wife that "it was at the change of the moon that he conducted himself that way" (*OBSP,* 1850–51, 9th sess., case 1502, 362–66).

Medical testimony began with Mrs. Huggins's physician commenting on the defendant's bizarre behavior: "[I] should refer them to the conduct of an insane person decidedly." The following interchange ensued:

> Prosecuting attorney: Are you a licensed keeper of any asylum?
> Dr. Sawyer: No. I have no doubt that at times the prisoner did not know right from wrong. . . . I should say he did not know right from wrong

when he was thinking of committing suicide—his having congested liver, would produce irritation of the brain—I am not capable of judging whether he knew right from wrong when he said to the policeman "I am a suspected person, and I won't answer questions."

ATTORNEY: Should you attribute such an expression as that, in such a man as the prisoner, to a desire to escape from responsibility of a discussion, or that he was not in his senses?

DR. SAWYER: I believe at the time he did not know right from wrong—I believe he was temporarily mad.

JUDGE: Having entertained an idea of committing suicide, and not doing it, what effect do you give to that circumstance as to his distinguishing right from wrong.

DR. SAWYER: These questions are very difficult to solve—I think that a difficult question." (Ibid., 366–68)

Dr. Sawyer's ineffectual testimony helps to illustrate the peril a general practitioner might face when he dared to declare the presence of "insanity, decidedly." He is immediately asked if his professional experience includes asylum management and then is pressed repeatedly on his grounds for inferring that the prisoner could not distinguish right from wrong. Listening in court to this sorry display of medical speculation was the next witness, John Conolly, who began his testimony with the clear and unequivocal evocation of professional grounding:

> I am a physician at the Asylum at Hanwell. For the last 12 years I have been entirely devoted to the subject of diseases of the mind—at the desire of the prisoner's family, I have had interviews with him since he has been in prison—after a great deal of conversation with him, I am, as a physician, of opinion that his mind is not perfectly sound, that his judgment is impaired.

In the tradition of defense counsel carefully crafting questions of medical witnesses, the following query is given to Dr. Conolly

ATTORNEY: Suppose a person to have lived upon terms of the greatest affection with a woman for seven years, and then suddenly to change his conduct, and to treat her as the object of his most determined dislike, and to ill-use her, without any apparent reason; to what, in the absence of an explanation, would you refer such a change?

CONOLLY: It is one of the most frequent of the symptoms of insanity. . .

With this, the prosecuting attorney attempts to discredit Conolly's previous declaration of "impaired judgment":

ATTORNEY: On the subject of impaired mind, I suppose any false judgment, or wrong reasoning is what you would call almost an impaired mind?

CONOLLY: I do not say that any person committing a crime is impaired . . . if a man, who appeared to be fond of his wife for many years, beat her frequently and violently, I should strongly suspect that he was mad—I should not consider a man quite sound that beat his wife, under any circumstances, not a *gentleman.*

But it was at the point of asking whether he believed Huggins could distinguish right from wrong that Conolly engaged directly the law's most fundamental question. "I feel this to be so important, this question is so often asked, and medical men think so

much depends upon it, that, perhaps you will permit me to say . . . that we medical men do not consider that a question of distinction at all—I should question the power of a mind in the state in which the prisoner's has been, to appreciate right from wrong." The following interchange ensued:

ATTORNEY: You can perfectly understand my question, because as you say, it is one that is so often put to you: do you mean that at the time he was beating his wife, or any of the period that you have spoken to, he could not distinguish right from wrong?

CONOLLY: I am perfectly aware that is the question.

JUDGE: If that is the question, it can surely be answered.

CONOLLY: I do not think it can absolutely be answered: I think it can only be answered in the manner in which I have answered it.

ATTORNEY: You can give me your opinion and I must trouble you for it: in your opinion, could he distinguish right from wrong?

CONOLLY: Well, sir, I do not understand rightly that question—if you mean positively absolutely, on every subject, I cannot answer you—I could not say that he was unable to distinguish right from wrong, but I say that his power of appreciating it is impaired—his power of reasoning accurately is impaired, the power of controlling or resisting a train of thought tending to criminal action [is impaired].

JUDGE: How do you apply that?

CONOLLY: I think in many morbid states of mind, the patient is in that condition that ideas will present themselves in his mind having a tendency to crime, which he has not an equal and constant power of resisting. (Ibid., 368–69)

Conolly is followed to the witness box by Sir Alexander Morison, Physician to Bethlem Hospital, lecturer on insanity, prolific author, and a witness at McNaughtan's trial.

MORISON: I am physician, to Bethlehem Hospital. My attention has been directed for a great many years to persons of unsound mind—I have had the management, and charge of the lunatics at Bethlehem Hospital for about seventeen years. . . . I have not had an interview with the prisoner—I have heard the whole of the evidence which has been given in Court to-day on the part of the prosecution and defense. . . . I think he was of unsound mind at the time this act is said to have been committed.

JUDGE: Of unsound mind in all respects; incapable of distinguishing between right and wrong?

MORISON: I do not mean that—I am not here to decide the question of responsibility in an insane person, and therefore I cannot go to the length of answering what lawyers frequently ask, is he capable of distinguishing right from wrong. I mean to state his brain is in a disordered state, but I cannot define the degree of responsibility and consciousness which he possesses.

Morison speaks directly to a derangement of the moral sentiments, specifically naming lesion of the will as the form of moral insanity that the defendant's condition clearly approximates. "He was not equally sensible of the distinction [between right and wrong] as a sane person would be." This response prompted the final question of cross-examination,

> Suppose you were to take into consideration a deliberate preparation for 18 months to commit an offense . . . and then an avoidance of answering questions from fear he should get into difficulty by saying that being a suspected person he would not answer any, would that be indicative of a sound or unsound mind, that is of a person knowing right from wrong.

Morison concludes his testimony with the following:

> His saying he would not answer any question is not anything at all—it very often happens that in committing crime, an insane person is quite sensible he is doing wrong. . . . I will not undertake to say on oath that he did not [know right from wrong], I will undertake to say that he was in a diseased state when he did it, that his power of preventing crime was impaired, and that he did not possess that degree of consciousness and responsibility. (Ibid., 369–71)

Thus did Alexander Morison come full circle. The witness who began his testimony with the unambiguous statement that he was not in court "to decide the question of responsibility of an insane person" ended by employing lesion of the will and its associated imagery of an impaired power to resist ideas when he declared that Huggins did not possess "that degree of consciousness and responsibility." Morison's ease in engaging questions of culpability continues the theme sounded in the first trial, when the medical witness asserted that women in such menstrual fits "would not be answerable" for their conduct. Such opinion was rather something more than tracing the course of a disease or speculating on its behavioral consequences. It was instead the basis for the legal community's greatest uneasiness about expert witnesses: the elision of the role of expert witness with that of juror.

Perhaps it was the "ultimate diagnosis" character of such testimony that prompted the first judge to be confronted with "lesion of the will" to question the implications of testimony treating volition as a medical matter, especially in the area of criminal responsibility. Dr. Hodgkin's testimony at the trial of Edward Oxford elicited the following:

> JUDGE: What is the limit of responsibility a medical man would draw?
> HODGKIN: That is a very difficult point—it is scarcely a medical question—I should not be able to draw the line where soundness ends and unsoundness begins—it is very difficult to draw the line between eccentricity and insanity. (*OBSP,* 1840, 9th sess., case 1877, 505)

The stark difference between the testimony of Hodgkin in 1840 and of Conolly, Morison, and other physicians glimpsed in these post-McNaughtan trials is that such courtroom diffidence was fast disappearing. Whether it was work-related experience that had emboldened them or a variant of the same zeal that animated their professional odyssey from custodians of the mad to "clinicians" of the deranged, the first generation of asylum superintendents—not simply *madhouse keepers*—did not shrink from en-

gaging directly the legal stricture of knowing right from wrong, and occasionally insisting on rephrasing the questions they would choose to answer. The nonspecialist—whether jail surgeon or general physician—could expect to hear his opinion contextualized in cross-examination that underscored his limited experience with the mad—or with "female problems," for that matter. As mental medicine was becoming, in McMurdo's own words, "a branch [of medicine] of itself," the expert's opinion was beginning to separate not only from the layperson's but from the general practitioner's as well.

Asserting a Privileged Gaze

Although there were numerous points of congruence shared by lay and medical testimony—attributing madness to physical causes, reciting tales of sudden outbursts, describing fits of delirium—the *facts* of the neighbor and the *opinion* of the physician grew increasingly distinguishable in one telling aspect: direct acquaintance with the accused. Neighbors, lovers, and co-workers reported their perceptions to the court: the *facts* of the accused's behavior, conversation, and appearance. These were, of necessity, first-hand experiences that revealed the products of sensory perception, not judgments about the necessary effect of the disturbance on the afflicted's behavior. Although the medical witness had initially shared similar direct involvement with the defendant, by the midpoint of the 19th century, he was just as likely to have had no previous acquaintance with the defendant. Indeed, he may not even have interviewed the prisoner prior to the trial. Few details separated the two types of witnesses more fundamentally than this.[25] That the medical man could deliver an opinion with no more first-hand acquaintance with the prisoner than any court bystander underscored the supposed possession of a very particular sort of knowledge: how mad *people* thought and behaved as a class. Although folk wisdom may have also embraced a certain belief in the legibility of madness, the distinguishing feature of medical testimony was to challenge directly the intelligibility of both purportedly sane *and* insane behavior. It was by drawing attention to the surface impression of normalcy that medical witnesses carved out their professional niche, both by disparaging the layperson's observation and by questioning

[25] Although medical witnesses were becoming more likely not to have had first-hand familiarity with the defendant, Allnutt's trial revealed that this was not always the case. It seems that forensic-psychiatric witnesses could assert their professional credentials either way: through sustained familiarity with a class of distracted persons, making direct acquaintance with the defendant not essential, or through sustained *treatment* of the patient cum defendant, giving insight beyond that of the lay observer.

the law's view that *apparently* purposeful behavior was necessarily intentional.[26]

The three post-McNaughtan trials reviewed here illustrate a further trend in questioning conventional interpretations of madness: the self-evident *meaning* of behavior. In terms of Learned Hand's delineation of the two types of courtroom testimony, medical evidence sought to transport the seemingly transparent "facts" of the layperson's gaze into the "fair range of dispute." Although William Allnutt may have appeared to comprehend the *principle* of right and wrong, such comprehension failed to inform his moral universe and thus constrain his behavior. The attorney's question, "Do you consider when he did this that he did not know that poisoning his grandfather was a wrong act?" clearly resonated with contemporary common sense: such an act, indeed, such repeated acts, had to strike the young boy as grossly wrong. And yet it was the necessary impact of such awareness on behavior that the medical witness raised as a compelling question. No longer restricted to confused intellect, insanity might instead be a matter of deranged conduct (only). Similarly, the self-evident "fact" of the arsonist's refusal to answer the policeman's on-scene questions did not at all reveal to Alexander Morison "a person knowing right from wrong." Such a supposition, according to the asylum physician, was "not anything at all." Knowledge of the difference between right and wrong as an abstraction was of little consequence when, on the day of the crime, the accused's "brain was disordered in such a degree as to take away his perfect knowledge of right and wrong." In such a "diseased state . . . his power of preventing crime was impaired," and thus he "did not possess that degree of consciousness and responsibility." Nor was there anything self-evident in Mary Ann Hunt's efforts to evade discovery by the authorities. At her trial, the medical specialist explained to the court that, when in the throes of a fit brought on by suppressed menses, such women "would not be capable of knowing what they were doing, and would not be answerable for it."

The fact that not all medical witnesses in Hunt's trial found her insane raises an intriguing question for her trial and for the inclusion of expert opinion in general. At one level, the difference in medical opinion is not difficult to explain: Court-appointed medical men found her sane, "defense" physicians ascribed her behavior unambiguously to insanity stemming from

[26] Carving out a professional niche did not automatically translate into ensuring an acquittal for the defendant. Both the juvenile poisoner and the arsonist were eventually convicted. Although it is doubtless hazardous to speculate on the reasons for a verdict in any one case, the jury in the former case may have found the heinousness of the killing simply beyond the pale—regardless of the medical testimony—and the arsonist so clearly displayed familiarity with the law in advising the arresting officer of criminal procedure that notions of "moral insanity" simply failed to persuade the court that his moral compass was spinning out of control.

suppressed menses. But one sees in her trial, and in that of the young poisoner as well, the nascent signs of a "relevant scientific community," so strategically important to the credentialing of expertise. It is the general acceptance of a discovery or a principle by such a community that would come to define the standard for the admission of expert opinion in the courtroom.[27] English courts at the time of Mary Ann Hunt's trial had no such criterion, indeed the preceding quote by Learned Hand suggests that the separation of fact from opinion was simply one of disputed facts: Opinion was needed when the layperson's observations were in contention. And yet one can see in these trials the proffered refinement of medical practice into subspecialties that would perform their own gate-keeping functions. In Hunt's trial, the prison surgeon is forced to acknowledge the limits of his expertise with "women's problems." In the Allnutt case, the same witness avers that mental medicine had become "a branch of itself for many years." And when general practitioner Sawyer opines that Huggins conducted himself "as an insane person decidedly," he is met with the question: "Are you a licensed keeper of any asylum?"

Still, it is one thing to separate lay from medical witnesses for the purpose of distinguishing fact from opinion or to separate general practitioner from mad-doctor for the sake of elevating specialist opinion, and quite another to suggest that specialists in mental medicine constituted a *community* capable of articulating "general acceptance" of any particular principle in mental medicine. One could well argue that at the time of these trials, the most contentious issue among practitioners of mental medicine was precisely the subject of Conolly's testimony: the existence of an insanity confined to moral sentiments. One certainly finds no general acceptance within medical circles that a form of insanity could exist devoid of cognitive defect, a point forcefully made by the editors of the *British and Foreign Medical Review* (1843:82). In every case of true insanity, they wrote, "some latent disorder of the intellectual powers" had to obtain. Such dissension was not confined to the pages of professional literature. In the Huggins trial, Surgeon McMurdo contemptuously dismissed the work of well-known author Forbes Winslow, "siding" instead with John Conolly. Doubtless differences of opinion exist within any scientific field. Indeed, the years that witnessed the rapid rise of medical witnesses in court saw a host of "schools" of medical psychology, each seeking to explain the origin of madness. Traditionally, though, consensus affirmed that some confusion, some delirious condition lay behind the in-

[27] *Frye v. United States* (1923) represented the first judicial recognition of the need to specify the rules for including scientific evidence. A novel scientific principle or discovery, if it is to be admitted to the court, "must be sufficiently established to have gained general acceptance in the particular field in which it belongs."

sanity. The Pinel circle—whose ideas one finds in the testimony of Conolly and Prichard—represented a qualitative break with such conviction. If the mid-19th-century judge had approached the question of whether to admit a Conolly or a Winslow through a "general acceptance" standard—admittedly an anachronistic hypothesis—he could easily have found a well-experienced asylum doctor to dispute the idea of an insanity limited to derangement of the passions. In fact, the judges appear to have been comfortable probing questions of *relevance* for themselves, asking of expert witnesses whether moral insanity was "really a medical question at all."[28]

Assessing the *reliability* of the asylum physician's diagnosis was only addressed elliptically and with no prompting by the judge. One hears in medical testimony not the consistency of agreement among practitioners but the consistency of observation among visits: the opportunity that sustained familiarity afforded for detecting counterfeited madness, or for "compar[ing] like and dissimilar cases." The professed capacity to "pierce the smoke screen of sanity" and to avoid the layperson's perceptual error was at once a claim to reliability and a distancing from the neighbor's perception. If the essence of expert opinion is that not all "facts" are self-evident, the task of the first generation of forensic-psychiatrists was clearly to decenter the layperson's faith in what he saw and heard. Given the long tradition of employing lay witnesses in English insanity trials, this must have seemed a daunting task.

But not an impossible one. Medical men concentrating their interest on the minds of the mad were not the only courtroom participants interested in fashioning expertise out of their experience. Defense attorneys engaged asylum doctors and superintendents to visit the accused awaiting trial; the Lord Mayor employed jail surgeon McMurdo (and madhouse keepers such as John Sutherland) to observe prisoners endeavoring, one suspects, to catch them unaware. Indeed, given the regular employment of McMurdo and his successors from the 1830s to the 1850s, one would be hard put to construct a chronology of exactly whose appearance precipitated whose. Families procured the services of an asylum superintendent to counter the testimony of the prison surgeon, whose services had been enlisted by the Lord Mayor, suspicious that the prisoner might have been contemplating an insanity plea since he had once been under the care of a general physician. In Mary Ann Hunt's trial, after

[28] There is a certain modern sensibility evinced by these judges that resonates with the post-*Frye* attitude toward expert opinion found in *Daubert v. Merrell Dow Pharmaceuticals*. This 1993 Supreme Court decision affirmed that the "general acceptance" standard based on *Frye* had indeed been superseded by the Federal Rules of Evidence, which gave judges a more liberal hand in determining the relevance and reliability of scientific opinion.

all, there were no fewer than three *rounds* of medical testimony. Whatever the sequence of events, it is clear from the *OBSP* that medical evidence was not simply offered by ambitious doctors: it was actively sought and subpoenaed. Mental medicine's evidence was fast becoming a key element in both an activist defense strategy and a proactive prosecution.

That said, the newest of courtroom expert witnesses were not merely propelled into court by external factors. Narratives of their testimony reveal that they were hardly "hostile" witnesses, but rather willing and active participants in these highly charged courtroom dramas. They continued the effort to distinguish their testimony from the layperson's by concentrating on the moral consequences of physical pathology and by explicit reference to professional experiences that so clearly set their observations apart. Increasingly in the post-McNaughtan years, they engaged legal questions directly—another departure from lay evidence—even to the point of pronouncing defendants "unanswerable" for their actions. That the courts would eventually grow uneasy about the influence such medical specialists might exercise over the jury is ironic, since it was the law in the form of ambitious attorneys that was responsible for the enhanced medical presence in the first place. Once the door was opened to expert testimony bearing on madness, one could neither anticipate nor limit which topics—the nature of criminal responsibility, for example—might be explicitly drawn into the "fair range of dispute."

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