Sense and sensibility: fateful splitting in the Victorian insanity trial

Joel Peter Eigen

Sometime before Sunday dinner on 22 October 1848, 12-year-old William Newton Allnutt added arsenic to the family sugar bowl. There could have been no mistake about his intended victim: only the boy's grandfather was in the habit of sprinkling sugar on his after-dinner fruit, and this Sunday was no exception. Recovering from this first attempt on his life, the victim attended church accompanied by his murderous grandson, but he would not survive a second poisoning. Allnutt's eventual trial and conviction in London's central criminal court, the Old Bailey, took place five years after the celebrated 1843 insanity acquittal of Daniel McNaughtan.¹ Unlike the famous would-be assassin of Robert Peel, however, the young poisoner did not have nine prominent medical practitioners and authors to explain his mental state to the jury. William Newton Allnutt's three medical witnesses included only a family physician, a relative who happened to be a doctor, and a mad-house superintendent who had never actually met him.

Although Allnutt and his trial have received nowhere near the attention accorded to McNaughtan, the testimony medical witnesses offered on the 12-year-old's behalf affords today's legal historian an invaluable glimpse into courtroom dynamics that shaped the assertion of expert medical opinion in the mid-Victorian insanity trial. Forensic-psychiatric opinion was hardly a novel occurrence to the English courtroom; at the time of the Allnutt trial, mad-doctors had been appearing in English courts for almost one hundred years.² The simple fact of participation, however, tells one little of the substance of early forensic-psychiatric testimony, and in the case of the juvenile poisoner, may easily obscure the qualitative shift that such opinion would take. William Newton Allnutt's trial would be no ordinary Victorian insanity case; jurors would not hear testimony about delusion or delirium *leading* the young boy to his murderous deed. Instead, medical men would use the occasion to introduce into the English courtroom a 'species' of derangement that had nothing to do with confusion, incoherence, or insensibility. In their testimony, they would

proceed to place Allnutt among an emerging population of mid-Victorian defendants whose mental process was split between the functions of understanding and feeling: between the resources of *sense* and *sensibility*.

I Fact or opinion

The unique province claimed by medical witnesses in this, and other nineteenth-century trials, rested initially on the question of mental derangement's status as a fact – no different from other facts entered into evidence. Traditionally, English law considered facts to be direct sensory products: what neighbours saw, heard, or smelled. Neither judgement nor inference was thought to be required. Facts were conceived to be unproblematic reports of on-scene impressions.³ This was, after all, the reason that witnesses were called into court to begin with: to inform the jury of the physical circumstances surrounding the offence. By considering such observations, the jury drew its own inferences regarding the sequence of reported events, the probable identity of the perpetrator, and the consequent criminal liability, if any.

Not all observations were free from ambiguity, however, and not all testimony was free from equivocation. As early as 1311 one finds the appearance of specialist witnesses, called to the court to draw their own inferences regarding ambiguous observations. Saddled with the unfortunate name of 'expert witnesses', these persons were thought to possess knowledge beyond the ken of the ordinary lay person.⁴ Because their job description ran perilously close to that of the jurors' in that they also drew inferences and rendered opinions, the use of expert witnesses has historically provoked disquiet among members of the legal community who feared that the expert would eventually usurp the lay juror's role. Although usually voiced in contemporary legal texts, this sentiment could also be expressed in open court. In his instructions to a jury at the Old Bailey in 1877, Mr Justice Lash addressed the prosecution counsel's objection to a medical witness giving his opinion regarding the mental state of the accused at the time of the crime. '[T]his was the form of question often put and objected to, and it was in reality not a question of medical science, but was the question which the Jury alone could properly decide.'⁵

Were these fears justified? It is difficult to say how much importance lay people attached, or indeed currently attach, to the opinions of an expert witness. In any criminal trial there are likely to be contradictory or disputed observations reported by on-scene witnesses, and sometimes persons of particular training have been deemed necessary to assist the lay juror in determining the facts of a crime. One has little way of knowing, however, how readily the lay juror relinquished *his* role as fact finder. Certainly there are some situations when lay persons would welcome the testimony of a physician to explain, for example, whether a head wound could have resulted from a fall or from the blow of a blunt instrument. Or why some wounds bled, while others remained dry. Or how a drowned man could have been found with no water in his lungs.

There was one medical condition, however, that even when grounded in physical, and hence ‘specialist’, knowledge encountered a dubious lay public when proffered as a *scientific* specialty. English juries had been considering the possibility that debilitating mental states were responsible for some defendants’ criminal behaviour for at least two hundred and fifty years *before* the first medical witness walked into a trial to comment on the defining characteristics of insanity. Appearing in the House of Lords in 1760, physician superintendent of Bethlem John Monro testified that Earl Ferrers suffered from ‘occasional insanity’, only to hear the Lords unanimously reject the legal significance of a defence based on a *partial* degree of derangement. Ferrers’s conviction for murder underscored eighteenth-century law’s dismissal of any state but total madness – a total want of memory or understanding – as the grounds for an insanity acquittal.⁶

The standard of complete and total insanity had necessarily restricted the scope of forensic-psychiatric opinion, since raving madness was hardly an ambiguous skull fracture or a mysterious bloodless-wound. Eighteenth-century madness, in Roy Porter’s words, was ‘spectacularly on view . . . few doubted nature’s legibility’.⁷ When medical witnesses appeared late into the 1700s – and infrequently, at that – they did little more than legitimise the testimony of the neighbour, the lover, or the co-worker who was, after all, in a much better position to comment on the verbal pandemonium and behavioural histrionics of the accused. There was certainly no animus between the medical practitioner and the jurist in the early years of forensic psychiatry for the most understandable of reasons. Mad-doctors were only offering *facts* to the court: the appearance of insanity, the incoherence of delirious ranting, the seemingly legible signs conveyed by the expression, ‘[he behaved] like a mad bullock’. These reports could have been supplied by the defendant’s neighbours, and indeed usually were. Most often it was, in fact, the neighbour’s vivid depiction that was merely affirmed by the medical men who then advised the jury, ‘I have looked upon him as a man insane.’⁸

Fact or opinion? In the eighteenth-century context, insanity was most definitely a ‘fact’.

II *Opinion and dispute*

The emergence of medical testimony *as opinion* can be timed to the dissolution of total madness as the grounds for an insanity acquittal. Beginning in 1800, medical witnesses employed terms for certain states of mind – delusion, monomania, circumscribed delirium – that depicted insanity in cognitive, not restrictively behavioural, terms. Delusion appears, in retrospect, to have been the first forensic-psychiatric concept: hidden from public view, resisting exposure to any but the most adroit medical excavator, and, finally, impelling in its power.⁹ It was the last element that gave early nineteenth-century insanity its critical courtroom significance, since criminal responsibility had long

rested on the individual's capacity to choose evil. Only someone who understood the nature and consequences of his actions had been thought to exercise will. This is precisely why delusion had potential consequences for the law: sensations filtered through a delusory lens left the sufferer in such a confused state of misperception that he could not be said to have *chosen* to do evil.

At the level of misperception and error, delusion was an unexceptionable term. Lay persons were certainly well familiar with the ravages of religious delusions and persecution paranoia. Where medical testimony began to diverge from lay belief was in the clinician's pronouncing the *consequences* of delusion for vanquishing human agency. In the *McNaughtan* trial, for example, the jury heard from medical witnesses of the power exerted by the Scotsman's delusion: 'I mean that black spot on his mind . . . the commission of the act is placed beyond his moral control.' Subsequent medical testimony depicted *McNaughtan*'s delusion as one that 'grinds' on his mind . . . 'impels . . . destroys moral liberty . . . carr[ies] a man quite away'.¹⁰

Although delusion may have appeared to challenge fundamentally the law's notion of human agency, it was far less provocative to the court than the diagnosis of *moral insanity*, which had been introduced into the court three years before *McNaughtan*. One who suffered from this particular derangement suffered no errors in judgement, no confusion, no delirium. It was rather the 'moral sentiments' that were deranged – how one ought to feel towards others, not what one *believed* about others. Medical witnesses alleged that criminal activity so motivated was no more *chosen* than the acts of the delusional, thereby calling attention to the critical element of voluntariness, again said to be missing. Moral insanity had made its conspicuous courtroom debut in medical testimony during the trial of Edward Oxford, prosecuted in 1840 for an unmotivated, unprovoked, indeed seemingly *indifferent* attack on Queen Victoria. As Oxford informed one of the medical witnesses who visited him prior to the trial, 'Oh, I might as well shoot at her as any body else'.¹¹

For present purposes, moral insanity marked the first true migration of insanity from neighbour's fact to medical witness's opinion. Lay people were well familiar with hidden delusion – with an insanity limited to a particular subject – activated only when a 'trip-wire' was pulled. Medical witnesses may have distinguished themselves in their speculation regarding the implications of delusion for choice and self-control, but they were hardly sketching out a departure in cultural notions about derangement. Oxford's insanity was something altogether different, and its existence as a medical phenomenon was restricted to the testimony of the medical expert. A crime motivated by no discernible motive and offering the perpetrator little chance of escape was only possible if one were to accept the possibility of independently deranged moral sensibilities. The judge in the *Oxford* trial clearly took exception to the very term 'moral insanity', and asked the following question to discredit the cloaking of inexplicable criminality with explicable medical imagery: 'Do you consider this is really a medical question at all which has been put to you?'

The medical witness replied, 'I do – I think medical men have more means of forming an opinion on that subject than other persons.'¹²

In answer to the judge's further query, 'Why could not any person form an opinion whether a person was sane or insane from the circumstances which have been referred to,' the medical witness answered, 'Because it seems to require a careful comparison of particular cases, more likely to be looked to by medical men, who are especially experienced in cases of unsoundness of mind.'¹³ This unselfconscious avowal of professional insight met no courtroom opposition. The jury, for its part, had little trouble applying the proffered concept of deranged moral sentiments to the would-be assassin's actions. The verdict in the *Oxford* case not only introduced moral insanity as possible grounds for acquittal, but appeared to bolster medical claims to an expertise that rested on a greater familiarity with the deranged than the lay person's.

The years following the *McNaughtan* acquittal witnessed just such 'particular cases' making their way into the Old Bailey in the form of defendants alleging an array of ever-expanding aberrant mental states. Accounts of these trials are given in the *Old Bailey Sessions Papers*, verbatim transcripts of trial testimony taken down by shorthand writers and sold on the London streets the next day.¹⁴ These *Papers* remain intact, and provide today's legal historian with contemporary courtroom testimony, cross-examination, and, in a few instances, the judge's charge to the jury. An analysis of courtroom testimony and jury verdicts over a period of ten years following the *McNaughtan* trial yields a total of ninety defendants in London's central criminal court who raised some form of mental debility in their trial.

Although certain of these states of distraction closely resembled the eighteenth-century courtroom's experience with delirium and insensibility, post-*McNaughtan* medical witnesses described behavioural states that challenged for the first time the law's assumption that individuals were *continuous* persons. Since at least the thirteenth century, the English common law had assumed that knowledge of right and wrong informed criminal intent: understanding the evil of one's acts conferred responsibility for one's subsequent actions. The common law's psychology rested on the notion that individuals were relatively continuous beings: associations learned and remembered constituted one's moral sounding board when considering future behaviour. But how was the law to respond to a defendant who was 'not himself' on the day of the crime? The fact that the accused individual *customarily* understood the difference between right and wrong was of little significance unless he could remember these lessons and realise that he was the person committing the action. Courtroom testimony alleging that 'he seemed to know no more about it, any more than it was done by another person', challenged the jury to determine *who* exactly had committed the crime. Seen against the backdrop of a defendant population increasingly 'missing' at the time of their crimes, the concept of moral insanity represents much more than a momentary courtroom diversion on the way to the *McNaughtan* Rules.¹⁵ It signalled the beginning

of medical testimony that would question whether intellect, cognition, and will were integrated in any meaningful way.

Post-*McNaughtan* defendants who suffered bouts of amnesia, who committed an assault while sleepwalking or experienced states of 'absence' when attacking a neighbour, or who 'disappeared' on the witness stand only to be replaced by a ranting, delirious 'double', exposed the limited utility of 'knowing right from wrong' as the standard for assessing degrees of derangement in relation to criminal responsibility. In each of the above instances, no long-standing pathology preceded the crime; no state of delirium or even delusion 'led' the accused to the crime. Rather, these defendants revealed lapses in consciousness that suggested they were 'missing' at the time of the crime. In some unaccounted-for way, these defendants were described as more bystander to than perpetrator of their own crimes.

Consideration of such states of dissociation was not unique to the courtroom. Popular entertainments demonstrating hypnotic and mesmeric trances, literary explorations of sleepwalking, and medical commentary documenting cases of 'doubled personality',¹⁶ ensured that jurors were well familiar with the possibility of multiple planes of consciousness. After *McNaughtan*, the Old Bailey became merely the latest arena to feature *doubles*: individuals whose psyche split into several persons. But this was a forum with a difference. Literary and medical consideration of the phenomenon of splitting need only serve the genre of fiction or the medical case history: no abiding legal exigency intruded upon the analyst's formulation. The courtroom existed to determine culpability, however, not to explore human variability as a curiosity. As with the centuries-long experience with insanity, the assertion of an exaggerated medical condition *began* the inquiry, it did not end it. When the *Allnutt* jurors learned, therefore, that the juvenile poisoner suffered a 'split' in psychic integrity – that his knowledge of right and wrong need not necessarily have informed his choice of action – they had to ask what practical significance this carried for their determination of responsibility. Medical witnesses may have suggested that the youth's faculties of cognition and volition had belonged to two different people, but the judge was on hand to remind the jurors that only one defendant was facing them in the witness box.

III *Splitting the defendant*

For all the attention Victorian medical men paid to questions of 'splitting', sleepwalking, and mesmeric trances, it would be an error to assume that forensic-psychiatric witnesses were unanimously arrayed on the side of the defendant. Prison surgeon Gilbert McMurdo rarely supported a defence of insanity in any of the twenty insanity trials in which he testified, and he failed to find sufficient grounds to affirm such a plea in the trial of *Allnutt*.¹⁷ In the employ of the Corporation of London to visit prisoners thought to be contemplating an insanity plea, McMurdo informed the *Allnutt* jury as follows:

'I have not observed anything about him which induces me to doubt his being of sound mind – the evidence to-day does not alter my opinion of his sanity.' McMurdo was then asked a highly unusual question, the first time in his career that he was queried about the grounds for his opinion:

(Cross-examination): You have not, I believe, particularly studied matters of this sort?

Mr McMurdo: 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, there are many distinctions and forms which insanity takes, not at all apparent to ordinary observers.¹⁸

This was a terribly important question because it effectively grouped McMurdo with neighbours and acquaintances who also commented on their conversations with, and observations of, the accused. The defence lawyer's question implicitly limited the weight of McMurdo's testimony because the prison surgeon could base his *opinion* on nothing more than common cultural understandings used by 'ordinary' observers. He had only the *fact* of a conversation to give the jury, not an opinion informed by schooling in this particular branch of medicine.

But of what, exactly, did this 'branch' of medicine consist? When medical witnesses commented on a *lesion of the will* or *brain fever*, was there in fact a branch of physical medicine to which they could refer? Or was insanity purely a mental disease, consisting of a derangement of the moral sensibilities? The first medical witness called by the defence immediately rooted the defendant's derangement in his chronic scrofula – establishing a critical link between physical illness and its mental consequence.

[T]he irritation of ring-worm might have the effect of disturbing an already . . . disturbed mind. The nature and character of scrofula is calculated to affect the mind. . . . When he was suffering from [partial insanity] it would prevent him distinguishing right from wrong . . . when I saw him in prison, he spoke of a voice inducing him to do what he is charged with . . . I consider that to be a delusion . . . the brain was certainly in a diseased state . . . [and] . . . as a medical man . . . I have no hesitation in saying so.¹⁹

So testified the victim's brother-in-law, disclosing no obvious *animus* towards his nephew, the defendant. Still, one wonders how the boy could *not* have known that it was wrong to put arsenic in his grandfather's sugar. What else could he have thought he was doing?

The next medical witness's testimony reveals that the migration of medical testimony from fact to opinion entailed something more challenging to the law than mere claims to expertise. Six months before the alleged poisoning, Allnutt's mother had consulted Frederick Duesbury, a 'Doctor of medicine at Clapton', in hope of securing treatment for her son's scrofula. Testifying about his young patient's physical condition at the subsequent murder trial, Dr

Duesbury added a comment about the boy's sleepwalking episodes. 'I do not believe him to have been in a sane state of mind at the time [these episodes] occurred.' Under cross-examination, Duesbury was asked to specify whether he considered Allnutt 'permanently insane, or liable to accidental derangement'. Duesbury's reply engaged the law's fundamental conception of 'the person'.

Dr Duesbury: My opinion is that it is the early stage of insanity, implicating the moral sentiments, the sense of right and wrong, and not as yet having reached the intellect in any marked degree, or interfering with his judgement of right and wrong.

Cross-examination: What do you mean by a marked degree? Has it gone to a length to injure the intellect, so as not to know he was poisoning a person when he did it?

Dr Duesbury: He might know [right from 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, or 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 as being wrong – I am speaking of moral feeling.

Cross Examination: [D]o you consider when he did this that he did not know that poisoning his grandfather was a wrong act?

Dr Duesbury: I think he has not the moral sense of wrong distinguished from right, or right distinguished from wrong, to give him a moral sense of feeling; that it was an irresistible impulse on his part – I draw that conclusion from his having perpetrated this act without hesitation, or struggle of mind, or remorse, or compunction, and without any sensible object[ive]; and also another circumstance which I heard, leads me to believe his conscience is diseased, that he could not feel it as an influential agent to distinguish between right and wrong, although his intellect leads him to understand what others tell him.²⁰

Duesbury was followed into the witness box by renowned mad-house superintendent John Conolly, who had not interviewed Allnutt prior to the trial. Conolly's opinion was based on the testimony of the previous forensic medical witnesses, and on his own experience in assessing insanity generally.²¹ He affirmed the image of a scrofulous boy, unmindful of his acts, prone to sleepwalking, and altogether 'imperfectly organized'.

Conolly: [T]aking the word 'mind' in the sense in which it is used by all writers, I should say he is of unsound mind . . . that the future character of his insanity would be more in the derangement of his conduct than in the confusion of his intellect – that is conjecture.²²

The physicians' testimony brought into focus the role that cognition – and hence *consciousness* – was thought to play in human functioning. Traditionally,

English common law assumed that knowledge of right and wrong necessarily informed (perhaps constrained?) the choice to commit evil. Yet the *Allnutt* court was confronted with a young defendant described as capable of understanding the difference between right and wrong, though nonetheless unrestrained when it came to his murderous deed. What level of conscious awareness attended his mixing arsenic with the family sugar? Medical opinion left the unmistakable impression that cognitive awareness of his deed was totally separate from the moral consideration of what he was doing. As Duesbury testified, although the defendant's intellect 'leads him to understand what others tell him, he could not feel [his conscience] as an influential agent to distinguish right from wrong'.

The jury did not have to wait long for guidance from the bench. Baron Rolfe advised that 'Such evidence ought to be scanned by juries with very great jealousy and suspicion, because it might tend to [justify] every crime that was committed.'²³ The use of the term 'jealousy' could not have been lost to members of the jury: it was *their* function that such medical testimony threatened to usurp. Expert opinion equating insanity with moral depravity would make it next to impossible to convict any felon of anything. In this regard, it was particularly unwise for Duesbury to cloud the issue by interjecting the term 'irresistible impulse'. Then as now, the difference between an irresistible impulse and an unresisted impulse was nowhere apparent, and once this argument could be successfully challenged, the *splitting* of cognition from volition was an easy target. '[T]he object of the law was to compel persons to control influences . . . which medical men might choose to say [the defendant] could not control.'²⁴ As reported in *The Times*, Baron Rolfe 'rejoiced' that the jury 'had thrown to the winds the idle sophistry [of the defence case]'. What else was crime, asked the judge, '[but the] willing indulgence in such evil vice.' As for moral insanity, it was 'only the self delusion of hardened conscience'.²⁵

Although one may be tempted to see Baron Rolfe's contemptuous tone as a rather predictable instance of juridical hauteur, there is a tag line at the end of his instructions that perhaps concedes more than he intended. His rejection of medical opinion regarding moral sentiments was encased in an unequivocal avowal of physicalist theories of insanity. Indeed, his voluble rejection of moral insanity originated in its having been put forward as a disease of the *mind* . . . and he was clearly having none of this. It was the independence of moral sentiments from organic grounding that he rejected, refusing 'to assume that the mind, in its essence, is susceptible of disease which the body does not share'. Touching on the defining aspect of expert testimony, he added,

if this theory were just, the physician or surgeon would be as incompetent as any stranger to the profession, to form an opinion on lunacy. . . . But let it be assumed that the mind is capable of disorder apart from bodily ailment, what do we know of it more than others? The mind has no pulsation . . . no dyspepsia

... but though [the physician] may truly say that he has known this or that visionary idea to be prevalent in some case of mania, he will not say he has felt competent to decide on the existence of mania by the prevalence of the visionary idea alone ... the visionary idea must be associated with irregularity of the animal functions to satisfy his mind.²⁶

IV The fact of a juvenile poisoner

The debating points one hears between this resolute judge and the more cognitively ambitious medical witnesses were not those of physic versus metaphysic, lawyer versus doctor, or witness versus juror – although they were, of course, about all these things. Most particularly, however, this territorial dispute was about nothing so much as ‘opinion versus fact’. Insanity as a ‘fact’ had long existed at the Old Bailey. Its common features of insensibility, delirium, and delusion, were familiar to, and accepted by, the courts. In the years that witnessed the quantum growth in medical participation in insanity trials (1825–43) – and not coincidentally, the growing incidence of delusion to typify the precise derangement of the accused – the rooting of delusion in organic substance figured prominently in medical testimony.²⁷ The physician’s *opinion* about insanity’s material basis nicely complemented the *fact* of delusion – transported into court by the lay witnesses’ observations: hearing the ranting, seeing the behaviour, perceiving the dramatic change in behaviour whenever the delusion was touched upon. Not surprisingly, medical witnesses who spoke to the thrust of delusion – its supposed bodily origin and its presumed behavioural consequence – were neither derided nor dismissed. What the courts were *not* willing to entertain, however, was medical opinion that asserted categories of derangement divorced from physicalist renderings of functioning – even when those physicalist renderings had never been made very clear.

Baron Rolfe’s remarks to the *Allnutt* jury – in which he drew such a distinction between physiologically based insanity and the free-floating notions of moral derangement – are likely to strike today’s reader as not a little disingenuous. Delusion had, of course, no more organic basis in bodily disruptions than a *diseased* will could take on a ‘lesion’. Once juries accepted delusion as the *sine qua non* diagnosis for a legally recognised criminal insanity, the courts were also bound to entertain the inevitable force of delusion to find its conclusion in crime. An often unspoken assumption was delusion’s existence as a physical entity; inducing blood flow was sometimes mentioned as a possible remedy. The materialist basis for this psychological affliction was underlined by endowing delusion with a force all its own. Neither courtroom questioning nor the official Rules that followed the *McNaughtan* acquittal challenged the notion that delusion could ‘lead the defendant to any act’. When a medical witness in the *McNaughtan* trial concluded that ‘nothing but a physical force would have stopped him from the act he was compelled to do’, the Crown prosecutor did not stand up to object.

In retrospect, delusion – with or without an explicit physiological basis – paved the way for questions about human agency to sit at the centre of all subsequent trials that turned on questions of suspended or *missing* consciousness. Defendants who alleged a history of sleepwalking, or being ‘absent’ at their crime – ‘as if it had been done by another person’ – or who were *replaced* by another self while on the witness stand, were supported by medical witnesses prepared to question the assumed integration of consciousness and volition that had framed similar discussions about delusion. Each of these behavioural states challenged the common law’s perception of ‘the person’: an individual whose remembered associations informed future action, one whose continuous consciousness linked thought to action and responsibility to assault. Perhaps not as ‘discontinuous’ as the sleepwalker or as *absent* as the amnesiac, Allnutt’s psyche, according to the medical witnesses, nonetheless revealed a failure to integrate moral feeling with cognitive awareness.

Although anathema to the law, the possibility that persons occupied varied planes of consciousness was hardly foreign to common cultural consciousness in an era awash with parlour-induced mesmeric trances and hypnotic spells. What was unique in newly professed medical opinion was the possibility that one’s *criminal* behaviour could belong to *another* self or to a self that had failed to integrate disparate psychic elements. Commenting on contemporary notions of dissociation, philosopher Ian Hacking has written that persons who suffer twentieth-century multiple personality syndrome do not experience a multitude of personalities, they rather lack one coherent personality.²⁸ Medical testimony offered in the *Allnutt* case held out just such a possibility to the nineteenth-century court: the William Newton Allnutt who poisoned his grandfather was not the William Newton Allnutt who understood the difference between right and wrong. Perhaps the reason this understanding failed, in the words of Dr Duesbury, to ‘control’ him, was that *he* who understood was not *he* who poisoned.

Although it was the medical witness whose opinion affirmed the possibility of multiple states of being, one should not lose sight of the legal forces that framed this debate. Earlier work on the origins of forensic-psychiatric testimony has highlighted the observation that while professional motives did indeed animate an enhanced role for medical witnesses in the courtroom, the professional most active in the proffering of medical opinion was the defence counsel. In the *Allnutt* trial he was the one who minimised Prison Surgeon McMurdo’s basis of expertise; he was the one who called the victim’s own brother-in-law to speak on behalf of the defendant’s scrofula. Medical witnesses, then as now, did not flock to the courtroom in search of professional aggrandisement since they were likely to encounter the hostile comments of the judiciary. They were in court, quite simply, because they had received a subpoena.²⁹ The courtroom served as a critical forum to find a professional voice, however, and in trials such as Allnutt’s, medical men engaged legal questions directly, offering opinions where the court might have preferred they cleave closer to *materialist* fact.

The adversary process was prepared to accept – indeed, it appeared eager to solicit – medical opinion that spoke to the ‘fact’ of insanity, or in the words of Baron Rolfe in *Allnutt*, an insanity ‘physiologically based’. It is endlessly curious to speculate about what was behind this concession – for that is indeed what it was. Easy traffic between the body and the mind had long embraced the notion of a materialist basis for psychological distress. In reifying this connection, however, it seems that judges were ceding more territory to the medical witness than they were gaining. It now appears that the decision to embrace materialism – and by extension medical testimony – was a strategic decision that allowed judges to repel notions of moral insanity, lesion of the will, and monomania.³⁰ The basis for rejecting these states was not the lack of *agency* such states connoted, because compulsion had already been admitted as the likely result of delusion. It seems more to reflect the judges’ belief that they could circumscribe the range of forensic-psychiatric opinion by restricting the type of insanity that medical witnesses could introduce as ‘fact’.

There is a further way to consider the obstacle medical witnesses faced with concepts embracing a moral rather than a cognitive basis for insanity, which has little to do with a judge’s penchant for physicalist renderings of insanity. A recent text on science and the law depicts the struggle between the two professions originating in their rather particularist ‘job descriptions’. Law is said to be prescriptive; science, descriptive.³¹ Naturally these two characterisations need considerable parsing, but at the level of the forensic-psychiatric testimony in this particular trial, there may be something instructive in this rendering. Insanity as *fact* is a descriptive category; medical witnesses might be employed to detect its more recondite characteristics – and its more dexterous circumnavigations – but no one had to be convinced that bizarre, *uncharacteristic* behaviour flowed from delusory perception. In the evolving opinion of the *Oxford* medical witnesses, however, insanity was an aberration in how one ought to feel. Nothing could be more prescriptive than this. Perhaps one way to appreciate Baron Rolfe’s vituperative reaction to the *Allnutt* medical testimony is to consider the perceived assault on the law’s prescriptive function: the normative standard of behaviour that law alone was charged to defend.

Although this separation of law and medicine into sovereign territories is meant to be a contemporary historical idea, it was not lost on nineteenth-century medical men that they were entering a forum fraught with potential professional assault. Then, as now, forensic-psychiatric witnesses faced questioning that not only aimed to expose differences in professional opinion, but differences regarding whether such opinion should even be seen as creditable. Assuming that these medical men were not self-selected masochists, one would have to wonder why forensic-psychiatric witnesses answered as they did. Although their appearance in court may have been prompted by a subpoena, their testimony does not reveal a diffident posture when asserting their claims to asylum-based professional knowledge. At times the arrogation of a privileged

gaze was made in response to a defence counsel's clear prompting; at other times it was uttered in response to judicially assaultive questions, as seen in the *Oxford* trial. In either case, medical men such as prison-surgeon Gilbert McMurdo and Dr Duesbury found themselves called into court – and often on opposite sides – precisely because the Crown prosecutor and the defence counsel believed they could win their case by enlisting, shaping, and eliciting forensic-psychiatric opinion touching on the *facts* of the case. That medical men were at the Old Bailey at the law's behest was clear, but it was much less apparent that they were bound to respect the division of labour they found there. Once the lawyers opened the door to opinion-based testimony, they could hardly control the direction such testimony would take.

Courtroom narratives have therefore proven an invaluable resource for capturing the process by which medical facts became courtroom opinion – and for reasons that had little to do with medical plans for enhancing its courtroom role. The law has its own designs, and by employing medical testimony to advance either side of the case, the courts lent their considerable cultural authority to various claims of 'splitting'. In its effort to exclude the notion of autonomous psychological faculties, the courts also explicitly embraced materialist conceptions of derangement that further affirmed medicine's assertions to greater means of 'forming an opinion on insanity than other persons'. It would not be the first time in the history of forensic medicine that the needs of law would serve to reify, however inadvertently, the clinical practitioner's claims to expertise.

Notes

- 1 For a comprehensive study of the *McNaughtan* trial and its political context, see Richard Moran, *Knowing Right From Wrong: the Insanity Defense of Daniel McNaughtan* (New York: Free Press, 1981).
- 2 Nigel D. Walker, *Crime and Insanity in England, vol. 1: the Historical Perspective* (Edinburgh: Edinburgh University Press, 1968).
- 3 According to John Henry Wigmore, the witness must speak as a knower, not a guesser. He must see an action, not merely believe it took place. *Evidence in Trials at Common Law*, vol. 7 (Boston: Little, Brown, 1985), p. 2.
- 4 For a discussion of the legal provisions for opinion-based testimony, see Learned Hand, 'Historical and practical considerations regarding expert testimony', *Harvard Law Review*, 15 (1901), 40–58, 45; and James Bradley Thayer, *A Preliminary Treatise on Evidence at the Common Law* (Boston: Little Brown, 1898).
- 5 *Old Bailey Sessions Papers* (hereafter *OBSP*), 1876–7, case 246, 4th session, p. 456.
- 6 Walker, *Crime and Insanity*, pp. 60–2.
- 7 Roy Porter, *Mind-For'd Manacles: a History of Madness in England from the Restoration to the Regency* (London: Athlone Press, 1987), p. 35.
- 8 Joel Peter Eigen, 'Intentionality and insanity: what the eighteenth-century juror heard', in William F. Bynum, Roy Porter, and Michael Shepherd (eds), *The Anatomy of Madness*, vol. 2: *Institutions and Society* (London: Tavistock, 1985), pp. 34–51.

- 9 Joel Peter Eigen, 'Delusion in the courtroom: the role of partial insanity in early forensic testimony', *Medical History*, 35 (1991), 25–49.
- 10 OBSP, 1842–3, case 874, 5th session, pp. 760–3.
- 11 *Ibid.*, 1840, case 1877, 9th session, p. 506.
- 12 *Ibid.*, 1840, case 1877, 9th session, pp. 505–10. Analysis of the Oxford trial can be found in Walker, *Crime and Insanity*, pp. 186–7; and Richard Moran, 'The punitive uses of the insanity defense: the trial for treason of Edward Oxford (1840)', *International Journal of Law and Psychiatry*, 9 (1986), 171–90. A discussion of the origins of moral insanity in the courtroom can be found in Joel Peter Eigen, *Witnessing Insanity: Madness and Mad-doctors in the English Court* (New Haven and London: Yale University Press, 1995), pp. 76–9 and 150–2.
- 13 OBSP, 1840, case 1877, 9th session, p. 505.
- 14 The utility of the OBSP to historical reconstruction of the day-to-day workings of London's central criminal court is comprehensively described by John H. Langbein in 'The criminal trial before the lawyers', *University of Chicago Law Review*, 45 (Winter 1978), 263–316.
- 15 Following the acquittal of Robert Peel's would-be assassin, the McNaughtan Rules were fashioned to provide jurors with criteria with which to assess the legal significance of a defendant's alleged mental derangement. These guidelines restricted the jurors' consideration of the defendant's cognitive faculties: *knowing* the difference between right and wrong; *knowing* the nature and likely consequences of an act. The Rules conspicuously limit insanity to matters of intellectual incoherence, excluding states of autonomous behavioural chaos. The latter would encompass 'moral insanity' or 'lesion of the will', which left the afflicted fully aware of his or her act, yet either indifferent to the outcome or incapable of resisting a compelling impulse.
- 16 Early nineteenth-century medical tracts that explored this phenomenon include Samuel L. Mitchill, Felix Pascaslis, and Samuel Akerly, *The Medical Repository of Original Essays and Intelligence Relative to Physic, Surgery, Chemistry and Natural History* (New York: T. J. Swords, 1817); and H. Dewar, 'Report on a communication from Dr Dyce', *Transactions of the Royal Society of Edinburgh*, 9 (Edinburgh: William and Charles Tait, 1823). Historical appraisal of the 'doubling' phenomenon can be found in Henri F. Ellenberger, *The Discovery of the Unconscious: the History and Evolution of Dynamic Psychiatry* (New York: Basic books, 1970), see esp. pp. 127–48; and Ian Hacking, 'Double consciousness in Britain 1815–75', *Dissociation*, 4: 3 (September 1991), 134–46. The history of the array of mesmeric and somnambulist states in the 1800s is the subject of Alison Winter's *Mesmerized: Powers of Mind in Victorian Britain* (Chicago: University of Chicago Press, 1998).
- 17 McMurdo's contributions to the history of medical testimony bearing on insanity is discussed in Eigen, *Witnessing Insanity*, see especially pp. 129–30.
- 18 OBSP, 1847–8, case 290, 2nd session, p. 289.
- 19 *Ibid.*, pp. 291–2.
- 20 *Ibid.*, p. 293.
- 21 Assessing Allnutt from this particular vantage point was not unusual for Conolly. He had been prominent among members of the first generation of asylum superintendents cum expert witnesses who claimed a familiarity with insanity 'in the general case' by virtue of their experience with 'many hundreds'. Given their unique work-related experience – *the* critical element that permitted mad-doctors to claim

- expertise and thus to offer opinions – these first forensic-psychiatric witnesses commented not only on the probable origins of the mental derangement, but the likely consequences this condition would auger for subsequent behaviour.
- 22 *OBSP*, 1847, case 290, 2nd session, p. 294.
- 23 *Times* (16 December 1847), p. 8.
- 24 *Ibid.*
- 25 ‘Analytical reviews: Baron Rolfe’s charge to the jury’, *Journal of Psychological Medicine and Mental Pathology*, 1 April 1848, p. 201.
- 26 *Ibid.*, p. 215.
- 27 Eigen, *Witnessing Insanity*, see especially pp. 145–9.
- 28 Ian Hacking, *Rewriting the Soul: Multiple Personality and the Sciences of Memory* (Princeton: Princeton University Press, 1995).
- 29 The various professional and affiliational paths medical witnesses took into the courtroom are examined in Eigen, *Witnessing Insanity*, pp. 122–30.
- 30 Baron Rolfe’s complete charge to the jury can be found in the 1 April 1848 *Journal of Psychological Medicine and Mental Pathology*, pp. 193–219.
- 31 Sheila Jasanoff, *Science at the Bar: Law, Science, and Technology in America* (Cambridge, Mass.: Harvard University Press, 1995).