

SOME IMPLICATIONS OF THE DURHAM CASE

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FOR better or for worse, psychiatrists today are frequently invited to express opinions on criminal responsibility. Initially, psychiatrists were chiefly responsible for this change, but more recently they have been abetted by solicitors needing help. This practice seems to be basically sound and rests on agreement that there are instances when the individual is not responsible for his conduct because of mental disease. Difficulty arises when the medical witness feels that his opinions are tested by rules no longer sound, or that legal procedure prevents him from expressing them. Although I doubt whether these difficulties will ever be resolved to the satisfaction of both lawyer and doctor, any attempt at improving the situation, in the light of modern thinking, is worth consideration, and such is the purpose of this paper.

Before doing so I propose to inflict a little psychiatric theory on my legal listeners, with apologies. A seriously antisocial act may be the product or end result of profound underlying mental disturbance: an indication of breakdown in a system of adaptive reactions evolved to balance stresses and conflicts in the mind. If the psychiatrist is to understand such behaviour, he must go beyond the act and try to evaluate the total personality of the offender, both in its conscious and unconscious aspects. Whether we like it or not, "the unconscious" has come to stay. It is this kind of insight which the psychiatrist uses in his practice and which he wishes to communicate to the court, when so required. This wide inquiry invites a corresponding extension of its application in law to a number of persons whose antisocial behaviour does not fit into the description of psychosis, and who may be outside the legal definitions of insanity. Acceptance of this concept would lead, and perhaps already is leading, to some changes in our penal system, whereby fewer persons would be treated by imprisonment, but some might still be removed, when necessary,

by commitment, from the opportunity of further destructive behaviour, and, where practicable, given appropriate treatment. Individual responsibility is not a fixed or absolute thing, and its definition over the centuries has been subject to change. At present it seems to be regarded in law as a function of the intellect and of conscious volition; psychiatry, whilst recognizing the role of the intellect and the will, would give to the emotions and the unconscious mind greater weight in the balance of total mental forces. Today, at law, responsibility is disavowed in the small child and in certain psychotics. Tomorrow an intermediate group of defectives and mentally sick persons who cannot be fitted into the conventional categories of insanity may also be excluded.

It is not my intention to review comprehensively the defence of insanity in English speaking and other countries. It is well known and has recently been collated by the British Royal Commission on Capital Punishment. It is of interest that one of the twelve members of this Commission was a psychiatrist. But to see the Durham case in perspective, reference must be made to the M'Naghten rules which have governed British, American and Australian courts for the past 116 years. The answers given by the fifteen judges in 1843, which referred to a defendant affected by paranoid (persecutory) delusions and which were apparently an attempt to select for exculpation those individuals who could not be restrained by threat of legal sanctions or for whom punishment could not act as a deterrent, have since been extended to become a comprehensive declaration of law applicable to any person presenting the defence of mental illness. As now in use they can be reduced to two rules: "That, at the time, the accused did not know the nature of its act; or if he did, that it was wrong." A third rule relating to partial delusions was so palpably absurd that it has been quietly dropped. Most psychiatrists, with a number of distinguished lawyers, have never approved these rules as an adequate test. Mental disorder severe enough to disturb seriously a person's judgment, control and actions may involve, psychologically, more than a defect of conscious intellectual knowing or the inability to form a moral judgment between right and wrong. Acts of the kind under consideration also involve the emotions, and are not infrequently unconsciously motivated. It must also be recognized that so far no one has developed reliable methods of measuring the specific mental capacity of an individual to make ethical judgments.

Moreover, a defendant, affected by certain types of severe mental disease, may perform antisocial acts both knowing intellectually their quality and nature, and knowing that they are contrary to his country's legal code. I refer particularly to instances of psychotic depression leading to homicidal acts. In such cases the defects inherent in the M'Naghten rules are sometimes overcome, particularly in Australia, by interpreting inability to know wrong to mean "moral wrong" only, and by considering that, as gross pathological depression can lead to grossly disordered moral judgment (such as a belief in the desirability of killing one's children) the defendant should not be held responsible. The position is equally unsatisfactory with some schizophrenics, where their thinking and feeling are different in many respects from our own, and they are also liable to change from moment to moment. The rules are also inappropriate to persons acting under irresistible compulsion or impulse, who may know what they are doing, and its wrongness, but yet are unable to resist or control the overwhelming force of their perhaps unconscious urges. An early and clear example of this is the case of Burton in 1863; an 18-year-old boy murdered an acquaintance who had done him no harm because he had a compulsive urge to be hanged. The strongest criticism of "McNaghten" has come from the U.S.A. where in addition to technical medical objections, psychiatrists have often felt frustrated by court procedures, a state of affairs happily minimal in the State of Victoria at this time. An American, Mr. Justice Frankfurter, in his testimony before the British Royal Commission on Capital Punishment, said: "I do not see why rules of law should be arrested at the state of psychological knowledge at the time when they were formulated. If you find rules that are discredited and which cannot be justified except by interpretations which distort them, it is not a desirable system. Therefore I think the M'Naghten rules are in large measure, shams." In Australia, psychiatrists, though somewhat less outspoken, feel similarly. Of local and personal interest is a paper read by W. L. Mullen and J. W. Springthorpe at the Intercolonial Medical Congress, Sydney, in September, 1892, which, with very few variations of nomenclature, represents present-day medical views. This paper was later published in the *American Journal of Insanity*, January, 1893, and was the subject of a short article in the Melbourne Law Students' Society magazine, *The Summons*, in December, 1892.

It must not be thought that in opposing the present position psychiatrists aim to usurp the prerogative of the courts—rather the reverse. Whilst believing that laws relating to mental disorder must, in the final analysis, be based on the customs and opinions of the community, and hence subject to community judgment through legal processes, they would wish to give their evidence with more freedom, and in accord with present-day ideas.

It was against this background that Judge Bazelon, of the Court of Appeal for the District of Columbia, U.S.A., on July 1, 1954, in the Durham case, propounded a new test or rule, namely, "that an accused is not criminally responsible if his unlawful act was the product of a mental disease or mental defect". Details of this case may be read in the American Law Reports and in summarized form, with comments, in Hall and Glueck's *Criminal Law Cases*, 1958. Briefly, Monte Durham, aged 26, had been convicted of housebreaking, despite a defence of unsoundness of mind at the time. There was a long history of previous imprisonments and committals to mental hospitals. In 1945, at the age of 17, he had been discharged from the Navy, after psychiatric examination, because of a "profound personality disorder". In 1947 a charge of car stealing was followed by attempted suicide and admission to St. Elizabeth's Hospital in Washington. In 1948 he was convicted of passing bad cheques, but when found of unsound mind was readmitted to St. Elizabeth's for fifteen months, the diagnosis being "psychosis with psychopathic personality". After discharge as "recovered", he was returned to gaol to serve his previous sentence. He was later paroled, but soon afterwards violated this by passing further bad cheques. A jury again found him of unsound mind and he returned to hospital for three months. Two months later the housebreaking occurred. At this time he was reported to have hallucinations, was again adjudged of unsound mind, and returned to St. Elizabeth's Hospital for sixteen months, during which he was given insulin treatment. When released he was returned to gaol, and decreed mentally competent to stand trial. When he was again convicted following the trial court's rejection of the defence of insanity in accordance with the M'Naghten rules and the "Irresistible Impulse" provision in use in the District of Columbia, the case came before Judge Bazelon, on appeal. It was argued that "M'Naghten" and "Irresistible Impulse" were unsatisfactory tests, and the Judge, after reviewing

the objections to these rules, agreed with this contention and decided to invoke the inherent power of the court to make a change. He then announced what is now known as the Durham rule: "that an accused is not criminally responsible if his unlawful act was the product of mental disease or mental defect". "Disease" is here used as meaning "a condition which is capable of either improving or deteriorating, and 'defect' as a condition which is not considered capable of improving or deteriorating, and which may be either congenital, or the result of injury, or the residual effect of a physical or mental disease". Historically, this view is based on the ideas of a pioneer American psychiatrist of the early nineteenth century—Dr. Isaac Ray, one of the fifteen founders of the American Psychiatric Association—and in practice, it closely resembles that adopted in the State of New Hampshire in the case, *State v. Pike*, by Justice Doe in 1869; correspondence recently published shows Justice Doe's indebtedness to Ray. In his judgment, Justice Doe referred to the M'Naghten rules as based on "old exploded medical theories" and went on to say, "Whether the old or the new theories are correct is a question for the jury. The Law does not change with every advance of science; nor does it maintain a fantastic consistency by adhering to medical mistakes. The legal principle is that a product of mental disease is not a contract, a will or a crime. It is often difficult to ascertain whether an individual had a mental disease; and whether an act was a product of the disease; but these difficulties arise from the nature of the facts to be investigated, and not from the law; they are practical difficulties to be solved by the jury." I am sure you must be impressed by his reference to "exploded medical theories". Were he less a good judge he might have said "exploded legal theories".

Under the Durham rule it appears that the medical witness is able to give any relevant testimony and examine all aspects of the accused's personality. The jury evaluates this testimony, and has the final say. The legal basis of this procedure, as stated by Justice Doe in other words, is the premise that when an act is the product of mental disease the accused should not be held responsible. Rather than be sent to prison, he should be placed in a suitable institution for treatment, and if possible, rehabilitation. Wide and various discussion followed this judgment, and the District of Columbia Council on Law Enforcement was directed to inquire whether the new rule necessitated legislative action. After consideration the rule was given legislative approval

with only minor additions relating to disposal, by an act of August 9, 1955.

It should be pointed out that prior to the Durham case there was provision in the District of Columbia for committing persons found not guilty on the ground of insanity to a suitable mental institution, as Durham's previous experiences illustrate, and as is done here. However, in some of the American States there is no such provision, and those found not guilty on this plea are set free. To use, as some critics have done, this result as a criticism of the Durham rule seems not relevant, and would not apply in countries where proper legal provision for commitment to a mental institution avoids the dilemma of "absolute acquittal or absolute conviction".

Since 1955 controversy has continued. Leading American forensic psychiatrists, such as Guttmacher and Overholser, working in the District of Columbia, the former in Baltimore, the latter as Superintendent of St. Elizabeth's Hospital in Washington, both favour the change. In an address delivered by Justice William Douglas, of the United States Supreme Court, at the William White Institute on January 28, 1956, entitled "Law and Psychiatry", complete approval of the new rule is expressed. I commend this full and learned review to all interested. A paper by Abe Fortas in the *American Journal of Psychiatry*, January, 1957, is on similar lines and discusses most of the medico-legal implications. On the other hand, some jurists consider its terms too wide and, in particular, point out that interpretations of the word "product" might include within the meaning of the rule minor forms of mental aberration or disorders of conduct. In a recent letter, Dr. Overholser writes: "Some courts have indicated that they have little interest and have said they were bound by statutes and so could not change without legislative authority—psychiatrists are overwhelmingly pro-Durham. I have read most of the comments in legal journals which have come out since the rule was enunciated five years ago. The substantial majority of these have been pro-Durham. I certainly have hopes that we may gradually see a greater acceptance of the principle." The American Law Institute has for some years been engaged in the Herculean task of drawing up a Model Penal Code, and from time to time brings out what are modestly termed "Tentative Drafts". In Draft No. 4, April 25, 1955, "Mental disease or defect in relation to criminal responsibility" is considered. The Committee working on the draft was chiefly composed of eminent

lawyers, but included Drs. Guttmacher, Overholser and Freedman. The majority disapproved of both the M'Naghten and the Durham rules and suggested (p. 27) a new rule, along with two minority variants. On pp. 156-192 the problem is discussed in detail, and included in the Draft is a memorandum by Dr. Guttmacher on the "Criteria of Responsibility", together with correspondence (nine letters) between the chief reporter, Professor Wechsler, of Columbia University Law School, and Dr. Guttmacher in which, in effect, they agree to differ. A tentative formulation for a new rule was suggested: "Whether the capacity of the accused to control his conduct in accordance with the law was impaired so greatly, or whether the criminal act was so clearly a product of mental disease, that he, justly, could not be held criminally responsible" (p. 187).

The matter has also been considered by the "Committee on Psychiatry and the Law" of the Group for the Advancement of Psychiatry, a body of about one hundred and fifty persons, containing many of the leading psychiatrists in the United States, in Report No. 26, May, 1954, dealing with "Criminal Responsibility and Psychiatric Testimony". They too reject the McNaghten rules, but without suggesting any alternative. Their rejection follows and approves one of the conclusions of the British Royal Commission on Capital Punishment. In conclusion iii (p. 116), after considering yet other suggested alternatives, the Commission (three members dissenting) stated "that a preferable amendment would be to abrogate the M'Naghten rules, and leave the jury to determine whether at the time of the act the accused was suffering from disease of the mind (or mental deficiency) to such a degree that he ought not to be held responsible". This view is also held by the well-known British psychiatrist, Sir David Henderson.

My own opinion is also that it is impossible to draw up any rule that will cover all cases. This opinion is based on the great variability and complexity of mental illness and the fact that no rule—many have been put forward—has, so far, proved entirely adequate. I suggest, with others whom I have quoted, that a rule may not be necessary.

Acceptance of this proposition would probably require the presentation of medical evidence in a somewhat different—and to psychiatrists, preferable—form. Dr. Guttmacher, at the conclusion of an admirable paper "The quest for a test of criminal responsibility", after approving Conclusion iii of the British

Royal Commission, states: "What should then be expected of the psychiatrist in court is as follows:

- "1. A statement as to whether the defendant is suffering from a definite mental disease, and how this conclusion is reached.
- "2. The name of the alleged mental disease and its chief characteristics and symptoms, with emphasis on its effects on an individual's judgment, self-control and social behaviour.
- "3. A statement of the way and degree in which the malady has affected the particular defendant's behaviour, especially in regard to the above categories.
- "4. He should then be asked whether, in his opinion, the alleged criminal act was the product of mental disease."

In order to give evidence of this nature, two further requirements have to be met: adequate facilities and opportunities for the psychiatrist, or psychiatrists, to make a complete examination, and the employment of psychiatrists with the necessary knowledge and experience. As suggested by Professor Norval Morris and others, some of these might be members of a panel appointed by the Crown Law Department.

These, then, are some of the implications of the Durham case; I trust they will provoke fruitful discussion.

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Discussion

MR. PETER BRETT said that the subject was so wide that he proposed to make a series of separate observations upon different aspects of the paper.

One matter for comment was that, although the Durham decision was given in 1954, and although it could be traced to the thinking of Dr. Isaac Ray some years before the M'Naghten case, no other jurisdiction had adopted it, with the exception of New Hampshire where the rule embodied in the Durham decision had been accepted since 1869. In other jurisdictions in the United States the courts had rejected the Durham decision, either on the ground that it involved a change beyond the court's power or, in several instances, on the ground that the change involved was undesirable.

One difficulty which would be inescapable in the practical use of the Durham rule lay in the need to explain the rule to the jury. He had not found an exposition of what the psychiatrist meant when he said the act was the product of mental disease. Strictly, the process of reasoning involved the proposition that the accused had a mental disease and that his crime was the product of that disease, but he felt that when a psychiatrist said that a crime was the product of mental disease he meant little more than that it had been committed by a man who had a mental disease.

In the District of Columbia in *Carter v. United States*, the court explained that the key question to be put to the psychiatrist was, "Would the man have committed the crime if he had not been suffering from the mental disease?". The court thought that this was logically impossible to answer, but that practically it might be answerable.

He himself thought that the question was almost impossible to answer, and if that were so the onus of proof in the trial assumed a very large importance. In the District of Columbia, once the defence of insanity was raised the onus of proving the accused sane rested upon the Crown. Consequently, if the psychiatrist's answer to the question under discussion were "I do not know", the prosecution failed. Under English law, the onus of proving the defence of insanity rested upon the accused, and the result would therefore be just the opposite.

The second comment was that it was important to analyse what is the real subject of discussion. Dr. Springthorpe had mentioned that in some jurisdictions in the United States the

defence of insanity resulted in absolute acquittal, and he pointed out that in Victoria we do not face that situation. In some respects he thought this was unfortunate in that it produced the result that, in Victoria, a decision on the question of insanity was really a decision upon the problem of the disposal of the accused—whether he was to be detained as a criminal or as a lunatic.

Experiments conducted by the University of Chicago Law School had shown that, when juries know that what depends on their decision is the ultimate disposal of the accused, it does not really matter to them which form of insanity rule is used. In these experiments panels of jurymen had the facts of the Durham case presented to them and were asked to decide whether Durham should be acquitted on the ground of insanity. Half of the experimental juries were charged in accordance with the M'Naghten rules with the addition of irresistible impulse, and the other half were charged in accordance with the Durham rule. The results of the experiments showed that it made not the slightest difference to the juror which form of charge was used and the inference possibly was that discussion on the subject amounted to beating the air.

His third comment related to the difficulty of ascertaining the meaning of the expression "mental disease". Dr. Guttmacher, quoted by Dr. Springthorpe, had said that the task of the psychiatrist was to establish the fact of a specific disease, assigning its name to it, establishing its symptoms and the manner in which the symptoms are reflected in the patient's conduct. Against this approach, a substantial school in the United States with adherents in this country did not wish to diagnose cases in those terms or to talk in terms of specific mental disease. An illustration of the difficulty of assigning a meaning to the term mental disease was to be found in the English trial of Christie, who was tried for the murder of seven women. The defence was taken that Christie was insane, and it did not appear to be difficult to infer insanity from the acts involved in the murders. One psychiatrist was called on Christie's behalf, who said that Christie was insane, that he was suffering from gross hysteria and that hysteria was a mental disease. Two psychiatrists were called for the prosecution. One of these said that he doubted whether Christie was suffering from hysteria, and even if he were it was not a mental disease but a character or personality defect. It is fair to say that this psychiatrist's view

was that there was nothing wrong with Christie except that he liked killing women. The second psychiatrist said that he did not regard Christie's behaviour as indicative of mental disease and said in general terms that extraordinary behaviour is not necessarily a means of diagnosing mental disease. The question how one diagnoses mental disease except by conduct was not asked.

Probably the psychiatrist and the lawyer approached the question of what was a mental disease from different angles. A psychiatrist such as Dr. Guttmacher might say that neurosis is a mental disease and that everyone has a neurosis of some kind. The lawyer is concerned with abnormality from what might be called a statistical point of view and is not concerned with the kind of abnormality such as a common cold which is shared by all people. Even if a rule were accepted that any person shown to be suffering from mental abnormality should be exculpated from crime, there would still be a great difference between what the psychiatrist on the one hand and the lawyer on the other regarded as abnormality.

MR. JUSTICE BARRY said that underlying the subject of this discussion there were two assumptions which it was probably necessary for society to make provisionally, but which were unproved and possibly unprovable. These assumptions could lead to mischief if they were regarded as absolute truth beyond examination. The first assumption was that the human being has freedom of will in the sense that he is capable of making a choice between doing and abstaining from a prohibited action. This assumption was not the subject of philosophical agreement and ultimately in a court of law it was a question of fact whether a particular individual on a particular occasion was able to refrain from the prohibited act. An inherent difficulty was that psychiatrists were conscious that the extent of freedom of choice was much less than the lawyer assumed. The lawyer was operating, in the criminal law, a mechanism of social control, and to make this control acceptable, the existence of criminal responsibility was postulated. However, criminal responsibility was not a characteristic of the individual but was something which society imputed to him for the purpose of determining whether he is justly liable to punishment.

The second assumption was that punishment was an effective deterrent. The problem of punishment was complex and baffling

and whereas some psychiatrists had thrown some small light upon the matter, the extravagant claims of others had further confused the issue because they led to the abandonment of the theory of moral responsibility. Whatever the determinist might think of moral responsibility, it seemed at the present stage necessary to act upon it in order to enable society to function.

He thought that there should be no great difficulty in deciding whether an act was the product of mental disease, and that if it were, the accused should be exculpated from criminal responsibility. However, a successful defence of insanity should not be followed by discharge of the accused.

Strictly, the defence of insanity involved proof that the person was insane at the time of the act, and it involved an assumption that he was sane at the time of trial. If the accused were insane at the time of trial he would not be tried because he would be unfit to plead, and a verdict to that effect would be returned. The English Trial of Lunatics Act 1800, which was embodied in the Victorian Crimes Act, made provision for a verdict on the grounds of insanity and also made provision for taking the jury's verdict on the question of fitness to plead. If a verdict of either insanity or unfitness is returned, the prisoner must be held in custody. In England, such persons were sent to Broadmoor, but in Victoria they were held in gaol for lack of any other place to send them. The small numbers involved would scarcely justify the expense of setting up a special institution.

DR. ALAN JEFFREY said that it was interesting to hear comment from lawyers on the question of mental disease and freedom of will. There had been no important publication in psychiatric journals or texts in the last fifty years which did not tend more and more towards the deterministic view of human behaviour. The use of the terms "punishment", "deterrent" and "mental disease" were indicative of thinking based on the writings of the last century.

MR. P. D. PHILLIPS, Q.C., said that Durham was charged with burglary and tried twice. He was convicted at each trial, and after each trial the conviction was quashed by the Court of Appeal. After the second appeal, he was charged with petty larceny, pleaded guilty, and was convicted. It was reasonable to guess that there was some kind of bargain between the prosecution and the defence.

After the introduction of the Durham rule in the District of Columbia, there was a series of some fifteen trials in which the trial judges charged the jury substantially in accordance with the Durham decision and in which evidence was given by psychiatrists called by the defence who said that the accused was suffering from a disease of the mind and that that disease caused the relevant conduct, and by laymen called by the prosecution who said that at the relevant times the accused had appeared normal. In all cases the jury convicted and the convictions were quashed by the Court of Appeal.

This suggested that the rule was highly unsatisfactory in operation in that at least it did not satisfy the people of the District of Columbia.

The essence of the problem did not lie in the question whether punishment was a deterrent or in the theory of determinism. The law was trying to achieve a compromise between, on the one hand, the enforcement of a standard of essential conduct felt by the community to be desirable, and on the other hand, the recognition that it is morally wrong to inflict punishment on a person not responsible for his conduct. All the formulations of the defence of insanity were directed to finding an appropriate compromise. In operation, the Durham rule, which was intended to bring scientific conceptions of responsibility into the legal sphere, had imposed such a burden upon the prosecution that it had come into disrepute in the eyes of the ordinary citizen.

DR. J. BRYANT CURTIS said that the law might free itself of the difficulties involved in the concept of freewill if it modified its rules so that the verdict of guilty or not guilty involved only a finding that the accused did or did not commit the act, and left the question of insanity to be investigated in relation not to guilt but to the consequences of guilt. The vital question was that the law should decide what it was going to do when a person was found guilty and on what grounds it should act. In the past the law had no clear concept of the end to be achieved in finding persons guilty or not guilty, and an exact definition of the purpose to be achieved was necessary before embarking upon inquiries as to the medical definitions of irresponsibility.

JUDGE NORRIS said that the introduction of the question of causation into the Durham rule must be productive of enormous difficulties. The objective standard, independent of causation,

would provide a better working rule, and in fact the M'Naghten rules, even though out of line with the contemporary thought of psychiatrists have not been seriously unsatisfactory in operation.

DR. SPRINGTHORPE, in reply, said that it had been the intention of the Durham decision not to avoid the rule that the jury gave the final verdict, but that the essence of the problem should be more clearly put before them.

He did not agree that the M'Naghten rules had worked satisfactorily. Their "working" had been assisted by the fact that they were often ignored and often distorted. They had lasted for 116 years and might well be reconsidered in the light of medical and legal thought that had long regarded them as inappropriate in cases of mental illness. He had hoped to hear more discussion on the question of their abrogation as recommended by the British Royal Commission.