

Psychosurgery and the Psychiatric Implications of the Kaimowitz Case*

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Introduction

If the professional relevance of and interest in a treatment modality can be measured by the editorials devoted to the topic in medical journals, then psychosurgery is today a hot subject. Editorials have recently appeared in the *New England Journal of Medicine*, *JAMA*, *The Journal of Nervous and Mental Diseases*, *Lancet*, and the *Medical Journal of Australia*.¹⁻⁵

This international recrudescence of interest has prompted one vociferous critic to alert the psychiatric profession⁶ and to warn that a second wave of lobotomists is upon us.⁷ This critic, Dr. Peter Breggin, ends an article in *Mental Hygiene*⁸ by calling for the abolition of all lobotomy and psychosurgery. At the same time, even major textbooks in psychiatry, including Freedman, Kaplan, and Sadock,⁹ and also Kolb,¹⁰ have suggested certain diagnostic classifications which could warrant psychosurgery, and Kolb ends his section on psychosurgery by stating that "all the recent studies of outcomes suggest that the current tendencies to avoid prescription of this procedure is unwarranted when other therapeutic measures have failed to bring about relief."¹¹

It was in this professional climate that Gabe Kaimowitz,¹² a lawyer, filed a writ of Habeas Corpus in Michigan on behalf of John Doe and The Medical Committee for Human Rights, alleging that John Doe was being illegally detained in the Lafayette Clinic for the purpose of experimental psychosurgery. John Doe had been committed many years earlier under the state's criminal sexual psychopath statutes and after signing an informed consent form was transferred to the Clinic for an experiment comparing the effects of surgery on the amygdaloid portion of the limbic system of the brain with the effect of the drug cyproterone acetate on the male hormone flow.

In order to clarify the issues involved in the legal outcome of this case, a brief history of psychosurgery follows.

The History of Psychosurgery

The operation of lobotomy, a procedure for interrupting some connections between the prefrontal lobes and other parts of the brain (particularly the thalamus), was developed by the Portuguese neurologist, Egas Moniz, and first performed by the neurosurgeon, Almeida Lima, in 1935. Moniz published a monograph on the subject in 1936¹³ and presented an article in the May, 1937, issue of *The American Journal of Psychiatry*.¹⁴ Moniz was honored for his work with a Nobel prize in 1949. Drs. Freeman and Watts started performing prefrontal lobotomies in the United States in September, 1936,¹⁵ and Dr. Freeman remained an advocate of the surgery until his death recently. Like many new promising techniques, lobotomy was met with initial enthusiasm. It has

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been estimated that during the period through the 1950's as many as 50,000 state hospital patients received lobotomies. The equivocal results, the advent of psychotropic drugs, and more advanced community resources contributed to loss of interest and faith in the procedure during the 1950's. It is interesting to note that the International Psychosurgical Congress in Lisbon in 1948 was not followed by a second Congress until the meeting held in Copenhagen in August, 1970.

During the hiatus between 1948 and 1970, two major factors contributed to the current new rise of enthusiasm in psychosurgery. First, major advances in technique have been accomplished as lobotomies have been replaced by leucotomies (severing only the white matter¹⁶) and with the subsequent development of modified operations like bimedial frontal leucotomies,¹⁷ cingulotomies,¹⁸ amygdalotomies,^{19,20} and anterior thalamotomy.^{21,22} Precision of these techniques has been greatly increased by the development of stereotaxic implantation of electrodes for stimulating discrete areas of the brain and the addition of new techniques for producing circumscribed lesions, like implantation of Yttrium seeds and cold probes. These new techniques are reputed to cause fewer psychological and physical damaging side effects. Secondly, a growing body of experience has brought about reassessment of the psychological indications for psychosurgery, and it is now generally accepted that schizophrenics often respond poorly to the procedure; this conclusion has ended a major controversy within the area. Psychosurgery is now primarily prescribed (especially surgery of the limbic system) for patients with phobias, anxieties, obsessions, and the affective component (when present) of schizophrenia²³—in other words, what has been termed the syndrome of "tortured self-concern."⁵

Despite these advances, critics^{24,25} point to the following scientific concerns regarding the evaluation of psychosurgery:

1. Inadequate assessment of the personality *in toto* (not just target symptoms) before and after surgery.
2. The lack of independent evaluation of the results.
3. The impracticality or impossibility of an adequate control group.
4. Except for rare instances, the relative lack of long-term follow-up.

Nevertheless, the growing optimism about psychosurgery in the literature is readily apparent. To quote the editorial in *Lancet*:

If no more effective medical means become available . . . , it can be taken without further argument that some form of lobotomy is here to stay. Results are excellent, usually permanent and on occasion almost miraculous.⁴

It was in this medical context that the Kaimowitz case developed.

The Kaimowitz Case

In the Kaimowitz case,¹² the Michigan circuit court found that experimental psychosurgery was unlawful even though the subject had given a purported consent, on the basis that it is impossible for an involuntarily confined patient to give a truly competent, informed and voluntary consent. Informed consent implies three things: 1) competence, 2) knowledge, and 3) voluntariness. The court ruled in this case that none of the three was possible. Professor Wexler has discussed the legal implications and I would like to add the psychiatric implications of the case ruling.

The court decided that the very nature of his incarceration diminishes the capacity of the involuntarily detained patient to consent to psychosurgery. It added that the patient is particularly vulnerable as a result of his mental condition, the deprivation resulting from his involuntary confinement, and the effects of the phenomena of "institutionalization." The area of competence as it relates to informed consent is a complex and difficult question, and it is, therefore, unfortunate that the concepts of "mental condition," "deprivation," and "institutionalization" are vague both legally and psychiatrically. For example, how long must a patient be hospitalized before

“institutionalization” renders him incompetent to give consent to psychosurgery or to any other procedure? Secondly, how severe must his mental condition be to render him incompetent? How does this ruling relate to the competence of the acute schizophrenic to give informed consent to a psychotropic drug study? Thirdly, the progressive trend in mental health law has been to refute the concept of legal incompetence based solely on mental patient status (voluntary or involuntary), but the logical extension of the Kaimowitz ruling runs counter to that progressive trend.

An interesting and ironic outcome of the case is that when in a separate issue the constitutionality of the subject's detention was challenged, he was released on the basis of expert testimony that he was competent to return to society. Therefore, the patient was ruled competent to leave the hospital by one court but incompetent to give informed consent by another court. Since the Kaimowitz court stated that it did not intend to rule out psychosurgery for organic disease, the question remains “What treatment modality other than psychosurgery would the patient have been considered incompetent to consent to?” Although, in fact, the court singled out psychosurgery, the logical extension of its ruling on competence opens the possibility for exclusion of other types of experimental treatment modalities. Finally, the court decided that parental or guardian consent was legally ineffective in the psychosurgery situation. Since the patient was considered incompetent and the parents' consent legally ineffective, didn't the court effectively deprive the patient of the right to participate in such experimentation and, by extension, such therapy?

The second element of informed consent relates to knowledge. The court decided that lack of knowledge of the specific subject of psychosurgery makes a knowledgeable consent to psychosurgery literally impossible. Here again the phrase “lack of knowledge” lacks specificity and opens the possibility of extension to other areas, e.g. psychotropic drug research (especially with new compounds), electroshock treatment, and certain forms of behavior modification, especially aversive conditioning. It should be again stressed, however, that the present author feels that the court was specifically ruling out psychosurgery. But considering the impressive body of knowledge now accumulating, the obvious question is “When will we have enough knowledge?”—a question which probably in the final analysis relates more to values than to facts.

The final element involves the concept of voluntariness. Professor Wexler has, I believe, hit on the heart of the matter by pointing out that, although logically they could do so, the courts would not extend the concept of implied coercion resulting from involuntary detention to other treatment modalities. In fact, courts in general have recently frequently cooperated with community treatment facilities (compare alcoholism treatment programs) by offering offenders the choice between incarceration and treatment on an outpatient basis—a clear-cut coercion toward treatment. So it is most likely that voluntariness as it is invoked is a camouflage for condemning certain treatment choices. This then raises the serious question, “Who decides which choices are fair and permissible—the patient in his relationship with his physician, the courts, or the legislature?” The way we resolve this question will have far-reaching implications not only for researchers and institutions, but for the practicing clinician.

Some general comments are in order. Informed consent has become society's means for establishing (some would say re-establishing) responsible techniques for research and treatment. Psychosurgery is a scary issue not only because of the actual physical trauma to the brain, but also because of moral and ethical issues regarding the inviolability of the individual, free will, and the possible invasion, if you will, of another person's soul. It is possible that these emotional factors were operant in the court's decision in Kaimowitz, for its reasoning alone is open to criticism. But it seems clear that the spectre of 1984 raised by much recent brain research can no longer be relegated to the area of science fiction, and must be faced squarely by moral and responsible physicians in cooperation with our legal colleagues and those in related professions.

Conclusions

Regardless of one's position on the various specifics of human experimentation and informed consent, observers are generally agreed that the issue involves basic questions of values, the value of the rights of the individual versus the right of society to accumulate and advance knowledge. The legal concept of informed consent has become the vehicle for re-establishing the rights of the individual, which the public and many professionals fear have been lost in experiments like the Tuskegee syphilis experiment, the injection of live cancer virus into unknowing subjects,²⁶ and the inadequate appraisal of certain pharmacologic agents like Thalidamide. All of these situations were subsequently followed by needed governmental or professional regulation of research with human subjects.

So also the Kaimowitz case, whatever its weaknesses and strengths, calls attention to the need for close professional scrutiny and supervision of the growing field not only of psychosurgery but of all human brain experimentation. The danger, however, exists that psychosurgery will become the *cause célèbre* for a more generalized attack on both human experimentation and treatment by other organic treatment modalities, including electroshock treatment, psychotropic drug research, and by logical (or illogical) extension, behavioral modification techniques.

There can be no doubt that the advances in the psychiatric, psychological, and neurological sciences in the last twenty years are the result of cooperation between responsible mental health researchers and concerned clinicians. It is important, therefore, that as the complex issues here involved continue to be debated, we do not allow the issues to degenerate into a good guy-bad guy split, clinician versus researcher, or some other inappropriate factionalism. For in the final analysis, the major party hurt by such professional infighting or outfighting is the patient himself.

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