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The *Kaimowitz Case: A Short Term Legal Restraint Contrary to the Long Term Public Good*

Yale David Koskoff, M.D. *

It is commonplace to hear the view expressed that we live in a rapidly changing world. Therefore, Judge Frank M. Johnson’s observation that:

> certainly the founding fathers would be astonished to awaken in the mid 1970’s and to survey the growing list of fundamental social problems which are each day presented to the Federal Courts for adjudication

should not surprise us. One social problem which has recently received attention in the courts has been the relationship between human experimentation and treatment. In 1957, Ladimer noted in the *New England Journal of Medicine:*

> The conduct of medical practice generally conceived to be diagnosis, treatment and care is governed by state statute and supporting administrative licensing and regulatory bodies. There is no existing broad police power statute for control of human research although it is by nature subject to general police power.

> Human research . . . warrants (legal) recognition as a separate endeavor affected with public interest as significant as medical practice itself.

In *Kaimowitz v. Department of Mental Health,* 3 a Michigan court courageously and somewhat emotionally attempts to draw for the first time a judicial line between experimental research and acceptable treatment. It deals not only with current legal issues in psychosurgery but with human experimentation in general. The opinion

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appears destined to influence future judicial and legislative activity, and to produce future litigation and controversy.\textsuperscript{4} In this connection, Justice Benjamin N. Cardozo's admonition comes to mind: "declare the law not only as the past has shaped it . . . but as the future ought to shape it in cases yet to come."\textsuperscript{5}

It was historically predictable that the first judicial line between experimental research and therapy would be drawn in psychosurgery; psychosurgery being defined as the surgical removal or destruction of brain tissue with the primary intent of altering the behavior of the patient. From its inception, psychosurgery has been dogged by controversy, often bitter, acrimonious and destructive; truth frequently obscured by faulty or incomplete information or built-in bias about the surgical approach to the modification of behavior. It was an unfortunate name, both philosophically, and psychologically and was anatomically untenable. The brain is the organ of the mind, the place of the mind. Changes in brain alter mental processes—the way a person perceives himself, his world, and how he feels about happenings within and without. "But mind always as we know it is insulated and devoid of direct liason with other minds."\textsuperscript{6} It does not involve chemistry and physics as it proceeds like a ghost in the spatial world. Surgery of the mind, the psyche, the soul, conjures up the metaphysical, the magical, the untouchable. The name \textit{psychosurgery} is threatening.

It was G. Burckhardt,\textsuperscript{7} Swiss psychiatrist, who was the first to treat mental disorder by brain surgery. He applied the technique to severely disturbed schizophrenic patients. Violent patients dangerous to their comrades became harmless working patients. Eventually, as a result of recriminations from his colleagues, Dr. Burckhardt was forced from practice.

In 1935, Egas Moniz,\textsuperscript{8} Portuguese neurologist, later Nobel Laureate, with the help of his neurosurgical colleague, severed frontal pathways in twenty patients. Following the report of his results, the modern era of neurosurgical treatment of psychiatric disorders was

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born. The infant was transported to America. It grew to prodigious, some say monstrous, size. Its American father was the late Walter Freeman, neurologist, who, with James Watts, performed the first frontal lobotomies in this country. Freeman named the infant psychosurgery, apparently in contradistinction to psychoanalysis which had reached its zenith in America at about the same time. Eventually Freeman and Watts parted and Freeman continued with his own transorbital technique.

Varieties of procedures evolved directed toward reducing undesirable side effects and to achieve more specificity in the treatment of varying disturbances of behavior. One operation (topectomy) was designed to remove different areas of the frontal lobes depending on the presenting symptomatology. In other words, the operation was tailor made for each specific presenting problem. For most neurosurgeons, the generally performed technique involved the sectioning of the medial and orbital pathways of the frontal lobes. Temporal lobectomies were performed in isolated instances on the theory that the temporal lobe was the most important association area. Thalamotomy was carried out by the use of "stereencephalotome," the forerunner of the contemporary stereotaxic instruments. It appeared to me at least that, in so far as frontal lobotomy for the relief of suffering was concerned, results appeared to depend more on the quantity of fibers severed than on the specific regions involved.

This new treatment method, however, was not without disadvantages. One of the early untoward results of brain surgery for the relief of psychiatric disorders was the permanent cognitive-affective loss. Although later surgery markedly reduced the incidence of such loss a new word was introduced. "Lobotomized"—the state resulting from a neurosurgical approach to the treatment of psychiatric disorders—was introduced. This new treatment method, however, was not without disadvantages. One of the early untoward results of brain surgery for the relief of psychiatric disorders was the permanent cognitive-affective loss. Although later surgery markedly reduced the incidence of such loss a new word was introduced. "Lobotomized"—the state resulting from a neurosurgical approach to the treatment of

suffering—was permanently branded in our language as synonymous with "zombie." The good that the procedure had done in relieving the suffering of the tormented mentally ill in the back wards of our mental hospitals, and of those wracked by the pain of cancer was "interred" while the "evil" lived after.

Controversies arose during this era of psychosurgery. For the most part, the general public was not involved, nor were politicians and the courts. It was mainly an interprofessional conflict. Many psychiatrists, with their holistic views, were unwilling to accept the neurosurgeons direct attack on the brain as a valid treatment of mental disorder. Those who sought neurosurgical honors were admonished to read Karl Menninger's remarks on "polysurgical castration devices, not those of strictly phallic significance but those that maim and destroy the creative function of a non-mutilated body."  

Brain surgical procedures for the mentally ill gradually became more and more infrequent. After 1952, the advent of the tranquilizer, the energizers, and other psychopharmacological agents hastened the demise of psychosurgery, as applicable in the treatment of mental disorder. The view of the distinguished psychiatrist, Viets, expressed in 1949, that "a new psychiatry may be said to have been born in 1935 when Moniz took his first bold step in psychosurgery"  did not appear prophetic.

Thus, psychosurgery remained dormant until ten years ago, when the hard-to-abandon procedure came to life like a phoenix arising from its ashes. Occasionally, the psychiatrist whose patient remained intractably disabled would recommend psychosurgery. A few neurosurgeons continued the procedure in the treatment of the suffering of cancer.

The limitations of pharmacotherapy became apparent whenever drugs failed to eliminate certain specific symptoms. In addition, comparison of the effect of two different psychotropic drugs offered little hope for the acquisition of reliable information if the site or mechanism of action of either was not available. After all, psychosurgery is the only biological treatment based on specific knowledge of brain function. Comparisons of operative procedures could offer the opportunity for acquiring valuable data concerning normal brain function while serving the needs of the mentally ill. Experi-

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mental data, clinical observations, sophisticated surgical techniques afforded new information, particularly concerning the old limbic areas of the brain.

The perfection of a stereotaxic device for delivering one or more electrodes to a predetermined target in the brain gave the neurophysiologist and neurosurgeon an instrument for reaching the limbic system with minimum damage to intervening structures. This allowed for the recording of electrical behavior, and stimulation of selected structure to confirm physiological correlates. Precise destruction of the target was used to treat behavioral disturbances. These techniques were also applied to patients suffering intolerable pain, muscle rigidity and involuntary movements of parkinsonism.

Stereotaxic surgery opened the way for bilateral procedures as well as offering a convenient technique to determine the offending side by electroencephalographic observations via depth electrodes. A significant target proved to be the tip of the temporal lobe, the amygdala, which had become identified as a crucial part of the expanded concept of the limbic system. Focal brain disorder involving the amygdala appeared to be associated with poor impulse control and aggressive behavior particularly in the epileptic patient. This was not to say that temporal lobe epilepsy caused aggression, but rather that involvement of the amygdala may reveal itself as a form of epilepsy or aggression or both. It must be stated that most epileptic patients are not violent, but lead normal and productive lives, and have occasionally been persons of genius.

Bilateral stereotaxic amygdalotomy, when restricted to patients with seizure disorders demonstrating episodic aggression, did not arouse significant controversy among neurosurgeons, nor between neurosurgeons and psychiatrists. Nor did the procedure arouse the public, create moral or civil liberty issues, and judicial or political concern. However, when amygdalotomy was applied to those in whom violence was the presenting sign, the controversy engendered reached the halls of Congress. All psychosurgery came under attack, neurosurgical research projects lost funding and the privilege of the entire field of human experimentation was questioned.\(^\text{18}\)

As one might anticipate from the brief history of psychosurgery outlined above, the leader of the opposition to the procedure was and is a psychiatrist, Dr. Peter Roger Breggin. Dr. Breggin's ap-

proach is not that of a psychiatric colleague disagreeing with a neurosurgeon, but rather that of a crusader with the imagination of a novelist and the skill of a lobbyist. As such, he has been the most potent force in politicizing psychosurgery.

I too wish to confess to the pretensions of a novelist. On April 15, 1947, I performed a bilateral frontal lobotomy on Millard Wright, a recidivist burglar. This surgery formed the basis of a novelized documentary published twenty-one years later. The case, concerned with the first criminal subjected to psychosurgery, previously had been discussed by E. Mayer. The circumstances surrounding the operation have been succinctly described:

In 1945 Millard was arrested for ten house breakings and robberies in Pittsburgh, Pennsylvania. Six weeks after his arrest, he refused to eat or converse, seemed confused and apparently attempted suicide. He was therefore transferred to a hospital for the criminally insane until he was placed on trial in 1947. At that time both Wright's lawyers and the local district attorney requested that the defendant be lobotomized in an attempt to cure him of his criminal tendencies. The judge agreed, but upon Wright's return to court two months after his lobotomy a different judge was presiding. Both the surgeon and the defendant were eager to have the opportunity to test the efficacy of the procedure, but the new judge was not convinced that Wright should be allowed to be free. However, because of Wright's demonstrated desire to help medical science, he received the comparatively light sentence of two to twelve years of the possible forty years to life. Wright later committed suicide while in prison.

I was in search of decisive judgments concerning the effects of frontal lobotomy on a man who was also a criminal. I hoped to make such a study significant for man, as well as to learn if the procedure could alter repetitive antisocial behavior. It was an intensive study. It was my good fortune to study a living man before and after placing lesions in his brain and to have the privilege of verifying the site and extent of those lesions on post-mortem examination.

It may be decisively stated that following the frontal lobotomy Millard Wright remained a pain complaining person. It is significant that in his instance lobotomy was performed before the onset of an ulcer-cancer syndrome (of the stomach), thus furnishing an unexpected opportunity to test the effect of frontal lobotomy as a prophylaxis against the development of anxiety associated with pain which so clearly constitutes suffering. Tension and anxiety were unrelieved by the surgery. In about one month the style of language characteristic of Millard Wright before lobotomy had completely returned. And while it is true for a time at least Wright experienced fewer dreams following lobotomy, he did "daydream" and on occasion experienced sustained anger. It is obviously not true of the postlobotomized Millard Wright that he avoided adventure and sought a more or less stereotyped routine of activities . . . (Millard Wright's) pattern of operation as a burglar was essentially unchanged.22

His return to criminal behavior four years after the frontal lobotomy, at a time when he apparently had achieved a satisfactory status in society was disheartening. For Millard Wright, "authentic living" required entering the dark side of the house.

Twenty-five years ago it was possible for a neurosurgeon in search of decisive judgments to perform a psychosurgical procedure on a criminal. Recognizing that much of his previous work involved the pyramiding of unknowns he was grateful to the subject, who had requested the surgery, and to the attorneys and the court for making possible the intensive study of a man before and after the experimental procedure. Now such study would be precluded by the Kaimowitz decision and its legal restraint.

Why did the Kaimowitz case come to fruition at this time? Events between 1947 and now have made society so vulnerable to human scientific investigation that David Bazelon, Chief Justice of the Court of Appeals for the District of Columbia, could say:

A cult may be growing up around the ethics of human experimentation that may neither be good for patients nor the progress of medicine . . . Experimentation is becoming a "dirty" word.23

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22. Koskoff, supra note 19, at 216-17.
First: The Nuremberg Military Tribunal exposed the crimes against human beings performed by physicians during the Holocaust in the name of research. The Nuremberg Code is a judicial summary presented in the case of the Nazi doctors accused of these war crimes. The code, involving ten principles concerning human experimentation, developed by the Nuremberg Military Tribunal, is not considered legal precedent in America. Yet, so pervasive was the travesty of human experimentation perpetrated by a perverse political regime that it produced what I refer to as a traumatic neurosis, a terror neurosis, the Nuremberg neurosis characterized by world guilt. The Nuremberg Code, adopted in 1948, is reflected in numerous statements of medical ethics. All ten principles of the Code were embodied in the Kaimowitz opinion.

Second: The momentum of research has rapidly increased. Thirty years ago three major classes of drugs were unknown: The antibiotics, the antihistaminics, the psychoactive drugs. Despite extensive animal trial, the human being remained the essential test site. Not to have tested polio vaccine on children would have been unthinkable.

Surgical research, particularly in organ transplants and heart maladies, came to the fore in dramatic fashion. Again the human being remained the essential test site. With advancing technology there came an inevitable distancing of medical personnel from the patient. The very sick were monitored. Vital signs were recorded. No nurse or other human agent was required. Precision with its attendant safety features supplanted the touch of human hands.

Third: With advancing technology and its dramatization by the press, fear of control by brain manipulation became heightened. For example, Arthur C. Clarke observed:

Electronic possession of human robots controlled from a central broadcasting station is something that even George Orwell

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never thought of; but it may be technically possible long before 1984.27

And Karen Wagner titled a paper *Psychocivilization or Electroligarchy.*28 Elliot Valenstein of the University of Michigan, in his authoritative and critical examination of brain stimulation and psychosurgery, notes:

Most people have a grossly exaggerated impression of the omnipotence of various brain manipulations, a distorted view of the way specific brain regions are related to behavior, and an uncritical attitude toward suggestions of application of brain technology to social problems.29

In short, brain control has become a modern myth.

Fourth: The psychologist and his theories have come under scrutiny. There has been increasing concern, particularly in the Bureau of Prisons, over the propriety of using behavior modification techniques in the criminal justice system.30 The experimental and theoretical basis of these forms of behavior modification may be traced to B. F. Skinner, who was in search of a behavior technology "to make vast needed changes in human behavior."31 He argues against philosophers who try to stay within the world of the mind; against the psychotherapist who regards the disturbing things men do as symptoms, superficial compared with the Freudian drama staged in the depths of the mind. Rather, Skinner would use a technology of behavior to change the world in which we live. Instead of emphasizing freedom and dignity as personal attributes, he directs our attention to the physical and social environments in which we live.

Behavioral programs involving the systematic manipulation of behavior along the psychological principles evolved in the Skinner system have been increasingly tested at both the state and federal levels. But any form of manipulation raises the spectre of control. Who will ultimately use such technology and to what end?

27. E. VALENSTEIN, BRAIN CONTROL 7 (1973), quoting A.C. CLARKE, PROFILES OF THE FUTURE (1964) [hereinafter cited as VALENSTEIN].


29. VALENSTEIN, supra note 27, at 7-8.


Fifth: Behavior control with drugs has been an expanding part of medical care. Currently there is far reaching reliance on psychotropic (mind controlling) drugs, particularly those in the phenothiazine family—Thorazine and Mellaril. These anti-psychotic drugs have been the target of investigations of their use in hospitals for the mentally ill and mentally retarded. Reliance on drugs is almost universal for the juvenile and adult inmates in the nations nearly two hundred institutions. In a survey conducted in 1967 by Ronald Shipman, a psychologist at the National Institute of Mental Health, 51 percent of the patients surveyed were receiving psychotropic drugs regularly; 39 percent were receiving phenothiazines (Thorazine, Mellaril). Duration of utilization of such drugs ranged from four years to indefinite use. Obvious side effects included: Parkinsonism, chemical hepatitis, tardive dyskinesia characterized by uncontrollable movements of tongue, face, hands and feet. More subtle, but perhaps in the long run more damaging because covert, particularly in children, was reduced alertness and cognitive impairment. Suppression of learning occurred at a time when the growing child was most receptive to intellectual and emotional maturation, and while certain adverse effects of medication are reversible, time lost for learning is not. This should be remembered when evaluating the so-called irreversible effects of psychosurgery in children.

The issue of drug abuse in institutions was recognized to involve difficult medical and ethical judgments. The warning was loud and clear that if the medical and allied professions would not, or could not, handle the problems, the courts would.

Sixth: The concept that mental health is a civil rights issue has had far reaching consequences. Civil rights history was said to have been made in 1971 in Alabama in the case of Wyatt v. Stickney. According to the decision reached in this case, when persons are committed for mental deficiencies they have "a constitutional right to receive such individual treatment as will give them a realistic opportunity to be cured or to improve his or her mental condition."  

34. Id. at 784.
Thus, the right to treatment doctrine was born. In 1974, *Welsch v. Likins* took *Wyatt* a step further. The court there held that excessive use of tranquilizing medication as a means of controlling behavior, not merely as a part of therapy, may likewise infringe on plaintiff's rights.

The right to treatment doctrine poses, however, some delicate practical problems. The responsibility of the state to those it has confined may, of course, be discharged by the release of those being confined. Dr. Allan Stone of the Harvard Law School, has expressed this concern lest patients be released unfit for society: "What we are really addressing is the enormous matter of social responsibility. It is true that a state could comply by abdicating its responsibility to help the mentally ill."37

It further seems that the issues involved are more complex than indicated by the civil rights arguments. Legislators are not eager to spend money for the mentally ill. HEW is the first to suffer the consequences of budgetary cuts. The psychiatrist then becomes the scapegoat. In *Donaldson v. O'Connor*,38 the plaintiff was awarded $38,500 in damages against two psychiatrists at the Tallahassee Hospital. The psychiatrist, already difficult to attract to the professional staff of a public mental hospital, will now be aware that he becomes exposed to liability in negligence for a legislature's inadequacies in supplying facilities and adequate staff. Psychiatrists will practice defensively. They will join the ranks of their surgical colleagues in the present endemic of negligence suits, further aggravating the impending crisis in medical care.

Apart from all other concerns, including who is competent to make decisions concerning the health of the patient, should the patient after discharge prove to have suffered mental changes as the

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35. The rationale behind the doctrine has been described thusly:
We held that where the justification for commitment was treatment, it offended the fundamentals of due process if treatment were not in fact provided; and we held that where the justification was the danger to self or others, then treatment had to be provided as the *quid quo pro* society had to pay as the price of the extra safety it derived from the denial of the individuals' liberty.

Wyatt v Aderholt, 503 F.2d 1305, 1312 (5th Cir. 1974).


result of as yet undiagnosed organic maladies, including brain tumor, the doctor may be held liable in a negligence action. He is caught between the pincers of the civil liberties lawyers and those specializing in negligence actions.

The adversary position between Medicine and Law aggravated the general attack against psychiatry itself by psychiatrists like Dr. Thomas Szasz (Professor of Psychiatry, Upstate Medical Center) who believes that there are no mental patients, and that the psychiatric problem is purely a penal problem—all psychiatry is penology.39 Judge Bazelon, however, warns that promoting the idea that there is no such thing as mental illness, only a sick society with a distorted view of people, is destructive; in the long run, the patient is the sufferer.40

Peter Sedgwick, political scientist-psychologist best expresses my own view concerning the main flow of the antipsychiatry movement:

The revisionists have brought themselves and their public into a state of complete inertia. They can expose the hypocrisies and annotate the tragedies of official psychiatry, but the concepts which they have developed enable them to engage in no public action which is grander than that of wringing their hands.41

Seventh: The concept of informed consent has been expanded and has become a legal requirement. It is tort law that consent is the mechanism by which the patient grants the physician power to act in his behalf, and protects him from unauthorized invasion of his person. Recently, the requirement of informed consent has become an essential part of the transaction between patient and physician with ever widening application. An operation upon a patient without his informed consent is the tort of battery. This applies to research. Benjamin Cardozo is often recalled to give emphasis to the doctrine of informed consent: “Every human being of adult years and sound mind has a right to determine what shall be done with his body.”42

The requirement of informed consent in therapeutic and experi-

40. Bazelon, supra note 23, at 1317-22.
41. Sedgwick, Illness, Mental and Otherwise-Salunagurdi, reprinted in 1 Hastings Cen-
mental procedures has been received with ambivalence. For some, who believe that patients and subjects are best protected by the Hippocratic admonition that above all no harm should be done, the doctrine seems unnecessary. Dr. Ingelfinger regards the process of obtaining informed consent as an elaborate ritual: "The subject's only real protection depends on the conscience and compassion of physician, scientist and his peers." A Pennsylvania court, however, has noted:

As the patient must bear the expense, pain and suffering of any medical treatment, his right to know all material facts pertaining to the proposed treatment cannot be dependent upon the self-imposed standards of the medical profession.44

What constitutes being informed? The simple dictionary meaning is having information. But in the context of interaction between two people, the patient and the doctor, there are psychological, semantic, and ethical complexities. The informant has no difficulty in reciting hopes and hazards of the contemplated procedure, and the courts recognize that it is not essential to give stressful information to emotionally vulnerable people. But all patients are undergoing varying degrees of stress. Denial mechanisms reject what the doctor is saying. Recall is spotty. There is no adequate language to describe sensory experience; one must feel it to have knowledge of it. The transaction between doctor and patient is inherently unequal by virtue of the doctor's knowledge and experience. Furthermore, there is regression in illness; above all else the patient needs reassurance. Of course, it is ethically wrong to deny the patient the human dignity of communication with his doctor. But in the final decision the patient will ask: "What do you think Doctor?" Not to relieve a sick person of the necessity of decision is, in my view, cruel and unusual punishment.

The issue of informed consent is crucial to the Kaimowitz case. Kaimowitz widened the scope of its application, raised problems of great complexity and added unrealizable requirements. A landmark decision became in part a semantic swamp.

Because the Kaimowitz case was brought to public attention through dramatization by the press, presentation of a few of the news accounts would be appropriate at this juncture. Newspapers

are one of society's personal documents, reflecting the hopes and concerns of people, while at the same time informing them. Civil libertarians and those concerned with ethical problems have voiced the view that it behooves the physician and scientist to take the public into their confidence. The news report ensures that this becomes at least partly inevitable. Indeed, there may have been no Kaimowitz case had it not been for the Detroit Free Press.

On March 12, 1973, The New York Times blazoned forth in front page headlines: PSYCHOSURGERY WILL FACE A KEY TEST IN COURT, and described the pending Kaimowitz hearing as a “precedent-setting case thrusting John Doe into the center of a mounting controversy over the use of brain surgery to erase the symptoms of an otherwise untreatable behavioral and emotional disorder.” 45 The article was accompanied by a diagramatic representation of the limbic system or emotional brain and an x-ray picture of the skull with deep electrodes in situ. In addition to drawing vivid attention to psychosurgery, critical questions in psychiatry, law and medicine were raised:

[W]hatever the outcome of the case, the consequences of the debate in psychosurgery will be felt by countless thousands of people. Ordinary people with families and jobs as well as institutionalized patients and prisoners whose lives are made intolerable by behavioral or emotional problems that cannot be treated by traditional psychotherapeutic methods. Research is likely to be affected. 46

The concern over the effect on research was not without substance. Dr. Jacques Gottlieb, Director of the Lafayette Clinic cautioned: “The adventure of research is becoming more difficult with more and more stumbling blocks and it is frightening to the young men who want to become investigators.” 47 Dr. Henry K. Beecher, Harvard anesthesiologist added:

The waters are muddy. I would be loathe to use individuals labeled criminally insane but on the other hand, here are people who are sick, intolerably sick. Where can they go? Are we going to cut off every avenue of rehabilitation? Talk about civil

46. Id.
47. Id.
liberties. . . it would seem the hope for relief is a rather important one. 48

A New York Times Sunday editorial noted that a myriad of tough questions were raised and the psychosurgeon found himself in the middle of an international controversy:

The present controversy . . . has had the effect of halting nearly all studies of the technique in this country raising a not unfamiliar dilemma. Without further studies the potential of psychosurgery for good or ill will never be known. 49

One of the major questions raised in the suit was: When is the psychosurgeon permitted to do the surgery? William K. Stevens, reporting on the results of the hearing, stated: “Experimental psychosurgery may not be performed on persons confined against their will in state institutions even when such a person’s consent is formally obtained.” 50 The unanimous forty-one page opinion did, however, leave the way open for the performance of psychosurgery when the procedure has advanced to a level where its benefits clearly outweigh its risks. Gabe Kaimowitz, plaintiff’s attorney stated:

The medical profession will have learned as a result of this to shy away from any kind of experimentation on captive populations and high risk experimentation on voluntary populations. This puts the doctors on notice that their work is subject to scrutiny. 51

Years ago a more mature observation concerning doctors came from the pen of Justice Cardozo: “We may scoff at [the physician] in health but we send for him in pain.” 52

An extract from the text of the Kaimowitz opinion clarifies the circumstances and issues involved:

This case came to this Court originally as a complaint for a writ of Habeas Corpus brought by Plaintiff Kaimowitz on behalf of John Doe and the Medical Committee for Human Rights, al-

48. Id.
52. B.N. CARDozo, CHIEF JUSTICE OF THE COURT OF APPEALS OF NEW YORK 970 (1931) (text of address before N.Y. Academy of Medicine, Nov. 1, 1928).
leging that John Doe was being illegally detained in the Lafayette Clinic for the purpose of experimental psychosurgery. John Doe had been committed by the Kalamazoo County Circuit Court on January 11, 1955, to the Ionia State Hospital as a Criminal Sexual Psychopath, without a trial of criminal charges, under the terms of the then existing Criminal Sexual Psychopathic Law. He had been charged with the murder and subsequent rape of a student nurse at the Kalamazoo State Hospital while he was confined there as a mental patient.

In 1972, Drs. Ernst Rodin and Jacques Gottlieb of the Lafayette Clinic, a facility of the Michigan Department of Mental Health had filed a proposal "For the Study of Treatment of Uncontrollable Aggression."

This was funded by the Legislature of the State of Michigan for the fiscal year, 1972. After more than seventeen years at the Ionia State Hospital, John Doe was transferred to the Lafayette Clinic in November of 1972, as a suitable research subject for the clinic's study of uncontrollable aggression.

Under the terms of the study, twenty-four criminal sexual psychopaths in the state's mental health system were to be subjects of experiment. The experiment was to compare 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. The comparison was intended to show which, if either, could be used in controlling aggression of males in an institutional setting, and to afford permanent relief from such aggression to the patient.

Substantial difficulties were encountered in locating a suitable patient population for the surgical procedures and a matched controlled group for the treatment by the anti-androgen drug. As a matter of fact, it was concluded that John Doe was the only known appropriate candidate available within the state mental health system for the surgical experiment.

John Doe signed an "informed consent" form to become an experimental subject prior to his transfer from the Ionia State Hospital. He had obtained signatures from his parents giving consent for the experimental and innovative surgical procedures to be performed on his brain, and two separate three-man review committees were established by Dr. Rodin to review the scientific worthiness of the study and the validity of the consent obtained from Doe.

The Scientific Review Committee, headed by Dr. Elliot Luby, approved of the procedure, and the Human Rights Review Committee, consisting of Ralph Slovenko, a Professor of Law
and Psychiatry at Wayne State University, Monsignor Clifford Sawher, and Frank Moran, a certified public accountant, gave their approval to the procedure.\(^5\)

Certainly, it would appear that the procedure was careful, and the review committees were appropriate. Only one suitable candidate for the psychosurgery was found. One may reasonably express some concern about the choice since subsequently John Doe was regarded as capable of living in the outside world after his long incarceration. Apparently, the discharge, ordered by the court in consultation with a single psychiatrist, was a calculated risk, perhaps motivated by the previously determined violation of his constitutional rights.\(^5\)

The law, as well as medicine, must take risks affecting both the individual and society.

Even though no experimental subjects were found to be available in the state mental health system other than John Doe, Dr. Rodin prepared to proceed with the experiment on Doe, and depth electrodes were to be inserted into his brain on or about January 15, 1973. In response to the avalanche of publicity initiated by the Detroit Free Press, Dr. Yudaskin withdrew his approval of the project. Subsequently, Mr. Doe decided not to consent to the procedure. In other words, there were no stated plans to carry out the research nor a subject suitable for it.

Nevertheless, it was held by the court that even though the experiment would not take place, the matter was not moot and the basic issues involved were ripe for declaratory judgment. Why? Although it is not altogether clear, the court states:

The nature of the case is such that we are likely to again receive the question in the near future, and doctors and other people dealing with public hospital corporations cannot hope to have an answer to the questions raised unless we proceed to decision.\(^5\)

In surgery, when we are uncertain as to whether to proceed, we hold action in abeyance. We remember the Hippocratic admonition

\(^5\) Kaimowitz v. Department of Mental Health, Civil No. 73-19,434-AW (Cir. Ct. Wayne Co., Mich., July 10, 1973) slip op. 1-5.\(^5\)

\(^5\) Id. at 1 n.2.

—Do not harm. The ill-timed court action did harm. It amplified existing problems arising from the doctrine of informed consent; it impeded needed investigation in the field under consideration, in research in humans by humans for humans and the potential for relief of suffering in countless patients.

The two issues framed for decision in this declaratory judgment action were as follows:

After failure of established therapies, may an adult or a legally appointed guardian, if the adult is involuntarily detained, at a facility within the jurisdiction of the State Department of Mental Health give legally adequate consent to an innovative or experimental surgical procedure on the brain, if there is demonstrable physical abnormality of the brain, and the procedure is designed to ameliorate behavior, which is either personally tormenting to the patient, or so profoundly disruptive that the patient cannot safely live, or live with others?

If the answer to the above is yes, then is it legal in this State to undertake an innovative or experimental surgical procedure on the brain of an adult who is involuntarily detained at a facility within the jurisdiction of the State Department of Mental Health, if there is demonstrable physical abnormality of the brain, and the procedure is designed to ameliorate behavior, which is either personally tormenting to the patient, or so profoundly disruptive that the patient cannot safely live, or live with others? 56

The second issue was rendered moot since the answer to the first question was “no.” The court, in a most arbitrary way, stated: "Psychosurgery should never be undertaken upon involuntarily committed populations when there is a high risk, low benefit ratio as determined in this case." 57 This determination could not have been made on the basis of facts in the case of John Doe. John Doe was apparently well enough to be discharged. Without irreverence to the court, I find a kind of logic of the absurd in talking of "this case" as if hard evidence had been presented. The court talks properly of declaratory judgments depending on a choice of conflicting views of experts in the fields of neurology, psychiatry and electroencephalography. In other words, the court was in the untenable position of making a medical decision in a complex area, not a legal

56. Id. at 8-9.
57. Id. at 13.
decision. It naively asks if brain function is related to abnormal aggressive behavior, and adds in a non sequitur: "This fundamentally is what the case is all about." Such a proposition leads to blind alleys and confusion. All behavior—normal, pathological, aggressive, nonaggressive—remains a function of the brain. This has been known at least since Hippocrates.

The court observed that psychosurgery does not provide any assurance that a dangerously violent person can be restored to the community. What it failed to recognize was that medicine makes no assurances. If guarantees were possible, experimentation would be unnecessary. To claim there is no scientific basis for establishing that the removal or destruction of an area of the limbic brain would have any direct therapeutic effect in controlling aggressiveness or improving tormenting personal behavior, absent the showing of a well defined clinical syndrome, is an oversimplification.

Not infrequently, the physician and surgeon is required to treat disabling symptoms in the absence of well-defined clinical entities. But even epilepsy, regarded in this case as a well-defined clinical syndrome, is in fact a variety of disturbances referred to generically as the epilepsies, the symptoms of which may vary widely from overt convulsions to obscure behavioral disturbances. Research has been carried out in behavioral disorders with and without overt convulsive disturbances directed toward the limbic system. V. Balasubramaniam and his co-workers believe "there are many behavior disorders which are amenable only to stereotaxic interruption of various parts of the limbic system." Heimburger performed stereotaxic destruction of the amygdala in twenty-five severely epileptic and/or dangerously aggressive patients. Overall improvement included reduction in hyperactivity, hostility, destructiveness and hypersexuality. It must be stated that, in my view, it is unlikely that aggression, a form of instinctual drive utilized in the service of sex, exploration of the environments as well as hate and violence, is localized in a specific "center" of the limbic system. What we wish to learn is whether or not stereotaxic surgery directed toward the amygdala, a part of the limbic system, may be useful in relieving

58. Id. at 14.
those tormented patients who are destructive to themselves and the world about them. That is what the case is all about.

The basic reason why psychosurgery should never be undertaken upon an involuntarily committed population, the court says, is the impossibility of obtaining truly informed consent from such populations. Medicine deals for the most part, not with impossibility, but with probability. We regard the impossible as inadmissible.

It is contended that before the Kaimowitz court fashioned its demanding standards of informed consent for the proposed experimental amygdalotomy on John Doe, the procedural safeguards enunciated by the Wyatt "right to treatment" opinion were not being adhered to. Paramount would have been the insistence on the right for John Doe to secure independent counsel. The idea of that right did not become apparent until after the Michigan Legal Services challenged the proposal.

The procedural safeguards utilized in the case of Millard Wright could have served as a model. The neurosurgeon was consulted by a subject concerning the possible use of psychosurgery in the presence of the subject's attorney. Following the detailed discussion with Millard Wright concerning the hope and hazards of the contemplated procedure, Wright gave his consent in the presence of his attorney. The presiding judge was consulted, and a court order was issued to the effect that the surgery be performed.

Nevertheless the Kaimowitz court chose to grapple with the heavily burdened issue of informed consent, designing more exacting standards with a strong reliance on the Nuremberg Code. According to the court, for the involuntarily committed mental patient to meet the requirements of voluntary consent, he must be competent and knowledgeable. The Kaimowitz court affirms the principle that an institutionalized patient may be competent to give consent for a "regular surgical procedure" but that an involuntarily detained mental patient is not competent to give consent for experimental psychosurgery.61

The court’s reasoning appears inconsistent. The court described the deleterious effects of prolonged institutionalization on the capacity of the person to give informed consent, noting: "The very nature of his incarceration diminishes the capacity to consent to

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psychosurgery. He is particularly vulnerable as a result of his men-
tal condition, the deprivation stemming from involuntary confine-
ment, and the effects of the phenomenon of institutionalization."
But should amygdalotomy cease to be considered experimental,
then the involuntarily detained patient could give consent to the
performance of the procedure. In other words, the decision rests on
whether or not the procedure is experimental rather than on the
capacity to give informed consent. According to the court:

Although guardian or parental consent may be legally ade-
quate when arising out of traditional circumstances, it is le-
gally ineffective in the psychosurgery situation. The guardian
or parent cannot do that which the patient absent a guardian
would be legally unable to do.\footnote{62} Again, a possible absurdity. Though the opinion notes that at some
future time an involuntarily detained mental patient could consent
to demonstrably therapeutic amygdalotomy, this suggestion is
meaningless for the reasons stated above.

If it were supposed that competency is a trait which can never be
established in any member of the entire institutionalized mental
population, case by case evaluation becomes inevitable. What is
served by discriminating against a class? Can one say with a degree
of medical probability that involuntary commitment establishes the
determination of lack of competency? According to the Kaimowitz
court voluntary consent is impossible because of the inherent ine-
quality between doctors and administrators and the patient:

Involuntarily confined mental patients live in an inherently
coercive institutional environment. Indirect and subtle psy-
chological coercion has profound effect upon the patient popu-
lation. Involuntarily confined patients cannot reason as equals
with the doctors and administrators on whether they should
undergo psychosurgery. They are not able to voluntarily give
informed consent because of the inherent inequality in their
position.\footnote{64}

As previously described, the inherent inequality, particularly be-
tween doctor and patient, is universal.

\footnote{62. Id. at 25.}
\footnote{63. Id. at 26.}
\footnote{64. Id. at 29.}
The paradox is this: The court is aware of psychosurgery's therapeutic potential and is aware that experimental research is essential for establishing the therapeutic value of amygdalotomy. But the court believes that lack of knowledge about the subject of experimental brain surgery, "makes a knowledgeable consent to psychosurgery literally impossible for the present time." Therefore, knowledgeable consent to experimental psychosurgery is impossible. There are no individuals available for psychosurgery and there can never be under the circumstances proposed. Ironically, as nowhere else the proper study of Man is Man. It is almost impossible by nonintrusive studies alone to determine whether amygdalotomies on human beings can ever be therapeutic. Yet, despite the fact that other avenues of research theoretically remain open (cingulotomy, orbital undercutting, even electrical stimulation of the brain E.S.B.) all forms of psychosurgery have been held in abeyance. Psychosurgery of any kind will be illegal if courts follow Kaimowitz.

The court's concern about the violation of civil rights of patients subjected the experimental brain surgery is unique and provocative. The court based its reasoning on a hypothetical assumption that valid consent could be given to the procedure "someday" at some unspecified time. The Kaimowitz court, apparently sensitive to possible threats to civil liberties, considered its constitutional analysis to be dicta. The warning of the late Justice Frankfurter comes to mind: "in constitutional adjudications dicta are peculiarly pernicious usurpers. To let even accumulated dicta govern is to give the future no hearing." Kaimowitz dicta indicate that the judiciary must guard against violation of constitutional rights; and that there are constitutional limits in the emerging right to treatment doctrine. A constitutional right to be free from experimental psychosurgical operations is one such limit. However, judicial intervention in the area of medical research might produce the untoward result of obstructing the basic "right to treatment."

In citing the first amendment, the judges observed "that the government has no power or right to control men's minds, thoughts and expressions." If the first amendment protects the freedom to ex-

65. Id. at 27.
66. Frankfurter, Mr. Justice Brandeis and the Constitution, 45 Harv. L. Rev. 33, 85 (1931).
press ideas, it necessarily follows that it must protect the freedom to generate ideas. It is argued:

Psychosurgery often limits the ability to generate new ideas. . . . Its potential for injury to the "creativity" of the individual is great, and can impinge upon the right of an individual to be free from interference with his mental prowess.88

Such statements fail to take into account the fact that patients often are capable of generating new ideas after psychosurgery. These ideas may be adaptive and lead to a more useful, less tormented life. Anatomical loss may be associated with functional gain. Sometimes the capacity to generate new ideas is essentially unchanged as in the case of Millard Wright.

A further question raised by the above quotation is what is meant by "creativity"? Creativity, as most conceive the term, indicates a capacity of gifted people to conceive a work of art, or scientific enterprise, or an imaginative way to make people live more happily together. To my knowledge such data before and after psychosurgery are not available. Millard Wright was a more "creative crook" after frontal lobotomy than before. He could formulate and execute a plan with skill and style.

In any case, the first amendment protects the right to generate and disseminate ideas which the individual himself has the freedom to express. If a person has a valid reason for wanting psychosurgery, there can be no constitutional need to prevent him from doing so.

Logically the government can no more interfere with an individual's choice to undergo brain surgery than it can to coerce free speech under the guise of protecting society's first amendment interest.69

What if a committed person insists on having a psychosurgical procedure performed? Are his constitutional rights infringed upon if he is denied the procedure? An appropriate case needs to be brought before a federal court. When tested at a higher court I believe the Kaimowitz restraint will prove to be "short term."

The constitutional concept of the right of privacy is brought to bear in the Kaimowitz case. The arguments are eloquent:

68. Id. at 36.
69. Mason, supra note 4, at 329.
Nor are the intimate internal areas of the physical habitation of mind and soul any less deserving of preservation from unwarranted and forcible intrusion than are the intimate internal areas of the physical habitation of wife and family. Is not the sanctity of the body even more important, and therefore, more to be honored in its protection that the sanctity of the home. 70

The garden of the mind, however, may not always be a private Eden. It can be a hell of suffering, a generator of violence threatening the self and the world about it. Yet, says the Kaimowitz courts: "There is no privacy more deserving of constitutional protection than one's mind." 71

Intrusion into one's intellect is an intrusion into one's constitutional right of privacy. But the world of the mind is always private. Sherrington, in a philosophical mood, believed brains were invented so minds could communicate with each other. The Kaimowitz expansion of the concept of right of privacy enters the domain of the metaphysical. The founding fathers probably would have understood these excursions into the realm of metaphysics but the "true purpose of the Bill of Rights is to establish limits on governmental power, not to foreclose individual choice. The rights of free speech and privacy should not preclude a mental patient from having an operation to which he has voluntarily consented." 72

The present epidemic of negligence suits which has brought medical care to a crisis has spread to the area of psychosurgery. 73 Psychosurgical procedures for established therapeutic, as well as experimental, reasons are being brought to an abrupt halt. The patient suffering the intractable pain of cancer is deprived of the option psychosurgery may offer. Experimental and therapeutic techniques, often interrelated, involving such procedures as cryosurgery for Parkinsonism, implanted stimulating devices to abort convulsive attacks, and similar techniques involving the use of implanted electrodes have come under the threat of negligence actions. Risk characteristic of the frontier of the acquisition of knowledge in the serv-

71. Id. at 38.
72. Mason, supra note 4, at 330.
73. On December 3, 1973, five months after the Kaimowitz decision was rendered, a suit for negligence was filed by a patient on whom psychosurgery had been performed to alleviate violent rage. Killie v. Mark, Civil No. 681,998 (Super. Ct. Suffolk Co., Mass., filed Dec. 3, 1973).
ice of the patient will not be taken. This inhibiting effect on human experimentation is contrary to the long term public good.

The Kaimowitz extension of the doctrine of informed consent poses insuperable problems for institutionalized persons, other than mental patients. I refer particularly to prisoners. If one agrees that, "the infantalizing depersonalizing, helplessness and anonymity that occur within a prison environment force the prisoner into a state of total dependency,"**74** informed consent, according to the Kaimowitz criteria, becomes unobtainable. Such blurring of individual differences in the way persons respond to adverse circumstances obscures the true facts of contemporary psychology. Each person, depending on his constitutional psychological makeup, the time in his life situation, and a host of other factors, will react in varying degrees to incarceration or any other stress. To consider prisoners as a group and deprive each in the group of a choice of options, regardless of what subtle or overt motivations may uniquely affect his decision, is to deprive each prisoner of his rights. The human and civil rights of the prisoner are best protected on an individual basis.**75**

Neuroscientists, including neurosurgeons are in retreat. Neuroscientists, while recommending that psychosurgery be available to individuals suffering from certain recognized incapacitating mental disorders, say that such procedures should not be performed on prisoners.**76** Dr. Vernon Mark believes that

under present conditions it would seem that the performance of psychosurgery should be prohibited . . . and further, prison inmates suffering from epilepsy should receive only medical treatment; surgical therapy should not be carried out, because of the difficulty in obtaining truly informed consent.**77**

Hazards of negligence and battery suits, even criminal action, aggravated by the tripartite elaboration of the doctrine of informed consent in the Kaimowitz opinion, have become ominous possibilities. Anxieties in surgeons are heightened by the published views of Alvin J. Bronstein of the American Civil Liberties Union who argues

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75. The above considerations apply to behavior modification by drug and operant conditioning techniques as well as psychosurgery.
76. See, e.g., statement of Theodore Bullock, President, Society for Neuroscientists, 32 Arch. Neurol. 73-75 (1975).
that experiments on prisoners should be banned. However, Professor Freund of the Harvard Law School believes:

[T]here seems to be no good reason for depriving this group of the satisfactions of participation on an informed basis, satisfactions to them are often great indeed, bolstering their self esteem and furnishing links to the general community and its values.

The argument that the prisoner is a “captive” in a unique sense is in itself untenable. Is not the guilt-laden noncaptive volunteer imprisoned by his neurotic masochistic needs? Professor Louis Lasagna asks:

Does it really protect the rights of a prisoner to forbid him to volunteer for dangerous but potentially important experiments in anticipation of some reward? Is such volunteering generally different from the case of the test pilot who risks his life in return for money, excitement or both?

Has the zealous concern with health as a legitimate function of civil liberties been productive, however humanitarian in outlook? It is fair to say that in certain instances the clamor resulting from civil liberty actions has dramatized the poor quality of care, particularly in mental hospitals. Doctors have known this for a long time. But in the main doctors have been powerless to effect changes in facilities and medical staff primarily because the goal of improved mental health has only lately come to the fore, and only in certain areas. To institute suits against psychiatrists is to misjudge the responsible target and to underestimate the extent of the problem. Basically, it is a question of economics in a society more concerned with profits than patients.

Experimentation with human subjects is a generally acknowledged necessity of modern scientific research. This is particularly true in the area of medical investigation. There is an experimental component in all medical diagnosis and treatment. Indeed, “[w]e have to live with ambiguity, the treacherous impurity of everything

79. Freund, Ethical Aspects of Experimentation with Human Subjects, 98 Daedalus viii, xii (Spring 1969).
80. Lasagna, Special Subjects in Human Experimentation, 98 Daedalus 449, 455 (Spring 1969).
There are no certainties. There are always risks. Medicine is becoming increasingly experimental and so are the risks. The modern teaching hospital which admittedly delivers the best health care is the embodiment of research and treatment. The teaching hospital develops our medical teachers, researchers, and therapists vital to the best quality of medical care.

Kaimowitz aggravated the assault on the already vulnerable concept of human experimentation as essential to innovative therapy and scientific progress. Teachers and students will become more and more disenchanted with the adventure of the acquisition of new knowledge in the service of their patients. Lawyers with the most lofty intentions who wish to protect patients' civil liberties must remember that often "Hell is paved with good intentions," and those they most desire to help will be those who will be hurt the most.

To deny the abuses in human experimentation is unwarranted, but to obstruct human experimentation itself is foolhardy. We do need additional safeguards beyond those now prevalent in experimental brain surgery. National professional guidelines and procedures need to be formulated to assure: that the individual suffers from an incapacitating mental disorder; that psychosurgery is an appropriate technique; and that informed consent, despite all its ritualistic, symbolic qualities and its limitations, be obtained.

The psychosurgeon must study the individual patient before and after each procedure, assiduously, carefully and in collaboration with other specialists in the general field of human behavior. Nothing supplants the intensive study of the single case. Careful, long term follow-up and detailed reporting of results should be required. It appears desirable that psychosurgery be performed in special institutions prepared to learn the most from every experience for the understanding and guiding of future decisions.

Declaratory judgments, judicial opinions and statutes will not at the present time be productive because such controls obstruct human experimentation essential to progress in medical care. Elliot Valenstein believes:

The struggle for the proper balance between the welfare of the

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82. I.J. Boswell, LIFE OF S.R. JOHNSON 555 (Everyman ed. 1775).
individual and that of society will always be with us and cannot be permanently resolved by decrees that prohibit experimentation in one situation or another.\footnote{3}

I believe the conscience, integrity and the skills of the experimenter remain the best safeguards of human rights.

\footnote{83. Valenstein, \textit{supra} note 27, at 346.}