Psychosurgery and the Involuntarily Confined

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PSYCHOSURGERY AND THE INVOLUNTARILY CONFINED

Men ought to know that from the brain and from the brain only arise our pleasures, joys, laughter, and jests as well as our sorrows, pains, griefs and tears. Through it, in particular, we think, see, hear, and distinguish the ugly from the beautiful, the bad from the good, the pleasant from the unpleasant... It is the same thing which makes us mad or delirious, inspires us with dread and fear, whether by night or by day, brings sleeplessness, inopportune mistakes, aimless anxieties, absentmindedness, and acts contrary to habit.

Hippocrates
The Sacred Disease

I. INTRODUCTION

During its developmental stages, and throughout the fifties and sixties, the legal issues involved in the performance of psychosurgery were largely ignored by the legal community. The development of scientifically refined techniques for psychosurgery, however, coincided with the climate of general political unrest in the late 1960's. This climate, evidenced in part by a general fear of behavior control and a concern about the possible abuse of minorities, provided the background against which a growing public concern about the uses of psychosurgery arose. Dr. Peter Breggin, a psychiatrist, wrote a series of articles that criticized the increased incidence of psychosurgery and the political implications of suggestions that urban riots and other acts of "senseless violence" might be prevented, at least in part, by appropriate diagnostic techniques and surgical intervention. The popu-
lar novels *A Clockwork Orange*, 11 *One Flew Over the Cuckoo's Nest*, 12 and *The Terminal Man* 13 contributed to a growing public awareness, as did reports that psychosurgery had been performed on prisoners in California.14

Reacting to this widespread public concern, the legal community formulated a tentative response to the issues raised by the performance of psychosurgical procedures. Due to the emotional nature of the issues, that initial response was, in some cases, an overreaction to the problem.15 Gradually, however, a more reasoned approach to the use of psychosurgery has been formulated. This comment will focus on the adequacy of the law's response to psychosurgery, with specific reference to the performance of psychosurgery on two distinct classes of individuals: the involuntarily confined mental patient and the prison inmate. In evaluating the legal response to psychosurgery, particular emphasis will be placed on the constitutional analysis involved to determine the extent to which the various regulatory approaches have preserved the individual's physical and mental integrity, the physician's ability to pursue his vocation of medical practice and research, and the future patient's access to the potential benefits of contemporary psychosurgical research.


The proposal that acts of violence could be prevented by psychosurgery was first made by Drs. Ervin, Mark, and Sweet in a letter which linked "arson, sniping and physical assault" to "brain dysfunction." Ervin, Mark & Sweet, *Role of Brain Disease in Riots and Urban Violence,* 201 J.A.M.A. 895 (1967). The authors called for an extensive screening of Americans to discover and treat potentially violent individuals. *Id.* See also V. Mark & F. Ervin, *Violence and the Brain* (1970).


   A California prison hospital has experimented with brain surgery to control violent, aggressive spasms of inmates it described as "brain damaged."

   Three inmates with a history of episodic seizures of uncontrollable violence, apparently caused by brain damage, had portions of their amygdalas destroyed by a relatively new and sophisticated technique known as stereotaxic surgery.

   According to prison officials, all three inmates—in their lucid moments—granted consent to the operations, as did members of their families. (This could not be verified, since access to medical records was denied.) Furthermore, according to L.J. Pope, a retired Navy doctor who is superintendent of Vacaville, the subjects were quite anxious to be helped.

   *Id.*

   These general issues also received wide exposure in articles appearing in a number of popular magazines. See, e.g., Mason, *New Threat to Blacks: Brain Surgery to Control Behavior*, *Ebony,* Feb. 1973, at 62; *Time,* April 3, 1972, at 50.

15. For example, in 1973, Congressman Louis Stokes introduced legislation that would have prohibited all forms of psychosurgery designed to alter behavior from being performed in federally funded health care facilities. H.R. 5371, 93d Cong., 1st Sess., 119 CONC. REC. 6761-64, 6784 (1973).
II. PRELIMINARY INFORMATION

A. Psychosurgery Defined

As widespread disagreement over the safety and effectiveness of psychosurgery exists, a precise definition of the actual procedure remains illusive. Proponents of psychosurgical operations sharply distinguish classic frontal lobe surgery from the more technologically refined contemporary

16. A central issue surrounding the practice of psychosurgery has been the underlying medical justification for the procedure. Report, supra note 6, at 7. A survey of the literature would appear to indicate that psychosurgery has met with considerable therapeutic success. Neuritic patients have benefited from the performance of psychosurgery. Restak, The Promise and Peril of Psychosurgery, SAT. REV. WORLD, Sept. 25, 1973, at 54. Substantial success has also been reported in the treatment of obsessive-compulsive neurosis, a disorder often characterized by a constant fixation on a single object or activity. Bridges, Goktepe & Maratos, A Comparative Review of Patients with Obsessional Neurosis and with Depression Treated by Psychosurgery, 123 BRIT. J. PSYCH. 663, 664, 673 (1973); Tan, Marks & Marset, Bimedial Leucotomy in Obsessive-Compulsive Neurosis: A Controlled Serial Inquiry, 118 BRIT. J. PSYCH. 155, 163 (1971). Certain operations have enabled previously institutionalized patients to return to their families and resume partial or full employment. Ström-Olsen & Carlisle, Bi-Frontal Stereotactic Tractotomy, 118 BRIT. J. PSYCH. 141 (1971). Moreover, psychosurgery has provided a substantial benefit to patients suffering from intractable pain, whether caused by unknown psychological factors or by untreatable physical disease. Roberts & Vilinskas, Control of Pain Associated with Malignant Disease by Freezing, Cryoleucotomy, 37 CONN. MED. 184 (1973); Selker & Jannetta, Central Pain and Central Therapy of Pain, CURRENT PROB. SURGERY, Feb. 1973, at 59. More modest claims have been asserted concerning the effectiveness of psychosurgery in the treatment of schizophrenic patients. Templer, The Efficacy of Psychosurgery, 9 BIOLOGICAL PSYCH. 205, 206-08 (1974).

In contrast, other medical experts assert that the risks of psychosurgery are unreasonably high, noting the irreversibility of the procedure and the inconclusive and contradictory data regarding the effects of psychosurgery, particularly upon "violent" patients. Chorover, Psychosurgery: A Neuropsychological Perspective, 54 B.U. L. REV. 231, 239-45, 247-48 (1974). In addition, since most psychosurgery is performed in the context of clinical practice, and is therefore without a research protocol or any form of review, few attempts have been made to systematically measure the patient's preoperative status against his post-operative condition. Furthermore, subsequent evaluations are rarely performed by persons who have no vested interest in the outcome of the surgery. E. VALENSTEIN, BRAIN CONTROL 296 (1973). See also Means, Law and the Physical Control of the Mind: Experimentation In Psychosurgery, 25 CASE W. RES. L. REV. 565, 599-600 (1975). Furthermore, a significant number of studies are conducted without proper research controls, which would permit the researcher to measure the effects of the surgery compared against the effects of other forms of treatment, or no treatment. Breggin, The Return of Lobotomy and Psychosurgery, reprinted in 118 CONG. REC. 5567, 5575 (1972); Templer, supra, at 206-07. Another criticism involves the application of techniques to humans by surgeons who have neither full knowledge nor appreciation of the complexity and implications of the results of animal research. E. VALENSTEIN, supra, at 326-55. Valenstein, for example, reports that incisions in the limbic system in animals produce unreliable and unpredictable results, often either increasing aggression or producing marked abnormalities in behavior. Id. at 137. See also Chorover, supra, at 238.

17. The classic prefrontal lobotomy or leucotomy is accomplished by severing certain fiber tracts running between the two frontal lobes and the rest of the brain with a special knife, the leucotome, which is inserted through a small opening drilled in the skull. Goldstein, Prefrontal Lobotomy: Analysis and Warning, 182 SCIENTIFIC AM., Feb. 1950, at 44. For a discussion of the historical development of the lobotomy procedure, see notes 32-50 and accompanying text infra.
procedures. A typical definition of contemporary psychosurgery is "any neurosurgical operation that affects human behavior, even if the patients being treated have obvious brain disease." Definitions of psychosurgery offered by critics of the procedure contain similar factual elements, but include words with a strikingly different emotional emphasis:

Psychosurgery is any surgery which mutilates or destroys brain tissue to control the emotions or behavior without treating a known brain disease. . . . [P]sychosurgery is a pacifying operation which blunts the emotions and subdues behavior regardless of the presence or absence of any brain disease or any particular psychiatric problem. It is simply a mutilating operation whose effect is to destroy the individual's ability to respond emotionally.

In 1974, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (Commission) was established to investigate past uses of psychosurgery and to recommend to the Secretary of Health, Education, and Welfare "policies defining the circumstances (if any) under which the use of psychosurgery may be appropriate." Psychosurgery was defined in the Commission's report as follows:

18. The stereotaxic method of psychosurgery, which is considerably more exact and sophisticated than the lobotomy, allows the placement of needle sized electrodes deep inside specific regions of the brain, which are then used to stimulate or destroy certain portions of brain tissue. Chorover, supra, note 16, at 235-37; Kelly, Richardson & Mitchell-Heggs, Stereotactic Limbic Leucotomy: Neurophysiological Aspects and Operative Technique, 123 Brit. J. Psych. 133, 137-38 (1973). For a discussion of this form of surgery and photographs of the tools and techniques used, see V. Mark & F. Ervin, supra note 10, at 71-85.


20. Breggin, supra note 10, at 11,396-97. Breggin, one of this country's most vocal opponents of psychosurgery, has characterized psychosurgery as no more "a medical procedure . . . than the mutilation of an arm as punishment for a crime is a medical procedure." Hearings on S. 974, S. 878 and S.J. Res. 71 Before the Subcomm. on Health of the Senate Comm. on Labor and Public Welfare, 93d Cong., 1st Sess. 359 (1973) (Sup. Doc. No. Y4.L11/2:H34/32/973) (remarks of Dr. Peter Breggin [hereinafter cited as Hearings]. This definition has legal implications because neither individuals nor their legal guardians may consent to a procedure that may be considered a mutilation. See, e.g., 4 W. Blackstone, Commentaries on the Laws of England *205; Annot., 86 A.L.R.2d 268 (1962). Although the ancient rationale for this rule centered on the king's right to aid his subjects, its modern justification is grounded upon the state's interest in maintaining the health of its citizens. Annas & Glantz, supra note 4, at 255-56. See State v. Bass, 255 N.C. 42, 46-47, 120 S.E.2d 580, 583 (1961) (doctor convicted as accessory before the fact to crime of mayhem for anesthetizing fingers of individual who desired to have them amputated in order to collect insurance proceeds). The analogy between psychosurgery and mutilation of mayhem, however, has rarely been made in a legal context. Kidd, Limits of the Right of a Person to Consent to Experimentation on Himself, 117 SCIENCE 211, 212 (1953); Note, Experimentation on Human Beings, 20 STAN. L. REV. 99, 116 (1967).


The term "psychosurgery," ... means (except as stated below): brain surgery, implantation of electrodes, destruction or direct stimulation of brain tissue by any means (e.g., ultra-sound, laser beams), or the direct application of substances to the brain when any of these procedures is performed either (1) on normal brain tissue of a person, for the purpose of changing or controlling the behavior or emotions of such person, or (2) on diseased brain tissue of a person, if the primary purpose of performing the procedure is to control, change, or affect any behavioral or emotional disturbance of such person. Such term does not include (a) electric shock treatments, (b) surgery or other invasions of the brain designed to cure or ameliorate the effects of movement disorders (e.g., epilepsy, parkinsonism), and (c) excision of brain tumors.

With respect to the relief of pain, surgical or other invasions of the brain which interrupt the transmission of pain along sensory pathways are not within the definition of psychosurgery; however, when such procedures are designed to relieve the emotional response to pain (without affecting the sensation of pain) they fall within the definition of psychosurgery.\textsuperscript{24}

In summary, the generic definition of "psychosurgery," agreed upon by those who favor, oppose, or are "morally neutral" to it appears to be: any procedure involving the physical manipulation of the brain for the primary purpose of specific behavior modification.\textsuperscript{25}

\textsuperscript{24} Id. at 57. Psychosurgery was defined in the Commission's enabling legislation as brain surgery on (1) normal brain tissue of an individual who does not suffer from any physical disease, for the purpose of changing or controlling the behavior or emotions of such individual, or (2) diseased brain tissue of an individual, if the sole object of the performance of such surgery is to control, change, or affect any behavioral or emotional disturbance of such individual. Such term does not include brain surgery designed to cure or ameliorate the effects of epilepsy and electric shock treatments.

\textsuperscript{25} See also Note, Psychosurgery: The Rights of Patients, 23 Loy. L. Rev. 1007, 1009 (1977); See also Annas & Glantz, supra note 4, at 249.
B. A Brief History of Psychosurgery

The first procedure fitting the generic definition of "psychosurgery" was performed by Dr. Gottlieb Burckhardt in 1891. Burckhardt had attempted to calm excitable patients by destroying a strip of cerebral cortex. Notwithstanding his belief that some patients had improved, Burckhardt was forced to discontinue the operations due to vigorous opposition by the medical community.

The widespread adoption of psychosurgery is generally attributed to the development of the classic prefrontal lobotomy by Dr. Egas Moniz, a Portuguese neuropsychiatrist. In 1935, after hearing a report of the calming effect of frontal lobe removal on monkeys and chimpanzees, Moniz operated on certain patients who had allegedly proven unresponsive to other modern psychosurgical techniques did not develop until the late nineteenth century. See notes 28-31 and accompanying text infra. The practice of psychosurgery, however, reportedly traces to "trephining," a primitive method of opening the skull performed by the Incas over 12,000 years ago, probably with the expectation of releasing demons. Note, Beyond the "Cuckoo's Nest": A Proposal for Federal Regulation of Psychosurgery, 12 HARV. J. LEGIS. 610, 612 (1975). See also Flor-Henry, Psychiatric Surgery—1935-1973: Evolution and Current Perspectives, 20 CAN. PSYCH. A.J. 157, 157 (1975); TIME, supra note 14, at 50. Ancient Roman writings contain later references to the relief given to the insane through sword wounds to the head. Restak, supra note 16, at 54-55. See also Note, supra, at 612. The development of psychosurgery can also be traced to the eighteenth century science of phrenology, which was based on the theory that the many aspects of human behavior could be reduced to an enumerable set of "faculties," "functions" or "powers of the mind," each of which could be localized within the brain. Chorover, supra note 16, at 232. The phrenologists produced detailed schematic diagrams and argued that individual differences among people could be correlated with differences in the relative degree of development of particular parts of the brain. Id. See generally J. DAVIES, PHRENOLOGY, FAD AND SCIENCE: A 19TH CENTURY AMERICAN CRUSADE (1955).

26. Modern psychosurgical techniques did not develop until the late nineteenth century. See notes 28-31 and accompanying text infra. The practice of psychosurgery, however, reportedly traces to "trephining," a primitive method of opening the skull performed by the Incas over 12,000 years ago, probably with the expectation of releasing demons. Note, Beyond the "Cuckoo's Nest": A Proposal for Federal Regulation of Psychosurgery, 12 HARV. J. LEGIS. 610, 612 (1975). See also Flor-Henry, Psychiatric Surgery—1935-1973: Evolution and Current Perspectives, 20 CAN. PSYCH. A.J. 157, 157 (1975); TIME, supra note 14, at 50. Ancient Roman writings contain later references to the relief given to the insane through sword wounds to the head. Restak, supra note 16, at 54-55. See also Note, supra, at 612. The development of psychosurgery can also be traced to the eighteenth century science of phrenology, which was based on the theory that the many aspects of human behavior could be reduced to an enumerable set of "faculties," "functions" or "powers of the mind," each of which could be localized within the brain. Chorover, supra note 16, at 232. The phrenologists produced detailed schematic diagrams and argued that individual differences among people could be correlated with differences in the relative degree of development of particular parts of the brain. Id. See generally J. DAVIES, PHRENOLOGY, FAD AND SCIENCE: A 19TH CENTURY AMERICAN CRUSADE (1955).

27. See text accompanying note 25 supra.

28. E. VALENSTEIN, supra note 16, at 266-68.

29. Id., discussing Burckhardt, Über Rindenexcisionen, als Beitrag zur operativen Therapie der Psychosen, 47 ALLG. ZSCHR. PSYCHIAT. 463 (1891).

30. E. VALENSTEIN, supra note 16, at 268. Burckhardt operated on six patients, one of whom died as a result of the operation. Id. Although the survivors continued to exhibit psychotic symptoms, they were described by Burckhardt as being more peaceful and easier to manage. Id.

31. REPORT, supra note 6, at 1. See also E. VALENSTEIN, supra note 16, at 268.

32. See notes 39 & 41-42 and accompanying text infra. For a discussion of the nature of psychosurgical procedures currently being performed in the United States, see notes 53-57 and accompanying text infra.

33. For a discussion of the classic prefrontal lobotomy, see note 17 supra.


forms of treatment. Moniz' monograph, describing the generally favorable results obtained on his first twenty patients, encouraged other neuropsychiatrists and neurosurgeons to adopt similar procedures.

Frontal lobe surgery was introduced into the United States in 1936 by Drs. Walter Freeman, a neurologist, and James Watts, a neurosurgeon, of George Washington University. The popularity of the procedure gradually increased, and over the next twenty-five years approximately 50,000 prefrontal lobotomies were performed in the United States. The majority of these operations were performed between 1945 and 1955. During this period, the urgent need for the efficient treatment of the many psychologically disturbed veterans of World War II, combined with the optimistic reports of the results of the procedures, resulted in a wide scale adoption of frontal lobe surgery. By the end of the fifties, however, the psychiatric

36. Chorover, supra note 16, at 234. Moniz initially used injections of alcohol to coagulate certain fiber tracts running between the frontal lobes and other parts of the brain. This technique, however, was abandoned in favor of what came to be known as the classic prefrontal lobotomy or leucotomy. Id. For a description of this procedure, see note 17 supra.


38. THE AGE OF MADNESS, supra note 34, at 158-60. During a 10-week period beginning in November 1935, Moniz performed a total of 20 operations. Chorover, supra note 16, at 234. Moniz claimed that seven of the patients had been "cured" by the surgery and that another eight, who had previously been violent and agitated, became calm, tractable, and generally easier to manage. THE AGE OF MADNESS, supra note 34, at 158. See also Edson, The Psyche and the Surgeon, N.Y. Times, Sept. 30, 1973, § 6 (Magazine), at 14, 78. Intelligence and memory were preserved, although complications in sphincter disturbances, sluggish pupils, apathy, loss of initiative, and disorientation were observed. Greenblatt & Myerson, Psychosurgery, 240 New Eng. J. Med. 1006, 1014-15 (1949).

39. REPORT, supra note 6, at 1. In the 15 years following the initial work of Moniz, more than 100,000 lobotomies were performed worldwide. Hearings, supra note 20, at 340 (testimony of Dr. Bertram Brown).


41. Hearings, supra note 20 at 340 (testimony of Dr. Bertram Brown). The procedure became so popular that prefrontal lobotomies were being performed not only on continuously hospitalized psychotic patients, but also on nonhospitalized neurotics and individuals with psychosomatic complaints. Chorover, supra note 16, at 234; Chorover, The Pacification of the Brain, 7 Psych. Today, May 1974, at 59-60. Dr. Freeman indicated that he alone had been personally involved with lobotomies performed on more than 3,500 individuals during his career. Freeman, supra note 40, at 622. See also Restak, supra note 16, at 56.

42. Report, supra note 6, at 1.

43. Id. See also Psychosurgery in Veterans Administration Hospitals: Joint Hearings on an Examination of Psychosurgery at Veterans' Administration Hospitals for the Purpose of Behavior Modification Before the Subcomm. on Health of the Senate Comm. of Labor and Public Welfare and the Subcomm. on Health of the Comm. on Veterans' Affairs, 93d Cong., 1st Sess. 7-8 (1973) (Sup. Doc. No. Y4.L1/2/P85/2) (statement of Donald E. Johnson) [hereinafter cited as Veterans Hearings].

44. It was reported, for example, that schizophrenic patients who had been habitually hospitalized and who were irritable and helpless became "quiet, more cooperative, clean, able to eat by themselves, capable of working in the hospital, and could even be sent home to their families." Goldstein, supra note 17, at 44.

45. E. VALENSTEIN, supra note 16, at 55, 390 n.7. See also Veterans Hearings, supra note 43, at 7-8.
community had substantially lost its enthusiasm for the prefrontal lobotomy.  

Mounting concern over bad results coupled with the emerging popularity of alternative forms of treatment, such as drugs and electroshock, brought psychosurgical practices to a virtual halt.  

During the sixties, the accumulation of knowledge regarding the neuroanatomical regions that regulate emotional responses and the refinement of surgical techniques encouraged the belief that crippling psychiatric symptoms could be alleviated with a minimum of risk by making small and very localized incisions. The result of these advances was a resurgence of psychosurgery. Currently, approximately 500-600 psychosurgical operations are being performed annually in the United States.

47. Id. at 234. With the increase in the number of candidates for psychosurgery who were drawn from segments of the population that exhibited fewer “disturbed” forms of behavior, the occurrence of side effects became increasingly apparent. Id. See note 41 supra. Passivity, blunted emotions, and a reduced capacity to plan were frequently found in post-operative patients. Id. See note 41 supra. M. Pines, The Brain Changers: Scientists and the New Mind Control 18 (1973); Knight, Neurosurgical Aspects of Psychosurgery, 63 Proc. Royal Soc'y Med. 1099 (1972). Dr. Walter Freeman, acknowledging these side effects, wrote:

What the investigator misses most in the more highly intelligent individuals is the ability to introspect, to speculate, to philosophize, especially in regard to the self.  

Creativeness seems to be the highest form of human endeavor. It requires imagination, concentration, visualization, self-criticism, and persistence in the face of frustration, as well as trained manual dexterity.  

Theoretically, on the basis of psychologic and personality studies, creativeness should be abolished by lobotomy.  

... [O]n the whole psychosurgery reduces creativity, sometimes to the vanishing point.

Freeman, Psychosurgery, in 2 American Handbook of Psychiatry 1521-26, 1534-35 (1959). In many cases, the procedure was thus less a cure than a pacifier, and reduced many patients to post-operative vegetables. Older, Psychosurgery: Ethical Issues and a Proposal for Control, 44 Am. J. Orthopsychiatry 661 (1974).

48. Mark, supra note 19, at 217-18. With the advent of powerful ataratic drugs, capable of achieving the same therapeutic goals, the need for surgery decreased. Id. at 218.  
49. Note, supra note 26, at 613. Electro-convulsive therapy (ECT) became increasingly popular because it was a reversible and less drastic means of treatment. See Kalinowsky, The Convulsive Therapies, in Comprehensive Textbook of Psychiatry 1279 (A. Friedman & H. Kaplan ed. 1967). It is principally because ECT represents a temporary, albeit severe, intrusion upon the brain that it is distinguishable from psychosurgery. See note 24, and accompanying text supra.

50. Chorover, supra note 16, at 235. There is some indication, however, that a limited number of prefrontal lobotomies continue to be performed at the present time. Report, supra note 6, at 2.

51. Report, supra note 6, at 2. For a discussion of the stereotaxic method of psychosurgery, see note 18 supra.

52. Report, supra note 6, at 2.

53. Older, supra note 47, at 662.

54. Edson, supra note 38, at 72. It is virtually impossible to report exactly the number of psychosurgical operations being performed, or where they are being performed, because of the lack of any centralized record keeping. Breggin, supra note 16, at 5567. Dr. Breggin, as a result of his personal correspondence with practitioners, estimates that approximately 400-600 operations are performed each year in the United States. Id. at 5570. Furthermore, Dr. Breggin notes that there are approximately 40 practicing psychosurgeons in the United States today. Id. at 5567.
patients are of all ages and races, and suffer from a variety of illness and problems. Most surgery today is performed on the limbic system, which is the center for violence, hunger, sexuality, and emotional tone. In addition, most subjects apparently are neither violent nor psychotic, but rather suffer from some form of neurosis.

III. THE LAW'S RESPONSE TO PSYCHOSURGERY

In 1949, the Stanford Law Review addressed the problems involved in drafting a statute to regulate the performance of lobotomies on mental patients and concluded that "the greater good will be achieved by avoiding legislative fetters and relying for protection on the high standards of the medical profession and the individuals who compose it." This conclusion reflected the attitude of the judiciary which, in the earlier part of this century, had adopted a "hands-off" attitude toward the mental health system. Until the early 1970's, the medical profession was thus allowed to police itself while patients could protect their rights only through traditional medical malpractice actions. In response to mounting public concern, 

55. Templer, supra note 16, at 205. Dr. Orlando Andy, Chairman of the Department of Neurosurgery at the University of Mississippi, has employed psychosurgery as a treatment for disturbed children. Restak, supra note 16, at 54-55. Dr. Andy has operated on 13 or 14 children ranging in age from 6 to 19. Hearings, supra note 20, at 353. Psychosurgery has also been performed on prisoners. Shapiro, Legislating the Control of Behavior Control: Autonomy and the Coercive Use of Organic Therapies, 47 S. Cal. L. Rev. 237, 246 (1974). Moreover, it has been proposed as a "cure" for sexual deviants. Brain Surgery for Sexual Disorders, 4 Lancet 250, 251 (1969).


59. Id. at 474.

60. Plotkin, Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment, 72 Nw. U. L. Rev. 461, 483 (1977). The "hands-off" doctrine resulted from a judicial reluctance to interfere with institutional management and medical decisionmaking, rather than from any belief that courts lacked the legal authority to intervene. Id. The courts had accepted the assertion that judicial review of administrative practices in the mental health institutions would subvert treatment efforts. Id. This attitude paralleled the judicial policies toward correctional institutions as well. See, e.g., Note, Beyond the Ken of the Courts: A Critique of Judicial Refusal to Review the Complaints of Convicts, 23 Vill. L. Rev. 613, 614-15 (1978), 72 Yale L.J. 506, 507, 524 (1963). See also Siegel v. Ragen, 88 F. Supp. 996 (N.D. Ill. 1949), aff'd, 180 F.2d 785 (7th Cir.). cert. denied, 339 U.S. 990 (1950). In Siegel, the district court stated:

This court . . . is not prepared to establish itself as a "co-administrator" of State prisons along with the duly appointed State officials. . . . [I]t is not the function of a Federal Court to assume the status of an appellate tribunal for the purpose of reviewing each and every act and decision of a State official.

88 F. Supp. at 99.

61. Annas & Glantz, supra note 4, at 261.

62. Id. A psychosurgical patient might successfully sue for malpractice on any of the following three grounds: 1) negligence in the performance of the procedure; 2) failure of the patient to give informed consent to the procedure; or 3) negligence in the method of reviewing the proposed surgery or the patient's consent thereto, if such review is required. Id. at 251-58.

63. See notes 2-14 and accompanying text supra.
however, courts, state legislatures, and administrative agencies have disagreed with the conclusion that psychosurgery should not be regulated and have limited, to varying degrees, the performance of psychosurgical procedures.

A. The Judicial Response

In 1973, the first legal challenge to the use of psychosurgery was decided by a Michigan state court in *Kaimowitz v. Department of Mental Health*. The *Kaimowitz* case involved proposed psychosurgery on Louis Smith, an involuntarily committed adult mental patient who had been confined as a criminal sexual psychopath. In 1972, Smith and his parents signed a consent form submitting him to psychosurgery as part of a re-

64. For a discussion of the judicial response to psychosurgery, see notes 67-174 and accompanying text infra.
65. For a discussion of the legislative response to psychosurgery, see notes 175-207 and accompanying text infra.
66. For a discussion of the administrative response to psychosurgery, see notes 208-32 and accompanying text infra.
68. *Judiciary Report*, supra note 67, at 510 n.1. The name John Doe was used throughout the proceedings and was used in the *Kaimowitz* opinion in order to protect the true identity of the subject involved. *Id.* After the commencement of the suit and during the proceedings, however, Doe’s true identity as Louis Smith became known. *Id.*
70. *Judiciary Report*, supra note 67, at 511. The complete form signed by Smith and his parents provided:

> Since conventional treatment efforts over a period of several years have not enabled me to control my outbursts of rage and anti-social behavior, I submit an application to be a subject in a research project which may offer me a form of effective therapy. This therapy is based upon the idea that episodes of anti-social rage and sexuality might be triggered by a disturbance in certain portions of my brain. I understand that in order to be certain that a significant brain disturbance exists, which might relate to my anti-social behavior, an initial operation will have to be performed. This procedure consists of placing fine wires into my brain, which will record the electrical activity from those structures which play a part in anger and sexuality. These electrical waves can then be studied to determine the presence of an abnormality.

> In addition electrical stimulation with weak currents passed through these wires will be done in order to find out if one or several points in the brain can trigger my episodes of violence or unlawful sexuality. In other words this stimulation may cause me to want to commit an aggressive or sexual act, but every effort will be made to have a sufficient
search study. Plaintiff Kaimowitz sought a writ of habeas corpus on Smith's behalf, alleging that Smith's detention for the purpose of experimental surgery was illegal. Although state funding for the project was cancelled shortly after the suit was filed and the physicians terminated the proposed study, the empanelled three-judge court continued to hear the petition for habeas corpus relief and found Smith's detention unconstitutional. After argument on the remaining consent issue, which the court

number of people present to control me. If the brain disturbance is limited to a small area, I understand that the investigators will destroy this part of my brain with an electrical current. If the abnormality comes from a larger part of my brain, I agree that it should be surgically removed, if the doctors determine that it can be done so, without risk of side effects. Should the electrical activity from the parts of my brain into which the wires have been placed reveal that there is no significant abnormality, the wire will be simply withdrawn.

I realize that any operation on the brain carries a number of risks which may be slight, but could be potentially serious. These risks include infection, bleeding, temporary or permanent weakness or paralysis of one or more of my legs or arms, difficulties with speech or thinking, as well as the ability to feel, touch, pain and temperature. Under extraordinary circumstances, it is possible that I might not survive the operation.

Id. at 511 n.5.

71. Id. at 510-11. The research study was the result of a "Proposal for the Study of the Treatment of the Uncontrollable Aggression at Lafayette Clinic" filed by two physicians in 1972 with the Michigan Department of Health. Id. at 510. Two separate review committees—the Scientific Review Committee and the Human Rights Review Committee—approved the experiment following an assessment of the general scientific worthiness of the study and the validity of the consent obtained from Smith. Id. at 511.

72. The plaintiff, Gabe Kaimowitz, an attorney with Michigan Legal Services, entered the proceeding on his own motion, grounding his standing on his status as a Michigan taxpayer. Note, Kaimowitz v. Department of Mental Health: A Right to be Free from Experimental Surgery?, 54 B.U. L. REV. 301, 302 & n.8 (1974).

73. JUDICIARY REPORT, supra note 67, at 510. The case came to the Michigan courts originally on a petition for habeas corpus filed by Kaimowitz and the Medical Committee for Human Rights, alleging that Smith and at least 23 other similarly situated individuals were being illegally held. Id. The suit focused on the surgery to be performed on Smith because he was the only appropriate subject that could be found within the state's mental health system. Id. at 511. Notwithstanding the lack of other available subjects the decision was made to proceed with the surgery. Id.

74. Id. In response to adverse publicity, the Director of the Department of Mental Health withdrew funds for the research study and the two doctors terminated their plans to pursue the proposed research. Id. See also E. VALENSTEIN, supra note 16, at 342.


Following the testimony of Smith and a psychiatrist who testified that Smith could safely be released into society, the Wayne County Circuit Court ordered his release. JUDICIARY REPORT, supra note 67, at 512 & n.7. Subsequent to Smith's release, the county prosecutor's office filed
considered ripe for declaratory relief,\textsuperscript{76} the court entered a judgment for the plaintiff, holding that an involuntarily committed mental patient was incapable of giving legally adequate consent to experimental psychosurgery.\textsuperscript{77}

Initially, the Kaimowitz court, recognizing the experimental nature of the proposed operation,\textsuperscript{78} focused on the "risk-benefit ratio" of the experiment.\textsuperscript{79} In considering the risks involved, the court noted the lack of knowledge about the brain,\textsuperscript{80} the complex interaction of its various sections,\textsuperscript{81} and the irreversible nature of brain surgery,\textsuperscript{82} and stressed that any surgical intrusion into the brain must be approached with the utmost caution.\textsuperscript{83} Since neither "animal experimentation" nor "non-intrusive human experimentation" had been exhausted, the court determined that the procedure presented a considerable risk.\textsuperscript{84} In considering the possible benefits of the surgery, the court found that no relationship between brain dysfunction and abnormal aggressive behavior had been clinically established,\textsuperscript{85} and

a petition for a bench warrant for Smith's arrest on the original murder and rape charges. See People v. Smith, 57 Mich. App. 556, 226 N.W.2d 673 (1975) (attempt by defendant to quash indictment). Smith eventually confessed to the original charges and was sentenced to life imprisonment. Annas, Psychosurgery: Procedural Safeguards, \textit{7 Hastings Center Report} 12 (April 1977).\textsuperscript{86}

76. \textit{Judiciary Report}, supra note 67, at 512. The court held that even though the original experimentation program had been terminated, there was nothing that would prevent it from being instituted again in the near future, and therefore the controversy was not moot. \textit{Id.}, citing United States v. Phosphate Export Ass'n., 339 U.S. 199, 203 (1968); Milford v. People's Community Hosp. Auth., 380 Mich. 49, 55-56, 155 N.W.2d 835, 838 (1968).

77. \textit{Judiciary Report}, supra note 67, at 512, 523. Framing the key issue in the case, the court queried:

\begin{quote}
\textit{After the 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?}
\end{quote}

\textit{Id.} at 512. This question was answered by the court in the negative. \textit{Id.} at 523.

78. \textit{Id.} at 514.

79. \textit{Id.} at 513-15. One commentator has described the risk-benefit ratio as follows:

\begin{quote}
The risk-benefit ratio is a device used by physicians to determine the advisability of a medical procedure. Although not actually expressed as a ratio, the term denotes the two classes of factors to be weighed against one another; the risk of failure or adverse effects versus the probability of achieving the desired result.
\end{quote}


81. \textit{Id.}

82. \textit{Id.} at 514.

83. \textit{Id.}

84. \textit{Id.}

further noted the possibility of adverse consequences.86 The court concluded that psychosurgery should never be undertaken upon involuntarily committed populations where there is a high risk–benefit ratio due to the impossibility of obtaining truly informed consent from such individuals.87

In determining whether Smith was in fact incapable of informed consent,88 the Kaimowitz court adopted three standards from the Nuremberg Code89 to govern an individual's capacity in this area: competency, knowledge, and voluntariness.90 Competency, the court recognized, "requires

86. JUDICIARY REPORT, supra note 67, at 515. The specific adverse reactions noted by the court included flattened emotional responses, lack of abstract reasoning ability, loss of capacity for new learning, general sedation and apathy, impairment of memory, and, in some cases, heightened rage reactions. Id.

87. Id. at 514. The relationship between the risk–benefit ratio and informed consent was explained by the court as follows:

Informed consent is a requirement of variable demands. Being certain that a patient has consented adequately to an operation, for example, is much more important when doctors are going to undertake an experimental, dangerous, and intrusive procedure than, for example, when they are going to remove an appendix. When a procedure is experimental, dangerous, and intrusive, special safeguards are necessary. The risk–benefit ratio must be carefully considered, and the question of consent thoroughly explored. Id. at 517. With regard to the question of the degree of risk, one court has held that a 1% chance of paralysis constituted a risk of serious harm, stating: "[A] very small chance of death or serious disablement may well be significant." Canterbury v. Spence, 464 F.2d 772, 778 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972).


The general standard with respect to informed consent is derived from Natanson v. Kline, 187 Kan. 186, 354 P.2d 670 (1960). The Natanson rule requires disclosure of facts which a reasonable medical practitioner in a similar community and similar school of medical thought would have disclosed to a patient who is about to undergo treatment. Id. at 189-90, 354 P.2d at 673. The Natanson rule has been adopted by the majority of American jurisdictions. Note, supra note 25, at 1010 n.10. There is also a minority rule which requires the disclosure of all information which a reasonable patient would have thought "material" in making a decision to undergo treatment. See, e.g., Canterbury v. Spence, 464 F.2d 772 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972); Biedinger v. Colburn, 361 F. Supp. 1073 (D. Idaho 1973); Cobles v. Grant, 8 Cal. App. 3d 229, 104 Cal. Rptr. 505 (1972). The special informed consent form signed by Smith and his parents included the disclosures required under either the Natanson rule or the minority rule. See note 70 supra.

89. United States v. Karl Brandt, 2 Trials of War Criminals Before the Nuremberg Military Tribunals 181, 181-82 (1947). In 1947, various defendants were found guilty of crimes against humanity for carrying out medical experiments on human subjects. Id. at 181. The Military Tribunal set forth 10 principles for the conduct of medical experiments which have since become known as the Nuremberg Code. Id. at 181-82.

90. JUDICIARY REPORT, supra note 67, at 517-18. The court emphasized the first principle of the Nuremberg Code, which provides:

1. The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the interven-
the ability of the subject to understand rationally the nature of the procedure, its risks, and other relevant information." The court found that Smith's competency was "particularly vulnerable as a result of his mental condition, the deprivation stemming from involuntary confinement, and the effects of the phenomenon of 'institutionalization.'" On the issue of Smith's knowledge, the court concluded that a knowledgeable consent was "literally impossible" because of a lack of scientific information necessary for predicting the outcome of the surgery. With regard to the voluntariness of the consent, the Kaimowitz court noted that the Nuremberg Code refers to a "free power of choice, without the intervention of any element of force, fraud, deceit, duress, over-reaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision. This latter element requires that before the acceptance of an affirmative decision by the experimental subject there should be made known to him the nature, duration and purpose of the experiment, the methods and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon his health or person which may possibly come from his participation in the experiment.

United States v. Karl Brandt, 2 Trials of War Criminals Before the Nuremberg Military Tribunals 181-82 (1947) (emphasis added). See JUDICIARY REPORT, supra note 67, at 517. By adopting the Nuremberg Code as its standard for reviewing Smith's informed consent to the psychosurgical procedure, the Kaimowitz Court rejected as inadequate the traditional disclosure requirements of informed consent. Id. For a discussion of the traditional informed consent standards, see note 86 supra. Instead, the court substituted a standard similar to that enunciated by the United States Supreme Court for review of a waiver of constitutional rights. See, e.g., Brady v. United States, 397 U.S. 742 (1970); Miranda v. Arizona, 384 U.S. 436 (1966). In Miranda, for example, the Court held that a defendant's waiver of his right to remain silent and his right to counsel must be knowingly, intelligently, and voluntarily made. Miranda v. Arizona, 384 U.S. 436, 475-76 (1966). Similarly, in Brady, which dealt with the voluntariness of a guilty plea, the Court stated that "[w]aivers of constitutional rights not only must be voluntary but must be knowing, intelligent acts done with sufficient awareness of the relevant circumstances and likely consequences." Brady v. United States, 397 U.S. 742, 749 (1970) (footnote omitted).

91. JUDICIARY REPORT, supra note 67, at 518. 
92. Id. The Kaimowitz court noted: Although an involuntarily detained mental patient may have a sufficient I.Q. to intellectually comprehend his circumstances . . . , the very nature of his incarceration diminishes the capacity to consent to psychosurgery. . . . The fact of institutional confinement has special force in undermining the capacity of the mental patient to make a competent decision on this issue, even though he be intellectually competent to do so. In the routine of institutional life, most decisions are made for patients. . . . 

Institutionalization tends to strip the individual of the support which permits him to maintain his sense of self-worth and the value of his own physical and mental integrity. An involuntarily confined mental patient clearly has diminished capacity for making a decision about irreversible experimental psychosurgery. Id. at 518-19 (emphasis supplied by the court). It is submitted, however, that the court's analysis of the factors bearing on Smith's diminished capacity is not relevant to its concept of competency. See text accompanying note 91 supra. Rather, the factors are more appropriate to an analysis of the voluntariness of the consent. Barnhart, Pinkerton & Roth, Informed Consent to Organic Behavior Control, 17 SANTA CLARA L. REV. 39, 78-79 (1977); notes 94 & 95 and accompanying text infra.

93. JUDICIARY REPORT, supra note 67, at 519. See notes 79-86 and accompanying text supra.
fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion." The court found that mental institutions create a pervasive atmosphere of constraint and coercion which precludes the voluntary nature of a consent to such an experimental procedure.

Although the disposition of the consent issue fully resolved the merits of the case, the Kaimowitz court also stated alternative, constitutional reasons for not recognizing the patient's consent. The court reasoned that the use of experimental psychosurgical techniques on a mental patient involuntarily confined in a state institution, even with the patient's formal consent, would violate the patient's first amendment right to generate ideas as well as his constitutionally protected right to privacy. Initially, the court noted that the first amendment protects freedom of communication and freedom of expression of ideas. Since these freedoms would be meaningless without the

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94. JUDICIARY REPORT, supra note 67, at 519, quoting United States v. Karl Brandt, 2 Trials of War Criminals Before the Nuremberg Military Tribunals 181-82 (1947) (emphasis supplied by the court). For the text of the relevant portion of the Nuremberg Code, see note 90 supra.

95. JUDICIARY REPORT, supra note 67, at 519-20. The court focused on the degree of control exercised by institutional authorities over the privileges of a patient and the desire of the patient to exhibit an attitude of cooperation. Id. at 519. Dr. Erving Goffman has described the effects of prolonged confinement in "total institutions," which he defines as places of "residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life." E. Goffman, Asylums xiii (1961). One of the effects noted by Dr. Goffman is the process of "mortification of the self," whereby the patient's self-concept is weakened by the immediate and total loss of the support provided by certain stable social arrangements in his "home world." Id. at 14. Whatever the effect of 18 years of confinement on Smith, it should be noted that Smith himself withdrew his consent to the surgery after he had been released. N.Y. Times, April 5, 1973, at 26, col. 1.

With respect to the Kaimowitz court's analysis of the consent issue, some commentators have construed the opinion as finding that the dual factors of institutionalization and the unfavorable risk-benefit ratio were separate and independent reasons for invalidating Smith's consent. Annas & Glantz, supra note 67, at 262-63. Noting the court's concern over the effect of institutionalization on the patient's capacity to render voluntary consent, the commentators question the importance of the risk-benefit ratio. Id. The court, however, established the relationship between the risk-benefit ratio and the consent of the individual, noting that the more unfavorable the ratio, the greater the need to evaluate the consent. JUDICIARY REPORT, supra note 67, at 517. See note 87 supra. Because of this relationship, the court asserted that its holding did not prevent involuntarily confined patients from giving adequate consent to accepted neurological procedures or even to the procedure proposed in the research study (amygdalotomy) should it ultimately become an accepted, nonexperimental technique. JUDICIARY REPORT, supra note 67, at 523. This conclusion has been criticized as being logically incompatible with the court's holding with respect to the informed consent of Smith in Kaimowitz. See Annas & Glantz, supra note 74, at 262-63.

96. JUDICIARY REPORT, supra note 67, at 520-23. The court found the requisite state action in the fact that the involuntarily committed mental patients had been detained by the state. Id. at 520.

97. Id. at 520-23.

98. Id. at 521. The first amendment to the United States Constitution provides: "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the government for a redress of grievances." U.S. CONST. amend. I.
freedom to generate ideas, it was urged that the first amendment must necessarily protect the process of mentation. The court found that psychosurgery tends to result in "the blunting of emotions, the deadening of memory," and the reduction of sensory perception, and that the procedure "limits the ability to generate new ideas." The court determined that this reduction in the capacity to generate new ideas places psychosurgery in conflict with the protections of the first amendment, stating:

To allow an involuntarily detained mental patient to consent to the type of psychosurgery proposed in this case, and to permit the State to perform it, would be to condone State action in violation of basic First Amendment rights of such patients, because impairing the power to generate new ideas inhibits the full dissemination of ideas.

Furthermore, the court concluded that the proposed psychosurgery would violate the right of privacy recognized by the Supreme Court of the United States as emanating from the first, fifth, and fourteenth amendments. In the court's view, psychosurgery constituted an impermissible...
intrusion into the patient's protected mental processes. Finally, the Kaimowitz court found that no compelling state interest in fostering psychosurgery on involuntarily confined mental patients had been shown which was sufficient to overcome the protections of the first amendment or the right of privacy.

A similarly restrictive position was adopted in Wyatt v. Hardin, where the United States District Court for the Middle District of Alabama imposed an absolute ban on psychosurgery in state operated institutions in Alabama. The Hardin decision is one part of the litigation involving the seminal case of Wyatt v. Stickney. Stickney involved a class action originally filed in 1970 on behalf of patients involuntarily confined for treatment at Bryce Hospital in Alabama. In 1971, in a formal opinion and decree, the district court held that these involuntarily committed patients "unquestionably have a constitutional right to receive such individual treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental condition." The court concluded that patients at Bryce...
were being denied their right to treatment,\textsuperscript{113} and granted the defendants\textsuperscript{114} six months in which to raise the level of care at Bryce to the constitutionally required minimum.\textsuperscript{115} The court also ordered the defendants to file reports defining the mission and functions of Bryce Hospital,\textsuperscript{116} specifying the subjective and objective standards required to furnish adequate care to the treatable mentally ill,\textsuperscript{117} and detailing the hospital’s progress toward the implementation of minimum constitutional standards.\textsuperscript{118}

After reviewing these reports, the district court concluded that the defendants had failed to promulgate and implement a treatment program satisfying minimum medical and constitutional requisites.\textsuperscript{119} From the evidence, the court determined that whatever treatment was provided at Bryce was grossly deficient and failed to satisfy the minimum standards.\textsuperscript{120} Consequently, the district court ordered that a formal hearing be held at which the parties and \textit{amici} would have the opportunity to submit proposed standards for constitutionally adequate treatment and to present expert testimony in support of their proposals.\textsuperscript{121}

Pursuant to this order, a hearing was held\textsuperscript{122} after which the district court promulgated minimum medical and constitutional standards for public institutions involved in the treatment of the mentally ill\textsuperscript{123} and ordered their implementation.\textsuperscript{124} As part of these minimum requirements, the district court set forth standard 9 which concerned the use of extraordinary or potentially hazardous modes of treatment.\textsuperscript{125} Standard 9 provided: “Patients have a right not to be subjected to treatment procedures such as lobotomy, electro-convulsive treatment, aversive reinforcement conditioning or other unusual or hazardous treatment procedures without their express and informed consent after consultation with counsel or interested party of the patient’s choice.”\textsuperscript{126}

\textsuperscript{114.} The defendants included the Commissioner and Deputy Commissioner of the Department of Mental Health of the State of Alabama, the members of the Alabama Mental Health Board, the Governor of Alabama, and the probate judge of Montgomery County, as a representative of the other probate judges in Alabama. \textit{Id.} at 782.
\textsuperscript{115.} \textit{Id.} at 785.
\textsuperscript{116.} \textit{Id.}
\textsuperscript{117.} \textit{Id.} at 785-86.
\textsuperscript{118.} \textit{Id.} at 786.
\textsuperscript{120.} \textit{Id.} at 1344. The district court found that the defendant’s treatment program was deficient in three fundamental areas in that it failed to provide: 1) a humane psychological and physical environment; 2) qualified staff in numbers sufficient to administer adequate treatment; and 3) individualized treatment plans. \textit{Id.} at 1343-44. More specifically, the court found that certain conditions, such as nontherapeutic, uncompensated work assignments and the absence of any semblance of privacy, constituted dehumanizing factors contributing to the degeneration of the patient’s self-esteem. \textit{Id.} at 1343.
\textsuperscript{121.} \textit{Id.} at 1344.
\textsuperscript{122.} 344 F. Supp. at 375.
\textsuperscript{123.} \textit{Id.} at 376, 379-86.
\textsuperscript{124.} \textit{Id.} at 376, 378.
\textsuperscript{125.} \textit{Id.} at 380.
\textsuperscript{126.} \textit{Id.}
In 1974, however, following a suggestion by the defendants, the district court undertook a substantial revision of standard 9. After considering the requests and responses filed by the parties and amici, and after reviewing Bryce's experiences in operating under standard 9, the district court, in part, ordered: "1. No lobotomy, psychosurgery or other unusual, hazardous or intrusive surgical procedure designed to alter or affect a patient's mental condition shall be performed on any patient confined at any institution maintained by or under the control of the defendants." In the opinion accompanying the order, the district court emphasized that it was not undertaking to determine appropriate forms of treatment in particular situations, as "[s]uch a diagnostic decision is a medical judgment and is not within the province, jurisdiction or expertise of this Court." The district court failed, however, to adequately explain the basis for its ban on psychosurgery and it is unclear whether the court relied on medical or legal arguments in making its determination.

In contrast to the strict prohibitive approach adopted in Kaimowitz and Hardin, a recent California decision, Aden v. Younger, sets forth a less restrictive attitude toward the performance of psychosurgery. In Aden, a mental patient who desired psychosurgery and the patient’s physician challenged the constitutionality of the then existing version of California’s Lanterman-Petris-Short Act, which set forth the conditions under which psychosurgery could be performed. The petitioner alleged that the legis-
lation limited access to psychosurgery and therefore violated his first amendment and privacy rights. 137

The petitioner's argument was based on the premise that there exists a fundamental right of privacy, a right to treatment, and rights of freedom of speech and thought which may not be inhibited by legislation absent a compelling state interest. 138 While noting that the right to privacy includes privacy of the mind, 139 the court in Aden chose not to base its decision on this protected interest. Moreover, the court did not find it necessary to decide whether the right to treatment "is deserving of constitutional protection in and of itself." 140 Instead, the court focused on the freedom of thought

If a patient wants psychosurgery, then the conditions for performing such surgery include:

(a) The patient must give written, informed consent, dated, witnessed and entered in his record. The consent may be withdrawn at any time. An oral explanation by the doctor is necessary.

(b) The patient must have capacity to consent.

(c) An oral explanation must be given to a responsible relative, guardian or conservator.

(d) The reasons for surgery must be in the patient's treatment record, other treatments must be exhausted and surgery must be critically needed.

(e) Three appointed physicians (two board-certified psychiatrists or neurosurgeons), must examine the patient and unanimously agree with the treating physician's determination that the patient has capacity to consent. There must be a 72-hour wait after the patient's written consent before surgery.

Id. 137. Id. at 672-73, 129 Cal. Rptr. at 541-42.

138. Id. at 678, 129 Cal. Rptr. at 545-46. The Aden court noted that the rights of privacy, freedom of speech and freedom of thought, and the right to medical treatment were complementary in nature, stating: "On the one hand, out of deference to personal autonomy, the state prohibits involuntary treatment. On the other hand, again out of deference to personal autonomy, the state promotes access to voluntary treatment which restores functionality and thus enhances future autonomy." Id. at 678 n.9, 129 Cal. Rptr. at 546 n.9. See Shapiro, supra note 55, at 257.

139. 57 Cal. App. 3d at 679, 129 Cal. Rptr. at 546. The Aden court's analysis of the source of the right to mental privacy was similar to that employed by the Michigan court in Kaimowitz. See id.; notes 104-07 and accompanying text supra.

and speech, which it noted may have been indirectly diminished by the California legislation. The court stated:

The right to be free in the exercise of one's own thoughts is essential to the exercise of other constitutionally guaranteed rights. First Amendment rights of free speech would mean little if the state were to control thought. Here the state has sought to control neither what is thought by mental patients, nor how they think. Rather, the state is attempting to regulate the use of procedures which touch upon thought processes in significant ways, with neither the intention nor the effect of regulating thought processes per se. Yet despite the lack of any showing the state has attempted to regulate freedom of thought, this legislation may diminish this right. If so, the legislation can only be sustained by showing (1) it is necessary to further a "compelling state interest" and (2) the least drastic means has been employed to further those interests.

According to the Aden court, the state's interests included "the protection of the right to refuse treatment" and "the prevention of unnecessary administration of hazardous and intrusive treatments." Examining the legislation in light of the announced interests of the state, the court invalidated the requirement of notification to a "relative, guardian or conservator" of the reasons for the surgery and an explanation of the procedure before the treatment could be administered. The court found that this requirement constituted an impermissible invasion of the patient's right to privacy and confidentiality, and that it served no legitimate state purpose. Other


141. 547 Cal. App. 3d at 679, 129 Cal. Rptr. at 546.
144. 57 Cal. App. 3d at 681, 129 Cal. Rptr. at 547. The Aden court, citing Kaimowitz, found that psychosurgical procedures are "destructive" of brain tissue and "experimental" in nature, and present "undisputed dangers" to the patient. Id. at 671-72, 129 Cal. Rptr. at 541, citing Kaimowitz v. Department of Mental Health, No. 73-19434-AW (Mich. Cir. Ct., Wayne County, July 10, 1973).
145. 57 Cal. App. 3d at 681, 129 Cal. Rptr. at 547. For a summary of the challenged provisions of the statute, see note 136 supra.
146. 57 Cal. App. 3d at 681, 129 Cal. Rptr. at 547. The court's conclusion that the provision requiring notification to a third party served no compelling state interest was based on the fact that no third party had standing to assert the patient's individual rights. Id. Furthermore, in regard to the requirement that a procedure be "critically needed" for the patient's welfare, the court found that the term was "so imprecise" as to be "impermissibly vague" because the term
provisions of the statute were upheld as furthering the state's interest with a minimal invasion of privacy.  

The provisions requiring mandatory approval of the psychosurgery by a review committee posed the most difficult issues for the Aden court. It was noted that the requirement of approval may result in the denial of one particular form of treatment to some patients, which would result in the continued impairment of their freedom of thought. In its search for compelling state interests supporting the mandatory review provisions, the court distinguished between review of the patient's consent and review of the substantive merits of the proposed surgery. With respect to the review of the patient's consent, the Aden court characterized the state's interest in protecting the right of the patient to refuse treatment as an adequate justification for a review procedure that would insure the competency and voluntariness of the patient's consent. Committee review of a mental patient's competence to consent was reasoned to be constitutional because, given the fact of involuntary detention, there was reason to suspect that the patient may be incompetent for the purpose of consenting to psychosurgery. In
analyzing the requirement of substantive review of the proposed psychosurgery, the court recognized that the legislation was designed to protect the individual's autonomy. Substantive review was therefore upheld as a means of insuring the wisdom of the patient's consent.

The Aden court also approved the requirement that the three physicians be unanimous in their review of the patient's consent and their approval of the proposed surgery. The court concluded that "[r]equiring unanimity by the review committee insures each approved treatment is an appropriate use of an experimental procedure."

The major impact of the Aden decision was its approval of a review committee mechanism to insure that informed, voluntary, and competent consent was actually obtained from the patient prior to the surgery. A psychosurgery to such persons, as the Michigan court did in Kaimowitz, or providing for a substitute decisionmaking process. Id., citing Kaimowitz v. Department of Mental Health, No. 73-19434-AW (Mich. Cir. Ct., Wayne County, July 10, 1973). The Aden court concluded that the establishment of a review committee to evaluate the patient's consent was justified by the state's interest in preventing the involuntary administration of psychosurgery. 57 Cal. App. 3d at 682-83, 129 Cal. Rptr. at 548. By upholding the validity of the review committee, the California court implicitly rejected the holding of Kaimowitz that an involuntarily confined individual was incapable of giving legally adequate consent to psychosurgery. For a discussion of the Kaimowitz holding on the issue of consent, see notes 88-95 and accompanying text supra.

The hazardous, experimental nature of psychosurgery is a legitimate reason for the state to regulate its use as a treatment of last resort. Requiring unanimity by the review committee insures each approved treatment is an appropriate use of an experimental procedure. The importance of assuring that consents to psychosurgery be voluntarily given by informed, competent mental patients, plus the need to regulate an experimental procedure, justify the Legislature's decision to remove these considerations from the sole discretion of the treating physician. There are sound reasons why the treating physician's assessment of his patient's competency and voluntariness may not always be objective, and he may not necessarily be the best or most objective judge of how appropriate an experimental procedure would be. Because the consequences to the patient of such a procedure are so serious, and the effects he may suffer are so intrusive and irreversible, tort damages are totally inadequate. The need for some form of restraint is a sufficiently compelling state interest to justify the attendant invasion of the patient's right to privacy.

The Aden court, however, distinguished electro-convulsive therapy from psychosurgery and concluded that a similar review procedure requiring substantive review of the decision to administer ECT constituted a serious infringement of the patient's right to privacy. Id. at 684, 129 Cal. Rptr. at 549. The court reasoned that since ECT was not an experimental procedure, and its hazards were not as serious as those of psychosurgery, the state had no interest which justified the substitution of a review committee's decision for that of the attending physician once it had been determined that the patient's consent was informed and voluntary. Id. The Aden court, like the court in Kaimowitz, thus indicated the possibility that further scientific validation of psychosurgery would warrant a different, less restrictive approach to its regulation.

For a discussion of this aspect of the Kaimowitz opinion, see note 95 supra.
second form of review procedure was accepted by the Supreme Court of Minnesota in Price v. Sheppard. In Price, the mother of a minor who was involuntarily committed to a state mental hospital brought suit against the medical director of the hospital for assault and battery and for violation of the minor's civil rights. The plaintiff, as mother and natural guardian of the minor, objected to a series of twenty electroshock treatments administered to her son, against her express wishes. The trial court ordered summary judgment for the defendant and, on appeal, the order was affirmed.

The court in Price first rejected the claim that the administration of the treatments constituted cruel or unusual punishment. The court also held that the director, who had acted in good faith and without knowledge that he was possibly violating a clearly established constitutional right, was immune from liability under the civil rights statute and was immune from tort liability.

Recognizing the potentially great impact of these more intrusive forms of treatment, however, the Price court was reluctant to leave the imposition of these procedures solely to the discretion of the medical personnel at the state hospitals in those cases where a parent or guardian has refused to consent to the treatment. For that reason, the court adopted the following procedure:

(1) If the patient is incompetent to give consent or refuses consent or his guardian other than persons responsible for his commitment also refuses his consent, before more intrusive forms

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158. 307 Minn. 250, 239 N.W.2d at 905 (1976).
159. Id. at 251-52, 239 N.W.2d at 907. The civil rights claim was brought under 42 U.S.C. § 1983 (1976).
160. 307 Minn. at 251-53, 239 N.W.2d at 907-08.
161. Id. at 252, 239 N.W.2d at 907. The defendant's motion for summary judgment on the assault and battery claim was granted on the basis of the trial court's ruling that the defendant, acting in his official capacity, was immune from suit. Id. Summary judgment was also granted on the civil rights claim on the ground that electroshock treatments were neither cruel nor unusual punishment under the eighth amendment to the United States Constitution, U.S. Const. amend. VIII, nor a violation of the right to privacy. 307 Minn. at 252, 239 N.W.2d at 907.
162. 307 Minn. at 252, 239 N.W.2d at 907.
163. Id. at 256, 239 N.W.2d at 909. The court held that "if the electroshock treatments . . . served a legitimate purpose rather than deterrence or reprimand, the Eighth Amendment claim must fail." Id. at 255, 239 N.W.2d at 909. See generally Trop v. Dulles, 356 U.S. 86, 96-97 (1958). The Price court concluded that since the patient had failed to respond to other forms of treatment, the administration of the electroshock treatments was not cruel or unusual punishment. 307 Minn. at 256, 239 N.W.2d at 909.
164. 307 Minn. at 261-62, 239 N.W.2d at 912.
166. 307 Minn. at 260, 239 N.W.2d at 912.
167. Id. at 250 n.9, 239 N.W.2d at 912 n.9.
168. Id. at 262, 239 N.W.2d at 912-13.
169. Id. at 262, 239 N.W.2d at 913.
of treatment may be utilized, the medical director of the state hospital must petition the probate division of the county court in the county in which the hospital is located for an order authorizing the prescribed treatment;

(2) the court shall appoint a guardian ad litem to represent the interests of the patient;

(3) in an adversary proceeding, pursuant to the petition, the court shall determine the necessity and reasonableness of the prescribed treatment.\textsuperscript{170}

In making this determination, the \textit{Price} court concluded that the patient’s need for treatment should be balanced against the intrusiveness of the prescribed treatment.\textsuperscript{171} Factors which should be considered included:

(1) the extent and duration of changes in behavior patterns and mental activity effected by the treatment, (2) the risks of adverse side effects, (3) the experimental nature of the treatment, (4) its acceptance by the medical community of this state, (5) the extent of intrusion into the patient’s body and the pain connected with the treatment, and (6) the patient’s ability to competently determine for himself whether the treatment is desirable.\textsuperscript{172}

Although the \textit{Price} court was unable to delineate those forms of treatment which required this procedural hearing from those which did not,\textsuperscript{173} it specifically held that the procedure must be followed where psychosurgery or electroshock therapy is proposed.\textsuperscript{174}

\textbf{B. The Legislative Response}

While a number of state legislatures have attempted to regulate the performance of psychosurgical procedures, their enactments have not been entirely responsive to the issues that are involved. One group of states has adopted a retained rights approach to mental patients that provides the pa-

\textsuperscript{170} Id. (footnotes omitted).

\textsuperscript{171} Id. at 262, 239 N.W.2d at 913.

\textsuperscript{172} Id. at 262-63, 239 N.W.2d at 913 (footnote omitted). In formulating the factors to be considered by the reviewing court, the court in \textit{Price} relied in part on the decision in \textit{Kaimowitz}. Id. at 263 n.12, 239 N.W.2d at 913 n.12, \textit{citing} Kaimowitz v. Department of Mental Health, No. 73-19434-AW (Mich. Cir. Ct., Wayne County, July 10, 1973). For a discussion of the holding in \textit{Kaimowitz} on the issue of consent, see notes 88-95 and accompanying text supra.

\textsuperscript{173} 307 Minn. at 263, 239 N.W.2d at 913.

\textsuperscript{174} Id. The Minnesota Supreme Court thus rejected the distinction between psychosurgery and electroshock therapy which the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research accepted in its report on psychosurgery. \textit{See} note 24 and accompanying text supra. For a discussion of the distinction between psychosurgery and electroshock therapy, \textit{see} note 49 supra. \textit{See also} New York City Health & Hosp. Corp. v. Stein, 70 Misc. 2d 944, 335 N.Y.S.2d 461 (1972) (patient, while sufficiently mentally ill to require further retention, had mental capacity to know and understand whether she wished to consent to electroshock therapy).
tient with certain enumerated rights, including a right to refuse psychosurgery.\textsuperscript{175} Other states prohibit the performance of psychosurgery without the consent of the patient or, if the patient is incompetent, a third party.\textsuperscript{176} These regulatory schemes, however, do not establish any procedures for determining the medical appropriateness of the surgery or for insuring that the patient's consent is both voluntary and informed. A limited number of states, recognizing the difficulties involved, have provided for judicial review of the proposed surgery.\textsuperscript{177} Only two states have statutory requirements for mandatory review of any proposed psychosurgical procedure.\textsuperscript{178}

In 1973, Oregon enacted the first comprehensive legislation for the regulation of psychosurgery.\textsuperscript{179} The Oregon statute provides that psychosurgery may be performed only if a Psychosurgery Review Board (Review Board or Board) has approved the performance of the operation on the individual patient.\textsuperscript{180} The Review Board is composed of nine members appointed by the governor from specified medical, psychological, neuroscientific, and lay backgrounds.\textsuperscript{181}

A physician seeking to perform psychosurgery must first file a petition with the Review Board stating that the patient or his legal guardian, if any, has consented to the surgery and that the proposed treatment has "legitimate clinical value" and is "needed" by the patient.\textsuperscript{182} Following notification to the concerned parties, the Review Board must conduct a "consent hearing" to determine whether the patient or legal guardian has given and continues to give "voluntary and informed" consent\textsuperscript{183} to the treatment. If

\begin{itemize}
\item\textsuperscript{180} Id. § 426.705.
\item\textsuperscript{181} Id. § 426.750. Section 426.750(4) provides that all decisions of the Review Board must be made by an affirmative vote of not less than six members. Id. It should be noted that at least five, and as many as seven, members of the nine-person board may be physicians, while only one need be an attorney and only one is designated as a "member of the general public." Id. § 426.750(3). The Review Board is thus heavily weighted toward the scientific community and may approve the performance of psychosurgery even against the dissent of the lay members.
\item\textsuperscript{182} Id. § 426.710(1).
\item\textsuperscript{183} Id. § 426.715. Within 10 days of the filing of the petition, the Review Board must schedule a hearing to be held within 20 days, and must give at least seven days notice of the
the patient is believed to lack the capacity for voluntary and informed consent and there is no legal guardian, the Review Board must request that one be appointed. 184 The patient and guardian must be notified of their respective rights to legal representation at the consent hearing. 185

If the Review Board finds that adequate consent has been given, it must then determine whether the proposed operation has clinical merit and is an "appropriate" therapy for the specific patient. 186 Before an operation may be deemed appropriate, several prerequisites must be satisfied. It must be shown that:

(a) All conventional therapies have been attempted;
(b) The criteria for selection of the patient have been met;
(c) The operation offers hope of saving life, reestablishing health or alleviating suffering; and

hearing to the patient, the legal guardian, if any, the legal counsel, if any, and the petitioner. 1d. § 426.710(2).

Before the Board will determine that the consent given was voluntary and informed, it must appear that:

(a) A fair explanation was made of the procedures to be followed, including an identification of those which are experimental;
(b) A description was given of the attendant discomforts and risks, if any;
(c) A description was given of the benefits to be expected, if any;
(d) A disclosure was made of appropriate alternative treatments, if any, that would be advantageous for the subject;
(e) An offer was made to answer any inquiries concerning the treatment;
(f) Notice was given that the patient is free to withdraw his consent and to discontinue the authorized treatment at any time;
(g) Disclosure was made of the relationship between the patient and the institution, hospital or physician obtaining the consent; and
(h) Notice was given that the patient or his legal guardian, if any, had a right to consult with and be advised or represented by legal counsel, and if he could not afford one, legal counsel would be appointed for him pursuant to subsection (2) of ORS 426.735. 1d. § 426.715(2).

Section 426.715(5) provides that "[i]f the patient appears to be incapable of giving an informed and voluntary consent to the proposed operation, the necessary consent shall be required to be given or withheld by the patient's legal guardian." 1d. § 426.715(5). If the patient has a legal guardian, the Board is thus required to review only the consent of that guardian. The patient need not testify, and the Board may approve the procedure even if the prospective patient specifically opposes it. Unlike Kainowitz, therefore, the statute can be read as sanctioning the performance of psychosurgery on a nonconsenting, involuntarily committed mental patient under guardianship so long as six of the nine board members approve the procedure. See note 287 infra.

185. 1d. § 426.715(2)(h). The Oregon statute further provides that indigent persons are entitled to appointed counsel upon request. 1d. § 426.735. Section 426.735(2) provides that if the parent or legal guardian requests, but cannot afford, legal counsel, the circuit court shall appoint as counsel the county public defender, if one exists, or a member of the Oregon State Bar. 1d. § 426.735(2).
186. 1d. § 426.730(1). This aspect of the review procedure is a two-step process: the Review Board must first determine that the surgical procedure has "clinical merit" and then conclude that the procedure is appropriate for the specified patient. 1d.
(d) All other viable alternative methods of treatment have been tried and have failed to produce satisfactory results. 187

Finally, if the operation is permitted, a written report of its outcome must be submitted to the Review Board. 188 Throughout its brief history, the Review Board has been an effective safeguard of the patient’s rights. 189

California has enacted two differing approaches to the regulation of psychosurgery. The first involves the availability of psychosurgical therapies to those persons who are involuntarily confined pursuant to the Penal Code, wherever institutionalized. 190 The second approach concerns the performance of psychosurgery upon all other persons, whether institutionalized or not. 191

The preamble to the penal legislation declares the state’s policy to be the protection of the patient’s constitutional rights of privacy and freedom of thought from interference by imposed “organic” therapies. 192 California, unlike Oregon, 193 does not recognize proxy or guardian consent to psychosurgery; rather, the performance of psychosurgery upon individuals who lack the capacity to render informed consent 194 is prohibited. 195

Both California statutes recognize that a person under guardianship, having been adjudicated legally incompetent as a general matter, may nevertheless retain the specific capacity for informed consent to

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187. *Id.* § 426.720(3). The Review Board may conduct site visits with experts in the field during the course of its deliberations. *Id.* § 426.720(2). Furthermore, the Board may undertake a specific diagnostic evaluation to aid in its determination. *Id.* § 426.720(4).

188. *Id.* § 426.740. It should be noted that § 677.190(23) of the Oregon statutes provides that the performance of psychosurgery or intracranial brain stimulation without the permission of the Review Board constitutes grounds for the suspension or revocation of a license to practice medicine. *Or. Rev. Stat.* § 677.190(23) (1977).

189. G. ANNAS, L. GLANTZ & B. KATZ, INFORMED CONSENT TO HUMAN EXPERIMENTATION 229-31 (1977) [hereinafter cited as *ANNAS*]. During the first four years of its operation, the Board reviewed five cases, rejecting three petitions and suspending the other two pending appointment of a guardian or reapplication. *Id.*


191. *Cal. Welf. & Inst. Code* §§ 5325–5328.9 (West Cum. Supp. 1978). It was an earlier version of this legislation which was attacked as unconstitutional in *Aden*. For a discussion of *Aden*, see notes 133–57 and accompanying text *supra*. In the fall of 1976, the Governor of California signed into law the current statute, which was designed to meet the *Aden* court’s objections. 1976 Cal. Stats. ch. 1109. See *ANNAS*, *supra* note 189, at 228. For a discussion of the court’s objections to the original statute, see notes 145 & 146 and accompanying text *supra*.


1. Psychosurgery, including lobotomy, stereotactic surgery, electronic, chemical or other destruction of brain tissues, or implantation of electrodes into brain tissue.

2. Shock therapy, including but not limited to any convulsive therapy and insulin shock treatments.

3. The use of any drugs, electric shocks, electronic stimulation of the brain, or infliction of physical pain when used as an aversive or reinforcing stimulus in a program of aversive, classical or operant conditioning.

*Id.* § 2670.5(c).


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psychosurgery. Conversely, an otherwise legally competent patient may lack such capacity and would therefore be ineligible for psychosurgery.

The distinctive feature of the California penal legislation is its provision for mandatory judicial review. The warden or superintendent of the confining institution must petition a court for an order authorizing psychosurgery, specifying the "mental illness, disorder, abnormality, or defect [that] justifies" the psychosurgery. If the inmate is indigent, the

(a) For purposes of this article, "informed consent" means that a person must knowingly and intelligently, without duress and coercion, and clearly and explicitly manifest his consent to the proposed organic therapy to the attending physician.
(b) A person confined shall not be deemed incapable of informed consent solely by virtue of being diagnosed as a mentally ill, disordered, abnormal or mentally defective person.
(c) A person confined shall be deemed incapable of informed consent if such person cannot understand, or knowingly and intelligently act upon, the information specified in Section 2673.
(d) A person confined shall be deemed incapable of informed consent if for any reason he cannot manifest his consent to the attending physician.

Id. Section 2673 of the Penal Code requires that the subject of the surgery be given certain information:
(a) For purposes of this article, "informed consent" requires that the attending physician directly communicate with the person and clearly and explicitly provide all the following information prior to the person's decision:
(1) The nature and seriousness of the person's illness, disorder or defect.
(2) The nature of the proposed organic therapy and its intended duration.
(3) The likelihood of improvement or deterioration, temporary or permanent, without the administration of the proposed organic therapy.
(4) The likelihood and degree of improvement, remission, control, or cure resulting from the administration of such organic therapy, and the likelihood, nature, and extent of changes in and intrusions upon the person's personality and patterns of behavior and thought or mentation and the degree to which these changes may be irreversible. This information shall indicate the probable duration and intensity of such therapy and whether such therapy may have to be continued indefinitely for optimum therapeutic results.
(5) The likelihood, nature, extent, and duration of side effects of the proposed organic therapy, and how and to what extent they may be controlled, if at all.
(6) The uncertainty of the benefits and hazards of the proposed organic therapy because of the lack of sufficient data available to the medical profession, or any other reason for such uncertainty.
(7) The reasonable alternative organic therapy or psychotherapeutic modality of therapy, or nonorganic behavior modification programs, and why the organic therapy recommended is the therapy of choice. These alternatives shall be described and explained to the person in the manner specified in this section.
(8) Whether the proposed therapy is generally regarded as sound by the medical profession, or is considered experimental.

Id. § 2673.
195. Id. § 2670.5(b). See also CAL. WELF. & INST. CODE § 5326.6(a) (West Cum. Supp. 1978) (providing that psychosurgery, wherever administered, may be performed only if the patient gives written informed consent).
199. Id. § 2675(a),(b).
court must appoint both an independent medical expert and a public defender to assist the inmate.\textsuperscript{200} Initially, the court must determine whether the person has the capacity for informed consent and has manifested that capacity in the process of consenting to the proposed psychosurgery.\textsuperscript{201} If the court so finds, it must then review the merits of the proposed operation.\textsuperscript{202} To authorize psychosurgery, the court must find that the operation would be “beneficial,” that there is a “compelling interest justifying” the operation, that there are “no less onerous alternatives,” and that the operation “is in accordance with sound medical-psychiatric practice.”\textsuperscript{203}

By comparison, the nonpenal California legislation does not require judicial review of proposed psychosurgery for persons outside the criminal justice system. The legislation relies instead upon a committee’s review of both the patient’s consent and the merits of the operation.\textsuperscript{204} After personally examining the patient and determining that the patient has the capacity for informed consent,\textsuperscript{205} the committee must agree with the attending physician that “all other appropriate treatment modalities have been exhausted,” and that the operation “is definitely indicated and is the least drastic alternative
available" for treatment at that time. In addition, no psychosurgery may be performed for at least seventy-two hours after the patient's written consent.

C. Federal Administrative Regulations

At the present time, there are no federal regulations specifically governing the performance of psychosurgery in the United States. The Department of Health, Education, and Welfare (HEW), however, has been active in reg-

knowingly and intelligently, without duress or coercion, clearly and explicitly manifests consent to the proposed therapy to the treating physician and in writing on the standard consent form prescribed in Section 5326.4.

(b) The physician may urge the proposed treatment as the best one, but may not use, in an effort to gain consent, any reward or threat, express or implied, nor any other form of inducement or coercion, including, but not limited to, placing the patient in a more restricted setting, transfer of the patient to another facility, or loss of the patient's hospital privileges. Nothing in this subdivision shall be construed as in conflict with Section 5326.2. No one shall be denied any benefits for refusing treatment.

(c) A person confined shall be deemed incapable of written informed consent if such person cannot understand, or knowingly and intelligently act upon, the information specified in Section 5326.2.

(d) A person confined shall not be deemed incapable of refusal solely by virtue of being diagnosed as a mentally ill, disordered, abnormal, or mentally defective person.

(e) Written informed consent shall be given only after 24 hours have elapsed from the time the information in Section 5326.2 has been given.

To constitute voluntary informed consent, the following information shall be given to the patient in a clear and explicit manner:

(a) The reason for treatment, that is, the nature and seriousness of the patient's illness, disorder or defect.

(b) The nature of the procedures to be used in the proposed treatment, including its probable frequency and duration.

(c) The probable degree and duration (temporary or permanent) of improvement or remission, expected with or without such treatment.

(d) The nature, degree, duration, and the probability of the side effects and significant risks, commonly known by the medical profession, of such treatment, including its adjuvants, especially noting the degree and duration of memory loss (including its irreversibility) and how and to what extent they may be controlled, if at all.

(e) That there exists a division of opinion as to the efficacy of the proposed treatment, why and how it works and its commonly known risks and side effects.

(f) The reasonable alternative treatments, and why the physician is recommending this particular treatment.

(g) That the patient has the right to accept or refuse the proposed treatment, and that if he or she consents, has the right to revoke his or her consent for any reason, at any time prior to or between treatments.

Id. § 5326.2. Compare these informational requirements with the requirements of the California penal legislation, CAL. PENAL CODE § 2673 (West Cum. Supp. 1978). For the text of § 2673, see note 194 supra. For the informational requirements of the Oregon legislation, see note 183 supra. For a discussion of the requirements imposed by the Nuremberg Code, as adopted by the Michigan court in Kaimowitz, see note 90 supra. 206. CAL. WELF. & INST. CODE § 5326.6(d) (West Cum. Supp. 1978). With respect to the appropriateness of psychosurgery as a form of treatment, § 5326.6(d) expressly prohibits the performance of psychosurgery upon minors under the age of 18 years. Id. See also TENN. CODE ANN. § 33-320(f) (1977) (prohibiting surgical procedures on minors for the treatment of mental, emotional, or behavioral disorders).

ulating experimentation on human beings. HEW proposed\textsuperscript{208} and adopted regulations for the protection of human subjects.\textsuperscript{209} These regulations became effective on July 30, 1974,\textsuperscript{210} and extend to "all Department of Health, Education, and Welfare grants and contracts supporting research, development, and related activities in which human subjects are involved."\textsuperscript{211} Since the regulations only extend to research activity funded by HEW,\textsuperscript{212} however, and since most psychosurgery is performed in the context of clinical practice,\textsuperscript{213} these regulations are not applicable to most of the psychosurgery currently being performed in the United States.\textsuperscript{214}

In 1977, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research released its report and recommendations concerning the use of psychosurgery.\textsuperscript{215} The Commission determined\textsuperscript{216} that psychosurgery may be effective in treating certain disorders and relieving certain symptoms,\textsuperscript{217} and therefore concluded that psychosurgery should not be absolutely banned.\textsuperscript{218} Limitations on psychosurgery were recommended, however, because of the potential misuse of psychosurgery for social control and the concern for the safety of a

\begin{footnotes}
\item[211] 45 C.F.R. § 46.101(a) (1978). Under the regulations, initial and continuing review of the projects by an Institutional Review Board (IRB) at the institution conducting the research is required as a condition to receiving federal funding. Id. § 46.102(a), (d). Each IRB must be composed of "not less than five persons with varying backgrounds" who must be identified to HEW. Id. § 46.106(b)(1)-(2). A summary of the proposed research, along with documentation of informed consent, must be submitted to HEW in advance of the project. Id. §§ 46.106(c)-(e), 46.110.
\item[212] Hearings, supra note 20, at 343. HEW has ceased funding of research in the biobehavioral control field. Note, supra note 26, at 619. Most of the studies are now aimed at "understanding the behavioral consequences of altered brain function as a result of war injury, accident, disease, or surgery performed because of clinical necessity, such as removal of malignant brain tumors." Hearings, supra note 20, at 341 (testimony of Dr. Bertram Brown).
\item[213] E. VALENSTEIN, supra note 16, at 296; Mearns, supra note 16, at 599-600. Because most psychosurgery is performed in the context of clinical practice, a formal research protocol and review is not considered necessary by the physicians performing the surgery. See note 16 supra. E. VALENSTEIN, supra note 16, at 296; Mearns, supra note 16, at 599-600.
\item[214] Hearings, supra note 20, at 341 (testimony of Dr. Bertram Brown).
\item[215] REPORT, supra note 6. For a discussion of the Commission's organization and mandate, see notes 21-24 and accompanying text supra.
\item[216] See REPORT, supra note 6, at 57-70. Two of the Commission’s recommendations concern psychosurgery performed on adult patients voluntarily residing in mental institutions and the treatment of minors, and will not be discussed further in this comment.
\item[217] REPORT, supra note 6, at 58-59.
\item[218] Id. at 59. Pennsylvania, however, through the rules and regulations of the Department of Public Welfare, has categorized psychosurgery as a prohibited procedure. 8 PA. BULL. 2443 (Sept. 2, 1978).
\end{footnotes}
patient in an operation which, while potentially therapeutic, is not an accepted procedure.\textsuperscript{219} The Commission believed that safeguards against these dangers could be provided by an Institutional Review Board (IRB), whose composition and procedures must be approved by HEW.\textsuperscript{220} According to the Commission’s recommendations, the IRB would assess: 1) the competence of the surgeon; 2) the plans for the evaluation of the treatment; 3) the diagnostic evaluation of the patient’s fitness for psychosurgery; and 4) the informed consent of the patient.\textsuperscript{221}

The Commission also proposed conditions precedent to the performance of psychosurgery on patients who are involuntarily confined and/or lack the capacity to give informed consent.\textsuperscript{222} Recognizing a right to treatment,\textsuperscript{223}
the Commission maintained that such individuals should be allowed access to psychosurgical procedures. The Commission concluded that, in addition to the physical dangers thought to be associated with psychosurgery, the possibilities of coercion and behavior modification for the purpose of institutional control are inherent in the situation of the involuntarily confined individual. To safeguard against these dangers, the Commission recommended a three-level review mechanism for approving the performance of psychosurgery on these individuals.

On the first level of review, a national psychosurgery advisory board would determine the potential benefit to the patient of the proposed procedure. The second and third levels of review would be conducted by the IRB and the courts, respectively. In addition to the usual functions of the IRB, the review would take place at an institution in which the patient was not involuntarily confined. The review by the IRB and the courts would focus on possible inducements to psychosurgery as a condition of probation, parole, reduction of sentence, or release. Under no circumstances, however, would psychosurgery be performed if the patient objected to the procedure, even if all three levels of review had approved the procedure and the guardian of the patient had consented.

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224. REPORT, supra note 6, at 64.
225. Id. at 64-65.
226. Id. at 64-66.
227. Id. at 65. The process of national review would be initiated at the request of the surgeon wishing to perform the psychosurgery. Id. The Commission stated:

[T]he determination of demonstrable benefit by the Psychosurgery Advisory Board should be made on the basis of (1) the use of the specific psychosurgical procedure to treat the particular disorder in patients who are not prisoners, institutionalized, under guardianship, or believed incapable of giving informed consent, (2) treatment of such persons who underwent the procedure prior to 1977 or outside the United States, or (3) when neither of the above approaches are feasible, persuasive scientific evidence or rationale to support a belief that the procedure is likely to alleviate the specific disorder.

Id.

228 Id. at 65. “Following approval by the Psychosurgery Advisory Board, the surgeon may initiate review by the appropriate IRB. Following IRB approval, court review is initiated by a representative of the patient for whom surgery is proposed.” Id.

229. See notes 220 & 221 and accompanying text supra.
230. REPORT, supra note 6, at 64-65.
231. Id. at 66.
232. Id. at 64, 66. With respect to the issue of guardian consent, the Commission noted that such consent should be reviewed with an awareness of the potential for conflicts of interest inherent in such third-party involvement. Id. at 66. The Commission recommended that the guardian should not be associated with the institution where the patient is confined or where the operation is to be performed. Id. Consent by a legal guardian of a patient who is not institutionalized, but who is incapable of giving informed consent, should also be scrutinized to take into account the potential conflicts of interest that may be associated with the responsibility of providing care for such persons. Id.

If the IRB has good reason to believe that a patient, lacking a legal guardian, is incapable of giving informed consent, the IRB should withhold approval pending authorization by a court and consent of a court appointed legal guardian. Id. If no court accepts jurisdiction, however, the operation should not be performed. Id. Similarly, the Commission deferred to those states which prohibit third-party consent, concluding that the operation should not be performed if
IV. REFINING THE LEGAL RESPONSE

The judicial, legislative and administrative responses to psychosurgery consist of widely divergent opinions within the legal community. A number of states, by requiring the formality of informed consent without providing procedures to evaluate the legal adequacy of the consent, have adopted a laissez-faire approach to the regulation of psychosurgery. Conversely, some jurisdictions have adopted a prohibitive approach, banning psychosurgery with respect to entire classes of patients and institutions. Between these extremes, a variety of regulatory schemes have been adopted.

Due to this diversity of opinion and approach, two initial observations must be made before any detailed analysis of the law's response to psychosurgery can be attempted. First, it is submitted that an absolute prohibition of psychosurgery is not justifiable. Such a restriction denies the patient access to the potential benefits of psychosurgery and is in conflict with the right to treatment. One difficulty in applying a right to treatment analysis to psychosurgery is that psychosurgical procedures are still considered "experimental" by segments of the medical and legal community.

the patient objects to the procedure. Id. For a further discussion of the Commission's report, see Note. Return to the Cuckoo's Nest: An Examination of the National Commission's Report on Psychosurgery, 6 Hofstra L. Rev. 941 (1978).

In November of 1978, the Secretary of the Department of Health, Education, and Welfare published a determination regarding the Commission's report and recommendations concerning psychosurgery. 43 Fed. Reg. 53,242 (1978). The Secretary concluded that under present law, HEW had no "clear authority" to regulate directly psychosurgical procedures currently being performed in the United States. Id. at 53,243. Furthermore, based on the Commission's findings concerning the nature of psychosurgery, the Secretary concluded that an effort to secure regulatory legislation would not be warranted. Id. In lieu of regulatory legislation, it was determined that HEW would assist leading professional organizations in forming a Joint Committee on Psychosurgery to establish mechanisms for the voluntary regulation and reporting of psychosurgical procedures. Id. Furthermore, HEW will promulgate regulations covering procedures supported by HEW programs. Id. These regulations will generally follow the Commission's recommendations, but would ban the use of psychosurgery on prisoners, children, involuntarily confined mental patients, legally incompetent patients, and any patient who, in the judgment of the attending physician, is not competent to give informed consent. Id. at 53,243-44.

233. For a discussion of the judicial response to psychosurgery, see notes 67-174 and accompanying text supra.

234. For a discussion of the legislative response to psychosurgery, see notes 175-207 and accompanying text supra.

235. For a discussion of the administrative response to psychosurgery, see notes 208-32 and accompanying text supra.

236. See notes 175-77 and accompanying text supra.


238. See note 16 supra.

239. For a general discussion of the right to treatment, see note 140 supra.

240. See note 16 supra.

241. See notes 78-87 and accompanying text supra, and note 144 supra.
munities. Even assuming, however, that psychosurgery is a treatment of last resort, if all indications for surgery are present, any lesser treatment employed where surgery is indicated may be less than constitutionally adequate.\textsuperscript{242} Furthermore, any general prohibition of psychosurgery will necessarily limit the physician's ability to pursue his vocation of medical practice and research. Such a limitation may result in a deprivation of the physician's right to liberty under the fourteenth amendment.\textsuperscript{243} Finally, although the probability of permanent side effects remains high,\textsuperscript{244} benefits have been realized from psychosurgery\textsuperscript{245} and those benefits may be increased by future technological advances.\textsuperscript{246} It is therefore submitted that while the dangers from psychosurgery clearly justify some degree of regulation,\textsuperscript{247} no similarly compelling state interest justifies a prohibition of psychosurgery in derogation of the right to treatment.

Second, it is submitted that a "hands-off" approach to psychosurgery, which relies on the "high standards of the medical profession and the individuals who compose it" for protection,\textsuperscript{248} is equally unacceptable. Implicit in the judicial response to psychosurgery is the assumption that such surgery intrudes upon the individual's physical and mental integrity and that the individual is protected under the Constitution from such intrusions.\textsuperscript{249} It is submitted, however, that the current constitutional analysis is unfocused since it is presently unclear whether the protected interests which trigger a more rigorous review of the individual's consent\textsuperscript{250} are grounded in the right of privacy or in the freedom of speech and thought found in the first amendment.


\textsuperscript{243} \textit{Cf.} Meyer v. Nebraska, 262 U.S. 390 (1923). In \textit{Meyer}, the United States Supreme Court overturned a state statute which prohibited the teaching of foreign languages to children who had not yet reached the eighth grade. \textit{Id.} at 402-03. The Court based its conclusion, in part, on the fact that the statute interfered with the teacher's right to pursue his chosen profession. \textit{Id.} at 400. See \textit{also} Doe v. Bolton, 410 U.S. 179, 198-200 (1973).

\textsuperscript{244} See notes 86 & 87 supra.

\textsuperscript{245} See note 16 supra.

\textsuperscript{246} \textit{Compare} notes 38 & 44 supra (discussing the benefits achieved through the performance of lobotomies) \textit{with} note 16 supra (discussing the benefits achieved with more contemporary psychosurgical procedures).

\textsuperscript{247} For a discussion of the compelling state interests cited by the \textit{Aden} court to justify the regulation of psychosurgery, see notes 143 & 144 and accompanying text supra; note 147 supra.

\textsuperscript{248} See Note, supra note 58, at 474. See notes 58-62 and accompanying text supra.

\textsuperscript{249} See notes 96-107 & 138-46 and accompanying text supra.

\textsuperscript{250} It has already been noted that the patient's consent to a psychosurgical procedure is tantamount to a waiver of constitutionally protected interests and it is for that reason that a strict review of the patient's consent is required. See notes 88-90 & 107 and accompanying text supra.

Both the \textit{Kaimowitz} and the \textit{Aden} courts stated that further technological advances in psychosurgical procedures, which result in increased scientific validation of the procedure, could result in a less restrictive approach to psychosurgery. See notes 95 & 134 supra. It is submitted, however, that any technological advances in procedure, while reducing the physical dangers of psychosurgery, will do nothing to lessen the intrusion into the constitutionally protected in-
A. An Analysis of the Constitutional Considerations

The Kaimowitz court proposed two alternative constitutional theories to support its nonrecognition of Smith's consent, concluding that the use of experimental psychosurgery on a mental patient involuntarily confined in a state institution, even with the patient's formal consent, would violate the patient's first amendment right to generate ideas as well as his constitutionally protected right of privacy.251 These same alternative constitutional theories were also advanced by the petitioners in Aden.252

With respect to the right of privacy, the Kaimowitz court maintained that this protected interest would be violated by a psychosurgical intrusion into the intellect of the patient.253 Citing recent Supreme Court decisions involving privacy,254 the Kaimowitz court held that an individual's mental processes are protected by the right of privacy255 and that an authorization of surgery would "fail to recognize and follow the mandates of the Supreme Court of the United States, which has constitutionally protected the privacy of body and mind."256 It is submitted, however, that the privacy arguments of Kaimowitz and the right of privacy as applied to psychosurgery are unsupported by current constitutional standards.

The threshold question with respect to the applicability of the privacy concept is whether judicial opinions in the privacy area, such as Roe v. Wade257 and Griswold v. Connecticut,258 can be applied to the psychosurgery issues. Rights pertaining to privacy in Roe and Griswold were directed toward prohibiting state regulation of activity alleged to be private and a matter of personal choice.259 The Supreme Court's analysis in the privacy area has not focused on the individual's right to exercise control over his body or mind per se. Indeed, the Court in Roe stated:

The privacy right involved, therefore, cannot be said to be absolute. In fact, it is not clear to us that the claim asserted by some amici that one has an unlimited right to do with one's body as one

251. JUDICIARY REPORT, supra note 67, at 520-23. See notes 96-107 and accompanying text supra.
252. 57 Cal. App. 3d at 679-80, 129 Cal. Rptr. at 546-47. See notes 138-42 and accompanying text supra.
253. See notes 97 & 104-07 and accompanying text supra.
255. JUDICIARY REPORT, supra note 67, at 523.
256. Id.
258. 381 U.S. 479 (1965).
259. See note 254 supra.
pleases bears a close relationship to the right of privacy previously articulated in the Court’s decisions. The Court has refused to recognize an unlimited right of this kind in the past. 260

A second difficulty with the privacy analysis is that it makes an alleged violation of the right of privacy virtually indistinguishable from the tort of battery. 261 There is nothing in the privacy analysis to distinguish psychosurgery from any unwarranted interference with one’s “personal integrity.” 262 It is submitted that the right of privacy would no more be violated by the performance of psychosurgery than by subjecting a patient to any other intentional and unpermitted contact. Under the privacy analysis of psychosurgery, the right to privacy becomes superfluous as an unnecessary duplication of the rights already available under tort law. 263

It is submitted that a first amendment analysis of the interests to be protected by psychosurgery regulation is a more convincing alternative than the privacy argument. The premises of the first amendment analysis are that certain mental activity precedes communication, that psychosurgery is treatment altering mental activity that may be necessary to communication, and that protection of communication is meaningless unless the first amendment also protects the activity which makes communication possible. 264 The conclusion which follows from these premises is that the protection afforded by the first amendment includes a right to refuse treatment which alters the mental activity essential to communication, as well as right of access to treatment which alters the same activity. 265


261. Comment, supra note 79, at 219. Dean Prosser defined the interest protected by the law of battery as "[t]he interest in freedom from intentional and unpermitted contacts with the plaintiff's person..." W. PROSSER, LAW OF TORTS (4th ed. 1971).

262. W. PROSSER, supra note 261, at 35.

263. Comment, supra note 79, at 219. One commentator has maintained that tort law provided a sufficient basis for the holding in Kaimowitz, and that the court should not have engaged in a constitutional analysis. The Devil's Advocate, 2 BULL. AM. ACAD. PSYCH. & L. 64, 65 (1974).

264. Shapiro, supra note 55, at 256. Professor Shapiro formulated the argument in the following manner:

(1) The first amendment protects communication of virtually all kinds, whether in written, verbal, pictorial or any symbolic form, and whether cognitive or emotive in nature.

(2) Communication entails the transmission and reception of whatever is communicated.

(3) Transmission and reception necessarily involve mentation on the part of both the person transmitting and the person receiving.

(4) It is in fact impossible to distinguish in advance mentation which will be involved in or necessary to transmission and reception from mentation which will not.

(5) If communication is to be protected, all mentation (regardless of its potential involvement in transmission or reception) must therefore be protected.

Id. (footnotes omitted) (emphasis in original).

265. Id. at 257. Professor Shapiro concluded his analysis as follows:

(6) Organic therapy intrusively alters or interferes with mentation.
The right to refuse treatment implies that coerced psychosurgery constitutes violation of first amendment rights. Coercion includes not only the performance of psychosurgery against the patient’s will, but also subjecting a patient to psychosurgery without having obtained his informed consent.\(^\text{266}\) It was this latter aspect of the first amendment argument that concerned the court in *Kaimowitz*,\(^\text{267}\) where the court held that since institutionalization prevents competent, knowledgeable, and voluntary consent, it thereby obviates informed consent to psychosurgery.\(^\text{268}\) In *Kaimowitz*, no compelling state interest could be found to support the violation of this first amendment right.\(^\text{269}\)

The right of access to treatment as an aspect of first amendment rights to free speech and thought was recognized in *Aden*.\(^\text{270}\) The *Aden* court maintained that first amendment freedoms may be impaired by the lack of access to psychosurgery,\(^\text{271}\) and that a compelling state interest must be shown to justify a limitation of access and a denial of first amendment rights.\(^\text{272}\)

**B. Technical Refinements in Psychosurgery:**

**Review Procedures**

In evaluating the procedures adopted by those jurisdictions which have established mandatory review of a decision to perform a psychosurgical procedure,\(^\text{273}\) it should be noted initially that the review procedure is con-

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\(^{266}\) See Note, *supra* note 25, at 1022.

\(^{267}\) JUDICIARY REPORT, *supra* note 67, at 521-22. See notes 98-103 and accompanying text *supra*.

\(^{268}\) See notes 88-95 and accompanying text *supra*. But see note 95 *supra*.

\(^{269}\) JUDICIARY REPORT, *supra* note 67, at 522. See notes 106 & 107 and accompanying text *supra*. Allowing the performance of psychosurgery without the informed consent of the patient may further two possible state interests: 1) a reduction in the cost of confinement; and 2) paternalism—benefiting the patient by altering his mental activity to function in such a way that “normal” communication is possible. Shapiro, *supra* note 55, at 277. These interests, however, may lack the status of “compelling” so as not to outweigh the serious intrusion on the patient’s first amendment rights. Id. at 277-96.

\(^{270}\) 57 Cal. App. 3d at 679, 129 Cal. Rptr. at 545-46. See note 138 and accompanying text *supra*.

\(^{271}\) 57 Cal. App. 3d at 679-80, 129 Cal. Rptr. at 546-57. See notes 141 & 149 and accompanying text *supra*.

\(^{272}\) 57 Cal. App. 3d at 679-80, 129 Cal. Rptr. at 546-47. As has been noted, the *Aden* court found a compelling state interest to support the state’s regulation of psychosurgery. See notes 143 & 144 and accompanying text *supra*. See also notes 147-56 and accompanying text *supra*.

ducted on two separate and distinct levels: medical and legal. 274 In spite of the dual nature of the review process, the evaluation is generally conducted by a single board or committee. 275 It is submitted that the review functions should be separated and delegated to two distinct committees.

The first review board, which would consist of appointed members of the related medical fields, 276 would review the technical aspects of the proposed psychosurgery, such as the competence of the operating surgeon to perform the operation, the evaluation procedure, and the diagnostic evaluation of the surgical candidate. 277 The medical review board would then make a determination concerning the medical justifications for the proposed surgery and the fitness of the candidate for the specific procedure. The decision of the medical review committee would be final and would not be subject to judicial review. This policy recognizes the complexity of the medical judgment involved and the judiciary's inability to effectively review such a determination. 278 To mitigate the possibility of abuse, however, it is suggested that the medical review committee be a permanent, centralized body. 279 With a single committee reviewing all proposed psychosurgery within a given state, the possibility of the development of conflicts of interest between members of the committee and those actively engaged in the practice of psychosurgery would be minimized. 280

The second review committee, consisting of lay persons, members of the bar, or a combination of the two, 281 would review the legal adequacy of


275. See note 274 supra. The Kaimowitz case may provide an illustration of the problems involved in having only one committee perform both review functions. One member of the review committee in Kaimowitz failed to attend any of the meetings relating to the proposed surgery, stating: "As a layman I am unqualified to comment on any of the technical aspects which are involved in the project. Therefore we must all trust the good intentions and technical competence of the Hospital Medical Committee, psychologist, psychiatrists, neurologists, etc., who have reviewed and evaluated John Doe's case." Letter from Frank Moran, Complaint, exhibit F, Kaimowitz v. Department of Mental Health, No. 73-19434-AW (Mich. Cir. Ct., Wayne County, July 10, 1973), reprinted in part in Annas, supra note 189, at 221. Furthermore, relying on untrained laymen to make decisions concerning the advisability of a proposed psychosurgical procedure could arguably constitute medical malpractice on the part of the review committee. See note 62 supra.

276. For example, psychiatry, psychology, neurology, and neurosurgery should be represented on the medical review board.

277. REPORT, supra note 6, at 60. In reviewing the fitness of the proposed surgical candidate, the medical review board, through personal interviews with the candidate, could aid the patient in making an informed decision by acting as a neutral and authoritative body from which the patient could receive answers to his or her questions about the proposed procedure. Annas, supra note 189, at 231.

278. See text accompanying notes 129 & 130 supra.

279. This is the procedure adopted in Oregon. See OR. REV. STAT. § 426.750 (1977). This procedure was not, however, adopted in California. See CAL. WELF. & INST. CODE § 5326.6(d) (West Cum. Supp. 1978).

280. As a further precaution against possible conflicts of interest, individuals currently engaged in the practice of psychosurgery should be excluded from membership on the medical review committee.

281. Since the consent review board would be quasi-judicial in nature, it may be advisable to restrict membership to attorneys. Since the board, however, would be making a determination
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the consent given by the proposed subject of the psychosurgical procedure. This consent review committee would evaluate the knowledge and competency of the patient, the procedures employed in obtaining the consent, and the voluntariness of the patient’s action. Since the consent review committee’s determination would be legal in nature, judicial review of its decision should be permitted. Moreover, in light of its purpose, it is suggested that the functions of the consent review committee also be centralized and that a requirement of unanimity be imposed on the determinations of both the medical review committee and the consent review committee.

A second area requiring clarification is the extent to which a third party can consent to the performance of psychosurgery when it is determined that a patient lacks the capacity to provide the necessary consent. Although a number of states currently provide for various forms of third-party consent, the use of such consent is highly questionable in light of the constitutional analysis approach to psychosurgery.

The question of substitute consent presents one of the major dilemmas in psychosurgery regulation. If the approach taken in Kaimowitz is adopted, and substitute consent is not recognized, patients who are deemed to be incapable of giving legally adequate consent will be barred from the surgical procedures. Such a result may be a violation of the pa-

as to the sufficiency of informed consent according to statutory standards—a determination typically made by juries in malpractice cases—such a limitation may not be required.

283. See Id.
284. JUDICIARY REPORT, supra note 67, at 517-18.
285. See note 279 and accompanying text supra.
286. The requirement of unanimity of the medical board of review is imposed by the California legislation, CAL. WELF. & INST. CODE § 5326.6(d) (West Cum. Supp. 1978), and was upheld in Aden. 57 Cal. App. 3d at 683, 129 Cal. Rptr. at 548. See notes 155 & 156 and accompanying text supra.
288. JUDICIARY REPORT, supra note 67, at 519. In Kaimowitz, both the patient and his parents signed the consent form. Id. at 511. See note 70 and accompanying text supra. Even though the parents had agreed to the procedure, the court refused to permit the surgery to take place. JUDICIARY REPORT, supra note 67, at 519. The court stated:

Equally great problems are found when the involuntarily detained mental patient is incompetent, and consent is sought from a guardian or parent. Although guardian or parental consent may be legally adequate when arising out of traditional circumstances, it is legally inoperative in the psychosurgery situation. The guardian or parent cannot do that which the patient, absent a guardian, would be legally unable to do.

Id. The Kaimowitz court’s determination that third-party or substitute consent is not proper in the psychosurgery situation has received some support among the commentators. See Gauvey, Leviton, Shuger & Sykes, Informed and Substitute Consent to Health Care Procedures: A Proposal for State Legislation, 15 HARV. J. LEGIS. 431, 471-75 (1978); Comment, supra note 79, at 217.
289. JUDICIARY REPORT, supra note 67, at 511. See note 287 supra.
On the other hand, if the Oregon procedure is accepted, and substitute consent is legally adequate, a review board may be required to review only the consent of the guardian and may approve a psychosurgical procedure even if the patient specifically opposes it. Such a result would be an infringement upon the patient’s right to refuse treatment.

The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, in its report on psychosurgery, resolved this dilemma by preserving both a procedure for substitute consent and the right of the patient to refuse treatment. Under the Commission’s proposal, psychosurgery on a patient incapable of giving informed consent may be performed if the patient’s guardian has given informed consent, a court in which the patient has legal representation has approved the performance of the operation, and the patient does not object to the treatment. The Commission also recommends that substitute consent be reviewed with an awareness of the potential for conflict of interest inherent in such consent and that the consenting guardian not be associated with the institution where the patient is confined or where the operation is to be performed. If the substitute consent is given by one who is responsible for providing for the care of the patient, such consent should also be carefully scrutinized for possible conflicts of interest.

In light of the conflicting rights involved in the issue of substitute consent to psychosurgery, it is submitted that the compromise position reached by the Commission is preferable. A procedure for substitute consent is provided, thereby preserving the patient’s right to treatment. Moreover, psychosurgical procedures cannot be performed over the objections of an adult mental patient, even following adjudication of incompetence and even though a legal guardian has consented to the operation.

V. CONCLUSION

The legal response to psychosurgery provides us with a glaring example of the consequence of the failure of the law to keep pace with a rapidly developing technology. The serious legal issues involved in the performance

290. For a general discussion of the right to treatment, see note 140 supra.
292. For a discussion of the right to refuse treatment, see notes 143 & 151 and accompanying text supra.
293. REPORT, supra note 6, at 64-67.
294. Id. at 64. See note 232 supra.
295. REPORT, supra note 6, at 66.
296. Id.
297. Id. The probability of such conflicts of interest appears to be especially high under the Oregon procedure for substitute consent. OR. REV. STAT. § 426.730 (1977). The Oregon statute provides that the guardian will be appointed according to the following preferences: spouses, next of kin, personal friends, public guardians, and others. Id. § 426.730(2).
298. REPORT, supra note 6, at 66.
of psychosurgery were initially ignored. Only a general rise in public concern prompted a response from the legal community. That response, and the associated attempt to balance a series of conflicting rights, has occurred while psychosurgical technology has continued to advance. Since the medical status of psychosurgery remains largely unsettled, the corresponding legal issues are equally undetermined.

Some basic issues have been decided, however. First, it is manifestly clear that psychosurgery represents more than simply an advancement in medical technology. The first amendment interests affected by the performance of psychosurgery indicate a greater need to regulate and review these procedures than traditional medical procedures. Consequently, psychosurgery will continue to be regulated. Second, the basic nature of the regulatory schemes are still being established. The focus should continue to be on the adequacy of the consent given by proposed candidates for psychosurgical procedures.

While the exact nature of the regulation is still unsettled, perhaps it should remain so. Technological advances will continue, and the law should be flexible enough to accommodate those advances. Any attempt to firmly settle the legal response to psychosurgery will eventually result in a failure of the regulatory approach. The law in this area must therefore adapt itself to the medical developments, focusing always on the established rights of the parties involved, but accommodating new developments within that basic legal framework.

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299. See notes 2-4 and accompanying text supra.
300. See notes 6-15 and accompanying text supra.
301. See note 16 supra.