Return to the Cuckoo's Nest: An Examination of the National Commission Report on Psychosurgery

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NOTES

RETURN TO THE CUCKOO'S NEST:
AN EXAMINATION OF THE NATIONAL COMMISSION REPORT ON PSYCHOSURGERY

One Flew Over the Cuckoo's Nest\(^1\) describes the use of psychosurgery to rid MacMurphy, an inmate-patient who challenged the authority of his "keepers" in a psychiatric institution, of his allegedly violent tendencies. The operation transformed him into a human vegetable. His friend, the "Chief," another patient at the hospital, recognized that MacMurphy's life was now without meaning and mercifully suffocated him. The author's indictment of abuses in mental institutions was published in 1962, when the practice of psychosurgery was waning in the United States.\(^2\)

Cuckoo's Nest should belong to a bygone era, one replaced by an age in which more humane treatments are administered. However, debate surrounding psychosurgery has again arisen, and it has been revealed that several hundred psychosurgical procedures are still performed each year in the United States.\(^3\) In 1974, Congress passed the National Research Act\(^4\) which created the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. One of the duties of the Commission was to conduct an investigation of psychosurgery in the United States to determine the appropriateness of its use and to recommend to the Secretary of Health, Education, and Welfare (HEW) standards defining any circumstances under which use of psychosurgery may be appropriate.\(^5\) The Commission report issued

2. See note 17 infra and accompanying text.
in March 1977, concluded that psychosurgery is appropriate for both voluntarily and involuntarily committed patients under certain circumstances and “encouraged” the Department of HEW to carry on research to evaluate the safety and efficacy of psychosurgical procedures. On May 23, 1977, Representative Louis Stokes introduced a measure in the House of Representatives to prohibit the performance of psychosurgery in “federally connected health care facilities.” The events giving rise to renewed debate over the issues which were raised by the Commission report, informed consent and the rights to receive and to refuse medical treatment, will be examined in this note.

Psychosurgery is defined in the Commission report as brain surgery: (1) on physiologically healthy brain tissue of an individual, who does not suffer from any physical disease, to change or control his behavior or emotions; or (2) on diseased brain tissue of an individual if the primary purpose of the surgery is to control, change, or affect any behavioral or emotional disturbance of such individual. Psychosurgical procedures include lobotomy, implantation of electrodes in the brain, brain stimulation, and direct application of various substances to the brain. However, the Commission excluded surgical treatment for epilepsy and parkinsonism from the definition, and the bill to ban psychosurgery excepts “treatment of a known and diagnosed physical disease of the brain.”

HISTORY OF PSYCHOSURGERY

The practice of psychosurgery began during the late Middle Ages when “trephening,” drilling a hole in the patient’s skull

6. Id. at 26,331.
7. H.R. 7371, 95th Cong., 1st Sess., 123 CONG. REC. H4830 (daily ed. May 23, 1977). As of the date of publication of this note, no action has been taken on H.R. 7371 by the committees to which it was referred, House Committee on Interstate and Foreign Commerce and the House Ways and Means Committee.
8. Report of the National Commission, supra note 5, at 26,318-19. However, numerous commentators and a landmark decision in the field have emphasized that psychosurgery is usually performed in the absence of evidence of any abnormality in the targeted area of brain which has caused the behavioral disorder. See Aden v. Younger, 57 Cal. App. 3d 662, 129 Cal. Rptr. 535 (4th Dist. 1976); Kaimowitz v. Department of Mental Health, 1 MENTAL DISABILITY L. REP. 147, 148 (Mich. Cir. Ct. 1973); Barnhart, Pinkerton & Roth, Informed Consent to Organic Behavior Control, 17 SANTA CLARA L. REV. 39, 57 & nn.67 & 68 (1977).
10. Id.
11. H.R. 7371, 95th Cong., 1st Sess., 123 CONG. REC. H4830 (daily ed. May 23, 1977). This exception appears to be a fatal flaw because it effectively nullifies the desired result of the legislation. See text accompanying note 216 infra.
through the temple, was performed to let "demons," the alleged causes of mental illness, escape. Its modern development can be traced to Europe at the end of the last century. In the United States, surgical procedures, in which fibers between the frontal lobes and other parts of the brain are severed, were first performed in the 1930's. Approximately 50,000 frontal lobotomies were performed in the United States between 1940 and 1960. Although some favorable results were achieved, enthusiastic lobotomy advocates underplayed some of the effects of the operation: It often produced partial paralysis, convulsions and loss of bladder control, and left patients apathetic and intellectually blunted. The use of lobotomies waned after 1960 with the development of drug therapy and electroconvulsive procedures to treat mental illness.

Numerous events led to the revival of interest in psychosurgery. Drug allergies, blood abnormalities, and disorder in muscle tone and movement were caused by thorazine, a drug widely used as a chemical lobotomy. New forms of brain surgery were developed in which the surgeon did not have to cut manually or remove portions of the brain to reach a targeted area. In 1967, a year of widespread urban violence in the United States, Doctors Mark, Sweet, and Ervin, psychosurgery researchers, argued that these disturbances and other acts of violence might be prevented by psychosurgery. Funding was subsequently appropriated by Congress in 1970 for further research.

12. See TIME, April 3, 1972, at 50.
16. N. KITTRIE, supra note 13, at 305-06.
19. Chorover, Psychosurgery: A Neuropsychological Perspective, 54 B.U.L. REV. 231, 235-36 (1974). These procedures include stereotaxic surgery, in which electrodes attached to fine wires are threaded into the brain to the target area, following an elaborate coordinate system where ultrasonic beams and radiation transmission are aimed at pinpointed targets.
21. The money was appropriated to the Neuro-Research Foundation at Boston City Hospital. The grant was made on the condition that no research on human subjects would be conducted. Informed Consent, supra note 14, at 738 n.88; Restak, supra note 15, at 57.
concern that any group in power might use psychosurgery as a tool to suppress minorities grew out of these reports.\textsuperscript{22} Little research had been done to evaluate the effectiveness and safety of psychosurgery;\textsuperscript{23} in 1973, during Senate debate on the National Research Act, an amendment was proposed which provided for a two-year moratorium on psychosurgery until the Commission, created by the Act, could complete a study of the use and efficacy of such operations.\textsuperscript{24} Ironically, the amendment was deleted because "Congress had insufficient information to justify such a measure."\textsuperscript{25} Approximately five to seven hundred psychosurgical procedures are still performed annually in the United States.\textsuperscript{26}

**NATURE OF PSYCHOSURGERY**

The replacement of lobotomies with drug therapy was met favorably.\textsuperscript{27}

Time and experience had tarnished the operation's early promise. Schizophrenics before lobotomy were schizophrenics after. The procedure was less a cure than a pacifier. Many patients became less volatile and easier to manage after lobotomy, but instead of emptying the hospitals, the operation began to fill them with a new type of patient, whose stereotype was the postoperative vegetable . . . .\textsuperscript{28}

Psychosurgery is an experimental procedure\textsuperscript{29} and is generally con-

\textsuperscript{22} Interview with Peggy Jones, Assistant to Representative Stokes (Aug. 1, 1977). Stokes was not the first to suggest this possibility. The use and present feasibility of psychosurgery as a means of social control has been discussed. See Older, *Psychosurgery: Ethical Issues and a Proposal for Control*, 44 Am. J. Orthopsychiatry 661, 671 (1974). The Commission was also aware of this danger. See Report of the National Commission, *supra* note 5, at 26,327.

\textsuperscript{23} *Informed Consent, supra* note 14, at 737.

\textsuperscript{24} Report of the National Commission, *supra* note 5, at 26,319.

\textsuperscript{25} *Id.*


\textsuperscript{27} *See generally* Older, *supra* note 22.

\textsuperscript{28} *Id.* at 661.

\textsuperscript{29} This proposition has been enunciated by courts and by commentators. See Aden v. Younger, 57 Cal. App. 3d 662, 671, 129 Cal. Rptr. 535, 541 (4th Dist. 1976); Kaimowitz v. Department of Mental Health, 1 Mental Disability L. Rep. 147 (Mich. Cir. Ct. 1973); Older, *supra* note 22, at 662; Barnhart, Pinkerton, & Roth, *supra* note 8, at 58. The Aden court examined California legislation severely restricting the use of psychosurgery. The Kaimowitz court held that an involuntarily confined mental patient could not give informed consent to a proposed psychosurgical procedure. The patient could not make a knowledgeable decision, one of the requisites for informed consent, because psychosurgery is still experimental and doctors
considered a treatment of last resort.\textsuperscript{30} Psychosurgery is experimental in that scientists cannot ascertain why it works when it works.\textsuperscript{31} Admittedly, healthy brain cells are destroyed to alter the thoughts and behavior of a mentally ill individual.\textsuperscript{32} Although lesions in a particular area of the brain of many individuals will produce similar results, man's understanding of the brain's functions is too primitive to permit a determination of how the procedure produces its effects.\textsuperscript{33} Why, then, is psychosurgery performed? Valuable insight into this question can be obtained from the Commission report.\textsuperscript{34} The Commission based its empirical findings on two postoperative studies of sixty-one patients who had received operations during the period 1965-1975.\textsuperscript{35} The studies drew upon interviews and objective tests.\textsuperscript{36} They demonstrated that "(1) more than half of the patients improved significantly following psychosurgery, although a

\textsuperscript{30} Report of the National Commission, \textit{supra} note 5, at 26,326 (summary of statement of John Donnelly, M.D., made at public hearing held by the Commission on June 11, 1976). \textit{See OR. REV. STAT. §§ 426.700-.755 (1975). This statute requires that all alternative treatments and therapies be attempted before psychosurgery is performed. Id. § 426.720(3)(d). If it is to be performed, the statute limits the use of psychosurgery to instances where it is necessary to save life or alleviate suffering. Id. § 426.720(3)(c). One of the treatments for mental illness often used prior to psychosurgery is electroconvulsive treatment (ECT). The Aden decision found that ECT is generally accepted throughout the medical community as a form of treatment for certain types of mental illness, particularly manic depression and schizophrenia. \textit{See Aden v. Younger, 57 Cal. App. 3d 662, 684, 129 Cal. Rptr. 535, 549 (4th Dist. 1976). However, it has been argued that since there is no consensus as to how ECT affects the brain and how it changes behavior, and because the hazards of ECT are as deleterious as those of psychosurgery, ECT should also be labeled an experimental procedure and its use severely limited. \textit{See Informed Consent, \textit{supra} note 14, at 745-52.}


\textsuperscript{33} Kaimowitz v. Department of Mental Health, 1 MENTAL DISABILITY L. REP. 147, 148 (Mich. Cir. Ct. 1973); Restak, \textit{supra} note 15, at 56. Man's lack of knowledge concerning the brain is not the only reason why psychosurgery is an experimental procedure. In addition to, and as a direct result of, this lack of knowledge, the term mental illness has no fixed meaning. \textit{See Barnhart, Pinkerton, & Roth, \textit{supra} note 8, at 42.}

\textsuperscript{34} Report of the National Commission, \textit{supra} note 5, at 26,319.

\textsuperscript{35} Id. at 26,329.

few were worse and some unchanged and (2) none of the patients experienced significant neurological or psychological impairment attributable to the surgery.”37 The Commission emphasized that the vast majority of the patients did not undergo preoperative evaluations against which gains or losses clearly attributable to surgical intervention could be measured.38 It concluded that the studies “appear to rebut any presumption that all forms of psychosurgery are unsafe and ineffective.”39 Since it found that some forms of psychosurgery have therapeutic value,40 the Commission did not recommend a wholesale ban on psychosurgery. While the Commission recognized the potential abuses of psychosurgery,41 it proposed safeguards which could effectively eliminate the dangers.42

Amid charges that psychosurgery is merely experimental and has a great potential for abuse,43 the concern arose that patients give informed consent44 to proposed psychosurgery. The Commission recommended that an Institutional Review Board (IRB)45 be established at every mental institution to assure that a patient who

37. Report of the National Commission, supra note 5, at 26,329. The studies were conducted by two neuropsychologists at Boston University and two neuropsychologists and one neurologist at the Massachusetts Institute of Technology.
38. Id. at 26,323. Eighteen of the 34 patients evaluated in Teuber's study had undergone preoperative examinations. This lack of preoperative evaluation and inherent subjectivity of evaluation has been one of the criticisms of psychosurgeons' work. See, e.g., E. VALENSTEIN, BRAIN CONTROL 296 (1973). Without such evaluation, critics contend, it is impossible to conclude that psychosurgery is beneficial. Id.
40. Id.
41. Id. The Commission stated:
The Commission affirms that the use of psychosurgery for any purpose other than to provide treatment to individual patients would be inappropriate and should be prohibited. Accordingly, the Commission is recommending safeguards that should prevent the performance of psychosurgery for purposes of social or institutional control or other such misuse.
Id. (emphasis in original).
42. The Commission recommended that all proposed psychosurgical procedures be reviewed by an Institutional Review Board (IRB) approved by the U.S. Department of Health, Education, and Welfare (HEW) and comprised of a neurosurgeon, a psychiatrist, a neurologist, and a psychologist. The IRB would carry out preoperative and postoperative evaluations to determine the competence of the surgeon as well as assess whether proper consent had been given by the patient or his guardian to protect the patient’s rights. Id. See notes 167-205 infra and accompanying text. Judicial review of all IRB decisions was recommended only in cases involving involuntarily committed mental patients. Report of the National Commission, supra note 5, at 26,330.
43. Id. at 26,329; see generally Older, supra note 22.
45. See note 42 supra.
is capable of consenting to an operation has provided informed consent before psychosurgery is performed. 46

INFORMED CONSENT

The recognition of a physician’s duty to obtain informed consent before administering medical treatment is a relatively new development in American law. It has grown from the notion that a physician is obligated to disclose information to the patient about treatment. The modern concept of informed consent originated at the beginning of the twentieth century in Hunter v. Burroughs, 47 where the Supreme Court of Virginia stated that “it is the duty of a physician in the exercise of ordinary care to warn a patient of the danger of possible bad consequences of using a remedy.” 48

The extent of disclosure which a physician must provide has been at issue since Burroughs. Under the full disclosure standard, liability is founded on a physician’s failure to provide the patient with sufficient information to make a meaningful choice based on the risks inherent in the treatment and the consequences of foregoing it. 49 This standard does not apply to all forms of treatment. Only limited disclosure is required for “common,” as opposed to “complicated,” treatments. 50 If a proposed treatment is common,

46. The Commission recommended that under certain circumstances, psychosurgery should be performed on patients who cannot themselves provide informed consent. Report of the National Commission, supra note 5, at 26,330. See text accompanying notes 119 & 120 infra.

47. 123 Va. 113, 96 S.E. 360 (1918).

48. Id. at 133, 96 S.E. at 366. Plaintiff sued his doctor to recover for burns he sustained as a result of X-ray treatments administered to treat a skin disorder. Plaintiff asserted that the physician was negligent for breaching his duty to inform the patient of the potential dangers involved in the X-ray treatment and that the treatment was negligently administered. Id. at 119-22, 96 S.E. at 362-63. The court found that the patient was misled by the physician since the physician had given assurances of recovery. Id. at 133-34, 96 S.E. at 366-67. However, the court determined that plaintiff failed to satisfy his burden of proving that the treatment was administered negligently and decided for the defendant. Id. at 146, 96 S.E. at 371.

49. Failure to obtain informed consent was first recognized as a possible basis of recovery for battery in Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees, 154 Cal. App. 2d 560, 317 P.2d 170 (1st Dist. 1957). In Salgo the court suggested that full disclosure of all risks would be required when a physician seeks to obtain consent to surgery from a patient. In all cases which exceed minimal, routine treatments or where the patient is highly emotional, the physician may exercise his discretion in determining the amount of information he discloses. The court stated that a doctor always has a duty to fully reveal all the facts the patient needs to issue a meaningful consent. See id. at 518, 317 P.2d at 181.

the physician need not describe remote risks. If the procedure is complicated, the physician is obliged to describe all possible risks regardless of how remote they are. Under the limited disclosure standard, plaintiff must prove not only that the doctor failed to inform him of the risks involved, but also that this failure to inform constituted a deviation from the custom of other physicians practicing in the community.

Recent cases, however, appear to favor the full disclosure approach. In Cobbs v. Grant, the California Supreme Court adopted the full disclosure standard. The court criticized the limited disclosure approach because its vagueness effectively vests the physician with absolute discretion. According to this court, the only time a patient should be denied the opportunity to weigh the risks is where it is evident that he cannot evaluate data, that is, where there is an emergency or the patient is a child or an incompetent. In addition, the Texas Supreme Court in Wilson v. Scott, while not adopting the full disclosure standard, may have weakened the limited disclosure test when it applied this test and found that the practice of physicians in the community where defendant practiced was to provide full disclosure.

The highly intrusive and experimental nature of psychosurgery and the trend of judicial opinions mandate that full disclosure to prospective patients be required to satisfy the informed consent requirement. But it is arguable whether a mentally ill individual can give informed consent. If so, what elements, if any, in addition to full disclosure must be present to determine whether the requirement has been satisfied?

51. Id. at 244, 502 P.2d at 11, 104 Cal. Rptr. at 515.
52. Id. The court stated that the physician need not give the patient a lengthy discourse or a mini-course in medical science, but rather must discuss the risk of death or bodily injury and the problems of recuperation. Id.
55. 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).
56. Id. at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514.
57. Id.
58. 412 S.W.2d 299 (Tex. 1967).
59. Id. at 303.
Kaimowitz v. Department of Mental Health

In Kaimowitz v. Department of Mental Health, a landmark decision in the field of psychosurgery, the court held that an involuntarily confined mental patient was unable to give informed consent to a proposed psychosurgical procedure. The case involved a mental patient who had been committed to a state hospital under Michigan’s criminal sexual psychopath law for raping and murdering a nurse at another mental institution. He and his parents signed consent forms allowing him to participate in a state-sponsored experimental psychosurgical program designed to control violent behavior in persons suffering from uncontrollable aggression. Kaimowitz, a Detroit attorney, brought suit on behalf of Louis Smith, the subject of the proposed experiment, and all others similarly situated, seeking a writ of habeas corpus. The complaint alleged that Smith “was being illegally detained in the Lafayette Clinic for the purpose of experimental psychosurgery.” As a result of adverse publicity generated by the case, the project was terminated. The court, however, denied defendant’s motion to dismiss based on mootness because the project might be revived at a future date and the issues raised were “ripe for declaratory judgment.”

The court framed two issues for consideration: The first was whether an involuntarily detained mental patient can give legally adequate informed consent to experimental psychosurgery when the experiment is designed to alter thoughts, emotions, or behavior. The second issue was, assuming he can consent, can the State Department of Mental Health legally conduct experimental psychosurgery on involuntarily confined mental patients in hospitals under its jurisdiction. Since it answered the first question in

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61. Id.
62. Id. at 151.
63. Id. at 147.
64. The Michigan Legislature appropriated funds for 24 criminal sexual psychopaths in the state’s mental health system to be subjects of the experiment. The experiment was to compare the effect of surgery on the limbic portion of the brain with the effect of a drug on the male hormone flow. “The comparison was intended to show which, if either, could be used in controlling aggression of males in an institutional setting, and to afford lasting permanent relief from such aggression to the patient.” Id.
65. Id.
66. Id.
67. Id. at 147-48.
the negative, the court never considered the second issue.68

To ascertain the elements of informed consent, the court examined the judgments of the Nuremberg military tribunals that tried Nazi war criminals following World War II. Standards for medical experimentation on humans were enunciated at the Nuremberg tribunals in United States v. Brandt.69 The Kaimowitz court gleaned

68. Id. at 153.

69. II Trials of War Criminals Before the Nuremberg Military Tribunals 171 (1947). The court stated:

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 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 method 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.

The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs or engages in the experiment. It is a personal duty and responsibility which may not be delegated to another with impunity.

2. The experiment should be such as to yield fruitful results for the good of society, unprocurable by other methods or means of study, and not random and unnecessary in nature.

3. The experiment should be so designed and based on the results of animal experimentation and a knowledge of the natural history of the disease or other problem under study that the anticipated results will justify the performance of the experiment.

4. The experiment should be so conducted as to avoid all unnecessary physical and mental suffering and injury.

5. No experiment should be conducted where there is an a priori reason to believe that death or disabling injury will occur; except, perhaps, in those experiments where the experimental physicians also serve as subjects.

6. The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment.

7. Proper preparations should be made and adequate facilities provided to protect the experimental subject against even remote possibilities of injury, disability, or death.

8. The experiment should be conducted only by scientifically qualified persons. The highest degree of skill and care should be required through all stages of the experiment of those who conduct or engage in the experiment.

9. During the course of the experiment the human subject should be at liberty to bring the experiment to an end if he has reached the physical or mental state where continuation of the experiment seems to him to be impossible.
three elements of informed consent from the Nuremberg standards: competence, knowledge, and voluntariness.\textsuperscript{70}

Competence, the court stated, "requires the ability of the subject to understand rationally the nature of the procedure, its risks, and other relevant information."\textsuperscript{71} The court stated that the nature of his incarceration diminishes the involuntarily confined mental patient’s capacity to consent to psychosurgery,\textsuperscript{72} even if he possesses the intelligence to understand the nature of the procedure. Based upon statements by counsel for defendant-doctors and testimony presented at trial,\textsuperscript{73} the court observed that institutionalization tends to strip an individual of his self-worth and his physical and mental integrity.\textsuperscript{74} The court in \textit{Kaimowitz} employed the testimony of Louis Smith as an example. Smith testified that it was very unusual for him to be consulted by his doctor about his preference regarding treatment.\textsuperscript{75} Thus, the court found that Smith was not competent to give consent to the proposed surgery. Further, the court asserted that in the case of psychosurgery, if the patient is not competent to give consent, neither is his guardian competent to consent for him.\textsuperscript{76}

10. During the course of the experiment the scientist in charge must be prepared to terminate the experiment at any stage, if he has probably \textit{sic} cause to believe, in the exercise of the good faith, superior skill and careful judgment required of him that a continuation of the experiment is likely to result in injury, disability, or death to the experimental subject. \textit{Id.} at 181-82.

\textsuperscript{70} \textit{Kaimowitz v. Department of Mental Health, 1 MENTAL DISABILITY L. REP. 147, 150-51 (Mich. Cir. Ct. 1973).}

\textsuperscript{71} \textit{Id.} at 150.

\textsuperscript{72} \textit{Id.}

\textsuperscript{73} Counsel for the physician-defendants acknowledged that a capable doctor could elicit a patient's consent to nearly any procedure where the patient has been treated for a serious illness. \textit{Id.} at 149.

\textsuperscript{74} \textit{Id.} at 150.

\textsuperscript{75} \textit{Id.}

\textsuperscript{76} \textit{Id.} The court may have dismissed the issue of guardian consent too lightly. It has been held that guardians of voluntarily and involuntarily committed patients cannot consent to have psychosurgery performed because they have no standing to assert the rights of the patient. \textit{Aden v. Younger, 57 Cal. App. 3d 662, 681, 129 Cal. Rptr. 535, 547 (4th Dist. 1976)}. The court did not explain its position. \textit{See} notes 152-153 \textit{infra} and accompanying text. One commentator has argued that guardian consent for an experimental procedure such as psychosurgery is never valid. \textit{See Comment, Kaimowitz v. Department of Mental Health: Involuntary Mental Patient Cannot Give Informed Consent to Experimental Psychosurgery, 4 N.Y.U. REV. L. & SOC. CHANGE 207, 217 (1974)}. Since psychosurgery is experimental and so little is known about it, the author claims a guardian cannot provide informed consent any more than can an incompetent patient. \textit{Id.} To allow guardian consent in this setting would result in the exploitation of incompetent patients since they might be used in an experiment to which their guardians consented, while a competent pa-
The court reasoned that the involuntarily committed patient's lack of competency cannot be ameliorated by full disclosure of the proposed psychosurgery, its potential benefits and hazards, and problems in recuperation, because medical science simply does not have sophisticated knowledge of the nexus between the limbic system of the brain, the area slated for surgery, and human behavior. The court asserted that there is no medically recognized syndrome for aggression, that the potential risks in performing psychosurgery are unknown, and that psychosurgery is generally considered a treatment of last resort. Therefore, the court in Kaimowitz concluded that psychosurgery is "clearly experimental," that the record illustrated that benefits of the proposed psychosurgical procedure were uncertain at best, and that the procedure could possibly have severe side effects. Since his doctors were not particularly knowledgeable about psychosurgery, Smith could not possibly have given knowledgeable consent.

77. For a discussion of the full and limited disclosure standards, see notes 47-59 supra and accompanying text.

78. Kaimowitz v. Department of Mental Health, 1 MENTAL DISABILITY L. REP. 147, 147 (Mich. Cir. Ct. 1973). The limbic system is thought to be the "emotions center" of the brain. Restak, supra note 15, at 56. This is the area in which some believe aggression originates, Kaimowitz v. Department of Mental Health, 1 MENTAL DISABILITY L. REP. 147, 147 (Mich. Cir. Ct. 1973).

79. Kaimowitz v. Department of Mental Health, 1 MENTAL DISABILITY L. REP. 147, 148 (Mich. Cir. Ct. 1973). The court mentioned a statement by Doctors Mark, Sweet, and Ervin in which they noted the primitive state of our understanding of the specific portion of the limbic system targeted for surgery, the amygdala. It is interesting that these same researchers have been among the most ardent advocates of psychosurgery for the purpose of eliminating violent behavior. See note 20 supra and accompanying text.


81. Id.

82. Id. at 149. Doctors, who were expert witnesses at trial, agreed that at the present time, psychosurgery does not provide any assurance of calming violent patients. Indeed, the court pointed to evidence that psychosurgery could result in heightened rage instead of placidity. Accord, Statement of Dr. Ayub Ommaya, Acting Chief, Surgical Neurology Branch, National Institute of Neurological and Communicative Diseases and Stroke, in Restak, supra note 15, at 57.


84. Id. at 150-51.
The court concluded its evaluation of informed consent by examining voluntariness. The inability of the involuntarily confined patient to consent completely to psychosurgery is associated with his inability to choose voluntarily to undergo or to refuse psychosurgery. Nearly every important aspect of Smith’s life was determined without his participation in decisionmaking. The court noted, based upon testimony by the defendant-physicians, that a doctor can persuade his patient to consent to almost anything. The court thus found that Smith could not exercise his power of free choice without the intervention of an “ulterior form of constraint or coercion,” as required by the Nuremberg standards. Since Smith could not competently, knowledgeably, or voluntarily choose to undergo psychosurgery, the court held that he could not provide informed consent and that the operation could not be performed on him under any circumstances.

*Kaimowitz* is important because it is the first thorough judicial analysis of informed consent in the context of psychosurgery. It has not been the final discourse on the issue. The National Commission believed that *Kaimowitz* went too far in limiting the access of a patient to a procedure which might be of therapeutic value. Although the Commission acknowledged that psychosurgery is experimental, and that the dangers of psychosurgery cannot be eliminated entirely, the Commission asserted that its use as a means of institutional or social control and as pure medical experimentation without regard to the patient could be eliminated by the establishment of IRB’s. These Boards would assure that informed consent has been given. Where informed consent cannot be obtained from the patient, the Commission would allow a guardian to consent to psychosurgery for the patient, a point expressly rejected in *Kaimowitz*.

85. *Id.* at 151.
86. *Id.* at 149; see note 73 *supra* and accompanying text.
88. *Id.* at 151. The Nuremberg standards are enumerated at note 69 *supra*.
90. At the outset of its recommendations, the Commission noted the experimental nature of psychosurgery, stating that the safety and efficacy of psychosurgical procedures have yet to be determined. *See id.* at 26,329. The strict review procedures which it recommended further indicate this view. *See id.* This is not surprising since the overwhelming majority of the evidence presented before the Commission indicated that psychosurgery is experimental.
91. *Id.*
92. *Id.* at 26,330.
The Commission Report

The Commission began with the premise that some forms of psychosurgery provide effective treatment.93 It based its conclusion upon postoperative evaluations of sixty-one patients who had undergone psychosurgery between 1965 and 1975.94 The Commission stated that more than half of the sixty-one patients improved significantly after the operation.95 An examination of each of the four studies performed for the Commission, however, reveals that only one or two more patients improved than the number who did not improve or who regressed.96 Side effects caused by the psychosurgery which were enumerated in the studies97 were not mentioned in the Commission report. The studies did not show psychosurgery to be effective but, according to the Commission, merely rebutted the presumption that all psychosurgery is ineffective.98 Hence, the report implicitly recognized exactly what the Kaimowitz court found, that there is no evidence that psychosurgery is sufficiently effective to be characterized as an accepted treatment: Rather, it is merely an experimental procedure.

This conclusion is supported by two of the Commission’s recommendations. It first recommended that no individual undergo psychosurgery until “[a] national psychosurgery advisory board has determined that the specific psychosurgical procedure has demonstrable benefit for the treatment of an individual with the psychiatric symptom or disorder of the patient.”99 Second, it recommended that the federal government “conduct and support studies to evaluate the safety of specific psychosurgical procedures and the efficacy of such procedures in relieving specific psychiatric symptoms and disorders.”100 These recommendations indicate the Commission’s recognition both of the dearth of knowledge about psychosurgery and the dubiousness of this procedure’s efficacy. Thus, the Commission and the Kaimowitz court reached similar conclusions on the present state of knowledge about the nature of psychosurgery. These two sources differ in their view of informed consent. Unfortunately, in its effort to criticize and downplay

93. Id. at 26,329.
94. Id.
95. Id.
96. Mirsky & Orzack, supra note 36, at II-126.
97. Id.
99. Id. at 26,330. (emphasis in original).
100. Id. at 26,331. (emphasis in original).
Kaimowitz, the Commission did not properly emphasize two points.

The Commission concluded that informed consent can be given by or on behalf of voluntarily and involuntarily committed patients;\(^ {101} \) informed consent can be effectively guaranteed by the establishment of IRB's\(^ {102} \) to review each proposal of psychosurgery. The Commission attempted to ameliorate the problems articulated by commentators and by the Kaimowitz court by requiring the IRB first to determine the competence of the surgeon to conduct preoperative evaluations and second to assess the appropriateness of the procedure for the patient and conduct postoperative evaluations in addition to assuring that informed consent is given.\(^ {103} \) The Commission did not specify what elements should be examined to determine whether the patient has truly given informed consent. The Commission agreed with the finding in Kaimowitz that institutionalization diminishes a patient's capacity to provide voluntary consent.\(^ {104} \) It concluded, however, that diminished capacity is insufficient reason to deny a patient the possible benefit that psychosurgery might provide.\(^ {105} \)

One basis for the Commission's recommendations was an Oregon legislative scheme\(^ {106} \) enacted in 1975. This statute created a single state Psychosurgery Review Board.\(^ {107} \) The Board is comprised of nine members from the medical, psychiatric and neuroscientific professions and two members of the general public, at least one of whom is an attorney.\(^ {108} \) Unlike the Commission's recommendations, the statute details a method of assuring informed consent. The Oregon Board is required to hold a hearing, at which the patient may be represented by legal counsel,\(^ {109} \) to determine

\(^ {101} \) id. at 26,330.
\(^ {102} \) id. at 26,329. See note 42 supra.
\(^ {103} \) Report of the National Commission, supra note 5, at 26,329. The makeup of the IRB is not discussed in the report. However, written testimony submitted to the Commission and reproduced in the report contended that neurosurgeons alone are not sufficiently objective to select patients for psychosurgery. Input is needed from other professions. Id. at 26,329 (statement of Ernest A. Bates, M.D.). See, e.g., Or. Rev. Stat. § 426.750 (1975). See also text accompanying note 112 infra.
\(^ {104} \) Report of the National Commission, supra note 5, at 26,331. See notes 73-75 supra and accompanying text.
\(^ {105} \) Report of the National Commission, supra note 5, at 26,331.
\(^ {108} \) Id.
\(^ {109} \) Due process may require that the patient be represented by legal counsel
whether or not informed consent was given. The Oregon legislature adopted the informed consent standards enunciated in Kainowicz—knowledge, voluntariness, and competency. On the issue of knowledge, the statute requires disclosure to the patient of the procedures to be followed and identification of those which are experimental; it also necessitates disclosure of attendant risks and benefits, alternative treatments, and the patient’s ability to withdraw his consent and discontinue the treatment at any time. It must also be disclosed that the physician will answer any question the patient asks, that the patient or his legal guardian has the right to be represented by counsel, and that if the patient cannot afford one counsel will be appointed for him. The statute further provides that the Board determine the appropriateness of the operation for the patient by use of clinical data and permits. However, it does not require the Board to conduct an independent preoperative evaluation of data on the patient. It declares that psychosurgery is a treatment of last resort, to be used only after all other known treatments have been attempted.

The Commission did not entirely follow its stated model. Nowhere in the report is it recommended that psychosurgery be used as a treatment of last resort, nor is the right to counsel throughout all proceedings starting from the time psychosurgery is proposed. In Wyatt v. Hardin, 1 MENTAL DISABILITY L. REP. 55 (M.D. Ala. 1975), the court set minimum constitutional requirements for the employment of “certain extraordinary or potentially hazardous modes of treatment.” Id. at 55. The court banned psychosurgery in all hospitals maintained by the Alabama Department of Mental Health and severely restricted the use of electroconvulsive therapy and of aversive conditioning. Both a Human Rights Committee and an Extraordinary Treatment Committee must approve the proposed treatment. The patient must be represented by counsel, the court ordered, to assure that all alternative forms of treatment have been examined and that the patient has given informed consent. See id. at 56. Hardin was innovative in its approach to assure the patient’s right to refuse treatment. See notes 206-208 infra and accompanying text on the right to refuse treatment. However, even before Hardin, courts had recognized an individual’s right to counsel in other proceedings in the mental health field. Heryford v. Parker, 396 F.2d 393 (10th Cir. 1968), held that every subject of involuntary commitment proceedings has the right to counsel at each stage of the proceedings. See id. at 396. Accord, Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972). If an individual is entitled to counsel at commitment hearings, he should have the right to counsel before surgery is performed on his brain.

111. Id. § 426.715.
112. Id. § 426.720.
113. Id.
guaranteed in proceedings before the IRB. The Commission was more explicit than was the Oregon statute in recognizing the deterioration in voluntariness caused by institutionalization. However, the statute indicates that the Oregon legislators agreed with the conclusion of the Commission. The bulk of this statute deals with strict disclosure requirements, examination by an impartial body, notice of all proceedings to the patient's guardian and the requirement that the patient be represented by counsel. That such strict review is required indicates the legislature's recognition that an institutionalized mental patient has diminished voluntariness. The Commission's proposed review procedures are not nearly as stringent as are the statute's procedures. The Commission's procedures should have paralleled the law more closely to avoid or at least to reduce the impact of diminished voluntariness.

There is, however, one exception to the Commission's laxity. The Commission distinguished patients who commit themselves voluntarily from those who are involuntarily committed. The Commission recommended that a voluntary inmate should not undergo psychosurgery until after the IRB has determined that he has given informed consent. If he cannot give informed consent, his guardian may consent in his place. Guardian consent is also permissible in the case of an involuntarily committed patient who cannot provide informed consent. However, in this case, guardian consent is subject to mandatory judicial review and the court must approve the psychosurgery recommended by the IRB before it may be performed. The Oregon legislation does not provide for judicial review.

It has been argued that judicial scrutiny should be mandatory for all proposed psychosurgical procedures because a court is the only forum in which an individual's rights can be protected. Indeed, one member of the Commission dissented from the majority

114. Not providing for the right to counsel may be unconstitutional. See note 109 supra.
115. See notes 104 & 105 supra and accompanying text.
116. See note 109 supra and accompanying text.
117. Report of the National Commission, supra note 5, at 26,330. The Kaimowitz court was not presented with this problem and did not consider it.
118. Id.
119. See note 76 supra and accompanying text for a discussion of guardian consent.
121. Informed Consent, supra note 14, at 728-29.
recommendation, arguing that judicial review of IRB determinations with respect to both voluntarily and involuntarily committed patients should be mandatory.\textsuperscript{122} She cited the effect of institutionalization on the ability of all patients to give informed consent.\textsuperscript{123} Since individuals who "voluntarily" enter institutions may not do so entirely as a product of their free will,\textsuperscript{124} she asserted that no distinction should be made between voluntarily and involuntarily admitted patients. Despite its approval of the California legislation, the Commission did not go far enough in guaranteeing that patients' rights will be safeguarded and that informed consent must be given.

There is ample evidence that institutionalization diminishes a patient's ability to give voluntary consent;\textsuperscript{125} since courts are "singly equipped to insure adherence to . . . due process and fundamental fairness,"\textsuperscript{126} all IRB approvals of proposed surgery should be subject to mandatory judicial review.

The case which the Commission adopted as a guide and from which it drew the purported distinction between voluntarily and involuntarily committed mental patients is \textit{Aden v. Younger}.\textsuperscript{127} It also used \textit{Aden} to criticize \textit{Kaimowitz}. \textit{Aden} was a California action brought by a physician on behalf of two institutionalized mentally ill individuals challenging legislative changes in the law governing the manner in which a patient may consent to psychosurgery and electroconvulsive therapy (ECT). One petitioner wanted to receive

\begin{itemize}
\item \textsuperscript{122} Report of the National Commission, \textit{supra} note 5, at 26,332 (dissenting statement of Patricia A. King).
\item \textsuperscript{123} See notes 73-75 \textit{supra} and accompanying text.
\item \textsuperscript{124} Ms. King indicated that as part of "plea bargaining," some persons may "agree" to voluntarily commit themselves to mental institutions in exchange for reduced or dropped charges. See Report of the National Commission, \textit{supra} note 5, at 26,332 (dissenting statement of Patricia A. King). Another example, not cited in the dissent, is that individuals may agree to institutionalization after strong pressure from their families. In these instances, the patient's voluntariness may be in doubt.
\item \textsuperscript{125} See notes 72-75 \textit{supra} and accompanying text.
\item \textsuperscript{126} \textit{Informed Consent}, \textit{supra} note 14, at 729.
\item \textsuperscript{127} 57 Cal. App. 3d 662, 129 Cal. Rptr. 535 (4th Dist. 1976). This case was brought in the appeals court. The court had original jurisdiction under state common law interpreting CAL. R. CT. 56(a)(1). This rule grants appellate courts original jurisdiction where "proper." The court found that since the constitutionality of a state law was challenged and the rights of mental patients would be dramatically affected by delaying a decision on the constitutionality of the legislation, it had original jurisdiction. See \textit{Aden v. Younger}, 57 Cal. App. 3d 662, 670, 129 Cal. Rptr. 535, 540 (4th Dist. 1976).
\end{itemize}
ECT and the other sought psychosurgery. The opinion does not indicate whether petitioners had been voluntarily or involuntarily committed.

The California statute challenged in Aden modified previous legislation; it was aimed at protecting the right of mental patients to refuse treatment and at preventing unnecessary administration of hazardous and intrusive treatments. Voluntarily as well as involuntarily committed mental patients were included within the scope of this statutory Bill of Rights for mental patients. The court stated that this recognizes that the voluntary and involuntary labels do not always indicate the voluntariness of a specific patient's consent. Thus, the court implicitly acknowledged the effect of institutionalization on a person's ability to make voluntary choices.

A former provision which allowed the denial of a patient's right to refuse treatment for "good cause" was made inapplicable to psychosurgery and to ECT by requiring informed consent of the patient prior to treatment. The purpose of requiring informed consent was to insure that consent is competent, informed, and voluntary. A review by three physicians was required to determine the patient's competence and the necessity and appropriateness of the proposed treatment. To obtain informed consent, the law required in all cases notice of the risks of treatment to a rela-

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131. See Act of Sept. 27, 1974, ch. 1534, § 1, 1974 Cal. Stats. 3459 (current version at CAL. WELF. & INST. CODE § 5325 (West Supp. 1978)).
133. For a discussion of the effects of institutionalization on voluntariness, see notes 72-75 supra and accompanying text.
135. See CAL. WELF. & INST. CODE § 5326.6 (West Supp. 1978).
tive or guardian as well as to the patient.\textsuperscript{138} In addition, a system of reporting was established to control abuses of patients’ rights.\textsuperscript{139}

Petitioners in \textit{Aden} alleged that the statute is constitutionally infirm for three reasons: (1) It violates the equal protection clause because it classifies mental patients in an unreasonable manner by requiring that of all ill patients, only mental patients are required to receive full disclosure of the risks and possible side effects of psychosurgery and ECT;\textsuperscript{140} (2) The procedures for informing the patient so he may consent and the procedures for obtaining review board approval of the proposed therapy violate due process because the language is unconstitutionally vague;\textsuperscript{141} and (3) The statute violates due process because a patient’s constitutional rights of privacy, freedom of thought, and access to medical treatment are infringed without any “sufficient relation” to a compelling state interest.\textsuperscript{142}

The court held that parts of the statutory sections on psychosurgery and ECT were constitutional and parts were not,\textsuperscript{143} and concluded that to make the infirm portion valid would entail a complete redraft by the legislature of those sections. The court, therefore, declared the entire section on psychosurgery and ECT unconstitutional.\textsuperscript{144}

In dismissing the equal protection argument, the court stated that mental patients are distinct from other patients because they are more likely than other patients “to lack the ability to understand the nature of a medical procedure and appreciate its risks.”\textsuperscript{145} In addition, the court continued, their ability to voluntar-

\begin{enumerate}
\item \textit{Id.}
\item \textit{Id.} All treatments had to be recorded and treatment records were to be available to the Director of Health and, with names concealed, to the Legislature. This would prevent a physician from giving unnecessary treatments to patients and, if carefully monitored, would prevent a doctor from recording treatments that were never administered.
\item \textit{Aden v. Younger, 57 Cal. App. 3d 662, 672, 129 Cal. Rptr. 535, 542 (4th Dist. 1976).}
\item \textit{Id. at 673, 129 Cal. Rptr. at 542.}
\item \textit{Id.} For a discussion of these constitutional rights, see \textit{notes 167-202 infra} and accompanying text.
\item \textit{Id. at 674, 129 Cal. Rptr. at 542.}
\end{enumerate}
Informed Consent to Psychosurgery

ily accept treatment is questionable. The court thereby extended the Kaimowitz finding, that institutionalization causes a decrease in the voluntariness of involuntarily committed patients, to those who voluntarily commit themselves. The court noted that “voluntary” is a label created by the legislature and “only means that the patient did not formally protest hospitalization.” The court concluded that, under these circumstances, separate treatment of mental patients rationally relates to the state’s objective of assuring the patients’ statutory right to refuse treatment.

The court found, however, that the requirement that a procedure not be performed unless critically needed for the patient’s welfare is unconstitutionally vague. The court reached this conclusion because the degree of need required before psychosurgery or ECT may be performed was left unspecified and could result in patients with the same conditions being treated differently.

In its initial examination of the alleged due process violations, the Aden court outlined the competing interests to be considered. The state has an interest in protecting patients from “unwarranted, unreasonable and unconsented-to invasions of body and mind.” Arrayed against this state interest is the patient’s “right to medical treatment.” Requiring informed consent furthers the state’s compelling interest in protecting a patient against unnecessary

146. See id.
147. Id. at 674, 129 Cal. Rptr. at 543.
148. See id. Interestingly, the court held the state to different standards of proof. To justify differentiating mental patients from other patients, the state was required to meet, and met, a “minimum rationality” burden, one that is relatively easy to meet. However, in reviewing the constitutionality of the procedures to be followed before a patient could undergo psychosurgery or ECT, the state had to satisfy the “compelling interest” test, a much greater burden, to justify infringing a patient’s rights. The decision in Aden was a direct result of the application by the court of these two standards to different portions of the legislation.
149. Act of Sept. 27, 1974, ch. 1534, § 3, 1974 Cal. Stats. 3461 (current version at CAL. WELF. & INST. CODE § 5326.6 (West Supp. 1978)).
151. Id. at 678, 129 Cal. Rptr. at 545-46.
152. Id. at 678, 129 Cal. Rptr. at 546. The right to privacy can refer both to the right to select medical procedures as well as the right to freedom from intrusion into the brain. Freedom of speech and thought can refer both to freedom to undergo psychosurgery to enhance speech and thought, and to freedom to prevent tampering with speech and thought by means of psychosurgery. Although the terms “right to privacy” and “freedom of thought” might often be associated with the right to refuse treatment, see, e.g., Kaimowitz v. Department of Mental Health, 1 MENTAL DISABILITY L. REP. 147 (Mich. Cir. Ct. 1973), the Aden court associated these terms with the right of access to treatment. See note 172 infra.
treatment. However, the court found no state interest is furthered by disclosing to a relative or guardian the information disclosed to the patient. Furthermore, the requirement that a relative or guardian be so informed violates the patient’s right to privacy. The court reasoned that since the statute does not grant relatives standing to assert the patient’s rights, it is doubtful that disclosure to them furthers protection of the patient’s rights or prevents unnecessary treatment. For purposes of psychosurgery and ECT, the guardian of the mental patient’s rights under both California legislation and the Commission’s recommendations is a board of review.

Preventing abuses of patients’ rights is the stated purpose of the reporting system. The court upheld this provision, which requires that when records are released to the legislature for use in deliberations on mental health, the names of individual patients must be deleted to protect their privacy.

Perhaps the greatest contribution of the Aden decision to the rights of the mentally ill is its discussion of review procedures designed to assure that a patient has given informed consent. The Commission report relies heavily on the validity of the IRB to support its basic thesis that psychosurgery should be performed. The proposed legislation, by totally banning psychosurgery, implicitly takes the opposite view.

The court in Aden examined the process of assuring consent to psychosurgery in the California statute as applied to three categories of mental patients: those who are incompetent, those who are involuntarily committed, and those who voluntarily commit themselves. The review procedures were declared valid as to the incompetent patient because such an individual cannot consent and the state has a compelling interest in protecting him from the dangers of such procedures. This, the court stated, justifies whatever right to privacy may be infringed by the release of information about the patient to the review board.

154. CAL. WELF. & INST. CODE §§ 5326.6(d), 5326.7(6) (West Supp. 1978); Report of the National Commission, supra note 5, at 26,329.
155. See note 139 supra.
157. Id. at 682, 129 Cal. Rptr. at 548.
158. See note 137 supra and accompanying text.
160. Id.
The procedures were also determined valid as to an involuntarily committed patient because the court held that the voluntaryness of consent from such a patient can never be adequately confirmed.\textsuperscript{161} The establishment of a board to make the treatment decision is justified by the state’s compelling interest in preventing involuntary administration of psychosurgery.\textsuperscript{162}

Finally, review of the recommendation by the patient’s physician that psychosurgery be performed on a voluntarily committed patient was declared proper. Even though the patient is competent and voluntarily consents to the procedure, the importance of assuring that consent is informed and voluntary and the need to regulate an experimental procedure justifies the legislature in removing the decision from the sole discretion of the treating physician.\textsuperscript{163}

The court considered consent to ECT separately because it found that ECT was an accepted form of treatment and was not experimental.\textsuperscript{164} Its discussion of ECT highlights its view of the nature of psychosurgery. The court held that the same considerations underlying its decision with regard to the performance of psychosurgery on voluntarily and involuntarily committed patients apply to the treatment of such individuals with ECT; it therefore validated mandatory review procedures.\textsuperscript{165} However, the court stated that where informed consent is assured and the procedure is not experimental, there is not the same need for review as where informed consent is not assured and the procedure is experimental. In the latter case, a substitute decisionmaker is required.\textsuperscript{66} On the other hand, where consent is informed and voluntary, the decision is best left to the doctor and patient since voluntarily committed patients can give informed consent to a nonexperimental treatment.

\textsuperscript{161} Id. at 682-83, 129 Cal. Rptr. at 548. The court’s recognition of the potential use of psychosurgery as a control tool on unwilling patients may have been influenced by disclosures that in 1968 several inmates from California prisons underwent psychosurgery at the Vacaville Correctional Facility. The surgery was conducted under an experimental state-funded program to eliminate violence from prisoners who had a record of violent behavior in and out of prison and who were serious management problems. The experiment was ended, without explanation, after three operations.

\textsuperscript{162} Id. See Older, supra note 22, at 665; see generally Trotter, supra note 17.


\textsuperscript{164} See id. at 684, 129 Cal. Rptr. at 549. But see Informed Consent, supra note 14, at 747-52, 755, where the author indicates that ECT is just as experimental as psychosurgery and that the same review procedures should apply to both.


\textsuperscript{166} Id.
Since the state has no compelling interest which overrides the infringement of a patient’s right to privacy, the mandatory review of consent, given by voluntarily admitted patients, to undergo ECT was found unconstitutional. The court did not view election to undergo ECT differently than election to receive an injection of antibiotics. The decision emphasizes the court’s belief that psychosurgery is experimental.

In amending the statute to conform with the decision, the California legislature stated that psychosurgery may be performed only after all other treatments have been attempted. The Commission unfortunately did not declare psychosurgery to be a treatment of last resort. However, the Commission went beyond the Aden decision and recommended mandatory judicial review of all IRB approvals of psychosurgery, at least for involuntarily committed patients. The California statute provides for mandatory judicial review only where an involuntarily confined mental patient consents to undergo ECT. Curiously in light of Aden, the statute does not require judicial review of consent by any patient to psychosurgery.

OTHER CONSTITUTIONAL ISSUES

The Aden court referred to several constitutional issues in its discussion of informed consent. One of the state’s interests is protecting a patient’s right to refuse treatment. On the other hand, the patient’s interests include access to treatment and maintenance of his right to privacy and freedom of thought.

Right of Mentation

The Kaimowitz court held that there exists a fundamental right to freedom of mentation. The bases of this freedom are the first
amendment freedom of communication and the first and fifth amendments’ right to privacy as applied to the states through the fourteenth amendment.\textsuperscript{174} The court stated: “To the extent that the First Amendment protects the dissemination of ideas and the expression of thoughts, it equally must protect the individual’s right to generate ideas.”\textsuperscript{175} The court reasoned that “[w]ithout the latter protection, the former is meaningless.”\textsuperscript{176} Psychosurgery cannot pass constitutional muster, the court stated, because it often “leads to the blunting of emotions, the deafening of memory . . . and limits the ability to generate new ideas.”\textsuperscript{177}

Several pronouncements on the first amendment by the Supreme Court, relied upon in \textit{Kaimowitz}, illustrate the connection of mentation with free speech. In \textit{Abrams v. United States},\textsuperscript{178} Justice Holmes stated that the basis of the first amendment is that free trade in ideas is the best means to improve society.\textsuperscript{179} In \textit{Whitney v. California},\textsuperscript{180} Justice Brandeis asserted:

\begin{quote}
Those who won our independence believed that the final end of the State was \textit{to make men free to develop their faculties}; and that in its government the deliberative forces should prevail over the arbitrary . . . . They believed that freedom to think as you will and to speak as you think are means indispensable to the discovery and spread of political truth; that without free speech and assembly discussion would be futile; . . . [and] that \textit{the greatest menace to freedom is an inert people} . . . . \textsuperscript{181}
\end{quote}

A second strand in case law supports the proposition that the right to privacy includes the protection of mental autonomy. As early as 1886, the Supreme Court declared that the essence of the

\textsuperscript{174} \textit{Id.} at 152.
\textsuperscript{175} \textit{Id.} at 151. The court continued: “We are free only if we know, and so in proportion to our knowledge. There is no freedom without choice, and there is no choice without knowledge,— or [none] that is [not] illusory. [Implicit,] therefore, in the very notion of liberty is the liberty of the mind to absorb and to beget.” \textit{Id.} (quoting B.N. Cardozo, \textit{The Paradoxes of Legal Science}, in \textit{Selected Writings of Benjamin Nathan Cardozo} 317 (M. Hall ed. 1947)).
\textsuperscript{176} \textit{Kaimowitz v. Department of Mental Health}, 1 \textit{Mental Disability Law Rep.} 147, 152 (Mich. Cir. Ct. 1973).
\textsuperscript{177} \textit{Id.}
\textsuperscript{178} 250 U.S. 616 (1919).
\textsuperscript{179} \textit{Id.} at 630 (Holmes, J., dissenting).
\textsuperscript{180} 274 U.S. 357 (1927).
\textsuperscript{181} \textit{Id.} at 375 (emphasis added).
fourth and fifth amendments is the protection of the sanctity of the individual. In his well-known dissent in Olmstead v. United States, Justice Brandeis declared that the fourth and fifth amendments illustrate that the framers recognized an individual's right to privacy:

The makers of our Constitution undertook to secure conditions favorable to the pursuit of happiness. They recognized the significance of man's spiritual nature, of his feelings and of his intellect. They knew that only a part of the pain, pleasure and satisfactions of life are to be found in material things. They sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred, as against the Government, the right to be let alone—the most comprehensive of rights and the right most valued by civilized men.

Moreover, in Griswold v. Connecticut, the Court recognized a fundamental right to privacy as the constitutional basis for deciding the issue before it.

These two threads came together in Stanley v. Georgia. In Stanley the Court recognized the individual's right to be free from thought control and found that privacy of the mind is necessary in a society which strongly values speech, communication, and individuality. An intrusion into one's intellect is an intrusion into one's constitutionally protected right of privacy. If one is not protected in his thoughts, behavior, personality, and identity, then the right to privacy becomes meaningless.

Right to Treatment

The Commission report relied heavily on a statement in Aden that state regulation of psychosurgery places obstacles in the path of those patients who may need and desire psychosurgery by re-

183. 277 U.S. 438 (1928).
184. Id. at 478 (Brandeis, J., dissenting).
185. 381 U.S. 479 (1965).
186. 394 U.S. 557 (1969). The Court stated: “Our whole constitutional heritage rebels at the thought of giving government the power to control men’s minds . . . . Whatever the power of the state to control public dissemination of ideas imical to the public morality, it cannot constitutionally premise legislation on the desirability of controlling a person’s private thoughts.” Id. at 565-66.
187. See Kaimowitz v. Department of Mental Health, 1 MENTAL DISABILITY L. REP. 147 (Mich. Cir. Ct. 1973). The Kaimowitz court restricted its holding to involuntarily confined mental patients. However, this principle could be properly extended to all individuals.
INFORMED CONSENT TO PSYCHOSURGERY

viewing and possibly reversing their choice to undergo the operation; these obstacles impair their freedom to submit to a particular treatment.\textsuperscript{188} The Commission recognized the variance between its view, that both voluntarily and involuntarily committed patients can give informed consent,\textsuperscript{189} and the Kaimowitz decision. Although it agreed with the Kaimowitz court that institutionalization may diminish the ability of mental patients to make free choices,\textsuperscript{190} the Commission concluded that the right of a patient to seek benefit from new treatments should not be denied on the basis of an irrebuttable presumption of diminished capacity or by prohibiting third party consent.\textsuperscript{191}

The right of an institutionalized mental patient to receive treatment was argued before the Supreme Court in O'Connor v. Donaldson.\textsuperscript{192} In Donaldson the Court of Appeals for the Fifth Circuit had held that an involuntarily confined mental patient has a right to treatment or release.\textsuperscript{193} The Supreme Court, however, did not reach the right to treatment issue in order to affirm the Fifth Circuit's decision. The Court instead focused on the constitutional right to liberty and held that "a State cannot constitutionally confine without more [than mere custodial care] a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."\textsuperscript{194}

The Fifth Circuit had previously decided that mental patients do have a right to treatment. Relying on the District of Columbia case of Rouse v. Cameron,\textsuperscript{195} in which Chief Judge Bazelon based the right to treatment on statutory grounds,\textsuperscript{196} the Fifth Circuit

\textsuperscript{188} Report of the National Commission, supra note 5, at 26,322 (citing Aden v. Younger, 57 Cal. App. 3d 662, 679-80, 129 Cal. Rptr. 535, 546-47 (4th Dist. 1976)). The Aden decision did not state that mental patients have a right to treatment. However, the court implied that it accepted that proposition by stating that denial by the state of an individual's choice to undergo psychosurgery must be justified by a compelling state interest. Generally, a state must show a compelling interest to override a fundamental right. See, e.g., Jacobson v. Massachusetts, 197 U.S. 11 (1905).

\textsuperscript{189} Report of the National Commission, supra note 5, at 26,330.

\textsuperscript{190} Id. at 26,331.

\textsuperscript{191} Id.

\textsuperscript{192} 422 U.S. 563 (1975).

\textsuperscript{193} Donaldson v. O'Connor, 493 F.2d 507 (5th Cir. 1974), aff'd, 422 U.S. 563 (1975).


\textsuperscript{195} 373 F.2d 451, 453 (D.C. Cir. 1967).

\textsuperscript{196} Id. at 454. See D.C. Code Enycl. § 21-562 (West 1967) which provides:
in Wyatt v. Stickney\textsuperscript{197} held that when individuals are involuntarily civilly committed, "they 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."\textsuperscript{198} Thus, according to this court, the only justification for involuntary hospitalization from a constitutional standpoint is treatment.\textsuperscript{199} In the absence of "[a]dequate and effective treatment, the hospital is transformed 'into a penitentiary where one can be held indefinitely without conviction for any offense.' "\textsuperscript{200} This court further stated: "To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process."\textsuperscript{201}

The Commission would have provided firmer ground for its recommendations had it advanced the argument presented in Wyatt—that patients have a right to treatment and that if all other treatments have been exhausted, they should have the right to undergo psychosurgery. The only question then remaining would have been whether psychosurgery is "adequate and effective treatment" as required in Wyatt v. Stickney.\textsuperscript{202}

The Commission might have tried to argue from its findings that psychosurgery provides a "realistic opportunity to be cured or to improve [the patient's] mental condition,"\textsuperscript{203} and that the right to treatment requires that psychosurgery be used if a patient has given informed consent. The problem is that the studies performed for the Commission do not support that proposition; by the Com-


\textsuperscript{198} Id. at 784.

\textsuperscript{199} Id.

\textsuperscript{200} Id. (quoting Ragsdale v. Overholder, 281 F.2d 943, 950 (D.C. Cir. 1960)). The majority of inmates in the hospital involved had been involuntarily committed. However, the court's reasoning should apply to anyone who is committed voluntarily or involuntarily since the purpose of institutionalization is treatment. Id.


\textsuperscript{202} See note 200 supra and accompanying text.

\textsuperscript{203} See note 199 supra and accompanying text.
mission's own words, they merely rebut any presumption that psychosurgery never works. Thus, the right to treatment argument presented in Wyatt would not have been appropriate in the Commission report. Indeed, because it has not been shown that psychosurgery provides a patient with a "realistic opportunity to be cured or to improve his or her mental condition," a patient may not, or perhaps should not, have the same right of access to psychosurgery as he does to other less intrusive forms of therapy.

Concomitant with the right to treatment is the right to refuse treatment. The doctrine of informed consent and the right to mentation form the basis for this latter right. The basic purpose of the review procedures discussed in this note is to assure that a patient has not been coerced into submitting to treatment he does not truly wish to undergo. The right to mentation, the right to privacy, and the freedom to communicate provide the constitutional basis for the right of a patient to refuse a particular treatment. Unless a patient is given the right to refuse treatment, the promise of a right to treatment that will cure or improve the patient's condition is empty since it subjects the patient to whatever the institution prescribes, regardless of this prescription's effectiveness and risk. Thus, review procedures are necessary to assure informed consent; judicial review is additionally required since it is ultimately the only forum in which a patient's rights can be fully protected.

CONCLUSION

The Commission was overzealous in its advocacy of psychosurgery and was too quick to criticize Kaimowitz. Its own studies reveal that the efficacy of psychosurgery is not yet known. The Commission may have overlooked some of the deleterious side effects of psychosurgery on the patients it examined. The Commission failed to consider adequately the effect of institutionalization.

204. Report of the National Commission, supra note 5, at 26,329; See text accompanying notes 39 & 98 supra.
206. See notes 173-177 supra and accompanying text.
207. See notes 85-88 supra and accompanying text.
208. See note 121 supra and accompanying text.
210. See notes 95-97 supra and accompanying text.
tion on the voluntariness of any patient and on a patient’s ability to provide informed consent.\textsuperscript{211} The Commission report does, however, have two positive aspects. First, it recommends mandatory IRB review for all proposed psychosurgery.\textsuperscript{212} This is designed to assure informed consent. Whether it goes far enough in protecting a patient’s right to effective treatment and right to refuse treatment is open to question. Mandatory judicial review is recommended in the case of involuntarily committed patients;\textsuperscript{213} the same considerations that led to this recommendation also suggest the conclusion that judicial review should be required for proposed psychosurgery on voluntarily committed patients as well.\textsuperscript{214} The report’s second positive point lies in its recognition that psychosurgery can be used as a means of social control, but should not be used for such purposes.\textsuperscript{215} That psychosurgery can be used for social control supports the argument that two levels of review, the IRB and the courts, are absolutely necessary.

The legislation proposed by Representative Stokes is poorly drafted and contains the seeds of its own destruction. The bill excludes from its definition of psychosurgery “the treatment of a known and diagnosed physical disease of the brain.”\textsuperscript{216} This creates a loophole which would permit a doctor to perform any psychosurgical procedure without review merely by stating that a patient has a particular disease. This bill, therefore, does not ban psychosurgery at all. Indeed, if this proposal were enacted, the very horrors which the Nuremberg standards\textsuperscript{217} sought to prevent and which Representative Stokes so greatly fears could easily come to pass. Even if Representative Stokes’ bill did ban psychosurgery, it merits rejection. By completely banning psychosurgery, the bill denies mental patients access to it at some time in the future when advances in scientific research and technology may result in psychosurgical procedures that will no longer be experimental and can properly be called treatment.

The findings of the \textit{Kaimowitz} court, concerning the medical profession’s lack of knowledge about psychosurgery and the del-

\textsuperscript{211} See notes 104 & 105 supra and accompanying text.
\textsuperscript{212} Report of the National Commission, \textit{supra} note 5, at 26,329-30.
\textsuperscript{213} \textit{Id.} at 26,330.
\textsuperscript{214} See notes 121-124 supra and accompanying text; see also Barnhart, Pinkerton, \& Roth, \textit{supra} note 8, at 80.
\textsuperscript{215} Report of the National Commission, \textit{supra} note 5, at 26,329.
\textsuperscript{217} See note 69 supra and accompanying text.
eterious effects of institutionalization on the capacity of mental pa-
tients to exercise free choice, mandate the conclusion that the
promise psychosurgery offers is perhaps a generation away. Until
dramatic advances are achieved, its use should be restricted to an
experimental procedure of last resort performed only after mul-
tilevel scrutiny, including judicial review. Until medical science
climbs out of the Cuckoo's Nest, the perils outweigh the promise.

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