Lessons of the First Era of Psychosurgery

Jack El-Hai, B.A.

Walter Freeman, the American neurologist and psychiatrist who devoted his career to championing lobotomy as a treatment for psychiatric disorders, died just over 35 years ago. His reputation was then at a low ebb, and it has not since risen appreciably. It is tempting to write Freeman off as a fringe figure in American medicine, an aberrant doctor who somehow managed to get his hands on 3400 psychiatric patients so that he could treat them with his infamous ice pick and leave them much worse for the experience. Freeman may not have been a neurosurgeon, but for a time he was America's best known performer of brain operations, and his work affected the public perception of what happens in the neurosurgery ward. However, we now consider lobotomies abominable and possibly criminal, so why attach much significance to Freeman's work?

After 10 years of immersion in Freeman's career, I have often asked myself about the value of studying and reading his work as well as writing about it. I will admit to feeling a sickening thrill in following the rise and fall—the crash and burn—that charted the course of his professional and personal lives. That is obviously not enough to justify resurrecting his ghost so many decades after the peak years of lobotomy in the 1940s and 1950s. That first era of psychosurgery may be long gone, but a second era of functional neurosurgery has begun, and it seems valuable to look for lessons from the first period to better illuminate the second. That potential to cast light on what we are doing today strikes me as a very good reason to examine Walter Freeman's life.

The first lesson that Freeman offers today's physician and scientist concerns the close link between our lives at work and at home. Freeman led a deeply troubled personal life. His wife was an alcoholic and his extramarital affairs strained his marriage. At the peak of his fame, Freeman witnessed the horrifying death of his 11-year-old son Keen, who fell into a river and was swept over a waterfall while camping at Yosemite National Park. Freeman later had to grapple with the premature deaths of two other children and his own battle against cancer. As a result of all this hardship, Freeman frequently withdrew into the shelter and solitude of his medical work. He became a workaholic, a man who used the demands of his career to shield himself from the pains and sorrows of his personal life. He rarely expressed his anguish directly; instead, he dove into his work with added energy. This tendency led to isolation from his peers, bad professional decisions, and the development of his strong attachment to the lobotomy procedure. He refused to stop his support of lobotomy when common sense and medical expediency demanded that he do so. His stubborn advocacy of lobotomy during the 1950s and 1960s, and the many patients who were drawn in by his championing of the procedure, is a large part of the tragedy of the first era of psychosurgery.

Would the lobotomy story have unfolded differently if someone had noticed Walter Freeman's personal distresses and taken steps to see that Freeman received help, a sympathetic ear, or direction in his professional work? Do personal problems affect the professional conduct and judgment of people you know?

The second lesson from Freeman's experience points to the importance of giving more than lip service to medical ethics and high standards of patient care. Freeman, for the record, did not show the least interest in medical ethics as they existed during his career. They were his great blind spot, and he accorded them the same low level of respect as he did Freudian psychoanalysis and what he characterized as other forms of medical dithering. When people railed against lobotomy on ethical grounds, Freeman responded that lengthy debates on the ethics of the procedure only raised barriers to the application of an effective treatment that served patients, their families, and the institutions that treated them.

However, we all need ethical standards, not just those handed to us by institutions, but also personal guidelines that remind us why we entered the work we are in and what we hope to accomplish. Freeman sorely lacked this type of personal ethical standard. He embarked on his development of lobotomy by using the operation only as a treatment of last resort. Over the years, gradually and steadily, he enlarged the categories of patients on which he would operate. By the end of his career, he saw lobotomy as an appropriate early intervention intended to keep mental disorders from worsening to the point that institutionalization became necessary. He eventually performed lobotomies on children, adolescents,

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Author of *The Lobotomist: A Maverick Medical Genius and His Tragic Quest to Rid the World of Mental Illness* published by John Wiley & Sons. The book's web site is at http://lobotomist.com.

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patients with terminal cancer, and others who would have not met early standards for the operation if he had them.

Freeman's shifting standards led to the third lesson that he teaches us today: the difference between advocating on behalf of patients and advocating on behalf of a treatment or a technology. Patient advocates keep the care of patients foremost in mind, learn from their mistakes, remain flexible about treatment options, and stay open to new approaches to treatment. In the closing years of his career, Walter Freeman did none of these things. As the lobotomist, the self-appointed spokesman for lobotomy during those early decades of its use, he occupied his thoughts with ways to increase the scope and the frequency of the operation. Instead of considering the best treatment to be used on a particular patient, he focused on whether lobotomy could be used.

This sort of preoccupation is a common fault. Today's technologies are so expensive and time-consuming to acquire and learn, it is understandable that we would look for ways to make the most of that steep investment, like Freeman did. Thinking of this kind, however, leads to rigidity, self-centeredness, closed minds, and a tendency to follow the path of least resistance when treatment choices are considered.

Freeman swore his allegiance to the treatment he advocated. The needs of his patients fell somewhat lower on his list of priorities. Where do your allegiances stand? Do you practice medicine to apply a set of treatments or to treat patients?

Recently, the story of lobotomy, formerly a tale best known among psychiatrists, neurologists, and neurosurgeons, has broken into the public domain, and not just because of my book. Other books, including a memoir by lobotomy patient Howard Dully as well as radio documentaries and television programs have brought the story to people with no professional connection with medicine. It resonates with them because the story is richly complex and intertwined with the best and worst qualities of the people involved in the fight against mental illness. I have found that even readers without a medical background are interested in hearing about the lessons of lobotomy. The lessons await our attention, if only we will open our minds to them.

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