Law Quadrangle (formerly Law Quad Notes)

Volume 18 | Number 1 Article 4

Fall 1973

Experimental Neurosurgery

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At the Present Time EXPERIMENTAL NEUROSURGERY Cannot be Performed on Involuntarily Confined Mental Patients

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The following is a part of the brief submitted by Burt and Allen, arguing that state-compelled psychosurgery would be cruel and unusual punishment under the Eighth Amendment and that state compulsion would inevitably taint any apparent consent for psychosurgery of involuntarily detained mental patients. The Court agreed with the result sought by this brief, though its opinion rested on First Amendment grounds related to the "thought control" implications of psychosurgery.

Editor's Note: *In July, 1973, a three-judge Circuit Court for Wayne County, Mich., ruled that experimental psychosurgery could not be performed on any person involuntarily detained in state mental institutions, even if consent were given to the experiment* (Kaimowitz v. Department of Mental Health (1973). *This was the first court case to consider the propriety of psychosurgery. It received considerable national attention and is a striking precedent regarding both psychosurgery and, more generally, medical experimentation with captive populations.*

The litigation was filed after one subject had been selected by experimenters at the Lafayette Clinic in Detroit, a unit of the State Department of Mental Health affiliated with the Wayne State University Medical School. Because it was a taxpayer's suit challenging the expenditure of state funds, and had not been filed at the direction of the experimental subject, the Court determined that the subject needed his own counsel and appointed Profs. Robert A. Burt and Francis A. Allen of the University of Michigan Law School as principal counsel and co-counsel respectively. Prof. Andrew S. Watson of the Law School and the U-M Department of Psychiatry examined the subject and testified at the trial.

The experimental subject, known in the litigation only as "John Doe," had been confined for 18 years in the state maximum security mental institution after being indicted for murder and judged to be a "criminal sexual psychopath" under then-applicable Michigan law. The experimenters considered that Doe was "habitually aggressive" and that he could not be cured by any conventional therapies. The psychosurgery would involve destruction of small portions in the amygdala region of the brain if the experimenters found what they considered "demonstrable physical abnormality" following electrode implantation deep in the subject's brain.

In preliminary proceedings, Doe's counsel successfully argued the unconstitutionality of the statute under which Doe was confined. Though Doe was thus free, and though the Clinic then decided to end the experiment altogether, the Court ruled that the questions raised were sufficiently important to support an action for declaratory judgment. A 10-day trial was then conducted, with evidence ranging widely over the neurological justifications of psychosurgery and the prospects for obtaining adequately informed consent for medical treatment or experimentation in state mental institutions.

Because the state is constitutionally prohibited from compelling experimental neurosurgery for aggressivity, and because the taint of compulsion cannot be dispelled for involuntarily confined mental patients, no such experimental surgery can at the present time be performed on involuntarily confined mental patients.

A. State compulsion for the contemplated experimental neurosurgery violates the constitutional prohibition on cruel and unusual punishment and the fundamental right to privacy.

There is. . .one striking exception to [the] general rule [that any medical procedure without consent is a battery]. Persons who are involuntarily committed to state mental institutions, on a permanent commitment order, need not give consent to medical treatment. The precise purpose for such commitment status is to displace the ordinary rule that doctors are forbidden to treat without consent.

The questions for resolution by this Court have been framed with the apparent assumption that consent is a necessary prerequisite, by a patient or his guardian, to experimental neurosurgery for aggressivity. In order to formulate the standards against which that consent must be measured, however, it is necessary to understand the basis for ruling that consent is required. E. Gordon Yudashkin, Director, Michigan Department of Mental Health, for example, suggested that the Department of Mental Health might well have authority to compel a committed person to accept this experimental surgery, just as the Department has authority to compel acceptance of drug therapy or psychotherapy. He did state that the Department, under his direction, would not exercise any such authority to compel experimental neurosurgery.

At bottom, then, the Cruel and Unusual Punishments Clause prohibits the infliction of uncivilized and inhuman punishments. The state, even as it punishes, must treat its members with respect for their intrinsic worth as human beings. . . .The primary principle is that punishment must not be so severe as to be degrading to the dignity of human beings.

In elaborating this standard, Justice Brennan suggests that the test

will ordinarily be a cumulative one: If a punishment is unusually severe, if there is a strong probability that it is inflicted arbitrarily, if it is substantially rejected by contemporary society, and there is no reason to believe that it serves any penal pur-

Robert A. Burt (left) and Francis A. Allen

pose more effectively than some less severe punishment, then the continued infliction of that punishment violates the command of the Clause. . . .

By these standards, compelled experimental brain surgery is clearly impermissible. Its risks, and its possible deprivation of personality attributes, are "degrading to the dignity of human beings." It would be "unusually severe." The passions surrounding this trial are themselves ample evidence of the ethical discomfiture in "contemporary society" regarding psychosurgery generally; the virtually automatic assumption by all parties that compelled neurosurgery would be unthinkable testifies to its "substantial reject[ion] by contemporary society" as a compelled treatment. . . .

The remaining two standards posited by Justice Brennan require a more extended discussion. The question whether the contemplated surgery "serves any penal purpose more effectively than some less severe punishment" has two aspects. First, the testimony [at trial]. . .has established that any beneficial result, to control or diminish aggressivity, is wholly unpredictable, and that aggressivity can only be reliably controlled in the present state of neurological knowledge by destruction of such extensive amounts of brain tissue that other personality functions are excessively impaired. It would thus appear impossible adequately to demonstrate that the contemplated surgery is more effective than "some less severe" intervention, such as conventional psychotherapy (with all its uncertain effectiveness). Second, the question posed for resolution by declaratory judgment in this case posits that all conventional therapies must be exhausted before invocation of the surgical procedure. Exhaustion of conventional therapies to demonstrate that the surgery is "more effective. . .than some less severe" disposition is accordingly constitutionally required if the surgery is compelled. . . .

Justice Brennan's remaining standard is whether "there is a strong probability that [the punishment] is inflicted arbitrarily." This standard appeared to be the basic ground for Justice Stewart's conclusion that the death penalty was invalid because it is imposed on "a capriciously selected random handful." Justices White and Douglas rely on the same essential ground. . . . (Justice Marshall's lengthy opinion appears generally to track Justice Brennan's analysis.)

The arbitrariness of the contemplated surgical procedures is amply established by the testimony. . .regarding the total absense of correlation between one purported diagnostic key—"demonstrable physical abnormality of the brain"—and aggressive conduct. Indeed, one admitted purpose for the experiment according to Dr. Ernst Rodin, the principal experimenter, Professor of Neurology at the Lafayette Clinic, is to determine whether current belief is correct in asserting that there is no such correlation. Since there is thus no established basis for distinguishing between aggressive persons who do and who do not have "demonstrable physical abnormality of the brain," selection of candidates for destruction of brain tissue on that basis is patently arbitrary. (On this score, it should be noted that if future animal research, for example, establishes a more sufficient base for a correlation between brain "abnormality" and aggression, this argument would no longer apply.)

Beyond this fundamental arbitrariness in selection, the testimony at trial clearly establishes that the "Criteria for Inclusion in the Aggression Project" is a grab bag of essentially miscellaneous criteria. Dr. Yudashkin stated that the ten criteria were not a "specific diagnostic entity," but were essentially a "miscellaneous sociological description." Dr. Andrew Watson, Professor of Psychiatry and Law, The University of Michigan, testified that the criteria were not "narrow, carefully defined, and carefully limited criteria likely to screen out very many people" and that he was "hard pressed to imagine what you end up with" in applying these criteria. Similarly, Dr. Ayub Ommaya at the National Institute of Neurological Diseases and Stroke, testified that the study criteria did not define a "homogeneous population." Accordingly, there is (in Justice Brennan's words) "strong probability that (the surgery would be) inflicted arbitrarily," on (in Justice Stewart's words) a "capriciously selected random handful" for whom (in Justice White's words) "there is no meaningful basis for distinguishing the few cases in which it is imposed from the many cases in which it is not."

It is thus clear that—if the surgery were compelled by the state—it would violate the constitutional ban on cruel and unusual punishment. Moreover, in view of the drastic assault on human personality and bodily integrity involved in the surgery, it is equally clear that such compelled surgery would contravene the constitutional "right of privacy" recently invoked by the Supreme Court to invalidate state laws that compelled women to bear unwanted children.

As a matter of state law, there is no precedent in Michigan cases and little precedent elsewhere that we have found addressing whether there are any exceptions to the general rule that committed persons may be compelled to accept any treatment imposed by the state commitment institution. Our research has found attorney generals' opinions in Vermont and Wisconsin that address this question, and each concludes that as a matter of law no consent is required. The most directly applicable is a 1948 Wisconsin attorney general's opinion considering whether "drastic therapy, such as prefrontal lobotomy" must be consensual by the person or his guardian, [which] concludes as follows:

> . . .[H]aving in mind the drastic nature of prefrontal lobotomy or psychosurgery, its permanent effects as well as the fairly high mortality rates accompanying or following the procedure (approximately 2 to 3 per cent), and the rather limited percentage of cases resulting in improvement ("good" or "favorable" results in 20 per cent of "cases of dementia praecox" and 55 per cent of "involutional melancholia cases"; "fair results" in 37 per cent of the former and 33 per cent of the latter.), we would most strongly urge obtaining the consent of near relatives or guardians wherever possible. . . .
>
> We wish to make it clear that this conclusion is in the nature of advice as to policy, and that as to the law relating generally to the care and treatment of insane persons in state institutions we subscribe to the view expressed. . .by the attorney general of Vermont that in the absence of express statutory provision the care and treatment of inmates in state mental institutions must be discretionary in the duly appointed officers of the institution.

No explicit provision in Michigan statutes governing mental health commitments requires a different result. . . .

We submit, nevertheless, that the state may not compel anyone to accept the contemplated experimental neurosurgery for aggressivity. Such compulsion would, we contend, violate the ban of the Eighth Amendment on cruel and unusual punishment. Moreover, because consent for such operation is constitutionally required, judicial intervention to assure the total absence of state compulsion is most emphatically required. But, as the record in this case amply demonstrates, institutional confinement is itself so inherently coercive that the taint of state compulsion cannot be adequately dispelled to satisfy the necessary burden of showing consent for the contemplated experimental neurosurgery for aggressivity at its present state of scientific development.

Because it is central to our argument that state compulsion to the contemplated experimental surgery would be cruel and unusual punishment, it is necessary at this point to consider at some length the modern standards that have evolved under the Eighth Amendment to understand their applicability to this contemplated surgery.

As a preliminary matter, it is clear that provision of seriously inadequate, inappropriate, or harmful medical care for involuntarily incarcerated persons is itself cruel and unusual punishment violative of the Eighth Amendment. Second, the Eighth Amendment prohibition applies to state compulsions whether or not those compulsions are imposed in prisons or in other "therapeutically labelled" institutions. Accordingly, the fact that John Doe or other persons are confined for aggressive conduct in a "hospital" rather than a "prison" does not affect the applicability of the constitutional ban against cruel and unusual punishment. Similarly, whether such persons are confined against their will for danger to others or to themselves is immaterial in applying the constitutional ban.

In *Trop v. United States*, (1958), the Supreme Court gave modern statement to the principle of the Eighth Amendment. In holding "cruel and unusual" a federal

"[The risks of] compelled experimental brain surgery . . . and its possible deprivation of personality attributes are 'degrading to the dignity of human beings.' "

law which stripped wartime deserters of citizenship, the Court ruled that statelessness

> subjects the individual to a fate of ever-increasing fear and distress. He knows not what discriminations may be established against him, what proscriptions may be directed against him, and when and for what cause his existence in his native land may be terminated. . . .It is no answer to suggest that all the disastrous consequences of this fate may not be brought to bear on a stateless person. The threat makes the punishment obnoxious.

Mr. Justice Brennan amplified this reasoning in his concurring opinion:

> [I]t can be supposed that the consequences of greatest weight, in terms of ultimate impact on the petitioner, are unknown and unknowable. Indeed, in truth, he may live out his life with but minor inconvenience. . . .Nevertheless it cannot be denied that the impact of expatriation. . .may be severe. Expatriation, in this respect, constitutes an especially demoralizing sanction. The uncertainty, and the consequent psychological hurt, which must accompany one who becomes an outcast in his own land must be reckoned a substantial factor in the ultimate judgment.

Subjection to experimental brain surgery—uncertain and grave in its risks of harm, assaultive on basic emotional and cognitive functions, disruptive and potentially destructive of human personality and personal identity—the "threat" of all this equally "makes the punishment obnoxious." It is, above all, "an especially demoralizing sanction."

The standards governing the Eighth Amendment ban have recently been given extensive elaboration in the Supreme Court's decision on capital punishment. *Furman v. Georgia*, (1972). Although the five members of the Court majority differed in their reasons for invalidating the death penalty. . .the opinions indicate that all five would regard experimental neurosurgery for aggressivity in the same way, and that all five would consider such compelled surgery to be constitutionally impermissible.

Justice Brennan's opinion most directly returns to the reasoning of the *Trop* case, to distill this principle:

> In view of the constitutional principle at stake, that forbids the state from compelling persons into experimental neurosurgery, it is essential that the state discharge a high burden of proof that any such surgery performed by its officers is free from any taint of compulsion. Accordingly, the standards to assure absence of compulsion must be more stringent and exacting for state officers than, under ordinary malpractice law, the requirement that private physicians obtain consent for medical procedures. The Constitution regulates state action; it does not directly constrain private conduct. Accordingly, the elaborate analogies that defendants' counsel . . . has drawn during this trial between the compulsions operating on dying patients, for example, who consent to risky experiments and the compulsions operating on persons confined by the state are wholly inapposite. A private physician may choose to overlook the compulsions operating on his dying patient. The state, under malpractice laws, probably will not ordinarily intervene to countermand the physician's judgment, and, in any event, it is not constitutionally obliged to intervene. But the state itself is not entitled to overlook the compulsions it directly imposes on potential "patients" involuntarily detained in state institutions, since the Constitution requires the state to refrain from compelling its citizens into accepting the experimental surgical procedures at issue here.

B. The taint of state compulsion cannot be adequately dispelled from any involuntary mental patient's decision to accept experimental neurosurgery for aggressivity.

John Doe testified in this Court, concerning the reasons that he agreed to the contemplated surgery while involuntarily confined in state custody, and the reasons he withdrew his consent after—and only after—this Court had ruled unconstitutional the Criminal Sexual Psychopath statute under which Doe was confined. Dr. Andrew Watson, a psychiatrist who had seen Doe both before and after this Court's opinion, confirmed in his testimony the dramatic change in psychological capacity that accompanied this change in legal status. [When asked] whether the Court's action regarding the CSP statute "was a quite significant part of this psychological mechanism" that led John Doe to withdraw his consent, Dr. Watson stated, "Absolutely. He sees himself now as an entirely different person. And he comes into the process in an entirely different way." John Doe's testimony establishes that the pressures on an institutionalized person are both pervasive and impossible to allay while that person remains involuntarily confined.

These pressures do not, of course, affect all persons in the same way. Some persons, for example, fight institutional pressures to the last ditch. Others, like John Doe, bow to institutional pressures in order to prove themselves "cooperative" and therefore worthy for freedom, or even more trivially, for minor privileges (such as a reading lamp for one's bedroom or ground passes to have picnic lunches with visiting parents). But since the state is constitutionally obliged to assure that no one is compelled by the state to accept experimental neurosurgery for aggressivity, it is insufficient to argue that since *some* can resist state pressures, it is permissible to overlook the existence of others—such as John Doe—who cannot so resist.

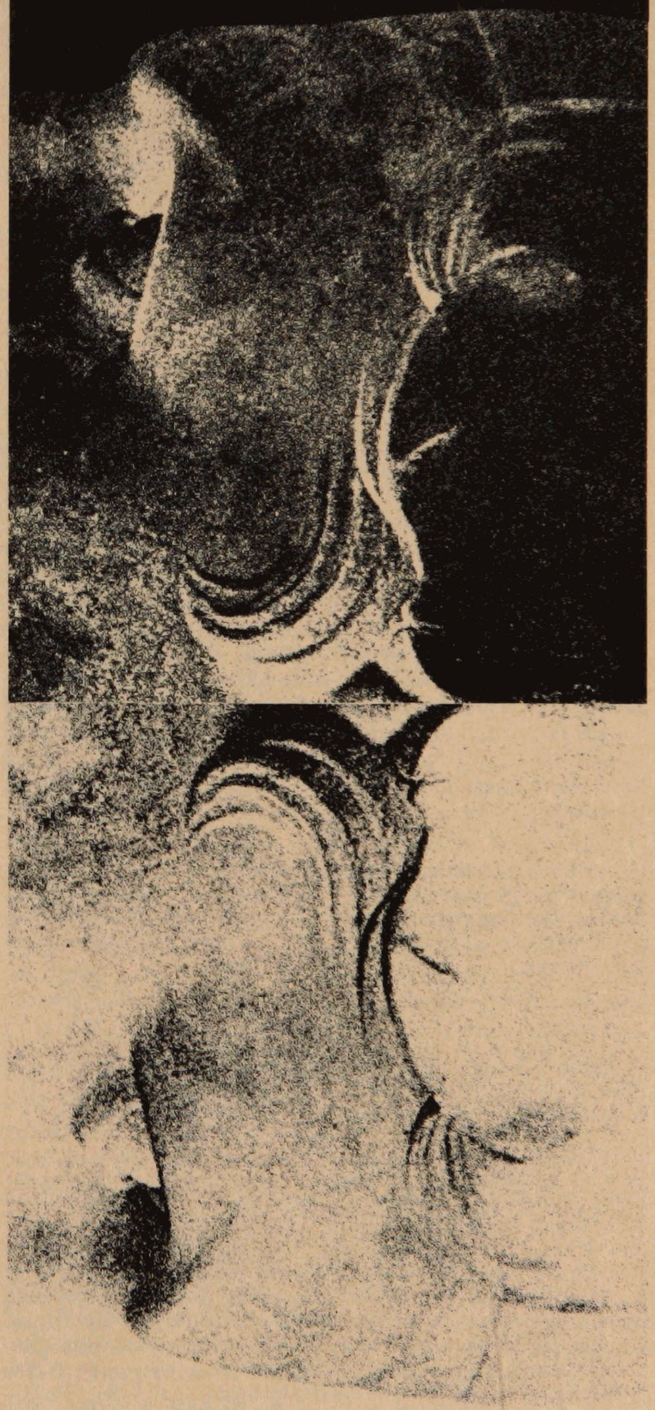
There are two possible responses to the reality that some persons, at least, involuntarily confined by the state will not have psychological capacity to exercise free choice regarding the contemplated surgery. One response, apparently pursued by defendants in this case, is to design mechanisms that screen out those in the institutionalized population who do and those who do not have the necessary capacity. But that response, we submit, is patently inadequate. John Doe, for one, was subjected to as extensive a screening procedure—to test the reality of his consent—as is ever likely to be carried out. That screening procedure failed; it did not identify the inappropriate motives that led Doe to consent to the operation. Dr. Yudashkin, who first presented the contemplated surgery to Doe and who interviewed him several times on this question, "doubt[ed] that [persons] would submit themselves to unnecessary surgery in order to gain their release."

When asked if Doe had told him that an important motive of his was to volunteer just to increase his chance to get out, whether or not the surgery would be done, Dr. Yudashkin replied: "I would have advised him against it."

The fact, is, however, that this was a central motivation for John Doe in consenting to the surgery. The fact emerged with considerable clarity in the course of his testimony in this trial. . . .

For purposes of understanding John Doe's motivation, it is not dispositive whether Dr. Yudashkin indicated any desire that Doe agree to the surgery. Indeed, Dr. Yudashkin has testified that he meant to exercise no influence one way or the other with Doe, and when directly asked the question, Doe stated, "I wouldn't say he was really advising me. I would say that he was really asking me. You know—there was no pressure." But this statement by Doe illustrates why the institutional setting is so powerful in undermining truly voluntary consent. The pressure need not come from the individual's conscious intent. In perfect good faith, Dr. Yudashkin could believe that he was leaving John Doe free to accept or reject the surgery. In perfect good faith, John Doe could believe that he was in fact free on this matter. But the circumstance, the total environment, in which both men

"[The] coercive environment gave John Doe a powerful motive to hide from himself, and from all others, the real, inappropriate motives that led to his consent [to the surgery]."



acted kept from John Doe both his freedom and his capacity to see how coerced and inappropriate his motives were in agreeing to the surgery. Even more importantly, that coercive environment gave John Doe a powerful motive to hide from himself, and from all others, the real, inappropriate motives that led to his consent.

Dr. Watson's testimony clearly establishes this, as follows:

> In my first contact with him [John Doe], he was still believing that his destiny was linked with getting that surgery. And he got angry with me when I threatened that by challenging that. As I said earlier, [I said to him], if everything is going so fine, why do you want to get this surgery? And you see, that is a threat psychologically. And he wanted to get it because that is how he was going to get the end he wished to achieve.
>
> I would construe that behavior, by the way, as a manifestation of the defense we call denial, which is a way of obscuring from one's self dangerous things one does not know how to cope with. He does not know how to cope with these feelings back then, and if he did, he would have to change his mind, which he did not wish to do with the dominant part of his decision making.

The institutional pressures that led John Doe to hide from himself and others the true character of his consent to the surgery had an even more treacherous impact in this case, according to Dr. Watson's testimony. Those pressures also likely led John Doe to present a false or exaggerated picture of the intensity of his "emotional surges." Because John Doe had not engaged in any violently aggressive acts for eighteen years—during the entire period of his confinement at Ionia—these self-reported "surges" were the central basis for the doctors' judgment that he was a proper candidate for the contemplated surgery. Dr. Watson testified as follows:

> He also told me, . . . during the point where he was still justifying surgery to me and to himself and to everyone else—he told me . . . whenever he feels some emotion, he feels it more intensively than other people. . . . [H]e was endeavoring then to prove to me on that first interview that he was a violent person who has these episodic rages.
>
> By the way, I thought it was a catechism which they had him recite over and over.
>
> Q. What would have motivated him—I am sure it was against his interest to portray himself as you describe, as a violent, aggressive, uncontrollable individual—what would have motivated him to try to do that?
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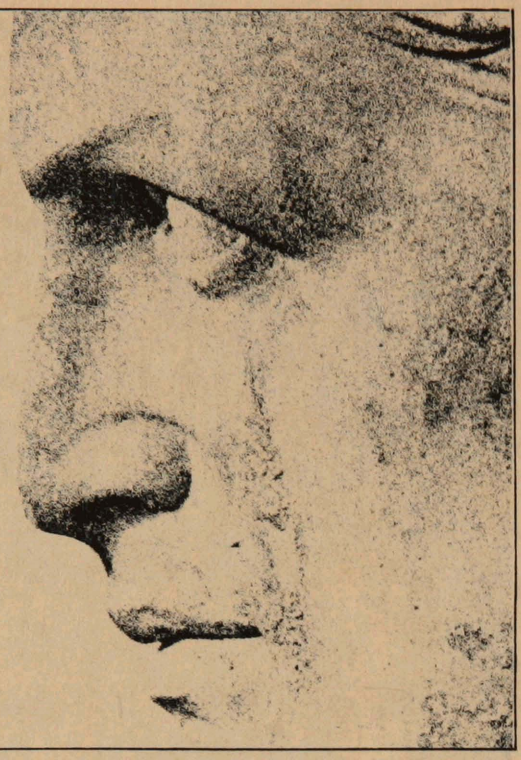
> A. It sounds like that, but [if] his motivation is to get himself this surgery so as to get him out of Ionia, then it is not against his interest. . . .
>
> Q. So, are you saying that in the way he presented himself, he falsely,—although unconsciously—falsely tried to distort the diagnostic impression that the diagnoser would get in order to qualify for this surgery?
>
> A. By the point of time I saw him, he wanted that surgery because he thought that was going to serve his end and that was what he was talking about. He had described that very thoroughly.
>
> Q. Is it possible that this conduct on his part that you are describing could fool some diagnosticians?
>
> A. Oh, yes. People fool people all the time in the sense, you know, that they are misled, especially if they have done something like kill somebody. That mere idea instantly potentiates everybody's misperception, and, indeed, I think I could trace through the record of Ionia for year after year after year precisely that type of non-perception of John. . . .

John Doe's testimony, and Dr. Watson's explanation of Doe's state of mind in his testimony, thus establishes two propositions:

first, that John Doe's consent to the experimental surgery was for "social gain . . . not medical gain." As Dr. Watson testified, "he was tying his major motivation to the wish to please—to cooperate—and, therefore he

"The arbitrariness of the contemplated surgical procedures is amply established by the testimony . . . regarding the total absence of correlation between one purported diagnostic key—'demonstrable physical abnormality of the brain'—and aggressive conduct."



would get treatment. Now, that is not the same linkage at all as going for a medical—a dangerous medical procedure in order to change something in order to be able to behave differently"; and

second, that the environmental pressures of the institution which pushed John Doe to this inappropriate consent also led him to conceal, from himself and from others, the real basis for his consent and, perhaps even more importantly, the real reason for his descriptions of the "emotional surges" that made him appear appropriate for the operation. This second proposition establishes the virtual impossibility of designing effective screening mechanisms to differentiate among involuntarily confined persons who should and should not participate in experimental neurosurgery for aggressivity.

This second proposition is further proven by considering the elaborateness of the procedural screening mechanisms that John Doe passed through, to the point that the implantation of depthelectrodes would have occurred if this litigation had not been filed. In this screening mechanism, the director of the State Department of Mental Health interviewed Doe several times. Doe was interviewed by three members of a Consent Committee, composed of a clergyman, a layman, and a lawyer. The latter, Ralph Slovenko, professor of Law and Psychiatry at Wayne State University, testified regarding John Doe's motives as follows:

We all have various motives, and . . . the major one in this case is that this person was concerned about his self-control over his aggression.

In other words, he had put aside whether or not this was a consideration for discharge. It was a matter—he looked upon it entirely as therapeutic, as a means of dealing with his aggressive outbursts.

The propriety of the medical diagnosis in John Doe's case was reviewed by a three-man professional committee chaired by Dr. Elliot Luby of the Lafayette Clinic, and they concluded that John Doe was a suitable candidate. Dr. Rodin, the principal investigator, testified as follows:

Q. In your judgment, did he consent as you have described it in order to assure that he would be released from institutional confinement?

A. No, he wanted to be relieved of his uncontrollable urges.

Dr. [Jacques] Gottleib, the director of the Lafayette Clinic, talked with John Doe, and testified to his motivation as follows:

A. Well, I think he expressed that pretty clearly, that he has surges from time to time that he would like to be relieved of that are disturbing to him. And this offered an opportunity for him to be relieved of these surges and urges so that he could regain his position in society.

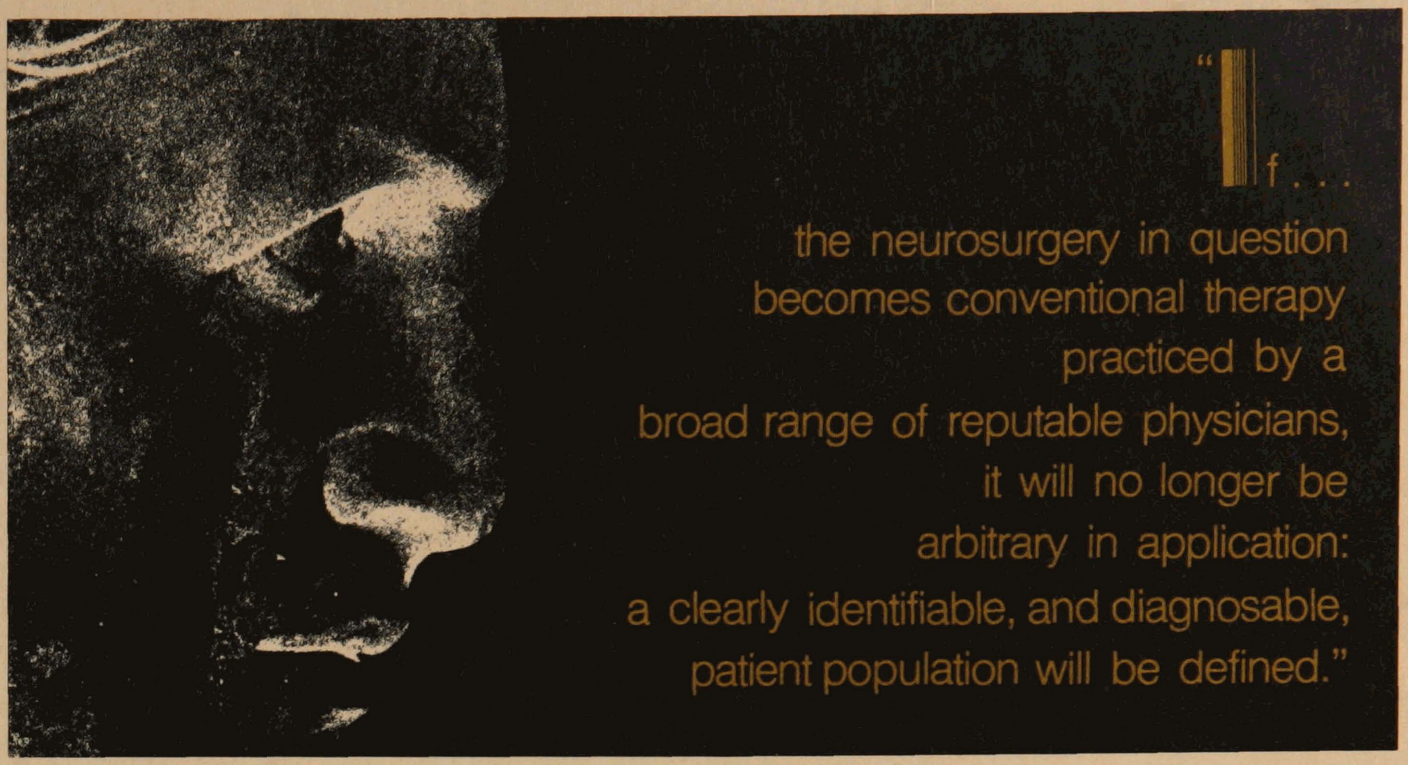
In this trial, however, we have had a quite unique and fortuitous opportunity to conduct a "controlled experiment" (better controlled, we would note, than the experimental surgery contemplated in this case). We have had extensive testimony of John Doe's attitudes toward surgery while he was involuntarily confined in the state mental hospital system. Then, because on March 23, 1973, this Court ruled that John Doe was illegally detained, John Doe testified in this Court on April 4 as a free man (though still residing in a state mental hospital while community placement was being arranged). In that testimony, the following exchange took place:

Q. . . . Now, in January, before this suit was filed, we understand from the doctors that they were prepared—they were ready—they had done everything up to the point of actually implanting these electrodes deep in your brain. Is that your understanding?

A. Yes.

Q. Could you tell us what your current attitude toward that procedure is? Whether today you are willing to have that happen to you?

A. Well, as I understand it right today, I am not willing to go through with this. . . . I have went through a number of changes and I would like to be able to pursue a convalescent status and be able to go out on this type of thing because I am finding that since I have been out from under the pressure of Ionia and I see that I have gotten a future and I have settled down quite a bit and the feelings that I was constantly going through have decreased a considerable amount. And I think that when I am out from under the institutional life and policies that I think that I will become even more stable. And I have become even less with problems of nervousness and so forth.



John Doe's experience, and his testimony, proves that the state cannot discharge its constitutionally required obligation to demonstrate that no taint of compulsion would accompany the decision of an involuntarily detained person to agree to experimental neurosurgery for aggressive conduct. Because that taint of compulsion cannot be removed, because it is inescapable in the coercive setting of a state confinement institution, it is "cruel and unusual punishment" and an invasion of the constitutionally protected "right to privacy" for the state to sponsor such surgery on its captive population.

This holding need not mean that no conventional medical treatment can be provided to a captive population. For those committed to mental institutions, conventional treatment at least related to cure of mental illness can be offered without regard to consent. Conventional treatment for other purposes to those committed to mental institutions, and conventional treatment of all sorts for those confined in prisons, are—by their very conventionality—much less likely to be viewed by commitment patients or prisoners as keys to their freedom or even to increased privileges.

More difficult questions are presented for medical experimentation on these captive populations. Consent to experimentation, for example, for malaria or cancer cures might be viewed by inmates as leading toward earlier parole or better institutional treatment. But the most troubling, the least assuredly consensual of all possible experiments, is an experimental procedure directly related to the reason that originally brought the potential subjects to be committed. That is, medical experiments related to "cures for aggressivity" are likely to be viewed by institution inmates and staff alike as particularly pressing concerns. John Doe might or might not prove his worth for release, his "cooperativeness" by agreeing to an experiment that might cure malaria. Whether he would consent to an experiment that might cure his "aggressivity" is, however, much more patently relevant to his view, and staff views, of Doe's worth for release, his "cooperativeness." Accordingly, this Court's ruling that the contemplated surgical procedure cannot be performed on involuntarily confined persons in state mental institutions would not necessarily imply that no medical experiments of any sort can be performed on state mental hospital or prison populations.

Further, this ruling would not necessarily mean that neurosurgery for aggressivity could never be performed in the future on state mental hospital or prison populations. The specially stringent standards, to assure no taint of compulsion, are imposed by constitutional norms. But if this neurosurgery becomes widely accepted conventional therapy for aggressive conduct, the constitutional norm would not apply with full force to it. If, that is, the neurosurgery in question becomes conventional therapy practiced by a broad range of reputable physicians, it will no longer be arbitrary in application: a clearly identifiable, and diagnosable, patient population will be defined. It will no longer have unknown risks and uncertain benefits: risks and benefits will be clearly and persuasively identified in the course of its wider use in the medical profession. And community dismay and unease at this procedure will be substantially allayed; the acceptance of this neurosurgical technique as conventional treatment by the medical community generally will amply testify on this score. Accordingly, the basis for ruling that compelled neurosurgery for aggressivity is constitutionally impermissible may, in the future, be so attenuated that it will be permissible to perform this surgery in institutional settings notwithstanding the inescapably coercive pressures of those settings.

Proscribing experimental neurosurgery for aggressivity on involuntary mental patients would not, moreover, stifle future scientific development of this technique. [T]here is a powerful case that the time is not yet proper for any human experimentation for this technique. Much additional animal work can and must be done. But, at most, as defense witness Dr. [Earl] Walker [Professor of Neurology, Johns Hopkins University] testified, "the art has progressed to the point where a very careful study might be carried out on a few cases. . . ." Those few cases need not, and should not, be drawn from involuntarily confined persons in state mental institutions. The experimental procedure itself is, at best, at the far end of legally permissible medical experiments on human beings. It would be wrong to authorize such an experiment to be performed on a population whose participation is, in any event, itself, at best, at the far end of the legally permissible spectrum for truly voluntary consent.