Prefrontal Leucotomy

Sir, - I write in support of the views in Dr. D.W. Winnicott's letter (Aug 25, p496-497) against the practice of leucotomy. The supporters of leucotomy claim that it is an effective last resort for untreatable neuroses, such as the opinion from Dr. Atkin's letter (Sept. 8th, p606). However such a claim is dubious both medically and ethically.

Leucotomy more often than not leaves the patient in a debilitated state. An argument by the leucotomy supporters to justify this is the suggestion that such patients are in no prior disposition to lead a qualitative life, often showing depressive tendencies or suicidal inclinations. Leucotomy allows them to regain 'functional' efficacy, as such in the case of the article by Dr. G. D. F. Steele (14 July, p84-86), where the patient is able to resume domestic duties. However the progress of a patient's recovery post-operation should not be solely merited on the ability to their functional use in society; instead our duty of care is to the patient's wellbeing as an individual.

An issue raised by those such as Winnicott about the unresolved debilitation to the emotional capacity of the patient caused by leucotomy is that it amounts to no less than spiritual murder. As raised by Dr. Walter Freeman's article *Psychosurgery* (July, 1950) the patient is left without an emotional component, and is indeed reported in the case in Steele's article. In the letters from both Winnicott and A.L. Rowson (Sept. 8th, p606), also raise the moral question of having individual choice to suffer or not suffer. Such is in the case of leucotomy that there is the choice between stunted emotion or continued mental disorder. Leucotomy may have a modicum of agreeable morality in the presence of patient consent for extreme cases of neurosis, as to be noted in the Dr. Steele case where the patient and husband wholeheartedly agreed to the operation. However in regarding patients undergoing involuntary hospitalisation can doctors of care be trusted to choose in interests of the patient, i.e. whether the sacrifice of the murder of persona in the pursuit of treatment and to limit pain is in their best interest? It is a moral fallacy to believe one is capable of deciding for such a patient, and to enforce psychosurgery is a horror upon them if they do not concur. As raised in the letter from M.J. Mannheim (Sept. 8th, p606) there is the concern that even for voluntary patient's leucotomy may be strongly suggested when it is not needed, and there is a lack of restriction for its use in only the most serious of cases.

In terms of recovery post-surgery, physical rehabilitation period is typically quick, as is such in the Steele case where the patient was discharged in 7 weeks. However as noted by Freeman's *Psychosurgery*, the length of social rehabilitation is dependent on the length of their previous institutionalisation, which may take a period of many years. Freeman also highlights that considerate training and dedication are vital to the efficacy of such post-operative rehabilitation. However at this current time there are no safeguards to ensure that effective rehabilitation takes place post surgery to maximise the patient's chances of social reintegration and recovery. As noted by Dr. Charles Burlingame on the subject of *Rehabilitation after leucotomy* in *Clinical aspects of psychosurgery* (Sept. 12, 1949, p31) proper rehabilitation is not a short or easy process; often the burden of post-operative care falls upon the patient's family or relatives, however it is often the case that they are unable to provide this sufficiently. Dr. Burlingame also calls for needed specialised long term post-operative training programs for leucotomy patient's. Such is the case that the current quality and length of the rehabilitation process is lacking and overlooked in our institutions.

I cannot disagree that at this current time leucotomy may be of some restricted use in the most extreme cases, if employed with consideration by practitioners experienced in the field of leucotomy, such as noted by Freeman. However I also must criticise the claim by the supporters of leucotomy as being a final treatment of 'guaranteed effectiveness' for such 'untreatable' neuroses. I align with the opinions in the letter from Mr Joseph Schorstein (July 28, p239) of the widening definition of psychosomatic disorders, and share concern for their treatment with the application of more widespread and lax use of leucotomy, as demonstrated in the work of Dr. William Sargant, with his article *Leucotomy of psychosomatic disorders*. Sargant also admits that leucotomy do not always effectively disperse acquired negative ideas connotated to the cause of psychosomatic disorders.
Freeman's *Psychosurgery* also talks of the extent to which personality changes occur is dependent on the amount of matter in the frontal lobe that is disconnected. It is apparent there is too much variability in the results of prefrontal leucotomies. Either the there is excess debilitation, or if not enough cerebral matter is removed the treatment is ineffective, and the patient is still left with residual symptoms of their original issue. As in the 1943 case in Sargant's article, a second leucotomy was suggested, but ultimately not carried out, as the first operation proved unreliable, with a relapse in pre-surgery symptoms.

Leucotomy is a practice with many flaws, and I believe psychopharmacology shows a promising for development of new medicines to treat such psychoneuroses. Via personal correspondence with Dr. Jean Delay, he has shown more promising results of the therapeutic effects of chlorpromazine hydrochloride for treatment of severe cases of psychotic disorders such as schizophrenia. The use of

drugs for the treatment of such extreme neuroses may replace the use of leucotomy and avoid its use in less serious psychosomatic disorders. Such medication may even prove to be more effective compared to current psychosurgery and shock therapies. The negative side effects induced by leucotomy are permanent, however with psychopharmacology any negative side effects are reversible simply by halting the prescription of medication, and to expect such a prescription and thus the side effects to not run for an indefinite course. In similar opinion to the letter from Dr. Anton-Stephens (Aug. 11, p361), I believe in the future leucotomy will be phased away with the introduction of better treatment such as psychopharmacology for current untreatable or long term neuroses. - I am, etc.

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