

Virtuosity and Ethics in Medicine: Pellegrino's Taxonomy as a Temporal Metric for Lobotomy

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In 1936, American neurologist Walter Freeman performed the United States' first frontal lobotomy. At the time, and indeed for decades thereafter, lobotomies were practiced on patients who exhibited extreme neuroses, psychosis, schizotypal personality disorders, "hysteria," and other related manifestations of a perceived neurodivergent nature. In a sense, the surgery was seen as—no pun intended—cutting-edge. Today, frontal lobotomies are non-existent in practice and have been replaced by controlled shock therapy and removal of hyper-specific regions of the brain to offset physiological brain trauma and dysfunction. Yet it took decades of unsound practice and unethical usage of this highly invasive brain-cutting procedure for modern medicine to eschew the usage of such a surgery because of its immorality and anti-ethical philosophy. Only as recent as the 1970s did the United States begin banning this procedure *en masse*, which was seen as disproportionately aimed at the mentally disturbed, poor, women, and minorities.

Edmund Pellegrino's essay, "The Virtuous Physician and the Ethics of Medicine," raises a defense of medical dogma which calls for duty and virtue as primary components of a physician's creed. Pellegrino posits that the imposition of human law is the ultimate ethical imperative under which doctors should operate, followed by the ethical duty to which a physician is obligated independent of laws, and finally the act of virtue (operationally defined as compassion and humanity). This tripartite legal-ethical-virtue framework, according to Pellegrino, is a hierarchical system of commitments that all physicians must undergo. The foregoing constructs, for sake of clarity referred to henceforth as *Pellegrino's Taxonomy*, would have been an outlandish and

unwelcome structure during the heyday of the frontal lobotomy. Indeed, had Pellegrino's Taxonomy existed, it would likely have been warped in such a way to justify the status quo relative to the ubiquity of lobotomies as a course of regular treatment.

Pellegrino's Taxonomy identifies the law of the land as the authority which guides how doctors should interact within the framework of patient care. Yet, the law as it exists at any given time is only as ethical as its intentions. It was once illegal in the United States to harbor fugitive slaves who escaped their enslavement. It could be argued that the ethical consideration of the person's life outweighed any law which mandated their return as chattel to a life of dehumanization, violence, and suffering. Laws may not be ethical, and ethics are not innately legalistic. Like law, the ethical history of medicine in the United States has a sordid past, rife with abuses and deceit. Within a legalistic framework, the ethical considerations of Pellegrino's Taxonomy could still allow for abuse under certain backdrops. Indigent defendants in the United States were not always assured a right to counsel, and poor criminal defendants who experienced psychiatric disorders are still today punished more severely than their non-afflicted peers.

Some of this punishment sent convicts into the hands of antiquated and overzealous neurosurgeons. This legal-medical pipeline resulted largely from the criminal justice system's general inability to differentiate between criminals, the mentally ill, and the "criminally insane," the latter of which were often found as such by wildly nebulous assertions of incurable mental illness. Modern concepts in criminal justice such as incorrigibility, competency to stand trial, psychometric evaluation, or a defendant's mental feebleness stemming from deprivation were not adequately considered as mitigating factors by judges who instead relied on archaic medical professionals who interacted regularly with the

criminal justice system. As agents who were sought after so that they could convey impartial medical insight to the court, physicians often erred within a legalistic framework and relegated indigent defendants to lobotomization as an arbitrary cure for incorrigibility.

The whole premise of legally based ethics in medicine during the early and mid-20th century found at its intersection with criminal justice the allowance of medical professionals to make assumptions of a criminal defendant on only the most cursory of evaluations. Forensic psychiatry—a profession in its early infancy during the 1930s—and the development of uniform criminogenic-medical evaluations—a rarity even under the best circumstances into the late 20th century—were more often existent to the extent that any medical professional claimed their incidence and made arbitrary decisions resultantly which courts would take at face value as proficient. The search for a neuropathological basis for “criminal insanity,” therefore, was a way for medical professionals to receive a nigh infinite pool of test subjects to perfect their craft and, however legally and ethically, oppress those perceived to be enfeebled by their own morbidity, intransigence, immorality, or stupor. All of this occurred within a legal framework and meets Pellegrino’s taxonomic legal criterion.

Pellegrino’s second taxonomic echelon—prioritizing ethical rights and duties beyond what the law stipulates—could be similarly perverted to suit unscrupulous medical acts. Within a societal setting, rightly or wrongly, criminals are maligned and detested. The prison systems set up to reform them often include systemic violence as a means of further punishing those at the fringes of our society. While crimes are deserving of reformation and differential strata of punishment based on the crime’s impact and scope, crimes rarely necessitate corrective brain surgery. A multi-state bank robber in 1948 was sentenced to a lobotomy by a judge as a means of

curing his criminogenic behavior. The robber's incorrigibility was noted as an aggravating circumstance in this sentence, despite no longitudinal attempt being made to reform the 28-year-old criminal. Instead, a quicker path was suggested by a court-appointed counsel and a district attorney. They believed that it was in the defendant's best interest to receive a lobotomy. The presiding judge requested guidance from a local neurosurgeon who provided context to the court regarding what a lobotomy *could* do: reduce the likelihood of the criminal's recidivism. Missing from the neurosurgeon's assessment was what a lobotomy could *not* do (reprogram a criminalistic mindset), let alone what it *would* do (stupefy the recipient of the lobotomy). The ethical imperative, as the neurosurgeon saw it, was to uphold the opinion of the robber's defense counsel and district attorney in the case without legislation mandating the lobotomy as a course of action. It was then seen as the duty of the neurosurgeon to destroy the physiological component which was thought to provoke the robber's pathological behavior. It was the ethical duty of the neurosurgeon to incise the offender's brain, and so he did.

The practicability of virtue—the third component of Pellegrino's Taxonomy—is also highly subjective based on context, relative time in which one lives and works, personal identity, and many other variables. A truly virtuous physician, according to Pellegrino, would recognize sociological forces which demand conformity and continuation of the status quo. From this certitude, a physician would determine that such influences may ultimately detract from or at the very least fail to surpass the moral challenges of society writ large. Stated differently, a virtuous doctor would challenge the cultural norms and mores of the times if they believed what they were practicing was in line with a higher morality and deeper ethical standard that went well beyond what could be expected from a sensible, normative practitioner. The

morality of stopping psychopathic behaviors, intercepting peculiar manifestations of disruptive and violent behavior, application of medical knowledge to reduce aberrant or deviant thoughts, and destruction of criminal operability are all objectively positive actions irrespective of how these acts are carried out. To a lobotomist, undertaking neutralizing actions to prevent future crimes while assuaging the public that there is a medical approach to solving crime is rightly honorable and virtuous.

Lobotomies did not occur without controversy, and indeed their usage for a short time span of human history indicates the identification of such procedures as indignant and violative. Nevertheless, the underlying applicability of Pellegrino's Taxonomy as a means of retroactively justifying one of the medical world's great shames should serve as a cautionary tale of how patient-provider relationships can be piloted by neological and subsequently prevailing ethical sensibilities. Though Pellegrino's Taxonomy has been used to redefine acceptable margins of ambiguity in patient-provider relationships and better identify ethical weaknesses in patient care, the existence of this Taxonomy is by no means a guarantee that all providers will adhere to the same creed and means of caregiving. By extension, the room for medical misconduct and abuse exists wherever good intention mixes with contemporaneous ethical and legal considerations.

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