Walter Jackson Freeman, M.D. (1895-1972), is one of the most revisited physicians of the 20th century, but from the 1950s through the 1950s he was celebrated, showered with awards, and featured on the covers of magazines, all for his single-minded advocacy of frontal lobotomy as an almost universal cure for a wide variety of mental illnesses.

Now, in a new biography, “The Lobotomist: A Maverick Medical Genius and His Tragic Quest to Rid the World of Mental Illness” (Hoboken, N.J.: John Wiley & Sons, 2005), medical journalist Jack El-Hai attempts to explain Dr. Freeman’s celebrity and, in small part, tries to rehabilitate Dr. Freeman’s reputation by connecting his biological orientation to that of modern-day psychiatrists.

Mr. El-Hai is not successful. Instead of feeling better disposed to Dr. Freeman, I was astounded at the numerous examples of Dr. Freeman’s jaw-dropping callousness, arrogance, and almost pathologic disdain for scientific rigor.

Mr. El-Hai starts Dr. Freeman’s story in 1939. At the annual meeting of the South ern Medical Association that November, Dr. Freeman, chair of neurology at George Washington University in Washington, described his work with neurosurgeon James Winston Watts, M.D. Following the experience of psychiatrist Egas Moniz in Portugal, they had given frontal lobotomies to six patients.

The technique called for boring holes on both sides of the skull and cutting both frontal lobes in several places. Although one of the patients seemed to have suffered serious damage after they cut several blood vessels, Dr. Freeman’s report was positive: “All of our patients have returned home, and some of them are no longer in need of nursing care.”

The mood of the audience appeared to range somewhere between skeptical and horrified, until a towering psychiatric leader, Adolf Meyer, M.D., spoke for the defense and saved the day for Freeman and Watts. Not that psychiatrists as a group ever warmed up to the surgery, as Freeman commented 10 years later, “If we waited for psychiatrists to send patients to us, we’d still be working on our first 100 cases instead of our fifth hundred.”

Even though he had no formal training as a surgeon or psychiatrist, Dr. Freeman had many strong opinions about surgery and psychiatric patients. Dr. Watts allowed him to be an equal participant as a surgeon in the 10 years in which they operated together, even though there was never a dearth of objections to Dr. Freeman’s involvement from witnesses and others. Dr. Freeman knew he had to acquire independence.

To this effect, in 1946 Dr. Freeman instituted two modifications. Instead of anesthesia, he would give the patient an electroshock, and he would devote himself to “transorbital lobotomy,” which he described very tellingly to one of his sons as “knocking [patients] out with a shock and while they are under the anesthetic thrusting an ice pick up between the eyeball and the eyelid through the roof of the orbit[,] actually into the frontal lobe of the brain[,] and making the lateral cut by swinging the thing from side to side.”

Dr. Freeman was probably correct in thinking that no local hospital would allow him to undertake the procedure unaided in its operating rooms. Never shy about his ability to eliminate bad connections in the brain so that formerly hopeless patients would be better able to function. Indeed, the 1949 Nobel Prize in Physiology or medicine was awarded to Egas Moniz for “his invention of a surgical treatment for mental illness.”

At the top of his prestige and acclaim, Dr. Freeman came to think that he could pridefully hang in his office—on his fifth hundred cases instead of our fifth hundred.”

The moral of the story is that we must not rely on credentials alone. Solid clinical research, persistent demands for compelling evidence when a new procedure is proposed, and ongoing supervision of its application are the best defenses against any future travesty.

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