OF MICE AND MEN: VIOLENCE AND HUMAN EXPERIMENTATION

Paddy Rawlinson

Abstract: Unethical human experimentation has long been a murky feature of medical research, most notoriously in the death camps of Nazi Germany. Despite the subsequent creation of the Nuremberg Code principles for the protection of human subjects, harmful medical trials continue to be conducted in the name of scientific inquiry and for the advancement of public health. Most, but not all, of the victims are marginalized groups, racially, ethnically and/or socio-economically defined, those for whom justice is often little more than a utopian hope. The article examines the violence behind the beneficent arm of the state in its role as health provider, and how the collaboration with medical science and the pharmaceutical industry have resulted in laboratories of human suffering involving society’s most vulnerable. By locating the abuse of human subjects of medical research within the paradigm of state crime the article highlights the growing propensity for serious harm and abuse, diluted by the more common use of the term unethical rather than “criminal”, as a consequence of this state, public health and corporate triumvirate.

Keywords: state-corporate crime; unethical human experimentation; harm; ethics; public health

Introduction

If medicine becomes, as Nazi medicine did, the handmaiden of economics, politics, or any force other than one that promotes the good of the patient, it loses its soul and becomes an instrument that justifies oppression and the violation of human rights. (Pellegrino 1997: 307)

The fruits that heal and the fruits that kill all too often hang on the same knowledge tree. (LaFleur 2008: 3)

Unethical human experimentation has been conspicuously absent from criminological investigation, and for the most part discussions have been confined to the disciplines of bioethics and philosophy. Yet, harms inflicted on human subjects and the impunity afforded those directly or indirectly responsible for them, are clearly social justice issues. That these harms emanate from the triumvirate of the state, medical science and pharmaceutical industry is further justification for their inclusion in the growing field of state “crime” research. The medicalization of society has become “one of

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the most potent social transformations of the last half of the twentieth century in the West’ (Clarke et al. 2003), providing a basis not just for burgeoning legal drug markets but also a heightened awareness of health as a security issue, most notably in the discourse of pandemics. Our dependency on medical research and unwillingness to bite the hand that heals us, or promises to, opens up the potential for myriad forms of abuse, harms that become obfuscated by the beneficent outcomes we routinely attribute to the state’s delivery of public health. A reluctance to censure the state when it appears to be fulfilling the benign role of welfare provider, in contrast to the “warfarist” position it has taken since the terrorist attacks on the US in September 2001, is perhaps understandable, but therein lies a danger of turning the critical gaze away from more nuanced forms of violence, those that as Žižek puts it, lie within the systemic functioning of “normal” life (Žižek 2009: 2).

A major turning in the history of human experimentation was the Nuremberg Code which provided the first international framework for the protection of the human subject in medical research. Responding to the horrors of human experimentation under the Third Reich, the Code set out ten principles for researchers including the requirement of voluntary consent by the subject, the avoidance of “all unnecessary physical and mental suffering and injury” and the provision of the protection of “the experimental subject against even remote possibilities of injury, disability, or death”. Yet, as with many lessons to be learned from the crimes of the Third Reich, there has been a distinctly subjective understanding and implementation of the Nuremberg and subsequent codes for research subjects, which has allowed the continuation of unethical experimentation, including in and by those countries which stood in judgement at the so-called “Nazi Doctors” trial. In some cases unethical practices have been as systematically implemented as were those under the Third Reich. While not driven by the intensity of racial hatred that “legitimized” human experimentation by the Nazi doctors, the demographic of victimization has been similar, focussing on the marginalized and weak, the socially despised and the foreign “other”. And in clear-cut cases of damage – whether physical, psychological or emotional – and even death, inflicted on human subjects of medical research, punitive measures against those responsible and compensatory measures for victims and their families have been relatively negligible and, more often than not, non-existent.

This article investigates the dark side of public health in western societies, focussing on the unethical treatment of human subjects of experimentation from marginalized and vulnerable populations. Through a number of case studies it looks at how human rights issues have been consistently trumped by the legitimizing impact of privileged discourses of power and scientific-medical hegemony. It argues that these discourses facilitate the inflicting of harms on subjects of human experimentation and the reluctance to respond punitively to those responsible. In understanding the nuanced manifestations of state violence as part of the collaborative project
of public health it is possible to gain a clearer understanding of the lessons to be
learned from the horrors of human experimentation under the Third Reich, most
significantly in the acknowledgement that the capacity for this type of abuse cannot
be historically or culturally isolated but remains an ever-present possibility within
the current structures and provision of public health in advanced western societies.

State Crime and “Good Intentions”

The state crime paradigm, within which the article locates unethical human exper-
imentation, interrogates the legalistic framework which defines certain acts as
criminal. It regards this framework as limited and thus problematic “insofar as
state-defined crime is ideologically biased and fails to address a wide range of
objectively identifiable forms of harm” (Friedrichs and Friedrichs 2002). This was
clearly the case of the medical atrocities carried out under the Third Reich which
were fully sanctioned by that state and only designated “crimes against humanity”
retrospectively by the victorious allied powers. The historical (re)constructions of
acts by the state as criminal underlines the importance of broadening criminology
beyond the contemporary conceptions of crime to include those acts whose
seriousness is diluted through a semantic sleight of hand. As the article argues,
unethical human experimentation has become the common terminology for a broad
range of medical abuse conducted and/or directed by liberal states, post-Nuremberg,
the consequences of which are as injurious as were those under Nazi Germany.

One of the problems in expanding definitional boundaries to include “harm” and
“social injury” is that the remit becomes so inclusive it is in danger of undermining
the state-crime paradigm. Critical criminologists constantly scrutinize the challenges
of the terminology such as differentiating between state crime and state harm (Ward
2004) or providing a typology of the “definitional variants” (Michalowski 2010).
However, even in the absence of a general consensus, the notion that “great power
and great crimes are inseparable” (Michalowski and Kramer 2010: 212), is ever
more relevant at a time when the state becomes increasingly entwined with corporate
power. That this inevitably leads to “an enormous gap between the normative ideal
of human rights…and the selective and hypocritical promotion of such rights”
(Green and Ward 2004: 9) is all too evident in the dark side of the alliance between
the state, medical science and the pharmaceutical industry.

Many aspects of unethical human experimentation can be understood as state-
corporate crime even when there is no obvious direct action or indeed tacit collusion
of the state with private research and/or industry. Griffin and Miller’s study of
the Oxycontin case, the pain management drug whose addictive qualities led to
widespread abuse and misuse, identified “regulation deficiency” as a crucial factor in
facilitating the actions of the producer, Purdue Pharma, which misled and defrauded
clinicians in its aggressive advertising campaign for the drug. Their modification of the state-corporate crime paradigm calls for a greater focus on regulation deficiency which “occurs when the government fails to protect individuals from societal harm despite good intentions” (Griffin and Miller 2011: 223). In failing to ensure the instigation and implementation of adequate regulation the state becomes a passive facilitator in the victimization process but facilitator nonetheless. And in becoming even more firmly entrenched in a partnership with the corporate world, the good intentions of the state are increasingly likely to produce social harms.

Health and Death

The Nazification of German science and medicine was accompanied by an increased focus on statistics... There never was a government as obsessed with counting, setting, sorting and sifting as was the Nazi regime. It is an era of mass screenings: of women for cervical and breast cancer, children for dental cavities, students for TB, factory workers for silicosis and lung cancer, pregnant women for health impairments, and so on. (Proctor 1999: 40)

Nazi medicine reflects a disquieting proximity between beneficence and brutality, and an unsettling distance between professional ethics and morality. The general view of medical science and public health under the Third Reich, presented as one of the numerous pathological traits of Nazism, is one of systematic euthanasia programmes, horrific experiments conducted on Jews and Gypsies, epitomized by the Auschwitz “twins experiments” of Josef Mengele. This perspective is summed up by Telford Taylor, Counsel for the Prosecution at Nuremberg, when he accused the Nazi doctors of turning Germany “into an infernal combination of a lunatic asylum and a charnel house” (Proctor 2000: 335). Yet the reality of Germany’s public health system belies this overriding concept of the Dante-esque nightmare. The Third Reich offered one of the most advanced systems in the world, promoting high standards of health and well-being at work, in the home, in public spaces and across generations and incomes. It was in Nazi Germany that the links between smoking and lung cancer were identified (findings expediently disregarded by American scholars after World War II), mass screening programmes initiated for the early detection of cancer, the connection between food dyes and carcinogenesis investigated and a healthy diet encouraged for its therapeutic qualities. Employing relatively sophisticated statistical data, public health officials were able to gauge and respond to the health concerns of its (Aryan) citizenry, providing fitness and health programmes that in many respects match those offered in developed countries today.

As with that other authoritarian behemoth, the Soviet Union, the healthy body became a site of national propaganda, an ideologically infused symbol of power and productivity, purity and progress (Efstathiou 2009; Starks 2008). In contrast,
the racialized exclusion of those deemed unworthy of participation in public health programmes, which by its very nature rendered these marginalized groups more vulnerable to illness, enabled “disease” to become a powerful and dangerous metaphor. What followed was the now familiar narrative of Third Reich public health, the dark side of medical progress, and the conflation of the biological with the political as an issue of national security. Hence “the idea that the Jews were a ‘diseased race’ and ‘disease incarnate’ within the body of the German nation meant oscillating so wildly between political and medical discourse that one can barely tell them apart” (Neocleous 2003: 30). From this perception it was a small step to the tragic irony of human experimentation in the camps. The Jewish people and others designated as Untermensch, became simultaneously the problem of disease, political and biological, and the means of addressing it. Their eradication was a necessary condition for the healthy development of the master race; at the same time, the extermination process presented a means of combating physical disease through the provision of unlimited human experimental material for medical research. Health and death, beneficence and brutality occupied two sides of the same coin, or perhaps more accurately, manifested as different imprints of the amalgam of science and the state. Nor, as Bauman argues, was there anything uniquely German, Nazi or fascist in the rationale that facilitated the brutalities of the Third Reich, “being fully in keeping with everything we know about our civilization, its guiding spirit, its priorities, its immanent vision of the world – and of the proper ways to pursue human happiness together with a perfect society” (Bauman 1988: 8).

The rationale behind the defence statements of the accused in the Nazi doctors’ trial bears out Bauman’s disquieting analysis. In 1947, seven out of the 24 defendants in the Nuremberg medical trials were executed for inter alia “crimes against humanity”, “war crimes” and “membership in a criminal organization”. Repeating the words of Justice Jackson, Counsellor for the Prosecution Telford Taylor described the heinous nature of these acts as being “so calculated, so malignant, and so devastating that civilization cannot tolerate their being ignored because it cannot survive their being repeated” (Taylor 1946: 13). Yet not one of the defendants presented themselves as evil, pathological individuals. Nor, it would appear, were they at any time coerced into conducting the experiments. In their statements they justified the experiments on various grounds including the pursuit of scientific advancement, duty to the Reich especially in a time of war, a firm belief in the value-free role of the scientific researcher and the utilitarian notion of sacrificing the few in the interests of the majority. As Caplan concluded, “most of those who participated [in human experiments] did so because they believed it was the right thing to do” (2008: 65) (emphasis added). There was no trace of hatred towards their victims, no genuine sense that they had betrayed their principles as medical investigators and physicians. The most chilling aspect of the experiments lay in what
Pellegrino describes as the lethal symbiosis between the caduceus and the swastika (1997: 307). In its harmful constructions of race, ethnicity and other attributes of non-Aryanness, the state was able to strip individuals of every element of humanity and hand them over to a profession which prided itself on “value-free” scientific inquiry. Human subjects were coldly transformed into scientific objects. And in the final stage of this brutal metamorphosis, scientific data collated from the experiments would be employed for the advance of public health allowing the state to reinforce its benign role as welfare provider in a callous circularity of health and death.

Closing the moral distance between beneficence and brutality was not a question of ethical nihilism. A number of laws were passed in 1930s Germany for the protection of human and animal experimental subjects, doctors were tasked with warning patients against the health effects of tobacco, professional standards of care delivery were constantly scrutinized, and so on. As Proctor notes, the majority of doctors were fully compliant with the ethical standards of their day. So while ethics were “typically sexist and racist there was also a stress on cleanliness, punctuality, orderliness and obedience to legal authority” (Proctor 2000: 343). In other words, the absence of ethics was not the issue but rather the values that informed their conception. Nor can the blame be laid entirely at the door of Nazi ideology. Scientific discourse, with its putative value-free ontology, carries the potential for abuse in the denial or rejection of existent bigotries that inform the knowledge structures within which the discourse is constructed. Contemporary formulations of scientific misconduct follow a similar reasoning in that they “say nothing about whether a given research practice may be abusive, or racist, or sexist – nothing about its larger context or implications” (ibid.: 344). Hence, “value-free” becomes its very opposite – value-laden, and more dangerous because the former brings together the illusion of scientific objectivity with the rationality of a crude utilitarianism to form a toxic version of state beneficence and public health in liberal societies as well as authoritarian.

Expediency and Justice

As the clouds of moral outrage hung over Nuremberg, discoveries of equally appalling incidents of medical experimentation on humans were occurring in Japan. Unit 731, a covert military medical operation, more than rivalled its counterparts in Auschwitz, Ravensbrueck, Dachau, Buchenwald etc. for the extent and depth of suffering and death accompanying the experiments. Located in occupied Manchuria, Unit 731 operated between 1931 and 1945 under the management of an ambitious Japanese army doctor, Shiro Ishii. Its prime (but not exclusive) purpose was to test for the effects of biological weapons which had been used in World War I presaging the possibility of a new and terrifying form of warfare. Experiments on prisoners
were conducted both within the Pingfang camp and amongst unsuspecting Chinese civilian populations in the surrounding areas (Harris 1991). These included tying armoured individuals to stakes and dropping anthrax bombs in the nearby vicinity to observe the impact and timeframe of biological killing; spreading plague bacilli-infested fleas to produce epidemics amongst the local Chinese; war-related injury experiments including hypothermia experiments similar to those conducted in the Nazi death camps. Accurate figures are hard to come by but some estimates of immediate deaths from experiments conducted under Ishii put the figure at 10,000 (ibid.: 172).

While the level of atrocities echoed those in Nazi Germany, the punitive responses by the Allies, in particular, the US, could not have been more different. In a deliberate and systematic cover-up the US State-War-Navy Coordinating Subcommittee (SWNCC) granted total immunity to Ishii and his colleagues in return for the acquisition of all available data collated from the experiments. This position was extraordinary given its contemporaneity with the Nuremberg trials. So too was the rationale for granting immunity – in the interests of national security – astonishing insofar as it echoed one of the main justifications offered by the Nazi doctors in the defence of their crimes. A telegram from Washington to the SWNCC read: “since any war crimes trial would completely reveal such data to all nations, it is felt that such publicity must be avoided in the interests of defence and security in the US. It is also believed that ‘war crimes’ prosecution of Ishii and his associates would serve to stop the flow of much additional information of a technical and scientific nature” (Harris 2002; Dickinson 2008). There was little doubt that any moral qualms concerning a cover up and the use of data acquired through these unspoken “crimes against humanity” should be ceded to the more pragmatic rationale that not only supported national security but the advance of scientific inquiry in the field of biological warfare: “Data already obtained from Ishii and his colleagues have proven to be of great value in confirming, supplementing and complementing several phases of US research in BW and may suggest new fields for future research.” Ishii and his colleagues walked free, some of them subsequently to take up posts in universities and other research institutions (Harris 1991: 194).

At the same time that the principles of the new Nuremberg code were being buried under a mound of strategic silence, the centuries old Hippocratic oath – *primum non nocere* (first do no harm) – which Telford Taylor had accused the Nazi doctors of grossly violating was being systematically undermined by his own countrymen. In 1946 the US-led Atomic Energy Casualty Commission, set up to investigate the effects of radiation on the victims of the atomic bombs dropped on the two cities of Nagasaki and Hiroshima in 1945, stipulated a “no-treatment policy” for individuals requiring medical attention, effectively turning the devastated cities into huge laboratories. Medical intervention, it was argued, would threaten to
contaminate crucial data being collected by US scientists (Lindee 1994). The untold unnecessary suffering that resulted was a small price to pay for an exclusive insight into the effects of the first and only use of atomic weapons on civilian populations.

National security interests and the advance of scientific inquiry provided the rationalized defence of the Nazi doctors and physicians of Unit 731 for conducting the human experiments they were respectively punished for or offered immunity from. Similar justifications were offered by the US as an explanation for the appropriation of data from the spoils of Japanese experiments. However, the most ethically complex reasoning offered by the defendants at Nuremberg and implicitly woven into the security discourse of the US, was a utilitarian argument. Securing the happiness and well-being of the majority lies at the heart of most state policies, not least those relating to public health. However, the utilitarian paradigm (in the crude form embraced by policy-makers) does not concern itself with who comprises the majority, or more importantly, who falls outside it. The few who were “sacrificed” in human experimentation for the good and health of the larger group, whether from the Nazi, Japanese or American perspective all shared to some degree racialized, socially and/or politically marginalized identities. This pattern of status-driven selection – according to race, ethnicity, class, disability and gender – continues to define the majority of victims of unethical medical experimentation since the introduction of the Nuremberg Code.

Foucault points out in *Birth of the Clinic* the existence, in eighteenth century France, of an implicit economic imperative in the structure of social relations and illness that almost demands sacrifice without compensation:

> In a regime of economic freedom, the hospital had found a way of interesting the rich; the clinic constitutes the progressive reversal of the other contractual part; it is the interest paid by the poor on the capital that the rich have consented to invest in the hospital; an interest that must be understood in its heavy surcharge, since it is a compensation that is of the order of *objective interest* for science and of *vital interest* for the rich. (1975: 85)

Poverty, in Foucault’s context, facilitated the transformation of those who sought medical help from the clinic into objects of the “clinical gaze”. For “what was being deciphered in him [the poverty-stricken patient] was seen as contributing to a better knowledge of others. Furthermore, while observing, the clinic was also carrying out research…” (ibid.: 83). In this rationalization comes the persuasive notion of altruism, which disguises the reality facing numerous subjects of medical research: their “gift” is in fact a debt that they are forced to pay for the marginalized status they are allocated by the state. Human experimentation in liberal states has followed this pattern both before and after Nuremberg, a pattern that, as the article concludes, has been further intensified by the profit-making arm of the state-medical triumvirate, the pharmaceutical industry.
Hypocritical Oaths

The ethics of research can be relativized either by the atmospherics of war or by the blandishments of opportunity. And when the public is being massaged into acceptance of an extraordinary breakthrough in the offing, the reasons given for going forward with research immediately are, virtually without exception, noble and unobjectionable. (LaFleur 2008: 3)

The “interests of national security” have provided medical ethics with a broad remit for interpretation. Despite the inception of the Nuremberg Code and subsequent frameworks (see below) for the protection of human subjects, experimental abuse for military purposes has continued unabated. The Cold War and surrogate conflicts have spawned a litany of medical trials in which human subjects were uninformed and/or unprotected during the trials or subjected to unacceptable levels of harm. To name but a few: in experiments similar to those conducted by Unit 731, US planes allegedly dropped cholera-infected insects onto North Korea during the 1950s (Hurst 2008); Britain’s military research centre, Porton Down, has been attributed with the indirect deaths of unknown numbers of servicemen in experiments and one direct death from sarin poisoning (Evans 2004); Project MKULTRA, a CIA behaviour modification programme, set up to test mind-altering drugs to uncover espionage and sabotage during the Cold War was responsible for the deaths of at least one subject and harm to hundreds of others used as unsuspecting “guinea pigs” (Project MKULTRA: The CIA’s Program of Research in Behavioral Modification, Joint Hearing 1997).

Nor are these examples confined to a “dark time” of biological and chemical warfare history. The post 9/11 war on terrorism has provided ample opportunity for unethical human experiments especially in detention centres such as Guantanamo Bay. Situated in a jurisdictional no-man’s land as a holding camp for putative terrorism suspects, Guantanamo Bay has become synonymous with the systematic infringement of the Geneva Convention’s treatment of “prisoners of war” by US administrations since its creation in 2002. In further defiance of the Convention detainees were subjected to water-boarding and sleep deprivation, research into what is euphemistically termed “enhanced interrogation techniques” (Raymond 2010). The most recent revelation of experimental abuse is contained in a report by the Center for Policy and Research at Seton Hall University of Law in Newark, into the testing of mefloquine, an antimalarial drug, on inmates without their knowledge and/or consent (Denbeaux 2012). The drug is known to have potentially serious side-effects from the neuropsychiatric including paranoia, hallucinations and depression to convulsions and, in some cases, brain injury. The authors of the report concluded that the forcible administering of mefloquine to inmates with no
malaria symptoms made no sense whatsoever other than as a means of disrupting the inmates’ mental state so as to acquire intelligence for military purposes, concurring with the findings of the Physicians for Human Rights report that actions of this nature “constitute torture under U.S. law and under the U.N. Convention Against Torture” (Raymond 2010: 25). Thus, disease has now become a mode of intelligence gathering as well as a weapon of war.

The state might seek to justify unethical human experimentation during war or conflict on the grounds that it is acting in the interests of the public against a common enemy, however, such moral sophistry has even less resonance if the state engages in similar behaviour against its own citizenry. When the American media exposed the story of the infamous Tuskegee Study in 1972 into syphilis in poor male black Americans by the US Public Health Service, the reaction was one of disbelief and shame. One editor wrote “that he was shocked by “the flagrant immorality of what had occurred under the auspices of the United States government”” (Jones 1993: 11). The investigation, conducted over a 40-year period, involved observing the morbidity and mortality rates of 400 tertiary stage syphilitics who were convinced that they were receiving treatment for “bad blood”. None of the subjects were informed that they had syphilis and no-one received treatment. Indeed, they were actively discouraged, to the point of coercion, from seeking any form of medication that would have addressed the syphilis, so as not to compromise the study.

Tuskegee stands out in the hall of scientific infamy as a prime example of racialized medical research. In the selection of likely subjects to be offered/“volunteer” for human experimentation there has been a distinct demographic pattern. Alongside race stand ethnicity, class and gender. Many have lived in institutional settings such as prison, special homes, orphanages, etc. which also rendered individuals especially vulnerable to exploitation. The structurally coercive nature of such institutions, low levels of literacy of many of the inhabitants, and the relative absence of personal advocates, such as family, has ensured compliance rather than resistance, and a reluctance, as well as inability to seek redress. As the following cases show, the state not only let down its most defenceless but tacitly approved acts of medical violence as the norm in its unwillingness to modify legislation and/or ensure legal remedies for the victims.

Experiments conducted in these particular institutional environments in liberal states are well documented (much of what occurs in authoritarian-style states such as Russia, China and North Korea is difficult to access and verify but it takes little imagination to guess the magnitude of experimental abuse). The use of prisoners goes back to, and probably beyond, early eighteenth century England when inmates in Newgate were offered a pardon if they consented to receiving the small pox variolation1 (Barquet and Domingo 1997). A number of experiments involving the infection of hundreds of US prisoners with malaria and hepatitis B as well...
as exposure to dioxin (a chemical in Agent Orange, a highly toxic pesticide used to destroy foliage during the Vietnam war) were carried out in Chicago, Atlanta, and Pennsylvania between 1940 and 1966 (Reiter 2009). While many prisoners consented to the trials, the extent to which this was an entirely free decision remains questionable. Defiance of rather than compliance with the authorities can carry unarticulated penalties, or at least, the withdrawal of privileges which renders the prisoner population especially open to exploitation (Schuklenk 2000: 974).

Institutional coercion was also a factor in the deliberate infection of mentally disabled children with the live hepatitis virus during the 1960s and 70s at the Willowbrook State School in New York City. Although the consent of parents was sought, as the authors of The Willowbrook Wars observe, the letters they received about the trials were deliberately skewed to minimize and even obfuscate risk factors, as in the following:

Almost every phrase in the particular letter encourages parents to commit their children to the unit. The team is “studying” hepatitis, not doing research. The virus “is introduced” in the passive voice, rather than the team’s being said to feed the child a live virus… a claim of “no attack” [of the disease] was false… Finally, the letter twice described introducing the live virus as “a new form of prevention” but feeding a child hepatitis hardly amounted to prevention. In truth, the goal of the experiment was to create, not deliver, a new form of protection. (Rothman and Rothman 1984: 266)

In many ways, these were the lucky ones, having carers who were able, at least, to advocate for those harmed by the drugs. In contrast, children in orphanages were often denied even a modicum of pastoral oversight. “Forgotten Australians”, the name given to tens of thousands of indigenous, migrant and non-indigenous children in the care of the state from the early twentieth century up until 1999, were the subject of numerous unethical forms of experiment. Orphanages provided the human material for a range of trials including the testing of vaccines for diphtheria, whooping cough, herpes, measles, polio and human pituitary hormones. A 1950s trial of a herpes vaccine involved “Eighty-three babies aged six to eight months old [who] had been infected with the disease when the experimental agent was found to be worthless” (Murray 2007). As yet unsubstantiated (largely through difficulty in accessing the required information), there are claims that many Aboriginal children of the “stolen generation” were injected with serums designed to treat leprosy. Dr Norman Wethenall, a renowned Melbourne paediatrician, who was involved in testing the whooping cough vaccine on orphaned children, commented in 1997 when the abuses came to light: “it was not a mistake at the time but only a mistake by today’s standards” (ibid.). Forty years after the inception of the Nuremberg Code the statement betrayed an expedient application of historical amnesia and an implicit faith in the inviolable value of contemporaneous medical research. While “today’s
standards” reflect a more rigorous adherence to the principles of Nuremberg within western states, beyond the jurisdictions of “advanced” societies abuse in medical research has found new populations upon which to turn its clinical gaze.

“Sick” Society and Foreign Bodies

According to the World Health Organization (WHO):

Immunization is one of the most successful and cost-effective health interventions ever…. We are entering a new era in which it is expected that the number of available vaccines will double. Immunization services are increasingly used to deliver other important health interventions, making them a strong pillar of health systems. (WHO/Unicef 2005: 3, emphasis added)

The aspiration towards a healthy global society would appear to be increasingly informed by medical rather than structural solutions. Vaccines offer a more immediate remedy than improved sanitation, access to clean water, healthy diets etc. and while the latter are crucial to health improvement, within the current dominant framework of positivistic assessment, quantifying their success is more complicated than counting, administering and monitoring immunization programmes. Yet, behind the triumphalist immunization narrative of a supranational health organization lie some worrying issues. The WHO claims that immunization is cost-effective but fails to articulate for whom. It is no coincidence that the intensification of vaccination programmes runs parallel with the increase in outsourcing medical research to the private sector.

While research and development of vaccines is a costly business, the profits from the vaccine industry have been steadily increasing with the burgeoning demand on the world market (Carlson 2012). In the US, the pharma-industry was given a shot in the arm with the passing of the National Childhood Vaccine Injury Act of 1986 which provided protection for the industry against safety-related financial liability for vaccine injuries thus facilitating a more favourable economic milieu for the manufacture of vaccines. It was hardly surprising that from around that period up until 2002 “the number of vaccines recommended by the [US] government’s Advisory Committee on immunization practices for small children increased from ten shots to protect against seven diseases to twenty-eight different injections for fifteen different diseases” (Heller 2008: 153). The construction of risk and preventative health and its links with corporate profitability was given further credibility when the WHO itself was caught up in a conflict of interest scandal in what might be described as Inter-governmental organizational-corporate crime. An investigation led by the British Medical Journal (BMJ) and Bureau of Investigative Journalism discovered that some of the experts advising the WHO on the prospective
influenza pandemic of 2009 had professional links with pharmaceutical companies producing the flu vaccine H1N1 (Godlee 2010). The pandemic turned out to be “a damp squib”, as many western governments were left with stockpiles of unused drugs. In contrast, the profits of vaccine-producing companies were given a healthy boost, GlaxoSmithKline reporting a 13 per cent increase in its profits for 2010 based on the sales of the H1N1 vaccine (Telegraph online 2010).

The expansion of the vaccine market assumes an increase in medical research which, in turn, requires more drug trials and the growth of human experimentation. As the demand for human subjects increases, the criteria enabling the ethical use of human subjects have become more exacting. Since the 1960s various international and national protocols and their amendments such as the “Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects”, the “International Ethical Guidelines for Biomedical Research Involving Human Subjects” and the influential US Belmont Report have set out regulatory frameworks which build on the ten principles of the Nuremberg Code, in a move to further guarantee protection and justice to human subjects in medical trials. However, by positioning medical research in the context of the free market, and driven by competitive tendering for government contracts, the pharmaceutical industry as an essentially profit-making venture comes into conflict with regulation, and in many cases, as with the 1995 amendment to the National Childhood Vaccine Injury Act, is actively engaged in weakening it.

The criminogenic culture embedded in much of corporate business, including that of the pharmaceutical industry, and the harms that ensue, have been well documented by academics (Slapper and Tombs 1999; Punch 1996; Braithwaite 1984). Human experimentation is yet another aspect of this. As pharmaceutical companies continue to survey the global terrain for the expansion of the legal drugs and vaccine market, they are simultaneously seeking new jurisdictions for clinical trials. Hence, the shift away from the US and Western Europe to those regions where the rule of law is weak, public sector corruption high, education low and poverty widespread. According to the US Department of Health and Human Services, trials for new drugs conducted in foreign countries for use by Americans increased from 271 in 1990 to 6,485 in 2008 (Glickman et al. 2009). Attracted by the low costs for clinical trials which can be up to 60 per cent cheaper in countries such as India than in the West (Yee 2012), and with no shortage of willing participants from the poorest regions, the migration of drug testing to areas in Russia, China, Eastern and Central Europe, Africa and Thailand reflects economic rather than altruistic motives for the mass displacement of human laboratories. It is hardly a coincidence that many of these countries are run by authoritarian governments, and/or suffer high levels of poverty and corruption, and pay scant attention to the rule of law. Driven by economic need and often lacking the education, resources and support to take on powerful
pharmaceutical companies and their local representatives, those who “volunteer” for trials are less likely to complain or seek legal redress when experiments go wrong.

Despite the numerous exposés of unethical experiments in the developing world, little has been done on an international and national scale to protect and adequately compensate the damages inflicted on the most defenceless of the globally vulnerable, harms perpetrated largely for the health benefits of the developed world. As far back as the mid 1990s members of the medical community in the West voiced concern over trials conducted for the drug AZT (used to delay the development of AIDS) on HIV-infected pregnant women in a number of African states. One of the issues raised involved the extent to which the women were fully aware of the nature of the trials and attendant risks given the problems of translating culturally, as well as linguistically, the consent forms. Another concern lay in the use of a placebo-treated control group in contrast to a similar study conducted in the US that gave all patients access to antiretroviral drugs (Angell 1997; Lurie and Wolfe 1997). In the latter case, comparisons were made with the Tuskegee syphilis experiment, in what was to become an inflamed debate amongst researchers, academics and public health officials (McIntyre et al. 1998). The justification given for the placebo-controlled trials was based on the principle that the women who were part of the placebo-controlled group were no more disadvantaged than had they not taken part in the trials, given the fact that AZT was not available as part of the local standard of care. As Schuklenk pointed out, however, “in the real world there is no such thing as a fixed local standard of care. Rather, the local standard of care in, for example, India, is a standard of care determined by Western pharmaceutical multinationals” (Schuklenk 2000: 973). Amendments to the “International Ethical Guidelines for Biomedical Research Involving Human Subjects” (above), have attempted to address the loophole but unethical trialling in developing countries continues unabated.

India is currently one of the most popular areas for human experiments, given its relatively large proportion of poor and illiterate population. An investigation by the British newspaper The Independent in 2011 revealed that survivors of the 1984 Bhopal disaster, in which a gas leak from a chemical plant run by the US company Union Carbide was alleged to have been responsible for the subsequent deaths of 25,000 people, were used as “guinea pigs” by pharmaceutical companies in the UK, France and the US. Fourteen people died during the trials which were conducted on patients at the hospital founded for the treatment of Bhopal survivors. Many either had no knowledge of the trials or gave consent based on inadequate information. While the hospital was said to have received the equivalent of £140,000 for the trials, “Not a penny was given to patients to compensate them for travel expenses, inconvenience or loss of income” (Lakhani 2011). Over the past four years data from the Indian Drug Controller General put the death toll from “Serious Adverse
Events” during drug trials at 2,193, with only 3 per cent of the 438 cases in 2011 receiving compensation (Singh 2012).

Even when victims can garner advocacy via the media, non-governmental organizations or grassroots movements in order to redress the harms perpetrated, compensation as the first (and usually last) punitive action is notoriously difficult to acquire and access in what can be a painfully (literally in some cases) slow process of civil action. It took 13 years for the drug company Pfizer to pay out to the families of the eleven children killed during trials for antibiotics (one of which, Trovan, was untested) during the 1996 meningitis epidemic in Kano state, Nigeria. Many of the remaining children from the 200 subjects were left with varying degrees of brain damage (Stevens 2007).

Death and Health

Although bioethicists are now acknowledging similarities between the rational constructions motivating Nazi experiments with the unethical behaviour of medical researchers in post-Nuremberg liberal society, they are also keen to maintain an essential distinction. In LaFleur’s introduction to the edited collection Dark Medicine: Rationalizing Unethical Medical Research, he states, almost apologetically: “we recognize the specific genocidal motive in the Holocaust and do not find evidence of such a dimension in either the Japanese or American medical programs examined in this volume” (2003: 3). The genocidal motive driving the Holocaust is undisputable; it is less clear to what extent this was a motivating force behind the experiments conducted in the camps, and one that was certainly not included in the defence statements of the Nazi doctors. Their moral myopia, as discussed earlier in the article, occurred largely within the context of scientific inquiry, duty to the state and an almost slavish respect for the pragmatic qualities of a crude utilitarianism. Yet, for those who suffered under the Nazi medical gaze, the intentions behind their victimization, genocidal or otherwise, were irrelevant; at that point, they were nothing more than objects of medical research, doomed to pain and death at the hands of those who believed that what they were doing was the right thing to do.

The emphasis on genocidal intent invokes the rationale behind liberal democratic criminal justice. Mens rea, a cornerstone of criminal law, led to the execution and imprisonment of the Nazi doctors found guilty of abusing their positions; its absence, in the post-Nuremberg context of human experimentation, has ensured that criminal cases are exceedingly difficult to bring against any of those responsible for fatalities or morbidities resulting from unethical research, either in western societies or the developing world. The killing, maiming and social harming of thousands of vulnerable individuals with little effort to remedy the gross injustices does not need some form of (socially constructed) criminal intent to raise serious objections
to such activities. It does, however, demand a critical understanding of the values that grant these acts a diluted and dangerous form of legitimacy, an interrogation of the principles which have enabled the continuation, and indeed, acceleration, of unethical human experiments on society’s most vulnerable, a task for future discussion within the criminological context. One final comment on genocidal intent is necessary here.

It was the ideological pursuit of the Aryan race, “perfected” in the image of a mythical past, that engendered one of the darkest moments in modern history. Death found its calling in health, as the Third Reich rolled out its political and scientific machinery in the creation of a certain kind of body and a certain form of health, disseminating its message through streams of images in the media, and recreational activities offered in schools, local communities, etc. The perfect body and the perfect citizen were as one. Those who despoiled these images became non-citizens, excluded from the mainstream and eventually eradicated. What began with euthanasia programmes for the mentally and physically disabled, blatant despoilers of the Aryan image, evolved into the ultimate act of mass murder as the apparatuses of medical science became more efficient and sophisticated in the art of killing. The wealth of data extracted from experiments conducted on Germany’s Untermensch had the prime task of fulfilling this utopian vision: the few brutally sacrificed for the health and perfection of the many.

In her challenging critique of the development of medical science Elshtain warns against the fundamentalist tendencies that currently prevail, especially in the field of genetics: “…the notion that who I really am comes down to my DNA. We are obsessed with it and obsessed with the human body as a project” (2008: 168). Health and the human body is a prime concern for the twenty-first century, a particular kind of health, a particular kind of body. Perfection is described not according to a state ideology but to a collaborative vision of healthy, economically productive citizens, medically dependent bodies and commercially crafted identities. This requires a human price, selectively chosen, and not always by the subjects themselves. In pursuit of the healthy body, public health agendas in developed societies increasingly require the imbibing of preventative medicine and vaccines against all kinds of perceived health risk (they also encourage the birth of perfect children, prompting large number of abortions of foetuses tested positive for Down’s syndrome, which amounts to “eliminating an entire category of human being” (Elshtain 2008: 168)).

The acceleration of human experiments and commensurate growth of unethical medical research ultimately serves the purpose of an elite group at the cost of a “lesser”. There is no genocidal intent behind this, but a discomforting echo of eugenics, of similar aspirations, lurks in the shadows. Western liberal states cannot be accused of genocidal motivation, but does the aspiration towards a certain kind of “perfect body” feed another type of ideology, which also aligns beneficence and
brutality as comfortable bedfellows? When the value of life is determined not by racial but rather by economic principles, where the healthy body serves to maximize productivity and the unhealthy body to stymie it, where public health is increasingly shaped by profit-maximization as willing partners of a prolific pharmaceutical industry, will the commodification of human life eventually lead medical science, already entrenched in its own ethical superiority, to accept that harming the few for the many, for the sake of our own enlightened values, is the right thing to do?

Note

1. Variolation refers to the antiquated form of immunization which involved using material from the pustules of patients with the mild form of smallpox on other patients with the aim of inducing a less threatening form of infection than one contracted naturally.

References


