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FROM THE PAST TO THE PRESENT

The Guatemala STD Study and Multi-Layered Bioethical Critique

By Alicia Gonzalez

Use the Guatemala STD Study as a case study for modern bioethics and public policy surrounding pharmaceutical human subjects research. The Guatemala STD Study was a two year clinical experiment financed and conducted by the United States Public Health Services (US PHS) to intentionally infect Guatemalan subjects with the sexually transmitted diseases (STDs) syphilis, gonorrhea and chancroid, in order to see if a then newly-discovered drug, Penicillin, could prevent infection after exposure. The same conditions that made the Guatemalan subjects vulnerable to mistreatment have only grown in magnitude. This is an especially concerning development since clinical trials are conducted more frequently abroad today and without proper oversight. Through the study of the Guatemala STD Study, researchers can identify conditions that lead to possible unethical treatment. This essay is designed to add to the incisive analyses already provided by academics on the Guatemala case so far. I have taken an interdisciplinary approach in order to answer three important questions: 1) how the study occurred in the first place, 2) why the researchers disregarded the subjects' lives and wellbeing and 3) how the current legal-regulatory system manufactures a form of justice (or injustice) for the surviving victims. The Guatemala study was "a dark chapter in the history of medicine" as NIH director Francis Collins lamented, however without careful critique of modern bioethics, the same mistakes may repeat themselves. I conclude that a compensatory system may deter future wrongdoing and restore trust in patients after malpractice or injury has occurred.

I. Background

Berta was a female patient in the Psychiatric Hospital. Her age and the illness that brought her to the hospital are unknown.

In February 1948, Berta was injected in her left arm with syphilis. A month later, she developed scabies (an itchy skin infection caused by a mite). Several weeks later, [lead investigator Dr. John] Cutler noted that she had also developed red bumps where he had injected her arm, lesions on her arms and legs, and her skin was beginning to waste away from her body. Berta was not treated for syphilis until three months after her injection.

Soon after, on August 23, Dr. Cutler wrote that Berta appeared as if she was going to die, but he did not specify why. That same day he put gonorrhoeal pus from another male subject into both of Berta's eyes, as well as in her urethra and rectum. He also re-infected her with syphilis. Several days later, Berta's eyes were filled with pus from the gonorrhoea, and she was bleeding from her urethra.

On August 27, Berta died.¹

Berta was a patient in a study undertaken by the United States Public Health Service (US PHS) in a trial run from 1946 through 1948. Her experience represents some of the most heinous human rights abuses perpetrated by United States officials overseas. Dr. Cutler was not a Nazi doctor, although this experiment occurred simultaneously with the Nuremberg Trials; nor was he a rogue scientist, although he and his colleagues violated ethical and legal standards of even their own time.² Dr. Cutler unlikely perceived his actions as problematic because he conducted this and hundreds of other similar experiments at the behest of his employer, US PHS. The small group of government officials who planned and carried out these experiments went to great lengths to hide their work from the public eye, and so Berta's story remained unheard—that is, until Wellesley professor Susan Reverby stumbled upon Dr. Cutler's records over 60 years later.

Even Reverby described her story as the stuff of popular legend.³ While working on a book that chronicles the Tuskegee study, she meticulously reexamined archives of US PHS material. In 2003, she hit a vein when she found Dr. Cutler's personal documentation of a clandestine experiment, buried within the University of Pennsylvania archives. Before a small circle of academics at a 2010 conference, she described a two year study, funded and executed by the US PHS, to intentionally infect Guatemalan subjects with sexually transmitted diseases (STDs), such as syphilis, gonorrhoea and chancroid, in order to understand the efficacy of chemical

1 Presidential Commission for the Study of Bioethical Issues, *"Ethically Impossible" STD Research in Guatemala from 1946 to 1948*, by Amy Gutman, et al. (Washington D.C.: Presidential Commission for the Study of Bioethical Issues, 2011), 208.

2 "The period from 1946 to 1948 was an especially important time for bioethics. During these years, the Nuremberg Medical Tribunal considered charges against 23 individuals accused of complicity in concentration camp experiments, many of which were geared towards the Third Reich's war effort." (*"Ethically Impossible" STD Research in Guatemala 1946 – 1948*, 98-9.)

3 Susan Reverby, "Ethical failures and history lessons: the U.S. Public Health Service research studies in Tuskegee and Guatemala." *Public Health Reviews*. 34.1 (2012): 1-18.

prophylaxis.⁴ Dr. Cutler and his colleagues did not find informed consent necessary and only provided treatment to approximately half of the hundreds of prisoners, soldiers, psychiatric patients and prostitutes intentionally infected with the diseases. Of those treated, the amount of medicine was not always sufficient, nor was it the standard of care at the time for the US military at the time for the treatment of STDs: the antibiotic penicillin.⁵

The experiments, which came to be known as the Guatemala STD Study, were originally designed to provide full penicillin treatment to all subjects. However, according to surviving records, doctors intentionally inoculated 446 prisoners, female commercial sex workers, psychiatric patients, and soldiers. Methods were painful and dangerous; they ranged from male genital scarification and cervical swabbing with contaminated tools to coerced sexual activity between infected sex workers and male subjects. Only 294 of subjects exposed to STD pathogens received any treatment.⁶ Hundreds of orphans and lepers also became subject to serology testing, which involved blood draws and painful cisternal punctures.⁷ It has been suggested by survivor testimony and documents that children were infected and left untreated as well.^{8,9} Eventually eighty-four Guatemalans died in the course of the experiments. The remaining subjects never received compensation for their participation aside from bars of soap, cigarettes, and iron pills, occasionally given as payment for blood draws. The barracks, prisons, and hospitals in which the experiments took place suffered from a dire lack of supplies and trained medical experts. US PHS promised training for Guatemalan medical personnel and provided some; however, Dr. Cutler noted that the hospital paid for supplies donated by US PHS.¹⁰

Perhaps to their present embarrassment, few at Reverby's presentation in 2010 found her findings particularly alarming.¹¹ Foreseeing the ramifications of such a revelation, a colleague in the days after the presentation urged Reverby to turn over the Cutler documents to the Centers for Disease Control (CDC).¹² Immediately, officials at the CDC reeled in horror and issued their own report.¹³ That same night, Secretary of State Hillary Clinton called president of Guatemala Alvaro Colom to extend a personal apology. The following day, President Obama publically expressed regret on behalf of the United States to the nation of Guatemala, effectively accepting national culpability. He requested that the Presidential Commission on Bioethical Issues convene a fact-finding commission. In the months that followed, the CDC made publicly available Dr. Cutler's documents on the Guatemala STD Study. In the meantime, the question loomed uncomfortably: why would the US PHS condone such a study and what would its discovery's ramifications be?

4 In this context chemical prophylaxis is a drug used to prevent infection during or after exposure to a bacterium or virus. This is opposed to mechanical prophylaxis, such as a condom.

5 "Ethically Impossible" *STD Research in Guatemala 1946 – 1948*, 208.

6 "Ethically Impossible" *STD Research in Guatemala 1946 – 1948*, 57-8.

7 Cisternal puncture (a kind of spinal tap): the withdrawal of cerebral spinal fluid from the back of the skull. ("Ethically Impossible" *STD Research in Guatemala 1946 – 1948*, 131)

8 "Ethically Impossible" *STD Research in Guatemala 1946 – 1948*, 118.

9 Class Action Complaint for Injunctive Relief and Damages, *Garcia v. Sebelius*. No. 1:11-cv- 00527-RBW D.D.C., 2011.

10 *Ethically Impossible" STD Research in Guatemala 1946 – 1948*, 208.

11 Donald J. McNeil, "US Apologizes for '40s Syphilis Study in Guatemala." *New York Times*, October 1, 2010.

12 Kasdon, Louisa. "Presidential Panel Slams 1940s Guatemalan STD Study." *Boston University Today*, August 31, 2011.

13 Department of Health and Human Services, The Center for Disease Control and Prevention. *CDC Report on Findings from the U.S. Public Health Service Sexually Transmitted Disease Inoculation Study of 1946-1948, Based on Review of Archived Papers of John Cutler, MD, at the University of Pittsburg*, 2010.

II. Introduction

Hope for treatment when none else is available, coupled with infrastructural weakness and social prejudice, makes countless populations vulnerable to exploitation—much like the subjects of the Guatemala study. As a case study, Guatemala highlights gaping holes in human subject protections, especially with regard to structural violence. As a discipline, anthropology possesses a unique set of theories and methods that prove extremely useful in reexamining the Guatemala STD study through the “eyes of identity.” Leading anthropologists have certainly found it well within their purview to conduct ethnographies of historical material. One such anthropologist, Renato Rosaldo, argues that social processes do not appear as discrete snapshots in time. Instead, distinct historical events shape the particularities of any given moment.¹⁴ This thesis is designed to add to the incisive analyses already provided by academics on the Guatemala case so far. I have taken a multi-layered approach in order to answer three important questions: 1) how the study occurred in the first place, 2) why the researchers disregarded the subjects’ lives and wellbeing, and 3) how the current legal-regulatory system manufactures a form of justice (or injustice) for the surviving victims. Hence, the following paper will come in the form of a three-pronged approach.

I employ four main methodologies. First, I elucidate theoretical frameworks that will be used to analyze data. Critical race theorist and philosopher Tommy J. Curry has brought into focus a specific model of political economy, which I will use to discuss the transnational structures between Guatemala and the U.S. during and after the STD study. Frantz Fanon, a theorist of decolonization, psychoanalyst Jacques Lacan and by extension, his predecessor Sigmund Freud, provide useful psychoanalytic models for discussing social imaginaries, commonly held social beliefs that are not necessarily based on fact, which US PHS researchers relied upon to rationalize their actions. Second, I draw upon secondary sources from historical accounts of Guatemala–U.S. relations during the Guatemala study. Third, I analyze the correspondence found in the Cutler files as primary resource material. These include letters between him and his US PHS colleagues, daily laboratory notes and published reports based on the Guatemala studies. I will analyze relevant passages to understand exactly what researchers believed they were doing and how they mediated conflicting beliefs. I have extensively drawn from the files provided in the National Archives and Records Administration database of Dr. Cutler’s correspondence.¹⁵ Finally, I draw upon data from present-day studies in order to understand how problematic elements of the Guatemala study have continued into the present day. Presently, scholars have discussed racial prejudice in modern-day medical encounters and the political economy of human subjects research today. In conclusion, I will make suggestions for improving health policy in order to better protect human subjects, while still promoting biomedical innovation.

The Guatemala study was in fact, “a dark chapter in the history of medicine” as NIH director Francis Collins lamented.¹⁶ Nonetheless, it also set the precedent for transnational human subject research, which has grown to extraordinary levels in recent years. For example, current data from ClinicalTrials.gov shows that 44% of registered studies (68,587) are non-U.S.

14 Rosaldo, Renato. *Ilongot Headhunting: 1883-1974: A Study in Society and History*. Stanford: Stanford University Press, 1980.

15 Cutler, John, “Records of John C. Cutler” (Historical Records, National Archives and Records Administration, Atlanta, Georgia, 2011), <http://www.archives.gov/research/health/cdc-cutler-records/>.

16 Elizabeth Landau, “Studies Show ‘dark Chapter’ of Medical Research.” *CNN*, October 1, 2010. Accessed October 1, 2010. <http://www.cnn.com/2010/HEALTH/10/01/guatemala.syphilis.tuskegee/>.

only, exceeding the number of U.S.-only studies (63,028) by three percentage points.¹⁷ The impact of this figure is demonstrated by another statistic reported by the Department of Health and Human Services in 2010: the number of non-US studies for US market pharmaceuticals grew 2000% from 1990 to 2008.¹⁸ The globalization of clinical trials is a phenomenon that continues to grow, and poses similar ethical problems to the ones that plagued the Guatemala STD Study. In 2013, a letter published in the *Hastings Center Report*, Commission member and bioethicist Kayte Spector-Bagdady urged for the further use of the Guatemala experiments as a case study of structural inequalities as a problematic characteristic of modern human subjects research.¹⁹

Initially, commentators analogized the Guatemala STD Study as another Tuskegee, a bioethical nightmare of the past, only this time in Latin America.²⁰ The Tuskegee Syphilis Study indeed bore similarity to the Guatemala Study. From 1932 until its public discovery in 1972, the US PHS dispatched researchers to find individuals with syphilis and observe the disease-course without treatment. Doctors located 399 lower-class African-American sharecroppers to enlist, all of whom tested positive for syphilis. By telling them that aspirins and blood draws were part of a greater treatment plan for “bad blood”, they prevented the majority of participants from learning that they had the disease. They exhibited a shocking disregard for the subjects’ lives and asked draft boards to withhold medicine even when participants joined the military to fight in war. When late-stage syphilis eventually took the lives of some subjects, they reimbursed the funeral costs to widowers in order to perform autopsies on the bodies. When viewed together, the Tuskegee Study and Guatemala studies can be seen as part of a larger endeavor at the US PHS to transform the public’s view of STDs as a moral affliction into a measurable, scientific one.²¹ This endeavor came at a devastating cost to some populations, including clinical subjects.

Reverby described Dr. Cutler as “a Tuskegee doctor” in her initial report—and rightfully so. He oversaw the notorious study for several years throughout the 1960s, not long after his work in Guatemala ended.²² In a 2012 article, she noted less obvious, but powerful commonalities:

Each study conjures up almost primordial and powerful fears: lack of control over our own bodies, dangers of abuse by those with great power, terror of putting trust in physician/scientists who respond with what many see as close to medical torture, and perhaps most destructively the racism of treating people of color as “other” both in the U.S. South and the Global South.²³

Reverby alluded to the fact that human subjects abuse is a real concern today, and that the Guatemala STD Study is still relevant today. Therefore, the study should be reexamined to avoid

17 “Trends, Charts, and Maps,” *National Library of Medicine*, November 14, 2013. <http://clinicaltrials.gov/ct2/resources/trends>.

18 Department of Health and Human Services, Office of Inspector General. *Challenges to FDA’s Ability to Monitor and Inspect Foreign Clinical Trials*, by Daniel R. Levinson, OEI-01-08-00510 (Washington D.C.: Department of Health and Human Services, 2010), 50.

19 Kayte Spector-Bagdady, “Public Health Service Research in Guatemala: Toward New Scholarship.” *Hastings Center Report* 43.4 (2013): 3.

20 Kellee Terrell, “The Guatemala Experiments: Another Tuskegee?” *BET News*, September 1, 2011. Accessed October 1, 2012. <http://www.bet.com/news/health/2011/09/01/the-guatemala-experiments-another-tuskegee-.html>.

21 Allan M. Brandt, *No Magic Bullet: A Social History of Venereal Disease in the United States since 1880*. New York: Oxford UP, 1985.

22 Susan Reverby, ““Normal Exposure” and Inoculation Syphilis: A PHS “Tuskegee” Doctor in Guatemala, 1946-1948.” *Journal of Policy History*, 23.1 (2011): 6-28. doi: 10.1353/jph.2011.0002.

23 Reverby, *Ethical Failures and History Lessons*, 2-3.

bioethical violations in modern clinical trials. Despite the commission and commentators initially placing the majority of blame on Dr. Cutler and his colleagues, Reverby urged scholars not to view them as caricatures, but rather that as individuals that “we could have been,” under the same circumstances.²⁴ In other words, she asks us to revisit the experiments with what scholar Anne Herrington calls the “eyes of identity:”

The challenge of discovering past images and phantasms of goodness *could* have seduced us too—not in the name of brutality or evil, but in the name of salvation and reform.... [We can be tempted to serve myths of goodness] even at the expense of the human beings in whose names they were allegedly constructed.²⁵

Cutler himself may have believed he was doing good. Even though he was not, records indicate otherwise. Cutler’s letters note that he and his team felt that their work constituted legitimate scientific work to fight what at the time were tangible, dangerous diseases.²⁶

Fortunately, such an endeavor does not prove impossible. The initial layer of my analysis defines the historical moment and macro-structures that brought about the Guatemala study. A growing exchange of intellectuals between the U.S. and Guatemala, and economic dependency of the former on the latter paved the path for US PHS to perform trials abroad. For decades, historians have detailed the complex relationship between Guatemala and the United States during the “Ten Years of Spring:” a short-lived period from 1944 until 1954, in which Guatemala enjoyed democracy and social reform. This however, was not to last, and was abruptly ended by a manufactured military coup, led in conjunction with the CIA.²⁷ In her critique of the Commission’s report, Charlene Galarneau, one of Reverby’s Wellesley colleagues, discussed structural injustices, such as racism, poverty and sexism, which created extreme vulnerability in the STD study subjects. My historical study in chapter one complements her work; I pay careful attention to structural injustice as well. In addition to her approach, I use a specific model, that of political economy, to build upon existing structural injustice analyses.

Historians have stated that during the “Ten Years of Spring” Guatemala remained extremely resource poor.²⁸ Some argue that the United States still largely controlled the Guatemalan public health system through the Pan-American Sanitary Bureau. As a nation, Guatemala had little autonomy or ability to function without U.S.-provided funds.²⁹ The small medical elite that led public health measures was ambitious enough to provide consent on behalf of their own patients (who were almost uniformly “Indian” and poor) in exchange for prestige among U.S. public health circles.³⁰ Such a scenario closely coincides with what Tommy J. Curry defines as political economy:

24 Susan Reverby, “The Guatemala STD Inoculation Studies: What Should We Do Now?” Paper presented at the Petrie-Floam Center for Health Law Policy, Biotechnology, and Bioethics, Harvard Law School, Cambridge, Massachusetts, November, 2012. <http://petrieflom.law.harvard.edu/events/details/the-guatemala-std-inoculation-studies-what-should-we-do-now>.

25 Anne Herrington. “Unmasking Suffering’s Masks: Reflections on Old and New Memories of Nazi Medicine.” *Daedalus: Journal of the American Academy of Arts and Sciences*. 125 (1996): 181-205.

26 John Cutler to John Mahoney. (1947, Sept 20). Correspondence. PCSBI HSPI Archives, Record Group 442,

27 Kinzer, Stephen and Schlesinger, Stephen. *Bitter Fruit: The Story of the American Coup in Guatemala*. Cambridge: Harvard University Press. First David Rockefeller Center for Latin American Studies Edition 1999.

28 Kinzer, Schlesinger, *Bitter Fruit*.

29 Reverby, “Normal Exposure.”

30 Comisión Presidencial para el Esclarecimiento de los Experimentos Practicados con Humanos en Guatemala. “Consentir el Daño: Experimentos Médicos de Estados Unidos, 1946-1948.” by Rafael Espada, et al. (Guatemala : Vicepresidencia de Guatemala, 2011) 129.

A means to explain the character of a nation—the dynamic that sustains the racial organization of society insofar as the complex interactions of economics, theology, politics, history, and philosophy naturalize the hierarchies of that society to be necessary to the nation(al) enterprise.³¹

The poor, incarcerated or conscripted subjects were not party to this arrangement. Rather, they were commodified. In the case of the Guatemala STD study, public health officials provided test subjects in exchange for prestige in the US health circles.³² Contemporaneous media and scholarly work depict an intricate combination of ideologies, or “social imaginary,” that justified exploitation in order to create a modern capitalist economy and national infrastructure. This argument is based on first-hand accounts, such as a United Fruit Company historian romanticizing the “uninhabited empires,” and U.S. anthropologists who described the Guatemalan “Indians” as impediments to modernity. Additionally modern historians’ reflections of that time period add an important layer to the critique because of the wealth of data uncovered since the STD study.

The correspondence between Dr. Cutler and other US PHS personnel that he kept, along with his lab notes, open an intimate perspective to the thoughts and beliefs of clinical trial researchers. An examination of the surviving letters shows that they negotiated between sets of ethics that were often contradictory. A scenario emerges in which US PHS and Guatemalan doctors created a distinct stereotype of non-human property, in order to justify their own transgressions. The dehumanization of economically exploited populations is consistent with the description proposed by the Fanon school of post-colonial psychoanalysis. Although many scholars believe that Frantz Fanon largely abandoned psychoanalysis in his monumental critique of Western imperialism *The Wretched of the Earth*, Derek Hook has shown that Fanon continued to use it in a subtler manner. Fanon effectively argued how political economies function through psychological means. He stated that the colonist (or opportunistic political entity) creates an imaginary stereotype of the degenerate, incompetent colonial subject in order to rationalize an exploitative presence.³³

Using discourse analysis to review the correspondence, we begin to piece together a conflicted subjective self of Dr. Cutler. This challenges the assumption that scientists will intuitively make the “correct” choice when confronted with an ethical dilemma. On one hand, Dr. Cutler premised the STD trials on good-will treatment while on the other he and his colleagues resorted to abusing subjects to produce positive results.³⁴ For example, Dr. Arnold, Dr. Cutler’s supervisor, wrote to Dr. Cutler warning that the psychiatric patients “do not know what’s going on,” but quickly questioned his own judgment, adding, “Maybe I’m too conservative.”³⁵ Throughout this process, he began to create a multi-faceted stereotype of the patients he promised to treat, that of a largely ignorant “Indio” whose value rested mostly in his usable body parts.³⁶ Psychologist

31 Tommy J. Curry, “The political economy of reparations: an anti-ethical consideration of atonement and racial reconciliation under colonial moralism.” *Race, Gender & Class* 18.1-2 (2011): 7.

32 It should be noted that US PHS personnel promised Guatemalan doctors that subjects would receive treatment. As Reverby noted, some Guatemalan officials involved may not have understood the full difference between “inoculation” and “treatment”. (Reverby, “Normal Exposure.”)

33 Derek Hook, *A Critical Psychology of the Postcolonial: The Mind of Apartheid*. New York: Routledge, 2012.

34 “Positive results” involved successfully infecting a group of Guatemalan subjects with STDs. Dr. Cutler wished to investigate how well penicillin served as a prophylaxis. In order to test this, they needed a control group who would become infected after infection, and who would not use a prophylaxis. (“*Ethically Impossible*” *STD Research in Guatemala 1946-1948*.)

35 “*Ethically Impossible*” *STD Research in Guatemala 1946 – 1948*, 57.

36 Indio refers to a Mayan descendant, although this categorization rested more on social positioning than

Derek Hook calls stereotyping “conflict management,” a mechanism that allows individuals to deny their own racism even while normalizing racism in practice.³⁷ Cutler and other researchers used tropes of charity and social betterment to justify their experiments to the public, while personally crafting and subscribing to an image of patients as disposable objects.

The experiences of the surviving subjects once the study came to light characterize troubling predicaments in modern human subjects research. After the revelations of the Guatemala study, the surviving subjects sought compensation in the highest United States District Court. Nonetheless, the Court ruled that the plaintiffs had no standing, a decision that set precedent for the regulatory laws that protect human subjects from possible abuse by their doctors. Commission member and bioethicist Julie Aultman has noted that this decision means that no human subject abroad may receive compensation for injuries incurred throughout the course of a clinical trial.³⁸ Bioethicists have noted that this reflects the common predicament for all human subjects today: that regulatory laws limit the liability of scientists to a state of nonexistence. Although authorities may readily admit that a crime occurred, little protects human subjects, especially in countries with limited institutional oversight. Even with Institutional Review Board and bioethical requirements, internal corruption resulted in disastrous, and preventable, injury to human subjects. The conditions that gave rise to the Guatemala Study have only grown in scale today. As a case study, the experiments are instructive for reforming modern health research policy.

III. The Historical Moment: Political Economy, Dependency, and Vulnerability

Political, economic, and social structures, in which Guatemala was reliant on the United States for public health care, undeniably left the study’s human subjects vulnerable to clinical mistreatment. Nonetheless, it is important to tease out precisely what conditions placed them in the hands of Dr. Cutler and his colleagues. More recent controversies, such as the Trovan trials in Nigeria, have shown that pharmaceutical industries recruit subjects within undeveloped nations for trials that frequently have experimental designs with limited bioethical oversight, which often result in fatalities.³⁹ Bioethicist Carol Levine asserted in an influential article published in 2004 in *The American Journal of Bioethics* that a priori categories of vulnerability in human subjects research standards today do not sufficiently identify possible sources of mistreatment. In fact, deeming some patients unable to consent may cause them unnecessary injury or death, and individuals deemed fit to consent have died preventable deaths during experimentation.⁴⁰ Clearly, a new method for detecting vulnerability is needed.

I argue that the model of political economy introduced by Tommy J. Curry, Professor of Philosophy at Texas A&M University, effectively identifies the conditions that left the Guatemala subjects defenseless to cruel treatment. If used carefully, with attention to empirical evidence

visible biological characteristics. This topic will be discussed in greater depth in section one.

37 Derek Hook. “(Post)colonial Racism: Racial Otherness and the Colonial Stereotype.” Eds. by G. Stevens, V. Franchi and T. Swart. in *A Race against Time*, 203-226. Pretoria: UNISA Press, 2006.

38 Julie M. Aultman, “Abuses and Apologies: Irresponsible Conduct of Human Subjects Research in Latin America.” *The Journal of Law, Medicine & Ethics* 41.1 (2013): 353–368.

39 Cameron R. Nelson, “In Remembrance There Is Prevention: A Brief Review of Four Historical Failures to Protect Human Subjects.” *Journal of Research Administration* 43.1 (2012): 98-111.

40 Carol Levine, et al. “The Limitations of “Vulnerability” as a Protection for Human Research Participants.” *The American Journal of Bioethics*, 4.3 (2004): 44-49. doi: 10.1080/15265160490497083

and the particularities of any given population, this model may provide a practical basis for recognizing further vulnerability. He interprets a concept originally proposed by the first African-American field officer in the United States Army, Martin R. Delany, as applicable to the United States today, which is:

A means to explain the character of a nation—the dynamic that sustains the racial organization of society insofar as the complex interactions of economics, theology, politics, history and philosophy naturalize the hierarchies of that society to be necessary to the nation(al) enterprise.... Because a country is defined by its historical and cultural cohesion, the racial aliens occupying that geography are incorporated into the nation only as bodies through governmental decree. When contrasted to the “natural citizen,” the “racial citizen’s” social existence is dictated by the government’s recognition of them as descendants distinct in character from “the people of the nation.” Thus, the racialized peoples lack the historical and cultural connections that make the country a unified whole, and remain excluded from the spiritual and political sustenance of the nation.⁴¹

The Guatemala STD Study exemplified the definition of political economy Curry presented. Curry’s argues that a nation, and the United States in particular, is reliant upon a hegemonic structure in which “natural citizens” disenfranchise “racialized citizens”. The Guatemala STD is an example of the political economy in operation. In addition, I intend to show that Curry’s model of political economy effectively identifies vulnerability to clinical exploitation if applied to transnational as well as national relations. Anthropologist Adriana Petryna points out that most contemporary clinical trials are outsourced to underdeveloped nations with “treatment-naïve” populations, meaning those with no history of pharmaceutical treatment, and sometimes no medical treatment at all.⁴² The very criterion of being poor and without a pharmaceutical history makes contemporary subjects particularly attractive for pharmaceutical research, much as the Guatemalan prostitutes, inmates, soldiers, patients, children and lepers were for the US PHS for exposure studies. Nonetheless, examining the relationship between political economy and social beliefs in the United States and in Guatemala clearly illustrates *why* and *how* the particular subjects became involved in the unethical study.

Four arguments connect Curry’s political economy model to the Guatemala Study. I will use primary historical documents to recreate a “social imaginary” that Claudia Strauss has described in its broadest sense. She writes, “Conceptions of average people, widely shared, enabling and legitimating practices because they carry a sense both of ‘how things usually go... and how they ought to go’, largely implicitly learned and expressed through practices, images, stories, and so on.”⁴³ Social imaginaries are apparent in historical accounts because Americans viewed Guatemala as an economic resource, rather than an autonomous nation.

First, popular U.S. publications describe American attitudes towards Guatemala and the pervasive trend of “manifest destiny”; that is, a religious and social charge to intervene on Guatemalan national matters. This contrasted with the political ideology of the democratic president at the time, Juan José Arévalo, who espoused a form of individualistic rights called

41 Curry, “The Political Economy of Reparations,” 7-8.

42 Adriana Petryna, “Ethical Variability: Drug Development And Globalizing Clinical Trials.” *American Ethnologist* 32.2 (2005) 183-97.

43 Claudia Strauss, “The Imaginary.” *Anthropological Theory*, 6.3 (2006): 322-344.

“spiritual socialism.” Secondly, historical accounts of Arévalo’s presidency, and some primary material indicate the infrastructural weakness of Guatemala, including that of their public health system. The deep U.S.-Guatemala relationship lent itself to the dependence of Guatemala on the United States for proper training of its medical elite and supplies. This exchange exacerbated already precarious ethnic and class relations within Guatemala.

Third, prominent U.S. anthropologists studying Guatemala at the time attempted to discard purely biological categories of race, and instead view “Indian-ness” as socially constructed. Such efforts sought to incorporate Indians into a capitalist structure of which they were already part as a laboring class.⁴⁴ I will also discuss the work of a U.S.-trained, Guatemalan anthropologist who defied simplified notions of race and superiority. These arguments mirrored the reasoning of US PHS officials in the Tuskegee Study. US PHS doctors shared the same imaginary: symptoms of being a “racial citizen” in a political economy were not the result of economic devastation and social exclusion, but rather part and parcel of a particular “culture.” The ramifications were that US PHS doctors and anthropologists implicitly blamed excluded populations for their own exclusion from national resources. My final argument in this section is that clinical researchers, and authorities working with them, devised their own complicated sets of bioethics, based on an imagined sense of social need, legal constraints, and political motivations. Treatment of subjects also consistently reflected the unconscious, or implicit, biases of researchers in cotemporaneous studies. The elements discussed in each section, transnational imaginaries, economic dependency, popular theories of race, and malleable bioethics set the stage for the Guatemalan STD subjects’ vulnerability.

As noted in the introduction to this paper, Cutler wrote that Assistant Chief of the Venereal Disease (V.D.) Division at US PHS (1947-48) and Chief of the Pan-American Sanitary Bureau, Guatemala Office (1945-46), Dr. Joseph Spoto, insisted that the “Indians” did not need any explanation because it would only confuse them further.^{45,46} This reflected a historical and troubling divide in Guatemala of this moment, commonly referred to as the “Indian Problem” by elite national intellectuals.⁴⁷ Nonetheless, the view held by the Guatemalan upper class that “Indians” barred the nation from experiencing modernity, and therefore social unity, was deeply shaped by political, economic, and social trends emerging from the United States.

Levine correctly pointed out that a priori categories of vulnerability do little to discern vulnerable groups of people. In fact, these very “Indian” subjects could hardly have their social status defined by other Guatemalans. Antonio Gouband, Harvard educated and University of Chicago trained anthropologist, first director of Guatemala’s Instituto Indigenista Nacional (IIN) and Guatemalan ambassador to the United States at the time of his death in 1951, ordered municipal township surveys of the definition of “Indian” while still director of IIN. He found that “surveys revealed that there was no general agreement.... The few criteria that did exist varied from department to department and were vague: ‘customs and habits,’ followed by language.” He stressed that what counted in social life and structure were “relations between members,” rather than the contents of some a priori category.⁴⁸ The status of “Indian” was not defined by biological

44 Carol A. Smith, “Anthropology Discovers the Maya” in *The Guatemala Reader: History, Culture, Politics*, Eds. Greg Grandin, Deborah T. Levenson and Elizath Oglesby, Duke University Press: 2011.

45 “*Ethically Impossible*” *STD Research in Guatemala from 1946-1948*, 114.

46 “*Ethically Impossible*” *STD Research in Guatemala from 1946-1948*, 66.

47 Richard N. Adams, “The Evolution of Racism in Guatemala: Hegemony, Science and Antihegemony.” *Histories of Anthropology Annual*. 1 (2005): 132-180. doi: 10.1353/haa.0.0011

48 Abigail E. Adams, “Antonio Gouband Carrera: Between the Contradictions of the Generación de 1920 and U.S. Anthropology.” in *After the Coup: An Ethnographic Reframing of Guatemala, 1954*, ed. Timothy J. Smith and Abigail E. Adams, (Urbana: University of Illinois, 2011.), 17-48.

characteristics, or culture in a purely social sense, but rather by a group's access to resources and historical relationship to the governing powers of Guatemala.⁴⁹

Richard N. Adams, former president of the American Anthropological Association and Latin American Studies Association, writes that,

In Guatemala the hegemonic model had been used for the subjugation of Indians as forced labor by the late-19th-century liberal society that sought to construct Guatemala as a European nation-state. The indigenous peoples—more than half the population—were effectively barred from political franchise and the economic benefits of national development.... During the first half of the 20th century... the major part of the non-Indian society of Guatemala generally shared the common 19th-century hegemonic perspectives on race.⁵⁰

Gouband's extensive fieldwork corroborates this model: he found that most indigenous people lacked access to national rights, such as basic education.⁵¹ Although Gouband's colleague David Vela, who founded the IIN, succeeded in securing certain provisions for indigenous peoples, ultimately he could not convince Arévalo's revolutionary government to include special statuses for them.⁵² By this point, indigenous populations continued to produce much of the nation's food supply and labor on plantations and lived in impoverished conditions.⁵³ This is not to say that the revolutionary government brazenly dismissed the rights of indigenous peoples; in fact, as City University of New York Distinguished Professor Emerita June C. Nash⁵⁴ writes, "Guatemala's revolution of 1944 was a stunning rejection of U.S. support for Jorge Ubico y Castañeda's reinforcement of an agricultural export economy during the 1920s and 1930s."⁵⁵ Nonetheless, an agricultural export economy and accompanying hegemonic racism remained powerful by the time US PHS researchers had arrived at the beginning of Arévalo's presidency.

The enduring presence of multi-national corporations (MNCs) such as United Fruit Company (UFCO) explains much of the hegemonic racism in Guatemala. In exchange for ownership of internal and external transport and communications infrastructure three major MNCs, UFCO, Empresa Eléctrica de Guatemala, S.A., a subsidiary of American Foreign Power Co., and W.R. Grace and Co. gave Jorge Ubico y Castañeda and his predecessor Lázaro Chacón the necessary political support to remain in power.⁵⁶

UFCO, possibly the most powerful of the three, conveyed a false ideology of social, and even theological, responsibility toward Guatemala in order to justify its exploitative nature.⁵⁷ In

49 "After the Coup: An Ethnographic Reframing of Guatemala 1954,"155.

50 Adams, "The Evolution of Racism in Guatemala: Hegemony, Science and Antihegemony."

51 Adams, *Antonio Gouband Carrera: Between the Contradictions of the Generación de 1920 and U.S. Anthropology*, 37.

52 Adams, *Antonio Gouband Carrera: Between the Contradictions of the Generación de 1920 and U.S. Anthropology*, 27-8.

53 Smith, "Anthropology Discovers the Maya," 188-9.

54 June C. Nash, "Recovering the Truth of the 1954 Coup: Restoring Peace with Justice", in *After the Coup: An Ethnographic Reframing of Guatemala, 1954* Eds. Timothy J. Smith and Abigail E. Adams, 17-48. Urbana: University of Illinois, 2011.

55 Nash, "Recovering the Truth of the 1954 Coup: Restoring Peace with Justice."

56 José M. Ayabar de Soto, *Dependency and Intervention: The Case of Guatemala in 1954*. (Boulder: Westview Press, 1978),

57 UFCO had deep connections within US politics. For example, major shareholder John Foster Dulles would serve as Secretary of State for the US under President Eisenhower. He was instrumental in fomenting Operation PBSUCCESS, which destroyed Guatemala's short-lived revolutionary government. Kinzer, Schlesinger, *Bitter Fruit*.

1914, UFCO historian Frederick U. Adams wrote,

It seems strange, does it not, that the Guatemalan railroad was not constructed years and years ago? It seems such an obvious thing to do, yet our American tropics are filled with obvious opportunities and with political problems for which there are obvious remedies.

In this passage, published originally in the book *The Conquest of the Tropics*, Adams described Guatemala as “our American tropics” and created a mythology of a rich territory awaiting U.S. colonization. He continued,

We of the United States spend tens of millions of dollars on huge engineering plants intended to bring our deserts to cultivation, but our statesmanship declines to glance south of the Rio Grande and of Tehuantepec, which uninhabited empires of rich soil are already provided with water and with the climate which must have existed in the Garden of Eden.⁵⁸

The myth he described both denies the existence of any significant persons in Guatemala, because it is part of “uninhabited empires,” and was religious in nature because Guatemala ostensibly holds land comparable to the “Garden of Eden.” The argument was as follows: the United States held a spiritual and social responsibility to develop Guatemala, even if Guatemalans objected to it. However, Arévalo remained hopeful that Guatemala could replicate the success of U.S. capitalism and share the spoils among all Guatemalans.

Inspired by an unprecedented true democracy and United States President Franklin Delano Roosevelt’s New Deal reforms, President Arévalo sought to make Guatemala the “vanguard of Latin America.” This entailed the dispatching of Guatemalan intellectuals abroad for education and proper funding, as well as the presence of foreign nationals to provide training and resources at home. However, this plan strongly followed in a long-established trend to “modernize” Guatemala. Past dictators, including Ubico, worked to establish national infrastructures, including a public health institution, and appointed officials to run them. Arévalo continued the exchange of specialized professionals with the United States and other European nations in an attempt to establish Guatemala as a developed nation. Although Ubico disappeared during the Ten Years of Spring, the pre-existing infrastructure, and many individuals who occupied it, remained.⁵⁹ As a result, the insulated and elitist culture that characterized earlier national institutions would plague that of a democratized Guatemala as well.

Since economic agreements of past dictatorships with the United States were financially detrimental to Guatemala, new Guatemalan leaders could not reestablish an autonomous infrastructure, including public health institutions. An agreement made in 1943 and extended through September 1, 1945, a year after Arévalo began his presidency, stipulated that the United States would provide Guatemala with funding.⁶⁰ Arévalo himself appreciated the American ideology of capitalism and rejected the eradication of social hegemony. He believed that Guatemala ultimately would achieve democracy by the protection of every citizen’s individual rights. In a speech as president, he said,

⁵⁸ Frederick U. Adams, “Conquest of the Tropics”, from *Conquest of the Tropics*, Vol. 1 of *The Romance of Big Business*. (Garden City: Doubleday, Page and Co., 1914)

⁵⁹ *Consentir el Daño: Experimentos Médicos de Estados Unidos en Guatemala, 1946 – 1948*.

⁶⁰ *Consentir el Daño: Experimentos Médicos de Estados Unidos en Guatemala, 1946 – 1948*, 35-36.

Our socialism does not... aim at ingenious distribution of material wealth to economically equalize men who are economically different. Our socialism aims at liberating men psychologically and spiritually. We aim to give each and every citizen not only the superficial right to vote, but the fundamental right to live in peace with his own conscience, with his family, with his property and with his destiny.⁶¹

President Arévalo sought to further modernize Guatemala in order to help establish it as an autonomous and powerful nation, however, this required the help of foreign entities.

Arévalo faced a difficult situation at the beginning of his presidency. In some regions, illiteracy among indigenous populations reached 95% and life expectancy was 40 years.⁶² According to the Guatemalan Presidential Commission, the entire population suffered from a lack of proper health resources: the infant mortality rate was a staggering 102.7 deaths per 1000 live births and the life expectancy for the Ladino population was a mere 50 years.^{63, 64}

Guatemala's public health infrastructure, especially, could not match the resources needed to properly serve its population. Legislation enacted by Arévalo at the beginning of his presidency mandated certain health related statutes, such as treatment and isolation of those with STDs.⁶⁵ This containment strategy was modeled largely on the plan laid out by the US PHS in the late 1930s, which then Surgeon General Thomas Parran argued to be the most scientific and effective for controlling the spread of STDs.⁶⁶ Nonetheless, as noted by Dr. Cutler in his correspondence with other US PHS officials, Guatemalan hospitals lacked even basic tools, such as a medical library, the anti-epileptic Dilantin or penicillin.^{67, 68, 69}

Thus, without education and funding provided by the United States, Guatemala's public health infrastructure simply could not survive. This did not entail an even distribution of resources but rather resembled an asymmetric collaboration between the US PHS and the African American population similar to the Tuskegee syphilis experiment. In the Tuskegee experiment, a liaison was needed between the lower-working class, African American population in Macon, Alabama and the white, wealthy officials of the US PHS. US PHS officials therefore hired an African American nurse, Eunice Rivers, to assist in the study.⁷⁰ The Guatemala study also needed a liaison to help communicate with the subjects of the study. And just as Eunice Rivers' participation was a watershed for black medical professionalism in America, so too did the participation of Guatemalan doctors prove to be a landmark moment for Latin Americans entering the Western medical science enterprise. Collaborating with US PHS enriched the medical institutions in Guatemala and also elevated the standing of doctors involved. Dr. Cutler wrote to Dr. Mahoney:

[i]n view of the wholehearted cooperation that we have received officially and unofficially from the Guatemalan Medical profession and government Agencies and

61 Kinzer, Schlesinger, *Bitter Fruit*, 39.

62 Kinzer, Schlesinger, *Bitter Fruit*, 38.

63 *Consentir el Daño: Experimentos Médicos de Estados Unidos en Guatemala, 1946 – 1948*, 25.

64 Kinzer, Schlesinger, *Bitter Fruit*, 38.

65 *Consentir el Daño: Experimentos Médicos de Estados Unidos en Guatemala, 1946 – 1948*, 26-28.

66 Brant, *No Magic Bullet: A Social History of Venereal Disease in the United States since 1880*.

67 John Cutler to John Mahoney. (Undated). Correspondence. PCSBI HSPI Archives, Record Group 442,

68 John Cutler to John Mahoney. (1948, Feb 6). Correspondence. PCSBI HSPI Archives, Record Group 442,

69 John Cutler to John Mahoney. (1946, Nov 12). Correspondence. PCSBI HSPI Archives, Record Group 442,

70 James H. Jones, Nancy M. P. King, "Bad Blood Thirty Years Later: A Q&A with James H. Jones." *Journal of Law, Medicine & Ethics* 40.4 (2012): 867-872.

in view of the fact that we may later want to return for other work and will want to continue to enjoy the same cooperative relationship I feel that it would be a mistake not to leave the laboratory equipped and functioning upon our departure.⁷¹

The United States Presidential Commission reported that “Dr. Cutler also requested that Dr. Abel Paredes Luna, a Guatemalan Public Health Services physician who worked with Pan-American Sanitary Bureau (PASB), receive a fellowship at Staten Island and be given the opportunity to study with Dr. Mahoney.”⁷² In addition to the training and laboratory provided by US PHS, Dr. Cutler assured that the other doctors involved would become international leaders in the study of STDs. Two of his indispensable Guatemalan collaborators, Dr. Funes, Chief of the Venereal Disease Section of the Guatemalan National Department of Health, and Dr. Salvado, Director of the Psychiatric Hospital, would be placed in charge of post-experimentation observation, thus propelling their respective careers.⁷³ Dr. Mahoney also appreciated the assistance of Dr. Funes, as well as his ability to keep the trials a secret, writing that,

[W]e have always felt that it would be expedient to do everything possible to push Funes to the fore as the leading Central American syphilologist. I am sure that this will be worthwhile in the event of a broad program of venereal disease control work being developed in Central America.

Dr. Cutler did not intend to improve the quality of the Guatemalan public health system, but rather to obtain the help of somebody who would not expose ethical wrongdoing during the clinical trials.

Although the trials presented an opportunity for Guatemalan doctors to become inducted into an elite international circle of public health experts, ultimately those who already lacked access to proper medical resources—the subjects, their partners and families—paid the price. Attempts to integrate these populations into “modern society” through anthropological work only furthered alienated them from precious national resources.

The Guatemala STD study occurred in a historical moment when the US government employed anthropologists and other social scientists to examine race relations domestically and internationally. In attempts to move away from scientific models of race that had driven recent Nazi horrors, many of them developed a popular theory that conceptualized race as a matter of cultural difference.⁷⁴ Ironically, many scholars who shaped integration efforts concluded that an attachment to a pre-modern culture, and not social or economic inequalities, prevented social unity across racial lines.⁷⁵ The correspondence of Dr. Cutler and his colleagues consistently spoke of difference between Guatemalan “Indian” and American subjects as a social, but still inherent and therefore unchangeable, matter. Thus, attributing higher rates of STDs to the culture of particular groups, such as African Americans and “Indians” (as opposed to systematic exclusion from national resources) aligned with the expert opinions of prominent social scientists at the time. This makes sense in light of US PHS officials’ desire to empirically refute hypotheses of

71 John Cutler to John Mahoney. (1948, June 21). Correspondence. PCSBI HSPI Archives, Record Group 442,

72 “*Ethically Impossible*” *STD Research in Guatemala from 1946-1948*, 83.

73 “*Ethically Impossible*” *STD Research in Guatemala from 1946-1948*, 95.

74 Adams, “The Evolution of Racism in Guatemala: Hegemony, Science and Antihegemony,” 163.

75 Adams, “The Evolution of Racism in Guatemala: Hegemony, Science and Antihegemony.”

biological race, and in turn prevent medical racism, through the Tuskegee study.⁷⁶ James Jones described a facet of the Tuskegee Study only discovered in more recent years:

Physicians believed syphilis was endemic in the black community, with the result that over the generations African-Americans had become “seasoned” and suffered little more than trifling infection. In their clinics, PHS officers had examined enough African American patients with advanced, untreated syphilis to know that this was nonsense, and those same PHS officers understand that this belief provided rationale for inaction on the part of the medical community... Consequently, the PHS officers who initiated the Tuskegee Study were eager to provide scientific proof that syphilis was a deadly disease for African-Americans, just as it was for Caucasians.⁷⁷

Therefore, the US PHS doctors were aware of racism and did not view themselves as racist. The United States Presidential Commission Report noted that US PHS doctors continued to perceive disease as a baseline in the African American population. As “sickness replaced health as the normal condition of the (African American) race, something was lost from the horror and urgency with which physicians defined disease.”⁷⁸ Doctors had begun to combat racism at this point, but had not begun to critically assess racism in public health.

State public health officials throughout the 1930s and 1940s consistently attributed high STD rates to African American’s natural tendency towards sexual promiscuity, thus providing a justification that such individuals were likely to contract STDs anyway.⁷⁹ Therefore, the logic of withholding proper treatment from one cohort in order to better treat the rest of the population did not appear malicious. A similar line of thinking shaped treatment of subjects in Guatemala.

Prominent anthropologists extensively studied race relations from the 1920s until the 1950s in Guatemala in order to understand why a white and Latino population seemingly embraced “modernity,” while a poorer, “Indian” population did not.⁸⁰ Individuals such as Antonio Gouband spoke to the strong intellectual currents present during the pre- and post-WWII eras. Richard N. Adams described the purposes of American anthropologists and the ideological atmosphere that shaped their theories of race:

Robert Redfield and Sol Tax came to Guatemala under the auspices of the Carnegie Institution of Washington’s program in social anthropology. Redfield himself did limited research in Guatemala but was responsible for hiring Tax as well as some other Carnegie-support investigators... Redfield was also close to the Chicago School of Sociology, whose theories of racial assimilation in the United States at the time were vigorous. Both he and Tax placed much faith in education as the major mechanism by which acculturation of the Indian would be facilitated.⁸¹

76 Despite this, many scientists and doctors in post-WWII United States believed that races were in fact biologically different. The US Presidential commission report stated, “...Surgeon General Thomas Parran described syphilis as being ‘biologically different’ in African Americans, and said that African American women ‘remain[ed] infectious two and one-half times as long as the white woman.” (*Ethically Impossible” STD Research in Guatemala from 1946 to 1948*, 84)

77 Jones, King, “Bad Blood Thirty Years Later: A Q&A with James H. Jones”, 868.

78 *“Ethically Impossible” STD Research in Guatemala from 1946-1948*, 72.

79 John Parascandola, *Sex, Sin, and Science: A History of Syphilis in America*. Westport: Praeger, 2008.

80 Smith, “Anthropology Discovers the Maya.”

81 Adams, *The Evolution of Racism in Guatemala: Hegemony, Science and Antihegemony*, 160.

According to Carol A. Smith, Tax would also assist in the building of the IIN, and ultimately, the national plan to “integrate Guatemala into a single national identity.” Nonetheless, Tax and his contemporaries failed to take into account that Indians systematically faced educational obstacles because of traditional forced labor in the agriculture economy and a total absence of schools in Indian communities. Instead of taking structural inequalities into account, they adopted a general consensus that “most existing Indian traits were basically negative. Indians were those who ‘lacked health, sanitation, education, capital, food- and wealth-producing capacity.’”⁸²

Dr. Cutler praised his own experiments as an opportunity for “pure” science with “pure” Indians.⁸³ Nonetheless, he compared the subjects’ behaviors in coerced sexual encounters as that of “rabbits,” attributing the duration of sexual contact to different “cultural” and “socioeconomic” groups in a final report issued in 1952.⁸⁴ Even Dr. Spoto told him that, “the Indians in the prison may do our work with little or no explanation, as they are only confused by explanations and knowing what is happening.”⁸⁵ Paradoxically, although US PHS and PASB doctors believed, like their anthropologist counterparts, that Guatemalan Indians lacked necessary education, they viewed opportunities to provide education as inevitably self-defeating. While US PHS doctors may have rejected biological notions of race, they still believed that the supposed cultural backwardness of their subjects was immutable. The researchers did indeed possess a set of ethics, however, this ideology encompassed the subjects as lesser “racialized” citizens, with fewer “natural” rights.

The Guatemala STD Study coincided with a game-changing moment in global bioethics. At the close of the Nuremberg Trials, American expert witness Dr. Andrew Ivy concluded that German Nazi experimentation on humans constituted war crimes. The jury agreed this was the case for 18 defendants and sentenced 12 to death⁸⁶. Eventually, this culminated in the Declaration of Helsinki that medical researchers must always obtain consent from human subjects and to never knowingly inflict suffering upon participants⁸⁷. However, at this exact moment researchers from U.S. government branches continued three notoriously unethical experiments: the Guatemala study; Tuskegee STD study; and the Radiation Experiments, which exposed U.S. citizens to damaging ionizing radiation without their knowledge.⁸⁸

Certainly, there were bioethical principles in place, but as Allen M. Hornblum, an activist and a faculty member at Temple University has pointed out, U.S. scientists believed that in comparison to the horrors of Nazi experimentation, their own bioethical violations appeared benign.⁸⁹ This resonates with renowned English scholar, Anne Herrington’s, warning that “past images and phantasms of goodness *could* have seduced us too—not in the name of brutality and evil, but in the name of some vision of salvation and reform.”⁹⁰ As well as the STD studies and Radiation Experiments undertaken by U.S. governmental officials, countless other researchers performed ethically dubious experiments on Americans immediately following WWII. One such experiment involved exposing inmates to Dioxin, better known as the carcinogenic substance

82 Smith, “Anthropology Discovers the Maya,” 188.

83 “*Ethically Impossible*” *STD Research in Guatemala from 1946-1948*, 74.

84 John Cutler. (1952, October 29). Experimental Studies in Gonorrhoea. Report. PCSBI HSPI Archives, Record Group 442.

85 John Cutler to Richard Arnold. (1946, Aug 26). Correspondence. PCSBI HSPI Archives, Record Group 442,

86 Robert Shnayerson, “Judgment at Nuremberg.” *Smithsonian Magazine*, October, 1996.

87 “*Ethically Impossible*” *STD Research in Guatemala from 1946-1948*, 99-101.

88 “*Ethically Impossible*” *STD Research in Guatemala from 1946-1948*, 116-7.

89 Allen M. Hornblum, “They were cheap and available: prisoners as research subjects in twentieth century America.” *British Medical Journal*. 315 (1997): 1437-41.

90 Herrington, “Unmasking Suffering’s Masks.”

Agent Orange.⁹¹ Although the Nuremberg Trials sparked the creation of official bioethical guidelines, it did not include specific applications to American testing scenarios. This left those most attractive for experimentation, prisoners and the institutionalized, largely unprotected by any ethical regulations.

Social and economic relations between the US and Guatemala and the nature of clinical testing after WWII played an important role in the vulnerability of the Guatemalan subjects. Guatemala was not chosen as a testing site merely because there would be little oversight there, but rather due to a long history between the United States and Guatemala, in which the former acted as a colonizer. Although unethical human subjects based research was not unusual at the time, the Guatemala Study was particularly heinous and purposefully kept secret. The social prejudice of the US PHS and the few Guatemalan researchers gave them an essential tool to justify medical malpractice.

IV. Between Social Imaginary and Individual Fantasy

If the last section was a discussion of the macro structures that “set the stage” for the Guatemala Study, then this section explains the micro choices and beliefs of the “actors” on stage. The US PHS doctors and their counterparts were not automatons, or mindless slaves to their culture; the letters between Dr. Cutler and his US PHS colleagues found at the University of Pennsylvania archives prove this point. In these letters, they described telling Guatemalan officials and patients that the experiments were a “treatment...utilizing serum followed by penicillin.”⁹² There is no evidence that the study sections planned the experiments in order to encourage the active deception of the involved parties. Instead, these decisions were those of Dr. Cutler and his immediate colleagues.⁹³ This corroborates the conclusion put forth by the United States Presidential Commission on the Study of Bioethical Issues:

The Commission believes not only that there were moral wrongs carried out in Guatemala, but also that some of the participants were morally culpable and blameworthy for these wrongs. ...The usual challenges associated with making moral judgments about the past are not substantial obstacles for the Commission in reaching its conclusions because many of the actions undertaken in Guatemala were especially egregious moral wrongs and because many of the individuals involved positions of public institutional responsibility.⁹⁴

Dr. Cutler and his colleagues had the expertise to understand that their actions were unethical. In spite of that, he believed that his work would result in social good.

When facing the defunding of his study, Dr. Cutler insisted,

“we have scientific opportunities which only come rarely, but in order to take advantage [sic] we need competent people, and competent people also have to pay the costs

91 Hornblum, *They were cheap and available: prisoners as research subjects in twentieth century America*, 1444.

92 John Cutler to Richard Arnold. (1947, June 5). Correspondence. PCSBI HSPI Archives, Record Group 442

93 “*Ethically Impossible*” *STD Research in Guatemala from 1946 – 1948*, 31.

94 “*Ethically Impossible*” *STD Research in Guatemala from 1946 – 1948*, 93-4.

of living required here, and cannot do their best work if they are under financial difficulties.”⁹⁵

Dr. Mahoney also saw the apparent value in the STD study, and wrote to Dr. Cutler the next year, “I hope that you will feel perfectly free to use any material which has accumulated in the course of the study which you are convinced is the most profitable for the work and for science as a whole.”⁹⁶ This example of individuals working with contradictory social values is at the heart of cultural anthropological study today. In their survey of anthropology, *Social and Cultural Anthropology: The Key Concepts*, anthropologists Nigel Rappaport and Olivia Overing insist:

Between the (structurally) given and what this becomes in an individual life there is a perennial (and unique) interplay; individual experience cannot be reduced to objective determinants.... Imagination is the key to this depiction: the key resource in consciousness, the key to human being. Imagination is an activity in which human individuals are always engaged; and it is through imagination that individuals create and recreate the essence of their being, making themselves what they were, are and will become.⁹⁷

Rappaport’s and Overing’s discussion of interplay between the individual and structure is very similar to Lacanian psychoanalysis, which has gained popularity in anthropology today. In essence, Lacan agrees with structural anthropologists Claude Levi-Strauss and Edward Sapir that language and meaning structures society. Individuals do not interact directly with the “real” and objective system behind social life per se but rather with unstable, socially constructed meanings; in other words, individuals interact with culture.⁹⁸ This existence is illusory, and yet for every individual it is also “real” because it gives birth to his or her self-image. Nonetheless, “the inadequacy of an identity constructed in this way, its failure to recognize real lacks, is a source of anxiety” as well as the imaginative capacity of the individual.⁹⁹

On a deeper level, this section is also about the identity and anxieties of the researchers, and their inability to reconcile their self-images with the fantasized demands of the illusory “big Other.” In the last section, I described the “social imaginary” that helped to create the self-image of the US PHS researchers and their views of minority and poor human subjects. US PHS followed in a trend of transnational intellectual exchange in which U.S. social theorists began to embrace a form of social racism, which perpetuated the existence of a racialized political economy. This section will demonstrate that Dr. Cutler and the other scientists conducting the experiments rationalized their actions by stereotyping their subjects and believing that that they were doctors and scientists working towards social good, even if they had to break ethical codes in order to achieve this goal.

As internationally recognized experts in the public health sector, the US PHS researchers enjoyed an abundance of rights that accompanied their elevated social status. Comparatively, these can be thought of as the given rights of a “natural citizen” in a political economy hierarchy,

95 John Culter to John Mahoney. (1947, Sept 20). Correspondence. PCSBI HSPI Archives, Record Group 442

96 John Mahoney to John Cutler. (1948, February 2). Correspondence. PCSBI HSPI Archives, Record Group 442

97 Olivia Overing and Nigel Rappaport, *Social and Cultural Anthropology: Key Concepts*. USA and Canada: Routledge, 2003.

98 Lenart Kodre, “Psychoanalysis for anthropology: An introduction to Lacanian anthropology” *Anthropological Notebooks* 17.1 (2011): 53-72.

99 Strauss, “The Imaginary”, 828.

as opposed to the rights of “racial citizens,” such as the Guatemalan study subjects. US PHS officials lauded its researchers as “good men” who ultimately would exert the best judgment, even in the absence of ethical regulation.¹⁰⁰ Dr. Mahoney described the social elevation Dr. Cutler received for his research, who at this point had lived in Guatemala for approximately two months, writing, “I enjoyed my visit to your home city and have selected the spot in the city square where they will eventually erect a monument to you.”¹⁰¹ Although Dr. Cutler had only graduated from medical school four years earlier, he achieved enough fame to have his own statue in Cleveland, Ohio. Prior to his work in Guatemala, Dr. Cutler also served as a researcher in the Terre Haute Prison studies, in which “volunteer” inmates were exposed to STDs and then to prophylaxis.¹⁰² This study, which ultimately would serve as a blueprint for the Guatemala experiments, received an immense amount of interest in American medical circles. The US Commission reported,

As Dr. Cutler was beginning his research in Terre Haute in October 1943, Dr. Mahoney announced his results to a “jam-packed” session at the American Public Health Association’s annual meeting. The initial results were so promising that one researcher called the work “probably the most significant paper ever presented in the medical field.”¹⁰³

However, the Terre Haute Study ended due to an inability to successfully infect subjects with STDs via mechanical exposure. They concluded that sexual intercourse was the only surefire way to successfully undertake prophylaxis experiments and that Guatemala would be the perfect place to create such an experiment design.¹⁰⁴ When Dr. Cutler initially undertook the experiments, his scientific peers shared the same vigor they expressed during the Terre Haute study. On October 15, 1946, Dr. Mahoney wrote to Dr. Cutler,

Your show is already attracting rather wide and favorable attention up here. We are frequently asked as to the progress of the work... (United States Surgeon General) Parran and probably Doctor Moore might drop in for a visit after the first of the year.¹⁰⁵

Another US PHS official expressed a desire to have the same opportunity as Dr. Cutler to undertake the experiments, writing, “I was so taken by the chances for investigative work in that country that I find it hard to get down to work here again. As Fred Brady would say, ‘I’m looking over the fence.’”¹⁰⁶ The Guatemala STD Study not only afforded Dr. Cutler fame within the social realm he grew up in, but also within the national medical echelons. Other doctors in high positions of power at US PHS attested to this, at times even expressing their personal envy. Within months, Dr. Cutler began not only to speak of the study in terms of opportunity, but also as promised by “agreements” in government-awarded grants. When Dr. Mahoney informed Dr. Cutler that he would no longer receive cost of living funds, Dr. Cutler blasted the decision,

100 Kayte Spector-Bagdady and Paul A. Lombardo. ““Something of an Adventure”: Postwar NIH Research Ethos and the Guatemala STD Experiments.” *The Journal of Law, Medicine & Ethics* 41.3 (2013): 697-710.

101 John Cutler to John Mahony. (1946, Nov 18). Correspondence. PCSBI HSPI Archives, Record Group 442.

102 “*Ethically Impossible*” *STD Research in Guatemala 1946 – 1948*, 20.

103 “*Ethically Impossible*” *STD Research in Guatemala 1946 – 1948*, 24.

104 “*Ethically Impossible*” *STD Research in Guatemala 1946 – 1948*, 22-3.

105 John Cutler to John Mahony. (1946, Oct 17). Correspondence. PCSBI HSPI Archives, Record Group 442.

106 G. Robert Coatney to John Cutler. (1947, February 17). Correspondence. PCSBI HSPI Archives, Record Group 442.

saying, “the law is the law and changes the rules from day to day and has no respect for the effort or promise of those designated its agents.”¹⁰⁷ Nonetheless, after carefully examining each letter available in the National Archives, I could not find a single instance where Dr. Cutler or his colleagues mentioned the rights of their subjects. Ironically, they did not recognize, or at least advocate for, the rights of patient populations they claimed to help.

Petryna has made an important connection to the ethical dubiousness of the clinical trial today. She has noted that, “pharmaceutical outsourcing reflects what in economics is known as the theory of incomplete contracts which explains how contracts are structured in situations of uncertainty, leaving room for contingent or opportunistic behaviors and unsolved liabilities.”¹⁰⁸ This theory applies here as well because, as I demonstrated in the last section, Guatemalan public health institutions suffered infrastructural weaknesses and had no other opportunities to receive necessary supplies and training than through foreign sources. This left the institutions particularly weak and with little bargaining power to determine the scope and shape of the STD studies. Furthermore, in a letter to Dr. Mahoney, Dr. Cutler suggests that initially US PHS offered a *treatment program*. He wrote:

Dr. Spoto has been introducing me to the various officials of the Guatemalan Public Health Service and to the chiefs of the Army groups with which we shall work. Our program has been outlined for them, and agreements are being signed. The men in their V.D. [STD] Program and the Surgeon General of the Army has even asked if we can set up a treatment program in the Military Hospital.

Nonetheless, what he adds later in the letter suggests that the agreement entailed capitalizing on resource poverty. Noting what he might need to ensure cooperation, Dr. Cutler wrote, “for the purposes of facilitating our work here Dr. Spoto believe(s) it very necessary for us to undertake some treatment programs.”¹⁰⁹

Much like with Tuskegee, Dr. Cutler believed that consent necessitated permission from public health officials, but not the actual subjects. He describes this belief in several different situations. I list here several examples from letters Dr. Cutler wrote to Dr. Mahoney:

October 17, 1946:

It is my feel(ing) that part of our success in gaining complete cooperation will depend upon setting up some treatment programs on a formal scale which can be done in the Military Hospital and their prison hospital.

November 5, 1946:

Dr. Tejada thoroughly enjoyed his visit with you at Staten Island and appreciated your attention. He is very much interested in our study and consequently we are counting on real cooperation from the Army.

¹⁰⁷ John Cutler to John Mahoney. (1947, Sept 20). Correspondence. PCSBI HSPI Archives, Record Group 442.

¹⁰⁸ Adriana Petryna, “Clinical Trials Offshored: On Private Sector Science and Public Health” *Biosocieties* 2 (2007): 21-40.

¹⁰⁹ John Cutler to John Mahoney. (1946, Sept 3). Correspondence. PCSBI HSPI Archives, Record Group 442.

January 20, 1947:

Thus far we have found a very ready acceptance of our group both on the part of the prison officials and on the part of the inmates which we think stems from the fact that we now have given them a program of care for venereal disease which they have lacked in the past.

Dr. Cutler, Dr. Mahoney and other scientists involved also understood the study not to be a treatment program, but as an exposure study with accompanying “good will” treatment, in order to gain “cooperation.” Dr. Mahoney suggested not to provide “too comprehensive” of a treatment program, which in essence implied only providing very limited treatment and training. Dr. Cutler agreed with this plan and wrote:

We shall follow you[r] suggestion about not embarking upon an extensive penicillin treatment program. We shall use our supply sparingly so as to have it available at all times for use in demonstration programs and to build good will.¹¹⁰

Evidently, Dr. Cutler did not believe that US PHS should concern themselves with the wellbeing of the human subjects. As noted above, lack of treatment allowed for “cooperation” in the prisons, yet Dr. Cutler wished to avoid bringing attention to the poor prison conditions, even if it involved outright deception:

To increase the number of exposures we shall bring in the source of infection as indicated along with some not infected so as to allay fears and suspicion. In that way, we shall be able to avoid political repercussions which are even now in the air, as papers are complaining of conditions in the prisons now.¹¹¹

US PHS’ deception of the Guatemalan subjects, and the fact that they had not been party to the original contract between US PHS and the Guatemalan Public Health Service, barred the subjects from claiming any rights throughout the experiments. The fact that most officials of the Guatemalan Public Health Service and other institutions involved did not know the true extent of the experiments prevented them from challenging Dr. Cutler’s nullification of patient rights. Although US PHS had gained the “consent” of the Guatemalan authorities in place of the patients, this consent was fully contingent on the nation’s resource-poverty, and the Guatemalan authorities’ misunderstanding of the real conditions of the experiments.

Although the US PHS researchers took immense care to hide the abuses inherent to the Guatemala study, they encountered resistance to their work. This resistance took several forms. Firstly, the patients at times refused to participate. Dr. Cutler’s laboratory notebook depicted one stark instance when, “after scarification, and the first application of the emulsion... (the inmate) fled the room and was not to be found until 2 hours later with the pledget still in place.”¹¹² Other times, subjects protested blood draws and physical examinations.¹¹³ Secondly, other US PHS officials, and eventually Dr. Mahoney, seriously questioned the scientific validity and ethics of

110 John Cutler to John Mahoney. (1946, Nov 30). Correspondence. PCSBI HSPI Archives, Record Group 442.

111 John Cutler to John Mahoney. (1947, January 7). Correspondence. PCSBI HSPI Archives, Record Group 442.

112 Reverby, “*Normal Exposure*,” 17.

113 “*Ethically Impossible*” *STD Research in Guatemala 1946 – 1948*, 57.

the STD study. This particular criticism culminated in the defunding of the study. Nonetheless, Dr. Cutler and his colleagues began to emphasize their role as “government agents” in order to defend their behavior, even when it contradicted the original purpose of the study. Instead of taking these warnings into account, Dr. Cutler internalized them as reason to further shroud the study in secrecy.

In April, 1947 the *New York Times* Science Editor, Waldemar Kaempffert, clearly ignorant of the Guatemala study, lauded exposure studies in rabbits but lamented that similar trials in humans would be “ethically impossible.”¹¹⁴ By June, Dr. Cutler appeared nervous about the nature of his experiment, writing, “as you can imagine we are all holding our breaths, and we are explaining to the patients and other concerned with but a few key exceptions that the treatment is a new one utilizing serum followed by penicillin. This double talk keeps me hopping at times.”¹¹⁵ Dr. Mahoney agreed with the need for deception, writing later that month, “in regard to the amount of gossip which the work in Guatemala has engendered, we are doing our utmost here to restrict our conversations.... We are forwarding all of your reports to Doctor Heller in a way which we hope will prevent their being read by unauthorized persons.”¹¹⁶

“Unauthorized persons” constituted a broad category of individuals, which he defined as medical personnel not directly invested in the study that presented a threat to the study’s continuation. A September 1947 letter written by Dr. Mahoney corroborates this:

I should like to add the admonition that having people in an organization who cannot be treated with complete impartiality is always dangerous.... Mr. Jobbins is in the hospital here. I think he has the usual engineer’s disdain for the medical mind and the medical approach.¹¹⁷

Dr. Arnold also wrote of the seeming hazard of human rights organizations and warned Dr. Cutler, “If some goody organization got wind of the work, they would raise a lot of smoke.... Your first study could be done in a short time and none would be the wiser.”¹¹⁸ Rather than discussing adjusting the study, Dr. Cutler also described threats in the form of the subjects themselves. He described the possibility of losing access to the asylum population:

We are having to order a large quantity of dilantin in order to protect ourselves. They have started treating the epileptics at the asylum with intravenous magnesium sulfate which caused thrombosis of the veins so that we are beginning to be unable to get blood samples. Out of self interest we agreed to furnish dilantin to treat all of the patients in whom we are interested.¹¹⁹

Even with looming opposition, and the fact that the experiments “lacked logical progression” the researchers still enjoyed respect as international experts. Dr. Mahoney mentioned a visit to Geneva, Switzerland to “lay the foundation for international controls of the venereal disease” while, ironically, most of the Guatemala prophylaxis arm of the study involved infecting patients

114 “*Ethically Impossible*” *STD Research in Guatemala 1946 – 1948*, 75.

115 John Cutler to Richard Arnold. (1947, June 5). Correspondence. PCSBI HSPI Archives, Record Group 442.

116 John Mahoney to John Cutler. (1947, June 30). Correspondence. PCSBI HSPI Archives, Record Group 442.

117 John Mahoney to John Cutler. (1947, Sept 8). Correspondence. PCSBI HSPI Archives, Record Group 442.

118 Richard Arnold to John Cutler. (1948, April 19). Correspondence. PCSBI HSPI Archives, Record Group 442.

119 John Cutler to John Mahoney. (1948, Feb 6). Correspondence. PCSBI HSPI Archives, Record Group 442.

rather than testing penicillin prophylaxis.^{120,121}

As noted in the previous section, US PHS exhibited deep institutional racism. While officials may have wished to eschew popular biological race theories, nonetheless, they conflated disease with race categories, thus perpetuating a “social” rather than “scientific” form of racial discrimination. When the Guatemala STD Study began to show serious methodological and ethical problems, Dr. Cutler began to stereotype his subjects and, in many cases, blamed failures on their inherent backwardness. I draw my analysis of racial stereotyping from University of London Professor of Social Psychology Derek Hook’s article “The Racial Stereotype, Colonial Discourse, Fetishism, and Racism.” In his article, he aptly connects stereotyping, a violent, dehumanizing form of representation to political ideology.¹²² A stereotype, he argues, serves as a defense mechanism for persons in positions of immense political and economic power in a political economy in that it allows individuals to hold contradictory principles, such as democracy and dependency, or good will and exploitation. I apply his notion of stereotyping to the political economy I have described in the last section.

Hook’s notion of a colonial stereotype fits well into the political economic structure of Guatemala and the United States in the Cold War era. He states that a colonial environment entails “extreme asymmetries of power (that) are played out here, where radical imbalances of privilege, affluence, and possession separate marginal from dominant groups.”¹²³ Undoubtedly, this was the case in Guatemala.

US corporations owned the overwhelming majority of Guatemalan resources and “Indians” faced a life expectancy of approximately 40 years. Although Dr. Cutler and his colleagues repeatedly claimed to be providing “good will” treatment, they exploited their subjects and deceived their Guatemalan counterparts even more frequently. Stereotypes, like political ideology, are based on “fantasy structure” that is manipulated to protect a narcissistic subjectivity.¹²⁴ Hook has argued that stereotypes function to protect the “‘originary’ or pure racial identity” of the subject. Dr. Cutler and his partners effectively reasserted their status as “natural citizens” entitled to the benefits of scientific research. In the last section, I described the rights Dr. Cutler asserted for himself and his scientist colleagues as “government agents,” such as living expense stipends, state-of-the-art equipment and scholarly awards. The subjects, who had already become disenfranchised in a powerful political economy, became once again exploited through coerced participation and transformed into “racial citizens,” who whites did not believe possessed the same set of rights as “natural citizens.” Ironically, this very role confirmed a pre-existing stereotype that US academics largely held of Guatemalan “Indians” as a group that lacked access to public goods, such as healthcare; economic independence; and other forms of infrastructure.¹²⁵

These stereotypes served as a stand-in for real conditions and created a racist belief structure that overrode moral contradictions. Importantly, it also provided reasoning that excluded racialized subjects from the natural right of public medical services. Stereotypes are an example of what is called a “fetish” in psychoanalytic theory. Fetishes work as defense mechanisms following a particularly traumatic event when the subject realizes that other individuals do not

120 John Mahoney to John Cutler. (1948, Feb 2). Correspondence. PCSBI HSPI Archives, Record Group 442.

121 “*Ethically Impossible*” *STD Research in Guatemala 1946 – 1948*, 42.

122 Derek Hook, “The Racial Stereotype, Colonial Discourse, Fetishism, and Racism,” *Psychoanalytic Review* 92.5 (2006): 701-724.

123 Hook, “The Racial Stereotype, Colonial Discourse, Fetishism, and Racism,” 704.

124 Hook, “The Racial Stereotype, Colonial Discourse, Fetishism, and Racism,” 720.

125 Smith, “Anthropology Discovers the Maya.”

possess the same “element of subjectivity...that has been socially valorized and loaded with narcissism—an element of subjectivity that functions as a vehicle of pleasure, identity and self-investment alike.”¹²⁶ The realization that they might be “castrated” of this subjective element is “a threatening, or even *persecutory*, reality.”¹²⁷ To deal with this dilemma, a fetish must replace this “castrated” element, and stereotypes work quite well at this task. When Dr. Cutler conducted the experiments, he found himself in an extremely elevated social position, as described in the first part of this section. Nonetheless, he and his colleagues could not undertake the study without active deception and falsifying data. To protect his identity as a groundbreaking scientist, Dr. Cutler blamed much experimental failure on the subjects’ social backwardness—specifically on their ignorance of medicine. Ironically, this very ignorance was manufactured. In order to gain “consent” the researchers claimed the experiments were in fact treatment. Although subjects may have resisted out of suspicion, the researchers attributed this to a fantasized stereotype of a subject, who inherently lacked the intelligence to understand.

For example, Dr. Cutler wrote to Dr. Mahoney in January 1947, “It is very difficult to do any medical work with the Indians as they are very suspicious of physicians.”¹²⁸ This contradicted the reality that he falsely promised treatment in order to gain the cooperation of the “Indians.” In another letter, he attributed an inability to successfully infect subjects to their own characteristics. He wrote:

Of the last study, of 24 single exposures to three sources of infection only 1 infect resulted...in any event it would seem the natural exposure with these men is rather low. Perhaps it is that they are like rabbits. In the group given two or more chances, though, the second try in the evening they take a good deal longer than two to four minutes.¹²⁹

In a report, Cutler would attribute duration of “coitus” to the “culture” and “socio-economic” group of the subjects.¹³⁰ Dr. Arnold also noted Dr. Mahoney’s strong distaste for the subjects, saying, “(Dr. Mahoney) does not think much of the natives.”¹³¹ Further exhibiting a belief that subjects were inferior to himself and his partners, he described Guatemalan participants in mechanical terms. Throughout the experiments, Dr. Cutler called the commercial sex workers “sources of infection.” He suggested, “it would be well to select subject that have a long prepuce so that the mucous membranes are moist.”¹³² Through a dehumanizing language such as this, US PHS doctors created a circular logic that the subjects were already “sources of infection,” or at least “rabbit”-like, and, therefore, did not require treatment—despite the fact that the scientists’ deceptive and coercive practices produced the subjects’ initial infection. This very logic made the study altogether useless.

Importantly, Dr. Cutler believed that the study could produce fruitful information. The burgeoning popularity of similar experiments, and institutional norm that “good men” would make moral choices, furthered this belief. On the contrary, US PHS and other funders were not willing to invest the resources to make an equitable offer to study participants, and on a greater level, to the public health infrastructure of Guatemala. Instead of choosing to forgo further

126 Hook, “The Racial Stereotype, Colonial Discourse, Fetishism, and Racism,” 713.

127 Ibid.

128 John Cutler to John Mahoney. (1947, January 2). Correspondence. PCSBI HSPI Archives, Record Group 442,

129 John Cutler to Richard Arnold. (1947, June 5). Correspondence. PCSBI HSPI Archives, Record Group 442,

130 “*Ethically Impossible*” *STD Research in Guatemala 1946 – 1948*, 73.

131 Richard Arnold to John Cutler (1947, April 10). Correspondence. PCSBI HSPI Archives, Record Group 442,

132 Richard Arnold to John Cutler. (1947, July 21). Correspondence. PCSBI HSPI Archives, Record Group 442,

study, he and his partners resorted to deception and invasive infection techniques in attempts to produce expected results. In order to bridge the contradiction between medical professionalism and exploitation, US researchers created a dehumanized, expendable, and fantasized image of the subjects. By viewing subjects as the sum of body parts, they found fewer moral qualms in treating subjects inhumanely. Although research regulations have since changed and Institutional Review Boards (IRBs) and bioethical standards have become the norm, the commodification and dehumanization of study participants continues to be a serious problem.

V. The Landscape of Modern Human Subjects Research

Though 60 years have passed since Dr. Cutler and his team left Guatemala, the conditions that facilitated their exploitative research—for instance, resource poverty and social inequities—have proliferated. Human subjects research transcends borders and ethical boundaries with increasing speed. Therefore, bringing the Guatemala STD study into academic conversation is critical for evaluating modern public policy. The Health and Human Services (HHS) Inspector General stated that in 2008 that the number of overseas trials for US-market bound pharmaceuticals had increased 2000% since 1990, from 271 to 6,485. Meanwhile, efforts to expand oversight are minute in comparison; the HHS also found that year that less than 1% of these sites received inspection.¹³³

After the Guatemala study came to light, survivors and their heirs filed a class action lawsuit against the current PHS and Pan-American Health Organization (PAHO) office holders, successors to Dr. Cutler, and other responsible personnel.¹³⁴ Senior Policy and Research Analyst at the Presidential Commission for the Study of Bioethics, Elizabeth R. Pike notes that federally and privately funded research historically has provided no recourse for injured overseas patients. Until recently, torts litigation was the sole means of compensation for the cost of injury incurred. The recent dismissal and failed appeals of the Guatemalan victims' lawsuit signals a new era of U.S. policy in which America no longer provides viable remediation for overseas participants at all.¹³⁵

Anthropology has long focused on the nature of health in the context of pharmaceutical innovation and devastating illness. In the 1990s anthropologists Paul Farmer and Nancy Scheper-Hughes made the concept of structural violence (a social structuring in which the lowest socioeconomic classes are systematically denied access to basic goods and necessities), highly visible in the academic community.^{136, 137} More recently, Petryna has added to a multidisciplinary debate surrounding human subjects research and protections. Although the 2010 Patient Protection and Affordable Care Act, passed by the Obama Administration, calls for “quality outcome” in human subject trials, she asserts that its meaning remains nebulous.¹³⁸ While she focuses on patients' individual pathways to recovery and their “sick roles,” such a perspective values singular experiences above collective ones.

133 Kathlyn Stone, “NerveCenter: October 2012.” *Annals of Neurology* 72.4, A6-A7. doi: 10.1002/ana.23750.

134 Class Action Complaint for Injunctive Relief and Damages, Garcia v. Sebelius. No. 1:11-cv- 00527-RBW D.D.C., 2011.

135 Elizabeth Pike, “In Need of Remedy: US Policy for Compensating Injured Research Participants.” *Journal of Medical Ethics* 40.3 (2013): 182-5. doi:10.1136/medethics-2012-100771,

136 Scheper-Hughes, Nancy. *Death without Weeping* (1992) Berkeley: University of California Press.

137 Paul Farmer, “On Suffering and Structural Violence: A View from Below.” *Daedalus* 125, no. 1 (1996): 261-83. <http://www.jstor.org/stable/20027362>

138 Adriana Petryna, “The Right of Recovery.” *Current Anthropology* 54.S7 (2013): S67-76. doi: 10.1086/670720.

Petryna's viewpoint also risks bypassing the macro social structures that shape individual action. Therefore, in order to truly evaluate the role of recovery in clinical trials, scholars and policymakers must once again scrutinize the political and economic inequalities surrounding them. The Guatemala case is instructive because it exemplifies the impunity of researchers and funding bodies in the case of malpractice, and the asymmetrical costs of injury and illness. The United States recognized its wrongdoing with immense clarity after the study's discovery, yet most of its subsequent actions serve only symbolic rather than corrective purposes.

For example, the day after the Center for Disease Control (CDC) issued a preliminary summary of Dr. Cutler's documents, President Obama publicly expressed regret for the United States' violations against the citizens of Guatemala.¹³⁹ Nonetheless, the United States has claimed sovereign immunity against any claims of the Guatemalan victims and has not made efforts towards direct compensation. However, the Presidential Commission at the same time strongly recommended remediation and exercising a wider range of ethics. These recommendations and apologies may simply be symbolic—that is, they serve to reconcile the relationship between state or Multi-national Corporation and disenfranchised citizens. However, they certainly do not accept direct responsibility.¹⁴⁰

In this section, I argue that political and economic incentives more than bioethical principles determine the nature of human subjects research. Three major factors support this conclusion. First, by calling upon on the individual researcher or institution to practice sound ethics, policymakers and bioethicists risk ignoring the macro structures that define research ethics. As I showed in the first section, individual researchers are situated in the (racialized) political economy, which shapes vulnerability. Second, the U.S. compensatory system has historically discouraged liability rather than provided remedy, a trend that reached a pinnacle with the Guatemala lawsuit. As criminologist Kitty Calavita argues, “law” resists definition and instead is a complex reflection of political and economic realities and social normativity. Nonetheless, because law hinges on ideology it obfuscates its social construction and appears natural.¹⁴¹ Third, attempts to incorporate moral schemas into compensation policy have failed because they are based on inconsistent, or even contradictory, principles. The social landscape that shapes a participant's experience is extremely diverse across populations and especially nations. A more pragmatic stance, based on structural equality and an understanding of social conditions, ultimately protects participants and ensures the sustainable progress of the research enterprise.

Even with the general acceptance of bioethics, they do not incorporate the majority of factors that make some human subjects more susceptible to preventable harm. In a Hastings Center report, Charlene Galarneau noted that the presidential commission reflected the PHS's own prejudices in their findings. For example, it excluded the female sex workers when it listed vulnerable targets only as “prisoners, conscripted soldiers, institutionalized psychiatric patients and children.” They also did not list days in which Dr. Cutler infected the sex workers as “experiment days.” Finally, the commission failed to include rape as a violation resulting from the study. As Galarneau notes, “simply put, unconsented intercourse is rape.... To the extent that consent was not obtained, the research amounted to dual state-sanctioned rape of both men

139 “Ethically Impossible”: *STD Research in Guatemala from 1946-1948*, 208.

140 Aultman, J. M. “Abuses and Apologies: Irresponsible Conduct of Human Subjects Research in Latin America.” *The Journal of Law, Medicine & Ethics*. (2013) 41: 353–368. doi: 10.1111/jlme.12025.

141 Kitty Calavita, *Invitation to Law & Society: An Introduction to the Study of Real Law*. Chicago: University of Chicago Press, 2010.

and women.”¹⁴² Even bioethicists fall victim to social prejudice, which can be detrimental to the development of sound subject protections.

With bioethical principles in place, overseas counterparts find it exceedingly difficult to implement them. For example, Julie M. Aultman, Associate Professor of Family and Community Medicine at Northeastern Ohio Medical University, wrote that Latin American researchers do not receive adequate bioethical training and oftentimes must choose from varying international codes that give different weight to various principles, such as informed consent. Although they prize bioethics principles, this situation frequently evolves into “ethical code shopping,” for which there is little oversight.¹⁴³ As Galarneau and bioethicists Kayte Spector-Bagdady and Paul A. Lombardo have noted, the Commission and media reports placed blame explicitly on the Guatemala researchers, at the expense of calling for institutional responsibility.^{144, 145} This view bypasses an essential factor in the practice of experimental bioethics. After WWII, federally funded research experienced a boom, especially in the area of military medicine. Congress created a special appropriation of \$800,000 for the production of antibiotics, and grant applications increased from \$18,000,000 in 1941 to \$115,000,000 in 1946.

With this growth, however, research bodies became more autonomous. For example, the Guatemala Study section was part of the newly implemented peer review system, meaning that bioethical evaluation relied upon a small, closely related group. Dr. Cassius Van Slyke, Chief of the then newly-created Division of Research Grants in 1946, lauded “scientific freedom” and argued that sound bioethics would result from “(freedom of scientists to) follow their ideas... and selection of good men and good ideas—and rejection of the inferior.”¹⁴⁶ Although it has experienced immense revisions, they note “peer review still forms the basis of the NIH’s dual review process.”¹⁴⁷ Therefore, not enough institutional oversight exists even today to prevent injury or unethical behavior. Even today, social inequities thrive in the funding arm of the biomedical research enterprise. The journal, *Science*, recently exposed that African American researchers were 13.2% less likely than whites to receive NIH awards for their proposals.¹⁴⁸ Even governmental funding bodies, which are supposed to objectively promote science, exhibit racial preference.

Another problematic aspect of modern research lies in participants’ common misunderstanding of experimental design. As Pike has shown, many subjects equate participation in a clinical trial to medical treatment. In a trial, even acting physicians must remain loyal to protocol in order to “creat(e) generalizable knowledge that can be used to benefit *future* patients.” This contradicts both the objective of medicine to treat a patient in the most effective manner possible and the implicit hope of many patients to recover.¹⁴⁹ Although all U.S.-sponsored trials must include “informed consent,” Mandava et. al. point out that there is a powerful difference between the knowledge of versus the appreciation of facts.¹⁵⁰ They wrote that even with informed

142 Charlene Galarneau, “Ever Vigilant in Ethically Impossible: Structural Injustice and Responsibility in PHS Research in Guatemala.” *The Hastings Center Report* 43.3 (2013): 36-45. doi: 10.1002/hast.161.

143 Aultman, “Abuses and Apologies”

144 Galarneau, “Ever Vigilant,” 37

145 Spector-Bagdady, Lombardo, “Something of an Adventure.”

146 Spector-Bagdady, Lombardo, “Something of an Adventure,” 701-2

147 Spector-Bagdady, Lombardo, “Something of an Adventure,” 706

148 D.M. Ginther, D. K., W. T. Schaffer, J. Schnell, B. Masimore, F. Liu, L. L. Haak, and R. Kington. “Race, Ethnicity, and NIH Research Awards.” *Science* 333.6045 (2011): 1015-019. doi: 10.1126/science.1196783.

149 Elizabeth Pike, “Recovering from Research: A No-Fault Proposal to Compensate Injured Research Participants.” *American Journal of Law and Medicine* 38.1 (2012): 7-62. <http://ssrn.com/abstract=1923817>.

150 Amulya Mandava, Christine Pace, Benjamin Campbell, Ezekiel Emanuel, Christine Grady, “The Quality of

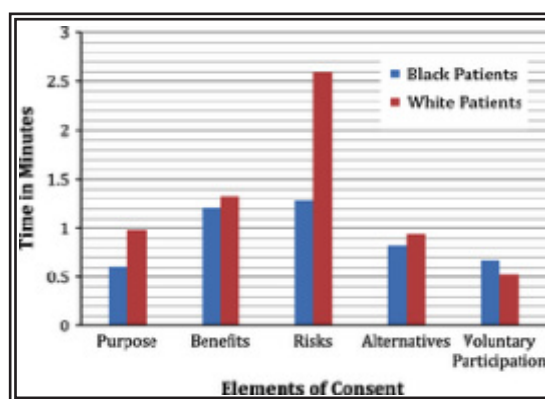
consent, “individuals across studies tended to know that they were involved in research and often responded correctly to questions about the nature and purpose of research, yet participants everywhere had difficulty understanding information about trial design, randomization and placebo control.”¹⁵¹

Undoubtedly, socioeconomic inequities shape the ability of clinical trial participants to understand the nature of research and their rights as subjects. Mandava and her colleagues’ analysis suggested that overseas participants experience higher rates of coercion to participate in trials. In studies surveying informed consent, international participants frequently indicated that they recognized their right to refuse participation, but felt they could not because their hospital would not allow it or because they could not access treatment outside of a clinical trial.¹⁵² Race and social inequities also influenced participants’ ability to consent in the United States: in a U.S. pediatric oncology trial, only 60% of minority race, non-English speaking parents understood the right to withdraw their child from the study at any time, as opposed to 90% their majority race, English speaking counterparts. Although informed consent requires disclosing known possibility of negative effects, there is no measurement of *understanding*, especially when ethical requirements from U.S.-based IRBs must be interpreted locally overseas. Researchers have argued that this means international participants likely do not know what truly occurs in clinical trials.¹⁵³

At a clinical level, studies have also shown that doctors systematically display implicit (unconscious) racial bias. A recent study found that oncologists spent significantly less time with black patients than white patients. Researchers concluded from topic-related word counts that doctors generally explained in greater depth the purpose of the trial, benefits, alternatives, and particularly risks to white patients. Only voluntary participation received more attention in encounters with black patients.¹⁵⁴ The graph below summarizes these findings.

FIGURE 1

TIME ON SUBTOPICS OF ELEMENTS OF CONSENT



Informed Consent: Mapping the Landscape. A Review of Empirical Data from Developing and Developed Countries.” *Journal of Medical Ethics* 38.6 (2012): 356-65. doi: 10.1136/medethics-2011-100178

151 Mandava, et al., “The Quality of Informed Consent,” 361.

152 Mandava, et al., “The Quality of Informed Consent,” 360-1.

153 Leslie London, Ashraf Kagee, Keymanthri Moodley, et al. “Ethics, Human Rights and HIV Vaccine Trials in Low-income Settings.” *Journal of Medical Ethics* 38.5 (2012): 286-93. doi: 10.1136/medethics-2011-100227.

154 Susan Eggly, Ellen Barton, Andrew Winckles, Louis A. Penner, and Terrance L. Albrecht. “A Disparity of Words: Racial Differences in Oncologist-patient Communication about Clinical Trials.” *Health Expectations* (2013). 6. doi: 10.1111/hex.12108.

This suggests that racial bias is correlated, if not the cause of, diminished understanding and increased vulnerability in clinical trials. A separate study, using implicit-bias measures, indicated that U.S.-trained doctors showed a significant, and subconscious, preference for white patients and were more likely to attribute “good qualities,” such as being “cooperative,” to white patients. This was true for every ethnic group, except African American doctors, who tended to show no racial preference.¹⁵⁵ Another analysis revealed a more startling result: even with high socioeconomic status and equitable access to private insurance, top-tier healthcare plans, and the best selection of hospitals, black patients still receive lower quality of healthcare than white patients. Although the authors of this study focused on institutional racism within the U.S. healthcare system (that is, “a set of organizational that create unequal outcomes based between groups on the basis of their race or ethnicity”) as the primary cause of domestic health disparities, this also has a similar disproportioning and harmful effect in the production of medical knowledge through clinical trials.¹⁵⁶

Aultman notes that shifting norms in publication standards may prevent the publication of unethical research but do not retroactively protect subjects that have already been harmed.¹⁵⁷ As Pike also states, the Guatemalan victims took the only course of action available to victims of clinical malpractice: torts litigation. Despite this, a judge dismissed the case, explaining, “this court is powerless to provide any redress to the plaintiffs.”¹⁵⁸ This powerlessness derives from the legal requirements of the tort system. As legal scholar Leslie Meltzer Henry writes,

The tort system requires injured research subjects to prove not only that the research study *caused* their injury, but that *fault* for the injury lies with the research team, pharmaceutical company, or institutional sponsor.¹⁵⁹

In a clinical experiment, this is difficult to prove, because the essential purpose of an experiment is to elucidate what is unknown. Therefore, fault, in the most literal sense, cannot be proven in torts litigation of clinical trials.¹⁶⁰

For transnational cases, overseas plaintiffs have a particularly difficult case if they were injured in federally funded experiments. In most cases, the United States may substitute itself in place of the government department. This legal action gives the United States sovereign immunity, which means that the United States government cannot be sued by a foreign entity if the crime occurred on foreign soil.¹⁶¹ Ultimately, the Guatemalan plaintiffs requested that the court carve out a limited waiver of immunity for the United States, which the court rejected.

155 Janice A. Sabin, Brian A. Nosek, Anthony G. Greenwald, and Frederick P. Rivara. “Physicians’ Implicit And Explicit Attitudes About Race By MD Race, Ethnicity, And Gender.” *Journal of Health Care for the Poor and Underserved* 20.3 (2009): 896-913. doi: 10.1353/hpu.0.0185.

156 Michelle Van Ryn, Diana J. Burgess, John F. Dovidio, Sean M. Phelan, Somnath Saha, Jennifer Malat, Joan M. Griffin, Steven S. Fu, and Sylvia Perry, “The Impact Of Racism On Clinician Cognition, Behavior, And Clinical Decision Making.” *Du Bois Review: Social Science Research on Race* 8.01 (2011): 199-218. doi: <http://dx.doi.org/10.1017/S1742058X11000191>

157 Aultman, “Abuses and Apologies,” 366.

158 Manuel Guidel Garcia, Et Al., v. Kathleen Sebelius, Secretary of Health and Human Services, Et Al. 1: 11-cv-00527 United States District Court for the District of Columbia. 13 June, 2012.

159 Leslie Meltzer Henry, “Moral Gridlock: Conceptual Barriers to No-Fault Compensation for Injured Research Subjects.” *The Journal of Law, Medicine & Ethics* (2013) 41: 411–423. doi: 10.1111/jlme.12052

160 Ibid.

161 Sullivan, Kyle T. “The” Bizarre Result”: The Alien Tort Statute, The Westfall Act, and the Problem of Wartime Detentions in *Ali v. Rumsfeld*.” *BCJL & Soc. Just.* 32 (2012): 59-421.

Rather, Walton replied, “(the plaintiffs’) pleas are more appropriately directed to the political branches of our government, who, *if they choose*, have the ability to grant some modicum of relief to those affected by the Guatemala Study. And it appears that these remedial efforts may be forthcoming, based on the United States’ representation to the Court that it ‘is committed to taking the appropriate steps.’”¹⁶² To date, the United States has neither offered compensation to the victims directly nor announced plans to create a congressional panel to consider the matter.

Interestingly, Walton said that the law obligated the court to dismiss Guatemala case, even if it dismissal might contradict “what might be good policy.”¹⁶³ While U.S. common law dictates that judgments should hinge on previous rulings, Calavita has cited studies that show that the Supreme Court “was guided by precedent only when it served the decision they preferred for ideological and political reasons.”¹⁶⁴ Therefore, reading the law incorporates subjective valuations, and their inherent biases. This particular case reflects an inherent possibility that researchers’ and their funders’ motivations, even if not always beneficial, may take precedence over human subjects’ health or emotional needs. Furthermore, it also illustrates that practicing responsibility for even the most heinous clinical malpractice is not always legally required.

Legal judgments, particularly in the case of human subjects research, tend to favor wealthy defendants, who have the valuable resources of time, money and highly trained legal personnel. In the Guatemala case, the Court essentially created a no-compensation policy for injured subjects. While the judiciary was only presented with arguments surrounding the study and previous cases brought under the Alien Torts Act, it did not possess the information to decisively form research policy. Federal advisory boards have hotly debated the topic of creating equitable compensation policy for 40 years, yet the case revolved largely around the topic of existing legal jurisdiction.¹⁶⁵ The United States currently does not mandate no-fault compensation for federally funded studies, unlike nearly every developed nation in the world.¹⁶⁶ Therefore, international research participants, and their governments, must bear the medical and psychological costs of injury. For example, Petryna described an instance in which a pharmaceutical company withdrew a drug halfway through a clinical trial in Brazil and then instructed subjects on how to sue their government to pay for it. By doing so, the U.S.-based company avoided the ethical quandary of providing medication to a population who could not afford it, and enjoyed the economic benefit of marketing a state-of-the-art product to the Brazilian government at the rate of \$200,000 per patient, per year.¹⁶⁷

To date, federal advisory boards have disagreed as to what moral principle should inform no-fault compensation infrastructure. As a result, no pilot protocols have been created. Nevertheless, the dilemma described by Petryna occurred because of economy dependency: facing the possibility of no resources for patients with a lethal, rare disease, the medical center director conceded the right of treatment during the trial. Aultman adds, “Latin America is also viewed as El Dorado because in comparison to the U.S., Canada, and many European countries, less of a financial burden exists to conduct research. Financial costs associated with recruitment and compensation of human subjects is significantly lower given the low-income brackets of

162 Ibid Manuel Guidel Garcia, Et Al., v. Kathleen Sebelius, Secretary of Health and Human Services, Et Al. pp. 25 [Emphasis added]

163 Ibid Manuel Guidel Garcia, et al., v. Kathleen Sebelius, Secretary of Health and Human Services, et al. pp. 14.

164 Calavita, “Invitation to Law and Society,” 112.

165 Henry, “Moral Gridlock,” 411-2.

166 Henry, “Moral Gridlock,” 416.

167 Petryna, “The Right of Recovery,” 73.

these developing countries.”¹⁶⁸ For this reason, trial funders stand to benefit—a benefit in which international participants do not share.

Two major issues stem from the absence of compensation policy. First, foreign countries have begun to bar trials that do not include guaranteed remediation. India, for example, requires this by law, and in 2011 threatened to block non-compliant pharmaceutical companies from conducting trials there. In 2008, a last minute decision by NIH to not provide insurance resulted in significant delay, loss of money, and subjects who became too sick to participate.¹⁶⁹ Secondly, Aultman has noted that the disingenuousness of the U.S. response to the Guatemala discovery has only exacerbated distrust of U.S. researchers in Latin America. While an apology may represent a desire to “look forward” and improve future foreign relations, the U.S. response thus far has been minimal.¹⁷⁰ The U.S. has offered \$1,775,000 in aid to fuel new STD related research in Guatemala as compensation for past wrongdoings. Bioethicists have argued this is not enough, especially given that the extent of related injuries has not been investigated.¹⁷¹ While most panels disagree as to whether “society” or research funders should bear the cost of compensation, the lack of defined policy grows increasingly deleterious.¹⁷²

Since the Guatemala Study, private pharmaceutical companies have also become an industry leader in clinical trials. One ostensible reason for conducting research in underdeveloped nations is cost.¹⁷³ Scholars Donald Light and Rebecca Warburton have explained the economic benefit of the current research structure:

For decades, the very high costs of R&D have been the industry’s rationale for high prices in the developed world, and the basis for claims that companies cannot afford research into primarily developing-world diseases, where high prices cannot be charged.¹⁷⁴

Nonetheless the costs of R&D have grown considerably over time. They conclude that publicly funding “clinically superior medicines” is not incentivized. The result: 85% of drugs show no significant improvement over previous medicines.¹⁷⁵

Based Light’s and Warburton’s findings, more transparency with the cost estimates of new pharmaceutical research and development is needed. In the past, lack of oversight made research subjects in federally funded trials vulnerable to mistreatment. With enormous tax breaks given to large pharmaceutical corporations and the growth of privately funded overseas clinical trials, multi-national corporations may now become the primary source of potentially unethical research.

Recent studies indicate that the medical profession has sought to reduce implicit racism and sexism through “cultural competency” training. Efforts to teach doctors, and by extension, clinical researchers, how effective communication through social boundaries have at times failed.

168 Aultman, “Abuses and Apologies,” 360.

169 Pike, “Recovering from Research,” 3.

170 Aultman, “Abuses and Apologies,” 360.

171 Glenn I. Cohen, and Holly Fernandez Lynch. “Guatemalans Used in Experiments Deserve Compensation.” *New York Times*, July 4, 2012. Accessed October 1, 2012. http://www.nytimes.com/2012/07/05/opinion/guatemalans-used-in-experiments-deserve-compensation.html?_r=0.

172 Henry, “Moral Gridlock.”

173 Henry, “Moral Gridlock.”

174 Light, Donald, and Rebecca Warburton. “Demythologizing the High Costs of Pharmaceutical Research.” *BioSocieties* 6.1 (2011): 34-50. doi:10.1057/biosoc.2010.40

175 Light, Warburton, “Demythologizing the high costs of pharmaceutical research,” 47-48.

Attempts to translate medical knowledge into “culturally-appropriate” terms have occasionally collapsed into the systematic stereotyping of entire ethnic and gender groups. This result only threatens to exacerbate implicit bias in the medical profession and create worse health outcomes for minority race or otherwise “vulnerable” patient-subjects.

Anthropologist Angela Jenks has indicated that an “open-mindedness” approach pioneered by psychiatrist and anthropologist Arthur Kleinman, may be effective for eliminating social bias in clinic settings. Such a model is process-oriented for understanding a patient’s beliefs, rather than relying on a system of stereotypes. Jenks warned, however, not to end the processual model of understanding at the individual, but rather to question larger forms of social violence and to pose inquiries such as, “What is it about life in the United States that has produced such high rates of diabetes for many populations, but not for others?” An understanding of forms of structural violence and stereotypes challenges the myth that groups of people choose poorer health outcomes as a result of “backwards” culture.¹⁷⁶

Michelle van Ryn et al has proposed an integrated model to lessen the impact of institutional racism in medical care. They include racial climate evaluations, monitoring systems for racial disparities in quality of care, equity-specific targeted feedback for individual clinicians, the implementation of work and clinic policy, the promotion of racial diversity in organizational hierarchy, and training programs.¹⁷⁷

Since there are, in fact, many types of subjects, perhaps there should not be a one-size-fits-all protocol for compensation. Pilots should be developed to at least gather data on efficacy and possible benefits. While the US has offered a small amount of aid, it is unclear how the Guatemalan victims stand to benefit. If our government values its standing as an ethical leader in science, then it should make good on a promise to right the “terrible wrong” of the STD study and actualize a compensation plan. When private pharmaceutical companies accept subsidies and tax breaks via public funds, they should also provide “proprietary” data for public scrutiny, since it is de facto jointly-owned. Social, as well as economic, injustice must also be addressed in future human subjects research. Currently, financial incentives for biomedical research are incongruous with both human rights and economic and social equality. Regulatory policy must correct this disparity in order to provide true benefits with more effective medical technology.

VI. Conclusion

Although innumerable advances have been made since the end of the US PHS’s experiments in Guatemala, the aspirations of biomedical research remains the same. Without question, human subject trials provide possible treatment, vaccines, and even definitive cures for devastating illnesses. Through experimentation, researchers can also find an opportunity to delve into what was once the scientific unknown and gather socially beneficial information. However, with greater participation across borders and socioeconomic lines, there is a dissonance between the hope and the reality of clinical trials. As a case study, the Guatemala experiments are instructive in unpacking the current dilemmas that prevent human subjects research from fully reaching the ethical ideals of the Nuremberg Code.

176 Angela C. Jenks, “From “Lists of Traits” to “Open-Mindedness”: Emerging Issues in Cultural Competence Education.” *Culture, Medicine, and Psychiatry* 35.2 (2011): 209-35. doi: 10.1007/s11013-011-9212-4

177 van Ryn, Michelle et al., “The Impact of Racism on Clinical Cognition,” 213.

Social violence, as the last section has illustrated, creates instances of vulnerability in medical encounters. While racism may not be as explicit as in the Guatemala case, implicit bias has a real and detrimental effect on medical care and research. Fortunately for the research enterprise, carefully tailored programs that take into account patient experiences of structural violence facilitate understanding across social groups with significant power differentials, such as that between patients and clinical researchers. Systematic challenges to implicit biases may help to break the “medical mind” that US PHS used to shield their actions against justified questioning. As the second section showed, in a position of greater power and with large incentives, researchers, such as Dr. Cutler, might justify withholding proper treatment or causing undue harm in order to satisfy their unconscious attitudes toward their research subjects.

In order to truly advance past the horrors of the Guatemala study, research regulations must place responsibility and the wellbeing of each subject above industry profit. The 1946 Guatemala STD study and its victims’ subsequent struggles for basic rights exemplified the problems that arise when this does not happen. Truly understanding the asymmetric burden between participant and investigator is a difficult and tedious endeavor. The colonial past and political and economic relations during the cold war left Guatemalan infrastructure weak. A similar situation exists today when pharmaceutical companies enjoy enormous tax breaks, use medical knowledge generated by publically funded research institutions, and contract cheap overseas participants. Formulas created from propriety and privatized data justify using research to create expensive and largely ineffective drugs. Unfortunately, these unverifiable, but largely unquestioned, axioms create public policies that do not encourage the efficient development of important medicines.

Additionally, since there are, many types of subjects, there should not be a one-size-fits-all protocol for compensation. Pilots should be developed to at least gather data on efficacy and possible benefits. While the US has offered a small amount of aid, it is unclear how the Guatemalan victims stand to benefit. If our government values its standing as an ethical leader in science, then it should make good on a promise to right the “terrible wrong” of the STD study and actualize a compensation plan as well as work to eliminate social bias in clinical settings. Cultural-competency programs have illustrated a desire to eradicate racial inequities in medicine, but initiatives must take a more vigorous and critical approach to debasing racism, and other forms of social violence. In cases of overseas trials, integrated “cultural competency” programs between US- and internationally-based researchers and health workers may create more equitable research environments and reveal areas of problematic bioethics that are particular to the local research site.

What scientists, institutions, and bioethicists may learn today, most importantly, is not to repeat the mistakes made by Dr. Cutler and US PHS. Unraveling how an unethical or exploitative study took place is a rigorous task that demands a multi-level analysis, from the historical, to the individual, and to the political and the economic. However, by doing so, future trials may bridge the dissonance between the patient subject’s hope for recovery and biomedical innovation. By heeding the warning not to demonize individuals or view unethical research as aberrant cases, scholars may understand the conditions that especially place minority, poor, and international subjects in harm’s way. While hoping for a research enterprise based on pure altruism may be naïve, with the proper thoughtfulness and resources science’s transformation into a more equitable and sustainable endeavor is possible.

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