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Experimentation with Human Beings: Light or Only Shadows?

Alexander M. Capron, LL.B.*

We have failed Jay Katz. Like the man looking under the lamp-post for his keys—not because that was where he was standing when he dropped them but because the light is better there—we have labored too long in the light and poked too infrequently into the shadows where the often painful truth is to be found. We have treated as exact the imprecise process of balancing research risks and benefits. We have exalted autonomy and made a sacrament of consent forms—even those that run to hellish lengths, littered with jargon—and forgotten the myriad constraints on subjects' choices. We have realized that, however well-intentioned researchers may be, their individual judgment of when and how to conduct research is usually very partial, in both senses of that word. Yet, from that realization we have moved to the contradictory conclusion that by instituting prior review by Institutional Review Boards (IRBs), we have solved the ethical problems involved in deciding when and how to conduct research.

Above all, we have developed elaborate rules and processes to normalize human experimentation, to treat it as an ordinary activity. We have thus avoided looking clearly at the moral dilemma that lies at the heart of every research encounter: “We are asking you to do this not for yourself but for others, even though we know that the role of human subject entails real and sometimes unforeseen risks including death.” Such a statement is significant not because—or not solely because—it clearly describes the potential harm. I agree with Jay that this is not the critical issue,¹ though it is hardly one that we can ignore, in

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1. Jay Katz has acknowledged the point often made by investigators that subjects may be at no greater risk than patients in ordinary treatment, but he suggested that it may be beside the point: “I want to distract attention from the prevalent and extensive debate on the permissible limits of physical harm to subjects and, instead, draw attention to the neglected and scant debate on the justifications for encroachments on subjects' rights to decisional authority in the conduct of research.” Jay Katz, *Human Experimentation and Human Rights*, 38 ST. LOUIS U. L.J. 7, 10 (1993) (citations omitted).

light both of the historical abuses of research subjects² and also of what has occurred much more recently at such renowned medical institutions as the University of Pennsylvania³ and Johns Hopkins.⁴ Rather, its central significance lies in its frank description of the aims of research and, hence, of the potential divergence of interest between the prospective subject and the person offering to enroll him or her in the research project.

I think Jay rightly expected that this sort of frank conversation was achievable when he began developing the modern scholarly analysis of research with human beings some forty years ago. Of course, he can take pleasure in seeing the things that have been accomplished because of the light he shed on ethical problems in the conduct of research. Doubtless, many harms have been prevented by the creation of the process of prior review of research projects and, on a more optimistic note, by investigators' "self-scrutiny" as they prepare to explain (or, one might say, defend) their protocol to a research ethics committee or to engage in a dialogue with prospective subjects whose informed consent they hope to obtain.⁵ The process may be imperfect, but compared to what took place

2. Such infamous research abuses as the Nazi concentration camp experiments and the Japanese Unit 731 during World War II and the U.S. government's Tuskegee syphilis study, conducted between 1932 and 1972, are chronicled, along with more recent cases, in JONATHAN D. MORENO, *UNDUE RISK: SECRET STATE EXPERIMENTS ON HUMANS* (2000).

3. In September 1999, Jesse Gelsinger, an eighteen-year-old young man with a mild form of an inherited immune deficiency who had volunteered for a study aimed at eventually curing his type of illness, died in a gene transfer experiment at the University of Pennsylvania's Institute of Human Gene Therapy. The FDA not only shut down the trial in which Gelsinger had participated and all gene transfer trials at that university but also suspended work at other leading medical institutions, as heightened scrutiny revealed at least six other unreported deaths attributable to genetic transfer research. Larry Thompson, *Human Gene Therapy: Harsh Lessons, High Hopes*, *FDA CONSUMER*, Sept.–Oct. 2000, at 19, 20–24, available at http://www.fda.gov/fdac/features/2000/500_gene.html.

4. On May 4, 2001, Ellen Roche, a healthy twenty-four-year-old woman who had volunteered for a study of asthma at Johns Hopkins Medical School where she worked as a lab technician, inhaled hexamethonium through a nebulizer (which was intended to challenge her airway). Shortly thereafter, she developed dyspnea and was hospitalized. Less than a month later, on June 2, 2001, she died of respiratory and renal failure. On July 19, 2001, the Office for Human Research Protections of the U.S. Department of Health and Human Services temporarily suspended all federally funded research at Johns Hopkins Medical Institutions. Mimi Zucker, *Johns Hopkins Cited After Research Death*, *RESPIRATORY REVIEWS*, Sept. 2001, at 1.

5. See Paul Freund, *Legal Frameworks for Human Experimentation*, 98 *DÆDALUS* 315, 323 (1969) ("To analyze an experiment in terms of risks and benefits . . . by way of presentation for consent is a salutary procedure for self-scrutiny by the investigator—like the preparation of a registration statement by a corporation issuing securities."), cited in JAY KATZ & ALEXANDER MORGAN CAPRON, *CATASTROPHIC DISEASES: WHO DECIDES WHAT?* 88 (1975).

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in the 1950s and 1960s, the required oversight has effected the abandonment or salutary modification of many projects that should not have been undertaken. And as poor as many consent documents may still be, they would probably be worse were it not for the attention of review committees and commentators.

Moreover, the processes and rules that originated in the United States have now spread around the world,⁶ albeit not quite as quickly as the practice of Western research institutions and pharmaceutical companies performing clinical trials in the countries of the South over the past decade. But that rising tide—or, more accurately, tidal wave—is not necessarily a bad thing. To narrow the “10/90 gap”—the fact that less than ten percent of global health investment is dedicated to problems that account for ninety percent of global disease⁷—investigators must discover and test preventive and curative interventions for the diseases that place a crushing burden on developing societies and that send a terribly high proportion of people in those societies to early graves. Yet the value of this research to more people in more parts of the world only makes it all the more important to be clear about what is at stake. We need to take another look at the heart of the matter before we simply export to Cambodia, Cameroon, and Costa Rica the rules and procedures developed over the past thirty years in the North. To begin to take that deeper look, I suggest we return to the point where Jay began his examination of human experimentation forty years ago.

I. THE BEGINNING

Jay has recounted how, around 1960, he first encountered the Nuremberg

6. Council Directive 2001/20, Directive on the Approximation of the Laws, Regulations and Administrative Provisions of the Member States Relating to the Implementation of Good Clinical Practice in the Context of Clinical Trials on Medicinal Products for Human Use, 2001 O.J. (L 121) 34 (EC), *available at* <http://europa.eu.int/eur-lex/lex/JOYear.do?year=2001> (follow “May” hyperlink; then follow “L121” hyperlink; then follow “34” hyperlink); CANADIAN INSTS. OF HEALTH RESEARCH ET AL., TRI-COUNCIL POLICY STATEMENT: ETHICAL CONDUCT FOR RESEARCH INVOLVING HUMANS (1998) (amended 2000, 2002, and 2005), *available at* <http://www.pre.ethics.gc.ca/english/policystatement/policystatement.cfm>; COUNCIL OF EUR., ADDITIONAL PROTOCOL TO THE CONVENTION ON HUMAN RIGHTS AND BIOMEDICINE CONCERNING BIOMEDICAL RESEARCH (2004); COUNCIL FOR INT’L ORGS. OF MED. SCIS., INTERNATIONAL ETHICAL GUIDELINES FOR BIOMEDICAL RESEARCH INVOLVING HUMAN SUBJECTS (2002); EUROPEAN AGENCY FOR THE EVALUATION OF MEDICINAL PRODUCTS, ICH TOPIC E 6: GUIDELINE FOR GOOD CLINICAL PRACTICE (2002), *available at* <http://www.emea.eu.int/pdfs/human/ich/013595en.pdf>; INT’L CONFERENCE ON HARMONISATION OF TECHNICAL REQUIREMENTS FOR REGISTRATION OF PHARMS. FOR HUMAN USE, ICH HARMONISED TRIPARTITE GUIDELINE: GUIDELINE FOR GOOD CLINICAL PRACTICE E6(R1) (1996), *available at* <http://www.ich.org/LOB/media/MEDIA482.pdf>.

7. GLOBAL FORUM FOR HEALTH RESEARCH, THE 10/90 REPORT ON HEALTH RESEARCH 2003-2004, at 35 (2004).

proceedings against the Nazi physicians in the criminal law casebook that was then being prepared by colleagues on the faculty of Yale Law School, which he had recently joined.⁸ What transpired in Nazi Germany has shaped Jay's life not only as a person but as a scholar,⁹ and it is not surprising that as he thought about the sickening "medical experiments" conducted in the concentration camps he determined to pursue the subject directly through a seminar on human experimentation, which led to the production of his seminal casebook.¹⁰ It was in connection with that book that I first encountered the subject of research with human subjects in 1970. After Abe Fortas (for whom I was supposed to clerk) resigned from the Supreme Court, Jay correctly surmised that I might be interested in returning to New Haven from Washington, D.C., for family reasons. Jay asked me to join him to finish the casebook and to collaborate on another project on "catastrophic diseases" (the issues raised by heart and kidney transplantation and haemodialysis).

The first thing I did was read through the existing materials in preparation for both teaching the seminar with Jay and editing and restructuring the book, which we saw as our major project for that year (though it took a little longer). As readers of the casebook know, it does not begin with the so-called "Doctors' Trial" before the tribunal at Nuremberg but with two more contemporary American case studies. The materials are organized according to a sequence—policy formulation, administration, and review of consequences—that owed much to the social scientists on the Yale Law School faculty.¹¹ Yet there was no question that the story of the Nazi doctors was central both to the book and to Jay's examination of the whole subject.

I found myself very comfortable with Jay's orientation to the subject, his aspiration to shine a bright, clear light on the burgeoning phenomenon of human

8. RICHARD C. DONNELLY ET AL., CRIMINAL LAW (1962).

9. Jay Katz, Human Sacrifice and Human Experimentation: Reflections at Nuremberg, Address at the Conference Commemorating the Fiftieth Anniversary of the Nazi Doctors' Trial at Nuremberg Convened by International Physicians for the Prevention of Nuclear War and Physicians for Social Responsibility (Oct. 27, 1996) (transcript available at <http://www.law.yale.edu/outside/html/Publications/pub-katz.htm>).

10. JAY KATZ ET AL., EXPERIMENTATION WITH HUMAN BEINGS: THE AUTHORITY OF THE INVESTIGATOR, SUBJECT, PROFESSIONS, AND STATE IN THE HUMAN EXPERIMENTATION PROCESS (1972).

11. Jay was particularly influenced by the policy-oriented jurisprudence of Harold Lasswell (who famously described politics as "who says what, in which channel, to whom, and with what effect") and Myers McDougal. See, e.g., HAROLD D. LASSWELL & MYERS S. MCDUGAL, JURISPRUDENCE FOR A FREE SOCIETY: STUDIES IN LAW, SCIENCE AND POLICY (1992); Harold D. Lasswell & Myers S. McDougal, *Jurisprudence in Policy-Oriented Perspective*, 19 U. FLA. L. REV. 486 (1967).

subjects research so as to impede any repetition of the atrocities perpetrated by the Nazi doctors and others in the name of medical science. I had not expected to be teaching and conducting research at a law school, but rather to be pursuing civil rights work of the sort I had undertaken—sometimes as a defendant—in Mississippi while in law school and before (which had, indeed, led me to law school in the first place). The things that motivated me—justice and fair treatment, equality and non-discrimination, autonomy—transferred easily from a civil rights context to the subject of human experimentation; indeed, with the revelations about the Tuskegee study,¹² the fields of civil rights and human subjects research clearly converged.

Yet I soon came to see that Jay's concern for subjects' rights was only one facet of what he thought was important here. The other aspect—and its neglect—is the heart of what this paper discusses. I begin by stating my thesis, and then I go back and connect it to the larger subject of the ethics of research with human beings, by starting again with Nuremberg. Thinking as I have these past months about that period more than thirty years ago when Jay and I were working elbow-to-elbow each day, I have come to the conclusion that part of Jay's message became obscured precisely because he was surrounded by lawyers. We lawyers (and later some of the philosophers who have labored in the vineyards of bioethics and have bottled some of its most notable vintages) have provided a *vocabulary of rights* (and reciprocal duties)—the right of privacy (and the duty of confidentiality), the right of bodily integrity (and the duty to do no harm), and, above all, the right of self-determination (and the duty to obtain informed consent).

Starting with the Doctors' Trial as Jay did, it is easy to look at research through the lens of human rights, since the transcript of that case—like other accounts of what transpired in the camps as well as in experiments both before and after the Nazi era—makes clear the horrible things that can happen when research is carried out with no attention to subjects' rights. Yet the very resonance of the rights language has obscured the other part of Jay's analysis, the one which, in my view, is actually closer to his central scholarly preoccupation, namely, to supply a *vocabulary of relationships* to fill the gaps, the moral silences, at the heart of human experimentation. It is that vocabulary—a language not solely of duties but of hopes and fears, of uncertainties and magical

12. See, e.g., PUB. HEALTH SERV., U.S. DEP'T OF HEALTH, EDUC. & WELFARE, FINAL REPORT OF THE TUSKEGEE SYPHILIS STUDY AD HOC ADVISORY PANEL (1973), available at <http://biotech.law.lsu.edu/cphl/history/reports/tuskegee/tuskegee.htm> [hereinafter TUSKEGEE ADVISORY PANEL REPORT]; Jay Katz, *Reservations About the Panel Report on Charge 1*, in TUSKEGEE ADVISORY PANEL REPORT, *supra*, at 14; J.H. JONES, BAD BLOOD: THE TUSKEGEE SYPHILIS EXPERIMENTS (1993).

thinking—that ties Jay’s work on experimentation to his central focus on the physician-patient relationship.

II. BACK TO THE BEGINNING, ONCE AGAIN

The enormity of the Nazi doctors’ abuse of the concentration camp inmates in their so-called research program is so great that I feel a risk in using it as a starting point; yet, it is the beginning of the story. The risk is that any discussion that tries to draw lessons from it for today impliedly aligns the Nazi crimes with contemporary research practices. This presents a two-fold problem, seeming at once to diminish the suffering and deaths of thousands of people at Buchenwald, Dachau, Natzweiler, and Ravensbrück, and to saddle current investigators with the callous disregard of life exhibited by Karl Brandt and his co-defendants. By noting the risks inherent in this comparison, I hope we will be able to avoid or diminish them in what follows.

Given the importance of the Doctors’ Trial to Jay’s thinking, we need to examine carefully the lessons of Nuremberg. Looking to the eponymous code that for most bioethicists is “Nuremberg,” the lessons appear to be that investigators must not use human beings for research without their free and informed consent, that those human subjects must remain free to withdraw from research despite that consent, and that the risks must be minimal and always proportionate to scientific ends that are themselves reasonably attainable.¹³ This is indeed what has guided, and continues to guide, the development of subsequent declarations, guidelines and regulations. It is not a bad lesson, but it is incomplete in at least two respects.

First, this interpretation treats Nuremberg like a moment in time, the final frame in a film. We need to wind the film back. To understand the meaning of Nuremberg, we must apprehend how those physicians came to be standing in the dock before that tribunal. This is not a tale solely about a group of sadistic monsters but also one about science gone wrong. The Nazi experiments were not simply a perversion of medical science; they were also an extension of that science. Long before the Nazis came to power, the arrogance of modern science led some physicians in the Nineteenth Century intentionally to infect healthy, but obviously uninformed and powerless, men, women, and even children with venereal diseases and to administer noxious and sometimes permanently harmful substances to them.¹⁴ The prevailing attitude toward research subjects was merely an extension of the way that hospital patients were treated as “material” for

13. 2 TRIALS OF WAR CRIMINALS BEFORE THE NUREMBERG MILITARY TRIBUNALS UNDER CONTROL COUNCIL LAW NO. 10, at 181-83 (1946-1949).

14. See KATZ ET AL., *supra* note 10, at 284-92.

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medical education.¹⁵ By the time of the Second World War, the ideology among some scientists (and not only in Germany)—to perfect mankind by weeding out weak or deviant specimens, and to provide knowledge that would be of benefit to the public and especially of use to the state—had overwhelmed physicians' assumed fidelity to the welfare of their patients. Looking back at the history of scientists' abuse of both patients and healthy subjects—which aroused concern and criticism from some quarters but seldom if ever serious discipline—it is possible to see how the lawyer for Siegfried Ruff could argue with a straight face to the Nuremberg tribunal that there was no reason for his client to have regarded mistreatment of subjects as criminal because there were no "written legal norms."¹⁶

By thinking of Nuremberg principally in terms of rules for ethical conduct in research and therefore pursuing ever greater refinements of those rules, we risk forgetting that there are goals that can seem worthwhile, even noble, yet whose pursuit puts in jeopardy the very society that science is supposed to enrich and advance. Today, with the biotechnological imperative stronger than ever, Jay's understanding of Nuremberg would lead us to pause and reconsider, very seriously, Hans Jonas's conclusion that "progress is an optional goal, not an unconditional commitment."¹⁷

15. See SUSAN E. LEDERER, *SUBJECTED TO SCIENCE: HUMAN EXPERIMENTATION IN AMERICA BEFORE THE SECOND WORLD WAR* 9 (1995).

16. See KATZ ET AL., *supra* note 10, at 300-01. This was, of course, an overstatement, as first the Prussian government in 1900 and then the Weimar government in 1931 had actually adopted rules on research that forbade experiments without free and informed consent. The obvious fact that the defendants did not feel themselves bound by any legal norms might be ascribed to the 1931 rules being mere guidelines without legal force, as some authorities contend. See Norman Howard-Jones, *Human Experimentation in Historical and Ethical Perspectives*, 16 *SOC. SCI. & MED.* 1429, 1436 (1982). Others, however, maintain that the rules were German law with binding effect until the Third Reich's fall in 1945. Hans-Martin Sass, *Reichsrundschreiben 1931: Pre-Nuremberg German Regulation Concerning New Therapy and Human Experimentation*, 8 *J. MED. & PHIL.* 99, 100 (1983). Sadly, however, Ruff's basic point—that many pre-World War II researchers who had done horrible things had still reaped honors, not opprobrium—was essentially correct.

17. Hans Jonas, *Philosophical Reflections on Experimenting with Human Subjects*, 98 *DÆDALUS* 219 (1969). While the well-known admonition summarizes the point, the full passage is worth considering:

Let us not forget that progress is an optional goal, not an unconditional commitment, and that its tempo in particular, compulsive as it may become, has nothing sacred about it. Let us also remember that a slower progress in the conquest of disease would not threaten society, grievous as it is to those who have to deplore that their particular disease be not yet conquered, but that society would indeed be threatened by the erosion of those moral values whose loss, possibly caused by too ruthless a pursuit of scientific progress, would make its most dazzling triumphs not worth having.

This leads me to the second reason why Nuremberg should not be reduced to the specific rules of the Code. To understand its lesson, we must understand what the judges saw as the central wrong in the defendants' conduct. One interpretation focuses on the fact that the victims were largely members of persecuted minorities. The Nazi campaign of "racial hygiene," actively championed by physicians, began with stigmatized groups—first, the mentally handicapped (the useless "fressers") and then Jews, gypsies, and other captive populations, who were themselves described as a disease weakening the health of the German people.¹⁸ In his opening statement to the panel of American judges at the Doctors' Trial, Telford Taylor drew attention to the minority status of the victims,¹⁹ and the theme he sounded there was echoed in the work of the new United Nations and especially in its human rights documents, which take human equality and non-discrimination as core principles.²⁰

Is this, then, the lesson of Nuremberg, that we need to protect vulnerable groups from harm in research? There is much that supports such a view—not only the story of research before (and, regrettably, after) World War II, which all too frequently made inmates of mental institutions and orphanages, patients in the public wards of hospitals, and racial minorities the objects (one cannot even say "subjects") of study,²¹ but also the experiments carried out by the Japanese military during the War in Unit 731, whose barbarities lack the infamy that attaches to the Nazi experiments only because the United States refrained from prosecuting after the war in order to conceal data about the chemical and biological agents tested by the Japanese on civilian populations and captured soldiers.²²

Id. at 245.

18. See ANDREW GOLISZEK, IN THE NAME OF SCIENCE: A HISTORY OF SECRET PROGRAMS, MEDICAL RESEARCH, AND HUMAN EXPERIMENTATION 87-99 (2003).

19. 1 TRIALS OF WAR CRIMINALS BEFORE THE NUREMBERG MILITARY TRIBUNALS UNDER CONTROL COUNCIL LAW NO. 10, at 27 (1946-1949).

20. Article 5 of the Universal Declaration of Human Rights, adopted by the United Nations General Assembly in the wake of the judgment in the Doctors' Trial, states that "[n]o one shall be subjected . . . to cruel, inhuman or degrading treatment or punishment." Universal Declaration of Human Rights, G.A. Res. 217A (III), art. 5, U.N. Doc. A/810 (Dec. 10, 1948). In 1966, Article 7 of the International Covenant on Civil and Political Rights explicated that this means that "no one shall be subjected without his free consent to medical or scientific experimentation." International Covenant on Civil and Political Rights, G.A. Res. 2200 (XXI), U.N. Doc. A/6316 (Dec. 16, 1966).

21. See KATZ ET AL., *supra* note 10, at 284-92, 306-21; TUSKEGEE ADVISORY PANEL REPORT, *supra* note 10; Gretchen Reynolds, *The Stuttering Doctor's 'Monster Study'*, N.Y. TIMES MAG., Mar. 16, 2003, at 36.

22. SHELDON H. HARRIS, FACTORIES OF DEATH: JAPANESE BIOLOGICAL WARFARE, 1932-1945, AND THE AMERICAN COVER-UP (2002); PETER WILLIAMS & DAVID WALLACE, UNIT 731: THE

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While the Nuremberg judges could have focused on the persecution of vulnerable minorities and the consequent need to develop rules to protect them, this was not the direction they took. Why not? Much of the actual judgment can be traced to material provided by the American expert medical witnesses, A.C. Ivy and Leo Alexander.²³ Perhaps they thought it best to rehabilitate the damaged reputation of modern scientific medicine (of which pre-War Germany had boasted many of the most renowned exemplars) by affirming the ancient standards of the profession, and suggesting that the problem was simply that, under the influence of a malign regime, the defendants had departed from the Hippocratic injunction, “above all, do no harm.”²⁴ Perhaps too, as Daniel Wikler has argued, Dr. Alexander did not want to be seen as an American Jew pleading for a special standard to protect a minority group, so he emphasized the general nature of the wrong (while having, of course, to be less than candid about the actual practices prevailing in the United States at the time).²⁵ For whatever reasons, the judgment was framed as a matter of universal application.

The question, then, is whether that distorts the reality of research with human subjects. When Nuremberg teaches that the well-being of individual subjects is in inherent tension with the good of the group, and hence that researchers must be constrained by limits (to obtain informed consent, to avoid coercion, to use human subjects only for good reason, to limit risks), is that a false lesson? Professor Wikler seems to think so, and concludes that the Nuremberg judgment is essentially a human rights document (that is, one aimed at protecting persons who are vulnerable to harm or neglect) and that the crimes of the Nazi physicians came from violating the principle that every person is of equal value and has the same rights.²⁶ There is much evidence on his side, because the catalogue of unethical research is replete with examples of subjects from especially vulnerable groups, even in the post-1946 United States: debilitated elderly patients at the Jewish Chronic Disease Hospital,²⁷ mentally handicapped children at the Willowbrook State School,²⁸ inmates (including children) in state facilities and prisons in the Cold War radiation experiments,²⁹

JAPANESE ARMY’S SECRET OF SECRETS (1989).

23. Michael A. Grodin, *Historical Origins of the Nuremberg Code*, in *THE NAZI DOCTORS AND THE NUREMBERG CODE* 121, 132-37 (George J. Annas & Michael A. Grodin eds., 1992).

24. LUDWIG EDELSTEIN, *THE HIPPOCRATIC OATH* 3 (1943).

25. Daniel Wikler, Harvard Sch. of Public Health, *The Ethics of Research with Human Subjects: History and Its Lessons for the Present*, Address at the National Continuing Medical Education Program in Anhui, China (Aug. 23, 2004).

26. *Id.*

27. See KATZ ET AL., *supra* note 10, at 9-65.

28. See *id.* at 1007-10.

29. See ADVISORY COMM. ON HUMAN RADIATION EXPERIMENTS, *THE HUMAN RADIATION*

to name but a few infamous examples.

This “equal treatment” lesson is worth remembering, but so is the “group versus individual” lesson, as Nuremberg has an element of both. These lessons can be complementary, even in the case of patients serving as research subjects, for whom I have long maintained greater protections are needed.³⁰ The circumstances need not be as extreme or the subjects as utterly defenseless as they were in the Nazi era for research to pose what Jay called the “age-old question: When may a society, actively or by acquiescence, expose some of its members to harm in order to seek benefits for them, for others, or for society as a whole?”³¹ Why have we so routinely failed to confront that question in the thirty-odd years since it was posed in the experimentation casebook? Fundamentally, I think, the reason is that an honest exploration of this question and its implications would simply be too painful, not only for investigators but for the rest of us as well. Jay understood this well, though perhaps he did not foresee that this same disinclination would pose an impediment to the field of bioethics being able to grasp and appreciate his vision of research with human beings as an enterprise that must confront certain inherent tensions that arise from us *all*—not just certain, powerless minorities—being vulnerable to intentional and unintentional harm.

III. IGNORANCE, DISPLACEMENT, DENIAL

Our persistent refusal to confront this unsettling truth produces a number of other symptoms that have the effect of reinforcing the avoidance of the inherent dilemma. Jay long ago demonstrated that another reason for failing to address the issue of conflicting interests is that physicians are so little educated about the need to talk with their patients generally that the notion of a candid dialogue in the context of an experimental intervention simply never occurs to them.³² We are doing a little better in medical schools these days, but for many student-physicians (as for their mentors as well), “informed consent” is still not a professionally generated custom, nor a welcome stimulus for dialogue with their patients. Instead, it remains a legally generated chore, simply one more procedure to be done to a patient, with an eye on malpractice law or the standards of the Joint Commission on Accreditation of Healthcare Organizations.³³ So, too,

EXPERIMENTS 210-12, 263-83 (1996).

30. Alexander M. Capron, *The Law of Genetic Therapy*, in *THE NEW GENETICS AND THE FUTURE OF MAN* 133, 149 (Michael P. Hamilton ed., 1972).

31. KATZ ET AL., *supra* note 10, at 1.

32. Jay Katz, *The Education of the Physician-Investigator*, 98 *DÆDALUS* 480 (1969).

33. *See, e.g.*, JOINT COMM’N ON ACCREDITATION OF HEALTHCARE ORGS., 2006-2007 STANDARDS FOR BEHAVIORAL HEALTH CARE (2006); JOINT COMM’N ON ACCREDITATION OF

investigators who attend the few hours of specialized education now required for anyone applying for federal research funds are more likely to be taught the regulatory formalities of prior review and the locally preferred version of an acceptable informed consent form than to be tutored in how to have an honest conversation with prospective subjects.

Thus, not surprisingly, whenever these obligations are not imposed, they are seldom spontaneously respected. Let me give you just one recent example. Last year, three Manhattan physicians reported that they had developed an alternative to old-fashioned tonsillectomy in which the tonsils are shaved down but not removed, which allows their patients, including those under three years of age and those who had been suffering from severe sleep apnea, to go home within hours of general anesthesia.³⁴ This practice may have been better for the children (and their parents), or it may not have, but it was indisputably a sharp break from the strong recommendation of the American Academy of Pediatrics. In other words, the physicians had tested an *experimental* protocol on 226 children, including 38 who were under the age of three. Had they informed the parents and asked whether they were willing to enroll their child in a study? No. In fact, they had not even submitted their plans to an IRB for review, since no federal research support or investigational drug was involved.

Even when investigators do acknowledge an obligation to obtain subjects' informed consent, their aversion to confronting what is really at issue can produce some very striking displacement. A decade ago, Jay critiqued a UCLA study in which schizophrenic patients who had recovered from their psychotic disorders were withdrawn from medication in order to learn more about the prodromal signs and symptoms of relapse.³⁵ Jay recognized the potentially important contribution such a study could make but was highly critical of the way the investigators tried to defend it in terms of benefits to the subjects. The investigators' behavior led to an inexcusable blurring of the line between the goal of the treatment the patients had been receiving—to improve their health—and the goal of the study—to produce scientific knowledge. Though it did not convey the real likelihood of a relapse or the harm this might pose to subjects, the consent form ironically went into exquisite detail about the trivial risks of a needle prick to obtain blood samples, which could have lulled subjects into thinking “that the investigators would disclose any other risks in similar detail and with similar candor.”³⁶ Having read hundreds of consent forms over the years, I am convinced that investigators often unconsciously displace their

HEALTHCARE ORGS., 2006 HOSPITAL ACCREDITATION STANDARDS (2006); JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORGS., 2005-2006 STANDARDS FOR LONG TERM CARE (2005).

34. Roni Rabin, *The Consent Gap*, NEWSDAY, Aug. 26, 2003, at A31.

35. Katz, *supra* note 1, at 41-51.

36. *Id.* at 47.

anxiety over the truly worrisome points by paying attention to minor risks about which they can offer more reassurance. Unfortunately, this practice implicitly makes the process of prior IRB review and subject consent seem like much ado about nothing.

After ignorance and displacement, the third problem is denial. When investigators think of this topic at all, they are likely to feel defensive: “Why are we subject to such scrutiny in the first place? Our activity is an honourable, even a noble one; compared to ordinary practice, we are not only more competent (and hence less likely to harm), but our whole approach is more scientific. Better the controlled risk of a clinical trial than the uncharted risks from the routine (and often misguided) administration of a standard intervention whose relative merits have never been adequately tested.” As a factual matter, this view is probably correct, but as an ethical matter, it misses the mark. The defensiveness of physician-investigators arises from a sense that our insistence on prior review and an informed consent dialogue impugns their motives. That is not the case (though one can see why they might think so, given the laxity of attention to such matters in ordinary care). Rather, our message to physician-investigators is (or should be) that their enterprise is, in principle, laudable, but that all those who work on it, including the subjects (or, as the current lingo has it, the “research participants”), must be aware both of the nature of the enterprise and of everyone’s role in it—including the investigator’s.

The suggestion that individual researchers might be tempted to defend the value of their activities against what they see as criticism is supported by an analysis of the Declaration of Helsinki, first adopted by the World Medical Association (WMA) in 1964, which is a well-known expression of the medical profession’s collective response to the dilemmas posed by human research.³⁷ The Declaration can be fruitfully analyzed as a defense of a morally worthy activity against the criticism that it amounts to exploitation of some for the benefit of all. The Declaration, like the Code, is open to several reasonable interpretations, but the perspectives tend to be of the glass is half empty or half full variety. The glass is half full view is that the WMA articulated high ethical aspirations for physicians; today, many strong advocates for patient welfare regard the Declaration (which has been strengthened in several respects over the years) as a bulwark against the pressures to cut back on what is owed to subjects, particularly in developing countries.³⁸ Looking at the Declaration in this fashion, one can see why the WMA in recent years has been tied up in knots over

37. World Med. Ass’n, *Declaration of Helsinki* (1964) (last amended 2000), available at <http://www.wma.net/e/policy/b3.htm>.

38. RUTH MACKLIN, *DOUBLE STANDARDS IN MEDICAL RESEARCH IN DEVELOPING COUNTRIES* (2004).

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whether, and if so how, to officially amend its code to refine the way its rules apply in certain circumstances and to allow for exceptions. My own sense is that the WMA would do better to state its aspirations more clearly and to leave the task of drafting detailed guidance, with suitable caveats, to others.

The glass is half empty view is that, rather than a true embrace of research ethics, the Helsinki Declaration was the medical establishment's attempt to distance itself from the Nuremberg Code.³⁹ Unhappy with a statement formulated by lawyers in the context of a criminal trial of monsters with whom upstanding physicians felt no kinship,⁴⁰ the WMA promulgated its own statement of duties, the thrust of which is to preserve the autonomy not of research subjects but of physicians, especially in the context of "research combined with professional care," to which the original 1964 version devoted most of its attention.⁴¹ Just as investigators chafe at requirements that implicitly criticize what they see as an activity of high moral worth (establishing safe and more effective care for patients), so practicing physicians want it recognized that their patients are inherently protected by their Hippocratic tradition.

IV. THE THERAPEUTIC ILLUSION

This is, of course, the nub of the difficulty identified by Jay—that physicians' failures to confront the fact that their dual roles in biomedical research are a problem rather than a solution leads them to disregard the need to discuss this duality frankly with their patients. Recently in *The Lancet*, David Horrobin described how his perception of clinical trials was radically altered when, after forty years as a biomedical and clinical researcher, he was diagnosed with advanced mantle cell lymphoma.⁴² Living in the "parallel universe" of cancer patients searching for information about possible treatments (including experimental ones), Horrobin came to some very caustic conclusions about the unethical nature of many oncology trials, which equally "apply to any other rapidly lethal disease."⁴³ For example, he criticized the effect of commercialism, saying that promising agents that lack patent protection are not pursued and that, in conducting trials, pharmaceutical companies use "overpowered" designs to make it "more difficult for rivals to recruit" from the limited pool of patients with

39. Alexander M. Capron, *Human Experimentation*, in *MEDICAL ETHICS* 135, 155 (Robert M. Veatch ed., 2d ed. 1997).

40. Sharon Perley et al., *The Nuremberg Code: An International Overview*, in *THE NAZI DOCTORS AND THE NUREMBERG CODE*, *supra* note 23, at 149, 157.

41. World Med. Ass'n, *supra* note 37.

42. David F. Horrobin, *Are Large Clinical Trials in Rapidly Lethal Diseases Usually Unethical?*, 361 *THE LANCET* 695 (2003).

43. *Id.* at 695.

the condition in question.⁴⁴ The heart of Horrobin's criticism, however, concerns the way patients are misled into becoming subjects. In particular, he claims that "although the risk of harm is usually well described in patient information leaflets, almost nothing adequate is ever said about the assumed effect size and the real chance of benefit."⁴⁵ Not only are subjects not warned about this low expectation of benefit, but large, multi-center trials, which are now the norm, are so cumbersome that "most patients entering most oncology trials will be dead before the results are known."⁴⁶

Once death becomes certain, many patients do have an interest in helping scientists to advance knowledge, but while they are still searching for a way to save their lives, the notion that patients are motivated by altruism is "a figment of ethicist's and statistician's imagination," in Horrobin's experience.⁴⁷ Thus, when patients who are still trying to find an effective cure are enrolled in large trials (which are large precisely because the predicted effects are small), their hopes—and their trust in the medical profession—are abused. Put another way, rather than dispelling patients' therapeutic illusions, physicians in these circumstances may be exploiting those illusions to enroll them as subjects in trials where the likelihood of a therapeutic response may well be much smaller than that of adverse events, which are "usually much more predictable and reliable in their occurrence."⁴⁸

Dr. Horrobin's scathing critique underlines the need to attend seriously to the precepts of research ethics rather than merely to recite their familiar injunctions. For example, an assurance that refusing to take part in a research project will not entail any adverse consequences is a standard part of informed consent documents. The statement aims to insulate potential subjects' decisions about participating in research from any sense that the person (or institution) on whom they are dependent for care will punish them for declining to enroll. Such a statement may make sense when the intervention in question is a discrete addition to what would otherwise occur (e.g., any intervention with normal volunteers or any extra test or procedure for patient-subjects). But the utility of such a statement is much more questionable when the research intervention *is* the

44. *Id.* at 696.

45. *Id.*

46. *Id.*

47. *Id.*

48. *Id.* Physicians are sometimes critical of patients' unrealistic hopes (and magical thinking) that lead them to pursue what the medical establishment regards as "quack remedies" and to ignore the suggestions of their physicians. Yet Dr. Horrobin points to the reciprocal phenomenon: By participating in clinical trials of interventions that are unlikely to produce a significant benefit for them, patients miss the chance to try other "potential treatments, many of which are not toxic" and "neither fringe nor irrational," but are merely unattractive to commercial sponsors.

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prospective “treatment,” and not some addition thereto. In that case, refusing to be a research subject typically means that the patient cannot obtain the intervention.⁴⁹ Consequently, because of the therapeutic illusion, the patient may perceive the statement that refusal would not entail any adverse consequences as either naïve or disingenuous.

To forestall this result—and to increase the likelihood that patients’ decisions will embody the sort of free choice that IRBs expect the “no adverse consequences” language to provide—investigators need to engage in much franker conversations with their potential subjects. Particularly in cases where the stakes are the highest—that is, when subjects have lethal diseases for which few if any effective therapies are available—it is essential that investigators make clear to each patient whether the research intervention holds any real chance of benefiting him or her. In the many instances when Horrobin’s skepticism about the likelihood of such benefits is justified, investigators will need to address the patient’s (probable) therapeutic misconception by making clear that the justification for asking the patient to enroll in the trial is to gain knowledge rather than to benefit him or her. For this to happen, IRBs will have to insist that the consent process involves an honest conversation, not merely a rote recitation of a very hollow reassurance. Even more important is that physician-investigators will need careful and supportive education in how to deal with the feelings—their own as well as patients’—that may be stimulated by an honest admission of the utilitarian (as opposed to beneficent) premise that inheres in the design of most clinical studies. To this end, a vocabulary of relationships—of common fear and uncertainty, of shared and diverging aims and hopes, and of mutual dependence and unequal power—must be explored, cultivated, and employed. It will not be enough to ask whether one has the right to do something; one must also ask why it would be the right thing for this person to do under these circumstances.

V. LIGHT AHEAD, OR JUST MORE SHADOWS?

The title of this paper asks whether we can see any light or only shadows in the field of research with human beings. This is, as my children would be quick to tell me, a trick question, for there can never be shadows without light. Perhaps we dwell in apparent darkness because one source of great intellectual and moral

49. The exception would be if a physician were willing and able to offer the experimental intervention under one of the “compassionate use” exceptions to the FDA rules for an Investigational New Drug (IND) (i.e., one which is licensed for clinical testing); exceptions can occur on a single patient basis or as part of an Expanded Access Program, which is usually for drugs in the late stages of development, where clinical trials have shown apparent effectiveness. Besides agreement from the physician, the patient would need approval from the drug sponsor and the FDA to receive an IND on a “compassionate” basis outside the clinical trial.

illumination—namely, Jay’s insights into the problems created by the silence at the heart of this relationship—has not been brought from the wings to center-stage, where we would see the light as well as the shadows it creates. The blame for this lies with those of us who have been, in one way or another, Jay’s students and have failed adequately to assume his mantle. I want to conclude, therefore, by considering what we can do to help ensure that Jay’s light shines as and where it should.

Having devoted much of this paper to the forces that have kept the light off-stage, I am under no illusion that what needs to be done can be easily accomplished, much less that these ideas are self-executing. My central thesis here has been that the failure of the system to address the true dilemma at the heart of human experimentation undermines the ethical legitimacy of the whole enterprise. There are mechanisms, such as the Secretary’s Advisory Committee on Human Subjects Research, through which these issues could be fruitfully addressed. Likewise, professional organizations of bioethicists and of IRB members could be encouraged to take this issue on; this was the heart of the keynote address that I delivered to the Public Responsibility in Medicine and Research annual conference in the winter of 2003.⁵⁰

Inevitably, some researchers will decry this effort and describe it as one more unnecessary burden that will slow down research. There may be room here to answer this complaint with Hans Jonas’s response,⁵¹ but we should also point out that bringing these issues out in public, especially in bodies that have the authority to address them, may well result in removing unnecessary requirements. As Jay wrote in his reservations to the report of the Advisory Commission on Human Radiation Experiments, a national board on human subjects research could “delineate exceptions to the informed consent requirements when competing principles require it.”⁵² Some epidemiologists, for example, complain that requiring individual consent for including information in disease registries not only adds to the difficulty and expense of collecting such data but may so bias the data as to defeat their scientific utility.⁵³ Yet we permit all sorts of similar activities, such as routine surveillance, to be carried out under

50. Alexander M. Capron, *Research with Human Beings: More Issues than Ever!*, Keynote Address at Public Responsibility in Medicine and Research’s 2003 Annual IRB Conference (December 7, 2003) (transcript available at <http://www.primr.org/education/publications.html>).

51. *See supra* text accompanying note 17.

52. Jay Katz, *Statement by Committee Member Jay Katz, in ADVISORY COMM. ON HUMAN RADIATION EXPERIMENTS, THE HUMAN RADIATION EXPERIMENTS* 543, 548 (1996).

53. Julie R. Ingelfinger & Jeffrey M. Drazen, *Registry Research and Medical Privacy*, 350 *NEW ENG. J. MED.* 1452 (2004) (recommending an NIH Certificate of Confidentiality and the combination of IRB review and two tiers of separate coding between data source and registry as a substitute for individual informed consent).

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the public health authority without individual consent. In such cases, permission for scientists to act comes from our democratically elected representatives. Of course, we must be alert to failures in oversight or inadequate controls, but, in theory, the collective balancing of risks and benefits through an open, public, and, one trusts, accountable process is sometimes an adequate substitute for individual balancing.

Sometimes, indeed, it is *only* through a collective act that the welfare of individuals can be protected. Just recently, the Cambodian government cancelled a randomized controlled trial that was also being carried out in several African countries; in this trial, HIV-negative sex workers would have received either the AIDS drug tenofovir or a placebo for a year, to see whether the drug was effective in preventing them from becoming infected.⁵⁴ At issue in the case was not only the question of benefit but the conflict inherent in research with vaccines or other preventive measures: The research can only succeed if a statistically significant number of subjects are exposed to the risk of harm despite the best efforts of researchers to educate the subjects about behavioral changes that will reduce the risk. In Cambodia, activists claimed that by failing to involve the organization that represents sex workers in planning the trial, the American sponsors had not designed educational interventions that would be effective and that they were not going to provide adequate treatment of those who seroconverted (either because they were on the placebo or because tenofovir failed to protect them). The researchers admitted that they had not communicated their plans adequately but insisted that they had adequately engaged the relevant communities.⁵⁵

Part of this dilemma relates to the controversial issue of post-trial benefits. Who owes what to whom and when? In the Cambodian case, should the trial sponsors have been responsible for providing lifelong HIV treatment for subjects who developed a condition that they probably would have gotten anyway in the absence of the trial? But the case is also an object lesson in the importance of taking seriously those collective interests of subjects that it is unrealistic to expect individual subjects to be able to protect in the context of a one-on-one relationship with a physician-investigator who is trying to recruit the patient into a trial.

Finally, we need to address the conflicts in the system that go beyond the dual role of physicians as investigators. For a start, this means taking seriously the inherent conflicts for IRBs, searching for better ways to insulate their members and staff from institutional pressures and, when that cannot be effected,

54. Kimberly Page-Shafer et al., *HIV Prevention Research in a Resource-Limited Setting: The Experience of Planning a Trial in Cambodia*, 366 THE LANCET 1499, 1499 (2005).

55. *Id.* at 1499-1502.

creating alternative, more independent review mechanisms. Were IRBs' decisions more open to scrutiny, not only would they be improved, but the boards could also participate in a process of mutual learning through the development of something akin to a common law of research ethics.⁵⁶ Taking that idea a step further, the Tuskegee Syphilis Study Ad Hoc Advisory Panel proposed that Congress establish a national board that could review and interpret the federal research regulations.⁵⁷

In such an effort, it seems to me essential to go beyond the Office for Human Research Protection and other signatories to the Common Rule⁵⁸ to include the FDA, both to ensure consistency among regulatory bodies and because so many of the situations in which powerful forces discourage opening up the researcher-subject relationship are in studies under the FDA's jurisdiction. Indeed, recent developments in the administration of clinical trials have made the risk of silence even greater. Faced with the need for speed, efficiency, and lower costs, pharmaceutical companies are hiring contract research organizations, which often rely on private physicians rather than university medical centers for Phase III testing.⁵⁹ Pointing to the added costs for drug companies when deadlines are missed in the approval process, McKinsey & Company recently urged clinical trial managers to "think like marketers" in dealing with physician-investigators, in order to overcome the failure to recruit enough patients in time, which "accounts for 85 to 95 percent of all days lost during clinical trials."⁶⁰ The specific advice was to set a target for the number of patients needed in a trial, and to treat that target as a "sales challenge" by using marketing techniques "to get enough patients to buy the 'product'—in this case, participation in the trial."⁶¹

Not surprisingly, the McKinsey authors see physicians as "salespeople" and remind the pharmaceutical companies that they need to "identify and manage the top performers systematically" by developing "deeper relationships with physicians who consistently deliver high number of patients."⁶² Nowhere in this advice do these consultants suggest that it might be necessary for physicians to inform patients that they have been "offered incentives—not only payment for their own time and other expenses but also free equipment, all-expense-paid trips

56. See, e.g., KATZ & CAPRON, *supra* note 5, at 127-29.

57. TUSKEGEE ADVISORY PANEL REPORT, *supra* note 12, at 23-24.

58. Basic HHS Policy for Protection of Human Research Subjects, 45 C.F.R. § 46.101-.124 (2005).

59. Kurt Eichenwald & Gina Kolata, *Drug Trials Hide Conflicts For Doctors*, N.Y. TIMES, May 16, 1999, at A1.

60. Janice Cruz Rowe et al., *A Cure for Clinical Trials*, 2002 MCKINSEY Q. 134, 135, available at <http://www.mckinseyquarterly.com> (search for "Cure for Clinical Trials").

61. *Id.* at 137.

62. *Id.* at 138.

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to conferences, and invitations to speak at prestigious events.”⁶³ In fact, disclosure of such information would be essential to protecting patient-subjects’ role as informed decision-makers; what patient wouldn’t want to know that the physician he or she trusts actually has a “deep relationship” with the company whose drug is being tested? Moreover, it would also be indispensable to the oversight process more generally. Since the consultants advise their pharmaceutical clients to “track the percentage of patients who . . . complete the trial, for this information permits those companies to develop accurate databases of physicians who have good access to patients, the necessary infrastructure, and the commitment to ensure that enough patients go on to the finish line,”⁶⁴ financial incentives may just as easily compromise the care with which physician-investigators apply inclusion and exclusion criteria, monitor and report clinical data, and continue or discontinue patient-subjects’ participation in a trial as they influence their recruitment practices.

This is not a pretty picture, but following Jay’s example we should not turn away; rather, we must confront it. And we should be under no illusion that this is an aberration; it is simply a franker description of the phenomenon that affects not only pharmaceutical trials but a much wider range of research with human beings. Perhaps the very starkness of this most recent slide away from professionalism—with physicians becoming self-interested marketers—will prompt the leadership of the profession to act. Let us then be clear that what is needed is not a return to the world of silence, the world where conflicts went unacknowledged and illusions were exploited rather than confronted. Rather, what is needed is to lift up the light that Jay has given us and to look clearly at what has been too long obscured in the shadows.

63. *Id.* at 137.

64. *Id.* at 138.

Response

Reflections on Jay Katz's Legacy

Ruth Faden, Ph.D., M.P.H.*

Like all the contributors to this issue, I am indebted to Jay Katz. When I was a graduate student at Berkeley, 3000 miles away from Yale Law School, I wrote Jay Katz a letter (we corresponded through letters in those pre-e-mail days). I had decided to write my dissertation on informed consent, and Jay's casebook, *Experimentation with Human Beings*,¹ had become my bible. It was then, and arguably remains today, the most thorough and diverse collection of materials on research ethics and law ever assembled between two covers. Amazingly, Jay not only responded to my letter, he also invited me to come to Yale for a chat. And I went. We talked for many hours. Jay then graciously and patiently read drafts of every chapter of my dissertation. Jay could not possibly have known how instrumental that conversation in New Haven was to my intellectual life, nor could he have known how much his comments on my drafts meant to me as I was working on my dissertation. A decade later, when Tom Beauchamp and I were writing our book on informed consent,² Jay's voice was constantly in mind and his work was my inspiration. In *Experimentation with Human Beings*,³ and later in *The Silent World of Doctor and Patient*,⁴ Jay evidenced that human psychology and human relationships are essential to understanding informed consent. Jay created the intellectual space in which I, as a student of human attitudes and behavior, could become a scholar of informed consent.

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1. JAY KATZ ET AL., *EXPERIMENTATION WITH HUMAN BEINGS: THE AUTHORITY OF THE INVESTIGATOR, SUBJECT, PROFESSIONS, AND STATE IN THE HUMAN EXPERIMENTATION PROCESS* (1972).

2. RUTH R. FADEN & TOM L. BEAUCHAMP, *A HISTORY AND THEORY OF INFORMED CONSENT* (1986).

3. KATZ ET AL., *supra* note 1.

4. JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* (Johns Hopkins Univ. Press 2002) (1984).

Not surprisingly, Jay's voice is also very present in Alex Capron's paper.⁵ And perhaps for that reason, there is little in Capron's paper with which I disagree. In this response, I elaborate on several themes in his paper that I find resonant precisely because they capture well some of Jay Katz's most insightful and complex contributions.

Capron is right to say that those of us who have followed Jay in exploring the moral dimensions of human experimentation have failed him. In numerous respects, scholars of biomedical ethics have accommodated the practice of human experimentation. We are comfortable with its place in science, and we do not question its place at the bedside. We have adopted the sanitized language of medical science in which "human experiments" have become "clinical trials" and "research studies," and, as Capron notes, the human beings on whom we experiment have become "research participants," rather than "human subjects."⁶ These shifts in our language have served to soften the moral edginess of human experimentation, to make it more acceptable, more routine.

I am not suggesting that accommodating medical research is, on balance, necessarily wrong. Although Capron is right to remind us of Hans Jonas's conclusion that "progress is an optional goal,"⁷ there can be little doubt that accommodating medical research within the framework of protections that has emerged over the past forty years has allowed substantial advancement in human welfare with far less abuse of the rights and interests of human beings than might otherwise have been expected.

However, I do submit that these accommodations have made it harder to see certain moral challenges for what they are. The current discussion of financial conflicts of interest in medical research, for example, touches only superficially on what is at the core of the matter. Physicians who conduct research on human beings, or who collaborate with such research, have always been deeply and inescapably conflicted. Fundamental conflicts were present long before financial considerations began to emerge as a concern. As early as 1953, when the post-war boom in medical science was just getting underway, Otto Guttentag recognized that the moral values and obligations of the scientist are profoundly different from, and can easily conflict with, the moral values and obligations of the practicing physician. Guttentag argued for a clear separation between what he called the "physician-experimenter" and the "physician-friend" in order to prevent the experimental exploitation of the sick that this conflict could

5. Alexander M. Capron, *Experimentation with Human Beings: Light or Only Shadows*, 6 YALE J. HEALTH POL'Y L. & ETHICS 431 (2006).

6. *Id.* at 442.

7. *Id.* at 437 (citing Hans Jonas, *Philosophical Reflections on Experimenting with Human Subjects*, 98 DÆDALUS 219, 245 (1969)).

otherwise produce.⁸ Guttentag who, like Jay, talked about *physicians making their patients subjects of experiments*, recognized the moral challenge in its rawest form. By contrast, most physicians and bioethics scholars, both then and now, talk about *physicians enrolling their patients in clinical trials*, a linguistic accommodation that enables us to look right past the moral conundrum at the heart of clinical research with human beings.

I can testify from first-hand experience that Jay does not believe in making accommodations. His principal concern has always been the dignity and rights of the people on whom experiments are conducted. When we were serving together on President Clinton's Advisory Committee on Human Radiation Experiments (ACHRE), Jay always moved our discussions to what I believe he views as the first and fundamental principle of ethical human experimentation: Did the subjects provide valid informed consent? It did not matter if the experiment posed no or little risk. As Capron notes, Jay's foremost commitment is to the authority of human beings to decide for themselves whether to volunteer to be subjects of medical experimentation.⁹

At the same time, Capron is also right to point out that consent is a facile and ultimately inadequate answer to the core dilemma in human experimentation: When is it justifiable to expose some human beings to harm so that all people may benefit?¹⁰ What is especially remarkable about Jay Katz is that, while he is a staunch defender of the essential moral importance of informed consent to ethical human experimentation, he is also an acute analyst of how human relationships and psychology make the prerequisites of valid consent—such as honesty, communication, and understanding—difficult. In *The Silent World of Doctor and Patient*, Jay powerfully describes how the human dynamics of illness, dependence, and desperation complicate, sometimes beyond recognition, any conversation about choice and consent.¹¹

As Capron argues, in our obsession with the rules and forms of consent we have failed to attend to the important implications for the ethics of human experimentation of Jay's critical insights into the power of magical thinking, displacement, and denial.¹² Despite decades of critical commentary, research ethics review committees continue to engage in an often fruitless obsession with the wording of consent forms while neglecting critical concerns about the extent to which people understand what is perhaps the most important moral fact of

8. Otto E. Guttentag, *The Problem of Experimentation with Human Beings: The Physician's Point of View*, 117 *SCIENCE* 207 (1953).

9. Capron, *supra* note 5, at 431 n.1.

10. *Id.* at 440.

11. KATZ, *supra* note 4, at 130-64.

12. Capron, *supra* note 5.

all—that they are agreeing to be subjects in an experiment. As Jay points out, people who are sick have a powerful need to believe in miracles, a need that the doctors who care for them often feel compelled to encourage, both because hope can be therapeutic and because it can be so difficult for a healer to admit the limits of her capacity to help. Yet once again, despite the voluminous literature prompted by Jay’s insights, review committees rarely challenge physician-scientists about the extent to which their patient-subjects have an accurate understanding of whether, or to what extent, participating in research will make them better.

Capron also invites us to consider Jay’s work in the context of the lessons of Nuremberg. Capron rightly cautions that Nuremberg should not be reduced to the specific rules of the Code but must be understood more deeply as expressing the boundaries of what is morally permissible in human experimentation.¹³ Jay, who frequently has reminded me of the Code’s first principle, which begins “[t]he voluntary consent of the human subject is absolutely essential,”¹⁴ certainly does not reduce the lessons of Nuremberg to legalistic rules. An unforgettable moment from our time on ACHRE exemplifies Jay’s profound grasp of what lies beneath and beyond the rules. We were hearing testimony about radiation experiments that had been conducted on boys at a state institution in Massachusetts to which they had been committed.¹⁵ There was discussion about parental consent, and it was suggested that, since the science required a setting in which the children’s diets could be controlled, boys in the residential setting of a state home were ideal for this research. Jay then asked, simply, had the investigators considered selecting as subjects children at Choate or Exeter? The room fell silent. Even if the risks had been minimal and the parental consent valid and meaningful, Jay was quick to see the fundamental immorality of the research.

In the field of biomedical ethics, Jay is rightly revered for his extraordinary insights about consent and communication, relationships and silences. But as this powerful anecdote suggests, for me, the real brilliance of Jay Katz lies in his uncanny capacity to discern when the conduct of physicians and scientists crosses a critical moral divide, and why.

13. *Id.* at 433-39.

14. 2 TRIALS OF WAR CRIMINALS BEFORE THE NUREMBERG MILITARY TRIBUNALS UNDER CONTROL COUNCIL LAW No. 10, at 181 (1948-1949).

15. ADVISORY COMM. ON HUMAN RADIATION EXPERIMENTS, THE HUMAN RADIATION EXPERIMENTS 196-226 (1995).

Response

Jay Katz: From Harms to Risks

Larry I. Palmer, LL.B*

Jay Katz's towering presence in the scholarship on human experimentation has been a source of personal and professional inspiration. As I noted over thirty years ago in my review essay about his classic work, *Experimentation with Human Beings*,¹ Jay's scholarship asks tough and penetrating questions about a truth we modern professionals hold to be sacred.² We have always assumed that growth in scientific knowledge and social progress are linked. Yet as Alex Capron discusses in his paper,³ scientific knowledge has sometimes been produced by means we would *not* consider socially progressive. Jay's analysis of the history of experimentation with human beings before, during, and after the Nazi era dispels the comforting notion that the Nazi investigators were individuals working outside the moral ethos of modern medicine and science (i.e., that they were merely racists and sadists). Instead, Jay reveals that they were physician-investigators searching aggressively (albeit blindly) for even better ways of making science socially useful and relevant.⁴

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1. JAY KATZ ET AL., *EXPERIMENTATION WITH HUMAN BEINGS: THE AUTHORITY OF THE INVESTIGATOR, SUBJECT, PROFESSIONS, AND STATE IN THE HUMAN EXPERIMENTATION PROCESS* (1972).

2. Larry I. Palmer, Commentary, *The High Priests Questioned or at Least Cross-Examined*, 5 RUTGERS-CAM. L.J. 237 (1973-1974).

3. Alex Capron, *Experimentation with Human Beings: Light or Only Shadows?*, 6 YALE J. HEALTH POL'Y L. & ETHICS 431 (2006).

4. See, e.g., Jay Katz, *The Consent Principle of the Nuremberg Code: Its Significance Then and Now*, in *THE NAZI DOCTORS AND THE NUREMBERG CODE: HUMAN RIGHTS IN HUMAN EXPERIMENTATION* 227 (George J. Annas & Michael A. Grodin eds., 1992) (observing that the Nuremberg Code's relentless and uncompromising commitment to the psychological integrity of research subjects has not been matched either prior to its promulgation or since); Jay Katz, *The Nuremberg Code and the Nuremberg Trial: A Reappraisal*, 276 JAMA 1662, 1663 (1996) (noting that, in the history of medical science, harms, including death, have always been associated with

In this response, I illustrate Jay's broad influence on the entire field of bioethics by beginning with a personal tribute that honors Jay as a scholar and teacher. As one of his former students, I can attest that his method of combining scholarship and teaching deserves the label "inspirational." Second, I discuss how my own scholarship and teaching have been shaped by Jay's courageous insistence that to protect human subjects we must develop new types of institutional arrangements.⁵ Jay used his position on bioethics commissions (starting with the panel to review the Tuskegee Study of Untreated Syphilis in the Negro Male)⁶ and his writings to advocate for institutional change of the manner in which we regulate research. Finally, I argue that Jay Katz's scholarship and career provide a warning to those of us who call ourselves "bioethicists" in what I have called the "human genome era."⁷ Bioethics is now in some senses a new "profession," with all of the accompanying risks and benefits of that societal recognition. We may need to return to Jay's work to uncover the reflective skills for analyzing our own role in promoting, or perhaps impeding, "social progress."

I. JAY'S INFLUENCE: A PERSONAL REFLECTION

I was one of approximately thirty students in Jay's Family Law class in the spring of 1968. At a certain point in the course, Jay invited Anna Freud to participate in our class for several weeks. On those occasions, the classroom was also packed with a large number of law school faculty members, including Joe Goldstein.

medical research, but death had not been part of the research design before the Nazi doctors); Jay Katz, *The Regulation of Human Experimentation in the United States—A Personal Odyssey*, 9 IRB: REV. OF HUM. SUBJECTS RES. 1, 2 (1987) [hereinafter Katz, *Regulation*] (arguing that Nazi studies had antecedents and recounting some earlier examples of investigators discounting the dignity of human beings); Jay Katz, Human Sacrifice and Human Experimentation: Reflections at Nuremberg, Address at the Conference Commemorating the Fiftieth Anniversary of the Nazi Doctors' Trial at Nuremberg Convened by International Physicians for the Prevention of Nuclear War and Physicians for Social Responsibility (Oct. 27, 1996) (transcript available at <http://www.law.yale.edu/outside/html/Publications/pub-katz.htm>) (reviewing other examples of research involving human subjects where human dignity was not maintained and observing that in medicine's quest to become a respected science, "doctors lost sight of the fact that it is one thing to experiment with atoms and molecules and quite another to do so with human beings").

5. Larry I. Palmer, *Paying for Suffering: The Problem of Human Experimentation*, 56 MD. L. REV. 604 (1997).

6. See PUB. HEALTH SERV., U.S. DEP'T OF HEALTH, EDUC. & WELFARE, FINAL REPORT OF THE TUSKEGEE SYPHILIS STUDY AD HOC ADVISORY PANEL (1973) [hereinafter TUSKEGEE ADVISORY PANEL REPORT], available at <http://biotech.law.lsu.edu/cphl/history/reports/tuskegee/tuskegee.htm>.

7. Larry I. Palmer, *Disease Management and Liability in the Human Genome Era*, 47 VILL. L. REV. 1 (2002).

The presence of Joe Goldstein and others signaled to me that our discourse with Anna Freud was part of a much wider conversation about the relationship between psychoanalysis and law, a topic Robert Burt elegantly addresses in his paper for this symposium.⁸ More important, it signaled to me Jay's generosity and openness to ideas and colleagues. In the classroom discussion of *Painter v. Bannister*,⁹ Anna Freud outlined her rationale for defending the court's disposition of the child custody dispute in favor of the grandparents, i.e., the "psychological parent," over the child's biological father. As it turned out, what was going on during Anna Freud's visits to our class was the outlining of themes that she, Joe Goldstein, and Albert Solnit subsequently pursued in their *Beyond the Best Interests of the Child*.¹⁰ Experiencing something rare and wonderful during that course stimulated me to work with my own students in such a way that the larger context of my scholarship could in turn inspire each student to find his or her light.¹¹ Thus, my first tribute to Jay is a personal note of gratitude: He has the ability to inspire those of us exposed to his light to take risks when we speak as citizens and as scholars.¹²

II. JAY'S INFLUENCE: TEACHING ETHICS

When Alex Capron was editor of a special edition of the American Society of Law, Medicine and Ethics' journal honoring Jay's work, he asked me to contribute a piece, and I chose to write about how Jay's approach to human research could be a model for revitalizing interdisciplinary teaching.¹³ At the time I was co-teaching a seminar for undergraduates on "Institutions and Social Responsibility"¹⁴ in Cornell University's Biology and Society Program that used some materials from Jay's casebook on human experimentation.¹⁵ In the course

8. Robert Burt, *The Uses of Psychoanalysis in Law: The Force of Jay Katz's Example*, 6 YALE J. HEALTH POL'Y L. & ETHICS 401 (2006).

9. 140 N.W.2d 152 (Iowa 1966).

10. JOSEPH GOLDSTEIN ET AL., *BEYOND THE BEST INTERESTS OF THE CHILD* (2d ed. 1979); see also JOSEPH GOLDSTEIN ET AL., *IN THE BEST INTERESTS OF THE CHILD* (1986).

11. Larry I. Palmer, *Research with Human Subjects as a Paradigm in Teaching*, 16 L. MED. & HEALTH CARE 183 (1988).

12. Joe Goldstein's warning to psychoanalysts to distinguish between their roles as scientists and their roles as mere citizens should be heeded by bioethicists today, who regularly are called upon to provide normative answers to whether a particular line of research—for instance, stem cell research on cloned embryos—should proceed. See Joseph Goldstein, *Psychoanalysis and Jurisprudence*, 77 YALE L.J. 1053, 1059-60 (1968).

13. Palmer, *supra* note 11.

14. *Id.* at 183.

15. KATZ ET AL., *supra* note 1, at 9-65.

of writing my article during the summer of 1989, I took a morning away from my duties as a vice president at Cornell to go to the library. There I encountered David Feldshuh, the author of the play, *Miss Evers' Boys*,¹⁶ a fictionalized account of the Tuskegee Study.

As we stood in the library lobby conversing, David, a physician by training with a Ph.D. in theater arts, asked me: "Do you know anything about the Tuskegee Syphilis Study?" Inspired, perhaps, by the generosity toward the perspectives of other scholars I remembered from Jay's class, I tried to hear the anxiety or the silence behind David's question and recognized the invitation to conversation. I told him about the paper I was writing, about Jay's role on the Tuskegee Syphilis Study panel, and about how I had followed the developments regarding the Tuskegee Study since 1972.¹⁷ That conversation led David to ask me to read a draft of what would become *Miss Evers' Boys* before he took the play to the Sundance Festival. David was not concerned, as some critics were, with the politics of race and gender that might overshadow his attempts, as a white, male, Jewish physician-playwright, to portray the fictitious heroine of his play—an African-American public health nurse. Rather, he was concerned with his portrayal of the African-American physician. The implication—albeit a fictitious one—that Dr. Brodus, a black physician, was somehow involved in a study condemned as unethical and racist would raise some special issues.¹⁸ The litigation on behalf of the survivors of the Tuskegee Study against the United States Government and the State of Alabama had alleged that the men were placed in the study without their consent solely because they were African-Americans.¹⁹

That conversation sparked several collaborations, including presentations of excerpts from the play before various audiences followed by interdisciplinary panel discussions about the issues of race, gender, and research raised by *Miss Evers' Boys*. The moving response of a large Cornell alumni audience to one of our panels convinced me to bring *Miss Evers' Boys* to Cornell as a way of engaging the entire campus in a conversation about research ethics, race, and gender. The 1991 theater production of *Miss Evers' Boys* at Cornell was a focal point of freshman orientation and became part of the eventual production of the prize-winning educational video, *Susceptible to Kindness: 'Miss Evers' Boys' and the Tuskegee Syphilis Study*.²⁰

16. DAVID FELDSHUH, *MISS EVERS' BOYS* (1995).

17. Palmer, *supra* note 2, at 245.

18. Palmer, *supra* note 5, at 614-16.

19. *Id.* at 609.

20. Videotape: *Susceptible to Kindness: 'Miss Evers' Boys' and the Tuskegee Syphilis Study* (Cornell Univ. 1994).

In writing the study guide to accompany the video, I was inspired again by Jay's approach to teaching and scholarship, in which framing the question is the key to analysis. Recall that each part of Jay's casebook starts with a narrative introduction that ends with four to six overarching questions.²¹ These questions help both the teacher and the student organize the process of reflection and engaging discussion provoked by the 200 to 300 pages that follow each introduction. I thought our forty-two minute video, which included vignettes from the play, comments by "experts," interviews with survivors from the Tuskegee Study, and documentary material about the conditions in rural Alabama, needed a set of questions that would help teacher-leaders guide a reflective discussion of the issues raised by the various vignettes from the play.²² I organized the study guide around a major question for each of the six vignettes from the play. For instance, given Jay's analysis of the role of the Hippocratic Oath in the success or failure of physician-scientists in securing consent,²³ I encouraged discussion leaders to ask, in relation to the nurse-scientist, Miss Evers, "[i]n a religiously diverse society, before whom should modern professionals take their oath?"²⁴ While that question related to the first of the six vignettes, the same question is discussed by the expert commentators on the video. Furthermore, in designing the questions, I had to keep in mind that the leaders and students considering my questions would come from a variety of disciplines.

Building from this interdisciplinary and collaborative work on the Tuskegee project, I began to develop a research agenda around two issues that are pervasive in research on human subjects. First, in my own writing about the issues of race and genetics, I have been inspired by Jay to develop a framework that will help us question some common assumptions about how to deal with increasingly diverse research subjects. Second, I have been drawn to consider what it means to be a "professional" in the field of bioethics.

III. PROFESSIONALISM, RACE, AND HUMAN SUBJECTS RESEARCH

The Institute of Medicine and others have called for greater training in "cultural competency"²⁵ on the part of health professionals in response to

21. KATZ, *supra* note 1, at 7, 8.

22. See Larry I. Palmer, *Writing Law*, in *WRITING AND REVISING THE DISCIPLINES* 113, 121-23 (Jonathan Monroe ed., 2002).

23. JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 93-94 (Johns Hopkins Univ. Press 2002) (1984).

24. LARRY I. PALMER, *SUSCEPTIBLE TO KINDNESS: MISS EVERS' BOYS AND THE TUSKEGEE SYPHILIS STUDY: STUDY GUIDE FOR DISCUSSION LEADERS* 9, 11 (1994).

25. INST. OF MED., *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN*

granting agencies' insistence that racial and ethnic minorities have "an equal opportunity" to participate in clinical trials. My concern is that we assume too easily that minority medical students, minority physicians, or minority outreach workers will not experience a cultural divide in seeking to recruit minority research subjects. Discussions of this topic often ignore the possibility that minority professionals may, in some cases, be committed primarily to the modern biomedical definition of "professional," thereby sharing with their non-minority colleagues tendencies toward silence in terms of sharing risks.²⁶ To put it another way, why should we believe that minority physicians will not concentrate as much as their majority counterparts on minimizing physical harm during interventions, while largely ignoring risks to the subject's sense of human dignity? Why do we assume that minority professionals will necessarily show greater respect for the authority of subjects to say "no" to participation in research?²⁷

When I listen to current discussions about the need to recruit minority members as organ donors, donors of tissue samples for genetic tests, or participants in clinical trials for diseases that disproportionately affect African-Americans such as sickle-cell anemia, I often think back to the conflicted role of Dr. Brodus in *Miss Evers' Boys*. Dr. Brodus is the same race as the men involved in the Tuskegee study, but he is culturally different from them. He does not, for instance, understand much about the form of folk dance in which one of the men is deeply involved.²⁸ He, like the white doctor in the play, Dr. Douglas, needs the black public health nurse, Miss Evers, to translate his medical terminology.²⁹ Dr. Brodus questions Dr. Douglas's decision to start the study of untreated syphilis in the Negro male, but eventually acquiesces when Dr. Douglas suggests that a scientific study might prove that both races are biologically the same.³⁰ Dr. Brodus's fictionalized struggle illustrates that employing racially diverse medical professionals is not a quick fix for the problems raised by the vulnerability of minority subjects. What we need, rather, is for bioethicists of all racial and ethnic backgrounds to find a forum for having open discussions about racial and ethnic differences in the genomic era.³¹ Issues of race and ethnic status cannot be resolved by a procedural approach built on avoiding physical harms. Thinking about race in the post-Tuskegee world, where *de jure* segregation no longer

HEALTHCARE 199-214 (2002) (encouraging medical educators to increase physician skills in cultural competence as a means of eliminating health disparities).

26. KATZ, *supra* note 23, at 1-29.

27. *See* Palmer, *supra* note 5, at 611-13.

28. FELDSHUH, *supra* note 16, at 72-73.

29. *Id.* at 72, 75-77.

30. *Id.* at 39-44.

31. Ari Patrinos, 'Race' and the Human Genome, 36 NATURE GENETICS S1 (2004).

exists, requires us to embrace Jay's call for more attention to risks to human dignity in human research.

IV. BIOETHICS AS A PROFESSION

The second challenge we must face is that of the professionalization of bioethics itself.³² When Jay, the insider and the outsider, worked with Alex Capron and Eleanor Glass on their classic book on human experimentation,³³ they challenged scientists of all kinds, including social scientists, to examine the ethics of their work. Since the outset of the Human Genome Project, the ethical, legal, and social implications (ELSI) of genetic developments have become part of the federal research agenda. But the allocation of three to five percent of genetic research funds to ELSI work³⁴ may be both a curse and a blessing.

We, the bioethicists, now have a potential source of funding that equips us to convince university administrators to build centers for bioethics within universities. This institutionalization within the federal research funding structure may be seen as a positive sign that we can carry on the process of providing the critical analysis of research development. On the other hand, given the failures that Alex Capron outlines in his paper,³⁵ we ought to pay attention to the possible downsides of our marriage to federal funding. Given this dilemma, how do we avoid becoming captive to the ethos that scientific knowledge automatically leads to social progress? How many of us will have the courage that Jay demonstrated to dissent?³⁶ Will we be able to challenge federal funding officials when the funding of our centers or programs is partially dependent upon our maintaining a certain kind of favorable visibility among program officers?

I am not suggesting that any of these dangers has been realized in any particular ELSI project of which I am aware. I am, however, suggesting that it is our responsibility to start asking questions about our own role in relationship to the funding for our work, and to develop a research agenda that reflectively assesses and challenges our own relatively new profession. We should not make

32. In *Grimes v. Kennedy Krieger*, 782 A.2d 807 (Md. 2001), the court relied upon bioethics literature to hold that researchers could be civilly liable for an impaired informed consent process where parents were asked to consent, on behalf of their children, to participation in a lead-abatement study involving low-income housing. See Larry I. Palmer, *Genetic Health and Eugenics Precedents: A Voice of Caution*, 30 FLA. ST. U. L. REV. 237, 244-53 (2001).

33. KATZ ET AL., *supra* note 1.

34. Human Genome Program, U.S. Dep't of Energy Office of Sci., Human Genome Project Information: Ethical, Legal, and Social Issues, http://www.ornl.gov/sci/techresources/Human_Genome/elsi/elsi.shtml (last visited Apr. 11, 2006).

35. Capron, *supra* note 3.

36. Katz, *Regulation*, *supra* note 4.

the fatal error of presuming that our own good intentions and so-called “expertise” in bioethics provide sufficient insurance against our participating in or enabling affronts to human dignity within the research process.

Let me use an illustration from my own recent work as the principal investigator on a grant for teaching cultural competency in medical schools. My proposal involved a disease-based model for training in cultural competency and built on some work dealing with sickle cell anemia already being done at my current institution.³⁷ When I was filling out the human subjects protection section of the grant proposal, I was tempted to state that there were minimal risks to the students and faculty involved in my “teaching experiment” because the *physical* risks were minimal. I was further tempted to admit only a risk of loss of confidentiality during the evaluation required by the request for proposals. Perhaps it was working on this paper that pushed me to venture beyond such boilerplate statements. Instead, I felt compelled to outline for the peer-review group the true risks to human dignity I could foresee even at this research design stage of the study. I proposed including in the consent form, in addition to the standard language about possible physical harms, some language about the risks of stigma and dignitary harms to both individuals and communities that might result from participation in a project that attempts to deal with race.

For example, in the context of a training program meant to increase the “cultural competency” of future physicians, it is possible that some of the materials used, such as the educational video on the Tuskegee Syphilis Study, could provoke teachers and leaders to make statements that would make some individuals feel stereotyped and disrespected. This risk applies to both minority and non-minority students. Being labeled a “racist” has professional implications for a future physician of any race or ethnicity. On the other hand, a racial or ethnic minority student’s learning might be hindered by provocative and insensitive statements by white students about supposed customs of Jews, Muslims, African immigrants, “Hispanics,” or African-Americans. These risks are real and worthy of mention in the context of a training project because training *is* human experimentation. We should be aware of the dignitary risks involved in education, in attempting to shape people’s minds as educators in a value-laden field such as ethics. Jay’s approach to research with human subjects, as I observed above, provides an excellent framework for analyzing the nature of teaching and education. If knowledge changes people, then those of us involved

37. Kathy Keadle, *Bridging the Gap*, MEDICINE (Univ. of Louisville, Louisville, KY), Fall/Winter 2002, at 8, available at <http://www.louisville.edu/hsc/medmag/fw02/sickle.html>; Tiffani Humphrey et al., The Medical Student Sickle Cell Project: Innovation, Outreach, Opportunities, Oral Presentation at the 32nd Annual Convention of the Sickle Cell Disease Association of America, Inc. (Sept. 30, 2004) (on file with author).

in the transmission of knowledge to others are constantly involved in human experimentation.

V. LESSONS FOR THE GENOMIC ERA

I have shown how Katz's analysis of human experimentation has influenced my own thinking with respect to issues of race, ethics, and education. I would like to close with some thoughts about how his insights should influence *all* of our thinking in the near future. Specifically, I want to caution that Katz's fundamental insight—that we must always consider carefully the potential implications of our work for the dignity of human persons—will be crucial as we enter the genomic era. Genomic science has conclusively shown that we are biologically one race.³⁸ With such worldwide scientific consensus and the growth of the research enterprise, we should be careful not to overlook the persistent and growing risks associated with social, ethnic, and religious differences. Put another way, as scholars and citizens, we are at risk of failing to respect “the dignity of difference.”³⁹ Jonathan Sacks, a theologian, philosopher, and rabbi, insightfully describes the challenge of thinking about ethical discourse in a pluralistic society: “Plato’s assertion of the universality of truth is valid when applied to science and a description of what is. It is invalid when applied to ethics, spirituality, and our sense of what ought to be.”⁴⁰

Jay challenges us—particularly those of us trained as lawyers—to move beyond law’s traditional focus on physical harms to subjects, to consider how risk-taking on the part of both subjects and investigators enhances or diminishes human dignity.⁴¹ I would propose that in dealing with the issue of race in the genomic era, we must combine Jay’s quest for *individual* human dignity within the research process with a new *systemic or institutionalist* perspective towards the dignity of racial, ethnic, and religious differences. Those of us mentored by Jay, as a teacher, scholar, and friend, are aware that the challenge to be faced involves not only protecting individuals, but also respecting—without stigmatizing—groups and developing analyses of the research process that facilitate that respect.

Genomics, informational technology, and a global economy have dramatically changed our human environment since the publication of Jay’s pioneering book on human experimentation. Alex Capron’s work at the World

38. Patrinos, *supra* note 31, at S1.

39. JONATHAN SACKS, *THE DIGNITY OF DIFFERENCE: HOW TO AVOID THE CLASH OF CIVILIZATIONS* (2d ed. 2003).

40. *Id.* at 54.

41. Jay Katz, *Statement of Committee Member Jay Katz, in* ADVISORY COMM. ON HUMAN RADIATION EXPERIMENTS, *THE HUMAN RADIATION EXPERIMENTS* 543 (1996).

Health Organization demonstrates that the scope of our concern as bioethicists has expanded to encompass the globe and its varied peoples. What has not changed—and, in my view, should not—is our continuous effort to emulate the respect for every human being Jay modeled in his teaching, scholarship, and everyday encounters.