



Presidential Commission
for the Study of Bioethical Issues

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TRANSCRIPT
Historical Investigation – Research Details

Meeting 6, Session 1
August 29, 2011
Washington, DC

1 SESSION 1: HISTORICAL INVESTIGATION - RESEARCH DETAILS

2 DR. HAUSER: Thank you, Jim. Delighted to.

3 Fellow Commission Members and audience, my name is
4 Stephen Hauser from the University of California, San
5 Francisco.

6 I would like to just briefly describe the
7 details of the experiments that were carried out in
8 Guatemala during this two-year period between 1946 and
9 1948 and maybe as a prelude just very briefly discuss
10 the scientific environment and milieu at this time. I
11 think without that, it's harder to understand the
12 rationale for what happened in Guatemala.

13 As we all know, sexually-transmitted diseases
14 throughout the 20th Century have been a giant problem,
15 both in the military and civilian populations. In the
16 military, it was estimated that hundreds of thousands
17 of individuals would become infected if we could not
18 develop effective prophylactic therapy post-exposure.
19 In the civilian populations, these illnesses,
20 particularly syphilis and gonorrhea, were also very
21 widespread.

1 Just as one example, it's been estimated that
2 at least 20 percent of people living in psychiatric
3 institutions at the time were there because of
4 neuro-syphilis. So these were enormous problems.

5 How was disease prevented in the mid 20th
6 Century? Well, the primary method was chemical
7 prophylaxis. I will say a few things here that are
8 graphic but I will keep these to a minimum, but I think
9 that without understanding a bit of the graphic detail,
10 it's very difficult to understand what was done.

11 Soldiers were advised after exposure to
12 urinate, to wash themselves with soap and water, and
13 then for gonorrhoea to inject a silver solution directly
14 into their urethras in the penis, and for syphilis to
15 rub a calomel ointment on their genitals and pubic
16 region. I would say that the evidence that these
17 chemical measures were useful was very limited at the
18 time.

19 There was a new very exciting advance for
20 treatment of established infection, of course, with the
21 development of antibiotics. Sulfanilamide first, a sulfa
22 drug for gonorrhoea, in 1938, and for syphilis,

1 penicillin, which was extremely effective for
2 established infections, first reported in 1943,
3 replaced arsenic-based therapies and earlier very toxic
4 mercury-based treatments.

5 So there was an earlier attempt to study the
6 effectiveness of some of these prophylactic measures in
7 the Terre Haute Prison earlier in 1943 to 1944 that was
8 unsuccessful and these experiments included inoculation
9 of some prisoners with gonorrhoea.

10 So it was with that as a background, as Dr.
11 Wagner said, the first question that I will summarize
12 is the following: what scientific questions were the
13 researchers trying to answer? Some of what we've
14 learned is retrospective, some of it is work based upon
15 the reports as long as a decade later of the principals
16 involved in the studies. So there is very little
17 information or proof in certain aspects of our
18 understanding of this question.

19 However, as stated later, in 1955, the overall
20 goal was to develop an effective prevention called
21 prophylaxis after exposure to syphilis as well as
22 gonorrhoea and then, as a second goal, prolonged

1 observation of individuals exposed to early syphilis
2 and treated with penicillin.

3 According to Dr. Cutler, the original primary
4 aim was to test this local wash named orvus mapharsen
5 against syphilis in prisoners who had recently had
6 sexual activity with an infected commercial sex worker.
7 This primary goal never happened.

8 The experimental transmission of syphilis to
9 human volunteers aligned with the desire to find
10 improved methods of prophylaxis was another aim. The
11 primary purpose of the gonorrhea experiments was to
12 test the effectiveness of a variety of prophylactic
13 measures, including a number of chemical lotions as
14 well as oral penicillin.

15 In his later writings, Cutler wrote that other
16 aims included trying to understand the changes in the
17 blood and in the body that occurred following injection
18 of syphilis organisms and whether these changes were
19 different when the syphilis was taken from rabbits who
20 had been passaging the syphilis or from humans who were
21 infected with syphilis. So were the organisms
22 different when they were coming from the experimental

1 laboratory animal or directly from humans? Was
2 virulence lost when it was passaged in animals?

3 What was the effectiveness of a broader
4 penicillin therapy and intramuscular penicillin
5 prophylaxis, and could treated subjects with early or
6 late latent syphilis become re-infected?

7 So the second question involves what methods
8 were used to carry out these studies and they were
9 basically of two main types, serologic studies, looking
10 at blood and other fluids, and intentional exposure and
11 inoculation studies.

12 The serologic studies included blood draws,
13 preparation of smears, taking tissue from the local
14 areas and culturing these materials. They also
15 involved lumbar punctures or spinal taps to sample
16 fluid bathing the surface of the brain and spinal cord
17 and cisternal punctures which are punctures in the neck
18 rather than in the lower back as is the case for lumbar
19 puncture. So those were the serologic studies done.

20 The intentional exposure experiments that
21 consisted in total of about 50 different experiments
22 involved, first for gonorrhoea, what was called normal

1 exposure which is exposure through sexual contact with
2 an infected carrier, a commercial sex worker.
3 Artificial direct inoculation, for sex workers
4 inoculation by swabbing the cervix, for males
5 inoculation inside the penis, sometimes following
6 sexual exposure, and also inoculation in other body
7 parts, including the rectum and the eyes.

8 For syphilis experiments, there were
9 experiments performed in which there was sexual contact
10 with known infected commercial sex workers, direct
11 injections into the cervix. There were also
12 experiments, called scarification and abrasion, where
13 the penis would be scarred or abraded to make the
14 epidermis possibly more accepting of the subsequently
15 inoculated organisms.

16 For chancroid, another sexually-transmitted
17 disease, there was a single experiment involving
18 abrasion of the penis, the arms, and the back.

19 So let's speak about who was involved, what
20 populations of individuals were involved in this series
21 of experiments. Commercial sex workers, prisoners,
22 soldiers from the military Honor Guard which provided

1 personal protection to the president of Guatemala, and
2 psychiatric patients in a state-run mental institution,
3 so those were the exposure populations.

4 For the diagnostic testing, the serology,
5 lumbar punctures, cisternal puncture population, most
6 of the subjects consisted of children from an orphanage
7 or school, leprosarium patients, U.S. Air Force
8 personnel, and all of the other populations discussed
9 previously in the inoculation studies, and again the
10 serology experiments did not involve intentional
11 inoculation.

12 We believe that more than 5,000 individuals
13 were involved in diagnostic testing, serology or lumbar
14 or cisternal taps, and somewhat more than 1,300
15 individuals were exposed by contact or inoculation to
16 one of those sexually-transmitted diseases.

17 Of the 1,300, under 700 received some form of
18 treatment as best as could be documented. So this
19 involved in total approximately 5,500 individuals in
20 both groups which overlap.

21 Of these groups, we believe that there were 83
22 deaths. We do not know to what degree the deaths were

1 directly or indirectly related to these experiments but
2 there are a number of ways to try to get at this that
3 staff and the Commission are exploring.

4 We do know that with some of the cisternal
5 punctures, there was inoculation of infectious material
6 and that several patients developed symptoms suggestive
7 of bacterial meningitis and one person became paralyzed
8 for a two-month period, almost certainly related to
9 damage to the spinal cord from the needle insertion in
10 the neck.

11 So one last question. Was the methodology
12 sound for the standards of the day? The Commission
13 identified numerous problems with both methodology and
14 recordkeeping. Multiple experiments were conducted that
15 were excluded from Cutler's summary reports. The
16 note-taking was, at best, haphazard. The experiments
17 at times lacked a logical progression. Baseline
18 experiments for background infection rates, for
19 example, were conducted after treatment prophylaxis
20 experiments began. So the timing of the experiments
21 was suboptimal.

22 More experiments were started before the

1 results of the previous experiment was known. There
2 was a clear deliberate effort to deceive experimental
3 subjects and also the wider community, both the
4 scientific and lay community, that might have objected
5 to the work.

6 I would say, in conclusion, that there were
7 also differences in the Guatemala experiments from the
8 Tuskegee experiments. The events occurred over a
9 shorter period of time, ended at an earlier date,
10 subjects in Guatemala but not Tuskegee were subjected
11 to deliberate inoculation, and also in Guatemala,
12 subjects were citizens of a foreign country.

13 DR. WAGNER: Thanks, Steve. Thank you, Steve.
14 Appreciate that review.

15 One of the conversations I know that
16 we've -- a couple of us had offline and, Nelson, I
17 might go to you on this, aside from the ethics
18 questions that just scream from the raw facts, talk to
19 us a little bit about experimental design. Was this
20 even good science beyond that?

21 DR. MICHAEL: Thanks, Jim. Thanks, Stephen.
22 That was a great summary of the dark period.

1 So I'm an experimental researcher myself. I
2 direct the U.S. Military HIV Research Program at the
3 Walter Reed Army Institute of Research. I've been
4 doing science almost my entire professional life and
5 when you look into what happened here, again taking off
6 the ethical imprimatur which is difficult to do, when one does that and
7 looks at in a cold objective way, it's actually
8 difficult to perceive why these kinds of experiments
9 would even pass preliminary muster for asking basic
10 scientific questions in a clinical environment and
11 deriving meaningful information from those kinds of
12 experiments, as heinous as one would view them and one
13 should view them.

14 If we look at them from an objective
15 standpoint, it is difficult to understand the specific
16 aims. Looking at the methodology, the absence of
17 alternative strategies, the haphazard note-taking, as
18 Stephen mentioned, if you look at that body of work in
19 its entirety, my conclusion, and I think I said this
20 pretty clearly in London, it just was bad science. It
21 was bad science.

22 So regardless of what you think about the

1 ethical issues and I think that it's difficult to find
2 any sanction or any succor in the ethical issues which
3 we'll describe and we'll talk about later, from a
4 purely scientific standpoint, I found this body of work
5 really bereft of merit.

6 DR. WAGNER: Barbara, yes.

7 DR. ATKINSON: I'd just like to comment the
8 same way. I absolutely agree that one of the main
9 things that struck me was the work was never published
10 in scientific journals by the people that did the work.
11 They did -- Dr. Cutler did submit a report in 1952 for
12 some of the studies and even later, I believe, for some
13 of the other ones, the syphilis one wasn't reported
14 till 1955, and you can wonder why it never was
15 submitted or they were submitted as secret reports to
16 the people that had funded it but not to scientific
17 journals.

18 And in my mind, it was either because the
19 scientific conclusions didn't match or couldn't really
20 be concluded from the way the studies were done. The
21 records were so poor and the way the studies were set
22 up was so poor that you couldn't really believe the

1 scientific outcome but also I think there was -- again,
2 you can't separate the ethics.

3 I think there was a recognition that these
4 were -- had real ethical issues that would have
5 horrified the public if they'd actually seen them in
6 scientific journals. So I think there were both
7 aspects to the fact that this was never published.

8 DR. WAGNER: Amy, sure.

9 DR. GUTMANN: I think we are beginning with
10 the science, first of all, because you can't even
11 understand why these experiments were done if you don't
12 know what the people who were doing them thought they
13 were doing and they thought they were doing science and
14 presumably they thought they were doing good science,
15 but I think it's important that the Commission states
16 clearly, and we will do this in our report, that there
17 is no dichotomy between good science and ethics, that
18 you cannot have an ethical experiment on human subjects
19 that exposes human subjects to any risk, no matter how
20 small, if you don't have good science.

21 So good science is the precondition, it is the
22 groundwork upon which any experiment with human

1 subjects that's ethical can be done, and so it's very
2 important if you think, well, why even ask about the
3 science because there's some obvious ethical problems
4 with these experiments. The most obvious first ethical
5 problem with these experiments were that they were not,
6 even by the standards of the time, good science.

7 DR. WAGNER: May I ask a little conversation
8 here then? What corrupts then, Amy? I think everybody
9 agrees that there is -- you really can't divorce the
10 two. It can't be good science if it has this sort of
11 violations of safety for human subjects. But maybe we
12 should have a little conversation on what were the pressures
13 corrupting this. I think one could imagine anything
14 from mad science, which I don't think is entirely the
15 case with Dr. Cutler, but we've spoken only about him,
16 but also some of the national pressures, pressures in
17 the national interests being brought to bear at that
18 time.

19 Nelson.

20 DR. MICHAEL: I'll be brief. I am a military
21 officer and a scientist, as well as a soldier and a
22 physician So I can tell you that at the time, World War

1 II was just winding down. The United States was a much
2 smaller population, had almost 11 million people in
3 uniform, had just fought a war that raged across the
4 entire world, and there was significant issues in terms
5 of military readiness to find ways to keep troops
6 healthy and doing their job and not sick and in
7 hospitals. That includes the entirety of medical
8 practice, includes sexually-transmitted infections.

9 So, clearly, there was that kind of pressure
10 that would have provided at least some rationale for
11 asking those kinds of questions, if they were asked in
12 a meaningful and scientifically-rigorous way, and done
13 in an ethical fashion, they would have had value.

14 So I think that I've tried to ask myself
15 whether or not that was really the driver for why the
16 science was just so atrocious because there was just
17 pressure to do that kind of work, but I must say that I
18 can't find that evidence for that being a major driver.
19 What I do find is a relatively junior scientist who was
20 existing far away from the home laboratories that he
21 reported to without much local mentorship in terms of a
22 scientific mentorship and lack of periodic review.

1 I think those are -- you know, I'm dealing
2 with hypotheticals, but I tried to put myself in that
3 individual's shoes back in 1946 and he was pretty far
4 away from effective mentorship and I think his work was
5 desultory and described a meandering pathway.

6 I'm not sure he really knew what he was doing
7 scientifically from a standpoint of rigor, but I would
8 say that I think the pressures of the time of the
9 military issues that were at that time had -- frankly,
10 the United States was demobilizing. We
11 demobilized very, very quickly at that time. So I don't
12 think that can be a reasonable justification.

13 DR. WAGNER: Christine and then John, Nita.

14 DR. GUTMANN: Introduce yourselves, actually.
15 Thank you.

16 DR. GRADY: I'm Christine Grady. I work
17 currently at the National Institutes of Health,
18 Clinical Center, Department of Bioethics.

19 What struck me about this question of what
20 happened, the scientific questions that Steve read that
21 were articulated after the fact in the reports were not
22 unreasonable questions. They were actually good

1 questions. What can prevent syphilis? You know, does
2 penicillin prevent it if it's given post-exposure?
3 Those are reasonable scientific questions.

4 The problem is it wasn't clear from the
5 history whether or not those questions preexisted the
6 studies or came up later, Number 1, and, Number 2, even
7 if they did preexist what the conduct of the studies,
8 it doesn't justify how they tried to answer them.

9 So it's a really complicated issue in terms of
10 what made them do it. I don't know that we'll ever
11 really know the answer to that question, but it is
12 absolutely true, also, that at that period of time,
13 Nelson spoke about military readiness, but a major
14 focus of research was STDs. I mean that was one of the
15 major problems in the United States for sure, maybe
16 around the world, and so a lot of research was focused
17 on trying to find ways to treat and prevent STDs.

18 DR. WAGNER: John.

19 DR. ARRAS: Yeah. Thanks for that historical
20 background. It was very well done, really appreciate
21 it.

22 DR. GUTMANN: Introduce yourself.

1 DR. ARRAS: Oh, I'm sorry. John Arras. I
2 teach Philosophy at the University of Virginia.

3 When we think about the moral dimensions of
4 this study, we make a distinction in our report between
5 contemporary standards, what we think today about the
6 principles and practices in research and what people
7 thought at that time, and I want to raise a similar
8 question here with regard to scientific methodology,
9 right, because, I mean, if you read any study published
10 in a medical journal, there are always going to be
11 people who are going to quibble with the methodology.
12 There are always going to be people who say, well, the
13 methodology isn't quite right. It subtracts from the
14 scientific value of the study.

15 I'd like to get your opinions on, you know,
16 the extent to which you think this set of studies
17 really deviated from a contemporaneous conception of
18 good enough science at the time and what was it
19 precisely about the defects in their methodology that
20 undercut the research.

21 In other words, were the defects things that
22 cast some measure of suspicion on the results or was it

1 more serious than that? Did they just completely
2 subvert any kind of scientific validity that we could
3 have expected?

4 DR. WAGNER: Is that to us generally or are
5 you asking Steve in particular because I have my own
6 view on that.

7 DR. ARRAS: Well, you know, I don't even
8 pretend to be a doctor on TV, you know. So I'm
9 primarily interested in the opinions of people with
10 scientific background but, you know, whoever wants to
11 take a shot at it, sure.

12 DR. WAGNER: Well, it's not unusual even in
13 modern science to pose a hypothesis that assumes that
14 one can build an experiment around that hypothesis.

15 In this case, if part of the hypothesis was what
16 might be an appropriate prophylaxis for these sorts of
17 diseases and the experimental design requires a pool of
18 people infected and it turns out that that's the bad
19 assumption, that it turns out that I can't actually
20 build that experiment, and then to get stuck in that
21 and run out of control because you have deviated from
22 good scientific practice happens sadly all the time, I

1 hope with not these sorts of tragic results, but it's
2 not unusual for, particularly as you say, an unseasoned
3 scientist to find that they are spending all of their
4 time redefining, pursuing, reshuffling the cards of the
5 experiment and almost forgetting the hypothesis that
6 they had originally and losing discipline as a result
7 of that.

8 I'm sorry. Steve, were you going to comment?

9 DR. HAUSER: Yes. I would, I think, agree
10 completely with Dr. Wagner's position and with what
11 some of the others have said.

12 The decision that one needs an experimental
13 group who are infected under certain conditions so that
14 you can then judge the effectiveness of therapy was
15 solved by actually infecting a group experimentally.

16 Second, there was a published literature at
17 the time indicating that in this specific situation,
18 this was unethical and not achievable.

19 Third, the data was kept private and records
20 not kept to standards of the time and, fourth, the data
21 was not published.

22 DR. WAGNER: I think Anita was next and then

1 Barbara.

2 DR. ALLEN: There seemed to be a mixing of
3 research scientific goals with therapeutic goals in
4 some of these experiments and the one that stands out
5 that I'd love to have you comment on, Stephen, is the
6 experiment in which there was cisternal puncture of
7 epileptics and their rationale was, well, maybe this would
8 shock the epileptics into not having seizures anymore
9 which strikes me as being something that a contemporary
10 neurologist might, you know, find baffling or at least
11 puzzling.

12 What do you think about that? I mean, was
13 there in this case an inappropriate, from a sort of
14 scientific point of view, inappropriate mingling of
15 research agenda and possible therapeutic medical
16 treatment?

17 DR. HAUSER: We have treated epilepsy over
18 time in numerous inappropriate non-evidence-based ways,
19 but I thought that for this particular situation,
20 Anita, that this was part of a post-hoc description of
21 the variety of benefits that might accrue from these very
22 sad experiments.

1 Others included the goal to establish a
2 competent infrastructure for STD treatment in Guatemala
3 to better understand the natural history of STDs and to
4 understand ethnic differences in the clinical
5 manifestations of these disorders.

6 So post-hoc, there were numerous
7 rationalizations given for this work but clearly the
8 primary goal was to establish models of infection in
9 human beings to test the effectiveness of treatment.

10 DR. WAGNER: Barbara.

11 DR. ATKINSON: I just would like to go back to
12 John's question a little bit and talk about the
13 methodology using the syphilis as an example.

14 In my mind, it goes even back further than in
15 some of the mistakes they made. In syphilis, you can't
16 always tell if a person has it or not if you miss it at
17 the first primary stage and so that's why they wanted
18 to do the serologies to find out if there was a
19 background level in the population that had it or not
20 because their studies wouldn't be meaningful if there
21 was and they actually found a high background level but
22 they didn't do those studies until after they'd done

1 the original ones infecting people. So they did it in
2 the wrong order. They didn't look at that first.

3 Then when they infected people, they tried the
4 commercial sexual workers but they found almost no
5 transmission that way, very low levels, five percent
6 maybe transmission that way. So they had to readjust
7 right in the beginning and they just kept readjusting,
8 readjusting all out of order, all out of synchrony,
9 without any kind of a plan, and that really was in my
10 mind what was the matter with the methodology of the
11 whole thing.

12 So you can't prevent something if the people
13 who already have it and you can't know if the results
14 are accurate in the end when you've had so many
15 different changes to the protocol as you went along and
16 so much variation in everything you try.

17 DR. WAGNER: I'm sorry. Yes, Nita.

18 DR. FARAHANY: I want to build on that just to
19 be crystal clear. So as we talk about the methodology
20 being flawed and the fact that the reports weren't
21 published, are we clear that there was no -- nothing
22 that we've learned from these experiments -- I mean,

1 for example, given that at the time this was such a
2 priority for the military, that it was such a priority
3 for understanding STDs and the effect of penicillin for
4 having models, were these studies in fact -- did they
5 yield valuable science nevertheless or, Barbara, as you
6 put it, is it such that because the methodology was so
7 tainted the accuracy of any of the studies, whether
8 they are models or the treatment of penicillin for
9 syphilis or for any other studies, that simply there
10 was no value to the studies whatsoever?

11 DR. MICHAEL: There was no value, Nita. I
12 mean, it was -- I think Stephen laid it out pretty
13 nicely when he went down the list that included, you
14 know, poor note-keeping, but a meandering research
15 series of questions.

16 I think what stings the most for them in terms
17 of it being bad science is that the work never passed
18 peer review, it was never published, and in my world,
19 if it's not published, it's as good as not done and
20 therefore it doesn't influence medical practice or
21 advance the field.

22 DR. WAGNER: You can't build on it. Yes, Amy.

1 DR. GUTMANN: When we talk about bad science,
2 when it is science involving human subjects, one of the
3 things that comes most glaringly in focus is how bad
4 science abuses human subjects when there's any risk
5 involved.

6 In this case, as I read through the historical
7 documents and reread them and read them again, I kept
8 asking the question of what -- how could they do this?
9 These were people who had a certain pedigree. I mean,
10 they were as young and inexperienced as Dr. Cutler was,
11 Dr. Mahoney was not inexperienced, and people all the
12 way up the chain who knew about the experiments. There
13 were other people kept in the dark but the people who
14 knew about them approved of them, and this is a segue
15 to the discussion of the ethical aspects of it, but the
16 conclusion that I come to in this is the only way such
17 bad science could be done, so serology studies done
18 after the evidence was needed that they would yield on
19 human subjects.

20 Now mind you, the serology studies didn't
21 impose the worst risks on some of the human subjects,
22 except the ones that included lumbar and cisternal

1 punctures which did, how could that happen?

2 My conclusion is, and it has to be a reluctant
3 conclusion when you're judging other human beings, that
4 the people who were doing these, people in positions of
5 authority and responsibility and privilege, doctors did
6 not treat those human beings as if they were human
7 beings worthy of respect, worthy of consideration as
8 human beings, that the only way you could continue
9 doing this is to think of what you were acting on as
10 material as opposed to other human subjects, and that
11 I'm not saying that's the way they thought but that's
12 the way you could only act like that if you think,
13 Number 1, you're doing good science which I think no
14 doubt they must have believed, and, secondly, the
15 people you were doing it on don't matter as much as the
16 people you would normally be associating with in your
17 daily life, your family, your friends, and other
18 people, because as we will get into the next section,
19 the people weren't asked to consent to these
20 experiments, they weren't told what the risks were, and
21 the experiments were not done according to the
22 standards of science at the time, the good standards of

1 science at the time.

2 DR. WAGNER: I'd love to take your segue but I
3 do have one other --

4 DR. GUTMANN: No, I didn't mean it to be, but
5 it's the way in which you can't separate science and
6 the fact that it's operating on human beings.

7 DR. WAGNER: I think Nelson would suggest that
8 if it were even dealing on things, it was still bad
9 science.

10 The point there --

11 DR. GUTMANN: But not as bad.

12 DR. WAGNER: One point I'd like to hear us say
13 to each other, and I hope we can say this, it is so
14 easy to look back on a whole history of failed science
15 of all different kinds, you know, and to bash it from
16 our perspective.

17 I want to make sure that we are not doing that
18 and I don't think we are. I just want to hear the
19 Commission say that, that we believe really at the
20 standards available at the time, with the
21 sophistication of scientific practice in that era, and
22 not just in our own hindsight, do we feel that this was

1 appropriate science.

2 Raju, you haven't said anything. Let me turn
3 it to you and introduce yourself, please.

4 DR. KUCHERLAPATI: Raju Kucherlapati from
5 Harvard Medical School.

6 I think there are a couple different points
7 that have not been mentioned. I think that they're
8 very important.

9 One is that prior to the initiation of the
10 study, there was a proposal that was made and the
11 proposal was reviewed by a group of peers and there
12 were different points of view by that group. So the
13 original proposal to do the experiments, whatever they
14 were, were, indeed, reviewed by the peers and the
15 funding was based upon that review. So that's an
16 important component.

17 The second thing that I think that's also
18 important to recognize is that throughout the period of
19 the time that the experiments were conducted, there
20 were reports that were sent from Guatemala to
21 Washington, D.C., and there are individuals who had the
22 opportunity to actually see the reports and they're not

1 the people who are inexperienced people. These are
2 people who are tremendously experienced and
3 knowledgeable about what is going on and are at a
4 distance from the experiments.

5 So one cannot say that the principal, Dr.
6 Cutler, who was doing the experiments, whatever the
7 motivations and however he did the experiments, there
8 were, indeed, opportunities for other people to review
9 what was happening and that the other groups had the
10 opportunity to have those findings reviewed by the
11 appropriate people, if they didn't know by themselves,
12 or they would be able to say that, you know, these
13 experiments are not scientifically -- this is not the
14 way to go and that you should, you know, do
15 differently.

16 So those two are actually very important
17 points to mention.

18 DR. GUTMANN: That's why whatever we say, I
19 think it's very important that this is not the action
20 solely of a principal investigator. This principal
21 investigator reported up, Cutler to Mahoney and all the
22 way up. They did, the people who were in the know, did

1 want to keep it secret because they feared that if it
2 were to become more broadly known, it would be subject
3 to public criticism.

4 There were some doctors who dissented. There
5 was a doctor who wanted to be involved and they were
6 afraid to involve him because he might be critical. So
7 there were different views in the scientific community
8 at the time but what Raju is saying is absolutely
9 right. This is not the actions of one person and what
10 I've said is to suggest that it was not an accident
11 that this happened in Guatemala with a foreign
12 population that was seen as ethnically, racially,
13 nationally different because we do know that some of
14 the people who were involved in this experiment said,
15 explicitly said we could not do this in our own
16 country.

17 DR. WAGNER: Christine had a comment, Lonnie,
18 and then I think we'll wrap this session.

19 DR. GRADY: I wanted to respond, Jim, to your
20 comment that we should not bash science without
21 understanding it and go back to Nita's question about
22 value.

1 I think some of the serological work actually
2 probably did have some value. They were published.
3 They compared different serological tests, you know.
4 That was not useless science in some respects, and also
5 for the most part, although there were some exceptions,
6 as Steve pointed out, did not expose the people that
7 were involved in them to a great deal of risk. So
8 there is some value perhaps in those studies.

9 The second thing I think is important to put
10 on the table is I think Steve mentioned that one of the
11 scientifically wrong aspects of this set of experiments
12 was using human beings as a model, an infectious
13 disease model, and I think we need to be very cognizant
14 of the fact that this was certainly not the only study
15 that did that and that even today, we use those kinds
16 of models.

17 So that if that is not in my view anyway the
18 thing that makes these set of experiments wrong but
19 there are lots of things about how those kinds of
20 infection experiments are done that are very important
21 to make them acceptable.

22 DR. WAGNER: Lonnie.

1 MS. ALI: Hi. I'm Lonnie Ali, caregiver.
2 Coming from a lay point of view and not having the
3 medical background and just reading this and being
4 horrified by a lot of what I was reading, I just don't
5 want to belabor Dr. Gutmann's point, but I think it's
6 important to note that if -- that these being doctors
7 and medical scientists and doctors who are supposed to
8 do no harm, to do good, I think it's important to note
9 that even though during these course of experiments and
10 studies that were going on and there was actually a
11 prophylactic that was discovered, penicillin, that was
12 effective and they decided to change course and figure
13 out whether or not penicillin could prevent infection,
14 but what was important to me, too, is that the way they
15 viewed the Guatemalans is that they left so many people
16 untreated after they had infected them.

17 It was like they were disposed of, they didn't
18 care what happened to them, and, you know, what
19 happened to them after they had actually been infected
20 with something that they intentionally infected them
21 with. So I think that's important to note, that when
22 it goes to how these people were viewed, that when they

1 had the opportunity to treat them and cure them of this
2 STD, that they failed to do so. They left so many who
3 were actually involved in the study, not people outside
4 in the general population but people who were actually
5 involved in the study, left them untreated.

6