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Bad Blood: Medical and Ethical Implications of the Tuskegee Syphilis Study

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“For the most part, doctors and civil servants simply [do] their jobs,” explained Dr. John R. Heller, Jr., director of the Venereal Diseases division of the United States Public Health Service from 1943 to 1948 [1]. “Some merely follow orders,” he continued; “others work for the glory of science.” On the surface, Heller’s statement innocuously reflects the general arc of the medical profession and its position as a force for progress. What Heller actually meant was, shamefully, far more sinister.

Heller, alongside dozens of physicians from 1932 to 1972, facilitated the Tuskegee Study of Untreated Syphilis in the Negro Male, one of the most notorious violations of ethical principles and patients’ rights in U.S. history. Over the course of the study, 399 African-American patients with syphilis, colloquially known as “bad blood” in the early 20th century, were falsely informed that they were receiving treatment for their disease, when in fact they were being monitored until death as the disease ran its unaltered course [2]. For forty years, physicians working for the Public Health Service performed an unethical, racially discriminatory study on a mass scale under the false guise of advancing scientific progress. The study significantly damaged trust in physicians among African-Americans, worsening their health outcomes, and prompted the medical community to establish more exhaustive ethical codes to prevent continued injustice in the medical field. Attempts to advance medical knowledge, though crucial to human survival, engender more harm than progress when conducted at the expense of justice and human rights, as witnessed in the Tuskegee Syphilis Study.

The Tuskegee Syphilis Study was not always intended to be malicious. It was originally conceived as a 6-month study followed by a treatment phase until funding for treatment was withdrawn after the economic fallout of the Stock Market Crash of 1929 [2]. Rather than postponing the study, however, physicians within the PHS became enthused by the idea of a
long-term experiment in which syphilis was allowed to run its full course on the human body without intervention. Dr. Thomas Parran, Jr., Health Commissioner of New York and future Surgeon General of the United States, suggested performing the study in Macon, Alabama, an impoverished county with a majority African-American population [3]. Parran recognized that the high poverty rate would increase the likelihood of participation due to the enticing promise of free health care and covered funeral costs offered by the study. However, both offers were deceptive and self-serving. The physicians covertly avoided treating syphilis-related complications, the primary health concern of the patients, and they covered funeral costs solely to ensure that they could perform an autopsy prior to burial [4]. Furthermore, offering free “health care” ensured that patients would not turn to other health care providers, who might discover the presence of syphilis and treat it, interfering with the study.

Indeed, the PHS actively hindered patients from accessing real treatment or even understanding their disease. Penicillin was established as the standard treatment for syphilis merely fifteen years after the study began, but physicians never offered it to a single patient in the study, despite its widespread accessibility and low risk of complications [4]. Instead, physicians performed spinal taps on patients, collecting fluids to use in the development of syphilis screening tests while claiming the procedure itself was the treatment. Additionally, physicians never clarified to patients that they specifically suffered from syphilis rather than “bad blood” or educated them on exactly what their disease entailed [2]. When questioned by patients who believed they had discovered alternate treatment methods, physicians insisted that there was no other valid treatment for their disease and directly deterred patients from accessing treatment programs available to other residents of Macon.
An advantage conferred by preying on the impoverished was their willingness to trust physicians more readily than highly educated patients might. Dr. Sidney Olansky, director of the study from 1950 to 1957, explained, “The fact that [patients] were illiterate was helpful, because they couldn’t read the newspapers. If they were not [illiterate]… they might have been reading the newspapers and seen what was going on,” referring to the newly validated use of penicillin to treat syphilis [4]. Low health literacy made patients more vulnerable to deception. They were falsely informed that the study would last for six months, yet when the study continued on for years, they easily accepted the idea that their treatment simply needed more time.

Although medical ethical codes had not yet been widely established by law, the government-backed Tuskegee Syphilis Study violated and raised questions about timeless ethical principles, especially pertaining to patient autonomy and justice. A primary issue at hand was informed patient consent—the process of receiving permission to conduct medical treatment or research on a patient if and only if the patient or legal guardian clearly understands the full implications of the treatment or study. Early interpretations of the Hippocratic Oath, a foundation of medical ethics, advised that physicians conceal medical information from their patients as much as possible for the sake of beneficence [5]. It even deemed it acceptable to lie to patients when the physician sees fit. Conversely, influential post-Enlightenment physician Thomas Percival, whose 1803 book Medical Ethics laid the groundwork for the American Medical Association’s 1847 Code of Medical Ethics, opined that patients deserve truthful information regarding their medical condition. Nevertheless, he still made no mention of whether patient consent is explicitly requisite to treatment and research.

It was not until the Nuremberg Code was established in 1947, after the infamous Doctors’ Trials, in which Nazi physicians were tried for the countless medical experiments they conducted
on concentration camp prisoners during World War II, that informed consent from patients was legally recognized as an ethical principle of medical research and treatment [6]. The Nuremberg Code heavily influenced the 1964 Declaration of Helsinki; together, these two documents, initially dismissed by Western entities like the American Medical Association for their heavy emphasis on informed patient consent, contradicting the teachings of Hippocrates and Percival, proved to be cornerstones for international regulations that revolutionized human rights and research practices [7]. Despite the establishment of these documents during the course of the Tuskegee Syphilis Study, researchers made no attempt to alter their methods or acquire informed consent from their subjects at any point, demonstrating a complete disregard for patient autonomy and justice.

Physicians conducting the Tuskegee Syphilis Study attempted to justify their methods, wading in controversial grey areas of medical ethics. They rationalized that participants in the study, impoverished African-American men in the Jim Crow South, would not have received treatment for syphilis regardless due to their race and socioeconomic status, so the experiment effectively did no harm [4]. Moreover, they alleged that information gleaned from the study was for the sole purpose of advancing medical knowledge. The question of whether scientific progress outweighs patients' rights, raised in the aftermath of this study, prompted the passage of the National Research Act by Congress in 1974, which created the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research [2]. The Commission dictated new guidelines for human subject research, establishing the priority of informed consent of all human research subjects. The Office for Human Research Protections, a division of the Department of Health and Human Services, was also founded, which implemented Institutional
Review Boards to ensure that research conducted in the United States adheres to ethical principles in medicine, a practice still in existence to this day.

While strides were later made to prevent continued healthcare injustice, terminating the Tuskegee Syphilis Study provoked resistance from prominent medical institutions. As medical ethical codes became more thorough and increasingly prioritized informed patient consent throughout the 20th century, the Public Health Service devoted more effort to keeping the study clandestine rather than simply halting it [4]. It was not until Peter Buxtun, a young social worker, discovered ethical violations upon interviewing patients that action was taken to terminate the study. Buxtun initially sent a letter to the director of the study, who, with the support of the Center for Disease Control and Prevention and the American Medical Association, rejected the letter. Buxtun then leaked the story to the press in 1972, instigating acute public outcry that successfully led to the study’s termination. The NAACP filed a subsequent lawsuit that resulted in the U.S. government paying nine million dollars to survivors of the study, and in 1997, President Bill Clinton issued a formal apology. Though action was taken to compensate the victims, there has been lasting damage in the relationship between African-American populations and the medical community.

The United States has a prolonged history of abusing African-American communities in countless ways, including in health care. Dr. Martin Luther King, Jr., killed four years before the public fallout of the Tuskegee Syphilis Study, asserted that “of all the forms of inequality, injustice in health is the most shocking and inhuman” [8]. Ultimately, 128 patients in the study died of syphilis or related complications. Forty passed the disease on to their wives, and nineteen children of patients were born with congenital syphilis [2]. It was not a coincidence that an impoverished black community like Macon, Alabama, was victimized by this sinister study; it
was merely part of a longstanding tradition of exploiting marginalized populations and denying them fair access to proper health care while condoning and even rewarding oppressors.

The Tuskegee Syphilis Study was conducted by the U.S. Public Health Service, the primary division of what would become the Department of Health and Human Services, and was fully supported by the Center for Disease Control and the American Medical Association [4]. In other words, the mass abuse of African-Americans was sanctioned by the U.S. government and defended by the largest association of physicians in the nation. Dr. Thomas Parran, Jr., who first proposed performing the study in an impoverished black community due to the ease with which it could be exploited, went on to become the Surgeon General of the United States in 1936 [3]. Dr. Sidney Olansky, director of the study from 1950 to 1957, became an esteemed professor of dermatology at both Duke and Emory University [9]. Dr. John R. Heller, Jr., director of the study from 1943 to 1948, became director of the National Cancer Institute and President of the Memorial Sloan-Kettering Cancer Center [10]. Heller also received the World Peace through World Health Award from the Eleanor Roosevelt Cancer Foundation and was featured on the cover of Time magazine. None of the physicians who perpetrated the atrocities conducted during the study were held responsible for their roles during their lifetimes; rather, they went on to hold powerful positions and receive prestigious awards. Conversely, Peter Buxton, who leaked the story to the press, risked his career and endured severe opposition from the Public Health Service and the American Medical Association for his role as a whistleblower [4]. He eventually turned to a career in law instead of health care.

The outcomes of those who were involved in the study reflect a practice of pardoning those who commit injustice and punishing those who seek to rectify it. It is easy to disregard the urgency of this matter and accept the Tuskegee Syphilis Study as simply the product of a more
racial divisions. However, it is quintessential to recognize modern-day parallels, in which marginalized populations do not receive the same protections and level of care as wealthy, white populations. Is it mere happenstance that, decades after the promise of free health care offered by the study, places like Macon County still do not have 24-hour medical service [11]? Members of the medical community have a responsibility to promote justice and actively condemn ethical violations and inequality, despite intimidation or opposition, to ensure a future in which patients' rights are protected and in which all individuals have fair access to proper health care.

The harmful consequences of healthcare injustice are still as poignant today as they were when the Tuskegee Syphilis Study ended. It should come as no surprise that to this day, African-Americans have a higher degree of medical mistrust than their white counterparts [12]. This mistrust translates to a decreased willingness to seek medical treatment, increased use of emergency medical services due to prolonged avoidance of primary care, and worsened overall health outcomes. One study measuring mortality in African-American men suggests that average life expectancy dropped by 1.4 years following public disclosure of the Tuskegee Syphilis Study, accounting for nearly 35 percent of the gap in life expectancy between black and white men [13]. Several other ongoing factors contribute to this disparity in health care, including racial bias of physicians. Physicians have been shown to respond more accurately to pain in white patients than to that of any other demographic [14]. One study found that physicians are twice as likely to underestimate pain in black patients than in white patients [15]. Hence, black patients are substantially less likely to receive proper diagnosis and treatment for their medical issues. This discrepancy stems from unfounded biases primarily held by white physicians regarding biological and cultural differences between black and white people in regard to pain tolerance. Strides must be taken to educate physicians regarding cultural competence and racial sensitivity
to minimize prejudice and ensure that the deliverers of medical treatment are not the ones perpetuating inequality. Undoubtedly, bad blood still exists and remains untreated between African-Americans and health care in the United States, even in the 21st century.

Medical research is an inextricable element of scientific progress. Physicians who conduct human research play a crucial role in advancing medical knowledge and promoting human survival, but they carry an immense responsibility—to uphold ethical principles and to protect patients’ rights. Progress in the absence of justice is futile. The Tuskegee Study of Untreated Syphilis in the Negro Male may have originated as a genuine inquiry into the nature of a formidable disease, but removed from ethical principles and practices, it devolved into one of the most abominable cases of racist, predatory manipulation and experimentation in U.S. history, at the hands of physicians and prestigious medical institutions throwing ethics to the wind. Medical professionals today have a choice: support progress through ethical means while upholding justice in health care and avoiding bias in their treatment of patients; or be complicit as peers and institutions exploit the poor and disenfranchised for the sake of convenience at an expense whose lingering damage will seep through marginalized populations for generations.
Works Cited


