Body as Object: Ethical Concerns Underlying Medical Research and Practice

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What ordinary people would consider violations of ethical norms of society are seldom seen as such by medical practitioners and researchers who may go against such norms in the larger interests of science. The conduct of clinical trials in India illustrates this conflict which arises primarily because of particular objectifications of the human body. This article emphasises the need for drawing upon philosophy and the sociology of science, and their inclusion in medical curriculum in order to develop ethical practices within the medical community.

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The Karnataka department of medical education's sudden decision to impose a temporary ban on clinical drug trials and research projects, in both private and government medical colleges and hospitals in Karnataka, was announced recently by Medical Education Minister S A Ramdas.[1] A two-month temporary ban would purportedly give time to a committee to study measures to regulate clinical trials across the state. It was hurriedly revoked by the Karnataka chief minister the very next day: B S Yeddyurappa denied the ban when speaking at a Biotrade expo in Bangalore, in what could be seen as a placatory gesture to the biotech brigade. As yet, it is not known what prompted the sudden ban or its immediate revokal; the media quoted Ramdas saying it was against the use of people as "guinea pigs". He said he was also against corporate-sponsored junkets to foreign countries, given as an incentive or pay-off to medical researchers for conducting clinical research.

Interestingly, following the Karnataka government's see-saw on clinical trials, there were reports in the mainstream media on the inquiry into the clinical trials of the Human Papillomavirus (HPV), an anti-cervical cancer vaccine, done in Gujarat and AP, which resulted in the deaths of four girls.[2] It was reported that a team of three senior doctors who helped in the investigation "found almost everything was wrong with the HPV vaccine trials, the most prominent one being the questionable lack of ethical standards".[3] The connection between the announcement of the temporary ban, its subsequent denial, and the report of the inquiry committee in the HPV clinical trials could be clearly made and sounds a warning bell to civil society of the dangers of unregulated or poorly regulated clinical trials.[4] Another more ominous interpretation, given the current proclivities towards neo-liberalisation, points to this as yet another instance of the shift in the position of the State which is seen increasingly as "steward" of the private sector, "promoting and smoothening the process of privatisation".[5]

Despite its sudden demise, the flopped ban, however, does serve other purposes: it draws the attention of civil society to the necessity of regulating medical research in the face of increasing numbers of private and global players in public health. It has been estimated that soon about 20% of global clinical trials will be in India.[6] As things stand, the medical community itself will not be able to come up with such regulatory frameworks which, in fact, must be framed with active participation from the larger civil society. The ban also provides an opportunity to reflect on the underpinnings of the larger medical system comprising doctors, educators and researchers. Thus, rather than reacting to and regulating superficial manifestations of unethical behaviour such as sponsored junkets and other

incentives/pay-offs to medical researchers, this event alerts us to at least three issues about the possible regulatory framework: first, it must take into account the basis of knowledge of that very system in order to understand the scope of the problem of ethics; second, it must make medical researchers more accountable to the norms of civil society rather than allowing a laissez-faire attitude to prevail; third, it must feed into both professional as well as educational contexts in order to effectively cultivate ethical perspectives in the long run.

Scant Research

There is scant research on the philosophy of medicine in India although what has been done is extremely significant.[7] Much more has been done on the philosophy and sociology of science and this has illuminated our understanding of the practice of science itself – the paradigms of knowledge, the politics of science, and even, most recently, the place of women in science.[8] While it has been pointed out that there is "[w]ide though not unanimous agreement that clinical judgment, or at least diagnosis, is based on, or at least strongly influenced by, scientific elements" ("Medical Ethics: Who Decides What?", *Journal of Medical Ethics*, Vol 9, No 2, 1983), it is not immediately apparent whether and to what extent critiques of science which have come from philosophy, history and sociology of science would be appropriate and sufficient for medicine, particularly in the Indian context. Such critiques of science may, however, be good starting points to engage with questions of ethics with medical researchers.

For instance, both doctors and medical researchers currently work within a scientific paradigm where there is a difference between "subject" and "object". The transmutation of "object" into "objectification" as a concept worthy of attention has been used mainly in Marxist and feminist studies and critiques. In medical education and research, this conceptual difference is not customarily addressed and its implications are even less understood despite the fact that there is a clear practice of the objectification of the human body by doctors. This is no mere quibble over language but draws our attention to the strong political implications of practice, as I shall explain below. I suggest that it is this objectification which underlies many of the problems related to ethical issues prevalent in medicine, and is part of what has been often called "the clinical gaze".[9]

Objectification of the human being by doctors takes several other more concrete and familiar forms. Famously referring to patients as "cases" and "bed numbers", again for so-called expeditious reasons, doctors continue the charade of treating human beings albeit as inanimate objects under the guise of a medical paradigm.[10] Organs will always be "the heart", not *your* heart; "the kidneys", never *your* kidneys. By removing possessive pronouns from their references in the presence of the very patients themselves, doctors reveal their views of our bodies as isolatable and open to manipulation, and therefore objectified.

While many in the medical profession defend such objectification as requisite to their profession, a kind of "distancing" in the face of continuous suffering and trauma, the experience of common people suggests otherwise. The increasing specialisation of the medical profession and the inability of biomedicine to treat the complete person are two instances which point to the objectification of the human body. A decline in the "bedside manner" of doctors is yet another indicator of such objectification. Such instances have less to do with (bad) practices and more to do with the assumptions and the world view underlying medicine, and, as such, comprise a paradigm of sorts. Whereas feminist critiques have revealed the darker side of treating women as objects as, for instance, their sexual objectification in advertisements, one of the most important aspects of this darker side is that it points to the lower status of women vis-à-vis men, and their concomitant powerlessness. Similarly, we must see how the medical profession has taken our bodies away from ourselves under the guise of medical treatment and examine how power is intrinsically involved in this. Such an understanding is critical when seen in the current neo-liberal scenario, where increa sed corporatisation enhances the scope for such objectification as it is dependent on extreme forms of objectification for its "success".

Objectification in Clinical Trials

Objectification is also revealed in the rampant, unregulated (and in some cases genuinely naïve) conduct of clinical drug trials. All is fair in the name of medical research since the benefits are supposedly for the rest of humanity. Currently, it is largely people from western Europe, south and central America who are being recruited for clinical trials by American companies. It is anticipated however, that due to a variety of reasons, India will provide a substantial amount of these human resources in the near future (Srivastava 2010: 1505). Unfortunately, it is the poor, weak and vulnerable who are disproportionately represented in this scenario.[11] We do not need to evoke pharmaceutical companies, especially foreign ones, to observe this commonly observed and unethical act within India itself. The clinical gaze must turn upon its own navel. Others have remarked upon the "new colonialism" inherent in some of these clinical trials conducted by multinational companies in developing countries.[12] As such, clinical trials are only another manifestation of a world view of neocolonisation where poorer nations (and poorer people in these nations) effectively pay the price of medical research with their very bodies.

This is not "just" an exploitation of poor by the rich; it also indicates how easily we have bought into a paradigm which creates and validates knowledge begotten this way. If such advancement of medical knowledge is at the cost of poor and marginalised people, it is imperative that we understand it to be an ethical issue – where some people benefit but at the cost of many others who are powerless, in one way or the other, to decline participation. It is not only the poor who are exploited but more generally the vulnerable which in turn reveals how powerless we all are in any interface with the medical community, effectively giving them a carte blanche. To many ordinary people, approaching a sick person to take part in research may itself be considered an unethical act since one may be in possession of one's faculties but still be vulnerable because they are seeking medical care. However, to a doctor,

this situation has nothing to do with ethics, much to do with pragmatics. To the medical fraternity, bodies, rich or poor, are free game to be harvested in the name of scientific knowledge; bodies are thus objects of the most accessible kind to doctors. In this sense, the Karnataka medical education minister's use of the word "guinea pig" may well be an accurate observation.

With this wide difference in perceptions of the ethical norms between ordinary people and the medical professional, much more needs to be done to make this relationship more equitable and more in accordance with the ethical norms of the larger society.[13] Further, it is central to formulating policy as well as influencing practice, for it will show us what real alternatives exist, if any.

While ethical considerations of medical research require informed consent from patients before any clinical trial or medical research is done, and imply the freedom to say "no", imagine what kinds of freedoms are compromised when a sick person has a form thrust under her nose and a summary of the research study to be done is rapidly gone through. In some cases, it is quite possible to imagine the perfunctory nature of much of these information-sharing situations under which consent is obtained.[14] Researchers are obliged to state that care for the patient will not be denied; care will also not be stopped, if already underway. But these are empty promises unless the power hierarchy is clearly understood and taken into account.

Hierarchy

The fact of the matter is that hierarchy is intrinsically built into this relationship: not just asymmetry between the doctor and patient, but also the inherent hierarchy of knowledge which underlies this. In this sense also then, the patient is vulnerable because at the receiving end of care from a powerful figure. The doctor (anyone in a white coat) is seen as powerful and, regardless of personal preferences on being subjected to research, must be placated and pacified by the patient agreeing to participate in the research. Worse, they may even feel it would benefit them. This power of the doctor appears in yet another guise when "doctors feel that they have a right to decide what is good or bad for their patients and deliver accordingly" (Srivastava 2010: 1506).

In the Indian scenario at least, doctors routinely do not explain procedures of possible side-effects to patients, even in the best of private hospitals. To raise a question about the possible negative effects about any of the procedures and/or medications which are already on the market merits only impatience or a facile denial of their possibility. This further ensures the powerful visage of doctors with whom we have only a one-way conversation and whom we must believe to be omniscient about our body/illness. How much more ire or baseless reassurances will be drawn by our questions regarding consequences of chemicals can only be envisaged.

This is not an issue relevant only to the medical community. The larger scientific community also deploys their technical knowledge claims to negate democratic discussions on so-called scientific issues such as building of dams and nuclear energy plants which profoundly impact the lives of people. Thus, we cannot talk about medical ethics without engaging with the larger problems of science which require an understanding of, and engagement with, the history and philosophy of science.

Making Research Ethical

What are the real rights of patients in this situation? What is the nature and value of "informed consent"? Is it possible to negotiate the politics inherent in this relationship? In other words, in what contexts and on what basis is it possible for people to just say "No"? Such issues must be explored through philosophy and sociology of medicine so as to make medical research and practice more ethical. Civil society must engage with this issue and hold the medical fraternity more accountable on ethical grounds. The ban on clinical drug trials must open an engagement with larger ethical issues which are equally relevant to the medical community, in order to revive and reinstate healing in its proper place within the medical sciences. Given that medical education in India has strongly kept out disciplines in the humanities and social sciences, and continue to behave as if medical research and practice have nothing to do with society, it may be a long while before matters of ethics and the rights of ordinary people become part of medical education. Meanwhile, the State as steward may just sign our bodies away.

NOTES

1 See *Deccan Herald,* 4 May 2011, "No Clinical Trials from Today" for the initial announcement. "Clinical Drug Trials Will Continue in Hospitals", *Deccan Herald,* 5 May 2011, for the immediate denial.

2 See *The Hindu,* 8 May, "Centre Halts HPV Vaccine" and *The Hindu,* 10 May 2011, "HPV Vaccine: AP Issued Orders to Educational Institutions" and other reports for Brinda Karat's letter to Union Health and Family Welfare Minister Ghulam Nabi Azad on the ethical issues involved in the clinical trials.

3 *Deccan Herald*, 9 May 2011, "Controversial HPV Vaccination in AP Becomes Murkier".

4 See J S Srivastava (2010), "The Need for Ethical Oversight of Clinical Trials in India', *Current Science 99*, 10 December.

5 Quoted in Imrana Qadeer and Indira Chakravarthi (2010), "The Neo-liberal Interpretation of Health", *Social Scientist* 38, pp 49-61, in which they also make an exposition of stewardship in the context of neo-liberalism and the Draft National Health Bill 2009.

6 Maiti and Raghvendra quoted in Srivastava (2010: 1505).

7 See Bhargavi Davar (1999), *Mental Health of Indian Women: A Feminist Agenda* (New Delhi: Sage) for a singular and comprehensive overview of philosophy of science in mental health, especially from a user's perspective. Also see Z Zalewski (1999), "Importance of Philosophy of Science to the History of Medical Thinking", *Croat Med J*, 40, pp 8-13, for an overview.

8 See Sundar Sarukkai (2011, forthcoming), *What Is Science?* (New Delhi: National Book Trust); Claude Alvares (1991), *Decolonising History* (New York: The Apex Press); Shiv Viswanathan (1997), *Carnival for Science: Essays on Science, Technology and Development* (New Delhi: Oxford University Press); AnithaKurup and R Maithreyi (2011), "Beyond Family and Societal Attitudes to Retain Women in Science", *Current Science 100*, pp 43-48 for work related to these areas.

9 See Foucault (1994), *The Birth of the Clinic*, (Vintage Books) for an exposition of medical perception.

10 Deepa Dhanraj's classic documentary film, *Something Like a War* (1991), on the Government of India's family planning programme, which shows doctors performing laproscopy as part of the family planning initiatives, has some hard-hitting images of this objectification.

11 One of the problems of the HPV trials was that it apparently used only teenage tribals, living away from parents, as subjects.

12 See Srivastava (2010, op cit) for further references to this in the medical literature.

13 The graphic images in Dhanraj's film (1991, op cit), when screened to postgraduate students in public health programmes, drew a very matter-of-fact response about the way female sterilisation was conducted by the Government of India in a mission mode in the 1970s. The same film when screened to students of other disciplines drew responses of horror and outrage.

14 This was another ethical issue in the HPV clinical trials where apparently hostel wardens signed the consent forms, presumably in their role as guardians, without informing the parents.