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- 21 Joint Evaluation of Emergency Assistance to Rwanda. *The International response to conflict and genocide: Lessons from the Rwanda experience*. Copenhagen: Steering Committee of the Joint Evaluation of Emergency Assistance to Rwanda, 1996.
- 22 Ignatieff M. *The warrior's honor: ethnic war and the modern conscience*. New York: Henry Holt, 1997.
- 23 Hart M, vanPraet S. The Sudan: dying a slow death. In: *World in crisis: The politics of survival at the end of the 20th century*. London, New York: Medecins Sans Frontières, 1997:181-203.
- 24 Brett R, McCallin M. *Children: the invisible soldiers*. Stockholm: Swedish Save the Children, 1998.
- 25 Martin I. Hard choices after genocide: human rights and political failures in Rwanda. In: Moore JM, ed. *Hard choices: moral dilemmas in humanitarian intervention*. Lanham, MD: Rowman and Littlefield, 1998:157-75.
- 26 De Waal A. Humanitarianism unbound? *Current dilemmas facing multimandate relief operations in political emergencies*. London: African Rights, 1994.
- 27 Perrin P. The risks of military participation. In: Leaning J, Briggs SM, Chen LC, eds. *Humanitarian crises: the medical and public health response*. Cambridge: Harvard University Press, 1999:309-23.
- 28 Sandoz Y. The establishment of safety zones for persons displaced within their country of origin. In: Al-Nauimi NN, Meese R, eds. *International legal issues arising under the United Nations Decade of International Law*. Dordrecht: Kluwer Law International, 1995:899-927.
- 29 Minear L, Weiss TG. *Humanitarian action in times of war: a handbook for practitioners*. London: Lynne Rienner, 1993.
- 30 Stremmler J. *People in peril: human rights, humanitarian action, and preventing deadly conflict*. New York: Carnegie Corporation, 1998.
- 31 Weiss TG. *Military-civilian interactions: intervening in humanitarian crises*. Lanham, MD: Rowman and Littlefield, 1999.

Eugenics and human rights

Daniel J Kevles

During the Nazi era in Germany, eugenics prompted the sterilisation of several hundred thousand people then helped lead to antisemitic programmes of euthanasia and ultimately, of course, to the death camps. The association of eugenics with the Nazis is so strong that many people were surprised at the news several years ago that Sweden had sterilised around 60 000 people (mostly women) between the 1930s and 1970s. The intention was to reduce the number of children born with genetic diseases and disorders. After the turn of the century, eugenics movements—including demands for sterilisation of people considered unfit—had, in fact, blossomed in the United States, Canada, Britain, and Scandinavia, not to mention elsewhere in Europe and in parts of Latin America and Asia. Eugenics was not therefore unique to the Nazis. It could, and did, happen everywhere.

Origins of eugenics

Modern eugenics was rooted in the social darwinism of the late 19th century, with all its metaphors of fitness, competition, and rationalisations of inequality. Indeed, Francis Galton, a cousin of Charles Darwin and an accomplished scientist in his own right, coined the word eugenics. Galton promoted the ideal of improving the human race by getting rid of the “undesirables” and multiplying the “desirables.” Eugenics began to flourish after the rediscovery, in 1900, of Mendel's theory that the biological make up of organisms is determined by certain factors, later identified with genes. The application of mendelism to human beings reinforced the idea that we are determined almost entirely by our “germ plasm.”

Eugenic doctrines were articulated by physicians, mental health professionals, and scientists—notably biologists who were pursuing the new discipline of genetics—and were widely popularised in books, lectures, and articles for the educated public of the day. Publications were bolstered by the research pouring out of institutes for the study of eugenics or “race biology.” These had been established in several countries, including Denmark, Sweden, Britain, and the United States. The experts raised the spectre of social degeneration, insisting that “feeble-minded” people (the term then commonly applied to people believed to be mentally

Summary points

Although eugenics programmes are usually associated with Nazi Germany, they could, and did, happen everywhere

They focused on manipulating heredity or breeding to produce better people and on eliminating those considered biologically inferior

In the 1920s and 1930s eugenic sterilisation laws were passed in 24 of the American states, in Canada, and in Sweden

Eugenics was criticised increasingly between the wars and was attacked widely when its role in the holocaust was revealed

Many people believed that individual human rights mattered far more than those sanctioned by science, law, and social needs

retarded) were responsible for a wide range of social problems and were proliferating at a rate that threatened social resources and stability. Feeble-minded women were held to be driven by a heedless sexuality, the product of biologically grounded flaws in their moral character that led them to prostitution and producing illegitimate children. “Hereditarian” biology attributed poverty and criminality to bad genes rather than to flaws in the social corpus.

A drive for social improvement

Much of eugenics belonged to the wave of progressive social reform that swept through western Europe and North America during the early decades of the century. For progressives, eugenics was a branch of the drive for social improvement or perfection that many reformers of the day thought might be achieved through the deployment of science to good social ends. Eugenics, of course, also drew appreciable support from social conservatives, concerned to prevent the proliferation of lower income groups and

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save on the cost of caring for them. The progressives and the conservatives found common ground in attributing phenomena such as crime, slums, prostitution, and alcoholism primarily to biology and in believing that biology might be used to eliminate these discordances of modern, urban, industrial society.

Race was a minor subtext in Scandinavian and British eugenics, but it played a major part in the American and Canadian versions of the creed. North American eugenicists were particularly disturbed by the immigrants from eastern and southern Europe who had been flooding into their countries since the late 19th century. They considered these people not only racially different from but inferior to the Anglo-Saxon majority, partly because their representation among the criminals, prostitutes, slum dwellers, and feeble-minded in many cities was disproportionately high. Anglo-American eugenicists fastened on British data indicating that half of each generation was produced by no more than a quarter of married people in the preceding generation, and that the prolific quarter was disproportionately located among the “dregs” of society. Eugenic reasoning in the United States had it that if deficiencies in immigrants were hereditary and eastern European immigrants out-reproduced natives of Anglo-Saxon stock, then inevitably the quality of the American population would decline.

Positive and negative eugenics

Eugenicists on both sides of the Atlantic argued for a two pronged programme that would increase the frequency of “socially good” genes in the population and decrease that of “bad genes.” One prong was positive eugenics, which meant manipulating human heredity or breeding, or both, to produce superior people; the other was negative eugenics, which meant improving the quality of the human race by eliminating or excluding biologically inferior people from the population.

In Britain between the wars, positive eugenic thinking led to proposals (unsuccessful ones) for family allowances that would be proportional to income. In the United States, it fostered “fitter family” competi-

tions. These became a standard feature at a number of state fairs and were held in the “human stock” sections. At the 1924 Kansas Free Fair, winning families in the three categories—small, average, and large—were awarded a governor’s fitter family trophy. “Grade A” individuals received a medal that portrayed two diaphanously garbed parents, their arms outstretched toward their (presumably) eugenically meritorious infant. It is hard to know exactly what made these families and individuals stand out as fit, but the fact that all entrants had to take an IQ test and the Wasserman test for syphilis says something about the organisers’ views of necessary qualities.

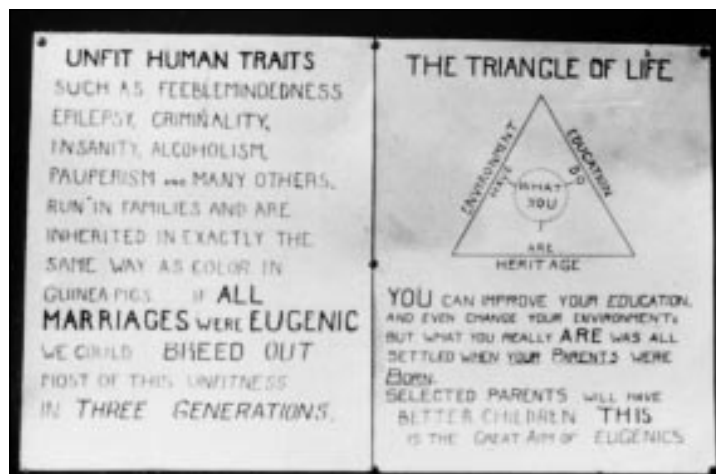
Much more was urged for negative eugenics, notably the passage of eugenic sterilisation laws. By the late 1920s, sterilisation laws had been enacted in two dozen American states, largely in the middle Atlantic region, the Midwest, and California. By 1933, California had subjected more people to eugenic sterilisation than had all other states of the union combined. Similar measures were passed in Canada, in the provinces of British Columbia and Alberta. Almost everywhere they were passed, however, the laws reached only as far as the inmates of state institutions for the mentally handicapped or mentally ill. People in private care or in the care of their families escaped them. Thus, the laws tended to discriminate against poorer people and minority groups. In California, for example, the sterilisation rates of blacks and foreign immigrants were twice as high as would be expected from their representation in the general population.

Society before individual rights

The sterilisation laws rode roughshod over private human rights, holding them subordinate to an allegedly greater public good. This reasoning figured explicitly in the US Supreme Court’s eight to one decision, in 1927, in the case of *Buck versus Bell*, which upheld Virginia’s eugenic sterilisation law. Justice Oliver Wendell Holmes, writing for the majority, averred: “We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the State for these lesser sacrifices, often not felt to be such by those concerned, in order to prevent our being swamped with incompetence. It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes... Three generations of imbeciles are enough.”²¹

In Alberta, the premier called sterilisation far more effective than segregation and, perhaps taking a leaf from Holmes’s book, insisted that “the argument of freedom or right of the individual can no longer hold good where the welfare of the state and society is concerned.”^{22, 3}

Sterilisation rates climbed with the onset of the worldwide economic depression in 1929. In parts of Canada, in the deep south of the United States, and throughout Scandinavia, sterilisation acquired broad support. This was not primarily on eugenic grounds (though some hereditarian-minded mental health



Charts illustrating the inheritance of socially deleterious traits, and the imperative importance of getting rid of them, were often displayed at the eugenics exhibits at American state fairs



The family of AB Rollins, winner in the "large family" class at the Texas state fair, 1925

professionals continued to urge it for that purpose) but on economic ones. Sterilisation raised the prospect of reducing the cost of institutional care and of poor relief. Even geneticists who disparaged sterilisation as the remedy for degeneration held that sterilising mentally disabled people would yield a social benefit because it would prevent children being born to parents who could not care for them.

In Scandinavia, sterilisation was broadly endorsed by Social Democrats as part of the scientifically oriented planning of the new welfare state. Alva Myrdal spoke for her husband, Gunnar, and for numerous liberals like themselves when in 1941 she wrote, "In our day of highly accelerated social reforms the need for sterilization on social grounds gains new momentum. Generous social reforms may facilitate home-making and childbearing more than before among the groups of less desirable as well as more desirable parents. [Such a trend] demands some corresponding corrective."⁴ On such foundations among others, sterilisation programmes continued in several American states, in Alberta, and in Scandinavia well into the 1970s.

Eugenics under fire

During the interwar years, however, eugenic doctrines were increasingly criticised on scientific grounds and for their class and racial bias. It was shown that many mental disabilities have nothing to do with genes; that those which do are not simple products of genetic make up; and that most human behaviours (including

deviant ones) are shaped by environment at least as much as by biological heredity, if they are fashioned by genes at all. Science aside, eugenics became malodorous precisely because of its connection with Hitler's regime, especially after the second world war, when its complicity in the Nazi death camps was revealed.

All along, many people on both sides of the Atlantic had ethical reservations about sterilisation and were squeamish about forcibly subjecting people to the knife. Attempts to authorise eugenic sterilisation in Britain had reached their high water mark in the debates over the Mental Deficiency Act in 1913. They failed not least because of powerful objections from civil libertarians insistent on defending individual human rights. More than a third of the American states declined to pass sterilisation laws, and so did the eastern provinces of Canada. Most of the American states which passed the laws declined to enforce them, and British Columbia's law was enforced very little.

The opposition comprised coalitions that varied in composition. It came from mental health professionals who doubted the scientific underpinnings of eugenics and from civil libertarians, some of whom warned that compulsory sterilisation constituted "Hitlerisation." Sterilisation was also vigorously resisted by Roman Catholics—partly because it was contrary to church doctrine and partly because many recent immigrants to the United States were Catholics and thus disproportionately placed in jeopardy of the knife. For many people before the second world war, individual human

rights mattered far more than those sanctioned by the science, law, and perceived social needs of the era.

The revelations of the holocaust strengthened the moral objections to eugenics and sterilisation, and so did the increasing worldwide discussion of human rights, a foundation for which was the Universal Declaration of Human Rights that the General Assembly of the United Nations adopted and proclaimed in 1948. Since then, the movement for women's rights and reproductive freedom has further transformed moral sensibilities about eugenics, so that we recoil at the majority's ruling in *Buck versus Bell*. History at the least has taught us that concern for individual rights

belongs at the heart of whatever stratagems we may devise for deploying our rapidly growing knowledge of human and medical genetics.

Competing interests: None declared.

- 1 *Buck v Bell* [1927] 274 US 201-7.
- 2 Christian T. The mentally ill and human rights in Alberta: a study of the Alberta Sexual Sterilisation Act. Edmonton: Faculty of Law, University of Alberta, nd: 27.
- 3 McLaren A. *Our own master race: eugenics in Canada, 1885-1945*. Toronto: McClelland and Stewart, 1990.
- 4 Broberg G, Roll-Hansen N, eds. *Eugenics and the welfare state: sterilization policy in Denmark, Sweden, Norway, and Finland*. East Lansing: Michigan State University Press, 1996.

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North-South research partnerships: the ethics of carrying out research in developing countries

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The new phase of North-South research collaboration was caught in a snapshot published recently in a popular weekly newsmagazine.¹ The picture is that of a participant in an AIDS study in Guatemala City. He looks jaunty, even confident. In 1997, he participated in a "life-and-death lottery," as the article is entitled, and beat the odds to be entered into a Merck drug trial of different doses of a triple cocktail containing their new drug, Crixivan. He was one of only 59 patients who were lucky enough to be entered into a trial, among the many who join the "scramble for cutting edge medications in a country where there aren't nearly enough of them to go around." The clinic caring for him "takes up the slack—for example, by enlisting its patients in drug studies."

"I felt myself stabilizing [he said]. I had the energy to go back to work." However, his future, as well as the futures of the rest of the participants who participated in and benefited from the study, is uncertain. "The year long study ended last September, and the leftover medicine will run out in the fall. Participants say they were led to believe that the company would supply them the drugs for the rest of their lives. Merck and the clinic doctors say the only promise was that the company would try to offer more drugs after the study, and the company did agree to provide Crixivan for five years. But the patients have to come up with the other two components of the cocktail on their own. That won't be easy. Participants worry that if they go off the drugs the virus will emerge stronger and more resistant to the drugs."

It is perhaps inevitable that AIDS will provide the backdrop for much of the rethinking that is going on with regard to research done by the North in developing countries. In 1998, HIV/AIDS ranked number four among the top 10 causes of the global burden of disease, accounting for 5.1% of the total disability adjusted life years. The burden is borne overwhelmingly, 98.6%, in middle income and low income countries.² In developed countries AIDS has become a high profile disease primarily because of strong and persistent advocacy. Aside from being a major burden,

Summary points

North-South research collaboration is currently plagued by differing interpretations of ethical standards of doing research in developing countries and by inequitable funding, with only 10% of global research funding going to diseases which comprise 90% of the global burden

Health research is a public good, and the burden and benefits of doing health research should be shared equally by the North and South partners.

Three guideposts—Think action. Think local. Think long term—can be used to resolve ethical dilemmas and address inequities in research funding

Scientific advances are not the only yardstick to measure the success of North-South research collaboration: the choice of identified priorities as areas of work, the sustainability of the studied interventions outside the research setting, and the investment in local research capacity are becoming equally important as indicators of success

HIV/AIDS is a highly fatal disease, and the cost of drugs to stall the progress of the disease is high—beyond the reach of many low income countries, where the average per capita expenditure on health is less than half of the \$US12 that the World Bank suggests will fund an essential package of public health and clinical services.³

Claims and counterclaims

Two years ago a controversy erupted over a report and an accompanying editorial that claimed that it was unethical to use placebo controls in studies in developing countries on the prevention of perinatal transmis-