THE REAL BODY SHOP, PART 1: BLOOD AND CORPSES

We should consider allowing the sale of blood and body parts, writes **Jeremy Shearmur**

Today, there are expanding possibilities for the use of human body parts and human bodily material. We are all familiar with blood donations and kidney transplants. We may also recollect old stories about grave-robbing, or of the more recent ghastly occurrence where some of the bones of the distinguished radio commentator Alistair Cooke were stolen by a dishonest funeral director to be used in the manufacture of human-bone-based medical devices.

The mention of blood donations may well have conjured up associations with blood-donor recruitment drives, 'the gift of blood,' and gratefulness to blood donors. It may also have reminded some readers of Richard Titmuss's *The Gift Relationship* (1970). This pathbreaking work combined an innovative comparative study of blood provision focused on the US and UK with an extended argument for the moral and practical benefits of a donor-based as opposed to a market-based system for soliciting blood donations. Titmuss argued that the donor-based system of blood supply offered a model case against the extension of markets into the provision of social and medical services.

Titmuss's argument was a powerful factor in moves that led to the elimination of commercial provision of blood in the US in the 1970s, where it had previously played a limited but significant role in the health system. It has inspired continuing discussion among philosophers and by writers more generally concerned with problems of 'commodification.' In addition, it has reinforced the ethos of using volunteer donors rather than paid ones not only for blood and blood products, but for organs, human tissue, and human milk.

These issues are sensitive, but it seems to me that there is a case for reexamining our dependence on donor provision, and looking again at whether there is a place, here, for commerce—for the 'Real Body Shop' of my title. Before I do this, though, let me briefly discuss Titmuss's arguments for the use of donors. I will then turn to the case against Titmuss, drawing on a range of recent literature for illustration.

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The gift relationship

In *The Gift Relationship*, Titmuss discussed the case of blood provision as part of a more extended argument with people writing for Britain's Institute of Economic Affairs and, more generally, with those who favoured extending commercial provision into the medical and social services.[1] There were two main dimensions to Titmuss's case.

On the one hand, he thought that the practice of giving showed people's moral equality, enhanced social solidarity, and exemplified a form of 'anonymous altruism' that was particularly attractive to him as a socialist. 'Anonymous altruism' involved people giving for the benefit of their fellow citizens, simply to meet need wherever it might occur, as opposed to their giving just to a particular person or group. The valuable opportunity to give in this way was, Titmuss thought, in danger of being undermined by commercial blood provision (he documented a shift towards commercial provision in the US).

Titmuss also argued that a donor-based system was more efficient. In doing so, he made some empirical claims about the performance of the US and UK systems that were subsequently argued to have been problematic.[2] At the heart of Titmuss's argument on efficiency, however, was a concern with hepatitis transmission through donated blood, and some more general lessons he thought could be drawn from this problem.

At the time Titmuss wrote, hepatitis transmission through the blood supply was a problem. It was especially so in the US, where the prevalence of hepatitis in the population at large is relatively high. At the time, little was known about the disease other than that a form of it (or, rather, what turned out to be two forms: hepatitis B and C) could be transmitted through blood and blood plasma. In addition, there were higher rates of hepatitis transmission through blood and plasma obtained from poorer areas, especially in donations purchased from people who were 'down-and-out.' Investigators in the US documented a wide range of problematic arrangements, including people giving blood in exchange for coupons usable a local bottle shop. In my own research, I have come across a procurement arrangement from the late 1960s where prisoners gave blood in return for cigarettes.

Titmuss argued that there were two kinds of problems associated with using blood from disadvantaged people. First, he argued that there was something ethically preferable about drawing blood from a wide range of good-hearted volunteers, rather than depending on the poor. It is not that clear, though, that this is a forceful argument: the poor were, after all, getting money in return for their blood or blood plasma, and we seem happy enough that unpleasant services of other kinds are provided, in societies like our own, by poor people. Second, Titmuss raised what could well be described as an adverse selection problem: that those who would most readily sell were not the people from whom you would most wish to purchase.[3] This was not a matter of snobbishness about purchasing blood from the unfortunate, or even the stronger point that one might expect that, other things being equal, those who undertook the relatively stigmatised action of selling their blood would be more prone to carrying disease than other members of the population. Titmuss had another, very specific, concern.

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There were no widely-used tests for hepatitis at the time Titmuss was writing, but it was nonetheless the case that some forms of behaviour might flag someone as an unsuitable donor. The concern was that, if someone was, say, desperate for a drink (or for drugs), they might not tell the truth if they were asked about behaviours that put them at risk of contracting hepatitis. This issue was also of importance once tests became available. Many tests for blood-borne disease rely on the detection of antibodies. But these antibodies are produced only *after* someone has been infected, and there is, typically, a window between their being infected and their producing antibodies that a test can detect, and during this window they can nevertheless infect others.

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His work, as I have indicated, was influential beyond the sphere of the provision of blood and blood products. Volunteerism is also very much the ethos of provision where human organs are concerned. A significant body of philosophical literature on donation took its cue from Titmuss's book.

The Gift Relationship was an important and pioneering piece of work that remains of interest as a piece of social philosophy. But the broad lesson that Titmuss drew— in which he was followed by others—is incorrect or misleading if it is used as the basis of a general argument. I have already indicated that Titmuss made empirical claims about the relative efficiency of the British as opposed to the US system that were swiftly contested, but what is more important here are the flaws in his case for the use of volunteer donors.

Drawbacks of volunteer donation

Clearly, no one can have anything but admiration for those who give blood. But admiration for donors does not equate to its being good public policy to rely on volunteers for donations. Here, there is a lot wrong with Titmuss's case. I will deal with the problems under three headings: supply, disease transmission, and donor characteristics.

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Supply

While reliance on volunteer donors is fine in some circumstances, in others it has led to shortages—whether of blood products (where even recently in Australia, some of those who require blood-derived products are not being prescribed the desirable amounts due to endemic shortages), or of whole blood (as has been the case in some US cities). In the US, some hospitals, when it was legal for them to do so, moved from relying on volunteers to creating paid panels of people drawn from their volunteer group, on the grounds that it was cheaper to do so and that paid donors were more reliable.

Also, while we may generally think of blood donation in terms of the transfusion of whole blood to patients who need it, blood is increasingly split into different components before being used. Some components, including blood plasma and its derivatives, are ingredients used for various purposes by pharmaceutical companies. When a shift from paid to volunteer donors was being discussed in the US, it became clear that there would be problems in obtaining sufficient supplies of blood plasma just from donors. Even in the early 1970s, it was commented that it seemed strange to ask people to *give* blood and blood products to for-profit pharmaceutical companies, rather than to sell it to them. The problem of supply, as we shall see, is also relevant when it comes to human organs.

Disease transmission

The case of blood-derived hepatitis transmission that Titmuss used to illustrate his argument for volunteer donation does not exhibit patterns typical of blood-borne diseases generally. With hepatitis, it was advantageous to avoid having blood supplied by the people who were down-and-out. But this was emphatically not the case with regard to HIV, carriers of which included members of the gay community, who were not only middle class, but also enthusiastic volunteer blood donors. The Titmussian distinction between the moral and behavioural qualities of paid and volunteer blood donors, which was useful in avoiding hepatitis transmission, did not assist in avoiding HIV transmission.[4] Part of the tragedy of that particular story is that it was relatively late into the epidemic of HIV transmission that just what was taking place was discovered.

It can even be argued that the commercial blood plasma industry reacted more speedily and decisively to screen gay donors than did the blood banks. This was not least because blood banks needed to maintain the goodwill of their donors, and because of the concerns—prior to causality being definitely established—about the potential loss of life that would follow if they could not meet their commitments to supply blood to hospitals. The story receives a further twist with regard to 'mad cow disease' (bovine spongiform encephalopathy [BSE], which can infect humans as new variant Creutzfeldt-Jakob disease [nvCJD]). There is a risk that this can be transmitted through blood. In the US, there would presumably be a greater risk of it being carried by affluent Americans who would have consumed BSE-infected British

or European beef than by those poorer people likely to sell their blood or blood plasma. Where BSE and nvCJD are concerned, a Titmussian preference for a wider social group of donors that includes the relatively affluent creates a greater risk of transmission than does buying blood from the down-and-out. It is striking that in the face of BSE, Britain is now obtaining processed blood products sourced from commercial sellers of blood plasma in the US instead of using products from British donors—the US commercial product is safer.

Donor characteristics

The third issue relates to a misleading impression that many of Titmuss's readers have formed from his work. The US blood supply, at the time when Titmuss wrote, was not drawn from a simple mix of volunteer and paid donors. As Titmuss himself makes clear, the largest proportion of blood provision at the time was from a sector that typically relied upon a mixture of insurance and blood replacement arrangements. There were also other forms of provision, which I will discuss shortly. Typically, these insurance and replacement arrangements depended on people giving blood regularly, in return for which they and their families would receive blood without charge should they need it during the course of the year. People who lived in the areas supplied with blood by such arrangements would receive it if needed, but would then be faced with either paying a hefty fee, or, as was preferred, replacing it with several units of blood for each that they had been given. This would be done not by the individuals themselves, but by their friends, their extended families, and by volunteer groups. Arrangements were set up, modelled on the transfer system of the banks, that allowed for the physical transfer of net balances between different hospitals and areas. There were a variety of slightly different insurance arrangements in place, and there were also various schemes for the purchase of blood that did not involve people who were down-and-out.[5]

In addition, an interesting scheme was suggested that combined donation and purchase, where people might donate their blood to a church, charity, or social group, and that group would arrange for the blood to be sold to a collection agency. This hybrid arrangement would have made use of volunteers, allowing for Titmuss's adverse selection concern to be addressed, while also allowing for the operation of commercial incentives. It could appeal to a wider group of people than those who currently have a tradition of giving blood, and would also allow suppliers to easily stop dealing with any source of supply that proved problematic.

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Organs from the dead

The Titmussian donor ethos is also strong in the field of the provision of human organs. Here there is a major problem of supply. Advances in our understanding of the human immune system have led to a situation where it is not necessary that, say, kidneys be obtained from close relatives. But the supply of them is limited. Currently, kidneys—like other organs—are largely obtained from corpses. But nowhere near enough are available to be able meet the demand for them. A kidney specialist in upstate New York brought this fact home to me through a chance remark that spring was his favourite season because fit young men started to go out on their motorbikes again.

Currently, different countries operate different systems into which people either have to opt in or opt out. In opt-in systems, organs are available from corpses only if the deceased has indicated positively that they are willing for this to take place. In opt-out systems, they are available unless the deceased has explicitly indicated that they are *not* willing for this to occur. There are, however, currently some legal complications to these systems. The disposal of people's bodies is not a straightforward matter of divining what the deceased wished, but is rather a matter for the deceased's family to decide. In addition, there are different regimes for the harvesting and effective utilisation of organs. Spain's has a reputation for being particularly effective, but it is not clear that adopting current best practice would solve the supply problem.

The shortfall in kidney availability threatens to become much worse due to the dramatic spread of type 2 diabetes, one of the long-term effects of

which is to damage people's kidneys. In addition, there is the difficulty that some religious traditions hold ambiguous positions on to the permissibility of using the organs of dead people for transplants, while in others, and in some highly religious cultures, there are deep-seated taboos against doing so.

There are also practical problems inherent in using kidneys (and other organs) from corpses. As medicine improves, there will be a risk that people will increasingly live to ages at which their organs will not be of much use as transplants. Further, as the economist David B. Johnson has argued, being the subject of a campaign of intensive moral persuasion to give may itself be an unpleasant experience. Some economists have, very reasonably, argued that a good policy move would be to allow for payment to be made to a person's estate in exchange for the use of their bodily materials. (The remains could of course be cremated, and the ashes returned to their relatives along with a cheque.) This seems attractive, not least because some of the purposes for which bodily materials may be used include cosmetic surgery. It is one thing to appeal to the relatives of someone who has just died to ask if their organs might be used to save the lives of others, but it would more difficult still to explain that one wished to use their skin for purely cosmetic surgery.

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There are grim stories relating to the fact that there are a wide range of possible uses for parts of human bodies, which are currently supplied through a variety of channels ranging from the distasteful (the sale of surplus bodies donated to US university medical schools, without the people making the donation knowing that their bodies might be offered on this secondary market) to the criminal (the case of Alistair Cooke). As is familiar enough when a market is illegal, there are also often problems of quality control; this may mean that bodies are used that are medically unsuitable, such as those of people who have died from cancer.[6]

There seems every reason to legalise the selling of corpses, although clearly there is a need for regulation to make sure that bodies and body parts are treated with appropriate respect. It is also true that those who are relatively poor might be the main source of such material. This might be distasteful to those who were worried about the poor selling their blood and plasma. Yet it would surely be a good thing if poor people and their relatives could offset the cost of funerals by selling their corpses for medical use.

Provisional conclusions

So far, I have discussed issues relating to the sale and donation of blood and blood plasma, and I have also considered some problems relating to the obtaining of bodily material from corpses. I have suggested that, in the face of practical problems relating to the supply of blood, blood products, and organs, we should look again at moving from a regime of volunteer donation towards considering certain kinds of commodification of bodies—towards, as it were, a Real Body Shop. Yet much more needs to be said about how this move would be implemented and regulated. I will discuss these further in future, in 'The Real Body Shop, Part 2.' There, I will discuss the contentious issue of the donation and purchase of kidneys from *live* donors

My intention in writing on this subject is to explore issues that lead to some difficult problems. While I am, on balance, inclined towards commodifying bodies and body parts, I do not think this is an area where there are easy answers to questions. However, I suggest that we need to look again at our relatively dogmatic but at the same time uncritical preference for the use of volunteer donors. Donation is fine when it works. But Titmuss's arguments in favour of volunteer donation are really not as good as is often supposed. If our reactions to body-commodification are due to our revulsion at the intrusion of commerce into such an area, it is worth bearing in mind that the cost of our sensitivity could be borne by those who suffer and die because they cannot get access to organs and other human-derived materials.

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