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Giving Blood

The institutional making of altruism

Edited by
Johanne Charbonneau and
André Smith

Giving Blood

Giving Blood represents a new agenda for blood donation research. It explores the diverse historical and contemporary undercurrents that influence how blood donation takes place and the social meanings that people attribute to the act of giving blood. Drawing from empirical studies conducted in the United States, Canada, France, Australia, China, India, Latin America, and Africa, the book's chapters turn our attention to the evolution of blood donation worldwide, examining:

- the impact of technology advances on blood collection practices
- the shifting approaches to donor recruitment and retention
- the governance and policy issues associated with the establishment of blood clinics
- the political and legal challenges of regulating blood systems.

This innovative examination moves the focus from individual explanations of rates of blood donation to a social, structural explanation. It will appeal to international scholars and students working in the areas of sociology, medical anthropology, healthcare, public policy, socio-legal studies, comparative politics, organizational management, health and illness, the history of medicine, and public health ethics.

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Introduction

Blood donation and the range of historical and institutional trajectories

Johanne Charbonneau and André Smith

In 1971, Richard Titmuss published *The Gift Relationship*, in which he argued in favour of an anonymous, voluntary, non-remunerated blood collection system as opposed to one based on the payment of blood donors. He felt confident that there were enough people intrinsically motivated to donate blood without compensation to ensure both the quality and viability of such a system, even in market economies. In the decades since Titmuss' book was published, major international health organizations, such as the Red Cross and the World Health Organization (WHO), have encouraged governments worldwide to establish voluntary blood donor programs and to eliminate paid donation. They believe that voluntary donation is the best way to guarantee blood products' safety.

The need for blood transfusion for the treatment of serious illnesses and injuries has increased over the years. "About 234 million major operations are performed worldwide every year, with 63 million people undergoing surgery for traumatic injuries, 31 million more for treating cancers and another 10 million for pregnancy-related complications" (WHO/IFRCRCS 2010, 9). According to the WHO (2011), approximately 92 million blood donations are collected annually around the world, half of these in high-income countries where only 15 percent of the world's population live. In contrast, the African Region accounts for 4 percent of donations worldwide, with 12 percent of the global population. The United States, China, India, Japan, Germany, the Russian Federation, Italy, France, the Republic of Korea, and the United Kingdom are, in order of magnitude, the ten countries with the largest volume of blood collected. Forty-seven percent of the countries with the fewest collections are in the WHO African Region.

Despite the intensive promotion of voluntary and non-remunerated blood donation by international health organizations, only 62 countries collect 100 percent – or almost 100 percent – of their blood supplies from voluntary unpaid blood donors (WHO 2011). Forty countries collect more than 75 percent of their blood supply from family/replacement or paid donors. Family/replacement donors are those who give blood when it is required by a member of their own family or community. In recent years, India has reported the greatest increase in the amount of voluntary unpaid blood collected.

Blood collection services which rely on voluntary unpaid blood donation are generally able to meet the demand for blood and blood products. However,

apheresis components (plasma, platelets) are still procured from compensated donors in many high-income countries, such as Germany and the United States. This USA alone provides 55 percent of the world's supply of plasma derivatives (Farrugia *et al.* 2010). Blood can meet the needs of more patients when separated into components (red cells, plasma, platelets, etc.). In high-income countries, 91 percent of the blood collected is separated as compared to 31 percent in low-income countries.

There are also significant differences in how efficiently countries collect blood: the average annual collection per blood centre is 30,000 in high-income countries, but only 3,700 in low-income countries (WHO 2011). The 2008 WHO report based on responses received from 164 countries, covering 92 percent of the world's population, states that 39 countries still do not routinely test blood donations for transfusion-transmissible infections. Thirty-four countries also reported lacking a national blood policy.

Treatment of complications during pregnancy and childbirth, severe childhood anaemia, trauma, and the management of congenital blood disorders accounts for the largest proportion of transfusion prescriptions in countries where treatment options are limited (WHO/IFRCRCS 2010). In high-income countries, sophisticated medical and surgical procedures, trauma care (e.g., for road traffic injuries), and the management of blood disorders (thalassemia and sickle-cell disease) have produced a growing demand for blood and blood products. In many countries, the health needs of an older population are placing pressure on blood supplies, while stricter donor selection criteria and an aging donor base are reducing the pool of eligible blood donors.

The increasing need for blood and blood products across the world and the conviction that in systems based on voluntary blood donation, patients have improved access to safe blood transfusion are two of the most important factors motivating research on the social leverages of blood donation. Scholars have first confirmed the important role altruism plays in the motivation of blood donors. However, this type of research has overwhelmingly emphasized individual-level determinants of blood donation. Considerably less attention has been given to understanding the influence of broader factors influencing blood donation, including the role blood collection agencies play in leveraging social resources to recruit donors, although we know from epidemiological research that blood donation rates vary significantly by community, ethnicity, age, gender, education, social class, occupation, and religion (Alessandrini 2007; Zou *et al.* 2008).

In 2006, Kieran Healy partly addressed this gap in knowledge with a comparative study of blood collection regimes in Europe and the United States. The observation of discrepancies between blood donation rates across different countries suggests the advantages of a structural approach to researching the phenomena of blood donation and donor recruitment. According to Healy, one must go beyond psychosocial analyses of individual motivations to get a better handle on the cultural and institutional factors that guide the practice of blood donation. He hypothesizes that differences in the nature of institutional regimes for

supplying blood products impact not only the size and socio-demographic characteristics of donor populations but also the nature of the donations themselves and the meanings attributed to donating. Healy does not deny that individuals have their own reasons for donating blood, but he nonetheless argues that organizations contribute to defining a set of available and widely accepted reasons for donation, from among which donors are able to pick and choose. Healy invites researchers to study the institutional context that gives rise to the conditions surrounding the practice of blood donation, as well as the rhetoric of altruistic donation. In a sense, this was the invitation that prompted us to write this book. Our chief objective is to demonstrate the importance of institutions (be they medical, political, legal, or administrative) in shaping blood collection systems and in constructing a rhetorical discourse aimed at reinforcing donor motivation.

In her analysis of charitable giving, Barman (2007) states that donors' behaviour may be accounted for by studying their personal attributes, by examining the social relationships between donors and fundraising organizations, or – as she has chosen to do herself – by looking instead at the dynamic of the organizational field, in which there exist defined strategies of solicitation, i.e., the opportunities and constraints surrounding donation. As Barman points out, organizations do not act in isolation. A surrounding organizational field structures them. Barman goes so far as to hypothesize that variations in charitable giving practices may be better explained by the dynamic of relationships between the organizations existing in the field than by the relationships between individuals and organizations.

As readers will see, each author has chosen a distinct set of theoretical instruments, depending on the topic addressed. However, to organize the overall content of this book, interpreting blood donation and transfusion as an organizational field seems a useful approach. In doing so, we draw from various institutional theories from sociology and organizational studies (DiMaggio and Powell 1983; Fligstein and McAdam 2012; Meyer and Rowan 1977; Scott and Meyer 1983).

An institutionalist analytical framework

Field theory has its roots in Lewin's (1951) and Bourdieu's (1984) ideas that fields operate as mesolevel social orders, and constitute the basic structural foundation of modern political/organizational life in society. A field is an arena of action and of power relationships; each field is organized according to a logic determined by specific issues or circumstances (Bourdieu 1984). According to DiMaggio and Powell (1983), organizational fields "constitute a recognized area of institutional life: key suppliers, resource and product consumers, regulatory agencies, and other organizations that produce similar services or products" (148). For Fligstein and McAdam (2012), each field is part of a broader environment that contains other fields, whether distant or proximate, with which it interacts. Powell (2007) further remarks that organizations may themselves be embedded in social and political environments. Geographical borders may also

have some importance in defining the limits of a field, although this is increasingly uncommon, as social relationships are developed and maintained at a variety of territorial levels. In particular, Drori and colleagues (2006) emphasize how organizational fields stretch across national borders.

A field is constructed in such a way that social actors must share its institutional logic, which involves an understanding of what is at stake within the field (Bourdieu 1984; Scott 2001). Dynamic processes animate all fields, as participants constantly vie for material advantages, for recognition, or for the achievement or maintenance of dominance in their field (Emirbayer and Johnson 2008; Martin 2003). According to Hoffman (1999), fields should be seen as contested centresa of debate. They are characterized by a power structure dominated by a small number of actors who set rules and agendas (Bourdieu and Wacquant 1992; Powell 2007). But in each field, there are also "challengers" (Fligstein and McAdam 2012), or "institutional entrepreneurs," as DiMaggio (1988) defines them. The interactional dynamic between social actors often involves competition, but also cooperation (Mahoney and Thelen 2009; Powell 2007). As Mahoney and Thelen (2009, 8) point out:

> In some cases, the power of one group (or coalition) relative to another may be so great that dominant actors are able to design institutions that closely correspond to their well-defined institutional preferences. But institutional outcomes need not reflect the goals of any particular group; they may be the unintended outcome of conflict among groups or the result of "ambiguous compromises" among actors who can coordinate on institutional means even if they differ on substantive goals.

All participants in a specific field try to leverage resources to transform or create new institutional arrangements and to define the "rules of the game." As Barman (2007) notes, citing Geertz (1973) and Lamont (1992), the corporate elite holds ownership of the cultural models that serve as a reference: "A cultural model, in a general sense, refers to a shared conceptualization of a set of goals and the legitimate means by which to achieve them" (1433). Defining the rules of the game also means defining the logic behind actions and cultural frames.

The cultural approach of the institutionalist current of sociology, presented by Hall and Taylor (1996, 939), emphasizes the role of cultural logics played by institutions:

> Institutions provide moral or cognitive templates for interpretation and action. The individual is seen as an entity deeply embedded in a world of institutions, composed of symbols, scripts and routines, which provide the filters for interpretation, of both the situation and oneself, out of which a course of action is constructed. Not only do institutions provide strategically useful information, they also affect the very identities, self-images and preferences of the actors.

The logics of action produced by the dominant social actors within an organizational field are therefore composed not only of formal rules, procedures, and norms but also of symbolic systems, cognitive scripts, and moral reference models. According to DiMaggio and Powell (1983), individual efforts at managing uncertainty and constraints tend to create homogeneity in structures, cultures, and results. Organizational fields are consequently fraught with strong pressure toward conformism and rationality. To counter a sense of uncertainty, organizations strive to copy the models of other, seemingly more legitimate organizations (e.g., Western ones) and to conform to norms, for instance, under the influence of professional networks associated with the academic world or of the agencies that provide their funding.

Meyer and Rowan (1977, 343) consider such norms of rationality to be deeply embedded in social reality:

> Many of the positions, policies, programs, and procedures of modern organizations are enforced by public opinion, by the views of important constituents, by knowledge legitimated through the educational system, by social prestige, by the laws, and by the definitions of negligence and prudence used by the courts. Such elements of formal structure are manifestations of powerful institutional rules which function as highly rationalized myths that are binding on particular organizations.

The part played by the state in the dynamics of organizational fields has retained the attention of many scholars (DiMaggio and Powell 1983; Hall and Taylor 1996; Scott and Meyer 1983). The modern state is a very influential actor, owing to the promulgation of laws and rights or the creation of regulatory authorities. Changes in rules, normative systems, or cognitive beliefs may contribute to redefining an organizational field (Powell 2007). As noted by DiMaggio and Powell (1983), the state and professions are great rationalizers. In some cases, states can also form alliances with groups from other fields in order to achieve their own goals.

As Powell (2007) pointed out, research demonstrated that "regulation and legal mandates were as much an endogenous force as an exogenous constraint" (4). Professionals inside organizations may help construct laws and create regulations. In this regard, Fligstein and McAdam (2012) used the term "internal governance units" in describing organizations whose purpose is to ensure order and stability within a strategic action field, and which are strongly influenced by the interests and views of the dominant actors.

Studying an organizational field reveals a constant and dynamic movement spurred by changes in issues or in actors' positions, but also sometimes by crises and major changes resulting from them. A field can emerge as a result of technological advances, population growth, or the intrinsic development of social organizations. Nation-states, by means of their authoritarian actions, may themselves contribute to the creation of a new field (Hall and Taylor 1996; Scott 2001). The stabilization of the field is achieved when most actors share its

institutional logic. According to Fligstein and McAdam (2012), this outcome depends on skilled social actors' abilities to assert their dominance over an emerging field. The importance of resources in the process of a field's emergence brings to mind the structuration theory of Giddens (1977, 1984). For this author, rules and resources define a social structure. An organizational field's stability rests on the dominant actors' powers and social skills in using the resources at their disposal to maintain their position and domination within the field. In this regard, the actors can use various forms of resources: group size, access to government, existing law, professional expertise, knowledge of organizing technologies, and external allies.

External events, the arrival of new actors, or changes in internal dynamics can all destabilize a field. Critical junctures open up opportunities for historic agents to alter the trajectory of organizations (Mahoney and Thelen 2009). According to Giddens (1984), uncertainty leads to social change, when trust in organizations is broken down. "Internal participants and external constituents alike call for institutional rules that promote trust and confidence in outputs and buffer organizations from failure" (Meyer and Rowan 1977, 358). The uncertainty that arises in a field is conducive to the redefining of power rules and relations, as well as to the use of innovative forms of action.

In short, the institutionalist analytical framework offers us many tools for an organizational analysis of blood donation.

Blood donation: an organizational field?

The first question to ask in this regard is whether blood donation and transfusion indeed constitute an organizational field in their own right. The answer is undoubtedly in the affirmative. Doctors, hospitals, and charitable associations like the Red Cross were leading social actors in the field's emergence, and in fact, they contributed to creating the agencies, whether private (commercial) or public, that have become responsible for the supply of blood products. These agencies have become dominant social actors in the field. Over time, other actors have also become involved, namely the plasma industry, regulatory bodies, and civic associations. Donors and recipients alike are essentially individual actors in this context, but they can also be represented by associations seeking to defend their interests. This was the case, in particular, in the context of the contaminated blood scandal.

Actors from other distant or proximate fields – in particular, the state (health, political, and legal systems), international organizations, professional groups, and the media – influence the field of blood donation and transfusion. It is a field in which controlling the rules of the game is a key issue – certain internal governance units have in fact been created to do this – but the functions of regulation and certification are also shared by the state and by certain international authorities.

The dominant actors in this field constantly seek to ensure the field's stability in order to reassure the population (donors and recipients); yet the history of blood transfusion has been marked by periods of crisis – such as the contaminated

blood scandal – that have led to a profound redefinition of the field and to substantial changes in its power relations.

In Western countries, the field appears to be relatively stable in spite of its ongoing debates, which include the question of blood donor remuneration and body commodification. In other countries, however, the field is still emergent or under transformation, and a number of cultural action models for donor recruitment and blood donation practices are competing with one another, even while the World Health Organization and the Federation of Red Cross and Red Crescent Societies attempt to impose a universal model inspired by the one established in Western countries.

This is a field in which the rules of the game are quite formal and well known but are not necessarily accepted by all the actors involved: one might take the example of the associations representing homosexual interests and challenging the rules excluding them from blood donation.

As a result, the actors in this organizational field find themselves confronted with a number of issues and concerns: risk control, body commodification, the defining of social solidarity and of the donation dynamic, and relationships of trust/mistrust between the health and political systems and the population. The foremost concern for those dominating this field is to demonstrate that the system, as they have defined it, is functional (Meyer and Rowan 1977) and hence that blood products are safe and available:

> Institutionalized organizations must not only conform to myths but also maintain the appearance that the myths actually work.… The more an organization's structure is derived from institutionalized myths, the more it maintains elaborate displays of confidence, satisfaction, and good faith, internally and externally.
>
> (Meyer and Rowan 1977, 356–358)

The proof of the reference model's efficiency is tied to the decisions and viewpoints which those dominating the field are able to impose upon others. These decisions and viewpoints are largely made in connection with body issues, risk, trust, and solidarity, and they translate into technologies, physical facilities, rules and norms, logics, strategies, and cultural frames of action.

Book sections and chapters

The analytical framework suggested by authors belongs to the institutionalist sociological current and is highly relevant to analyzing the rules and institutional dynamics that define the world of blood donation. It also allows the grouping the chapters of this book into three parts:

1 Technology and the evolution of blood clinics.
2 The institutional politics of donor recruitment.
3 The governance of blood donation: the authority of state control.

Part I Technology and the evolution of blood clinics

Part I brings together four chapters on the emergence of the field of blood donation and transfusion in four different territorial contexts: the United States, Africa, China, and France. However, the third and fourth chapters, which deal with China and France, do not examine the period that initially enabled the development of the countries' blood transfusion system. Instead, their primary aim is to understand how the field, as it stands today, emerged following the contaminated blood crisis of the early 1980s in France, and in the early 1990s in China.

The history of blood transfusion and the development of blood clinics show, first and foremost, the role that certain pioneering physicians played in the emergence of these novel medical practices. The development and dissemination of innovative technologies was also an extremely important factor in structuring and organizing activities. One might cite the example of conservation techniques for blood products, which have enabled the development of blood banks. Although some countries have been more advanced in developing new technologies, importing these into foreign countries lacking the basic infrastructure to accommodate them has, in some cases, represented a major challenge for local social actors.

In many countries, the vital issue of supplying blood products to soldiers during World War II drove the emergence of this field of medical practice. Blood donation was often a political and patriotic act. This was the case in the United States, China, and France, but not so much in Africa, where the main issue has most often been simply to meet patient needs. In Africa, as in other developing countries, expertise has come from abroad – more specifically, from Western countries. The colonial powers imported their model from European countries in order to develop the field in Africa.

In all countries, the field of blood donation and transfusion rapidly spread from hospitals, new collection centres, volunteer associations such as the Red Cross, and public administrations. Populations needed to be convinced to donate blood. In each country, this goal led to alliances between hospitals and the Red Cross, or to depending on donations from institutions such as the army, schools, and prisons. In China, work units were also swiftly leveraged for the cause. In addition, the media, which have often been called upon in order to recruit donors, have also constituted important disseminators of the arguments of the various groups that have defended distinct development models for blood collection and production activities, i.e., voluntary donation, replacement donation (from family and friends), and commerce.

In all countries, the state has acted as arbiter, very often to protect against health hazards but also sometimes to guarantee the promotion or preservation of values deemed to be fundamental. This was the case in the United States when the state sought to end the segregation of blood products from white or black donors, and in France when the state strove to reassert the importance of voluntary, unpaid donation in spite of pressure from the plasma industry to develop a commercial model.

For their part, politicians have not always played a positive role in the history of the emergence and establishment of this strategic action field. In certain American states, some have defended the policy of segregating the blood of whites and blacks, while in many African countries, blood transfusion systems have been continually disrupted as a result of political instability.

The study of the African situation clearly shows the influence of many internal and external events on the development of blood collection and transfusion systems, be these events the end of colonization, economic crises, or epidemics, such as AIDS. As in the case of the contaminated blood scandal, these events have acted as catalysts for changes to power relations in the field of blood transfusion. New social actors have emerged, such as human rights organizations or supranational authorities disseminating new guidelines. New hierarchies have become established, and some organizations find themselves bestowed with new powers in order to control health hazards or to better guarantee the circulation of blood products.

The field of blood donation and transfusion began to be structured during World War II. In the 1980s and 1990s, the contaminated blood scandal marked a major break in the organization of national systems for blood transfusion. Authorities implemented substantial efforts to diminish public uncertainty in these systems, contributing to restoring some measure of order. As we will see in Part III of this book, this field has always been characterized by dynamic processes of change resulting from both new issues and from the variations dependent on countries' different characteristics and situations. In this respect, geographic borders continue to hold great importance in the dynamic of the field's structuring, in spite of the strong presence of international organizations.

Part I chapters

In Chapter 1, Jean-Paul Lallemand-Stempak tackles the history of blood donation and transfusion in the United States, from the beginning of the nineteenth century to the early 1980s, focusing on two major issues that have intersected at various moments in its evolution: the questions of institutionalization (Boltanski 2009; Boltanski and Thévenot 1991) and racialization (Wieviorka 1996). Although historically defined by their status as, respectively, a healthcare technique and a commodity within medicine, transfusion and donated blood appear in Lallemand-Stempak's analysis as political tools that reflect the racialized attitudes predominant in American society during these periods.

In Chapter 2, William H. Schneider argues that there were important historical circumstances in Africa that distinguished blood donation there from donation elsewhere. Schneider highlights the differences across French and British colonial administrations in their efforts to establish modern, centralized transfusion centers. After independence, central coordination became increasingly difficult. Several factors played a role, including the world economic crisis and political instability, which were followed by the AIDS epidemic ten years later.

In Chapter 3, Vincanne Adams, Kathleen Erwin, and Phuoc Le argue that there is an important role for strong national public health programs. Their exploration of China's donation system is haunted by the public health crisis that emerged from China's initial inattention to HIV/AIDS prevention, and the mushrooming of HIV transmission from contaminated blood in the early 1990s. The success of the Public Health Bureau campaign arises in part from strategies used in China to publicize the marketing of blood donation as a public good in ways that make cultural sense to Chinese donors.

In Chapter 4, Sophie Chauveau draws our attention to France in the early 1980s and the reasons why the country sustained one of the highest rates of HIV – and hepatitis C – contaminated transfusion recipients and hemophiliacs in Europe. The nation-wide scandal sparked a major transformation in the economy of blood transfusion in France. The result is the co-existence of a moral gift economy (Godbout and Caillé 1992; Bourdieu 2000), which accommodates the obtaining of blood as raw material, and that of a market economy (Healy 2006; Scheper-Hugues and Wacquant 2002; Waldby and Mitchell 2006), which determines the availability, safety, and quality of all blood products.

Part II The institutional politics of donor recruitment

In the second part of the book, the authors turn to cases in which the field is relatively stable. In this environment, what is examined is how the current institutional context creates the conditions needed for the field to work. The authors seek to establish how the system supplies a context conducive to the practice of blood donation and how it produces an effective rhetoric to convince the population to give blood. As Meyer and Rowan (1977) point out, institutional organizations need to convince populations that their "myths" work. This is the condition needed for them to foster trust, satisfaction, and good faith, both internally and externally. It is essential for the dominant social actors in a relatively stable field to use all the resources at their disposal to maintain the established order. The blood collection and transfusion system therefore needs to prove that it is able to supply safe blood products that can meet the growing needs of hospitals and health institutions.

Of the three examples presented in the second part of the book, two describe situations in Canada. These, however, involve the responsibility of distinct suppliers of blood products. The third example describes a situation in India, where maintaining or increasing the number of blood donors has become a focal issue following the implementation of legislation prohibiting remunerated blood donation.

In Canada, the organizational structure of the field of blood donation and transfusion was overhauled in the 1980s in the wake of the contaminated blood crisis. Government powers authoritatively created two organizations to oversee the supply of blood products: Héma-Québec for the province of Québec and Canadian Blood Services (CBS) for the rest of Canada. All rules governing blood product safety and health hazard prevention are nevertheless supervised and defined by Health Canada, a federal organization. Some internal governance